

HealthWatch

A newsletter of the Worker Health Protection Program, a partnership between Queens College, CUNY and the following organizations: United Steelworkers, Atomic Trades and Labor Council, Fernald Medical Screening Program

Volume 7, Issue 11 Spring 2008

H. R. 2764 Assures Funding for Former Worker Program and Early Lung Cancer Detection at Mound, Fernald and the GDPs

President Bush Signs Bill on December 26, 2007

The Worker Health Protection Program (WHPP), and the DOE Former Worker Program (FWP) as a whole, owe a tremendous debt of gratitude to the outstanding efforts of the members of Congress who passed H. R. 2764, the Omnibus Appropriations Bill for 2008. WHPP also thanks the local union leaders who took the time to meet with and inform their Congressional delegations of how vital the FWP medical screening program is and the importance of extending the lung cancer screening to sites not yet reached by the



US Senator McConnell (R-KY)



US Senator Bunning (R-KY)



US Congressman Whitfield (R-KY)



US Senator Alexander (R-TN)



US Congressman Wamp (R-TN)



US Senator Brown (D-OH)

WHPP Early Lung Cancer Detection Program.

The following US Senators and Congressmen played a key role in passage of the bill: Senator Lamar Alexander, (R-TN); Senator Pete Domenici (R-NM); Senators Mitch McConnell (R-KY); Congressman David Obey, Chair, House Appropriations Committee (D-Wisc); and Congressman Pete Visclosky (D-IN). All of the above served on the Senate or House Appropriations Committee. Special thanks for their efforts also go to Senator Sherrod

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Newly Released Report Highlights Success of the DOE Former Worker Medical Surveillance Program

Innovative and *groundbreaking* are two words that come to mind when describing the Department of Energy's program for remedying the occupational health legacy of nuclear weapons production -- the Former Worker Medical Surveillance Program (FWP). The FWP, which was Congressionally mandated in 1993, provides free medical screening for DOE workers at risk for occupational disease, as a result of their hazardous exposures at a DOE defense nuclear facility.

The FWP covers the entire DOE complex and is the first comprehensive industry-wide occupational medical screening program in the country. It is also the first major medical screening program to involve workers and their unions directly in the planning and implementation. Another unique aspect of the FWP is the collaboration between DOE and the academic centers involved, in crafting the National Medical Protocol, the document that lays out the basic elements of the screening (such as blood-work, X-ray etc.) and describes additional tests (such as

beryllium lymphocyte proliferation blood tests) to be done in cases where specific occupational hazards have been identified.

Over 600,000 contractor employees have worked in the DOE weapons complex during the past 60 years. Many have been exposed to radioactive materials and toxic chemical agents without adequate protections or monitoring.

The goal of the FWP is to detect work-related health conditions at an early stage, when appropriate steps can be taken to restore or conserve health. DOE has worked with the academic centers around the country to ensure that this is achieved.



Glenn S. Podonsky, Chief Health, Safety and Security Officer, US Department of Energy

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Message from Dr. Markowitz, WHPP Project Director

There is a new revolution in manufacturing. It is called nanotechnology, and it involves manufacturing very small particles, that is, less than 100 nanometers in size, or about one thousandth the width of a human hair. One of the areas of great excitement about nanomaterials is their use in medicine for diagnosis and for drug delivery, because these particles may elude normal barriers between cells and organs, are reactive, and can carry large quantities on their surfaces relative to their size.

Of course, revolutions in industry are worrisome to workers, the public and the occupational health professionals interested in protecting the health of workers and the public. The United Steelworkers and other unions are very active in raising appropriate health and safety concerns as nanotechnology industries develop. And it is none too soon, since nanotechnology products are expected to be a \$1 trillion dollar (US) global market involving 2 million workers within the next 7 years.

The National Institute for Occupational Safety and Health (NIOSH) has now proposed “interim guidance” for medical screening of workers potentially exposed to engineered nanoparticles. These guidelines state that, since very little is known about the human toxicity of these materials at present, no medical screening is recommended, though employers may wish to voluntarily undertake medical screening for their workers.

