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

BULLETIN

Volume 11 • Issue No. 1 | *Over 200 Years of Service to the Medical Community of Queens County* | Fall 2019

Inside This Issue

From the President's Desk

Dear Friends and Colleagues,

Happy Autumn!
I hope that all of you had a wonderful summer and that this message finds you and your loved ones well.

Autumn represents for me a time of significant change: colder weather, colorful foliage, the busy start of school, and the reconvening of our New York State Assembly. This past summer, we saw many developments in healthcare policy and public health: the end of our national measles outbreak after over 1200 cases, removal of the religious exemption for vaccines in our state, hundreds of lung injury cases from vaping, physician response to address surprise bill legislation, blocked implementation of a 90-day ban on most flavored e-cigarettes in our state, etc.

As members of one of 60 county medical societies which comprise the Medical Society of the State of New York, we all have an important role advocating for ourselves as physicians and for our patients. As I mentioned in my inaugural address in May 2019 at Russo's on the Bay, we can seize on ample opportunities to learn about important healthcare policies affecting us and our patients, increase our medical knowledge, and meet other skilled and compassionate colleagues through our Medical Society.

We are blessed to live in the most ethnically diverse county in America: Queens has 2.3 million residents who come from more than 190 countries and speak more than 130 languages. As a proud native of Queens, I have lived here for 30 years and cared for patients as a primary care physician for the past 15 years.

As President of our Medical Society: I have two goals this year–to strengthen our Society by increasing our membership of over 1400 physicians and by deepening our engagement in Queens.

The core of our Society is our membership. Over the next year, I invite all of you to bring in at least ONE new member who will participate in our activities. Secondly, during this year, I encourage all of you to serve our Society in at least ONE new way–in an activity that you feel passionate about.

I extend a warm invitation to all of our new physician members from Northwell Health who have joined us earlier this year. I also invite all of our members to play a more active role in our Medical Society:

- Attend our monthly Comitia Minora meetings (members/non-members welcome)
- Participate in our professional and/or social events
- Join one of our Standing or Special Committees
- Organize a professional or social event for our Society
- Contribute to our quarterly Society newsletter
- Meet with legislators to advocate for physicians and patients in March 2020 in Albany on Physician Lobby Day

Through participation and service, you will find colleagues, role models, mentors, and friends. They will broaden your perspective and inspire you to return again and again. Additionally, you will improve the health of your patients and other Queens residents. In so doing, you will make your Queens community a healthier and more enjoyable place to live and work. Over time, you will find higher meaning and greater joy in your professional and personal lives.

It is my privilege to serve all of you. Our Medical Society looks forward to providing unique opportunities for professional education, networking, and socialization this year. We welcome your ideas and participation. Please contact me anytime at liana.leung@gmail.com or by cell at 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 Meetings are held on the 1st Tuesday of the month, unless otherwise notified.	November 12, 2019 • 6:00 pm December 3, 2019 • 6:00 pm
Comitia Minora Leadership Meetings Meetings are held on the 1st Tuesday of the month, unless otherwise notified.	November 12, 2019 • 7:30 pm • *"OPMC 101"* Paula Breen, Acting Director NYS DOH Office of Professional Medical Conduct December 3, 2019 • 7:30 pm Ning Lin, MD, Neurological Surgery NYP Queens/Weill Cornell Medicine
First District Meetings Refer to e-mails from this organization for details	November 21, 2019 • 7:00 pm / TBA
MSSNY Council Meeting	November 7, 2019 • 8:00 am
MSSNY House of Delegates 2020	April 24-26, 2020 / Tarrytown, NY

Upcoming Programs / Events

- **Symposium on Women's Health - "Health Matters for Women"**
  Saturday, November 2, 2019 • 7:30 am - 12:30 pm [CME - accredited activity]
  Location: NYC Health+Hospitals/Queens, Conference Room A-540
  82-68 164 Street, Jamaica, NY
  To Register
  https://docs.google.com/forms/d/e/1FAIpQLSe9zloLYo7LUNcgpV8bEx3Xn4tQlnzhwTXPZRBO1cde04QfMw/viewform

- **Effects of Dapagliflozin Beyond Glycemia: Implications for Prevention of Hospitalization for Heart Failure in Type 2 Diabetes**
  Wednesday, December 4, 2019 • 6:00 pm
  Presenter: Hillary Bell, PA-C, Cardiometabolic Clinical Science Liaison
  Location: Mythos Authentic Greek Cuisine
  19629 Northern Blvd., Flushing, NY
  RSVP to attend
  hillary.bell@astrazeneca.com

Programs & events details See pages 16, 17, 18

- **A Patient Safety Documentary - "To Err is Human"**
  Tuesday, December 10, 2019 • 7:00 pm - 8:45 pm [Not a CME - accredited activity]
  Location: Medical Society of the County of Queens
  112-25 Queens Blvd., 4th Floor, Queens, NY
  RSVP to attend by 12/06/2019
  718-268-7300 or E-mail to: ERTripp@QueensMedicalSociety.org

