INSTRUCTION CONCERNING RISKS
FROM OCCUPATIONAL RADIATION EXPOSURE

This instructional material is intended to provide the user with the best available information concerning what is currently known about the health risks from exposure to ionizing radiation. A question and answer format has been used. The questions were developed by the NRC staff in consultation with workers, union representatives, and licensee representatives experienced in radiation protection training. Risk estimates have been compiled from numerous sources generally recognized as reliable. A bibliography is included for the user interested in further study.

The biological effects that are known to occur after exposure to high doses (hundreds of rem) of radiation are discussed early in the document; discussions of the estimated risks from the low occupation dose (< 5 rem per year) follows. It is intended that this information will help develop an attitude of healthy respect for the risks associated with radiation, rather than unnecessary fear or lack of concern. Additional guidance is being or will be developed concerning other topics in radiation protection training.

1.   **What is meant by risk?**

Risk can be defined in general as the probability (chance) of injury, illness, or death resulting from some activity. However, the perception of risk is affected by how the individual views its probability and its severity. The intent of this document is to provide estimates of and explain the basis for possible risk of injury, illness, or death resulting from occupational radiation exposure. (See Questions 9 and 10 for estimates of radiation risk and comparisons with other types of risk.)

2.   **What are the possible health effects of exposure to radiation?**

Some of the health effects that exposure to radiation may cause are cancer (including leukemia), birth defects in the future children of exposed parents, and cataracts. These effects (with the exception of genetic effects) have been observed in studies of medical radiologists, uranium miners, radium workers, and radiotherapy patients who have received large doses of radiation. Studies of people exposed to radiation from atomic weapons have also provided data on radiation effects. In addition, radiation effects studies with laboratory animals have provided a large body of data on radiation-induced health effects, including genetic effects.

The observations and studies mentioned above, however, involve levels of radiation exposure that are much higher (hundreds of rem) than those permitted occupationally today(< 5 rem per year). Although studies have not shown a cause-effect relationship between health effects and current levels of occupation radiation exposure, it is prudent to assume that some health effects do occur at lower exposure levels.

3.   **What is meant by prompt effects, delayed effects, and generic effects?**

a.   Prompt effects are observable shortly after receiving a very large dose in a short period of time. For example, a whole-body dose of 450 rem (90 times the annual dose limit for routine occupational exposure) in an hour to an average adult will cause vomiting and diarrhea within a few hours; loss of hair, fever and weight loss within a few weeks; and about a 50 percent chance of death within 60 days without medical treatment.

b.   Delayed effects such as cancer may occur years after exposure to radiation

c.   Genetic effects can occur when there is radiation damage to the genetic material. These effects may show up as birth defects or other conditions in the future children of the exposed individual and succeeding generation, as demonstrated in animal experiments. However, excess genetic effects clearly caused by radiation have not been observed in human populations exposed to radiation, It has been observed, however, that radiation can change the genes in cells of the human body. Thus, the possibility exists that genetic effects can be

caused in humans by low doses even though no direct evidence exists as yet.

4. **In worker protection, which effects are of most concern to the NRC?**

The main concern to the NRC is the delayed incidence of cancer. The chance of delayed cancer is believed to depend on how much radiation exposure a person gets; therefore, every reasonable effort should be made to keep exposures low.

Immediate or prompt effects are very unlikely since large exposures would normally occur only if there were a serious radiation accident. Accident rates in the radiation industry have been low, and only a few accidents have resulted in exposures exceeding the legal limits. The probability of serious genetic effects in the future children of workers is estimated in the BEIR report, based on animal studies, at less than one-third that of delayed cancer (5-65 genetic effects per million rem compared to 160-450 cancer cases). A clearer understanding of the cause-effect relationship between radiation and human genetic effects will not be possible until additional research studies are completed.

5. **What is the difference between acute and chronic exposure?**

Acute radiation exposure, which causes prompt effects and may also cause delayed effects, usually refers to a large dose of radiation received in a short period of time; for example, 450 rem received within a few hours or less. The effects of acute exposures are well known from studies of radiotherapy patients, some of whom received whole-body doses; atomic bomb victims; and the few accidents that have occurred in the early days of atomic weapons and reactor development, industrial radiography, and nuclear fuel processing. There have been few occupational incidents that have resulted in large exposures. NRC data indicate that, on the average, 1 accidental overexposure in which acute symptoms are observed occurs each year. Most of these occur in industrial radiography and involve exposures of the hands rather than the whole body.

Chronic exposure, which may cause delayed effects but not prompt effects, refers to small doses received repeatedly over long time periods; for example, 20-100 mrem (a mrem is one-thousandth of a rem) per week every week for several years. Concern with occupational radiation risk is primarily focused on chronic exposure to low levels of radiation over long time periods.

6. **How does radiation cause cancer?**

How radiation causes cancer is not well understood. It is impossible to tell whether a given cancer was caused by radiation or by some other of the many apparent causes. However, most diseases are caused by the interaction of several factors. General physical condition, inherited traits, age, sex, and exposure to other cancer-causing agents such as cigarette smoke are a few possible contributing factors. One theory is that radiation can damage chromosomes in a cell, and the cell is then directed along abnormal growth patterns. Another is that radiation reduces the body's normal resistance to existing viruses which can then multiply and damage cells. A third is that radiation activates an existing virus in the body which then attacks normal cells causing them to grow rapidly.

