Effective Communication with Terminally Ill
More than Giving Accurate Information

Physicians who manage cancer patients are sometimes faced with the terrible ordeal of telling an individual that his or her disease is terminal. A Robert Kagan, MD, an ACRO member, and Romaine Clifton, LCSW, both from the Kaiser Permanente Medical Group in Los Angeles, explain that an effective clinician recognizes that giving accurate information is only one aspect of effective communication with these patients.

For the terminally ill, the physician must eventually switch roles. That is, instead of recommending “curative” measures to treat the cancer, the physician becomes a supporter by being truthful and comforting. Kagan and Clifton write in the December 2004 issue of the American Journal of Clinical Oncology (pages 547–549) that truthfulness is important for the patient who needs to make plans regarding investments, insurance, and other family matters. Yet with truth should come a large measure of tact and sympathy. The authors state that a response such as “unlikely” to a question about being alive at some critical future time is truthful but not as harsh as “no chance.”

Treatment Options
Due to the complexities of scientific information, treatment plans may differ from physician to physician. This only confuses the patient, who is thus faced with many options and perhaps unable to make a decision. The authors even question the value of informed consent in this situation. “Of what issues should patients be informed?” they ask. Kagan and Clifton recommend that patients be told of the risks and benefits of treatment and of the consequences if treatment is refused.

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Many radiation oncologists, specifically, seem to have trouble separating curative from non-curative treatments. In addition, they may discuss a patient’s condition in medical terminology and statistics not understood by the patient. “This habit of speaking an ‘insider’ language,” the authors write, “can only be broken when the physician is aware of and can acknowledge the need for clearer and simpler communication.” Finally, many physicians will “order multiple diagnostic procedures as a substitute for communication.” Kagan and Clifton suggest that the ability to talk simply to patients should be learned during the residency.

Overlooking Palliative Care

Still, many physicians continue to offer active treatment primarily to protect against potential legal complications if no treatment is recommended. The authors acknowledge that physicians are torn between wanting to support the patient during a time of crisis and, at the same time, having to “justify medical decisions to health maintenance organizations and hospitals.” Consequently, “the competitive nature of oncology with its mission to treat, overtreat, and treat to the last second of life allows little room for telling a patient there is no effective anticancer treatment left.”

The main problem is thus stated succinctly by the authors: “The desire to obtain complete tumor response has dampened [physicians’] interest in the palliative patient’s welfare.” They suggest that physicians strive to make the terminally ill patient feel less helpless by developing an “action plan,” which may include treating symptoms for comfort, not cure, and, as examples, telling the patient to join a support group, meet estranged relatives, or finally take that long postponed vacation. Of course, this cannot be done by the physician alone. A multidisciplinary team, including social workers, psychiatrists, and nutrition experts, to name a few, can be important when helping patients regain some control over their lives.

The authors realize that physicians and patients meet each other with different perspectives on disease and dying, which makes communication difficult. Physicians, then, must attempt to address their patients’ feelings, motivations, and issues.
When it comes to wages, many physicians become secretive or defensive. Doctors are supposed to be concerned with the health of their patients, not with their wages. Yet most people realize that physicians make more than most average workers, and a public survey conducted more than two decades ago showed that two-thirds of Americans believe doctors are “too interested” in making money. However, as Atul Gawande, MD, a surgeon, found (and subsequently reported in the April 4, 2005, issue of The New Yorker), “the healthcare system requires doctors to give inordinate attention to matters of payment and expenses.”

Usual, Customary, Reasonable
Dr Gawande explained that for years American physicians were paid based on fees that were “usual, customary, and reasonable”; in reality, this was whatever the physician charged. Over time, fees rose. Payments for procedures outpaced payments for diagnoses.

By the mid-1980s, the federal government decided it was time to restructure the medical payment system and reimburse physicians based on the amount of work they did. A Harvard economist, William Hsiao, was asked to measure physician performance. Hsiao and his colleagues surveyed thousands of physicians representing 24 specialties and developed the following formula:

\[
\text{Work} = \text{Time Spent} + \text{Mental Effort} + \text{Technical Skills} + \text{Physical Effort} + \text{Stress}
\]

To this, they factored in overhead and training expenses. Eventually, they had a relative value for every procedure a doctor performed. Congress converted Hsiao’s values to dollars, and Medicare began reimbursing according to this new system in 1992.

