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# IARC Monographs: 40 Years of Evaluating Carcinogenic Hazards to Humans

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**Competing financial interests:** Bruce Armstrong was formerly Deputy Director of IARC (1991-1993). James Huff and Harri Vainio have previously served as head of the IARC Monographs Program. Most (but not all) other authors have served on IARC Monograph Working groups, and several have worked for IARC in the past.

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## Abstract

**Background:** Recently the International Agency for Research on Cancer (IARC) Programme for the Evaluation of Carcinogenic Risks to Humans has been criticized for several of its evaluations, and also the approach used to perform these evaluations. Some critics have claimed that IARC Working Groups' failures to recognize study weaknesses and biases of Working Group members have led to inappropriate classification of a number of agents as carcinogenic to humans.

**Objectives:** The authors of this paper are scientists from various disciplines relevant to the identification and hazard evaluation of human carcinogens. We have examined here criticisms of the IARC classification process to determine the validity of these concerns. We review the history of IARC evaluations and describe how the IARC evaluations are performed.

**Discussion:** We conclude that these recent criticisms are unconvincing. The procedures employed by IARC to assemble Working Groups of scientists from the various discipline and the techniques followed to review the literature and perform hazard assessment of various agents provide a balanced evaluation and an appropriate indication of the weight of the evidence. Some disagreement by individual scientists to some evaluations is not evidence of process failure. The review process has been modified over time and will undoubtedly be altered in the future to improve the process. Any process can in theory be improved, and we would support continued review and improvement of the IARC processes. This does not mean, however, that the current procedures are flawed.

**Conclusions:** The IARC Monographs have made, and continue to make, major contributions to the scientific underpinning for societal actions to improve the public's health.

## Introduction

Important advances in human health have come from the recognition of health hazards and the development of policy actions to address them (Brownson et al. 2009; Espina et al. 2013; Samet 2000). Government and non-governmental organizations use expert panels to review the scientific literature and to assess its relevance to public health policies. Scientific experts are charged with reviewing the quality and quantity of the scientific evidence and providing scientific interpretations of the evidence that underpin a range of health policy decisions.

The IARC Monographs on the Evaluation of Carcinogenic Risks to Humans of the International Agency for Research on Cancer (IARC) are a prominent example of such an expert review process. The goal of the Monograph Programme is to assess carcinogenic hazards from occupational, environmental, and lifestyle exposures and agents, thus providing an essential step in the societal decision-making process to identify and then control carcinogenic hazards. For these evaluations, IARC assembles groups of scientists with a range of relevant scientific expertise (called "Working Groups") to review and assess the quality and strength of evidence from informative publications and perform a hazard evaluation to assess the likelihood that the agents of concern pose a cancer hazard to humans (Tomatis 1976). IARC has used this approach for four decades since the first Monograph in 1972 ([Anonymous] 1972). Although widely accepted internationally, there have been criticisms of the classification of particular agents in the past, and more recent criticisms have been directed at the general approach adopted by IARC for such evaluations ([Anonymous] 2013; Boffetta 2007; Boffetta et al. 2009; Ioannidis 2005; Kabat 2012; McLaughlin et al. 2010; McLaughlin et al. 2011).

The Monographs are widely used and referenced by governments, organizations, and the public around the world, therefore it is critical that Working Group conclusions be clear and

transparent. In addition to the actual evaluation, a major contribution of the Monographs is the assembly of relevant literature and its dissemination to the public. We recognize that no system of evaluation is perfect. It is important to foster continuing improvement of the methods used by IARC and other bodies that review scientific evidence. The IARC process itself has been modified from time to time (e.g., addition of specific evaluation of mechanistic data and greater use of formal meta-analyses and data pooling approaches). Indeed, as recently as April, 2014 IARC Monographs program has been a subject of a review by the Advisory Group to recommend Priorities for IARC Monographs during 2015-2019 (Straif et al. 2014). The Advisory Group has made a number of recommendations on further improvements in the Monographs process, specifically related to conflict of interest, transparency, and the use of the systematic review procedures in data gathering and evaluation. Thus, possible changes to the process are periodically considered by IARC governing groups (Scientific Council and Governing Council) and Advisory Groups.

In the current paper, we focus on current IARC processes and practices, since these have been the focus of recent criticisms. The authors of this paper are scientists from a wide range of disciplines who are involved in designing and conducting studies that provide data used in hazard evaluations, such as those performed by IARC. Many (but not all) of us have served on IARC Monograph Working Groups, but none are current IARC staff. We first discuss the history of IARC, and describe how the IARC evaluations are performed in order to foster evidence-based policy. We then describe why unbiased evaluations, based on the evidence and free of conflicts of interest, are necessary for public health decision-making. Finally, we consider the recent criticisms of the IARC approach.