What is known is that, in groups of highly exposed people, a higher than normal incidence of cancer is observed. Higher than normal rates of cancer can also be produced in laboratory animals by high levels of radiation. An increased incidence of cancer has not been demonstrated at radiation levels below the NRC limits.

7. **If I receive a radiation dose, does that mean I am certain to get cancer?**

Not at all. Everyone gets a radiation dose every day (see Question 25), but most people do not get cancer. Even with doses of radiation far above legal limits, most individuals will experience no delayed consequences. There is evidence that some radiation damage can be repaired. The danger from radiation is much like the danger from cigarette smoke. Only a fraction of the people who breathe cigarette smoke get lung cancer, but there is good evidence that smoking increases a person's

chances of getting lung cancer. Similarly, there is evidence that the larger the radiation dose, the larger the increase in a person's chances of getting cancer.

Radiation is like most substances that cause cancer in that the effects can be seen clearly only at high doses. Estimates of the risks of cancer at low levels of exposure are derived from data available for exposures at high dose levels and high dose rates. Generally, for radiation protection purposes these estimates are made using the linear model (Curve 1 in Figure 1). We have data on health effects at high doses as shown by the solid line in Figure 1. Below about 100 rem, studies have not been able to accurately measure the risk, primarily because of the small numbers of exposed people and because the effect is small compared to differences in the normal incidence from year to year and place to place.
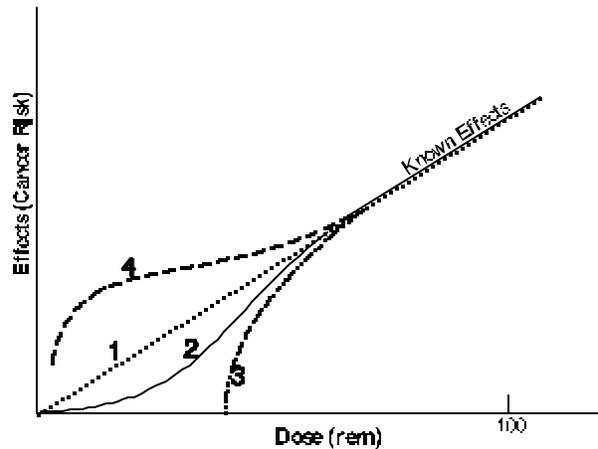

Figure 1. Proposed Models.

Most scientists believe that there is some degree of risk no matter how small the dose (Curves 1 and 2). Some scientists believe that the risk drops off to zero at some low dose (Curve 3), the threshold effect. A few believe that risk levels off so that even very small doses imply a significant risk (Curve 4). The majority of scientists today endorse either the linear model (Curve 1) or the linear-quadratic model (Curve 2). The NRC endorses the linear model (Curve 1), which shows the number of effects decreasing as the dose decreases, for radiation protection purposes.

It is prudent to assume that smaller doses have some chance of causing cancer. This is as true for natural cancer-causers such as sunlight and natural radiation as it is for those that are man made such as cigarette smoke, smog, and man-made radiation. As even very small doses may entail some small risk, it follows that no dose should be taken without a reason. Thus, a principle of radiation protection is to do more than merely meet the allowed regulatory limits; doses should be kept as low as is reasonably achievable (ALARA).

We don't know exactly what the chances are of getting cancer from a low-level radiation dose, but we can make estimates based on extensive scientific knowledge. The estimates of radiation risks are at least as reliable as estimates from the effects from any chemical hazard. Being exposed to typical occupation radiation doses is taking a chance, but that chance is reasonably well understood.

It is important to understand the probability factors here. A similar question would be: If you select one card from a full deck, will you get the ace of spades? This question cannot be answered with a simple yes or no. The best answer is that your chances are 1 in 52. However, if 1000 people each select one card from full decks, we can predict that about 20 of them will get an ace of spades. Each person will have 1 chance in 52 of drawing the ace of spades, but there is no way that we can predict which persons will get the right card. The issue is further complicated by the fact that in 1 drawing by 1000 people, we might get only 15 successes and in another perhaps 25 correct cards in 1000 draws. We can say that if you receive a radiation dose, you will have increased your chances of eventually developing cancer. It is assumed that the more radiation exposure you get, the more you increase your chances of cancer.

Not all workers incur the same level of risk. The radiation risk incurred by a worker depends on the amount of dose received. Under the linear model explained above, a worker who receives 5 rem in a year incurs 10 times as much risk as another worker (the same age) who receives only 0.5 rem. The risk depends not only on the amount of dose, but also on the age of the worker at the time the dose is received. This age difference is due, in part, to the fact that a young worker has more time to live

than an older worker, and the risk is believed to depend on the number of years of life following the dose. The more years left, the larger the risk. It should be clear that, even within the regulatory dose limits, the risk may vary a great deal from one worker to another. Fortunately, only a very few workers receive doses near 5 rem per year; as pointed out in the answer to Question 19, the average annual dose for all radiation workers is less than 0.5 rem.

A reasonable comparison involves exposure to the sun's rays. Frequent short exposures provide time for the skin to repair. An acute exposure to the sun can result in painful burning, and excessive exposure has been shown to cause skin cancer. However, whether exposure to the sun's rays is short term or spread over time, some of the injury is not repaired and may eventually result in skin cancer.

