THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

MEETING VII

DAY TWO

The verbatim transcript of the Meeting of the Veterans' Advisory Board on Dose Reconstruction held at the Sheraton San Diego Hotel, San Diego, California, on April 3, 2008.

STEVEN RAY GREEN AND ASSOCIATES
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CONTENTS

April 3, 2008

CALL TO ORDER AND OPENING REMARKS 7
(CHAIR)

BRIEFINGS BY SUBCOMMITTEE CHAIRS: 8

A REPORT FROM SUBCOMMITTEE 1 ON
DTRA DOSE RECONSTRUCTION PROCEDURES 9
(MR. HAROLD BECK)

A REPORT FROM SUBCOMMITTEE 2 ON
VA CLAIMS ADJUCICATION PROCEDURES 45
(DR. RONALD BLANCK)

A REPORT FROM SUBCOMMITTEE 3 ON QUALITY MANAGEMENT
AND VA PROCESS INTEGRATION WITH DTRA NUCLEAR TEST
PERSONNEL REVIEW PROGRAM 51
(DR. KRISTIN SWENSON)

A REPORT FROM SUBCOMMITTEE 4 ON COMMUNICATION AND
OUTREACH 68
(MR. KENNETH GROVES)

PUBLIC COMMENT SESSION 89

CONTINUATION OF DISCUSSION REGARDING
FUTURE ROLE OF VBDR 119

MEETING ADJOURNS 156

COURT REPORTER'S CERTIFICATE 157

TRANSCRIPT LEGEND

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-- (inaudible)/ (unintelligible) signifies speaker failure, usually failure to use a microphone.

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P R O C E E D I N G S

1 (8:30 a.m.)

2 **CALL TO ORDER AND OPENING REMARKS**

3 **VICE ADMIRAL ZIMBLE:** Good morning, ladies and
4 gentlemen, and welcome to day two of our -- of
5 our San Diego meeting. I hope you all had a
6 pleasant evening.
7 I want to take this opportunity to thank, first
8 of all, the veterans who -- especially you
9 folks that -- that are sticking out for two
10 days these -- these meetings. We really need
11 to -- to know from you how you are -- how you -
12 - how you are receiving what we're -- what
13 we're saying, and we need some feedback. It's
14 always very helpful to know whether or not
15 we're on the right track or if there are things
16 that we have overlooked, or if you feel that
17 we're not listening. Your comments from
18 yesterday, I will tell you, are -- are -- as
19 far as I'm concerned, are well-received. They
20 are documented and they will be discussed to
21 see what -- what -- what things are within our
22 purview and what things we could -- can -- can
23 do to -- what recommendations we could make to
24 either of the agencies that might rectify some
25 of those problems.

1 There are other things that have been brought
2 up that are going to require legislative
3 change, and this -- this is -- although we can
4 -- you know, it's in the minutes, it's
5 information that's available to -- to the
6 members and the staff on the Hill. It's
7 probably -- some of the elements that you have
8 presented to us need to be presented on -- on
9 the Hill, as well, and you know that.
10 **BRIEFINGS BY SUBCOMMITTEE CHAIRS:**
11 Today we're going to receive reports from four
12 -- the four subcommittee chair (sic) regarding
13 activities of the subcommittees, and then we'll
14 -- we'll be at -- talking a little bit more
15 about where we feel we should be going with the
16 -- the Board in the future, what -- what are
17 the major windmills that still need to be
18 challenged.
19 But I would also like to thank our staff for --
20 for making this an orderly meeting. I want to
21 thank the audio/visual people for -- for doing
22 a really fine job for us. And Ed -- Ed, are
23 you there?
24 **COLONEL TAYLOR:** I'm hearing you.
25 **VICE ADMIRAL ZIMBLE:** Okay, very good, Ed. I'm

1 glad you're here. That means we are -- all
2 members are present or accounted for.
3 **COLONEL TAYLOR:** I already accused Dale of
4 wiring me in so much I'm going to have to
5 participate whether I want to or not.
6 **VICE ADMIRAL ZIMBLE:** That's -- that's usually
7 the way it is.
8 **COLONEL TAYLOR:** It works out that way. No,
9 you -- you guys are doing a good job --
10 **VICE ADMIRAL ZIMBLE:** Okay.
11 **COLONEL TAYLOR:** -- and I really regret that
12 I'm not out there, but --
13 **VICE ADMIRAL ZIMBLE:** Okay.
14 **COLONEL TAYLOR:** -- the decision was right for
15 me to stay here and --
16 **VICE ADMIRAL ZIMBLE:** Yes. Well, I want you to
17 take care of yourself because we need your
18 input.
19 **COLONEL TAYLOR:** Good.
20 **VICE ADMIRAL ZIMBLE:** So Colonel, you take
21 care.
22 **COLONEL TAYLOR:** Take care. Thank you.

A REPORT FROM SUBCOMMITTEE 1 ON
23 DTRA DOSE RECONSTRUCTION PROCEDURES

24 **VICE ADMIRAL ZIMBLE:** Right-o. And now let's -
25 - let us get started. I would like first to

1 hear from Subcommittee 1 on the dose
2 reconstruction procedures. Mr. Beck.
3 **MR. BECK:** As usual, as Dr. Boice said, my
4 report is -- took the longest, I hope. It
5 usually is.
6 **UNIDENTIFIED:** The best, too, usually.
7 **MR. BECK:** And the best, right. So what I'm
8 going to do, as usual, is paraphrase some of
9 these comments here and leave you to read all
10 the details yourself, and copies of the report
11 are available.
12 Just to remind you of what the tasks of the
13 subcommittee are, we have two major tasks. One
14 is to assess the dose reconstruction
15 procedures, and these are the standard
16 operating procedures and the various
17 documentation that's been produced by DTRA to
18 do these dose reconstructions.
19 And the second important task is to conduct
20 periodic audits of a random sample of the dose
21 reconstructions to assure that the correct
22 procedures are being followed and to ascertain
23 the quality of the doses that have been
24 reported.
25 So I'm going to report to you today on our

1 latest audits, and also some of our other
2 activities since the last VBDR meeting.
3 Since the last VBDR meeting -- what we usually
4 do is pick six cases between each VBDR meeting
5 to audit randomly. This time we actually
6 picked five randomly and one was chosen by DTRA
7 for the double-blind exercise which you were
8 told about yesterday by Dr. Blake, which makes
9 for the six cases.
10 But this time we also picked an additional six
11 cases, not to do a full audit, but these are
12 cases that are being done under this expedited
13 process that you heard about. And what we
14 wanted to do there with these six cases is to
15 assure ourselves that these were being done
16 correctly in terms of the decision to expedite
17 them, and in terms of the documentation that
18 discussed why that decision was made.
19 And finally we picked one other case, which was
20 -- is done somewhat differently in that it is
21 not done by an outside contractor, SAIC, but is
22 done in-house by DTRA. And these are the cases
23 involving the Hiroshima and Nagasaki occupation
24 force cases where these are done in-house and
25 they're done slightly differently, so we wanted

1 to look at one of those, also, to see if it was
2 being done properly.
3 As usual, after we pick these cases and spend a
4 few months looking at them preliminar-- in a
5 (unintelligible) fashion, we meet with the
6 contractor and we have a full discussion of
7 each of these cases with the actual people who
8 did the dose reconstructions. And these are
9 very fruitful discussions in that we are able
10 to really hone in on some of the problems and
11 make sure we understand what was actually done.
12 At that meeting we also have an update from Dr.
13 Blake on the various activities and progress on
14 the various recommendations that were made by
15 SC-1 and the progress on the double-blind
16 exercise and on the development of the standard
17 operating procedures. We also discuss various
18 problems that we've noticed in our preliminary
19 audit of the six cases, and some of these
20 problems have to do -- and particularly, as you
21 saw yesterday with the various recommendations,
22 are they have to do with some of the
23 recommendations that are in progress rather
24 than the ones that have been fully implemented.
25 And then what we do is we meet before this

1 meeting for our final meeting where we prepare
2 this report and discuss the things that we're
3 going to tell you in this report.
4 And I just want to go over now some of the key
5 audit assessment findings from the last set --
6 batch of audits. We continue to find when we
7 look at these audits that the contractors,
8 NTPR, is generally providing the benefit of the
9 doubt in doing these -- in developing the
10 SPAREs and in doing the dose assessments. I
11 would remind you, though, that what's happening
12 now is that -- as you were told yesterday --
13 the vast majority of cases are now being
14 expedited and so that there are relatively few
15 full dose reconstructions. But these dose
16 reconstructions are the more complicated cases,
17 so they really have to be looked at more
18 carefully.
19 We found that significant progress has been
20 made in their documentation of the dose
21 assessments that they're doing and the
22 documentation of the calculations. And Dr.
23 Blake showed you some of the new techniques in
24 software and Mathcad templates that they're
25 developing and how they're improving their

1 methods in that sense.
2 We find that -- and for those of the veterans
3 here who have gotten some of -- have had a dose
4 reconstruction done, part of what you get is a
5 -- what's called a radia-- a dose assessment
6 report, an RDA report, and this report -- it's
7 only -- it's only supposed to be a summary of
8 what's -- all the calculations that were made
9 and all the -- this Scenario of Participation.
10 And we still feel that we could improve that
11 report so that it'll be more understandable to
12 the veteran. Right now it's still somewhat
13 perhaps obtuse to non-scientific people, so
14 that's one of the things that we're encouraging
15 DTRA to do is to improve that report so that
16 you can easily -- more easily understand that
17 report because we have seen cases where there's
18 some misunderstandings as to what some of the
19 things that are said in that report actually
20 mean.
21 One of the problems that we have -- are looking
22 at -- potential problems, I should say, has to
23 do with the fact that often there's a cancer of
24 a -- an organ where the particular organ for
25 which a dose should be calculated is really not

1 real clear. And sometimes the scientific
2 community hasn't developed these probability of
3 causations for certain organs so that we have
4 to pick a different organ as a surrogate organ,
5 and so we have to be very careful and see
6 whether that really represents the best organ
7 to pick. And also whether or not the -- the
8 organ for which a dose was done really
9 represents the right organ to calculate a dose
10 for for the particular medical condition. So
11 this is another issue that we are looking at
12 and encouraging DTRA to look at.
13 Again, case file documentation continues to
14 improve, but we still there's -- feel there's
15 still some room for improvement there. We've
16 come a long way in the time this Board first
17 started, so we're quite happy in that sense.
18 But we still think there's a little bit more
19 work to do.
20 As far as the particular -- the
21 Hiroshima/Nagasaki case that I mentioned, up to
22 now -- there are two types of
23 Hiroshima/Nagasaki veterans who come under this
24 category. One is the occupation forces, but
25 there are also prisoners of war who were in

1 Japan, and they're also covered as atomic
2 veterans, but -- and up to now these have been
3 handled pretty much the same way, in-house by
4 DTRA. And we've suggested that they might want
5 to consider changing that policy and having a
6 full dose reconstruction for the prisoners of
7 war since their Scenario of Participation is
8 much more complicated usually. And they're
9 very rare, there are not very many cases
10 involving them, so that's another item that we
11 recognized.
12 As far as the expedited cases that we looked
13 at, the sample of expedited cases, we
14 identified a need for better supporting
15 documents in the file to justify why the case
16 has been expedited. And you'll probably hear
17 more about this from Subcommittee 3 in terms of
18 the decision summary sheets, but this is, you
19 know, a fairly recent event where more and more
20 cases have been expedited. And we think it's
21 very important for there to be clear and
22 concise documentation as to why the decision
23 was made and to justify the decision.
24 We had also previously recommended that the
25 NTPR extend their quality assurance program

1 that's being -- to -- to include carrying out
2 the double-blind exercise that was discussed
3 yesterday, and Dr. Blake agreed to on that
4 yesterday. And we might mention that -- you
5 know, from Subcommittee 1's point of view,
6 although there have been I guess three attempts
7 at double-blinds, there has really been really
8 actually only one fully complete double-blind
9 exercise so far. So we're very happy that this
10 program's been instituted, but this is one of
11 the issues that, you know, will take some time
12 to see how it develops to where it gets to the
13 point where we're fully satisfied that it
14 really has been fully implemented. So we've
15 got a good start, but as Dr. Blake said
16 yesterday, there are a lot of kinks to work out
17 before we really get there.
18 In the write-up that I've given you it says
19 "future plans," but based on our discussion
20 yesterday I should probably say "immediate
21 future plans" because we weren't thinking ahead
22 more than till the next meeting. But as far as
23 at least for the next meeting in September, we
24 plan to audit some additional cases. We may
25 not pick six cases of full RDAs because the

1 number of full RDAs, as I said, has been
2 greatly reduced and we may concentrate more on
3 the expedited cases. But we will continue this
4 process of looking at a combination of full
5 RDs, expedited cases and the double-blind
6 cases, of which there'll probably be at least
7 two between now and our next meeting. So we
8 will be reporting on our audits of those at our
9 next meeting, and further on will depend on our
10 discussions that we have later on in September
11 as to where we'll go after that.
12 At least between now and our next meeting we'll
13 again conduct interviews with the NTPR
14 contractor analyst as part of our audit
15 procedure. And we'll continue our assessment
16 of both their established methods to make sure
17 that they really still apply, and the proposed
18 new methods that they're developing. And
19 particularly we'll closely monitor the
20 developments with respect to the new
21 probabilistic uncertainty analysis that Dr.
22 Blake talked about yesterday. There's some
23 issues there in the sense of exactly how it
24 will be finally implemented, but they've --
25 we've been briefed on that and they're making

1 very good progress, and this is -- we consider
2 a very worthwhile exercise. And exactly
3 whether it will be fully implemented or how it
4 will be used is something that we have to stay
5 on top of.
6 SC-1 recognizes that the independent QA process
7 by the Oak Ridge Associated Universities is
8 very beneficial and should be continued. And
9 we recommended that this process be expanded to
10 include expedited cases, and also enhanced by
11 the addition of quality checks on specific
12 calculations and codes. And since we are
13 always about six months behind in terms of the
14 recommendations of the Board and when things
15 become fully implemented, we're aware that --
16 you know, that they have accepted this
17 recommendation and they're starting to do that,
18 but we haven't seen it yet in our audits
19 because of the fact of this lag time. So as
20 we go forward and look at cases where they've
21 had a chance to do this, we'll be able to see
22 if they're doing it in the way we envisioned.
23 We have -- as far as recom-- suggested issues
24 for discussion and recommendations, SC-1 has
25 decided that we do not intend to make any

1 formal recommendations that we think the Board
2 should make to the agencies at this time. But
3 we have a number of issues that we -- are sort
4 of ongoing that we may decide that if we feel
5 in the future, in the next meeting, there's a
6 necessity for a formal recommendation because
7 enough progress hasn't been made, we might make
8 it at that time. But at this time it's just
9 mainly to -- for -- mainly for information to
10 the Board as to the outstanding issues that we
11 think are really important to stay on top of.
12 One is this use of upper bound factors, which
13 Dr. Blake talked about yesterday. And one of
14 the results of this probabilistic dose
15 assessment has been to satisfy one of the
16 things that we've been harping on for about two
17 years now, I guess, and that's to justify them.
18 They were put into place as a result of the
19 Green Book, the Academy book that said, you
20 know, that the uncertainties were being
21 underestimated at that time. And so as an
22 interim measure at that time, the NTPR decided
23 to use these interim upper bound factors, which
24 in fact became essentially default upper bound
25 factors. But the idea was that these would be

1 high enough so that they would give complete
2 benefit of the doubt to the veteran, that his
3 upper bound dose will always be well above the
4 95th percentile. But this was never completely
5 documented and -- and just now with this
6 probabilistic dose assessment, they are -- the
7 calculations that they are doing are really
8 showing that yes, for the most part -- at least
9 for the things that they've looked at so far,
10 those -- the factor of three for external is
11 indeed a good upper bound. So this is a very
12 important development in response to the
13 recommendation that we made, I think at our
14 last meeting, and we certainly are looking
15 forward to seeing this continue with the times
16 ten factor for internal, and also to see
17 whether it will apply to some of the specific
18 unusual dose scenarios.
19 The second issue that we're going to stay on
20 top of is the Hiroshima/Nagasaki prisoner of
21 war suggestion that I just mentioned a few
22 minutes ago, to see that separated out and done
23 in a different manner, perhaps as a full dose
24 assessment. And I think Dr. Blake has already
25 agreed to do that, so I don't think -- probably

1 is not even an issue anymore.
2 The surrogate organ issue I talked about, we
3 feel that there needs to be some improvements
4 in the standard operating procedures. And also
5 perhaps in the communication between DTRA and
6 the VA when a request comes in for a dose for a
7 specific organ, if there's some question about
8 whether that is the correct organ because there
9 -- at the present, the way things work now,
10 there isn't always a medical opinion involved
11 as to what organ they should really calculate a
12 dose for. So this is an issue where it may be
13 necessary for NTPR to go back to VA and say
14 hey, look, we need to have a medical person
15 look at this and say is this really the organ
16 that we should calculate a dose for, and this
17 should be then documented in the file. So
18 right now it's a suggestion for further
19 discussion. We're not making a formal
20 recommendation, but we do think it's a
21 potential issue because we've seen -- in our
22 last set of cases we've seen a couple of issues
23 as to the wrong -- what we think may have been
24 the wrong doses calculated, the wrong pathways,
25 and also perhaps the wrong organ as a surrogate

1 organ.
2 Finally, our last issue for -- is really
3 probably something for one of the other
4 subcommittees, but in the course of our audits
5 we of course identify quality assurance issues
6 and communications issues. And as I mentioned,
7 one of our big concerns has been this issue of
8 the -- the dose report, the RDA report that
9 goes to the VA and the veteran that summarizes
10 the results of the radiation dose assessment.
11 And we have recommended in the past that I
12 guess SC-4, the communications subcommittee,
13 look at this and try to work with DTRA to
14 perhaps improve this report to make it -- the
15 communication better. And to my knowledge,
16 this is still pending, and I think we still
17 would like to see this done because we think
18 that this communication that the vet-- this is
19 what the veteran sees in terms of the
20 explanation of how these doses were calculated,
21 and we think it's important to -- and we're not
22 saying it's -- that what they're sending now is
23 wrong or bad, but we do think it could be
24 improved, and this is something the Board could
25 help with.

