

THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
PUBLIC HEALTH SERVICE  
CENTERS FOR DISEASE CONTROL AND PREVENTION  
NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

convenes the

ADVISORY BOARD ON  
RADIATION AND WORKER HEALTH

The verbatim transcript of the Meeting of the  
Advisory Board on Radiation and Worker Health held  
via Teleconference on Friday, March 28, 2003.

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P R O C E E D I N G S

2:07 p.m.

1 [Preceding the call to order, a roll call of  
2 the Board was taken. All Board members were  
3 present.]

4  
5  
6 **DR. ZIEMER:** Let me officially call the  
7 meeting to order. This is the official  
8 conference call of the Advisory Board on  
9 Radiation and Worker Health.

10 The agenda has been distributed. It is also  
11 on the Web site. There are two things on the  
12 agenda. One is a public comment period for which  
13 we have allowed thirty minutes, and that thirty  
14 minutes will start when we start the actual  
15 comment period. And then the rest of the time is  
16 devoted to Board discussion. If there's time at  
17 the end of the Board discussion before the 5:00  
18 o'clock hour, we can -- that's 5:00 o'clock  
19 Eastern Standard Time -- we can take additional  
20 public comments.

21 I'd like to -- we had a roll call. All the  
22 Board members are present on the line, including  
23 the Executive Secretary, Larry Elliott.

24 We'd like to determine who's here from the  
25 general public, and how many wish to make public

1           comments so that we can allot the time. So let  
2           me just ask members of the public to identify  
3           yourself by name and either location or  
4           affiliation, and then indicate whether you wish  
5           to make public comment.

6           So anybody can start.

7           **MR. FOLEY:** Philip Foley from Paducah,  
8           Kentucky, with the Worker Health Protection  
9           Program.

10          **DR. ZIEMER:** And spell your name. Your last  
11          name is --

12          **MR. FOLEY:** F-O-L-E-Y.

13          **DR. ZIEMER:** Okay, from Paducah.

14          Anyone else?

15          **MS. BARRIE:** Terrie Barrie from Colorado,  
16          advocate. And I'm not sure if I'll be --

17          **DR. ZIEMER:** Do you need to have the name  
18          spelled?

19          **MS. ROBINSON:** Yes, please.

20          **MS. BARRIE:** B as in boy, A-R-R-I-E is the  
21          last name, Terrie, T-E-R-R-I-E.

22          **DR. ZIEMER:** Okay, others?

23          **MS. GONZALES:** Yes, can you hear me?

24          **DR. ZIEMER:** Barely.

25          **MS. GONZALES:** Can you hear me, gentlemen?

1           **DR. ZIEMER:** Yes, speak loudly.

2           **MS. ROBINSON:** I can't.

3           **MS. GONZALES:** My name is Carmen Gonzales.

4           **MS. NEWSOM:** I'm sorry, I can't hear that.

5           **MS. ROBINSON:** This is Teresa from Cambridge.  
6 I can't hear that.

7           **MS. GONZALES:** Okay. My name is Carmen  
8 Gonzales. I'm on a speaker phone. Can you hear  
9 me?

10          **MS. ROBINSON:** No.

11          **MS. GONZALES:** You can't hear me?

12          **MS. ROBINSON:** Now I can.

13          **DR. ZIEMER:** Barely.

14          **MS. GONZALES:** Hold on.

15                Okay, my name is Carmen Gonzales. Can you  
16 hear me now?

17          **MS. ROBINSON:** Yes.

18          **DR. ZIEMER:** Yes.

19          **MS. GONZALES:** Okay. I was on speaker phone.  
20 And I'm a survivor, and I'd like to comment on  
21 the special cohort.

22          **DR. ZIEMER:** Okay, we'll come back to you,  
23 then.

24                Others?

25          **MS. GONZALES:** I'm sorry?

1           **DR. ZIEMER:** We will come back to you after  
2 we have the roll call here.

3           Others?

4           **MS. DREY:** Kay Drey in St. Louis, and I do  
5 not want to make a comment.

6           **DR. ZIEMER:** Spell the last name again.

7           **MS. DREY:** D as in David, R-E-Y. I will not  
8 want to make a comment.

9           **DR. ZIEMER:** You do wish to make a comment?

10          **MS. DREY:** No, I will not want to make a  
11 comment.

12          **DR. ZIEMER:** No, okay.

13          Others?

14          **MS. LEWIS:** This is Mark Lewis from PACE 5689  
15 from Portsmouth, Ohio. I don't really have a  
16 comment planned, but who knows.

17          **DR. ZIEMER:** Okay, others?

18          **MR. BARRIE:** George Barrie, B-A-R-R-I-E.  
19 Sick worker from Rocky Flats, Colorado.

20          **DR. ZIEMER:** Okay, others?

21          **MR. SCHOFIELD:** Philip Schofield from  
22 Espanola, New Mexico. I'm with a project on  
23 worker safety.

24          **DR. ZIEMER:** Okay.

25          **MR. SILVER:** Ken Silver, Los Alamos POW.

1 Yes, I will have a comment.

2 DR. ZIEMER: Comment from -- okay, we'll mark  
3 you down.

4 Others?

5 MS. KIEDING: Sylvia Kieding from PACE, and I  
6 don't know if I will.

7 DR. ZIEMER: Okay.

8 MR. RAY: (Inaudible) Ray, R-A-Y, from  
9 (inaudible), Ohio.

10 MS. RAMADEI: I'm Cathy Ramadei from the CDC  
11 Committee Management Office.

12 DR. ZIEMER: Okay.

13 MS. ROSS: I'm Rene Ross from the CDC  
14 Committee Management Office.

15 DR. ZIEMER: Others?

16 MR. MILLER: Richard Miller from Government  
17 Accountability Project.

18 DR. ZIEMER: Okay. Any comments?

19 MR. MILLER: Yes, indeed.

20 DR. ZIEMER: Comment, okay.

21 Others?

22 MS. BROCK: Denise Brock from St. Louis,  
23 Missouri.

24 DR. ZIEMER: Denise, okay.

25 MR. FIELD: Bill Field from the College of

1 Public Health at the University of Iowa.

2 **DR. ZIEMER:** Okay.

3 Others?

4 **MS. BROCK:** This is Denise Brock again, and I  
5 did want to make a comment as well.

6 **DR. ZIEMER:** Okay, I'll mark you down,  
7 Denise. Thank you.

8 Others?

9 **MR. BARNES:** James Barnes, Rocketdyne/Boeing,  
10 Los Angeles.

11 **DR. ZIEMER:** Thank you.

12 Keep going.

13 **UNIDENTIFIED:** (inaudible)

14 **DR. ZIEMER:** I'm hearing a conversation. Is  
15 somebody speaking?

16 [No responses]

17 **DR. ZIEMER:** Any other members of the public  
18 on this phone call that haven't indicated?

19 **MR. KOTSCH:** Jeff Kotsch is here from the  
20 Department of Labor.

21 **DR. ZIEMER:** Okay. And I'll ask, in addition  
22 to members of the public, any federal staff or  
23 other agency staffers aboard?

24 **MR. NAIMON:** David Naimon from the Department  
25 of Health and Human Services.

1           **DR. ZIEMER:** Okay, David.

2           **MS. HOMOKI-TITUS:** Liz Homoki-Titus from  
3 Health and Human Services.

4           **MR. SUNDIN:** Dave Sundin, NIOSH.

5           **DR. ZIEMER:** Okay.

6           **MR. KATZ:** Ted Katz, NIOSH.

7           **MS. HOMER:** Cori Homer, NIOSH.

8           **MS. ROBINSON:** Teresa Robinson, Cambridge  
9 Communications.

10           **MS. NEWSOM:** Kim Newsom, Nancy Lee &  
11 Associates.

12           **DR. ZIEMER:** Okay. Any other members of the  
13 public aboard that have not identified?

14           **MR. TANKERSLEY:** This is Bill Tankersley from  
15 Oak Ridge Associated Universities.

16           **DR. ZIEMER:** Okay.

17           Anyone else?

18           [No responses]

19           **DR. ZIEMER:** Okay. Then I'm going to -- it's  
20 now just about 2:15, 2:14. I'm going to open the  
21 public comment period, and Ms. Gonzales, I have  
22 you first.

23           **MS. GONZALES:** All right. Is that Carmen  
24 Gonzales?

25           **DR. ZIEMER:** Yes. And let me just look here.

1 So far I see one, two, three, four, maybe five  
2 individuals who have indicated they wish to  
3 comment. So I ask you to try to limit your  
4 remarks to about five minutes.

5 **MS. GONZALES:** Sure. Okay. It will be less  
6 than that.

7 Good afternoon, gentlemen. My name is Carmen  
8 Gonzales, and I am the daughter of Miguel Almada  
9 (phonetic), who is deceased.

10 My father worked in Los Alamos for 34 years.  
11 Los Alamos National Labs is a facility that has  
12 been known to have missing, incomplete, and in  
13 our father's case inaccurate data in regards to  
14 exposure records. In light of the alarming  
15 discrepancies discovered in workers' files, it is  
16 of the utmost importance that the Los Alamos  
17 facility be included in the special cohort.

18 Having said that, the other concern now is  
19 that the number of cancers being considered for  
20 that cohort are now being drastically altered.  
21 This leads me to believe that the compensation  
22 act is becoming the selective compensation act.  
23 It appears that NIOSH and the Department of Labor  
24 is working overtime to make changes that are not  
25 claimant friendly, and seemingly

1 unconstitutional.

2 Is it possible that the purpose of these  
3 changes is to eliminate as many eligible claims  
4 and therefore lessen the cost to the federal  
5 government? I ask you gentlemen, is this  
6 (inaudible) viable? If your answer is yes, then  
7 it is one more blow to the affected workers and  
8 their families.

9 And thank you, gentlemen, for your time.

10 **DR. ZIEMER:** Okay. Thank you, Ms. Gonzales.

11 Then I have, I believe it's Mr. Silver, also  
12 from Los Alamos?

13 **MR. SILVER:** Yes. Thank you very much for  
14 including us in the conference calls.

15 I'm picking up where we left off last time, a  
16 question was in the air as to whether the rule  
17 would cover all 22 specified cancers. And one of  
18 the Board members, I think Dr. Andrade, pointed  
19 out that indeed the entire list is in Section  
20 83.5. But there's also a clause in 83.13 that  
21 allows NIOSH the discretion to limit the list of  
22 specified cancers to as few as just one cancer.

23 And I think it's important to think about  
24 this in terms of our system of government, our  
25 laws. I see this in a lot in different documents

1 that we developed -- the Constitution, apparently  
2 contradictory language in the Interstate Commerce  
3 clause, and the States' Rights clause. And  
4 that's really where the rubber meets the road,  
5 how these apparently contradictory sections of a  
6 legal document interplay with each other.

7 In the Americans with Disabilities Act we  
8 have reasonable accommodation, but on the other  
9 hand we have business necessity, and the last ten  
10 or twelve years we've seen how those two  
11 competing ideas have defined the scope of  
12 people's rights under the Americans with  
13 Disabilities Act. So finally in this regulation  
14 we see the list of specified cancers -- yeah,  
15 there's 22 of them -- but we have this quite  
16 objectionable clause in 83.13 to allow NIOSH to  
17 hack down the list to as few as one cancer.

18 Now what I want to know is where in  
19 legislative history there is any justification  
20 for that clause in 83.13. We followed this quite  
21 closely since the summer of '99. We've read the  
22 Congressional Committee hearing. We've studied  
23 the Committee (inaudible). We followed with  
24 great interest the floor debate and the floor  
25 statements from Congressmen. And I can't find a

1 single iota or shred of justification in the  
2 legislative history for NIOSH to hack down the  
3 list of specified cancers to as few as one. So  
4 we'd really like to know the source document, the  
5 page, (inaudible) for the justification you find  
6 in the legislative history for that clause.

7 Thank you for your time and attention.

8 **DR. ZIEMER:** Okay, thank you, Mr. Silver.

9 Then I also have Rich Miller. Rich?

10 **MR. MILLER:** Thank you, Dr. Ziemer.

11 During the last Advisory Board call there was  
12 an extended discussion both about the definition  
13 of what is a facility, but separately there was a  
14 discussion about whether multiple facilities  
15 could be included, regardless of how one defines  
16 the term "facility."

17 And understanding that NIOSH staff at least  
18 is taking the position that the Labor Department  
19 is the one dictating this particular definitional  
20 question of whether a single facility can be  
21 multiple facilities, I undertook a little bit of  
22 research. And what we've discovered is that  
23 where there is -- where interpreting of  
24 legislative enactment becomes an issue, the  
25 courts commonly resort to the rules of statutory

1 construction.

2 And there are many different textbooks out  
3 there for rules of statutory construction, and I  
4 had the occasion to review five separate ones in  
5 this matter in the law library and reviewing the  
6 Internet. And in every single book which deals  
7 with the rules of statutory construction, the  
8 singular includes the plural. And in fact, most  
9 drafting texts advise drafters to use the  
10 singular when possible because it is understood  
11 to include the plural.

12 And we also see that, as I noted in the e-  
13 mail I think I sent to you, Dr. Ziemer, and  
14 hopefully was circulated to the Board, words of  
15 one gender often include other genders, so that  
16 when one refers to "he" one doesn't mean to  
17 exclude "she."

18 So I guess the question in front of us here  
19 on the question of facility versus facilities  
20 takes on a very practical effect. One of the  
21 practical effects might be where you have what we  
22 euphemistically refer to are sponges, people who  
23 go into a job, take their annual dose in a day or  
24 two or a week, and move on to the next job. And  
25 yet you could easily conceive of a Special

1 Exposure Cohort of individuals, not necessarily  
2 construction workers but individuals who moved  
3 from facility to facility to facility who had an  
4 annual dose, but because of inadequate  
5 recordkeeping or notification or management of  
6 the rad system would have gotten cumulative doses  
7 which may not be estimable, in which case you may  
8 want to think about a multi-facility Special  
9 Exposure Cohort.

10 So I guess I would just urge the Board in  
11 thinking about developing its comments for NIOSH  
12 to consider the fact that the Department of  
13 Labor's regulations allow for this very  
14 circumstance at 20 CFR 30.214, which allows, for  
15 example, accumulating days of employment at  
16 multiple gaseous diffusion plants in three states  
17 in order to meet the 250-day workday threshold  
18 for the Special Exposure Cohort.

19 And I'd be happy if anybody wanted to have  
20 further conversation about this, but I don't  
21 think the rules of statutory construction inform  
22 this. And anybody who thinks because only the  
23 singular was used in a bill strains, I think,  
24 even the rules of strict construction about  
25 whether you could allow for a plural to be

1 construed from the singular.

2 The second point I would make is, very  
3 briefly, is this question about limiting the list  
4 of cancers. I had an opportunity to review, and  
5 I hope the Board has as well, the comments of the  
6 Health Physics Society with respect to the  
7 question of whether you could limit the list of  
8 cancers based on biokinetic models in a Special  
9 Exposure Cohort. And I guess there's sort of two  
10 points that the Health Physics Society makes  
11 which may be somewhat at odds with the position  
12 that this Board has taken.

13 And the first is that the effects we're  
14 dealing with here are stochastic effects and not  
15 deterministic effects. And early on, I believe  
16 it was the very first Advisory Committee, the  
17 Board said it was not going to open up that  
18 quagmire of whether or not there is a no  
19 threshold dose for the effects of radiation. And  
20 if you're not going to open up that particular  
21 debate, I don't know where the scientific  
22 justification comes from that says that there is  
23 a cutoff point beneath which one could reasonably  
24 estimate that certain cancers should or should  
25 not be included.

1           The second question I guess you have to  
2           grapple with is the question that Ken Silver  
3           raised, which is I had the chance at least to go  
4           back and read the legislative history on this  
5           deal as well, and I can find nothing that  
6           authorizes NIOSH to limit the list of covered  
7           cancers. And I had the chance to go talk with  
8           the key Senate staffers who actually worked on  
9           the conference on this bill on both sides of the  
10          aisle and in both the House and the Senate, and  
11          they in no way, shape, or form could recall any  
12          such discussions. And it seemed to stretch their  
13          credibility -- or credulity a little bit to think  
14          that this is how the rule was going to be  
15          interpreted.

16                 So I guess the question is if you're going to  
17                 shorten the list of cancers because you think  
18                 that this is good science, then I think the Board  
19                 needs to be prepared to say it is going to  
20                 jettison the no threshold hypothesis that the  
21                 Board has previously said it would not question.  
22                 Otherwise, I don't know at what level you  
23                 determine significance for the level of a  
24                 potential dose that you can't estimate to begin  
25                 with in the special cohort rule.

1           Those are my thoughts.

2           **DR. ZIEMER:** Okay, thank you, Richard.

3           Then I have Denise Brock, isn't it?

4           **MS. BROCK:** Yes, hi. How are you?

5           **DR. ZIEMER:** From St. Louis.

6           **MS. BROCK:** I would probably like to continue  
7           on where Richard left off, in the same manner  
8           that I'm feeling that Congress was pretty clear  
9           with their intent when they said 22 cancers. And  
10          I'm a bit perplexed at how someone else could go  
11          in and actually alter that and make it more  
12          organ-specific. It seems to be all about  
13          etiology, not science.

14          And I'm really not understanding how the 22  
15          cancers could be dropped down to organ-specific  
16          if you would say someone would be exposed to  
17          radon progeny, how can anyone say there would be  
18          a zero probability that maybe there wouldn't be  
19          daughter products that would come off of that and  
20          not just hit the lung but perhaps the pancreas,  
21          the colon. I'm not a doctor, but my concern  
22          there would be, as the lady said earlier, that  
23          it's just making something that's difficult  
24          already impossible. It's actually adding insult  
25          to injury.

1           And then I was looking at the DOL law, and I  
2           found under Section 738(4)(d) the purpose of this  
3           program actually, it's my understanding, would be  
4           to provide for timely, uniform and adequate  
5           compensation of covered employees, and where  
6           applicable survivors of such employees, suffering  
7           from illnesses incurred by such employees in the  
8           performance of their duties for the Department of  
9           Energy and certain contractors or subcontractors.

