

THE VETERANS' ADVISORY BOARD ON DOSE RECONSTRUCTION

MEETING V

DAY TWO

The verbatim transcript of the Meeting of the Veterans' Advisory Board on Dose Reconstruction held at the Tuscany Suites and Casino, Las Vegas, NV, on March 8, 2007.

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Mar. 8, 2007

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P R O C E E D I N G S

(8:35 a.m.)

CALL TO ORDER AND OPENING REMARKS

1
2
3 **VICE ADMIRAL ZIMBLE:** Ladies and gentlemen, we
4 are at our usual and traditional five minutes
5 past starting time, so I think it is time that
6 we -- we begin today's session. And as a first
7 -- first item of business, we -- we have -- we
8 have been missing one Board member because of -
9 - of other requirements, but -- but she -- Dr.
10 Vaughan is with us today by telephone and so
11 I'd like to take this opportunity to welcome
12 Dr. Vaughan to our meeting.

13 **DR. VAUGHAN:** Thank --

14 **VICE ADMIRAL ZIMBLE:** Good morning.

15 **DR. VAUGHAN:** Good morning. Thank you,
16 Admiral. Good morning, everyone.

17 **VICE ADMIRAL ZIMBLE:** Yeah, and -- and Dr.
18 Vaughan has been given all of the reports that
19 we're going to be discussing today, so she's --
20 she's -- I'm sure she's fully loaded to -- to
21 take on any issues that need to be brought up.
22 Okay. Ms. Durand, do you have any comments for
23 this morning?

24 **MS. DURAND:** My comment would be, again, a
25 reminder about your cell phones -- Mr.

1 Pamperin, will you turn yours off?

2 **MR. PAMPERIN:** Yes.

3 **MS. DURAND:** Cell phones, Blackberries,
4 anything else, that would be great. Thank you.

5 **BRIEFINGS BY SUBCOMMITTEE CHAIRS**

6 **VICE ADMIRAL ZIMBLE:** Okay. Now today's the
7 day when -- when we do some significant Board
8 business. We will be reviewing the work of the
9 four subcommittees that have been meeting since
10 our -- on a regular basis since our last Board
11 meeting and have reports of their work and
12 recommendations to bring to the Board for the
13 Board's review and deliberation and decision.
14 And so without further ado, I would ask the
15 Chairman of the Subcommittee Number 1, Mr.
16 Beck, to please present his report.

17 **SUBCOMMITTEE 1 ON DTRA DOSE RECONSTRUCTION**

18 **MR. BECK:** Thank you, Mr. Chairman. As usual,
19 our report is fairly long so I'm going to try
20 to paraphrase some of the main points and I
21 know that you all have copies or can get copies
22 outside to read all the details.
23 Just to remind you of the scope or the role of
24 this committee -- subcommittee, our
25 subcommittee's role is to address dose

1 reconstruction procedures -- assess the dose
2 reconstruction procedures used by NTPR and
3 their contractors, and these include the
4 procedures for doing the dose reconstructions
5 and related documentation. And also we are
6 tasked with conducting periodic audits or a
7 random sample of the NTPR dose reconstructions
8 to assure that correct procedures are being
9 followed and to ascertain the quality of the
10 reported doses and the associated uncertainty
11 estimates.

12 Since the last VBDR meeting we had a number of
13 activities. One of the more important ones was
14 to choose an additional six cases. Our policy
15 has been to try to audit six cases between each
16 of the VBDR meetings and then report our
17 preliminary findings at the VBDR meeting.
18 These six cases that we chose will make up a
19 total of 24 that we have now audited, or almost
20 finished audits on.

21 In January we distributed our reports on the
22 last set of six cases to all the Board members,
23 and I trust you've all looked at them and if
24 you have any comments we of course would
25 appreciate receiving them.

1 In February, as is our practice, we met at an
2 NTPR contractor facility in order to discuss
3 the current six audits that we're conducting
4 with the analysts who are actually doing or did
5 these audits. And the reason for doing this is
6 to make sure that we have all our facts
7 straight and that we can ask questions and
8 everything to make sure that we get it right
9 when we do these audits.

10 We had a number of observers present. Dr.
11 Zimble attended one day of that meeting, and we
12 also had a number of the contractor's -- NTPR
13 contractor's staff sit in so that they -- we
14 could ask them questions and they could
15 comment.

16 During that meeting, besides discussing the
17 audit cases, we also take the opportunity to
18 discuss the progress on the procedures that are
19 being prepared or updated. And Dr. Blake also
20 at that time gives us an update on the NTPR
21 activities since the last VBDR meeting and how
22 he is coming with implementing the
23 recommendations of the VBDR.

24 After that meeting we go back and we actually
25 prepare our audits. And we still haven't

1 completed these audits, but we have some
2 preliminary assessment findings that I will
3 tell you about now.

4 The current audits continue to demonstrate that
5 VBDR is generally providing the benefit of the
6 doubt in development of this SPARE or the
7 Scenario of Participation and Radiation
8 Exposure. However, while they are also
9 generally providing the benefit of the doubt in
10 their radiation dose assessments, this is not
11 always done in a consistent manner. We found a
12 few instances of issues raised in the SPARE
13 that were not addressed in the RDA, and we also
14 found some instances in which the application
15 of benefit of the doubt was perhaps carried to
16 an extreme. And Dr. Lathrop talked about this
17 yesterday, if you remember.

18 We still think that there's significant
19 progress that needs to be made in documenting
20 procedures and correctly referencing the
21 documentation used in the radiation dose
22 assessments, and assuring that all analysts use
23 consistent dose reconstruction methodology.
24 We still think that case file documentation
25 still needs to be improved. There's been a lot

1 of improvement since our first set of audits in
2 response to our findings of those audits, but
3 we still think some improvement is necessary.
4 But I should point out that because we -- there
5 is a lag between the cases that we are looking
6 at now and the cases -- and the cases that
7 they're doing at this moment, and presumably
8 they have now made these improvements already,
9 so I don't want to be too critical here. In
10 our next set of audits we -- what we are doing
11 is we're trying to pick cases that are recent
12 cases to see whether or not these
13 recommendations have actually been implemented.
14 So I'll have to apologize if I seem too
15 critical to NTPR at this point.
16 The audits suggest that for some exposure
17 scenarios the upper bounds were not properly
18 calculated, and this issue of uncertainty
19 analysis and upper bounds is one of the main
20 things that we have been focusing on in our
21 audits. Except for external neutron exposure,
22 NTPR has still not issued a formal technical
23 analysis demonstrating that the interim upper
24 bound factors presently being applied in
25 response to the recommendations of the 2003

1 NAS/NRC report always provide an upper bound
2 dose that is at least at the 95th percentile.
3 In addition, the audits suggest that NTPR still
4 does not consistently investigate whether
5 cohort badges or film badges of coworkers are
6 available to help in assessing the veteran's
7 dose.

8 In our audits we found some potential errors in
9 the current set of audits that may have
10 resulted in reported doses being too low. In
11 general such underestimates are not large
12 enough to possibly impact the outcome of the
13 veteran's claim. In one case, however, the
14 skin dose calculation made was inadequate,
15 given the assumed exposure scenario. However,
16 we believe that the exposure scenario assumed
17 was unrealistic and that the veteran's dose was
18 likely very small.

19 As far as our future plans, we plan to audit
20 six additional cases prior to the next meeting
21 of the VBDR in September. Again we -- as I
22 said, we'll choose these cases randomly, but we
23 will concentrate on picking cases that have
24 been done this year so that we can see if the
25 recommendations of the Board and of our

1 subcommittee are actually being implemented and
2 that we're starting to reach this consistency
3 that we're looking for.

4 Again we intend to conduct interviews with the
5 NTPR contractor analysts as part of our audit
6 process. We found this extremely useful, both
7 I think for the subcommittee in understanding
8 how the audits were done and how the methods
9 were applied, but I think it's also been useful
10 for the analysts themselves with -- with this
11 give-and-take that we've had with them.

12 As you've heard from Dr. Blake yesterday, NTPR
13 intends to issue several reports in the next
14 few months that will form the basis for new or
15 revised standard operating procedures, and some
16 of these reports are going to be peer-reviewed
17 by independent contractors. But we expect to
18 also look at some of them, and particularly
19 we're looking forward to being able to review
20 the final set of standard operating procedures
21 with respect to the dose assessments themselves
22 and the actual methodology that -- the
23 documentation on the methods. And as Dr. Blake
24 told you yesterday, that's going to be out
25 sometime later this year, I guess. And that's

1 going to be an important task, for our
2 subcommittee to look at that very carefully.
3 We have some suggested issues for discussion by
4 the Board, and possible recommendations. Let
5 me point out that the first four of these are
6 somewhat redundant in the sense that they are -
7 - they are -- some of them we have recommended
8 before and they have yet to be accomplished,
9 and so we're sort of putting them here again
10 with the idea of giving a little push to NTPR,
11 but we recognize they are working on them.
12 And they basically come -- all these four --
13 under the umbrella of uncertainty analysis and
14 upper bound. As I said, NTPR has not yet
15 implemented our previous recommendation that
16 they document that the -- these upper bound
17 factors that they're using now always result in
18 at least the 95th percentile dose, and we
19 recommend that this receive a high priority.
20 And we believe that NTPR has already accepted
21 that, so it's sort of a reiteration. However,
22 we want to go a little further this time and
23 recommend that a standard operating procedure
24 be developed that specifies when and how these
25 upper bound factors are to be applied, and

1 whether a single factor should be applied to
2 the veteran's total dose from all sources. And
3 we also recommend that the standard operating
4 procedure specify when uncertainty estimates
5 from individual sources should be assumed
6 independent or correlated, and when and how
7 uncertainty should be propagated.

8 If you'll remember, yesterday in our talk about
9 dose reconstruction, we were told that the long
10 term goal is eventually to go to a
11 probabilistic dose assessment for uncertainty.
12 And so what we feel is that there is a need to
13 really investigate down the line how we are
14 going to attack uncertainty, whether we're
15 going to continue to use these upper bound
16 factors or -- and if so, under what
17 circumstances.

18 And as part of this overall look at upper
19 bounds, again we are pointing out that the
20 ingestion dose upper bound we believe is
21 redundant, that the point estimate that's being
22 made for ingestion dose is extremely
23 conservative already and we believe already
24 exceeds the 95th percentile, and that there's
25 probably no need for adding an extra factor of

1 ten upper bound estimate to that. So we've
2 asked NTPR to look at this and come back to us
3 with a recommendation.

4 And finally, we also in our previous -- our
5 report pointed out that the present way that
6 they do uncertainty for doses based on cohort
7 film badges -- that they -- there is no
8 additional uncertainty for the fact that this
9 is a cohort badge rather than a badge actually
10 worn by the individual, and we continue to
11 recommend development of a method and a
12 standard operating procedure developed for
13 providing extra uncertainty for the use of
14 cohort badges.

15 And finally, skin dose uncertainty upper bound
16 analysis. Although, as it was pointed out
17 yesterday, most skin doses are now done on an
18 expedited basis, there still are a few skin
19 dose calculations that have to be done -- full
20 dose assessments -- for Hiroshima and Nagasaki
21 in particular, and so we still need for --
22 there's still need for a standard operating
23 procedure for a detailed methodology for how to
24 calculate these skin doses and how to estimate
25 the upper bounds in those skin doses.

1 Our next recommendation has more to do with --
2 not a recommendation to -- we are making this
3 recommendation basically to the Chairman of the
4 Board. In our audits we found that -- we
5 believe that the RDA report to the veteran that
6 Dr. Blake talked about yesterday -- it's part
7 of the dose reconstruction process. They do
8 the dose reconstruction and then they prepare a
9 report which they send both to the veteran and
10 to the VA, and this report has all the details
11 in the SPARE -- what was in the SPARE, and when
12 we read this report we find that we can
13 understand where veterans might have a lot of
14 trouble understanding this report. And so we
15 felt that this is a good opportunity for
16 Subcommittee 4, I believe, on communications to
17 work with DTRA and perhaps find a way to
18 improve this report so that it would be a
19 better communication vehicle between the
20 veteran and the -- the dose reconstruction so
21 perhaps they would be able to better understand
22 the results of the dose reconstruction and some
23 of the terminology. Right now there are a lot
24 of obtuse references. There -- one particular
25 point that we felt was important was that if

1 there had -- if the veterans had received
2 previous dose estimates or previous assessments
3 -- and one of the veterans I think mentioned
4 that yesterday, that over time he's received
5 three or four different doses, all different.
6 Well, I think it's very important, and our
7 subcommittee thinks it's very important, that
8 when a new RDA is issued that it should state
9 why things have changed. So these are issues I
10 think that I would hope the Chairman would task
11 Subcommittee 4 to work with DTRA, and Dr. Blake
12 has already agreed to participate in this so I
13 don't think there's a need for a formal
14 recommendation to DTRA. I think this is an
15 internal matter.

16 **VICE ADMIRAL ZIMBLE:** Could you just hold your
17 report for one minute? Let's see, since we
18 have the Chairman of SC-4 with us today, if we
19 could just get his comment regarding this
20 recommendation 'cause it may speed up our
21 deliberations.

22 **MR. GROVES:** Thank you, Admiral. Yeah, we had
23 discussed this yesterday with some of the
24 membership of -- of Subcommittee 1 and find
25 that it's consistent with what we believe our

1 responsibility is in Subcommittee 4. In fact,
2 I would -- I guess I would be willing to task -
3 - to be tasked further to look at all of the
4 correspondence that goes between the veteran
5 and -- and not only NTPR, but maybe even look
6 again at correspondence from the VA, to ensure
7 that the clarity is conveyed in such a way that
8 it -- it's understandable. And I realize the
9 need to have the technical basis behind that,
10 but I do agree that in communicating with the
11 veterans it would be useful to have it in a
12 more simple, straightforward and concise form,
13 so we -- we will take that.

14 **VICE ADMIRAL ZIMBLE:** Thank you very much.
15 It's always reassuring to know we have a
16 willing worker.

17 **DR. VAUGHAN:** Admiral, I have a comment.

18 **VICE ADMIRAL ZIMBLE:** Oh -- oh, yes, Elaine.

19 **DR. VAUGHAN:** Just that I think that what
20 Subcommittee 4 could do also, in addition to
21 looking at the content of any materials, would
22 be the process by which a veteran could get
23 clarification on any correspondence regarding
24 RDAs. So is there a process in place that's
25 clear, who do I call if I'm not understanding;

1 are there additional materials that are clear
2 for a non-science audience regarding the dose
3 reconstruction process and the assumptions that
4 are going into the final assessments. So I
5 would say it's a process issue as well as
6 content.

7 **VICE ADMIRAL ZIMBLE:** I -- we fully agree with
8 that, Elaine, and we'll take that aboard.
9 Thank you.

10 **MR. GROVES:** Elaine, thank you very much for
11 that comment, and -- and of course Elaine is
12 one of the members of the committee that will
13 be working on this, but I do think you're
14 absolutely right and I'm glad you raised the
15 point that in any of this correspondence it
16 needs to be clear that there is somebody you
17 can call to get additional clarification if --
18 if you need it, so...

19 **DR. VAUGHAN:** Yes, and in a timely manner.

20 **VICE ADMIRAL ZIMBLE:** Okay, thank you. With
21 that, I would ask that Mr. Beck resume his
22 report.

23 **MR. BECK:** Okay. I have just two more items
24 for discussion. Next one is on claim outcome.
25 Subcommittee 1 has continually noted that NTPR

1 is not informed about the outcome of claims
2 after the RDA is supplied to the VA. Therefore
3 no statistical conclusions can be obtained from
4 NTPR records regarding the percentage of
5 successful non-presumptive claims. NTPR and
6 VBDR have a need to know the outcome of claims.
7 The reason for this is this information could
8 be used to expedite dose reconstruction and
9 claims processing.

10 And just to expand on that a little bit, for
11 this committee, as well as for NTPR, to
12 recommend which kinds of doses can be
13 expedited, which kinds of methods could be
14 modified, this is the kind of information that
15 they could use. So we think that it would be
16 very useful and that a way should be found --
17 now Mr. Pamperin has provided Subcommittee 1
18 with the outcomes of some of the cases that we
19 are auditing. But this is a relatively small
20 number of cases, so it doesn't really fulfill
21 this ability for NTPR to look at the broad
22 picture and say well, these are the kinds of
23 cases perhaps are never going to be -- very
24 unlikely to ever be compensated and therefore
25 we ought to find a way to expedite them -- this

1 kind of thinking I think that would enable them
2 to make these kind of judgments.
3 Our final comments are on expedited RDAs for
4 cataracts. Yesterday Dr. Blake presented his
5 plan for possibly expediting radiation dose
6 assessments for certain types of cataracts.
7 Let me read this to make sure I get it right.
8 (Reading) Early detection of the onset and
9 presence of cataracts has improved markedly in
10 the past decade. Recent long-term studies cite
11 measurable changes in color and opacity for eye
12 doses ranging from 15 to 25 rads respectively.
13 NTPR is proposing to develop an expedited RDA
14 for claims from veterans having posterior
15 subcapsular cataracts. A SPARE, perhaps based
16 on a modified questionnaire, will be needed to
17 establish the plausibility of a sufficient
18 radiation dose to the lens of the eye. It is
19 necessary to establish that the veteran's face
20 near the eye could have been contaminated by
21 fallout particles, and that a fairly high
22 default dose to the lens could have been
23 received. We therefore recommend that VBDR
24 request that NTPR propose an appropriate
25 modified expedited RDA process that can be

1 reviewed by SC1.

2 **VICE ADMIRAL ZIMBLE:** Thank you very much, Mr.
3 Beck. I would like to add one additional
4 bullet to that last recommendation, and that
5 would be that once reviewed by SC1, that -- and
6 a -- and approved by SC1, that DTRA be allowed
7 to -- to then incorp-- implement that -- that
8 new expedited procedure. Otherwise we'll have
9 to wait till our next meeting to get Board
10 approval for the --

11 **MR. BECK:** I think we can -- we can make a
12 formal recommendation to the Board that would
13 do that. I mean -- I mean if the Board wishes
14 to, you know, to essentially appoint -- you
15 know, to essentially endorse VBDR's proposal,
16 subject to the approval of SC1.

