THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

MEETING II

DAY TWO

The verbatim transcript of the Meeting of the Veterans' Advisory Board on Dose Reconstruction held at the Sheraton Gateway Hotel, Los Angeles, California, on January 13, 2006.

C O N T E N T S

January 13, 2006

REVIEW AND BOARD APPROVAL OF REVISED SCOPE OF WORK OF SUBCOMMITTEE ON DTRA DOSE RECONSTRUCTION PROCEDURES AND SUBCOMMITTEE ON COMMUNICATION AND OUTREACH 7

A REPORT FROM SUBCOMMITTEE ON DTRA DOSE RECONSTRUCTION PROCEDURES 7
MR. HAROLD BECK

A REPORT FROM SUBCOMMITTEE ON VA CLAIMS ADJUDICATION PROCEDURES 59
DR. RONALD BLANCK

A REPORT FROM SUBCOMMITTEE ON QUALITY MANAGEMENT AND VA PROCESS INTEGRATION WITH DTRA NUCLEAR TEST PERSONNEL REVIEW PROGRAM 80
DR. CURT REIMANN

A REPORT FROM SUBCOMMITTEE ON COMMUNICATION AND OUTREACH
MR. KENNETH GROVES 93

BOARD MEMBERS QUESTIONS AND DISCUSSION 102

PUBLIC COMMENT SESSION 121

BOARD MEMBERS QUESTIONS AND DISCUSSION 164

COURT REPORTER’S CERTIFICATE 196

TRANSCRIPT LEGEND

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P R O C E E D I N G S

(9:00 a.m.)

VICE ADMIRAL ZIMBLE: Ladies and gentlemen, the hour is upon us. We want to start promptly so that we can end promptly.

The first item on the agenda, as I promised yesterday, was to ask Dr. Vaughan for her comments. We've had a discussion this morning. Most of her comments are related to the various reports, and she has -- she's willing to hold off on making comments until after the report has been given.

REVIEW AND BOARD APPROVAL OF REVISED SCOPE OF WORK OF SUBCOMMITTEE ON DTRA DOSE RECONSTRUCTION PROCEDURES AND SUBCOMMITTEE ON COMMUNICATION AND OUTREACH

So we will now begin the agenda item, which is to review the revised scope of work of the Subcommittee on Dose Reconstruction Procedures, Subcommittee Number 1; and the Subcommittee on Communication and Outreach, Subcommittee Number 4. And I'm going to ask the chairman of Subcommittee Number 1, Dr. (sic) Beck, to discuss his proposed revision of the scope of work.

Dr. (sic) Beck.

A REPORT FROM SUBCOMMITTEE ON DTRA DOSE RECONSTRUCTION PROCEDURES

MR. HAROLD BECK

MR. BECK: Well, thank you, Mr. Chairman. I really only have a change -- a suggested change of one word. And the task for the committee originally said "audit" dose reconstruction procedures, et cetera, and we'd like to change that word to "assess" dose reconstruction procedures.

VICE ADMIRAL ZIMBLE: Okay. Would you like to make that in the form of a motion?

MR. BECK: Yeah, I move that we change that one word.

VICE ADMIRAL ZIMBLE: Do I have a second?

MR. PAMPERIN: I second.

VICE ADMIRAL ZIMBLE: All right. Any discussion?

(No responses)

All -- all of who approve?

(Affirmative responses)

Okay. Okay, thank you. Without objection, that change has been made.

Now I would like to ask Mr. Groves for -- chairman of Subcommittee Number 4, to discuss

his proposed revision and place it in the form of a motion.

MR. GROVES: Yes, sir. I would -- the background is that the title of our committee originally was Subcommittee on Communication With and About Atomic Veterans. None of the other subcommittees had the term "atomic veterans" in their title. And since our Board is completely involved with and addressing issues related to the atomic veterans, it didn't seem that we needed to call out atomic veterans in our subcommittee title.

Also to expand the scope of what the committee would do, the -- it is our recommendation to rename the committee the Subcommittee on Communications and Outreach and, to add to the responsibility that the committee has, to coordinate communication and outreach functions, both internal to the Veterans Board on Dose Reconstruction and external to veterans for public meetings. So it expands the scope of our committee to provide communication-related issues within the committee, as well as our activities with the veterans.

And I would -- I would move that that -- that

change be adopted by the Board.

VICE ADMIRAL ZIMBLE: Do we have a second?

COLONEL TAYLOR: I second.

VICE ADMIRAL ZIMBLE: (Off microphone) Okay, and (unintelligible) approve?

Then without objection, those changes will be made.

Dr. Blanck, you...

(Whereupon, there was a discussion regarding the use of microphones which was held off-microphone and was therefore unintelligible.)

COLONEL TAYLOR: I seconded the second motion, the one on outreach.

VICE ADMIRAL ZIMBLE: (Off microphone) Unintelligible). Okay. The vote was without objection. Okay.

All right, well, now we -- now we can declare that the time is 9:15 and we'll ask for a report on the -- the -- the Subcommittee on Dose Reconstruction Procedures, so Dr. (sic) Beck, the floor is yours.

MR. BECK: Thank you, Mr. Chairman. Since this report is fairly long compared to some of the other ones, I'm not going to read the entire report. The entire report will be entered in

the record, and there are copies outside for anybody who already hasn't one. So I'm just going to try to hit the -- some of the highlights of this report and excerpt some of the major points.

First we started off with repeating what our tasks were, which as I said were to assess the dose reconstruction procedures and to audit a random sample of the DTRA dose reconstruction cases.

We then go through the activities of this subcommittee since the meeting that we had in Tampa that we carried out to complete these tasks, or at least to start completing these tasks.

The first thing we did was we select an initial six cases randomly from the cases that have been completed -- dose reconstructions have been completed since the May 20, '03 Academy report. These six cases that we picked, we used what's called a stratified random sampling that concentrates the sampling so that it represents the types of cases and the areas where the veterans were. And since, as Dr. Blake said yesterday, the vast majority of

cases that they have been doing in the last few years are skin cancer and prostate cancer, we chose our cases to represent that fact.

So six cases, there was a skin and prostate case from Project -- from GREENHOUSE in 1951; a prostate cancer case from TEAPOT, which is Nevada, in 1955; a thyroid cancer from CROSSROADS, which was in 1946; a skin cancer from the Hiroshima/Nagasaki occupation force participant; another skin cancer from CROSSROADS; and a prostate cancer, again from the Hiroshima/Nagasaki occupation force. So those were the initial six cases that we looked at.

In October the subcommittee had a meeting at a DTRA radiation dose assessment contractor facility, and the reason we had our meeting there was that so we could interview and have discussions with the contractor analyst who actually did these radiation dose assessments. And some of the -- we list a number of items that we discussed at this meeting. I'll just mention three right now.

We developed a preliminary audit plan for how we would go about doing these audits. We

discussed each of these audits with the lead analyst and we found these discussions were very informative with respect to the subcommittee's understanding of the current DTRA dose reconstruction procedures and practices. And one important thing that came out of this, immediate benefit, was that as a result of the discussions with the analysts, the DTRA RDA contractor acknowledged some issues regarding documentation of files and calculations and consistency of methodology, and informed us he has already instituted corrective measures to address some of these. So it was sort of immediate feedback, which we were very pleased with.

After that meeting we have spent a lot of time, the members of the committee, reviewing these six cases and reviewing the various procedures that were used to do these dose reconstructions. On Wednesday the committee -- subcommittee met to discuss our progress with -- in our individual reviews of these cases. We haven't been able to complete these six audits, but when we do complete them we'll have a formal report summarizing our findings on each

case audit that -- and we'll place that on the VBDR web site. So you will be able to access and read our -- these audits. They will not refer to any specific person, they will be anonymous, but you will be able to get an idea of our findings on individual audits.

I'm going to just sort of summarize some of the main findings from -- so far that we have. These are preliminary audit and assessment findings.

Based on the initial audits, Subcommittee 1 finds that the most significant area where NTPR exhibited progress is in application of the benefit of the doubt and in development of the SPARE in close cooperation with the veteran. A significant change in the overall approach by DTRA contractors in response to the 2003 National Academy of Sciences report is clearly evident.

We also, while we were there, examined the DTRA contractor's library at this facility, and we were impressed by the depth of personal knowledge. And we found this to be -- the knowledge of the analysts to be very noteworthy. The ability of the DTRA contractor

to validate veteran participation by locating and assembling copies of relevant documents that documented exposure scenarios -- such as personnel files, orders and unit operations reports -- was highly commendable.

Significant progress still needs to be made in documenting procedures assuring all analysts use consistent methodology. Our initial six audits indicate that analysts may not always be using consistent methodology, although -- at least from these six cases -- there is no indication that this has affected the credibility of the dose assessments. One reason for this is that new methods are being introduced in response to the National Academy of Sciences and Congressionally-mandated reviews, but this new methodology has not been formally adopted and documented in standard operating procedures.

Another finding is that case file documentation needs to be improved for audits to be carried out expeditiously. In some cases calculations could not be verified due to inadequate documentation in the case file.

DTRA contractors are developing templates that

can be used to move rapidly -- to more rapidly perform dose assessments for veterans whose exposure scenarios conform to a completed generic dose reconstruction with, at most, minor variations. Using templates and standard SPAREs will allow DTRA to only perform a detailed RDA if there are significant exceptions to the generic SPARE.

Skin dose calculations are very complicated and very uncertain. New methods being applied currently have not been reviewed by the VBDR, nor documented in standard operating procedures. Based on the average cost of about $9,000 for a radiation dose assessment that was given to you yesterday by Dr. Blake, it may not be beneficial to perform skin dose radiation dose assessments, particularly for squamous cell carcinoma where doses are likely well below that required for a successful claim. Because radiation dose assessments currently being performed are driven by the backlog and are dominated by easier cases, many of which are these generic cases, the cost of performing skin cancer radiation dose assessments could actually be higher than this $9K.

DTRA has not performed -- has not issued a formal technical analysis demonstrating that the interim upper bound factors that are being applied in response to the recommendations of the Academy report always provide an upper bound dose that is at least at the 95th percentile. After DTRA provides a technical justification for these interim upper bound factors, Subcommittee 1 will then formally review it.

Subcommittee 1 believes that continuing the current use of interim upper bound factors is acceptable for generic radiation dose assessments using templates, but it is not consistent with the recommendations of either the 2003 National Academy report or the 2004 Report to Congress. Unless a formal change in DTRA policy is adopted, an actual estimate of the 95th percentile dose is required. It might be reasonable to change this policy to require an actual calculation of the upper bound only when the outcome might be affected -- that is, the calculation of the probability of causation by the Veterans Administration -- and formally use the present, or possibly revised, interim

factors when the central estimate of the dose is far below the level that could result in a claim being granted. This would be consistent with the policy presently used in the NIOSH dose reconstruction program.

Although Subcommittee 1 has found some problems with documentation and use of inconsistent methodology, we found no indication in these first six audits that doses and upper bounds were being significantly underestimated, or that there were any errors that might have affected any decision by the VA on the veteran's claim. Audit criteria applied to all cases are shown in the attachment of this report, which I won't read, and include an examination of the reported upper bounds.

However, Subcommittee 1 cannot draw any statistical conclusions on the quality of the radiation dose assessments until a large number and variety of cases are audited.

Subcommittee 1 cannot adequately evaluate the calculation of skin doses at this time because the DTRA methodology has not been formalized.

In addition, the use of beta to gamma dose -- the gamma to beta -- beta to gamma dose ratio

method has not been formally validated.
Our future plans are to continue with this practice of interviewing -- meeting with the analysts and interviewing them. We intend to choose another six cases between each of the VBDR meetings. Our plan is to do about 24 audits per year.
Subcommittee 1 was not able to complete its reviews of any specific NTPR methodology as specified in our scope. However, we expect to continue our assessment of both established methods, as well as proposed new methods, and we will report our findings at future VBDR meetings as we complete these assessments.
We have a number of suggested issues for discussion by the Board. Based on our preliminary audit findings and the evaluation of DTRA dose reconstruction methodology, we suggest the following issues for VBDR discussion.
One issue is -- has to do with the outcome of dose reconstructions. At present there is no indication in the DTRA files that we are auditing regarding the resolution of claims for which the radiation dose assessment was

prepared for the VA. This could easily be remedied by the VA copying DTRA when notifying the veteran regarding the resolution of a claim. This would then allow us to compile statistics on what the effect of these various radiation dose assessments had on the claims. DTRA, as you heard yesterday, has proposed discontinuation of revised radiation dose assessments for prostate cancer rework cases. DTRA has indicated that they plan to discontinue revision of RDAs for prostate cancer claims that were -- that were returned to DTRA for reassessment as a result of the findings of the 2003 National Academy report. I apologize, sometimes -- we have "DRAFT" written across here and sometimes I can't read my own -- the "DRAFT" is blocking out my own words.

The rationale for this proposed action is that these doses, when revised upward using the interim upper bound correction factors that were initi-- adopted after the National Academy report, remain below the lowest dose that could qualify a veteran for compensation. Based on Dr. Blake's analysis of the 78 reassessment

prostate radiation dose assessments that he discussed yesterday in his presentation, Subcommittee 1 concurs that detailed reassessments of the 128 additional pending prostate cases not be done, providing pre-assessment identifies no factors that could significantly increase the dose. Unless there are unusual circumstances, it is not likely that reassessment of these would result in a dose that is high enough to suggest that a veteran's cancer was more likely than not to be due to his radiation exposure. Subcommittee 1 notes that the proposed change will enable DTRA to focus on the performance of radiation dose assessments for other pending claims. We also note that the proposed action does not apply to newer pending cancer claims for which a radiation dose assessment has not been performed.

Another issue for the Board to discuss is use of screening doses in lieu of detailed radiation dose assessments for new cases as well as reassessments. Subcommittee 1 notes that NIOSH provides an abbreviated radiation dose assessment when doses are considered

minimal. Considering the cost, it may not be cost effective for the government to perform detailed radiation dose assessments when the dose can be shown to be clearly below the level that would result in a successful claim. Reducing the number of detailed radiation dose assessments through the use of screening doses would serve to reduce the backlog of claims and result in more expeditiously handling future claims.

Regarding the continued use of upper bound factors, even if the NTPR continues to perform detailed radiation dose assessments for all new cases, the Board should consider whether or not the interim upper bound factors adopted in response to the 2003 Academy report should be made permanent for cases where the doses are considered minimal, as opposed to performing more detailed uncertainty analyses.

Finally our last item for the Board to consider is possibly recommending that certain types of skin cancers be made presumptive. We should consider requesting a cost-benefit analysis with respect to making certain skin cancers presumptive for the program. Because skin

cancers now constitute over half of the pending non-presumptive claims requiring radiation dose assessments, and the average cost of preparing these radiation dose assessments may well exceed the cost of any additional benefits that would be provided to veterans, making some or all skin cancers presumptive might well reduce the overall cost to the government. Doing so would significantly reduce the pending case backlog and expedite the processing of pending and future claims.

As you know, there are four members of this committee. However, Dr. Blake being the DTRA representative -- let me read this to be clear. Because he administers the NTPR dose assessment program, it would not be appropriate for him to be taking positions on the findings and proposed recommendations that I've just read or -- so these findings and recommendations represent the consensus of the three non-DTRA subcommittee members. But Dr. Blake does participate fully in our discussions, and in fact is crucial to the success of our subcommittee, so I certainly wouldn't want to belittle his services. The entire report is

submitted for your approval. Thank you.

VICE ADMIRAL ZIMBLE: Well, thank you very much, Dr. (sic) Beck. I need to compliment you and your committee for producing an excellent report that has a great deal of substance to it and some topics worthy of -- of our discussion and -- and potential recommendations to the agencies. I would first like to call on -- on one member who is -- who is here telephonically for her comments. Dr. Vaughan has a great deal of expertise in risk communication and has comments that are worthy of our consideration. So Elaine --

DR. VAUGHAN: Yes.

VICE ADMIRAL ZIMBLE: -- were you able to -- to hear Dr. (sic) Beck satisfactorily?

DR. VAUGHAN: Yes, I was, thank you. I have a couple of concerns or reservations about some of the -- a couple of the suggestions, but perhaps with some discussion these can be allayed. Let me start with the proposed discontinuation of the revised RDAs for the prostate cancer rework cases.

From a risk management perspective, what have the veterans been told about the reassessment?

I'm concerned that in the middle of a process a change in policy could cause several unintended consequences, such as they're -- they're not going to reassess us because there was a possibility that my claim could have gone forward. You know, people may attribute motive to -- to this action that are unintended, and I think the issue of framing this in terms of cost effectiveness in terms of monetary criteria has caused a lot of conflict in the past. So I'd like to hear a little bit more perhaps, if Dr. Blake is there or someone on the subcommittee, to talk a little bit about what are the expectations of the veterans. Have they been communicated with about their RDAs are being reassessed? Where are we in that process?

DR. BLAKE: Dr. Vaughan, this is Dr. Blake. With regards to your questions, the -- the cases that we're looking at expediting on this review and forwarding back have not been started yet with the veterans. Any of the cases that we'd actually started the SPARE and interactions with the veterans, we're going to continue doing those fully out because there's

expectations there that we complete it.

DR. VAUGHAN: Yes.

DR. BLAKE: But the cases that we -- that have been basically at DTRA since the end of 2003 with almost no interaction with the veterans, and that we have not started, are the ones that I have proposed for this expedited process. So --

DR. VAUGHAN: Okay.

DR. BLAKE: -- hopefully we -- we have not led the veterans to expect that we would be doing a complete process for these cases.

DR. VAUGHAN: Okay. That's a major consideration, because I think that often a cost-benefit or cost-effectiveness analysis has been criticized because they focus too narrowly on monetary criteria instead of looking at the broader consequences of losing trust in an agency and the quality of life issues for the affected parties. So as long as they have not been led to expect any reassessment, or if this information is public in some way that you began this process of revising RDAs or looking at them again and then you stopped in the middle, you can imagine how -- with the best of

intentions that DTRA has, because I understand the issue of it -- it's a zero-sum game. And if you're putting a lot of resources into this particular activity, then of course your backlog increases and there's some other cases that might be, in quotes, more worthy of consideration. But I'm very concerned about the appearance in this risk management context that there were other motives to changing this policy, so just to bring that to the attention of the committee and to Dr. Blake.

VICE ADMIRAL ZIMBLE: Elaine, this is Dr. Zimble, would you -- as I understand your comments, there would be no problem with our approving the current recommendation, which is to utilize this technique strictly for the backlog, and -- of the revised cases, the rework cases -- and then go out for public comment for a broadening of that policy to include all such cancers and -- well, first of all I'd like your comment regarding that.

DR. VAUGHAN: Yes, but I -- the comment I wanted to make yesterday also is something I hope we consider. One of the longstanding criticisms of quantitative risk assessment and

exposure assessment analyses, one big criticism for years now has been the fact that we're going from population-based -- and several committee members brought this up, by the way, yesterday -- to go from population-based statistics or averages or typical scenarios to the individual. And so I'm -- I'm raising this issue because so many times where risk assessment has failed decision-making is that it fails to bring in the context factors that might identify potentially relevant exposure pathways that were not identified at first. I was thinking about in a Theater of Operations, for example, if an individual was exposed to -- to radiation, there are other subsequent activities that could increase or decrease the risk -- the duration of exposure, was decontamination possible given the activities the individual was engaged in. And so I'm hesitant to say that when we're looking at each individual that the population-based or average estimates are always appropriate. So I wouldn't want us to miss anything that might change the estimated dose for an individual. I understand the SPARE and using some of the

templates seems very reasonable. But you always have to give yourself some room to incorporate individual-level factors that may have changed the dose than what you expected. So I think the issue in risk assessment which I didn't hear yesterday and I want to raise this -- we know that this is not just a matter of science, and so it is wrong to frame it that way. And some of the criticisms of veterans have been about moral/ethical issues -- who has the burden of proof here, where should we set the threshold to say that someone's health outcomes are more likely than not to be associated with a radiation exposure that's service-related. So I don't think that we'd want to use the guise of science to say that these are strictly scientific issues. These are policy value decisions that are being made, as well. And I'm raising that because I'm concerned about missing out on particularly vulnerable populations or sub-populations that may have been exposed in a way that increased the risks that perhaps were unanticipated, and particularly thinking about the context of exposure -- decontamination afterwards, were

they engaged in other activities that could have increased the duration of exposure. And from Dr. Blake's presentation yesterday I was really pleased to hear that there are these individual-level context factors that can be incorporated into the dose assessments, and I am assuming that that's the case. If that is the case, then I would feel more comfortable in saying we can do an abbreviated version of these RDAs in many of these cases, but I think we just have to be careful and realize the limitations of risk and dose assessment. Some of these limitations and uncertainties have to be related to the fact that we're talking about individuals, but we use population-level data times, and we have to be willing to accept the cost of a false positive, so maybe compensating someone whose dose really wasn't associated with a health outcome or the cost of the false negative leaving out individuals who really do -- are deserving of compensation. So that's a value issue and we need to talk about values and the ethical and moral aspect of this whole compensation procedure as well as the integrity of the science.