## The IARC Monographs

### History of the IARC Monographs

Shortly after IARC's establishment, its parent entity, the World Health Organization (WHO), asked IARC to prepare a list of agents known to cause cancer in humans. IARC recognized the need for a systematic process to determine which agents should be listed. Such a process was launched in 1972 by Lorenzo Tomatis, then Chief of the Division of Carcinogenicity of IARC (Tomatis 1976). IARC is funded by the governments of 24 countries that have decided to become members, in addition to competitive grants from funding agencies. The IARC Monograph Programme is mainly funded by the US National Cancer Institute through a renewable grant subject to peer review of the Programme. Other sources of external funding have included the European Commission Directorate-General of Employment, Social Affairs and Equal Opportunities, the U.S. National Institute of Environmental Health Sciences, and the U.S. Environmental Protection Agency.

The IARC process antedates current systematic review methods, but anticipated some of them, e.g. with regards to transparent literature identification. In the IARC process, agents are assessed for carcinogenic hazard and assigned to one of five categories, ranging from carcinogenic to humans to probably not carcinogenic to humans (Appendix 1). The classification categories are described in the preamble to the Monographs (http://monographs.iarc.fr/ENG/Monographs/PDFs/). Carcinogenic hazard identification refers to an assessment of whether an agent causes cancer. Hazard identification does not predict the magnitude of cancer risks under specific conditions; this can be determined only with appropriate exposure-response information (National Research Council 2009).

**The IARC Monograph Process**

The process for the preparation of an IARC Monograph is clearly described in the Preamble which is published as part of each Monograph ([Anonymous] 2014b). It starts with the nomination of candidate agents. Nominations come from national regulatory agencies, scientists and stakeholders, including public health professionals, experts in environmental or occupational hygiene, industry representatives, and private citizens. It is important to note that anyone (including private citizens) can participate in the nomination process. The Monograph Programme convenes meetings of special Advisory Groups (AG), composed of external scientists that possess a broad range of relevant professional skills, to review agents nominated for evaluation and to suggest IARC priorities for such reviews (Ward et al. 2010). Announcements of a review are made on the IARC website (http://monographs.iarc.fr/ENG/Publications/internrep/08-001.pdf). For example, in 2014 IARC sought nominations for agents to be evaluated in 2015-2019. An AG reviewed the nominated agents and exposures, added several new ones, and discussed the priorities for each.

The IARC staff make the final selection of agents for review by taking into account the prevalence and intensity of exposure (of both occupational groups and the general population) and availability of sufficient literature for an evaluation of carcinogenicity, as well as advice from the AG. The large majority of evaluations concern specific compounds, but there are also monographs on various occupations or industries, e.g. aluminum production, insecticide applicators, firefighters, leather goods manufacture, leather tanning and processing, welding, painter, petroleum refining, and pulp and paper manufacture. Some individual exposures that occur in these settings have also been evaluated.

The next step is the selection of members of the Working Group (WG). This is made by IARC staff who review the literature to identify Working Group candidates and specialists in relevant areas of expertise; they also seek names of possible candidates from the scientific community and advisory groups. The list of potential members, including disclosure of relevant conflicts of interest, is posted on the IARC website before the WG is convened and anyone can send comments. Members are typically scientists who have conducted research relevant to the agent under review, but not necessarily on the specific agent. Selection procedures are evaluated yearly by the Scientific and the Governing Councils. The IARC Section of Monographs also has an external Advisory Board made of independent scientists that periodically peer-reviews its activities. In addition to Working Group members, invited specialists, representatives of health agencies, stakeholder observers, and the IARC Secretariat also attend meetings.

The responsibility of the Working Group is to review the literature before the Monograph meeting, discuss the literature at the meeting, and then classify whether an agent is carcinogenic to humans, probably carcinogen, possibly carcinogenic, not classifiable as to its carcinogenicity to humans, or probably not carcinogenic to humans (see Appendix 1). Working Group members are also responsible for writing each IARC Monograph, which must both review the literature and explain why the Working Group came to their specific conclusions.

The procedures used to evaluate the scientific evidence are also described in the Preamble to the Monographs and on the IARC website (monographs.iarc.fr). It is important to stress that only Working Group members conduct the actual evaluation (Wild and Cogliano 2011; Wild and Straif 2011). IARC staff facilitate the evaluation process and ensure that the procedures described in the Preamble are followed; however, they do not determine the outcomes.

IARC assessments of carcinogenicity are based on, and necessarily limited to, scientific evidence available at the time of the review. The evidence comes from epidemiologic studies, animal bioassays, pharmacokinetic/mechanistic experiments, and surveys of human exposure. The aim is to include all relevant papers on cancer in humans and experimental animals that have been published, or accepted for publication, in peer-reviewed scientific journals, and also any publicly available government or agency documents that provide data on the circumstances and extent of human exposure. To this end, the search of the literature takes a comprehensive approach. Papers that are found not to provide useful evidence can be excluded later in the process. IARC staff first use previous IARC Monographs (if available), database searches using relevant text strings, and contact with investigators in the field to identify potentially relevant material. Thus, the initial assembly of the literature is performed by individuals who are not engaged in the actual evaluation. Working Group members are then assigned various writing tasks and they are instructed to perform their own literature searches to identify any further papers that might have been missed. In addition, all of the papers assembled by IARC are made available to the full Working Group before they meet, and any member can recommend other papers not identified, which they think should be considered. Finally, papers can be recommended by stakeholder representatives before or during the Working Group meeting.