- 9th Annual Geriatrics & Palliative Care Symposium
  Spotlight on Elder Abuse: Now is the Time for Multidisciplinary Collaboration and Intervention Across the Care Continuum
  Tuesday, January 14, 2020 • 7:30 am - 12:45 pm [CME - accredited activity]
  Location: NewYork-Presbyterian Queens • Theresa and Eugene M. Lang Center for Research and Education, 56-45 Main Street, Flushing, NY
  To Register
  718-670-1419 • www.nypqcme.org

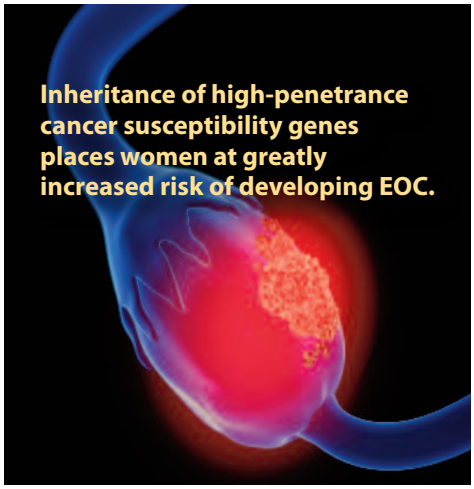
Epithelial Ovarian Cancer

David A. Fishman, 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 (III-IV), 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 the patient's family history of cancers and 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 multi-disciplinary team involving 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 Lynch syndrome-associated mutations. 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 where 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.

Biomarkers

Biomarkers have long played a role in the management of EOC. CA125 is a glycoprotein antigen that is the most commonly known and measured tumor marker. It is found in 85-90% of cases of EOC. However, it is only present in 47% of those women with early stage EOC. Therefore, using CA125 as the single marker in screening may miss more than 50% of cases of early stage ovarian cancer. Multiple publications have identified potential biomarkers for detecting ovarian cancer in addition to CA125. Human epididymis protein 4 (HE4), trasthyretin (TTR), apolipoprotein A1 (ApoA1) and transferrin are examples of protein biomarkers, that, in combination with CA125, have been used in panels with encouraging results in early stage EOC detection. Anderson et al. proposed a panel of biomarkers including CA 125, HE4, and mesothelin. The multivariate index assay OVA1 has been FDA approved for triage of pelvic masses since 2009. The test consists of CA125, beta2-microglobulin, transferrin, apolipoprotein A1, and transthyretin. OVA1 score ranging from 0 to 10 with cutoffs set as 5.0 for premenopausal women and 4.4 for postmenopausal women. Pelvic masses with scores higher than these thresholds are considered likely cancerous. The sensitivity of the test is initially reported to be greater than 90% with a negative predictive value of greater than 90%. A recent study on 516 women yielded an improvement of sensitivity and negative predictive value while decreasing specificity and positive predictive value when replacing the CA 125 with the multivariate index assay (121). These results, while requiring validation,

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Epithelial Ovarian Cancer

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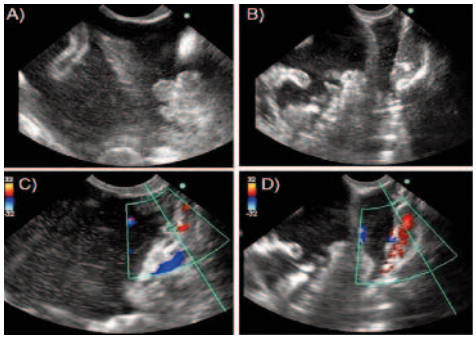
suggest that combinations of biomarkers may provide improved detection as the first step in a multimodal screening protocol.



Imaging Studies

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. In order to improve the efficacy of sonography, several new techniques have been combined with gray scale morphologic assessment. Three-dimensional ultrasound with power Doppler and microvascular contrast-enhancement are examples of techniques that have improved ovarian lesion characterization in sonography. 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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Managing Negative Online Reviews

Healthcare providers recognize that along with their practice websites, public websites such as Yelp, Healthgrades, and Rate MDs, and social media sites like Facebook and Twitter, can be used as marketing tools to inform the public of their services. The online community, however, is then afforded an opportunity to respond, rate, and, at times, complain about those services. These statements and reviews are readily accessible to anyone with an internet-ready device to open and read. While there is a basic instinct to immediately respond to negative online reviews, healthcare providers must remember that privacy rules make a complete response via social media inappropriate, and responding directly to an online post puts the healthcare provider at risk of disclosing protected health information (PHI). Your response may not contain any identifying statements, but the mere recognition of a patient-provider relationship is a potential HIPAA violation.

The following tips will help you successfully and appropriately respond to negative online reviews:

1. Critically review all social media posts for accuracy and authenticity. While some negative statements regarding the performance of you or your staff may be difficult to read, evaluate these reviews to determine if there is any opportunity for learning or process change.