So that's a long-winded answer, but it's -- I'm -- I'm raising issues of an individual level and an unusual case where the average RDA or the templates or the abbreviated versions of this process may not pick those up.

VICE ADMIRAL ZIMBLE: Thank you very much, Elaine. You raise some very valuable points. I would -- I would tell you that it's my understanding that individual dose assessments will still be done by exception for those cases in which there are all those mitigating factors that you spoke to.

But let me ask Dr. Blake to respond.

DR. BLAKE: Dr. Vaughan, Dr. Blake here. The -- those 128 cases, as the Subcommittee 1 recommended and we've proposed, we are going to go through individually. We are going to look to --

DR. VAUGHAN: Okay.

DR. BLAKE: -- see if there's any individual circumstances. The letters that we draft to go out with our -- we write them to the VA, but they're written towards the veterans, also, to explain what we're doing, what's going on here. And certainly if they have any questions to --

for us to be able to explain exactly what we've done for them. I think this is in the veterans' best interest. There's no reason, if we can't help them to get compensated, to keep dragging this out.

DR. VAUGHAN: Yeah.

DR. BLAKE: And we want to -- to get this finished for them and -- but we will do our best to answer any of the questions the veterans have to make sure that we haven't missed any unusual circumstances. We are looking on an -- on an individual by individual basis.

DR. VAUGHAN: Well, that's very reassuring, Dr. Blake, and I think that DTRA has to be more proactive in explaining this because this is exactly where some of the concerns come from and some of the conflict regarding the compensation process. And I think that a more proactive approach to explain this to people, that you're not ignoring individual circumstances, is very reasonable. And I agree that the -- prolonging the uncertainty of whether or not you're going to get compensated has a -- has a cost, as well. And for the

quality of life of these veterans, and for some kind of resolution, I agree with you completely that, if possible, that's a wonderful direction to go in. And it's more than money and cost effectiveness. It's about the consideration of these individuals. But I think that that needs to be -- perhaps there's a way to make that information more available or more salient because then it gives legitimacy to what you're proposing to do.

VICE ADMIRAL ZIMBLE: Thank you very much, Elaine. Your comments are very, very helpful, and I would say, in addition to the cost factors that you've mentioned, there's also the ability to attend to other claims that are -- that are in the hopper and -- and become more expeditious in moving those claims along, as well.

DR. VAUGHAN: Yeah.

VICE ADMIRAL ZIMBLE: So it's a question of -- of prioritizing workload to the benefit of the veteran.

Dr. Lathrop.

DR. LATHROP: Yes, Dr. Vaughan, I appreciate very much what you've been saying. I would

point out that we'll be examining the exact communications as they're sent to the veterans. I fully agree with your points that cost effectiveness is not the appropriate framing in terms of the explanation to the veteran --

DR. VAUGHAN: Yeah.

DR. LATHROP: -- although that can be part of it. At the same time we'll be taking a careful look at can the results be framed more clearly and simply in terms of -- of a set of upper bounds and what the upper bound is and relating that to the threshold dose that would have to be crossed for action, and a list of exceptions or possible exceptions. So there's a lot -- almost -- it's more than formatting, but a lot of it simply does have to do with the formatting and the presentation to the veterans.

DR. VAUGHAN: Yes.

DR. LATHROP: In the discussions yesterday and today, I wouldn't blame anybody for saying gee, this is all awfully complicated stuff. At the same time, the way we frame the actual missives to the veterans doesn't have to be that complicated.

DR. VAUGHAN: That's right.

DR. LATHROP: The basic background has to do with -- with upper bounds and comparative analyses and comparative sorts of numbers, which don't have to be bewildering and can be clear to the veteran. But it will take some work to do that.

DR. VAUGHAN: Absolutely, but these kinds of issues have been transmitted, translated to many public audiences, non-science audiences, and perhaps our subcommittee can help you with that. But there are wonderful examples outside of the particular compensation process that we're talking about where this kind of risk information or exposure information can be communicated to public audiences. So there's a lot of guidance out there.

I'm currently on a National Academy of Sciences committee looking at issues like this. And we're going to come out with some recommendations about these kinds of issues, but there's a lot of guidance -- and perhaps we can help you with that.

DR. LATHROP: Point well taken, thank you.

VICE ADMIRAL ZIMBLE: Thank you very much. Mr.

Groves.

MR. GROVES: Thanks again, Elaine, for your comments this morning. This is -- this is Ken Groves --

DR. VAUGHAN: Yeah.

MR. GROVES: -- and I -- I guess I'm speaking now in my capacity as the chair of the communications and outreach committee, of which both you and John Lathrop are members. And I guess that one of the functions that our subcommittee is charged with is to assist in improving the communications between both the VA and DTRA and the veteran. And so I don't think it would be unreasonable for us to assist you with the actual information that would -- that would go to the veterans on this subject. And we can of course be sensitive to those non-technical and non-scientific issues that both John and Elaine have mentioned. So I guess I would just offer our assistance as a subcommittee in -- in working with you on those communication vehicles to -- you know, to get the right information out in a way that is -- serves the purpose, but also is an appropriate information exchange with the veteran.

And I guess to that end, the question I was going to ask earlier was, for these particular 128 people, was there going to be a separate communication to them about the fact that that part of the cohort was going to get treated differently than the others in terms of having a full-blown dose reassessment on the rework?

DR. BLAKE: I'd certainly welcome the assistance of the Subcommittee 4. I believe we can incorporate those factors into our correspondence. What I'd like to do is in the next few weeks when we prepare this draft correspondence and discussion, forward it over to you for some critical review before we release it. So I think what -- you can look forward to us as a DTRA -- as an item -- action item from DTRA is some input for your review in the next few weeks on how we prepare to release this information as we go ahead with these 128 prostate rework cases.

MR. GROVES: That would be great, and I think that that's a -- that's appropriate and I will commit our subcommittee to assist you in a timely way, recognizing that we do want to get this information out as soon as possible so

that we could move forward with -- with the process.

VICE ADMIRAL ZIMBLE: Okay. Dr. Swenson. Oh, that's Dr. Reimann.

DR. REIMANN: I have a concern with some aspects of the switching of the skin cancers to presumptive, more in the communications and the language problems that that entails. For example, it makes the switch from presumptive, where there's at least conceptually the appearance that something has more compelling evidence of causation. To relabel something where the evidence -- there's not new evidence brought to bear, but to label it for convenience in processing strikes me as raising new communication problems. Whereas I don't disagree at all with the intent or the outcome, I think it brings new problems in communication to try to explain how something gets relabeled without any new evidence that indicates that that condition is now -- the evidence now suggests that that condition is -- is more associated with radiation than we used to think it was. So it's more of a problem of the communications and the language we use, not the

-- not the outcome that would flow from this.

VICE ADMIRAL ZIMBLE: Okay. Dr. (sic) Beck.

MR. BECK: The reason we're suggesting this as a discussion item is not necessarily because we think that the understanding of the risk has changed, but because of the fact that we have concerns about whether or not you can reliably do a good dose assessment and -- and whether it's worth doing it in terms of the cost benefit. There -- there -- it's already been decided by the health people, as you heard yesterday, that skin cancer can be -- certain types of skin cancer can be caused by radiation exposure. It's also -- these IREP tables, the -- the level that would be required is not that high. Because of the large uncertainty in doing these dose assessments, even though the actual dose may have been very small, we cannot reliably say that they haven't met this. So we -- we are doing these very complicated, very expensive dose reassessments when perhaps the cost of doing this is much greater than -- than giving the veterans this extra benefit, basically. This is in favor of the veteran, so even if they really didn't get their skin

cancer from radiation exposure, we will say they did. We will presume that they did. So the overall benefit -- it's a question of what's the overall benefit to the veterans and the overall benefit to the government of making this assumption. And we're making an assumption which would be in favor of the veterans, not the opposite.

DR. REIMANN: It does appear to be at the -- at the cost of -- of a labeling that is at least supposed to convey some sense of -- of the linkage between radiation exposure and -- and ultimate disease. And so I see that more as a communications problem. As I say, it isn't the answer or the outcome that troubles me at all. It's the fact that it gives still another opportunity for confusion, and it appears to -- it appears to be a shifting of -- of something from one column into another, driven by a convenience of what might happen as an outcome rather than new evidence that puts something on one list rather than another. I think it just adds to the -- to the confusion that people experience in understanding what drives the -- what drives the decision.

So I just wanted -- actually just wanted to -- to throw it out there because, to me, the outcome ultimately would -- would drive the way -- the way I would vote myself, but I just wanted to express that concern, particularly since I think Elaine was expressing comparable concerns about aspects of -- of similar information and how that -- and how that bears on veterans' confidence in what the -- what the overall government does and why it does it.

VICE ADMIRAL ZIMBLE: Okay. There's -- there's no question that we want to make sure that the recommendations that we make are not subject to misinterpretation. Let me at -- there's two -- two Board members that want to speak. Do either of you want to speak on this particular issue? Both of you on the issue of the skin cancer? Okay. Then Dr. Swenson, I'd like you to wait. Dr. Zeman's had his -- had his signal up for a long time.

DR. ZEMAN: Thank you. I wanted to address an issue that Dr. Vaughan raised, and that is the application of population or average data applied to the individual veterans. That issue was very important to us on Subcommittee 1 in

looking at the credibility and reliability of the dose reconstruction process. And what I want to point out to Dr. Vaughan and to all the members of the Board is that we -- we found a real difference between dose reconstructions in prostate cases versus dose reconstructions in skin cancer cases. In the case of prostate --

(Whereupon, there was a short power failure in the meeting room.)

VICE ADMIRAL ZIMBLE: Okay.

DR. ZEMAN: Are we all right now?

THE COURT REPORTER: Okay, I've got it back. It just blanked out.

DR. ZEMAN: Are we all right now?

THE COURT REPORTER: Yes, thank you.

VICE ADMIRAL ZIMBLE: The hiccup is over? Okay.

DR. ZEMAN: In the case of prostate, we found the dose reconstructions to be very credible and very detailed and a reasonably reliable estimate of dose. And this is because the primary mechanism of dose to the prostate was from external exposure to gamma rays and to neutrons that was either measured or calculated and -- and documented in some means at the

time, and reports were available and researched so that there was reasonable, credible evidence of what the dose to the body and the internal organs was.

This is not the case for the skin cancer. In skin cancer there's a large number of uncertainties and -- especially in individual cases. Dr. Vaughan brought up, you know, were people adequately decontaminated and when and how long after the exposure, and those are very credible questions. Anyone who's ever had dirt on their skin or salt water, you know, on their skin or on their clothing, or sand from the beach on their body, you know that it's not evenly distributed. It may or may not come off after you wash or you're decontaminated. It may be with you for a long time.

The individual variability in those cases introduces tremendous uncertainty, and it's unquantifiable uncertainty. It's not just that it's uncertain, but we don't know how uncertain and we're unable to really tell. So so far we have not seen that -- that DTRA or the contractors do in the RDAs have any way of getting their arms around the uncertainty in

skin dose assessments when -- when the fallout or the sea water or the sand is actually on the skin or on the clothing.

That being the case, that's part of the basis, a strong driver in why we've recommended that some of the skin cancers be made presumptive, simply because the uncertainty analysis can't be done. And if the dose analysis can't be done and the uncertainty analysis can't be done, we have a very uncertain process. So I wanted the Board -- Board members to understand that we see a real difference here between prostate -- which is reasonably reliable, with some confidence in the uncertainty levels that are assigned -- and skin cancer, which is highly uncertain and probably unquantifiable in many cases.

VICE ADMIRAL ZIMBLE: Thank you very much, that's a -- that -- that explanation needs to be included in the recom-- in the formal recommendation from the Board.

Dr. Swenson.

DR. SWENSON: I agree with the comments that are made from Subcommittee 1 on the skin cancer. But I think that you should take out

the comment that you think it will save the government money. When you make a cancer presumptive, if we do it for the veterans, it is very likely that the law for the Department of Labor veterans will also become a presumptive and therefore they'll get the lump sum -- $75,000, $100,000, $150,000 -- because they try to keep those lists very identical. And so if we make this change, this may very well impact the Department of Labor. And before we even recommend this I think we should talk to that Board and maybe discuss their issues with this. But the comment that it will save the government money, it may not because of that issue.

VICE ADMIRAL ZIMBLE: That's a very good point.

MR. BECK: I might mention that we did not -- what we said was we would request that this kind of analysis be done, 'cause as far as we know, we -- we do not really know what the cost benefit, if you want to use those terms, is. We don't know the overall cost to the government. So it was sort of conjecture on our part and that what we would like to see is this kind of discussion and information from

these other groups perhaps as to really what is -- is this beneficial in terms of cost. But again, I think the driving thing here is that if we, as we go forward, really do not feel we can support a dose reconstruction for skin cancer, then there really is a problem because it's really not fair then not to make it presumptive because basically what we would then do as an alternative is to require DTRA -- or suggest DTRA use such large uncertainties as to in effect pay everybody off, but still do the complicated dose reconstructions first.

VICE ADMIRAL ZIMBLE: Okay. I appreciate those comments. I would just point out that we needn't discuss the matter of cost, but only recognize that our advocacy is for the veteran and that we do what's best for the veteran. I don't mind apprising the Department of Labor regarding our recommendations and our decisions, but I think that we need to concentrate on -- on the -- on the people that we serve, and -- and that's the veteran. So I -- I can un-- I can -- I am very much persuaded by the -- by -- by the arguments both for the -- the prostate issue and the squamous cell

carcinoma issue for two totally divergent reasons. But -- but both reasons, to me, make -- make for irrefutable logic. So -- but that's just the Chairman's point of view. I'd -- I would propose -- wait a minute, before I propose anything, I see a couple of more signals over here, so Dr. Lathrop.

DR. LATHROP: Yes. Now I'll wear my decision analyst hat and I -- I would encourage the Board, and perhaps we can't come to a resolution here, to adopt fairly clear principles by which we make our decisions. And what's been floating around here in the last half-hour has been something on the order of if it's cost-effective and in the favor of the veteran, that's a reason to do something. And that actually makes some sense.

Then when Dr. Swenson pointed up ah, but it may not be cost effective, taking into account Department of Labor and some other things, well, then we need to think through it. I'm beginning to endorse what our distinguished chair has basically said, our -- our scope is doing our best in favor of the veterans within our particular scope. So we may, although it

may be politically touchy -- I don't know that we want to be explicit about it -- but adopt a general set of principles that include if it's cost effective within our scope and it's in favor of the veteran, we should consider very seriously doing it.

VICE ADMIRAL ZIMBLE: I'd like you to reverse those two concepts. I think if it's in favor of the veteran and oh, by the way, it's also cost effective, that's good news. Okay? Mr. Groves.

MR. GROVES: Well, I guess I would -- I would agree with the last statement that was made in that there are issues that affect other programs that are -- that for consistency in those programs I think there would be interest in -- in awards being -- being made for the same rationale. And I think that Dr. Zeman made an excellent case for why it is difficult to do the analysis for the skin cancers. I think, however, to serve our community, the veterans' community, we don't need to move this from presumptive -- from non-presumptive to presumptive, which would take a changing of the law, as it is currently written -- or at least

the application of it. It would seem that just to acknowledge that for that group of people, the uncertainty is such that more people will be awarded a positive outcome to their claim serves our community without having to impact other -- other programs that have to deal with the issue of skin cancer. So I think we can -- as you said, Admiral Zimble, what is important to us is to serve our community, the veterans. And I think we can do that by just expanding this uncertainty and, as Gary said, there will be more people will be paid for the skin cancer -- or their claim will be adjudicated in a positive way, I guess is the way to describe it.

VICE ADMIRAL ZIMBLE: So you're suggesting that by increasing the level of uncertainty which -- which we acknowledge exists, that the doses -- the -- the RDA would be higher, and high enough to reach PC for -- for a squamous cell carcinoma.

MR. GROVES: Yes. And our skin cancer and the way in which people may have been exposed are going to be different from the other programs and that -- and that we can keep it within our

house and under our control.

VICE ADMIRAL ZIMBLE: Dr. (sic) Beck --

MR. BECK: Yeah, I just wanted to clarify one thing. It's mainly basal and melanoma. Squamous really requires a --

VICE ADMIRAL ZIMBLE: I'm sorry --

MR. BECK: -- very large dose.

VICE ADMIRAL ZIMBLE: -- I'm sorry. I'm sorry, I meant -- I said squamous; I meant basal cell and --

MR. BECK: But basal, which -- which is the most common one --

VICE ADMIRAL ZIMBLE: Right.

MR. BECK: -- really, under the PC that's being used now, requires a fairly modest dose, which --

VICE ADMIRAL ZIMBLE: Right.

MR. BECK: -- would probably be exceeded if you put a reasonable uncertainty on the calculations -- for many of the veterans, not all of them.

VICE ADMIRAL ZIMBLE: Right, I -- I stand corrected.

Any other comments? Oh, Mr. Pamperin.

MR. PAMPERIN: Just to make clear, you know,

when we're talking about a law change, what we -- what we would be talking about would be a regulation change. And there -- you know, if there's a reasonable basis for it, we could -- you know, that could happen. There is an -- for everybody's information, there is a March 2005 OMB letter that gives direction to all agencies that if they are to propose any regulatory change that increases entitlement, that accompanying that regulatory change would be another regulatory change showing where you're going to get that money from, where's you're going to offset. So the -- the issue there I think is if it -- I think that's not insurmountable. If your -- if your argument is that you're going to increase the level of uncertainty to such a level that it's going to happen anyway, well then there is no cost. But I think that would have to be articulated well for us to put that in the preamble of any reg.

VICE ADMIRAL ZIMBLE: Thank you very much, Mr. Pamperin. I -- did you have a comment, Dr. Boice?

DR. BOICE: (Off microphone) Yes, I --

VICE ADMIRAL ZIMBLE: Yes.

DR. BOICE: Sort of a summary comment, just on these levels of uncertainty. It seems to be interesting that we have two cancers that are not highly radiogenic, the prostate and the skin. And because of uncertainty we're going to reward the cancer where the uncertainty in the dose assessment is greatest. Whereas for prostate, because the dose uncertainty is less, we're going to assume that they will not reach the upper level and therefore it would not get an award. But because of the skin, if I understand it correctly, because the assessment of the dose is so uncertain -- both high and low, I assume -- that that would then be level for award.

This is something that has always disturbed me a little bit, too, with the IREP is -- is that it rewards uncertainty, also. If you have a cancer site -- if two veterans come in and one cancer is not known to be highly radiogenic, the uncertainty is very great, and an award is made based on the 99 percent level. But then another veteran would come in -- this would be -- or another person with a site that the evidence is pretty well known on radiogenicity,

the uncertainty is lower and then the same dose would not receive an award. This is forgetting presumptive and non-presumptive. So I just saw that as an unusual rationale, in a way, is making awards based on uncertainty as a -- for one case but not for the other.

VICE ADMIRAL ZIMBLE: Let me try to recouch that with a different concept. And that is where do you want to place the burden of proof, on the veteran or on the government? If you're going to place the burden of proof appropriately on the government, then the veteran gets the benefit of the doubt with uncertainties. I think that's -- I think that's the way we should be proceeding, according to the spirit of the law, which says give us -- the veteran -- the benefit of the doubt in many, many areas. So I -- I agree with you that that uncertainty gets rewarded. But that's where the burden of proof is.

Dr. (sic) Beck.

MR. BECK: Yeah. No, I just want to follow up on that. It's not just the uncertainty in the dose, but because these are considered very -- maybe not radiogenic cancers, both of them,

prostate and skin, there is a very big discrepancy between the best estimate -- the 50 percentile level and the 99th percentile level, and that's why you can get rewarded now at the 99th percentile for this fairly low skin dose. It's because it -- both the PC and the skin dose are very uncertain. So you're right. I mean it's a combination of the two, but the -- you know, that gets into this whole concept of using 99th percentile.