We disagree with this approach. If there is a reasonable chance that such materials are toxic, especially in view of

animal studies that have demonstrated such toxicity, doesn't it make sense to start medical screening early so that problems can be detected early? Consider the history of exposure to radiation and chemical toxins in nuclear weapons production, beginning in the 1940's with broad medical screening instituted in the 1990's.

We recommend that NIOSH take the following sensible actions: 1) Recommend basic medical screening for nanotechnology workers now, 2) Develop an ongoing expert working group to monitor the evolution of scientific knowledge in this area and recommend changes in medical screening as needed, and 3) Develop a national nanotechnology health surveillance program, enrolling a large number of workers and tracking their health to identify unusual disease problems early. Industry should foot most of the bill for this work, since it is their duty to provide a safe and healthy workplace.

Our recommendations will not slow the nanomaterial juggernaut. And they are not a replacement for the implementation of protective strategies to reduce exposure, for the use of safest possible alternatives, and for the provision of detailed information on the composition and possible health hazards of materials.

DOE workers know better than most the costs in life and health of an earlier revolution – the introduction of radioactive and chemical toxins into the workplace and society. Shouldn't we have learned the lesson that it would be wrong to endorse a new nano-revolution without simultaneously taking bold, affirmative steps to avoid preventable harm to workers and the public?

WHPP Success At-A-Glance (as of 1-31-08)

USW: Gaseous Diffusion Plants, INL and Mound

No. of callers	18,977
No. of exams completed	15,450
No. of workshops completed (excluding Mound)	381
No. of participants who attended workshops (excluding Mound)	4,262

ATLC: ORNL and Y-12

No. of callers	3,736
No. of exams completed	2,405

Fernald Medical Screening

No. of callers	795
No. of exams completed	478

If you haven't taken advantage of the WHPP free medical screening exam, call toll-free to make an appointment today!

Fernald:	1-888-241-1199
GDP's & INL:	1-888-241-1199
Mound:	1-877-866-6802
ORNL & Y-12:	1-800-906-2019



Visitors to the **University Occupational Health** clinic are greeted by Dr. Bearwell, a member of Knoxville's sculptural artscape. Joining him are staff members (left to right) Norma Cate, receptionist; Joy Holiway, LPN; Brenda Leach, CMA nursing coordinator; Jennifer Parris, medical technician; Dr. Don Keeble; Dr. Jon S. Parham; and Dr. M. David Stockton, clinical director. **See full story on page 3.**

ATLC Early Lung Cancer Detection Program: A Successful First Year

August 2007 marked the one year anniversary of the Early Lung Cancer Detection (ELCD) Program for ORNL and Y-12 workers. And what a busy year it was! Over 1,500 ORNL & Y-12 workers received a low-dose screening CT scan; an additional 540 follow-up scans were done, for a total of 2,076 scans.

What is a low-dose CT scan?

The CT scanner that we use on the ATLC mobile unit is not different from a CT scanner you would find in a radiology office or at a hospital. Both use x-ray radiation to get a picture of the lungs. On our scanner, however, the settings are changed so that the participant receives a lower dose of radiation than a standard, diagnostic CT but the scan is sensitive enough to detect abnormalities too small to be seen on a conventional set of chest x-rays. The development of this new low-dose protocol in the 1990's meant screening for lung cancer could be done in a healthy population without exposing participants to a significant risk from the procedure itself.

Why do early lung cancer screening?

Lung cancer is the leading cause of cancer death for both men and women. About 160,000 people in the United States die of lung cancer each year. The five-year survival rate of all stages of lung cancer combined is 15%, meaning only 15 of every 100 people diagnosed survive at least five years. On the other hand, if lung cancer is found and treated by surgery early, before it has spread to lymph nodes or other organs, the five-year survival rate increases dramatically – as high as 70%. This means that 70 out of 100 of these patients will survive for at least five years. A recent study published in the *New England Journal of Medicine* in October 2006 showed that lung cancers detected by low dose screening CT scans at the earliest stage (Stage 1), and surgically removed within the first month of diagnosis, showed a projected 10-year survival rate of 92%.

To date, 21 ATLC program participants have been referred to their personal physicians for follow-up of suspicious nodules. We have detected six lung cancers, four of



which were found at the earliest possible stage, 1A. This mirrors the experience from our previous lung cancer screening program for the gaseous diffusion plants (GDP) workers where, over six years, we found 45 cancers, 80% of which were early. This is in stark contrast with the experience nationally, in the general population, where less than 16% of all cancers are detected at an early stage.