17 **VICE ADMIRAL ZIMBLE:** Without objection, I
18 would give SC1 the authority to make that
19 approval without -- without exception from the
20 Board. I think it's a -- it's an arduous
21 process to get concurrence from every member of
22 the Board in a -- in a short period of time.
23 In order to expedite the expedited process, I
24 think it would be good to -- to -- if -- if the
25 members -- the members of SC1 have the

1 expertise to determine whether or not the
2 proposed expedited process is acceptable -- and
3 if it's acceptable with SC1, I'm sure it's
4 acceptable to the Board -- unless there's some
5 objection I hear from the Board today. And if
6 not, I think that you ought to be able to -- to
7 grant them the authority to move ahead with it,
8 provided your committee agrees that it's an
9 appropriate methodology. So without -- without
10 objection, we'll -- we'll now -- Dr. Blake, you
11 want to speak to that recommendation?

12 **DR. BLAKE:** I certainly agree with that and it
13 is our intention to provide that information to
14 SC1 within one to two weeks, and have this
15 resolved hopefully within one to two weeks so
16 we can move out.

17 **VICE ADMIRAL ZIMBLE:** I'd hate to wait another
18 six months before you can implement it.
19 All right, the -- the Board members have --
20 have received the report from SC1. Are there
21 any comments from any of the members?
22 Comments? Questions?

23 **MR. PAMPERIN:** Just -- just one. Again, we've
24 in the past discussed the privacy concerns, and
25 on the claim outcome -- is it possible that we

1 could talk about -- there -- there's -- needs
2 to be some way to do that that -- can it be
3 just cumulative in terms of lumping particular
4 groups of people and -- you know, it -- I don't
5 know what the disability is, but say a
6 particular disability, we got five of them, we
7 denied five. Or does it need to be more
8 specific?

9 **MR. BECK:** Well, I'll give my opinion and I'll
10 let Dr. Blake give his. I mean I -- I
11 personally don't see the privacy concern
12 because of the fact that everything about the
13 veteran, other than the outcome of his claim,
14 is already known by NTPR, so they're not -- I
15 mean all this privacy information is already in
16 that file. I assume they're not going to
17 release that information and not other
18 information, so I'm not sure I understand
19 exactly what the concern is on privacy. But if
20 it really was so much of a concern, I think
21 that if you were going to release statistics
22 you would want it much more detailed than that.
23 In other words, you would want the -- you know,
24 skin cancer -- you know, the type of cancer --
25 **MR. PAMPERIN:** Right.

1 **MR. BECK:** -- the audi-- the NTS specific -- it
2 would have to be enough detail for NTPR and SC1
3 to use to recommend classes of types of
4 radiation dose assessments that could be
5 modified, so it wouldn't be just the complete -
6 - just, you know, number of cases that were
7 approved and number not approved.

8 **VICE ADMIRAL ZIMBLE:** I -- I would recommend --
9 there are going to be many very trivial details
10 that have to be worked through and I would ask
11 that if -- if the Board approves of this
12 recommendation that I ask Drs. Blake and -- and
13 Mr. Pamperin to have their respective agencies
14 negotiate the -- the specifics of that transfer
15 of information. I think, for example, to know
16 the outcome is a denial, even if it's for a
17 full category, I sure would want to know the
18 rationale for the denial if -- if it -- if --
19 depending upon the doses, or if it's a claim
20 that is approved, what's the rationale for
21 approval. You know, the adjudication process
22 is more than just a yes/no. It's a -- it's
23 some level of deliberation. So I -- I think
24 that's equally important in order for the
25 quality of the process to be -- to be approved.

1 **MR. BECK:** I would -- as far as NTPR is
2 concerned, I would think, in terms of the
3 reason, the most important thing would be if
4 the reason was the dose. I mean I think if
5 there are other reasons, I don't think that
6 NTPR -- but if -- if it's rejected because of
7 the dose reconstruction, then I think that's
8 what they would like to know.

9 **VICE ADMIRAL ZIMBLE:** Okay, but -- anyway,
10 bottom line today I think would be to get the
11 Board's approval for -- for negotiation between
12 DTRA and VA to work out the methodology for
13 giving them adequate information regarding the
14 -- adjudicating claim.

15 **DR. LATHROP:** Mr. Chair, just because I -- I
16 may not be part of some of the conversations, I
17 should point out that I get from Dr. Otchin a
18 spreadsheet which gives me the -- a case
19 number, a cancer type and -- several columns,
20 but it ends in favorable or unfavorable, so I
21 already get the -- the dose favorable part, but
22 then we don't know where it goes.

23 **VICE ADMIRAL ZIMBLE:** But it's a -- that's one
24 step shy of --

25 **DR. LATHROP:** Exactly.

1 **VICE ADMIRAL ZIMBLE:** -- the final decision.

2 **DR. LATHROP:** Exactly. All I know is it's
3 favorable.

4 **VICE ADMIRAL ZIMBLE:** It's the medical
5 recommendation.

6 **DR. LATHROP:** Right.

7 **VICE ADMIRAL ZIMBLE:** Okay. So again, that's
8 important and I'm glad to have that
9 information. And by the way, I would
10 appreciate your sharing that information with
11 the committee. I know, information is power.
12 Right.

13 **DR. FLEMING:** Mr. Chairman, can I second that,
14 please? I keep wondering where this
15 information is other than in John -- in John
16 Lathrop's hard drive, so if you'd be willing to
17 share it with us, John.

18 **VICE ADMIRAL ZIMBLE:** Oh, yeah, he's got e-mail
19 --

20 **DR. FLEMING:** And then putting it together with
21 the information that Subcommittee 1 is asking
22 for would seem to be pretty important.

23 **DR. LATHROP:** Okay, but by way of explanation,
24 I have not been distributing it because I've
25 been a little uneasy about confidentiality and

1 privacy con-- concerns. That changed a few
2 days ago when I saw some -- some thing on a
3 spreadsheet -- on a slide which said that Dr.
4 Lathrop's been -- been given this. Now that I
5 stand accused on -- on a PowerPoint slide, I
6 need to process it some, but then I -- I will
7 send it out.

8 **VICE ADMIRAL ZIMBLE:** Well, since this
9 committee has oversight and audit
10 responsibilities for the processing, and have
11 been auditing cases; and since NTPR has all the
12 privacy information in order to be able to
13 carry out dose reconstruction, we're really not
14 violating Privacy Act. I don't think we should
15 publish it for -- for the record -- for the
16 public. It needs -- it needs to be information
17 which has a -- a custodial element to it that
18 allows for the -- for respect for privacy.

19 **DR. LATHROP:** Okay, on -- on that line, should
20 I e-mail these encrypted? Which I can do, I
21 then would just have to tell you by voice what
22 the password is, and I can't do that here but -
23 -

24 **VICE ADMIRAL ZIMBLE:** That would be a good
25 procedure. That would be good.

1 **DR. LATHROP:** I will do that. It's easy to do
2 within Microsoft.

3 **VICE ADMIRAL ZIMBLE:** Okay. Any other comments
4 regarding any -- oh, Dr. Zeman.

5 **DR. ZEMAN:** Yes, as a -- as a member of SC1 I
6 just wanted to add my voice to Mr. Beck's to
7 emphasize that we really could use this
8 information to advantage. I think we need this
9 information. We've been very successful so far
10 I think in reviewing the skin doses, the
11 prostate doses and -- and helping DTRA develop
12 the rationale for expedited dose process -- or
13 expedited processing of those two cancers, and
14 it saved a lot of -- lot of time I think by
15 expediting those and not doing dose
16 reconstruction. If we're going to continue
17 with that kind of success, I think we need the
18 -- the outcome information. We've had a good
19 deal of discussion about the cataract issue
20 that we're -- that we're working on now and
21 that DTRA is drafting a procedure for. In
22 these cases there are doses just above and just
23 below what is conceivably the threshold for --
24 for cataract induction, but the cataract is not
25 in the IREP software so we don't have guidance

1 doses and we really need to know -- in that
2 area we need to know what -- what VA is doing
3 with the final -- you know, what the final
4 approval is. We can't make any reasonable
5 judgments about whether to expedite dose on the
6 high side or the low side, or to require dose
7 reconstruction, because things are very close.
8 So in order to make those decisions, we really
9 do need this information I think.

10 **VICE ADMIRAL ZIMBLE:** Okay, thank you very
11 much. Are there any other comments by the
12 members or any of the recommenda-- oh, I'm
13 sorry.

14 **DR. BOICE:** Thank you, Mr. Chairman.

15 **VICE ADMIRAL ZIMBLE:** Oh, I'm sorry -- okay,
16 Dr. Boice.

17 **DR. BOICE:** Yes.

18 **VICE ADMIRAL ZIMBLE:** I couldn't see whose
19 tower was there.

20 **DR. BOICE:** Okay, right. No, I just was -- a
21 comment on the cataracts because there was a
22 specific dose range that was mentioned in the
23 recommendation. I think the -- the -- it's
24 equivocal with regard to cataracts at that low
25 dose range, and not all the studies are

1 certainly consistent, you know, of a 15 to 25,
2 so it's sort of -- there's new evidence that
3 the risk of cataracts, and the posterior
4 capsular ones in particular, occur at a lower
5 dose than originally thought. But I don't know
6 if you have a -- there's really a need to have
7 that particular dose range put in there,
8 implying that the data are in fact
9 inconsistent. And I'm not sure that it even
10 applied to cataracts, those changes in color
11 and opacity, so perhaps you could use a
12 different wording of "at much lower doses" or
13 "doses under 100 rads."

14 **MR. BECK:** Perhaps as low as?

15 **DR. BOICE:** Yeah, "perhaps as low as" or -- or
16 "under 100 rads to perhaps as low as 15,"
17 something --

18 **MR. BECK:** Let me just expand on the -- the
19 rationale here for possibly making -- agreeing
20 that this should be expedited, and it really
21 stems from the skin dose calculation. Previous
22 -- in the doses that Dr. Blake showed yesterday
23 in his bar graphs that were -- where he showed
24 the doses that had been reported for previous
25 cataract cases, these I believe all were based

1 on no contribution from any skin dose from the
2 face itself because this was only really
3 recently -- stuff that got on the skin was --
4 was calculated as skin dose. It's only a very
5 recent development in terms of the NTPR dose
6 reconstruction.

7 Now the rationale for going to -- for
8 expediting skin doses was basically that we
9 have a very large uncertainty in saying what
10 the dose is if there's activity actually
11 deposited on the skin. And that derives, first
12 of all, for exactly where it was on the skin,
13 how long it stayed on the skin, how much got on
14 the skin, and we really concluded that if we
15 put reasonable uncertainty estimates on there,
16 the dose could be hundreds of rads -- range
17 from -- so that was the whole rationale for if
18 we really can't give a good dose estimate, and
19 if it really was a good possibility that it did
20 get on the skin, that it should be expedited.

21 Well, Dr. Blake is proposing to carry this
22 concept further in the sense that if a person
23 who has cataracts was in a situation where he
24 possibly could have gotten radioactivity on his
25 face in the region of the eye, then we would

1 have somewhat the same situation where we would
2 really not be able to do a good dose
3 assessment, and the dose could range from a
4 very low amount to a very high amount. And
5 that's really the basis of -- of the possible
6 recommendation here or the agreeing to the
7 recommendation, that what SC1 said was well, we
8 really in this case, though, want to have a
9 reasonable assurance that the scenario was such
10 that this was a possibility, that he could have
11 gotten radioactivity on his skin. So we need
12 at least a modified scope, we need to do a
13 questionnaire and find out if he was in a
14 situation where he could have gotten fallout --
15 either from descending fallout or resuspension
16 -- or from handling contaminated material that
17 could have gotten radioactivity on his skin.
18 And if that was the case, the uncertainty from
19 the dose from the skin to the eye lens, even
20 though it would be less to the eye lens than
21 the skin, it would still be an extremely
22 uncertain estimate, and that's the rationale
23 for making this -- and -- and so the exact
24 numbers we put in here are really sort of
25 irrelevant and --

1 **DR. BOICE:** Exactly, that's just what I was
2 going to say.

3 **MR. BECK:** Exactly.

4 **DR. BOICE:** I agree with you a hundred percent.

5 **MR. BECK:** They were just -- the point was, as
6 Dr. Zeman said, was that originally -- we
7 looked at this several years ago -- the thought
8 was that it took hundreds of rems -- or rads,
9 and -- and therefore -- which is we thought it
10 would be unlikely then that they could get
11 hundreds, but once you get down to where it's
12 possible that it could be a relatively low --
13 and you know, whether it's less than 100 or
14 less than 50, it's -- it's -- doesn't really
15 matter as far as the -- what we're saying here
16 is that since we can't estimate what it is
17 accurately enough, the best thing to do is to
18 basically assign a high enough dose that it
19 would be essentially a way of expediting the
20 procedure -- expediting the dose
21 reconstruction.

22 **DR. BOICE:** And again, I agree with that a
23 hundred percent, and I think all that's really
24 needed to say is that recent studies are
25 indicating that cataracts can occur at doses

1 much lower than what was previously thought.
2 And you really don't need to go down to a
3 lowest range or -- or something with a little
4 more careful modification.

5 **DR. ZEMAN:** I need to comment on that, please.
6 We put the numbers in there, Dr. Boice,
7 precisely so that some members of the Board
8 would recognize that there is some new
9 radiobiology that's been reported here in the
10 last few years, and this was news to us on SC1.
11 We -- we came into this believing that it took
12 a couple or few hundred rads to the eye to make
13 -- to induce sub-- posterior subcapsular
14 cataracts, but the recent radiobiology is
15 pointing at these much lower doses. So we put
16 the numbers in there precisely to draw your
17 attention to the fact that there is some new
18 radiobiology here and that's -- we're going to
19 take a closer look at that literature and, in
20 judging that literature, apply that judgment as
21 well to the expedited process that's being put
22 together. So it's both the radiobiology and
23 the dosimetry that's part of this.

24 **DR. BOICE:** No, I understand that, too. I'm
25 just commenting, though, that that number --

1 those numbers are inconsistent with the body of
2 information that's out there and that there are
3 other studies recently come out from the
4 Chernobyl cleanup workers and even with the
5 atomic bomb survivors that don't have excesses
6 for certain types of cataracts and subcapsular
7 at that particular dose range. They're at
8 higher dose ranges. So the thing was that
9 there's inconsistency now, and people are
10 looking at the radiation biology and I don't
11 think it's appropriate just to pick out one
12 particular number in one set. That -- that was
13 the main point there. One can still say
14 exactly I think what -- what we want to help
15 out with the veterans, saying that the doses
16 are much lower, without putting a range at that
17 specific -- you know, 15 to 25 rads. I think
18 that's what I was concerned about.

19 **DR. ZEMAN:** I'd like to add -- I'm sorry to go
20 on with this point, Admiral Zimble. I don't
21 want to take all morning on it, but we were
22 informed also that the VA was using a -- a low
23 number -- and I don't remember exactly what it
24 was, whether it was 20, 25 rads -- using that
25 number at that low a level for deciding on

1 medical -- service connection for cataracts
2 with regard to radiation dose. So --

3 **DR. BOICE:** Well, I don't think that would be
4 appropriate in giving every benefit of the
5 doubt to the -- the veteran, so that would be
6 appropriate to use a low level. But to -- to
7 state -- it's more like a scientific statement
8 here in the recommendation, that we have
9 observed things at these levels, and -- and
10 these are not consistently observed there. And
11 that's a -- again, that's the only thing I'm --
12 was concerned about.

13 **DR. ZEMAN:** Well -- well, I fully agree with
14 Dr. Boice that we ought to modify our report,
15 and also I'm -- I've been told that -- that a
16 new study of -- of post-Chernobyl cataracts is
17 due to hit the street within the mon-- next
18 month or so, presumably in *Radiation Research*,
19 so it will be --

20 **DR. BOICE:** I have it, and we distributed it
21 last ni-- yesterday.

22 **DR. ZEMAN:** Aha -- to whom?
23 Oh, Lathrop's got it on his hard drive.

24 **DR. LATHROP:** Paul, I'll send you a copy.

25 **VICE ADMIRAL ZIMBLE:** All right, subject to

1 rewording, that -- that final recommendation to
2 eliminate specific dosages but only indicate
3 the range, I would ask -- if there's no further
4 comments or questions regarding these seven
5 recommendations, that we vote en masse for --
6 for the acceptance of the report.

7 **VICE ADMIRAL ZIMBLE:** All those in favor?

8 (Affirmative responses)

9 **DR. VAUGHAN:** Yes.

10 **VICE ADMIRAL ZIMBLE:** Any -- those opposed?

11 (No responses)

12 **VICE ADMIRAL ZIMBLE:** The report is accepted.
13 Thank you very, very much and we'll -- we'll
14 put together the recommendations to send
15 forward.

16 **SUBCOMMITTEE 2 ON VA CLAIMS ADJUDICATION PROCEDURES**

17 Now I would ask Dr. Blanck to please report on
18 the work of Subcommittee 2, which deals with
19 the veteran claims processing.

20 **DR. BLANCK:** Thank you, Mr. Chairman.

21 Subcommittee 2 has the task of reviewing the
22 claims process through the VA and its
23 interaction with NTPR back to the VA. And in
24 so doing we audited cases which were reported
25 on in previous meetings. In addition we hired

1 a consultant, Ms. Jean York, to audit yet
2 further cases. Her findings were consistent
3 with what we had found -- that is, the members
4 of Subcommittee 2 -- in terms of delays, people
5 dealing with these claims weren't expert in
6 radiation illnesses and so forth. And after
7 her final six audits, we decided that it was
8 unnecessary to audit any further cases because
9 the VA has adopted our recommendation to
10 consolidate the claims processing at a single
11 office. And we are firm in the belief that
12 this will allow the development of expertise so
13 that the cases will be handled, one, properly;
14 two, in an expeditious, rapid -- more rapid
15 fashion.

16 We do plan to ask Ms. York to audit cases from
17 the regional office in Jackson, Mississippi
18 after that is -- is in operation and all of the
19 expertise has been developed, and we'll work
20 closely with the Veterans Affairs office on
21 that.

