



CAROL S. MARCUS, Ph.D., M.D.

MAILING ADDRESS: 1877 COMSTOCK AVENUE
LOS ANGELES, CA 90025-5014

PHONE: (310) 277-4541
FAX: (310) 552-0028
E-MAIL: csmarcus@ucla.edu

February 9, 2015

Annette L. Vietti-Cook
Secretary, USNRC
Attention: Rulemakings and Adjudications Staff
U.S. Nuclear Regulatory Commission
11555 Rockville Pike
Rockville, MD 20852

Dear Ms. Vietti-Cook:

I am submitting this petition for rulemaking pursuant to 10 CFR Part 2.802. The petitioner requests that the NRC amend 10 CFR Part 20, *Standards for Protection Against Radiation*, based on new science and evidence that contradicts the Linear No-Threshold (LNT) hypothesis, a model that has served as the basis for radiation protection regulations. I will present scientific data as reported in study after study to justify that safety regulations and policies should no longer be derived from the LNT model in order to ensure these requirements are more risk-informed. This ultra-simplistic concept assumes that all radiation absorbed doses, no matter how small, have a finite probability of causing a fatal cancer. The lower the quantity of radiation absorbed dose, the lower the probability of cancer induction, but the probability is never zero, let alone negative (i.e. beneficial or hormetic). The rate of radiation delivery is irrelevant, and all absorbed doses are additive; this is demonstrably false as evidenced by the practices of radiation oncology and of radionuclide therapy. Use of the LNT assumption enables regulators to feel justified in ratcheting down permissible worker and public radiation levels, either through actual dose limits or use of the “as low as reasonably achievable” (ALARA) principle, giving the illusion that they are making everyone safer (and creating ever-increasing workload for themselves and their licensees). There has never been scientifically valid support for this LNT hypothesis since its use was recommended by the U.S. National Academy of Sciences Committee on Biological Effects of Atomic Radiation (BEAR I)/Genetics Panel in 1956. The costs of complying with these LNT-based regulations are enormous. Prof. Dr. Gunnar Walinder has summed it up: “The LNT is the greatest scientific scandal of the 20th century (1).”

On the other hand, there is a vast literature demonstrating **no effects** or **protective effects** at relatively low doses of radiation. The literature showing no effects supports a **threshold** concept, in which radiation below a certain level is of no concern because it causes no deleterious effects. The literature showing **protective effects** supports the

concept of **hormesis**, in which low levels of potentially stressful agents, such as toxins, other chemicals, ionizing radiation, etc., **protect** against the deleterious effects that high levels of these stressors produce and result in **beneficial effects** (e.g. lower cancer rates). To properly characterize risk at low radiation doses, a range of health outcomes, including beneficial or zero health effects, must be acknowledged.

Biological organisms are exceedingly complex, and have evolved in a world full of stressors, particularly oxygen, and also the bombardment by low dose background radiation from above, below, and within our own bodies. **More than 150 genes** have been recognized so far that are involved in defense of the organism and the production of defensive systems to protect against noxious agents. Although low level radiation absorbed dose may cause cellular damage, this radiation also up-regulates a system of protective mechanisms in cells, tissues, animals, and humans that counteract the damage and then protect far more than they were damaged in the first place. As the levels of radiation absorbed dose rise, the damage and benefits equalize, and at higher doses the overall effect is harm (2).

The fortunes of the United States have been founded upon advances in science and technology. Agriculture, medicine, energy production, communication, and materials science, to name only a few areas, have revolutionized the way we live. Americans in general have embraced progress. Why then have regulators chosen to use the LNT model to put a choke hold on radiation-related activities? Why is valid science being denied, while the LNT ideology based on erroneous evidence is embraced? It is important to answer this question to fully understand how such a myth perpetrated on society could have survived for so long.