Struggling for Payment
Many years later, Dr Gawande heard of struggling physician groups and major hospital departments meeting financial disaster. From the money they took in, physicians were paying for malpractice insurance, office rent, computers, and other equipment. In addition, they were hiring medical assistants and treating some uninsured patients for free. He concluded that “doctors quickly learn that how much they make has little to do with how good they are. It largely depends on how they handle the business side of their practice.” For example, he was told by a medical financial specialist that when patients call, the physician must:

1. Find out if they have insurance.
2. If they do not have insurance, find out if they qualify for state assistance.

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3. If they have insurance, find out if their insurer includes the physician in its network plan.
4. Determine whether the service to be provided is covered by the insurance plan.
5. Obtain correct referral numbers.
6. Find out if the patients need to make a deductible payment or co-payment.

Physicians at War
The above list does not even touch on the regulations and detailed requirements physicians must meet to get insurance reimbursement after a patient visit. If anything is done incorrectly, the physician gets no money. The financial specialist Dr. Gawande met described the relationship between physicians and insurance companies as a “war.” Thus, if physicians want to be paid, they must

1. Computerize their billing systems,
2. Review bills and payments, and
3. Hire office help just to deal with the insurance companies.

Subsequently, Dr. Gawande was not surprised when a 2004 survey of Massachusetts physicians showed that 58% were dissatisfied with their income and the number of hours they work. Yet physicians refrain from complaining too loudly—especially since the median yearly income for a general practitioner is nearly $160,000, and much higher for specialists.

Cash Only, Please
Nevertheless, Dr. Gawande met physicians who have escaped the morass of regulation and reimbursement. One surgeon, who did not wish to be identified, did not accept insurance. His well-to-do patients pay cash, and he claimed to net $1.2 million a year. Dr. Gawande is convinced that, if he only accepted cash-paying customers, he probably would not make a million dollars, but he was sure he could make more than as a hospital-based surgeon and without the hassles of obtaining reimbursement.

Of course, if all physicians ran a service-for-cash operation, only people with money could afford healthcare. For some physicians, apparently, this would not be a problem. Like the unidentified surgeon, they have rejected their altruistic notions and consider themselves, first and foremost, a business person. In the final analysis, Dr. Gawande could not go this far. “If we fail ordinary people, then the notion that we do something special is gone,” he writes.

So despite the battles with insurance companies that distract from physicians’ main focus, most doctors stay in the field, work hard and long hours, and feel they are making a valuable contribution to society. ■
Economic Disaster or Potential Opportunity?

Stark II Loopholes Put Diagnostic Radiologists, Radiation Oncologists on Opposite Sides of the Self-Referral Issue

Radiation oncologists who attended the 2004 Scientific Assembly and Annual Meeting of the Radiological Society of North America (RSNA) this past November and who casually noted the concerns of their colleagues in the diagnostic-imaging fields could not help but realize that the issue of self-referral was a major topic. Ten studies were presented at RSNA 2004 showing that loopholes in a law that was supposed to restrict self-referral have increased utilization and expenses. Yet, these same loopholes give radiation oncologists an opportunity to bring diagnostic-imaging services into their practice.

Bankrupting the System
The Omnibus Reconciliation Act of 1989 (known as Stark I, named after Congressman Pete Stark [D-CA]) was supposed to ban self-referrals for clinical laboratory services under the Medicare program. The Omnibus Reconciliation Act of 1993 (known as Stark II) expanded the restriction to additional health services. But Stark II introduced two loopholes. One loophole is called the “in-office ancillary service exception.” Generally, it allows physicians to legally self-refer patients if three requirements are met:

1. Supervision. The designated health service must be performed by the referring physician, an employee in the referring physician’s practice, or an individual supervised by the referring physician.
2. Location. The designated health service must be performed in the same building where the referring physician practices or in a central building used full-time by the referring physician’s practice to perform health services.
3. Billing. The designated health service must be billed by the physician performing the service, the group practice of which the performing physician is a member, or a third-party agency acting on the behalf of the referring or supervising physician.

Thomas Greeson, a health-policy lawyer from the firm of Reed Smith in Falls Church, VA, asked RSNA members: “If the Stark anti–self-referral law was adopted for the purpose of trying to curtail the abuse of self-referral, then why does this exception exist?”

David C Levin, MD, professor and chairman emeritus of the Department of Radiology at Thomas Jefferson University Hospital in Philadelphia, has illustrated the effect of self-referral on costs. He quotes statistics showing that the overall utilization rate per thousand of cardiac nuclear scans between 1998 and 2002 rose 78% for cardiologists—all generated primarily by self-referral. N Reed Dunnick, professor and chairman of the Department of Radiology at the University of Michigan, believes self-referrals could bankrupt the entire healthcare system. “We don’t want to withhold medical care from people,” he said. “We want to eliminate examinations that don’t need to be performed.”

Opportunity for Oncologists?
The second exception in Stark II threatens to put radiation oncologists at odds with diagnostic radiologists. This loophole, called the “consultation exception,” states that when a radiation oncologist provides therapy as the result of a consultation with a physician outside the radiation oncologist’s practice, related designated health services are exempt from the Stark definition of “referral.”

