The Medical Society of the County of Queens
and The Academy of Medicine of Queens County

BULLETIN

Volume 11 • Issue No. 2 | *Over 200 Years of Service to the Medical Community of Queens County* | *Winter* 2019-2020

Inside This Issue

From the President's Desk

Dear Friends and Colleagues,

I hope that all is well with you, and we look forward to this year supporting all of you as valued members of our Medical Society.

Last year our Medical Society and Academy held several events, so we would like to thank all of our participants and members for their interest and enthusiasm. On November 2, 2019, our Academy of Medicine hosted a CME Symposium on Women's Health at NYC Health+Hospitals/Queens. I thank very much our speakers, Drs. Lisa Eng, Florence Shum, David Fishman, and Louis Auguste for their outstanding presentations. Regarding our Medical Society's events, I also thank our members who participated in our Chinese dim sum event, the educational dinner regarding dapagliflozin and heart failure sponsored by AstraZeneca, and the patient safety documentary film screening of "To Err is Human" last year. I am also grateful to the speakers at our Comitia meetings, Paula Breen, director of the New York State Department's Office of Professional Medical Misconduct, and Dr. Ning Lin, a neurosurgeon at NewYork-Presbyterian Queens/Weill Cornell Medicine, for informing our physicians about their organization's services.

As many of you know, New York State is facing a $6.1 billion budget gap, a large part of which is due to Medicaid overspending. Recently, the Cuomo Administration announced it was cutting Medicaid payments to physicians and health care providers by 1% to close New York State's budget deficit. Considering that our state will continue to have large budget gaps in the future, we expect such Medicaid cuts to continue. You have an opportunity to voice your concerns at this year's Physician Advocacy Day on Wednesday, March 4, 2020, in Albany. I hope that many of you will take this opportunity to visit our state capitol to meet with legislators to advocate for issues that are important to our profession, the practice of medicine, and patients.

Another important healthcare policy topic is women's health. Last year, the Trump administration informed healthcare facilities that they must stop offering or referring patients for abortion--"the domestic gag rule"–or they would lose Title X funding, a federal funding program dedicated to family planning. As a result, many healthcare facilities rejected Title X funding, and New York State intervened with emergency funding. Dr. Leana Wen, Past President of Planned Parenthood, has submitted an article to this newsletter on the importance of women's health. Please take a look at her submission and her recent piece on women's health in Time magazine as mentioned in her article.

We thank all of our members for their ongoing support of our Medical Society. Please take a few minutes to complete our Medical Society's physician member survey, so we can serve you better.

https://docs.google.com/forms/d/e/1FAIpQLSefD4bdLDIdfKUpuyJxN3u1dD2sVaX7wjqpsNyEkoaQpBemiw/viewform

Also, we have revamped our Medical Society's website at **www.MSCQ.org**, so that it features more useful information to all of you. Finally, we look forward to seeing many of our physician colleagues at the Medical Society of the State of New York's annual House of Delegates meeting on April 24 through April 26, 2020, in Tarrytown, NY.

As we begin a new year and decade, I wish all of you great prosperity in your personal and professional lives. It is my privilege and pleasure to support all of you in our noble profession of caring for patients. As always, feel free to reach out to me anytime with suggestions or concerns at liana.leung@gmail.com or 347-635-5233. ■

Best regards,
Liana Leung, MD, MPH, FACP, President

Need the perfect space for your meeting? Call or e-mail us.

MEETINGS

PROGRAMS / EVENTS

For information about placing a CME program listing, please contact 718.268.7300.

Upcoming Meetings	Date • Time • Speaker
MSCQ Board of Trustees Meetings All Board of Trustees Meetings are held on the 1st Tuesday of the month, unless noted	**February 4, 2020 • 6:00 pm** **March 10, 2020 • 6:00 pm** **April 7, 2020 • 6:00 pm** **May 5, 2020 • 6:00 pm** **June 2, 2020 • 6:00 pm**
Comitia Minora Leadership Meetings All Comita Meetings are held on the 1st Tuesday of the month, unless noted	**February 4, 2020 • 7:30 pm** • ***"Extracorporeal Membrane Oxygenation as a Therapy for Acute Respiratory Distress Syndrome"*** **Qiuping Zhou DO, FACEP** **Director of Cardiothoracic ICU** **LIJ Medical Center** **March 10, 2020 • 7:30 pm** • ***"Virtual Medication Assisted Treatment – The Kaden Model"*** **Aran Ron, MD** **Head of Clinical Innovation, Kaden** **April 7, 2020 • 7:30 pm** **May 5, 2020 • 7:30 pm** **June 2, 2020 • 7:30 pm**
First District Meetings Refer to your direct e-mails from this organization for details	**April 24, 2020 • 4:00 pm**
MSSNY Council Meeting	**March 5, 2020 • 8:30 am / Albany, NY**
MSSNY House of Delegates 2020	**April 24-26, 2020 / Tarrytown, NY**
AMA Meeting	**June 6-10, 2020 / Chicago, IL**

Upcoming Programs / Events

- **You *CAN* Quit Smoking**
  Freedom from Smoking® 8-week Cessation Program
  Classes offered May 7th – June 25th; and September 3rd – October 22nd
  Location: NewYork-Presbyterian Queens • 56-45 Main Street, Flushing, NY
  To Register: 718-670-1181 or email Anisha Rathod anr9105@nyp.org

- NewYork-Presbyterian Queens CME Program at Terrace On The Park
  21ST CENTURY CARDIOLOGY- Clinical Updates and Advances
  Saturday, March 21, 2020 • 7:30 a.m. - 1:15 p.m.
  Catered Hot Buffet Lunch 12:15 p.m. -1:15 p.m.
  Location: 52-11 111th Street, Flushing Meadows Park, New York, NY at Terrace On The Park
  To Register: 718-670-1419 • www.nypqcme.org

- **MSCQ 213th Past Presidents' Gala & Physician Expo**
  Details Coming Soon! Check our website: www.MSCQ.org or call 718.268.7300.