As with all screening methods, such as mammograms for breast cancer or PSA for prostate cancer, lung cancer screening is recommended on an ongoing basis. This is the key to early detection. If a cancer is found on a follow-up screening, it is more likely to be at an early stage -- before symptoms occur and the cancer has a chance to spread -- since a limited time has elapsed. So remember – even if you have a normal baseline screening, you should check within the recommended time frame to make sure nothing new has developed. Currently, there is no official guideline for how often lung cancer screening should be done. The Cornell international consensus screening protocol (I-ELCAP) recommends annual scans. The WHPP ELCD program offers one baseline and one annual screening CT scan and follow-up CT scans, when needed. It is important to note that 12 of the 45 GDP cancers were detected on the annual scan.

Garry Whitley, President of ATLC, remarked, “We are thrilled that the lung cancer screening program has become available to both current and former ORNL/Y-12 workers; over one thousand workers have called in to request the low-

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University of Tennessee and the Worker Health Protection Program: Combining Clinical Practice and Public Health Initiatives

University Occupational Health, in the Department of Family Medicine at the University Of Tennessee Graduate School of Medicine, is an occupational health facility that is contracted by the Worker Health Protection Program (WHPP) to provide medical screening exams for participants from Oak Ridge National Laboratory (ORNL) and Y-12.

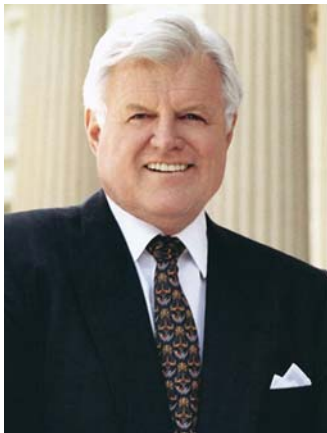
As part of the University of Tennessee Medical Center campus in Knoxville, the Department of Family Medicine participates in public health initiatives like WHPP, giving Family and Internal Medicine resident physicians an opportunity to be trained by the faculty physicians and other health professionals in the recognition of job-related illnesses in workers such as those at ORNL & Y-12.

“The academic medical center setting provides a unique opportunity that allows our resident physicians to better understand the medical issues surrounding health care for

workers that have been exposed to environmental and /or occupational hazards,” explains M. David Stockton, M.D., director for University Occupational Health. “Our proximity to Oak Ridge also allows us to demonstrate to these physicians how exposure to asbestos, beryllium, radiation and other cancer-causing agents impacts the lives and families of these workers.”

As part of the Worker Health Protection Program since May 2005, University Occupational Health has provided medical screening exams to more than 475 workers. “We are proud of our role in the early diagnosis of cancers and disorders associated with work-related hazards,” says Dr. Stockton. “Early diagnosis translates to improved outcomes for our patients. Improved health outcomes for our region lead to a better quality of life for all.”

Hostettler and Kennedy Hearings in 2006 and 2007 Highlight Need for Further EEOICPA Reform



US Senator Ted Kennedy (D-MA)

A nationwide call for reform has been heard since the inception of the Energy Employees Occupational Illness Compensation Program Act (EEOICPA) -- the landmark legislation that provides federal workers' compensation to energy workers. An amendment to the Act, passed in 2004, made significant improvements but further problems have been identified as experience with the claims process has gathered. In the

past two years, multiple Congressional hearings have addressed these new and lingering issues.

Most recently, Senator Kennedy's Health, Education, Labor and Pensions (HELP) Subcommittee hosted a hearing in the 110th Congress on October 23, 2007, entitled "EEOICPA: Is the Program Claimant Friendly for Our Cold War Heroes?"

In the previous Congressional session, Chairman John N. Hostettler of the House Judiciary Subcommittee on Immigration, Border Security and Claims, held five sets of hearings from March through December of 2006. The focus of these hearings was an Office of Management and Budget (OMB) memorandum to the Department of Labor that laid out a plan for limiting the cost of federal workers' compensation program for energy workers, with a particular emphasis on the Special Exposure Cohorts (SEC). See HealthWatch Issue 9 for further details on this hearing.