Regulators use the LNT assumption because nationally and internationally respected bodies recommend and advocate it. NCRP, ICRP, IAEA, and NAS-NRC's BEIR Committee come to mind. However, they appear to have lost their sheen of expertise and appear mostly committed to maintaining the *status quo*. An army of regulators at NRC, EPA, FDA, as well as DOE, would be unbudgeted if the LNT disappeared. In addition, there are politicians whose anti-nuclear stand gets them votes. Most regulators are fearful of political anger at their actions because they don't know how to successfully defend themselves and because they rely on Congress for their budgets. Those people who are against nuclear weapons are against nuclear everything, in general, and this thinking affects mass media such as the press, movies, and television. Children are taught lies about radiation, and we therefore have a badly misinformed citizenry. Lawyers make money on bogus radiation damage lawsuits. One of the most shameful groups are scientists themselves, established professors in fine universities whose grants, graduate programs, consulting jobs, and membership in prestigious supposedly scientific groups require toeing the LNT line. It is going to take a good deal of courage to stand up and state that "The Emperor has no clothes." But, it must happen.

In 2001 the NCRP published Report no. 136 entitled "Evaluation of the Linear-Nonthreshold Dose-Response Model for Ionizing Radiation" (3), in which the LNT was upheld. In 2003 Zbigniew Jaworowski of the United Nations Scientific Committee on the

Effects of Atomic Radiation (UNSCEAR) and Michael Waligorski destroyed that Report with an astonishing exposé of scientific misconduct (4). What they did not include in their scathing rebuttal is that the group that paid for the NCRP study was none other than the NRC, which created the appearance of a conflict of interest. Every radiation regulator should read this paper. It is not highly technical, and requires no advanced mathematical ability. It is a scathing indictment of the NCRP Report.

Prof. Edward J. Calabrese of the Univ. of Massachusetts has traced amazing misconduct by the nation's leading geneticists in mid-twentieth century (5, 6, 7). He states, "This paper extends a series of historical papers which demonstrated that the linear-no-threshold model for cancer risk assessment was founded on ideological-based scientific deceptions by key radiation genetics leaders. Based on an assessment of recently uncovered personal correspondence, it is shown that some members of the United States (US) National Academy of Sciences (NAS) Biological Effects of Atomic Radiation I (BEAR I) Genetics Panel were motivated by self-interest to exaggerate risks to promote their science and personal/professional agenda. Such activities have profound implications for public policy and may have had a significant impact on the adoption of the LNT model for cancer risk assessment." In addition, the antinuclear movement of the Cold War era promoted the lie that harm at any level of radiation would occur as part of their antinuclear everything agenda. There was no science here. The LNT is based on hogwash.

I am not talking about a few scientific papers that show that the LNT model is in error. **We are talking about thousands.** There are a couple of textbooks in this field, and journals that publish scientific findings that refute the LNT model. This is a whole field of science that regulators pretend does not exist. The attitude of today's regulators is reminiscent of the Catholic Church at the time of Galileo. The Church taught that the earth was flat, and Galileo insisted that it was round, and instead of looking at the evidence, the Church threatened to torture Galileo to death unless he rescinded his point of view. Galileo retracted his statements but was kept under house arrest for the remainder of his life. And while today's regulators do not have the tools of torture available that the Catholic Church used, today's regulators will certainly destroy careers for regulatory violations of questionable importance. The LNT model is more like a religion than anything else. It certainly isn't science. Imposing it upon the citizens of the United States must stop.

There are numerous human situations in which we have good data that support radiation hormesis. Sadly, there are scientists who look at these data and ignore the apparent beneficial effect of low doses of radiation. When they make graphs of relative cancer risk vs. radiation absorbed dose, they simply draw a straight line **that misses the low dose points** and then proclaim that their data support the LNT model. The most commonly referenced study is the Life Span Study of the Radiation Effects Research Foundation (RERF) which studies the **Japanese atomic bomb survivors**. Recent data (8) show a hormetic effect for all solid cancers in the 0.3-0.7 Gy (30-70 rad) dose range, and the study of leukemia rates in the 96,000 survivors (9) showed hormesis at low doses with a threshold at about 500 mSv (50 rem).