VICE ADMIRAL ZIMBLE: Thank you very much. I'm therefore go-- Dr. -- Dr. Lathrop.

DR. LATHROP: Ah, yes, I can tell some irritation. I'm used to that.

UNIDENTIFIED: (Off microphone) (Unintelligible)

DR. LATHROP: Yes, right.

VICE ADMIRAL ZIMBLE: We're used to that, too.

DR. LATHROP: Yes, I'm afraid so. I just wanted to share a question I have in my mind to help clarify at least my own thinking. One of the problems with my esteemed subcommittee chair's suggestion that maybe we should still go through some -- some dose estimation for the skin -- skin cancer, and of course then the

tail of the distribution will be above PC equals 50 and they'll get the award. The problem is that doesn't save us the money, to be perfectly crass, as moving to presumptive would. And then another conversation we've had seems to at least maybe suggest -- I'm putting words in people's mouths -- that we can be a little bit clever here and treat particular cases as if they're presumptive without putting that cancer on the presumptive list because of the implications to different agencies for that. And I just wondered, is that acceptable; could we do that? For instance, we might decide to have this particular skin cancer treated as if it's presumptive without putting it officially on the list. Is that too clever? Is that legally appropriate? I'm wording that as a question.

VICE ADMIRAL ZIMBLE: I'll -- we'll take that for consideration.

DR. LATHROP: I'm used to that response, too.

VICE ADMIRAL ZIMBLE: What I would like to propose is that Dr. Blake work with Dr. (sic) Beck and Mr. Groves in -- in constructing formal recommendations for the Board's

consideration and approval, hopefully, that takes into consideration all the various admonitions that have been -- that have been brought forward so that -- and -- and by all means, we'll make sure that our expert on risk communications, Dr. Vaughan, has an opportunity as a member of Subcommittee 4 to -- to review this to assure that we're doing our very best to eliminate a -- misconceptions of what we're doing.

Dr. Blake.

DR. BLAKE: Admiral, the only -- I'm certainly happy to help from the Defense Threat Reduction Agency, assisting both sub-chairs, but I believe my colleague, Mr. Pamperin from the Veterans Affairs, will also have to contribute in this if we're doing a cost-benefit analysis.

VICE ADMIRAL ZIMBLE: I'm happy to include Mr. Pamperin into the team.

MR. PAMPERIN: Yes, and I already sent an e-mail message to begin working on the cost estimate.

VICE ADMIRAL ZIMBLE: Dr. (sic) Beck.

MR. BECK: I think that Dr. Blake would, however, like a decision on his rework prostate

cancers. I think, you know, that bridge is where he'd like the Board to actually make a decision today. Is that correct, Dr. Blake?

DR. BLAKE: Yes, it is, Mr. Beck.

VICE ADMIRAL ZIMBLE: Well, I will be happy to ask for a consensus from -- from this Board as to whether we can approve, and I -- I think we can approve it. When we make that recommendation, it needs to be well phrased so --

DR. VAUGHAN: Yeah.

VICE ADMIRAL ZIMBLE: -- so there's no misunderstanding. But -- but I think we all agree that with -- with the various constraints that have been placed, this is to be for rework cases right now, that it -- that those cases will be looked at on an individual basis in accordance with the SPARE, et cetera, to see whether or not it fits a template or exceeds a template, and any case that exceeds a template is going to be -- is going to continue to be worked as it -- as it has been now.

Is that not right?

DR. BLAKE: With a small variation. We have not completed SPAREs on these cases yet, but we

are certainly going to review each and every -- every one for unusual circumstances, and if they're there, we will not treat them this way. We'll do the full RDA concept.

VICE ADMIRAL ZIMBLE: Okay. With -- with that in mind, I would ask for the Board's vote, yea, in favor of supporting this proposal from DTRA and -- Elaine --

DR. VAUGHAN: Yes.

VICE ADMIRAL ZIMBLE: -- I'll need a voice vote from you.

DR. VAUGHAN: Yes, with Dr. Blake's comments?

VICE ADMIRAL ZIMBLE: Right.

DR. VAUGHAN: Yes.

VICE ADMIRAL ZIMBLE: Okay. Is there any objection?

(No responses)

The Board -- the Board endorses the proposal of -- of Dr. Blake of NTPR to -- to take -- to make their changes in the prostate.

DR. VAUGHAN: Admiral Zimble --

VICE ADMIRAL ZIMBLE: Yes?

DR. VAUGHAN: -- I just want to make sure, though, that the language that Dr. Blake just presented to us accompanies --

VICE ADMIRAL ZIMBLE: Yes.

DR. VAUGHAN: -- a record of this recommendation.

VICE ADMIRAL ZIMBLE: Yes, it will.

DR. VAUGHAN: Okay.

VICE ADMIRAL ZIMBLE: Okay, let's see where we are on the agenda. We -- and by the way, this -- this completes that report. We're ready for the -- for the second report. We were to take a break at -- in five minutes. I -- I'm going to leave it to Dr. Blanck. Would you like to do your report before the break, if...

A REPORT FROM SUBCOMMITTEE ON VA CLAIMS ADJUDICATION PROCEDURES

DR. RONALD BLANCK

DR. BLANCK: Actually I believe I can do it briefly enough that we'll only push the break back by a minute or two, so yeah, perhaps we can do that.

VICE ADMIRAL ZIMBLE: Okay.

DR. BLANCK: Do the report, then take the break and then have a discussion.

VICE ADMIRAL ZIMBLE: That'll keep us on schedule. Thank you very much.

DR. BLANCK: Thank you.

VICE ADMIRAL ZIMBLE: So please proceed, Dr. Blanck.

DR. BLANCK: Mr. Chairman, members of the Board, it's my pleasure to present the draft report of the Subcommittee on the VA Claims Adjudication Procedures of the Veterans Advisory Board on Dose Reconstruction. A disclaimer -- Mr. Thomas Pamperin, who's of course a member of the Board, serves as the VA liaison to our subcommittee. Because he works for the VA it would not be appropriate for him to take any formal position on the findings and proposed recommendations in this report. Therefore these findings and recommendations represent the consensus of Dr. Zimble and myself. I would add that we've been well-served with excellent suggestions and comments, both from Dr. Fleming and Dr. Vaughan, on this report, and I'll try to note those at the appropriate times.

You have the report in front of you. I'll not review everything or read everything, but we essentially are to review the policies and procedures used by the VA and the Veterans Benefit Administration for claims by veterans.

This includes performing random audits on claims evaluation procedures, and decisions on claims for radiogenic and non-radiogenic disease. This will include evaluation of the methods for adjudication of claims and the scientific validity of decisions made on a suitably large number of randomly-selected claims. You have defined eligible veterans, and this definition of the population, including of course atomic veterans, is taken from VA publications.

On the second page I note and compliment the VA that they have created a VA Ionizing Radiation Registry where environmental health clinicians conduct a comprehensive physical examination. It's similar to other registries that the VA has. We've heard some testimony yesterday that sometimes that process is not as smooth as we would like. I know the VA takes that very, very seriously, but they do have that registry and more than 23,000 veterans have already participated in this registry.

They also -- the VA, that is, publishes a newsletter called *Ionizing Radiation Review*, which does two things. It both provides

information to veterans, but it also helps educate those in the VA and DoD. Because as we also heard yesterday, sometimes those in this large system of health care -- people aren't as aware of things as they ought to be, so it's a continual education process and I compliment the VA on doing that.

Now we then had, in our meeting in late November at the Veterans Benefit Administration Office in Washington, a series of comprehensive presentations on the processes and procedures used by the VA for veterans who fit into the -- the category on the first page. On the basis of possible exposure then, in the presence of disease, veterans may file a claim for disability compensation at any regional VA office. Claims are adjudicated based on the diagnosis or medical conditions. Cancers, in all cases except skin and prostate, as we've heard described, are presumptive for veterans for whom it can be demonstrated participated in some activity that would qualify them for exposure. That is, they were exposed to ionizing radiation. This automatic presumption means that no dose reconstruction is necessary.

Now there still is an issue with the timeliness of the VA handling these claims, but it -- and of course if they have to go to DTRA to have evidence generated of their exposure to ionizing radiation, there certainly can be a time factor, but it doesn't have to go through that dose reconstruction process.

We actually then concentrated on those conditions that are non-presumptive because those are the ones that are most problematic and take the longest time. As we looked of course at the VA process, any recommendations we have for improvements will affect both the presumptive and non-presumptive cases.

Compensation is ultimately based on disability, as for any other service-connected diseases. And I've already described the difference, and we all know it, between presumptive and non-presumptive.

The VA is trying to estimate the total number of veterans granted benefits due to radiation exposure and who are still in the system and so forth. This is very hard to get and we've heard a little bit about that yesterday. I am told by Mr. Pamperin that the VA hopes to have

that data perhaps by the end of this month or into -- into February. Skin cancer and prostate of course we've also heard make up more than 90 percent of the pending claims, and there is anticipation that most of the new claims will fit in that as far as the non-presumptive diagnoses.

Now with the presumptive group automatically being awarded service connection, and depending on the degree of illness, compensation, if it can be demonstrated that they were in a location and exposed to ionizing radiation, potential improvement in the process would be for the non-presumptive group, again realizing that as we make recommendations for the VA's initial handling of the claims, that would work for the presumptive as well. We kind of reviewed and walked through what would happen to a typical claim for a veteran in the non-presumptive group.

Again, the claim can be filed through any one of the 57 veterans benefit offices. The benefit office obtains medical evidence, sends a development letter to the claimant requesting information. Also the veterans benefit office

-- VA Benefit office contacts the military service department for verification of service and other information. We were informed that there is a difference as to how regional offices deal with these claims, depending on the level of staff experience and the number of radiation claims each year. The claim is then sent to the central office, usually in a, not the, matter of weeks, and eventually to the Defense Threat Reduction Agency for dose reconstruction.

Because of the volume of all of these cases, a lapse of time exists between receipt of the claim by the central VA office and conveyance to DTRA. The VA makes an attempt to put some resources and give priority to atomic veteran cases, but acknowledges that a lot of people are doing a lot of things, so sometimes these cases do not get the priority that we would wish.

DTRA subcontracts dose reconstruction to SAIC, and any additional data such as location of service member, time of exposure, is subcontracted to Titan Corporation, which has personnel located at the Military Records

Center in St. Louis. The DTRA process seems to take the longest. We've heard about that -- months to over a year.

When the dose reconstruction is complete, the information is then relayed via the VA central office to the Office of Public Health and Environmental Hazards for determination of service connection. If this connection is established, and that depends on the dose, and probability of causation/assigned share criteria is met, compensation is awarded. Very few non-presumptive cases meet the criteria.

The subcommittee also noted equity or fairness issues associated with differential between presumptive and non-presumptive cases, which we will go into more as we do our audits.

This provided an opportunity for us to review the processes and procedures at the VA. It remains for us to perform the random audits of the VA claims evaluation procedures and decisions on claims for radiogenic and non-radiogenic diseases, including -- and this is important -- evaluation of methods used for adjudication of claims -- we -- we got some initial information of that, but we need to do

it now in an audit way -- and the scientific validity of those decisions. We will audit the claims process and procedures, including interaction with the VAROs, the regional offices, with veterans filing claims and with DTRA on dose reconstruction requirements. What we would now ask for discussion, or perhaps provide recommendations on, is centralizing the ionizing radiation explos-- exposure claims. That is, having a single point or perhaps two points within the VA where all of the claims are handled by experienced people, allowing consistency and I think timeliness; providing VA personnel for DTRA, rather than having DTRA just rely on Titan Corporation, at St. Louis to help with rapidly acquiring needed information; developing scenario-specific templates so that reconstruction does not have to be done on an individual basis each time -- for people in a same location who have similar exposures, a template could be developed that would allow for rapid dose reconstruction, or at least more rapid; developing worst case scenario specific templates concerning potential eligibility

based on probability of causation so that, from the onset of filing a claim, a veteran understands -- gets this information and understands the likelihood of being eligible for compensation -- telling a veteran something up front I think would go a long way to establishing credibility, and of course having that individual interaction is part of that; developing a protocol to help those with a presumptive diagnosis so they know that it is presumptive, doesn't have to go through a huge process; verifying that they participated in an activity which would qualify as radiation exposure and trying to develop better ways to do that; finally, establishing a centralized database with both input and output data readily available.

Mr. Chairman, that concludes my report. Thank you.

VICE ADMIRAL ZIMBLE: Thank you very much, Dr. Blanck. Are there any comments?

DR. VAUGHAN: I have one question.

VICE ADMIRAL ZIMBLE: Dr. -- Dr. Swen-- oh, wait, I'm sorry --

DR. VAUGHAN: I'm sorry.

VICE ADMIRAL ZIMBLE: -- Dr. -- Dr. Vaughan, we'll -- I -- I promised we will always start with you.

DR. VAUGHAN: I can wait.

VICE ADMIRAL ZIMBLE: No, no, that's -- that's fine. You don't have in front of you the -- the latest draft, so --

DR. VAUGHAN: Okay.

VICE ADMIRAL ZIMBLE: -- did you -- were you able to discern whether your comments were incorporated into the report?

DR. VAUGHAN: Yes, this is just a very brief question for Dr. Blanck. According to the plans for the subcommittee, will you be able to identify regional variability in the efficiency of the adjudication process? 'Cause that might be an outcome, that there are some issues at a regional or local level as opposed to a centralized level.

DR. BLANCK: Ron Blanck here. We were given information that suggested those differences. We were not able to quantify them, but it was clear there were enough differences, there was enough variability, that we felt comfortable in recommending a central office location to -- to

take in and begin the claims processing procedures.

DR. VAUGHAN: Uh-huh, thank you.

VICE ADMIRAL ZIMBLE: Yeah. Dr. Vaughan, I would -- I would mention that both the veterans and the Veterans Administration acknowledge that the levels --

DR. VAUGHAN: -- cure a problem.

VICE ADMIRAL ZIMBLE: Okay. Dr. Swenson?

DR. SWENSON: Just as a point of clarification, in your document you say most cancers are presumptive, but in your statement you said all cancers other than prostate and skin. And there are some other ones that aren't, so I just -- for the minutes, there's CLL and there's some other cancers that are not, as well.

DR. BLANCK: Good point, thank you.

VICE ADMIRAL ZIMBLE: Okay. Thank you. So the recommendation that you would like the Board to consider at this point would be a recommendation to have one or two specialized VAROs that would handle all the radiation claims. And would that include counseling, as well?

DR. BLANCK: Yes, I believe so. I think having the single entry point, or perhaps two, with dedicated personnel would get at that, would allow that kind of individualized interaction. I would also have the VA ask DTRA if perhaps they could interact more with them at St. Louis to help get that needed information. The VA already has personnel there, yet as I understand it -- and I may be wrong here, Paul, the -- DTRA uses Titan Corporation rather than going to the VA. I think there's some interaction issues or ways that we could leverage the presence of folks there. And then if the VA would ask DTRA, DTRA would take on asking SAIC or perhaps DTRA itself to do those scenario-specific templates. I think this would streamline the process, too. And I believe most of these things are actually happening or being thought about or starting. And certainly the centralized database at the end is -- is well on its way.

VICE ADMIRAL ZIMBLE: I think that the -- those elements, other than the specialized VARO, are already underway, do not require a recommendation from the Board. Dr. Swenson.

Oh, okay.

Mr. Pamperin, did you have any reservations?

MR. PAMPERIN: Well, I'm a little -- I just want to make clear, when you -- when we say centralized claims processing, the veteran can still file their claim anywhere. It will just be moved to one of two places.

VICE ADMIRAL ZIMBLE: Right.

MR. PAMPERIN: So that they -- their traditional organization that they're used to dealing with would still receive it. And I don't know, Paul, if -- you know, we've got -- VA's got about 50 FTE at National Personnel Records Center, and that's what they were talking about, whether or not we couldn't pull those records for you.

DR. BLAKE: We certainly would be happy to work with you on that and look -- and look at that concept. I would just mention, the National Personnel Records Center is owned by the National Archives. Neither the Department of Defense nor the Veterans Administration are the ownership of that organization. But since we have personnel there, we certainly can look at working with you on that issue.

VICE ADMIRAL ZIMBLE: Is there a suggestion that there's duplicative work being performed by two agencies at that one location?

DR. BLAKE: One would appear.

VICE ADMIRAL ZIMBLE: Well, you know, the -- the -- the suggestion might actually also benefit quality control issues. You might -- you might get -- you might get a reduction of three days in your -- in your delay statistics.

MR. PAMPERIN: The only -- the only question that I would have for Paul is are any of the records that would have to be gotten classified?

DR. BLAKE: That's been -- that's very, very rare. There is expertise in looking at those records before they're sent back to our facility, but I'm happy to work with you and see what we can do on -- on that issue.

VICE ADMIRAL ZIMBLE: Colonel Taylor.

COLONEL TAYLOR: (Off microphone) (unintelligible) (on microphone) Mr. Pamperin considering this one or two central locations for the processing of atomic claims, do any particular areas come to mind to you in that -- in that field, co-location close to DTRA or

things of that type that might simplify this process altogether?

MR. PAMPERIN: Well, I have to -- I have to put on my VA hat now as opposed to (unintelligible) --

COLONEL TAYLOR: Yeah, right, that's -- that's what I'm asking.

MR. PAMPERIN: -- and that becomes an issue of jurisdiction. My job is one of policy and program development. The assignment of work is --

COLONEL TAYLOR: Comes outside of that.

MR. PAMPERIN: -- comes from our Office of Field Operations, and I wouldn't want to tread.

COLONEL TAYLOR: Okay, fair enough, thanks.

VICE ADMIRAL ZIMBLE: Dr. Zeman.

DR. ZEMAN: Thank you. Yes, I also have a question for Mr. Pamperin. Many of the veterans who have come and testified before us, both in Tampa and here, had multiple diseases or conditions for which they applied for compensation -- or for disability. If there's a centralized location for handling radiation, what I wanted to ask is how that would work with regard to the other conditions that

they've applied for that are being handled by their local regional office. And maybe in answering that, could you also tell me if -- if there are any other conditions or -- or hazards for which you have a centralized point of handling them that might be used as a model for -- for the radiation claims?

MR. PAMPERIN: Yes, I -- the -- you know, as we -- as we'd work through it, this might change a little based upon input from Office of Field Operations, but basically due to some capabilities that we've acquired in the last couple of years, we're capable of ordering an exam at any medical center from any location. So whereas five years ago if you were here in southern California, you pretty much only had access to three or four medical centers. So there would be no real good reason why the central location wouldn't handle all of the disabilities -- you know, dispose of all of them. If -- you know, that's something that would have to be a policy to decide whether or not we really want to do that, particularly if the -- if dose reconstruction still takes as long, you know, I don't know, maybe the local

office would do the other conditions.
With respect to centralization, we've got a number of examples of that. The ones that come to mind is that there is a provision in Title 10 for what's called imminent death, when members are being separated with anticipation that they will die within six months, if they do die they get all the benefits from DoD as though they had died on active duty in terms of burial and six months' worth of pay and all that kind of stuff. The statute also requires that the Secretary of Defense render those decisions within 48 hours of death, and we -- we never could quite do that so we consolidated all of those cases in Cleveland because the Defense Finance and Accounting Service is in the same building.
Likewise we have consolidated all in-service deaths, which -- in terms of DIC -- previously had -- might take 60 or 90 days to award benefits. We've centralized all of those in our Philadelphia regional office, which also has SGLI, and DIC is now awarded within 48 hours of notice.
We do centralize several other unique programs

and we now do benefit delivery at discharge in only two locations. So it is something that I think we are moving toward at an increasing pace because of the complexity of all these issues.

VICE ADMIRAL ZIMBLE: Thank you very much.

DR. ZEMAN: Thank you.

VICE ADMIRAL ZIMBLE: Dr. Blake.

DR. BLAKE: Just one minor point of clarification for Subcommittee 2's report. On page 3, the lower paragraph, there's a sentence in there that states the VARO, the VA Regional Office, also contacts the Military Service Department for verification of a service member's information. They actually contact the Defense Threat Reduction Agency. We provide that information. It's easier for DoD to have one central group than the individual services.

DR. BLANCK: Good, I'll make that change. Thank you.

VICE ADMIRAL ZIMBLE: Okay. And Mr. Groves.