The in-office ancillary loophole has divided the medical community, and the consultation loophole threatens to divide the radiology community. While much of organized medicine, led by the American Medical Association (AMA), has supported Stark II as written, the American College of Radiology (ACR) went on record a year ago calling for the Centers for Medicare and Medicaid Services (CMS) to narrow the scope of the in-office ancillary and consultation exceptions. In fact, Greeson and fellow health-policy lawyer Heather M. Zimmerman suggested in an article, continues on page 6
Economic Disaster or Potential Opportunity?

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titled “Imaging Services and Increasing Health-Care Costs: Limiting Self-Referral the Answer to Controlling Costs?” and published in the December 2004 issue of the American Journal of Roentgenology, that the ACR had acted in part as a response to recent attempts by the American Society for Therapeutic Radiology and Oncology (ASTRO) to expand the scope of the consultation exception.

The AMA has stated that it will oppose any move to repeal the Stark II exceptions. Its House of Delegates passed a resolution dealing mostly with the in-office ancillary service exception, stating that it increased service quality and provided care continuity. Other medical organizations representing cardiologists, gastroenterologists, internists, neurologists, neurosurgeons, OB/GYNs, orthopedic surgeons, and urologists quickly jumped on the AMA bandwagon.

Former Allies Feuding
Radiation oncologists are aware that ASTRO and ACR have usually been united regarding government regulation of the medical profession. But in this case, ASTRO sent comments to CMS that directly opposed the ACR position. In those comments, ASTRO supported expansion of the consultation exception to include “necessary and integral ancillary services requested and appropriately supervised by the radiation oncologist, including computed tomography, magnetic resonance imaging, and ultrasound.”

If ACR fails in its attempts to close the Stark II loopholes, it may pursue other courses of action. The organization could push for mandatory accreditation programs or certificate-of-need requirements. Meanwhile, Greeson and Zimmerman believe ASTRO will get its wish. But the overriding question is: Will this create a huge schism between diagnostic and therapeutic radiologists for years to come?

Practice Management Guide Available

The American College of Radiation Oncology Practice Management Guide was a culmination of work by 20 physicians, 1 attorney, 1 physicist, and 2 MBAs. All the authors are intimately involved in radiation oncology and have chosen this field as their career.

With a practical aspect in mind, the ACRO Board of Chancellors met to produce this manual to serve the needs of the specialty. It covers a wide range of useful information, including Stark rules, marketing, peer review, coding and reimbursement for external-beam and clinical brachytherapy, proton radiation oncology, valuation of a practice, group dynamics, and many other areas that will help the practicing radiation oncologist and prepare the new graduate for the complicated business dealings when building a practice.

It is a valuable tool in any radiation oncology department.

Copies can be ordered on-line at www.acro.org. This is a secure site for credit-card payment. Or, if you prefer, you can send a check to ACRO/Guide, 5272 River Road, Suite 630; Bethesda, MD 20816. The price for ACRO members is $83.50; non-members, $133.50 (includes shipping and handling charge.)

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Improving patient care
Finally—Evidence that Limiting Attorney’s Fees Reduces the Costs of Professional Liability

By Paul J. Schilling, MD, FACRO

During the past six years, the median jury award in medical malpractice cases nationwide has more than doubled to $1,000,000. Lawmakers in Wyoming, Oregon, and Pennsylvania are considering legislative proposals or ballot initiatives to cap non-economic damages. Lawmakers in Missouri and Iowa have recently vetoed proposed caps on non-economic damages. In 1975, California legislators passed the Medical Injury Compensation Act (MICRA).

The California Solution
MICRA takes a two-pronged approach to reform: capping non-economic damages and reducing contingency fees for attorneys. Although there has been contentious debate concerning the effect of both of these changes, one thing is clear: for 30 years, the rate of increase in professional liability insurance rates for California physicians is among the lowest in the nation.

Until now, there was little evidence that MICRA had any effect on reducing total awards for non-economic damages in medical malpractice cases. However, this legislation has had a direct role in 45% of the malpractice cases where there is a verdict for the plaintiff. The RAND Institute of Civil Justice studied 257 plaintiff verdicts in California medical malpractice trials from 1995 through 1999. MICRA reduced non-economic jury awards by $366,000. The original jury verdicts would have awarded these plaintiffs collectively $421 million whereas the final awards decreased by the MICRA cap reduced this by 30% to $295 million. Cases involving death were subject to post-verdict caps 58% of the time compared to 41% of those cases involving non-fatal injury. Plaintiffs who lost the highest percentage of their total awards due to the non-economic damage cap were those whose injuries led to economic awards of <$100,000 but who convinced the jury that their quality of life had declined and that they deserved financial compensation for pain and suffering.