1 So as I said, the details of some of these
2 things -- and I may have paraphrased things a
3 little wrong, so this -- what's written is the
4 official record.
5 Thank you, Mr. Chairman.
6 **VICE ADMIRAL ZIMBLE:** Thank you very much, Mr.
7 Beck, appreciate that.
8 Let me ask Ed Taylor first, since you're not
9 here but you're listening, do you have any
10 comments or -- or questions regarding this --
11 **COLONEL TAYLOR:** Yeah, I got a -- I got a -- I
12 am listening and it's coming in clear, but I've
13 got a (unintelligible), and what I -- I have a
14 very difficult cough right now, and what I'm
15 wondering if my coughing is coming in onto your
16 system.
17 **VICE ADMIRAL ZIMBLE:** No, I haven't heard any
18 coughing. Uh-oh, they've got a --
19 **COLONEL TAYLOR:** I just don't want to -- even
20 though I have a hard time trying to choke back
21 coughing --
22 **VICE ADMIRAL ZIMBLE:** Okay.
23 **COLONEL TAYLOR:** -- it gets the best of me and
24 I go into kind of a coughing --
25 **VICE ADMIRAL ZIMBLE:** Okay, I'm -- I'm getting

1 some signals from the audience that yes,
2 sometimes the coughing is coming through. Do
3 you have a mute button on your telephone?
4 **COLONEL TAYLOR:** That's what I'm looking for
5 right now. I've got a...
6 **VICE ADMIRAL ZIMBLE:** Okay.
7 **COLONEL TAYLOR:** Did that do anything to change
8 it?
9 **VICE ADMIRAL ZIMBLE:** Yeah, if you can find the
10 mute button, that'd be helpful. But it's a --
11 it's not disturbing me. I guess I just don't
12 hear it that much. But some other people are -
13 - are hearing you coughing and I would say God
14 bless you.
15 **COLONEL TAYLOR:** I'm going to -- I'll have a
16 cup of coffee or something to drink and keep
17 the cough down, but I don't want my own
18 infirmities in coughing and so forth --
19 **VICE ADMIRAL ZIMBLE:** Okay.
20 **COLONEL TAYLOR:** -- (unintelligible) your
21 system, that's all, because what you guys are
22 doing is coming across to me real clear.
23 **VICE ADMIRAL ZIMBLE:** Okay, good.
24 **COLONEL TAYLOR:** Able to make notes, I'm able
25 to hear it and when I need to ask a question I

1 speak up and you get me, so --
2 **VICE ADMIRAL ZIMBLE:** Yeah.
3 **COLONEL TAYLOR:** -- my approach is I don't know
4 who wired you guys in, but they did a good job.
5 **VICE ADMIRAL ZIMBLE:** Okay, you take care.
6 **COLONEL TAYLOR:** Good.
7 **VICE ADMIRAL ZIMBLE:** Okay. Now for the rest
8 of the members, are there any comments or
9 questions? I don't see any vertical signs --
10 oh, there's a vertical sign.
11 **MR. PAMPERIN:** I just have a question. From
12 what -- from what I am hearing you saying, am I
13 understanding correctly that where we are today
14 is really talking about fine points compared to
15 two years ago?
16 **MR. BECK:** Relatively speaking, yes. I mean
17 compared to two years ago. I mean when we
18 first started doing these things, I guess we
19 would say that things were not too good at all.
20 So the fine points -- I guess I wouldn't say
21 that fine. I mean a lot of the fine points, as
22 Dr. Blake said yesterday, we -- we haven't even
23 talked to the Board about. We've talked to him
24 about and he's taken care of them. Some of
25 these things -- like the organ issues, the

1 communication -- I don't consider fine points,
2 but you know -- so, but they're certainly not
3 major as -- anywhere near as major as some of
4 the issues we identified at the very beginning,
5 which have mainly been taken care of.
6 I think -- for instance, the upper bound -- the
7 justification of the upper bound was -- was --
8 had they not done anything, would not be a fine
9 point at all because we've been harping on that
10 for a couple of years. The fact that they have
11 -- now really are making progress on it I think
12 is a very important finding, and it's still
13 important to do it for the internal and for
14 some of these special cases. And the
15 documentation of the expedited cases, I don't
16 think any of us feel that's a fine point. I
17 think that -- since most of the cases are being
18 expedited, I think that -- it's a very major
19 point.
20 **VICE ADMIRAL ZIMBLE:** Okay. Dr. Boice.
21 **DR. BOICE:** It's a very similar question, I
22 guess, Harold, and I wanted to make sure I
23 understood. I think you said that there were
24 some instances where the dose to the specific
25 organ -- it might have been computed for the

1 wrong organ or the doses may not have been just
2 right. But then at the end you said -- it
3 seemed to imply that there was not any major
4 difficulties. I'm trying to -- so just -- my
5 question is, what is the -- the level of
6 degree? Because even if -- you know, would it
7 make a difference, and the simple que-- would
8 it make a difference to the claim that the
9 veteran made with regard to the improvements,
10 even on the pathway and the dose computed, you
11 know, to the -- the organ that's right next to
12 it. Would it have made a difference in that
13 scenario?
14 **MR. BECK:** There's two different questions
15 here. In our audit reports which we send to
16 you we have a spreadsheet, and there's two
17 columns where we make -- we say did it make a
18 difference to the dose, or did it make a
19 difference to the claim itself. We have very
20 rarely found situations where it made a
21 difference -- where we believe that it made a
22 difference to the claim -- a few, but -- and --
23 but we have found where it made a difference to
24 the dose, even though it wouldn't have changed
25 the claim -- the outcome of the claim at all.

1 I could be more specific on the organs we're
2 talking about if you really are interested for
3 these particular cases. One -- it had to do
4 with one where it was cancer of the appendix.
5 That's not covered in the IREP, of course.
6 They chose the upper large intestine. There's
7 a real question about, you know, the residence
8 time of radioactive material in one versus the
9 other, so clearly it would -- you know, it
10 would stay longer but it wouldn't get as much
11 into it. This is the kind of issue where it's
12 a technical issue, but it -- and it's -- it's
13 something that should have been discussed in
14 the file, even though we don't believe it would
15 have made a difference in the outcome at all.
16 You know, that's just one example. There are a
17 couple of other -- it's the kind of things that
18 we're picking up that I think should be picked
19 up in an audit and identified and pointed out
20 that -- you know, that it wouldn't have changed
21 the outcome of a claim. So that -- that's the
22 kind of things I'm talking about. Maybe Paul
23 or Gary want to elaborate on this or something.
24 **MR. VOILLEQUÉ:** I think you gave a good
25 example. You know, as you know, John, there

1 isn't a complete of every tissue in the body in
2 the ICRP dose coefficient files and so some
3 choices have to be made. But an important
4 aspect of this, I think, is that when you have
5 a surrogate organ and it -- it may be a
6 marginal choice -- well, even -- even if it's
7 the best imaginable choice, the uncertainty
8 ought to be increased because you're not
9 dealing with the dose to the particular tissue;
10 you're dealing with a dose to something else,
11 so...
12 **DR. ZEMAN:** Yeah, let me -- can I answer that
13 'cause I -- let me give you one other example
14 that was instructive to me when we came across
15 this one. It was a cancer of the eye, and the
16 analyst at the time calculated I believe a lens
17 dose, which a health physicist normally thinks
18 of an eye dose as a 3-millimeter-depth dose to
19 the lens. But it wasn't clear if this should
20 be some kind of maybe a cornea dose, which
21 would be a skin, or a deep dose. And in fact,
22 upon discussion with one of the physicians who
23 was at our review that day, that particular
24 cancer turned out to be related to the vitreous
25 humor, so it should have been a much deeper

1 depth than -- than the 3 millimeters. So it's
2 -- it's that kind of a -- a call as to -- you
3 know, the health physicist and the analyst
4 doing the work don't necessarily know the type
5 of cancer or where it is exactly located, so
6 they need a medical input or opinion on -- on
7 how to handle that case. And that was what we
8 had recommended, was that for -- when there's
9 any question about the nature of the disease
10 that they get a medical opinion on exactly
11 where to calculate the dose.
12 **VICE ADMIRAL ZIMBLE:** Dr. Fleming?
13 **DR. FLEMING:** All these things that we're
14 talking about here, these findings from the
15 audits, I'm curious as to whether or not they -
16 - they weigh -- in general whether they weigh
17 in favor of the veteran or whether they're --
18 or not. You may not be able to make a -- a
19 comment about in general, but -- but I do -- I
20 did note that there was some concern in the
21 first point about the application of the
22 benefit of the doubt was perhaps carried to an
23 extreme, so is the -- the inconsistent dose
24 reconstruction methodology, the choice of the
25 surrogate organ, the calculation of the

1 ingestion dose, all of these things, the way
2 that the default upper bound factors are being
3 used, are they weighing in favor of -- in other
4 words, in kind of increasing the benefit of the
5 doubt for the veteran or not -- or can -- can
6 you make that kind of general claim?
7 **MR. BECK:** Well, I think it's -- I'm not sure
8 we can say for sure. I think what I said was
9 that one of our columns on our spreadsheet is
10 that we think -- we think it would have made a
11 difference in the outcome of the claim, and we
12 very rarely have found that. But the few cases
13 that we have found that for had to do with
14 ingestion doses, I believe, and most of the
15 time it was well in the favor of the veteran --
16 sort of unreasonably so, in our opinion, but --
17 but it certainly was an extreme benefit of the
18 doubt, and there are a couple of other cases.
19 A lot of these other things, as I said, that
20 they may have raised the dose or lowered the
21 dose, and we haven't really counted up the plus
22 and minuses, but they probably -- doses are
23 still far too low to really have made any
24 difference in terms of the outcome. Even this
25 case of the appendix and the upper large

1 intestine didn't -- it really was -- it was a
2 very small dose either way, it wouldn't have
3 changed the outcome.
4 **VICE ADMIRAL ZIMBLE:** Okay, I -- I have a -- I
5 just have a couple of comments that I'd like to
6 make. First of all, I'm cur-- I'm curious
7 about the cancer of the appendix. Cancer of an
8 appendix ought to be a cancer of a colon,
9 basically, if it's -- it is an appendage of the
10 colon, which means it should have been a
11 presumptive cancer. And I'm not sure I
12 understand why there was a -- why that even
13 comes up as a potential -- for a -- for dose
14 reconstruction.
15 **MR. BECK:** I'd have to look at -- I mean I'm
16 not sure, first of all, whether it was not --
17 **VICE ADMIRAL ZIMBLE:** This may have preceded
18 the latest (unintelligible) --
19 **MR. BECK:** It may -- it may have preceded that,
20 but also they may not have recognized that.
21 Again, this has to do with -- what we're
22 talking about is a potential problem because,
23 you know, it's not clear that somebody would
24 have recognized what you just recognized
25 because of the fact that you -- you're a

1 medical person, and that's one of our problems
2 here is that we don't think that some of these
3 things --
4 **VICE ADMIRAL ZIMBLE:** Yeah.
5 **MR. BECK:** -- are looked at by a medical person
6 --
7 **VICE ADMIRAL ZIMBLE:** Right.
8 **MR. BECK:** -- before the --
9 **VICE ADMIRAL ZIMBLE:** Right.
10 **MR. BECK:** -- dose reconstruction is done.
11 **VICE ADMIRAL ZIMBLE:** It would be -- it would
12 be nice if there was a -- you know, that may be
13 a -- a recommendation that gets made, that at
14 least have it looked at, or a summary of the
15 case looked at quickly to make a determination
16 about whether or not this is -- this is one
17 that needs to have dose reconstruction at all.
18 If we can eliminate one more of those expensive
19 processes and those -- and get a response back
20 to the -- to the veteran quickly, that's -- you
21 know, that's what it's all about. So I -- I
22 don't know whether that recommendation needs to
23 come from you, but I -- I think that --
24 **MR. BECK:** Well --
25 **VICE ADMIRAL ZIMBLE:** -- perhaps the -- we

1 might -- I might just ask the Board for a
2 consensus on whether or not we want to make
3 that rec-- as a recommendation from the Board
4 that we have a -- a medical screen of records -
5 - and I think that that could be handled, you
6 know, fairly quickly. I would like -- before
7 we make that recommendation, I'd like to hear
8 what that impact would -- would have on the --
9 on the Veterans Administration or on DTRA.
10 **MR. BECK:** Perhaps Dr. Blake would like to talk
11 about -- we discussed this at our meeting
12 yesterday. We decided that perhaps it was too
13 early to make a formal recommendation. I'd
14 like to point out, though, that this is
15 somewhat related to the other problems that
16 we've -- the Board has talked about before with
17 respect to non-radiogenic diseases, because of
18 the fact that there is no pre-screening by VA
19 before they ask for a dose reconstruction -- by
20 medical people at the VA.
21 **VICE ADMIRAL ZIMBLE:** That's a -- that's a more
22 of a legal issue.
23 **MR. BECK:** Well, yeah, that is, but it -- but
24 it's in -- it's the same sort of situation from
25 the dosimetric point of view in the sense that

1 -- that the people who do the dose
2 reconstructions and the DTRA people who get the
3 requests, they do not have the medical
4 knowledge to decide well, is -- are they asking
5 for the right dose, are they telling me the
6 right organ. You know, basically the -- my
7 understanding is the VA sends a letter saying,
8 you know, the person has this cancer; calculate
9 a dose. And so it's that -- you know, how to
10 handle this, I guess, is -- should be between
11 Mr. Pamperin and Dr. Blake as to how best to
12 handle this, and that's why we're not making a
13 formal recommendation at this time, but we hope
14 that we'll get together and talk about this
15 issue.
16 **VICE ADMIRAL ZIMBLE:** Okay. I'll make a
17 recommendation that you two guys get together
18 and talk about this.
19 The other question I have is similar to the --
20 I think the point that Dr. Fleming was trying
21 to make -- or made. Basically, doing a full
22 probabilistic analysis is -- it's my
23 understanding that that is a major investment
24 in time and -- and a degree of expertise is
25 required and an understanding of Mathcad and a

1 few other things in order to accommodate that.
2 If you're talking about that kind of a
3 probabilistic analysis in order to justify the
4 factor that's being used, that sounds reas--
5 that sounds very reasonable. That's a one-time
6 investment to do it. To do a probabilistic
7 analysis on every one of the dose -- the full
8 dose reconstructions that are done is, again, a
9 significant in-- increment in the workload, an
10 increment in the cost, and I want to know what
11 is the anticipated outcome? Will this increase
12 the chances of providing a favorable
13 adjudication of a claim, or will there be no
14 real good return on that investment?
15 **MR. BECK:** Let me say -- and we -- we've
16 discuss-- we discussed this in some detail in
17 our meeting -- SC-1 meeting Tuesday, and I
18 think Dr. Blake suggested pretty much what you
19 just said, that he didn't think there would be
20 a need to do a full one, particularly since if
21 they have done this one for a typical case,
22 like a battalion maneuver, then you don't need
23 to do it again if you get the same case; you
24 have done it. That's one issue. So if you've
25 done it for the -- you know, for these major

1 unit type exercises and proved that the factor
2 of three is sufficient, for instance, for the
3 external and a factor of ten for those
4 particular ones, sure, there would be no sense
5 in doing it over for that specific case.
6 But there -- there's two issues here. One is
7 that they're now going to be down to perhaps a
8 couple of dozen cases a year for full dose
9 reconstructions. Perhaps a large fraction of
10 those will be ones that could be considered to
11 be -- have already been done by this
12 calculation where they've done it for this
13 unit, and so they don't need to do it again.
14 So I'm -- I don't anticipate a large number of
15 these having to be done.
16 Now there are other benefits for them to do
17 maybe five or six a year of special cases, not
18 just for the interest of this Board, but for
19 the interest of DTRA -- which I think Dr. Blake
20 is aware of -- because having this capability
21 would be extremely important if we got involved
22 in a dirty bomb situation or things like that.
23 So there are -- there are other benefits to --
24 to having this capability. And it's the kind
25 of capability that is now being used for

1 epidemiological dose reconstructions and things
2 like that, so it's -- it's an important skill
3 to have, so I think -- you know, and I don't
4 see it being that much of a burden for a half a
5 dozen cases or so a year that they might have
6 to do it for.
7 As for your other question about whether it
8 make a difference, probably not. But it may,
9 and the reason it may is that -- one of the
10 problems we have with this whole uncertainty
11 analysis, and I think some of the veterans have
12 sort of mentioned this, is that one of the
13 largest sources of uncertainty which has never
14 been taken into account is the scenario
15 uncertainty. If there's really not a good
16 record of what the veteran did and where he
17 was, that can make a much bigger impact on the
18 dose than any of the scientific dose
19 calculations. And we have seen some cases in
20 our audits where there has been some real
21 questions about how -- what the scenario was
22 and where -- you know -- and so if you then put
23 in uncertainties for that, it will -- could
24 make a difference.
25 **VICE ADMIRAL ZIMBLE:** Okay, I -- I appreciate

1 that. Let me -- let me just ask one other
2 question. How much additional time is required
3 to do the full probabilistic analysis? Because
4 the -- the thing that I'm concerned about is a
5 delay in getting a response back to the
6 veteran. So if this calculation is going to
7 consume a considerable amount of additional
8 time, then we're -- then what we're doing is
9 increasing the delay in -- in feedback to the
10 veteran as to whether or not his claim is going
11 to be adjudicated in his favor or not, and so
12 for that reason that might -- I don't know, I -
13 -
14 **MR. BECK:** I just would say one thing, that
15 what we originally recommended was they develop
16 the methodology to do this. If you develop the
17 methodology and modulize it -- modularize it,
18 basically what you have is -- to do the
19 calculation is not -- it's a computer
20 calculation. You know, the real big effort
21 here is in assigning the probability
22 distributions, you know, for the different --
23 for the scenario. You still have to do the
24 scenario anyway. It's assigning the
25 probability distribution, so personally I don't

1 think in terms of delay we're talking about
2 more than a couple of weeks type of thing to
3 actually do it once they've developed the
4 methodology.
5 Now it -- they're -- they're -- have spent, you
6 know, a fair amount of time developing this
7 already and he expects to have it done for the
8 external by July. The internal will take a
9 little longer. So -- but I would like Dr.
10 Blake to comment on what he thinks the effort
11 would be.
12 **DR. BLAKE:** Right now we have three full-time
13 scientists been working on this for a number of
14 months, and they're going to continue to -- to
15 work on it to produce our final report. We
16 produced an interim report, and then gave a
17 lengthy PowerPoint presentation on where we
18 were. That was about 60 pages of calculations
19 that summarized all the work in Monte Carlo
20 distributions and doing these probability
21 distribution functions. We still see a number
22 of months to go to answer the questions
23 completely. And even after that initial effort
24 there will be some other tweaking.
25 When we get down to the point of where we've

1 done these cases, validated the -- the interim
2 factors and also done a number of individual
3 veterans' cases, then -- then the workload
4 would slow down on that, and I expect probably
5 from -- from our viewpoint it would be less
6 than about a half a Full Time Equivalent
7 involved with doing that type of work. But
8 right now we're -- we have three scientists
9 completely involved -- about three-quarters of
10 our senior scientists involved just on the
11 uncertainty analysis, to do the good job on it
12 that I think we need to do. So that's --
13 that's where we are now. I would expect that
14 would relax by about the end of this fiscal
15 year.
16 **MR. BECK:** I guess in terms of Dr. Zimble's
17 question, would you consider it a large burden,
18 once you've finished this preliminary work, to
19 have to do a half a dozen or so full dose
20 reconstructions and when would it delay it that
21 much -- delay the results?
22 **DR. BLAKE:** When we look at the average
23 turnaround time, no, because of the number of
24 cases are smaller. Those particular veterans
25 could be delayed a few extra -- an extra week

1 or two to do this type of analysis as compared
2 to how we're doing oth-- to do it right, and --
3 and that -- and that could survive a full-
4 fledged audit, also, too. So it will have some
5 impact, and what I would tell you is, like with
6 any program manager at a federal agency, we'll
7 collect our data, analyze it, and then try to
8 do what's most cost effective and appropriate,
9 both for the veterans and the government. So I
10 think a reasonable implementation is the way to
11 go.
12 **VICE ADMIRAL ZIMBLE:** Okay, thank you very
13 much. Now we can -- oh, I'm sorry. Dr. Zeman.
14 **DR. ZEMAN:** I -- I would just like to comment
15 on the -- on the probabilistic analyses, and I
16 see real value in continuing these in at -- at
17 least some fraction of the small -- understand
18 it's a small number of cases now that are not
19 expedited, and the cases that do come through
20 that need a -- a full RDA or dose analysis are
21 those that have some complexity. In fact, one
22 category of cases are those for which
23 participation was not confirmed, and in those
24 cases it's very difficult for the analyst to
25 figure out where the person was when. So

1 putting together alternate scenarios and
2 analyzing which of those might give the best
3 benefit to the veteran as far as the dose
4 requires that this kind of analysis be done.
5 So in those -- in those few cases with
6 complicated scenarios, or when bene-- when
7 participation was not verified, it's a very,
8 very valuable tool that I think is in favor of
9 the veteran to do this complicated analysis.
10 **MR. BECK:** I want to add one thing. One of the
11 reasons for not expediting a case is because
12 the dose is possibly near where it would make a
13 difference. That's the whole basis for the
14 expediting. We expedite when we know that the
15 dose is far too low or way too high. If it's a
16 question, then you make a decision we can't
17 expedite. So there you really want to do the
18 best for the veteran. You want to have the
19 best uncertainty analysis to see if you put him
20 over that threshold, so I do think that there
21 are cases where it would be very important.
22 **VICE ADMIRAL ZIMBLE:** Okay, appreciate the
23 comments. Any other comments?
24 (No responses)
25 Do I hear a motion to accept the report?