MR. GROVES: My only comment was that a couple of the topics for further discussion would appropriately include input, and we would

certainly wish to participate with Subcommittee 2 in working issues which have communication-related activity, so...

DR. BLANCK: In fact we've even spoken about potentially having a joint subcommittee meeting with those at the VA. I think that'd be a good idea.

MR. GROVES: That would be great, and I think that -- I think it just gives me an opportunity to raise the point that, you know, our subcommittee has to wait, to a certain extent, on -- for the other subcommittees to identify issues that may have a communication component. And on behalf of our subcommittee, we will do whatever it takes in spreading the wealth of our membership to assist you all with those and -- and this is one of those opportunities.

VICE ADMIRAL ZIMBLE: Okay. Then without any -- I'm sorry, Dr. -- Dr. McCurdy.

DR. MCCURDY: I rarely will make a comment, but I just want to have a clarification here on the top of page 4, first paragraph. If you are going to include names for contractors and subcontractors, I think the other reports do not, but I believe SAIC is a subcontractor of

Titan, not DTRA --

DR. BLANCK: Okay.

DR. MCCURDY: -- if you are going to report it that way.

VICE ADMIRAL ZIMBLE: Thank you very much. Now without any objection from any members of the Board, I would like to ask, as an action item, for the Chair of the Subcommittee 2 to prepare a formal recommendation that the Board may -- for Board's consensus and -- and forwarding to the Veterans Administration.

All right. And -- so I assume there's no objection.

Okay, let's now have that delayed break. It is now 10:32 -- we'll call it 10:35 -- and ask that you come back in 15 minutes, which would be 10:50.

(Whereupon, a recess was taken from 10:32 a.m. to 10:50 a.m.)

VICE ADMIRAL ZIMBLE: The break is concluding. It is time to resume. I now would like to -- we're -- we're now running -- we're running about 20 minutes behind, but I'm very confident that we'll be able to catch up, and we're now going to hear a report from the Subcommittee on

Quality Management and the VA Process Integration with DTRA Test Personnel Review Program. Dr. Reimann, the floor is yours.

A REPORT FROM SUBCOMMITTEE ON QUALITY MANAGEMENT AND VA PROCESS INTEGRATION WITH DTRA NUCLEAR TEST PERSONNEL REVIEW PROGRAM

DR. CURT REIMANN

DR. REIMANN: Thank you, Mr. Chairman. The Subcommittee on Quality Management is pleased to submit and discuss its first report on the -- on its efforts to develop a quality management system for the overall efforts of the Department of Defense and Veterans Administration.

Let me just briefly touch on the key aspects of who we are and what we do.

(Pause)

VICE ADMIRAL ZIMBLE: Go ahead and proceed, Dr. Reimann.

DR. REIMANN: The -- let me -- let me first begin with a brief outline of our scope. I think this is going to be critical to see how we relate to the Board as a whole and how we relate to the individual subcommittees.

Our subcommittee will review all aspects of quality management in the dose reconstruction

and claims adjudication procedures used by NTPR and VA. Subcommittee will also provide recommendations on the integration of the work performed by NTPR and VA to facilitate the achievement of a quality management system on all aspects of things that serve the veteran. So in simplest terms, to meet the requirements of the veterans and to fulfill the expectations that were underlined in the 2003 National Academy report, a comprehensive and integrated quality management system should be designed and deployed. And that, by its nature, brings us into direct contact and I think cooperation with the other subcommittees.

As we -- to just give you some sense of the flow of our activities, we began by outlining the scope of our work, some of the details -- detailed implementation, particularly for the near term. We looked at the core elements of a quality management system so that we know not only what we're talking about in terms of specific substance, but also how we relate to the individual subcommittees and to the Board as a whole.

And particular emphasis was placed on the

importance of all of the elements. For example, relationship quality with the veterans so that this is a customer -- a valued customer relationship and not one of merely an administrative process. We're talking about procedural consistency of technical quality, so that the quality comes to underscore the technical reliability of the output. But also dealing with the relationship. For example, one can have a well-defined, clearly defined process that is extremely slow and extremely costly, and so we have to worry as well about the efficiency, because a key requirement of the veterans, and I think the aim of all of us here, is to ensure that we not only be technically sound but also that we be responsive in the personal sense and in the timeliness sense.

So we sorted through all those elements needed to define a system, and then figured out how we relate in an ongoing basis to the individual subcommittees and to the VBDR as a whole. We had meetings in September to set out our own work plan. We also had one of our members, Mr. (sic) Lathrop, serving with Subcommittee 4 on

communications. I participated in that meeting as well.

We took part in some meetings in October, trying to get some sense of how NTPR and VA operate together. Since they are I think clearly on a path of cooperation, we thought it would be very important for us to sit down with them and actually observe how that cooperation is moving because it's going to be critically important in the sense of defining a quality system.

One member of our committee accompanied the Subcommittee on Dose Reconstruction to try to gather some process information and sense of how that whole thing works, and we've already had a report in that and I think our work reflects that as well.

In November we had a member participate in Subcommittee 2 on the claims adjudication to try to gather information about how the VA processes work, the routing of claims, the decision processes, the record-keeping and so on, all very, very critical. A member also contacted the three service offices to try to encourage relationships there that would help

other parts of the military appropriately route claims that are in the purview of this Board to the NTPR office. So I think it's part of the spirit of outreach that I think has come up in a number of ways in the discussions so far today and yesterday.

We held a meeting with a contractor and subcontractor and NTPR personnel in December and reviewed -- at least at the first level -- their progress in implementing an overall quality management system built around ISO-9000, and were reviewing or attempting to review the major issues centering around not only process reliability but also their efforts to reduce the case load.

And here in January we met to pull together the thinking from -- and information that we had gathered over the last several months to pull it into a coherent package and relate it to the work of the other subcommittees as well.

Some of our observations and what we see as next steps are about as follows:

DTRA and VA have both been very cooperative and responsive and open in addressing the VBDR requests for information and data. It's been I

think a very realistic discussion and one built around working with us to try to enhance all of the -- and overcome the problems that have been pointed out in the past. The summary prepared by the NTPR program manager documenting process milestones since 2003 were particularly helpful because it gave us a picture of a sense of motion in the sense of progress. It also helped us to see where we should in the future direct our interests and concerns.

We feel that the use of the so-called SPARE, the Scenario of Participation, is a very, very beneficial step, one that is in the best traditions I think of relationship management. And it ensures that there's a direct dialogue with the veterans on things that are critical to understanding the individual aspects. So I know that in any large program, any individual such as a veteran dealing with a large program is always concerned with are we treated as a number and so on. I think that the effort to get at the specifics of the experience and get the best recollection from the veteran on that experience is a very, very positive step, not only in the relationship quality but also on

ensuring the best possible and most reliable possible outcome. So we feel that that was a very, very beneficial step.

We feel that progress is being made by DTRA in improving what we might call a process discipline via a quality management system, mainly the ISO registration. However, we note that this discipline is not yet fully deployed. And from listening to the very comprehensive and I think valuable report this morning from the Subcommittee on Dose Reconstruction, I think we can see that that creation of the processes, the detailed processes, have to await the completion of the best understanding that we can get of exactly how cases will be handled and the technical requirements in terms of models, input parameters, uncertainties and so on, how that plays out. So from our subcommittee point of view, we're not basically in any sense second-guessing the expertise in dose reconstruction. What we're trying to do is work with them to ensure that when there is agreement reached with the agencies and the subcommittee on what the technical out-- the best approach to a technical outcome would be,

we want to work with all parties to make sure that that's integrated and then becomes part of the operating procedure. And I think that that was one of the central concerns that was spelled out in the 2003 National Academy report.

So that design, in effect, is one that takes into account the -- all of the dose factors and also the efforts to learn from the experience of all of the cases to help expedite the cases so that then we're meeting both requirements of the veterans in this case, one of a reliable outcome and a more timely outcome.

I think that there is increasing attention at DTRA to the case-handling strategies, and I think that that was alluded to in a number of ways today and so I don't think needs further elaboration.

We see that VA and DTRA and their contractors probably need a more clear, explicit and regular use of metrics and goals to drive improvement. That requires more data and information about the timeliness and all of the key process that we see lots of bits and pieces that encourage us to believe that these things

are coming together, but we think that if this is going to be part of a more integrated system, it has to be more visible and more directly used at all levels. So that, for example, senior managers have broad, comprehensive data and can see how the overall effort is going, but the individual workers can direct their energies to improving and accelerating the outcome and improving their technical integrity of the outcome. And I think also then that the more shift is toward metrics and goals, the more likely it is that the interface between the agency, VA and DTRA and so on, will be based on a numerical information and less on relationship information, because it's always difficult to treat every problem of this sort in terms of relationship. So the issue here is show us the numbers and how it's going and how can we direct our energies and resources to the problems in service to the veterans.

Very interesting that some of the things we heard today, sort of cooperation in the making, was the possibility of cooperating in the St. Louis records office. That would offer a very

good way for the agencies to cooperate, and our subcommittee had identified that as well as a process change that, once defined, could be put in terms of the ongoing working standard operating procedures. And we also noted and concur in the comment from this morning that concentrating the efforts for atomic veterans within one VARO with the reservations and so on -- and provisos, I mean, mentioned by Mr. Pamperin this morning, consistent with that. But that would also be a very good opportunity to streamline and focus and enhance the relationship between the Veterans Administration and DTRA on one hand and the veterans on the other.

So that's pretty much where we're heading. We feel that in the future, as DTRA has opportunities via the -- via its contract and subcontract management that they consider building in -- adding incentives that focus on the balance between technical quality and timeliness so that both are achieved, and that the overall metrics and management system that we're all struggling to create here, that better data will lead to better monitoring and

then more immediate and more effective corrective action.

And I should mention here in closing that the members of the Quality Subcommittee -- Kristin Swenson, Dave McCurdy and John Lathrop. And John, as I mentioned, does double duty with the communications team.

So Mr. Chairman, that's our summary of our report. I think it should be appreciated by those listening that we have a delicate balance. We're critically dependent on the technical competence of the three subcommittees and also mindful of the fact that even though we're looking at systems and the Board as a whole is looking at systems, our niche in that is much more oriented toward the ongoing management of processes and systems, and that the Board as a whole has a much larger role which also depends upon the agencies operating as a system.

VICE ADMIRAL ZIMBLE: Thank you very much, Dr. Reimann. That's very helpful.

As I understand it, in order for this Board to carry out its oversight functions, there is a need to have standard operating procedures,

metrics and goals, and incentives in place so that there is an auditable -- an audible -- auditable trail that -- that we can -- that will allow us to assess the quality of the -- of the process, both at the Veterans Administration and at DTRA. And you know, I think it's -- it's -- it's rel-- it's -- it's timely that -- that the -- there's a process underway right now to let a -- to renegotiate the contractual arrangement with the -- the people who are going to be doing the work. And I think your suggestion that it include standard -- that the -- there be a negotiation for a standard operating procedure that can be well documented, that there be metrics and goals in place so that the -- so that the -- it can be well assessed, and that there be the incentives that would enhance efficiency can be incorporated. So I thank you for those suggestions.

DR. REIMANN: Yes, that was the case that we're trying to make, and something that I want to make sure it's a case that we're not making, and that is that the agencies and contractors and subcontractors are mindful of this, are

working on it and that in every parallel situation I've ever seen in my life, these are very, very difficult tasks. And these tasks I think are far above average in degree of difficulty because of the number of very sensitive judgments and the incompleteness of the records, which is not a -- not a fault of any of the individuals here. It's something that goes way back in history. So the question is on documentation accuracy and data accuracy and so for, how can that be -- how can that record be constructed as rapidly as possible and then be used to further leverage the learning so that we accelerate rather than bog down.

VICE ADMIRAL ZIMBLE: Right. I think your subcommittee report will be very helpful in that regard.

Dr. Vaughan, do you have any comments?

DR. VAUGHAN: No. No, thank you.

VICE ADMIRAL ZIMBLE: All right. Anyone else have any -- there we are. All right. Dr. McCurdy.

DR. MCCURDY: I just wanted to add a -- not a clarification, but in addition to what we had

on this last paragraph, have a little discussion on this. Not only we -- we feel that incentives should be included in any of the subcontracts being awarded, but also in the scope of the statement of work that the subcontractor, since we're looking at future multiple subcontracts doing dose reconstruction, that they really would have to have a quality assurance program, which would be integrated into the ISO-9000 DTRA (unintelligible). That's very important also, because right now they are working -- the current subcontractors are working on getting the QA program to be -- to come into ISO-9001, but it isn't there yet. So we know that that is an area that they're working on, they're improving on. But if you're going to have more contracts let, make sure that's part of the statement of work, that they have to have a QA program that fits in with what you have.

VICE ADMIRAL ZIMBLE: Okay, thank you very much. Any other comments?

(No responses)

All right. Let's move on to the report from Subcommittee Number 4, Mr. Groves.

A REPORT FROM SUBCOMMITTEE ON COMMUNICATION AND OUTREACH

MR. KENNETH GROVES

MR. GROVES: Good morning, everyone. I would first like to recognize the other members of the Subcommittee on Communication and Outreach, and they are John Boice, sitting to my right; and John Lathrop, who you have heard is doing duty on two of the subcommittees; Elaine Vaughan, who is with us on the phone; and Colonel Ed Taylor.

It is -- as you heard this morning, we have adjusted the scope and purpose of our subcommittee to include not only dealing with the veterans, but working communication and outreach issues within the Board itself. And I think we have been successful in that, and given the discussion that I had with you earlier about to a certain extent our committee depends upon the other subcommittees, as a part of their deliberations and work, to identify communication-related issues that then we can work with them on. And we're doing a lot of that at this meeting, as we've heard.

We somewhat focused our work in September, which was our subcommittee meeting in Bethesda,

on looking at some of those internal issues, and I would like to go over what some of those are for you this morning.

We had the pleasure of meeting with the web master for the VBDR.org web site, which is I believe an excellent web site from the get-go, and we had the opportunity to meet with the web master and to add some additional attributes to the web, which we think will pay some benefits to us. And one of those has already, in that we suggested that there be a way to track people who went to the web site and what types of things they -- which hot links they went to as a way to see how -- to see if we could measure what were the attributes on the web site that were more useful to the veterans. And we have received, within the last week or so, the first data dump from that process which our subcommittee will be analyzing. So we still believe that the web site is certainly the most timely way to share information from the Board, and we will continue to work with both NCRP as the secretariat and other members of the Board on ensuring that the web site is in fact always up to date and the way for

people to get information.
We also -- looking at different ways to communicate with the veterans community, and we had Colonel Taylor, on our behalf, help -- along with DTRA and NCRP -- build a list of veterans' organizations, to whom we have shared our press releases for this meeting and the agenda. And I don't know that we have a way to measure the effectiveness of that yet, but certainly we are going to explore every possibility of what avenues we can use to reach this community, which is estimated to have had up to 400,000 people be potential beneficiaries. And so a lot of those may not still be with us, but it is our goal to reach out to each and every atomic veteran through whatever means we can devise to let them know of the existence of the Board, what it is we could do, and certainly encourage them to attend the meeting and participate, as many of them have and hopefully will continue.
We were asked by the Board for the Communication and Outreach Subcommittee to work some of the details on the meeting locations and dates, and we have done that. And of

course that culminated in the meeting here in Los Angeles, and our next meeting which will take place in Austin, Texas later in June. And as you will remember, the criteria we initially established for meeting locations was to try to take our group, the Board, to locations where there were concentrations of veterans, a subset of which would be atomic veterans. And we certainly think it's clear that the states of Florida, California and Texas meet that criteria and that's the basis for those being the locations where we will have held our first three meetings.

We worked on establishing, at our meeting in September, a protocol that the Communication and Outreach Subcommittee would use in assisting the secretariat on handling press releases, requests for information. Those have seemed to have worked well and we certainly appreciate the input we've had in that process from the folks at NCRP, who are essentially the two full-time people who react to questions that are made either through the web site or through direct telephone calls to the 800 number which has been set up for the Board.

We have, as a way to provide some consistent information through the membership of the Board to veterans' organizations or others that might want to know more about the Board, have put together a draft PowerPoint presentation, which is essentially a summary of the charter and the activities of the Board. It also gives a brief description of the activities of DTRA and the Department of Veterans Affairs on how claims are handled. And this is in its final stage. It will go to the chairs of the other subcommittees to vent through their -- their subcommittees to ensure that we're saying the right things about what we are doing as a Board and what the individual subcommittees are doing. The purpose of this was that if any of us on the Board are asked to talk about Board activities, that we would have a consistent message to deliver on behalf of the Board. And so we believe that this is in its essential final stage of development, and hopefully within the next month or two we will have had a chance to circulate it among the Board, get your input, finalize it and then have it available for any of the Board members, should

you be asked to talk about the functions of the Veterans Board on Dose Reconstruction.

We have also taken advantage of some of the documentation that our sister organization has, and I particularly want to point to the work done by the Advisory Board on Radiation and Worker Health, which is the board that has a function similar to ours for Department of Energy employees. And Admiral Zimble asked me to attend one of their meetings, which I did. And for those of you that don't know, they have been around for a couple of years now, and in fact they have had 30-plus meetings of their board and certainly have a lot of experience that we hoped to gain from from them and what they had done in working with their stakeholder community. And one of the things that I found very useful at their meeting was a number of very straightforward fact sheets written in lay terms which seemed to be very useful to the folks who were beneficiaries of that. And so in our subcommittee we have taken these facts and -- their committee also deals with the issue of probability of causation and dose reconstruction, so they had already done some

very good work on describing some of those activities of their board, and we're just going to plagiarize it as best we can and make it unique to ours, but we will be providing this, as well, as an additional tool to communicate, hopefully effectively, the kinds of activities that the Board does and stimulate questions and access to us for more information as needed.

So we are again in the final stage of development of those fact sheets and we will again vent those through the rest of the Board before they are finalized.

We did have a discussion with the Veterans Administration bec-- or pardon me, the Department of Veterans Affairs because it would be through some of their facilities that the fact sheets -- that would be a good location to stockpile the fact sheets, so that as veterans come in and have questions about anything related to the atomic veteran community, they could access those. And so they may show up in the form of individual fact sheets. They may also show up as a collection of fact sheets in a brochure. But whichever way they show up, they are a means to take advantage of where the

veterans are and how better we can communicate to them the functions of the Board.

We expect our future actions to include continuing to work with the other subcommittees, as you heard this morning, as they develop any product that communicates what it is that their subcommittees are doing to coordinate that in a way that there is a consistent message from the Board; to complete the fact sheets to finish the presentation; to take advantage of the information we're collecting on who is visiting the web site and try to continue to make the web site a useful tool to the veterans; and to work as we continue to develop meeting sites and locations that best enable us to deal with and meet the veterans who are in fact interested in the work that we do.

So I think that that is -- are the activities that our subcommittee has been involved in and will continue to be involved in. I will say that one of the things that I heard at this meeting would tend to make me want to be interested in maybe developing some oral histories from some of the veterans themselves

who have participated in the tests and the -- and were in the Army or Navy, folks who were in the occupation of Hiroshima and Nagasaki. I think that we have a wealth of knowledge within those individuals. We all know we're dealing with an aging veterans community, and I think there's just some wonderful information that would be of use to us and other veterans if it was collected in a way and would be available to other potential beneficiaries.

So Admiral, that is -- that's our presentation.

VICE ADMIRAL ZIMBLE: Thank you very much. It's a very -- very complete report of your activities and your future plans. It's -- you're -- you've been extremely ambitious. I -- I commend the -- all the members of the committee and -- and your efforts so far. Colonel Taylor.

BOARD MEMBERS QUESTIONS AND DISCUSSION

COLONEL TAYLOR: (Off microphone) (unintelligible) (on microphone) I think there are two areas there that we may need a little help on, but I think they're very valuable to us. One is the development of a PowerPoint presentation in that we, as individual members

of the Board, may be called on to speak to certain organizations, both veterans' organizations, civic organizations and other type, and the development of a concise, fairly standard presentation that's available to the members will be very valuable to us.

