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

BULLETIN

Volume 12 • Issue No. 5 | *Over 200 Years of Service to the Medical Community of Queens County* | *Summer 2021*

Inside This Issue

Letter from the President's Desk

Dear Friends
and Colleagues,

The Medical Society of Queens County, Inc. is committed to optimizing patient care. The practice of medicine is more complicated than ever due to many factors, including the explosion of medical information. New biomedical technologies, computer sophistication, and scientific breakthroughs are unrivaled in the history of medicine. Artificial intelligence (AI) is now emerging from a theoretical into clinical reality. The benefit of AI is to improve patient care and reduce societal healthcare expenses. Presently over 60 AI-equipped medical devices have received FDA approval, and this will become the new standard of care. The utility of AI technology is broadly being applied to radiology, pathology and is critical for genomic and proteomic precision medicine. The challenge for the Society is that this evolving avalanche of critical medical information must be packaged and processed by each healthcare provider to benefit our patients. It is now crucial for the members of our Society to work together to use our diverse clinical expertise and experience such that we meet the challenges ahead. Focused CME presentations, lectures, and updates are part of our mission to bring this information into clinical practice. My goal over the next year is to encourage more membership interaction and participation in the Medical Society's educational and social experience as the goal is to offer optimal patient care. Again, the strength of our Society is its members and their commitment to improving the healthcare of the community we serve. I welcome all thoughts and comments from members to help us succeed in providing the best healthcare possible. ■

David A. Fishman, MD, *President*

daf2037@med.cornell.edu

About Dr. Fishman

David A. Fishman, MD is an internationally recognized gynecologic oncologist, especially noted for his innovative research on the regulation of ovarian metastasis and in developing new methods for the detection of individuals at risk for ovarian cancer and the detection of early stage ovarian carcinoma. He established The National Ovarian Cancer Early Detection Program in 1999 with a grant from the National Cancer Institute and philanthropic support. He is a Professor of Obstetrics and Gynecology at Weill Cornell School of Medicine. Dr. Fishman has authored over 300 scientific papers, abstracts, book chapters and books on gynecologic malignancies. His research has received awards from the National Institutes of Health, National Cancer Institute, Society of Gynecologic Oncologists, Gynecologic Cancer Foundation, American Cancer Society, Society of Gynecologic Investigation, and the Berlex Foundation. He serves as an editor for three journals and ad hoc reviewer for 43 medical and scientific journals He has received many awards such as Best Doctor in New York and Castle Connolly Best Cancer Doctor in America as well as the National Cancer Institute Early Detection Research Network Recognition Award. He is a member of many medical and honor societies and patient advocacy groups including the American Gynecologic and Obstetrical Society, Society for Gynecologic Investigation, AOA, the Society of Gynecologic Oncologists and the National Ovarian Cancer Coalition. Dr. Fishman, a member of the Society since 2017, became President on May 19, 2021.

My Farewell Address- Past President

David Vilabrera, MD
MSCQ Past President, 2020-2021

This past year has been a challenge for all of us in the medical profession, where we were hailed as heroes by some and vilified by others who alleged that we were not doing enough. Some of us were lost due to the ravages of the Covid-19 virus. I myself had to go into quarantine in March of last year for two weeks but fortunately it was a mild case, yet others lost their lives or lost family members do to this disease. Many great things were done by front-line health care providers, yet we are still being hobbled by forces that cannot see the forest because too many trees are in the way. The very idea that it has been proposed that the only hospital on the Rockaway peninsula should be closed due to budgetary reasons during a devastating pandemic is totally crazy, yet some of our lawmakers want to push this onto us. The Medical Society is very necessary during these times - to advocate for physicians and inform the lawmakers that closing a hospital during a pandemic is not going to save any money but will cost some lives - to inform physicians about some of the hidden regulations put forth by not only the legislatures but also the insurance companies, Medicare and Medicaid that will make our ability to provide care for our patients more and more difficult, and to educate physicians on how to negotiate their way through the regulatory maze in order to practice our profession. The next generation of physicians will need guidance from us in order to make it, as the flip remark that I was told when I finished residency 41 years ago - sink or swim - is not right. Our focus on helping young physicians find their own sincere way is important, and getting the lawmakers to understand that their constituents are our patients and that working with us to help make their lives better for them does not make us their adversaries in any way. The road to achieving this will be difficult, what with some politicians caring only about their poll numbers or who has paid them the most money or done them the most favors, so the work is really cut out for us. I hope that our incoming president, Dr. David Fishman, will get the same wonderful assistance that I received from Vangie, Gina, Moira and the rest of the staff - we had to have all of our meetings via ZOOM (which I did not like) but once the pandemic resolves hopefully we can get to in person meetings and concentrate on being there to help the physicians care for the patients in an effective manner. ■

Annual Meeting May 19, 2021
David Vilabrera, MD, passing the leadership gavel to our 2021 incoming President, David A. Fishman, MD.