Women's Healthcare is in Crisis. We Can Move the Needle by Starting with Points of Agreement.

Leana S. Wen, MD, MSc;
Nakisa B. Sadeghi

Women's healthcare, including preventive services, screening and treatment for common conditions like STIs and HIV, and family planning, is increasingly restricted. 19 million women in the US live in areas that lack the full range of contraceptive care. STI rates are at a record high for the fourth year in a row, with a 34 percent increase in syphilis diagnoses among women in just one year. In 2019, seven states have attempted to ban abortion before many women even know that they are pregnant. Earlier this year, the Trump administration implemented changes to the Title X program, the nation's only federal program for affordable family planning, that bans clinicians in Title X health centers from referring their patients for abortion care and threatens the physician-patient relationship.

Maternal mortality has steadily increased in the last 25 years. The Centers for Disease Control and Prevention has found that 2/3 of these deaths are preventable and the majority occur not during labor and delivery, but in the prenatal and postpartum periods due to undiagnosed and untreated chronic conditions.

Despite this landscape of insufficient access and poor outcomes, women's health is politicized. Physicians can leverage our voices as experts and health advocates to move the needle on divisive issues of women's health by focusing on the following key points of agreement:

• **First,** clinicians can advocate for the need to ensure access to healthcare so that women can be healthy throughout their lives.

• **Second,** we can highlight the crisis of maternal mortality and opportunities to improve maternal care through state and local initiatives and supportive policies.

• **Finally,** we can focus on prevention, including contraception, as the best medicine. Health professionals are in a unique position to advance women's healthcare in a time of ideological divide by focusing not on points of contention, but on areas of consensus with our patients and communities.

Read more about the state of emergency for women's health and these three points of agreement in TIME Magazine ("American Women Are Dying. To Save Them, We Need to Depoliticize Women's Health Care;" https://time.com/5708788/leanna-wen-womens-health-politics/). ■

About the Authors

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Introduction to Unconscious Bias

Penny Stern, MD, MPH, FACPM, FACOEM

The concept of unconscious bias (UB) and how it impacts health care delivery has received a fair amount of attention in recent years. Many of us have participated in seminars and workshops designed to explore the whys and wherefores of unconscious bias. We have learned how UB contributes to health disparities in this country. Studies have shown that merely participating in these kinds of programs – with no intention of changing behavior – actually impact on outcomes. Why? Because once you have heard about UB and have come to understand it, your awareness has been raised. You cannot 'unhear' this material once it's been presented to you and so even without clear intent, people's behavior will change for the better when they are exposed to this issue. Bias is actually a natural function of the human mind – to be human, thus, is to be biased. It is universal. Recognizing this fact (and understanding why we have bias) forms the basis of most UB training. We learn to see that we are the products of our backgrounds, our cultures, our individual experiences as well as the intrinsic 'hard-wiring' of our brains. Together, these elements work together to make us interpret the world in uniquely personal ways – in fact, we see the world based on how we are, rather than how it is. Of central importance in UB training, is coming away with the ability to practice conscious awareness. We need to recognize which biases are ours in order to minimize their impact in our lives – professionally and personally. Accepting that we have biases is the first step. Then, becoming consciously familiar with people who are unlike ourselves is also important as is feeling confident enough to ask for feedback from others on our behavior. Constructive feedback is the key. If you have the opportunity to participate in unconscious bias seminars or workshops, consider yourself fortunate and take advantage of the chance to make a difference in how you interact with the world around you. ■

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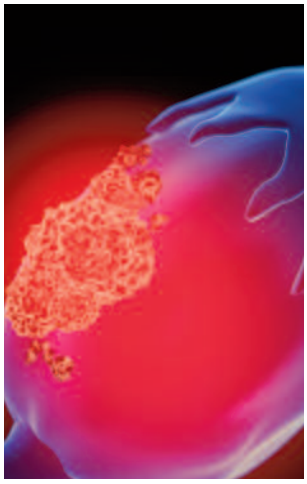
Epithelial Ovarian Cancer

David A. Fishman, MD;
Arthur C. Fougner, MD



Epithelial ovarian cancer (EOC) is the most lethal gynecologic malignancy, with an estimated 140,000 annual deaths globally. The majority of women are diagnosed in advanced stage (IIIIV), and despite advances in therapy, this figure remains unchanged over five decades. The prognosis of advanced stage EOC is poor, with a 5-year survival rate of 12-15%. In contrast, the 5-year survival rate of early stage (I) EOC approximates 90%. Current modalities of bimanual exam, CA125, and transvaginal sonogram together allow us to detect at best only 30% of women with early stage disease and this is more often due to the tumor biology rather than clinical acumen. Ideally identification of at-risk individuals would lead to prevention or possibly the detection of early stage disease when subsequent treatment would improve prognosis. We believe identification and intervention of at risk individuals will shift the paradigm of the treatment of EOC analogous to the role of cervical dysplasia in cervical cancer.

Genetics

All cancers have a genetic basis but not all cancers are hereditary. Approximately 20 % of ovarian cancers are associated with an inherited mutation. Diagnosis of genetic predisposition involves risk assessment based on patient family history of cancers, components such as family pedigree, age and personal history of cancer. Management includes testing for known genetic mutations and extensive pre-and post-test counseling performed by a multidisciplinary team involving board certified genetic counselors and for ovarian cancer gynecologic oncologists to aid the patient in understanding the implications of their condition and available treatments. Because the total number and type of gene mutations associated with hereditary ovarian cancer continue to rapidly expand from the initial two (BRCA1 and BRCA2), a negative work-up for a genetic mutation does not preclude management in the presence of a positive family pedigree.