10           And when you think about timely and you're  
11           looking at some of these situations where there  
12           hasn't been a site profile done yet or you have  
13           loss of records, destruction of records, or even  
14           in the case of Mallincrodt in the St. Louis and  
15           Weldon Spring areas as well as Hematite, when you  
16           have a situation where these workers were exposed  
17           to things they were never monitored for, my  
18           concern would be how would it be possible to even  
19           dose reconstruct it? And I know it's NIOSH's  
20           feeling that that's possible. I'm not an expert,  
21           so I obviously don't know. But I'm assuming that  
22           according to maybe the majority of the Board that  
23           they feel that that would not be feasible.

24           Then when you looked under Part B, Program  
25           Administration, I started looking under the

1 definitions, and it actually has the term  
2 "specified cancer" or the term "member of the  
3 SEC." And what that means, the term  
4 "occupational illness" and what that means, and  
5 it does cover beryllium illness, cancer,  
6 specified cancer, chronic silicosis. And I guess  
7 my concern would be how could that be changed.

8 And again, with facility versus facilities,  
9 in our area we have workers that had went from  
10 the downtown site, a lot of those workers perhaps  
11 moved into the Weldon Spring site. Maybe they  
12 did 200 days at the downtown and maybe 50 at  
13 Weldon or 50 at Hematite. My concern here is if  
14 they're using the same process (inaudible) or  
15 doing the same job, how would that not allow them  
16 the 250 days?

17 And again, I'm trying to see -- I think I had  
18 this section written down, and I think I had  
19 brought this up in Cincinnati. There's a  
20 section, I believe it was 83.7, incident and  
21 occurrence. And I'm curious how specific one  
22 must be if NIOSH, if I understood correctly, was  
23 wanting two witnesses to any occurrence. Most of  
24 these workers are dead. I mean, they were told  
25 not to discuss the specifics of their jobs.

1 Surviving spouses may not know anything but that  
2 their spouse had been injured or possibly  
3 hospitalized. And I think we know that most of  
4 these hospital records have been destroyed after  
5 ten years, and maybe the only proof is the story  
6 that the decedent relayed to them, or maybe a  
7 list of occurrences in the atomic energy industry  
8 that would just perhaps show the plants or the  
9 area and the year, but maybe no names on who was  
10 involved. And I'm curious at what point would  
11 somebody say that they're going to take somebody  
12 at their word.

13 And with 91 pages, is what I read, just as a  
14 layperson I feel like I have to read that and  
15 disseminate that to all these people. Again, it  
16 just feels like it's absolutely overwhelming.  
17 And you're making something that seemed to me  
18 Congress' intent was crystal clear, and now it  
19 seems to me that the easiest way to remedy it in  
20 our situation would be to actually have it  
21 legislated (inaudible) a petition for it if it  
22 seems much too difficult.

23 Thank you.

24 **DR. ZIEMER:** Okay, thank you, Denise.

25 Those are all that -

1           **UNIDENTIFIED:** Excuse me --

2           **UNIDENTIFIED:** Excuse me --

3           **DR. ZIEMER:** Yes?

4           **UNIDENTIFIED:** There's two more speakers here  
5 that would like to speak.

6           **DR. ZIEMER:** Oh, okay. Who is it?

7           **MS. JACQUEZ:** My name is Epifania Jacquez.  
8 Shall I spell that for you?

9           **DR. ZIEMER:** Yes.

10           **MS. JACQUEZ:** E-P-I-F-A-N-I-A, Jacquez, J-A-  
11 C-Q-U-E-Z. And I'm calling -- I'm what is known  
12 as a survivor in this package (inaudible). And  
13 so I'm calling again on behalf of my dad  
14 (inaudible) Los Alamos (inaudible). And of  
15 course, we're calling (inaudible) --

16           **MS. NEWSOM:** Excuse me, ma'am. You're  
17 breaking up, and I can barely hear you.

18           **MS. JACQUEZ:** Well, I'm speaking about as  
19 clearly and loud as I can. Can you hear me now?

20           **MS. NEWSOM:** Thank you. That's a little  
21 better.

22           **MS. JACQUEZ:** Okay. And so anyway, they're  
23 (inaudible) over 10,000 claims. And claimants, I  
24 think this point was brought up before, that the  
25 claimants were not notified about any changes in

1 this law. And as far as I'm concerned this is  
2 not acting in a respectful manner towards the  
3 claimants, and (inaudible) not allowing them to  
4 voice their opinions. So I call it (inaudible).  
5 This program has not been claimant (inaudible).  
6 It was supposed to be. It claimed to be claimant  
7 friendly, but it has not (inaudible).

8 **UNIDENTIFIED:** I can't hear.

9 **UNIDENTIFIED:** I can't hear her.

10 **MS. JACQUEZ:** And this Act --

11 **MS. ROBINSON:** I'm sorry. I cannot hear a  
12 thing she's saying. This is Teresa from --

13 **MS. JACQUEZ:** You want me to (inaudible)?

14 **DR. ZIEMER:** The recorder is having  
15 difficulty hearing you. You'll need to speak  
16 very loudly.

17 **MS. ROBINSON:** If she is on a speaker phone,  
18 ask her to please pick up.

19 **MS. JACQUEZ:** Let me switch phones, okay?

20 **DR. ZIEMER:** Yeah.

21 **MR. ELLIOTT:** There's also a background  
22 conversation going on that I would ask be  
23 stopped.

24 **MS. ROBINSON:** Yes. I hear that, too.

25 **MS. JACQUEZ:** Are we not supposed to have

1 anyone in the house? I'm just curious. I'm at  
2 home. I'm calling from home.

3 **DR. ZIEMER:** No, that's fine.

4 **MS. ROBINSON:** Now I can hear --

5 **MS. JACQUEZ:** I hope so, because I didn't ask  
6 anyone to leave. So if you are hearing a  
7 comment, my sister and I are here. We're both  
8 survivors.

9 **MS. ROBINSON:** And ma'am, if you could please  
10 repeat your name again for me.

11 **MS. JACQUEZ:** Epifania Jacquez, E-P-I-F-A-N-  
12 I-A, Jacquez, J-A-C-Q-U-E-Z.

13 And I'll start by saying that I am a  
14 survivor. And that I'm calling in regards --  
15 this is in regards to my father, Miguel  
16 (inaudible) Almada, worked at Los Alamos for 34  
17 years, and who died from esophageal cancer. And  
18 I'm calling in regard to this proposal, you know,  
19 to change this cancer relief.

20 And I want to start by saying that there are  
21 over 10,000, and claimants were not or have not  
22 been, myself have not been notified of any  
23 changes. And I believe that that lacks a lot of  
24 respect. I'm just voicing my opinion, but it  
25 lacks a lot of respect by not allowing claimants

1 to voice their opinions. And to me this section  
2 of this law, this program, has not been claimant  
3 friendly. (inaudible) thought to be (inaudible)  
4 beginning, but (inaudible).

5 And the Act was centered around the cancers,  
6 22 cancers were named (inaudible) acceptable  
7 (inaudible) started the program. One of these  
8 cancers was esophageal cancer, which (inaudible)  
9 died of. How can you even consider removing this  
10 from the requirement after three years? Even if  
11 it applied to (inaudible), as far as I'm  
12 concerned if you were included originally in the  
13 Special Exposure Cohort, all you had to do was  
14 (inaudible) was prove exposure.

15 This is not fair to claimants, it's not fair  
16 to their families. It is not acceptable. We  
17 demand you obliterate this rule. In my opinion  
18 it's not constitutional. In the law which was  
19 signed by President Clinton, by then President  
20 Clinton, it's a law. Do not turn yourselves into  
21 lawmakers because you are not.

22 And I think that we're right now calling this  
23 a conference call, and we're calling to give an  
24 opinion or a comment, but it also (inaudible).  
25 And (inaudible) the answers to these questions

1 that we're asking on these issues. We're not.  
2 We're not. We're just expressing what we feel.  
3 But I think that we need to get some answers, and  
4 I think there aren't any answers to justify what  
5 (inaudible). There are no answers.

6 No answers, well, you know, you can just --  
7 how many people, how many of these 10,000 people,  
8 are aware of this conference call today, call in  
9 and voice their opinion? I think we're -- you  
10 know, it's what I have heard before, one of my  
11 sisters expressed, you know, it's like we're  
12 (inaudible).

13 It all goes back to money. That's what it  
14 is. It goes back to money, goes back to power.  
15 It goes back to the fact that we're not that  
16 important. I'll tell you one thing, it's a shame  
17 that our government goes back on their word. I'm  
18 proud to be an American, but I want our  
19 government to stand behind (inaudible) and  
20 deliver the goods that they promised.

21 So I want you to think about this. I don't  
22 know if it's at all possible, because I know that  
23 your Board is there and they're listening to it.  
24 You have the answers. I'd like a little bit of a  
25 response to the comments that's been made. And

1 thanks.

2 **DR. ZIEMER:** Okay, thank you.

3 And was there another person --

4 **MS. SHINAS:** Yes, and I apologize for being  
5 late. I wasn't able to get here when you started  
6 the meeting.

7 My name is Betty Jean Shinas, and I'm the  
8 daughter of Miguel Almada, and I am a survivor.  
9 And I just basically wanted to say that the  
10 numbers that are calling in today are not really  
11 a true reflection of the families that would be  
12 affected by the change that you're proposing to  
13 make. And I just really, I strongly support the  
14 idea, please think about abiding by the spirit of  
15 the law that was passed three and a half years  
16 ago by President Clinton, and to not change  
17 (inaudible).

18 And many of our families, especially my dad  
19 with his records, there was not -- the dose  
20 readings were missing. Three of those years were  
21 missing. And to exclude many of those cancers,  
22 these families are not going to be compensated in  
23 any way. And I really truly want you to take to  
24 heart what you are considering. And I'm here to  
25 support all of these comments in support of not

1 changing it. I am truly, truly in support of  
2 these comments. Just leave it as it is. It was  
3 done to try to compensate families, and the  
4 change would really be a disservice to all these  
5 families.

6 Thank you.

7 **DR. ZIEMER:** Okay, thank you.

8 We still have a couple of minutes if there  
9 are other members of the public who have  
10 comments.

11 **UNIDENTIFIED:** Hello?

12 **MS. TRUJILLO:** Hello?

13 **UNIDENTIFIED:** I signed on.

14 **DR. ZIEMER:** Okay. Who is speaking?

15 **UNIDENTIFIED:** (Inaudible)

16 **MS. TRUJILLO:** This is Gloria -- oh, I'm  
17 sorry. Is there someone else?

18 **UNIDENTIFIED:** That's okay, go ahead.

19 **DR. ZIEMER:** There appear to be two of you.

20 **UNIDENTIFIED:** Yeah, go ahead.

21 **DR. ZIEMER:** Gloria, go ahead.

22 **MS. TRUJILLO:** I'm Gloria Trujillo.

23 **MS. ROBINSON:** What's your name again?

24 **MS. TRUJILLO:** Gloria Trujillo, and that's G-  
25 -L-O-R-I-A, and that's Trujillo, T-R-U-J-I-L-L-O.

1 And I'm also a survivor claimant.

2 And it's my understanding that NIOSH intends  
3 to make a change in the qualifying cancers for a  
4 Special Exposure Cohort. I'd like to express my  
5 strong disagreement to these changes. I feel  
6 this is very unfair to all claimants including  
7 survivor claimants. How can NIOSH make a  
8 decision that discriminates one claimant's  
9 qualifying cancer type requirement from another  
10 because they are in one qualifying group or  
11 another?

12 The law that was enacted originally with all  
13 the qualifying cancers should be adhered to by  
14 NIOSH. It's my opinion that to do otherwise  
15 would raise the question whether this is  
16 unconstitutional, and whether NIOSH has the  
17 authority to change this rule at all. That's  
18 mainly what I was calling about. I strongly  
19 disagree. I feel that it should be (inaudible)  
20 adhere to the original law that was enacted three  
21 years ago.

22 **DR. ZIEMER:** Okay. Thank you, Gloria.  
23 And there's one other gentleman?

24 **UNIDENTIFIED:** George.

25 **DR. MCKEEL:** Yeah, this is Daniel McKeel.

1 I'm a physician and a pathologist who has been  
2 advising and helping Denise Brock and the group  
3 in St. Louis for the Mallinckrodt chemical  
4 workers.

5 My comment is, number one, to express  
6 interest in this issue and to also comment as a -  
7 - specifically as a pathologist. It seems to me  
8 that the scientific basis for disallowing various  
9 kinds of cancers as possibly being caused by  
10 radiation exposure is really terrifically  
11 unsound, that it is very well known if you read a  
12 book like the Fajardo/Anderson Radiation  
13 Pathology book that came out two years ago, that  
14 every bodily system can have radiation-induced  
15 cancer. So that's the first thing, to object to  
16 the scientific basis for excluding cancer.

17 The other comment is that I have had actually  
18 three or four years' experience with dealing with  
19 the health related data of the Mallinckrodt  
20 workers, and to make this very short, just to say  
21 that I've had extraordinary difficulty getting  
22 from Department of Energy through Freedom of  
23 Information Act requests any really usable  
24 medical data on these patients, much less on  
25 their -- including actually requests about their

1 death certificate information.

2 So I would strongly support the idea for this  
3 group, at least, that the special cohort  
4 mechanisms are the way to go, because I doubt  
5 seriously, unless some new evidence is  
6 forthcoming, that the doses that they really  
7 received could be accurately reconstructed. And  
8 we don't have time to go into that more, but I  
9 just wanted to say that.

10 So I'm very interested. I'll keep tuned to  
11 what's going on. And if there's any way I can  
12 help, I'd certainly be happy to do that.

13 **DR. ZIEMER:** Thank you, doctor.

14 **MS. NEWSOM:** Excuse me, Dr. McKeel. Could  
15 you spell your last name, please?

16 **DR. MCKEEL:** Yes. It's M-C-K-E-E-L, first  
17 name is Daniel.

18 **MS. NEWSOM:** Thank you.

19 **DR. MCKEEL:** Thank you.

20 **DR. ZIEMER:** Thank you.

21 Was there another person?

22 **UNIDENTIFIED:** Yes, this is George --

23 **UNIDENTIFIED:** Yes, there is.

24 **DR. ZIEMER:** I'm sorry?

25 **MR. BARRIE:** This is George. I'm a sick

1 worker.

2 **DR. ZIEMER:** George, did you give your last  
3 name?

4 **MR. BARRIE:** Barrie, B-A-R-R-I-E.

5 And first of all, I'd like to thank the  
6 Health and Human Services for listening to the  
7 Board and public, and agree to extend the comment  
8 period from May 6, 2003.

9 The reason I am interested in this rule is  
10 that I have three precancerous conditions now. I  
11 am not dead yet, okay. From what I understand,  
12 the rules as they stand now say that NIOSH can  
13 limit the cancers in certain classes of workers  
14 from the 22 legislated by Congress. Am I correct  
15 in my understanding that this means that myself,  
16 a machinist from Rocky Flats who worked there  
17 almost ten years, who ingested plutonium and  
18 americium, could potentially be limited to, for  
19 instance, just lung cancer? If I develop cancer  
20 in my stomach, which I have chronic atrophic  
21 gastritis which is directly related to a chemical  
22 or radiation ingestion per Merck's Manual, even  
23 though that it is a covered cancer, that I might  
24 not be compensated?

25 That is beyond not being fair. That is

1           idiotic. And I'd just like -- I just get all  
2           this anger coming up. It's like, what do you  
3           guys mean? Twenty-two cancers legislated from  
4           EEOICPA for Special Exposure Cohort, I personally  
5           think that there needs to be more cancers and  
6           diseases covered. Please do not limit any class  
7           to any specific cancer, because you know as well  
8           as I do if you ingest any specific radiation it  
9           might decide to go to your kidney, and then  
10          decide to pick up and go to some other organ or  
11          some other part of your body.

12                 And I'm experiencing that kind of thing. You  
13           can't just say it's going to go there, because it  
14           went to my kidneys, it went to my liver, and it  
15           went -- apparently I'm not supposed to have any  
16           kind of lung burden, but yet I'm on C-PAP, and  
17           they can't explain it.

18                 So please, understand that we don't know  
19           enough about radiation, and we probably never  
20           will know enough about radiation. And this is  
21           strictly a personal thing, and you can't begin to  
22           even lie about something like this. And you need  
23           to kind of have a little bit of trust in all of  
24           these workers and survivors. We can't even come  
25           up with something this outrageous and be a lie

1 (inaudible).

2 So please, treat us professionally. That's  
3 all I've got to say. And I'm really sorry, but  
4 I'm just -- I'm getting worse each day, and I  
5 have all kinds of problems with the joint spacing  
6 in my bones. And it's just -- it's really bad.  
7 It's a mess. And I'm not going to cry or give  
8 you a pity-pot here, but I just want you to know  
9 that it's not getting better for us. And I  
10 appreciate you dealing with it.

11 **UNIDENTIFIED:** Where were you working when  
12 you ingested plutonium and americium?

13 **MR. BARRIE:** Rocky Flats. And I have  
14 documentation, and I have some documentation, but  
15 I've had other nasal smears taken from downdraft  
16 tables that I've worked on and they were  
17 conveniently lost.

18 And I just get really angry about all this  
19 stuff. And I try and keep my composure, but when  
20 I have a chance like this to speak my emotions  
21 take over. And I want to apologize if they've  
22 taken over too much on you guys. I really like a  
23 lot of you people that have been working with us  
24 like Mr. Silver and Mr. Miller, and would like to  
25 say hi to everybody else that's on the phone.

1 And please understand my emotions, and that's  
2 probably about all I've got to say.

3 **UNIDENTIFIED:** How long did you work at Rocky  
4 Flats?

5 **MR. BARRIE:** Almost ten years. I've machined  
6 alloys that I can't even discuss still. So I  
7 can't even get into anything more.

8 **DR. ZIEMER:** Thank you, George, for those  
9 comments.

10 Now our thirty minutes of public comment  
11 period has now elapsed, and we're going to --

12 **MR. BARRIE:** I'm really sorry.

13 **DR. ZIEMER:** That's all right.

14 And we're going to move on to the Board's  
15 discussion at this time. As I indicated earlier,  
16 if we complete the Board's discussion before the  
17 5:00 o'clock period, we will certainly allow  
18 additional time for other public comments.

19 But it's important that the Board now has  
20 some time to deliberate. Everybody is welcome to  
21 listen in to the deliberations. These are public  
22 deliberations. We simply ask members of the  
23 public to listen. This is not a time where we  
24 have an interchange with the public, but you're  
25 certainly welcome to listen to our own

1 deliberations as we proceed.