2. Do not become engaged in online arguments or retaliation–especially if the comments made are particularly negative and potentially detrimental to the reputation of the facility or physician.

3. According to federal and state confidentiality and privacy laws, providers are precluded from identifying patients on social media. In order to protect patient privacy, all patient concerns and complaints should be resolved by the practice by contacting the patient directly and not through social media.

4. If you do choose to respond via social media, use a standard response that also serves as a marketing opportunity for your practice.

Some examples include:

a. "[Insert name] Medical Group is proud to have been providing comprehensive and compassionate care in the community since [insert year] and takes our treatment of its patients and their privacy seriously. Because federal privacy laws govern patients' protected health information, it is not the policy of [insert name] Medical Group to substantively respond to negative reviews on "ratings" websites, even if they provide misleading, unfair or inaccurate information. We welcome all our patients and their families to address any concerns/requests or information about their care with us directly, as we strive to continue to provide individualized care in our community."

b."At our medical practice, we strive for patient satisfaction. However, we cannot discuss specific situations due to patient privacy regulations. We encourage those with questions or concerns to contact us directly at [insert phone number]."

5. If you feel the patient's complaint has disrupted the physician-patient relationship, consider discharging the patient from your practice. This action may be viewed as retaliatory by the patient and may set off a new series of negative posts. Attorneys at Fager Amsler Keller & Schoppmann, LLP are available to assist you to make this decision.

6. Notify your local authorities if you feel at any time that your safety, the safety of your staff or your family is threatened or at risk. ■

Protecting Your Medical Practice from Employment - Related Liability in New York State

Kathleen Sellers, JD, CLU

It's now been about two years since the #MeToo movement exploded. It's clear that all employers and supervisory employees have to work to prevent and address sexual harassment, which has existed for too long in many workplace cultures. While being mindful of these responsibilities, business owners and managers also need to consider the potential financial ramifications for our own businesses and workplaces. This is especially true in New York, where new laws addressing sexual harassment and discrimination in the workplace have made it easier for employers to be sued, and harder for them to defend themselves.

Healthcare businesses need to be aware of the potential for employment-related claims. According to the US Liability Insurance Group, a medical practice is more likely to have an employment claim brought against it than a general liability claim. Small practices aren't immune – over 40% of all employment claims are brought against businesses with less than 100 employees. The typical power structure in many medical practices – with mostly male physician owners and mostly female staff – results in a heightened risk of actual or alleged wrongful conduct in medical practices. Employment claims can include allegations of wrongful termination, breach of an employment contract, failure to promote, violation of anti-discrimination and harassment laws, wrongful demotion, and retaliation for making a claim of an illegal employment practice. And while sexual harassment scenarios are dominating headlines now, employees may bring claims of discrimination or harassment on the basis of race, national origin, religion, pregnancy, age, disability, and sexual orientation, as well.

New York State has responded to the #MeToo movement with legislation aimed at preventing sexual discrimination and harassment. Legislation passed in April 2018 required all New York employers to establish a written sexual harassment policy and to provide anti-sexual harassment training for employees by October 9, 2019 and annually thereafter. More legislation, signed into law in August 2019, made additional significant changes. For example, effective October 11, 2019, an employee suing for sexual harassment does not need to prove that the harassment is "severe or pervasive," which is the current legal standard for a claim of hostile work environment. Certain defenses, long relied upon by attorneys defending employers, will no longer be permitted. For successful employee claimants, punitive damages and attorneys' fees will now be available. And, effective February 8, 2020, the New York Human Rights Law's prohibitions against discrimination and harassment in the workplace will apply to all employers (currently, these apply to employers with four or more employees).

Medical practices, like other businesses, need to take action to establish a fair and safe workplace culture, by making sure that anti-harassment and discrimination policies and practices are in place, and that all managers and staff are trained to prevent and address improper workplace conduct. But even the best policies and procedures can't prevent all employment practices claims, which is where Employment Practices Liability Insurance (EPLI) comes into play. This insurance covers the cost of a judgment or settlement in an employment-related claim, up to the policy limit, as well as paying defense costs, which in many employment-related claims, exceed the eventual judgment or settlement (if there is one). Coverage for these types of claims is excluded from Workers Compensation and standard Business Owners Policies (although some Business Owners Policies may include or add on some Employment Practices Liability coverage). Employment Practices Liability coverage can be purchased on a stand-alone basis, or as part of a management liability package that can include Directors & Officers Liability coverage (for claims brought in connection with other wrongful acts or omissions by management) and/or Fiduciary Liability coverage (for claims against fiduciaries of employee benefit plans). EPLI policies can also include coverage for claims of harassment or discrimination brought by third parties, such as patients or customers and vendors (for example, a pharmaceutical representative who visits a medical practice). This coverage is more important than ever for businesses in New York. The 2018 budget legislation provided that employers may be liable to (non-employee) third parties, if the employer knew or should have known that the third party was being harassed and did not take corrective action.

US Liability Insurance Group offers a policy that we have put in place for many of our customers that is specifically designed for medical practices, and it can include coverage for defense costs for claims of patient molestation (availability of this coverage varies by medical specialty).