1 **MR. PAMPERIN:** (Off microphone)
2 (Unintelligible)
3 **VICE ADMIRAL ZIMBLE:** Okay, do I hear a second?
4 **DR. LATHROP:** Second.
5 **VICE ADMIRAL ZIMBLE:** Okay. All in favor?
6 (Affirmative responses)
7 **VICE ADMIRAL ZIMBLE:** And opposed?
8 (No responses)
9 **VICE ADMIRAL ZIMBLE:** All right, the report is
10 accepted. Thank you very much, Dr. -- Mr.
11 Blake (sic).

A REPORT FROM SUBCOMMITTEE 2 ON
12 **VA CLAIMS ADJUCICATION PROCEDURES**

13 Now if we could hear from Dr. Blanck.
14 **DR. BLANCK:** Good morning. I am going to
15 report on the activities of Subcommittee 2 and
16 the recommendations that we have. Subcommittee
17 2 is charged with reviewing the procedures and
18 policies of the Veterans Administration with
19 regard to how they handle claims for atomic
20 veterans.
21 Since our last meeting we had a visit by two
22 members of Subcommittee 2 to the Jackson
23 Regional Office where claims are now
24 consolidated. Dr. Fleming and Mr. Ritter from
25 our committee, and also Dr. Reimann from

1 Subcommittee 3, visited there, and the report
2 of their visit is attached to the report of
3 Subcommittee 2, and I'll comment on that --
4 that very, very important visit.
5 We also had our consultant audit 12 cases from
6 the Jackson Regional Office so that we could
7 see how they're dealing with claims now that
8 they are consolidated, hopefully with a
9 concentration of expertise. We have since had
10 a conference call to review those audits and to
11 talk about the visit that I already mentioned,
12 and we then began the process of coming up with
13 this -- this report.
14 We'd like to first of all congratulate the
15 Jackson Regional Office and the VBA for this
16 activity because we feel that what they're
17 doing is marvelous in terms of dealing with the
18 radiation claims with integrity, sincerity,
19 genuine concern for the veteran, and clearly
20 with a degree of efficiency that was not
21 previously noted.
22 We're very concerned, however, that while we
23 have the successes in that office, that Dr.
24 Otchin, as Mr. Pamperin said yesterday, has
25 departed, and that has the potential of leading

1 to delays, not from the Jackson Office, but as
2 to, when their work is completed, the Central
3 Office reviews and makes a final determination.
4 We would urge the VA to replace him as soon as
5 possible, and we do note that his deputy is
6 carrying out the work, but we think someone
7 with Dr. Otchin's credentials and expertise
8 would be important in that.
9 We think the major recommendation that our
10 Board has really made has been that
11 consolidation. And while that's clearly made a
12 big difference, as have other improvements, we
13 have a few issues that we'd like to bring
14 forward for both discussion and possible
15 recommendations.
16 First of all, we continue to ask -- and we've
17 made this recommendation before -- that the
18 Jackson Office have the proper number of
19 dedicated, trained personnel resources who will
20 focus on processing radiation exposure claims
21 adjudication, and you'll see further on that we
22 ask that the Jackson Office give these claims a
23 high priority.
24 We were very concerned that during the visit
25 already addressed we noted that the Jackson

1 Office had previously been given a review or
2 rating that was outstanding and led to certain
3 perks, bonuses and so forth, as they went about
4 their duty. Since they've consolidated and got
5 twice the number of claims -- of radiation
6 claims that were anticipated, they may have
7 been adversely affected in their ability to
8 achieve the performance recommendation -- or
9 recognition that they previously had, and
10 that's clearly something that, one, wasn't
11 their fault; two, isn't fair. So they've been
12 successful in diminishing the backlog. We note
13 that -- again, with Dr. Otchin's departure --
14 there may be the potential for -- for that
15 building back up.
16 And so what we'd like to ask the VA is to
17 quickly fill his position and also to look at
18 rewarding the Jackson Office for their success
19 with this program, with them diminishing the
20 backlog and really taking this program on and
21 doing a super job, and not disadvantage them
22 for future awards.
23 We would ask that we have a report at the
24 September meeting -- performance review on the
25 Jackson Office, hope that their work will be

1 excellent and that they will be recognized for
2 their sincere work in support of the mission of
3 supporting the radiation veterans -- radiation
4 claims.
5 Now, although radiation claims are consolidated
6 in Jackson, there -- right now, at least
7 according to the visit and -- and from what
8 I've heard, this may have changed -- there was
9 no level of priority during the visit given to
10 radiation claims. That is, they were
11 considered with all of the others, even though
12 they were consolidated in -- 'cause Jackson
13 continues to do the claims from their region.
14 So we recommend that the claims from atomic
15 veterans receive a high priority, particularly
16 when they see a claim from an aging atomic
17 veteran with multiple conditions.
18 Furthermore, it was noted in the visit that 34
19 percent of the claims sent to Jackson actually
20 were returned to the referring Regional Office
21 because there was no radiation exposure in
22 that. This just really bogs the system down,
23 and therefore we recommend that the stance of
24 the local VA Regional Offices and associated
25 service organizations receive further

1 education, continued education, in the
2 identification of radiation claims, and that a
3 standard protocol be developed that specifies
4 how to refer claims to the Jackson Office.
5 We heard that, I think in Mr. Pamperin's
6 report, that in the teleconferences with all
7 the Regional Offices this is emphasized, and
8 that obviously needs to continue, be re-
9 emphasized, and I think the development of a
10 protocol is a -- is an excellent idea, so we
11 make that recommendation.
12 Finally we recommend that the Central Office
13 provide to the Jackson Office personnel
14 ongoing, focused training on current trends and
15 issues -- and I would add to that sentence
16 "regarding radiation claims." This has to do
17 with some confusion about where CLL fits in all
18 of this. Leukemias are presumptive; CLL is
19 excluded from that. And there are other
20 examples of where there was confusion, and it's
21 simply a matter of education and training, so
22 we'd like to have that training provided.
23 And that concludes my report.
24 **VICE ADMIRAL ZIMBLE:** Thank you very much, Dr.
25 Blanck. Are there any comments, questions?

1 (No responses)

2 Mr. Pamperin, you have any response to the
3 recommendations?

4 **MR. PAMPERIN:** No, we'll -- no, we will bri--
5 we will brief the panel in September and we --
6 we'll bring this specifically to the direct
7 attention of our Office of Field Operations
8 about the referrals. And we will conduct a --
9 the training that's recommended.

10 **VICE ADMIRAL ZIMBLE:** Do I hear a motion to
11 accept the report?

12 **MR. RITTER:** (Off microphone) (Unintelligible)

13 **VICE ADMIRAL ZIMBLE:** And second?

14 **DR. SWENSON:** Second.

15 **VICE ADMIRAL ZIMBLE:** Then without objection,
16 the report is accepted. Thank you.

A REPORT FROM SUBCOMMITTEE 3 ON QUALITY MANAGEMENT AND VA PROCESS INTEGRATION WITH DTRA NUCLEAR TEST PERSONNEL REVIEW PROGRAM

17 All right, let's move on to the quality
18 assurance report. I understand that the --
19 that Kristin, you're -- you're elected to -- to
20 --

21 **DR. SWENSON:** Yes.

22 **VICE ADMIRAL ZIMBLE:** -- to be the captain.

23 **DR. SWENSON:** Good morning, everyone. Dr.
24 Reimann couldn't come today so I'm going to

1 give you the report for the quality management
2 subcommittee.
3 As -- in the quality management subcommittee we
4 are responsible for all aspects from the claim
5 process, from the submission of the claim
6 through DTRA and back to where the claim goes
7 back to the veteran, to ensure that there is a
8 quality management system that covers this
9 whole process. Because of this we have
10 committee members that attend Subcommittee 1's
11 meetings on the dose reconstruction,
12 Subcommittee 2 on the oversight and guidance
13 for the VA, and Subcommittee 4 on the
14 communication.
15 At this time we have no recommendations for
16 DTRA, and that is because they have made
17 substantial progress on the -- their quality
18 management system and program, and we continue
19 to receive documents from them as they update
20 those.
21 And our main issue is the decision summary
22 sheet, which they have agreed to work on. We
23 met this week discussing issues. And any
24 guidance we have given them they have taken,
25 and they are definitely making progress on. So

1 that's our main issue that we are working with
2 with DTRA.
3 And we also look forward to -- awaiting the
4 results and monitor progress on the double-
5 blind studies that they are doing. So we'd
6 like to commend them on their progress that
7 they have made in the area of quality, and also
8 look forward to continuing positive results
9 concerning the decision summary sheet and the
10 double-blind issues.
11 On the VA, we agree with Subcommittee 2 that --
12 Dr. Reimann actually went to the Jackson
13 Office, and that is definitely a huge benefit
14 to the veteran, that the claims adjudicators
15 are familiar with radiation and they basically
16 have the education to deal with these cases.
17 We look forward to the final report on this
18 focused radiation quality review that Edna
19 MacDonald spoke about yesterday concerning the
20 Jackson Office, and we also await Subcommittee
21 2 auditors' final results and hope to look over
22 those as well.
23 We do have one recommendation for the VA. As
24 Subcommittee 2 stated, with Dr. Otchin's
25 leaving that does leave a hole there. And so

1 our recommendation -- we had spoken about this
2 before within our subcommittee, it's really for
3 the Program for Clinical Matters, the Office of
4 Public Health and Environmental Hazards -- that
5 the VA develop standard operating procedures
6 with respect to running the interactive
7 radioepidemiological program, the IREP, in
8 interpreting these results and develop detailed
9 documents to support the decisions regarding
10 both radiogenic and non-radiogenic cases.
11 **VICE ADMIRAL ZIMBLE:** Thank you very much, Dr.
12 Swenson, for the report -- and Dr. McCurdy.
13 **DR. MCCURDY:** Can't move this thing. As
14 Kristin indicated, we were not having any
15 formal recommendations. We're waiting to
16 receive further documentations -- further
17 documents, actually, on the QAP and some of the
18 others. But two things we want to ensure
19 that's in those documents is that we need --
20 we've (unintelligible) indicate a double-blind
21 program has to be incorporated in your QAP SOP
22 802, I think, series module. But there should
23 be a quantitative basis for deciding that
24 there's significant difference between the
25 three reported doses. In other words, you can

1 do a double-blind, but you have to make a
2 decision whether it's significantly different
3 from one another, what have you. So you have
4 to have a quantitative way of doing that, and
5 that should be based upon whether or not it
6 would affect the compensation. So however you
7 want to do this on a mathematical basis, you
8 should have that in there. Just don't do
9 double-blinds and say yeah, yeah, okay, they're
10 close enough. Well, how close is close enough?
11 And also within the QAP we're expecting that
12 that will be updated to include the DSS. That
13 is your quality assurance as far as monitoring
14 the quality of the RDA process, those two
15 elements, double-blind and the DSS. Okay?
16 **VICE ADMIRAL ZIMBLE:** (Off microphone)
17 (Unintelligible)
18 **DR. BLAKE:** If I could, the -- we're certainly
19 in full agreement and we're in the process, as
20 we develop the double-blinds and the decision
21 summary sheets, to fold that right into our
22 procedures. We initially called them QAPs.
23 What we did was we consolidated these quality
24 assurance procedures into the quality SOP, so
25 that's where it'll go.

1 We did embrace the -- when we provided feedback
2 on metrics, we were looking at the double-
3 blinds -- I believe it was your group that gave
4 us feedback, and I folded that into the
5 procedures. What you just brought up now is
6 something slightly different than the feedback
7 we got. I'll certainly look into that and do
8 my best to do that, but that wasn't exactly the
9 feedback I received, I believe, for SC-3 when
10 we sent out the metrics on how we would do the
11 -- what was acceptable for the predefined
12 metrics on the double-blinds, to my
13 understanding.
14 **DR. MCCURDY:** Well, we -- both Harold and I
15 commented on your double-blind proposal. We --
16 **DR. BLAKE:** Right.
17 **DR. MCCURDY:** -- had comments in there, and
18 questions, and I don't know if we got any
19 feedback from you on those questions that we
20 had.
21 **DR. BLAKE:** Basi--
22 **DR. MCCURDY:** Other words, I was saying, you
23 know, overlap -- how you going to do this, are
24 you going to overlap -- we have a value and how
25 you going to calculate the difference between

1 the two, what -- were you going to look at
2 overlaps, what parameters you using -- I asked
3 some questions there, but I didn't get anything
4 back, I don't believe.
5 **DR. BLAKE:** It's -- I think I got those results
6 about a week or two ago and I did fold them
7 into procedures and -- and they were available
8 for discussion on Tuesday, we had a short time
9 together, but I -- I'd still -- I'll do my best
10 to -- to implement just the recommendations
11 you've made right now -- the suggestions, I
12 should say.
13 **DR. MCCURDY:** Well, it's not a recommendation.
14 **DR. BLAKE:** No, it's a suggestion.
15 **UNIDENTIFIED:** (Off microphone)
16 (Unintelligible)
17 **DR. BLAKE:** And I don't have a problem with it.
18 I'll do my best to -- to reflect that.
19 **VICE ADMIRAL ZIMBLE:** Yes, Dr. Fleming.
20 **DR. FLEMING:** Are -- are you asking -- I -- I
21 know that you're asking for an SOP for the
22 running of the IREP and interpretation. Are
23 you asking for an SOP for the processing of the
24 -- of the claim itself? I know that Curt
25 Reimann did receive, when we visited the

1 Jackson Office, a checklist -- that is
2 described on page 7 of that report -- that's
3 used to audit the radiation claims. And the
4 checklist is -- is -- uses basically the same
5 approach that is used by any -- for any claim.
6 Are you asking for a different or a separate
7 SOP for the radiation --
8 **DR. SWENSON:** No --
9 **DR. FLEMING:** -- processing?
10 **DR. SWENSON:** No, we're interested in how Dr.
11 Otchin's office handles the cases once he gets
12 them back, how does he go through the IREP
13 process, that, so specifically for his office.
14 Is that...
15 **DR. FLEMING:** So the -- and maybe there is an
16 SOP, but -- so but -- but the checklist that
17 Curt was given is deemed sufficient for
18 explaining the procedures that are used for --
19 for the processing of the radiation claims.
20 It's a generic checklist for how -- how all
21 claims are processed in --
22 **DR. SWENSON:** We have --
23 **DR. FLEMING:** -- that office.
24 **DR. SWENSON:** -- seen that, and we have looked
25 at it --

1 **DR. FLEMING:** Was it --
2 **DR. SWENSON:** -- much earlier --
3 **DR. FLEMING:** -- satisfactory?
4 **DR. SWENSON:** -- much earlier on, yes. We did
5 request SOPs at one time --
6 **DR. FLEMING:** That's what I thought --
7 **DR. SWENSON:** -- from Dr. Otchin.
8 **DR. FLEMING:** -- yeah. You've -- you've
9 removed that request.
10 **VICE ADMIRAL ZIMBLE:** Mr. Pamperin.
11 **MR. PAMPERIN:** I've got a question and a
12 comment. I'm sure that the SOP you're looking
13 for is actually guidance in our procedures
14 manual, M-21-1-MR, and I will get that to the
15 committee, on how that's done. But again,
16 displaying my ignorance here just so that I can
17 explain this to Dr. Deaton*, is -- is this
18 different that the BEIR report? Doesn't BEIR
19 VII or something -- isn't that what drives the
20 IREP? So I -- I mean I am ignorant here. I
21 don't know what -- I -- I'm trying to translate
22 how I'm going to bring this back, and is -- is
23 it just the mechanics of -- you know, you will
24 process these claims in five days and, you
25 know, you will do this and do this? Is it a --

1 is it a work process SOP that you're talking
2 about or you're really talking about how you
3 run the IREP model? I -- I don't understand
4 what we're saying here.
5 **DR. SWENSON:** I'll let John jump in here.
6 **DR. LATHROP:** Okay, I -- I just wanted to say,
7 having looked at the IREP model -- although we
8 refer to it -- oh, it's a model and you fill in
9 some inputs and you hit a button and you get
10 some results, there's actually quite a bit of
11 skill, that's at least not obvious to me, in
12 how you run it. And I'm afraid, as in so often
13 happens with institutions, we've lost either
14 the skill -- or no, let's not say that -- we've
15 lost the institutional memory with the
16 departure of Dr. Otchin. And so as in SC-3
17 it's appropriate for us to say gee, there ought
18 to be a way so we have documented how IREP is
19 actually run.
20 And let me go on to add, as you and I discussed
21 yesterday, Dr. (sic) Pamperin, that terms of
22 reporting of spreadsheets that came from Dr.
23 Otchin, we -- we need to see that, too --
24 **MR. PAMPERIN:** Sure.
25 **DR. LATHROP:** -- (unintelligible) keep it

1 within the lane of SC-3, we haven't seen yet
2 what would strike us as appropriate plugging
3 through a standard procedure for running of --
4 of IREP. Up until now, quite understandably
5 and in a human way, we were all very impressed
6 by Dr. Otchin and his -- his running of it.
7 But now we're sitting here saying well, there
8 ought to be a procedure that's written.
9 **MR. PAMPERIN:** Okay, I -- that's -- that's
10 fine. I understand now. I would have just
11 assumed that there's a user's guide that comes
12 with this thing, but I mean we'll -- we'll see.
13 **VICE ADMIRAL ZIMBLE:** I -- I would sub-- I -- I
14 would -- my assumption would be that the user's
15 guide is probably not sufficient, and -- and I
16 would think that there's a certain level of
17 expertise required to understand the
18 idiosyncracies of the model and -- and how to
19 interpret the result. Now I've looked at it,
20 and I would say I have questions, but I'm
21 seeing some ex-- some exasperation on the part
22 of several members, so I -- I would -- I'll
23 defer to Mr. Beck for right now. He seems less
24 exasperated than Dr. Boice.
25 **MR. BECK:** Actually -- I mean the IREP model --

1 I mean the -- it's on the web. I think they're
2 pretty clear instructions that any person with
3 some scientific background should be able to
4 run it. What -- my understanding, though, and
5 what's important here, having spoken to Dr.
6 Otchin many times, is that -- unlike the atomic
7 workers' program -- the IREP is not, by law,
8 required to make the decision for the VA. They
9 have adopted it and it's used as an advisory
10 thing. Now -- and I understand in most cases
11 they won't go against the result of it, but the
12 key thing here was that it's a tool -- was a
13 tool for a competent medical individual, mainly
14 Dr. Otchin, to provi-- to provide a medical
15 opinion as to whether it was more likely than
16 not. So there are these other -- the last
17 point you mentioned about the interpretation of
18 the result that really is the key thing here,
19 which is why you need a medical doctor to look
20 at this result and say is that correct for this
21 particular guy's case, and you also have --
22 **VICE ADMIRAL ZIMBLE:** There's also some
23 ambiguity -- there's some ambiguity as to what
24 you fill in the blanks on the input as well.
25 **MR. BECK:** Well, that -- that --