About the Author

David Vilabrera, MD
Immediate Past President
Medical Society of the County of Queens
vilabrera@aol.com

Excerpts from a Society Journal circa 1921-1923

The separation of the Queens-Nassau into two County Medical Societies was made during the occasion of a Testimonial Banquet to Dr. James S. Cooley on January 26, 1921. The Queens-Nassau Medical Society had applied to the Supreme Court of Queens, which was organized in 1806 and became Queens-Nassau in 1899 when Nassau County was formed out of parts of Queens. Reorganized, it had a membership of 128. Its officers for the year 1921 are: President Thomas C. Chalmers, MD of Forest Hills; Vice President – Charles B. Story, MD of Bayside; and Secretary-Treasurer – L. Howard Moss, MD of Richmond Hill.

On January 1, 1921, the Queens County Medical Society began its existence representing Queens County of today. The number of meetings was increased from four to eight yearly, and one of these meetings to be held early in June was to be primarily social. At first, the meetings were held in different parts of the county, but this arrangement did not prove satisfactory, and hopes of a centralized meeting place became more and more definite. Their culmination of which led up to purchasing land for a Society building. Jamaica was chosen as the most central locality.

On November 8, 1923, the acquisition of land for a building site for the Society and the beginning of a building fund made it necessary to add a Board of Trustees to the Officers of the Society. The amendment to the constitution further provides that each retiring president shall be elected of the Board of Trustees for five years, thereby a continuity of service for those who have experience in administering the affairs of the Society.

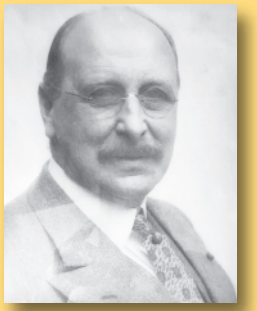
During the following year, in 1925 came the founding of the Bulletin, and 1926 saw the birth of the Committee on Graduate Education. Its project was to bring home to the members of the Society the latest and best in medical science. Among its achievements is an annual series of lectures by recognized leaders in Medical thought from all parts of the city. In addition, it organized various hospital services in the county of post-graduate clinical instruction.

The history of our Society, like the history of humanity, has shown consistent growth of social consciousness during the corresponding time. Slow and difficult at first but gathering momentum as the needs grew.

Today the Society has over 1,600 members of diverse backgrounds reflecting the modern-day Queens' communities. The Continuing Medical Education Committee exists today under the educational component of the Society, as the Academy of Medicine of Queens County. It continues its work to educate physicians further and continuously improve the quality of patients' care. As the healthcare landscape has become increasingly complex in 2021, the focus on insurance and governmental policies has continued to play a significant role in the provision. The Society works to provide physicians with a voice on a legislative level and will continue to do so into the future.

According to David A. Fishman, MD, President 2021-2022, ***"Today our mission continues with more challenges and opportunities to help provide our members the medical information to offer the residents of Queens optimal care. Hopefully soon we will once again be able to not only enjoy the educational component but the social activities that were initiated by the Society back in 1921."*** ■

Congratulations to MSCQ on 100 Years of Service!



Thomas C. Chalmers, MD
President 1921-1922
Medical Society of the County of Queens, Inc.

1923 Cornerstone Laying for the Society's building.

Completion of the Medical Society building.

MEETINGS / CME / EVENTS

Upcoming Meetings	Date / Time
MSCQ Board of Trustees Meetings All Board of Trustees Meetings are held on the 1st Tuesday of the month, unless noted.	September 14, 2021 • 6:00 pm October 5, 2021 • 6:00 pm November 2, 2021 • 6:00 pm December 2, 2021 • 6:00 pm
Comitia Minora Leadership Meetings All Comitia Meetings are held on the 1st Tuesday of the month, unless noted.	September 14, 2021 • 8:00 pm October 5, 2021 • 8:00 pm November 2, 2021 • 8:00 pm December 2, 2021 • 8:00 pm
First District Meetings Refer to emails from this organization.	Contact Ronald Blunt: bronxphysicians@gmail.com
MSSNY Council Meeting	September 23, 2021 • 8:00 am November 4, 2021 • 8:00 am
MSSNY House of Delegates 2021	September 18, 2021

Upcoming Presentations

▶ **"Human Trafficking"**

Tuesday, September 14, 2021 • 8:00 pm

(at Comitia Minora Meeting)

Presenter: Jessica L. Melton

Chief of the Human Trafficking Bureau;
Office of Queens County District Attorney Melinda Katz

Upcoming CME Programs

▶ **"Peripheral Arterial Disease: Critical Limb Ischemia Updates"**

Tuesday, October 5, 2021 • 8:00 pm

(at Comitia Minora Meeting - more details to be provided)

.5 AMA PRA Category 1 Credit(s)™

For information about placing a CME program listing in the BULLETIN, please contact our office at: 718.268.7300.