Workers exposed in the **nuclear power industry** comprise the largest group of occupationally exposed workers studied. They generally receive low radiation doses. Over 400,000 workers were studied from 154 facilities in 15 countries (10, 11) and the study showed a decrease in the risk of all cancers including leukemia. The BEIR VII report from the National Academy of Sciences points out that in most of the nuclear industry worker studies, mortality from all cancer and all causes is substantially lower than the reference population. While they have no explanation for this phenomenon, which could be caused by radiation hormesis, the National Academy Committee suggested the possibility of a “healthy worker effect”. This mysterious effect is often cited to explain lower cancer rates in workers receiving low doses of radiation, but a little thought will show that the “healthy worker effect” is actually backwards (12). Most radiation workers get into that industry in their twenties and thirties, when most people are healthy. Cancer is largely a disease of older people, with more than half of all cancers occurring in people over 65 years old (13). You have to be healthy to get old enough to die of cancer. Sickly people don’t live long lives and generally don’t die of cancer. People with hyperlipidemia die early of myocardial infarctions, people with cystic fibrosis often die early of infections, and people with juvenile onset diabetes often die early from infections, myocardial infarctions, renal failure, or complications from dialysis or kidney transplants. The “healthy worker effect” idea needs to quietly die. Hormesis is a perfectly good alternative explanation.

Thirty-one thousand, seven hundred and ten female patients with tuberculosis in Canadian sanatoriums from 1930-1952 were subjected to multiple fluoroscopies to monitor their disease status. Of these patients, 26.4 % received radiation doses to the affected side of 10 cGy (10 rads) or more, and therefore most received lower doses. The relative risk of eventual breast cancer was studied in all these patients. **Patients who received a total radiation absorbed dose in the range from 5 – 30 cGy (5-30 rads) had a breast cancer incidence up to one third less than the background incidence.** Only at radiation absorbed doses above 50 cGy (50 rads) did the cancer incidence begin to increase above baseline (14, 15).

The radium dial watch painters comprise another group of radiation exposed workers. In some 900 young women who sharpened paint brushes with their tongues, there were 54 bone sarcomas and 25 carcinomas of the mastoids and paranasal sinuses. Radium is a bone seeker. **None of these malignancies occurred at a radiation absorbed dose to bone less than 10 Gy (1000 rads) (16).** While these studies were not designed to demonstrate hormesis, they do show a threshold, and a very high one, for the induction of bone cancer.

Following World War II, after the invention of nuclear reactors and the expansion of peaceful uses of atomic energy, patients with hyperthyroidism were treated with radioactive iodine-131 (I-131); this is still the treatment of choice today. While the I-131 cured the hyperthyroidism, there was a concern about late effects from the radiation. The Cooperative Thyrotoxicosis Therapy Follow-Up Study of over 36,000 treated hyperthyroid patients looked at eventual leukemia rates in these patients, as leukemia is

considered the most radiosensitive of cancers and occurs faster than other radiogenic cancers. The total body radiation doses to these patients were 130-140 mSv (13-14 rem). **The age-adjusted leukemia incidence rate was 11/100,000 patient years in the I-131 treated patients and 14/100,000 patient years in patients treated by surgical removal of the thyroid gland (the standard procedure before I-131 became the therapy of choice).** While the authors concluded that there was no increased incidence of leukemia at this low whole body radiation dose (17), **the 22% decrease in the I-131 treated patients suggests a possible hormetic effect.**

The explosion of radioactive waste from a nuclear fuel reprocessing facility called “Mayak” in 1957 resulted in a stream of radioactive waste affecting an area in the East Urals of Russia. Research was performed on data collected from 1957-1987 on occupants of the 22 villages evacuated from the radioactive waste zone (18). Radiation absorbed dose groups were made for those receiving 40 mSv (4 rem), 120 mSv (12 rem), and 500mSv (50 rem). **Although all three groups had less cancer than the baseline expected in the area, the 50 rem and 12 rem groups were statistically significantly lower than the baseline cancer rate expected, suggesting hormesis.** The cancer death rate in the 50 rem group was 29% lower than the controls, and in the 12 rem group was 39% lower than the controls.

