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PRESIDENT'S PAGE

STOP THE TRAIN, I WANT TO GET OFF

By F. Thomas Siskron, IV, M.D.

I have been traveling a lot more than I ever have in my life over the last few years since my boys have flown the coop. I am almost to Platinum status with my airline of choice...for what that's worth. Some trips have been for fun, but most of them have been short weekend work trips. I have been doing Locums work for a while now, first as a means of getting my foot in the door of my eventual retirement plan. In all honesty, I initially started my work travels as a way to mentally and physically escape, even if just for a weekend, from a rough period of my life ten years ago; but, along the way, I realized that if I could get established to work in a few places, I could one day "retire" from my own practice, yet keep working by scheduling several work trips per year as needed or desired. I would be able to maintain a source of retirement income, continue to enjoy the practice of my profession, yet fully enjoy the well-deserved and hard-earned weeks of relaxation, hobbies, and other "fun" stuff in between trips—all on my own schedule! I have since come to really love the work trips for other reasons. They have broadened my horizons by exposing me to different cities and regional cultures, valuable techniques of practice, and, interestingly enough coming from an introvert, some gratifying personal and professional relationships I would have otherwise never had.

Speaking of relationships, it was on a recent Friday before leaving for one such trip that I came home after a quick morning of clinic to grab lunch and my travel bag before heading to the airport, when I was surprised by my son, Thomas, with a lovingly prepared and delicious lunch consisting of spinach and cream cheese-stuffed chicken breast, wrapped in bacon, and covered with cheese. Not only did he nail the meal as far as my nutrition philosophy is concerned, but he nailed it with a personal touch by surprising me with lunch. He loves to cook, which is something I have never enjoyed or even acquired a tolerance for doing. He may have inherited that trait from his mother, who has always loved to cook, or maybe by my mother, who is a wizard in the kitchen, though that gene obviously skipped a generation and is not an autosomal dominant trait. Maybe it was because for several years in their tweens and early teens, both my boys and I cooked our meals from scratch every night using one of the meal-delivery services that are now so common. As I already stated, I don't enjoy cooking, but I did that to spend quality time with them and also because I felt it was important to teach them how to "fend for themselves," so to speak, in the kitchen, just as I taught them to do their own laundry, clean their own toilets, change their own oil in their cars, and mow the grass.

I had no idea he was even going to be there that afternoon, much less, that he was preparing me a lunch before my travels, and it was such a pleasant surprise. We chatted for a while as I ate, and I will probably remember that little moment in our relationship forever. That meal stands in stark contrast to another meal I had recently, which was acquired and consumed without any human interaction whatsoever. I used an app on my phone to order and pay, drove to the restaurant by myself, and walked in and grabbed the bag with my name on it without saying a word to anyone, or even making eye contact with a single soul. I brought it back to my home and ate it alone, too. This form of consumerism has been becoming ever more common in recent years. We humans are increasingly making conscious or unconscious choices to minimize or entirely bypass interaction with other humans as we go about our daily lives. This behavior has exploded during the Covid-19 hysteria, and what little human interaction we have had over the last six months has been devoid of the facial expressions that make up so much of our communication without words. What's worse is that we are being told by our all-knowing leaders to accept this as the "new norm." What kind of traits are we selecting and developing in the future members of our society?

All you have to do is Google "nonverbal communication" to see how important it is to our interpersonal relationships and mental health. It is said that more is often communicated non-verbally than by what is spoken verbally. It is vital for establishing meaningful relationships in everyday life and helps us develop stronger relationships with others. Facial expressions, gestures, posture, and tone of voice are powerful communication tools. Success in personal and professional relationships lies in our ability to communicate, and the nonverbal cues and body language often speak the loudest. At every turn, we see these vital aspects of human interaction being abandoned, and then we wonder why the world is becoming so polarized and the people within it so uncaring and detached. It makes perfect sense to me.

We can order almost any household good on Amazon and can even have our groceries packaged and ready for pickup with minimal interaction. Many now accept that it is normal social interaction to engage with others by scrolling through countless pictures on Instagram, double tapping a few to show we care. Online dating has now surpassed natural interaction as the most common means of finding a date. We no longer have to interact with the IT department staff, who can now just take remote control of our computers to fix any problem. Wait, maybe not interacting with them is not such a bad thing after all. But seriously, think of all the ways we are now detached compared to the way things have been done in the past.

Since we don't have to enter the gas station to buy our gas at the pump with a credit card, there is no need for human interaction, and finding a service station with a human who will actually come out and "service" the vehicle is about as rare as hen's teeth. Boardrooms around the country and world are becoming obsolete as Zoom, and other virtual platforms, have relegated face-to-face meetings to the

dustbin of history. We are being encouraged to vote by mail in unprecedented numbers this year, rather than take the time and effort to go to the polling booth as we Americans have done for over two hundred years. Need to exercise? Don't bother going to a gym, just by a "connected" bike or a mirror to hang on your wall, and it is just as good, right?