At the meeting of the Working Group, the assembled documents are reviewed by discipline-related subgroups, which review and summarize them. However, any member of the Working Group has access to all of the assembled literature. The summaries are distributed to all subgroups, and information from all disciplines is discussed in plenary sessions prior to assigning the agents to a specific carcinogenicity category.

Because new findings continually emerge in the literature, agents are reconsidered when IARC and IARC Advisory Groups judge that there is sufficient additional information that might alter a previous evaluation. Thus, conclusions regarding human carcinogenicity of particular substances may change as new evidence becomes available. For some agents, this re-evaluation has resulted in progression toward greater certainty regarding their human carcinogenicity, whereas for others the progress has been moved toward less certainty. Such movements are expected in an open, transparent, and evidence-based process. A comprehensive update of all Group 1 carcinogens was recently accomplished in Volume 100 A through F (http://monographs.iarc.fr/ENG/Classification/).

Usually, several agents are evaluated in a single meeting lasting more than one week. The Working Group members after discussing the evidence fully, follow the published IARC procedures for combining information from epidemiologic studies and bioassay to arrive at a preliminary classification ([Anonymous] 2014b). Mechanistic data are then considered to determine if they warrant a change from this preliminary classification. The Working Group then votes on the final determination. Many votes are unanimous, but on occasion some reviewers may favour a higher or lower ranking than the majority. When there is dissent, alternative interpretations and their underlying reasoning are sometimes reported in the rationale for the evaluation if the dissenters feel their point of view is not sufficiently addressed in the monograph.

**Consideration of the totality of the evidence**

IARC Working Groups make every effort to provide full and transparent documentation of what evidence was assembled, how it was evaluated, and which papers were most important for the hazard evaluation. Consequently, the monographs are often quite lengthy with many evidence

tables (see, for example, the recent Monograph on Trichloroethylene ([Anonymous] 2014a)). Evaluations involve consideration of all of the known relevant evidence from epidemiologic, animal, pharmacokinetic/mechanistic, and exposure studies to assess cancer hazard in humans. Information on human exposure is not formally graded as part of the overall assessment of carcinogenic hazard; however, these data make a critical contribution to the process by characterizing the timing, duration, and levels of exposure in the population, and in evaluating the quality of the exposure assessment in epidemiologic studies.

Doubts and criticisms have sometimes been expressed about the relative weights attributed to evidence from individual disciplines to the assessment of cancer hazards to humans; however, each provides important evidence toward the overall evaluation of causality according to the Bradford Hill considerations (Hill 1965). Because the totality of the evidence is considered, deficiencies in one discipline are often offset by strengths in another. For example, epidemiologic studies may focus on population-relevant exposures, whereas findings from animal experiments usually involve higher exposures but are less susceptible to confounding.

Long-term animal bioassays and mechanistic studies provide critical information on the capacity of an agent to produce cancer in mammalian systems, including humans, and to contribute to decisions that would lead to better protection of human health. Bioassays are the backbone of regulatory science, because they provide the opportunity to rigorously evaluate potential hazards before there is widespread human exposure. Bioassays and mechanistic studies are sometimes criticized for employing exposure routes and doses that in most instances humans would not experience, although experimental dose categories sometimes approach exposure levels found in occupational situations. There is evidence that carcinogenicity in human and animal studies is often concordant, although data may differ as to the affected cancer site (Haseman 2000;

Maronpot et al. 2004; Tomatis 2002). A major effort to evaluate the concordance between animal and human results is currently underway; two Working Group were convened at IARC in 2012 and a systematic evaluation of the correspondence between human and animal data was undertaken (no report is publicly available yet).

## Criticisms of the IARC process

IARC Monographs are widely used to identify potential carcinogenic hazards to humans and serve as reference documents summarizing the literature on many different agents. In recent years, however, individuals have criticized both the classification of individual agents as well as the general evaluative approach ([Anonymous] 2013; Boffetta 2007; Boffetta et al. 2009; Kabat 2012; McLaughlin et al. 2010; McLaughlin et al. 2011). We discuss four of these criticisms below.