The 2007 Kennedy Hearings

The Kennedy hearing was organized by Senators Jeff Bingaman (D-NM) and Lamar Alexander (R-TN) and was chaired by Senator Alexander. Senators Sherrod Brown (D-OH), Wayne Allard (R-CO) and Patty Murray (D-WA) all made brief comments about the nuclear weapons sites in their jurisdictions and the need for fair and timely processing of EEOICPA claims.

According to testimony by the DOL Ombudsman, Malcolm D. Nelson given at the hearing, the primary complaint that the Department of Labor (DOL) receives is that the claims process for both Part B and E takes too long. Some DOE workers reported that they have waited years and others, who may not have waited years, are concerned, because they are older, sick, and fear they may die before receiving benefits. Claimants also described the burden of proof required by Part E as an insurmountable hurdle. Part E requires the claimant to provide proof of employment at a covered DOE facility and proof of exposure to toxic substances; in many cases these records are not available.

Fortunately, the hearings were not just a forum for voicing complaints. Constructive ideas were also presented. Dr. Ken Silver, Assistant Professor of Environmental Health Sciences at East Tennessee State University, proposed four-

teen specific reforms for improving EEOICPA. Some of these are:

- Mandate that Part B cancer claimants be given the dose reconstruction information used to analyze their claim so that they can evaluate the information for missing contamination episodes, incorrect years, missing radionuclides and other data that NIOSH is likely to miss. If a claim is denied, the claimant could then review the dose reconstruction with a worker advocate or other knowledgeable party, to see if there is a basis for appealing the decision.
- Revise DOL regulations to allow Part B claimants who receive a probability of causation of 40 to 49% (just under the 50% cut off needed for a successful claim) to submit a second expert medical opinion on the causation issue.
- Amend the Act to create a separate, DOL-independent Part E Advisory Board. (An independent Advisory Board already exists for Part B claims.)
- Expand the scope of the DOL Office of the Ombudsman to include Part B claims. Also, the Ombudsman should be explicitly authorized to "advocate" for claimants.
- Place a representative of the Ombudsman's office in each DOL EEOICPA Resource Center.

The Department of Labor and NIOSH testified at both hearings. Shelby Hallmark, Director for the Office of Workers' Compensation Programs, DOL, described the success of DOL in implementing both Part B and E of the Act. He said that "nearly 75 percent of all Part B cases have received at least one final decision from DOL."

"Under Part E, Mr. Hallmark continued, we've issued an initial decision on 80 percent of the 2,500 cases DOL inherited from DOE."

John Howard, M. D., Director of the National Institute for Occupational Safety and Health (NIOSH), gave an update on the number of approved SEC petitions, and two new resources for claimants -- an SEC petition counselor and a NIOSH ombudsman.

The Kennedy hearings have laid a foundation for EEOICPA reform just as earlier hearings provided the basis for the 2004 EEOICPA Amendment. Hopefully, these ideas for improvement, in combination with grass-root efforts by former DOE workers and other interested parties, will lead to timely and significant changes in this important piece of legislation.

I would encourage all my co-workers and other energy employees to take advantage of the free early lung cancer screening offered by WHPP. If you have any concerns about the possibility of having cancer, early detection could mean the difference between life and death.

Thomas Stephens, Y-12 worker whose lung cancer was detected by the WHPP Early Lung Cancer Detection Program at the earliest stage.

Newly Released Report Highlights Success of the DOE Former Worker Medical Surveillance Program

(continued from page 1)

The FWP, formerly part of the Environmental Safety and Health Office, became part of the newly named Health, Safety and Security Office headed by Mr. Glenn Podonsky, in August 2006. Mr. Podonsky has verbally supported the Program and has stated his commitment to ensuring its continued funding. At a December meeting of FWP staff from the academic centers that run the individual DOE-funded screening programs, he commented “If we spend billions on environmental restoration, certainly we should fund the human side of the program at a level that takes proper care of the workers who dedicated their lives to the national security mission of DOE and its predecessor agencies.”

In February 2008, Mr. Podonsky released a report entitled, “Making Peace with the Past: Addressing the Occupational Health Legacy of the Department of Energy” that describes the purpose of the FWP, the considerable successes of the program, and the challenges up ahead.