In medicine, we are being told that telemedicine is the way of the future and many are even encouraging patients to avoid the hassle of the face-to-face visit by building online platforms for completely virtual clinics. The development of the EMR, coupled with advances in diagnostics, has all but rendered the physical exam the least important part of the evaluation and management, and it is painfully obvious that some providers obviously spend very little time on the physical examination of the patients based on some of my experiences. If I sit here long enough and keep typing, I know I can come up with countless other examples of how human interaction is being stripped from our world at a frightening pace. Soon, we are all going to be like the morbidly obese cartoon characters in the Pixar movie, "WALL-E," who were content to exist in a nearly 100% virtual world as they zoomed around in their scooters eating junk food and watching personal video displays that blocked out the real world. Is this really where we are heading?

As I said, not all my recent travel has been for work. I consider myself blessed beyond measure to have the financial means and the time to travel on a whim, and I did just that last weekend to visit my other son, Campbell. He is at Arizona State, where he is a Sophomore studying Architecture. It was an exceedingly brief trip, as I arrived on Friday evening and returned home Sunday afternoon, but what an amazing Saturday we had! I will, like my moment with Thomas, remember that time with my younger boy forever. We climbed a popular mountain trail in the morning, I got a tour of his apartment, I had the opportunity to meet his three roommates, and I got to watch as he proudly showed off his skill at "racing" on the admittedly amazingly realistic PlayStation game, Gran Turismo. They even have a steering wheel and foot pedals connected to make it even more realistic. We went to our favorite restaurant and enjoyed a 10-ounce rare portion of deliciousness served on a 500-degree plate of sizzling butter. It was a full day, both in how it was scheduled, and in how it left my heart. One thing I enjoyed personally, given my love of speed, was a brief trip to an indoor go-cart racing track. Perhaps it is fitting to close with the fact that, despite my serious lack of skill keeping the car on the track in the Gran Turismo video game compared to my son or any of his roommates, I destroyed them in the real-world skill of racing around the track. I hope similar discrepancies in virtual abilities compared to real-world abilities don't become the affliction of the generation we are rearing in masks and virtual classrooms, to be the leaders of a society that is forgetting the value of, and losing the ability to foster real-world interpersonal relationships. I don't like where this virtual train is heading with what seems to be unstoppable momentum. Personally, I want to get off.



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EDITOR'S PAGE

MERCY AND THE WILLINGNESS TO ACCEPT ANOTHER'S CHAOS

By Richard J. Michael, M.D.

"I have always found that mercy bears richer fruits than strict justice."

– Abraham Lincoln

This quarterly expression of my simple and challenged mind has evolved into a type of therapy for me. I have come to realize that this process is helping me to navigate my life and limitations. I suspect, however, that many reading this column face similar challenges to me, and thus, I do hope my thoughts and words bring you some degree of introspection or insight or even inspiration.

I see clear evidence that COVID-19 has further taxed a very fragile health care system in America. I see some very exasperated and injured nurses, nursing assistants, physicians, and physician extenders, among others. I see and hear of staffing shortages in our local hospitals, because many health care workers have decided to leave the stress of hospitals in favor of a simpler career in a more controllable outpatient setting. Money and salary matter less than it used to for many of these health care workers. They realize that change is necessary for their happiness or even survival after years of abusing their bodies, minds, and souls with long hours and intense stressors that are routine in the hospital setting. Doctors are affected too and are re-evaluating what their careers should now look like. And outpatient settings in medicine are not a panacea, though they may be temporarily career and life sustaining.

These thoughts have been foremost in my mind of late. They have caused me to reflect on a 2014 commentary in JAMA that a mentor of mine from my residency at Vanderbilt Medical Center sent to me. **The Quality of Mercy...Will You Be My Doctor?** by Timothy Daaleman, DO, MPH is one of the most impactful things I have read since I completed my residency.

Dr. Daaleman first recounts a new patient who came to see him in his primary care clinic. She went through her complicated history with him, and at the end of the encounter, she cautiously asked him, "Will you be my doctor?" Many of us in primary care and more specialized disciplines of medicine realize that we have evolved to put systems in place to "screen" patients before they come to our clinic or to treat their initial encounter as an audition of sorts. This has been borne from challenges that arise from our patients due to their own social and economic hurdles OR from the crippling requirements of prior authorizations and medical forms for supplies or clinical needs OR from the fear of taking on that patient who needs a controlled substance to manage their health condition and improve their quality of life (with the

associated baggage of having to worry about the scrutiny of providing dangerous substances that have great benefits as well as great risks for patients).