Attorneys Beware
The sliding scale on attorney’s fees imposed by MICRA has had a dramatic effect on plaintiff–attorney compensation. The law prohibits attorneys from charging >40% of the first $50,000 of any recovery, 33% of the next $50,000, 25% of the next $500,000, and 15% of any amount >$600,000. The RAND report estimates that attorney’s fees would be $140 million, assuming a contingency fee arrangement of one third of recovery and using the non-capped original jury verdict. In all, attorneys’ fees were reduced by 60%; however, the sliding scale had a much greater depressive effect on attorney compensation than the damage cap.

The most important influence of MICRA may be on the much larger number of cases that do not reach a jury but are settled or never filed. The RAND report did not estimate the economic effect on this group of cases nor did it estimate the magnitude of the deterrent effect that

Dr Schilling is the delegate to the American Medical Association through the American College of Radiology. He practices at the Community Cancer Center of North Florida in Gainesville.
Bush Administration 2006 Budget Proposal and You

By Andrew Woods

President Bush released his administration’s FY2006 budget proposal in mid-May. This budget estimates mandatory spending for Medicare of $345.5 billion, a 17% increase over the estimated spending of $295.4 billion for FY2005. Much of this increase results from the implementation of the Medicare prescription drug benefit, which will take effect on January 1, 2006. Beyond the new spending for the drug benefit, the budget proposal does not include recommendations for reforms to the formula for Medicare reimbursements to providers. However, it does call for a $10 billion decrease in Medicare reimbursements to skilled nursing facilities, a $4.6 billion decrease in reimbursements to inpatient acute-care facilities, and an $860 million decrease in reimbursements to inpatient rehabilitation facilities. These cuts in Medicare reimbursements would occur over five years. Meanwhile, with respect to funding for cancer care and research, the budget proposal requests $4.842 billion in funding for the National Cancer Institute, an increase of just $17 million over FY2005 levels. In addition, the budget seeks a 1% reduction in funds for basic research and no change in funds for applied research. Overall, the National Institutes of Health would be funded at $28.8 billion in FY2006, an increase of 0.7%. The budget proposal also calls for cuts of > $500 million in the budget for the Centers for Disease Control, which would receive $4 billion in funding. Of particular interest, the budget proposal calls for $840 million in funding for prevention of chronic diseases (including cancer), a reduction of $59 million from current levels. However, the funding request levels for specific cancer research programs (including breast and cervical, colorectal, ovarian, prostate, and skin cancer) are unchanged from current funding levels.

Andrew Woods is the long-time legal counsel and lobbyist for ACRO from the Washington, DC, law firm of King & Spalding.

Dues Notice

If you have not yet paid your 2005 dues for ACRO membership, this will be the last issue of the ACRO Bulletin you will receive. Second dues notices were sent a month ago by regular mail and by email for online renewal. If in doubt about your membership status, contact ACRO at information@acro.org or call 301-718-6529.

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A Robert Kagan Scholarship Recipient Describes Her Work

Salma K. Jabbour, MD, from the University of Pittsburgh Medical Center, received the A Robert Kagan Scholarship in Palliative Care, supported by Proxima. Here she describes the work she did while on her scholarship rotation.

My experience as part of the University of Pittsburgh Comprehensive Palliative Care Program was invaluable to my future as a radiation oncologist and my goal of becoming a leader in comprehensive palliative care. I participated in a multidisciplinary team comprising palliative-care medicine faculty, nurses, psychiatrists, social workers, behavioral psychologists, hospice staff, and music therapists. The integration of a multidisciplinary approach to improve palliative care optimized the quality of life of terminally ill patients and assisted their family members. During my month-long elective, I cared for terminally ill patients requiring palliative-care symptom management and discussed end-of-life care and goals of treatment with patients and their families in both the outpatient and inpatient settings.

Identifying Adverse Drug Effects
This elective has helped me expand my knowledge of the evaluation and symptom management of palliative-care patients, specifically as related to pain management, nausea and vomiting, and delirium. One of the most instructive cases I managed was that of a 67-year-old man with a history of esophageal cancer, initially managed in 1999 with surgery. In late 2004, he was diagnosed with abdominal metastases resulting in abdominal pain, hiccups, and nausea. He was admitted to the hospital for these complaints and was seen by our palliative-care team. After much discussion about the long battle he had fought with his cancer, he decided to pursue a comfort-measures paradigm with the goal of home hospice. On the fourth day of his hospitalization, the planned day of discharge, his medications had been adjusted to control his symptoms; however, I found him to be quite somnolent and confused—a dramatic change from the previous day. On reviewing the side-effect profiles of the medications that could contribute to delirium, I suggested that the baclofen for hiccups and prochlorperazine for nausea be discontinued. Within 24 hours, his mental status improved, and he was discharged to home hospice. This case exemplifies many of the salient features I learned about managing the symptoms of terminally ill patients, both in terms of the medications that can be used and their potential side effects.