One of the goals of the Former Worker Program that is outlined in the report is to conduct appropriate medical screening of former DOE workers to permit the early detection of potential occupational illnesses. The report clearly shows success in this regard: 46,842 individuals from approximately 26 DOE sites have received at least one screening examination as of October 21, 2007. In addition, 4, 273 people have been re-screened, three years after their initial exam.

Two new programs addressing the special needs of difficult to reach sub-populations of DOE workers began in 2005-2006. DOE construction workers throughout the DOE complex are now served by a National Building Trades Former Worker Medical Surveillance Program. And, a National Supplemental Screening Program has been created

to find and offer medical screening to workers who have retired to locations distant from their worksites and also to workers whose medical screening programs have shut down or, in some cases, were never established.

Another important goal of the FWP -- to demonstrate to stakeholders (including Congress, unions, workers and contractors) that DOE is working to address past hazards and using the knowledge gained to prevent future ones -- has also been reached. During the past 15 years of the program, DOE has expanded the number of sites where screening is offered so the entire DOE complex is now covered; involved DOE workers and their labor unions directly in planning and implementation of the program; instituted ongoing re-screening of workers consistent with the mandate of Section 3162 of the Defense Authorization Act, the legislation that created the FWP; developed a highly innovative early lung cancer detection program at selected sites; and encouraged innovation in outreach and communication by individual screening programs. Thus, the FWP medical screening program overseen by DOE has evolved to meet the needs of former DOE workers and now represents an unprecedented effort to evaluate the presence of work-related disease in an entire industry.

The recently released DOE report gives tangible evidence of the commitment of the Department to address its occupational health legacy. The DOE intends to continue its nationwide, comprehensive system of occupational medical screening, conducted with considerable effort and success over the past 15 years, in cooperation with universities, unions, and other organizations.

For copies of the report, visit the DOE website: hss.energy.gov/healthsafety/fwsp/formerworkermed/fwp_report.pdf or call Mary Fields at 301-903-1613.

H. R. 2764 Assures Funding for Former Worker Program and Early Lung Cancer Detection at Mound, Fernald and the GDPs

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Brown (D-OH); Senator Jim Bunning (R-KY) and Congressmen Ed Whitfield (R-KY), and Zach Wamp (R-TN).

The final bill combined the Office of Environment, Safety, and Health and the Office of Security and Performance Assurance into a reorganized Office of Health, Safety and Security. It also provided \$16.5 million for the FWP medical surveillance program which was an increase of \$4 million over the President’s original budget request.

As proposed by the Senate, the bill also directed the Office of Health, Safety, and Security to initiate an early lung cancer screening program for Mound and Fernald workers and to resume screening at the three gaseous diffusion plants for eligible workers who did not have a chance to participate in the 2000-2006 GDP lung cancer screening program. The Senate language that was adopted in the final bill noted that the expansion of the lung cancer screening program was appropriate because the majority of lung cancers detected in

the GDP lung cancer screening program were in early stages where surgical intervention has been demonstrated to be successful. Also, studies indicate that early detection has led to an increase in lung cancer survival rates.

Planning of the new program at Mound and Fernald and the resumed program at the GDPs is happening at present. Program implementation is expected by early 2009.



US Senator Domenici (R-NM)



US Congressman Oby (D-Wisc)



US Congressman Visclosky (D-IN)

Prostate Cancer Screening: Current Recommendations for the Most Common Cancer in Men

What is the prostate gland?

The prostate gland is an organ that is located around the bottom portion of the bladder. Its main function is to produce the fluid portion of semen, as well as some of the substances that are found in semen, such as minerals and sugar.

What is prostate cancer and what are its risk factors?

Prostate cancer is a malignant (cancerous) tumor that consists of cells from the prostate gland. The tumor usually grows slowly and remains confined to the prostate for many years. During this time, the tumor usually produces little or no symptoms. However, if the cancer advances, it can spread beyond the prostate into the surrounding tissues, and in certain cases, it can spread farther to other areas of the body, such as the bones, lungs, and liver. So, for some men, prostate cancer is life threatening, while in many others, it can exist for years without causing health problems.