2 Board members, I do want to ask you all, is  
3 there anyone on the Board that does not have the  
4 *Federal Register* actual version rather than the  
5 90-page version of the proposed rulemaking?  
6 Because I would like to operate now out of the  
7 *Federal Register* version if we can. That should  
8 also be helpful to any members of the public who  
9 have downloaded it.

10 **UNIDENTIFIED:** How many pages is that?

11 **DR. ZIEMER:** The *Federal Register* version is  
12 maybe 14 or 15 pages.

13 **UNIDENTIFIED:** (inaudible)

14 **MR. GIBSON:** Dr. Ziemer, this is Mike. I do  
15 not have that with me.

16 **DR. ZIEMER:** Okay. Well, Mike, I'll try to  
17 stick to dealing with section numbers and so on.  
18 Actually I do have my other copy with me, so we  
19 can go back and forth if we need to.

20 **MS. MUNN:** This is Wanda.

21 **DR. ZIEMER:** Yes, Wanda.

22 **MS. MUNN:** I have not -- I didn't download  
23 the *Federal Register* --

24 **DR. ZIEMER:** Okay, so you're still working  
25 off the other version, then?

1           **MS. MUNN:** I'll try while we're talking to go  
2 to the --

3           **DR. ZIEMER:** Well, it may not be necessary.  
4 I'll try to make sure that in each case we know  
5 which section and paragraph we're working on.

6           **MS. MUNN:** All right. I had just assumed  
7 that we --

8           **DR. ZIEMER:** At the end of the last meeting  
9 we had gone up through Section 83.12, and it was  
10 indicated to the Board that we would open our  
11 deliberations with Section 83.13. That's in the  
12 original sort of typewritten version that began  
13 on page 79. In the *Federal Register* version that  
14 section begins on page 11308 in the middle  
15 column. And the title of the section is, *How*  
16 *will NIOSH evaluate petitions, other than*  
17 *petitions by claimants covered under 83.14?*

18           Does everybody have the section that we're  
19 talking about?

20           **UNIDENTIFIED:** Yeah.

21           **DR. MELIUS:** Dr. Ziemer, this is Jim Melius.  
22 Just a reminder, Tony Andrade and I also did  
23 prepare and circulate something on the issue of  
24 facility, which refers --

25           **DR. ZIEMER:** Right. And we will return to

1 those earlier sections. That actually was an  
2 outgrowth of the section on -- Section 83 --  
3 well, it was the section on definitions actually,  
4 definition of facility.

5 **DR. MELIUS:** Right.

6 **DR. ZIEMER:** And we will return to that.

7 This Section 83.13 had several issues that we  
8 flagged before.

9 One issue was more of the rewording issue on  
10 section -- let me get the right number here -- it  
11 would be paragraph (a) -- no, I'm sorry,  
12 paragraph (b), Arabic (1), Roman numeral (iii),  
13 and I believe Wanda had a concern about the  
14 wording of that paragraph. It currently says:

15 "In general, access to personal dosimetry  
16 data and area monitoring data are not necessary  
17 to estimate the max radiation doses."

18 Wanda, that was --

19 **MS. MUNN:** I believe I provided all of you  
20 with a suggested wording, more simplistic  
21 revision of wording. Did everyone get that or  
22 not?

23 **DR. ZIEMER:** Do you have that wording there,  
24 Wanda?

25 **MS. MUNN:** Yes, I do.

1           **DR. ZIEMER:** Could you read the wording for  
2 the record, that you're proposing?

3           **MS. MUNN:** Yes. The suggested wording was:

4            "In general, access to personal dosimetry and  
5 area monitoring data is not a defining factor  
6 that must be available in order to estimate the  
7 maximum radiation doses which could have been  
8 incurred by any member of the class."

9           **UNIDENTIFIED:** (Inaudible)

10          **DR. ZIEMER:** Do you want to read that once  
11 again, then?

12          **MS. MUNN:** Yes.

13          "In general, access to personal dosimetry and  
14 area monitoring data is not a defining factor  
15 that must be available in order to estimate the  
16 maximum radiation doses which could have been  
17 incurred by any member of the class."

18          **DR. ZIEMER:** And this is not intended to be a  
19 change in the intent of the paragraph so much as  
20 a change in how it's expressed.

21          **MS. MUNN:** It's intended to be clarifying  
22 language only.

23          **DR. ZIEMER:** With clarity.

24                Do any of the Board members object to  
25 recommending that change in language?

1 [No responses]

2 **DR. ZIEMER:** Okay. If not, we'll consider  
3 that agreeable.

4 Now the other thing I had flagged -- and this  
5 is the item that we've heard a number of comments  
6 on -- is the very next paragraph, would be Roman  
7 numeral (iv), that says:

8 "If NIOSH determines that it is not feasible  
9 to estimate radiation doses with sufficient  
10 accuracy, it will also determine whether such  
11 finding is limited to radiation doses incurred at  
12 certain tissue-specific cancer sites, and hence  
13 limited to specific types of cancers."

14 And I had simply flagged that, that that was  
15 an issue that the Board wished to discuss  
16 further. We've heard some comments from members  
17 of the public on this. We've heard some comments  
18 from NIOSH staff on the thinking behind this.  
19 And it has to do with whether or not if you can  
20 demonstrate, even though there may be unknown  
21 doses, if you can demonstrate that in fact  
22 certain organs were not actually exposed, then  
23 would you then allow cancers to be included if  
24 you could show that particular organ was not  
25 exposed, even in the cases where the dose to

1 other organs were unknown? And I would like to  
2 sort of open this for general discussion, if  
3 Board members have any questions on this.

4 **MR. GIBSON:** Dr. Ziemer, this is Mike Gibson.

5 **DR. ZIEMER:** Yeah, Mike.

6 **MR. GIBSON:** I have one example I'd like to  
7 give to you.

8 The biokinetic models for tritium exposure is  
9 known. However, folks that have worked around  
10 tritium systems and tritium labs, taken apart  
11 pipes, fixing that, tritium can actually adhere  
12 itself to the rust in the pipes, and then it  
13 becomes embedded in that rust. And when that  
14 pipe is cut out or taken out, it can become an  
15 airborne particulate that is lodged in the lung  
16 as an ingestion rather than an absorption in the  
17 skin. And that metal is insoluble, so therefore  
18 that tritium sits and radiates the lung tissue  
19 rather than following the biokinetic model that  
20 tritium would have by skin absorption.

21 So there's probably different processes with  
22 different isotopes that once things happen  
23 throughout the years, how can we really know that  
24 it was going to be (inaudible) specific organ or  
25 part of the body?

1           **DR. ZIEMER:** I don't know whether you're  
2 asking that as a rhetorical question, Mike, or if  
3 you're asking someone to comment on it  
4 specifically.

5           Obviously the people who attempt the dose  
6 reconstruction would initially have to determine  
7 whether or not in such cases the tritium in fact  
8 continued to stay with the metal in the body or  
9 whether it didn't. Tritium normally would be  
10 considered a whole body -- distributed whole  
11 body, and therefore all organs would be subject  
12 to it. And so you'd immediately have your list  
13 of 22 right away, unless you could somehow show  
14 that there's no way it could have detached  
15 itself.

16           **MR. GIBSON:** Well, Mound's had quite a  
17 history of this, not only from certain projects  
18 (inaudible) were classified where they actually  
19 used tritium and embedded it in certain metals.  
20 But just from naturally-occurring rust, people  
21 were never monitored for that. So you have not  
22 only the insoluble metal dosing the lung for  
23 however long you have the toxicity of whatever  
24 type of metal the pipe may have been made of.

25           **DR. ZIEMER:** Right, right. Well, I'll just

1 comment without looking at this closely, but --  
2 and of course tritium is known to adhere to  
3 metals, but there are virtually no cases where it  
4 doesn't exchange with surrounding water  
5 molecules. So one would expect that that would  
6 end up with a whole body exposure in any event.  
7 So it would be hard for me to see in that case  
8 where you would end up excluding any organs. But  
9 that's just sort of top of the hat. I think one  
10 would have to take specific cases and analyze  
11 them.

12 As I thought about this -- and let me just --  
13 we can think about certain examples, and my guess  
14 is in most cases you're not going to have -- it  
15 would be very hard to find a condition where you  
16 had complete restriction.

17 But as an example, suppose you were able to  
18 show that there was a class of workers who did x-  
19 ray diffraction work -- a commonly used  
20 analytical tool, by the way -- and the x-rays  
21 from x-ray diffraction units are of such low  
22 energy that you simply can't physically irradiate  
23 any of the deep organs. You can irradiate the  
24 skin and the lense of the eye. You simply --  
25 it's physically not possible to deliver dose to

1 any deep organs. So I asked myself, well, what  
2 would you do if you had a class of workers in  
3 that category? In other words, would you say,  
4 well, okay, let's certainly consider skin  
5 cancers, but if it's not possible to deliver dose  
6 to, say, the spleen by this mechanism, then why  
7 would you include it?

8 I just ask that rhetorically. And the thing  
9 is, you can think of a lot of special cases. You  
10 might think of cases where maybe extremities only  
11 were exposed. You don't know what the exposure  
12 is, but you knew that there was some kind of a  
13 limit on what was done. That's the scientific  
14 question. I think the sort of political question  
15 and the history of the rulemaking -- or not the  
16 rulemaking, but the legislation, is kind of a  
17 different issue.

18 But technically speaking, it seems like one  
19 could conjure up cases where it might not be  
20 possible in a -- I mean, I sort of look at it  
21 this way. In any event, you -- not all exposures  
22 deliver dose to all organs, number one. And  
23 number two, you may not know the dose with  
24 certainty to some set of organs, but you still  
25 can't defy the laws of nature in terms of what

1 organs could be exposed in a particular case if  
2 you knew something about either the nuclide or  
3 the nature of the exposure, even if you didn't  
4 know the total dose.

5 So I'm just kind of throwing out ideas here  
6 so that I can stimulate your thinking. I want  
7 you to come back against me on this and challenge  
8 it.

9 **DR. MELIUS:** Okay. It's Jim Melius.

10 **DR. ZIEMER:** Yeah, Jim.

11 **DR. MELIUS:** I guess my problem with it is I  
12 can think of those examples, but when I think of  
13 (inaudible) also examples where we could be able  
14 to estimate the dose.

15 **DR. ZIEMER:** Maybe, maybe not.

16 **DR. MELIUS:** Well, I just find it hard to  
17 come up with the example where (inaudible) not  
18 going to be able to estimate the dose, especially  
19 given the criteria that they (inaudible) here.  
20 And then we would want to somehow (inaudible) so  
21 they would be able to have enough information to  
22 limit the organ systems affected in some way,  
23 whether it be by exposure or some other factor.

24 And what I worry about is if we try to --  
25 because we're trying to go through, we're going

1 to have a list of whatever, 20-some cancers to go  
2 through, and we're going to have to try to figure  
3 out which ones are maybe affected or not in a  
4 situation where we're not going to have enough  
5 information or we have very little information  
6 about the exposure. And I wonder how we're going  
7 to --

8 **DR. ZIEMER:** Well, in those cases the less  
9 you have the more organs you'd have to include.  
10 I think that gets more like the uncertainty  
11 issues in the regular cases. I just think about  
12 things like, for example, there's a limit to how  
13 much, if you were talking about inhaling  
14 something like uranium, there's a limit to how  
15 much mass you can actually put in the lungs. So  
16 you could, yeah, get an upper limit in one sense  
17 for a lung dose, and could say, okay, how much of  
18 this material, if you could physically get this  
19 much into the lungs, what would the dose to other  
20 organs be? I mean, you can do that exercise.

21 **DR. MELIUS:** But then why couldn't you also  
22 calculate a maximum dose in that situation?

23 **DR. ZIEMER:** Well, you could only in the  
24 sense that it would be -- it might be an  
25 outlandish dose, and it would be -- you wouldn't

1 know whether it was something between, let's say  
2 -- I don't know, I'd have to pick out a number --  
3 but between zero and some outlandish figure. So  
4 yeah, in that sense you might be able to  
5 (inaudible) it.

6 But is that a dose reconstruction? You would  
7 certainly pay off for a lung cancer. The  
8 question is, would you for other organs if you  
9 could show that even in that worse case you  
10 couldn't deliver doses to the other cancers  
11 (sic). You're saying that that wouldn't be a  
12 Special Exposure Cohort, then?

13 **DR. MELIUS:** Yeah, that you've been through a  
14 maximum dose in that situation.

15 **DR. ZIEMER:** I see.

16 **DR. MELIUS:** And I think the -- at least  
17 (inaudible) -- and I actually think we should go  
18 back and discuss that, because I have some  
19 (inaudible) how they define that.

20 But assuming we were using that definition,  
21 (inaudible) think that situations where we're not  
22 going to be able to define a maximum dose are  
23 going to be situations we're going to have so  
24 little information that (inaudible) about a  
25 source or sources of exposure or how people

1 worked in there, whatever, that there will be so  
2 little information that I don't see how we could  
3 then have, would then have enough information to  
4 be able to limit organ systems involved. But  
5 whether it be due to an exposure possibility  
6 issue or some other plausibility issue here that  
7 (inaudible) then they could calculate which  
8 cancers would be, could be included and which  
9 shouldn't.

10 And I guess I worry that we end up making  
11 either very arbitrary decisions about what gets  
12 included or not included without any basis for  
13 doing that, any way, any sort of rational basis  
14 for making that cutoff.

15 **DR. ROESSLER:** This is Roessler.

16 Just to kind of continue this and expand on  
17 the not defying laws of nature, I think, Jim,  
18 that there are some fairly clear-cut ways of  
19 doing this.

20 And one of the examples that I think came up  
21 early on in our discussions was to look at the  
22 organ that's being considered to be in a class or  
23 not. And if you look at that organ and you say  
24 what kind of a dose would it take, and you have  
25 to go back to the compensable definition, what

1 kind of a dose would it take to make that organ  
2 compensable? Then if you -- let's say it's the  
3 thyroid, and the particular case I think that was  
4 used was plutonium 238 to the thyroid. Then if  
5 you go back and you say, well, what kind of a  
6 dose would it have taken to the lung? We don't  
7 know the dose, we can't reconstruct it. What  
8 kind of a dose would it take to the lung in that  
9 situation?

10 And I come up, by running some numbers and  
11 using dose coefficients, I come up with something  
12 like 5,000 rems to the lung. Well, that defies  
13 the laws of nature. In order to have that kind  
14 of a big, that big a dose to the lung, the person  
15 would not have lived through it. So there's some  
16 pretty clear-cut things that I think could be  
17 done.

18 **MR. GRIFFON:** This is Mark Griffon.

19 I think, Gen -- just to pick up on Gen's  
20 point -- I think you just made a very interesting  
21 point. You're basically saying that they are  
22 using IREP in this thing, or that it is the  
23 underlying principle --

24 **DR. ROESSLER:** Not really, no.

25 **MR. GRIFFON:** Because I agree -- huh?

1           **DR. ROESSLER:** Not really IREP, but -- well,  
2           using the compensable definition, and then using  
3           the -- some basic science to --

4           **MR. GRIFFON:** Well, I mean if you go back to  
5           page 13, the question I have from the preamble.  
6           And this is the old version -- I'm sorry, page 15  
7           in the old version. The preamble discusses --

8           **DR. ZIEMER:** It's the section called *Accuracy*  
9           *of Dose Reconstruction under Summary of Public*  
10          *Comments*, Roman numeral III, Item B. Is that the  
11          section? That's page 13 in the old version.

12          **MR. GRIFFON:** I'm sorry, it's actually page  
13          15.

14          **DR. ZIEMER:** Okay.

15          **MR. GRIFFON:** So it's under the same section,  
16          *Accuracy of Dose Reconstruction*.

17          **DR. ZIEMER:** Right.

18          **MR. GRIFFON:** Yeah, over on page 15, in the  
19          paragraph starting --

20          **DR. ZIEMER:** In the *Federal Register* version  
21          it's -- I'll pull it out here for the benefit of  
22          those using the *Federal Register* version -- it's  
23          page 11296, I believe, under *Accuracy of Dose*  
24          *Reconstruction*. And it's the paragraph that  
25          starts out, "The Health Physics Society?"

1           **MR. GRIFFON:** Right. And about halfway down  
2 that paragraph they talk about radon progeny or  
3 uranium, only concentrate or -- and significantly  
4 irradiate.

5           And I think Gen is getting at that definition  
6 of "significantly." Is that triggered by  
7 compensable, which I see as just a back door way  
8 to get IREP in this thing? But that's my  
9 opinion. So I guess that's a question to NIOSH:  
10 What do they mean by "significant"? What is a  
11 significant dose?

12           I agree with what Gen said and with what Jim  
13 Neton has told us earlier, that you get an  
14 exposure to the lung from uranium, the  
15 predominant organ might be the lung, but other  
16 organs will get some dose. Then at what level is  
17 this cutoff of significance? Is it based on the,  
18 more likely than not, under the IREP POC model?  
19 Or are they using some other metric to determine  
20 significance there? I guess that's what's not  
21 clear within this new structure, to me anyway.

22           **DR. ROESSLER:** An incident I gave as an  
23 example is one example that I tried to think  
24 through as to where this would apply. And I  
25 guess, too, I would like some clarification on

1           some of the wording here and how the process  
2           actually would work.  Is what I'm saying a  
3           reasonable scientific process?  I think it is,  
4           but I'd like to hear more from NIOSH on this.

5           **MR. GRIFFON:**  And the question with Paul,  
6           with -- this is Mark Griffon again, I'm sorry.

7           Paul, with your example, I just -- I'm  
8           sitting here wondering myself -- and I'll just  
9           throw it out since we're discussing it -- but I  
10          wonder if in your x-ray diffraction example if  
11          you knew the individual's exposure, how is that  
12          currently handled in the IREP model?  And are all  
13          organs at least considered to have some potential  
14          probability?  I don't know the answer --

15          **DR. ZIEMER:**  Well, I think in the current  
16          IREP model the energy is plugged in --

17          **MR. GRIFFON:**  Right.

18          **DR. ZIEMER:**  And Jim would have to help me  
19          here, but once you plug the energy in you  
20          calculate doses to the individual organs, much  
21          like you would do for a beta emitter.