Managing Pain
Managing opioids and other adjuvant medications for patients with uncontrolled pain can be difficult. A 45-year-old woman for whom I cared had presented to our service with severe pain due to a head-and-neck cancer recurrence in her right mandibular region, which was compressing her right carotid artery. To adequately relieve her pain, she required >1.5 g of morphine daily. I learned about the complexities of controlling her pain with hydromorphone patient-controlled analgesia and converting her dose to morphine sulfate (Avinza), an orally administered, long-acting morphine that can be administered through a gastrostomy tube, while adding adjuvant medications and using behavioral therapy and relaxation techniques to address her depression, anxieties, and fears. This case demonstrated that managing a patient’s pain is often a difficult and slow process because of the consideration of cross-tolerance between two opioid medications as well as the importance of adjuvant medications and therapies. Furthermore, the medical team must address a patient’s fear, stress, and anxiety over a terminal illness, as these can further heighten a patient’s sense of pain.

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Discussing the End of Life

One of the most challenging aspects of palliative medicine is discussing end-of-life issues with patients and their families because of the associated stigma (i.e., “withdrawing care,” “giving up,” or considering a situation “hopeless”). Perhaps some of the most difficult situations in which I was involved were those in which a patient was terminally ill, unable to communicate, and had no clear living will. In these instances, a family member was left to make a decision on behalf of the patient, speculating on what the wishes of the patient may have been. Patients’ families often experienced guilt, remorse, and anger at the medical team. Broaching a delicate subject such as this requires excellent listening skills, compassion, empathy, and clinical insight from the counseling healthcare provider.

This elective has served as a foundation for my future endeavors as a radiation oncologist. I would like to further advocate for patients by becoming a leader in comprehensive palliative care. I would like to help define the future of palliative care at an academic institution by participating in a multidisciplinary team and by educating medical staff and patients about palliative care. In oncology, I believe it is important to view palliative care as part of the patient’s treatment program. In all situations, providing compassion and hope are paramount in caring for terminal patients and their families, and I intend to pursue palliative care with dedication. I thank ACRO for giving me the opportunity to participate in this elective.

Resident Scholarship Guidelines

Each year several scholarships are awarded to radiation oncology residents to support subspecialty electives at any qualified United States institution demonstrating expertise in the desired subspecialty area. (There are no European elective grants.) Eligible applicants are U.S. citizens who are ACRO or Association of Residents in Radiation Oncology members in their second, third, or fourth years of an accredited North American residency program through June 2006 who have not previously been awarded an ACRO fellowship grant.

Applicants are responsible for arranging their electives with the host institution before the submission of their application. Electives must be arranged for a minimum of four weeks and for a maximum of eight weeks. Subspecialty electives include brachytherapy; conformal, and three-dimensional treatment-planning therapy; gynecologic radiation oncology; head-and-neck radiation oncology; pediatric radiation oncology; radiosurgery; palliative care; and medical informatics. In addition, there are travel awards to attend the 2006 ACRO Annual Meeting.

Applications are reviewed by the ACRO Resident Scholarship Committee. The committee chairman tabulates rankings and informs committee members of the final selections of the scholarships. Subsequently, the ACRO president sends formal notification letters to each winner. Also, the committee chairman forwards formal regret letters to applicants who were not selected for fellowship awards.

Upon the completion of the elective, the resident is required to obtain a letter from the program director or hosting physician indicating successful completion of the elective and the beginning and ending dates of the elective. In addition, the resident must submit a summary report of the experience specifying how the elective supplemented residency training and how it will benefit the future career as a radiation oncologist. As part of the scholarships, winners are expected to attend the ACRO Annual Meeting, which, in 2006, will be held in Orlando from February 23 to 26.

For further information about the resident scholarships, contact ACRO at 5272 River Road, Suite 630; Bethesda, MD 20816; telephone (301) 718-6515.
Combined Hyperthermia and Radiation Better than Radiation Alone
A late-spring report in the Journal of Clinical Oncology explains that radiation therapy may be more effective when tumors have been subjected to microwaves, which increase tumor temperatures to 112° F (44° C). This combined hyperthermia–radiation treatment has been used for patients who have breast, chest-wall, head, or skin cancer.

The author of the report, Ellen Jones, MD, a radiation oncologist at Duke University, explained that her research goal was to sensitize tumor cells to the “cell-killing potential of other therapies.” Researchers believe hyperthermia makes cancerous blood-vessel walls increasingly porous, which makes them more vulnerable to radiation.