### Criticisms of epidemiology

Some of the criticisms of the IARC process occur in the context of more general criticisms of epidemiology as a science (Boffetta 2007; Kabat 2008); these have been discussed in detail in a recent paper (Blair et al. 2009). Potential methodological weaknesses for observational epidemiologic studies are well recognized and can be found in any epidemiologic textbook (Checkoway et al. 2004; Rothman et al. 2008). Most studies are subject to one or more methodological limitations, but this does not necessarily invalidate their findings (Blair et al. 2009). In fact, the value of epidemiologic studies has been shown in identifying in multiple studies a number of well-established human carcinogens, including tobacco, asbestos, benzene, hexavalent chromium, and some viruses. Some critics also argue that small or non-existent health risks are unjustifiably highlighted and hyped by researchers who have a vested interest in continued research funding and the need to publish to benefit their careers (Boffetta et al. 2008;

Kabat 2008; McLaughlin et al. 2010; McLaughlin et al. 2011; Taubes 1995). However, such over-stated results are unlikely to exert much of an influence in a Monograph, because IARC evaluations are based on the totality of the evidence. The problem would have to occur in multiple studies and the Working Group would have to be unable to identify it, or be unwilling to weigh such studies appropriately. Incorrect positive conclusions regarding carcinogenicity may also occur in reviews of multiple studies because of publication bias, which may selectively populate the literature with only "positive" findings. However, once a topic is recognized as scientifically important, reports on relevant studies will be published regardless of the findings, so publication bias is mainly a concern for newly arising issues. To evaluate the potential for publication bias, Working Groups consider whether stronger, negative studies (both in terms of design and sample size) have emerged after publication of an initial cluster of smaller and/or weaker positive studies. Funnel plots help in the assessment of bias relating to sample size and publication bias (Borenstein et al. 2009). In contrast, there are no established statistical techniques to clearly characterize strength of design.

One of the distinctive features of epidemiology is that criticism and self-criticism are firmly embedded in the discipline. A great deal of work has been done on developing methods for critical appraisal (Elwood 2007) and for assessing the likely strength and direction of possible biases (Rothman et al. 2008). Epidemiologists and other members on Working Groups routinely use various approaches to assess possible bias in study design and analysis when weighing the strengths of different studies.

**The issue of false positives**

Epidemiology specifically has been criticized for a tendency to produce false positive results (i.e., individual study associations not borne out by the weight of the evidence), or to

preferentially report positive findings over negative or inconclusive findings (i.e., publication bias) (Boffetta et al. 2008, 2009; Ioannidis 2005; Kabat 2012; McLaughlin and Tarone 2013). This criticism has been most often applied to potential false positives from individual studies, but it has been inferred that this problem may also apply to overall hazard evaluations which use findings from multiple studies. We will consider each of these issues in turn.

False positive findings may occur by chance, particularly when many combinations of exposures and health outcomes have been examined in a single study without strong prior expectations of association; this happens often, for example, in GWAS studies where thousands of gene-disease associations are evaluated. Chance, of course, operates in all disciplines and in both observational and experimental studies. However, there are well-known statistical techniques to reduce the probability of declaring chance findings as "positive" (Rothman et al. 2008). Independent replication, however, is the most convincing way of checking for "chance" findings, and hazard evaluations such as those conducted by IARC Working Groups rely heavily on reproducibility in independent studies and interpret data following Bradford Hill principles (Hill 1965).

False negatives are more difficult to address, and perhaps they occur more frequently than false positives because of low statistical power, non-differential misclassification of exposure and/or outcome, and incomplete follow-up, which tends to reduce the observed difference in risk between the exposed and non-exposed populations (Ahlbom et al. 1990; Blair et al. 2009; Grandjean 2005; Rothman et al. 2008). A new positive association stimulates research, while studies finding no associations tend to stifle further work.

There are difficulties in conducting epidemiologic studies of agents that are relatively "weak" carcinogens, or for stronger carcinogens where exposure is very low because bias and confounding can obscure weak positive associations (Macmahon et al. 1981). In general, weak carcinogens and low levels of exposure result in a smaller "signal to noise" ratio making the real signal more difficult to detect. Although the identification of small relative risks to humans poses special challenges to scientific research, the refinement of study designs, improvements in methods of exposure assessment and the use of biomarkers have helped to address the problems (e.g., the newer studies on the effects of air pollution, and the growth in opportunities to examine gene- and environment interactions) (Gallo et al. 2011). In some situations, there is less of a problem. For example, in occupational studies, exposures and relative risks may be higher, while differences in lifestyle factors between different groups of workers are smaller (Checkoway et al. 2004), thus any confounding by non-occupational factors is likely to be weak, even from potent causes of cancer, such as cigarette smoking (Siemiatycki et al. 1988). Of course, the interpretation of such studies is enhanced when there is supporting evidence from bioassays and/or mechanistic studies.

False positive and false negative findings in individual studies may arise by chance, or bias, including bias due to confounding (Rothman et al. 2008). However, the evaluation of multiple, independent epidemiologic studies, from various geographic locations, involving a variety of study designs, as well as evidence from experimental studies, reduces the possibility that false positive findings from any individual study influences the overall evaluation process. Some studies may have greater influence than others because of methodological strengths and/or large sample size. The use of information from a variety of study designs reduces the likelihood of false positive evaluations, because it is unlikely that the same biases will occur in multiple

studies based on different populations under different study designs. Moreover, apparently conflicting results from epidemiologic studies do not necessarily indicate that some are false positive or false negative. This might, for example, reflect differences in levels of exposure or susceptibility to the effects of exposure (effect modification). Finally, judgment by the Working Group is not based exclusively on epidemiologic studies, but usually also on results from laboratory and mechanistic studies that provide further evidence and biological coherence. For the Monographs that evaluate carcinogenic hazards associated with specific occupations or industries, the exposures of interest usually involve a complex mixture of chemicals. For these evaluations, most information comes from epidemiologic studies, although exposures to individual agents occurring at these workplaces may have been evaluated in experimental studies.