While the causes of prostate cancer are still unknown, it is rarely diagnosed before the age of 40. The chances of prostate cancer being diagnosed rises rapidly after age 50. However, most, that is, 2 out of every 3, prostate cancers are found in men over the age of 65. Risk factors such as family history and race have been recognized. For example, African-American men have higher rates of this cancer. Certain occupational exposures (such as metal-working fluids) have been suspected, but not confirmed, to increase the risk of prostate cancer. So while there are other suspected risk factors for this cancer, advancing age is the most readily identifiable risk factor.

How common is prostate cancer?

Prostate cancer is the leading type of cancer diagnosed and second leading cause of cancer-related death among men in the United States (second to lung cancer). In 2004, over 189,000 men were diagnosed with prostate cancer and 29,000 men died from prostate cancer. It should be noted that the incidence of prostate cancer varies among different racial and ethnic groups. For example, African American men have about a 60 percent higher diagnosis rate and a two-fold higher mortality rate from prostate cancer than white men.

Are there any screening tests for prostate cancer?

Screening tests are those that are done at regular intervals to detect a disease, such as prostate cancer, at an early stage when there is a better chance of a cure. If the result of a screening test is normal, the disease is normally presumed not to be present. If a screening test is abnormal, the disease is then suspected to be present, and further tests usually are needed to confirm the suspicion (that is, to make a definitive

diagnosis).

The screening tests available for prostate cancer are a digital (finger) rectal examination (DRE) and a blood test called the PSA (prostate specific antigen). The DRE is a manual examination of the prostate to detect any irregularities in the size or shape of the gland. The PSA test is a blood test used

to detect a protein that is released from the prostate gland into the blood. The level of the PSA is usually higher in people with prostate cancer than in people without the cancer. Results of the PSA test under 4 are generally considered normal. Results between 4 and 10 are considered borderline abnormal. These borderline values are interpreted in the context of the patient's age, symptoms, signs, family history, and changes in the PSA levels over time. Results higher than 10 are considered abnormal, suggesting the possibility of prostate cancer.

While the PSA and DRE are valuable as screening tests for prostate cancer, there is controversy regarding the accuracy of these tests in detecting true cases of prostate cancer.

When is prostate cancer suspected and how is it diagnosed?

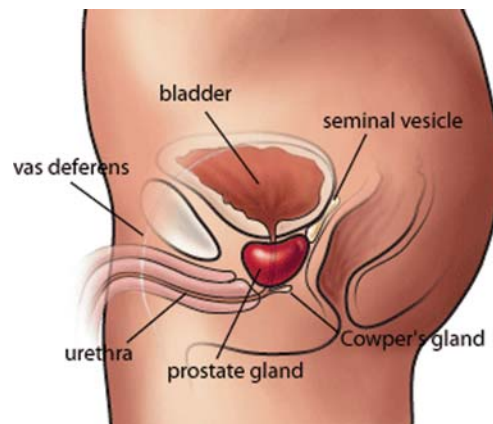
Prostate cancer is often initially suspected because of an abnormal PSA blood test or a lump felt on the prostate gland during a DRE. If one of the screening tests is abnormal, a diagnosis of prostate cancer is suspected and a biopsy of the prostate gland is usually done.

How is prostate cancer treated?

The choice of treatment for prostate cancer depends on the size, aggressiveness, and extent or spread of the tumor, as well as on the age and general health of the patient. There are many good options for treating prostate cancer including surgery, radiation therapy, hormonal treatment, chemotherapy, or a combination of these treatments. There is also the option of "watchful waiting" which is to periodically assess the tumor with the PSA and DRE, but without any actual treatment.

Is screening recommended for prostate cancer?

Most major U.S. medical organizations (such as the American Cancer Society, ACS) do not recommend screening for everyone over 50. Instead, they recommend that physicians discuss the potential benefits and possible harms of prostate cancer screening with their patients and individualize the decision to screen. If the decision is made to screen an individual over 50 (or younger if at high risk), the ACS recommends that the PSA blood test be offered at yearly intervals. For more information about prostate cancer, the American Cancer Society can be contacted at 1-800-ACS-2345 or on the Internet at <http://www.cancer.org>.