The effect upon a group of workers occupationally exposed to radiation may be an increased incidence of cancer over and above the number of cancers that would normally be expected in that group. Each exposed individual has an increased probability of incurring subsequent cancer. We can say that if 10,000 workers each receive an additional 1 rem in a year, that group is more likely to have a larger incidence of cancer than 10,000 people who do not receive the additional radiation. An estimate of the increased probability of cancer from low radiation doses delivered to large groups is one measure of occupational risk and is discussed in Question 9.

8. What groups of expert scientists have studied the risk from exposure to radiation?

In 1956, the National Academy of Sciences established advisory committees to consider radiation risks. The first of these was the Advisory Committee on the Biological Effects of Atomic Radiations (BEAR) and more recently it was renamed the Advisory Committee on the Biological Effects of Ionizing Radiation (BEIR). These committees have periodically reviewed the extensive research being done on the health effects of ionizing radiation and have published estimates of the risk of cancer from exposure to radiation (1972 and 1980 BEIR reports). The International Commission on Radiological Protection (ICRP) and the National Council on Radiation Protection and Measurement (NCRP) are two other groups of scientists who have no government affiliation. In addition, the United Nations established an independent study group that published an extensive report in 1977, including estimates of cancer risk from ionizing radiation (UNSCEAR, 1977).

Several individual research groups or scientists such as Alice Stewart, E.S. Gilbert, T.F. Mancuso, T.W. Anderson to name a few, have published studies concerning low-level radiation effects. The bibliography to this appendix includes several articles for the reader who wishes to do further study. The BEIR-80 report includes analysis of the work of many independent researchers.

9. What are the estimates of the risk of cancer from radiation exposure?

The cancer risk estimates (developed by the organizations identified in Question 8) are presented in Table 1.

TABLE 1
Estimates of Excess Cancer Incidence from Exposure to Low-Level Radiation

Source	Number of Additional Cancers Estimated to Occur in 1 Million People After Exposure of Each to 1 Rem of Radiation
BEIR, 1980	160-450
ICRP, 1977	200
UNSCEAR, 1977	150-350

In an effort to explain the significance of these estimates, we will use an approximate average of 300

excess cancer cases per million people, each exposed to 1 rem of ionizing radiation. If in a group of 10,000 workers each receives 1 rem, we could estimate that three would develop cancer because of that exposure, although the actual number could be more or less than three.

The American Cancer Society has reported that approximately 25 percent of all adults in the 20- to 65-year age bracket will develop cancer at some time from all possible causes such as smoking, food, alcohol, drugs, air pollutants, and natural background radiation. Thus in any group of 10,000 workers not exposed to radiation on the job, we can expect about 2,500 to develop cancer. If this entire group of 10,000 workers were to receive an occupational radiation dose of 1 rem each, we could estimate that three additional cases might occur which would give a total of about 2,503. This means that a 1-rem dose to each of 10,000 workers might increase the cancer rate from 25 percent
to 25.03 percent, an increase of about 3 hundredths of one percent.

As an individual, if your cumulative occupational radiation dose is 1 rem, your chances of eventually developing cancer during your entire lifetime may have increased from 25 percent to 25.03 percent. If your lifetime occupational dose is 10 rem, we could estimate a 25.3 percent chance of developing cancer. Using a simple linear model, a lifetime dose of 100 rem may have increased your chances of cancer from 25 to 28 percent.

The normal chance of developing cancer if you receive no occupational radiation dose is about equal to your chance of getting any spade on a single draw from a full deck of playing cards, which is one chance out of four. The additional chance of developing cancer from an occupational exposure of 1 rem is less than your chances of drawing an ace from a full deck of cards three times in a row.

Since cancer resulting form exposure to radiation usually occurs 5 to 25 years after the exposure and since not all cancers are fatal, another useful measure of risk is years of life expectancy lost on the average from a radiation-induced cancer. It has been estimated in several studies that the average loss of life expectancy from exposure to radiation is about 1 day per rem of exposure. In other words, a person exposed to 1 rem of radiation may, on the average, lose 1 day of life. The words "on the average" are important, however, because the person who gets cancer from radiation may lose several years of life expectancy while his coworkers suffer no loss. The ICRP estimated that the average number of years of life lost from fatal industrial accidents is 30 while the average number of years of life lost from a fatal radiation-induced cancer is 10. The shorter loss of life expectancy is due to the delayed onset of cancer.

It is important to realize that these risk numbers are only estimates. Many difficulties are involved in designing research studies that can accurately measure the small increases in cancer cases due to low exposures to radiation as compared to the normal rate of cancer. There is still uncertainty and a great deal of controversy with regard to estimates of radiation risk. The numbers used here result from studies involving high doses and high dose rates, and they may not apply to doses at the lower occupational levels of exposure. The NRC and other agencies both in the United States and abroad are continuing extensive long-range research programs on radiation risk.

Some members of the National Academy of Sciences BEIR Advisory Committee and others feel that risk estimates in Table 1 are higher than would actually occur and represent an upper limit on the risk. Other scientists believe that the estimates are low and that the risk could be higher. However, these estimates are considered by the NRC staff to be the best available that the worker can use to make an informed decision concerning acceptance of the risks associated with exposure to radiation. A worker who decides to accept this risk should make every effort to keep exposure to radiation ALARA to avoid unnecessary risk. The worker, after all, has the first line responsibility for protecting himself from radiation hazards.