MAKING A DIFFERENCE IN THE CARE FOR YOU AND YOUR FAMILY

It is with great pleasure that we announce the appointment of Dr. Eitan Melamed – Chief of Hand Surgery, NYC Health + Hospitals/Elmhurst.

After receiving his medical degree and completing his orthopedic surgery residency in Israel, Dr. Melamed completed a research fellowship at NYU Langone Medical Center and hand fellowships at Beth Israel/Albert Einstein School of Medicine and Johns Hopkins Medical Center. He is a member of the American Society for Surgery of the Hand (ASSH), actively serving on the Self-Assessment and Clinical Research and Grantsmanship Committees, and is a reviewer for the Journal of Hand Surgery.

Dr. Melamed specializes in hand and upper extremity surgery and has extensive experience with taking care of children and adults with special needs, including cerebral palsy, stroke, and brain injury patients, for whom hygiene and personal care are improved through surgery. Subsequently, Dr. Melamed has collaborated with physicians from diverse backgrounds, including physical medicine and rehabilitation, neurology, pediatrics, and primary care, with the aim of providing solutions to patients with neurological conditions.

His experience in working with the NYU Langone amputee clinic led to the development of a clinical algorithm for treatment of stump neuroma and phantom pain. As a hand surgeon with interest in peripheral nerve conditions, Dr. Melamed was able to offer these patients Targeted Muscle Reinnervation, which enhances prosthetic use, physical rehabilitation, and quality of life. Dr. Melamed also has the skills and knowledge to treat children with brachial plexus injuries.

Dr. Melamed brings new and innovative treatments for the following conditions:

- Peripheral nerve disorders including painful neuroma
- Traumatic and non-traumatic elbow pathology
- Spasticity surgery
- Wrist reconstruction

Please extend your congratulations and support to Dr. Eitan Melamed. We are confident that under his direction, our Hand Surgery capabilities will thrive, grow, and continue to provide high quality services to our patients and their families.

Dr. Eitan Melamed is part of
THE ELMHURST DIFFERENCE

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Live Your Healthiest Life NYC HEALTH+ HOSPITALS

Coronary CT Angiography and Fractional Flow Reserve Calculation: Safe, Effective and Efficient Tools for Evaluating Coronary Heart Disease

Kory A. Byrns, MD; June Koshy, MD; Ke Lin, MD

Coronary heart disease (CHD) represents the leading cause of mortality in the United States. Approximately 735,000 Americans have a heart attack every year and approximately one out of every five deaths is attributed to heart disease. Prevention and early diagnosis are important for improvement of outcomes and have led to a fifty-percent decline in coronary heart disease related deaths over the past 30 years. Nevertheless, it is estimated that fewer than two-thirds of those at risk have been identified and started on appropriate therapy. (Viera, et al)

Coronary CT angiography (CCTA) is a rapid technique for evaluating the coronary vessels and offers the highest sensitivity and specificity of any non-invasive approach. It can accurately assess the location, type, and extent of plaque within the coronary arteries. *(Figure 1)* In addition, CCTA can assess plaque composition (calcified, non-calcified, or mixed) and, unlike invasive angiography, whether there is positive or negative remodeling. All of these factors are pertinent for assessing the risk of a future cardiac event and how the patient should be optimally managed. Furthermore, with a negative predictive value of nearly 100%, it is extremely effective at ruling out obstructive CHD. The categories of patients who benefit most from undergoing CCTA are listed in Table 1.

Table 1: Indications for CCTA

- Symptomatic patients with low or intermediate risk for coronary heart disease
- Patients with new or worsening symptoms with a previous normal stress test
- Patients with atypical chest pain or an inconclusive stress test
- Evaluation prior to non-coronary cardiac surgery in intermediate risk patients
- Evaluation of patients with suspected coronary anomalies
- Determining patency of bypass grafts and certain coronary stents (greater than 3mm in diameter)

CCTA is excellent for assessing coronary anatomy, which is especially helpful in younger patients with unexplained chest pain. Anomalous origin of the coronary arteries, myocardial bridging, and coronary artery fistulas are among the congenital and acquired pathologies that are effectively identified by this non-invasive technique. Various non-coronary structures and associated pathologies can also be evaluated, including pulmonary vein anomalies, atrial enlargement, left atrial appendage thrombi, and valvular calcification.