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Protecting Your Medical Practice

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As a valuable add-on, most EPLI policies also provide access to services to help a business prevent or mitigate loss from an employment practices claim. These include sample employment policies, online anti-sexual harassment prevention training, a set amount of free consultation with a lawyer or human resources professional, and other smart hiring resources, such as discounts on background checks for job applicants.

When purchasing an EPLI policy, a business should consider what limits to purchase (many of our customers purchase a $1,000,000 limit), as well as the deductible and premium offered by the insurance company. In some policies, the costs of defending the claim are subtracted from the overall limit available for a judgment or settlement (this is referred to as defense "within" or "inside" the limit), while with others, defense costs are covered in addition to the limit (referred to as "outside" the limit). EPLI policies are written on a claims-made basis, which means that they cover claims made during the policy period, subject to the retroactive date. Claims based on acts that took place before the retroactive date, are not covered. If coverage is offered on a "Full Prior Acts" basis, there is no retroactive date, which means that more claims may be covered.

EPLI coverage is now more important than ever for the financial protection of medical practices, with the increased attention being brought to harassment in the workplace and changes in state law. Even if these issues aren't occurring in your practice, a disgruntled employee can sue your practice, alleging discrimination or harassment. An EPLI policy can help your practice survive the financial impact of such a claim. ■

About the Author

Kathleen Sellers, JD, CLU
Vice President, Charles J. Sellers & Co., Inc.

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MSSNY President Dr. Arthur C. Fougner *(right)* talks Surprise Bills on WRHU FM's Well Said with Dr. Ira Nash *(left)*.

To preview the video, click below.

Do Women with Dense Breasts Need Supplemental Imaging to Screen for Breast Cancer?

Ravali Kondaveeti, PGY-2

In clinical practice, breast cancer screening is recommended in asymptomatic women aged 40-74 years annually to biennially based on guidelines from different medical associations and expert groups. In the population at or above age 75 years, it is advised to discuss the potential risks and benefits with the patient to reach a shared decision whether to continue or stop screening. Women who are at increased risk of breast cancer benefit from early screening from age 40 years with annual mammogram and/or additional testing (genetic testing, MRI). According to the United State Preventive Services Task Force, in the population of women with dense breasts irrespective of age group, current evidence is insufficient to recommend for or against additional breast cancer screening (breast ultrasound, MRI, or other methods).

Dense breasts increase the risk of breast cancer and decrease sensitivity of the mammogram to detect breast cancer. Approximately 43% of women in the United States who are undergoing breast cancer screening have dense breasts. As the breast density increases, the sensitivity of the mammogram decreases. Density in mammogram is reported as one of four breast imaging reporting and data system (BI-RADS) categories. The first two categories of entirely fatty and scattered areas of fibroglandular density are considered nondense. The last two categories of heterogeneously dense and extremely dense breast tissue are considered dense and are now required to be reported in the radiological result as per the dense breast notification law that has been implemented in many states (currently 38 states and the District of Columbia). As per the New York State Department of Health, the physician or the facility that provides the mammogram must notify women if they are found to have dense breasts.

In the presentation given by Bobbi Ring, MD, Co-Section Chief for Breast Imaging Section at Main Street Radiology at the Medical Society's Comitia Minora meeting on September 10, 2019, she discussed several cases where ultrasound identified the abnormal tissue which was later determined to be breast cancer; this cancer was missed by the prior annual mammogram in women with dense breasts. Additional testing with breast ultrasound has increased cancer detection rates. This discussion highlighted the possible need for additional testing in certain populations of women with dense breasts. It also focused on digital breast tomosynthesis (DBT) which overcomes some of the limitations faced with a traditional 2D mammogram alone as DBT views thin sections and decreases the lesion masking and overlapping effect. DBT has also decreased recall rates. DBT can be of much help in detecting cancer, especially in women with dense breasts.

Supplementing mammography with breast ultrasound in women with dense breasts increases the cancer detection rate, but it also increases the false positive rates and follow up recommendations. So far, there has been no evidence or studies to support that the benefits outweigh the

risks of using ultrasound as additional imaging along with annual mammogram in women with dense breasts. However, patients and healthcare professionals should discuss breast density, its association with increased risk of breast cancer and the limitations of mammography in early detection of breast cancer in these women. In this manner, patients can be knowledgeable and then weigh appropriately the risks and benefits and make an informed decision if they would want to proceed with additional tests. ■

About the Author

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Edited by Bobbi Ring, MD
Co-Section Chief for Breast Imaging
Section at Main Street Radiology,
and Liana Leung, MD, MPH, President,
Medical Society of the County of Queens