Presently over 300 hereditary cancer syndromes have been recognized and over 592 genes are associated with inherited cancers. Inheritance of high-penetrance cancer susceptibility genes places women at greatly increased risk of developing EOC. Several of the more recognized genes include BRCA1, BRCA2 and those associated with Lynch syndrome. Women who have inherited a BRCA1 or BRCA2 gene mutation have a 35-70% and 10-30% respective lifetime risk of developing EOC. Those with Lynch syndrome associated mutations (MLH1MSH2, MSH6, PMS2, EPCAM) have an estimated 9-12% lifetime risk of developing EOC. However, there have been an increasing number of genes identified which have been associated with a higher risk in developing EOC: BRIP1, RAD51D, RAD51C, PALB2 and BARD1. Women of Eastern European, or Ashkenazi Jewish descent, are at higher risk of being positive carriers of BRCA1 or BRCA2 mutations. In fact, a family history of ovarian cancer in a first-degree relative triples a woman's lifetime risk of developing ovarian cancer. A number of familial ovarian cancer syndromes have also been identified such as Cowden disease, a.k.a. multiple hamartoma syndrome, and Li-Fraumeni syndrome. Although a positive patient history with risk factors is currently recommended prior to initiating work-up for inherited genes, almost one-third of women with hereditary ovarian carcinoma have no close relatives and 35% are greater than 60 years of age at diagnosis. There is new consensus that any women diagnosed with EOC regardless of age or family history should have formal genetic testing. Germline and somatic testing is now available to help identify those that are inherited and acquired which opens new venues to optimize patient care. Identifying women with genetic predisposition for EOC is the first step toward risk assessment and prevention.

Imaging Studies

Ultrasound remains the best diagnostic imaging modality to evaluate the adnexa. It has proven utility in detecting advanced stage ovarian cancer in asymptomatic women, although its value in detecting early stage disease has yet to be realized. Multiple studies have reported the utility and limitations of ultrasound for identifying Stage I EOC in asymptomatic women.

Transvaginal ultrasound is the initial diagnostic modality of choice for the evaluation of the adnexa but likewise has proven ineffective as a primary screening method for the detection of early stage EOC. Transvaginal ultrasound has been analyzed with the sensitivity of detection of early stage cancer ranging from only 25-30%. In addition, many women may develop ovarian cancer within six to twelve months after a normal appearing adnexal ultrasound.

In order to improve the efficacy of sonography several new techniques have been combined with gray scale morphologic

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Epithelial Ovarian Cancer *continued from page 4*

assessment. The last decade has seen rapid technological advances in diagnostic ultrasonography with the recent development of three dimensional transvaginal gray-scale volume imaging (3D TVS) and three-dimensional transvaginal power Doppler imaging (PD3D TVS). Initial studies suggested that these new technologies improve upon the diagnostic accuracy of two-dimensional transvaginal gray-scale imaging (2D TVS) in the differentiation between benign and malignant adnexal pathology. The reported advantages of 3D TVS using surface rendering include improved visualization of the internal architecture of adnexal masses containing cystic components. The addition of PD3D TVS allows for the thorough examination of the complex adnexal mass for abnormal vascularity in three distinct planes. The addition of 3D color doppler has also been studied in high-risk women with improved ability to characterize masses with malignant change (specificity increased from 54% to 75%). Three-dimensional ultrasound with power Doppler and microvascular contrast enhancement are examples of techniques that have improved ovarian lesion characterization in sonography. The addition of 3-D Doppler improved the ability to distinguish benign from malignant changes, and was particularly useful in differentiating adenofibromas and cystic teratomas from borderline and malignant tumors. However, even the addition of 3-D Power Doppler imaging has yet to improve our ability to identify ovarian cancers in normal sized ovaries.

The addition of Doppler examination is helpful in this regard due to the absence of vascular flow within the central regions of endometriotic cysts and the echogenic portions of most cystic teratomas. It is not unexpected that 2D TVS identified 100% of the malignant adnexal masses, because they were enlarged and complex in echo-architecture. The published literature has found that 2D TVS is 85% to 100% sensitive for identifying adnexal masses as malignant. Although 3D TVS with rendering improves visualization of the internal capsule wall and intracystic papillations, it is the addition of PD3D that we found most helpful. 3D TVS did not change the morphologic score (viz, cystic, multiloculated, complex, or solid), compared to the 2D TVS, however the rendering of the internal aspect of cystic masses can yield high detail of internal excrescences previously identified on 2D TVS. It is more useful, however, in ruling out excrescences rather than in their identification. In our experience three-dimensional power Doppler imaging better defines the morphologic and vascular characteristics of ovarian lesions resulting in a significant improvement in specificity (54% to 75%) for ovarian cancer detection. This improved diagnostic accuracy may promote improved patient care by separating complex benign masses from ovarian cancer, therefore facilitating appropriate physician referral.

Results in several studies show that these advanced techniques can be used to differentiate benign and malignant adnexal masses.

Conclusion

EOC continues to be a lethal disease despite advances in genetics, imaging and treatment of ovarian cancer. The key to changing outcomes in EOC requires a paradigm shift using genetics to identify those at-risk women for prevention and ultimately shifting treatment to early rather than advanced stage ovarian cancer. ■

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Don't Let Treatment Refusal Result in Legal Liability

Marilyn Schatz, Esq.

Informed consent is a well-established ethical and legal requirement in healthcare. This common law right of patients was recognized by Justice Cardozo over 100 years ago: "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages. This is true except in case of emergency, where the patient is unconscious and where it is necessary to operate before consent can be obtained."[1] Since that time, this doctrine has been codified In NY public health law § 2805-d.

Obtaining informed consent reflects the modern practices of shared decision-making and patient centered care. The doctrine recognizes that patients are autonomous and possess the fundamental right to self-determination. The partnership of a provider and a patient should consist of a communication process wherein the physician describes the diagnosis, prognosis, and treatment options, as well as the risks, benefits, and alternatives. The patient must be given an opportunity to ask questions, as well as adequate time to reflect on available approaches to treating their medical condition. Since treatment plans offered to patients should include the risks and benefits of no treatment at all, how should a physician proceed if this is the very option a patient selects? Under these circumstances, it is imperative that the physician obtain an informed refusal.