When preparing to undergo coronary CTA, patients are requested to refrain from eating or drinking up to 4 hours prior to the examination. Nitroglycerine is routinely administered just prior to the examination, so medications for erectile dysfunction such as Viagra, Levitra, or Cialis should not be taken during the prior 72 hours. All other prescribed medications, however, should be taken as directed. On the day of the examination, the patient is typically asked to arrive 30 minutes prior to the test. The staff will achieve intravenous access and review the patient's blood pressure and heart rate and rhythm. Electrodes are placed on the patient's chest for the procedure, which allow the CT machine to optimally synchronize image acquisition with the heart's motion.

- continued on page 7

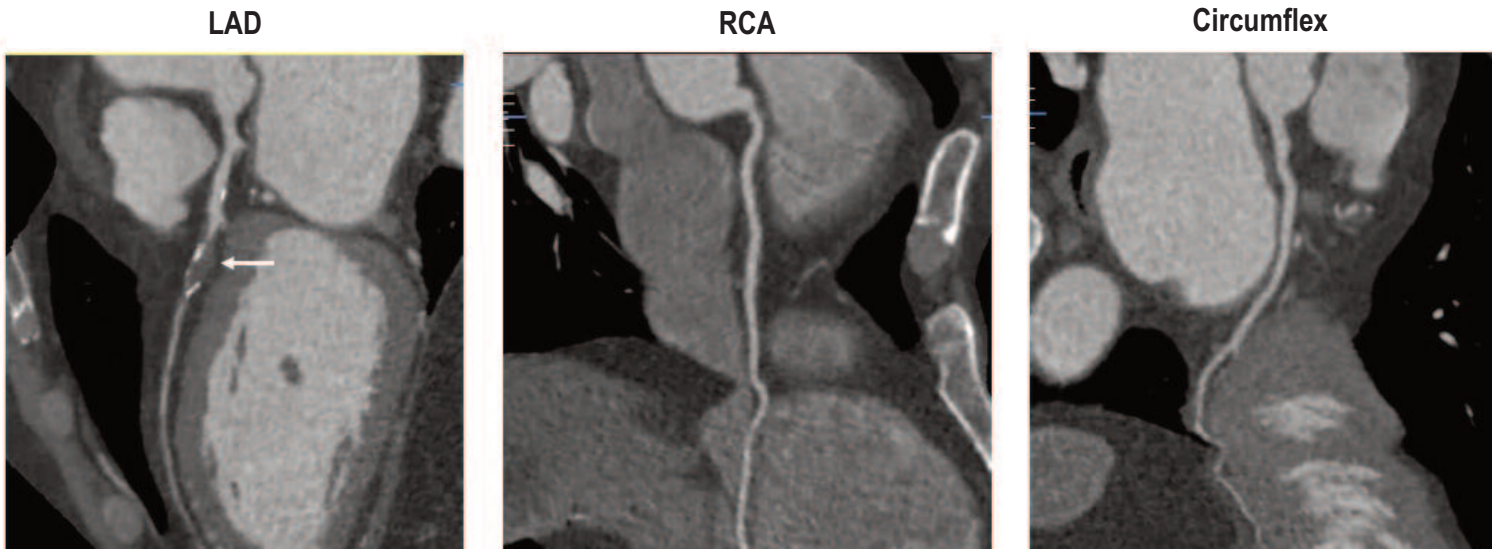

Figure 1: *CCTA of a patient with severe stenosis within the mid LAD from calcified and non calcified plaque. The RCA and left circumflex arteries are normal.*

Coronary CT Angiography and Fractional Flow Reserve Calculation: Safe, Effective and Efficient Tools for Evaluating Coronary Heart Disease *continued from page 6*

Once all preparation is complete, the scan itself is completed in seconds to minutes and quality assurance is performed by a physician in real time.

As with any contrast enhanced CT examination, there are contraindications and potential adverse events to be aware of. Patients with severe renal insufficiency (defined as estimated glomerular filtration rate less than 30 mL/min/1.73m^2 at our practice) or a history of severe allergic reaction to iodinated contrast should not undergo this examination. In the past, elevated or irregular heart rate would typically preclude CCTA. However, with the rapid and advanced imaging protocols offered by the 192-slice Siemens SOMATOM Force dual source scanner, we have had great success obtaining diagnostic studies even with these more challenging patients. In select cases, we may administer intravenous beta-blocker medications if necessary.

Concern over the long-term risks of ionizing radiation exposure has increasingly been on the minds of both patients and their physicians. Reassuringly, modern CT technology has significantly decreased the effective radiation dose through various methods, including prospective gating, tube modulation, and advanced post-processing. Currently, a typical coronary CT angiogram will expose the patient to a lower radiation dose than a routine chest CT, diagnostic invasive coronary angiogram, or nuclear stress test.