22          **MR. GRIFFON:**  Right, I guess my question --

23          **DR. ZIEMER:**  If it's a deep-lying organ,  
24          you're not going to find -- you know, let's say -

25          -

1           **MR. GRIFFON:** So are those probability curves  
2 zero? That's my question on those.

3           **DR. ZIEMER:** Yeah.

4           **MR. GRIFFON:** I guess they would be, but I'm  
5 not sure. I haven't done that exercise in IREP.  
6 But I think we'd want to certainly be consistent  
7 with that.

8           **MR. ELLIOTT:** Dr. Ziemer?

9           **DR. ZIEMER:** Yeah.

10          **MR. ELLIOTT:** This is Larry Elliott.

11          **DR. ZIEMER:** Yeah, Larry.

12          **MR. ELLIOTT:** Let me react a little bit here.

13                 First of all, I want to remind you all that a  
14 comment period is a time for the Department to  
15 listen to comments from the public --

16          **DR. ZIEMER:** Right. This is not a final  
17 rule.

18          **MR. ELLIOTT:** -- and the Advisory Board.  
19 You're right, it's not a final rule.

20                 And it's not a time for the Department or the  
21 staff here at NIOSH to interpret this pending  
22 rule or debate the meaning of the rule with  
23 members of the public or the Board. In our  
24 listening role we do not want to engage in any  
25 type of communication that any individual or

1 group may feel (inaudible) represents or serves  
2 to misrepresent the Department's offering of  
3 interpretations of the rule.

4 Therefore, we're going to continue to limit  
5 ourselves to directing you to pertinent parts of  
6 the proposed rule or to the statute for your  
7 discussion where we think it might provide  
8 clarity. We've very interested in hearing the  
9 comments from the Board and the public, and we  
10 encourage everyone to provide those written  
11 comments to the regulatory docket as indicated in  
12 the proposed rulemaking.

13 Let me just say this, too. Each dose  
14 reconstruction that we do considers the type of  
15 radiation exposure and the type of cancer that  
16 the employee contracted. It is also true, as in  
17 examples we've presented to the Board, the  
18 feasibility of a dose reconstruction can depend  
19 upon the type of radiation exposure and the type  
20 of cancer the employee contracted. The dose  
21 reconstruction for an employee with colon cancer  
22 and unquantified radon exposure may be perfectly  
23 feasible, while it might be impossible for a  
24 coworker with lung cancer.

25 The statute requires a determination that the

1 dose reconstruction is not feasible for HHS to  
2 add a class to the SEC. This Notice of Proposed  
3 Rulemaking proposes that the proposed class not  
4 include persons for whom a dose reconstruction  
5 can be done.

6 I think Jim's got something else he wanted to  
7 follow up with on that.

8 **MR. NETON:** Well, I think I was just going to  
9 add that when we approach a dose reconstruction  
10 we apply the efficiency process that is outlined  
11 in 42 CFR 82. In doing so, we complete the dose  
12 reconstruction as far as we need so that Labor  
13 could make an unambiguous decision regarding  
14 compensability. Now if that would be a  
15 maximizing assumption that would be an  
16 unreasonable -- a reasonable exposure given the  
17 circumstances of the person's work environment,  
18 we could do that and complete the dose  
19 reconstruction again by applying the efficiency  
20 process.

21 So the answer is not all organs are  
22 irradiated (inaudible), so when a certain organ  
23 is irradiated -- certain cancer types in certain  
24 organs, we can make certain very -- a broad  
25 (inaudible) assumptions by applying the

1 efficiency process to complete the dose  
2 reconstruction. That's the way it works.

3 **MR. ELLIOTT:** As well, pointing back to  
4 language in the NPRM, we used the phrase "may."  
5 We may, where appropriate, because of the ability  
6 to do dose reconstructions for certain cancers,  
7 we may define a class. Because we -- the statute  
8 also requires us to do dose reconstructions where  
9 feasible.

10 Thank you.

11 **DR. ZIEMER:** Okay.

12 Other Board comments?

13 **DR. ROESSLER:** Paul, this is Gen Roessler.

14 I have a question that came up while Larry  
15 was talking. There's a certain comment period,  
16 and the period has been extended. At the end of  
17 that time does the Board deliberate again, then  
18 being able to take into consideration public  
19 comments or anything else that might come up?

20 **DR. ZIEMER:** No. The process is the public  
21 comment period is really for the benefit of the  
22 Agency, which is going through rulemaking.

23 **MR. ELLIOTT:** Dr. Ziemer, if I may?

24 **DR. ZIEMER:** Yeah.

25 **MR. ELLIOTT:** This is Larry Elliott.

1           Yes, just for everybody on the call that may  
2           not have been made aware of this, at the Board  
3           meeting on March 7th the Board recommended that  
4           the comment period for the second Notice of  
5           Proposed Rulemaking for the Special Exposure  
6           Cohort be extended to 15 days, for a total of 45  
7           days of public comment. The Board indicated that  
8           it also wanted to ensure that both the Board and  
9           the public had adequate time to review and  
10          comment on its proposal, especially in light of  
11          significant changes that the first public comment  
12          produced.

13           The Department has agreed with the Board's  
14          recommendation that a longer comment period is  
15          desirable and has decided to provide an  
16          additional 30 days of comment, making the public  
17          comment period 60 days. And that deadline is now  
18          set for Tuesday, May 6th.

19           And you're quite right, the process is that  
20          at that point on that day the public comment  
21          period will close, and then the next step will be  
22          for us to review, evaluate, consider, and address  
23          those comments towards promulgating a final rule.  
24          So the Board must complete its business by the  
25          6th.

1           **DR. ZIEMER:** Which is basically just over a  
2 month away.

3           Now obviously you can take into consideration  
4 public comment that you've already heard. There  
5 may be additional ones that are submitted in  
6 writing and which would then appear in the record  
7 and so on. But in one respect the Board's  
8 comments are another set of comments that is  
9 considered by the Agency as well as the public  
10 comments. But it's technically not our job to --  
11 we don't respond directly to public comments.  
12 That's the Agency's process, where they take  
13 those into consideration in going to the final  
14 rule, as they take our comments into  
15 consideration.

16           And at this point -- well, let me tell you  
17 that I've sort of -- I've kept tabs as we've  
18 proceeded here, and actually have drafted based  
19 on things we've already reviewed, our comments up  
20 to this point. And what I do need to determine,  
21 what we need to determine, is what our comments  
22 will be on this section or on this particular  
23 issue.

24           The Board can make general comments. They  
25 can raise concerns. They can recommend specific

1           wording.  There's a whole variety of directions  
2           that we can go.  Whatever we recommend is  
3           something we need to agree on as a Board.  It may  
4           be helpful to, as we discuss this here, to get  
5           some idea of your individual views on this issue  
6           in terms of your comfort level on how NIOSH has  
7           delineated this in the proposed rulemaking, your  
8           discomfort level if that's more appropriate, or  
9           any alternatives.

10                 **DR. MELIUS:**  This is Jim Melius.  I guess  
11           I'll start things off.

12                 I guess my discomfort level is very high with  
13           two sections of this.  One is how well NIOSH has  
14           delineated this whole issue of sufficient  
15           accuracy of dose reconstruction and the  
16           parameters they placed on that.  And then  
17           secondly, I think flows out of that, is really  
18           the lack of delineation on this issue of specific  
19           cancer sites.

20                 And I think I can see from the public comment  
21           period this time and last time, that's raised a  
22           lot of -- a lot of people are upset about that.  
23           But even aside from that, I just find it very  
24           hard to follow what they're doing and seeing how  
25           that is justified.  I can see it in some sense in

1 a theoretical sense, but then when I (inaudible)  
2 back to a practical applied sense I see no limits  
3 on how NIOSH may choose to apply this, and how  
4 the Board can get involved in trying to make  
5 judgments on -- in reviewing NIOSH's application  
6 and making recommendations on which cancers  
7 should include.

8 And I'm just -- I just don't think the rule  
9 in these two sections as currently drafted is  
10 workable (inaudible) NIOSH as well as  
11 recommendations on how to improve that.

12 **DR. ZIEMER:** As far as process is concerned,  
13 if things proceeded as outlined here, as I would  
14 understand it, if a proposed class was defined --  
15 and let's say the proposed class was defined in  
16 terms of facility and a time period and so on,  
17 and let's say some subset of cancers in the main  
18 list -- that proposed class would have to come to  
19 the Board under this process.

20 **DR. MELIUS:** Correct, and then the Board  
21 would have to make a recommendation. Presumably  
22 NIOSH would recommend that certain cancers be  
23 covered (inaudible).

24 **DR. ZIEMER:** Right. And I would presume that  
25 in such a case the Board would be looking for

1 some kind of justification for this limitation  
2 that we're focusing on, and would have the  
3 opportunity to say that doesn't make sense  
4 scientifically or whatever.

5 **DR. MELIUS:** Yeah. But my concern, Paul, and  
6 this is that we don't -- I don't even know how --  
7 we don't even have the parameters to make that  
8 judgment and to do it in a consistent and non-  
9 arbitrary fashion. This is so -- these rules are  
10 so general that -- I keep going back to this  
11 case-by-case issue.

12 And I think the same thing applies when we  
13 are reviewing dose reconstructions, whether there  
14 was enough information to reconstruct the dose  
15 with sufficient accuracy. That rule is so vague,  
16 so general, that I think it would be very  
17 arbitrary as to -- again, we're going to be in a  
18 position of having to review at least some of  
19 those, that it's going to be very difficult to  
20 again draw the line.

21 And I'm (inaudible) very disappointed that  
22 NIOSH hasn't made more of an effort to define  
23 this better, to explain this better to us and to  
24 the general public.

25 **DR. ZIEMER:** Okay, other comments?

1           **MR. GRIFFON:** Yeah, this is Mark Griffon.

2           **DR. ZIEMER:** Mark.

3           **MR. GRIFFON:** Yeah, I also think -- I'm  
4 thinking about our role on the Board and these  
5 cases coming back to us. And the question comes,  
6 in my mind, again comes up that how was the  
7 determination made? Whether it's right or wrong,  
8 set aside for a second whether it's right or  
9 wrong to limit the list of cancers. But if a  
10 determination was made for one particular SEC  
11 class to limit their (inaudible) only two cancers  
12 or whatever, how was it made that -- how was the  
13 determination made that the other ones did not  
14 receive significant dose, whatever? What was the  
15 cutoff, what was the rationale used to make that  
16 determination?

17           I'm not sure -- you know, I've been saying,  
18 well, this significant stuff is only in the  
19 preamble. That's correct, but I just don't think  
20 that's clearly delineated in the rule itself.  
21 And again, we're going to be put on the spot to  
22 agree with that decision or disagree with that  
23 decision. So I think some clearer guidance up  
24 front in the rule is needed, so everybody has  
25 something to turn back to on that.

1           **DR. ZIEMER:** It'S a little difficult in the  
2 absence of a specific group of cases to actually  
3 delineate anything other than the process, I  
4 guess, at this point. Is that not correct?

5           I assume in the process that there would have  
6 to be something that convinced first NIOSH staff  
7 and then the Board that in fact that made sense,  
8 that it somehow made sense in a particular case  
9 or cases that would say, yeah, it makes sense  
10 that these particular cancers aren't included  
11 because something about either the nature of the  
12 nuclides involved or the process involved that  
13 those particular organs could not in any case  
14 have been exposed.

15           And again, it seems to me the more  
16 uncertainty there is in that, then the more  
17 likely it is you would have to include organs  
18 rather than exclude them.

19           **DR. MELIUS:** But how do we define that  
20 uncertainty, is the --

21           **UNIDENTIFIED:** That's the question.

22           **DR. MELIUS:** This is the problem I have, when  
23 you can't see --

24           **DR. ZIEMER:** I'm asking if you can do that á  
25 priori. I don't know the answer to that.

1           **DR. MELIUS:** Oh, I know you don't. I'm just  
2 saying that's the issue.

3           We all go back, kind of go back to the  
4 science of it and sort of the IREP approach and  
5 what we've constructed for when we are going to  
6 do dose reconstruction, and we know how difficult  
7 and how much uncertainty there is with that. We  
8 have a system that factors in that uncertainty.

9           Now we're in a situation where we can't do  
10 even (inaudible) a maximum dose, and then now  
11 we're trying to then make some (inaudible) on  
12 either on exposure or odds of exposure or organs  
13 that are (inaudible). I guess (inaudible) I  
14 think that has to be much more carefully  
15 delineated before it would really be something I  
16 could see being something that would be workable.

17           **MS. NEWSOM:** Excuse me, was that Dr. Melius?

18           **DR. MELIUS:** Yes, it is. I'm sorry.

19           **MS. NEWSOM:** Thank you.

20           **DR. ZIEMER:** I suppose -- I'm trying to think  
21 here in terms of the nature of the comments the  
22 Board can make on this, and we have a mix of  
23 backgrounds on the Board also.

24           But it seems to me that we might be able to  
25 construct something that indicates that we

1 recognize that in principle scientifically such  
2 situations might exist, that in practice we see  
3 some practical difficulties in actually doing  
4 what is proposed, and therefore may have some  
5 questions on the extent to which this selectivity  
6 issue can actually be carried out.

7           Again, I'm trying to help us think about what  
8 we can say that raises -- to some extent this  
9 issue needs to be flagged. It already has been  
10 flagged to the Agency by the public. I think  
11 there is some on the Board that feel that  
12 scientifically or at least in principle you can  
13 argue that it doesn't make sense, that in  
14 practice it may be very difficult to actually  
15 carry it out, and therefore is it of practical  
16 value.

17           **MR. GRIFFON:** There's one other thing to  
18 remember in this, Paul -- this is Mark Griffon,  
19 I'm sorry -- one other thing to remember, and  
20 that is that in order to get to this specific  
21 cancer side of the equation, and I guess it just  
22 ties back into the sufficient accuracy question,  
23 the first hurdle says that we can't determine  
24 dose.

25           Then if I, for a second, if I accept the

1 logic that if we know the source term and a  
2 reasonable amount about the processes, then we  
3 can in some way establish a maximum dose. That,  
4 in the current language, that meets the  
5 definition of sufficiently accurate. So you're  
6 already admitting, if they get past that hurdle,  
7 you're already saying we don't even have  
8 sufficient information about the source term, et  
9 cetera. And this is my circular argument here,  
10 that then you're going to try to limit organs  
11 when you've already said we can't even establish  
12 a maximum.

13 And under these guidelines, again, I'm not  
14 sure -- I'm not saying that I agree with this  
15 principle, but under these guidelines it says we  
16 can use maybe as little as source term  
17 information and processing information to be  
18 sufficiently accurate with a maximum estimate.  
19 If we can't even get to that hurdle, then you're  
20 saying but we know enough about the source term  
21 that we're sure it's only this isotope, or it's  
22 only -- they were only involved in x-ray  
23 diffraction exposure, so therefore we're going to  
24 limit the list.

25 I guess that's the other side of this, is

1 that -- that we need to consider.

2 **DR. ZIEMER:** Yeah. I can think at least in  
3 principle that there might be cases where you  
4 know something is present, that it's this and  
5 only this nuclide or these and only these  
6 nuclides. But perhaps the amounts are unknown,  
7 or there's something unknown about the process or  
8 the configuration or where people were, all of  
9 those uncertainties.

10 Now we know that certain kinds of dose  
11 reconstruction, at least limiting one, might be  
12 done even in those cases where we said yeah,  
13 there is no more than one microcurie of this  
14 stuff present in this whole site or something.  
15 That's one thing. But if the amount -- if the  
16 information -- there's got to be some  
17 information. That is, we've got -- you sort of  
18 have to know that there was something there,  
19 right?

20 **MR. GRIFFON:** Yes. Well, I'm just going by  
21 the definition presented in the text in the  
22 proposed rule for a second, you know, where they  
23 say that's sufficiently accurate. And I'm  
24 looking for it now.

25 **DR. MELIUS:** This is Jim Melius.

1           One of the -- two things I want to bring up.  
2           One is one of the practical issues that bothers  
3           me is that if when we're (inaudible) can't even  
4           estimate a maximum dose, how well do we really  
5           know that there's a limited source, that there's  
6           only one source? And I think the situation with  
7           Paducah and so forth with the plutonium and so  
8           forth, which whatever reasons wasn't recognized  
9           or acknowledged for a period of time, that there  
10          could be other things present there, and that  
11          changes this whole situation.

12          But to the other example I'd use, though,  
13          would be what if we had sufficient accuracy for a  
14          dose reconstruction to find differently and it  
15          was something other than a maximal dose, it was  
16          something, certain amount of dose records being  
17          available or coworker data or area sampling,  
18          something less general. So we'd have Special  
19          Exposure Cohorts where there would be -- you  
20          would not have -- would not be able to do their  
21          dose reconstruction under that scenario, but we  
22          might be able to do their maximal dose.

23          In that case then we'd have something to work  
24          off of to maybe look at some limitations of which  
25          cancer sites would be involved. At least we'd

1 have a little bit more certainty that we -- in  
2 terms of what we would be dealing with. Now of  
3 course, we'd want to define what we meant by  
4 being able to do a maximal dose, and so forth and  
5 so on. But to me that would give us an entree  
6 into making some of these determinations.

7 I just worry --

8 **DR. ZIEMER:** You're saying suppose you could  
9 reconstruct to the point where you said there was  
10 a maximal dose, that it met the probability of  
11 causation criteria for compensation?

12 **DR. MELIUS:** Yeah.

13 **DR. ZIEMER:** And you assign that to  
14 everybody?

15 **DR. MELIUS:** Yeah.

16 **DR. ZIEMER:** But that's a dose  
17 reconstruction, I believe --

18 **DR. MELIUS:** I'm also saying what if the  
19 definition of dose reconstruction was different?  
20 I guess what worries me is we've made -- by using  
21 the maximal dose as the test of sufficient  
22 accuracy for a dose reconstruction, what is left  
23 that allows us to make any sort of specification  
24 of a cancer site? I just find it very hard to  
25 come up with practical examples that that would

1 apply.

2 Now if we were in a situation where  
3 sufficient accuracy for dose reconstruction was -  
4 - has other parameters on it such as area  
5 exposure, whatever, but would not -- but then  
6 will you still be able to do a maximal dose, a  
7 maxed estimate of maximal dose, then at least  
8 there's a number to work off of and so forth,  
9 something to apply. But here, in a practical  
10 way, we're going to be -- a lot of guessing  
11 involved. And I find it hard to come up with  
12 practical examples.