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Don't Let Treatment Refusal Result in Legal Liability *continued from page 5*

Physicians should engage in the same process of communication, disclosure and documentation for obtaining informed refusal as they do for informed consent. Both concepts recognize respect for a patient's decisions, which must be balanced with a provider's duty of care to the patient. However, a patient's decisional capacity must continuously be assessed throughout ongoing communications and interactions. These evaluations will assist in the determination of whether the patient has an accurate understanding and appreciation of the nature of the proposed treatment, as well as the implications of available alternatives. If there is any doubt about a patient's mental competency, providers should consider obtaining a psychiatric consultation.

Treatment refusals may create difficult encounters in clinical practice. Parental refusals of vitamin K and newborn screening tests, as well as refusals to adhere to recommended vaccine schedules, have become more prevalent.[2] Complicated ethical dilemmas often develop when a pregnant patient's treatment refusal may have a detrimental effect on the health of an unborn fetus.[3] Some Jehovah's Witnesses may refuse blood transfusions in accordance with religious beliefs, while others may be amenable to autologous blood transfusions.[4]

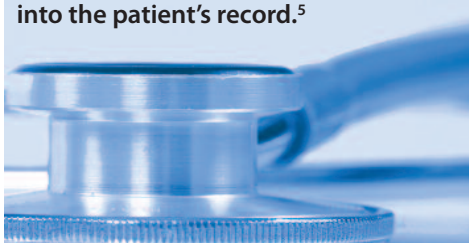
It is important to recognize that a patient's refusal imposes responsibilities on a physician, who must be able to show that the patient's decision to refuse treatment was based on a full understanding of all facts necessary to make an informed choice. The teach back method is a beneficial approach to use during these discussions with patients. It enables a physician to assess whether patients have a full grasp of the material facts in order to reach a reasonable and rational decision regarding their choices of treatment. Documentation of this process may provide the very basis for establishing that consent or refusal was truly "informed."

A detailed medical record that clearly reflects the decision-making process can be pivotal to the defense of a lawsuit based on the ramifications of treatment refusal.

To avoid liability or to offer evidentiary value to a defense, progress notes should include:

- **an assessment of a patient's competence to refuse;**
- **descriptions of discussions regarding why the recommended treatment is necessary and the risks of this treatment;**
- **descriptions of discussions regarding the available treatment alternatives and their attendant risks and benefits;**
- **descriptions of discussions regarding the consequences of refusal;**
- **documentation of other individuals or healthcare personnel who were involved in the treatment discussions; and**
- **the patient's reasons for refusal.**

Finally, a signed treatment refusal form must be incorporated into the patient's record.[5]



Should the patient refuse to sign this form, this fact needs to be documented on the signature line of the form, as well as in the progress notes. Appropriate management of a competent patient who refuses care should include compromise and negotiations to encourage compliance. Consider and address any factors which may negatively impact on the patient's decision making: depression; fear; finances; family member influences; religion; culture; psychosocial factors; or prior experiences. It may be helpful to explore external influences to assist the patient in diffusing their apprehension. Attempt to allay fears or concerns by asking the patient to involve a close friend or relative in these discussions. Physicians should recognize that any divergence in treatment approaches could lead to a deterioration in the relationship with a patient. Avoid coercion, intimidation, or threats to discontinue the professional relationship. Engage in further discussions to address concerns and explain your own. Maintain a tactful and sensitive demeanor to reach a suitable decision that is in the patient's best interest. Clarify, negotiate, compromise, document, and, finally, do not take refusals personally. ■

[1] Schloendorff v. Society of New York Hospital, 105 N.E. 92, 93 (N.Y., 1914).
[2] http://pediatrics.aappublications.org/content/pediatrics/138/3/e20162146.full.pdf
[3] https://www.acog.org/?/media/Committee?Opinions/Committee?on?Ethics/co664.pdf?dmc=1&ts=20190130T1632149463.
[4] http://bulletin.facs.org/2018/09/statement?on?recommendations?for?surgeons?caring?forpatients? who?are?jehovahs?witnesse/#.XFH3g4G?xok.email.
[5] A sample refusal form may be obtained by contacting an attorney at Fager, Amsler, Keller & Schoppmann, LLP.

About the Author

Marilyn Schatz, Esq. Fager Amsler Keller & Schoppmann, LLP, Counsel to MLMIC Insurance Company.

Marilyn Schatz is an attorney at Fager Amsler Keller & Schoppmann, LLP. She has broad experience in providing counsel and assisting healthcare practitioners and hospitals in various matters related to healthcare law, professional liability, insurance, and risk management. Ms. Schatz has been a medical malpractice claims attorney and counsel for risk management for several major New York teaching hospitals.

FAGER AMSLER KELLER & SCHOPPMANN, LLP
Attorneys and Counselors-at-Law

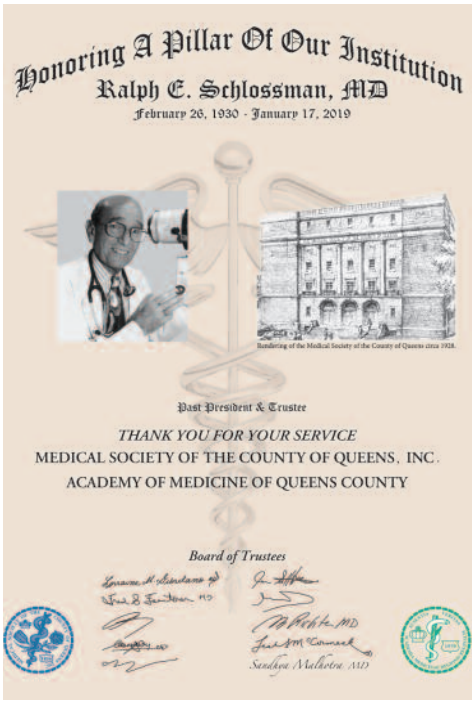
The Ralph E. Schlossman, MD Humanism in Medicine Award