In 1982 several orphan cobalt-60 (Co-60) sources were recycled accidentally in the steel scrap industry in northern Taiwan. This resulted in the Co-60 contamination of more than 20,000 tons of steel used in the construction of over 200 residential, industrial and school buildings in Taiwan. In 1992 this contamination was identified, and the exposed population was studied for cancer incidence (19). The population of 7271 people representing 101,560 person-years at risk was exposed to chronic radiation amounting to an average of about 5 cGy (5 rads) from 1983-2002. The range of radiation exposure was <1-2363 mSv (<0.1-236 rem). **The standardized incidence ratios (SIR) and the 95% confidence intervals calculated for all cancers was 0.8 (0.7, 1.0), for all cancers except leukemia was 0.8 (0.6, 0.9), and for solid cancers was 0.7 (0.6, 0.9).** (A SIR of 1.0 means the same as that of unirradiated controls.) The lowered cancer incidence rate was significant at the 95% confidence interval for all cancers except leukemia and for solid cancers. The lowered cancer incidence rate for all cancers was significant at the 90% confidence interval. The lowered cancer incidence rates in these people exposed to chronic, low levels of radiation suggest radiation hormesis.

The situation with residential radon exposure and lung cancer is most interesting. The seminal research of Bernard Cohen (20, 21, 22, 23) in the United States showed that **increasing levels of residential radon were associated with decreasing levels of lung cancer.** His data were carefully corrected for 54 socioeconomic variables, including smoking, but the inverse correlation of radon levels with lung cancer did not change. Bobby Scott (24) has analyzed the situation and has shown that low level radon and its radioactive daughters cause activated natural protection against lung cancer, including smoking-related lung cancer, at levels up to the Environmental Protection Agency’s (EPA’s) action level of 4 picocuries/L (about 150 Bq m⁻³). Somewhat above this level, the activated natural protection effect progressively goes to zero and it is here that we see

an increase in lung cancer. **Low levels of radon are hormetic.** Klaus Becker (25) has shown similar correlations in data from Central Europe.

In 1986, the Chernobyl reactor accident riveted much of the world, prompting huge hysteria (26). In the former Soviet Union, 336,000 people were forcibly evacuated, some from areas with five times lower radiation levels than are present in Grand Central Station in New York City, which is constructed with natural granite. There were large numbers of unnecessary abortions in Western Europe due to fears of mutant babies. Huge amounts of food were wasted because of miniscule levels of contamination which would hurt no one. The LNT was responsible for much of the hysteria, multiplying very small radiation doses times hundreds of millions of people to estimate huge numbers of cancer deaths. The affected population in the former Soviet Union was followed for increased cancer incidence. According to UNSCEAR 2000b (27) and the United Nations Chernobyl Forum in 2006, except for thyroid cancers in the highly contaminated areas, there was no increased incidence of leukemias or solid tumors, and no evidence of increased genetic diseases. The increase in thyroid cancers was found in children under 15 years of age in 1987, the year after the accident. However, the radiation doses were too low to have caused this, and there was no dose-response relationship. In addition, the timing was off---the mean latent period for radiation induced thyroid cancer is about 28 years (27). However, the increase was highly likely due to a mass screening effect (22). Occult thyroid cancer is actually extremely common, with an autopsy prevalence in various countries of 4.5% to 36% (28, 29). These are small cancers that never caused problems and were unknown during the person's lifetime. The development of sensitive ultrasound techniques have made the diagnosis of these occult cancers, or "incidentalomas", much more common. In the United States, a screening program uncovered a 2100% increase in thyroid nodules (30), and mandatory yearly screening in children in the contaminated areas around Chernobyl resulted in a similar phenomenon. **According to Jaworowski (26), the natural incidence of occult thyroid cancers is approximately 1000 times higher than the highest incidence of reported thyroid cancers in the countries with the greatest fallout from the Chernobyl accident. The supposed increased finding of thyroid cancer due to radiation from the Chernobyl accident is instead due to intense screening (31).** The Chernobyl accident resulted in 28 radiation deaths among rescue workers and employees of the power station who received 2.9-16 Gy (290-1600 rads). Three others died of different causes. The surviving workers show a 15-30% lower mortality from solid cancers than the general Russian population and the residents of the Bryansk district, which received the highest contamination, had a 5% lower solid tumor incidence than expected (26).

Informative reviews on **molecular mechanisms of hormesis** and related phenomena may be found in the papers by Tang and Loke (32) and Brooks and Dauer (33).