1 **VICE ADMIRAL ZIMBLE:** You know, it's --
2 **MR. BECK:** -- there are instructions --
3 **VICE ADMIRAL ZIMBLE:** -- there has to be some
4 selectivity and some judgment in what -- what
5 you put into the mach--
6 **MR. BECK:** Well, the -- the information --
7 **VICE ADMIRAL ZIMBLE:** -- machine. It's not
8 just age and gender.
9 **MR. BECK:** The information comes from DTRA and
10 in the file should be there to provide the
11 right information. That's why they went to
12 separating out the alpha doses and the neutron
13 doses and things like that.
14 **VICE ADMIRAL ZIMBLE:** Okay.
15 **MR. BECK:** So yes, I mean somebody would have
16 to practice using it, you know, to make sure --
17 but I don't think it's extremely difficult, but
18 I think that the medical judgment is still
19 important here and that -- that's -- I think
20 has to be clear --
21 **VICE ADMIRAL ZIMBLE:** Well, I guess what's
22 really worrisome to me is that there are now
23 118 cases languishing because Dr. Otchin's not
24 there.
25 **MR. BECK:** But is that because --

1 **VICE ADMIRAL ZIMBLE:** Why isn't someone else
2 there, you know? Is it an -- it's an office of
3 one and -- and now we're -- we're worrying
4 about a single heartbeat that's going to be
5 responsible for processing claims? I mean that
6 is a major roadblock.
7 **MR. BECK:** But this isn't -- this isn't the
8 (unintelligible). I mean theoretically, Dr.
9 Blake -- although (unintelligible) suggesting
10 this -- could run the IREP program with the
11 information he has and get the PC, you know.
12 In fact, half of it's already tabulated anyway
13 in the report he produced, basically. So I --
14 I mean the PC, whether or not it's 50 percent
15 or more, is fairly easy to get. But the -- the
16 VA requires the judgment, I guess by their
17 regulations, from their medical office. So I -
18 -
19 **VICE ADMIRAL ZIMBLE:** Okay.
20 **MR. BECK:** -- guess Dr. (sic) Pamperin would be
21 better to answer that question.
22 **VICE ADMIRAL ZIMBLE:** Dr. Blake.
23 **DR. BLAKE:** I would like to comment, since I've
24 done these calculations quite a bit of time
25 before we had the IREP and now we -- we

1 obviously look at it, and we had fre-- we have
2 had frequent discussions with Dr. Otchin. For
3 one thing, the IREP software is not everything
4 that Dr. Otchin does. It only covers, for
5 instance, most cancer cases. Obviously when we
6 have cataract cases, we have non-radiogenic
7 diseases, the IREP software is not of
8 assistance. And even with using the IREP
9 software for fairly standard cancers, you make
10 -- you -- there's a lot of choices, and Dr.
11 Otchin has made some rather unique choices over
12 the years, and so those ought to be documented
13 if someone else is going to try to continue
14 this to have the same level of fairness for all
15 veterans. And so it -- it is -- for instance,
16 one thing that's particularly challenging if
17 you -- depending upon how you implement the
18 IREP software, is looking at the uncertainty
19 distributions or the (unintelligible) or the
20 triangular, which one do you choose for this
21 particular period of time. You don't
22 necessarily have to do that choice. There's
23 some other options to use. But once again, a
24 simple straightforward procedure to say how
25 that that office implements it makes it much

1 easier if any other relief person comes in to
2 fill Dr. Otchin's position 'cause that way all
3 the procedures can be consistent.
4 So I -- I don't think it's a major effort, but
5 I do -- and I won't make any recommendations
6 from another agency, so...
7 **VICE ADMIRAL ZIMBLE:** Okay, any other -- yes,
8 Dr. Fleming.
9 **DR. FLEMING:** I think this -- this relates to
10 Dr. Zeman's question yesterday about whether or
11 not Subcommittee 2 has been looking at the
12 decisions of the -- you know, the final
13 decisions. And we have -- we have actually
14 noted the decisions in the audit -- audits that
15 we've received, but I don't recall that we have
16 actually looked at the rationale behind the
17 decisions and saw that interpretation, that
18 interpretive work. So you know, I'm -- I'm
19 making these comments as an affirmation of this
20 need for the SOP, which -- which you might work
21 up based on going back and looking at Dr.
22 Otchin's -- the basis for Dr. Otchin's
23 decisions. And we have not seen that
24 particular paperwork there -- or so forth.
25 **VICE ADMIRAL ZIMBLE:** Dr. Blanck.

1 **DR. BLANCK:** Not commenting on the
2 recommendation, but actually Subcommittee 2 did
3 look at those decisions and the rationale for
4 them well before you came on board --
5 **DR. FLEMING:** (Off microphone) Oh,
6 (unintelligible) --
7 **DR. BLANCK:** -- the committee.
8 **DR. FLEMING:** -- (on microphone) these would
9 have been decisions then -- well --
10 **DR. BLANCK:** Dr. Otchin came and explained his
11 rationale, how he did them -- we had a whole
12 presentation when we were at the VBA.
13 **DR. FLEMING:** Okay, thank you. Thanks for the
14 correction.
15 **VICE ADMIRAL ZIMBLE:** Okay, thank you very much
16 for that.
17 Any -- any further comments regarding the --
18 okay.
19 Do I hear a motion to accept the rec-- the
20 report of Subcommittee 3?
21 **MR. ROPIEK:** So moved.
22 **VICE ADMIRAL ZIMBLE:** And second?
23 **MR. VOILLEQUÉ:** Second.
24 **VICE ADMIRAL ZIMBLE:** Then without objection,
25 they are accepted and we'll move on to

1 Subcommittee 4, Mr. Groves.

A REPORT FROM SUBCOMMITTEE 4 ON COMMUNICATION AND

2 **OUTREACH**

3 **MR. GROVES:** Good morning. As you will be able
4 to see from the handout, at the end of the
5 meeting in Chicago last fall we had recommended
6 that we -- that we hold a joint meeting between
7 the Public Affairs staffs of both the VA, DTRA
8 and a select subset of Subcommittee 4. That
9 meeting took place. We didn't have quite as
10 many people as we would have liked to have had
11 for some personal reasons that came up on short
12 notice, but it was certainly a good-faith
13 meeting and I want to thank Tom Pamperin and
14 the folks over at VA for hosting that meeting.
15 That was -- this is a prelude to a
16 recommendation we're going to make at the end
17 of this report about getting at least the VA
18 and DTRA together, just to ensure that there is
19 a consistent message concerning the atomic
20 veterans, and that was certainly a good start.
21 Our subcommittee met then after the first of
22 the year, worked on a number of things. And I
23 want to acknowledge the work that Dr. Lathrop
24 did on behalf of our committee and at the
25 request of the Chair to develop the gap

1 analysis document, for lack of a better term,
2 but a collection of information about the
3 recommendations and the responses that I think
4 was extremely useful to all the -- all four
5 committees in preparing information today and
6 will be, I think, very helpful as we prepare
7 additional discussions for the September
8 meeting on where the path forward might be for
9 the -- for the committee. So thank you very
10 much, John, for that.
11 We are going to make a recommendation this
12 time, and let me preface why we have waited to
13 this point to make this recommendation. And it
14 has to do, I think, with what we all
15 acknowledge is the significant progress that
16 has been made, both in the -- in the different
17 dose reconstruction efforts, the expedited
18 doses, the -- where we stand on skin and
19 prostate cancer cases, and the significant
20 progress we all see by having consolidated the
21 radiation-related claims, and in particular the
22 veteran -- atomic veteran claims in a single
23 office.
24 Now that that has happened, Subcommittee 4
25 would like to say that the time is now for us

1 to have a major outreach effort, led by the VA,
2 to try and identify any remaining atomic
3 veterans who may not be aware of the program.
4 And we recognize that this is going to require
5 considerable resources. It might very well
6 create significant claims.
7 On the other hand, it is certainly a
8 demonstration of good faith to the atomic
9 veterans community and we feel it will go a
10 long way in increasing the trust by having
11 made, you know, one more effort to -- to reach
12 out and identify people who may have -- who may
13 have a legitimate claim, them or their
14 families.
15 So we are going to make that recommendation.
16 As a part of that recommendation we have
17 provided a draft letter that we think could be
18 used as a part of that outreach effort, along
19 with, I think, the -- another issue why the
20 timing of this is such as it is is that the
21 brochure that we have all worked very hard on
22 has now been forwarded to -- to the VA to use
23 for multiple uses to describe activities of --
24 of how one would apply for claims if you're an
25 atomic veteran. We think that makes an

1 excellent enclosure to the letter. And so we -
2 - we would look forward to doing whatever we
3 could do to help the VA in that.
4 While it was not a formal recommendation, DTRA
5 has provided significant support to this effort
6 by providing their database of -- of people who
7 have been identified through the years as -- as
8 atomic veterans and -- and that information has
9 been provided to the VA in a form that is
10 compatible with their database, so -- so we
11 feel that the VA has the best database
12 possible. And of course there'll be some work
13 to get that out, and some expense.
14 We would also like to make a recommendation
15 that is consistent with -- with work that was
16 described by both the VA and DTRA as concluded,
17 but I think we all recognize it is still an
18 ongoing effort, and that is to continue to work
19 jointly on this communication plan. And -- and
20 so we're -- we're going to formalize that in a
21 -- and the fact that we would like to have that
22 continue. Whatever our committee can do to
23 facilitate and work with you in that process,
24 we would be glad to do.
25 We have some activities our subcommittee is

1 doing, mainly with Mr. Ropiek, looking for ways
2 to describe activities of the VBDR and the
3 atomic veterans community in veterans'
4 magazines. Ultimately that will be something
5 that we will want to roll into DTRA and VA
6 space to do, but we will continue to work --
7 work with you on that.
8 Again, I think the fact that the
9 infrastructure, both at DTRA and VA, are in
10 place to take on this significant effort of
11 trying to do this outreach effort to the
12 remaining veterans that may not be aware of --
13 of the program that is there.
14 Unless any other members of the committee --
15 and Ed, that includes you -- want to make a
16 comment, I will open the floor for questions.
17 **DR. LATHROP:** Yeah, I would just like to add,
18 we -- we have adopted a style and manner here
19 of avoiding micromanagement or spelling out
20 detailed recommendations for implementation.
21 But I want in the soundtrack for the Board to
22 realize that the outreach effort that we're
23 talking about will involve some significant
24 effort from the VA. For instance, they -- they
25 have been given a compatible database from

1 DTRA. Now they are faced with the information
2 management task of combining that with other
3 information that they have in house, and
4 perhaps they could consider referencing -- Tom,
5 help me out here -- the IRS or Social Security
6 databases to do an efficient job of narrowing
7 things down to the -- to the veterans that are
8 -- are still -- still living. And I just want
9 the panel and the audience to recognize that is
10 a significant information management sort of
11 effort that we haven't spelled out here, but we
12 have an understanding with the VA. Am I
13 correct on that, Tom?
14 **MR. PAMPERIN:** Yes, you are.
15 **DR. LATHROP:** Good.
16 **MR. GROVES:** Ed, do you have any questions or
17 comments?
18 (No responses)
19 Ed may not be there. David?
20 (No responses)
21 Thank you very much, Mr. Chair.
22 **VICE ADMIRAL ZIMBLE:** Thank you. I -- I have
23 just one comment, and I'm going to apologize.
24 I've -- I've read this letter several times in
25 many draft forms over -- through -- through our

1 e-mail correspondence, and it didn't occur to
2 me until just now. This very first sentence in
3 this -- in this draft letter -- it -- it
4 depends on who it goes -- to whom it goes. If
5 we have had ongoing dialogue with an atomic
6 veteran, like -- like let's say this letter
7 went to Charlie Clark and he read this thing
8 and it says, "Our records indicate that you may
9 be an atomic veteran, someone who may have
10 participated...," blah, blah, blah, "and if you
11 think you're eligible...," well, I -- if I were
12 Charlie, my nose would be bent out of shape.
13 What are you talking about? You guys know me,
14 you've -- I've been dealing with you for years.
15 So is there -- will there be a way to sort
16 through this so that we don't send this to a
17 known correspondent atomic veteran?
18 **MR. GROVES:** I think that the goal was to --
19 **VICE ADMIRAL ZIMBLE:** It's to reach new ones.
20 **MR. GROVES:** -- yeah, was to look for people
21 who we do not -- who we had -- who we may have
22 identified in the system but have not been
23 claimants or that we had communicated with. So
24 we're looking for that subset of the atomic
25 veteran community that really doesn't know the

1 program exists.

2 **VICE ADMIRAL ZIMBLE:** So I -- I just --

3 **MR. GROVES:** So --

4 **VICE ADMIRAL ZIMBLE:** -- want the caveat --

5 **MR. GROVES:** Yeah.

6 **VICE ADMIRAL ZIMBLE:** -- that we want to make

7 sure -- 'cause I really think that would be an

8 embarrassment to send this --

9 **MR. GROVES:** Charlie, don't expect to get one

10 of these letters. Okay? We're saving the 31

11 or 41 or 81 cents, so --

12 **VICE ADMIRAL ZIMBLE:** But somebody's got to

13 sort through those.

14 **MR. GROVES:** No --

15 **MR. PAMPERIN:** And Ken, I -- I would caution --

16 I would not assure that Charlie will not get

17 one of these letters.

18 **MR. GROVES:** I take it back.

19 **MR. PAMPERIN:** They have -- I mean clearly

20 there are -- there are a couple of things that

21 can be done. When we match the NuTRIS database

22 to -- to our records, I think we were able to

23 identify most of the people who were in the

24 NuTRIS database. There -- there were some came

25 up no record at all. I mean you -- you can --

1 you can make business rules that say that --
2 don't send this letter to anybody who is in
3 receipt of compensation or has certain
4 diagnostic codes. But you -- that makes an
5 assumption. You know, you could have -- you
6 could have been in receipt of compensation for
7 something from 50 years ago and not be aware of
8 the -- the -- so I can't guarantee you that we
9 won't -- so -- so we perhaps will need to, you
10 know -- you know, say please accept our
11 indulgences if we're -- you're aware or
12 something.
13 **MR. GROVES:** We'll fix the letter so it has --
14 as to -- and again, it was just a
15 recommendation, but that was an excellent
16 point, Mr. Chair.
17 **VICE ADMIRAL ZIMBLE:** Something that -- I -- I
18 read this many times and just never occurred to
19 me that this might go to somebody that --
20 **DR. LATHROP:** That's a good --
21 **VICE ADMIRAL ZIMBLE:** What's wrong with the VA,
22 you know.
23 **DR. LATHROP:** And that's a good occasion to
24 basically say we are advisory and we have the -
25 - we have the greatest respect for Tom Pamperin

1 and his staff to -- this is just a draft that
2 they'll work from, and they'll probably change
3 a number of things. And I want to second what
4 -- what Tom said. As with any of these things,
5 you're effectively knowing you're going to be
6 giving it to some people who don't quite fit.
7 Just the nature of the game.
8 **MR. GROVES:** I guess one of the points we -- we
9 made by enclosing the letter at all is that we
10 thought there was great value in the letter
11 being simple, straightforward, not -- the least
12 amount of bureaucratese as possible, and have
13 additional information in the form of the
14 brochure so that people would at least read the
15 letter and -- and make a decision. And -- and
16 we actually had some help with Tom at our
17 subcommittee meeting on Tuesday -- I mean for
18 the government to send out a one-page letter is
19 -- is unique, and we are very pleased and I
20 want to acknowledge David Ropiek's part in
21 helping us keep this simple as a way to
22 hopefully entice the veterans to -- to read the
23 letter.
24 **VICE ADMIRAL ZIMBLE:** Of course that -- it
25 isn't unique for the government to send out a

1 one-page letter. At least when we had the
2 drafts it was not --
3 **MR. GROVES:** Yes -- yes, congratulations.
4 **VICE ADMIRAL ZIMBLE:** Right, right. R.J.
5 **MR. RITTER:** Thank you, Mr. Chairman. I was
6 fortunate enough to participate with the
7 subcommittee in preparing this letter. And I
8 just want to point out the last sentence -- the
9 last sentence of the letter that identifies the
10 potential for a surviving spouse or child that
11 may be able to put in a claim for benefits. So
12 in my opinion, I think that sentence trumps the
13 first sentence in that if we send the letter
14 out to atomic veteran who has -- was either in
15 the system and it gets to his -- to his widow,
16 she wouldn't otherwise know how to get back
17 with us. Okay? Thank you.
18 **VICE ADMIRAL ZIMBLE:** Dr. Boice.
19 **DR. BOICE:** Just wanted to make a -- a comment
20 about locating the atomic veterans from the
21 NuTRIS system. One of the difficulties with
22 the system is the Social Security number is
23 missing from 55 percent or 60 percent, and that
24 makes it difficult, of course, to link up with
25 IRS without a Social Security number because of

1 common names. So I'm sure the VA has other
2 systems and, using the BIRLS system, would be
3 able to -- because military identification
4 number is available on practically everyone in
5 the BIRLS system -- or in the NuTRIS system.
6 That would be a way to obtain some Social
7 Security numbers, through the linkages of those
8 veterans that have gone into the VA medical
9 system.
10 Another resource, too, is the Social Security
11 Administration. I just wanted to mention that.
12 And perhaps, Tom, you're aware of it. But if a
13 request comes from another federal agency, they
14 have a num* identification database for which -
15 - with name and date of birth -- they will
16 supply back the Social Security number. And
17 these are all the forms -- you know, when we
18 first applied years ago for our Social Security
19 number, they have that available. It's not
20 generally available to researchers, but if a
21 federal agency does request it, it would be
22 possible for -- so using that three-pronged
23 approach I think you would -- and perhaps
24 you've done it before -- would be able to
25 identify the many atomic veterans in the NuTRIS

1 system, the BIRLS system, the Social Security
2 system with the num ident system, and then IRS
3 if you have that ability to access it, which
4 would be special if you're able to do that.
5 Thank you.
6 **VICE ADMIRAL ZIMBLE:** And by the way, I'd like
7 to remind everybody today is April the 3rd and
8 April the 15th is the last day for the -- for
9 getting your correspondence to the IRS.
10 Okay. If there's no further co-- if there's no
11 further comments -- oh, I'm sorry. I've got to
12 do something about my vision.
13 **DR. SWENSON:** My ques--
14 **VICE ADMIRAL ZIMBLE:** Dr. Swenson.
15 **DR. SWENSON:** My question is, on the brochure
16 that's with this, does it talk about the IRR?
17 Because isn't it another goal to get the
18 veteran registered in the IRR, even if they're
19 not ill? So is that covered in the brochure
20 that -- 'cause it's not addressed here.
21 **MR. GROVES:** It is covered -- it will be
22 covered, I think, both in the letter and in the
23 brochure that even without a compensable
24 condition that you get into the system, you get
25 a free medical exam, you start receiving