Dr. Ralph E. Schlossman was a renowned physician in New York State for over 50 years. He mentored many medical students and physicians, including two individuals who later became President of the Medical Society of the State of New York. He not only leaves a legacy of service to the profession of medicine, but a legacy of service and leadership to his country as he proudly served in the U.S. Air Force from 1956 to 1958. He served as Chief Flight Surgeon of the 31st Tactical Fighter Wing and Commander of the 31st Tactical Hospital. He was the flight surgeon of a wing of the first generation of supersonic fighter bombers and one of the first physicians to fly faster than the speed of sound.

Dr. Schlossman cared for numerous patients and enjoyed turning their frowns into smiles and laughter with his warm sense of humor. He was a Diplomat of the American Board of Family Medicine and held teaching positions at the State University of New York Downstate Medical Center, the New York Hospital Weill College of Medicine of Cornell University, and the Touro College of Osteopathic Medicine. In addition, Dr. Schlossman was a regular health news contributor to Queens Public Access Cable TV.

Throughout his career, he was an attending physician at State University Hospital in Brooklyn and New York Hospital Queens. In December 1958, Dr. Schlossman joined both the Medical Society of the County of Queens and the Medical Society of the State of New York and served faithfully on numerous committees and in multiple officer positions. Dr. Schlossman served as President of the Medical Society of the County of Queens in 1970-1971; served on the MSCQ Board of Trustees from 1972-1984 and subsequently as its Chair for over twenty years and was serving as Trustee Emeritus until his passing.

Dr. Schlossman was the recipient of the Medical Society of the County of Queens highest honor, the ***MSCQ Lifetime Achievement Award.***



Commemorative plaque displayed in the office of the Board of Trustees at the MSCQ headquarters.

Dr. Schlossman served as President of the Medical Society of the State of New York in 1998-1999; and served on the MSSNY Board of Trustees from 2001-2005 and as its Chair in 2004-2005.

Dr. Schlossman was the recipient of the Medical Society of the State of New York's highest honor, the ***Henry I. Feinberg Award for Leadership.*** He was a longtime delegate from the MSCQ to the MSSNY and from the MSSNY to the American Medical Association.

About The Ralph E. Schlossman, MD Humanism in Medicine Award

The Ralph E. Schlossman, MD Humanism in Medicine Award was created in 2019 to commemorate and honor Dr. Schlossman who departed from us in January 2019. A family physician, he cared for generations of patients for over half a century. He was deeply admired by his colleagues who elected him as President of our county medical society as well as our state medical society. He also loved to teach medical students and residents. We will always remember him with love as a man of leadership, dignity, and integrity.

The Ralph E. Schlossman, MD Humanism in Medicine Award will be presented annually to one outstanding physician who has cared for patients in the county of Queens and has taught residents and/or medical students with compassion, dedication, and professionalism.

▶To Submit a Nomination
Please complete and submit a nomination form to nominate a deserving physician. Any individual or group may submit nominations.

▶Deadline for Nomination
April 1st, 2020
Go to page 8
to access a nomination form and details or visit our website: www.MSCQ.org

Medical Society of the County of Queens, Inc.
Academy of Medicine of Queens County

Nomination Process for the Ralph E. Schlossman, MD Award

Award will be presented at the Annual Dinner
May 2020

Dear Physician:

Thank you for your nomination. The Board of Trustees will review all nominations and will notify the recipient immediately. The awardee will be honored with a plaque at the Medical Society's Annual Dinner in May. (Venue to be determined).

Requirements

Full Name: _____ Credentials: _____

Title: _____

Company: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Tel #: _____ Mobile #: _____

Email: _____

Please include:

- ✓ Current CV.
- ✓ Two letters of recommendation (one from a supervisor if employed or both from peer physicians in the community if self-employed) describing accomplishments of the nominee and why the nominee deserves this award.
- ✓ Submission Instructions: *The deadline for submitting applications and all supporting documentation is* ***April 1st*** *of the current year.*
- ✓ Please submit your application, including attachments, electronically to ERTripp@QueensMedicalSociety.org

If you have any questions, contact Evangeline Rosado-Tripp, Executive Director, via email at: ERTripp@QueensMedicalSociety.org or call 718.268.7300.

Private Investments in Healthcare

David N. Vozza, Esq.

The consolidation of healthcare practices and health systems continues to be a paramount theme underlying the industry. Spurred by hyper-regulation, overbearing pressure by commercial and government payors and the trend towards value-based reimbursement schemes, practitioners found that affiliating with larger entities able to coordinate care more efficiently provided them the stability required to optimally treat patients. At the same time, it decreased their administrative responsibilities. There being a benefit to scale, these entities also provided practitioners access to additional ancillary services, improved infrastructure, and increased reimbursements from payors.

As a result, healthcare practices have become much more attractive to private investors. Approaching almost 20% of the national GDP, private investors are seeking to capitalize on these trends by entering into financial relationships with these healthcare practices and health systems. Of course, that is not without its own legal implications. In New York State, non-physician ownership in a medical practice remains strictly prohibited. Colloquially known as the Corporate Practice of Medicine ("CPOM") doctrine, the law in New York generally provides that medical licenses are provided to individual practitioners whose practice and judgment must be free from the intrusion of outside business interests.

Other relevant law provides as follows:

- Business Corporation Law authorizes the issuance of shares in a professional corporation only to those authorized to practice the profession. **Therefore, interest in a medical professional corporation could be issued only to licensed physicians, and shares issued in violation of this rule would actually be considered void.**
- Likewise, Limited Liability Law provides that members be licensed and actively practicing.