We have all seen that certain patient on our schedule and let out a muttered groan because we know they will be labor intensive at that visit. But Dr. Daaleman advocates for reminding one's self that, when you get that feeling of dread, it is the perfect time to recall that mercy is the willingness of someone to enter into the chaos of another person's life. We, as physicians, have the unique opportunity to do this daily in the most intimate and significant way for those seeking our expertise. And isn't that exactly why we went into medicine??

I know I fail to show mercy on a near daily basis. I accept that and know that I have plenty of room for improvement. I have found that if I stop and take a deep breath (and maybe even meditate for 30-60 seconds) during a busy day when something or someone is thrown at me at a most inconvenient time, and I reflect on what mercy means and how I could bring stability to a chaotic situation, I will often make a more humane decision and say "yes".

Wouldn't it be wonderful if we all tried to show just a little more mercy in our individual medical practices? See that extra patient who needs our expert medical care? Or go and do that consult on the floor or in the ER without a second thought of how we could avoid that particular task? It would benefit the patient and our fellow colleagues in health care. It would boost our morale and our colleagues' morale, I believe. It would improve the culture of medicine. It would potentially be the antidote to the exasperation and moral injury suffered by those in health care. There is a local ophthalmologist who always says, "I can see the patient any time you want me to do so. Just send them to my office." For 15 years, he has always acted this way. It inspires me. Maybe it also shames me into being more like him. If we all had his attitude, we would all be happier, and the culture of medicine would be awesome!!

Dr. Daaleman closed his commentary with the following: *"I do not know where mercy fits into future value streams, but I do know that mercy remains a prerequisite for caring, an individual and organizational capacity that needs to be awakened, deepened, and sustained. In current or emerging care settings, it is still during clinical moments—when patients seek help from physicians—that the actions of the individual physician and the larger health care system converge. These clinical moments lay bare the normative and moral work of physicians, endeavors that have historically provided the foundation for sustained therapeutic activity between patients and physicians. They also reveal a larger truth that **if the arc of medicine is to ultimately bend toward healing, mercy will be its fulcrum.**"*

My challenge to you (and to myself) is to reflect on mercy and to strive to show mercy on a more frequent basis. You will fail. We all will. But you will be a better person because of it.



ECONOMICALLY SPEAKING

CALIFORNIA'S COMING NEW CAR BLUES

By Alan B. Grosbach, M.D.

Politicians are notorious for trying to suspend the laws of economics. The latest example is California Governor Gavin Newsom's ban on the sale of new gasoline-powered cars in his state beginning in 2035. This breathing-taking edict would be truly laughable if it were not so outrageous.

To start, let's look at the numbers. In 2019, California recorded 1.89 million new light vehicle registrations, but that represented a decline compared with 2018, a decline that has been ongoing for several years. Meanwhile used car sales have remained steady. Fewer new cars being sold means that people are hanging on to their old cars or buying used cars, exactly what the green-minded Governor doesn't want. His goal is to increase the number of electric cars on the road.

More threatening to the success of Newsom's plan, electric car sales this year are down 17.1% compared with 2019 to just 61,325 units out of a total of 786,219 new cars and light trucks sold. Even taking into account the effects on sales of the COVID 19, epidemic, it's difficult to imagine electric car sales climbing 30-fold over the next fifteen years to numbers approaching the 1.89 million mark. But, even that obstacle may not be Newsom's biggest problem.

In an article entitled, "Ramifications Of California Governor Newsom's Ban On Gas-Powered Vehicles," published on the Heartland Institute's website October 5, Ronald Stein outlines what he calls, "a green new car wreck."

Newsom is swimming upstream against his state's demographics. He is apparently oblivious to the reality that 18 million of his state's citizens have incomes less than half that of today's electric car owners. So, even if a plentiful supply of electric vehicles materializes, it's doubtful that there will be enough potential buyers able to pay for them.

Stein also explains that continued re-registering of older cars that account for more emissions than state-of-the-art gas-powered cars will not only undermine Newsom's plan but could propel California in front of Cuba as the world's vintage car capital.

Newsom wants a dramatic increase in electric car charging stations at the very time when California's power grid is struggling to meet current demands, producing rolling blackouts when electricity demand is high. California has precipitated this debacle by shutting down one nuclear and three natural gas power plants in recent years. Plans currently call for closure of another nuclear plant and four additional natural gas facilities. To replace the capacity lost to those nine closures, California is relying on nothing more than the hope that the states that are already supplying roughly one-third of its electricity will increase their exports even more. California residents already pay the fifth highest electricity rate in the nation. Greater dependence on imported power can only make that rate rise.

Perhaps the biggest roadblock to Newsom's plan is California's massive highway infrastructure, nearly 400,000 miles of roads that are maintained in large part by \$7 billion in fuel taxes. Fewer gas-powered cars will mean reduced revenue for highway construction and upkeep.