The other thing involves what was spoken of in the idea of an oral history. And in thinking through that, I have been dealing with a man named Tom Weiner, who just published a book. He happens to be the historian of the Veterans History Project, which is also mandated by Congress, run by the Library of Congress and the American Folk Life System. And they literally have thousands of veterans' histories and interviews that have been professionally acquired. I know my own county is very much a member of that. We've been feeding them information for years. I plan to turn to Tom Weiner, rather, and ask him what he can do to help us in sorting out of that veterans who have literally atomic background, and may can help us provide -- give us some of that information without us having to go get it, because they've been working at it for years

and they're pretty good at it. So those kind of things I think will make a difference to us because the communications and outreach committee realizes that and I feel a little bit concerned with listening to veteran after veteran, both in our public comment and to us individually and working with the Veteran Service Officers, that oft of them have a degree of disappointment. And it generally comes out from length of time in the response and often how they were responded, which I think our fact sheets and so forth may help overcome that. Because if we can turn that sort of anti-VA dose reconstruction -- how many times have you heard we need to eliminate dose reconstruction out of the veterans? You've heard it several times in these meetings. If we can eliminate that, or at least make that a little bit more generally understood, it will make it easier, because when a veteran comes in with a preset notion that he has not been treated fairly or equitably, that is hard to turn around. Let's face it, it is very difficult. And if we can do it at the outset with our responses and our replies, it makes a

difference. And I say that in all candor to a group of people that I know have a tremendous capability to do that. And thank you for the opportunity.

VICE ADMIRAL ZIMBLE: Okay, thank -- thank you, Colonel. Dr. Vaughan, you have any comments regarding this fourth subcommittee report?

DR. VAUGHAN: Only to say that what we're calling communication issues actually cut across many aspects of decision-making and mismanagement. So there are many goals for communication, from instructing and informing to facilitating decision-making. And so I think our subcommittee's contribution will be in multiple areas. And you know, I -- I think that Mr. Groves gave a wonderful overview of how we could be helpful to other subcommittees as well.

VICE ADMIRAL ZIMBLE: Very good, thank you very much.

Are there any -- any other comments of the Board? Ah, yes, Dr. Swenson.

DR. SWENSON: I just have two things. One is a question. The fact sheets that you're preparing, are they on what VBDR does or are

they on the process that the veterans -- you know, that their claim goes through so that they can understand it better?

MR. GROVES: The fact sheets as we currently would see them are a way to describe some of these unique functions that happen during the process, like dose reconstruction and what the probability of causation methodology is all about. As we explore ways to streamline the process and ways to make it more understandable to the veterans, there may be additional fact sheets, like the process, even though I don't want to usurp the authority of the Veterans folks, but I think we can work with them to help facilitate a better understanding of what these critical parts of what the different steps are and how better to help the veteran understand what they are and what it entails to do them, so...

DR. SWENSON: And my second item, it's not a question, but the National Atomic Museum in Albuquerque also takes oral histories. They primarily were doing it -- and I don't know if you, Paul, went with -- when we were both in the service, but they were primarily I think

were talking to weaponeers, because they wanted to get that information down before they'd all retired or moved on. But they may be interested in taking oral histories of, you know, participants. So I'm not sure that would be another avenue to look into, because they also can take any kind of secret -- you know, part of their inform-- their oral histories are classified and then part probably aren't.

MR. GROVES: I appreciate that, and yes, I am aware that that is a location, as is the new Atomic Testing Museum in Las Vegas. Both of those sites are interested in this, and then as Colonel Taylor said, the history project is going to be another place. And I'm not looking to reinvent the wheel here, but I am interested in making sure that that subset of the veterans community that are the atomic veterans -- you know, we have -- we have some history from them through these different projects. Thank you very much.

VICE ADMIRAL ZIMBLE: All right, thank you. Dr. Zeman.

DR. ZEMAN: Thank you. Ken, I have a question. I think you've probably noticed as well as I

that our meeting room here is not filled to capacity. And I would like to ask what ideas your subcommittee has with regard to publicity and publication to get it -- better get the word out so that veterans are aware of our meetings and so that our meetings are accessible so that we can play to a packed house, and get the information out to the veterans in each of the areas that we go to. It's disappointing to me to come here to L.A., and I know there must be hundreds or thousands of veterans in the area that would be interested in what we have -- what we're doing here, but -- but yet I see only a few that have shown up.

Speaking of those who have shown up, I see Mr. Clark is in the audience, just came in, and I believe he was the one who got probably the most publicity for -- of all of us in Tampa by the television interview that he had when we were down there. So maybe there's some way that we could partner with the veterans' groups, with individual veterans, and reach the local communities before we have our meetings there and try to improve participation.

MR. GROVES: I couldn't agree with you more, Gary. And I think that that is going to be one of the challenges, is to -- how to reach out to a very small number of people in a great field of veterans. But that is the challenge we're willing to take on and we want very much -- I think by choosing the meetings in a location where there are lots of veterans is a place to start, but obviously we haven't been able to reach the veterans within that geographical area as effectively as we would have liked to have done, so...

VICE ADMIRAL ZIMBLE: I see we have Dr. -- Ms. Irene Smith here, who is the public affairs specialist from DTRA, who has been extremely supportive of our activities, and I -- I invite your comment.

MS. SMITH: Thank you, sir. Sir, just to give you an example of some of the outreach that we have done to bring people to today's conference, as well as yesterday, we sent out press releases to 48 media and veteran organizations in Nevada, Utah, Arizona and Oregon. We sent out 49 of the press releases to California veterans organizations, which I

can show you copies. We also sent out the press releases to 40 media listings in Long Beach, Los Angeles, San Diego, San Francisco, Sacramento -- and these consisted of both TV, print and radio media outlets. Last Friday I spoke to the military editor from *The Los Angeles Times*, *The San Diego Union*, *The North County Times*. All of them have expressed interest in coming out and visiting, taking interest in this matter. I can't pull them out of thin air here. I'm sorry, I wish I could. I also had an e-mail on January 5th. I went ahead and contacted the *Military Officers Magazine*, asking them to come out here, cover our meeting. This I thought might fall into their constituents' interest. The reply I have, and I'll be happy to show it to you on my Blackberry, it did not meet our current editorial needs.

I am open for suggestions. We have -- and oh, one more thing. Isaf sent these press releases out -- we didn't send them out just once. We sent them out twice, and the most recent being last -- last Thursday.

DR. ZEMAN: Thank you very much. I will admit

I looked at the MOAA, the military officer magazine, the latest issue, thinking oh, surely we were going to be in there, so I -- I --

MS. SMITH: Sir, if you know somebody on the editorial board that can twist their arm, I'll go ahead and contact them.

DR. ZEMAN: Thank you so much for all the effort that you did put in. I in no mean --

MS. SMITH: No --

DR. ZEMAN: -- in no way meant to -- meant to denigrate the excellent efforts, and I have to admit I was not aware of everything that was done.

MS. SMITH: No offense taken, it's --

DR. ZEMAN: This is -- this is marvelous what you've done. Why hasn't it worked? I -- I'm -- I can't understand. If I were in the population, I -- I would -- and if I saw the communications, I would come, so I -- I don't understand why they're not all here.

MS. SMITH: Sir, it's often the nature of the media for other events to be -- for interesting events to be overcome by other events. Reaching out to the reporters directly is the best way I'm aware of. We looked into it. We

also have Tom Philpott, who is military on line. He has expressed an interest in talking to Admiral Zimble, which we are going to arrange at a later date. We also had tentatively planned to have Admiral Zimble do an on-line interview with Terry Moran from Nightline News. Terry Moran is a neighbor of Dr. Schauer. He -- Terry Moran offered to do this out of the goodness of his heart. Due to other contingency issues, we've had to postpone that interview, but Terry Moran very much wants to come back, talk to Admiral Zimble. Once we -- and when this takes place we're going to do it at the Navy Media Center in Anacostia, Washington, and we will put that on-line on the VBDR site.

VICE ADMIRAL ZIMBLE: Okay, thank -- thank you very much. That -- the only suggestion I could make, Irene, is to pick slow news days to send out things. But I would like to mention that there's a very nice article about the Board, it's -- with an Irene Smith by-line, that's being published in *The DTRA Connection*. I would suggest that that be made available to the Veterans Administration for their

publication on ionizing radiation.

Okay, are there any other comments? Oh, yes, Colonel Taylor.

COLONEL TAYLOR: (Off microphone) (Unintelligible) in line with this public information and media drive to get veterans to attend, is there anything in what we do that can be communicated fairly that says something to the effect that we are reconsidering or trying to expedite the claims process to be as fair as possible? I think if I were reading a news release that said they're going to have a meeting of this Board in an area that I could attend, and the Board very definitely is about trying to make this system fairer and more inclusive and better and quicker for the veteran, I would be more intend to make effort to come here. Now look, we've had people from Hawaii, from Alaska, from all around that have taken the expense to come here and appear, and I congratulate them. But it is a small group of people that are themselves mostly oriented into veterans organizations. Very few of them come only as individuals. But we need to kind of tailor our appeal and our announcement and

our statements as to where we are and why we're meeting to let people understand a little bit more of what we're about, and we may get a little better attendance value on it. I only offer that as a suggestion.

VICE ADMIRAL ZIMBLE: Okay.

COLONEL TAYLOR: And looking at it from a veteran's standpoint, that -- that's important to me. Thank you.

VICE ADMIRAL ZIMBLE: Right on. Dr. McCurdy.

DR. MCCURDY: I have a question for the Chair. Is it the charter of the Board to actually provide communic-- education to the veterans --

VICE ADMIRAL ZIMBLE: No.

DR. MCCURDY: -- or is it for us to recommend...

VICE ADMIRAL ZIMBLE: Yeah, the charter for the Board is for us to look at the communications that have been developed by the agencies --

DR. MCCURDY: Correct.

VICE ADMIRAL ZIMBLE: -- and to -- and to offer recommendations in that regard. But there's nothing -- there's also part of the charter that says "other things" that we may feel are appropriate. And I think it's important for us

to let -- let -- to -- to communicate what the efforts of the Board are and -- and the advocacy of the Board, and so finding other ways to help facilitate communication I think is within -- is -- is -- it's within our domain to do that. Although --

DR. MCCURDY: Okay, I'm --

VICE ADMIRAL ZIMBLE: -- not -- it's not specifically mentioned in the charter.

DR. MCCURDY: Right. When we're developing these fact sheets I think we have to keep that in mind, that we're not -- we're not really usurping the responsibility of the agencies --

VICE ADMIRAL ZIMBLE: Right, absolutely, and -- and --

DR. MCCURDY: -- to do that type of thing.

VICE ADMIRAL ZIMBLE: -- any fact sheet that we develop we'll -- we'll pass by the agencies to -- to ensure that we're not sending out contradictory information and that nothing goes out without their -- without their support and approval.

DR. MCCURDY: Okay, I also have a suggestion that -- which would be very -- if -- if you're going to have information concerning the Board

as well as the process -- I mean this -- this nebulous dose reconstruction and dose conversion factors and how it's all done, one of the aspects that really doesn't come across is the -- looking at the radiation risks compared to the other risks. Even at the -- we had some high level, very well-known scientists here at this meeting presenting material, which I'm sure this went right over the head of most people in the audience, and I think it'd be better if you put things in perspective that they understand and say, as you pointed out, by the time you're 60, you're going to have prostate cancer. It may not be -- got to a stage where it's diagnosed, but everyone's going to have it.

Now, okay, what are the probabilities of getting these different cancers with -- and then what is it with respect to radiation. I'm sure the general audience doesn't know this, and it'd be nice to have, either at this -- the next meeting something that audience can understand about the whole process, rather than some high-level things for the Board.

VICE ADMIRAL ZIMBLE: One of the last topics on

our agenda today is to discuss future presentations before the Board, and I couldn't agree with you more. We need to put some -- some level of realism into the threat of ionizing radiation, as opposed to all of the other noxious elements that -- that we are faced with on a day to day basis. I think it's very important. I think that we have a public that has some misapprehension as to what radi-- what ionizing radiation is all about and -- and what the levels of -- of threat are. When -- when I -- when I talk to individuals who are afraid of purchasing radiated foods because of their concerns that there's some health risk, when in fact it's the least health risk of any food that you could purchase, so it's a question of basic education. And a lot of it is re-education. There's -- so trying to allay some of the misinformation that -- that currently exists in the population, so I -- I'm very much in favor of that and -- and I think we -- we -- we need to discuss that when -- when -- before this meeting is over.

DR. MCCURDY: And even the fact sheets may want to have something...

VICE ADMIRAL ZIMBLE: Okay, right. Okay, thank you very much. Any other comments? Yes, okay. Dr. Swenson.

DR. SWENSON: Along that same line, the VA -- and maybe Tom could enlighten us -- they may have fact sheets similar to that, like you said, and maybe those should be reviewed and they should come from the VA, or you should recommend that the VA do some fact sheets similar to that on those topics. And my guess is you might have -- maybe not the exact thing, but similar type information.

MR. PAMPERIN: Actually there isn't anything in VBA, in the benefits side, that would correspond to that. There is the mailing from Veterans Health Administration, but clearly we do a lot of fact sheets. They tend to be more toward -- well, actually toward specifically categories of vets, and atomic vets are a category of vets, so it's something that we could clearly look into, I (unintelligible).

COLONEL TAYLOR: Also in line with the business of education and re-education, Ken Groves and I came out a day early and we went to the Los Angeles County Veterans Center, and in the

process probably the one thing that Ken told them they were there was he gave them the web site, and before we left two or three of the staff on the computer reading the web site to getting the agenda of what we're doing here and why. It's that quick and that effective. And whoever came up with that web site, it is a very definite benefit to this committee and being able to explain it. In this case you're explaining it to veterans who deal with veterans' organizations, and they really I don't think were that much aware of it, do you, Ken? I know they picked it up immediately and responded to it. But it -- those things will help us tremendously. I can imagine how frustrated Irene is because of what she was doing and the result she got. Thank you.

VICE ADMIRAL ZIMBLE: Right. Thank you very much. If there are no other -- yes.

DR. MCCURDY: One follow-up on that. Does each of these veteran organizations, local organizations, all have e-mail addresses where --

COLONEL TAYLOR: Oh, yeah.

DR. MCCURDY: And you sent out a blanket e-mail

to all them about the announcement? Okay. Thank you.

COLONEL TAYLOR: (Off microphone) How many have you got on the list now (unintelligible) several hundred organizations (unintelligible) several (unintelligible).

(On microphone) It's probably several hundred organizations that list e-mail addresses, mail addresses, national publications, American Legion magazine, Army magazine, MOAA -- those kind of communicating to veterans publications that we try to center our effort with, and it does make a difference. It makes a big difference. I can walk into -- to Admiral Ryan's office and they immediately know who we are and where we are and what we're doing because they've been dealing with it, and she said I'm going to actually talk to the editor of the -- either the affiliate or the other magazine they publish and see what happened, but that -- that we will do. But that's the way it works.

VICE ADMIRAL ZIMBLE: Okay. Well, I'm pleased to say that we are back -- we are back on schedule. We're going to adjourn for lunch and

we will have public comment, as scheduled on the agenda, beginning at 1:30. Okay? So -- and certainly invite as much public comment as we can get at that time.

(Whereupon, a recess was taken from 11:50 a.m. to 1:35 p.m.)

PUBLIC COMMENT SESSION

VICE ADMIRAL ZIMBLE: Ladies and gentlemen, it is now 1:35, so we're -- we're starting off five minutes behind, so I'd like to call this meeting to order. I have -- I have a list of four individuals that wish to make comments. I'm going -- and I understand, Mr. Clark, that you have -- you have to get away, so let me start with Mr. Charles Clark from Hawaii. Aloha.

MR. CLARK: We say to you folks Haù oli Makahiki Hou, happy new year.

VICE ADMIRAL ZIMBLE: Okay. Thank you.

MR. CLARK: Thank you, Admiral. Thank you, Board. Thank you for this opportunity to come forward again, having met you in Tampa, and I certainly appreciate the opportunity to come again.

Today I'd like to just address, if I may, please, there's four items and they're very brief, one being beta radiation. I would like to bring the Board's attention to the fact that in our *Green Book* we have a citation which provides information relative to beta as it relates to the skin. And unfortunately I've received dose reconstruction from our people saying that they're referring to gamma only. I think we need to exercise our prerogative. The book says it started in 1998. We should have that endorsement and make sure that we have beta included in the veterans' information as it passes down. Very important.

The second item which -- the second item which I would like to address would be the water and the contamination of such in the Nishijima Reservoir during the per-- actually the periods of September to mid-October, 1945. That potable reservoir, we drank from it, we bathed in it, we ate food which was contaminated coming from it. Not only the water in the reservoir, but the fugitive water coming down through the streams over those bedrocks, which were also contaminated. I've never seen

anything relative to conditions of water at Nishijima.

The third item comes from Guam. Living out in the Pacific, I hear from them twice a week. I hear from other islands in the Pacific. Guam has a condition where they're asking the Board to consider perhaps lengthening the period of time wherein the construction of the -- I'm using the word trash disposal -- all of the remains of the test series were excavated and buried on Enewetak Island. Today that island is probably the hottest in the entire Pacific. The dome is leaking. But because they don't meet the time criteria as provided within our scope of work, they're not able to receive justice, I call it, at the regional offices in Honolulu or any other office where these veterans were living today. It's a unique problem. They have problems. We have three people on Guam right now. In fact one may be in -- hopefully he's in Honolulu today. He has serious heart problems. And incidentally, they pay their own way, so --

But the other item which is quite close to my heart, and I would like for the Board to take

in consideration something that we need to perhaps understand better in our communications with the veterans in our community, that community being the widow. I would like to see the Board adopt a policy wherein the widow would have her rights to come address you with her problems -- because they do have them, incidentally; they have severe problems -- address you orally or in writing, the widows of atomic veterans.

Admiral, that's it.

VICE ADMIRAL ZIMBLE: Well, Mr. Clark, let me answer that last one.

MR. CLARK: Surely.

VICE ADMIRAL ZIMBLE: They have that right. This is a public hearing, and it's open to anyone in the public to make comments, or to send us information by e-mail or by -- by snail mail.

MR. CLARK: Perhaps then we -- you need to put it out, inviting in such a way -- I right now have a lady for whom her husband expired eight years ago, and she has been told by the VA that she has to prove that he was in an operation where radiation was -- the lady can't prove

that. She's a widow. They didn't share these things on a white pillow, 50 years of secrecy. So we need perhaps a better communications tool, I'll use the word.

VICE ADMIRAL ZIMBLE: Okay. Yeah, made -- the other comments that you've made, I would like -- I'd like Dr. Blake to address them 'cause I think -- I think he can -- he can give you some substantive answers on some of those.

DR. BLAKE: On that first issue on the lack of beta dosimetry on a particular dose reconstruction, I'd have to see the specific dose reconstruction. In all cases I know, we'd look to account for that. There may be cases where it was not an important factor, but if you could provide a copy of your documentation to the Board, I'll be happy to provide you a written response --

MR. CLARK: I would be --

DR. BLAKE: -- on that one.

MR. CLARK: I have a copy here.

DR. BLAKE: Okay, that'll be great, and I can -- I'll take that for action.

On the second issue on the reservoir with regards to Hiroshima/Nagasaki, we have done

some reports on it. But once again, I'd be happy to -- if -- with your comments that we've had -- come back and provide a response, too, on that one.

MR. CLARK: Dr. Blake, then let me assure you that I'm in communication with the Mayor of Nagasaki in their archives and I will have that perhaps within the next two weeks --

DR. BLAKE: Oh.

MR. CLARK: -- and I'll pass it back to you. The Mayor -- Nagasaki maintains a tremendous archive as it relates to our problems, so I will pass that back to you, with your permission.

DR. BLAKE: Thank you, Mr. Clark.

VICE ADMIRAL ZIMBLE: I'd like to ask Mr. Beck if -- if he doesn't have a word or two to speak to the subject. As I recall our visit to the subcontractor, we were told that they use a worst case scenario for the -- this -- the incidents of bathing and drinking the reservoir water. Is that not correct?

MR. BECK: No, that -- that's correct. There is a report that's the basis for the calculations that are made for the occupation

forces, and it does cover this whole subject. It does do estimates of doses from drinking the water, from swimming in the water. It's part of the analysis.

The subcommittee will be looking at that again just to make sure, since it's one of the templates that have been developed, so we will be reviewing that. But the data is there. We know what they're using and we will be reviewing it again.

MR. CLARK: Let me assure you I have documentation from the occupation forces up through mid-October which goes back to their COs saying that the wa-- the lake was still contaminated through mid-October, 1945. So we were there a little ahead of that and that may be some of our problems.

MR. BECK: We'll have to look at the --

MR. CLARK: Yes.

MR. BECK: -- the values that --

MR. CLARK: Yes, sir.

MR. BECK: -- we were using in the calculation --

MR. CLARK: I understand.