In light of these prohibitions, private investors have acquired, or otherwise invested in,

what are known as Management Service Organizations ("MSO"). For a fee, MSO's generally perform some or all of the administrative functions of medical practice, allowing practitioners to focus their attention on patient care. **These services are memorialized in a management service agreement that emphasizes the role of the MSO as being non-clinical and distinct from those judgments required for the actual treatment of patients. Leaving these "back-office" and business functions to the MSO results in a more efficient and productive practice.** Since the management services performed by the MSO are not considered the actual provision of medicine, these arrangements do not run afoul of the CPOM doctrine or related regulations.These arrangements are not without legal jeopardy, however. **Physicians must consult with healthcare counsel to ensure the management services agreement and the actions of the parties remain compliant with the applicable law.**

Some necessary considerations are as follows:

- The physician-owners/members of the professional corporation or professional limited liability company must be allowed to practice medicine and assert their own independent judgment in furtherance thereof, without any interference by the MSO.
- The management fee must be a flat amount and set at fair market value for the services rendered. To that end, practices are encouraged to, via their healthcare counsel, retain accountants who specialize in appraising the fair market value of these services. Moreover, the management fee must not be based on a percentage of the revenue of the practice.
- While the MSO may have some standing to consult with the physicians regarding certain business aspects of the practice, the MSO must not exert control or be deemed to supervise the physicians. Likewise, the practice's accounts receivable and medical records must remain in the possession and control of the practice.
- When entering into these arrangements, it is strongly encouraged that a practice evaluate its relationships with third-parties who may refer patients, to ensure compliance with both federal and state Stark and Anti-kickback law regulations.

If you have any questions about this topic or any other matter, please feel free to contact me or visit our website:

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dnvozza@norrislaw.com
(917) 369-8867
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About the Author

David N. Vozza , Esq., devotes his practice to the areas of healthcare and litigation. Mr. Vozza's practice focuses on defending health care professionals in connection with disciplinary and regulatory actions before federal and state agencies, private and government payor audits, civil and criminal fraud investigations, hospital and privileges disputes, and general healthcare litigation in both the federal and state courts. Mr. Vozza regularly defends health care professionals before the Office of Professional Medical Conduct and Office of Professional Discipline. Mr. Vozza also frequently lectures at hospitals throughout New York State regarding medical fraud, regulatory agencies, professional licensure, and medical documentation.

NORRIS MCLAUGHLIN P.A. ATTORNEYS AT LAW

Parker Jewish Institute Implements New Therapy Modality

Lina Scacco

Parker Jewish Institute for Health Care and Rehabilitation is introducing Jintronix, a next-generation physical therapy modality for long-term and sub-acute patients.

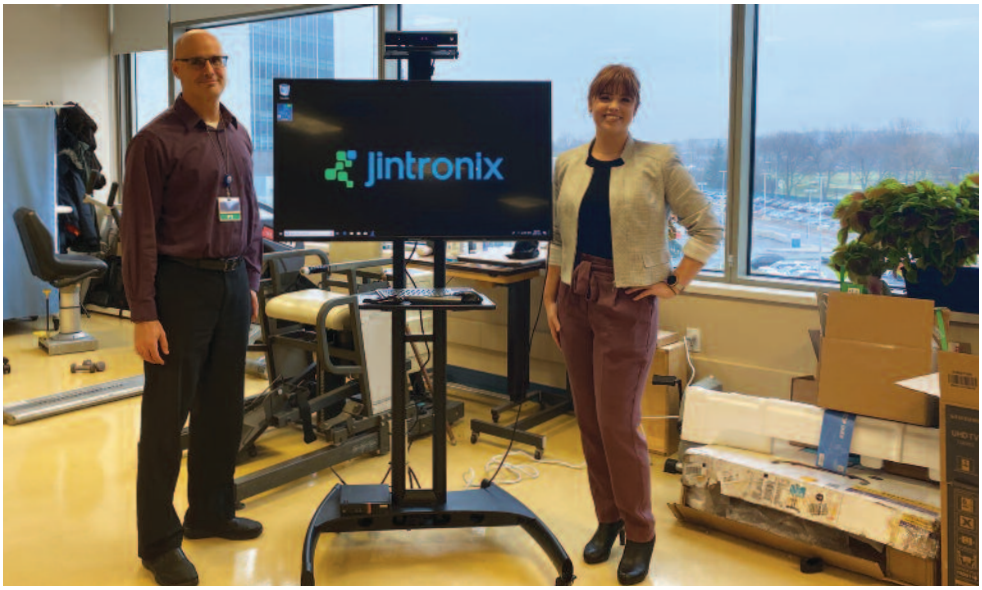
Through interactive therapeutic games, the engaging platform challenges rehab patients to expand their range of motion and improve their balance and mobility and other functional reactions.

Delivered on a TV monitor, these virtual activities and beneficial exercises are also entertaining, prompting patients to play football, ski, ride motorcycles and more.

Therapists can customize activities to the patients' cognitive and physical capabilities. And through realtime data collection, therapists can measure clinical outcomes and track and report patient progress. **"The modality makes physical therapy a lot more fun,"** said Brian Sidiski, Parker's Regional Director of Rehabilitation. **"Patients are smiling and having a great time."**

Parker had considered other therapy modalities but selected Jintronix. The compact, mobile system allows for a quick setup in all six of Parker's rehabilitation gyms, as needed.

Encouraging independence, the therapeutic games are enjoyable, motivating patients to meet the challenge of their exercise program. These factors can inspire patients to become more engaged with their therapy, and look forward to their next sessions.