It is important to compare a joint report of the French Academy of Sciences and of the French Academy of Medicine (34) on low radiation dose carcinogenic effects, published in 2005, shortly before a comparable report of BEIR VII/Phase 2 of the National Academy of Sciences-National Research Council (35) was published. Covering the same questions, the two groups of experts came to different conclusions (36). The French

report finds that as epidemiological studies have been unable to detect any significant increases in cancer after radiation doses of up to about 100 mSv (10 rem), that there are no convincing data showing any increase in cancer in adults, children, or infants receiving doses under about 100 mSv (10 rem). The LNT therefore greatly overestimates the risk of these low doses, and its use is unjustified and should be discouraged for doses below 20 mSv (2 rem). In contrast, the BEIR VII report concludes that “The committee judges that the balance of evidence from epidemiologic, animal and mechanistic studies tends to favor a simple proportionate relationship at low doses between radiation dose and cancer risk. Uncertainties on this judgment are recognized and noted.” The BEIR VII report recommends the continued use of LNT at low or very low doses. The BEIR VII report does not consider the cancer threshold data of the radium dial watch painters or that of patients in whom Thorotrast was used as an x-ray contrast agent (liver dose of 2 Gy [200 rads] required for hepatomas). The French report does. The two groups differ in their interpretation of the results of the Hiroshima/Nagasaki Life Span Study. The French report finds no significant increase in cancer after doses below 100 mSv (10 rem), while the BEIR VII report tends to lump the low dose data with higher dose data to find cancer increases. Animal studies have not shown increased cancer at doses below 100 mSv (10 rem); many show thresholds and about 40% show hormesis. The French report points out the high efficacy of DNA repair mechanisms and apoptosis (death of damaged cells), while the BEIR VII report minimizes this research because all the mechanisms have not yet been worked out. An important difference between the two reports concerns *in utero* radiation. While the BEIR VII report concludes that fetal doses of 10-20 mSv (1-2 rem) caused increased levels of leukemias and solid cancers, the French report doubts a causal relationship because this represents a biased sample of fetuses in which only pregnant women with problems were subjected to x-ray studies. The randomly irradiated fetuses in the Hiroshima/Nagasaki Life Span Study showed no such cancer increase, nor have *post partum* twin studies where one was irradiated and the other was not. More detailed comparisons are in (36). It is interesting to note that the BEIR VII report was funded by the EPA, the NRC, and the NIST. As the present radiation programs of the EPA and the NRC are based upon the LNT, one wonders about the appearance of a conflict of interest.

RECOMMENDED CHANGES FOR 10 CFR PART 20

It is therefore requested that the NRC greatly simplify and change Part 20 to take radiation hormesis into account. The following recommendations are made:

- 1) Worker doses should remain at present levels, with allowance of up to 100 mSv (10 rem) effective dose per year if the doses are chronic.
- 2) ALARA should be removed entirely from the regulations, as it makes no sense to decrease radiation doses that are not only harmless but may be hormetic.
- 3) Public doses should be raised to worker doses, as these low doses may be hormetic. Why deprive the public of the benefits of low dose radiation?
- 4) End differential doses to pregnant women, embryos and fetuses, and children under 18 years of age.

Obviously there will have to be many other changes to NRC regulations when 10 CFR Part 20 is brought up to present scientific standards. Examples include the medical regulations and low level radioactive waste regulations. But it all needs to start with ending reliance on the LNT model.

Thank you for your attention and consideration.

Sincerely,



Carol S. Marcus, Ph.D., M.D.
Professor of Radiation Oncology, of Molecular and Medical Pharmacology (Nuclear Medicine), and of Radiological Sciences; David Geffen School of Medicine at UCLA
and
Member of the ACMUI, 1990-1994

Contact Information: 1877 Comstock Avenue, Los Angeles, CA 90025-5014
Phone: (310)277-4541 Fax: (310)552-0028 E-mail: <csmarcus@ucla.edu>