10. **How can we compare radiation risk to other kinds of health risks?**

Perhaps the most useful unit for comparison among health risks is the average number of days of life expectancy lost per unit of exposure to each particular health risk. Estimates are calculated by looking

at a large number of persons, recording the age when death occurs from apparent causes, and estimating the number of days of life lost as a result of these early deaths. The total number of days of life lost is then averaged over the total group observed.

Several studies have compared the projected loss of life expectancy resulting from exposure to radiation with other health risks. Some representative numbers are presented in Table 2.

TABLE 2
Estimated Loss of Life Expectancy from Health Risks

Health Risk	Estimates of Days of Life Expectancy Lost, Average
Smoking 20 cigarettes/day	2,370 (6.5 years)
Overweight (by 20%)	985 (2.7 years)
All accidents combined	435 (1.2 years)
Auto accidents	200
Alcohol consumption (U.S. average)	130
Home accidents	95
Drowning	41
Natural background radiation, calculated	8
Medical diagnostic x-rays (U.S. average)	6
All catastrophes (earthquake, etc.)	3.5
1 rem occupational radiation dose, calculated (industry average for the higher-dose job categories is 0.65 rem/yr)	1
1 rem/yr for 30 years, calculated	30

These estimates indicate that the health risks from occupational radiation exposure are smaller than the risks associated with many other events or activities we encounter and accept in normal day-to-day activities.

A second useful comparison is to look at estimates of the average number of days of life expectancy lost from exposure to radiation and from common industrial accidents at radiation-related facilities and to compare this number with days lost from other occupational accidents. Table 3 shows average days of life expectancy lost as a result of fatal work-related accidents. Note that the data for occupations other than radiation related do not include death risks from other possible hazards such as exposure to toxic chemicals, dusts, or unusual temperatures. Note also that the unlikely occupational exposure at 5 rem per year for 50 years, the maximum allowable risk level, may result in a risk comparable to the average risks in mining and heavy construction.

TABLE 3
Estimated Loss of Life Expectancy from Industrial Hazards

Industry Type	Estimates of Days of Life Expectancy Lost Average
All industry	74
Trade	30
Manufacturing	43
Service	47
Government	55
Transportation and utilities	164

Agriculture	277
Construction	302
Mining and quarrying	328
Radiation accidents, death from exposure	< 1
Radiation dose of 0.65 rem/yr (industry average) for 30 years, calculated	20
Radiation dose of 5 rem/yr for 50 years	250
Industrial accidents at nuclear facilities (nonradiation)	58

Industrial accident rates in the nuclear industry and related occupational areas have been relatively low during the entire history of the industry (see Table 4). This is believed to be due to the early and continuing emphasis on tight safety controls. The relative safety of various occupational areas can be seen by comparing the probability of death by accident per 10,000 workers over a 40 year working lifetime. These figures do not include death from possible causes such as exposure to toxic chemicals or radiation.

TABLE 4
Probability of Accidental Death by Type of Occupation

Occupation	Number of Accidental Deaths for 10,000 Workers for 40 years
Mining	252
Construction	228
Agriculture	216
Transportation and public utilities	116
All industries	56
Government	44
Nuclear industry (1975 data excluding construction)	40
Manufacturing	36
Services	28
Wholesale and trade	24

11. **Can a worker become sterile or impotent from occupational radiation exposure?**

Observation of radiation therapy patients who receive localized exposures, usually spread over a few weeks, has shown that a dose of 500-800 rem to the gonads can produce permanent sterility in males or females (an acute whole-body dose of this magnitude would probably result in death within 60 days). An acute dose of 20 rem to the testes can result in a measurable but temporary reduction in sperm count. Such high exposures on the job could result only from serious and unlikely radiation accidents. Although high doses of radiation can affect fertility, they have no effect on the ability to function sexually. Likewise, exposure to permitted occupational levels of radiation has no observed effect on fertility and also has no effect on the ability to function sexually.

12. **What are the NRC external radiation dose limits?**

Federal regulations currently limit occupational effective whole-body radiation dose to 5 rem in any calendar year. However, when there is documented evidence that a worker's previous occupational dose is low enough, a licensee may permit an additional whole-body dose of approximately 5 rem per year as a *planned special exposure.*

13. **What is meant by ALARA?**

In addition to providing an upper limit on a person's permissible radiation exposure, the NRC also requires that its licensees maintain occupational exposures as far below the limit as is reasonably achievable (ALARA). This means that every activity at a nuclear facility involving exposure to radiation should be planned so as to minimize unnecessary exposure to individual workers and also to the worker population. A job that involves exposure to radiation should be scheduled only when it is clear that the benefit justifies the risks assumed. All design, construction, and operation procedures should be reviewed with the objective of reducing unnecessary exposures.

14. Has the ALARA concept been applied if, instead of reaching dose limits during the first week of a quarter, the worker's dose is spread out over the whole quarter?

No. For radiation protection purposes, the risk of cancer from low doses is assumed to be proportional to the amount of exposure, not the rate at which it is received. Thus it is assumed that spreading the dose out over time or over larger numbers of people does not reduce the overall risk. The ALARA concept has been followed only when the individual and collective doses are reduced by reducing the time of exposure or decreasing radiation levels in the individual and collective doses are reduced by reducing the time of exposure or decreasing radiation levels in the working environment.