**Discontent with IARC Monograph processes**

The IARC Monograph evaluation process has been criticized and it has been alleged that "a number of scientists with direct experience of IARC have felt compelled to dissociate themselves from the agency's approach to evaluating carcinogenic hazards."(Kabat 2012) This is a serious charge. However, the authors of this claim provide no evidence to support the charge that a "number of scientists" have dissociated themselves from the process, nor has there been any indication of how many scientists have taken this step, or for what reason. In science, we expect sweeping statements such this to be appropriately documented. We have not been able to identify any credible support for this contention.

There is an IARC Governing Council and a Scientific Council to provide oversight and guidance to the agency. The Governing Council represents the participating states and sets general IARC policy. It appoints the IARC Director and members of the Scientific Council. The latter are



 

independent scientists who are selected to provide scientific expertise and not as representatives of the member states. They serve for four years and serve without pay. The voting members of Monograph Working Groups are not employed by IARC and they perform this task without financial compensation (see above). There have been 111 volumes, including six separate documents under Volume 100, and three Supplements. Over the years, as the number of publications for each agent to be evaluated increased, the size of Working Groups has increased. Early in the process they were sometimes as small as 10, but now they sometimes include as many as 30 scientists. We estimate that over the entire Monograph series approximately 1500 scientists have served as Working Group members, and of course many scientists have also served on the Advisory Groups, Scientific Council and Governing Council. Thus, if even a small percentage of these scientists were disenchanted with the IARC process, it would result in a considerable number of such individuals and should be easy to document. To be taken seriously the "dissociation" criticism needs to be supported by documented information describing the number scientists who have taken this action.

**Criticisms of specific evaluations**

Some criticisms of the IARC process relate to specific agents, where it is asserted that the hazard evaluations of category 2B, 2A, or 1 are not supported by the scientific literature (Boffetta 2007). In the 111 volumes of the Monographs produced over the four decades since 1971, 970 agents have been considered, 114 (12%) have been classified as carcinogenic to humans (Group 1), 69 (7%) as probably carcinogenic (Group 2A), 283 (29%) as possibly carcinogenic (Group 2B), 504 (52%) as not classifiable regarding their carcinogenicity (Group 3), and 1 (<1%) as probably not carcinogenic to humans (Group 4). Thus, even for this highly selected group of agents (i.e., those selected for evaluation because there was some concern that they might be carcinogenic),

more than one half were 'not classifiable' or 'probably not carcinogenic', and a further 29% were placed into the category of possibly carcinogenic to humans. This distribution, based on nearly 1000 evaluations, in which fewer than one in five agents were classified as carcinogenic, or probably carcinogenic, to humans does not support a conclusion that the process is heavily biased towards classifying agents as carcinogenic (Boffetta 2007; Boffetta et al. 2009; Kabat 2012).

The Monographs for formaldehyde, coffee, DDT, and radiofrequency electromagnetic radiation have been cited as examples of problematic evaluations by some (Kabat 2012) (note that, among these, only formaldehyde was classified as known to be carcinogenic to humans (Group 1) by an IARC Working Group). These are important agents. However, to accept the charge that IARC evaluations are fundamentally biased, one has to assume that the scientists who were members of the Working Groups were incapable of appropriately evaluating weaknesses in the data, or that they distorted the evaluative process because of personal biases. In our experience neither of these assertions is correct. Dissent among scientists is not unusual in any area of science. It is a strength of the scientific process. The IARC process capitalizes on this by bringing scientists from different disciplines together in one room to evaluate the literature and to reach a reasoned conclusion. Differences of opinion occur among Working Group members. These differences, however, typically involve disputes related to assignment to adjacent classification categories. It is instructive that there are no instances in which a carcinogen classified at the Group 1 level by one Working Group has been reversed by another. The recent review of all Group 1 agents for Volume 100 provided ample opportunity to reverse such previous classifications, but none occurred. Every scientist could probably name a substance that has been reviewed by IARC that

they might personally place in a different category from that assigned by the Working Group, but this is one opinion against the collective wisdom and process of the Working Group,

**Criticisms of the composition of the Working Groups**

The composition of the Working Groups has also been criticized (Erren 2011; McLaughlin et al. 2010; McLaughlin et al. 2011); it has been argued that members of the Working Groups who have conducted research on the agents under evaluation have a vested interest in advancing their own research results in the deliberations. This criticism has been addressed directly by Wild et al. (Wild and Cogliano 2011; Wild and Straif 2011) from IARC, and we know of no evidence to support this contention. Even if some scientists on the Working Group have performed research on some of the agents being considered, they make up a minority of the Working Group because several agents are usually evaluated in a single meeting, so the number of Working Group members who have conducted research on any one agent is typically small. Our experience has been that having some scientists who are knowledgeable about the studies of the agent under evaluation (and can therefore answer technical queries) and others from different, but related, fields provides a knowledgeable and balanced mix of scientific backgrounds for a thoughtful evaluation of the literature.