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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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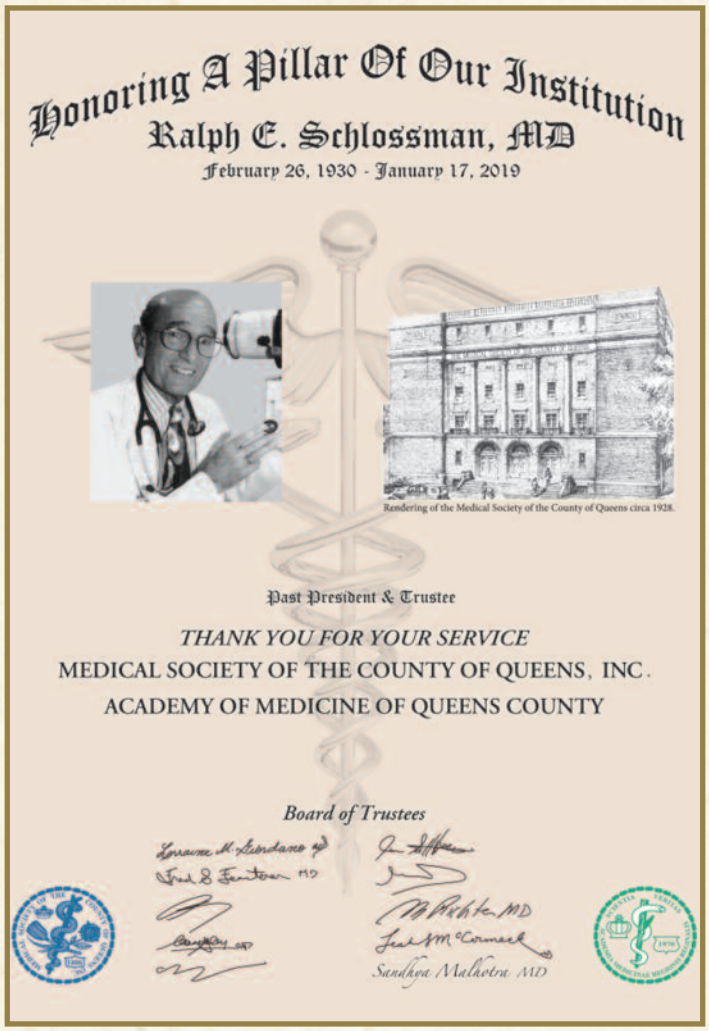
The Ralph E. Schlossman, MD Humanism in Medicine Award

The Ralph E. Schlossman, MD Humanism in Medicine Award was created this year to commemorate and honor Dr. Schlossman who departed from us in January. 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.

This Award will be given to one outstanding physician annually who has cared for patients in the County of Queens and has taught residents and/or medical students with compassion, dedication, and professionalism.

Presentation of the Award will begin in 2020.



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

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The Origin of NYC Health+Hospitals/Queens

Liana Leung, MD, MPH

Did you know that one of the two municipal hospitals in Queens owes its existence in part to the Medical Society of the County of Queens?


NYC Health+Hospitals/Queens

In 1928, our Medical Society (then known as the Queens County Medical Society) began petitioning the New York City Board of Estimate and Mayor Jimmy Walker for a free public hospital in Queens. Because there were no municipal general hospitals in Queens at that time, people were required to use Kings County Hospital in Brooklyn or Bellevue Hospital in lower Manhattan. Queens General Hospital was proposed by the city in 1929; it was also referred to as the new Queensboro Hospital. Construction was approved in 1930 and took place over the next two years.

Due to its many buildings including a power plant, a heating plant, and the laundry building, the new Queens General Hospital was referred to as a "miniature city." It contained specialized X-ray equipment, radium for the treatment of cancer (no longer in practice), and an iron lung–medical innovations at the time. Only patients who could not afford to pay were allowed to be admitted as in-patients; those who could afford to pay were required to use one of the private hospitals in the borough. Over the years, Queens General Hospital merged with Queensboro Hospital, Triboro Hospital, and many other healthcare facilities in Queens.

In July 1964, Queens Hospital Center became affiliated with the Long Island Jewish Medical Center, the Hillside Hospital in Glen Oaks, and the Mary Immaculate Hospital in downtown Jamaica. It faced overcrowding, shortages of equipment, and many financial challenges. In 1992, the Long Island Jewish Medical Center ended its 25-year-long contract to provide medical residents for rotation at the hospital. Later that year, Mount Sinai Medical Center agreed to supply doctors to the hospital.

In 1997, after his attempt to sell Queens General Hospital failed, Mayor Rudolph Giuliani announced plans to build a new hospital on the campus. Construction began in 1998 and was finally completed in 2001 at a cost of $147 million. The modern, state-of-the-art facility opened in January of 2002. The new Ambulatory Care Pavilion building across from the main hospital opened in January 2007 and provides primary care and sub-specialty services.

