August 7, 2008

State Health Coordinating Council, and
Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714
Fax 919-715-4413

Letter in support of Petition Regarding: Change Methodology for Radiation Oncology – Linear Accelerators For the 2009 State Medical Facilities Plan

Dear Ms. Potter,

This letter is **in support** of Cary Urology's petition for inclusion of a special need for a multidisciplinary prostate health center in Service Area 20 that will offer a full range of services to treat men with urologic and prostate cancer.

It has come to my attention that several respected radiation oncologists have written letters in opposition of this proposal. As a radiation oncologist myself, I must consider the arguments of my colleagues and either agree or disagree. Since I have my own practice specializing in prostate brachytherapy, I do not have any obligations to any one hospital or health system. I hope my view points will at the very least lead to a consideration of other conclusions.

Prostate cancer is quite prevalent, affecting 1 in six to eight men. The treatment options are quite diverse (observation, surgery, EBRT, brachytherapy, cryotherapy, IIIFU, ect) and appear to be growing everyday. No one will argue that prostate cancer is a very important and complex health issue with a number of health dollars at stake. If any disease organ requires special consideration, prostate cancer is one of them.

The most important issue in my mind is whether prostate cancer care improves, worsens, or stays the same if the Cary Urology's petition is approved. I have done much research on the matter and one point is very clear; multidisciplinary management of urologic and prostate cancers is believed to improve patient outcomes. For this reason, major academic centers have comprehensive prostate cancer programs such as at Duke and UNC. Many of the opposition letters reference these two programs as being examples of the quality care that prostate cancer patients have available.

True multidisciplinary management of urologic and prostate cancer is the focal point of the Cary Urology proposal. The question becomes not whether Duke and UNC's prostate programs are sufficient which they are, but whether a better model of multidisciplinary management for Service Area 20 can be created as proposed by Cary Urology and its supporter of over 10 urologists, a program that will offer access to all and complete

integration of services. It is important to note that not one of the opposition letters states that quality will decrease.

We all agree that multidisciplinary management is positive. The Cary Urology proposal is recommending complete integration of all specialties in the management of urologic cancers at levels not currently practiced because it is not compatible with the operations of hospitals, radiation facilities, or urology practices. One must keep in mind that the urologist is the gatekeeper of all prostate cancers. Most practicing radiation oncologists are probably only referred 40-50% of the prostate cancers with the majority already deciding on radiation therapy. Dr. Khoudary and other urologists that I have personally contacted believe that this proposal is creating an outlet for better communication and management in a structure that is feasible for the practice of both specialties.

The Cary Proposal raises some very exciting and stimulating changes in urologic cancer management. Unfortunately, much of their intentions are clouded by issues of self referral and financial gains. When it comes to any designated health service, abuses do and have occurred. There are several urologic specialty cancer centers in the United States and the number is growing. This practice has caused much concern within the radiation community as represented in the ASTRO letter. It can be argued that similar relationships exist with radiologists, medical oncologists, and multispecialty organizations who own radiation therapy practices. These relationships are far more prevalent than the above. It would be impossible for ASTRO to disallow all these practices.

One cannot assume that urologists are a different breed than any other physician in terms of professionalism or motives. I have not heard any substantiated claims from my radiation or urology colleagues that they treat inappropriately because of the ownership arrangements. I have been a partner in a radiation therapy facility, and I can attest that ownership does not influence my medical decision making.

The Cary Urology proposal appears to be sensitive to the financial and self referral issues and is recommending ownership by both urology and oncology, and not an employment situation. Financial reimbursements for treatments are mostly determined by Medicare and medical insurances that are based on a number of variables. Currently, the technical dollars for IMRT are considerable because the technology and implementation on IMRT is very expensive. Physicians do not have control over reimbursement issues. Ownership will have risks since CMS will most likely not repeal the in-office ancillary exception for radiation therapy but instead drastically reduce IMRT payments in the future as the technology becomes more standard. This was very similar to when 3 D conformal radiation therapy became the standard over conventional 2 D therapy.

The concept of a multidisciplinary urologic cancer center has great merit if done correctly. It is creating a model not yet tried in the State of North Carolina, a model that will be transparent and closely studied. The results can help guide the State and other physicians in the future as to the benefits and pitfalls of such a model for this or other

specialties. The Cary Urology proposal appears to have the correct leadership and vision. It would be unfortunate to let fear and mistrust cloud this vision.

Thank you for allowing me the opportunity to express my opinions.

Sincerely,

John Leung, MD
Radiation Oncologist
336-906-5489