"Incorporating Jintronix's innovative platform at Parker is part of our mission to continually improve programs and services, helping us to be a leader in health care," said Michael N. Rosenblut, Parker's President and CEO. **"Our dedicated staff is driven to deliver state-of-the-art rehabilitation to optimize recovery."**

About Parker Jewish Institute for Health Care and Rehabilitation

Parker Jewish Institute for Health Care and Rehabilitation, which is headquartered in New Hyde Park, New York, is a leading provider of Short Term Rehabilitation and Long Term Care.

At the forefront of innovation in patient-centered health care and technology, the Institute is a leader in teaching and geriatric research. Parker Jewish Institute features its own medical department, and is nationally renowned as a skilled nursing facility, as well as a provider of community-based health care, encompassing Social Adult Day Care, Home Health Care, Medical House Calls, Palliative Care and Hospice.

For more information,
please contact:
Lina Scacco
(718) 289-2212
or lscacco@parkerinstitute.org ■

About the Author

Lina Scacco serves as the Assistant Vice President of Corporate Outreach & Development at Parker Jewish Institute for Health Care and Rehabilitation. She has been a member of their executive team since 2013.

Parker Jewish Institute
FOR HEALTH CARE AND REHABILITATION

BBB ACCREDITED BUSINESS

FIVE SIMPLE STEPS TO IMPROVE COLLECTIONS

Dick Neary

1. Have a defined credit policy

The first step is to clearly define when accounts are to be paid. If customers are not informed that accounts are to be paid on time, chances are they'll pay late or sometimes not at all.

Make sure that your business's terms are clearly stated In writing to each customer.

2. Invoice promptly and send statements regularly

If your business doesn't have a systematic invoicing and billing system, get one.

Many times the customer hasn't paid simply because they haven't been billed or reminded to pay in a timely manner.

This situation frequently occurs in smaller or newer businesses where there isn't enough staff to handle invoicing and billing.

3. Use "Address Service Requested"

One of the more difficult collection problems is tracking down a customer who has "skipped," or moved without informing your business of the new address. The U.S. Postal Service has a procedure to address this situation.

Any statement or correspondence sent from a business should have the words "Address Service Requested" printed or stamped on the envelope, just below your business's return address in the top left corner.

If a statement or invoice is sent to a customer who has moved and the words "Address Service Requested" appear on your business's envelope, the Post Office will research this information.

If they can locate a change of address for that person, they will send you business

form #3547 with the correct address for a small fee. This also keeps your business's address file up to date.

4. Contact overdue accounts more frequently

No law says your business can contact a customer only once a month. The old adage "The squeaky wheel gets the grease" has a great deal of merit when it comes to collecting past due accounts.

Contacting late payers every 10 – 14 days will enable your staff to diplomatically remind the customer of your business's terms of payment.

5. Use a third party earlier

If your business has systematically pursued a past due account for 60 – 90 days from the due date, and it still isn't paid, the customer is sending a message.

More than likely, your business's staff has requested payment four to six times in the form of phone calls, letters and statements. The time and resources budgeted for internal collection efforts should be focused within the first 90 days when the bulk of accounts can and should be collected. From that point on, a third party can motivate a customer to pay in ways your business cannot, simply because the demand for payment is coming from someone other than your business. Avoid paying a percentage to a contingency collection agency, using small claims court or hiring an attorney by using a flat fee collection service such as Profit Recovery from Transworld Systems, (TSI). Using Profit Recovery can save your business time and money.

To learn more about how **Transworld Systems** can help you to recover your delinquent accounts and improve your profitability, please contact the Medical Society of the County of Queens at 718.268.7300, or your local TSI sales representative, Dick Neary. He is an authorized independent contractor for Transworld Systems, Inc. and can be reached on (941) 350-9918, or by email: Dick.Neary@TransworldSystems.com ■

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[2] Participating average monthly balance total must be equal to or greater than organization's previous membership anniversary date for contribution eligibility.

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- **We're your steadfast supporters throughout your recovery journey.**

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Poem... *The Doctor*
by Hugh R. Porter
featured in a 1929 publication
from the Medical Society
of the County of Queens.

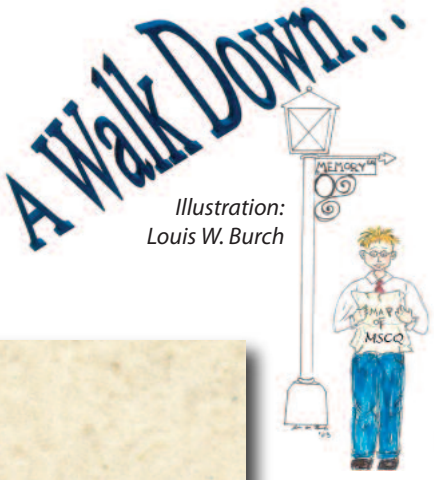


Illustration:
Louis W. Burch

THE DOCTOR

Who is it brings us into "Life"
When hearts are torn 'twixt hope and fear
That Death will claim the mother-wife,
And leave the home in darkness drear?
The Doctor.

Who is it when our children cry–
In the dead of night with wracking pain,
We straightway call, then watch and wait,
Until our darling smiles again?
The Doctor.

Who is it through storm and cold and rain,
Or in the winter's bitter cold,
Leaves his warm bed, nor hesitates
To ease our pain or bear our load?
The Doctor.

Who is it daily risks his life,
In battling with some dread diseases?
Who fights the scourge and pestilence,
That human suff'ring he may ease?
The Doctor.