REFERENCES

1. Muckerheide, James: Apply radiation health effects data to contradict and overturn radiation protection policies and rules. Proceedings of ICONE 8 (8th International Conference on Nuclear Engineering) April 2-6, 2000, Baltimore, MD.
2. Cutler, Jerry M: Remedy for radiation fear---discard the politicized science. Dose-Response (Prepress), 2014. ISSN:1559-3258, DOI: 10.2203/dose-response.13-055.Cutler
3. NCRP Report No. 136: Evaluation of the Linear-Nonthreshold Dose-Response Model for Ionizing Radiation. 2001. NCRP, 7910 Woodmont Avenue, Suite 800, Bethesda, MD 30814.
4. Jaworowski, Zbigniew, and Waligorski, Michael: Problems of U.S. policy on radiation protection. EIR Science and Technology, 16 May 2003, pp. 18-26.
5. Calabrese, Edward J.: The genetics panel of the NAS BEAR I Committee (1956): epistolary evidence suggests self-interest may have prompted an exaggeration of radiation risks that led to the adoption of the LNT cancer risk assessment model. Arch. Toxicol. Published online: 04 July 2014. DOI 10.1007/s00204-014-1306-7.
6. Calabrese, Edward J.: An abuse of risk assessment: how regulatory agencies improperly adopted LNT for cancer risk assessment. Arch. Toxicol. Published online: 18 January 2015. DOI 10.1007/s00204-015-1454-4.

7. Calabrese, Edward J.: Cancer risk assessment foundation unraveling: New historical evidence reveals that the U.S. National Academy of Sciences (US NAS), Biological Effects of Atomic Radiation (BEAR) Committee Genetics Panel falsified the research record to promote acceptance of the LNT. *Arch. Toxicol.* Published online: 20 January 2015. DOI 10.1007/s00204-015-1455-3.
8. Ozasa, Kotaro, Shimizu, Yukiko, Suyama, Akihiko, Kasagi, Fumiyoshi, Soda, Midori, Grant, Eric J., Sakata, Ritsu, Sugiyama, Hiromi, and Kodama, Kazunori: Studies of the mortality of atomic bomb survivors, report 14, 1950-2003: An overview of cancer and noncancer diseases. *Radiation Research* 177:229-243, 2012.
9. Cuttler, Jerry M.: Leukemia incidence of 96,000 Hiroshima atomic bomb survivors is compelling evidence that the LNT model is wrong. *Arch. Toxicol.* 88:847-848, 2014.
10. Cardis, E., Vrijheid, M., Blettner, M., Gilbert, E., Hakama, M., Hill, C., et al.: The 15-Country collaborative study of cancer risk among radiation workers in the nuclear industry: estimates of radiation-related cancer risks. *Radiation Research* 167:396-416, 2007.
11. CNSC, Verifying Canadian nuclear energy worker radiation risk: a reanalysis of cancer mortality in Canadian nuclear energy workers (1957-1994): Summary report. Minister of Public Works and Government Services Canada. Catalogue number CC172-65/2011E-PDF. ISBN 978-1-100-17760-1. Canadian Nuclear Safety Commission; 2011.
12. Marcus, Carol S., Stabin, Michael G., and Siegel, Jeffrey A.: The “healthy worker” effect could be backwards! *Health Physics News*, p.14, April 2011.
13. Wallis, Claudia: Never too old for chemo. *Scientific American*, pp 34-36, December 2014.
14. Cuttler, Jerry M. and Pollycove, Myron: Can cancer be treated with low doses of radiation? *Jour. Amer. Physicians and Surgeons* 8(4)108-111, 2003.
15. Miller, Anthony B., Howe, Geoffrey R., Sherman, Gregory J., Lindsay, Joan P., Yaffe, Martin J., Dinner, Paul J., Risch, Harvey A., and Preston, Dale L.: Mortality from breast cancer after irradiation during fluoroscopic examinations in patients being treated for tuberculosis. *New Eng. Jour. Medicine* 321:1285-1289, 1989.
16. Rowland, R.E.: Dose and damage in long term radium cases. In Cloutier, Roger J., Edwards, C. Lowell, and Snyder, Walter S., eds.: *Medical Radionuclides: Radiation Dose and Effects*. Proceedings of a symposium held at the Oak Ridge Associated Universities Dec. 8-11, 1969. CONF-691212, available from Clearinghouse for Federal Scientific and Technical Information, National Bureau of Standards, U.S. Dept. of Commerce, Springfield, VA 22151, pp 369-386, 1970.
17. Tompkins, Edythelena: Late effects of radioiodine therapy. *ibid*, pp 431-440, 1970