MR. BECK: -- of the doses. It's not a

question of whether it was contaminated, but what effect it had.

MR. CLARK: Appreciate it.

MR. BECK: We will look at that.

MR. CLARK: One other item, Admiral, if I may, please. The veteran has a problem in this relationship -- this actually is addressed to the VA. A veteran forms his claim for dose reconstruction, goes to the VA and goes on over to the DTRA for does reconstruction. In the interim -- I've been waiting ten years myself. In the interim, we file claims. I have a hole in my retina, I have -- my hearing is gone -- file claims and they sit on top of that particular claim pending review by the VA at some point in time in the future. I've been waiting now two years, and the RO in Honolulu can do nothing without that claim, so we have that problem, too.

VICE ADMIRAL ZIMBLE: Okay. Well, it -- that -- that information is now on the record. We have a representative from the V-- from the VAB here with us today and -- on the Board, so we have that -- we have that for consideration.

MR. CLARK: Thank you, Admiral. And thank you,

folks. I really appreciate meeting you.

VICE ADMIRAL ZIMBLE: Okay, thank you.

MR. GROVES: Mr. Clark, before you leave the microphone -- if it's all right, Admiral? I'm sorry.

VICE ADMIRAL ZIMBLE: Yes.

MR. GROVES: One, thanks -- thanks for coming back, and you and I were having a discussion off-line --

MR. CLARK: Yes.

MR. GROVES: -- and if it's all right with you, I would like to share it with the committee, and that is that in your capacity as an officer in the National Atomic Veterans Association --

MR. CLARK: Yes.

MR. GROVES: -- you had said that when you received the notice of this meeting that you sent out I believe it was 150 letters to --

MR. CLARK: Yes, I did.

MR. GROVES: -- members. And I -- and since we had had this issue come up this morning about trying to find ways to communicate, I want to congratulate you on doing exactly what we were hoping would happen, and that is to get the information to -- to people like yourself who

would then get it out directly to our potential beneficiaries. And I want to thank you very much for taking that second step to do that.

MR. CLARK: If I may, I'll just add to that conversation. We have people addressing the microphone from Anchorage, Alaska, from Maryland, from Minnesota, from Idaho, otherwise they've -- they took an acception (sic) to the letter, come on down. So thank you again.

VICE ADMIRAL ZIMBLE: Thank you. Have a safe trip.

Next is Mr. -- Mr. Bankston.

MR. BANKSTON: Good afternoon, panel and Mr. Chairman and ladies and gentlemen, comrades. My name is John Bankston, Waldorf, Maryland and I work with Veterans Affairs in -- in -- in Maryland for atomic veterans and the Radiated Veterans of America, and I belong to all the other service organizations except one, and I'm a honorary member of the Korean War. The rest of them I'm a life member or either member. And I'd like to thank you for giving me this opportunity to appeal to the -- we hope it's the government of the United States of America on behalf of all the radiated veterans of

America and all other chemical-tortured veterans. I want to strongly emphasize that we still love and honor our country, as much as when we were sacrificing ourselves for her. I have never heard an atomic veteran denounce or threaten our homeland, although we have been and still are treated cruelly by our government -- that sounds rough, but that's what it is; that's the only thing I can say what it is -- in the form of super-secrecy, and that started from the day that the TRINITY test, July the 16th, 1945 when the President Truman told the principals declare it super-secret. It's been that way ever since.

I have -- excuse me. Although we have been -- for 60 years we've been looking for some relief, it has not come to us -- from exposure to ionizing radiation. It is -- I hate to use this, but it's true -- our rogue leaders -- it took me 60 years to say that, but there's too much -- too much waste. I -- I -- I went to the -- all the way to the Deputy of Department of Veterans Affairs and I wrote it through Congressman Callahan, and I -- I showed him where I could come up with, in writing,

millions of dollars. In other words, the Veterans Administration wastes $1 million a day. That was in *The Mobile Register*.

Then I saw another report, $22 million, and I spent $8.30 verifying that. And it just goes on, on and on. We know about the kick-backs. We know about the delays. We understand -- we -- we're not -- we don't try to do your job because you're professionals, but we understand at a certain plane of everything that's gone on and possibly will keep going on, and this is not right. I personally believe it's damning the United States of America.

I had a grandson adamantly wanting to go into the Coast Guard, and he saw me turn in a report -- I believe I sent it to a General Atkins; I won't try to verify that because I have a small archive -- I sent a report to him what we were faced with, the radiated veterans and the National Association of Atomic Veterans, and he -- he refused to go in the Coast Guard for seeing my medical record, which you have a copy, Mr. Chairman. And this goes all the way back to President Truman days. There's no -- there's no question about it. From that first

day, remember -- you know. You've probably -- well, on the -- on the committee that invented it and followed it all the way through.

Okay, this -- it's President Truman and his White House staff, and we all know that, heedlessly ignored Albert Einstein warning of the danger to radiation exposure to humans. We know this. Those cruel leaders, that's what they were, when they put a famous division like the 2nd Marine Division and put us in Nagasaki and don't even mention the word radiation, much less what it'll do for you. That is nothing but cruel.

They trample on our Constitutional rights, if we even have a Constitutional right. I'm beginning to doubt it. They did this without concern or impunity.

My family tree and coat of arms, it goes back to the year 1504. There is no record that anyone -- anyone's sibling or whatever has suffered with the same sickness and death as my immediate family and atomic veterans. It was once said -- and this is -- this is real true, and you folks, some of you are geniuses, no doubt. It was once said, when geniuses get to

the top of their plateau, they will commit to anything that satisfies their aspirations. I hate to believe that, but when you look back to the atomic veterans, what we have, I'm beginning to believe it fully.

As a matter of fact, it should be readily agreed that any and all leaders who have not exhausted their efforts to come to the atomic veterans' rescue from radiation sickness, they should have all the historical records stripped back to President Truman days. That's my opinion. It's a hard one, but I've lived a hard life.

The responsible leaders who are still living should be fined -- heavily, I say -- and imprisoned for the rest of their lives for failing to rescue atomic veterans from our horrific suffering caused by invisible enemies.

During the anthrax attack on Washington, D.C. Congressmen, Senators and their staff, they ran for immediate safety -- and understandably so, 'cause we know why they ran. But what we don't know and understand is why they didn't consider us and come rescue us like they were.

Attention was immediately given to their

matter. However, we are blatantly reminded that little or nothing has been done for atomic veterans and their families' safety. In fact, they have been literally destroyed instead of helped. I can prove that a million times over, most likely.

Like President Thomas Jefferson said, to keep a nation strong, the people must be informed. When VA doctors -- because we're not informed, the people. Eighty percent of people -- you can talk to people about atomic veterans, they don't want to hear it 'cause they think it's a myth or something, that we give them a sea story. Eighty percent of the people should get behind atomic veterans and all the military so we will maintain a safe country.

Here's one now that's true to my case. When VA doctors examine atomic veterans without touching them or without using instruments, not even a thermometer, how can it be determined that atomic veterans have never suffered from atomic radiation? It took me six or eight weeks to get a -- to the right contract in Washington because I got the run-around by the rosebush and dead end numbers. And when I got

up there, the doctor did not touch me. We shook hands when I went in and when I went out, and then I got a letter -- had no signs of radiation. He didn't look at my medical history. Every time I mentioned what things should be and shouldn't be in protecting atomic veterans, the only logical comment I got from him said isn't it that way with everything? And you know my feelings because what I've just said.

The military man's credo for commanding officers -- some of you are commanding officers -- is not to leave any troop behind. Our famous 2nd Marine Division that protected America was radiated on purpose, thus destroying families and killing tens of thousands, if not millions. And I'm here to tell you that I know it, radiation sickness is the sickest sick you can get.

It is very obvious to atomic veterans that the American medical -- this is -- this is hard for me to say, but I have seen it. I believe I can put it together, the puzzle. We have a little common sense. It is very obvious to atomic veterans that the American Medical Association,

the AMA, and Veterans Administration, the very people that's supposed to -- designed to help veterans -- the administration, the VA and the media, including *The New York Times*, and we know that little baby, too, of deceptive writing imbedded with the government. That is pathetic for America to tolerate that. American people shouldn't tolerate it. And then the other governmental bodies all worked in unison -- you folks know it, you're right in the midst of it; you know it from A to Z and I recognize that, and I know it's complex and I give you credit for being so highly intelligent. Some of us didn't get to go to all the maximum because of being radiation sick. The complex that kept secrets on how extremely dangerous ionizing radiation is to humans, to us this was purely human experimental-- tation -- experimentation, excuse me. We believe this has been highly damning to our country, and will continue to escalate -- I hope not, that's my belief, though -- if justice is withheld. That's what's going to happen 'cause we're out there with the people. We see it.

These acts are the cruelest since the Roman days of torturing their own people. And it is impossible for atomic veterans to defend ourselves in the short time allotted for presenting our case, especially when having to -- I told Senator -- Congressman Callahan these very words -- especially when having to compete with the entire government and an army of doctors and lawyers specializing in nuclear physics articulating 100 percent against our cause in a most unfaithful manner. That's hard but it's true. That's the way we feel because we've been down that tortuous road.

I could go on and this -- I could tell my whole book. I wrote one, it's *The Invisible Enemy of the Atomic Veterans*. I didn't try to use the -- all your technical formulas like beta, alpha and how to split an atom. I just told it just like it was. And the name of it is *Invisible* -- I'm not doing this to sell the book. I care less whether I sell one. In fact, I give my -- what little I've made, I haven't marketed it because taking care of my wife, who took care of us and killed herself early, but I haven't marketed it because I haven't had a chance.

But I wrote it for one reason, to spread the work about how atomic veterans have been treated.

And thank you -- I want to thank you very much for listening. It's our sincere prayer that we have relayed to you a message of the suffering atomic veterans and their families and what they have endured these past 60-plus years. We now ask you to urge the responsible governmental bodies to immediately resolve the issues of atomic veterans and their families.

Thank you, sir.

I have some questions for you folks but they're too lengthy, and I could have written probably 10,000, but I kept it to 28. I wish you'd, Mr. Chairman, pass it around to them, please, sir.

VICE ADMIRAL ZIMBLE: I have -- you have this one question --

MR. BANKSTON: Yes, sir.

VICE ADMIRAL ZIMBLE: -- let me read the question. Is -- is this subcommittee here for the sheer pleasure and aid to our President ultimately or to his staff, will he get this report from this committee and the veterans alike? That was your question. And I will

just tell you that the Veterans Board for Dose Reconstruction was created by Congress to specifically offer recommendations to two agencies, to the Veterans Administration and to the -- to the Defense Threat Reduction Agency, the people that are doing the dose reconstruction. That's our charter. And we are diligently determined to make recommendations that will enhance the process, so I can promise you that.

MR. BANKSTON: Yes, sir, I know some have did it and I sure appreciate it.

VICE ADMIRAL ZIMBLE: But we'll make sure that -- I mean your remarks have been duly recorded verbatim and will be made part of the official record.

MR. BANKSTON: Thank you, sir.

VICE ADMIRAL ZIMBLE: Thank you.

MR. BANKSTON: Thank all of you.

VICE ADMIRAL ZIMBLE: Right. Now I have on the list that Mrs. Bankston wish to -- or Senith Bankston wishes to speak. All right, the floor is yours. More reading material. Thank you.

MS. BANKSTON: (Off microphone) (Unintelligible) and my name is Senoth.

VICE ADMIRAL ZIMBLE: Senoth, I'm sorry. Okay.

MS. BANKSTON: Good afternoon, Honorable Chairman, ladies and gentlemen. My name is Senoth D. Bankston. I am a daughter of Captain Lynn A. Deflorin*, Sr. My dad was the captain of the Belmont. That was a sailing ship that later turned in to be a vessel -- I think that when my dad went down with his ship I was four and half in January the 20th, 1940, and I believe at that time it was used for coal. My mom was only 28 and she had three of us and she wouldn't talk about my dad until -- she's deceased now, but I don't know that much about my father, other than he was a Merchant Marine and his ship went down off Tampa Bay.

My oldest brother, Lynn A. Deflorin, Jr., served two tours in Vietnam. He has battled cancer, prostate and lung, two times. And he said if it comes a third time he's not going to fight it, he's going with it.

My stepfather, John M. Paranowicz*, served under General Eisenhower in World War II. He was also in Korea. And I stayed with him and my mom until he drew his last breath. He had cancer from head to toe for a year and a half.

And I don't know if you gentlemen or ladies has ever sat with anybody while they died. It isn't easy, and you do miss them every day. My dad -- they never recovered his body. There's no closure there, and that's real hard. Also I had a -- my former husband was in Korea in the Marine Corps and he died January the 10th a year ago with cancer of the stomach and the lungs and the thyroid.

And my friend that I've been friends with at church for over 40 years, her husband, Norman, served with the occupational forces in Nagasaki, Japan in 1945. Norman died with lung cancer, and after Norman died he -- before he died, though, while he was serving in -- before he served in Nagasaki or any branch of the service, he had two children born of this marriage. After he served in Nagasaki he had a daughter that was born after he came home. This daughter, Susan, died just before Christmas this year of a brain tumor. She has a son that's 32 years old that is dying of a brain tumor. I don't know if that's, you know, generically (sic) passed on or not, but you know an alcoholic can pass on these genes, so I

don't know if -- I'm not, you know, medically knowledgeable about that. This radiation can be generically (sic) transferred or not is not up to me, but it is obvious that this is happening.

I am the past president of the P.L. Wilson Marine Corps Ladies Auxiliary, and I do know and have been around a lot of different veterans, mostly Marines, and I have witnessed many of them dying of different cancers. I've gone to too many graves. I've held too many widows' hands and their children, and I know about death. These veterans were more than likely -- well, some was in World War II, some was in the Chosin Reservoir, there's three of them I know in the Chosin Reservoir. There's some that's been in Vietnam, some Desert Storm. I don't know if they died of ionized radiation, Agent Orange or whatever chemicals.

I recently married John Bankston and he is also, as y'all know, a former Marine and who was exposed to ionine (sic) radiation in Nagasaki during the occupational duties from September 23rd, 1945 to July the 8th, 1946. John now lives in Waldorf, Maryland with his

daughter and which -- Betty Christianson. Among other symptoms, she has a thyroid disease. All these indications point to the transfer of radiation. I also learned that John's two grandchildren and three of his great-grandchildren are showing signs of radiation sickness.

On my first visit to Waldorf, Maryland after our marriage, I had the occasion to visit -- to view what I call John's personal archives, a history on the atomic veterans and how radiation destroyed these veterans and their families trying to be cared for. During our short visit I noticed that he had several atomic veterans and their wives seeking medical help or on knowledge of what to do or where to go, and he told me that he got two or three of these a day -- or during the week, seeking information.

During the Christmas holidays John and I went to my former husband's grave to put flowers on and then went to his former wife's grave, and there I noticed that John had a child died at the age of five and a half months of colon cancer. The doctors just couldn't help the

baby because they thought it was too hard giving deadly enemas -- painful enemas to a five-and-a-half-month-old baby, so they operated on him and the baby died.

John later had another child, John Thomas, that was at the age of 12 and a half years old that died from liver problems. This child knew he was dying, planned his own funeral.

John's late wife, Bobbie -- Bobbie Louise, died January the 20th, 2005, and I've been told by the family that she died damaging her health taking care of these babies and John during their sicknesses.

I also notice that John has chronic and severe sleeping problems. The only time he seems to get any relief is when he takes a sleeping pill, and that's only about five hours. He has severe and -- you know, leg problems, cramps and all, and they're chronic. He has sores like here on his face or on his legs or something that just doesn't look normal, and they don't seem to be able to take care of them or they don't go away.

Since then I've read his medical records and I firmly believe that they confirm that he did

have radiation -- iodized (sic) radiation. And his medical records show that he had surgery for basal -- basal cell -- cell carcinoma and he had many skin diseases removed, cancer skin diseases.

In closing I wish to make it known, through my many years of association with veterans, their wives, their families, my family and friends and the issues related to their health, it is my opinion that our veterans are very lacking in proper health care, which has been ignored far too long. I have also tried to help many of the ladies just to deal with daily things at the loss of their husbands. As I've told y'all, I've dealt with death quite a few times. Health benefits and different things that our men made sacrifices, they laid their lives down, they laid their -- like the -- our forefathers, they put their wealth, their health, their families on the line. And here we, as Americans, say thank you? No, thank you.

Thank you for allowing me to share what I feel, and I pray that y'all do take this back. And President Bush is my President. This is my

country, and I'll stand and say as long as I can and fight to defend all veterans. Thank y'all, ladies, gentlemen.

VICE ADMIRAL ZIMBLE: Thank you. And again, those comments will be considered --

MR. BANKSTON: (Off microphone) Mr. Chairman, (unintelligible)?

VICE ADMIRAL ZIMBLE: Sure.

MR. BANKSTON: She told -- really -- what she said is very true, but one slight mistake. The youngest son that died at five and a half months old, he had an enlarged colon --

VICE ADMIRAL ZIMBLE: Okay.

MR. BANKSTON: -- which he had to have deep enemas daily, and it was going to take nine operations to get him to where he could live comfortably.

VICE ADMIRAL ZIMBLE: Sure.

MR. BANKSTON: And instead of being a cancer --

VICE ADMIRAL ZIMBLE: Right, it was -- was a megacolon.

MR. BANKSTON: Yes, sir.

VICE ADMIRAL ZIMBLE: Right, okay. Thank you very much.

I want to reassure you that on this Board there

are eight distinguished veterans, so we understand -- we understand your feelings and we can -- we can show some compassion for what you've gone through. Now -- and -- and we'll see, you know, what is related to ionizing radiation and what isn't. We'll do what we can. Okay.

MS. BANKSTON: Sir, I don't mean to be rude --

VICE ADMIRAL ZIMBLE: Okay.

MS. BANKSTON: -- but have you ever lost a loved one as --

VICE ADMIRAL ZIMBLE: Yes, I have.

MS. BANKSTON: -- as a wife --

VICE ADMIRAL ZIMBLE: Yes, I have.

MS. BANKSTON: -- or child?

VICE ADMIRAL ZIMBLE: I have.

MS. BANKSTON: Then you know. You can't relate to someone that hasn't. They don't know that loss. That's only something you and you alone.

VICE ADMIRAL ZIMBLE: Right.

MS. BANKSTON: And that's what I wish to get across.

VICE ADMIRAL ZIMBLE: Okay. Thank you very much.

MS. BANKSTON: Thank y'all.

VICE ADMIRAL ZIMBLE: Thank you. Mr. Wyant, you have some additional testimony for us since yesterday?

MR. WYANT: (Off microphone) I appreciate (unintelligible) appreciate me, but...

I will say this, though. Since yesterday I've had a lot of people thanking me for what I said. Now I don't know how many of you appreciate what I said, but what I said is the truth. I'd venture to say not one of you people know anything about me except if you were in Tampa and you heard me there. And I'll say it for the people who are here who do not know. I'm the oldest living veteran who worked in Los Alamos, which was called Manhattan District Engineers of Tennessee. That was our cover. Bob Oppenheimer was my boss. He picked me out of Washington, D.C. four months before out of 3,500 veterans that had been returning from Europe.

They put us in this deal. I thought we were going to work for the Post Office because it was in October. I knew after one week no way was this a Post Office job. I couldn't figure out what it was all about, but I knew it must

be something rough. And when I was able to talk to my folks, who didn't even know I was in the States on top of it, getting all this information from the federal government, the FBI checking my folks, my dad, where I worked, where he worked -- telephone company for 49 years, my mother was a nurse, she worked for the Red Cross out at the air base, the kids I went to school with, the doctors, all the neighbors that I had. In those days in Iowa, you knew everybody for 50 miles around and they knew you. When I come to the west coast I couldn't believe that you could live next door to your neighbors and not even know who the heck they are. It's the same way today.