In recent years, CCTA has become even more powerful with the advent of CT fractional flow reserve calculation (FFR-CT). In conjunction with HeartFlow, Inc., we can now not only identify and characterize CHD, but also determine the functional significance of a lesion and whether the patient may benefit from percutaneous coronary intervention (PCI). A three-dimensional anatomic model of the patient's unique coronary arteries is constructed and computational fluid dynamics are used to perform the same calculations achieved invasively with cardiac catheterization. With FFR-CT, it has been shown that one third of mild stenoses (between 30-50% luminal narrowing) are actually functionally significant and may require PCI (defined as a FFR < 0.8). *(Figure 2)*

CCTA and CT-FFR are safe, efficient, and powerful tools for excluding or characterizing CHD with the patient's comfort in mind, potentially sparing him or her from more invasive testing. Our practice is excited to offer this service to the patients and providers of our community and we welcome you to reach out with any questions.

Reference

Anthony J Viera, Stacey L Sheridan. Global risk of coronary heart disease: assessment and application. Am Fam Physician. 2010 Aug 1;82(3):265-74. ■

About the Authors

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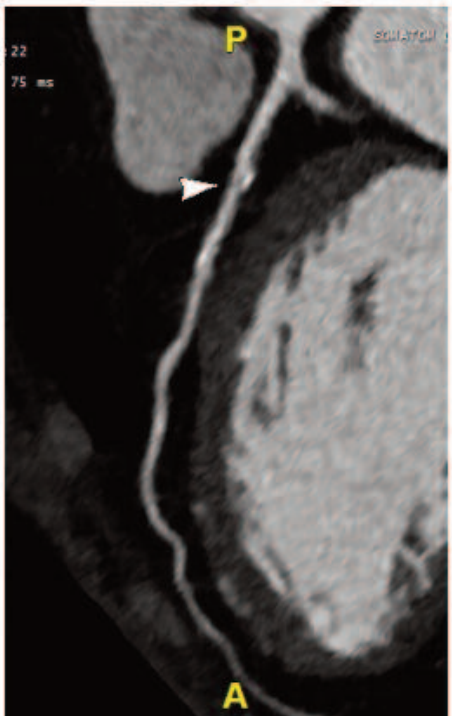
June Koshy, MD, *Radiologist, NewYork-Presbyterian Queens;*
Ke Lin, MD, *Radiologist, NewYork-Presbyterian Queens*



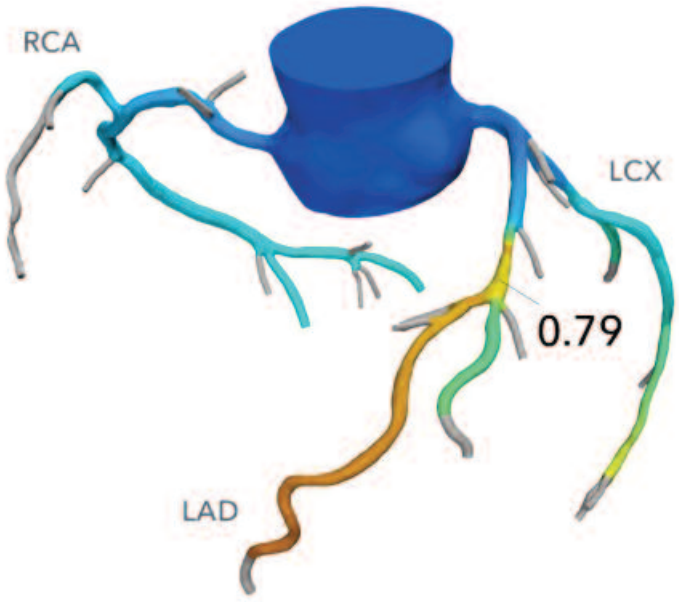


Figure 2: *CCTA of a 58-year old female patient demonstrates mild stenosis of the LAD (left, arrowhead). However, FFR-CT (above) showed this to be a functionally significant obstruction (FFR < 0.8). The patient subsequently underwent PCI.*

Queens Medical Society and NSPC Brain & Spine Surgery Center Launch Online CME Platform

May 13, 2021
Rockville Centre, NY

Leaders of the Academy of Medicine of Queens County and NSPC Brain & Spine Surgery, Rockville Centre, NY, have announced the start of a new online, Continuing Medical Education (CME) Platform entitled, "NSPC CME NOW."

This "Free" service will enable Queens Medical Society members, and community physicians, to earn AMA PRA Category 1 credits by enrolling and completing Patient-Based Case Studies and Webinars online on desktop or mobile devices in a variety of subject areas, including Neurovascular, Spine, Brain Tumors, and other Neurosurgical Conditions.

According to John Pile-Spellman, MD, a Partner and Attending Interventional Neuroradiologist at NSPC, "Since it has been so hard to meet other physicians for dinner or conferences to discuss interesting cases, my colleagues and I were eager to develop a safe, convenient way for us to share our clinical insights with other doctors in the community and provide them with the added benefit of being able to earn CME while doing it. Our partners at the Queens Medical Society recognized the need, too, and helped us create a new digital platform for learning and collaborating."