1 information. Should you then develop a
2 condition that might make you eligible, you're
3 -- you've already done some of the homework and
4 things should move faster.
5 **VICE ADMIRAL ZIMBLE:** (Unintelligible) priority
6 six.
7 **MR. GROVES:** That's right. Now let me also add
8 that we have worked very closely with Mr.
9 Sloane in Tom's office who has now taken over
10 as the editor of the IRR Newsletter. And as
11 you heard in Tom's remarks yesterday, we -- you
12 know, we certainly hope to play a role in
13 having input to that newsletter to not only
14 describe the activities that have happened at
15 the Board meetings, but to advertise the future
16 Board meetings as yet another way to get, you
17 know, more participation at our meetings.
18 **VICE ADMIRAL ZIMBLE:** Dr. Blake.
19 **DR. BLAKE:** Thank you, sir. Two comments, if I
20 may. The first one dealt with the NuTRIS
21 database that's been turned over to the VA on
22 the letter going out saying whether it's an
23 atomic veteran or not. That database that we
24 maintain has a little over a half a million
25 veterans in it. However, it is basically two

1 parts. One -- since DTRA serves the Department
2 of Defense as the verification process for the
3 VA to define an atomic veteran, we keep in
4 there all interactions with veterans. And
5 there's approximately -- from a historical
6 viewpoint, when we started this in 1978,
7 approximately 20,000 veterans that we
8 considered non-parts, we could not verify
9 participation. That was not turned over to the
10 VA. What were turned over to the VA was the
11 487,000, approximately, veterans that are
12 formally defined -- that we believe are defined
13 as atomic veterans. And that's why I'd like to
14 add the caveat.
15 When we do a formal letter back to the VA and
16 the veteran verifying participation, the first
17 thing we look in -- look in our database and
18 say is that person there, but that's not
19 sufficient. We always, before we do a formal
20 letter back, do our best to find two
21 independent means of verification through
22 correspondence -- and the military kept
23 excellent records. If that, just one letter.
24 Or the final step is, for instance -- and we
25 know there -- for instance, the fire that was

1 at National Personal Records Center in St.
2 Louis years ago burned some of the Army records
3 down -- the VA can come back when we say we
4 can't verify this, here is all the conditions
5 we understand, they can then say -- step in and
6 say we validate that condition, and then we
7 consider them a validated veteran for -- atomic
8 veteran.
9 But my only point would be, even though we have
10 that database, it's been accumulating since
11 1978. And in the early years it was the
12 separate services doing it. Obviously there
13 was different types of quality control on that.
14 That's one reason we go out and say, before we
15 formally put in writing in the letter, we look
16 for independent verification. So I don't think
17 there's any program manager who has a database
18 of a half a million veterans that will say that
19 database is 100 percent perfect. I think it's
20 very good, but when you receive that, you --
21 there would be some conditions where it may not
22 be an atomic veteran that's actually in that
23 letter, and I -- I think it's a few percent.
24 In fact, there was a verification done during
25 the National Academy of Sciences study back in

1 2003 where they saw the assurety rate on that
2 was on the order of about 98 percent. So they
3 did a sampling and verified that our database
4 is fairly good. But we don't accept that. We
5 -- we verify before we go out. That's my first
6 point.
7 The second point is on the second
8 recommendation made by SC-4, as far as I can
9 tell, that was the same recommendation that was
10 made in September of 2007 where VA and DTRA
11 formalize an advisory role for VBDR in
12 development of communications. And at least in
13 my case on recommendation number 18, we already
14 addressed that and -- and said we would
15 implement that and -- and do that.
16 So I guess my question is -- we have no problem
17 with that concept and we certainly want to
18 continue it, but does it serve a purpose to
19 send the same recommendation back to the agency
20 if we've already embraced it, that we're going
21 to do it.
22 **MR. GROVES:** I think that this one -- there's a
23 -- there may be a subtle difference in that,
24 and let me, before I answer that question, go
25 back and answer the question that Subcommittee

1 brought up about asking us to review some of the documents that you have for consistency, continuity and ease of reading on behalf of the veterans and which we've done -- we've done some of that, but we have not done all of that -- is that this one in particular wants to look at our -- our public affairs and our documentation and our newsletters and our brochures and our outreach programs. And I think that that's a little -- maybe a little broader than the last one and we wanted to capture, in the term "communication program," all of those aspects. And it is certainly started. I think our recommendation is -- is to say that that's something we want to continue and that we want to play a role in that, as best we can, to help it go forward. And I -- and it -- I apologize if it's a redundant recommendation.

DR. BLAKE: I would just ask, when it goes up through the chain of command, I -- I think it's important to clarify what differences there are in that recommendation than what was previously passed. Otherwise, there'll be some significant questions coming back.

1 **MR. GROVES:** Then --
2 **MR. PAMPERIN:** The same -- the same applies for
3 VA. You know, when we do -- this is sort of
4 like a site survey, and the worst thing that
5 can possibly happen is to have a second
6 recommendation on something that you already --
7 already said okay on. So I would ask that it
8 be worded carefully.
9 **MR. GROVES:** Well, I -- I would be happy to --
10 having heard the comments from both of you all
11 that you're committed to continuing the process
12 that we've -- that we've started it and can
13 capture it in broad terms of coordinating our
14 communication efforts, that if we don't feel we
15 need the recommendation I'll be happy to
16 withdraw the second recommendation.
17 **VICE ADMIRAL ZIMBLE:** Yeah, without -- without
18 objection, I'd suggest that we just withdraw
19 that second recommendation.
20 **MR. GROVES:** Okay.
21 **VICE ADMIRAL ZIMBLE:** We have the assurances
22 from the -- from both agencies that --
23 **MR. GROVES:** Then we'll just --
24 **VICE ADMIRAL ZIMBLE:** Okay.
25 **MR. GROVES:** -- take that recommendation off.

1 **VICE ADMIRAL ZIMBLE:** Okay. And let's see --
2 yes, Mr. Ropiek.
3 **MR. ROPIEK:** I'd just like to commend to the VA
4 -- I'm -- I'm personally very encouraged to
5 find their receptivity to the idea of this
6 outreach. I can't imagine anything more loudly
7 speaking to the veteran -- atomic veterans
8 community that we're not trying to delay and
9 we're not trying to hide and we're not trying
10 to save ourselves a few bucks in sending out
11 some hundreds of thousands of letters that
12 could bring in some probably thousands of
13 claims, demonstrating that they're serious
14 about reaching the guys and letting them know
15 what they're eligible for and they want to pay
16 it if the guys are eligible. So there's a --
17 there's an underlying value besides just the
18 technical accomplishments of the letter in the
19 ongoing relationship between the atomic veteran
20 community and the VA in following on on this
21 recommendation.
22 **VICE ADMIRAL ZIMBLE:** Thank you very much. I
23 think that the entire Board would go along with
24 that commendation. I think this is a -- this
25 is a very, very important effort. This is --

1 this is the essence of good communication and
2 I'm very proud of the recommendation being
3 made.
4 I would commend the Board for filling the time
5 allotted so well, and we've now exceeded the
6 time for break so we're not going to have one -
7 - no, no. No, we will break now and we'll
8 reconvene at 10:30. Oh, yes, yes, yes -- do I
9 hear a motion to accept the report, as amended?
10 **DR. BLANCK:** (Off microphone) (Unintelligible)
11 as amended.
12 **VICE ADMIRAL ZIMBLE:** As amended. Okay. Is
13 there --
14 **DR. MCCURDY:** (Off microphone) (Unintelligible)
15 **VICE ADMIRAL ZIMBLE:** -- without objection, it
16 is accepted.
17 (Whereupon, a recess was taken from 10:10 a.m.
18 to 10:40 a.m.)
19 **VICE ADMIRAL ZIMBLE:** All right, ladies and
20 gentlemen, I've been very lenient. We've given
21 you extra time. It's -- it's -- is beyond
22 10:30 by ten minutes. You know if you take any
23 longer for the break, we're going to have to
24 call it a vacation. So I'm call -- call this
25 Board to order.

1 **PUBLIC COMMENT SESSION**

2 The next piece of business on the agenda is to
3 receive public comment. We have one atomic
4 veteran who wishes to speak to the Board and
5 I'm delighted that he does so, and that is --
6 it's Mr. John -- is that Argeris?

7 **MR. ARGERIS:** Yes.

8 **VICE ADMIRAL ZIMBLE:** Ah, yes, well, that's
9 second class, right?

10 **MR. ARGERIS:** Yes.

11 **VICE ADMIRAL ZIMBLE:** Yeah, right, Seaman 2nd.
12 Cl. Argeris, please, come forward. There's a
13 microphone -- yeah, it's coming, it's right
14 there.

15 **MR. ARGERIS:** Okay, thank you.

16 **VICE ADMIRAL ZIMBLE:** Okay. So you have -- you
17 have the floor.

18 **MR. ARGERIS:** This is true democracy in action,
19 and I thank all of you. This morning I want to
20 make an appeal to medical Board members here
21 because of a consideration that I don't think
22 you've taken into account. The Japanese atomic
23 veterans -- that is, us Americans -- were, at
24 the time, 15, 16, 17, 18 years old, a lot of us
25 were. And there was eight-- don't forget,

1 there were 18 million World War II veterans, 18
2 million.
3 Now in appealing to the medical community, I
4 know for a fact that when you're 15 and 16 year
5 old and you're subjected to plutonium
6 radiation, it can affect your organs, your
7 skin, your total body much more magnified than
8 if you were a 40-year-old man because you're
9 still developing. I want the Board members,
10 especially the medical Board members, to
11 consider that a lot of us veterans were not
12 developed yet physically -- and mentally,
13 probably.
14 I wish we had a Ministry of Health in the
15 United States like they do in Japan instead of
16 the Veterans Administration, which is playing
17 hard ball with us 1944 and 1945 veterans. You
18 got to look way back. Don't look at the
19 veterans now that are in the Air Force shooting
20 off missiles and handling atomic weaponry.
21 This is -- I'm talking about 1944 and '45,
22 Alamogordo, Japan, and the south Pacific,
23 that's what I'm talking about.
24 Yesterday Dr. Sasaki mentioned, and you
25 questioned him, about the 250,000 Japanese

1 survivors that are still living in -- in and
2 around -- but they're scattered out, I think --
3 in Japan, 250,000. I was in touch with another
4 Japanese doctor, Dr. A-n-z-a-i, Anzai, and this
5 doctor figured out a dose reconstruction for my
6 plutonium radiation -- it's only an estimate.
7 There's no way -- we had no film badges, no
8 Geiger counters, no nothing to know about the
9 radiation exposure rate. Anyhow, this other
10 Japanese doctor figured that about roughly
11 250,000 -- this was about 20 years ago --
12 atomic veterans were still living, 250,000.
13 It's a coincidence to me why Dr. Sasaki
14 mentioned 250,000 survivors were still in Japan
15 and 20 years ago there were still 250,000
16 atomic veterans. That's a very strange
17 happening.
18 Anyhow, the main point I want to make here is
19 that -- not to belabor it, but that a lot of us
20 were not fully developed when we volunteered.
21 And incidentally, we were volunteers, because
22 when you're that age you don't get drafted.
23 And the people in charge know that out of the
24 18 million of us, a lot of us were under-age, a
25 lot of us.

1 Yesterday the lady from Virginia that was
2 sitting over here mentioned that they had a
3 backlog of 246 atomic veteran cases on hand
4 that they had to file. I don't understand how
5 there could be only 246 cases pending of atomic
6 veterans when there were 250,000 of us. I know
7 a lot of us have died. I've got -- I've got
8 some atomic veterans right now that are in
9 nursing homes and they're on their last legs, I
10 know that.
11 There's also the -- I'm not going to make a
12 long speech here, I'm closing here real quick.
13 There's also the psychological effects of
14 atomic radiation. When our daughter was five
15 years old, she was hit with acute leukemia. We
16 were overseas at the time and she almost died.
17 Our son today has skin problems and other minor
18 problems, but he's not 100 percent, either.
19 But at least our daughter is here -- right over
20 here -- (unintelligible) would you stand -- our
21 daughter is here. There's a plutonium survivor
22 for you.
23 Now as far as us atomic veterans, we've been
24 hitting our head against a wall for too many
25 years, too many years. And just as a question,

1 are we supposed to take our case to the Justice
2 Department? Because the Veterans
3 Administration has been under-funded. I'm not
4 criticizing the Veterans Administration because
5 this is political. They've never had enough
6 money to do the job properly. The veterans
7 have never had enough money to do it.
8 And with that, I'm closing, and I thank you.
9 **VICE ADMIRAL ZIMBLE:** Wait, John, don't go
10 'way. I would like to -- I would like to give
11 you some responses. First of all, your concern
12 about age is a -- is a legitimate concern,
13 about the age at which exposure occurs.
14 **MR. ARGERIS:** Correct.
15 **VICE ADMIRAL ZIMBLE:** You need to know that
16 that is taken into consideration. I don't know
17 if we go all the way back to age 15 -- or 14 in
18 the IREP, but -- but it is -- we -- we
19 recognize the vulnerabilities of -- and
20 sensitivities to radiation that varies with age
21 and the (unintelligible) --
22 **MR. ARGERIS:** Thank you, thank you.
23 **VICE ADMIRAL ZIMBLE:** -- that's known, and that
24 is taken into consideration. Okay? That's --
25 that's number one. That's very important.

1 Secondly, I would tell you that this -- the
2 entire Board agrees with you regarding the
3 question of why so few claims with so many
4 veterans. And that's exactly the reason that
5 the communications subcommittee has made the
6 recommendation that we send letters to as many
7 of these people who potentially could be atomic
8 veterans -- we don't know them. We're sending
9 out letters to find out -- or at least to
10 advise people that they may be atomic veterans.
11 And if so, what their benefits are, what their
12 eligibility is and what they need to do if they
13 have a condition which may be a result of
14 exposure to radiation. So -- so we -- that's
15 exactly one of the things that this Board is
16 making a recommendation for the Veterans
17 Administration to do, and I thank you for that.
18 That's the outreach.
19 Now one other question I had, have -- do you
20 have a claim pending?
21 **MR. ARGERIS:** I've had five claims turned down.
22 **VICE ADMIRAL ZIMBLE:** Okay. And they were
23 claims for what? If you want to talk about --
24 **MR. ARGERIS:** Ionizing radiation.
25 **VICE ADMIRAL ZIMBLE:** That -- but that's --

1 that's -- that's not a medical condition. What
2 condition do you have that may -- that may
3 perhaps have been a result of ionizing
4 radiation exposure?
5 **MR. ARGERIS:** I've got too many things, Admiral
6 --
7 **VICE ADMIRAL ZIMBLE:** Okay.
8 **MR. ARGERIS:** -- I've got too many things. I
9 would rather not discuss that here.
10 **VICE ADMIRAL ZIMBLE:** Fine, and of course, I --
11 we respect your privacy, but there may be
12 someone that -- our representative -- our
13 representative from the VA -- he -- is -- is
14 here and I really suggest that you talk with
15 him and -- and go over -- go over some of the
16 situations and -- and I'm sure the Veterans
17 Administration will look at it. Do they play
18 hard ball? No, but they play by the rules.
19 There's a difference. And -- and the rules are
20 such that you need to assure in -- in certain
21 cases that you were exposed to a sufficient
22 amount of radiation for a particular condition
23 that there's a probability that that radiation
24 caused it. That has to be shown, unless it's
25 one of a list of 23 diseases that we're -- that

1 we're already presuming if you have those
2 diseases you're -- you're going to be -- you're
3 going to -- you're going to be evaluated
4 without the need for the dose reconstruction.
5 But those are the rules. Those are the rules
6 that the -- that the VA must adhere to, and --
7 and I will tell you that there's no stronger
8 advocate for the veteran than the Veterans
9 Administration, the people that I know that are
10 at the top of the Veterans Administration, no
11 question about it.
12 **MR. ARGERIS:** I never -- I've never -- excuse
13 me, Admiral. I've never had a explanation of
14 whether 750 rems or rads -- rems, whatever you
15 call them, are enough to affect the human body
16 -- 750 rems of plutonium. I've never got an
17 answer on that.
18 **VICE ADMIRAL ZIMBLE:** Okay, I -- I -- that --
19 that's -- that is a significant dosage, but in
20 your case, it must be a salubrious one because
21 that -- that normally would -- if it's total
22 body radiation, 750 rem would be fatal. So --
23 but -- but you're here and you look -- you look
24 fine to me. So -- but again, please talk to
25 the VA rep and see whether or not there's

1 something that's --
2 **MR. ARGERIS:** (Off microphone) (Unintelligible)
3 **VICE ADMIRAL ZIMBLE:** You bet, thank you. I
4 really appreciate your testimony.
5 Any comments? R.J.
6 **MR. RITTER:** I just wanted to address the
7 question about why there might be another
8 150,000 or 200,000 vets out there who don't
9 know about the possibility of -- of being
10 entitled to benefits for radiation exposure.
11 And mostly that has to do with the fact that
12 for 43 years they were under an oath of
13 secrecy. That oath of secrecy was lifted by
14 Secretary of Defense William Perry in 1993 and
15 it wasn't made public like we see on TV every
16 day today. We see everything on TV today.
17 Back then it was -- it was -- it happened, but
18 it didn't get to the veterans. So part of this
19 outreach program is to let these veterans know
20 that they can talk about what they did back
21 then, the fact that they were in atomic bomb
22 test-- testing programs. They're no longer
23 held to that oath -- oath of secrecy. And
24 unless we can get that word to them, they still
25 believe they can't say nothing to nobody. So

1 we're hoping to -- to at least let them know
2 that we're here and we really want to work to
3 help them. Thank you.
4 **VICE ADMIRAL ZIMBLE:** Yeah, and R.J., you bring
5 up an interesting point. Your society, as well
6 as some of the other organizations, like
7 Charlie's organization, we -- we really would
8 like your assistance in making this outreach,
9 this -- there -- there are ways that I think
10 you could -- your organizations could be of
11 help, and I would submit to the VA that it
12 might be a good idea to include a list of the
13 various organizations and -- and their -- their
14 points of contact that are involved with atomic
15 veterans -- maybe that ought to go into -- into
16 the letter as well as the -- be appended to the
17 letter so that there might be some local
18 opportunity to make that -- that outreach.
19 **MR. RITTER:** I might say that the Ionizing
20 Radiation Review, since its conception, has
21 been sent to our list of atomic veterans that -
22 - that get our newsletter as well, and we have
23 --
24 **VICE ADMIRAL ZIMBLE:** They will be going --
25 they will be --

1 **MR. RITTER:** Right.
2 **VICE ADMIRAL ZIMBLE:** -- going to all those who
3 are registered (unintelligible) --
4 **MR. RITTER:** They will be going to all the
5 members of the National Association of Atomic
6 Veterans. The government is sending them a
7 copy. I send them the Excel mailing list and
8 they send it out, as many -- many as we wish.
9 And I usually get 100 or so to -- to distribute
10 to those who may not have gotten it -- someone
11 calls in, oh, by the way, I heard about this --
12 and I'll mail it to them on my own. But we
13 have an excellent relationship with the VA on
14 that point and we also get an electronic copy
15 and post it on our web site, and we've had a
16 lot of hits on it.
17 **VICE ADMIRAL ZIMBLE:** Okay.
18 **MR. RITTER:** So, yeah, I think -- I'm very
19 pleased that in the last two or three years
20 since I've known Mr. Pamperin that we've --
21 we've developed a relationship that we can get
22 the news out when it's needed, and our
23 newsletters reflect the proceedings of these
24 meetings as well.
25 **VICE ADMIRAL ZIMBLE:** Perhaps the -- the IRR

1 Review might -- might indicate what the -- the
2 points of contact for that -- for those various
3 local organizations. That might be a help,
4 too.
5 **MR. PAMPERIN:** We'll have to -- we'll have to
6 take a look at that. Generally speaking, we --
7 when we provide information about those who can
8 assist, we provide comprehensive of DAV, VFW,
9 American -- we -- we are specifically
10 prohibited from recommending a particular
11 organization, so we can do that. But I would
12 like just to clarify one thing for you, sir.
13 When Ms. MacDonald was up here, she was not
14 saying that there were 241 claims pending.
15 What she was referring to was a focused review
16 of 241 completed claims to determine the
17 quality of those. I'm -- I'm sorry, I don't
18 have the number of pending claims that are down
19 in Jackson right now, but I believe it's
20 substantially more than 241.
21 **VICE ADMIRAL ZIMBLE:** All right. We have
22 another -- another atomic veteran that wishes
23 to speak. Would Mr. Richard Haight come
24 forward? Good afternoon, sir.
25 **MR. HAIGHT:** And good afternoon to you. I just

1 came into the meeting so I missed some of the
2 information you've been passing on. One thing,
3 sir, at the lead table that I would love to
4 correct with you, you have a very, very, very
5 high regard for the VA and its operation. You
6 obviously came in through the top. I came in
7 through the bottom, and I have an opposing
8 view. It is a bureaucracy, and bureaucracies
9 are notoriously slow and inefficient, and I've
10 encountered that.
11 I don't know how I can help you gentlemen and
12 the meeting, but I just thought I would mention
13 that in passing. Yes, I am an atomic veteran.
14 I was aboard the USS Shangri La at Bikini, at
15 CROSSROADS, and I believe -- and maybe you can
16 tell me -- that you've already had a
17 description of how the enlisted, which I was,
18 personnel were handled during the explosion.
19 Are you aware of it?
20 **VICE ADMIRAL ZIMBLE:** Yes, we are.
21 **MR. HAIGHT:** Very good, then I don't need to go
22 into that. So all I can do is -- is say that I
23 admire you for coming down here and trying to
24 help the veterans through the Veterans
25 Administration. You've got one hell of a big

1 job. Thank you.
2 **VICE ADMIRAL ZIMBLE:** Mr. Haight, are you in
3 good health? Do you have -- do you have --
4 **MR. HAIGHT:** I've -- I've lost my hair.
5 **VICE ADMIRAL ZIMBLE:** That speaks to a high
6 testosterone level. There's nothing wrong with
7 that.
8 **MR. HAIGHT:** I've heard various rumors to that
9 effect. Yes, I do have some health issues.
10 **VICE ADMIRAL ZIMBLE:** Are they related to your
11 exposure to ionizing radiation, or do you
12 believe they are, and have you filed a claim?
13 **MR. HAIGHT:** I believe, yes, and I have filed a
14 claim. And as you know, through the rules and
15 regulation of the bureaucracy known as VA,
16 those poor people are hidebound to go and cross
17 every T and dot the I's and all that, and
18 sometimes I think they go a little far, but
19 that's my opinion.
20 **VICE ADMIRAL ZIMBLE:** Okay.
21 **MR. HAIGHT:** And yes, I -- I have some issues
22 with them and I have filed a claim. We'll see
23 how it goes.
24 **VICE ADMIRAL ZIMBLE:** Okay, good. Thank you.
25 **MR. HAIGHT:** Thank you.