18. Kostyuchenko, V.A., and Krestinina, L.Yu.: Long-term irradiation effects in the population evacuated from the East-Urals radioactive trace area. *The Science of the Total Environment* 142:119-125, 1994.
19. Hwang, S.L., Guo, H.R., Hsieh, W.A., Hwang, J.S., Lee, S.D., Tang, J.L., Chen, C.C., Chang, T.C., Wang, J.D., and Chang, W.P.: Cancer risks in a population with prolonged low dose-rate γ -radiation exposure in radiocontaminated buildings, 1983-2002. *Int. J. Radiat. Biol.* 82(12):849-858, 2006.
20. Cohen, Bernard L: Expected indoor ^{222}Rn levels in counties with very high and very low lung cancer rates. *Health Physics* 57(6):897-907, 1989.
21. Cohen, Bernard L.: Test of the linear-no threshold theory of radiation carcinogenesis for inhaled radon decay products. *Health Physics* 68:157-174, 1995.
22. Cohen, Bernard L.: Lung cancer rate vs. mean radon level in U.S. counties of various characteristics. *Health Physics* 72:114-119, 1997.
23. Cohen, Bernard L: The linear no-threshold theory of radiation carcinogenesis should be rejected. *J. Amer. Physicians and Surgeons* 13(3):70-76, 2008.
24. Scott, Bobby: Residential radon appears to prevent lung cancer. *Dose-Response* 9:444-464, 2011.
25. Becker, Klaus: Health effects of high radon environments in central Europe: Another test for the LNT hypothesis? *Nonlinearity in Biology, Toxicology, and Medicine* 1(1):3-35, 2003.
26. Jaworowski, Zbigniew: Observations on Chernobyl after 25 years of radiophobia. *21st Century Science and Technology*, summer, pp 30-45, 2010.
27. UNSCEAR 2000b. United Nations Publication Sales No. E.00.IX.4; ISBN 92-1-142239-6.
28. Moosa, M. and Mazzaferri, E.L.: Occult thyroid carcinoma. *The Cancer Journal* 10(4):180-188, 1997.
29. Tan, G.H. and Gharib, H.: Thyroid incidentalomas: Management approaches to nonpalpable nodules discovered incidentally on thyroid imaging. *Annals of Internal Medicine* 126:226-231, 1997.
30. Ron, E., Lubin, J., and Schneider, A.B.: Thyroid cancer incidence. *Nature* 360:113, 1992.

31. Jargin, Sergei V.: Chernobyl-related cancer and precancerous lesions: incidence increase vs. late diagnostics. *Dose-Response* 12:404-415, 2014.
32. Tang, Feng Ru, and Loke, Weng Keong: Molecular mechanisms of low dose ionizing radiation-induced hormesis, adaptive responses, radioresistance, bystander effects, and genomic instability. *Int. Jour. Radiation Biology*, published online, pp1-15, 2014. ISSN 0955-3002 print/ISSN 1362-3095 online. DOI: 10.3109/09553002.2014.937510.
33. Brooks, Antone L. and Dauer, Lawrence T.: Advances in radiation biology: effect on nuclear medicine. *Seminars in Nuclear Medicine* 44:179-186, 2014.
34. Joint report n°2, Académie Nationale de Médecine, Institut de France—Académie des Sciences: Dose-effect relationships and the estimation of the carcinogenic effects of low doses of ionizing radiation. Edition Nucleon (Paris 2005) ISBN 2-84332-018-6.
35. BEIR VII, Phase 2. National Academy of Sciences-National Research Council: Health risks from exposure to low levels of ionizing radiation. National Academies Press, 2006, Washington, D.C. ISBN 0-309-53040-7 (pdf).
36. Tubiana, M., Aurengo, A., Averbeck, D., and Masse, R: Recent reports on the effect of low doses of ionizing radiation and its dose-effect relationship. *Radiat. Environ. Biophys.* 44:245-251, 2006.