15. What is meant by collective dose and why should it be maintained ALARA?

Nuclear industry activities expose and increasing number of people to occupational radiation in addition to the radiation doses they receive from natural background radiation and medical radiation exposures. The collective occupational dose (person-rem) is the sum of all occupational radiation exposure received by all the workers in an entire worker population. For example, if 100 workers each receive 2 rem, the individual dose is 1 rem and the collective dose is 200 person-rem. The total additional risk of cancer and genetic effects in an exposed population is assumed to depend on the collective dose.

It should be noted that, from the viewpoint of risk to a total population, it is the collective dose that must be controlled. For a given collective dose, the number of health effects is assumed to be the same even if a larger number of people share the dose. Therefore, spreading the dose out may reduce the individual risk, but not that of the population.

Efforts should be made to maintain the collective dose ALARA so as not to unnecessarily increase the overall population incidence of cancer and genetic effects.

16. Is the use of extra workers a good way to reduce risks?

There is a "yes" answer to this question and a "no" answer. For a given job involving exposure to radiation, the more people who share the work, the lower the average dose to an individual. The lower the dose, the lower the risk. So, for you as an individual, the answer in "yes."

But how about the risk to the entire group of workers? Under assumptions used by the NRC for purposes of protection, the risk of cancer depends on the total amount of radiation energy absorbed by human tissue, not on the number of people to whom this tissue belongs. Therefore, if 30 workers are used to do a job instead of 10, and if both groups get the same collective dose (person-rem), the total cancer risk is the same, and nothing was gained for the group by using 30 workers. From this viewpoint the answer is "no." The risk was not reduced but simply spread around among a larger number of persons.

Unfortunately, spreading the risk around often results in a larger collective dose for the job. Workers are exposed as they approach a job, while they are getting oriented to do the job, and as they withdraw from the job. The dose received during these actions is called nonproductive. If several crew changes are required, the nonproductive dose can become very large. Thus it can be seen that the total occupational dose and the resulting collective risks.

The use of extra workers to comply with NRC dose limits is not the way to reduce the risk of radiation-induced-cancer for the worker population. At best, the total risk remains the same, and it may even be increased. The only way to reduce the risk is to reduce the collective dose; that can be done only by reducing the radiation levels, the working times, or both.

17. Why doesn't the NRC impose collective dose limits?

Compliance with individual dose limits can be achieved simply by using extra workers. However, compliance with a collective dose limit (such as 100 person-rem per year for a license) would require reduction of radiation levels, working times, or both. But there are many problems associated with setting appropriate collective dose limits.

For example, we might consider applying a single collective dose limit to all licensees. The selection of such a collective dose limit would be almost impossible because of the wide variations in collective doses among licensees. A power reactor could reasonably be expected to have and average annual collective dose of several hundred person-rem. However, a small industrial radiography licensee could very well have a collective dose of only a few person-rem in a year.

Even choosing a collective dose limit for a group of similar licensees would be almost as difficult. Radiography licensees as a group had an average collective dose in 1977 of 9 person-rem. However, the smallest collective dose for a radiography licensee was less than 1 person-rem, and the largest was 401 person-rem.

Setting a reasonable collective dose limit for each individual licensee would also be very difficult. It would require a record of all past collective doses on which to base such limits. Setting an annual collective dose limit would then amount to an attempt to predict changes in each licensed activity that would increase or decrease the collective dose. In addition, annual collective doses vary significantly from year to year according to the kind and amount of maintenance required, which cannot generally be predicted in advance. Following all such changes and revising limits up and down would be necessary if a collective dose limit were to be reasonable and help minimize doses and risks.

18. How are radiation dose limits established?

The NRC establishes occupational radiation dose limits based on guidance to Federal agencies from the Environmental Protection Agency (EPA) and, in addition, considers NCRP and ICRP recommendations. Scientific reviews of research data on biological effects such as the BEIR report are also considered.

For example, recent EPA guidance recommended that the annual whole-body dose limit be established at 5 rem per year and indicated that exposure, year after year, to 5 rem would involve a risk to a worker comparable to the average risks incurred by workers in the higher risk jobs such as mining. In fact, few workers ever reach such a limit, much less year after year, and the risks associated with actual exposures are considered by the EPA to be comparable to the safer job categories. A 5-rem-per-year limit would allow occasional high dose jobs to be done without excessive risk.

19. What are the typical radiation doses received by workers?

The NRC requires that certain categories of licensees report data on annual worker doses and doses for all workers who leave employment with licensees. Data were received on the occupational doses in 1977 of approximately 100,000 workers in power reactors, industrial radiography, fuel processing and fabrication facilities, and manufacturing and distribution facilities. Of this total group, 85 percent received an annual dose of less than 1 rem; 95 percent received less than 2 rem; fewer than 1 percent exceeded 5 rem in 1 year. The average annual dose of those workers who were monitored and had measurable exposures was about 0.65 rem. A study completed by the EPA, using 1975 exposure data for 1,260,000 workers, indicated that the average annual dose for all workers who received a measurable dose was 0.34 rem.

Table 5 lists average occupational exposures for workers (persons who had measurable exposure above background levels) in various occupations, based on the 1975 data.