Evangeline Rosado-Tripp, Executive Director, Academy of Medicine of Queens County, says, "Our organization will partner to accredit the courses created by the comprehensive faculty of neurological and neuroscience specialists at NSPC Brain & Spine Surgery, one of the largest, private neurosurgical practices in the U.S."

NSPC, QMS Launch Online CME Platform

Co-Course Director Sundeep Mangla, MD, an Attending Interventional Neuroradiologist at NSPC notes, "We are excited to partner with the Academy of Medicine of Queens County to provide our NYC, Queens, and Long Island communities of healthcare professionals an easily accessible opportunity to remain abreast of the latest advances in subspecialty neurosurgical care with the launch of our on-demand digital CME platform."

To date, four neurovascular case studies have been credentialed for CME by the Academy of Medicine of Queens County. They are:

- **Dural Arteriovenous Malformation** (AVM)
- **Symptomatic Near-Occlusion of the Carotid Artery**
- **Ruptured Basilar Aneurysm**
- **Acute Ischemic Stroke in a Nonagenerian**

Online registration for these courses started in June 2021. For more information about the new "NSPC CME NOW" Continuing Medical Education Platform, please call:
NSPC Brain & Spine Surgery
(516) 442-2250, Ext. 2039 ■

To access Platform:
https://casestudies.nspc.com/case-studies/cme.html

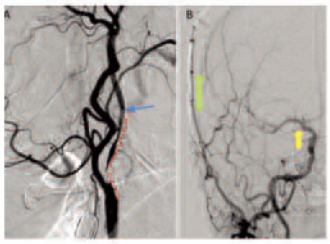
NSPC CME NOW

FREE

A New, No Cost, Online Continuing Medical Education (CME) Platform
Earn AMA PRA Category 1 Credits For Completing Patient-Based Case Studies & Webinars

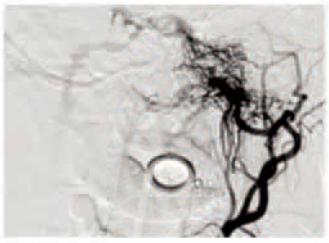
About The Program

Leaders of the Academy of Medicine of Queens County and NSPC Brain & Spine Surgery, Rockville Centre, NY, have partnered to create a new online, Continuing Medical Education (CME) Platform entitled, "NSPC CME Now."



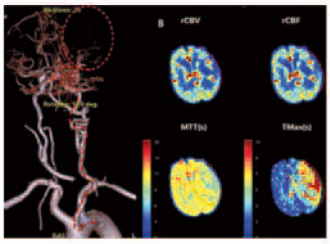
Symptomatic Near Occlusion of the Carotid Artery CME Case Study

Severe Carotid Stenosis has multiple pathophysiologic mechanisms that may result in mild to severe symptomatic presentations. The choice of revascularization techniques has evolved over the last decade and affords a multi-disciplinary experienced team to choose the best strategy for each individual patient's presentation, anatomic and physiologic features, and risk factors. This course is worth 1 CME credit.



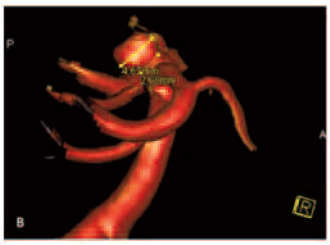
Dural Arteriovenous Malformation CME Case Study

Dural AVMs are direct (e.g. carotid-cavernous sinus fistula) or indirect (via meningeal branches of the carotid or vertebral arteries) connections between neck/meningeal arteries and intracranial sinus veins. The history may reveal a preceding trauma or surgery. Otherwise, dAVMs may occur spontaneously or may be associated with thrombosis and hypercoagulable state. This course is worth 1 CME credit.



Acute Ischemic Stroke in a Nonagenerian CME Case Study

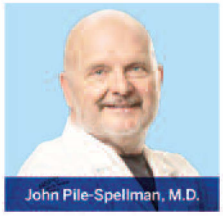
Although mechanical thrombectomy has become the standard of practice for Large Vessel Occlusions in Acute Stroke, many challenges remain. Among them, selecting patients that are most likely to benefit and expanding care to these populations. This course is worth 1 CME credit.



Ruptured Basilar Aneurysm CME Case Study

Clinical presentations for rupture of a brain aneurysm are often diverse and may be difficult to determine. The natural history of untreated ruptured aneurysms remains poor with studies suggesting re-bleed rates from 1-4% daily, and mortality rates approaching 50-60% at 1 year. Early multi-disciplinary management is essential. This course is worth 0.5 CME credits.

Course Directors


John Pile-Spellman, M.D.


Sundeep Mangla, M.D.


Jae Choi, M.D.