22 We then have three specific recommendations
23 that came out of our recent meeting. The first
24 has to do with our recommendation that non-
25 radiogenic illnesses not be sent for dose

1 reconstruction since it appeared to us that
2 there was no way that those were going to be
3 favorably judged and it simply slowed down the
4 process for those cases that would receive a
5 favorable review. The VA feels that they must,
6 by law, send the cases to NTPR and they so
7 answered. Therefore, in view of that, we
8 recommend that the VA send these cases of non-
9 radiogenic diseases to DTRA and that DTRA
10 actually render the competent expert medical
11 opinion called for by the law and that the non-
12 radiogenic diseases felt by this competent
13 medical authority not to require dose
14 reconstruction would be returned to the VA --
15 to the VBA, who will then send it to the VHA
16 for review prior to final adjudication.
17 So there would be, first of all, a claim made
18 for a non-radiogenic disease. It would be sent
19 to DTRA. DTRA would provide a medical review
20 of it. If it was felt that this was not going
21 to be favorably judged, it wouldn't go through
22 dose reconstruction -- seems to be no need for
23 that -- returned for the final review to the
24 VA, and then adjudication would be made. But
25 we believe this meets the requirements of the

1 law and would speed up the process considerably
2 and allow those cases that would potential
3 receive favorable consideration to go through
4 the dose reconstruction process.

5 **VICE ADMIRAL ZIMBLE:** Dr. Blanck, with your
6 permission --

7 **DR. BLANCK:** Yes.

8 **VICE ADMIRAL ZIMBLE:** -- I would like to open
9 each of your two recommendations to the Board
10 for discussion because I feel that there --
11 there may be some -- some significant
12 discussion involved.

13 Dr. Blake.

14 **DR. BLAKE:** I would just comment there are not
15 that many of these cases. There are less than
16 two percent, and when we do review them through
17 a board-certified radiation oncologist who's
18 academically oriented, in some cases we -- we
19 proceed with a dose reconstruction. But in
20 other cases that I mentioned the other day,
21 they truly, even if we did the dose
22 reconstruction, there would never be a positive
23 medical opinion and therefore they are slowing
24 things up. So we're very happy to, from DTRA's
25 viewpoint, to support this recommendation. But

1 it -- it is -- there's a few cases right now in
2 the backlog. Future cases will be fairly
3 minimal. It truly is not a big -- a true big
4 part of the program.

5 **DR. BLANCK:** I would add that members of
6 Subcommittee 2 reviewed 14, but you had sent
7 some additional cases so I'm not sure of the
8 total number -- around 20 cases of non-
9 radiogenic diseases, and it was clear to us
10 that there was no point in doing the dose
11 reconstruction in that in fact it would slow up
12 the process for others.

13 **VICE ADMIRAL ZIMBLE:** Dr. Swenson.

14 **DR. SWENSON:** I would ask that we table
15 discussion on this recommendation -- we have a
16 similar recommendation in SC3 -- and that we
17 open it at that time when you've heard both
18 recommendations, please.

19 **VICE ADMIRAL ZIMBLE:** Oh, very well, we will --
20 we will table that recommendation number one
21 and you may presume -- resume your report.

22 **DR. BLANCK:** Recommendation number two, there's
23 been much, much discussion on the challenges of
24 dose measurements, dose reconstruction, the
25 uncertainties of that whole process. And we

1 understand what the VA is charged to do, what
2 NTPR is trying to do. But we think one of the
3 things that may get at some of this is to look
4 at selected populations. And so our
5 subcommittee recommends -- and -- and I hope
6 the committee will take on and discuss -- that
7 the VA at least look at or consider designated
8 -- designating certain military units, perhaps
9 those on a ship or those that were in a certain
10 unit for some of the Nevada tests, that kind of
11 thing, as special exposure groups, much as the
12 Special Exposure Cohort used by the Department
13 of Labor, for which radiation dose assessments
14 then would not be required. We know the
15 exposure. That is, the exposure is known and
16 they can go through the process far more
17 rapidly. So it -- it kind of does away with
18 some of the individual dose reconstructions and
19 all of the sorts of things that we've been
20 talking about.

21 We believe that this is within the -- the
22 purview of the VA. I'm not sure the VA
23 believes that, but at least it's -- it's worthy
24 of considering and may be a way to get out of,
25 at least for those in those units, this whole

1 process, expedite it and move on and -- and get
2 a quick decision.

3 **VICE ADMIRAL ZIMBLE:** I have one comment
4 regarding this particular recommendation that
5 looks to going to special units. It sounds a
6 great deal like the template concept that --
7 that NTPR's already establishing and -- and
8 certainly it's within the scope of current
9 legislation --

10 **DR. BLANCK:** Right.

11 **VICE ADMIRAL ZIMBLE:** -- to -- to provide a
12 dose reconstruction and leave it to NTPR to
13 determine the process for that reconstruction.
14 And if the reconstruction is simply knowing
15 what -- what operational units were doing at
16 the time and have a basis for a maximum dose
17 for that unit, they can do a dose
18 reconstruction that way rather than the current
19 process. So I don't think that's going to
20 require any change other than to -- to endorse
21 the template construction.

22 **DR. BLANCK:** Dr. Blake, do you think that fits
23 in with what we're recommending here?

24 **DR. BLAKE:** We certainly can explore that.
25 That's -- we have the expertise on what the

1 dose levels are for the different units that
2 were involved. That doesn't reside at the VA
3 so that -- DoD does have to be involved. Up
4 until now all our doses have been specifically
5 to specific organs based on specific diseases.
6 What we'd be saying here, basically for this
7 entire unit, here is the generic external or
8 skin dose. We're not looking at the disease,
9 and based on that --

10 **DR. BLANCK:** And apply it.

11 **DR. BLAKE:** Apply it. So it would be a
12 different concept for us to explore, but we're
13 certainly willing to take a look at that and
14 come back next meeting with some comments on it
15 from at least DoD's side.

16 **DR. BLANCK:** Excellent. Mr. Pamperin?

17 **VICE ADMIRAL ZIMBLE:** Okay, let -- I'd like to
18 take the Chair's --

19 **DR. BLANCK:** I'm sorry.

20 **VICE ADMIRAL ZIMBLE:** -- prerogative to -- to
21 go one bridge further. What -- what I envision
22 is a special exposure group that will apply to
23 all those who are included in the generic
24 category of atomic veteran, and eliminate dose
25 reconstruction for the atomic veterans. And I

1 think that dose reconstruction is a very valid
2 process. It is scientifically oriented. It --
3 it is -- it is quite precise and it gives good
4 results. But it will not ever relieve any of
5 the current uncertainties that exist during the
6 time frame of the 1940s and '50s and early '60s
7 because of several reasons. And if you -- if --
8 -- if you'll give me an opportunity, I would
9 like to point out those reasons.

10 First of all, the age of the atomic veterans is
11 such that we -- when we send them an 8-page
12 questionnaire we're asking them to remember
13 what they did at an -- at an -- back in their
14 early -- in their very early years. And I
15 think that that's -- I can't remember some of
16 the things I've done just last week, and to --
17 to be able to fill out a very complex
18 questionnaire, I think, is arduous and is
19 subject to uncertainty.

20 Secondly, the age of many of those individuals
21 there were at an age when they felt relatively
22 invulnerable and they felt fairly cavalier.
23 We've heard testimony from the atomic veterans
24 as to some of the things that they did,
25 ignoring the potential risks involved. And I

1 think that adds a specific level of
2 uncertainty.

3 In addition to that, we know that the
4 dosimeters were not up to the caliber of
5 dosimeters that are being used today. And we
6 know that we have film records that have been
7 destroyed or eroded or decayed. In addition,
8 we know that so many of the individuals did not
9 have dosimetry, certainly for not all of their
10 activities.

11 We know that there were sa-- whatever safety
12 controls were established were at the time,
13 which were far less rigid, less strict than the
14 safety controls that are established today,
15 that those controls were frequently overlooked,
16 that there was a cavalier attitude. And again,
17 just yesterday we heard from R.J. Ritter, a
18 quote that if it -- I didn't -- if it -- it
19 didn't happen syndrome, that -- something was a
20 major violation, the command would say hey,
21 that didn't happen. We know that went on.

22 So I also got from Mr. Charles Clark a very
23 interesting document which was initially
24 classified as top secret, has been reduced to
25 now being unclassified, which was a

1 conversation between General Leslie Groves and
2 a Lieutenant Colonel physician at Oak Ridge
3 Hospital, 9:00 a.m. on the 25th of August, 1945
4 -- and I won't read this entire telephonic
5 conversation, but I will make it available to
6 the -- to members of the committee -- but it
7 points out from -- from the level of the -- of
8 the leadership of Manhattan Project, the level
9 of lack of concern for the -- lack of
10 appreciation of the risk of ionizing radiation.
11 And then that -- also of the physician with
12 whom he was speaking.

13 I think with -- taking all those elements into
14 consideration, I would like to propose that we
15 make a recommendation for a legislative relief
16 and that that legislative relief be to
17 establish a special exposure group for the
18 atomic veterans, as defined, so that we could -
19 - we could much faster accommodate their --
20 their claims.

21 **DR. BLANCK:** Mr. Chairman, I -- I personally
22 agree with you wholeheartedly, and I suspect
23 others have -- have -- have opinions which
24 they'll voice. I would recommend not changing
25 the current recommendation, because this is

1 something that we can do now. You've heard Dr.
2 Blake say that he would look at this and -- and
3 do the special -- potentially do the special
4 exposure groups by military units.

5 As a therefore fourth recommendation, I would
6 add to the subcommittee's report then that we
7 ask the Board to consider and recommend the
8 legislative relief that you've suggested. That
9 would be distinct and separate 'cause that's
10 going to take some time, legislation does,
11 whereas what Dr. Blake can do, we -- can be
12 done fairly quickly, so --

13 **VICE ADMIRAL ZIMBLE:** Okay.

14 **DR. BLANCK:** -- can we put that as
15 recommendation four?

16 **VICE ADMIRAL ZIMBLE:** That's fine.

17 **DR. BLANCK:** That -- and -- and do you want to
18 phrase it or should I write it out?

19 **VICE ADMIRAL ZIMBLE:** If you'll let me phrase
20 it it'll take four paragraphs.

21 **DR. BLANCK:** Excellent. I can do it in about a
22 sentence.

23 **VICE ADMIRAL ZIMBLE:** That would be good.

24 **DR. BLANCK:** Okay.

25 **VICE ADMIRAL ZIMBLE:** Okay.

1 **DR. BLANCK:** Done. So the recommendation would
2 be to ask for legislation essentially doing
3 away or eliminating the need for dose
4 reconstruction and --

5 **VICE ADMIRAL ZIMBLE:** Right.

6 **DR. BLANCK:** -- considering all atomic veterans
7 as a --

8 **VICE ADMIRAL ZIMBLE:** Right.

9 **DR. BLANCK:** -- special exposure group.

10 **VICE ADMIRAL ZIMBLE:** I would like to make the
11 --

12 **DR. BLANCK:** I don't know whether they'll do
13 that, but we'll see -- but at least we're going
14 to recommend it.

15 **VICE ADMIRAL ZIMBLE:** I think that somehow or
16 another we're also going to need to -- to work
17 out what -- what procedures would be -- would
18 be placed in lieu of dose reconstruction. And
19 I think we need to -- we need to look at that
20 and talk about -- talk about the non-
21 deterministic type of medical conditions and
22 non-deterministic conditions that have -- that
23 have a low sensitivity to radia-- to the oncol-
24 - oncogenic effects of radiation which would
25 probably not be included in a presumptive group

1 but that would take using a SPARE technique, a
2 template technique to resolve. I think -- I
3 don't know whether those things need to be
4 worked out for legislation or need to be worked
5 out as a -- on a procedural basis within the
6 Code of Regulations, probably the latter, so
7 that -- but I think that we need to take a look
8 at that and perhaps that would be something we
9 want to take up at the September meeting and
10 give everyone a good opportunity to -- to think
11 about what -- what would be a realistic,
12 adequate procedural methodology to -- to look
13 at all claims, those that are non-radiogenic,
14 those that are radiogenic but only at the
15 significantly elevated dose levels, and those
16 that should be included as a -- as a
17 presumption. So that -- I think that's going
18 to take some time.

19 But at any rate, I think that's a good idea.
20 We'll make that a fourth recommendation.

21 Mr. Beck.

22 **MR. BECK:** I don't -- I don't want to be the
23 bad guy here in terms of -- I'm -- I'm not
24 against getting rid of the dose reconstruction,
25 but not for the reasons that you -- I think

1 that -- it's not correct to say that you -- the
2 dose reconstructions for most of these cases
3 could not be done reasonably and were not done
4 reasonably. I think the point is is that the
5 doses, as Dr. Kocher pointed out in --
6 yesterday, that are required to really satisfy
7 the law as written, in terms of more likely
8 than not, are -- even with the uncertainties in
9 the dose reconstructions, the doses in most
10 cases are not high enough. The problem with
11 the dose reconstruction system as used is not
12 the dose reconstruction. It's the law, it's --
13 it's the unfairness of the law in having two
14 classes, presumptive and non-presumptive, when
15 some of the present presumptive diseases are
16 less likely than some of the non-presumptive
17 diseases for the same dose.
18 So it -- what -- the fix here is not to say
19 well, let's get rid of all of them, in which
20 case we're sort of contradicting ourselves
21 because you yourself have said that it's
22 extremely unlikely that any of these people
23 would get prostate cancer from doses they
24 received. The fix here is to make either
25 everything that's -- reasonably could have been

1 caused by radiation when they were atomic
2 veterans, to make them presumptive, but not to
3 have this broad thing of -- of a special class.
4 So that -- that would be a -- I would like to
5 argue -- I mean I'm -- I'm not against having
6 an argument about this and a discussion about
7 this, but I think it has to be done on a basi--
8 on a different basis. It's not a problem with
9 the dose reconstruction itself. Sure, there
10 are cases where there are uncertainties and
11 we've made -- we've taken care of a lot of the
12 worst ones with the expedited. But it -- but
13 we're not taking care of this unfairness.
14 We're not taking care of the fact that if a
15 veteran has to have a dose reconstruction for
16 lung cancer when somebody else got paid off
17 already because it's presumptive. That --
18 that's a basic unfairness and I think that's
19 where we should be putting our attention.

20 **VICE ADMIRAL ZIMBLE:** Okay, I -- I don't
21 disagree with -- with your -- with your
22 reasoning. Just -- it's a question of how do
23 we -- how do we work a process that's going to
24 be effective. One of the things I'll promise
25 you is that you're not going to -- you're not

1 going to remove any item from the presumptive
2 list in legislation. Entitlements live
3 forever.

4 **MR. BECK:** I would add, I would not --

5 **VICE ADMIRAL ZIMBLE:** I understand. I
6 understand. And -- and I agree with you a
7 hundred percent.

8 **DR. FLEMING:** Can I -- can I just say, though,
9 as an emphasis, that your point is well-taken,
10 Dr. Zimble, because it could -- it could go in
11 the other direction. One could easily argue
12 that to achieve equity or fairness that the
13 presumptives be looked at and they be treated
14 similarly to the non-presumptives, rather than
15 what's being argued here. So I do think that
16 just from a -- I guess you could -- it's a
17 purely justice point of view, Dr. Zimble's
18 point is very well-taken, even though it may
19 not be the way that we would want it to go.

20 **VICE ADMIRAL ZIMBLE:** Right. If I understand,
21 what you're saying, Elaine (sic), is that --
22 that someone could say reasonably that wait a
23 minute, these cases -- if -- if it's in -- if
24 it's true that there are presumptive diseases
25 that really should not be presumed because

1 their doses -- they are more resistant to the
2 oncogenic effects of ionizing radiation, then
3 let's do dose reconstruction on them. And we
4 know that if that happens that claims will be
5 denied. So -- and I -- and I really feel that
6 the people that have -- that have accepted,
7 those things that are presumptive need to
8 continue to accept them, so it gets a little
9 bit dicey.

10 **MR. BECK:** I agree, but it also gets a little
11 bit dicey by making the broad statement of
12 let's make them a special exposure cohort. I
13 mean, you know, if we do say let -- let's get
14 rid of the whole system, it shouldn't be
15 because of dose reconstruction, is my point.
16 It should be for other reasons. I mean there -
17 - there's valid reasons for saying this is an
18 expensive thing, these people served and went
19 through this and the easiest way is to treat
20 them all as service connected and not have this
21 system at all. But once you've got this law
22 with this dual thing which is very uneven and
23 very unfair, there is a problem with how do you
24 fix it piecemeal.

25 **VICE ADMIRAL ZIMBLE:** We may have to look to

1 the legislatures for -- for advice.

2 **MR. BECK:** We had some -- we had a legislator -
3 - legislative person here yesterday who asked
4 for some suggestions.

5 **VICE ADMIRAL ZIMBLE:** Correct. Correct.

6 **UNIDENTIFIED:** (Off microphone)

7 (Unintelligible)

8 **VICE ADMIRAL ZIMBLE:** He's still here today.

9 **DR. FLEMING:** Can I -- can I just also add --
10 it -- I'd have to spend a little time working
11 on this, but I think one could also argue that
12 -- because we dealt with this in RECA when we
13 were looking at those counties where if we were
14 to use PC, the members -- the individuals in
15 those counties with certain diseases would not
16 have qualified for compensation through RECA.
17 But the -- the United States government through
18 its legislation did make some commitments to
19 those populations in the past, and so there may
20 -- may be a trumping duty or obligation to
21 continue to fulfill promises made. It would
22 really be based on the nexus between promise-
23 keeping and fairness. So I could work a little
24 bit on that if we need to go that way.

25 **VICE ADMIRAL ZIMBLE:** Okay. Thank you very

1 much, Elaine (sic).

2 **DR. BLANCK:** Right now the -- excuse me, Mr.
3 Chairman, the -- the recommendation, without
4 any cause -- that is, whether it's because of
5 fairness or dose reconstruction -- is, so that
6 we're all clear what we're debating, is
7 recommend legislative action to consider atomic
8 veterans as a special exposure group -- and
9 there's certain things that would happen within
10 that that we've talked about up above -- of
11 eliminating -- and eliminate dose
12 reconstruction, period.

13 **VICE ADMIRAL ZIMBLE:** Okay. Dr. Swenson.