Ed Mee, Atomic Trades and Labor Council Medical Screening Program Coordinator

In 2003, I retired from the Oak Ridge National Laboratory located in Oak Ridge, Tennessee. During my 33 years of service at the Laboratory, I worked as a pipe fitter, served as Business Manager of Pipefitters Local 718 and, for the last 10 years of my employment, I was elected to serve as First Vice-President of the Atomic Trades and Labor Council (ATLC). The ATLC is affiliated with the Metal Trades Department of the AFL-CIO, and is comprised of 16 international unions representing approximately 2,200 current employees at the Y-12 National Security Complex and the Oak Ridge National Laboratory.

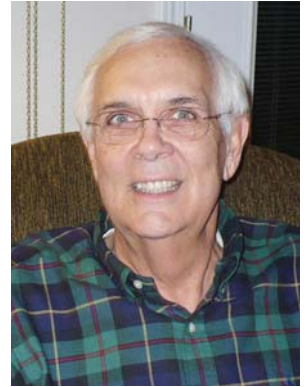
Shortly after retiring, I was offered the opportunity to work as the local WHPP Coordinator for the ATLC/Queen's College Medical Screening Program. As Coordinator, I work with program participants, and potential participants, in a number of ways. When people call in with questions about the program, I provide them with information on the benefits of going through the screening, which I know so well from my own experience. I know many of the callers from my many years on the job and that helps a great deal in understanding their concerns.

One of the most important aspects of my position as local Coordinator is working with the Queens College staff to plan outreach efforts to get the word out to former workers who may not know about this important program. We are currently sending out program brochures to

everyone that was on the original list of retirees or other rosters obtained through the Department of Energy, who has not had a physical yet. We are also working with local newspaper and television stations in an effort to reach former workers within the local area.

If a participant has abnormal test results after going through the WHPP screening and wants to file for compensation under the Energy Employees Occupational Illness Compensation Program (EEOICP) and the State of Tennessee workers' compensation laws, I assist him or her compile information for the claim. Also, upon request, I attend hearings with the participant. Because participants often do not have the documentation needed to establish dates and areas of employment or documentation of the toxins they could have potentially been exposed to, I advise participants on how to obtain their personnel records through the Freedom of Information Act.

I am very much aware of the exposures that workers received during their years of employment at ORNL and Y-12; therefore, I understand the importance of this screening program and am proud to be a part of it as a staff member and a participant.



Ed Mee

Tribute to Our Friend, Sam Ray (June 26, 1932 to April 28, 2007)

Sam Ray was a great union man. He believed in a fair day's pay for a fair day's work. He also believed in fair and equal treatment for all workers.

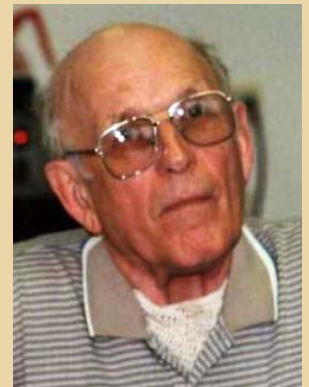
Sam was very active in organizing the Portsmouth atomic plant in the 1950's. He was a union steward for many years and held many different union positions. He was always willing to help and contribute in any way he could for the betterment of the union and the membership.

Even after he retired due to health reasons, Sam would not sit idle. He was effective at persuading Congress to provide free medical screenings for all current and former workers at the plant. Because of his own health problems, Sam knew early detection was the key.

After screenings were secured, he became the lead coordinator, and highly respected member, of the Portsmouth arm of the Worker Health Protection Program. Even after his illness worsened in the last two years, Sam showed his devotion to the Program by coming to the union hall on a daily basis to assist former and current DOE workers with EEOICPA claims or issues related to the screening.

Sam's work went beyond the medical screening program. He testified before the United States House and Senate for a compensation bill, not for himself, but for all nuclear workers. This bill was passed and is the Energy Employees Occupational Illness Compensation Program Act of 2000. The bill was not perfect and Sam knew it. He urged members of the United States House and Senate to make improvements. With his help, the law was changed in 2004. Because of this involvement in the passage of the 2004 EEOICPA Amendments, Sam was honored with the prestigious R.G. Norris Award in 2005. This award is given to one layperson annually by the Ohio Trial Lawyers Association.