Working Group members do not receive any fee for their work, but are paid travel expenses, and there is some prestige associated with service on an IARC Monograph. However, most scientists asked to serve on IARC Working Groups have already achieved some measure of scientific stature, and there is no reason why this should bias their evaluation in one direction of the other. In addition, IARC strictly requires that any conflict of interests are divulged, and does not allow those with conflicts of interest to serve on Working Groups, although non-voting observers who may conflict of interest are able to attend the Working Group meetings.

## Conclusions

For over four decades the IARC Monograph Programme has provided evaluations of cancer hazards to humans from many different exposures and agents. These are often the first evaluations of new and emerging threats to public health and, consequently, are subject to intense scrutiny. Although these evaluations are widely respected and used by many organizations, institutions, companies, and government agencies to improve the public's health, IARC has recently been subject to criticism over conclusions on specific agents, the process that leads to such conclusions, and membership of the Working Groups. Debate and criticism facilitate self-correction and a check on the validity in science. We are concerned, however, that the criticisms expressed by a vocal minority regarding the evaluations of a few agents may promote the denigration of a process that has served the public and public health well for many decades for reasons which are not supported by data.

There has been very broad involvement of the scientific community in the IARC Monograph Programme through participation in the Working Groups and service on the IARC Governing and Scientific Councils and ad hoc Advisory Board for the Monograph Programme. The long list of scientists who are coauthors of this paper attests to the strong support that IARC has in the scientific community. Many exposures that IARC has evaluated have also been independently evaluated by other institutions, e.g., the U.S. National Toxicology Program; U.S. Environmental Protection Agency; National Academy of Sciences; the ACGIH TLV/BEI threshold limit values; the Nordic Expert Group for Criteria Documentation of Health Risks from Chemicals (http://www.av.se/arkiv/neg/?AspxAutoDetectCookieSupport=1); Institute of Occupational Medicine (IOM), Edinburgh, Scotland; WCRF/AIRC Expert Reports; European Chemicals Agency (https://echa.europa.eu); Swedish Criteria Group for Occupational Standards

(https:gupea.ub.gu.se/handle/2077/34986); California Office of Environmental Hazard Assessment (http://oehha.ca.gov/prop65/background/p65plain.html); Bureau of Chemical Safety in Canada (http://www.hc-sc.gc.ca/ahc-asc/branch-dirgen/hpfb-dgpsa/fd-da/bcs-bsc/index-eng.php); Scientific Committee on Occupational Exposure Limits (SCOEL); European Commission, Employment, Social Affairs and Inclusion (http://ec.europa.eu/social/main.jsp?catId=148&langId=en&intPageId=684); European Food Safety Authority (EFSA) (http://www.efsa.europa.eu/en/search/doc/3132.pdf); and European Chemicals Agency (ECHA)(http://echa.europa.eu/), and assessments from these groups typically come to conclusions similar to those from IARC. This further indicates broad agreement within the scientific community regarding evidence on carcinogenicity in the scientific literature and expands the number of scientists who do not have a "vested interest", but who have generally agreed with those conclusions.

Disagreement with the conclusions in an IARC Monograph for an individual agent is not evidence for a flawed or biased approach. Some disagreement about the carcinogenic hazard of important agents seems inherent to the scientific enterprise and unavoidable at early stages of the hazard evaluation, where IARC usually operates. Because the evaluations are not, and should not be, static it is difficult to see how such assessments could be addressed any differently. Substances now universally recognized as human carcinogens (e.g., tobacco and asbestos) at one time went through a quite lengthy period of contentious debate (Michaels 2006, 2008). Any process can in theory be improved with fair and constructive criticism, and appropriate reviews may take place from time to time, and we would support continued review and improvement of the IARC processes. However, as a group of international scientists, we have looked carefully at

the recent charges of flaws and bias in the hazard evaluations by IARC Working Groups, and we have concluded that the recent criticisms are unfair and unconstructive.

## References


[Anonymous]. 1972. Iarc monograph. Some inorganic substances, chlorinated hydrocarbons, aromatic amines, n-nitroso compiunds, and natural products. Lyon, France:IARC.

[Anonymous]. 2013. Epidemiologists speak out about the challenge of false positives in cancer epidemiology. Epidemiology Monitor.

[Anonymous]. 2014a. Trichloroethylene, tetrachloroethylene, and some other chlorinated agents. Lyon:IARC.