Today, NYC Health + Hospitals/Queens is a major healthcare provider and an affiliate of Mount Sinai School of Medicine that serves the communities of central and southeastern Queens. Its mission is to provide quality, comprehensive care to all members of the public regardless of their ability to pay. Medical services are provided through an affiliation agreement with its academic partner, the Mount Sinai School of Medicine. The hospital offers residency training in Dental Medicine, Internal Medicine, OB-GYN, and Ophthalmology. ■

NYC Health + Hospitals/Queens Statistics

- Beds in Service: 271
- Clinic Visits: 314,042
- Emergency Room (ER) Visits: 91,295
- Discharges: 13,673
- Births: 1,743

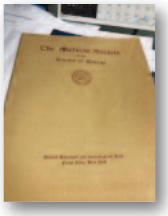
References

1. "About Queens." *The City of New York,* 2019, https://www.nychealthandhospitals.org/queens/about-us/ Accessed 10 October 2019.
2. "Queens Hospital Center." *Wikipedia,* https://en.wikipedia.org/wiki/Queens_Hospital_Center Accessed 10 October 2019.

About the Author

Liana Leung, MD, MPH has served as the Associate Director of the Department of Ambulatory Care and Associate Program Director of the Internal Medicine Residency Program at NYC Health+Hospitals/Queens for the past six years.

Advertisement for The Boulevard Hospital in this 1929 publication from the Medical Society of the County of Queens.



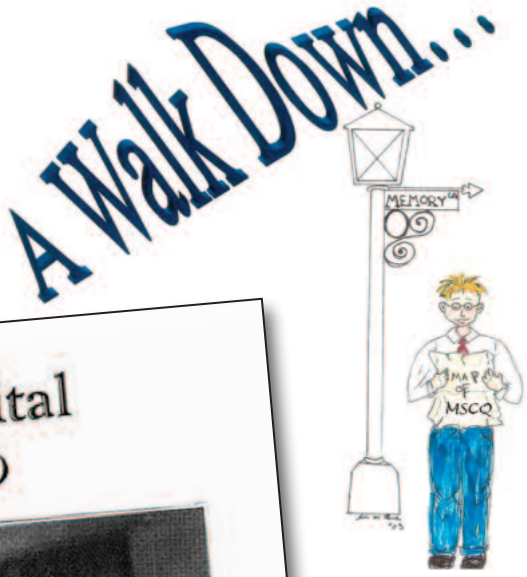
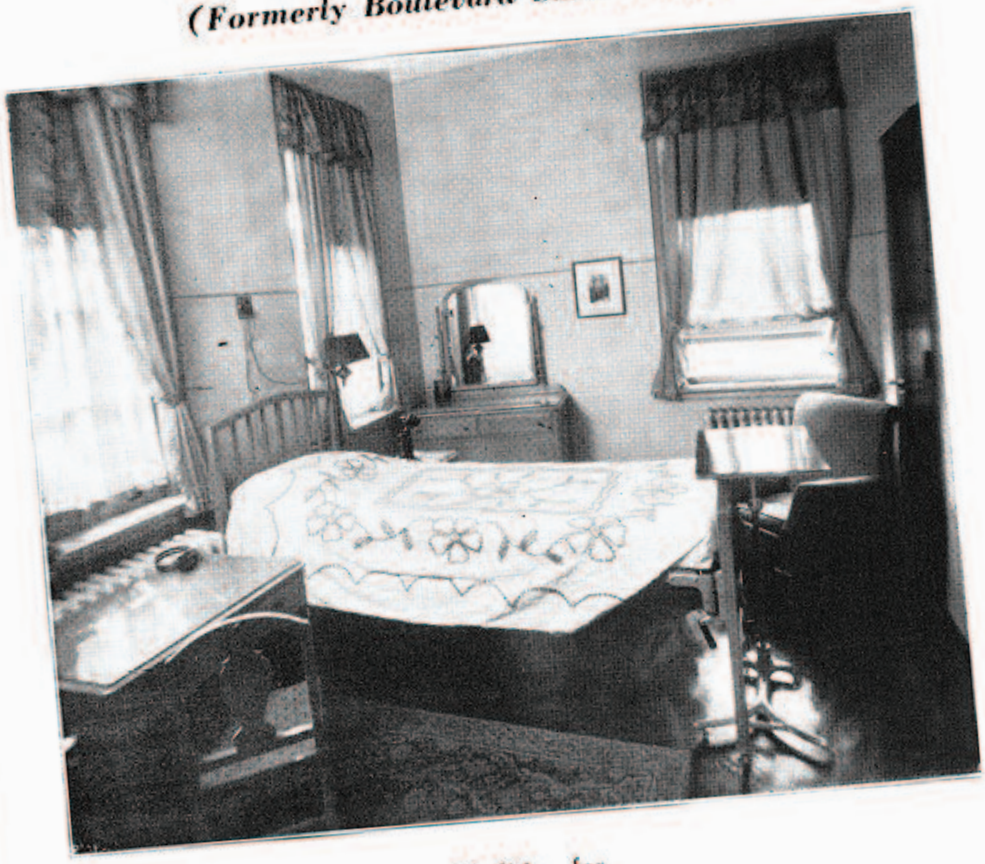


Illustration: Louis W. Burch

The Boulevard Hospital

(Formerly Boulevard Sanitarium)



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Memorandum from the NYC Commissioner of Health – circa 1929

New York's Diphtheria Campaign

By SHIRLEY W. WYNNE, M.D., Dr.P.H.