14 **DR. SWENSON:** I would agree with Harold Beck,
15 and also with Pat, that I think it needs to be
16 looked at before -- I agree the recommendation
17 should be there, but it should be that this
18 Board needs to further evaluate it and research
19 this area before we come up with a statement.
20 Our statement should be well thought out so
21 that Congress can work with it and make things
22 happen that benefit the vets, that'd be fair
23 and equitable.

24 **VICE ADMIRAL ZIMBLE:** Okay, sub-- subject to
25 that amendment, is that -- is that acceptable

1 to you, Ron?

2 **DR. MCCURDY:** I'd be very careful on the
3 wording, because what's come up right now is
4 implying something that we may not be agreeing
5 on that will be done.

6 **UNIDENTIFIED:** Say that again.

7 **DR. MCCURDY:** Well, you -- you're implying that
8 we're going to decide whether or not
9 everything's going to be presumptive to get rid
10 of the dose reconstruction. That may not be
11 the final thing --

12 **DR. BLANCK:** No, that's not -- that's not what
13 we're saying, huh-uh. We're just saying you
14 don't have to do dose reconstruction; you can
15 apply almost the templates across the spectrum
16 of the special exposure group.

17 **DR. MCCURDY:** But I'm saying why don't we have
18 a generic wording that we're not making even
19 that conclusion, just we're -- look at
20 alternative ways to reduce the burden of dose
21 reconstruction.

22 **DR. BLANCK:** So -- so then our recommendation
23 would to -- would be to look at actions which
24 would standardize the approach, eliminate dose
25 reconstruction for a recommendation on

1 legislative action, something like that?

2 **DR. MCCURDY:** (Off microphone) (Unintelligible)

3 (On microphone) alternative options other than
4 dose reconstruction. I wouldn't -- you know, I
5 wouldn't put that idea you're going to
6 eliminate it in there. I'd just say look at
7 the options for improving or expediting the
8 claim process.

9 **DR. BLANCK:** Okay, I think I have it --

10 **DR. MCCURDY:** I think what you're
11 (unintelligible) read something like that --
12 this is -- with -- there's a foregone
13 conclusion of this is what you're trying to
14 look at, you know; this is what you're trying
15 to get rid of or make a decision on. And I
16 don't know if we've made that clear what we're
17 trying to do, based upon comments here.

18 **DR. BLANCK:** So recommend -- if -- if what
19 you're saying and -- and we'll have to see if
20 this is what everybody else thinks is
21 reasonable -- recommend looking at alternative
22 courses, other than dose reconstruction, for
23 atomic veterans -- something like that?

24 **DR. MCCURDY:** Well, it could include dose
25 reconstruction as an expedited way of doing it,

1 but -- right?

2 **DR. BLANCK:** Well, if we're saying alternative
3 courses, it's to what, it's essentially to dose
4 reconstruction.

5 **DR. MCCURDY:** Well, then -- then also I want to
6 hear from Tom because we have retroactive
7 issues here on what's been done over the last
8 20 years, which -- you know, what do you do
9 with, you know, the people that were not
10 included in what we're going to do in the
11 future, so I think Tom has to talk about that
12 issue. So that's why I -- right now I -- I
13 don't think we want to make a -- a specific
14 recommendation till we hear from everyone.

15 **VICE ADMIRAL ZIMBLE:** If I might suggest a
16 rewording that says let's look at alternatives
17 to the current methodology for individual dose
18 reconstruction, would that be acceptable?
19 Okay.

20 **DR. BLANCK:** Would you repeat it, please?

21 **VICE ADMIRAL ZIMBLE:** I don't think I can
22 repeat --

23 **DR. BLANCK:** Alternatives to current
24 methodology --

25 **VICE ADMIRAL ZIMBLE:** Alternatives --

1 DR. BLANCK: -- for individual --

2 VICE ADMIRAL ZIMBLE: Alternatives to our
3 current methodology of individual dose
4 reconstruction.

5 DR. BLANCK: Okay.

6 MR. BECK: Including possible legislative --

7 DR. BLANCK: Including --

8 VICE ADMIRAL ZIMBLE: Including --

9 DR. BLANCK: -- legislative relieve for --

10 VICE ADMIRAL ZIMBLE: Including -- including --

11 DR. BLANCK: Legislation --

12 VICE ADMIRAL ZIMBLE: -- necessary or requisite
13 legislative relief.

14 DR. BLANCK: Okay.

15 MR. BECK: This is a recommendation for the
16 Board, not for the agency.

17 VICE ADMIRAL ZIMBLE: Correct -- oh, correct.

18 DR. BLANCK: Exactly right, yes. I mean there
19 are constraints --

20 VICE ADMIRAL ZIMBLE: Right, that's a
21 recommendation to the Board. And if -- if I
22 could modify protocol just for a moment, we do
23 have a representative from -- from Senator
24 Reid's staff who -- who is -- has oversight on
25 matters relating to this legislation. He'd

1 like to speak.

2 **MR. FOGER:** Good morning, Board. My name is
3 Charvez Foger. I'm Senator Reid's director of
4 military and defense, and our main concern with
5 this is that our -- the calls that we get in
6 our office is the time length it is taking for
7 -- for veterans to receive their compensation,
8 so I -- I agree in the special group -- to have
9 veterans in a separate group because we did
10 this in the VA as Steve (unintelligible) -- you
11 know, veterans over 70, we have put a -- we
12 have created a tiger team so their cases goes
13 directly to them to be expedited. And this is
14 something -- what I see is the recommendation
15 that we should do with our veterans, a special
16 group that their cases can go to -- especially
17 those with -- with cancer in their last stages,
18 that we can get this expedited and this is what
19 I wanted to bring back to the Senator next week
20 to see what we're going to try to do upon your
21 recommendation as far as the dose
22 reconstruction and things that we need to do to
23 try to get it -- make it a much better program.
24 You have any questions?

25 **UNIDENTIFIED:** (Off microphone)

1 (Unintelligible) tiger team in (unintelligible)
2 compensation (unintelligible) return from that
3 tiger team was a couple of months back
4 (unintelligible) months ago.

5 **MR. FOGER:** He needs to call our office then.

6 **VICE ADMIRAL ZIMBLE:** Yeah, sounds like a paper
7 tiger.

8 **MR. FOGER:** That's right. Yes, Doctor.

9 **UNIDENTIFIED:** (Off microphone)

10 (Unintelligible) it was thrown to the lions.

11 **COLONEL TAYLOR:** I'm reading a -- extracting
12 from the morning paper about this meeting, and
13 it was (unintelligible) Dr. Zimble, Chairman of
14 the Board, Veterans Advisory, Ritter slideshow.
15 Takes years for them to get a claim reser-- a
16 claim resolved and this is absurd, Zimble said
17 during a break in Wednesday's meeting. Asked
18 if the Board should recommend absolving dose
19 reconstruction in light of Ritter's remarks,
20 Zimble said I think there are areas where we
21 are spending taxpayers' money foolishly. This
22 whole issue is being aired rather significantly
23 in today's paper, and I'm sure there'll be a
24 lot of interested people watching where we go
25 with this, and I think it's thoroughly

1 appropriate that it be a matter of discussion
2 between this Board and with people like
3 yourself and carried back, and I just invite
4 your attention to what's being published in
5 local -- locally that's pretty on-track.

6 **MR. FOGER:** So just once again I just
7 (unintelligible) --

8 **COLONEL TAYLOR:** Thank you.

9 **MR. FOGER:** Thank you. We are going to take
10 the recommendations from -- from this Board --
11 I'm going to take it back to the Senator, but
12 as you -- I want you to know that our main
13 concern is the veterans and making sure that
14 their compensation is expedited through so that
15 we can get them taken care of.

16 **VICE ADMIRAL ZIMBLE:** Right. Thank you very
17 much. Yes?

18 **MS. DURAND:** I would just ask for one
19 clarification, since I don't -- what I'm
20 getting is the Board hasn't fully agreed with
21 exactly what the recommendation should be, if
22 you could hold off on going back to the Senator
23 until you -- until the Board is able to give
24 you the --

25 **MR. FOGER:** Yes --

1 **MS. DURAND:** -- written recommendation --

2 **MR. FOGER:** -- a recommen-- recommendation.

3 **MS. DURAND:** -- so that we get it right the
4 first time.

5 **MR. FOGER:** Correct, that's what I will wait
6 for.

7 **MS. DURAND:** Thank you.

8 **VICE ADMIRAL ZIMBLE:** And I would ask for one
9 more thing.

10 **MR. FOGER:** Yes.

11 **VICE ADMIRAL ZIMBLE:** If the Senator wants --
12 wants a recommendation from this Board -- now
13 normally this Board reports to two agencies.

14 **MR. FOGER:** Okay.

15 **VICE ADMIRAL ZIMBLE:** We report either to VA or
16 DTRA --

17 **MR. FOGER:** Okay.

18 **VICE ADMIRAL ZIMBLE:** -- our sponsoring
19 agencies.

20 **MR. FOGER:** Correct.

21 **VICE ADMIRAL ZIMBLE:** To make a recommendation
22 that goes to the Hill --

23 **MR. FOGER:** Okay.

24 **VICE ADMIRAL ZIMBLE:** -- I think would require
25 a formal request from the Senator --

1 **MR. FOGER:** We can --

2 **VICE ADMIRAL ZIMBLE:** -- so --

3 **MR. FOGER:** We can do that.

4 **VICE ADMIRAL ZIMBLE:** -- if we could have a
5 request, then I could go to OLA and -- and we
6 could work out how to respond to you.

7 **MR. FOGER:** Not a problem.

8 **VICE ADMIRAL ZIMBLE:** Okay.

9 **MR. FOGER:** Not a problem.

10 **VICE ADMIRAL ZIMBLE:** Thank you.

11 **MR. FOGER:** Okay.

12 **DR. BLANCK:** So Mr. Chairman, if I may, I will
13 read what I believe is the wording that -- I
14 won't say that we've agreed upon, but at least
15 that we're moving towards so far.

16 Recommend that the VBDR consider and develop
17 alternatives to current methodologies of
18 individual dose reconstruction, to include
19 possible legislative relief.

20 **VICE ADMIRAL ZIMBLE:** That sounds good to me.
21 Okay. Now do we -- do you want to -- do you
22 want to talk about your other recommendations
23 and then we can go to -- oh, I'm sorry, Mr.
24 Pamperin.

25 **MR. PAMPERIN:** As you all know --

1 **MR. WYANT:** (Off microphone) (Unintelligible)

2 **VICE ADMIRAL ZIMBLE:** Clyde, yes, you can speak
3 today but you'll have to wait until the public
4 comment session.

5 **MR. WYANT:** Oh, okay.

6 **VICE ADMIRAL ZIMBLE:** Okay? There -- there is
7 a public comment session.

8 **MR. WYANT:** (Off microphone) (Unintelligible)
9 I'm way back (unintelligible) --

10 **VICE ADMIRAL ZIMBLE:** Okay.

11 **MR. WYANT:** -- you people are not talking about
12 that, you're talking about (unintelligible) we
13 got (unintelligible) claims (unintelligible) --

14 **VICE ADMIRAL ZIMBLE:** Now, Clyde, you're going
15 to --

16 **MR. WYANT:** -- (unintelligible) --

17 **VICE ADMIRAL ZIMBLE:** -- please -- please hold
18 your --

19 **MR. WYANT:** -- (unintelligible) --

20 **VICE ADMIRAL ZIMBLE:** -- please hold your
21 comments un--

22 **MR. WYANT:** -- (unintelligible).

23 **VICE ADMIRAL ZIMBLE:** Okay.

24 **MR. WYANT:** (Unintelligible)

25 **MR. PAMPERIN:** Yeah. Obviously, as you all

1 know, as the VA representative I can't vote on
2 this thing. Admiral Zimble did let me read the
3 transcript from 1945 and, you know, in my
4 humble opinion, I find it appalling. The -- I
5 do think that what I'm hearing here is
6 gradations of a solution that go all the way to
7 the complete elimination and everything's
8 presumptive to something that -- that might
9 perhaps only affect a particular subset of --
10 of cancers. So I don't -- I'm kind of
11 uncomfortable about -- 'cause I'm not sure I
12 understand what it is that -- that we're
13 talking about. It has a lot of implications in
14 the long run, and those implications -- if the
15 Congress decides to do that -- we'll just deal
16 with. But I -- I do think that we need to be
17 able to hash this out in terms of what
18 everybody is thinking so that we can understand
19 it and come -- come back with something that is
20 workable. And if you are looking for
21 legislative language, of course -- Congress
22 will need some -- if -- if you want discretion,
23 if you want discretion about some things, you
24 have to be very clear because if you give very
25 concrete language, then it has the meaning that

1 the words normally mean and you have no
2 discretion. So I -- I do think that it is a
3 topic very, very much worth discussing and
4 solving, but at this stage of the game I'm just
5 really uncomfortable about what I understand --
6 or don't understand.

7 **DR. BLANCK:** Well -- well, this would -- Tom,
8 if I may respond -- charge the Board, and the
9 Chairman may choose to set up a -- an ad hoc
10 committee to look into this, of which I suspect
11 you would be a part, to actually consider and
12 develop those alternates to make sure that --
13 that all of -- of what you've stated was
14 clarified and taken into account. And clearly
15 there are people that have a lot of expertise
16 in some other ways to do it than the -- the
17 current way.

18 **VICE ADMIRAL ZIMBLE:** I -- I fully agree with
19 that. Dr. Lathrop.

20 **DR. LATHROP:** Just one small thing to add to
21 your draft, because we do want to communicate
22 to people what's being considered. Should we
23 add a phrase like "alternatives to consider
24 legislative relief or modification to
25 regulations"? Because that was brought up

1 yesterday, yeah.

2 **VICE ADMIRAL ZIMBLE:** Okay. Dr. Reimann.

3 **DR. REIMANN:** I want to build on something I --
4 interpretation from Tom and from some other
5 comments. I think as a matter of principle, in
6 keeping with the faith of what we're trying to
7 accomplish, we are here on behalf of the
8 veterans, but we have -- the subcommittees have
9 a technical mission, and I think we also have a
10 major obligation for technical competence. And
11 if we start mixing political considerations in
12 technical reports, we're going to get wrapped
13 around the axle, so to speak, and get very
14 confused. So I think the kinds of issues that
15 you're raising and that have been commented on
16 quite appropriately I think are deliberations
17 of the Board that go beyond the technical scope
18 and say okay, now that we're this far along and
19 I think making progress on the technical front,
20 how are we -- how are we doing in the larger
21 sense of our commitment to the veterans and
22 what they did for the country, we might want to
23 look at some alternative, but then we won't end
24 up mixing technical issues with political
25 issues. So that's an objection that I'd --

1 that I'd like to raise, that as we move forward
2 with our reports that we also remember that
3 people will be looking at the technical work we
4 do and see whether that made sense in terms of
5 the technical requirements involved, and that's
6 I think what the committee -- subcommittee work
7 is -- is all about. As a larger group I think
8 we can tackle these other issues quite
9 appropriately, but I think -- speaking I think
10 and what Tom was getting at, we have to frame
11 those so that we know what it is that we're
12 getting at and -- and that we're following the
13 appropriate political rule as we -- as we go
14 down that path.

15 Okay, off my soap box.

16 **VICE ADMIRAL ZIMBLE:** Okay, very good. Dr.
17 Lathrop.

18 **DR. LATHROP:** I'm -- I'm excited because for
19 the first time in two and a half years I'm
20 realizing why I was appointed to the Board.
21 Yes, I know risk analysis --

22 **DR. MCCURDY:** We still can't figure that out.

23 **DR. LATHROP:** No, nobody else can, right,
24 right. I -- I am here with my qualifications
25 as -- in risk assessment and risk

1 communication. But in fact what I really am is
2 a decision analyst, and that was one of the
3 considerations bringing me before the Board.
4 Why I'm bringing this up is because we can,
5 working through decision analysis tools,
6 maintain our -- our technical role and our
7 technical expertise and still make
8 recommendations that have thought through what
9 the alternatives are in the political sphere.

10 **VICE ADMIRAL ZIMBLE:** Okay. Dr. Zeman.

11 **DR. ZEMAN:** Admiral, the letter from General
12 Groves obviously had a profound effect on you
13 as well as Mr. Pamperin. I just wanted to make
14 sure that it was going to be distributed or
15 available to us --

16 **VICE ADMIRAL ZIMBLE:** Yes.

17 **DR. ZEMAN:** -- through -- maybe through --

18 **VICE ADMIRAL ZIMBLE:** Yes.

19 **DR. ZEMAN:** -- Dr. Lathrop's C drive --

20 **VICE ADMIRAL ZIMBLE:** His hard drive.

21 **DR. ZEMAN:** -- his hard drive. And if it's not
22 -- if it's not too long, could you perhaps read
23 it to us now or is it too long?

24 **VICE ADMIRAL ZIMBLE:** It's -- it's three pages.

25 I'll -- I'll -- and it -- it's the sense that

1 you need to get. You'll get a copy of it.

2 **DR. ZEMAN:** Thank you.

3 **VICE ADMIRAL ZIMBLE:** Mr. Groves.

4 **MR. GROVES:** I guess my question concerning
5 this path forward we're going to take is that
6 the timeliness of this -- whatever we come up -
7 - the form of the recommendation seems to be
8 critical given the indications we had yesterday
9 from -- from Ms. Schroder representing
10 Representative Berkeley and from the comments
11 we've heard from Senator Reid's staff person.
12 And what I'm looking for is some way to do this
13 -- the Board normally works on -- doesn't work
14 at -- at the speed of light, and -- and this
15 recommendation probably has a timeliness
16 component to it, given what we've heard from
17 both the Senator's representative and the
18 Representative's representative, that
19 legislation that has been introduced in the
20 past is certainly expected to be introduced
21 again, and there are a number of current events
22 -- without getting into details -- that may
23 likely drive this to happen sooner rather than
24 later. So I just want to be sure that whatever
25 deliberative process we choose, and I think it

1 does need to be one of the committee, and it
2 may be that you may want to appoint a
3 subcommittee of the committee chairs, or
4 however you want to do that, but I think we
5 need to set some definitive time lines sooner
6 rather than later so that if in fact this comes
7 about, we're in the right place in the time
8 sequence to get this into the -- the
9 legislative process.

10 **VICE ADMIRAL ZIMBLE:** I'm already in the
11 process of composing a list of membership for
12 that subcommittee.