[Anonymous]. 2014b. Preamble. In: Trichloroethylene, tetrachloroethylene, and some other chlorinated agents iarc monographs on the evaluation of carcinogen risks to humans, Vol. 106. Lyon:IARC, 7-30.

Ahlbom A, Axelson O, Hansen ES, Hogstedt C, Jensen UJ, Olsen J. 1990. Interpretation of negative studies in occupational epidemiology. Scandinavian Journal of Work Environment & Health 16:153-157.

Blair A, Saracci R, Vineis P, Cocco P, Forastiere F, Grandjean P, et al. 2009. Epidemiology, public health, and the rhetoric of false positives. Environmental Health Perspectives 117:1809-1813.

Boffetta P. 2007. Transparency in the relationship between iarc and the petroleum industry. Epidemiologia & Prevenzione 31:170-170.

Boffetta P, McLaughlin JK, La Vecchia C, Tarone RE, Lipworth L, Blot WJ. 2008. False-positive results in cancer epidemiology: A plea for epistemological modesty. Journal of the National Cancer Institute 100:988-995.

Boffetta P, McLaughlin JK, La Vecchia C, Tarone RE, Lipworth L, Blot WJ. 2009. A further plea for adherence to the principles underlying science in general and the epidemiologic enterprise in particular. International Journal of Epidemiology 38:678-679.

Borenstein M, Hedges L, Higgins JPT, Rothstein HR. 2009. Introduction to meta-analysis. West Sussex, England:Wiley.

Brownson RC, Chriqui JF, Stamatakis KA. 2009. Understanding evidence-based public health policy. American Journal of Public Health 99:1576-1583.

Checkoway H, Pearce N, Kriebel D. 2004. Research methods in occupational epidemiology. 2 ed. New York:Oxford University Press.

Elwood M. 2007. Critical appraisal of epidemiological studies and clinical trials. 3rd ed. New York:Oxford University Press.

Erren TC. 2011. Iarc's plea for traditional 'expert' working groups-a recipe for problems? International Journal of Epidemiology 40:1727-1728.

Espina C, Porta M, Schuez J, Hernandez Aguado I, Percival RV, Dora C, et al. 2013. Environmental and occupational interventions for primary prevention of cancer: A cross-sectorial policy framework. Environmental Health Perspectives 121:420-426.

Gallo V, Egger M, McCormack V, Farmer PB, Ioannidis JPA, Kirsch-Volders M, et al. 2011. Strengthening the reporting of observational studies in epidemiology-molecular epidemiology (strobe-me): An extension of the strobe statement. Plos Medicine 8.

Grandjean P. 2005. Non-precautionary aspects of toxicology. Toxicology and applied pharmacology 207:652-657.

Haseman JK. 2000. Using the ntp database to assess the value of rodent carcinogenicity studies for determining human cancer risk. Drug Metabolism Reviews 32:169-186.

Hill AB. 1965. The environment and disease: Association or causation? Proceedings of the Royal Society of Medicine 58:295-300.

Ioannidis JPA. 2005. Why most published research findings are false. Plos Medicine 2:696-701.

Kabat G. 2012. How activism distorts the assessment of health risks. Forbes. 20 November.

Kabat GC. 2008. Hyping health risks: Environmental hazards in daily life and the science of epidemiology. New York, NY:Columbia Univeristy Press.

Macmahon B, Yen S, Trichopoulos D, Warren K, Nardi G. 1981. Coffee and cancer of the pancreas. New England Journal of Medicine 304:630-633.

Maronpot RR, Flake G, Huff J. 2004. Relevance of animal carcinogenesis findings to human cancer predictions and prevention. Toxicologic pathology 32 Suppl 1:40-48.

McLaughlin JK, Lipworth L, Tarone RE, La Vecchia C, Blot WJ, Boffetta P. 2010. Re: A further plea for adherence to the principles underlying science in general and the epidemiologic enterprise in particular response. International Journal of Epidemiology 39:1679-1680.

McLaughlin JK, Boffetta P, La Vecchia C, Lipworth L, Blot WJ, Tarone RE. 2011. Problems with iarc's 'expert' working groups response. International Journal of Epidemiology 40:1728-1729.

McLaughlin JK, Tarone RE. 2013. False positives in cancer epidemiology. Cancer Epidemiology Biomarkers & Prevention 22:11-15.

Michaels D. 2006. Manufactured uncertainty - protecting public health in the age of contested science and product defense. In: Living in a chemical world: Framing the future in light of the past, Vol. 1076, 149-162.

Michaels D. 2008. Doubt is their product: How industry's asault on science threatens your health. New York: Oxford University Press.

National Research Council. 2009. Science and decisions: Advancing risk assessment. Washington, DC.

Rothman KJ, Greenland S, Lash TL. 2008. Modern epidemiology. 3rd ed. Philadelphia:Lippincott Williams & Wilkins.

Samet JM. 2000. Epidemiology and policy: The pump handle meets the new millennium. Epidemiologic Reviews 22:145-154.