So much for that. I'd like to ask you a question. When I first come up with this 31 or so cancers, what I'm going to ask you wasn't on there, but shortly afterwards it was. And I'm going to ask you the question. How do you determine bone cancer? What -- in your position, how can you say that it's radioactive when the doctors who deal with this bone all the time, who have worked on me and prayed with me and done everything, not one of them ever

said that I had radiation because I'm telling you the truth, 65 years later they did not know anything about radiation. The government did not talk about radiation during World War II, hardly said a word. And then you expect the doctors today in the hospitals -- I'm talking about the VA hospital in Portland right at the moment, and the one up in Seattle. Those doctors don't know anything about radiation, and they admit it. We would like to know more. My own doctor I had for five years, I finally gave her some information when I could talk about it, in 2000. I've been 65 years under surveillance with the FBI. They check with me all the time. They called me in February and asked me, trying to find out if I was still alive after he told me there was 243 in my classification. And during that time I was in Los Alamos, the only veterans that were there were Army, 243. Now I only know of seven that worked in the area where I did. I presume a lot of the MPs who patrolled the top of the -- of the area, and the bottom because it's a plateau, 100 to 200-foot straight cliffs, only one road up -- and they might be classed in

that. He couldn't tell me that, but he had been two and a half months calling that roster. He neither talked to the parents, he neither talked to the veteran or his wife or his children. He talked to a few cousins who (sic) nothing about it whatsoever, didn't even know what he was talking about. And that's the fact.

You've already admitted yesterday and today that we need to do more advertising, letting people know that there are atomic veterans and we're in badly (sic) need of help. But what are you doing? You're setting here on this dose registration -- reconstruction. You been doing it for -- for almost 60 years, at least since '70, and you haven't gained one thing. You have spent thousands of dollars on something you can't prove because it doesn't help me because you can't say whether I've got radiation or not. There's no doctors that you can send me to that's going to tell me I've got radiation, because nobody knows. The VA, who has in charge of Orange and R and R, radiation examinations, they finally, after calling back and forth to Portland to the gal that's

supposed to represent us there and I'd been there two different times and she says Clyde, I don't know what to do for you. We only have it from '50 on up to '70. We don't have nothing in '40, '45. I'm -- can't do anything.

So this Helen -- I'll call it Larwakovich*, that's as close as I can come to it. Anyway, she correspond with her in February -- in September of '40 for about two weeks back and forth, and also with Dick Kontz*, who then was the state command-- national commander of the atomic group. He wrote to them and told them that Clyde Wyant is the only one left. He is the sole survivor of Los Alamos. But you think they believed him? No. But I did get a letter from her saying the committee has been reviewing your form -- your claim, and we have come to the conclusion that you are presumptive -- is that the right word, presumptive? That you are radioactive, and we have decided that you are 100 percent radioactive.

Now you tell me after 67 years that I'm 65 percent radioactive? Yes, I worked in the chemical laboratory with Bob Oppenheimer making this stuff. I had it in my hands. I

transported it. I handled the drafts where it came out and went to the washer. I did all of that. I have a letter of October the 1st of '45 thanking me for my service. I left there -- I was there in Los Alamos in '45 when we tested the TRINITY site. I was in Camp Beale, California when they said the dropped the bomb on Japan, and I'm saying to myself so that's what they did with it. Now I couldn't tell a soul. I was confined to that military base. I couldn't go anywhere. I had to report to headquarters, G-2, four times a day. The night O.D. of the camp come and checked my bunk to see if I was in it. I was in a organization that was shipping people overseas all the time. Every day I was on that list, too. And they finally give up. They wanted to know who I am, what I am, how do I get paid and what do I do. Well, you know what? I couldn't tell them one damned word because I'm under security. I haven't been able to talk about this till 2000 when I got my citation, was called TRINITY site advisor, and the letter of Bob Oppenheimer proved that I was there.

Now I'm asking why, after the President said in

2001, after he become President, at Arlington, after he gave his speech in the morning and praising the Purple Heart boys -- there were ten of them there -- afterwards, and then he said -- and these are my words -- his words, I just discovered three months ago that there are a group of veterans who are morally mistreated and neglected and abused and badly need of medical attention. That is the atomic veteran with radiation, ionized radiation. And he said we do not know what to do for them. We do not know what to do for them. And what did he say? I'm recommending to Congress that they get a Purple Heart and get compensation and get their medical problems solved somehow or another, but do it. I haven't heard one word from Washington. I haven't word (sic) from anybody helping me solve my problem. All my medical -- all my fusions, all my medical stuff has been outside of the veterans' hospital because I could not get it done. My insurance policy and my pocket paid for it. It's still paying for it.

VICE ADMIRAL ZIMBLE: Mr. Wyant --

MR. WYANT: And what I'm saying to you again --

VICE ADMIRAL ZIMBLE: Okay.

MR. WYANT: -- please -- well, this -- this man here who -- just talking to you a few minutes ago and give -- I think he's the one with the book, every word that he said -- I hope you set down and think about what he said, because I've been trying to say the same damned thing for 20 years.

VICE ADMIRAL ZIMBLE: Right, and we have --

MR. WYANT: I am working --

VICE ADMIRAL ZIMBLE: -- your testimony.

MR. WYANT: -- to help the veteran.

VICE ADMIRAL ZIMBLE: Right.

MR. WYANT: I am asking you people to do something about it to get us. My national commander, R.J. Ritter, and I have talked about what to do. I'm talking about another group. And we know that if we do this, you won't be having to argue about what you're trying because what you're all talking about ain't helping us any. You are spending money, but we're not getting any help. I have got no compensation for radiation in 65 years. I have 100 percent in 1999. You know how I got it? After my third operation they called me and

said they're reviewing my claim. They said when was the last time you worked? I says I haven't worked since 1975 when I had my second fusion. You haven't worked for anybody; have you paid any taxes? I says no, I haven't paid any taxes up to this day. That was last year -- I mean in 2000. And he said well, we're reviewing it. He says you now have 60 percent. Yeah, I got that two days ago after my third back operation. It was 40 percent, and then while I was in there they decided to make it 50 and then after I got out I got a call from Washington that said we're making it 60. Two weeks later they called me from Washington again and asked me when I worked. Guess what? I got 100 percent. Why did I get 100 percent? Because I haven't worked for -- I had to be over 70 years old at that time. I haven't worked for five years for any company, had taxes withdrawn and paid taxes. And since I haven't, they gave me 100 percent.

Well, in those days it was about $1,300. It's up now, as of yesterday it's $2,300. But look all the expense I've had. I need -- I -- I'm blind. I have a closed circuit TV that I got

from blind school in Tacoma. Cost $8,000. I come home with $10,000. I got all kinds of stuff to read but I can't read it -- talking calculators and all that kind of crap, I can't see to read it or write it. Anyway, I'm getting now a machine that reads printing. This I got from Washington from Marlena Hester*, 31 pages. It took me over ten days to read it because I can only see two words at a time. But now this reader, it's like a printer. You put that in, turn the button, turn the switch, turn the volume on and it reads it, literally reads it, word for word. I can stop it, back it up, move it forward, whatever. Anything I want to put -- newspaper, magazine, anything I want to put under it, it will read it. Now I've got -- I've got 72 pages of stuff from Washington that I haven't been able to touch and they've been in my -- on my machine now -- by machine for almost two months because I cannot read it because when I was -- went up to American Lake because I was worried about my blindness because I'm not supposed to be seeing anything, I've been blind for nine years and up until six months ago I

can -- supposed to be seeing you as an image, which was --

VICE ADMIRAL ZIMBLE: Okay, Mr. Wyant --

MR. WYANT: -- was the truth. But now --

VICE ADMIRAL ZIMBLE: -- much of this --

MR. WYANT: Just give me two minutes, you know.

VICE ADMIRAL ZIMBLE: All right, two more minutes.

MR. WYANT: I -- I'm -- I am deserving --

VICE ADMIRAL ZIMBLE: We have much of this --

MR. WYANT: -- of this.

VICE ADMIRAL ZIMBLE: Yes, you are. We have much of your testimony --

MR. WYANT: Well --

VICE ADMIRAL ZIMBLE: -- from yesterday.

MR. WYANT: -- just a minute, because I'm leaving here and I'm going over to the VA hospital.

VICE ADMIRAL ZIMBLE: Yes, you are.

MR. WYANT: They're coming after me.

VICE ADMIRAL ZIMBLE: Right.

MR. WYANT: But anyway, I'm saying this is the most ridiculous thing I've ever seen in my life. I don't get no help from anybody. No family, I never had any children, as I said.

My folks don't know about it, they're long dead. My nephew is my trustee now. He lives in Florida. He's trying to help me. I live by myself. My wife's daughter took me in a divorce in 2003 for a whole year. It cost me $187,000. Where in the hell do you think I got that out of my Social Security and VA pension and it isn't what I'm getting today. But she got it, and I sold my house -- big three-bedroom ranch, 50 by 70, on a big lot, sold it for $175,000. I could have got, any day of the week, $200,000, $225,000, $250,000. When people found out that the house had been sold, when did you sell it? I said I didn't sell it, the court sold it. They put it on the market and an hour and 15 minutes it was sold. And the court didn't give a damn how much they got, they said it's sold, so I'm stuck with it. So I'm on the broke side a little bit. And I could use a little compensation for the radiation which I've been putting up with for 60-some years. I think I'm deserving of it and I'm pleading with you, see that I get it.

As far as the Purple Heart is concerned, it doesn't mean a damn, but except it would raise

my deal from whatever I got now to six, I think it is, and you get more benefits, more doctors and more everything, and it's in that. I would get it. I would like to have that. But I'm afraid I'll be dead before I get it. I'm 85 now.

VICE ADMIRAL ZIMBLE: Right.

MR. WYANT: They told me I wouldn't live to be 50.

VICE ADMIRAL ZIMBLE: Okay.

MR. WYANT: I thank you very much for your patience. I know you heard me in Tampa and you're hearing me twice today. I appreciate it.

VICE ADMIRAL ZIMBLE: Right, we have it --

MR. WYANT: I just thought --

VICE ADMIRAL ZIMBLE: -- we have it on the record.

MR. WYANT: -- your group needs to come to -- oh, I know one thing I was going to ask because they've already asked me to say it. Why do not you people request that they take me to Walter Reed or someplace and check me out to find out how come I'm alive after all my fellows that worked in Los Alamos are dead over 30 years

ago? Why am I the only one that's still alive? Can you tell me? Have you got an answer for that?

VICE ADMIRAL ZIMBLE: No.

MR. WYANT: I would like to know. How come I'm still alive? And I told my doctor a month ago, I'm going to live another 15 years. I'll be almost 100.

VICE ADMIRAL ZIMBLE: And I believe that, too.

MR. WYANT: And I will be back --

VICE ADMIRAL ZIMBLE: Okay.

MR. WYANT: -- in the fall. Wherever you'll be, you'll see me again, but I hope by that time I'll have a little more information.

VICE ADMIRAL ZIMBLE: Okay. Okay.

MR. WYANT: Sorry, but I -- I think over two times now in the three months --

VICE ADMIRAL ZIMBLE: Okay.

MR. WYANT: -- that I think you're beginning to get the word that this gentleman just behind me also verified what I've been trying to tell you --

VICE ADMIRAL ZIMBLE: Okay.

MR. WYANT: -- so maybe two of us, don't know one another, don't even know we're here, is

telling the -- basic -- some of the same things I've been trying to tell you for two times. Please think about it. If you want to know more, you want to talk to me, you want me to come someplace, I -- I love to travel. Call me.

VICE ADMIRAL ZIMBLE: Okay, thank you very much.

MR. WYANT: (Off microphone) I thank the committee and they're intelligent and -- oh, yes, I do like to thank General Taylor.

VICE ADMIRAL ZIMBLE: Okay.

MR. WYANT: (Off microphone) He's (unintelligible) he is a regular Army man, retired. I'm a regular Army man and I (unintelligible). I was in Kodiak, Alaska when they bombed Pearl Harbor. I don't have (unintelligible). Thank you.

VICE ADMIRAL ZIMBLE: Okay. I -- if there's anyone else that is not on this list that would like to make a comment? If not -- and I thank you, I thank those folks who took the time and -- and made the -- made the effort to come to provide us with some testimony. Is it -- what's next on my agenda? I lost -- oh, here

it is. No, it isn't.

UNIDENTIFIED: (Off microphone)

(Unintelligible)

VICE ADMIRAL ZIMBLE: Okay, thank you. All right. It's time -- we can take a short breather. Let's take a break for 15 minutes, then when we come back we'll finish up with more of the Board's business, as indicated in the agenda. Thank you.

(Whereupon, a recess was taken from 2:35 p.m. to 2:50 p.m.)

BOARD MEMBERS QUESTIONS AND DISCUSSION

VICE ADMIRAL ZIMBLE: Ladies and gentlemen, let's please resume. The first piece of business -- Dr. David Kocher had some comments that he wanted to make earlier yesterday and we -- we've asked that he address the Board to -- to talk about some new and exciting developments.

DR. KOCHER: Yes, thank you, Mr. Chairman. I just wanted to say a few words about the Interactive RadioEpidemiological Program, this famous IREP, sort of in the vein of where do we go from here with this program. And I do this

because, if you choose, this committee has a role to play in the future direction of development of this program.

IREP is a living thing. It is being continually thought about and investigated by, you know, the scientific staff at NIOSH and by the technical staff in Oak Ridge, at SENES Oak Ridge. We meet two or three times a year for essentially a two-day retreat to just talk about new scientific developments and what do we need to do to make this program better. It's not like the 1985 radioepi tables that were frozen in time for 15 years, so there are opportunities. So I wanted to just sort of give you a flavor of how this process works, and maybe even some of the things that we're working on that might be of interest to the atomic veterans' program.

Future developments are clearly driven in part by activities by the BEIR committees, say. I mean BEIR VII is a -- is a crucial benchmark that --in large measure the basic risk models from the A-bomb survivor data clearly will end up in IREP. Will everything that the BEIR committee has recommended end up in IREP? I

think the answer is absolutely not. There are whole issues of importance to IREP that they don't deal with, and there are other issues on which there are honest disagreements of opinion about whether they have represented the state of knowledge, and NIOSH may well take a different view.

So it's -- it's not a conflict, but there are basically two things going on. You have your high level committees that make pronouncements every ten or 15 years, and then there's the foot soldiers down in the trenches who go to work every day and are trying to look at these things, and we may have a different point of view. And the political and governmental system works all this out, but it's very dynamic.

For example, we are working on a model for chronic lymphocytic leukemia, which everybody knows is not radiogenic. But a decision has been made to look into this and to see what's really there, so you may see something come down the road here pretty soon that CLL is now in IREP. I can't predict the future.

Dr. Land mentioned yesterday that a very

important parameter in this program is this famous dose and dose rate effectiveness factor, DDREF. And basically what it does is it reduces risk estimates at high acute doses in A-bomb survivors for application to low doses and low dose rates. And we have been for a year now working extensively to review all the literature and try to come up with some recommendation for changing the present assumptions about DDREF in IREP. And this is one area where I think it is virtually -- it is absolutely certain that we will not recommend what the BEIR committee did to NIOSH. And I think there's a 95 percent chance that NIOSH will not adopt what BEIR says -- BEIR VII committee said and do something different. So stay tuned. I mean this is fun stuff. This -- this is -- this is really fun stuff.

But I just want to emphasize that this is a dynamic system and you people, when you have technical issues that you want to bring to the fore, you should be encouraged to do so and I'm certainly, if they're not doing it already, encouraging -- going to encourage NIOSH to communicate to you when they make changes or

have proposed changes, because IREP is now a bedrock of your program. No -- no question about it.

A couple of other just very quick remarks. Julian Preston mentioned the desire for a program that would calculate dose risks and probability of causation all in one fell swoop. Of course their interest was Nevada Test Site fallout. But in fact we have such a program for Nevada Test Site. It calculates dose, lifetime risk, future risk from today if you're disease free, probability of causation if you have disease today, and it washes your windows and cooks dinner before 6:00 o'clock.

One final comment, I very much appreciated the discussions earlier today about communicating information about radiation risk to veterans. I can tell you in all honesty, I have failed miserably on every attempt to do this, so I will be looking for some method that works. A possible vehicle to provide you with some information was a report on screening doses calculated by IREP that we did produce, and I believe Subcommittee 1 has this report. It's basically a table of how much it takes for

every -- how much dose it takes for every one of the 32 cancers in IREP, depending on how old you were when you were exposed and how old you were when you got disease, so it's just a mind-numbing array of numbers. But when you look at it, you know, the message comes through that it takes a lot of dose to reach 50 percent PC at the 99 percent confidence limit. But that's a data resource you can use to factor into how you're going to couch this in terms that lay people can understand.

Thank you for your time.

VICE ADMIRAL ZIMBLE: Thank you very much. And -- and is there any discussion from the Board?

(No responses)

I -- I -- I very much appreciate it and I'm one of those lay people that you've got -- that you've got to convince, but I -- I thank you very much for that -- for those comments.

Oh, there -- the first item on the agenda is -- is to dis-- and if there's -- to see if there's any further discussion regarding the PC or dose reconstruction assessments. And I don't see any volunteers for further discussion, so -- I can't even see that.

UNIDENTIFIED: (Off microphone) (Unintelligible)

VICE ADMIRAL ZIMBLE: Oh, Elaine is not -- is not on line any longer. She's -- she has other commitments.

Okay, then let's talk to -- the discussion of background materials that are relevant to this committee. I'm not sure what that agenda item is. Isaf, can you enlighten me?

DR. AL-NABULSI: Subcommittee 4 suggested to have a library for the Board, and I received input from the Board what do we need to have in the library. If you have additional -- you know, anything in mind that you would like to include in the library, I would appreciate that.

VICE ADMIRAL ZIMBLE: Okay. Right.

MR. GROVES: Let me suggest that --

VICE ADMIRAL ZIMBLE: Mr. Groves.

MR. GROVES: -- it was -- it was made known to us yesterday that the report that -- and I believe it was Dr. Preston's report, or was it Dr. Land's report?

DR. AL-NABULSI: Are you talking about the RECA?

MR. GROVES: Yes, the RECA --
DR. AL-NABULSI: I have that report.
MR. GROVES: Okay. Is that a -- how big is that? I mean bigger than a bread box or -- I mean is it some --
DR. AL-NABULSI: It's about 400, 450 pages. You'll receive a copy of it.
MR. GROVES: Oh, we will? Okay, that's what I --
DR. AL-NABULSI: You already have. I sent it to all of you.
MR. GROVES: Okay, fine. I just wanted to be sure that we all had -- had a copy of it because it sounded like there was probably some information in there that would be useful to all of us, so -- okay.
VICE ADMIRAL ZIMBLE: Well, I'll --
COLONEL TAYLOR: (Off microphone) (Unintelligible)
(Pause)
I think at the last meeting Isaf and I had a discussion on that, and the discussion was that probably this Board needs a good library somewhere, and the logical place is with her and she's undertaken that. I've recommended

several publications and all to her. She's added them to it. The point being that somewhere available to the Board are reference materials that the Board might need. And I don't think that's ever been really explained to the Board, but Isaf has been working on a library for some time and I applaud her for the effort she's done on it. Thank you.

VICE ADMIRAL ZIMBLE: Of course that -- that library will include all of the reports and data that NCRP has already produced and is in the process of producing.

COLONEL TAYLOR: (Off microphone) Plus there's some publications (unintelligible) --

UNIDENTIFIED: (Off microphone) (unintelligible) the microphone.

COLONEL TAYLOR: -- (on microphone) very good.

VICE ADMIRAL ZIMBLE: Very good. Dr. Swenson.

DR. SWENSON: One thing for Subcommittee 4, you might want to look at the American College of Radiology, too. They put out information on radiation for both cancer patients or diagnostic patients. So when you're reviewing some of the publications maybe the VA puts out or you want to couch your own, they do use

pretty good layman's terms because it is for patients. So it might be on their web site, and I know that Dr. Tenforde was going to try to get one of their publications that's now out of print -- they only had a few left. It's *Radiation Risk, a Primer*, and it should be updated because it is pretty good information for kind of a lay person, or at least not the radiation expert.

MR. GROVES: Is Lynn Ferabent* still there at the American College -- Lynn Ferabent?

DR. SWENSON: That doesn't sound familiar, but I recently talked to Penny Butler --

MR. GROVES: Okay.

DR. SWENSON: -- on the information from that *Radiation Risk, a Primer*.

MR. GROVES: Okay, thank you.

VICE ADMIRAL ZIMBLE: I have to say that after receiving testimony yesterday and today, I think that that would be a worthwhile project for one of the agencies to take on to prepare a radiation risk primer that's -- that's -- that's relevant for today.

Dr. McCurdy.

DR. MCCURDY: Also there's a -- in reference to

this, the Health Physics Society does have some background material for dealing with the public on education for risk, risk assessment for radiation.

The question I have also is, on this background material or library, how does the Board member become acquainted with it or use it and how do we get it back to you? Is it sort of a take-out type of thing or how is this going to work?