13 **DR. ZIEMER:** Okay.

14 Others on the Board have comments?

15 **DR. ANDRADE:** Yeah, Paul, this is Tony  
16 Andrade.

17 **DR. ZIEMER:** Tony.

18 **DR. ANDRADE:** It appears that we've reached  
19 an impasse here to at least a couple of items.

20 One, let me take the trivial one first, and  
21 that is the way the law is written -- not law,  
22 the proposed rule is written with respect to this  
23 particular paragraph. That's 83 -- what is it,  
24 14?

25 **DR. ZIEMER:** Thirteen.

1           **DR. ANDRADE:** Thirteen, Roman numeral (iv).  
2           We need a little bit more clarity for the public  
3           as well as ourselves to understand that this may  
4           be a way to -- and I believe either help define a  
5           group, or alternatively to discredit whether or  
6           not a (inaudible) whether a group really should  
7           exist for a certain situation. So I think there  
8           needs to be some writing in there that provides  
9           further clarity. But like I said, this is the  
10          least of the two ideas that I have. That's one.

11                 But number two is the following. I think  
12          that we can all sit here and think of an infinity  
13          of potential situations or, for example, of what  
14          might metastasize from one site to another,  
15          whether or not it was caused by internal or  
16          external exposure. And I really believe that it  
17          may be that this -- what we should really -- the  
18          way we should handle this is that if ever NIOSH  
19          has to invoke the potential use of looking at  
20          specific cancer sites, that those cases be  
21          presented to the Board. I can -- for our advice,  
22          for our comment, so that they can go forward with  
23          these.

24                 Practically speaking I agree with you, Paul,  
25          in that I don't think that we're going to see a

1 lot of these cases. But there -- I'm sure that  
2 we will see some. And I can think of my own  
3 example, you ingest plutonium or americium, it  
4 goes to the liver first, and over the course of  
5 your lifetime it goes, it starts to transform out  
6 into your bone. So you can't just look at liver  
7 cancer. You're going to have to look at bone  
8 cancer and perhaps others that metastasize from  
9 these.

10 So what I'm saying is that to go around this  
11 impasse, at least for now, I would propose that  
12 somewhere in the rule, the proposed rule, that we  
13 very clearly specify that if this is ever  
14 invoked, that this immediately goes to the Board  
15 for review. And I think there's value added  
16 there. I think there will be due diligence in  
17 review of the cases and sending them back to  
18 NIOSH for a relook in case there are people that  
19 would sit on the Board that have legitimate and  
20 strong concerns about the possibility that  
21 specific cancer sites may very well have effected  
22 the cancer to another site.

23 **DR. ZIEMER:** Okay, thanks, Tony.

24 I would like to point out that under the  
25 provisions of Section 83.15 the Board in fact has

1 to consider all petitions to the Special Exposure  
2 Cohort. So are you suggesting something other  
3 than the process that's already here? It says  
4 the Board will consider the petition and the  
5 NIOSH evaluation, and then the Board may obtain  
6 additional information not addressed in the  
7 petition.

8 **DR. ANDRADE:** No, not really, Paul. What I'm  
9 trying to do is say that I really think that the  
10 wording should be there that goes above and  
11 beyond what is said for just any petition; that  
12 in particular with this very controversial  
13 situation that, number one, we're not eliminating  
14 looking at any of the 22 cancers, that we  
15 emphasize that, and that we also emphasize the  
16 fact that if this is invoked that this will  
17 receive --

18 **DR. ZIEMER:** Receive added attention in some  
19 way.

20 **DR. ANDRADE:** Added attention by the Board.

21 **DR. ZIEMER:** Are you suggesting something  
22 along the lines where in any cases where the  
23 Special Exposure Cohort is limited to, let's say,  
24 less than all of the cancers on the list that the  
25 NIOSH staff would have to have specific

1 justification for excluding of any cancers?

2 **DR. ANDRADE:** Absolutely.

3 **DR. ZIEMER:** How do others of you feel about  
4 that kind of an approach?

5 **MR. PRESLEY:** Bob Presley. I agree with  
6 that.

7 **MR. GIBSON:** This is Mike Gibson.

8 I guess I'm just kind of concerned that, and  
9 based on hearing some of the public comments,  
10 does NIOSH have this legal authority to take this  
11 interpretation based upon what was presented in  
12 the legislation?

13 I, personally as a Board member, don't know  
14 that I would feel comfortable even entertaining  
15 looking at something that NIOSH has come up with  
16 that may be -- that may in fact not be with the  
17 spirit and intent of the law, any kind of comment  
18 or debate on a petition that NIOSH has come up  
19 with a recommendation or a denial on. So I would  
20 be more comfortable if NIOSH had Congressional  
21 approval to keep this section in here, if that  
22 was truly the intent of Congress.

23 **MR. ESPINOSA:** This is Richard Espinosa.

24 I agree with exactly what Mike's saying. If  
25 we're going to limit the 22 cancers, I totally

1 believe it's unfair and it's not the intent of  
2 Congress.

3 **MS. MUNN:** This is Wanda.

4 **DR. ZIEMER:** Okay, Wanda.

5 **MS. MUNN:** I, in the first place, cannot  
6 conceive in my own mind the wording that would  
7 get around this problem adequately. May be in  
8 there, but I don't know what it is.

9 And secondly, perhaps I'm missing a key point  
10 here. I do not understand either the public  
11 concern or what other people are talking about  
12 when they talk about limiting the number of  
13 cancers, reducing the number of cancers that are  
14 covered by the law. I don't see that this is  
15 what this section does at all.

16 It appears to me that what this section is  
17 doing is talking about how one can approach the  
18 issues that are before us with respect to Special  
19 Exposure Cohorts. And I don't see that that's  
20 reducing the specified cancers, and the specified  
21 cancers are there for a reason. There is a  
22 scientific (inaudible).

23 So I am at a loss. I have not heard anyone  
24 suggest that they could provide wording that  
25 would clarify the intent that the individual has

1 in mind for what this ought to say, other than  
2 what it does in fact say. I don't see that it's  
3 giving NIOSH undue authority over and above what  
4 the law has (inaudible). And I certainly can't  
5 guess what the Congressional intent is, having in  
6 the back of my mind what that sense of Congress'  
7 statement included, which was completely  
8 erroneous and not factual.

9 I guess I think we may have a situation where  
10 we can't meet everyone's desire to be specific  
11 enough and broad enough at the same time to cover  
12 what the issue is here.

13 **DR. ZIEMER:** Well, obviously there is a  
14 concern that we -- regardless of the extent to  
15 which one does or does not agree with how the law  
16 was generated, it does exist. And I just want to  
17 suggest that how we understand that law may not  
18 be completely clear cut.

19 I'm reading from the section on *Special*  
20 *Exposure Cohort*, where the criteria is, one,  
21 "it's not feasible to estimate with sufficient  
22 accuracy the radiation dose to the class  
23 (inaudible)." This is in the law. They use the  
24 words "with sufficient accuracy." And then two,  
25 "there's a reasonable likelihood that such

1 radiation dose may have endangered the health of  
2 the members of the class." And that's the way  
3 the law reads.

4 Now the issue of likelihood that it  
5 endangered the health, when I look at that from a  
6 scientific point of view I have to first ask  
7 myself -- and we're talking about cancers here,  
8 and all of them are potentially included -- but  
9 if it's a specific cancer I have to say to  
10 myself, is there a likelihood that radiation  
11 endangered that person's health or the people in  
12 this class by delivering dose to the organs of  
13 concern? I mean, I can read that in the law.

14 So to the extent that the law says that you  
15 have to sort of make that determination, one can  
16 argue this approach. I'm trying to be a devil's  
17 advocate on this side now. But all I'm saying is  
18 I don't think it's completely obvious that the  
19 law says that any of the 22 cancers applies in  
20 every exposure situation, because that does not  
21 meet the test of reasonable likelihood that the  
22 health was endangered if you have a particular  
23 case where you simply couldn't get -- again,  
24 theoretically -- couldn't with either the  
25 exposure scenario conditions or nuclides or

1 radiation source have delivered exposure to a  
2 particular organ.

3 But in the absence of specific cases it's  
4 very hard to come to grips with that notion.  
5 That's part of the struggle here. And I think it  
6 would be possible to include statements that  
7 indicated that some Board members have concerns  
8 about the appropriateness and so on. I know this  
9 is an issue that's kind of at the heart of many  
10 of the things here. It certainly is in the  
11 public, it's a very crucial issue, and I think we  
12 have to be cognizant of that. We are also  
13 charged by law to do certain things as a Board.

14 **MR. GIBSON:** This is Mike Gibson again.

15 **DR. ZIEMER:** Yeah, Mike.

16 **MR. GIBSON:** I guess just my point is the  
17 daily records are so inadequate. We've had a lot  
18 of discussion about source term, and maybe DOE's  
19 records are not adequate that that was the only  
20 source term, there could have been other isotopes  
21 mixed in or whatever else. But just in reading  
22 the certificate we got from President Bush, it  
23 says it's our duty to fulfill the duties of the  
24 law.

25 **DR. ZIEMER:** Yeah.

1           **MR. GIBSON:** And if so, if we have such  
2 varied opinion, what's the objection to, whether  
3 it's NIOSH or the Board, going back to Congress  
4 and asking them what their intent was? I mean,  
5 we all have our own interpretation of the law,  
6 but I don't know that that's our right. I think  
7 we should get it clarified by the folks that have  
8 the authority to implement this legislation.

9           **DR. ZIEMER:** I don't know if anybody can  
10 speak to that question, Mike, and at this point  
11 I'm not sure we can simply say to the Secretary,  
12 take this back to Congress.

13           **MR. ESPINOSA:** This is Richard Espinosa.  
14 What's preventing us from doing that, Paul?

15           **DR. ZIEMER:** I don't know. I don't know the  
16 answer to that.

17           **DR. MELIUS:** This is Jim Melius.

18           I certainly think we can put in a comment to  
19 the effect that given what we've heard from the  
20 public that this is, as well as members, some  
21 members of the Board or whatever, that there is a  
22 concern about this and whether this  
23 interpretation is appropriate given the basic  
24 background legislation, and that's an appropriate  
25 way of communicating that. Unless NIOSH or HHS

1 provides us with some other information, which  
2 it's my understanding is they (inaudible) not  
3 during the comment period.

4 **MS. MUNN:** This is Wanda.

5 I have real reservations about the political  
6 ramifications and the scheduler problem involved  
7 in requesting a Congressional review of this  
8 portion of the law. My personal assessment is  
9 that you will push back any claims that you have  
10 currently ongoing that might fall into this  
11 Special Exposure Cohort at least a year and a  
12 half, and probably longer than that. I can't  
13 imagine that you could get this question through  
14 both houses of Congress this calendar year. Just  
15 can't imagine it would happen.

16 **MR. ESPINOSA:** Dr. Ziemer, this is Richard  
17 Espinosa again.

18 You know, I don't believe it has to go  
19 through -- even if we can get some of the head  
20 staffers over this issue to comment on it, I  
21 think that will help out a lot. I'm just feeling  
22 really, really uncomfortable with this right now.

23 **MS. MUNN:** This is Wanda.

24 I'm afraid that we were placed in an  
25 uncomfortable position when we agreed to take

1 this responsibility. And from my observation,  
2 NIOSH has done an incredible job of trying to put  
3 together, and in most cases very successfully so,  
4 the kinds of rules that would appear to cover as  
5 best one can the meaning of the law.

6 As I heard someone say, we can't interpret  
7 it. One has to interpret it if you're going to  
8 carry it out. That may make us feel as though we  
9 are not fully competent to do that, but then no  
10 one is.

11 **DR. MELIUS:** This is Jim Melius.

12 All we're saying, at least I was  
13 recommending, is that we go back and ask for  
14 clarification on it. I'm not saying things  
15 should be delayed because of that. That's their  
16 decision. And to say that's going to take a year  
17 and a half and somehow hold up something is  
18 ridiculous.

19 I think that we communicate this issue needs  
20 to be clarified. And then it's up, then, to the  
21 Secretary and NIOSH to determine how they go  
22 about doing that. For all we know they may have  
23 done that already in the comment period or  
24 whatever other procedure they have, they may not  
25 want to share any of that information with us.

1           So I think all we're saying is that should be  
2 a comment from the Advisory Board, and let it --  
3 doesn't mean we will hold up our comments or that  
4 we hold up the regulation. That's up to them.

5           **MR. ESPINOSA:** I agree with Dr. Melius, and  
6 I'd like to see that in the form of a motion.

7           **DR. ROESSLER:** Before we go much further,  
8 maybe it's because the connection has been bad --  
9 this is Roessler -- it's not clear to me  
10 specifically what questions are or what the  
11 comment is. So I wish maybe Jim could repeat  
12 that, or Rich.

13           **DR. ZIEMER:** Rich, I think was your comment.

14           **MR. ESPINOSA:** On that last part, what Dr.  
15 Melius was saying, I would really like to see  
16 what Congressional intent was on this, and based  
17 on what Dr. Melius was saying basically put it in  
18 the form of a motion from the Board, or from Dr.  
19 Melius. I can't repeat his exact words on that  
20 last statement.

21           **DR. DeHART:** Paul, this is Roy.

22           **DR. ZIEMER:** Yeah, Roy.

23           **DR. DeHART:** In my experience with  
24 regulations I don't think that Congress is in the  
25 void on this. It's now in the *Federal Registry*

1 [sic]. They study the *Federal Registry*. There  
2 are those advocates who will make sure that the  
3 appropriate people in Congress will oversee it.  
4 And if they have concern they will raise that  
5 concern, and it will be documented and they will  
6 be heard from. So I'm not worried about that. I  
7 think that certainly will happen if the concern  
8 is that that degree of level of height.

9 I do agree that there needs to be somewhere  
10 along the way satisfaction within the regulation  
11 or within the preamble as to how this concern is  
12 raised, and why it is not in violation of what is  
13 presumed to be the previous regulation.

14 **DR. MELIUS:** This is Jim Melius again.

15 I think all we're suggesting -- I agree with  
16 Roy, that other (inaudible) may take this up  
17 also, including people from the appropriate  
18 staff. And I believe Richard Miller already  
19 addressed that in the public comment period.

20 But all we do, that we simply say that raise  
21 the concern. We've heard it from the general  
22 public, heard it within the Board, and that this  
23 issue needs to be clarified. And then see what  
24 happens.

25 Now whether we can seek clarification, obtain

1 clarification within the comment period, I don't  
2 know. But I think for better or worse we just  
3 should certainly raise the issue, something we've  
4 heard from the general public.

5 **DR. ZIEMER:** And again, keep in mind that in  
6 any case where, as we've already indicated, where  
7 something did come forward that actually had such  
8 a limitation in it, the Board would actually have  
9 an opportunity to require that there be a  
10 justification. It would have to make sense to  
11 the Board as well as to the staff.

12 **DR. MELIUS:** Jim Melius again.

13 My point earlier was not that this was not  
14 going to come to the Board; we knew it was going  
15 to come before the Board. But how was the Board  
16 going to make sense of, evaluate this coming  
17 forward when it was such a vague and general  
18 regulation? It provides no parameters for making  
19 that -- at least parameters that I can  
20 (inaudible) how to judge one case from another or  
21 know where to draw the line. And agreeably,  
22 (inaudible) individual cases will vary. But one  
23 would think there would be some more specific  
24 parameters, so when this (inaudible) cancer issue  
25 would apply.

1           **DR. ZIEMER:** Okay, we've heard a number of  
2 comments. Are we at a point where we can have  
3 some level of specificity?

4           There's an issue on, or there's some  
5 suggestions that our comments include some  
6 clarity on -- that was clarity on, I guess, on  
7 the definition of sufficient accuracy? Or what  
8 was the clarity issue? Just on the process?

9           **DR. ANDRADE:** This is Tony Andrade.

10           It was more on the process in which  
11 particular -- in which this particular, I don't  
12 know, mechanism would be (inaudible) invoked to  
13 make a judgment that cancer is not likely from  
14 (inaudible) for a given group.

15           **DR. ZIEMER:** And also some suggestion that  
16 NIOSH be asked to somehow confirm the intent of  
17 Congress, or --

18           **UNIDENTIFIED:** Correct.

19           **DR. ZIEMER:** Is that sort of the notion, Jim,  
20 that you're raising?

21           **DR. MELIUS:** Yeah, that NIOSH clarify the  
22 appropriateness of this procedure given the whole  
23 list that was in the legislation, as well as what  
24 the intent of Congress was with that legislation.

25           **DR. ZIEMER:** What I'm going to suggest doing

1 here is -- I've jotted down a number of things.  
2 I'm thinking what I might do is draft a straw man  
3 and get it out to everybody to look over  
4 pertaining to this section, which means we will  
5 have to have a final conference call in a few  
6 weeks to agree to it. But I don't know that we  
7 can draft it right now.

8 I wonder how others of you feel about that  
9 approach?

10 **MS. MUNN:** This is Wanda.

11 I would very much like to have some words to  
12 be looking at, very much.

13 **MR. ESPINOSA:** Dr. Ziemer, this is Richard  
14 Espinosa.

15 I agree with what Wanda is saying. It's --  
16 there's a lot out there right now, and to me it's  
17 getting a little bit confusing as well. So I'd  
18 like to see some words before this section kind  
19 of continues, and with another public -- not  
20 another public comment period, but with another  
21 Advisory Board conference call.

22 **DR. ZIEMER:** Right, okay.

23 I will piece something together here, and  
24 actually what I will plan to do -- well, we'll go  
25 on to some other items, but I'll piece something

1 together. I may want to shoot it out to a couple  
2 of you to take a preliminary look at, and then --  
3 particularly those who raised the issue, make  
4 sure it captures everyone's ideas, and then get  
5 it out to the Board. And then we would have to  
6 discuss it in probably another conference call  
7 two or three weeks from now.

8 But let's proceed and see what else we have  
9 to deal with before us, okay. Is that agreeable?

10 **DR. MELIUS:** Yes.

11 **DR. ZIEMER:** Now let me see, we're still here  
12 in this same section, 83.13. Are there any other  
13 things in this section that anyone had, 83.13?

14 [No responses]

15 **DR. ZIEMER:** Okay, what about 83.14, *How will*  
16 *NIOSH evaluate a petition?* Were there any issues  
17 on that one? I didn't have any flagged from  
18 before.