Siemiatycki J, Wacholder S, Dewar R, Cardis E, Greenwood C, Richardson L. 1988. Degree of confounding bias related to smoking, ethnic group, and socioeconomic status in estimates of the associations between occupation and cancer. Journal of Occupational and Environmental Medicine 30:617-625.

Straif K, Loomis D, Guyton K, Grosse Y, Lauby-Secretan B, El Ghissassi F, et al. 2014. Future priorities for the iarc monographs. Lancet Oncology 15:683-684.

Taubes G. 1995. Epidemiology faces its limits. Science 269:164-&.

Tomatis L. 1976. Iarc programme on evaluation of carcinogenic risk of chemicals to man. Annals of the New York Academy of Sciences 271:396-409.

Tomatis L. 2002. The iarc monographs program: Changing attitudes towards public health. International Journal of Occupational and Environmental Health 8:144-152.

Ward EM, Schulte PA, Straif K, Hopf NB, Caldwell JC, Carreon T, et al. 2010. Research recommendations for selected iarc-classified agents. Environmental Health Perspectives 118:1355-1362.

Wild CP, Cogliano VJ. 2011. A plea on behalf of expert evaluation and the experts involved. International Journal of Epidemiology 40:253-253.

Wild CP, Straif K. 2011. Expert working groups-a reliable recipe response. International Journal of Epidemiology 40:1730-1731.

## Appendix 1: Classification categories for the Overall Evaluation for the IARC Monographs

**Group 1: The agent is *carcinogenic to humans.***

This category is used when there is sufficient evidence of carcinogenicity in humans. Exceptionally, an agent may be placed in this category when evidence of carcinogenicity in humans is less than sufficient but there is sufficient evidence of carcinogenicity in experimental animals and strong evidence in exposed humans that the agent acts through a relevant mechanism of carcinogenicity.

**Group 2.**

This category includes agents for which, at one extreme, the degree of evidence of carcinogenicity in humans is almost *sufficient*, as well as those for which, at the other extreme, there are no human data but for which there is evidence of carcinogenicity in experimental animals. Agents are assigned to either Group 2A (*probably carcinogenic to humans*) or Group 2B (*possibly carcinogenic to humans*) on the basis of epidemiological and experimental evidence of carcinogenicity and mechanistic and other relevant data. The terms *probably carcinogenic* and *possibly carcinogenic* have no quantitative significance and are used simply as descriptors of different levels of evidence of human carcinogenicity, with *probably carcinogenic* signifying a higher level of evidence than *possibly carcinogenic*.

**Group 2A: The agent is probably carcinogenic to humans.**

This category is used when there is *limited evidence of carcinogenicity* in humans and *sufficient evidence of carcinogenicity* in experimental animals. In some cases, an agent may be classified in this category when there is *inadequate evidence of carcinogenicity* in humans and *sufficient evidence of carcinogenicity* in experimental animals and strong evidence that the carcinogenesis

is mediated by a mechanism that also operates in humans. Exceptionally, an agent may be classified in this category solely on the basis of *limited evidence of carcinogenicity* in humans. An agent may be assigned to this category if it clearly belongs, based on mechanistic considerations, to a class of agents for which one or more members have been classified in Group 1 or Group 2A.

**Group 2B: The agent is possibly carcinogenic to humans.**

This category is used for agents for which there is *limited evidence of carcinogenicity* in humans and less than *sufficient evidence of carcinogenicity* in experimental animals. It may also be used when there is *inadequate evidence of carcinogenicity* in humans but there is *sufficient evidence of carcinogenicity* in experimental animals. In some instances, an agent for which there is *inadequate evidence of carcinogenicity* in humans and less than *sufficient evidence of carcinogenicity* in experimental animals together with supporting evidence from mechanistic and other relevant data may be placed in this group. An agent may be classified in this category solely on the basis of strong evidence from mechanistic and other relevant data.

**Group 3: The agent is not classifiable as to its carcinogenicity to humans.**

This category is used most commonly for agents for which the evidence of carcinogenicity is *inadequate* in humans and *inadequate* or *limited* in experimental animals.

Exceptionally, agents for which the evidence of carcinogenicity is *inadequate* in humans but *sufficient* in experimental animals may be placed in this category when there is strong evidence that the mechanism of carcinogenicity in experimental animals does not operate in humans.

Agents that do not fall into any other group are also placed in this category.

An evaluation in Group 3 is not a determination of non-carcinogenicity or overall safety. It often means that further research is needed, especially when exposures are widespread or the cancer data are consistent with differing interpretations.

**Group 4: The agent is probably not carcinogenic to humans.**

This category is used for agents for which there is *evidence suggesting lack of carcinogenicity* in humans and in experimental animals. In some instances, agents for which there is *inadequate evidence of carcinogenicity* in humans but *evidence suggesting lack of carcinogenicity* in experimental animals, consistently and strongly supported by a broad range of mechanistic and other relevant data, may be classified in this group.