13 **MR. GROVES:** I would -- I would certainly say
14 that Dr. Vaughan and -- and others who have had
15 some experience in some of the other programs
16 of -- of -- that had legislation that supported
17 veterans and others -- we would benefit very
18 much from their input for the process.

19 **VICE ADMIRAL ZIMBLE:** Well, Dr. Vaughan can
20 certainly be a consultant to that committee.

21 **MR. GROVES:** Absolutely.

22 **DR. VAUGHAN:** Uh-huh, yes.

23 **MR. PAMPERIN:** Admiral Zimble, I'd just point
24 out that unless this was a free-standing -- you
25 know, if -- if this came to be legislation,

1 unless this was some free-standing piece of
2 work, it would seem to me that it would most
3 likely be part of the Veterans Benefits
4 Improvement Act of 2007, which would probably
5 be passed in November, or the Defense
6 Authorization Act. And if that were the case,
7 any -- any suggestions to the Hill, it seems to
8 me, would really need to be formalized by July,
9 for sure.

10 **VICE ADMIRAL ZIMBLE:** And let me just ask a --
11 a question. I -- I believe that what
12 legislative relief we want would still allow
13 the agencies to provide the codification for
14 the implementation of the legislation. So if
15 the -- if the legislation were general enough
16 to allow the agencies to do the appropriate
17 codification to implement the methodology, that
18 -- that could work.

19 Okay. Do you have another recommendation?

20 **DR. BLANCK:** Question first.

21 **VICE ADMIRAL ZIMBLE:** Colonel.

22 **COLONEL TAYLOR:** Listening -- listening to
23 this, it seems to me like if we're talking
24 about September, we're talking about history.
25 I think we're talking about some actions by

1 this Board that will need to have occurred much
2 sooner than the next meeting, and I think --

3 **VICE ADMIRAL ZIMBLE:** Yes.

4 **COLONEL TAYLOR:** -- that may bear into --

5 **VICE ADMIRAL ZIMBLE:** Yes, yes.

6 **COLONEL TAYLOR:** -- consideration when we're
7 sitting and scheduling ourselves --

8 **VICE ADMIRAL ZIMBLE:** Yes, and the --

9 **COLONEL TAYLOR:** -- because this event is far
10 more rapid than things we've done before.

11 **VICE ADMIRAL ZIMBLE:** I -- I do believe that --
12 that something can be -- can be worked sooner
13 and -- and that we'll -- we'll put together a
14 committee to do just that.

15 **DR. BLANCK:** Final recommendation is -- like
16 everyone else, we would like the outcome data,
17 as well, and data on the current population of
18 atomic veterans, and that's kind of an ongoing
19 thing which I know the VA is trying to provide.
20 That completes my brief report, Mr. Chairman,
21 members.

22 **VICE ADMIRAL ZIMBLE:** Brief, but -- but
23 certainly worthy of much discussion.

24 **DR. BLANCK:** And I'll have this typed and try
25 to get circulated to everyone before the end of

1 the meeting.

2 **VICE ADMIRAL ZIMBLE:** Could you go -- let's go
3 through these -- the recommendations that you
4 now have given us, to refresh our memory. I
5 think rather than -- than voting on these in
6 block, that we ought to take each of your
7 recommendations and -- and be assured that we
8 have a -- we had a concurrence of the Board.

9 **DR. BLANCK:** Recommendation one on non-
10 radiogenic disease, we are deferring to the
11 report of Subcommittee 3 for discussion with
12 them. Is that correct?

13 Recommendation two is that we recommend VA or
14 DTRA consider certain military units as special
15 exposure groups. Dr. Blake has agreed to
16 report on that by the next meeting, and -- and
17 that needs to be, I think -- you would agree is
18 an ongoing process and won't be interfered with
19 by -- by anything else.

20 Recommendation three is that the VA provide
21 outcome of claims to NTPR and to the committee,
22 and data on the current population of atomic
23 veterans.

24 The last recommendation, the one that we
25 discussed at some length, is recommend the

1 VBDR, us, consider and develop alternatives to
2 current methodologies of individual dose
3 reconstruction, including possible legislative
4 relief and/or modification of regulations.

5 **VICE ADMIRAL ZIMBLE:** Any further comments?

6 (No responses)

7 Okay. All who approve the recommendations as
8 amended?

9 (Affirmative responses)

10 Any opposed?

11 (No responses)

12 Hearing none, your report is accepted. Thank
13 you.

14 **PUBLIC COMMENT SESSION**

15 Now I'm looking at the time and I've been
16 reminded that at 10:15 we're supposed to -- we
17 have -- we have advertised that we would have a
18 public comment, and I'm willing to defer the
19 reports from Subcommittees 3 and 4 until we've
20 had our public comment session. But I'm going
21 to modify that. If any member of the public
22 would prefer to speak after hearing all four
23 reports, I'll allow that and take a -- a
24 shortened public comment session now. Is there
25 anybody -- any -- anyone that wishes to speak

1 now -- okay --

2 **UNIDENTIFIED:** (Off microphone)

3 (Unintelligible)

4 **VICE ADMIRAL ZIMBLE:** Okay, I'm going to ask
5 that we have each -- each member speak just
6 once so that we -- we need to get out of here -
7 - it's essential that we be -- that we be free
8 this afternoon. We have other Board business,
9 so if you're going to speak now, then please
10 don't come back and speak again after --

11 **UNIDENTIFIED:** No, I'll be leaving -- I have to
12 --

13 **VICE ADMIRAL ZIMBLE:** Oh, okay. All right.

14 **MR. VERLINICH:** With the modifications that
15 you're doing there to gain the atomic veterans
16 -- to get communications to them, we should
17 have some kind of form and then we can check
18 off A, B, C, D or whatever you are going to
19 recommend or that we can do -- oh, hell, I
20 don't know what I'm talking about. I don't
21 know how to explain it. See, like -- and then
22 like Larry was saying, vision, thyroidism and
23 all that, okay, analogy. I go to my mother,
24 how you doing, Mother? She says oh, like an
25 old car, little rust here and there. She's in

1 her 80s. Okay, we are in the same -- getting
2 into that or in that generation, so then when
3 you come out and say oh, ocular, thyroid, oh, I
4 can do that, and you're going to start getting
5 a flood of all kind of mail. And -- and to get
6 communication with us people, like it took me
7 years before I found anything about atomic
8 vets.

9 **VICE ADMIRAL ZIMBLE:** Okay. We'll be sure --
10 we -- we are working very hard at getting
11 better levels of communication, and we will
12 make sure that -- that whatever substantive
13 changes are made that will affect the veterans,
14 they'll get the word right away.

15 **MR. VERLINICH:** Thank you very much.
16 Appreciate everybody.

17 **VICE ADMIRAL ZIMBLE:** Thank you. Clyde, did
18 you want to speak now or do you want to -- want
19 to hold your peace until --

20 **MR. WYANT:** (Off microphone) (Unintelligible)
21 couple of words.

22 **VICE ADMIRAL ZIMBLE:** Okay. Come to the
23 microphone, please.

24 **MR. WYANT:** I'm sorry to take up too much time,
25 but if I don't do it now I'll probably forget

1 about it. This dose radiation was created in
2 '78. It's been a -- we've had five checks on
3 it have taken three to five years. When we
4 created this thing in San Diego and I was
5 there, after it was approved of this Board,
6 which I am 100 percent for, I asked what -- how
7 long's it going to take to do what you want to
8 do? She said in three to five years. I says
9 we'll all be dead. Why are you doing something
10 that's been done over and over again? Dose
11 radiation -- and I wished you people would
12 realize it, I think you're beginning to -- dose
13 radiation is the cause of all our problems. We
14 got thousands of claims that have been
15 approved, except for dose radiation. And I'll
16 tell you, I was in the laboratory from '43 on.
17 Nobody told me anything about radiation. I
18 didn't have any tests, and I'm sure those out
19 in the Pacific -- and I've got my heart
20 bleeding for them -- they didn't have it,
21 either. So why don't this Board really say we
22 want it out because if we can get it out 90
23 percent of our problems that you're trying to
24 work on -- and I believe you are sincere about
25 what you're doing -- but you're letting that

1 hassle you. Thank you.

2 **VICE ADMIRAL ZIMBLE:** Thank you, Clyde. All
3 right, are there any -- any other comments?
4 Yes, Mr. Clark. Aloha.

5 **MR. CLARK:** Aloha, and I'll be saying aloha 'oe
6 a little later. 2:00 a.m. tonight I leave --
7 2:00 a.m. I leave this city to go back to
8 Honolulu, so you folks, when you're m'oe m'oe,
9 when you're sleeping, think about it.

10 **UNIDENTIFIED:** (Off microphone)
11 (Unintelligible)

12 **MR. CLARK:** I just wanted to address the Board,
13 if I may, please. Just -- as you know, I was
14 instrumental in introducing 29-62*, the
15 elimination of the dose reconstruction, last
16 year. My Congressman, Neil Abercrombie, has
17 taken a very significant role in this matter.
18 As I speak to you today I'll speak to you in
19 terms of three Congressmen: Neil Abercrombie,
20 Bob Fillner and Mike Thompson. Mike Thompson,
21 northern California. Combined two bills in
22 particular, Veteran's Right to Know and Dose
23 Reconstruction. It's momentary -- as I speak
24 right now, it's momentary when the bill's
25 number will be assigned to be introduced into

1 Congress. Mr. Fillner has made it very
2 personal that he wants to push it through --
3 just a heads-up. And in conjunction with that,
4 Senator Akaka has expressed his extreme desire,
5 once we get a number on it, he wants to
6 introduce it in the Senate.

7 **VICE ADMIRAL ZIMBLE:** Okay. Thank -- thank
8 you, Charles.

9 **MR. CLARK:** Yes, sir.

10 **VICE ADMIRAL ZIMBLE:** You have a -- you have a
11 safe trip back.

12 **MR. CLARK:** I'll do that.

13 **VICE ADMIRAL ZIMBLE:** I -- I -- I would just --
14 I want to make the comment, and I'm sure that -
15 - that -- that this is the consensus of the
16 Board, that dose reconstruction is a very valid
17 and -- and good --

18 **MR. CLARK:** Yes, sir.

19 **VICE ADMIRAL ZIMBLE:** -- methodology that needs
20 to be selectively applied to those people in
21 which the levels of uncertainty --

22 **MR. CLARK:** It has its place in society.

23 **VICE ADMIRAL ZIMBLE:** Yes, it does.

24 **MR. CLARK:** In particular in the future
25 because, fellas and ladies, we're dealing in

1 Hawaii, and I -- I submit this to you, that I -
2 - the General and I were talking yesterday, I
3 travel into (unintelligible) quite often to
4 hear the Marines leave -- deploying out of
5 Kane'ohe, and they're on their fourth
6 deployment right now. To hear those gentlemen
7 going forward for their physicals prior to
8 deployment and hear the medical officer say
9 you'll not be returning back. If you plan a
10 family, we would suggest you make other
11 alternatives -- ways in thinking because of
12 exposure to DU. We have a problem. So I
13 submit again, dose reconstruction has to be
14 looked at from a favorable way. We've got --
15 we're an obligation. Thank you, sir.

16 **SUBCOMMITTEE 3 ON QUALITY MANAGEMENT AND VA PROCESS**
17 **INTEGRATION WITH DTRA NUCLEAR TEST PERSONNEL**
18 **REVIEW PROGRAM**

19 **VICE ADMIRAL ZIMBLE:** Thank you. And now we'll
20 hear from Subcommittee 3, Dr. Reimann.

21 **DR. REIMANN:** Thanks, Mr. Chairman. I think
22 we'll probably be able to gain back some of the
23 time. We're -- our role, reminding this group
24 and those in the audience interested, that our
25 subcommittee is concerned with all aspects of

1 quality management, which is -- includes
2 quality control, quality assurance and related
3 procedures and so forth, but also goes beyond
4 that to issues of relationships, overall
5 strategy, communications and costs and through-
6 put and so on. So it's a comprehensive
7 approach to quality and it entails some of the
8 work and integration of the VBDR subcommittees
9 and we have important liaison roles and -- and
10 these, I think, are especially important in
11 early years of the Board.
12 But because of that close liaison work, a lot
13 of the observations and recommendations of our
14 committee are fairly parallel, not
15 surprisingly, to the other subcommittees. So
16 we'll start with a few observations and then
17 skip directly to the recommendations.
18 So first we applaud the responsiveness of NTPR
19 and VA to our past recommendations. These
20 things are being worked on and certainly in our
21 judgment, certainly in my personal judgment,
22 are being worked on with great vigor and
23 energy, I think, on behalf of the broad goals
24 of the program in support of the veterans. And
25 I hope that's -- that's appreciated.

1 That has led to, I think, much better
2 cooperation that I think we can all feel. We
3 see the case handling as much more strategic,
4 and that strategy is helping to create much
5 better focus on the quality requirements. And
6 that focus I think has been one of the major
7 benefits of moving toward a much better
8 definition of what the quality is that we're
9 all trying to achieve.

10 Through the use of checklists and guidance
11 documents, worksheets -- and now -- and now I'm
12 quoting from both VA and NTPR, those things
13 that they're developing which are rolling
14 forward into the overall quality system, I
15 think are moving well. We would echo the
16 concerns of SC1 and others that -- that this
17 needs to -- needs to continue, and so that --
18 that speaks to some of our particular
19 recommendations.

20 First to the -- now to the recommendations to
21 VA, we urge them to capitalize on this
22 consolidation with the Jackson VARO and their
23 STAR system that is used throughout the whole
24 department; that it move quickly to formulate a
25 quality plan and program, including specific

1 metrics and the use of those metrics -- we know
2 they use metrics. We'd like to have a little
3 better sense of how they're going to be used in
4 real time by the overall department and the --
5 and the Jackson VARO to actually improve
6 against their STAR metrics and improve cycle
7 time, which is not currently part of their STAR
8 metrics system, and to produce continuous
9 quality improvement. So the secret weapon of
10 metrics is their use. Otherwise it's just a --
11 another report to file and -- and it gets -- it
12 gets put on with -- on a pile with other
13 reports. So how this is being used for
14 continuous improvement, and I think that's the
15 spirit behind some of these comments earlier
16 that we'd like to know better what the outcomes
17 have been because that can drive further
18 improvement. So our major role is to -- is to
19 prod to the -- on that point to -- to help
20 bring that about.

21 The other issue that came up in connection with
22 the discussion from SC2, we believe that you
23 should put in place -- we recommend that you
24 put in place a mechanism that avoids having the
25 non-radiogenic cases slow down the

1 responsiveness and drive up costs without any -
2 - any off-setting benefit. And the need for
3 competent medical opinion, it was our view that
4 that competent medical opinion ought to be in
5 the first instance at the -- on the VA side,
6 and I think that's the point of difference. So
7 it's not a difference at all in -- in the end,
8 it's more of a difference in the -- in the best
9 approach to doing it. And in the end I think
10 what we -- what we want is a pragmatic answer
11 that everyone can live with, but we thought
12 that since you had made the point one way and
13 we had made it the other way, at least throw
14 that out so that it can be addressed in a very
15 direct way.

16 And to NTPR, we encourage them to adhere to the
17 proposed schedule, and we appreciate that
18 proposed schedule, in developing the QA plan
19 and program, including the standard operating
20 procedures, the standard methods and all the
21 associated documentation and metrics. And we
22 would encourage that the -- that they give more
23 emphasis than in the past to the metrics
24 relating to quality and not just case-handling
25 efficiency. I think the focus on the key

1 quality requirements and the tracking against
2 those key quality requirements is going to
3 ultimately drive down costs and speed up the
4 time of case handling and benefit everyone. So
5 we feel that that's -- we're not yet at the
6 point where that -- where the -- where the
7 procedures, SOPs and so on, are sufficiently
8 well-defined to drive the metrics, which then
9 drives the improvements. So we're hoping that
10 that engine will -- will greatly improve the
11 performance in the program.

12 And we certainly look forward to the execution
13 of the double-blind analyses. We think that
14 that will be a huge eye-opener that will
15 hopefully give us a snapshot and a moving
16 picture of -- of whether things are -- are
17 working.

18 We feel that the metrics should be used to set
19 goals: for example, reducing the backlog so
20 that cases can all be processed within a period
21 of about six months to get this backlog, which
22 is now several years down and that it can be
23 kept so that the expectations can be set of how
24 long it would take to process a claim.

25 And again, we reinforce the comments of SC1

1 regarding case file, case file documentation,
2 upper bounds and so on. But we recognize that
3 in their role they are the experts in what
4 these parameters should be and what the
5 associated documents and -- and technical
6 reports should be. We want to see those things
7 built into a quality system which is clearly
8 apparent to all and that it operates in a -- in
9 a smooth fashion so that the SC3 and others can
10 -- can verify that -- that the program is
11 working as intended and that the energies are
12 then directed toward any of the problems with
13 ongoing analyses that -- that still identify
14 places where perhaps the procedures are -- are
15 not as -- as well-defined as -- as they should
16 be and so on, and also take account of some of
17 these changes that we heard today, like the
18 cataract cases and so on.

19 So that's our -- that's our report. Again, I
20 emphasize that -- that our liaison roles, which
21 we feel are working well, create numerous
22 parallels in terms of the recommendations. So
23 most of our recommendations, if not all, are --
24 are basically support recommendations relative
25 to the primary responsibilities of

1 adjudication, case handling, RDA and
2 communications and so on.

3 So on that note I'll close and maybe ask my
4 colleagues in the quality mafia here to speak
5 out or add -- add anything that -- from your
6 perspective that I might have missed.

7 **VICE ADMIRAL ZIMBLE:** I'd like to -- I'd like
8 to hear their comments regarding the secret
9 weapon of metrics and -- that's being used.

10 **UNIDENTIFIED:** (Off microphone) I think we need
11 to have discussion on the --

12 **VICE ADMIRAL ZIMBLE:** Yes, what I'd like to do
13 now is ask for comments on all of the
14 recommendations, with the exception of the
15 recommendation regarding the -- the competent
16 medical authority, so if we could have a show
17 on -- I'm sorry --

18 **UNIDENTIFIED:** (Off microphone)
19 (Unintelligible)

20 **VICE ADMIRAL ZIMBLE:** Okay. Any comments
21 regarding any of the recommendations of the
22 subcommittee, with the exception of the
23 recommendation regarding competent medical
24 authority?