TABLE 5
U.S. Occupational Exposure Estimates

Occupational Subgroup	Average Whole Body Dose (millirem)	Collective Dose (person-rem)
Medicine	320	51,400
Industrial Radiography	580	5,700
Source Manufacturing	630	2,500
Power Reactors	760	21,400
Fuel Fabrication and Reprocessing	560	3,100
Uranium Enrichment	70	400
Nuclear Waste Disposal	920	100
Uranium Mills	380	760
Department of Energy Facilities	300	11,800
Department of Defense Facilities	180	10,100
Educational Institutions	206	1,500
Transportation	200	2,300

20. What happens if a worker exceeds the quarterly exposure limit?

Radiation protection limits, such as 1¼ rem in 3 months, are not absolute limits below which it is safe and above which there is danger. Exceeding a limit does not imply that your have suffered an injury. A good comparison is with the highway speed limit, which is selected to limit accident risk and still allow you to get somewhere. If you drive at 75 mph, you increase your risk of an auto accident to levels that are not considered acceptable by the people who set speed limits, even though you may not actually have an accident. If a worker's radiation dose repeatedly exceeds 3 rem in a quarter, the risk of health effects could eventually increase to a level that is not considered acceptable to the NRC. Exceeding an NRC protection limit does not mean that any adverse health effects are going to occur. It does mean that a licensee's safety program has failed in some respect and that the NRC and the licensee should investigate to make sure the problems are corrected.

If an overexposure occurs, the regulations prohibit any additional occupational exposure to that person during the remainder of the calendar quarter in which the overexposure occurred. The licensee is required to file an overexposure report to the NRC and may possibly be subject to a fine, just as you are subject to a traffic fine for exceeding the speed limit. In both cases, the fines and, in some serious or repetitive cases, suspension of license are intended to encourage efforts to operate within the limits. The safest limits would be 0 mph and 0 rem per quarter. But then we wouldn't get anywhere.

21. Why do some facilities establish administrative limits that are below the NRC limits?

There are two reasons. First, the NRC regulations state that licensees should keep exposures to radiation ALARA. By requiring specific approval for worker doses in excess of set levels, more careful risk-benefit analysis can be made as each additional increment of dose is approved for a worker. Secondly, a facility administrative limit that is set lower than the quarterly NRC limit provides a safety margin designed to help the licensee avoid overexposure.

22. Several scientists have suggested that NRC limits are too high and should be lowered. What are the arguments for lowering the limits?

In general, those critical of present dose limits say that the individual risk is higher than is estimated by the BEIR Committee, the ICRP, and UNSCEAR. Based on studies of low-level exposures to large groups, some researchers have concluded that a given dose of radiation may be more likely to cause biological effects than previously thought. Some of these studies are listed in the bibliography (Mancuso, Archer) and the BEIR-80 report includes a section analyzing the findings of these and other studies. Scientific opinion differs on the validity of the research methods used and the methods of statistical analysis. The problem is that the expected additional incidence of radiation-caused effects such as cancer is difficult to detect in comparison with the much larger normal incidence. It cannot be shown without question that these effects were more frequent in the exposed study group than in the unexposed group used for comparison, or that the observed effects were caused by radiation. The BEIR committee concluded that claims of higher risk had "no substance."

The NRC staff continually reviews the results of research on radiation risks. With respect to large-scale studies of radiation-induced health effects in human populations exposed to low-level ionizing radiation, the NRC and EPA have recently concluded that there is no one population group available for which such a study could be expected to provide a more meaningful estimate of the low-level radiation risk. This is due, in large part, to the observed and estimated low incidence of radiation health effects from low doses. However, the results of ongoing studies, such as that on nuclear shipyard workers, will be carefully reviewed and the development of a radiation-worker registry is being considered as a possible data base for future studies.

23. What are the reasons for not lowering the NRC dose limits?

Assuming that the 5-rem-per-year limit is adopted there are three reasons:

a. Health risks are already low.

The estimated health risks associated with current average occupational radiation dose (e.g., 0.5 rem/yr for 50 years) are comparable to or less than risk levels in other occupational areas considered to be among the safest. If a person were exposed to the maximum of 5 rem per year for 50 years, which virtually never occurs, he or she might incur a risk comparable to the average risks in mining and heavy construction. An occasional 5-rem annual dose might be necessary to allow some jobs to be done without a significant increase in the collective dose. If the dose limits were lowered significantly, the number of people required to complete many jobs would increase. The collective dose would then increase since more individuals would be receiving nonproductive exposure while entering and leaving the work are and preparing for the job. The total number of health effects might go up as the collective dose increased.

b. The current regulations are considered sound.

The regulatory standards for dose limits are based on the recommendations of the Federal Radiation Council. At the time these standards were developed, about 1960, it was unlikely that exposure to these levels during a working lifetime would result in clinical evidence of injury or disease different from that occurring in the unexposed population. The scientific data base for the standards consisted primarily of human experience (x-ray exposures to medical practitioners and patients, ingestion of radium by watch dial painters, early effects observed in Japanese atomic bomb survivors, radon exposures of uranium miners, occupational radiation accidents) involving very large doses delivered

at high dose rates. The data base also included the results of a large number of animal experiments involving large doses and dose rates. The animal experiments were particularly useful in the evaluation of genetic effects. The observed effects were related to low-level radiation according to the linear model explained in Question 7. Based on this approach, the regulations in 10 CFR Part 20, "Standards for Protection Against Radiation," also state that licensees should maintain all radiation exposures, and releases of radioactive material in effluent, as low as is reasonably achievable. More recent scientific reviews of the large body of experimental data, such as the BEIR-80 and the recent EPA guidance, continue to support the view that use of a 5-rem-per-year limit is acceptable in practice. Experience has shown that, under this limit, the average dose to workers is near 0.5 rem/yr with very few workers consistently approaching the limit.

c. There is little to gain.