1 **VICE ADMIRAL ZIMBLE:** I -- I see no other
2 volunteers for public comment. We can move on
3 -- wait.
4 **DR. LATHROP:** I -- I just wanted one -- want to
5 comment with --
6 **VICE ADMIRAL ZIMBLE:** Okay.
7 **DR. LATHROP:** -- the speaker. We -- we have
8 discussed the idea that it's one thing to talk
9 to Tom Pamperin, which is marvelous, and I
10 forget how high up he is, but he's way high up;
11 quite another thing to then talk, as R.J. has
12 been saying -- you know, so we're getting these
13 brochures, are the brochures going to be on the
14 fourth floor or in the lobby? So although you
15 -- we come across I'm sure as a bunch of egg-
16 headed kind of people, we do get down to that
17 because there are a lot -- there are going to
18 be a lot -- and this is from R.J. -- they'll be
19 a lot more beneficial if they're in the lobby
20 than if they're on the fourth floor. So we try
21 to get down to that level. We sympathize.
22 That's -- that's the level you'd see, the lobby
23 and the fourth floor, so we understand that.
24 **UNIDENTIFIED:** (Off microphone) Yes, sir,
25 (unintelligible) --

1 **VICE ADMIRAL ZIMBLE:** Wait, wait, wait, we have
2 a microphone for you.
3 **MR. TEMPLIN:** Arthur Templin, I spoke
4 yesterday. I have a claim that I filed. I
5 want to thank you and the committee for the
6 work that you're doing. But one of the things
7 that I would like to ask of you is the length
8 of time it is taking to process these claims,
9 and I'd like to use myself as an example. My
10 second claim -- first claim I filed in 1988, it
11 was denied because it was -- my exposure rating
12 they said was not high enough to cause the
13 problems (unintelligible) in my throat
14 (unintelligible) on and forgot about it. Dr.
15 Blake -- I met him about ten, 15 years ago and
16 you took my case and did a lot of research and
17 gave me some new figures on exposure ratings
18 and stuff like that, and I filed a new claim in
19 January of this past year. The length of time
20 it takes from the time you file a claim until
21 these issues get resolved is taking way too
22 long. I don't know what you can do about it,
23 but you've got to remember when you're talking
24 Nagasaki, Hiroshima and Bikini, the youngest
25 men you're going to find is probably 80 years

1 old. We would like to see these issues
2 resolved, and I think this is something that if
3 you can do anything about it, the atomic
4 veterans would very much appreciate it. Thank
5 you.
6 **VICE ADMIRAL ZIMBLE:** Right, we ap-- we
7 appreciate the -- the comment, and we're aware
8 of the -- we're aware of the -- the excessive
9 time that's involved in the processing of the
10 claim. One -- that's one of the topics that we
11 have taken on, and I would just tell you that -
12 - that -- that from our auditing we are seeing
13 a reduction in the time over -- over this past
14 year. This is -- this is getting better. Now
15 have you -- have you had a resolution to the
16 claim that you filed or is it still pending?
17 **MR. TEMPLIN:** (Off microphone) Pending, it's in
18 -- (on microphone) they say it's in Washington,
19 D.C. now.
20 **VICE ADMIRAL ZIMBLE:** Okay.
21 **MR. TEMPLIN:** But it's still pending.
22 **VICE ADMIRAL ZIMBLE:** Okay. Well --
23 **MR. PAMPERIN:** So it's probably awaiting a dose
24 -- a medical opinion.
25 **VICE ADMIRAL ZIMBLE:** Okay. It is probably --

1 if it's pending right now and it's in
2 Washington, Mr. Pamperin says it's probably
3 awaiting the medical decision and -- and that's
4 a -- a recent -- a recent hiccup that we're --
5 we have addressed with our recommendations.
6 The individual who's responsible for those
7 final medical opinions, Dr. Otchin, has
8 recently retired and his replacement has not
9 been yet identified, and that -- that's an
10 issue that we have taken on and we have asked
11 that that be done as soon as possible, that
12 that be expedited. So I -- I -- we are looking
13 at every area where there is a holdup in the
14 claims and we are working very hard to get
15 those reduced with our recommendations. So
16 thank you for that, and I -- I don't want you
17 to wait -- I don't want you to file another
18 one. I want you to get this one as soon as
19 possible. Okay?
20 **MR. TEMPLIN:** I'm getting old, Admiral.
21 **VICE ADMIRAL ZIMBLE:** I know, we all are, but
22 we'll get -- we'll get it back to you.
23 Yes -- yes, sir.
24 **DR. LATHROP:** I -- I just wanted to respond by
25 sharing with you briefly a conversation I had

1 with Dr. Blake this morning. He's getting the
2 turnaround time on the DTRA part of it down to
3 like 40 days. And as a representative of a
4 subcommittee here that's worrying about quality
5 and checking, we were -- we have a
6 recommendation which has to do with a little,
7 you know, more quality checking, making sure
8 things are done con-- consistently. And Paul
9 Blake said well, you know, that might add 14
10 days to the turnaround time. And I said wow,
11 we -- we're having second thoughts about that
12 then, do we want to do that. And he explained
13 to me that we're going to try it out for a
14 while and see if it delays the turnaround time,
15 and then make a choice about do we get enough
16 out of that extra ten or 14 days to make it
17 worthwhile or -- or not. I'm just speaking on
18 -- on his behalf and letting you know that
19 turnaround time is -- is at the top of a lot of
20 people list -- people's lists here, getting
21 that time down.
22 **VICE ADMIRAL ZIMBLE:** And the fact that they
23 had this huge backlog a year ago -- huge
24 backlog -- was -- was due to several factors,
25 but that also increased the -- the turnaround

1 time. That has now been reduced. The backlog
2 is gone. We're down to -- I'll let -- I'll let
3 Dr. Blake talk to that.
4 **DR. BLAKE:** Mr. Templin's dose reconstruction,
5 he had a full dose reconstruction and we
6 released it back to him in July of 2007, and
7 then the case was sent back to VARO Jackson and
8 so -- from what we're hearing, if it's up in
9 D.C., it's now awaiting a medical opinion
10 because it wasn't a standard determination. So
11 I -- I believe that's exactly where -- where
12 your case is now, and hopefully we can get that
13 resolved -- we'll see --
14 **VICE ADMIRAL ZIMBLE:** In short order.
15 **DR. BLAKE:** -- in short order.
16 **MR. PAMPERIN:** When I -- when I get back on
17 Monday we'll look into your case specifically.
18 **MR. TEMPLIN:** I'm asking als-- not just for
19 myself, but for the other atomic veterans. The
20 length of time that it's taken to get this
21 issue resolved -- you know, I don't know what
22 you can be -- can be done about it, but you
23 take the older veterans, the Nagasaki,
24 CROSSROADS, like I say, they're 80 years old,
25 and I don't know if you can put any order on --

1 **VICE ADMIRAL ZIMBLE:** Priority, yes --
2 **MR. TEMPLIN:** -- the process --
3 **VICE ADMIRAL ZIMBLE:** -- yes, yes, we can. We
4 are doing -- the VA is doing that. It is
5 placing a priority on it now. It is moving.
6 Okay? I -- I am encouraged by what I see,
7 recog-- I was discouraged when I first saw the
8 length of time that it was taking, years, to
9 get -- to get claims resolved. That's getting
10 reduced. It's getting reduced very quickly at
11 DTRA and at the Veterans Administration. But
12 you may be caught in -- in a recent, current
13 holdup and we're going to work to resolve that.
14 But I -- I want to assure all the veterans that
15 it is not the intent of the VA to let you folks
16 die off and not worry about it. Okay? That --
17 that has been accusation that's been made.
18 It's a perception. We're trying to overcome
19 that perception and we're trying to regain the
20 trust -- this Veterans Administration,
21 bureaucratic? Yes. And does that cause some -
22 - some problems? You bet. But the -- but the
23 intent is for them to be the best advocate they
24 can be for the veterans. That's very, very
25 important, and that's the message that's coming

1 down. And yeah, there are -- I will tell you,
2 when you have a large organization all across
3 the nation, it's going to be -- it's going to
4 be tough to get those things done. Moving all
5 the radiation claims to one office, which is
6 what we've just accomplished, is going to
7 really move things along much faster because
8 we'll have expertise in that one area that can
9 resolve the problem. It's not going to be at
10 57 different VAROs around the country. It's
11 going to be one, and they're -- they're going
12 to be held -- their feet are being held to the
13 fire to get these jobs done.
14 Yes, sir?
15 **MR. RINGOLD:** I'm Bill Ringold and I have been
16 told that -- that priority six means nothing,
17 from the VA. I have been -- went to Region
18 Office, I've been around to the VA, and I think
19 it's been very disgraceful what you have done
20 to the atomic veterans. I have many claims,
21 and it has -- I've submitted a claim and it has
22 been rejected. There is many things going on
23 that -- at the region level. I went to region
24 and lower (unintelligible) and they would not
25 check on anything that I told them. They just

1 said it don't mean nothing. And I'm one of
2 those 80-year-olds and not going to be around
3 too long, but they do not listen to our
4 problems.
5 **MR. PAMPERIN:** Sir -- sir, if you -- if you
6 would see the VA representative in the back,
7 we'll -- we'll check this out and get back to
8 you next week.
9 **MR. RINGOLD:** What's that?
10 **VICE ADMIRAL ZIMBLE:** The information that you
11 received from -- from whatever individual told
12 you it is -- it's -- it's no -- it doesn't mean
13 anything. He was wrong. It means something.
14 It means something, and so we're -- we're -- I
15 -- we -- we need this kind of feedback so we --
16 we can -- I mean you've got some --
17 **MR. RINGOLD:** Well, the region --
18 **VICE ADMIRAL ZIMBLE:** -- big shots right here.
19 Okay.
20 **MR. RINGOLD:** -- the region director at Little
21 Rock would not call Atlanta to find out if I
22 was priority six. They went through -- I went
23 through eligibility there on emergency, and
24 they said I was AG. I don't know what the hell
25 that means, but they -- and I told them I was

1 six out of Washington, and they said that don't
2 mean nothing, either. They sent me to the
3 coordinator, Agent Orange and radiation, and he
4 knew nothing at all. And also your Review, I
5 went with a Review over there to the region
6 manager. He said oh, I got a copy of that. I
7 checked the copies he had, though, in the
8 library there and it was a year old. He didn't
9 have the latest one. I had the latest one. So
10 the -- the -- these people out in VA in the
11 region areas are not -- are not following
12 instructions. For instance, they said that in
13 Washington, D.C. they told me that I could get
14 a physical in 30 days. I got one eight months
15 later, and I was told that the -- the orders
16 that they had passed on to -- for 30 days
17 didn't mean nothing. I got one eight months
18 later, the physical. Now I've had this
19 physical three times and they -- all it is is a
20 -- vital signs. They don't check nothing else.
21 **VICE ADMIRAL ZIMBLE:** Okay. That's noted.
22 It's now in the record. Thank you.
23 **MR. HAIGHT:** I'm back again -- with a question,
24 please. The results -- the work that the
25 committee is doing here, is there any way that

1 we as individuals out here in the big world
2 will be informed of your work and progress?
3 **VICE ADMIRAL ZIMBLE:** Absolutely. If you have
4 -- do you -- do you have access to the
5 internet?
6 **MR. HAIGHT:** Yes.
7 **VICE ADMIRAL ZIMBLE:** Okay. If you'll go to
8 our web site, you'll see all the latest
9 information, every single word is transcribed.
10 We have minutes of the -- of every meeting
11 that's been held. We have a list of all the
12 recommendations that have been made. We have a
13 list of every report that's been returned.
14 It's all there. You -- you can be -- you can
15 be immersed in information regarding what this
16 committee does. We want to be very
17 transparent.
18 **MR. HAIGHT:** Will you continue on --
19 **VICE ADMIRAL ZIMBLE:** Yes.
20 **MR. HAIGHT:** -- or when your job is completed
21 and you can't do anything more with the VA, do
22 you dissolve?
23 **VICE ADMIRAL ZIMBLE:** Well, we -- we haven't --
24 we haven't made any determination about
25 completing -- about finishing. We may -- we

1 may modify ourselves, but we're not going to --
2 we're -- we're -- we have a legislative mandate
3 to be a board, and there's no sunset on that
4 board.
5 **MR. HAIGHT:** Okay.
6 **VICE ADMIRAL ZIMBLE:** As a matter of fact, the
7 recommendation that was made that created -- by
8 the National Academy of Sciences that created
9 the Board, through Congress, asked --
10 specifically asked for a continuing oversight
11 function for the process of atomic veterans'
12 claims and dose reconstruction. So we will
13 continue and we will -- we will certainly keep
14 the web site up -- up to date, and that I can
15 promise you.
16 **MR. HAIGHT:** Thank you. May I presume also at
17 the web site we can have further input, as
18 needed?
19 **VICE ADMIRAL ZIMBLE:** There are -- there's a
20 way to contact the office and -- and right
21 there's our executive assistant. We have a way
22 of contacting the office by phone or by e-mail.
23 We don't have a chat room, but we do have voice
24 and e-mail.
25 **MR. HAIGHT:** Right. Thank you very much.

1 **VICE ADMIRAL ZIMBLE:** You betcha. Yes, sir.
2 **MR. TEMPLIN:** Admiral, yes, just a thought.
3 We're talking about reaching the veterans, but
4 you know, you go out in the real world and a
5 lot of people don't go to the internet to get
6 information. And my thought last night as I
7 was thinking about this, I have doctors that
8 the only thing they know about Bikini is that
9 it is a brief swimsuit. I think that, you
10 know, maybe getting some of this information to
11 the newspapers or medical magazines and stuff
12 like that might be just as beneficial as the
13 internet. Just a thought.
14 **VICE ADMIRAL ZIMBLE:** Yes, well, again, we've
15 had our -- our subcommittee on communication
16 has -- has really brain-stormed ways to get the
17 information out through the letter, the
18 brochure. Dr. -- Mr. Ropiek here has his --
19 has a vertical sign right here, that means he
20 wants to speak, and he is a communicator of the
21 first order and -- be happy to listen to his
22 comments.
23 **MR. ROPIEK:** I don't want to speak, I want to
24 ask -- is it Mr. Temple? Is that how you
25 pronounce --

1 **MR. TEMPLIN:** Templin.
2 **MR. ROPIEK:** Templin. So in the event -- one
3 of the things that we want to do vis a vis
4 communications is fill in -- identify and fill
5 in any gaps that DTRA and the VA might have in
6 letting you guys know what's up. That's one of
7 the things. So specifically what I want to ask
8 you is -- and I guess it's a question for all
9 the vets who are here, is if your case drags
10 on, as we hear many folks testify who come to
11 these meetings, how well does the government do
12 keeping you up to date on where things stand,
13 and might that be something that we could
14 suggest that they improve so that every time,
15 you know, the -- your paperwork goes through
16 another hoop, they at least tell you what the
17 hell's up. How well do they do that, do you
18 think?
19 **MR. TEMPLIN:** I think very poorly, to tell you
20 the truth. My -- I -- using myself as an
21 example, I filed a claim and it was denied, and
22 then I received a notice -- you know, the
23 procedure to go through to appeal it and --
24 which I did. And that is basically where it
25 ended, right there.

1 **MR. ROPIEK:** So the appeal is underway.
2 **MR. TEMPLIN:** The appeal is underway, and I
3 have heard no updates other than --
4 **MR. ROPIEK:** Well, you know, they can't update
5 you every third day to tell you what's up.
6 **MR. TEMPLIN:** No, no, no, but --
7 **MR. ROPIEK:** But every time it goes through
8 some sort of significant step, I would think
9 might be an opportunity to update you at least
10 on the status of the case. That would be
11 something that we could think about in part of
12 the ongoing communications plan. That's a
13 fancy name for thinking about how we can
14 improve things in the future. Thank you.
15 **MR. TEMPLIN:** Well, the appeal that I have has
16 now been in process for about -- I think seven
17 months.
18 **MR. PAMPERIN:** Have you got--
19 **MR. TEMPLIN:** (Unintelligible) short time.
20 **MR. PAMPERIN:** Have you gotten a statement of
21 the case yet?
22 **MR. TEMPLIN:** No. What I was referring to in
23 communications, I talked to -- and I talked to
24 a VA doctor who I go to and showed her the
25 report from Dr. Blake, and she says oh, this is

1 interesting. A lot of people are not aware of
2 what you guys are doing. You're doing a lot of
3 good work and I want to compliment you on it.
4 But there's a lot of people out there that do
5 not go to the internet to get information.
6 That was the only point I was trying to make is
7 in communicating I think you should use some
8 other resources as well as the internet to get
9 this information out 'cause you've got good
10 information. Thank you.
11 **VICE ADMIRAL ZIMBLE:** Okay.
12 **MR. ARGERIS:** Just one last comment, Admiral.
13 **VICE ADMIRAL ZIMBLE:** Okay.
14 **MR. ARGERIS:** I want to thank the VA -- I'm
15 critical of the VA, but I want to thank them
16 for adequate and more than adequate medical
17 staff, and I emphasize medical. The other
18 clerical staff, not so hot. But the medical
19 people are on the ball and they really helped
20 us out a lot, so I thank you for that.
21 **VICE ADMIRAL ZIMBLE:** I'm glad you brought that
22 up. I -- I -- you need to know that -- or you
23 may already know that -- that the last several
24 years the VA has achieved remarkable successes
25 and has gotten great acclaim and recognition

1 from many medical bodies as to the quality of
2 care at the VA. It's a shame that the --
3 unfortunately, with all that quality of care,
4 there still is -- is not sufficient supply to
5 cover the full demand. And I know that the
6 previous Secretaries have tried desperately to
7 get everybody -- although -- anybody that's
8 eligible, care. That's very, very, difficult
9 to achieve. But you're right, the VA health
10 care is terrific and has -- has made its mark
11 in American medicine. So I thank you for
12 bringing that up. And -- and we're going to
13 work hard to make sure that the -- that the
14 Veterans Benefit Administration can match the
15 Veterans Health Administration.