25 (No responses)

1 Seeing none, I would ask for a vote on approval
2 of those recommendations.

3 (Affirmative responses)

4 Any objections?

5 (No responses)

6 Seeing and hearing none, I'll now ask that we
7 enter into a discussion over the recommendation
8 for competent medical authority. Dr. Blanck.
9 **DR. BLANCK:** Obviously we agree that there
10 should be some review of those cases of non-
11 radiogenic disease. In discussions with the
12 VA, and Mr. Pamperin specifically, the VA feels
13 that if there is a medical opinion provided by
14 the veteran, they must send it to -- to DTRA.
15 DTRA has now under their employment an expert
16 medical review physician -- a radiation
17 oncologist, as I remember -- who they are
18 willing to use to give that expert competent
19 medical opinion in some cases, which would lead
20 then to further actions at dose reconstruction,
21 what have you, and most cases would have the
22 case returned to the VA and the benefits side
23 would have the case sent to the health side for
24 a final review before the -- the adjudication
25 is done. Working with the two agencies, we

1 believe that is the best case. We had
2 originally actually had the recommendation as
3 you do, but would submit that, with the
4 agreement of both of the agencies, that's kind
5 of what we've worked out.

6 **VICE ADMIRAL ZIMBLE:** Thank -- oh, go ahead,
7 Dr. Swenson.

8 **DR. SWENSON:** We believe that the Veterans
9 Health Administration should make the decision
10 on health, that they are really the medical
11 experts --

12 **DR. BLANCK:** They do --

13 **DR. SWENSON:** -- this is my opinion.

14 **DR. BLANCK:** They do, they are the final
15 reviewer.

16 **DR. SWENSON:** And they actually have an expert
17 currently available, I believe, and NTPR or
18 DTRA hired the individual they have because of
19 this particular reason, that he was not brought
20 in for other reasons. So to be good stewards
21 of money, rather than sending more money over
22 to NTPR and to DTRA and down that road, why
23 don't we utilize that physician, who is an
24 expert in this area, in the VA? And that's my
25 opinion.

1 **VICE ADMIRAL ZIMBLE:** Mr. Pa-- Mr. Pa-- oh, I'm
2 sorry. Dr. Fleming.

3 **DR. FLEMING:** Just a point of clarification.
4 Would either one of these recommendations
5 eliminate the need for the veteran to seek a --
6 a medical opinion from his physician or provide
7 one themselves?

8 **MR. PAMPERIN:** No, they would not. In order to
9 --

10 **DR. FLEMING:** It would not eliminate that?

11 **MR. PAMPERIN:** No, because in order for a non-
12 radiogenic disease to even get to DTRA, they
13 have to submit some medical evidence to support
14 their contention.

15 **DR. FLEMING:** So -- so then is it the case that
16 because the veteran is submitting that, it --
17 it must go to DTRA?

18 **MR. PAMPERIN:** That's our view, that -- there's
19 a court case called Combee* that we believe
20 suggests that that's what has to happen, absent
21 competent medical evidence to the contrary.
22 Now if -- my per-- my perspective on this is --
23 I do understand your point of view that we are
24 the -- the medical people and that we should
25 make that kind of a determination. But I look

1 at this more in the construct of the current
2 process, and that in fact in all things
3 radiation we go to DTRA. And that -- I would
4 personally prefer to have DTRA do that for a
5 couple of reasons.

6 First of all, it -- it focuses all those issues
7 about radiation with them. Secondly, I think
8 we would increase consistency and we would
9 certainly reduce cycle time on those because --
10 Paul, you said you could turn those in a month
11 or so.

12 **DR. BLAKE:** Even -- in a few weeks.

13 **MR. PAMPERIN:** Right, and you know, the reality
14 is that if -- what we would -- it's not clear
15 to me, if you're referring to Dr. Neil Otchin,
16 that he would be giving those medical opinions.
17 It may very well be that they would be farmed
18 out to oncologists around the system and then,
19 you know, I -- I won't promise you when you'd
20 get an answer.

21 **VICE ADMIRAL ZIMBLE:** If -- if I could be
22 audacious enough to propose a Solomonistic
23 recommendation, I think -- we all agree that
24 competent medical authority is required and we
25 feel that the current procedures fall short of

1 -- of reaching competent medical authority.
2 Where the individual is located, whether it's
3 in DTRA or in VA, could be a subject for
4 negotiation between those two agencies, and for
5 ultimate resolution it does not have to be part
6 of the Board's decision. I think that the
7 recommendation that comes from us ought to take
8 into account the opinion -- the Daulbert*
9 opinion of 1983, or the 702 opinion, which very
10 precisely characterizes the necessary expertise
11 to provide a competent opinion. And if we
12 would say that -- that our recommendation is
13 that the agencies arrange for a -- an opinion
14 that meets the criteria of 702 in order to --
15 prior to dose reconstruction, that that would -
16 - that would meet the sense of the argument.

17 **DR. SWENSON:** I would --

18 **VICE ADMIRAL ZIMBLE:** Dr. Swenson.

19 **DR. SWENSON:** I would concur with that, but I
20 do have a question for Tom. For those non-
21 atomic -- when you say you're treating all the
22 veterans the same and they would get the same
23 treatment, for those non-atomic veterans that
24 have a non-radiogenic cancer, you are still
25 making assessments within the VA.

1 **MR. PAMPERIN:** So you're talking occupational?
2 When we're talking occupational radiation we
3 get our reconstructed dose estimate from -- or
4 a dose estimate, I wouldn't say it's a
5 reconstructed one -- from the Service
6 Department, and that's provided to Dr. Neil
7 Otchin, who does use the IREP model to -- and
8 as he explained before -- yesterday, sometimes
9 when it isn't in the IREP model he looks at
10 other -- other processes to come to a medical
11 opinion. But I think as you -- as you saw in
12 the -- the documents that DTRA prepared, they
13 are very, very comprehensive and they're --
14 they're very persuasive. Clearly I think
15 that's the kind of product that he's producing.
16 While it might be arcane and difficult for most
17 people -- to include the veteran, particularly
18 if he's suffering -- from understanding, but --
19 but they are understandable. And I -- I just
20 think that if it was -- for me, as a practical
21 person adjudicating claims, I would much rather
22 have the kind of analysis that was done by DTRA
23 going forward in denying a person than
24 something that I'm not quite sure what we would
25 get across the system.

1 **VICE ADMIRAL ZIMBLE:** Okay. I think we can --
2 we can resolve that argument by rephrasing the
3 -- the recommendation from --

4 **UNIDENTIFIED:** Agree.

5 **VICE ADMIRAL ZIMBLE:** I'm sorry. Paul.

6 **MR. VOILLEQUÉ:** I don't have the competence to
7 pass any judgment on the recommendations that
8 were made by the person who's employed by DTRA,
9 but it -- having that decision made or that
10 recommendation made at DTRA gives the
11 perception of a conflict of interest. And in
12 fact the reason that person is hired is because
13 historically, as I understand what Dr. Blake
14 has told us, they had -- they had these cases
15 on their plate and it seemed like it was
16 inappropriate to do dose reconstructions, and
17 so there -- I think there's a potential problem
18 there and I don't think we're going to solve it
19 by telling the two agencies to negotiate.

20 **MR. PAMPERIN:** Well, you know, I -- I, too, am
21 cognizant of the potential for a perception of
22 conflict of interest. However, the way I see
23 it is that we've fulfilled our duty to assist
24 by sending it to DTRA. And DTRA is the manager
25 of their resources and they're saying now wait

1 a minute, we're the experts in -- in this kind
2 of stuff. We don't think we need to expend
3 \$12,000 on this kind of an issue. And -- and
4 as Paul said, every once in a while they get
5 one of these things back that says well, yes,
6 you do. But that's their initial response to
7 us, that by their own resources they've looked
8 at this and said this doesn't make sense to do
9 this kind of a -- a thing, so they kick it back
10 to us and we ask our medical people to review
11 it and determine whether they agree.

12 Now if -- if Neil or whoever it is says I
13 disagree, then it goes back to DTRA, you know,
14 to do the dose.

15 **VICE ADMIRAL ZIMBLE:** Yeah, the -- the other
16 piece of that is I -- I think that you could
17 find argument for conflict of interest from
18 either side.

19 **DR. BLAKE:** (Off microphone) (Unintelligible)

20 **VICE ADMIRAL ZIMBLE:** There's a conflict of
21 interest --

22 **DR. BLAKE:** Could I comment on that?

23 We -- we have another option that we can
24 consider. Admittedly, we've done a lot of
25 cases already to get the backlog done, but in

1 the long term both agencies support a contract
2 for the Board. This function could be -- even
3 though the Board may eventually diminish in
4 size and so forth, I think both agencies see
5 the value of having an independent group review
6 what we do. And even if it downsizes in scope,
7 that contract that's supported by both agencies
8 to support the Board could take on that
9 function. An appropriate -- just like we're
10 doing for the double-blind studies through the
11 NCRP, once again we could bring in appropriate
12 people through a contract modification that
13 would be independent of the Board's, and so
14 that's at least another option to look at that
15 would be independent of the two agencies.

16 **VICE ADMIRAL ZIMBLE:** Dr. Blanck.

17 **DR. BLANCK:** Excellent suggestion. May I
18 suggest that be part of the negotiation and not
19 part of the recommendation, that we simply go
20 with Dr. Zimble, what you said, negotiate
21 between the two agencies based on the case
22 reference, which I can't recall, and -- and
23 then you can work out the best possible way.
24 Final decision, by the way -- getting at the
25 conflict of interest -- is by the VA. So

1 which I won't go through and read, but I do
2 want to talk about the activities that we are -
3 - have on our plate as our continuing
4 activities.

5 We will continue to meet with the other
6 subcommittees, and we had an actual formal
7 recommendation or suggestion from Subcommittee
8 1 this morning that -- that our group look at -
9 - look at -- at a particular document, and I
10 had suggested this morning that we, as the
11 communication and outreach subcommittee, would
12 be willing to and in fact it would probably be
13 appropriate that we looked at all of the
14 documents that go back and forth to see if we
15 can make them more understandable, more
16 readable and more helpful to -- to the veteran,
17 because there is a lot of technical content. I
18 guess I would add to that that we would -- we
19 would look at all of those document-- all that
20 documentation -- reports, brochures and other
21 things -- from a standpoint of -- of -- of risk
22 communication, as well, recognizing that that's
23 a major component of -- of what we are -- what
24 we are doing, and so we certainly have staff on
25 the committee and available to the subcommittee

1 to -- to help us do that. So I think it's --
2 it's probably fair to say that that's an
3 appropriate activity for our subcommittee to be
4 involved in and -- and we're happy to take that
5 on.

6 We are still struggling, as -- as you know,
7 with trying to get more people to the meetings.
8 And I'm -- I very much want to appreciate the
9 number of people we've had at this meeting,
10 which is significantly larger than we had at
11 Hampton. And -- and -- and I'm also happy to
12 see a lot of familiar faces in the crowd, as
13 well as -- as some new folks.

14 One of the things we're particularly looking at
15 is taking advantage of some of the major
16 veterans' organizations, the -- the American
17 Legion, the VFW, the AmVets, the Disabled
18 American Vets --who have a huge constituencies
19 and -- and -- and interface with them on a way
20 that I think that we can get articles about the
21 committee and about the program, the atomic
22 veterans program, in their publications. We've
23 talked about the fact that a lot of the
24 constituents we're trying to reach are not
25 familiar with utilizing computers and things

1 like that, so the way that we would communicate
2 with today's generation is -- is significantly
3 different than the way to effectively reach out
4 to an older generation. And I -- just as an
5 example, my -- my father is a World War II
6 veteran and he receives a number of
7 publications, including ones from the VFW. And
8 he doesn't read anymore because of macular
9 degeneration, but I look through these when
10 they come in and see if there's anything in
11 there that might be relative for him, and I
12 think that a number of the atomic veterans may
13 have children or grandchildren or friends or
14 acquaintances that would be familiar with these
15 publications. And so I think it's a -- it's
16 another opportunity to continue our outreach to
17 identify what is available to the veterans.
18 Now we have had the discussion yesterday that
19 that doesn't necessarily mean that they will
20 come forward, that they have an interest, a
21 need, a desire. But I think that we have an
22 obligation to make sure that they -- to do
23 whatever we can to ensure that they know about
24 the program's existence and then -- then they
25 can have their own choice on that.

1 We -- along that line, we are in the final
2 stages of developing the -- the glossy brochure
3 that we talked about at previous meetings. And
4 I want to take this opportunity to thank the
5 folks at DTRA for helping us with the -- the
6 draft and the -- putting it in a form that I
7 think will be very useful as the VA takes
8 advantage of that and places it in a number of
9 their facilities. As yet another in the many
10 ways that we're trying to describe the program
11 to the veterans community.

12 Also along that line, we have been offered the
13 opportunity to take advantage of a -- of a
14 graduate student who is doing some work in
15 intergenerational communications supported by -
16 - by DTRA and -- and -- and we are certainly
17 going to take advantage of the opportunity to
18 work with that individual and see if, as a part
19 of her research, we can elucidate other ways in
20 which we can improve the communication
21 methodologies that we might employ to -- to
22 better reach this -- this group of -- of
23 veterans.

24 So I don't have any formal recommendations from
25 Subcommittee 4, but I think, as you see, we

1 have a number of ongoing outreach and
2 communication activities, both internal to the
3 Board -- which is a part of our charter -- as
4 well as through the VA and -- and DTRA and to
5 the larger veterans community. Thank you, sir.
6 **VICE ADMIRAL ZIMBLE:** Thank you. Dr. Boice.
7 **DR. BOICE:** Yeah, I wanted to bring up again
8 one of the -- the concerns that I've had for
9 several years now about contacting the atomic
10 veterans -- actually contacting them. Not just
11 through the meetings or the veterans'
12 organizations, but in some way through the
13 mailing lists or actually doing something very
14 proactive to send the 100,000, the 200,000
15 atomic vets that are out there a notice saying
16 this program exists, and if you have a claim or
17 concern, please contact your local office.
18 And this was reinforced yesterday when the --
19 the kind lady spoke about her husband, an
20 atomic vet, and she was not aware of the
21 program or the process. And it seems that
22 there are the people here in the room that
23 know, but the -- that there's large numbers
24 that don't, and they have entitlements that are
25 not coming to them.

1 So it seems to me there should be a way to
2 contact them, and I have just one or two
3 examples. One, I'm from Rockville, Maryland.
4 Okay? Now you should know Rockville, Maryland
5 for two things. One, unfortunately we're the
6 home of the sniper a number of years back, was
7 not a good thing; that was right near my house
8 where a lot of those activities occurred. But
9 the second thing is, just a while ago there was
10 a computer that was stolen from the VA with all
11 these records of the veterans. Now this was
12 right down the str-- it was the same street
13 that I live on was the VA employee, so -- so
14 I'm a magnet for stuff.
15 Now -- all right. Well, this happened, and
16 there was a concern -- it had names, Social
17 Security number on it, and it was recovered.
18 But just a week or so after that, I received a
19 letter from the VA and it said not to worry,
20 but if you do worry, please call this number.
21 Now -- now somehow -- I've never made a claim
22 to the VA. I didn't even know I was in your
23 system, but I did receive a letter, so some--
24 so one thing was -- the DTRA mailing -- the
25 DTRA lists that they've prepared and with other

1 -- there must be ways in which we could be
2 proactive and -- and somehow reach out to those
3 that have never heard of -- or have forgotten
4 about their experience being atomic vets and
5 don't -- don't -- really aware that they're
6 entitled to these. So I'd like to somehow
7 encourage us some way in which to -- to look at
8 that very seriously in -- in actually
9 contacting the 100,000 or so in some way.

10 **VICE ADMIRAL ZIMBLE:** Thank you very much for
11 that recommendation. It's a good one and I
12 think the fact that we have a brochure that's
13 almost ready for production would be the idea
14 way I think to be proactive.

15 **MR. GROVES:** Yeah, this -- this was an issue
16 that came up at our meeting which John -- John
17 was at and we specifically had asked and -- and
18 had a representative from Tom's office to work
19 with us at that meeting, along with Dr. Blake's
20 folks -- and in fact, Dr. Blake's predecessor,
21 who had been involved in some of the mass
22 mailings that had taken place in the past. And
23 -- and I think we are -- we're looking at the
24 possibility of doing that, and I think that the
25 first step in that process is essentially

1 working as we speak in that there is an
2 exchange of databases going on between DTRA and
3 the VA right now. And -- and Paul probably
4 knows better than I how to describe that, but
5 we do -- we are trying to match up people that
6 we had originally mailed information to about
7 this program that were in that atomic veterans
8 community. So -- so you're absolutely right,
9 John. That is one of the actions that we're
10 taking to try to see if there is a way to have
11 a specific mailing list that would go to this
12 particular set of beneficiaries and -- and I
13 think Ed wants to comment on that, as well.

14 **VICE ADMIRAL ZIMBLE:** Okay. Thank you very
15 much again.

16 **COLONEL TAYLOR:** The direction --

17 **VICE ADMIRAL ZIMBLE:** Colonel.

18 **COLONEL TAYLOR:** -- this entire Board is
19 turning is very refreshing to me and we've kind
20 of walked through and done a lot of things, but
21 a lot of things have fallen together very well.
22 And one of the things that I see is in dealing
23 with veterans and veterans' clubs and
24 organizations, which I do all the time, is I've
25 learned to ask people that have any knowledge

1 or any part of being an atomic veteran -- and
2 the term is very descriptive as to who is an
3 atomic veteran -- to contact other people that
4 they know and ask them to get on board.
5 I think anything we publish or write about it
6 recommends that whether you have any intention
7 of making a claim or involved in it or not, you
8 should register yourself on the IRR. The IRR
9 becomes a pretty good master list of who the
10 veterans we have and to work on the mailing
11 list on that with it. And I think that we need
12 a couple of measures, and Ken has alluded to
13 them, of comparing lists and so forth and
14 communicating through the national publications
15 which are very, very well read. And I know, as
16 a sidelight, a person put my name on a -- try
17 to get in touch with somebody in the back of
18 one of them, I've forgotten -- I think it was a
19 VFW magazine. I bet I got 150 phone calls from
20 people saying that I was on the list. I found
21 out later it was my exec, and I'm not sure he
22 didn't do it as a crank, but nevertheless, I
23 sure got a lot of phone calls, which was an
24 indication of how generally that thing is read
25 and how people respond to it.