Reducing the dose limits, for example, to 0.5 rem/yr has been analyzed by the NRC staff. An estimated 2.6 million person-rem could be saved from 1980 through the year 2000 by nuclear power plant licensees if compliance with the new limit were achieved by lowering the radiation levels, working times, or both, rather than by using extra workers. It is estimated that something like $23 billion would be spent toward this purpose. Spending $23 billion to save 2.6 million person-rem would amount to spending $30 to $90 million to prevent each potential radiation-induced premature cancer death. Society considers this cost unacceptably high for individual protection.

24. Are there any areas of concern about radiation risks that might result in changing the NRC dose limits?

Yes. Three areas of concern to the NRC staff are specifically identified below:

a. An independent study by Rossi and Mays and other biological research have indicated that a given dose of neutron radiation may be more likely to cause biological effects than was previously thought. Other recent studies cast doubt on the issue. The NCRP is currently studying the data related to the neutron radiation question and is expected to make recommendations as to whether neutron dose limits should be changed. Although the scientific community has not yet come to agreement on this question, workers should be advised of the possibility of higher risk when entering areas where exposure to neutrons will occur.

b. It has been known for some time that rapidly growing living tissue is more sensitive to injury from radiation than tissue in which the cells are not reproducing rapidly. Thus the embryo or fetus is more sensitive to radiation injury than an adult. The NRCP recommended in Report No. 39 that special precautions be taken when an occupationally exposed woman could be pregnant in order to protect the embryo or fetus. In 1975, the NRC issued Regulatory Guide 8.13, "Instruction Concerning Prenatal Radiation Exposure," in which it is recommended that licensees instruct all workers concerning this special risk. The guide recommends that all workers be advised that the NCRP recommended that the maximum permissible dose to the embryo or fetus from occupational exposure of the mother should not exceed 0.5 rem for the full 9-month pregnancy period. In addition, the guide suggests options available to the female employee who chooses not to expose her embryo or fetus to this additional risk.

Since it is known that the unborn child is more sensitive to radiation than adults, particularly during certain stages of development, the regulatory agencies have established a special dose limit for protection of the unborn child if the mother *declares* her pregnancy. Since this limit could result in job discrimination for women of child-bearing age and perhaps in the invasion of privacy (if pregnancy tests were required) it only applies to the unborn child of woman who *declare* their pregnancy. The regulatory agencies have taken the position that special protection of the unborn child should be voluntary and should be based on decisions made by workers and employers who are well informed about the risks involved (see specific guidelines on declaration of pregnancy).

c. Also of special interest is the indication that female workers are subject to more risk of cancer

incidence than male workers. In terms of all types of cancer except leukemia, the BEIR-80 analysis indicates that female workers have a risk of developing radiation-induced cancer that is approximately one and one-half times that for males. This increased risk is primarily due to the incidence of breast and thyroid cancer in women. These types of cancer, however, have a high cure rate. Thus the difference between men and women in cancer mortality is not great. Incidence of radiation-induced leukemia is about the same for both sexes. Female workers should be aware of this difference in the risks of radiation-induced cancer in deciding whether or not to seek work involving exposure to radiation.

25. How much radiation does the average person who does not work in the nuclear industry receive?

We are all exposed from the moment of conception to ionizing radiation from several sources. Our environment, and even the human body, contains naturally occurring radioactive materials that contribute some of the background radiation we receive. Cosmic radiation originating in space and in the sun contributes additional exposure. the use of x-rays and radioactive materials in medicine and dentistry adds considerably to our population exposure.

Table 6 shows estimated average individual exposure in millirem from natural background and other sources.

TABLE 6
U.S. General Population Exposure Estimates

Source	Average Individual Dose (mrem/yr)
Natural background (average in U.S.)	100
Release of radioactive material in natural gas, mining, milling, etc.	5
Medical (whole-body equivalent)	54
Nuclear weapons (primarily fallout)	5 - 8
Nuclear energy	0.28
Consumer products	0.03
Radon Gas - Daughter Products	198
Total	~ 360 mrem/yr

Thus, the average individual in the general population receives about 0.36 rem of radiation exposure each year from sources that are a part of our natural and man-make environment. By the age of 20 years, and individual has accumulated about 7.2 rem. The most likely target for reduction of population exposure is radon.

26. Why aren't medical exposures considered as part of a worker's allowed dose?

Equal doses of medical and occupational radiation have equal risk. Medical exposure to radiation should be justified for reasons quite different, however, from those applicable to occupational exposure. A physician prescribing an x-ray should be convinced that the benefit to the patient of the resulting medical information justifies the risk associated with the radiation. Each worker must decide on the acceptance of occupational radiation risk just as each worker must decide on the acceptability of any other occupational hazard.