CONTINUATION OF DISCUSSION REGARDING
16 **FUTURE ROLE OF VBDR**

17 Okay, if there's no further comments, I think
18 we'll move on with the last piece of our
19 business. By the way, it -- it's now 11:20.
20 There are some people that really want to try
21 to make a flight and so I would ask if there's
22 anyone that has an urgent need to make a flight
23 and doesn't have anything to add right now to
24 our -- our ruminations regarding our future,
25 please feel free to -- to -- to depart.

1 Otherwise, I'd like to hear any comments that
2 you might have after one night's ruminations.
3 And I know that Mr. Beck has got something to
4 contribute.
5 **MR. BECK:** Well, yesterday the Admiral told us
6 to think outside the box, so I have a couple of
7 suggestions that we might consider about
8 thinking outside the box.
9 **VICE ADMIRAL ZIMBLE:** (Off microphone)
10 (Unintelligible) (on microphone) a bigger box.
11 **MR. BECK:** I beg your -- a bigger box. And one
12 of the things that's obviously been on the
13 minds of the vets all along, and it's also
14 bothered me with these compensation programs,
15 is the -- (unintelligible) with me about the
16 fairness issue, but the fact that we have this
17 dual system of presumptive and non-presumptive
18 has really always been a problem, to my mind.
19 So I think that we need to consider somehow --
20 although we can't make recommendations to
21 Congress directly, we can make recommendations
22 to the agencies asking them to make
23 recommendations to Congress, as I understand
24 it. And the -- what we need to think about is
25 -- it would be much better if there were just

1 one system, all presumptive or all non-
2 presumptive, much fairer. Obviously the
3 veterans would prefer to have it all
4 presumptive. And we have now a series of set
5 diseases that are presumptive, some of which
6 have less probability of getting cancer than
7 some of the non-presumptive ones, which is
8 really not very fair. So you have people who
9 can get compensated with no dose at all, and
10 people who have gotten some dose probably won't
11 get compensated because it's not high enough,
12 because they didn't have the right cancer or
13 the right time frame.
14 So one of the ideas here would be let's look at
15 the list of radiogenic cancers, perhaps say
16 that we have to add a few and we also specify,
17 and then we say all right, everybody who gets a
18 radiogenic disease, cancer or other disease,
19 it's presumptive and we get rid of dose
20 reconstruction. That would, I don't think,
21 cause Dr. Blake any great grief. It's an idea,
22 you know, of -- which I think we ought to at
23 least discuss.
24 The other option is to say --
25 **VICE ADMIRAL ZIMBLE:** Well, before -- before --

1 before you leave that option, may-- maybe we --
2 we -- there might be some discussion regarding
3 it. I would say that -- that if you were to go
4 to a total presumptive list, what we -- you'd
5 need to do is set some kind of parameters and -
6 - and indicate which additional conditions
7 might be considered for that presumptive list
8 and -- and again, we don't have the authority
9 to make that recommendation directly, but the -
10 - but we might ask the Offices of Legislative
11 Affairs to -- of the two agencies to at least
12 consider it. But -- but again, it'd have to
13 have parameters.
14 **MR. BECK:** I agree, have very clear parameters,
15 because --
16 **VICE ADMIRAL ZIMBLE:** Clear.
17 **MR. BECK:** -- it's not going to work unless --
18 you're not going to be able to get rid of it if
19 you're still going to have to do some dose
20 reconstructions. You're still going to have
21 the same problems, so you -- you really want to
22 find a way to get rid of -- if you really want
23 to get rid of the dose reconstruction program,
24 for this particular application, it would have
25 to be very clear.

1 **VICE ADMIRAL ZIMBLE:** You might really say --
2 and -- and this -- I'm going to say it. We
3 really have made de facto presumptive diagnoses
4 on two skin cancers. We've done that. We --
5 we have -- the -- the expediting of the process
6 has the ad-- adequate assumptions that gives
7 benefit of the doubt to the veteran that makes
8 them legitimate candidates to be considered for
9 presumption. Now there may be a few others --
10 not many, but there may be a few other
11 conditions that could also -- posterior
12 subcapsular cataract, there may -- and those --
13 we need to really think through what this
14 recommendation is and what it's going to mean.
15 But I couldn't agree with you more. I think
16 there's a -- this dichotomy of presumption and
17 non-presumption is -- is crazy.
18 Now there will be other conditions that we
19 don't believe fit into the picture of
20 radiogenic -- radiogenic at a low enough dose
21 to -- to be compatible with life and -- and
22 those are going to have -- if -- if someone
23 comes forward with one of those, according to
24 VA regulations, that a local physician has said
25 this could be due to radiation, that's going to

1 have to be processed as a -- as a non-
2 presumptive case, so we'll never get rid of
3 every condition that's non-- that's -- that
4 would require dose reconstruction.
5 **MR. BECK:** Well, you still may get rid of the
6 dose reconstruction aspect because you can
7 still say all right, if a medical board judges
8 this particular cancer or disease really could
9 have been due to radiation, then it becomes --
10 **VICE ADMIRAL ZIMBLE:** That means a change in
11 the law.
12 **MR. BECK:** Well, I think that -- this would
13 have to change the law, no matter what.
14 **VICE ADMIRAL ZIMBLE:** Right.
15 **MR. BECK:** So I mean it's just a question of
16 then if you decided to try to change the law,
17 how would you try to change it. And to my
18 mind, if you're going to go to the trouble of
19 changing the law, you might as well do it so
20 that you don't end up with a small part of the
21 problem left. You either want to do it all the
22 way or not at all.
23 I just might mention, you know, that there are
24 several compensation programs -- we've been
25 briefed on this -- and the real problem is is

1 that -- you know, you have the RECO (sic)
2 program; you were there, you get paid off. We
3 have the worker program special cohorts. It
4 really is sort of silly, you know, and I'm not
5 talking from a scientist -- you know, I'd argue
6 with some of the veterans that say you can't do
7 dose reconstruction. You can do dose
8 reconstruction. It's a valid scientific tool,
9 except that there's large uncertainties
10 sometimes. So it's not a question of whether
11 you can do it or not; it's just a question of
12 here we have this dual system of doing it for
13 some and not doing it for others, which never
14 has made sense to me.
15 **MR. PAMPERIN:** Well, there's -- there's a
16 couple of things, I think, that people need to
17 understand. First of all, it is possible to
18 move cancers from 3.311 to 3.309 without
19 legislation. We did that when RECA expanded --
20 when they published their list of presumptive
21 cancers which did not include -- it included
22 like -- I think it was five cancers that were
23 not on our list of presumptive cancers. And
24 Secretary Principi made a decision that it
25 would be unfair to have uniformed service

1 persons, who served next to civilians in some
2 of these activities, have to go through a dose
3 reconstruction when the civilian counterparts
4 did not. And as a result of that, we did add
5 five cancers -- lung cancer was one of them,
6 colon -- to the list.
7 Now there are parts of this that would require
8 legislative change. For example, CLL is
9 expressly excluded as a radiogenic disease by -
10 - by Congress, so there's nothing we can do
11 about that. That's something that Congress
12 would have to change.
13 Additionally, Congress would have to change the
14 concept of -- because there is a requirement
15 for us to submit cases to DTRA for
16 reconstructed dose, certain cases. So that
17 would require legislative change.
18 Now getting to -- to skin cancer and
19 subcapsular cataracts, we -- we have to be
20 frank and blunt here. What the Board has done
21 makes it theoretically easier to move those
22 cases -- those kinds of cases from 311 to 309.
23 And the reason it makes them easier -- well,
24 we're -- there are -- there are two elements to
25 why you would move them, or that OMB, Office of

1 Management and Budget, would look at. One is
2 what is your rational basis for doing this; and
3 secondly, what is the cost of doing this.
4 Now it makes it easier because it could be
5 argued that in fact there is no or minimal cost
6 because of the revised dose estimate. That
7 still leaves us with the rational basis that
8 this committee would need to help us with.
9 But in the larger scale of things -- and I -- I
10 know this is -- this is not popular, it is --
11 it -- and it -- it is not intended to -- to
12 comment on the -- the value of the service
13 that, whether people were drafted or they're
14 volunteers, it makes no difference. The people
15 have served the military have -- a minority of
16 people in this country have stood up and said
17 "Yes, I will," and -- and I, for one, will say,
18 from the beginning, that veterans and veterans'
19 benefits are an exception because of
20 exceptional service.
21 But I will tell you that last spring, in 2007,
22 I attended a day-long meeting hosted by the
23 Comptroller of the Currency. And there were
24 people from DoD there, Department of Education,
25 OPM, all kinds of folks, and a lot of amnesty

1 groups. And the premise or the issue that was
2 under discussion and GAO -- or OMB, rather,
3 published a report on this which is available
4 on the web site -- is what are we going to do,
5 the numbers don't add.
6 Thus far the American people have not
7 demonstrated a willingness to tax themselves to
8 the extent to which we have made commitments to
9 the American people. And as of at least a year
10 ago the estimate from the Congressional Budget
11 Office was that we have a $300 trillion
12 unfunded liability -- whether that's Social
13 Security, Medicare, civil service retirement,
14 veterans' benefits, there are a number of
15 benefits in Department of Education and other
16 programs -- nonetheless, the estimate is $300
17 trillion. And the argument at the time was
18 that the day of reckoning is coming, and it's
19 coming fairly soon, within the next 40 years.
20 Something will have to be done.
21 And I -- I merely say that in the environment
22 where you're talking about an administrative
23 agency moving conditions from proof-based to
24 presumptive, OMB looks at those things very,
25 very closely.

1 We had a propo-- we -- we had a proposal that
2 we think is very, very rational regarding a
3 particular disability for which veterans have
4 the potential for compensation. It is a
5 condition for which there is extreme
6 dissatisfaction among veterans. And from an
7 administrative perspective, it is
8 extraordinarily costly, when if we -- if we did
9 one thing, the problem would go away and it
10 would cost virtually nothing. It would cost a
11 little, probably would cost in the neighborhood
12 of $100 million over ten years. And in
13 budgeting, that's not a lot of money, you know.
14 But -- but that proposal has not moved forward
15 because the Congress is currently operating
16 under the concept of pay-go -- if you're going
17 to pay money here, show me where you're going
18 to save money someplace else.
19 Similarly, there were a number of legislative -
20 - legislative proposal that the Department --
21 as all Departments have an opportunity each
22 year to recommend things that they would like
23 to see to improve the performance of their
24 agencies, to give benefits where they think
25 they're appropriate. And we made three such

1 recommendations, none of which were accepted.
2 And -- and the thing is that -- my argument
3 would be that they were fairly worthy issues,
4 but none of them were accepted because of the
5 inability to find savings someplace else.
6 So -- I mean that is -- as much as we want to -
7 - to do everything possible for veterans, you
8 really do run into some very, very practical
9 issues. Not everyone in the government shares
10 your view of what veterans are entitled to.
11 There are people -- at the present time the --
12 I deal a lot with foreign departments of
13 veterans affairs, and there is no other country
14 that comes anywhere near what the United States
15 government gives to veterans, none of them.
16 Some of them, in certain circumstances, if
17 you're in combat -- for example, we have 24-
18 hour coverage for any disability that you
19 incur, whether it's a disease or illness and
20 whether it's while you're performing duty or --
21 I remember the first time I really understood
22 this situation, when I was a young adjudicator,
23 where we awarded compensation to a veteran who
24 was on leave and he and his brothers and dad
25 were -- went hunting and one of them

1 accidentally shot him. Okay? And because of -
2 - of 24-hour coverage, that individual was and
3 is, under current law, entitled to compensation
4 for that.
5 Now -- so nobody else does what we do, but
6 there have been in the past -- in the past five
7 years, in 2003, there was an effort to make VA
8 disability compensation a very, very workmen's
9 comp sort of program where you would have --
10 the actual scenario that was discussed, that
11 you would have to be on active duty -- you'd
12 have to be performing military duties, and one
13 of the examples was while you're at lunch and
14 something happens to you at lunch, is -- would
15 that be covered or wouldn't, and the answer was
16 no, it wouldn't.
17 There are -- again, the -- I think that the
18 American people need to have a candid
19 discussion about what they're willing to do to
20 support those who have served, those who are
21 handicapped at birth, those who are -- it's all
22 part of a very large discussion. And I will
23 tell you that I think that inside VA we have
24 some very particular views about what should
25 happen for veterans, and that generally

1 speaking those views are that -- regardless of
2 what is going on in any other part of the
3 entitlement world, we believe that -- that
4 veterans' benefits are an exception because
5 they involve people who have stood up and are
6 willing to defend the country.
7 But it doesn't change the problem. It doesn't
8 change the issue of how much the -- the
9 American people will pay for income support, of
10 all types, whether it's SSI, Social Security,
11 veterans' benefits, whatever. The Department
12 of Veterans Affairs has -- this year will spend
13 $97 billion between health care and veterans'
14 benefits. Last year we added 200,000 people to
15 the rolls of people in receipt of compensation.
16 Those are facts. And the -- the -- you know,
17 we -- we want to compensate people for
18 disabilities that they incur defending the
19 nation, whether it's peacetime or wartime.
20 But I think people have got to be fair and
21 recognize some of the competing issues that are
22 in -- that are going on in the discussion of
23 what the government will pay for and what it
24 will not. When you look at the federal
25 government's budget this year, which is a

1 trillion dollars, and you subtract out the 42
2 cents out of every dollar that is spent to pay
3 for interest on the national debt, and you
4 subtract out all of the entitlement programs,
5 and you subtract out the defense budget, you
6 are dealing with a discretionary budget in the
7 United States of less than $200 billion. And
8 you know, it's -- it's something -- it's --
9 it's a discussion that has to be had about
10 what's possible and what is not. And I say
11 this not to say that I don't support the
12 notion. But you -- we cannot continue to have
13 discussions that are one-sided. There are
14 other issues here, and that's all I'll say.
15 **VICE ADMIRAL ZIMBLE:** Thank you, Tom. It's --
16 I think it's very helpful to bring that -- that
17 sense of reality in terms of budget and debt
18 and obligation and commitments and
19 entitlements, et cetera. It suggests to me
20 that we really need to have a very persuasive
21 argument in terms of cost benefit to -- to
22 convince the OMB, and convincing OMB is not
23 easy, but to convince OMB that this -- this
24 process will be at zero cost or at a savings,
25 and -- and that could possibly be done, but it

1 would require someone with a level of expertise
2 that can look at all aspects of it and go to
3 budgeteers and be able to persuade them that
4 yes, indeed, this is going to give them
5 discretionary money somewhere else, that
6 there's a true total offset, if we're ever
7 going to make any progress in -- in that
8 recommendation. But it may be worth trying.
9 But it will be a board's responsibility to --
10 to do that cost benefit analysis.
11 You want to say something, John?
12 **DR. LATHROP:** I just want to run this by Tom.
13 I was -- I -- wonderful set of comments, and do
14 I interpret that to mean that if we do a -- a -
15 - if we look at proposals for rearrangements as
16 -- as Jim Zimble just said, they should be at
17 least revenue-neutral, if not cost-savings.
18 And one of the things we have to be
19 uncomfortable with, but you've given us some
20 reality training, is we have some options that
21 seem more equitable, but cost more -- forget
22 them.
23 **MR. PAMPERIN:** I don't think necessarily overly
24 harsh. I -- I mean equity is certainly an
25 important issue, but is not in my experience --

1 and by the way, in a former life I was a
2 budgeteer. I currently am responsible for --
3 my staff prepares the compensation part of the
4 President's budget, and we do costings, we --
5 I'm kind of familiar with how this stuff works,
6 and I -- and I know all the people at OMB who
7 will say "no" personally. But the thing is
8 that to -- to have something -- there is this -
9 - this arcane little reality in life, and --
10 that OMB has this bizarre notion that if
11 something costs less than $4 million, then they
12 don't care. So it's -- costing money sometimes
13 is cost-neutral. But -- but the thing is, I --
14 I think, and I think -- you know, I cannot
15 speak officially for the agency right now
16 because -- but I -- particularly since any
17 regulatory change has to have the signature of
18 the Secretary, and we don't know what the view
19 of the Secretary would be on this issue. But
20 you know, it -- it seems as though making these
21 two conditions presumptive makes sense.
22 But I will throw into this one other piece of
23 reality, and that is that we are talking about
24 entitlement funds here. So the fact that you
25 can have a savings to Dr. Blake is irrelevant

1 because those are GOE dollars, those are
2 discretionary dollars that are spent every
3 year, Congress decides whether or not he can
4 have another million dollars. The fact that
5 you save GOE dollars doesn't mean a hill of
6 beans when it comes to obligating mandatory
7 dollars, those that, once Congress says or the
8 regulation says, then the government is
9 obligated to pay those forever.
10 **VICE ADMIRAL ZIMBLE:** There's -- there's a
11 legacy attached to entitlements that goes on
12 forever.
13 You want -- you want to make another recommen--
14 **MR. BECK:** I just want to make a quick thing
15 about -- if you really wanted to save money and
16 get it through, you would go the other way.
17 You would make them all non-presumptives, then
18 nobody would get paid off, pretty much. You'd
19 save a lot of money. It would be fair 'cause
20 everybody would be treated the same. The
21 veterans, of course, you know, (unintelligible)
22 thesis that you put forward about, you know,
23 the veterans really should be paid off, but
24 that wouldn't happen. But as far as the Office
25 of Management and Budget, they would love it

1 now because the cost would go away from the
2 entitlements. Right?
3 **MR. PAMPERIN:** Well, the other reality in
4 Washington is that once given, never taken
5 back. Okay?
6 **VICE ADMIRAL ZIMBLE:** Dr. Fleming.
7 **DR. FLEMING:** Yeah, just to -- just a couple of
8 comments just to remind us that treating --
9 treating someone fairly or justly doesn't --
10 most often doesn't mean treating them equally.
11 I know that you know that, Harold. So Harold's
12 proposition to treat them all presumptive or --
13 or all non-presumptive would be equitable or
14 fair if -- if it was based on the -- the claim
15 that there is no real significant difference
16 among these diseases, or with these cases. And
17 I -- for whatever reasons that the distinction
18 between presumptive and non-presumptive came
19 into being, and many people tell me it was
20 political more than it was scientific and so
21 forth -- for whatever reason, the -- the
22 ethical presumption has to be that there is
23 what we in ethics call a morally significant
24 difference -- not just a difference, but a
25 morally significant difference -- that allows