19 [No responses]

20 **DR. ZIEMER:** On 83.15 I didn't have anything  
21 flagged. Does anyone have any items on that  
22 section?

23 **MS. MUNN:** This is Wanda.

24 **DR. ZIEMER:** Yes, Wanda.

25 **MS. MUNN:** I recall -- oh, I was told that

1 was okay. I raised the issue about privacy  
2 issues early on, and I was reassured about that.

3 **DR. ZIEMER:** You're okay on that?

4 **MS. MUNN:** (Inaudible) covered.

5 **DR. ZIEMER:** Okay, 83.16. I did make a note  
6 on 83.16, item (c). Someone had raised the  
7 question as to whether or not there should be a  
8 time deadline inserted in the time for final  
9 decision on designation of a class. Did we  
10 decide that we could not mandate that to HHS?

11 **MS. MUNN:** My memory of our original  
12 discussion was that we sort of ran out of  
13 (inaudible) without coming to any conclusion  
14 whether it should or should not be there. But I  
15 think the general tenor that I recall was that we  
16 really couldn't do that.

17 **DR. ZIEMER:** Yeah, I think that's right. I  
18 think we just left it with the assurance that  
19 this would be done in a timely fashion following  
20 the Agency's normal process, so that it doesn't  
21 need to have a timeline in it. There is a  
22 timeline on HHS providing information to the  
23 petitioners and so on, so that's already in  
24 there.

25 Okay, then let me go back, and I'm going to

1 identify for you the items that we have already  
2 agreed on, and then we come to one item that we  
3 need to discuss in a little more detail dealing  
4 with facilities.

5 We agreed to -- let me give you page numbers  
6 here, 112296 [sic], column three; and in the old  
7 version this is the section on public comments on  
8 the accuracy of dose reconstruction, I believe.  
9 Yeah, *Summary of Public Comments*, Section B on  
10 *Accuracy of Dose Reconstructions*.

11 **MR. ESPINOSA:** What page is that, Paul?

12 **DR. ZIEMER:** It's 11296 in the *Federal*  
13 *Register*, and it is page 15 in your typewritten  
14 version. In the *Federal Register* it's column  
15 three, paragraph two, last sentence.

16 Simply that the statement is confusing.

17 I think, Wanda, this was your item, and we're  
18 just asking NIOSH to rewrite that sentence to  
19 clarify it. So it's not a substantive change.

20 **MS. MUNN:** No. I wasn't asking for a change  
21 in meaning. I was just --

22 **DR. ZIEMER:** Right.

23 Page 11303, column one, paragraph two, we are  
24 asking -- in the second sentence we are asking  
25 for the insertion of the word "occupational"

1 after the word "sufficient," so it reads, "If the  
2 employee had sufficient occupational radiation  
3 exposure outside of the work as a member of  
4 cohort." So it was just specifying that it was  
5 additional occupational exposure. That was more  
6 of an editorial.

7 Then page 11306, column three, *Definitions*.  
8 We had flagged that. There was concern about the  
9 definition of a facility, and we had asked Jim  
10 and Tony to develop some wording on the use of  
11 the word "facility" in this document.

12 Now as a starting point, and Jim and Tony had  
13 distributed, I believe, a one-pager called  
14 facility definition issue. Did everybody get  
15 that?

16 [Affirmative responses]

17 **DR. ZIEMER:** Distributed by Cori.

18 And they point out that there is a definition  
19 of facility in Subtitle B, Section 3621, that is  
20 in the regulation itself. And there also is in  
21 the -- that was in the legislation. In the bill  
22 regarding Special Exposure Cohort there is a  
23 statement on the *Designation of Additional*  
24 *Members of the Special Cohort*, and the statement  
25 that says "The Advisory Board shall advise the

1 President where there is a class of employees at  
2 any Department of Energy facility who were likely  
3 exposed," and so on. So there's those two uses  
4 of facility in the legislation and in the bill.

5 And then there is a recommendation on this  
6 paper that says -- and it's the last paragraph on  
7 the paper by Jim and Tony -- that says:

8 "For the purposes of this draft regulation,  
9 the Board recommends that "facility" should be  
10 considered broadly (e.g., Los Alamos, Rocky  
11 Flats). Then the "class" definition would be  
12 used to limit the class to those workers who  
13 worked in some specific operation(s) at the  
14 facility and whose dose could not be  
15 reconstructed with sufficient accuracy. If  
16 facility was defined to refer to specific  
17 buildings, etc., NIOSH would have to spend  
18 considerable effort developing an inventory of  
19 defined "facilities" at each DOE site and would  
20 have difficulty considering new SEC classes for  
21 workers in operations that might have taken place  
22 in more than one building or "facility" at a DOE  
23 site."

24 So as I read it, it's this last paragraph  
25 that Jim and Tony are recommending be included in

1 our comments.

2 Is that correct, Jim and Tony?

3 **DR. MELIUS:** Correct.

4 **DR. ANDRADE:** Yes, that's correct.

5 **DR. ZIEMER:** And let me ask you also, is it  
6 your motion that we should include in this  
7 rulemaking the official definition of facility  
8 that shows up in the legislation? Some of the  
9 other definitions are repeated from the  
10 legislation as well. Would it be helpful to have  
11 that in here as well?

12 **DR. MELIUS:** The problem is that there are  
13 two definitions of facility that are not quite  
14 consistent with each other. There's one of an  
15 AWE facility which talks about facility in a  
16 broad sense, and there's another one where it  
17 talks about a Department of Energy facility which  
18 talks about facility in a much more building-  
19 specific sense.

20 I think what's (inaudible) some of those make  
21 sense, because what the definitions are used for  
22 in the legislation are to determine which  
23 employees are eligible. So it's an employee  
24 working in such a facility, any such facility.

25 **DR. ZIEMER:** Right, right.

1           **DR. MELIUS:** And if one looks through the  
2           legislation and looks for (inaudible) talks about  
3           exposure, then it never talks -- the bill, at  
4           least the section I read, never talked about the  
5           exposure at a facility, or restricted to a  
6           facility in any way. It just talks about an  
7           employee having an exposure, but doesn't limit  
8           that exposure to facility the employee worked at  
9           or whatever.

10           So Tony and I in our e-mail discussions about  
11           this, if you remember from the last conference  
12           call, sometimes it's somewhat a question of  
13           perspective. My perspective is that Los Alamos  
14           is a facility. I think of it that way. Tony,  
15           who works there, knows lots of different  
16           facilities at Los Alamos. I'm sure it's the same  
17           with Wanda and everybody else who worked at what  
18           those of us on the outside refer to as a facility  
19           or think of as a facility.

20           But if one then -- I think in our  
21           deliberations if one thinks of how -- what we're  
22           going to be doing in terms of a Special Exposure  
23           Cohort, it sort of makes sense to think of  
24           facility in the broad sense and then use the --  
25           define the class in a way that would limit the

1 people that were eligible for that Special  
2 Exposure Cohort to maybe defined as an operation,  
3 maybe defined as working at a particular building  
4 or whatever. Lots of ways would be appropriate  
5 to do that, but not use the definition of  
6 facility in order to make that restriction if  
7 that restriction is appropriate. I think the --

8 **DR. ZIEMER:** It's more the idea of not  
9 starting from the narrow point of view and  
10 working outward, but starting from the broader  
11 point and then narrowing down to the class from  
12 there, is that correct?

13 **DR. MELIUS:** Yeah. I think the example used  
14 there is that if one had to go through and define  
15 it in each building, building facility, would be  
16 difficult. At the same time, there's a concern  
17 that if one defined a special cohort as the  
18 facility, then the whole -- everybody who ever  
19 worked at the facility would be part of that  
20 cohort. And I think the way this process works,  
21 class would be defined and would be used, what  
22 would be used to restrict the eligibility, those  
23 that are in the class. That's how you'd define  
24 the class.

25 **DR. ZIEMER:** Are you, Tony, Jim, are you

1 suggesting that this would somehow be part of the  
2 definition section, or just a comment to -- in  
3 other words, are you suggesting -- would you be  
4 suggesting to NIOSH that they include an  
5 operational definition here in this section, such  
6 as you describe?

7 **DR. ANDRADE:** Jim -- this is Tony.

8 I think Jim and I would both like to see this  
9 included in the definition section. And I would  
10 just like to point out that I think this provides  
11 us with the flexibility that the entire Board  
12 would like to see, where facility, as Jim stated,  
13 is really an entire complex, if you will, in  
14 certain cases like Los Alamos --

15 **DR. ZIEMER:** Or could be, yeah.

16 **DR. ANDRADE:** And that a class can be used in  
17 many instances for a variety of instances. It  
18 could be a building; it could be an operation;  
19 and so on. And so if that is clarified, then I  
20 believe it will make life easier for ourselves  
21 and for NIOSH.

22 **DR. ZIEMER:** Okay. Are you -- for proposes  
23 of getting kind of closure on this issue, let me  
24 suggest that one of you move the adoption of this  
25 recommendation.

1           **DR. MELIUS:** Jim. I move.

2           **DR. ANDRADE:** And I'll second.

3           **DR. ZIEMER:** Okay. Now, Board members, want  
4 to comment pro or con on this recommendation?  
5 And the motion would be to adopt this last  
6 paragraph as a recommendation with the intent  
7 that it be included in some form as an  
8 operational definition, right?

9           **DR. MELIUS:** Correct.

10          **MS. MUNN:** This is Wanda, and I'd like to  
11 make a friendly recommendation. I think that  
12 Tony and Jim have captured the crux of the  
13 matter, and have proposed wording that would both  
14 clarify and simplify what needs doing.

15           I would suggest that rather than repeat the  
16 two definitions, which might have a tendency to  
17 muddy the water even more, that what we suggest  
18 be included in *Definitions* is the statement which  
19 would begin with one preceding sentence, that  
20 sentence being "There are two definitions of  
21 facility existing in the legislation under  
22 Subtitle B, Section da-da-da, and Section 3626,  
23 Designation," period; then the last paragraph,  
24 "For the proposes of this draft regulation the  
25 Board recommends."

1           **DR. ANDRADE:** I have no objection to that.  
2 This is Tony.

3           **DR. MELIUS:** Yeah, same. That's fine with  
4 me.

5           **DR. ZIEMER:** Okay, any other comments?

6           **MS. ROBINSON:** Paul, this is Teresa from  
7 Cambridge Communications. Could you make sure  
8 you repeat (inaudible)?

9           **DR. ZIEMER:** Repeat what?

10          **MS. ROBINSON:** Repeat what Wanda just said.

11          **DR. ZIEMER:** Wanda, can you repeat that?

12          **MS. MUNN:** Yes, I can.

13               I suggest that in addition to the last  
14 paragraph which we are going to -- we are looking  
15 at as potentially including in *Definitions*, that  
16 we precede that paragraph with a single sentence  
17 which reads, "There are two definitions of  
18 facility existing in the legislation, namely, in  
19 Subtitle B, Section 3621 and Section 3626,  
20 *Designation of Additional Member of Special*  
21 *Exposure Cohort*," period. Then begin the final  
22 paragraph as written by Jim and Tony, "For the  
23 proposes of this draft regulation," et cetera.

24          **DR. ZIEMER:** And we can take that as a  
25 friendly amendment, right?

1           **MS. MUNN:** Yes.

2           **DR. ZIEMER:** Okay. Did you get that?

3           **MS. ROBINSON:** Yes, I did. Thank you.

4           **DR. ZIEMER:** Again, Board members, any  
5 discussion, pro or con?

6           [No responses]

7           **DR. ZIEMER:** There appears to be none. Is  
8 that correct? Are you ready to vote?

9           [Affirmative responses]

10          **DR. ZIEMER:** All who approve this suggested  
11 change, say aye.

12          [Ayes respond]

13          **DR. ZIEMER:** Opposed? Let me just ask it  
14 this way. Are there any Board members opposing  
15 the change?

16          [No responses]

17          **DR. ZIEMER:** Any abstaining?

18          [No responses]

19          **DR. ZIEMER:** I'm going to take that as,  
20 rather than a roll call, everybody then voted  
21 yes, just for the record.

22          **DR. MELIUS:** This is Jim Melius.

23                 Just one follow up. Tony and I did not get  
24 into the issue of facility versus facilities  
25 issue, the plural issue there, just so that's

1 understood. I'm not sure we're capable of it  
2 this Friday afternoon.

3 **MR. ESPINOSA:** Paul?

4 [No responses]

5 **MR. ESPINOSA:** Dr. Ziemer?

6 [No responses]

7 **MS. HOMER:** Uh-oh, we've lost him.

8 **MR. ESPINOSA:** Is this Cori?

9 **MS. HOMER:** This is Cori.

10 **MR. ESPINOSA:** It sounds like we lost  
11 everybody.

12 **DR. ANDERSON:** I'm here. It's Andy. I'm  
13 here.

14 **MS. MUNN:** Wanda's here.

15 [Affirmative responses]

16 **MS. MUNN:** I'm fearful we've lost our leader.

17 **MR. PRESLEY:** Bob Presley. I'm here.

18 **DR. ANDERSON:** Maybe he put his on mute.

19 **MS. HOMER:** Entirely possible. We will have  
20 to wait for a couple of minutes to see if he can  
21 reconnect.

22 **MR. ESPINOSA:** Did the public get cut off  
23 too, or --

24 [Negative responses]

25 **MS. BROCK:** This is Denise Brock. I'm here.

1           **MS. SHINAS:** Betty Shinas. I'm here.

2           **MS. JACQUEZ:** Epifania Jacquez, I'm here.

3           **MS. GONZALES:** Carmen Gonzales, (inaudible).

4           **UNIDENTIFIED:** Quick, let's take a vote.

5           [Laughter]

6           **MR. ESPINOSA:** Cori, this is Rich. There's a  
7 lot of background noise.

8           **MS. HOMER:** Yeah, I know.

9           **UNIDENTIFIED:** Yes, there is, and it's really  
10 interfering.

11           **MS. HOMER:** Yeah, it is. I'm not sure where  
12 the background noise is coming from.

13           **UNIDENTIFIED:** Those who have mute, if you  
14 could --

15           **DR. ZIEMER:** This is Ziemer. I got cut off.  
16 I'm back. Did we -- did others get cut off, or  
17 just me?

18           **MS. HOMER:** I believe so, it was just you.

19           **UNIDENTIFIED:** If anybody -- if everybody who  
20 has a television or something could please mute.

21           **DR. ZIEMER:** Did that background noise come  
22 on when I came on?

23           **MS. MUNN:** No, it did not. It was on while  
24 you were quite silent. Somebody had something  
25 going on in the background (inaudible).

1           **DR. ZIEMER:** The last thing I had was  
2 everyone had agreed to Wanda's friendly  
3 amendment. Were there other comments at that  
4 point? Oh, we voted, didn't we?

5           [Affirmative responses]

6           **DR. ZIEMER:** I was still on when we voted.

7           **MS. NEWSOM:** Dr. Melius? Dr. Melius, you  
8 made one comment about the difference between  
9 facility and facilities.

10          **DR. MELIUS:** I was just -- yeah, that's when  
11 everybody left (inaudible).

12          Tony and I, we didn't get into the issue of  
13 facility versus -- what facility meant, whether  
14 it mean facilities or facility.

15          **MS. MUNN:** This is Wanda.

16          Under the kind of broad definition that  
17 you've given in here, I don't see that it's a  
18 problem.

19          **DR. ANDRADE:** Wanda, this is Tony Andrade.

20          The issue before us is one that has been --  
21 the question, I think, came from the public, and  
22 that's the way it came about. And that is  
23 whether there was any real limitation on defining  
24 a special cohort or a piece of a special cohort  
25 that could cross facility boundaries.

1           And I think the comment that Jim made earlier  
2           was that we might not be able to handle this this  
3           afternoon.  However, personally I feel that we  
4           should not put any boundaries or limitation --  
5           I'm hearing background conversation.

6           **DR. ZIEMER:**  I am too.

7           **DR. ANDRADE:**  We're trying to conduct  
8           business here.  If you're going to conduct  
9           background conversations, please mute your phone.

10          In any case, what I would like to say is that  
11          I would really like to see either in the  
12          definitions, perhaps immediately following what  
13          we just said with respect to the definition of  
14          facility or in some other part of the proposed  
15          legislation, that a group -- that is, a proposed  
16          group that would be considered as part of a  
17          special cohort not be limited in any way to cross  
18          boundaries.  I personally don't see any reason  
19          why we can't be specific about that and just  
20          adopt it this afternoon.

21          **DR. ZIEMER:**  When you say boundaries, be more  
22          specific.

23          **DR. ANDRADE:**  Yeah.  I'm saying if somebody  
24          out there really believes that a group can  
25          actually be -- set of people that worked at

1 Livermore and then worked at Mallinicrodt and then  
2 worked at maybe another place, or just two  
3 places, and that this group comprises a situation  
4 in which their doses could not be reconstructed  
5 at either of the buildings or operations or so on  
6 and so forth that they were involved in at two  
7 different facilities, as Jim and I have defined  
8 it, I don't see why that could not be considered  
9 a Special Exposure Cohort.

10 **DR. ZIEMER:** The only time that this would be  
11 important would be if they didn't meet the 250-  
12 day criteria at one or the other, and they needed  
13 to add it together? Because otherwise they meet  
14 the criteria anyway.

15 **DR. ANDRADE:** Right. And I think that --

16 **DR. ZIEMER:** And you only need one.

17 **DR. ANDRADE:** You only need one. But what --

18 **DR. ZIEMER:** But suppose they have 200 days  
19 at one and 50 days at the other. Is that the  
20 case you're talking about?

21 **DR. ANDRADE:** Exactly, exactly. And I don't  
22 see any reason at this point to limit potential  
23 petitioner from that sort of definition.

24 **DR. ZIEMER:** But you haven't included that  
25 here? That would be a separate comment?

1           **DR. ANDRADE:** It would be a separate comment.  
2 I'm saying that I think we can work this one out  
3 this afternoon.

4           **DR. ZIEMER:** Well, let's have input from  
5 others.

6           **MR. OWENS:** Dr. Ziemer?

7           **DR. ZIEMER:** Yes.

8           **MR. OWENS:** This is Leon Owens at Paducah.

9           I'm struggling right now, in all due respect,  
10 to the prior deliberation in regard to your  
11 comment to circulate a draft to the Board, final  
12 recommendation.