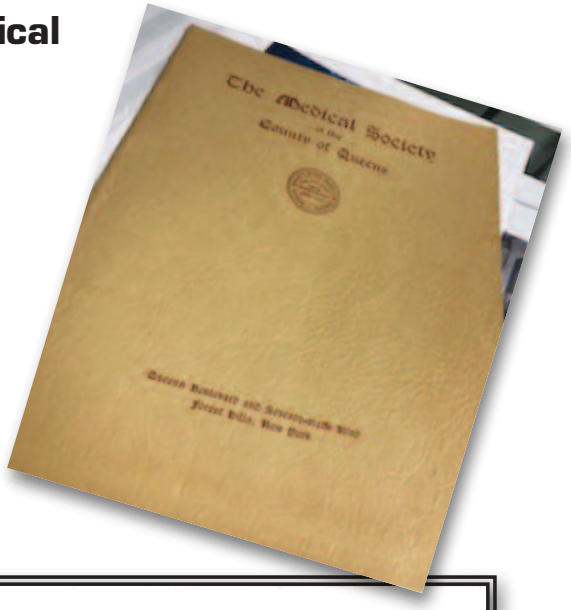
Who is it too, when all seems lost,
And in the dark we sadly grope,
Who whispers then, "there still is life"
And bids despairing souls to hope?
The Doctor.

Who is it when Death's shadows fall,
Across our threshold, yet seeks still
To comfort give, though he may know,
That we have naught to pay his bill?
The Doctor.

Who is it too, when spent and worn,
With overwork and little rest–
In middle life is broken down,
Yet still goes on and gives his best?
The Doctor.

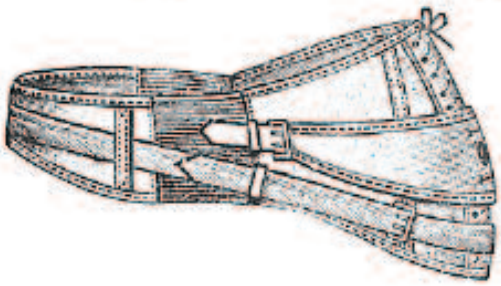
Of whom, shall it be said at last,
When GOD, Himself shall call him home;
"You have been faithful and have earned
The Great Physician's praise; well done?"
The Doctor.

Advertisement...
for Wagenseil Surgical Appliance Co.
featured in a 1929 publication from the Medical Society of the County of Queens.



Telephone Bushwick 4117

Wagenseil Surgical Appliance Co.



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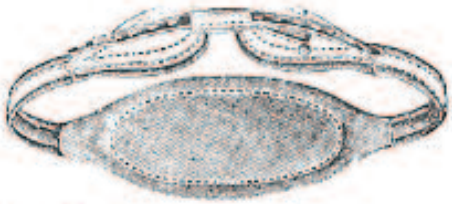

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Visit Lung.org/ffs for more information about the program
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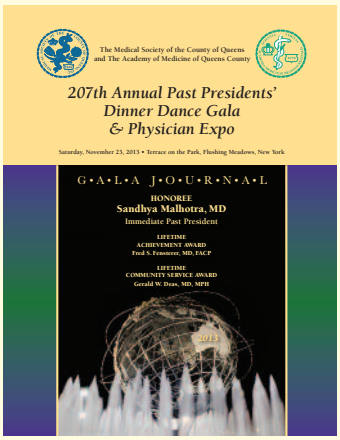
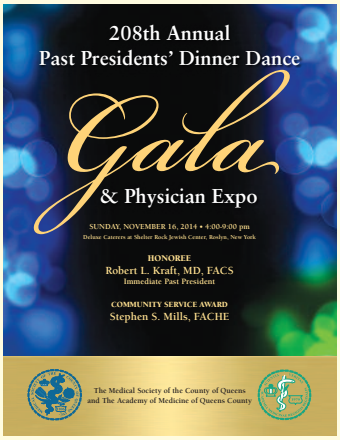
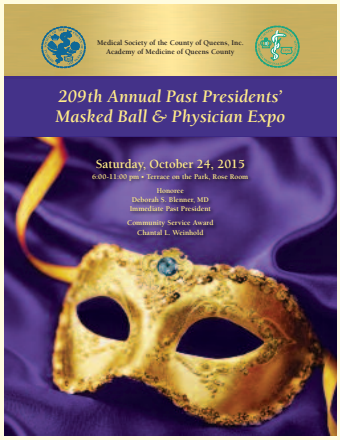
AMERICAN LUNG ASSOCIATION. | FREEDOM FROM SMOKING®

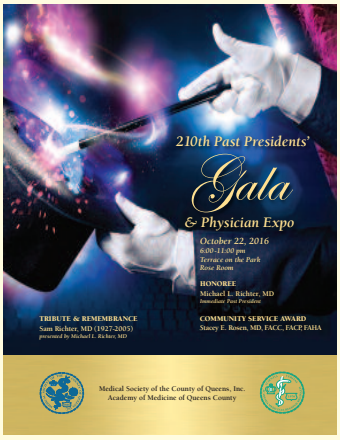
NewYork-Presbyterian Queens

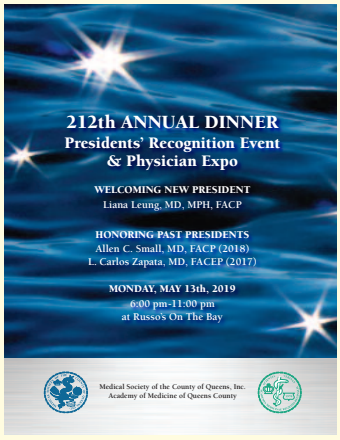
We've enjoyed so many wonderful Galas over the years...











Details Coming Soon!

Don't Miss This One!

213th Past Presidents' Gala & Physician Expo

Look forward to this special evening of fine dining, dancing and quality time with colleagues, family members and friends.

▲ Visit: www.MSCQ.org or call 718.268.7300 for event details.

The Medical Society of the County of Queens

IN MEMORIAM

It is with profound sadness that the
Medical Society of the County of Queens
reports the passing of our fellow members
during 2019.

Our esteemed colleagues leave a legacy of dedication to
their families, friends, patients, colleagues, and profession.
We honor their memory and celebrate their lives.
We are thankful to have known them and we will remember them.

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May 2019
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June 2019
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Details Coming Soon!

213th Past Presidents' Gala & Physician Expo

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