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Monday, April 5, 2021

The Honorable Andrew Cuomo
Governor of the State of New York

Dr. Howard A. Zucker, MD, JD
Commissioner of Health of New York State

Dear Sirs:

The Medical Society of the County of Queens wishes to express its concern regarding the proposal of closure of St. John's Episcopal Hospital. The policy of closing hospitals over the past decades in order to eliminate or reduce the state budget gap has been no less than disastrous. Queens County alone has lost at least 10 hospitals, leaving the county with the lowest ratio of hospital beds per population. Indeed, Queens County has less than 1.5 hospital beds per 1000 population, while Manhattan has six per 1000 population. This lack of bed capacity was acutely felt during the initial surge of the COVID pandemic in New York City when people died not only because of the virulence of the infection but because the already depleted hospital resources were simply overwhelmed and could not provide adequate care to so many patients. It is with a certain trepidation that we would like to remind you that this worldwide pandemic is far from being brought under control and that we are still living with the fear in New York city that another spike of COVID infections may be looming in the not-too-distant future.

In addition, St. John's Episcopal Hospital is the only acute care facility for the entire Rockaway peninsula population, amounting to nearly 120,000. This population with an average income significantly lower than that of the rest of the county can ill afford extra transportation cost to cross over to other boroughs for their medical care and could lose timely access to care in case of emergency. A micro-hospital of 15 beds may feature well in the accounting books but could not possibly meet the needs of that community.

Finally, the Medical Society of the County of Queens would like to express its opinion that the policy of shuttering hospitals to balance the state budget has not been an effective solution or anything close to what it was expected to accomplish. Health Insurance companies have seen their profits continue to soar, while the process of hospital mergers has largely contributed to the steady rise in health care costs to individuals. This solution proposed in 2007 may have seemed promising, but in reality, it has not delivered the expected outcome. The Medical Society of the County of Queens wishes to amplify the cries of despair of the poor, the underrepresented, and the voiceless of our county and speak strongly against the closure of St. John's Episcopal Hospital. We urge you, Governor and the New York State Health Commissioner, to pursue other more humane options to rein in the cost of health care in the state, perhaps by capping the profits of the Insurance companies, the pharmaceutical industry, and the medical device manufacturers. The poor communities may seem to be the low-hanging fruits, but should they be…

Sincerely,

Louis J Auguste, MD, MPH, FACS, FSSO
Chair Board of Trustees of the MSCQ

David Vilabrera, MD
President/MSCQ

The Impact of the Affordable Care Act on Disparity in the Care of the American Women with Breast Cancer

Louis-Joseph Auguste, MD, MPH, FACS, FSSO

We hold these truths to be self-evident, that all men are created equal, that they are endowed by their Creator with certain unalienable Rights, that among these are Life, Liberty and the pursuit of Happiness.
Declaration of Independence of the United States of America • July 4, 1776

A review of early American history reveals that this principle did not apply to all human beings living on this land. This statement holds particularly true when one looks at the delivery of health care. Starting with a system that simply eliminated by drowning the Africans that had been stolen from their homeland and that were deemed too weak or too sickly to survive the "passage" to the "New World." This differential approach to health care extended to the plantations. The first European physicians are reported to have started tending to the colonists as early as the very creation of the Jamestown colony in 1607. The first contingent of Africans arrived in the American Colonies in 1619, as indentured servants. The first hospital was erected in 1751. At the same time, the Negroes toiling inhumanely on the plantations had to care for their own. They used traditional remedies imported with them from Africa as well as other herbal medicines learned from the Native inhabitants, but had no access to hospitals.

The Civil War of 1861 - 1863 officially ended slavery on the land, but this was soon followed by the institution of Jim Crow laws, which essentially created with the backing of state governments, two completely different standards of living for the Caucasians and the Negroes, as well as a two-tier system in health care delivery. For example, the state of Alabama passed a law that prohibited any person or corporation from requiring a white female nurse to work in hospital wards or rooms, either public or private, in which "negro men" were being kept. In Georgia, the Board of Control of Mental Hospitals was instructed to see "that proper and distinct apartments be provided for mental patients," so that "in no case shall negroes and white persons be together."

In 1948, the United States of America along with 131 other nations of the world signed the chart of the World Health Organization. It is stated in the Preamble of its Constitution that: "The enjoyment of Health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition. Yet, this American Apartheid system did not end officially until the Civil Rights Act of 1964, forced upon the country by the civil rights movement of the 1960s.

At that time, all the vital statistics pointed to a shorter life expectancy and an overall worse health status for the African American population. These dismal numbers were reported in medical textbooks as a given, an expected result of the inherent constitutional inferiority of the Negro. Indeed, in 1975 -1977, the five-year survival for a black woman with breast cancer was 62%, while it was up to 76% for her Caucasian counterpart.