1 us to treat some cases differently than others.
2 Equity is treating like cases alike and
3 treating unlike cases differently.
4 So if we were to move in either one of those
5 two directions, we would have to be saying that
6 we really have no -- no basis, no moral--
7 morally sig-- there are no real morally
8 significant differences between presumptive and
9 non-presumptive diseases.
10 It's possible there's a third alternative, and
11 that is to take -- you know, take another look
12 at -- at these lists and say some of these
13 diseases that are presumptive shouldn't be and
14 some of these diseases that are non-presumptive
15 should be. And now what is that based on? It
16 has to be based, again, on a morally
17 significant difference. So what would that be?
18 It -- it sounds to me like, you know, right now
19 it's based on the degree of uncertainty or the
20 degree of certainty.
21 Now if we take this same concept of equity, not
22 equality, and we apply it to the differences
23 among the compensation plans, that's I think
24 where we -- where we do see at least prima
25 facie, or from the first glance, a presumed

1 inequity because we say to ourselves how can
2 being a civilian occupational worker be morally
3 significantly different than being a member of
4 the military, being a person that lived, you
5 know, downwind from the Nevada Test Site,
6 because the compensation plans are different
7 and they seem to be based on -- on just what
8 population you ended up being a part of, and
9 how is that any -- so that's where we're
10 getting our -- our disconnect about our sense
11 of lack of fairness among those plans.
12 Although I think, looking at them in more
13 detail, we would find a little bit more actual
14 -- we'd probably find more appropriate ethical
15 response in the VA plan than in the RECA plan,
16 even though it's a lot to get the -- in some
17 respects, to get the money from RECA. RECA is
18 incomplete. It does not give medical care. It
19 gives $75,000 or $50,000. It does not give
20 medical care, and one could argue that an
21 appropriate response to -- to suffering an
22 effect of radiation would be the medical care
23 as well.
24 So -- and then of course if we take it up
25 another level, which is where Tom would like us

1 to take it, it would be trying to figure out
2 how we fairly allocate scarce resources. It is
3 a -- it's a pretty complicated situation that
4 we face, and I don't have any easy answers,
5 except to say that treating everything equally
6 is really not the appropriate answer unless you
7 can show that there is no significant
8 difference.
9 Okay, so much for that.
10 **VICE ADMIRAL ZIMBLE:** Okay. Luckily we only
11 have to be involved with the veterans.
12 **DR. FLEMING:** Yes, right.
13 **VICE ADMIRAL ZIMBLE:** So we don't have to take
14 on the bigger moral issue. We can limit
15 ourselves to a smaller moral issue.
16 **DR. LATHROP:** But haven't we --
17 **VICE ADMIRAL ZIMBLE:** At any rate --
18 **DR. LATHROP:** -- but haven't we said that if we
19 take some actions moving things onto
20 presumptive list, that has ripple effects on
21 other compensation programs that we shouldn't
22 ignore. Is that right?
23 **VICE ADMIRAL ZIMBLE:** No, I --
24 **MR. PAMPERIN:** (Off microphone) No, I don't
25 think -- (on microphone) no, I don't think

1 that's true.
2 **DR. LATHROP:** (Off microphone) (Unintelligible)
3 All right. 'Cause we're saying well, what --
4 what will this do for RECA now. Oh, we should
5 be worrying about that. You're saying we
6 shouldn't be.
7 **MR. PAMPERIN:** I don't think we should be
8 worrying about that.
9 **DR. LATHROP:** That's great. That's
10 significant, because in the past we've said
11 that.
12 **MR. PAMPERIN:** Well, you know -- and we're
13 getting way off -- way off the path here, but
14 for example, with Agent Orange and birth
15 defects there is enormous concern inside the
16 federal government about that because of the
17 implications of that, not only for other
18 programs, but also for insurance companies, for
19 -- things like that. You've got -- right now
20 we're looking at quality of life. We've had
21 three commissions say we should do quality of
22 life. It -- it seems, on the surface, to be a
23 very, very appropriate thing to do. I don't
24 know what it is. Aristotle called --
25 characterized quality of life as happiness. I

1 just don't -- I don't know what it is and,
2 contrary to what some of the proponents of it
3 say, that it's a well-established process in
4 this country, I beg to differ. It is not. It
5 is a litigated process, which is not a claims
6 adjudication process. It's adversarial and it
7 is person-specific.
8 But again, some in the -- some in the -- in the
9 public say we need to go there. You know, VA
10 will do that if they pass a law. We'll try and
11 figure out how to do it as equitably and
12 probably as morally and least expensively as
13 possible, but -- I mean we wou-- if Congress
14 says to do it, we will do it. But there -- but
15 there is in this country this swirl of how are
16 we going to pay for all this.
17 **VICE ADMIRAL ZIMBLE:** R.J.
18 **MR. RITTER:** There's a saying that no good deed
19 ever goes unpunished. Of course we've all
20 heard many ramifications, there are many
21 versions to that. But just to elaborate a
22 little bit on Admiral Zimble's statement about
23 the skin cancer issues and how the Board was
24 adequately able to address that in favor of the
25 veterans, the good news went out. The veterans

1 who belong to our group were requested to go --
2 refile, and many of them did. And then they
3 received letters from the VA stating that yes,
4 it was service connected, but with zero
5 disability. And of course the -- the downside
6 to that is I had no recourse or answer to -- to
7 give them that was satisfactory to those
8 questions. One veteran here in the state of
9 California said he would have been happy with
10 ten percent, because it would have allowed him
11 to get his license plate renewed on his car for
12 ten bucks. So there are some secondary
13 benefits that he pointed out to me that I've
14 become keenly aware of. But -- but there
15 again, to receive a letter saying that yes,
16 your body was damaged by the effects of
17 radiation while you served your country, but
18 we're not going to give you zero, anything,
19 without further explanation, was -- in my
20 opinion -- not -- not really served up good.
21 So anyway, I wanted to let the Board know that
22 -- that the good part was yeah, they're being
23 accepted in favor of the veteran, but the bad
24 part is, when they get the letter, they don't
25 really understand what that zero compensation's

1 all about. And it really -- it's really a
2 grievance area, in my opinion.
3 **VICE ADMIRAL ZIMBLE:** Mr. Beck. Did you -- you
4 said you had two.
5 **MR. BECK:** Well --
6 **VICE ADMIRAL ZIMBLE:** You want to -- you want
7 to share the other -- other one or want to
8 think about (unintelligible) --
9 **MR. BECK:** Well, as far as this particular
10 issue, my -- my two were either all presumptive
11 or all non-presumptive and that -- to address
12 what Pat said about the fact that, you know,
13 they also have to be equal. Well, see, the
14 problem in that was that they're not -- the
15 ones that are on the list now are not equal, so
16 to my mind, the criteria for determining
17 whether they're equal would be just radiogenic
18 or not radiogenic, and not the amount of
19 radiogenic. In which case you could argue, as
20 you said, that you prepare a list where if
21 there's any possibility that radiation could
22 have caused a disease, that's what we mean by
23 equal. And if there's not, there's no case.
24 And that would be what we'd have -- the
25 argument we would have to make if we were

1 trying to convince them. And you know, Pamp--
2 Mr. Pamperin is absolutely right. I mean we're
3 all fully aware of the likelihood of this going
4 through, and the problems, so I think we just
5 wanted to get discussion out. You know, I
6 think even if we -- if we did make this
7 recommendation, or try to, it would be very
8 unlikely it would go through, in my opinion.
9 But you know, it might be worth it just to
10 bring it out on the table and see what other
11 people think about it. So that -- that -- as
12 far as this particular issue --
13 **VICE ADMIRAL ZIMBLE:** Well, you know, there's
14 an old saying that if you don't ask, you'll
15 never get. Okay? That's a guarantee, that if
16 you don't ask, you won't get. So it -- it may
17 be worthwhile at least to ask. Okay? We'll
18 think about it.
19 But I do -- I do say that it really has to be
20 shown to be absolutely neutral and -- and --
21 and whatever entitlement accrues from the --
22 from that determination has to be -- has to be
23 really -- less than $4 million.
24 **MR. BECK:** Well, each one would be.
25 **VICE ADMIRAL ZIMBLE:** Have to do them one at a

1 time.
2 **MR. BECK:** I had another issue, if we're
3 finished with this, with respect to the
4 continuation of the discussion that we had
5 yesterday about where the Board would be going.
6 I had some thoughts on that --
7 **VICE ADMIRAL ZIMBLE:** Okay.
8 **MR. BECK:** -- if you're ready for that.
9 **VICE ADMIRAL ZIMBLE:** We're ready.
10 **MR. BECK:** I think yesterday it became clear to
11 a number of us I think that -- that this Board,
12 as it's presently constituted, is not ready to
13 go out of business. But I think it is perhaps
14 ready to scale down to give the agencies time
15 to catch up so that we can say have they
16 completed all these things. So from my point -
17 - viewpoint, I would be thinking about, after
18 our September meeting, that the Board probably
19 wouldn't have to meet for about a year, except
20 for perhaps the subcommittees meeting in
21 between, at which point we would then be able
22 to see whether all these things were completed
23 and operating at some levels -- some
24 maintenance level. At that point, this Board
25 could be reconstituted into some kind of other

1 advisory committee, which I strongly would
2 recommend not be a FACA. I think, from my
3 point of view and from the point of view of
4 continuing oversight, it's just too many
5 problems with having a FACA, you know, in terms
6 of -- for instance, if you don't have a FACA
7 you can then have a small group where you can
8 rotate expertise as you need it. Within a
9 couple of weeks you can change the personnel
10 and the -- and you can still have it -- you can
11 also -- as Dr. McCurdy pointed out, you can
12 have it constituted in such a way that it's not
13 associated directly with DTRA in terms of us
14 being paid by DTRA. It could be run --
15 somewhat similar to the double-blind exercise
16 where an independent organization such as NCRP
17 is contracted and in turn gets experts to have
18 an advisory committee and the agencies just
19 contribute to the cost of that, and it wouldn't
20 be that much of a cost, either.
21 **VICE ADMIRAL ZIMBLE:** That's a good point.
22 **MR. BECK:** Another thing I would see is the
23 continuing oversight, and that would be just to
24 make sure they don't slip.
25 **VICE ADMIRAL ZIMBLE:** Right.

1 **MR. BECK:** Make sure that they're continuing to
2 do the things they're supposed to do.
3 **VICE ADMIRAL ZIMBLE:** In accordance with The
4 Green Book.
5 **MR. BECK:** In accordance with the
6 recommendations of --
7 **VICE ADMIRAL ZIMBLE:** The Green Book's
8 recommendation --
9 **MR. BECK:** -- recommendation, and I think that
10 could be --
11 **VICE ADMIRAL ZIMBLE:** -- that there be ongoing
12 oversight.
13 **MR. BECK:** Right, I think this would be in
14 accordance with what Congress --
15 **VICE ADMIRAL ZIMBLE:** Okay.
16 **MR. BECK:** -- intend, although we might have to
17 get Congress to agree, since they put some
18 specifics in the law that perhaps wouldn't be
19 continued, you know, in having --
20 **VICE ADMIRAL ZIMBLE:** Well, I --
21 **MR. BECK:** -- this number of people and that
22 number of people and that kind of stuff.
23 **VICE ADMIRAL ZIMBLE:** So I think perhaps all of
24 us ought to be thinking, over the course of the
25 next five months, about how you could -- how

1 you might conceive a reconstitution of the
2 Board, whether or not we can get out from the
3 FACA constraints, what size Board should be --
4 should it be, should it be a contractual thing
5 other than the way it's currently set up, what
6 should the size -- should the membership still
7 meet the prerequisites of Congress in terms of
8 the various types of expertise that would be
9 necessary for that oversight. I -- I think
10 those are the kinds of things that we ought to
11 be discussing at the September meeting. And --
12 and then should this Board go into a --
13 abeyance for a year and then reconvene with --
14 with the same subcommittees having met whatever
15 number of times that is necessary in order for
16 them to be able to report the results of their
17 oversight of their particular areas. You know,
18 those are the kinds of things that we ought to
19 be discussing at the September meeting. So let
20 -- I -- and let's -- I'd like to hear a lot of
21 ideas. I think that -- I think --
22 **MR. GROVES:** I was up first.
23 **VICE ADMIRAL ZIMBLE:** Did you have your -- did
24 you have your sign up first?
25 **MR. GROVES:** I guess I was going to add -- add

1 to what Harold had said in that we -- we'd
2 probably -- it might be certainly premature
3 now, and maybe even premature in September, to
4 think about reconstituting the Board until all
5 the actions were completed. But I do think
6 that there are tremendous activities that take
7 place in support of the Board by the
8 subcommittees, and I would not want there to be
9 -- and there has certainly been no discussion
10 of curtailing the work of the subcommittee,
11 other than to say that the -- the only way that
12 the veterans hear about what happens at the
13 subcommittee meetings is when we meet as a
14 Board. And -- and then there are certainly
15 ways to, through the Ionizing Radiation
16 Newsletter, through the publications by the
17 different veterans' groups, even though the
18 work by the subcommittees has not been -- you
19 know, there wouldn't -- certainly wouldn't be
20 appropriate for us to make recommendations
21 without coming to the Board, but certainly you
22 could track the work and meet our communication
23 requirement, other than the Board meeting. So
24 to delay the Board meeting for a year, I don't
25 think we would -- I think we would certainly be

1 -- could meet the spirit of -- of the law by,
2 you know, publishing what activities the
3 subcommittees are doing, and I think that
4 certainly for our subcommittee, you know, this
5 recommendation we've given to the VA is one in
6 which -- as we've all agreed -- is going to be
7 hard. And -- and we're -- we're not just
8 throwing this over the fence and say "Tom,
9 here, take this and run by yourself." We're
10 prepared to help in what -- in every way we
11 can. DTRA's committed to helping with that
12 process. And so, you know, a way to keep that
13 going is through the subcommittees. So I -- I
14 think -- I do believe that the subcommittees
15 can continue to meet and be very effective in -
16 - in providing the veteran community with what
17 we're doing.
18 **VICE ADMIRAL ZIMBLE:** Again, that's -- that's
19 one of the decisions we'll make in September.
20 Okay?
21 Yes, sir, Dr. Lathrop.
22 **DR. LATHROP:** Yeah -- yeah, I -- I want to
23 second that and say, as I reviewed yesterday
24 the ongoing processes of monitoring and so
25 forth, which is -- which is Subcommittee 1 and

2, and the unfinished business of the decision summary sheets and the outreach and the communication plans of SC-3 and 4, all really are -- should be ongoing at the subcommittee level.

Now I would like to say something even less popular, which is I think we need to resurrect the famous -- infamous Subcommittee 5 -- which, by the way, is no extra people; it's just a repackaging of some of the people here -- to address the issue that you've kept reminding us of and we've talked about, about thinking outside the box, looking at equity and moving things to the -- to the presumptive list. 'Cause frankly, that doesn't happen to fit -- I don't think well -- into any of the four subcommittees. And we've had Subcommittee 5 constituted pretty much with that -- with that charter, roughly speaking.

VICE ADMIRAL ZIMBLE: You're -- you're suggesting the establishment of a "skunk works" committee --

DR. LATHROP: Okay.

VICE ADMIRAL ZIMBLE: -- a "skunk works" subcommittee that can --

1 **DR. LATHROP:** Yeah. My dad used to work for
2 the skunk works, so I like that.
3 **VICE ADMIRAL ZIMBLE:** Yes, yes, okay. All
4 right, we'll talk about that in September.
5 Very good. Anybody else have any comments?
6 Oh, yes, David.
7 **MR. ROPIEK:** I have a question, Mr. Chairman.
8 Can you suggest, or can we discuss here, a way
9 to keep this conversation going between now and
10 September rather than having all of these --
11 within the rules of openness and transparency
12 and so forth. These are complicated matters,
13 with subtleties involved, that are tough to
14 condense into a day and a half of seeing each
15 other after the last six months.
16 **VICE ADMIRAL ZIMBLE:** I -- I can only --
17 **MR. ROPIEK:** Floating ideas amongst one
18 another, et cetera, we can do it informally,
19 formally --
20 **VICE ADMIRAL ZIMBLE:** I think that --
21 **MR. ROPIEK:** -- I don't know what the rules
22 are, but --
23 **VICE ADMIRAL ZIMBLE:** I think we use --
24 **MR. ROPIEK:** -- I suggest that ongoing
25 conversation might be beneficial for the

1 decisions that we face --
2 **VICE ADMIRAL ZIMBLE:** Sure. Sure, I think that
3 that's -- that's perfectly legitimate and we
4 use the current methodology, we've got -- we've
5 got e-mails, we've got multiple address
6 capability and I think that's -- that's fine.
7 **MR. ROPIEK:** I ask the question by way of
8 encouraging it to happen.
9 **VICE ADMIRAL ZIMBLE:** (Unintelligible) could
10 have made it happen even if you didn't ask the
11 question.
12 R.J.
13 **MR. RITTER:** Just a -- just a tidbit of a
14 comment following up on the communications end.
15 It would be very easy to put in our newsletter
16 and on our web site the fact that a
17 subcommittee went somewhere and did something.
18 We don't have to explain in depth what they
19 did, but just an overview and that they're --
20 that they're looking at this as an improvement
21 on behalf of the veterans.
22 **VICE ADMIRAL ZIMBLE:** Well, we have to be
23 careful that it's not misinterpreted.
24 **MR. RITTER:** The words would certainly have to
25 go through someone like David, obviously, to

1 make sure that it's proofed before it's put
2 out.
3 **VICE ADMIRAL ZIMBLE:** 'Cause there -- we --
4 there's an absolute proscription --
5 **MR. RITTER:** Exactly --
6 **VICE ADMIRAL ZIMBLE:** -- to (unintelligible) --
7 **MR. RITTER:** -- and I understand that.
8 **VICE ADMIRAL ZIMBLE:** -- any recommendations or
9 contact be made with the agencies except
10 through the Board.
11 **MR. RITTER:** Exactly, and I just wanted to say
12 we have no problem with that, but it has to be
13 -- has to be properly formatted.
14 **VICE ADMIRAL ZIMBLE:** Right. Okay. Dr.
15 McCurdy.
16 **DR. MCCURDY:** Remind me again about the
17 requirements or limitations for the openness
18 again. How many people can be meeting at one
19 time?
20 **VICE ADMIRAL ZIMBLE:** I'd need a lawyer to
21 remind me of that. I'm -- I'm not sure. It
22 has to be less than a quorum. And what is --
23 what did we say the quorum was. Eight? Okay.
24 The quorum is eight, it's got to be less than
25 eight.

1 **DR. MCCURDY:** All right. That would provide no
2 problem. A lot of times SC-1 and SC-3 -- I
3 think as we're moving forward, when I have some
4 joint meetings, I want to make sure that, you
5 know, we don't have some problems here.
6 **VICE ADMIRAL ZIMBLE:** All right, I don't see
7 any more signs being raised. It suggests a
8 sense of the Board that they would like to
9 adjourn, and I will entertain a motion.
10 **MR. GROVES:** Second.
11 **VICE ADMIRAL ZIMBLE:** I haven't heard the
12 motion --
13 **DR. MCCURDY:** So moved.
14 **VICE ADMIRAL ZIMBLE:** -- you can't second --
15 okay. Then without objection, we are
16 adjourned. Thank you very much. It's been a
17 great meeting. Thank you, staff, and I really
18 appreciate the input this year. It's been
19 good.
20 (Whereupon, the meeting was adjourned at 12:15
21 p.m.)
22
23