1 So we need, in addition to asking them to
2 identify themselves, is give them a place on
3 which they can be identified that we can pick
4 up from there and compare lists and so forth.
5 I'd open to any comment on that.

6 **VICE ADMIRAL ZIMBLE:** Okay. Thank you very
7 much, Colonel. Appreciate that, and I'm sure
8 that the Chairman has taken that aboard.

9 **MR. PAMPERIN:** Admiral Zimble, on behalf of the
10 VA, John, thank you for bringing up that --
11 that event.

12 **VICE ADMIRAL ZIMBLE:** Just before -- before
13 postage goes up again.

14 **MR. PAMPERIN:** You know, the -- that database
15 that a part of it was stole is what's called --
16 stolen was -- is called BIRLS, our Beneficiary
17 Identification Records Locator System. It has
18 over 40 million people in it. Everybody prior
19 to 1973 basically had to file some sort of a
20 claim -- loan guarantee benefits, education
21 benefits, hospitalization, whatever -- to get
22 into the system. Since 1973 -- well, since
23 1973 everybody who got out of the service, a
24 copy of their DD214 was sent to Austin, Texas
25 where it was entered into it. And since the

1 middle '80s everyone who enters military
2 service -- we get a direct feed from the
3 Defense Manpower Data Center to expand the
4 database. So we know the people who are on
5 active duty right now.

6 And the way we did that is we took that file
7 and we gave it to IRS to attach addresses to
8 it, and most of -- most of you -- like you,
9 fortunately, only got one. A few people, the
10 Post Office delivered bags. So we just wanted
11 to make sure how really sorry we were -- but it
12 is a -- it is a process -- we've had the
13 Institute for Defense Analysis look at the
14 database, and it is amazingly complete. They -
15 - they view that the only veteran population
16 that is under-represented are women veterans
17 from World War II and Korea, because at -- in
18 that cultural time they usually ended up
19 marrying other vets. And since they were
20 typically stay-at-home moms, it was -- they
21 used the -- the man's service in order to get
22 loan guarantee benefits or something like that,
23 but Institute for Defense Analysis believes
24 that the database is over 99 percent accurate.

25 **DR. BOICE:** That's amazing. Just thank you

1 very much for the explanation. And I guess the
2 follow-up would be is there ways in which,
3 since you already have the 40 million names and
4 addresses that --

5 **MR. PAMPERIN:** No, we do not --

6 **DR. BOICE:** You don't?

7 **MR. PAMPERIN:** -- that system does not have
8 addresses in it. You would have to -- there
9 are ways of -- of getting addresses from NIOSH
10 under certain research and outreach kinds of
11 things. There are ways perhaps of getting them
12 from Social Security or IRS, but those things
13 would all have to be worked out.

14 **DR. BOICE:** I'm sorry, I misunderstood. I
15 thought when you mailed out the letters, you
16 matched to the IRS for the addresses, that
17 that's how --

18 **MR. PAMPERIN:** Right, we did, and that was --
19 well, we got the address from them.

20 **DR. BOICE:** I see, and that was just for a
21 special, one-shot --

22 **MR. PAMPERIN:** Right.

23 **DR. BOICE:** -- activity? I see.

24 **MR. PAMPERIN:** Right.

25 **COLONEL TAYLOR:** That's interesting information

1 and I appreciate it very much. I wonder if
2 those names have any of the specialty
3 qualifications of the people involved.

4 **MR. PAMPERIN:** No, they do not.

5 **COLONEL TAYLOR:** And that -- that -- that's
6 where we need to go.

7 **MR. PAMPERIN:** No, they -- they do not. They -
8 - what -- this is basic data: name, Social
9 Security number, service number, insurance
10 number, date of birth, date of death, branch of
11 service, EOD, RAD, character of discharge, some
12 things like whether or not you were a POW,
13 whether or not you'd been in the Gulf War.

14 **COLONEL TAYLOR:** Yeah, there are all kind of
15 specialty events --

16 **MR. PAMPERIN:** Yeah.

17 **VICE ADMIRAL ZIMBLE:** Colonel, but -- but Dr.
18 Blake has recently provided VA with about
19 480,000 names which do have that
20 characterization.

21 **COLONEL TAYLOR:** Well, there's another area
22 that you might go into on that. For example,
23 you look at MOS's, Military Occupational
24 Specialty, which is a four-digit number. They
25 had prefixes to it. For example, if you are a

1 paratrooper you'll get a pre 6 7. I use
2 basically about three different MOS's, all of
3 them are prefixed with a 7. If you are a
4 nuclear trained employment officer, you have a
5 prefix 5. So things like that begin to
6 identify individuals in the group that help --
7 that help us let -- get who they are --

8 **DR. BLAKE:** Col-- Colonel --

9 **COLONEL TAYLOR:** -- 'cause getting a list of
10 names is important to us.

11 **DR. BLAKE:** Colonel, in our database we -- we
12 don't have the MOS's and the other codes that
13 we use in the other services consistently.
14 It's in there to some extent, and so what -- I
15 do have listings of veterans with a lot of
16 data. That can't be used as a complete tool,
17 unfortunately, to do some of the sorting.

18 **FORMATION OF NEW SUBCOMMITTEE**

19 **VICE ADMIRAL ZIMBLE:** Okay, let's move on to
20 the next piece of business and that's going to
21 be my creation of a fourth -- a fifth
22 subcommittee, the Subcommittee for Exploration
23 of Alternatives to Dose Reconstruction. And I
24 -- I listed a few names, but I think I'm going
25 to go with the recommendation of Mr. Groves to

1 pick the four chairs. The chairs may
2 substitute members of their -- a member of
3 their committee to serve in their stead if they
4 so desire. In addition to that, I would like
5 to have Dr. -- Dr. Fleming on that board as the
6 ethicist, and I would ask that Dr. Vaughan, as
7 our risk communicator, be a consultant to that
8 board. And if -- if she -- or subcommittee.
9 If she can't serve, that we do have another --
10 other alternatives for risk communication, and
11 so I'd like to -- to establish that committee,
12 and since it really emanated from Subcommittee
13 2 and since he's now out of the room, I -- I
14 will appoint General Blanck to serve as its
15 chair.

16 **FUTURE MEETINGS**

17 Okay. The next piece of business will be a
18 discussion regarding future meetings of the
19 Board. We do have a meeting established in
20 September, which would be from September the
21 17th through the 21st, and that will be in
22 Chicago. And I would ask Mr. Groves if he has
23 recommendations for subsequent meetings.

24 **MR. GROVES:** Let me ask the Board to turn to
25 Tab 7 in their notebook, and -- and I -- and

1 the first question I'm going to ask you is --
2 (Whereupon, multiple speakers commented
3 simultaneously.)

4 **MR. GROVES:** I'm sorry, 12 -- is to look at the
5 fact that we have two dates that are close
6 together, the December and January date, and --
7 and let me remind you why -- why those are
8 there. It came up at our meeting in Hampton
9 that based on the material that came out of the
10 meeting this month, we would decide whether or
11 not the December meeting, which we had already
12 all given our availability for, was needed.
13 And I guess I would -- I would make an
14 observation in -- in hopes that there would be
15 concurrence by the rest of the -- of the Board
16 that obviously we don't need to meet both in
17 January and in December. And I would like to
18 suggest that I have heard nothing from this
19 Board this time that would require us to meet
20 at the December date, so I think I'm going to
21 recommend that the meeting after the September
22 meeting be held in January on the dates that
23 are listed here on the tab. So I -- it -- it --
24 -- unless somebody has discussion relative to
25 the December date, I think we will eliminate it

1 as one of the dates we are considering. So I'm
2 looking around and don't see anybody having a
3 heartburn with that.

4 Okay, now let me go back to the September
5 meeting, which is our next meeting. I think
6 that our discussions in Hampton were that we
7 would try to have a meeting at a veterans'
8 facility. I talked with Mr. Pamperin and he
9 put me in touch with the regional -- one of the
10 regional --

11 **UNIDENTIFIED:** Medical center.

12 **MR. GROVES:** -- medical center folks in the
13 Chicago area, which is where we had decided we
14 would hold this meeting. We have been offered
15 the -- one of the facilities at the Jesse Jones
16 --

17 **MR. PAMPERIN:** Jesse Brown.

18 **MR. GROVES:** -- Jesse Brown Medical Center. We
19 have done some preliminary work with the staff
20 on looking at the facilities to support that,
21 hotel and otherwise. Dr. Zeman, who works at
22 Argonne National Lab in Chicago, has agreed to
23 meet directly with the -- the folks from the
24 veterans medical center to review the venue to
25 see if it meets our needs, and he will be doing

1 that within the next week or two. So I think
2 it's -- I think it's fair to say that the
3 meeting will be held in the Chicago area,
4 preferably at the Jesse Brown Medical Center at
5 the dates that are listed here.
6 We have a -- a couple of -- of speakers that we
7 had deferred from this meeting because of
8 issues that came up at Hampton, and I will
9 remind you who those are -- Dr. Ray Johnson --
10 Raymond Johnson, who is another risk
11 communicator, and Mr. John Taschner, who is a
12 retired Air Force officer, retired from Los
13 Alamos National Lab and was actually a
14 participant in above-ground nuclear testing,
15 who was going to give us his thoughts and some
16 history of actual atomic veteran participation.
17 And I think that -- I'm looking for Isaf -- I
18 don't know that we have any other speakers
19 lined up at this time, so we will certainly
20 take any suggestions from the -- from the Board
21 as to -- based on what we've heard at this
22 meeting, are -- are there particular people we
23 would like to hear from at our next meeting.
24 But -- so I think that we -- that -- that's the
25 plan, Admiral Zimble, is to do the meeting, you

1 know, in the Chicago area, preferably at the --
2 at the VA location. And -- and I do think that
3 we have a hotel, Melanie, that we've already
4 picked out that we'll get the information out
5 to all the Board members, as soon as Dr. Zeman
6 gets a chance to validate that the facility at
7 the hospital is going to work. And if not,
8 we'll -- we'll look to the hotel to support the
9 functions, so -- Paul, you --

10 **DR. BLAKE:** Just on recommendations on
11 speakers, if -- if I may. The two speakers
12 that you've brought in there are -- are
13 primarily on communication. The speakers that
14 we had yesterday were more based on SC1 and
15 SC2. The ones that I would recommend are --
16 more emphasize SC3 as we move into quality
17 assurance. And where I can't speak for the VA,
18 certainly from DTRA, the group that supports us
19 I think would be appropriate to bring in and
20 have a presentation given on DTRA quality
21 assurance by the contractor who actually does
22 that if the Board would like that. I don't
23 know if the VA would like to do something
24 similar. But we're -- we're at the stage where
25 our QA manual should be out. We should give

1 you some feedback on what I -- where our QA
2 processes are, I believe.

3 **MR. GROVES:** I would certainly agree with that,
4 and -- and I see that -- that Tom's light is
5 on, and I -- and I hope that you're going to
6 offer us a speaker on the status of the
7 Jackson, Mississippi central location.

8 **MR. PAMPERIN:** Right, I -- it may be -- I'll
9 probably even commit -- Neil will shoot me --
10 Joe Adair, the director of the Jackson regional
11 office, to make a presentation.

12 **MR. GROVES:** That would be great. I also think
13 that, Admiral, given what may be having -- what
14 may be happening in the legislation as well as
15 our recommendations relative to the
16 legislation, that as this process develops over
17 the next couple of months there may be a
18 speaker or speakers who would be able to talk
19 directly to those issues. And I guess I'd like
20 to hold some spaces open on the agenda, and I
21 think that that's fine with just the four
22 speakers that we currently have now, to be able
23 to accommodate that, so...

24 **VICE ADMIRAL ZIMBLE:** That sounds fine to me.
25 I have no problem with that.

1 Now, that takes care of September the 17th.
2 What are we going to do about the December
3 date?

4 **MR. GROVES:** Well, I think that that --
5 remember, I had put a map on the -- on the wall
6 at the --

7 **VICE ADMIRAL ZIMBLE:** Never mind, never mind --
8 forget it.

9 **MR. GROVES:** -- at the last -- at the last
10 meeting and we had -- we had talked about the
11 fact that in our continuing desire to move the
12 meeting around the country to --

13 **VICE ADMIRAL ZIMBLE:** Yeah, I -- I was in the
14 midst of another conversation when that
15 decision was made, but I see that -- that --
16 that the DFO has taken care of me and crossed
17 that out on my thing.

18 **MR. GROVES:** Oh, okay. Sorry.

19 **MS. DURAND:** Now can I ask a question?

20 **VICE ADMIRAL ZIMBLE:** Loca-- the location now
21 for the 21st of January.

22 **MR. GROVES:** Right, and the --

23 **MS. DURAND:** Can --

24 **MR. GROVES:** -- and -- go ahead.

25 **MS. DURAND:** I want to go back to September and

1 just -- and maybe I missed it, just to
2 everyone's clear on, one, the reason for
3 Chicago and, two -- I'm not quite sure how to
4 put this in a positive light -- the experience
5 we had at Hampton was a difficult one I think
6 logistically in going from a hotel to the VA,
7 and that was our lowest turnout of veterans.
8 I'm not sure that had anything to do with it.
9 I know nothing about the layout in Chicago. I
10 voice concern, though, about trying to do that
11 again. It seems to be more convenient for both
12 the Board members, subcommittee members, as
13 well as the veterans, to do it in one place.
14 So I -- I'm not sure that -- again, knowing
15 nothing about the physical layout of that, that
16 that's a good road to go down again, given the
17 experience that we had in Hampton.

18 **MR. GROVES:** Ed, did you have a comment on
19 that?

20 **COLONEL TAYLOR:** Yes. I agree with her on the
21 complexities of the Hampton situation. And if
22 you look at the veteran population, Hampton
23 should have been by far the greatest turnout of
24 veterans, and it was the lowest. So we need to
25 look at that.

1 But the other thing that occurs to me on there
2 is the veterans -- we probably need to put out
3 some information to the veterans because I've
4 received a number of complaints that we end up
5 in a very expensive hotel and they have a
6 significant cost to come here from a distance,
7 and then they seem to feel obligated to stay in
8 that motel, both of which are additional
9 individual costs to them. And then they
10 attribute -- say, no, you guys shouldn't do
11 that; you should apply that money to benefits
12 for us. Well, that's a logical follow-on to
13 the discussion. But the point being that when
14 we choose a place and have a meeting, I think
15 we need to go kind of the route we're going,
16 but we need to find a couple of adjunct places,
17 maybe, Melanie, where veterans can stay more
18 reasonably and still communicate, whether it be
19 in a military installation around there or a VA
20 installation, or just a more inexpensive motel,
21 but someplace that they can be encouraged to
22 come and stay and be at the meeting because one
23 of the very primary purposes of moving these
24 meetings is to go where veterans are and to get
25 them to come. So we need to work in that and

1 any direction we can. Thank you.

2 **VICE ADMIRAL ZIMBLE:** I'm -- I'm going to ask
3 Ms. -- Mrs. Todd, is there some -- is it
4 feasible for us to be looking at the hotel for
5 the -- for the meeting site instead of the
6 Jesse Brown facility?

7 **MS. TODD:** Is it on? Okay. We have a -- a
8 hotel right now in Chicago for subcommittee
9 meetings and for sleeping rooms, and it was my
10 understanding that we were definitely going to
11 have it at the Jesse Brown VA medical facility.
12 So -- and that is the closest -- the -- the
13 hotel that I have is the closest to that
14 facility. So if we go change that right now,
15 I'm not sure if we have a big VBDR meeting room
16 there yet -- I haven't checked -- if you want
17 to. But there's always problems with -- it --
18 it's better for the -- I know one veteran said
19 to me they like having it at one place so
20 they're not having to travel. We try to get
21 them into our group -- our group rate. Now
22 whether there's any lower hotels -- you know,
23 fees or I should say there's -- you know, like
24 Hotel -- Motel 6 or whatever, they're still
25 going to have to travel back to the hotel. So

1 there's, you know -- there's some --

2 **VICE ADMIRAL ZIMBLE:** Pros and cons.

3 **MS. TODD:** There's pros and cons with
4 everything. So right now what we have for
5 September is we do have the Jesse Brown medical
6 -- VA medical facility. They do have a room
7 there and we do have a hotel that's probably a
8 mile away. That's the closest -- we did not
9 want to go downtown because you've got that
10 rush hour traffic back and forth. So we do
11 have one close enough. It may not be, you
12 know, close enough to drive, but it's the
13 closest one I could find that is okay. So...

14 **VICE ADMIRAL ZIMBLE:** Okay, thank you.

15 **MS. TODD:** Okay.

16 **VICE ADMIRAL ZIMBLE:** I appreciate that.

17 **MS. TODD:** Okay.

18 **VICE ADMIRAL ZIMBLE:** Let's -- let's -- for the
19 -- for the present, let us con-- let us
20 continue to pursue the use of the Jesse Brown
21 facility, but I would ask, Melanie, if you
22 would also check with the hotel that you have
23 selected and see if, number one, you can get
24 the group rate; number two, if you can have a -
25 - a room, approximately this size, for the two-

1 day Board meeting. And then I would ask that
2 the DTRA also explore the possibility, which
3 they've done in the past, of taking care of
4 parking fees for any veterans that come. And -
5 - and if we have -- that we can make that --
6 make it -- that alternative decision a little
7 bit later, once we have -- once we know
8 feasibility. Okay? All right.

9 Now -- now I'd like to move on with the January
10 meeting because I want to give Mrs. Todd as
11 much time as possible to make arrangements.
12 The sooner the better in this day and age. And
13 secondly, I would -- I just learned that we
14 have one more speaker for public comment, and
15 so I would ask that once we get through this
16 last meeting date, that we then ask for public
17 comment. So Kenneth?

18 **MR. GROVES:** We had discussed the fact in our
19 moving around the country that we had not been
20 either to the northwest -- Seattle/Portland
21 area -- or the northeast -- New York/Boston
22 area. But I also look at the dates in January
23 and that's -- sorry, David. The suggestion has
24 been made that we might want to go south again.
25 And since we started our rotation in Tampa,

1 that maybe there would be an opportunity to --
2 to go back there. There's a large
3 concentration of veterans in Florida certainly,
4 and it -- and without committing to a venue
5 there, I guess I would like to at least offer
6 for consideration by the Board that we -- that
7 we might go back to Tampa again in the -- for
8 the January meeting. And -- and Ed, that saves
9 you having to drive very far.