Over the past few decades, great strides have been made forward in the understanding and the treatment of breast cancer, the most common cancer found in American women and the second most lethal cancer among women. The incidence of breast cancer has been decreasing steadily, as well as the mortality from that disease. Between 2007 and 2011, the death rate for breast cancer has decreased by 3.2% and 1.8% per year for white women and by 2.4% and 1.1% per year for black women, respectively of less than 50 years of age and more than 50 years of age. By 2010, the disparity was still persistent with an over-all five-year survival of 92% for the Caucasian woman and 80% for the black woman.

During the past 20 years, the tone of the debate has changed. A spotlight was directed at the health care disparity observed across the board, in the management of both malignant and benign diseases. As this topic of health care disparity was being dissected both in governmental and academic circles, several contributing factors were identified and efforts have been made to compensate for them or reverse their effects, when and if possible.

First, over the past decade, it has become clear that not all breast cancers are the same. Based on their expression of different hormone receptors and amplification of certain oncogenes, they have been classified into four groups: Luminal A and Luminal B, which have a better prognosis, while the other two, HER2neu (+) and Triple Negative portend a worse prognosis. For a yet unexplained reason, the last group has been found to be more prevalent in the African American population. ■

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All of Us:
An Unprecedented Research Effort

Allen Small, MD, FACP,
MSCQ Past President, 2018-2019

Queens, NY, is a community of many communities. The traditions, diversity, and health conditions can benefit from active participation in the National Institutes of Health (NIH) programs. I am introducing the NIH ***All of US*** **Research Program** to our Medical Society of the County of Queens Inc., (MSCQ) Members and ask that we consider outreach to enhance enrollment and active participation.

"It's one of the largest longitudinal studies ever undertaken. It is ambitious, it is multifaceted, and it is incorporating people from across the nation. It's amazing seeing the number of people from everywhere across the country coming together with ideas representing their communities, representing the people in their neighborhoods, and having a voice, and then reflecting that into the program."

- Shenela Lakhani, M.Sc., CGC, CCGC
Director of Genetic Counseling and Clinical Engagement, Center for Neurogenetics at Weill Cornell Medicine

credit: NIH

The *All of Us* Research Program is a 10-year research program designed and funded by the NIH to study the health, activities, habit, activities, environment, and genome, with a goal of understanding the factors that may be modifiable to provide a pathway to better health outcomes. The goal is to enroll more than one million participants to be followed over ten years. The enrollment is to equitably represent our diverse communities both locally & nationally. Participation will require the completion of Multiple Questionnaires and may utilize Wearable Sensors to monitor physiologic variables such as heart rate, blood pressure, and sleep. Blood tests may include a complete sequencing of a participant's genome, with an option for connecting the results to their Electronic Medical Record. Records will be maintained in a Databank and a Biobank in a de-identified manner, under state-of-the-art security. Hosted by the Mayo Clinic, the Biobank will be fully automated, robotic, secured, searchable, barcode connected with a capacity for 32 million specimens. It is envisioned that the research program can help spot patterns on what makes us sick or keep us healthy, how we respond to stress or anxiety, or environmental factors such as pesticides or toxic metals.

Trust and Transparency are paramount in the special consent process. There will be diversity amongst the research team as well as the enrolled participants. Designed into the program are features for open two-way communication to participants. The participants will have the opportunity to learn information about themselves, including how to keep healthy and how to manage their health. This will be facilitated through direct outreach to Community Health Centers, Federally Qualified Health Centers (FQHC), and Rural Health. Focusing on having the right connections and channels in the communities. Harvesting the experience and resources among the Community Based Organizations (CBO) and promotors who live among the participants and who are familiar with the resources and challenges.

The enrollment process may include tele-visits over high-speed internet, email, or even mobile phone. There are extensive safeguards for those community members who have concerns about the privacy of their History of Present Illness (HPI), as well as regarding employment or other concerns. The participants have toll-free access directly to the program's staff via 844-842-2855, as well as their website: www.joinallofus.org. Furthermore, multiple ethnic Medical Societies have endorsed this research program, including National Medical Association, National Hispanic Medical Association, and the AARP & AMA. One regional Hospital Network System has already connected the *All of Us* action lever or button into their My Chart Patient Portal system. There has also been outreach to Veterans for participation, which may be another resource for our MSSNY Veterans Affairs Liaison/ Campaign. The efforts and investments in the *All of Us* Program will provide for the development of actionable advances for our families & communities. This will not just be a repository of AI algorithms or cookbook medicine protocols. The legislators that serve our communities may appreciate our MSCQ informing them, as their trusted Doctors, about the resources and potential of the *All of Us* Program. It is a concerted extended investment to identify pathways, foster prevention, driving better health, and improved overall outcomes. For more information about the *All of Us* Research Program, visit: https://allofus.nih.gov/ ■

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