In the study, 108 cancer patients with “incurable” cancer underwent hyperthermia. Then half of the patients received continued hyperthermia and radiation therapy twice a week for 20 sessions, while the other half received radiation therapy alone. Sixty-six percent of the patients who had undergone the combined therapy experienced tumor shrinkage; 42% of the patients who had undergone only radiation therapy had tumor shrinkage. The researchers concluded that the combined therapy could slow the spread of local tumors and improve quality of life. They did not suggest, however, that it could improve survival rates.

Hyperthermia has been used to treat cancer for more than two decades with mixed results. Only now is the technology available to maintain and deliver microwaves effectively to the tumor.

More Thorough Imaging Leads to More Accurate Treatment, Less Chance of Erectile Dysfunction for Prostate-Cancer Patients
A study from the University of Michigan suggests that imprecise radiation therapy due to the use of a single imaging modality for prostate-cancer treatment planning leads to erectile dysfunction. Findings were published in the January 2005 issue of the International Journal of Radiation Oncology Biology Physics.

Typically, only computed tomography (CT) is used to pinpoint prostate cancer and target treatment. However, the combined use of CT and magnetic resonance (MR) imaging provides improved visualization and enables physicians to avoid irradiating blood vessels below the prostate that relate to erectile and urine sphincter functions.

Peter W. McLaughlin, MD, clinical professor of radiation oncology and author of the study, believes combining CT and MR imaging will lead to more accurate treatment planning and reduce subsequent adverse effects from radiation exposure.

Radiation for Prostate Cancer Doubles Risk of Rectal Cancer
As if the previous report describing the risk of erectile dysfunction from radiation treatment for prostate cancer wasn’t enough, a few months later, a research team headed by Nancy Baxter, MD, PhD, a colon and rectal surgeon at the University of Minnesota, found that men who undergo radiation therapy for prostate cancer have a 70% greater risk of later having rectal cancer than men who undergo surgery alone. The study was published in Gastroenterology. Dr. Baxter explained that the findings were not necessarily a call to change prostate-cancer treatment approaches.

The research was based on an evaluation of data from the National Cancer Institute’s Surveillance, Epidemiology and End Results Registry. A total of 85,000 men (ages, 18–80 years) were diagnosed with prostate cancer from 1973 to 1994. A total of 30,552 men received radiation therapy; of these, 1,437 later had rectal cancer. The radiation treatments did not adversely affect the colon.

Critics of this research state the radiation-therapy technology of the 1970s and 1980s delivered higher doses of radiation to healthy tissue surrounding the prostate than the more accurate equipment used today. The researchers responded that even today parts of the rectum are still exposed to high doses of radiation, and patient monitoring five years after prostate-cancer treatment is essential.

Tamoxifen Better than Low-Dose Radiation Therapy for Reducing Treatment Side Effects
Researchers at the University Federico II School of Medicine in Naples, Italy, have shown that tamoxifen is better than low-dose radiation therapy at preventing breast pain and breast enlargement for prostate-cancer patients who are taking bicalutamide. The findings were published this past spring in Lancet Oncology.

The study involved 151 men who had undergone either radiation therapy or surgery for their prostate cancer. For six months, 51 men received 150 mg of bicalutamide daily; 50 received 150 mg of bicalutamide and 10 mg of tamoxifen
daily; and 50 received 150 mg of bicalutamide daily and, at the start of treatment, low-dose radiation. Thirty-five from the first group, four in the second group, and 15 in the third group developed enlarged breasts. Also, those men receiving tamoxifen had reduced occurrences of breast pain compared with those who received radiation therapy.

**Combined Radiation and Chemotherapy No Greater Risk for the Elderly Patients**

A study conducted at the Mayo Clinic and reported in the June 1, 2005, issue of *Cancer* suggests that elderly patients who undergo combined radiation and chemotherapy for lung cancer are not at higher risk of death than young patients who undergo the same treatment. Two- and five-year survival rates for patients >70 years old were not significantly different from those <70 years old (17% and 22%, respectively).

Radiation therapy and chemotherapy improve lung-cancer survival as compared with chemotherapy alone. The study concluded that “fit elderly patients with locally advanced, limited-stage, small-cell lung cancer should be encouraged to receive combined-modality therapy, preferably on clinical trials.”

**Despite Radiation Therapy and Infertility, Woman Gives Birth**

A Reuters news story published earlier this year described a British woman who, at 14 years old, was diagnosed with bone cancer. She underwent radiation therapy and chemotherapy and completely recovered but went through early menopause. There was clear medical evidence of ovarian failure, so physicians told the woman she was infertile. However, at 21 years old, she gave birth naturally to a healthy baby. According to the Reuters report, the physicians involved with her cancer care believe this is a first in medical history.