13           Paducah, Portsmouth, Ohio, Oak Ridge, and the  
14 Amchitka Island test site in Alaska, those  
15 facilities were designated as Special Exposure  
16 Cohorts. And I think the expectation from the  
17 other sites throughout the country is that they  
18 also will be treated in a like manner when they  
19 petition for exposure cohort designation. And I  
20 think that it is plain, the legislation is plain  
21 that would allow these additional sites to  
22 petition.

23           And I think that the Board should consider  
24 what the legislation currently states for those  
25 sites who have the 21, 22 listed cancers. It

1 doesn't matter if an individual is a clerical  
2 worker or if they're a process worker, if they're  
3 hourly or if they're salaried. Provided that  
4 they meet the Congressional intent, they qualify  
5 under the Special Exposure Cohort for  
6 compensation. And I think that is the  
7 expectation for the other sites who are covered  
8 under the DOE complex.

9 **DR. ANDRADE:** Are you suggesting -- this is  
10 Tony Andrade -- that, for example, Los Alamos in  
11 its entirety, all 47 square miles with all 7,000  
12 employees, could actually be considered as a  
13 special part of -- a Special Exposure Cohort?

14 **MR. OWENS:** What I am suggesting is currently  
15 in Paducah, Kentucky, provided an individual  
16 meets the minimum qualifications, the 250  
17 aggregate days, if they have one of the listed  
18 specified cancers, by virtue of them being a  
19 Special Exposure Cohort designee they receive the  
20 compensation.

21 And I again feel that the expectation of the  
22 general public -- we're not talking about  
23 individuals who are as well versed in reading  
24 legislation as some of us may be; we're talking  
25 about individuals who are dying by the day.

1 We're talking about senior, elderly individuals,  
2 and we can call them Cold War veterans if we may.  
3 Their expectation is that they will receive the  
4 same equitable treatment as these four sites  
5 have.

6 **DR. ZIEMER:** There is a constraint placed on  
7 us by the legislation that does not appear to be  
8 there for the others, Leon, and that is that they  
9 have to have been exposed to radiation at the  
10 facility and that it's not feasible to estimate  
11 their dose for dose reconstruction proposes. So  
12 those are some limitations that are placed on us  
13 by that legislation.

14 But to the extent that there would be, for  
15 example, individuals who are not in the  
16 restricted areas where they are exposed, or to  
17 the extent there are people whose dose  
18 reconstructions can be done, it would appear to  
19 me that the legislation requires us to -- in  
20 place the restrictions that aren't placed on  
21 those others sites.

22 What the expectation of individuals is is not  
23 the thing that -- we have to follow the dictates  
24 of the law as Congress imposed it upon us as an  
25 Advisory Board. So unless I'm misunderstanding

1 what you're saying, I think there are constraints  
2 that perhaps aren't there in the legislation that  
3 set up the original exposure cohort. They are  
4 much more inclusive, as I would see it.

5 **MR. OWENS:** Well -- this is Owens again, Dr.  
6 Ziemer.

7 I understand your comments. But again, I  
8 think that from a credibility standpoint -- I'm  
9 not expecting or asking the Board to go beyond  
10 its authority. But I do feel that if -- the  
11 Board should consider the expectations of the  
12 public, and that way we would ensure that the  
13 process itself is transparent and that the  
14 credibility of the Board is (inaudible). Because  
15 again we need to consider the individuals who we  
16 are addressing, and also the areas within the  
17 country where this work was accomplished.

18 **DR. ZIEMER:** Okay.

19 Well, let's see. Are there -- the item we're  
20 immediately talking about is whether or not to  
21 include something that would allow the combining  
22 of exposures at more than one site, which I think  
23 would sort of parallel the other situation where  
24 the existing Special Exposure Cohorts or  
25 locations can be combined to get the 250 days.

1           How do others of you feel on that issue?

2           **DR. MELIUS:** This is Jim Melius.

3           I agree that it certainly makes sense that if  
4 a person worked at more than one site and  
5 accumulated dose there, and that site's part of  
6 their time that would make them eligible for a  
7 Special Exposure Cohort, that it could certainly  
8 include more than one site or more than one  
9 facility. And it seems to me that when we were  
10 discussing individual dose reconstructions,  
11 actually some of the examples we used I thought  
12 did have more than one site or more than one  
13 facility.

14           And so it certainly on scientific and  
15 practical grounds it doesn't make sense that a  
16 person would have to prove themselves in multiple  
17 Special Exposure Cohorts, couldn't accumulate  
18 time or whatever or other eligibility-related  
19 issues for this to make them eligible for  
20 compensation. So I think that does make sense.

21           **MR. PRESLEY:** Dr. Ziemer, this is Bob  
22 Presley.

23           **DR. ZIEMER:** Yeah.

24           **MR. PRESLEY:** That definitely makes sense for  
25 Oak Ridge. Many, many times we've had people

1 that have worked at Y-12 (inaudible) sites  
2 (inaudible).

3 **DR. ZIEMER:** Others?

4 **MR. ESPINOSA:** You're talking about with just  
5 the -- this is Richard Espinosa --

6 **DR. ZIEMER:** Yeah, Rich.

7 **MR. ESPINOSA:** You're talking about with just  
8 the accumulation of the 250 days, correct?

9 **DR. ZIEMER:** Yeah. For example, if -- let's  
10 say they were at two completely different sites,  
11 maybe not even -- maybe Los Alamos and Rocky  
12 Flats, say; and didn't have the 250 day total at  
13 one or the other but together did have; and in  
14 both cases were in situations where they would  
15 otherwise be in Special Exposure Cohorts, I think  
16 is what we're talking about, in both cases where  
17 you couldn't do dose reconstructions.

18 **MR. ESPINOSA:** Okay. I understand that.  
19 It's getting -- okay, I understand it in the  
20 terms of the 250 days, and I agree with what's  
21 being said.

22 **DR. DeHART:** Paul, Roy.

23 If we have an individual at two different  
24 sites, would both sites then have to be special  
25 cohort in order to accumulate those hours or

1 those days? The mere fact that one worked at Y-  
2 12 and one worked at X-10 to accumulate 250,  
3 would that -- would they have to be special  
4 cohort --

5 **DR. ZIEMER:** Well, in my mind that's what  
6 we're talking about, if it's going to parallel,  
7 the existing thing. For example, you can get  
8 your 250 days by adding together, let's say, two  
9 of the gaseous diffusion plant exposures. But I  
10 don't believe it allows you to use part of one of  
11 those and some completely other exposure that's  
12 not on the list, right?

13 **DR. DeHART:** That seems to make sense, and  
14 that's why I asked the question.

15 **DR. MELIUS:** This is Jim Melius.

16 I also think there might be situations out  
17 there, whether it be a group of workers that  
18 worked at multiple sites, and that we would want  
19 to define that as a Special Exposure Cohort, not  
20 worry about --

21 **DR. ZIEMER:** That could grow out of the  
22 regular process, could it not?

23 **DR. MELIUS:** I'm not -- it's not completely  
24 (inaudible) that it could. But I think that's  
25 one of the other examples we want, (inaudible)

1 the other situations we'd want to include in  
2 (inaudible) possibility for.

3 **MR. ESPINOSA:** This is Richard Espinosa  
4 again.

5 I agree with what Dr. Melius said. As a  
6 sheet metal worker, I can work at 15 different  
7 sites at LANL in just a week's time, and I can be  
8 exposed to numerous different items. And so the  
9 250 days is a concern, not to mention we're going  
10 to have to rely on the contractor's recordkeeping  
11 on where the person was scheduled at at that  
12 time.

13 **DR. ANDRADE:** Richard, this is Tony Andrade.  
14 That's precisely why I was proposing what  
15 we're talking about, is this potential for  
16 including different physical locations, whether  
17 they are at the same complex or maybe workers who  
18 went to different places around the country, so  
19 long as they had been employed for a total of 250  
20 days no matter where they were in situations in  
21 which they could potentially have been exposed.  
22 Then I think that this is a friendly sort of  
23 definition that we can use, and that it would be  
24 consistent with other policies that we've helped  
25 draft.

1           **MR. ESPINOSA:** Yeah, I agree with you, Tony,  
2 with what you're saying. I hope I didn't make it  
3 sound like I wasn't agreeing with you.

4           But also what Dr. Melius says, in the SECs  
5 alone there's going to be classes of employees  
6 such as building trades or guards or RCTs.

7           **DR. ANDRADE:** Right.

8           **MR. ESPINOSA:** So I certainly agree with  
9 what's being said.

10          **MR. GRIFFON:** This is Mark Griffon.

11          I agree with Tony's amendment, too, and I  
12 just -- I can give one case that I think might  
13 help to -- a theoretical case that might to  
14 clarify.

15          I mean, I can think of a situation of the old  
16 traveling radiation technician that may have went  
17 to several DOE facilities, and they as a group  
18 might decide to petition as one class, but they  
19 weren't necessarily at just one facility.

20          **DR. ANDRADE:** Yeah, right.

21          **MR. GRIFFON:** And part of the reason you  
22 can't determine their dose maybe is that they  
23 were -- the nature of their work, and they had  
24 similar types of activities at all the facilities  
25 they went to. So that might help clarify it.

1           But I agree with Tony's recommendation.

2           **DR. ZIEMER:** Tony, did you formalize that  
3 recommendation in the form of a motion?

4           **DR. ANDRADE:** I can't think of the words  
5 right now, Paul. Perhaps somebody could help me,  
6 but I would say that the class definition is not  
7 limited, would not be limited to workers at one  
8 facility.

9           I don't know, Jim. Maybe --

10          **DR. ZIEMER:** Tony, it seems to me we could  
11 have both situations. One would be a class of  
12 workers that were in multiple facilities; the  
13 other might be an individual worker who could be  
14 part of two classes.

15          **DR. ANDRADE:** Absolutely.

16          **DR. ZIEMER:** If you understand what I'm  
17 saying.

18          **DR. ANDRADE:** Yeah.

19          **DR. ZIEMER:** But who did not have sufficient  
20 time in one or the other facility by itself to be  
21 actually in the class who otherwise would be.

22          **DR. ANDRADE:** Yeah, that's very inclusive.

23          **DR. ZIEMER:** Because it could be a unique  
24 situation for that worker in terms of the  
25 combination of places they went to, and might

1 have otherwise been included in an SEC but didn't  
2 have enough days at the particular site, but  
3 taking two or three sites together perhaps would  
4 have. Which could either apply to an individual  
5 or even a group at some point that could become a  
6 new exposure cohort that included in itself  
7 multiple facilities.

8 **DR. ANDRADE:** Right.

9 **DR. ZIEMER:** But as a starting point that you  
10 wouldn't have to have that situation, as I  
11 understand what you're recommending.

12 **DR. ANDRADE:** That's correct.

13 **MR. GIBSON:** This is Mike Gibson.

14 I have to agree with that, and especially in  
15 light of the fact that under 31.61 workers have  
16 preferential hiring at other DOE sites, so as a  
17 lot of them get laid off at their home facility  
18 they move, go on to another DOE facility.

19 **DR. ZIEMER:** So what this recommendation  
20 would be, something along the lines that the  
21 Board recommends that NIOSH consider including or  
22 allowing -- I don't have the wording -- allowing  
23 the individuals to combine exposures in -- I'm  
24 going to put it in just kind of just rough idea -  
25 - in what would otherwise be separate SECs in

1 order to receive the 250 day total.

2 **MR. PRESLEY:** Dr. Ziemer, this is Bob  
3 Presley.

4 **DR. ZIEMER:** Yeah.

5 **MR. PRESLEY:** Tony used the word exposure  
6 (inaudible) date or something like working days.

7 **DR. ZIEMER:** Yeah, working days.

8 **MR. ESPINOSA:** Dr. Ziemer?

9 **DR. ZIEMER:** Yeah.

10 **MR. ESPINOSA:** The preamble says NIOSH will  
11 use 250 days employment only when it lacks  
12 sufficient basis to establish a lower minimum.  
13 Should this be --

14 **DR. ZIEMER:** Well, there is a case where if  
15 it was an incident like a criticality incident,  
16 where all you have to do is show that you were  
17 present during -- and that might be like one day.  
18 That is a very special case. Is that what you're  
19 referring to?

20 **DR. MELIUS:** Yeah, this is Jim Melius.

21 I guess I would -- since we don't have all  
22 the examples yet, I just think our language  
23 should at least be general enough that what if a  
24 person with a series of incidents or whatever  
25 that was required, so you're required that you

1 have three weeks' of high involvement or a series  
2 of these incidents or something. I think we can  
3 craft language that maybe would use appropriate -  
4 -

5 **DR. ZIEMER:** The incident case, though,  
6 generally all you have to show is you're present  
7 at one of them and you've made it, right?

8 **DR. MELIUS:** I guess all I'm saying is that  
9 we don't know that NIOSH is always going to use -  
10 - it's only going to be incident cases where  
11 you're there, present or not present, or 250  
12 days. Could there be something in between? And  
13 I think they've left it open, that they could  
14 define it in the absence of a definition.

15 **DR. ZIEMER:** Yeah. The, quote, "incident"  
16 might be longer than one hour, one day. It might  
17 be something less than 250 but longer than a day.

18 **DR. MELIUS:** Yeah. And I just think if we  
19 make our language appropriate, (inaudible)  
20 recommend to NIOSH make it appropriate to  
21 whatever parameters that are defined for that.

22 **DR. ZIEMER:** Okay. The words need to be  
23 polished here.

24 I'm trying to see, is there kind of  
25 consensus? We don't have a formal motion. Is

1 there a consensus that we should include some  
2 wording along this line? Any objection?

3 **MR. GIBSON:** Can I make one that -- Dr.  
4 Ziemer, this is Mike.

5 **DR. ZIEMER:** Yeah, Mike.

6 **MR. GIBSON:** One additional comment, that the  
7 reference to the 250 day criterion is in the  
8 preamble and not in the rule. Should we not also  
9 include that part in with this that we're  
10 deliberating, the rulemaking part, recommend that  
11 the NIOSH?

12 **MR. ESPINOSA:** Yeah, that's the point that I  
13 was trying to make.

14 **DR. ZIEMER:** Oh, I see. That the rule  
15 doesn't require --

16 **MR. KATZ:** This is Ted Katz. Let me  
17 (inaudible) something out here.

18 It is in the rule. It's not just in the  
19 preamble. The rule specifies --

20 **DR. ZIEMER:** This is Ted Katz, I think.  
21 Ted, help us out. Where is this?

22 **MR. KATZ:** And it's in Section 83.13 -- oh, I  
23 don't have my finger on it. I assure you it's in  
24 here very specifically. Oh, here. It's under --  
25 these are hard to find -- 83.13, then subsection

1 -- just above subsection small (c), which is on  
2 page 113 --

3 **DR. ZIEMER:** Yeah, it's the middle column on  
4 11309, top paragraph.

5 **MR. KATZ:** Right. Middle column, top  
6 paragraph. That's where it's specified.

7 **MS. MUNN:** This is Wanda.

8 It's also included in the original law.

9 **MR. KATZ:** Right. It comes from -- well, it  
10 relates to EEOICPA, which specified 250 work days  
11 --

12 **MS. MUNN:** Correct.

13 **MR. KATZ:** -- for the folks at the gaseous  
14 diffusion plants. So it relates to that.

15 **DR. ZIEMER:** Okay.

16 **UNIDENTIFIED:** Give me the page it's on in  
17 the typewritten copy.

18 **DR. ZIEMER:** Typewritten copy --

19 **UNIDENTIFIED:** Page 82.

20 **UNIDENTIFIED:** 82.

21 **MR. KATZ:** Page 82, the last full paragraph,  
22 double I.

23 **DR. ZIEMER:** It's about four lines from the  
24 bottom on 82.

25 **UNIDENTIFIED:** Okay, I see that.

1           **MR. KATZ:** Dr. Ziemer?

2           **DR. ZIEMER:** Yeah.

3           **MR. KATZ:** This is Ted Katz again.

4           I just thought I'd also help you, at least  
5           try to help you out with the two recommendations  
6           you're formulating.

7           The one about defining of classes at  
8           potentially including multiple facilities, that  
9           one's very clear what you're recommending there.

10          The second about recommending that days, if  
11          you're in multiple classes, if you sort of  
12          qualify to be in multiple classes that you would  
13          aggregate the days if necessary from multiple  
14          classes. But you could do that -- the only  
15          clarity I just wanted to give you on that, I  
16          think that recommendation you're making is really  
17          a recommendation to the Department of Labor,  
18          because the Department of Labor will determine  
19          compensation. All we're defining is who is  
20          included in a class. But as far as aggregating  
21          days for people in different classes --

22          **DR. ZIEMER:** Yeah, I guess -- the concern we  
23          have here, that somebody is excluded from a  
24          particular class because they have, say, only 200  
25          days, and also they worked somewhere else and

1 there's a separate class where they worked, let's  
2 say, 100 days. And the point is they should be  
3 allowed to aggregate those. And you're saying  
4 Labor will already do that? Because they're not  
5 in either of the classes since they didn't  
6 qualify.

7 **MR. KATZ:** No. And I wasn't saying Labor  
8 would already do that. I mean, Labor just does  
9 that for the folks at the gaseous diffusion  
10 plants, aggregates the days.

11 **DR. ZIEMER:** Yeah, yeah.

12 **MR. KATZ:** What I'm saying, I guess it wasn't  
13 clear to me what was being meant, then, about --  
14 are you talking about making a class out of the  
15 individuals that are in two separate classes but  
16 don't qualify --

17 **DR. ZIEMER:** No, not necessarily. That could  
18 occur if there was a lot of people that had the  
19 same pattern.

20 I think what we're saying is suppose you have  
21 a class, and there's an individual who would  
22 otherwise qualify for that class except they  
23 don't have enough days. And that individual also  
24 worked somewhere else where there's another  
25 class, and they don't meet -- they don't have

1 enough days there either, but taken together  
2 would have enough days for that individual.

3 **MR. KATZ:** Right. No, so I understood that,  
4 really.

5 I guess my question is are you trying to  
6 recommend that NIOSH create this new aggregate  
7 class, or --

8 **DR. ZIEMER:** Well, does that become a new  
9 class if they have two pieces like that?