10 **COLONEL TAYLOR:** (Off microphone)

11 (Unintelligible) Orlando.

12 **MR. GROVES:** But what we could do is our
13 committee could -- if you were to agree that
14 that location was one that we could consider,
15 we could, you know, certainly take that on as a
16 subcommittee action to explore the different
17 opportunities and -- and we're not going to
18 wait till September to get back to you on that,
19 but we -- between now and then we would make a
20 recommendation that -- that you all could give
21 us your opinions on.

22 **VICE ADMIRAL ZIMBLE:** Okay. Dr. Fleming.

23 **DR. FLEMING:** I want to ask if the subcommittee
24 has considered the -- the Oakland Bay area. It
25 strikes me that there is probably a large

1 concentration of veterans in that area.
2 January, the -- if -- if we're worried about
3 climate, it's -- it's not exactly spring yet,
4 but it's almost around the corner. Just -- has
5 -- does anybody know what kind of population
6 there is -- population base for vets there is
7 in the Oakland -- I mean it's maybe not the
8 prettiest -- careful what I say here -- but we
9 -- but I'm aware that there's quite a few mil--
10 military installations and -- and hospitals.
11 There's a veterans' home, I believe, up in the
12 Yountville area, which is a little further
13 away.

14 **COLONEL TAYLOR:** (Off microphone)
15 (Unintelligible) (on microphone) there are two
16 or three elements in trying to go to a place
17 where veterans are. One is, where are the
18 number of veterans which can be pretty well
19 determined by the retirees, the veterans, the
20 rest of them. Just because you're a veteran
21 may not put you on somebody's list because
22 there are an awful lot of people who were
23 veterans that aren't getting any benefit any
24 way so they're not on anybody's list.
25 The other thing that goes with that is how many

1 local veterans type organizations are there
2 that have contact with a lot of people, and how
3 many local veterans or military or VA type
4 facilities -- hospitals, bases, commissaries,
5 all kind of things -- are ways to communicate
6 to people who have -- who are veterans. So in
7 addition to finding a number of veterans, we
8 need to kind of look to see what other vehicles
9 or facilities or organizations are there that
10 can help us communicate to those veterans. I
11 have found that when I turn to the various
12 veterans organizations in St. Johns County, I
13 turn to 25 organizations and I can get to close
14 to 10,000 veterans right quick. So it becomes
15 an easy way to communicate going through those
16 kind of systems. So you need to kind of
17 consider that and it's a good point you're
18 talking about Oakland. It has some good
19 facilities, I think, in that same regard.

20 **VICE ADMIRAL ZIMBLE:** Mr. Beck.

21 **MR. BECK:** Yeah, I -- I would be opposed to
22 going back to the same place. I think the
23 principle that we established was that we were
24 going to move around to give different groups
25 of veterans --

1 **UNIDENTIFIED:** Yeah.

2 **MR. BECK:** -- a chance to come to our meetings,
3 and we gave the groups of veterans in the
4 vicinity of Tampa the ability to come to our
5 meeting, and I really think we should stick to
6 our plan of moving around.

7 **VICE ADMIRAL ZIMBLE:** Okay.

8 **UNIDENTIFIED:** I agree.

9 **VICE ADMIRAL ZIMBLE:** Okay, we have some
10 agreement to that. I -- I also agree. There --
11 -- the largest concentrations of veterans --
12 unless there's been a significant demographic
13 change in the last few years, the largest
14 concentration of veterans in the United States
15 are -- and especially retirees, that I know for
16 sure, is Texas and California -- southern
17 California -- southern California, Texas and
18 Florida. I -- I think that the Orlando site
19 could be explored, but I also think one -- one
20 should look at San Antonio. We've not been
21 there and there's a major concentration of
22 military in San Antonio.

23 **COLONEL TAYLOR:** And organizations.

24 **VICE ADMIRAL ZIMBLE:** And organizations, right,
25 including USAA headquarters.

1 **DR. LATHROP:** Just to -- whenever I think of a
2 military town, I think of San Diego. I know we
3 were in Los Angeles, but San Diego is a long
4 way away from Los Angeles in miles and culture.

5 **VICE ADMIRAL ZIMBLE:** Oh, yes, it's really
6 Navy, much more Navy than San Antonio.

7 **MR. GROVES:** Well, may I -- may I suggest that
8 -- it sounds like we might not be able to
9 resolve this today, but that our subcommittee
10 will, having heard the comments and input, make
11 that a part of the deliberations for our next
12 meeting and that we will make a recommendation
13 to the Board within 60 to 90 days, plenty of
14 time in order for Melanie and others from our
15 support at NCRP to have -- have time to arrange
16 for the meeting.

17 **VICE ADMIRAL ZIMBLE:** Okay, that sounds good.
18 One -- one question.

19 **DR. LATHROP:** The -- the dates are firm?

20 **MR. GROVES:** I think that the dates are firm
21 and -- and tell me, Isaf, tho-- those were the
22 dates that when the Board was polled was the
23 date that most people could attend.

24 **VICE ADMIRAL ZIMBLE:** Okay.

25 **DR. BOICE:** Just --

1 **VICE ADMIRAL ZIMBLE:** Dr. Boice.

2 **DR. BOICE:** Just two quick comments. One, I'd
3 like to support strongly Shari's comment about
4 having the meeting in the hotel that we're
5 residing in. I can't say how -- how much I
6 support that. And even a little hassle, a
7 mile, to go to the -- the Jesse Brown Medical
8 Center and just -- whether it's a mile or five
9 miles, it -- it's -- it is an additional
10 hassle. You have to leave early. You have to
11 plan. You can't stay late at the meeting. I
12 don't think I agree -- you know, the Hampton
13 experience was not that positive, and so if
14 there is ways just to -- I'd just like to
15 reinforce that to have the meeting at the
16 hotel, it's -- I think it's an advantage
17 overall to everyone.

18 **VICE ADMIRAL ZIMBLE:** Okay. The hotel has been
19 picked, and I've asked Mrs. Todd to investigate
20 the -- the feasibility of -- of having that
21 meeting there, so she's going to do that and
22 we'll -- we'll --

23 **DR. BOICE:** I appreciate that. I had a second
24 comment. It was about -- for future speakers
25 for us to consider. And you know there are

1 other countries that have compensation
2 programs, and I'm thinking like in the United
3 Kingdom and also with the Japanese with the
4 atomic bomb survivors. They have standing
5 committees, they have procedures, they've dealt
6 with a lot of the issues that we're dealing
7 with, and perhaps a presentation from someone
8 from the United Kingdom and also someone from
9 the Japanese atomic bomb survivors might be
10 beneficial for the Board.

11 **VICE ADMIRAL ZIMBLE:** You could make -- if you
12 could supply after the meeting some -- some
13 names that you would recommend, appreciate
14 that.

15 **DR. BOICE:** Yeah, I -- I know both groups and
16 could supply them.

17 **VICE ADMIRAL ZIMBLE:** Right, that'd be great.

18 **MR. GROVES:** Fortunately Dr. Boice sits on the
19 committee that will be making some of these
20 recommendations, so we have access to him.

21 **VICE ADMIRAL ZIMBLE:** That sounds good. Okay.
22 Thank you.

23 **DR. ZEMAN:** Admiral, if I could -- Admiral, I'd
24 like to ask Ken Groves if -- in selecting these
25 January dates, have you considered the mid-year

1 meeting of the Health Physics Society? I
2 believe it meets right about that time and will
3 affect maybe three or four of us around the
4 table.

5 **MR. GROVES:** I'll have to admit that I don't
6 know that we knew the dates at the time this
7 calendar went out. Do we know for a fact that
8 it is a conflict? I mean that --

9 **DR. ZEMAN:** It's -- it's very close to the --

10 **MR. GROVES:** Yeah.

11 **DR. ZEMAN:** It's very close to this week. It's
12 either the week before, this week, or the week
13 after, and --

14 **UNIDENTIFIED:** (Off microphone)

15 (Unintelligible) being held?

16 **DR. ZEMAN:** It's in Oakland.

17 **MR. GROVES:** Let us look at that and -- and get
18 that information out as a part of the package
19 we're going to send you.

20 **DR. ZEMAN:** Thank you.

21 **VICE ADMIRAL ZIMBLE:** Any other -- further
22 comments? I see a couple of nameplates still -
23 - Dr. McCurdy?

24 **DR. MCCURDY:** Oh, no, that was the question I
25 had.

1 **VICE ADMIRAL ZIMBLE:** Okay. All right.

2 **DR. MCCURDY:** Thanks. Yeah, several of us had
3 (unintelligible) --

4 **VICE ADMIRAL ZIMBLE:** All right then, we'll --
5 we'll -- you have a comment?

6 **DR. BOICE:** I was looking at the Health Physics
7 meetings, 27-30 January 2008, Oakland
8 Convention Center. That's the mid-year topical
9 meeting, so that's 27-30 January 2008. It's in
10 Oakland.

11 **DR. ZEMAN:** Thank you. That does not conflict
12 with this then. Unless we meet in Oakland.
13 That would be a long stay in Oakland.

14 **VICE ADMIRAL ZIMBLE:** Okay. I'm going to leave
15 it -- leave it up to -- to Mr. Groves to
16 resolve the issues of -- of these dates and the
17 -- and the location. Okay. And sub-- you get
18 the hard ones, right. You submit that back to
19 us as soon as possible.

20 Okay, R.J., you had a comment?

21 **MR. RITTER:** (Off microphone) I didn't mean to
22 interrupt (unintelligible) mentioning location
23 (unintelligible) concentration of veterans,
24 keep in mind (unintelligible) very high
25 concentration of veterans.

1 **VICE ADMIRAL ZIMBLE:** Okay. I -- Ken did not
2 hear that, but Dr. Boice did, so we'll take --
3 look at Phoenix, as well. Good, that's -- you
4 know, I'm sure Senator McCain would be very
5 happy for us to go to Phoenix.

6 **PUBLIC COMMENT**

7 And now I would ask that Ms. Stephanie Evans,
8 who wants to make public comment, please come
9 forward and -- if you'd please introduce
10 yourself and...

11 **MS. EVANS:** Thank you for letting me speak.
12 I'm Stephanie Evans. I am Pat Broudy's
13 daughter, and I am here to read a statement
14 from her. This is a presentation by Pat
15 Broudy, Vice Commander and Legislative
16 Director, National Association of Atomic
17 Veterans.

18 Speaking on behalf of the atomic veterans
19 community and to the best of my information and
20 belief, none of the thousands of veterans
21 involved in underground testing have been
22 included in the Veterans Advisory Board on Dose
23 Reconstruction's goal, which is to provide
24 guidance and oversight of dose reconstruction
25 and claims compensation programs for veterans

1 of U.S.-sponsored atmospheric nuclear weapons
2 tests from 1945 to 1962, veterans of the
3 1945/1946 occupation of Hiroshima and Nagasaki,
4 Japan; and veterans who were prisoners of war
5 in those regions at the conclusion of World War
6 II.

7 However, what the VBDR does not include in
8 their mission statement is the presence of
9 thousands of underground test participants,
10 those exposed from 1962 through 1992 in the
11 tunnels underground at the Nevada Test Site.
12 The commitment of the United States to reduce
13 levels of worldwide fallout by refraining from
14 conducting nuclear tests in the atmosphere, in
15 outer space and underwater, was finalized when
16 the limited test ban treaty with the Soviet
17 Union was signed on the 5th of August, 1963.
18 Prior to the United States' testing moratorium,
19 six safety experiments in tunnels and four
20 weapons-related tests in tunnels were conducted
21 at the Nevada Test Site. Containment of
22 nuclear detonations was an engineering
23 challenge. Radioactive products from several
24 of these tests were not completely contained
25 underground. As a result, solving containment

1 problems would require years of underground
2 testing experience, and so the story of
3 underground test participants unfolds.
4 With the signing of the threshold test ban
5 treaty in 1974, and the peaceful nuclear
6 explosions treaty in 1976, the United States
7 and the Soviet Union agreed to limit the
8 maximum yield of underground tests to 150
9 kilotons. These treaties were not ratified by
10 the United States until September, 1990.
11 Problems weren't -- were resolved by new
12 U.S./Soviet verification proposals agreement,
13 the first of June, 1990. By this time
14 underground testing by the United States had
15 continued unabated from 1962 through 1992,
16 exposing thousands of DoD and DOE personnel
17 from DNA, not DTRA; other government
18 organizations, user laboratory contractors and
19 DoD contractor agencies. DoD and DOE-
20 affiliated personnel who participated during
21 the test period were mostly military and
22 contractor personnel.
23 Of recent interest, and to bring us up to date
24 on the subject of underground nuclear tests,
25 had the non-nuclear bunker-buster Divine Strake

1 been detonated as planned by the Defense Threat
2 Nuc-- Reduction Agency at the Nevada Test Site,
3 it would have lofted not only the surface
4 radioactive elements, but those contained in
5 the miles of radioactive tunnels underground at
6 the Test Site. Divine Strake was designed to
7 test for ways to penetrate underground
8 fortifications that may be built by an enemy.

9 **VICE ADMIRAL ZIMBLE:** Okay. Thank you very
10 much for that testimony. And --

11 **MS. EVANS:** Thank you.

12 **VICE ADMIRAL ZIMBLE:** -- I would ask -- well,
13 first off, let me make one comment, and then
14 ask any of the members if they'd like to make
15 comments, as well.

16 What -- what -- what is being requested by --
17 by your mother is beyond our capacity to take
18 on without getting su-- such direction to
19 modify our charter by the entities that have
20 established us, so -- so that's number one.
21 But -- so I think that the appeal that you're
22 making needs to be made to a different
23 authority. Okay?

24 **MS. EVANS:** (Off microphone) (Unintelligible)
25 understood that.

1 already signed up and registered to meet in the
2 lobby of the hotel at 1:15.

3 **VICE ADMIRAL ZIMBLE:** Okay.

4 **MR. GROVES:** We are probably going to just hail
5 a couple of cabs to get us over there. It's
6 not very far. It's a little more than walking
7 distance, but in -- in saving DTRA a lot of
8 money this time, we didn't get very many rental
9 cars, so we'll -- we'll -- we'll grab some cabs
10 and go down there as a group.

11 Just to remind everybody, we're going to have
12 both a presentation by Martha DeMarre, who is
13 the -- the person who is in charge of the
14 archives for all the testing, and then Ms.
15 Maggie Smith is going to lead our visit to the
16 museum. And we are anticipating being through
17 by 5:00 o'clock, which is when the museum
18 actually closes. However, we have been told
19 that if we are not through at 5:00 o'clock,
20 that for our group of -- and for our group
21 only, they will keep the museum open till 6:00
22 o'clock tonight if that's needed for all of us
23 to be sure we get to see what we want to see.
24 And there is not -- I would recommend us
25 changing to more comfortable clothes, if you

1 want to. There's no reason, unless the Chair
2 requires it, that we wear ties this afternoon.

3 **COLONEL TAYLOR:** (Off microphone)

4 (Unintelligible) --

5 **VICE ADMIRAL ZIMBLE:** Well, I -- I might --

6 **COLONEL TAYLOR:** -- (unintelligible)

7 **VICE ADMIRAL ZIMBLE:** Yes.

8 **MR. GROVES:** Yes, and -- and I know we have a
9 couple of members that are not going to go to
10 the museum tour because they -- they've already
11 had a chance to visit, but that he -- who may
12 also be going to the NTS tour, and I know that
13 you're going to tell everybody when you're
14 going to meet tomorrow morning for that. But
15 there has been a suggestion, Colonel Taylor,
16 and I certainly wouldn't disagree with it, that
17 maybe, since we have a large number of the
18 Board members here, we should get a group
19 picture, but we would have to do it here at the
20 hotel, right at the end of this meeting, since
21 I know some people are going to be leaving
22 shortly after the meeting and will not be at
23 the museum.

24 Now we will get a picture of those of us that
25 are at the museum, but if we wanted a picture

1 of all the current members we have with us,
2 it's -- it's right at the end of this meeting.

3 **COLONEL TAYLOR:** (Off microphone)

4 (Unintelligible) was not so much a picture
5 (unintelligible) group but a picture
6 (unintelligible) the museum.

7 **MR. GROVES:** Well, in that case then, there'll
8 be plenty of opportunities to get pictures of
9 members of the group at the museum in front of
10 some of the displays this afternoon, so we'll
11 do that.

12 **VICE ADMIRAL ZIMBLE:** I will prescribe no dress
13 code for the -- for the meeting this afternoon.
14 Dress -- dress comfortably for the tour at the
15 museum. And then I would ask all those who
16 plan to take the NTS tour tomorrow to please
17 meet in the lobby at 0830 -- 0830 hundred
18 hours, for the Army -- and -- Pacific time,
19 yes. And since it's before March the 11th,
20 it'll be Pacific Standard Time. And -- so Mr.
21 Wright -- Mr. Eric Wright will be the individu-
22 - look for him in the lobby at 0830. Right,
23 okay.

24 Next I would like to thank the Board members
25 for -- for I think another very successful and

1 productive meeting. I'd like to thank the
2 staff for accommodating all of our needs.
3 Thank the hotel for providing ample space.
4 Thank the court reporter -- well, maybe I'll --
5 I'll withhold my thanks to him until I see the
6 transcript, and I would thank the audio visual
7 people for doing a super job for us, and thank
8 you very, very much. I also would thank the
9 veterans for their -- for their comments, for
10 their attendance, for getting us some very
11 productive information that we can use to -- to
12 make recommendations that are salient and --
13 and practical.

14 So with that, I'll ask for a motion to adjourn.
15 Boy, you guys want to stay longer?

16 **MR. PAMPERIN:** I motion we adjourn.

17 **VICE ADMIRAL ZIMBLE:** Okay, do I have a second?

18 **MR. BECK:** Second.

19 **VICE ADMIRAL ZIMBLE:** So moved. Thank you very
20 much, everybody.

21 (Whereupon, the meeting was concluded at 11:30
22 a.m.)

23

24

25