Sam's union achievements could fill a book. He is very much loved and missed by all that knew him.



Sam Ray

EEO/PCA Part B Radiation Advisory Board Update: Slow but Sure Progress

In the past few years, the NIOSH Office of Compensation Analysis and Support (OCAS) program has made substantial progress in completing dose reconstructions for federal workers' compensation claims filed under Part B Energy Employees Occupational Illness Compensation Program Act (EEO/CPA). However, for many claimants, getting an answer is still taking well over a year. In January 2008, NIOSH reported that, of the approximately 26,000 cases received since the beginning of the program, the agency has completed dose reconstructions for approximately 19,000 (73%). About one-half of the cases remaining are cases that are more than one year old.

The Advisory Board on Radiation and Worker Health (The Board) is charged with auditing the quality of the radiation dose reconstructions, with a goal of reviewing 2.5% of all cases. The Board also recommends to the Secretary of Health and Human Services whether to add classes of workers who have petitioned to be included in the Special Exposure Cohort (SEC), and reviews the site profiles that summarize process and historical information about individual DOE sites and are used for evaluation of Part B claims. Sanford Cohen and Associates, Inc. (SC&A) is the support contractor for the Board and is tasked with assisting the Board on all of these technical reviews. However, in spite of the SC&A assistance and the Board's diligence, a large backlog of work has accumulated.

Advisory Board Dose Reconstruction Review

Sanford Cohen has completed approximately 160 of 650 planned dose reconstruction case reviews. After completing a set of cases, The Board and NIOSH, along with SCA, review SCA's findings through a five step comment resolution process. The Board is about one month away from final resolution on the first 100 case reviews and will be submitting a summary report on the findings to the Secretary of Health and Human Services.

Advisory Board SEC Petition Reviews

The SEC regulations were published in May 2004. SEC status means claimants do not have to undergo dose reconstruction because exposure data is missing or incomplete. To

date, 104 petitions have been received. 13 are in review for qualification (to determine if the minimum requirements for consideration of inclusion in the SEC class have been met); 51 did not meet the qualification criteria. A total of 28 of the 104 petitions have been qualified and reviewed by NIOSH, 3 of which were denied and 25 were approved. There are currently 12 SEC petitions that have been qualified and reviewed but final decisions regarding SEC status have not been made. NIOSH has a time limit of 250 days to complete an evaluation report on a qualified petition. When the evaluation reports are complete, they are passed on to the Advisory Board for review; the Board then submits an opinion to the Secretary of Health and Human Services (HHS). There is no time limit on the Advisory Board's review. The Board's review can take well over 9 months.

Part of the reason for the long review period stems from the Board's own internally established procedures for reviewing the NIOSH evaluation report, added to ensure claimants are not unjustifiably denied SEC status. When NIOSH rejects an SEC petition, the Board takes two additional steps. The first, called "proof of principle", requires that NIOSH demonstrate that dose reconstruction *can* be completed for all members of the class for all types of radiation exposure. An additional step the Board takes for denied petitions is to do a "data integrity review" to determine whether the data used for dose reconstruction are valid and complete. Whereas NIOSH may presume electronic data is good, the Board may require a comparison of hard copy records (such as log books) to electronic data, or review of individual case files to assure all appropriate dosimetry records for all time periods are in the electronic database. These additional Board procedures often require extensive work on the part of NIOSH, SCA, and the designated Board workgroup.

Upcoming meetings of the Advisory Board are posted on the NIOSH web site (www.cdc.gov/niosh/ocas) and are always open to the public (in person or via toll free phone line).

ATLC Early Lung Cancer Detection Program

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dose CT scan and hundreds of others have responded to invitations. Management has been exceptionally cooperative and shown their support of the program by agreeing to pay current workers time if appointments are made during work hours."

If you are a former or current worker at ORNL or Y-12 and would like to find out if you are eligible to partici-

pate, call our toll-free number 1-866-228-7226. Eligibility is based on age, smoking and work history, and health status.

We are looking forward to extending the lung cancer screening program to Mound and Fernald workers and to re-initiating screening at the three gaseous diffusion plants within the next year.

WHPP Health Watch

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