Commissioner of Health
City of New York

NEW YORK'S diphtheria prevention campaign is now ten months old. What have we to show for it? The fact that in those ten months, more than 165,000 children have been immunized. It is also interesting to note in this connection that during the first nine months of 1929, we have had 107 fewer deaths, and 1,460 fewer cases of diphtheria than the average for the corresponding period of the previous six years.

It has been a guiding policy of our diphtheria campaign to carry on an educational campaign directing people to private doctors to overcome the ethical prohibition against a doctor beckoning to practice. We have done this by advising in every piece of literature, in every spoken address that, wherever possible, parents should take their children to the family physician for treatment. We made an intensive effort to reach 200,000 families to whom were sent notices issued in the joint names of the Department of Health and the County Medical Societies. All projects of the diphtheria campaign are co-operative in which the medical societies share. The public can best be served and the health of the city best maintained only when the action that is started by the Health Department is supplemented by the wholehearted cooperation of the private doctor.

Of the number of children immunized since the first of the year, 41 per cent were immunized by private physicians and 59 per cent by the Department of Health. During the early summer months, the proportion of immunizations by private physicians decreased. This decrease was due, most likely, to the absence of children on out-of-town vacation and also to the vacation of physicians.

Diphtheria in our city—or in any other city—can only be banished through the combined efforts of parents, the medical profession and the Health Department. All three are responsible—the parents who must protect their children, the doctors who must urge the use of this protection, and the Department of Health which must demand that the children of the city be protected.

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Just What the Doctor Ordered

Joseph D'Amore, MD

Influences

My Jewish and Italian families conditioned me from birth to equate home cooking with love of family and friends. No one who came to our apartment in East New York, Brooklyn ever went home hungry. To me, there is no greater satisfaction than people enjoying your culinary efforts and asking for the recipe!

Career

I started out loading industrial dishwashers at age 15 and worked myself up over the next 9 years to bus boy-waiter-dessert chef and then sous chef at various places in Long Island. I flipped a coin at age 24 to see if I wanted the CULINARY INSTITUTE of AMERICA or medical school. ■

CASSOULET D'AMORE

Ingredients

8 cloves of garlic, 1 onion, 1 green bell pepper, chopped

1 and 1/4 pound of bulk hot Italian sausage meat, chopped

1/2 teaspoon EACH of salt, pepper, oregano, thyme, rosemary

2 tablespoons EACH of butter and olive oil

2 (1 pound) cans of drained white kidney beans

16 ounce can of diced tomatoes

- PREHEAT oven to 400 degrees
- Sauté sausage meat in butter and oil for 4 minutes, medium high heat
- Add bell pepper and onion and continue to sauté another 4 minutes
- Add in beans, spices and tomatoes and mix well for another 4 minutes
- Pour mixture into an oven proof casserole dish and bake uncovered for 20 minutes
- Garnish with fresh chopped basil or a dollop of pesto!
- SERVE HOT with crusty Italian bread and **ENJOY!**

FYI... An allergist at Medex, Dr. D'Amore now uses his culinary passion for charity events, including the Susan G. Komen Breast Cancer Foundation's "Cook for the Cure" program and the Great Chefs event, raising thousands of dollars for the endeavors. He spends anywhere from 25 to 50 hours each month volunteering, on top of a 60-hour work week.

HEALTH MATTERS FOR Women

Endometriosis • Fibromyalgia • Myalgic Encephalomyelitis

Symposium on Women's Health

Sponsored by the Medical Society of the State of New York & the Academy of Medicine of Queens County

When: **November 2, 2019**
7:30 am - 12:30 pm

Where: **NYC Health + Hospitals/Queens**
82-68 164 Street
A-540 Conference Room
Jamaica, NY 11432

▶ To Register Click Here

Schedule

7:30 - 8:30 am
Registration and Breakfast

8:30 - 9:30 am
Health Matters for Women: *Endometriosis**
Faculty: Lisa Eng, DO

Educational Objectives:
Review potential causes of pelvic pain and discuss how to identify endometriosis

Discuss the benefits and risks as well as the efficacy and limitations of available medical therapies for long-term treatment of endometriosis

Discuss implementation of individualized endometriosis treatment plans and options

9:30 - 10:30 am
Ovarian Cancer and Genetic Risk**
Faculty: David Fishman, MD

Educational Objectives:
Identify who is at risk for cancer

Explain what a genetic counselor is

Review cancer genes and cancer susceptibility

Describe future applications for new cancer treatments

10:30 - 11:30 am
Health Matters for Women:
Fibromyalgia and Myalgic Encephalomyelitis*
Faculty: Florence Shum, DO

Educational Objectives:
Review potential causes of chronic diffused pain and fatigue

Discuss how to accurately diagnose fibromyalgic and myalgic encephalomyelitis

Discuss treatment options for fibromyalgia and myalgic encephalomyelitis

11:30 - 12:30 pm
Genetic Profiling of Breast Cancer and Its Implication for Staging, Prognosis and Treatment**
Faculty: Louis Auguste, MD

Educational Objectives:
Describe different cellular proteins that can help predict the outcome of breast cancer

Discuss how genetic profiling is a better prognosticator

Funding provided by the New York State Legislative Grant

*The Medical Society of the State of New York is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide medical education for physicians.