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**A Call for ‘Clinical Pearls’**

Good research can be descriptive, but a bias has developed in the healthcare community leading to the exclusion of such work by many peer-reviewed journals in favor of experimental studies with randomization, which many assume to be the only valid design for obtaining new medical knowledge.

Consequently, the ACRO Bulletin is calling for submissions of “Clinical Pearls,” a 250–500-word description of a special clinical case you believe is unique but has not become part of the medical literature due to its exclusion from experimental research.

Unusual case reports not only provide interesting reading but complement quantitative work through a process research methodologists refer to as “triangulation.” Here is your chance to enhance medical knowledge by sharing a clinical case report with others in radiation oncology.

Please send your submissions to:

A Robert Kagan, MD; Editor, ACRO Bulletin
Department of Radiation Oncology; Kaiser Permanente Medical Group
4950 Sunset Blvd; Los Angeles, CA  90027
(323) 783-3865

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Program Administrator
Jeanne Carroll
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Elvis in the Morning

By William F. Buckley, Jr
Paperback, 2001, $14.00

Why did conservative political commentator William F. Buckley, founder of National Review, syndicated newspaper columnist of “On the Right,” and host of Firing Line, write this historical fiction novel? Certainly, the icon Elvis Presley has nothing to do with Buckley and his politics. Elvis had no interest in politics, wasn’t even a registered voter, and adeptly dodged political questions at press conferences. Nevertheless, political and social overtones emerge throughout this book. Somehow the King of Rock and Roll fills a niche for Buckley.

Elvis in the Morning opens in Wiesbaden, West Germany, in 1951. Bespectacled, independent-thinking schoolboy Orson Killere, the protagonist, lives there with his widowed American mother who works on a U.S. Army base. When 11-year-old Orson watches Elvis make his television debut in 1956 on Jimmy and Tommy Dorsey’s Stage Show, Orson is captivated by the young, rising singing sensation. The lesson Elvis imparts unto Orson is: “Do what you believe is right and ignore the establishment naysayers.”

In 1959, Orson decides Elvis’ music is common property, like the air and water, and breaks into the army base’s PX and steals Elvis acetates. Orson is caught, and a judge sentences him to a month without Elvis music. When G.I. Elvis, stationed in West Germany, learns about the incident, he pays a surprise visit to his young fan. Orson subsequently introduces Elvis to his classmate and Elvis Presley Fan Club co-president, Priscilla Beaulieu. It is then that a lifelong friendship between Orson, Elvis, and Priscilla develops.

After Elvis’ army stint and Orson’s graduation from high school, both men return to the United States. Elvis begins a career in the movies, and Orson attends the University of Michigan. At Michigan, Orson’s anti-capitalist predilections resurface, and he becomes an activist on campus as the leader of the Students for Democratic Peace. He organizes a student protest, which leads to his expulsion from school. He drifts to Salt Lake City where he takes a highway construction job and meets Susan Young, who dropped out of college after her parents were killed in an auto accident. They travel together until Orson meets the powers of an emerging computer company, who offer him employment and tuition to attend a university. Still, Orson gets caught up in the drug culture of the 1960s. After successfully going through rehabilitation, he tries to save Elvis from his substance abuse.

Although the characters of fictitious Orson and Susan were well developed, the portrayal of the real characters, such as Elvis and Priscilla, was two-dimensional. For the average reader who is not knowledgeable about the Greek-tragedy–like life of Elvis, this book lacks emotion and power.

Elvis Presley changed the landscape of pop culture and did so in a most unassuming, ingenuous way. Elvis had one simple ambition: to be a local entertainer like his idol, radio star Mississippi Slim. He never anticipated his unprecedented, meteoric rise to superstardom. It was his innocence, talent, and charisma that empowered him to mainstream rock and roll music, largely an African-American invention, into postwar, prejudiced America. He made it acceptable to be a non-conformist.

The revolution Elvis in large part started led to the breakdown of socioeconomic and racial barriers. Therefore, Elvis should not be viewed as just an entertainer but as a historical figure who politically influenced the subsequent decades in America. Buckley, then, could not have been more politically correct than to have written Elvis in the Morning.

Reviewed by Carol L Kornmehl, MD

Book Reviews Wanted!

After a long day of radiation oncology practice, have you sat down in the evening with an especially good book of fiction?

If so, share your reading with other ACRO members!

Send your book review to:
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Department of Radiation Oncology
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Several Ways to Join ACRO

Membership Categories

The mission of the American College of Radiation Oncology is to promote the education and science of radiation oncology, to improve oncologic service to the patient, to study the socioeconomic aspects of the practice of radiation oncology, and to encourage improved and continuing education in radiation oncology and its allied professional fields.