10 **MR. KATZ:** Well, I don't know. I think it's  
11 sort of a knotty problem. I mean, with you --  
12 the classes are going to be defined and must be  
13 defined generically, I think, in terms of what  
14 job categories, et cetera, what time period, as  
15 (inaudible) explained in these regulations. But  
16 then you're --

17 **DR. ZIEMER:** Well, let's talk about the  
18 parallels. Suppose you have someone who worked  
19 at one of the gaseous diffusion plants but  
20 doesn't have enough days there, and therefore is  
21 not in that class. Or are they all the same  
22 class, all the gaseous diffusion plants are  
23 considered the Special Exposure Cohort, so they  
24 all -- they automatically combine, don't they?

25 **MR. KATZ:** Yeah. DOL just automatically --

1           **DR. ZIEMER:** So we don't have the exact  
2 parallel here.

3           **MR. KATZ:** -- in terms of that 250 days.

4           **DR. MELIUS:** This is Jim Melius.

5           Why don't we just recommend that NIOSH figure  
6 out how to do this?

7           **DR. ZIEMER:** Yeah, yeah. The intent of what  
8 we're trying to do, I guess, is clear. How it  
9 would be carried out in a particular case would  
10 remain to be delineated, probably. But at least  
11 the principle could be there that you might allow  
12 this to occur.

13           **DR. ANDERSON:** I would agree with that. I  
14 don't think we have to wordsmith it for them.

15           **MS. MUNN:** This is Wanda.

16           Didn't we cover that pretty much when early  
17 on we added the "occupational" word in the  
18 sentence, if the employee had a sufficient  
19 radiation exposure, occupational radiation  
20 exposure outside of his work experience as a  
21 member of the cohort to qualify for compensation,  
22 then his dose reconstruction could be completed  
23 on the basis of his extraneous work history?  
24 Didn't that get everybody --

25           **DR. ZIEMER:** Well, that would -- this would

1 be a case where they didn't qualify for -- they  
2 didn't really have other work that qualified by  
3 itself.

4 I don't know. That was in the preamble also,  
5 I think.

6 **MS. MUNN:** Yeah, it was.

7 **DR. ZIEMER:** Again, I'll craft some words  
8 here as part of this document, and then you'll  
9 have a chance to look at it.

10 We're getting close to the end here. I want  
11 to see if we can sort of finish up where we are.

12 After the facility issue, Section 1130 -- or  
13 page 11307, it's Section 83.9, paragraph (c),  
14 Arabic (2), Roman numeral (iii). We had a  
15 rewording of that section that was provided by  
16 Mark Griffon which we agreed to last time. The  
17 rewording of that section is as follows:

18 "A report from a health physicist or other  
19 individual with expertise in dose reconstruction  
20 describing the limitations of DOE or AWE records  
21 on radiation exposure at the facility, as  
22 relevant to the petition. This report should  
23 specify the basis for believing the stated  
24 limitations might prevent the completion of dose  
25 reconstructions for members of the class under 42

1 CFR part 82 and related NIOSH technical  
2 implementation guidelines."

3 That's what we agreed to last time. I'm just  
4 reiterating it here for the record.

5 Also, on page 11307, column three, Section  
6 83.9, the very next paragraph, (c)(2) Roman  
7 numeral (iv), we reworded that section simply to  
8 provide clarity. It now will read:

9 "A scientific or technical report published  
10 or issued by a governmental agency or published  
11 in a peer-reviewed journal that identifies  
12 dosimetry and related information that is  
13 unavailable," and so on. And then we delete the  
14 last part of the sentence beginning with the  
15 phrase "and also finds," to the end of the  
16 sentence.

17 Am I going too fast?

18 [No responses]

19 **DR. ZIEMER:** The next change I have is page  
20 11307, column three, it's also Section 83.9.  
21 It's paragraph (3) and continues through the top  
22 of the page on 11308. The comment is this:

23 "This portion of the" -- and this is Jim  
24 Melius' work -- "This portion of the section  
25 deals with exposure incidents and describes the

1 process for evaluating the information required  
2 for such incidents in the event that NIOSH is  
3 unable to obtain records or confirmation of the  
4 incident. The Board recommends that NIOSH  
5 consider where the placement of this part of the  
6 section should be within the rule, since it  
7 refers to information required after the petition  
8 has been evaluated by NIOSH. As presently  
9 located, this portion could be confusing to the  
10 petitioner."

11 And then the next change we have is page  
12 11308, columns two and three. It's Section 83.9  
13 also. It also is paragraph (3), Roman numerals  
14 (i) and (ii). I believe this is Jim Melius'  
15 wording that we accepted also. It says:

16 "These paragraphs require either medical  
17 information or witness affidavits in the event  
18 that the exposure incident cannot be confirmed.  
19 For the requirement that two employees who  
20 witnessed the accident submit affidavits, the  
21 Board recommended that the petitioner be counted  
22 as one of these two witnesses if the petitioner  
23 was an individual employee who witnessed the  
24 incident."

25 And then another, continuing:

1           "The Board is also concerned that a  
2           petitioner may have difficulty finding witnesses  
3           to an exposure incident that occurred many years  
4           ago. Witnesses may no longer be living or may be  
5           difficult to identify or locate. In such cases  
6           the Board recommends that NIOSH offer the option  
7           for other parties to submit confirmation of the  
8           incident in the absence of available eyewitnesses  
9           or records."

10           And then page 11308, column one, Section  
11           83.11(b):

12           "The Board is concerned that there is no  
13           further appeal process for petitions that do not  
14           satisfy the relevant requirements. Accordingly  
15           the Board recommends that NIOSH explore possible  
16           appeal mechanisms within the DHHS for such  
17           cases."

18           I'll just add parenthetically that was a  
19           situation where we had the discussion as to  
20           whether the inadequate petition should have yet  
21           another appeal route if it was turned down. It  
22           would basically be after the second turndown.

23           And then that brought us up to the point  
24           where we started our discussions today, to 83.13.

25           So that's kind of an overall summary of what

1 I have so far.

2 Does anyone -- has anyone identified any  
3 additional points that I've excluded here?

4 [No responses]

5 **DR. ZIEMER:** I'm hearing some conversation.  
6 Am I missing somebody's discussion?

7 [No responses]

8 **MS. MUNN:** I don't think you are. Somebody's  
9 discussion has been going on, office background  
10 noise for an hour.

11 **DR. ZIEMER:** Then let me ask, we are going to  
12 need at least a final conference call.

13 What I will have will be some proposed  
14 wording for this section on -- well, let's see.  
15 We'll polish up the facilities thing. I think  
16 we're okay. We just need a second point on the  
17 250 day thing, and then need to have the other  
18 issue on the specific cancer issue wording dealt  
19 with.

20 So as I say, I'll work on a straw man for  
21 that and get it out to you, and then we need to  
22 have one final conference call, I would say  
23 sometimes in the next few weeks.

24 Cori?

25 **MR. ELLIOTT:** Dr. Ziemer, Cori had to leave

1 the call --

2 **DR. ZIEMER:** Okay. Should we identify a  
3 time, though?

4 **MR. ELLIOTT:** Yes, if you would, please.  
5 We'll have to get it in the *Federal Register*, and  
6 so we need to do that before May --

7 **DR. ZIEMER:** It would be better if we had at  
8 least two weeks to get time for the notice to get  
9 out and so on.

10 **MR. ELLIOTT:** Yes.

11 **DR. ZIEMER:** And that suggests that it be  
12 sometimes perhaps no earlier than April 11th. It  
13 could go later. Let me try some things here that  
14 would still be timely.

15 How's April 18th?

16 **MR. ESPINOSA:** April 18th's perfect for me.

17 **DR. ZIEMER:** Anyone for whom April 18th would  
18 be bad?

19 **UNIDENTIFIED:** Yeah.

20 **DR. ZIEMER:** It's Good Friday.

21 **MS. MUNN:** I'll be in Beijing.

22 **DR. ZIEMER:** Okay.

23 **DR. MELIUS:** Jim Melius. That's bad for me  
24 also.

25 **DR. ZIEMER:** Okay. How about April 11th?

1           **MS. MUNN:** April 11th, can do it.

2           **DR. ZIEMER:** Two weeks from today.

3           **DR. MELIUS:** Yeah, that'd be fine with me.

4           Only thing, we do have until May 6th, so --

5           **DR. ZIEMER:** Yeah, so it can be later.

6           Wanda, you're going to be in Beijing over  
7           what period?

8           **MS. MUNN:** I will be on the mainland until --

9           **DR. ZIEMER:** Starting when?

10          **MS. MUNN:** Starting the 15th until the 1st of  
11          May.

12          **DR. ZIEMER:** We probably could go as late as  
13          May 1st if we have to.

14          **DR. DeHART:** This is Roy. I will have  
15          returned by the 23rd of April.

16          **DR. ANDERSON:** How about the second of May?

17          **UNIDENTIFIED:** (Inaudible) for me.

18          **DR. ZIEMER:** I have a problem on the second.

19          **DR. ANDERSON:** The first is okay.

20          **DR. ZIEMER:** Roy, you're gone through what  
21          period?

22          **DR. DeHART:** I'll be back on the 23rd, back  
23          in the office on the 24th of April.

24          **MS. MUNN:** I could handle the first. I will  
25          be back home on the first.

1           **DR. ZIEMER:** How are others on the first of  
2           May?

3           **DR. ANDERSON:** After 2:00 your time.

4           **DR. ZIEMER:** Two o'clock May 1st. I don't  
5           think we need -- if we just have this one thing  
6           to polish up, it shouldn't take quite as long.

7           **DR. ANDERSON:** How about 3:00 o'clock  
8           Eastern?

9           **DR. ZIEMER:** Three o'clock okay?

10          **MS. MUNN:** That's fine with the West Coast.

11          **DR. ZIEMER:** Three to five?

12          **UNIDENTIFIED:** I wouldn't shortchange this  
13          one topic, though.

14          **DR. ZIEMER:** No, okay.

15          **UNIDENTIFIED:** But I hope we can resolve it  
16          before.

17          **DR. ZIEMER:** Well, if we have draft copy  
18          ahead of time we can do some polishing on it.

19          **UNIDENTIFIED:** Okay.

20          **DR. ZIEMER:** Is everybody okay for May 1st,  
21          3:00 p.m.?

22          **MS. MUNN:** Sounds good.

23          **DR. ZIEMER:** Larry, okay?

24          **MR. ELLIOTT:** Yes, we can do that.

25          **DR. ZIEMER:** And comments are due to the

1 Board -- or to the -- yes, to NIOSH and to the  
2 Secretary, then, by the sixth.

3 But basically what I'm going to provide you  
4 with is not only the draft of all the comments,  
5 then plus this stuff we talked about today, but  
6 I'll also provide a draft of a cover letter which  
7 I already have ready. The cover letter doesn't  
8 say what we're going to say, it just says that  
9 our comments are attached, basically. But it  
10 tells a little bit about the process of  
11 deliberation for this information.

12 Okay, we'll plan, then, to meet on telephone  
13 conference on April 1st -- May 1st, I'm sorry.  
14 This will be open to the public as well. We will  
15 have public comment period as well at that point.

16 **MS. JACQUEZ:** Excuse me, I've got to ask a  
17 question. How are you going to notify 10,000  
18 claimants about this conference call?

19 **DR. ZIEMER:** The only way we can do this is  
20 the way we do it now, and that's through the  
21 *Federal Register* and on our Web site. We have no  
22 mailing list for these that I'm aware of.

23 **MS. JACQUEZ:** But if they don't have a  
24 computer they don't know (inaudible) proceedings  
25 is going on. So you're not really fully

1           informing the public.  These claimants are not  
2           being informed, and that's not right.

3           **DR. ZIEMER:**  Well --

4           **MS. JACQUEZ:**  You have five callers coming  
5           in.  It was word of mouth.  But you need to  
6           inform them.  Something needs to be done, because  
7           you're not informing these claimants about these  
8           conference calls --

9           **MS. ROBINSON:**  Excuse me, who is this --

10          **MS. JACQUEZ:**  And they need to hear all this.

11          **DR. ZIEMER:**  Well, we're trying to do it in  
12          the way that's legally required, and that's --  
13          we're trying our best.

14                 The intent of the conference call is for the  
15                 Board to deliberate, and if you have folks that  
16                 you know that would be interested we'd be pleased  
17                 to have you pass the word along to them.  That  
18                 would be fine.

19          **MS. JACQUEZ:**  Well, you might consider  
20          finding a way to inform claimants about what is  
21          going on here.

22          **MS. ROBINSON:**  Excuse me, who is speaking?

23          **MS. JACQUEZ:**  A claimant.

24          **MS. ROBINSON:**  Say it again, please?

25          **MS. JACQUEZ:**  It's a claimant.

1 DR. ZIEMER: Yeah, for the record, I think --

2 MS. JACQUEZ: For the record I have every  
3 right to ask whatever question --

4 DR. ZIEMER: No, no. But we do keep --

5 MS. JACQUEZ: Oh, (inaudible).

6 DR. ZIEMER: We keep a transcript, if you  
7 don't mind identifying yourself for the  
8 transcript.

9 MS. JACQUEZ: Excuse me, Epifania Jacquez.  
10 And I'm speaking to Wanda, am I not?

11 DR. ZIEMER: No, that was the transcriber who  
12 asked for the identity for the record.

13 MS. JACQUEZ: Okay.

14 DR. ZIEMER: Okay, thank you very much.

15 It's now the 5:00 o'clock hour, and we do  
16 need to adjourn. I thank everybody for their  
17 participation today. We will then reconvene at  
18 the appropriate time on May 1st. And this  
19 meeting is adjourned.

20 UNIDENTIFIED: I'm so glad we have a better  
21 connection.

22 MS. BROCK: This is Denise Brock. Do you  
23 have time for any more public comment, or do you  
24 have --

25 DR. ZIEMER: No, we're required to adjourn

1 this at 5:00 o'clock, so thank you.

2 **MS. BROCK:** At five? Okay. Well, I would  
3 like to --

4 **DR. ZIEMER:** But I would mention, Denise and  
5 any others, if you -- the comments, all the  
6 public comments are very important for NIOSH in  
7 their deliberations. And if you have additional  
8 comments it's good for you to write them and  
9 submit them. Those will go on the public record  
10 and on the Web site, and are accessible to the  
11 Board as well.

12 **MS. BROCK:** Could you tell me where to send  
13 that to? I know I probably --

14 **DR. ZIEMER:** Yeah.

15 Larry, can you give us --

16 **MR. ELLIOTT:** If you'll look in the Notice of  
17 Proposed Rulemaking, at the back of it it tells  
18 you how to submit --

19 **MS. BROCK:** Right there? Okay. Well, thank  
20 you very much.

21 **DR. ZIEMER:** Yeah, that actually -- actually  
22 it's -- is it on the last page?

23 **MS. BROCK:** I actually have that with me.  
24 Let me look, and I probably should have seen it.

25 **MR. GRIFFON:** Paul, this is Mark Griffon.

1           One more question while she's looking. The  
2 next call, are we going to have time to -- you  
3 said that you're going to work on a straw man for  
4 this language. I would offer to give some input  
5 to you on that ahead of time.

6           **DR. ZIEMER:** Oh, yeah. Oh, yeah.

7           **MR. GRIFFON:** On the specified cancer issue.

8           **DR. ZIEMER:** Yeah, please do.

9           **MR. GRIFFON:** Because this call, I got cut  
10 off three times in today's call, and I heard  
11 static all -- you know, it was really difficult  
12 to exchange ideas.

13           **DR. ZIEMER:** I'll solicit from any of you  
14 that want to suggest some specific wording, just  
15 shoot it in to me and I'll try to fairly meld it  
16 together and get it out. How's that sound?

17           **MS. GONZALEZ:** If I may, just one additional  
18 before we leave, and I'm Carmen Gonzalez, another  
19 claimant.

20           I just need to know when the public  
21 commentary is going to take place, because if  
22 it's at the beginning or is it going to be at the  
23 end, so that people will be -- make sure to be  
24 there at the beginning of this.

25           **DR. ZIEMER:** I think we'd prefer to have it

1 at the beginning, so that we're sure to hear that  
2 before our deliberations.

3 MS. GONZALEZ: Okay. That's good. Thank  
4 you.

5 DR. ZIEMER: Thank you very much.

6 MR. ELLIOTT: Denise, this is Larry.

7 MS. BROCK: Hi, Larry.

8 MR. ELLIOTT: If you look on the first page  
9 of your *Federal Register* notice and rule, you'll  
10 find it there. It says addresses down under  
11 *Summary*.

12 DR. ZIEMER: Yeah, written comments.

13 MS. BROCK: Yeah, I've got that. And thank  
14 you very much. I don't know why I didn't notice  
15 that part before, but I appreciate that. And  
16 thank you very much.

17 DR. ZIEMER: Yeah. And actually it's very  
18 good to do it that way anyway, because then it  
19 really gets on the public record for sure, not  
20 just in our minutes.

21 MS. BROCK: Okay. And I just -- this was  
22 wonderful today, but there was so much background  
23 noise. And somebody -- it was so rude. You  
24 could hear --

25 DR. ZIEMER: It was difficult for us.

1           **MS. BROCK:** It was awful (inaudible).

2           **MR. GRIFFON:** Paul --

3           **DR. ZIEMER:** Again, thank you, everyone.

4           **MR. GRIFFON:** Paul, one more question. Mark  
5 Griffon.

6           **DR. ZIEMER:** Yeah, Mark.

7           **MR. GRIFFON:** The transcripts from our last  
8 Cincinnati meeting, would they be available prior  
9 to our next conference call? Is that possible?

10          **MR. ELLIOTT:** This is Larry --

11          **MR. GRIFFON:** Because there were good  
12 explanations by Ted Katz and Jim Neton, and I  
13 just wanted to review those.

14          **DR. ZIEMER:** Yeah, I don't think I've seen  
15 them.

16          Larry, do you know where --

17          **MR. ELLIOTT:** Yes, I can answer that  
18 question. The transcripts from the March 7th  
19 meeting will be on the Web site next week, I  
20 believe.

21          **MR. GRIFFON:** Next week? So we'll have them  
22 before our next conference call, definitely?

23          **MR. ELLIOTT:** They'll be there before the  
24 next conference call.

25          **MR. GRIFFON:** Okay, thank you.

1                   **DR. ZIEMER:** Okay, thank you, everyone.  
2                   We're adjourned.

3                   [Whereupon, the meeting was adjourned at  
4                   approximately 5:05 p.m.]

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