The Medical Society of the State of New York designates this live activity for a maximum of ***1.0 AMA PRA Category 1 credit***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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The Academy of Medicine of Queens County designates each of these live activities for a maximum of ***1.0 AMA PRA Category 1 credit***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Save the Date

for this important event sponsored by the Medical Society of the County of Queens

To Err Is Human is an in-depth documentary about medical mistakes and those working behind the scenes to create a new age of patient safety. Through interviews with leaders in healthcare, footage of real-world efforts leading to safer care, and one family's compelling journey from victim to empowered patient advocate, the film provides a unique look at our health care system's ongoing fight against preventable harm.

Target Audience

Attendings, physicians, physician assistants, nurse practitioners and residents

Location

Medical Society of the County of Queens
112-25 Queens Blvd., 4th Floor
Forest Hills, New York,11375

Parking

$10 Reduced parking fee for event attendees at the parking garage next to the Medical Society

Free street parking in the area after 7:00 pm

"To Err Is Human"

A Patient Safety Documentary
Director: Mike Eisenberg
Duration: 77 minutes

Tuesday, December 10th, 2019
7:00 pm - 8:45 pm

7:00 pm
Networking & Refreshments

7:30 pm - 8:45 pm
Film Screening

▶RSVP by 12/06/2019
tel: 718-268-7300
or by E-mail to:
ERTripp@QueensMedicalSociety.org

This is not a CME-accredited activity

Register early !

9th Annual Geriatrics & Palliative Care Symposium

Spotlight on Elder Abuse:

Now is the Time for Multidisciplinary Collaboration and Intervention Across the Care Continuum

This Symposium is presented collaboratively by:

NewYork-Presbyterian Queens
Division of Geriatrics
& Palliative Care Medicine

Weill Cornell Medicine
Division of Geriatrics
& Palliative Medicine

NYC Elder Abuse Center

Academy of Medicine of Queens County

Credit

Maximum of ***4.25 AMA PRA Category 1 Credit(s)***™

Nursing: 4.25 contact hours

Tuesday,
January 14, 2020
7:30 a.m. - 12:45 p.m.

NewYork-Presbyterian Queens
Theresa and Eugene M. Lang Center
for Research and Education
56-45 Main Street, Flushing, NY 11355

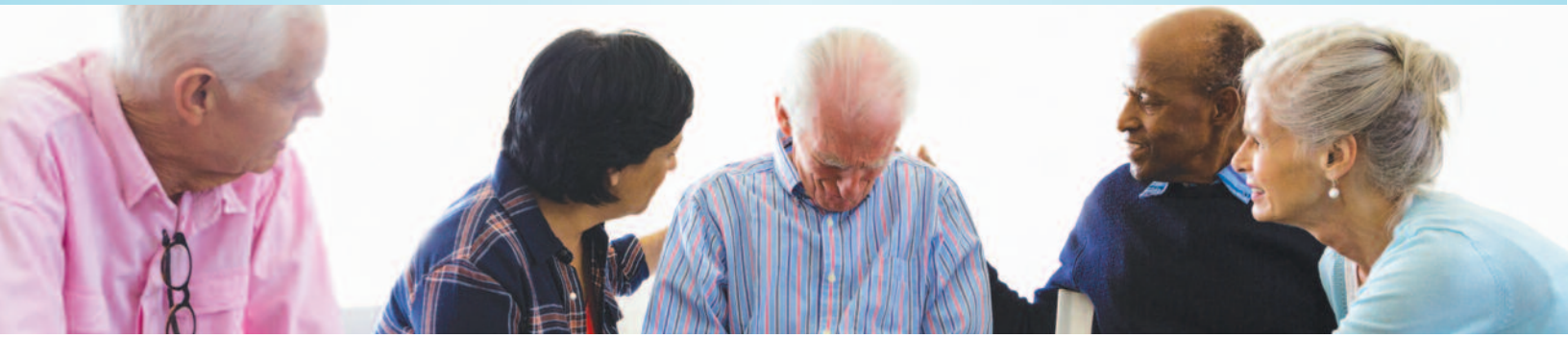
Symposium Moderators

Cynthia X. Pan, MD, FACP, AGSF
Jane Morris, MS, RN, ACHPN

KEYNOTE SPEAKERS

Risa Breckman, LCSW
Veronica LoFaso, MD

Click here to register
718-670-1419 • www.nypqcme.org



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Thank you.

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is published 3x/year for the membership of the Medical Society of the County of Queens and The Academy of Medicine of Queens County.

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