Active Membership

Membership in ACRO is open to physicians who limit their practice to radiation oncology, physicians currently enrolled in a fellowship program, and radiation oncology physicists in all types of practices, including universities, hospitals, freestanding clinics, fee-for-service practices, HMOs, government, etc. Membership is by application. Members receive quarterly newsletters that keep them abreast of matters related to the field of radiation oncology, along with information regarding upcoming medical accreditation courses and the ACRO annual meeting. Active Members have the right to vote in ACRO elections, hold elective office, and be appointed to committee positions.

Active “Regular” Members are eligible for Fellowship status and the right to use FACRO after the MD degree. Fellowship is by invitation and typically requires 10 years of continuous membership as a Regular Member and significant contributions to the College or radiation oncology. Letters notifying Regular Members that they may be eligible for Fellowship are sent in the Fall each year. If Fellowship is offered, the candidate must attend the next annual meeting in February to receive the diploma at the special Fellowship ceremony.

Annual dues are $350. Active members who are employed full-time by the military are granted a dues reduction and pay only $150. A concession is also made for first-year practicing physicians: dues are $250.

Associate Membership

Members are administrators, radiology technologists, and radiation therapists who are engaged in radiation oncology practice. Membership is by application. Associate Members receive quarterly newsletters and notice of the ACRO annual meeting. They can be appointed to the commissions and committees of ACRO.

Annual dues are $230.

Resident Membership

Resident Members are physicians who have never been Active Members and who occupy an approved oncology residency. Membership is by application. Resident Members can be appointed to the various committees. ACRO devotes significant time and resources to the educational concerns of future radiation oncologists. Quarterly newsletters and annual meeting registration information is sent out automatically. Resident Members may remain at this subsidized level of membership until their training is complete, up to four years, at which time they will be updated to active membership (first-year practicing physician).

In addition, ACRO funds 10 fellowship awards annually, granted to Resident Members in the amount of $2,000 each, to promote continued studies in radiation oncology. This financial assistance is limited to domestic programs. Information about residencies and fellowships in radiation oncology is available online in the AMA-FREIDA database (www.ama-assn.org/iwcf/iwcfmgr206/freida?531517115), which the AMA hosts and maintains in its “Medical Science and Education” section.

There are no dues for residents.

Corresponding and Retired Membership

Membership in ACRO is open to individuals who have a major interest in the College’s activities and who have proved evidence of involvement in radiation oncology or have worked for the betterment of radiation oncology. Membership is by application, and members receive the newsletters and notice of the ACRO annual meeting. They can be appointed to various commissions and committees.

Annual dues are $100.

For further information about ACRO or to receive a membership application, please contact ACRO headquarters at 5272 River Road, Suite 630; Bethesda, MD 20816; telephone (301) 718-6515.
Mark Your Calendar

Some 2005 Meeting Dates

American Association of Physicists in Medicine
One Physics Ellipse
College Park, MD 20740
Telephone (301) 209-3350
Website www.aapm.org

47th Annual Meeting
July 24–28, 2005
Seattle, WA

American Society for Therapeutic Radiology and Oncology
12500 Fair Lakes Circle, Suite 375
Fairfax, VA 22033
Telephone 800-962-7876
Website www.astro.org

47th Annual Meeting
October 16–20, 2005
Denver, CO

Image-guided Intensity Modulated Radiation Therapy Practicum at Sea
July 30–August 6, 2005
Seattle, WA (Alaskan cruise)

American Cancer Society
PO Box 360816
San Juan, PR 00936
Telephone (787) 767-2587

11th Annual Puerto Rico Breast Cancer Conference
October 28–30, 2005
Ritz-Carlton San Juan Hotel & Casino
Isla Verde, PR

Canadian Association of Radiation Oncologists
600 West 10th Avenue
Vancouver, British Columbia, Canada
Telephone (604) 877-6193
Website www.caro-acro.org

Annual Scientific Meeting
September 7–10, 2005
Victoria, British Columbia, Canada

International Atomic Energy Agency
PO Box 100
Wagramer Strasse 5
A-1400 Vienna, Austria
Telephone (431) 2600-0
Website www.iaea.org

2nd Research Co-ordination Meeting on Clinical and Experimental Studies to Improve Radiotherapy Outcome in AIDS Cancer Patients
October 3–5, 2005
Vienna, Austria

Radiological Society of North America
820 Jorie Boulevard
Oak Brook, IL 60523
Telephone (630) 571-2670
Website www.rsna.org

91st Scientific Assembly and Annual Meeting
November 27–December, 2005
McCormick Place
Chicago, IL

American Association of Physicists in Medicine
One Physics Ellipse
College Park, MD 20740
Telephone (301) 209-3350
Website www.aapm.org

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Website www.bir.org.uk

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