For another point of view, consider a worker who receives a dose of 2 rem from a series of x-rays or a radioactive medicine in connection with an injury or illness. This dose and the implied risk should be

justified on medical grounds. If the worker had also received a dose of 2 rem on the job, the combined dose of 4 rem would not incapacitate the worker. A dose of 4 rem is not especially dangerous and is not large compared to the cumulative lifetime dose. Restricting the worker from additional job exposure during the remainder of the quarter would have no effect one way or the other on the risk from the 2 rem already received from medical benefits and the risks associated with job-related exposure on the basis of employment in radiation areas for the remainder of the quarter.

Some therapeutic medical doses such as those received from cobalt-60 treatment can range as high as 6000 rem to a small part of the body, spread over a period of several weeks or months.

27. What is meant by internal exposure?

The total radiation dose to the worker is the external dose (measured by the film badge and reported as "whole-body dose") plus the dose from internal emitters. The monitoring of the additional internal dose is difficult. Because there is the possibility of internal doses occurring, a good air-monitoring program should be established when warranted.

The uptake of radioactive materials by workers is generally due to breathing contaminated air. Radioactive materials may be present as fine dust or gases in the workplace atmosphere. The surfaces of equipment and workbenches may be contaminated. Radioactive materials may enter the body by being breathed in, taken in with food or drink, or being absorbed through the skin, particularly if the skin is broken.

After entering the body, the radioactive material will migrate to particular organs or particular parts of the body depending on the biochemistry of the material. For example, uranium will tend to deposit in the bones where it will remain for a long time. It is slowly eliminated from the body, mostly by way of the kidneys. Radium will also tend to deposit in the bones. Radioactive iodine will seek out the thyroid glands (located in the neck) and deposit there.

The dose from these internal emitters cannot be measured either by the film badge or by other ordinary dosimeters carried by the worker. This means that the internal radiation dose must be separately monitored using other detection methods.

Internal exposure can be estimated by measuring the radiation emitted from the body or by measuring the radioactive materials contained in biological samples such as urine or feces. Dose estimates can also be made if one knows how much radioactive material is in the air and the length of time during which the air was breathed.

28. How are the limits for internal exposure set?

Standards have been established for the maximum permissible amount of each radionuclide that may be accumulated in the critical organs of the worker's body.

Calculations are made to determine the quantity of radioactive material that has been taken into the body and the total dose that would result. Then, based on limits established for particular body organs similar to 1 1/4 rem in a calendar quarter for whole-body exposure, the regulations specify maximum permissible concentrations of radioactive material in the air to which a worker can be exposed for 40 hours per week over 13 weeks or 1 calendar quarter. The regulations also require that efforts be made to keep internal exposure ALARA.

Internal exposure is controlled by limiting the release of radioactive material into the air and by carefully monitoring the work area for airborne radioactivity and surface contamination. Protective clothing and respiratory (breathing) protection should be used whenever the possibility of contact with loose radioactive material cannot be prevented.

29. Is the dose a person received from internal exposure added to that received from external exposure?

Exposure to radiation that results from radioactive materials taken into the body is measured, recorded, and reported to the worker separately from external dose. The internal dose to the whole body or to specific organs is summed into the effective annual dose and also reported to the worker.

30. How is a worker's external radiation dose determined?

A worker may wear three types of radiation-measuring devices. A self-reading pocket dosimeter records the exposure to incident radiation and can be read out immediately upon finishing a job involving external exposure to radiation. A film badge or TLD badge records radiation dose, either by the amount of darkening of the film or by storing energy in the TLD crystal. Both these devices require processing to determine the dose but are considered more reliable than the pocket dosimeter. A worker's official report of dose received is normally based on film or TLD badge readings, which provide a cumulative total and are more accurate.

31. What are my options if I decide not to accept the risks associated with occupational radiation exposure?

If the risks from exposure to radiation that may be expected to occur during your work are unacceptable to you, you could request a transfer to a job that does not involve exposure to radiation. However, the risks associated with exposure to radiation that workers, on the average, actually receive are considered acceptable, compared to other occupational risks, by virtually all the scientific groups that have studied them. Your employer is probably not obligated to guarantee you a transfer if you decide not to accept an assignment requiring exposure to radiation.

You also have the option of seeking other employment in a nonradiation occupation. However, the studies that have compared occupational risks in the nuclear industry to those in other job areas indicate that nuclear work is relatively safe. Thus, you will not necessarily find significantly lower risks in another job.

A third option would be to practice the most effective work procedures so as to keep your exposure ALARA. Be aware that reducing time of exposure, maintaining distance from radiation sources, and using shielding can all lower your exposure. Plan radiation jobs carefully to increase efficiency while in the radiation area. Learn the most effective methods of using protective clothing to avoid contamination. Discuss your job with the radiation protection personnel who can suggest additional ways to reduce your exposure.

32. Where can I get additional information on radiation risk?

The following list suggests sources of useful information on radiation risk:

Your Employer. The radiation protection or health physics office in the facility where you are employed.

Nuclear Regulatory Commission-Regional Offices
Suite 2900
101 Marietta Street
Atlanta, GA 30303
Telephone: (404) 331-4673

Headquarters
Occupational Radiation Protection Branch
Office of Nuclear Regulatory Research
U.S. Nuclear Regulatory Commission
Washington, D.C. 20555

Department of Health and Human Services
Office of the Director

Bureau of Radiological Health (HFX-1)
Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Environmental Protection Agency
Office of Radiation Programs
U.S. Environmental Protection Agency
401 M. Street, SW
Washington, D.C. 20460