DR. AL-NABULSI: Yes, you will -- I will send you the list, what we have, and if you would like to look at certain document, I will make it available to you.

DR. MCCURDY: Well, some of these documents you can get electronically or you can get as a hard copy. And probably for the Board, it may be more useful to get it electronic so you can just send that, you know, even over the web. You know -- I mean, you know, you could -- if it isn't too long.

COLONEL TAYLOR: (Off microphone) (Unintelligible)

DR. MCCURDY: Books?

COLONEL TAYLOR: Books themselves.

DR. MCCURDY: Yeah, the books wouldn't be, but

a lot of these NCRP -- a lot of these other reports are becoming --

DR. AL-NABULSI: Correct.

DR. MCCURDY: -- available on CDs and what have you, so I would suggest -- a lot of times they ask for either -- you can buy either one, I think, but --

DR. AL-NABULSI: Yeah.

DR. MCCURDY: -- you may want to make a decision on that.

VICE ADMIRAL ZIMBLE: Yeah, I would -- I would even suggest, Isaf, that you -- that we publish the list of good referen-- background material, references, on our web site. That could be a -- could be a web page that could give you a listing by subject matter, and then some of them, if they're electronic, could -- could even be hyperlinked.

DR. MCCURDY: Do you plan on having the NIOSH and IREP and all this material available in that library?

DR. AL-NABULSI: If you feel that's important to do it, we'll do it. Or we can have link to their web site if that -- if it's available on their web site, I can get permission to do it.

DR. MCCURDY: As long as we don't need a password.

DR. KOCHER: NIOSH-IREP is available as a public-accessible link, and that's what I would recommend you use.

VICE ADMIRAL ZIMBLE: Okay, thank you very much. Any other comments?

All right, the next -- the next topic for the Board to consider is who would we like to have help provide input at our next Board. What -- what type of experts would we like to invite? We have -- we already have several suggestions. One is Dr. Royal*, who is -- who is on the Veterans Advisory Board and -- just to -- to get a feel for what that board does and what -- what input they use in order to make their determinations for -- for VA regulations, so I think inviting him would be most appropriate. And John, I think you have another person that you think would be worthwhile to invite.

DR. LATHROP: Yes, I've already discussed this with Isaf, but just to present it to the Board, from a risk communication point of view, the name that often comes to my mind is Paul Slovic*. He's spent his entire adult life

talking about perceptions of risk, public attitude toward risk, and things that might be of relevance for us figuring out how best to communicate risk aspects to veterans.

VICE ADMIRAL ZIMBLE: And how best to understand perceptions.

DR. LATHROP: Yes, exactly.

VICE ADMIRAL ZIMBLE: Okay. Mr. Beck.

MR. BECK: I think we also discussed that we'd like to try to get somebody to give a talk on putting radiation risk in perspective with other risks so that people would maybe understand what really risk you're talking about with a certain dose. I'm not sure of any particular names, but I think it would help -- Dr. Land would have gone far enough but he really didn't do that.

VICE ADMIRAL ZIMBLE: Okay. I'm sure that if we were to ask Dr. Tenforde he could come up with a list of names that could -- could provide that, so that -- that's a good suggestion and, Isaf, we'll add that to the list. That's three, that's probably sufficient -- oh, I'm sorry. Dr. Swenson.

DR. SWENSON: The only other person I think

that might be worthy of hearing, Dr. Boice, when he talks about the epidemiology -- or if he doesn't -- since he's on the Board, if he doesn't want to speak he might be able to recommend someone else, but that could be very enlightening as he -- for some of the Board members that haven't heard him speak or read a lot about cancer epidemiology.

VICE ADMIRAL ZIMBLE: There's no question about Dr. Boice has a wealth of experience with many patient populations, so he probably is -- is one of our major source -- resources for -- for radiation epidemiology, so let's see if we can ask Dr. Boice to make a presentation.

Okay, any --

COLONEL TAYLOR: I have one recommendation, and unfortunately I don't remember his name off-hand, but I'll tell you a little bit about him. He's the author of the book *Shockwave*, which is the story of TRINITY, Hiroshima and Nagasaki. I read his book, gave a copy to Admiral Zimble. He knows it. The man is a Britain -- British. He came to Washington a couple of times. He was in town last time. He would be a tremendous speaker to us on some of the

background. And the second thing he is, he has written several TV documentaries, which means he has some capability that we as a Board might want to expose to him, so it may be a two-way street in that regard. I'll get you his name, Isaf, but he's -- he is a very capable man and he's written a very fine book and the research that went into that book was extremely wide. Thank you.

VICE ADMIRAL ZIMBLE: Okay, thank you. Dr. Zeman.

DR. ZEMAN: My suggestion is that we consider an expert in beta dosimetry or skin dosimetry. We have some important issues and discussions with regard to that coming up at our next meeting, and there are a couple of experts in the country that would be very good, I think. Some recognized experts like Dr. Tom Gisele* might be one that would be useful to --

VICE ADMIRAL ZIMBLE: Okay.

DR. ZEMAN: -- elucidate us on some of the --

DR. AL-NABULSI: I extended an invitation to Dr. Gisele. Unfortunately he wasn't available to attend this meeting. If you want -- or you still want to hear about beta dosimetry, I will

contact him again to see if he's available for the June meeting.

DR. ZEMAN: Thank you.

VICE ADMIRAL ZIMBLE: I would recommend that you give him both dates, the June meeting and whatever dates we decide for a November meeting. Some of these folks have schedules that are quite crowded.

Okay, let's now -- let's now talk about the -- the Board's work schedule and -- and the schedule for future meeting dates. And Isaf, I would appreciate it if you'd take the lead on this.

DR. AL-NABULSI: With regard to Board work schedule, I would like subcommittee chairs to communicate with members to schedule future meeting dates between now and the June meeting.

VICE ADMIRAL ZIMBLE: And we need now to decide on a -- on a date for the meeting that follows the --

DR. AL-NABULSI: June meeting.

VICE ADMIRAL ZIMBLE: -- the Austin, Texas --

DR. AL-NABULSI: Correct.

VICE ADMIRAL ZIMBLE: -- meeting. We need a date and a place.

DR. AL-NABULSI: Okay. Based on your schedule, you are available the first week of October and the first week of November. Let's decide which month first.

VICE ADMIRAL ZIMBLE: Right. Dr. -- Mr. Pamperin.

MR. PAMPERIN: I would just make an observation that the first week of October you're usually in a continuing resolution, and --

VICE ADMIRAL ZIMBLE: No-travel money.

MR. PAMPERIN: -- there's little or no travel money, so...

DR. AL-NABULSI: So you all prefer --

VICE ADMIRAL ZIMBLE: Yeah.

DR. AL-NABULSI: -- November?

VICE ADMIRAL ZIMBLE: If -- if November -- it's the week of November the 6th, I believe it's -- the dates would be the 9th and 10th --

DR. AL-NABULSI: Uh-huh.

VICE ADMIRAL ZIMBLE: -- of -- the Thursday and Friday --

DR. AL-NABULSI: Thursday and Friday.

VICE ADMIRAL ZIMBLE: -- with subcommittee meetings, if necessary, on the 8th.

DR. AL-NABULSI: Yes.

VICE ADMIRAL ZIMBLE: So let's make that -- let's just firm that up. That's good. And now of course we --

DR. AL-NABULSI: Now location.

VICE ADMIRAL ZIMBLE: -- need a location. I've had -- I have received two recommendations. One -- Commander Ritter of the NAAV is having his NAAV meeting in St. Louis in September. Unfortunately September is probably the worst month for DoD or VA travel because it's the end of the fiscal year and usually there's -- there's not money available and, again, with the continuing resolution we've picked a November date. But Mr. Ritter had still suggested that St. Louis might be better in order to see if we can get more participation from atomic veterans since it's mid-country and each coast would be equally available. I'm not sure that that is -- is going to be -- have that much of a weight factor.

The other recommendation was -- the other recommendation was in the Tidewater area, either Norfolk or Virginia Beach, where there's a large concentration of retired person-- retired personnel. So I would ask -- I would

ask for any other recommendations for the November meeting, preferably not in -- in Nebraska.

COLONEL TAYLOR: (Off microphone) (Unintelligible)

VICE ADMIRAL ZIMBLE: What?

COLONEL TAYLOR: I have a recommendation and it sounds a little strange, but the Nevada -- the Los Vegas area, with proximity to Desert Rock and the Atomic Museum and a few things out there, it's worthy of consideration. There are a lot of members of this Board that have never seen any of that part of it. And if you're aware of it, it'll make more sense to listen to veterans' comments and read things about it. That Desert Rock facility is still in existence, and a visit to it for about a half a day, and the Atomic Museum for a few hours, is some consideration as a spot sometime in the future. That was all I had.

MR. FAIRCLOTH: Colonel Taylor, isn't Desert Rock still inside DOE's classified confines?

COLONEL TAYLOR: (Off microphone) I don't believe so. I think -- I will find out for you, but I think this Board would get -- (on

microphone) I think this Board would get access to that facility, and a tour of it, without any problem. Considering who we are and what we do, I don't think there's anybody that would say no to taking us through that facility and look at it. Now a lot of it's desert, but there are parts of it that would -- would -- would make sense to you and that -- that -- that's only my -- my reason for suggesting it.

VICE ADMIRAL ZIMBLE: And I would impress this Board that -- that our administrative assistant would like to have a place recommended as soon as possible. It takes a long time to -- to establish a (unintelligible) --

COLONEL TAYLOR: Well, we can look for several -- several meetings out on that, too.

VICE ADMIRAL ZIMBLE: Well, that's right, but right now we're -- we're set for Austin -- we're set for June, we're not set for November and I think we shouldn't leave this meeting today without deciding on a location.

COLONEL TAYLOR: That's right.

VICE ADMIRAL ZIMBLE: So we now have (unintelligible) --

COLONEL TAYLOR: We can postpone that and I'll

bring it up later.

MR. PAMPERIN: Admiral Zimble?

VICE ADMIRAL ZIMBLE: Yes.

MR. PAMPERIN: Just to point out, I made a short list of the states that have the largest veteran population --

VICE ADMIRAL ZIMBLE: Okay.

MR. PAMPERIN: -- and you're covering Texas. We're in California now. We did Florida. The other -- the next three on the list are Virginia, Washington state and North Carolina, so Tidewater and Seattle are both, you know...

COLONEL TAYLOR: (Off microphone) (Unintelligible)

VICE ADMIRAL ZIMBLE: Okay. I think -- Dr. Zeman.

DR. ZEMAN: Thank you. I wanted to share with the Board a conversation I had at the break with Mr. Nelson Majia who's here from the local VA. What -- what I wanted to share was the idea that the choice of the venue within a city can affect the participation by local veterans. Here in L.A. we've chosen a hotel, for our convenience. We didn't -- we didn't have to brave the Los Angeles traffic to go to

someplace downtown, to some other hotel. It was very, very convenient for all of us. It's very inconvenient for anybody living in this L.A. area to brave the traffic, come out to this area and pay $20 or more to park for the day.

So the suggestion is that in selecting a venue within a town, we look at public transportation and general availability to veterans that live in the area. And did you want to maybe expand on that or...

MR. MUNAJILLO*: My name is Dennis Munajillo. I'm the CMP/POW* minority coordinator for greater Los Angeles VA hospital. (Unintelligible) mention transportation (unintelligible) from New York, California is one of the worst place traveling. This area is very hard to park and it costs a lot of money. Now if you go to the center of L.A. you will have more participation, you will have more attendance. Down here to the -- close to the airport, very hard. If you find a place closer to the middle of town, you will have more participation, you will have more attendance. That's my suggestion.

VICE ADMIRAL ZIMBLE: Okay, thank you. I think that's an excellent suggestion. Dr. Zeman.

DR. ZEMAN: And in thinking about that, the thought that crossed my mind is that --

UNIDENTIFIED: (Off microphone) (Unintelligible)

DR. ZEMAN: -- if -- if we're interested drawing veterans who are using or who have sought VA health care, we might even consider meeting at a VA hospital in one of the cities.

MR. PAMPERIN: We've done that with POW Advisory Committee and with other committees. That would not be difficult to arrange.

UNIDENTIFIED: (Off microphone) Does it work?

MR. PAMPERIN: I was out here about three years ago for a POW Advisory meeting and there were probably about 60 or 70 POWs in the audience.

VICE ADMIRAL ZIMBLE: All right, let -- if -- if we make -- if we accept the premise that a VA hospital would be a good locus, I want to turn to the VA hospital experts and ask which of the cities that we've mentioned would be more ideal in terms of VA hospital accessibility.

MR. PAMPERIN: Well, I -- correct me if I'm

wrong, but I don't believe there's a VA hospital in Austin. The closest one is Audie --

UNIDENTIFIED: (Off microphone) (Unintelligible)

MR. PAMPERIN: -- Audie -- there is one in Austin?

UNIDENTIFIED: (Off microphone) Yes, sir, (unintelligible).

MR. PAMPERIN: There's a clinic, yeah. The closest hospital is Audie Murphy in San Anto--

UNIDENTIFIED: (Off microphone) (Unintelligible)

VICE ADMIRAL ZIMBLE: Yeah. Yeah, Audie Murphy in San Antonio.

MR. PAMPERIN: Yeah.

VICE ADMIRAL ZIMBLE: But let's -- let's talk about the -- not so much --

MR. PAMPERIN: But there -- but there is a hospital in Hampton -- Hampton Roads.

MR. MUNAJILLO: If you don't mind my saying so, even if there's not a hospital, but if you get close to a town, transportation (unintelligible) state. Now like New York, Detroit, Chicago, they have easy

transportation. It would be better, you'd have more attendance. I myself was one hour looking for parking around here and I'm driving a government car. I have to put them in the parking lot and it cost me $20, and that's just here to listen, you know. So many of those people out there are not working and they are veteran, I believe it would be easier to get right to the middle of the town, my suggestion.

VICE ADMIRAL ZIMBLE: No, I think it's an excellent suggestion. I think that's what we're -- that -- yes, ma'am.

MS. BANKSTON: (Off microphone) (Unintelligible) had a lot of the (unintelligible) DAV and American Legion that (unintelligible) --

VICE ADMIRAL ZIMBLE: Right.

MS. BANKSTON: -- (unintelligible) and that way (unintelligible).

VICE ADMIRAL ZIMBLE: Right. That's good. That's a good suggestion. I would say, though, that since we are a veterans' advisory committee and since the hospitals will have -- be able to accommodate a good patient load, that a hospital venue might be more

appropriate, considering that we're looking at -- at -- at illnesses, various conditions that might be related to ionizing radiation, so I -- but I appreciate that -- I appreciate that input.

Go ahead, Ken.

MR. GROVES: I think that there are a number of issues to be considered here, and I think that as -- as you had mentioned earlier, we would really like to make a decision this afternoon on the follow-up meeting to Austin, is that it wouldn't be unreasonable to choose the Norfolk/Virginia Beach area, which -- and look at the opportunity of taking advantage of the VA hospital in Hampton Roads. And that -- that can kind of move us -- and I'd be willing to take on, as the Communication and Outreach Subcommittee, information on choices and venues and make a presentation at the Austin meeting. Then that can -- and so start thinking about meetings beyond the Virginia one, but --

VICE ADMIRAL ZIMBLE: Yeah. Okay, beyond --

MR. GROVES: But maybe it would just be easier today to --

VICE ADMIRAL ZIMBLE: Go ahead.

MR. GROVES: -- to choose the Norfolk area and --

VICE ADMIRAL ZIMBLE: We'll go with Tidewater --

MR. GROVES: Yeah.

VICE ADMIRAL ZIMBLE: If there's no objection, we'll go with the Tidewater area and -- and hotel close -- close to the VA so that we can -- we can work all those logistics. I -- I really like the idea of Las Vegas -- not for that reason. I really like the idea of Las Vegas to be able to visit some of these sites that have been -- we're talking about.

MR. GROVES: And let me just add to that -- you know, I'm retired from Los Alamos National Laboratory and we had a -- a Presidential advisory committee from the University of California and it was no problem for me to arrange a tour of the Nevada Test Site. And in fact, Ronnie, it was -- the person who was the lead person was a -- was a DTRA person, who did a great job of setting up the tour to the different sites and things. And so it would not be a problem for a committee such as this to have that access granted, so...

VICE ADMIRAL ZIMBLE: I'd -- I -- I would appreciate your committee looking at that. I would also mention, if I'm not mistaken, Nellis Air Force Base is co-linked with a VA hospital, is it not?

UNIDENTIFIED: (Off microphone) (Unintelligible)

MR. PAMPERIN: Yes. We have a -- we have new medical center I think in Las -- Las Vegas.

VICE ADMIRAL ZIMBLE: Okay. And there's something in New Mexico as well.

MR. GROVES: Yes, there is, there's a -- there is the -- of course the National Atomic Museum is in Albuquerque, as is a very extensive veterans' medical center, which is a joint U.S. Air Force/veterans' -- veterans' facility.

VICE ADMIRAL ZIMBLE: Okay. Well, then we're going to go to Tidewater for November, and the subsequent meeting will be suggested to us when we are in Austin, Texas by the -- by Subcommittee 4. Thank you very much.

Do we have any other -- is there any other business that needs to be brought before this Board before we adjourn?

MR. WYANT: (Off microphone) Could I put two

cents in?

VICE ADMIRAL ZIMBLE: You've already put in a nickel, but I -- it's okay.

MR. WYANT: (Off microphone) (Unintelligible) talk about (unintelligible).

VICE ADMIRAL ZIMBLE: Okay.

MR. WYANT: (Off microphone) (Unintelligible) retired (unintelligible) Reno, Nevada because (unintelligible) Las Vegas (unintelligible) nine different (unintelligible) we walked a mile (unintelligible) to get to the convention room and right across the way was a brand new (unintelligible) not one of us ever (unintelligible).

VICE ADMIRAL ZIMBLE: Okay. Okay.

MR. WYANT: (Off microphone) And the rates were $125 a month --

VICE ADMIRAL ZIMBLE: Right.

MR. WYANT: -- a night, plus tax.

VICE ADMIRAL ZIMBLE: Right.

MR. WYANT: (Off microphone) If you think you're going to get (unintelligible) Social Security (unintelligible) to spend $125 a night plus (unintelligible).

VICE ADMIRAL ZIMBLE: Okay. Thank you.

MR. WYANT: (Off microphone) (Unintelligible)
VICE ADMIRAL ZIMBLE: Okay.
MR. WYANT: (Off microphone) (Unintelligible) make sure (unintelligible) airport (unintelligible).
VICE ADMIRAL ZIMBLE: All right.
MR. WYANT: (Off microphone) International. I mean (unintelligible). But I guarantee you (unintelligible) $50 or $60.
VICE ADMIRAL ZIMBLE: Okay, thank you. I would like to close this meeting, first by thanking our VBDR support staff -- Isaf Al-Nabulsi, our program administrator, and Melanie Heister and Carlotta Teague. We thank you for all the effort that you've gone to to put together a very comfortable meeting that's been well-supplied, and we're very grateful for that. I also want to thank all the audio-visual folks that have done a super job -- except for the dog barking -- have done -- have -- have done a wonderful job in -- in supporting us and -- and I thank -- thank you. This hotel has been terrific. It's given us everything we've asked for and -- and so I thank the hotel staff and I'd appreciate it if you'd pass that on to the

hotel staff. I want to thank all the Board members for their dedication and diligence, and especially to all the work of the subcommittees in putting together four excellent reports. And -- and last but not least, I want to thank the participation of the atomic veterans for bringing us information and allowing us to have a little bit more insight into the concerns and -- and problems that you face. So thank you all. Enjoy the rest of Friday the 13th and try to stay safe, don't walk under ladders or break any mirrors. Thank you very much. The meeting's adjourned.

(Whereupon, the meeting was adjourned at 3:30 p.m.)

C E R T I F I C A T E OF COURT REPORTER

STATE OF GEORGIA

COUNTY OF FULTON

I, Steven Ray Green, Certified Merit Court Reporter, do hereby certify that I reported the above and foregoing on the day of January 13, 2006; and it is a true and accurate transcript of the testimony captioned herein.

I further certify that I am neither kin nor counsel to any of the parties herein, nor have any interest in the cause named herein.

WITNESS my hand and official seal this the 13th day of February, 2006.

Steven R Green CCR

STEVEN RAY GREEN, CCR

CERTIFIED MERIT COURT REPORTER

CERTIFICATE NUMBER: A-2102