Stein attributes Newsom's preposterous plan to poor planning and limited insight into the edict's ramifications. I think it's more basic. He simply has a greater commitment to promoting his green agenda than he has to understanding real world economics.

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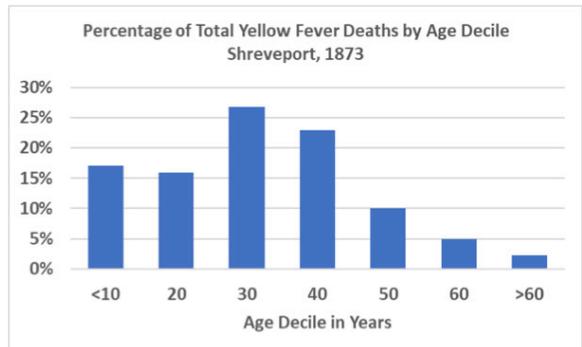
THE YELLOW FEVER EPIDEMIC IN SHREVEPORT IN 1873 – POSTLUDE

By Frederick J. White III, M.D.
Historian of the Society

When the physicians of Shreveport declared on October 30, 1873, that it was safe to resume contact with the outside world, Shreveport was a prostrate city. For two months the city had been isolated, and two of every three citizens had been struck by the terrible disease. Almost 800 people were dead, many of them buried in a mass grave in the southwestern quadrant of the city cemetery.¹ The city cemetery was reported to look “like a battlefield” with its many new and partially dug graves.² Over a hundred newly orphaned children were being cared for by the State.³ The Assistant Fire Chief reported that 39 of the 275 members of the Shreveport Fire Department were dead.⁴ Dr. Henry Smith of the Louisiana Equitable Life Insurance Company reported that in the demographics of a sample of 584 deaths the principal mortality was in younger people.⁵ However, this likely reflects the youthful age of the population, as the 1870 census found that about 60% of the Shreveport population was below age 45 years.⁶

Although fear lingered, on November 21 the Shreveport Medical Society adopted a resolution stating to the public that “in the opinion of this society, it is now perfectly safe for absentees to return, there being no yellow fever in the city.”⁷ By that time talk of

what caused the disaster began to grow. Some asserted that the skinned carcasses of the drowned cattle from the capsized steamer *Ruby* were the definitive cause, having been left to rot on the riverbank.⁸ Others asserted that the disease had been brought to the city as the “Mexican vomito” by the members of the Great Trans-Atlantic Circus, which was (incorrectly) thought to have been in Vera Cruz before travelling to Shreveport via the Texas Pacific Railway.⁹ Still others held that the exposure of the bed of the Red River by clearing of the great raft north of the city had allowed a miasma to arise.¹⁰ In a sermon from the pulpit of St. Mark’s Episcopal Church on November 16, Dr. W. T. D. Dalzell implicated the “criminal negligence of all sanitary regulations” in the city as causative to the epidemic.¹¹ However, the American Health Association, noting the effectiveness of carbolic acid as a disinfectant in the Shreveport experience, held that the fever was caused by a germ which, although capable of spontaneous generation, was in most cases nested in water and was transported from place to place by people and goods, often carried by ship.¹²



Dr. Joseph Jones, Professor of Clinical Medicine at Charity Hospital New Orleans, examined the possible causes of the epidemic in detail in the *Boston Medical And Surgical Journal*, and concluded that the fever “was carried from New Orleans, by one or more of the Red River line of steamboats, through goods and persons.”¹³ In late 1873, the Shreveport Medical Society formed a committee to examine the cause and impact of the outbreak. *The Report of the Committee on the Yellow Fever Epidemic of 1873 at Shreveport, Louisiana* concluded in 1874 that the disease originated in steamboat traffic from New Orleans.¹⁴ The report, which the *American Journal of the Medical Sciences* concluded was “conducted with great care and without bias” and reached “conclusions marked by good sense,” debunked the Red River raft and Trans-Atlantic Circus theories.¹⁵ Regarding sanitation, the Shreveport physicians concluded that “the fact seems to be overlooked that this condition of the city has always existed, and while on general hygienic grounds, want of cleanliness may foster and render more malignant the disease when once introduced, there is no evidence that filth and garbage, dead dogs and cats (and one would imagine that our city was paved with them) have ever, by themselves generated yellow fever.”¹⁶

Thus, through the terrible ordeal of the Shreveport yellow fever epidemic of 1873, the physicians of Shreveport remained true to the noble calling of our profession. They stayed at their posts at great personal risk. They cared for all, regardless of means or station in life. They held to and defended public health measures. They treated to the best knowledge of the day. They recorded data. They published their observations. And they resisted all popular and political pressures brought to bear on their scientific observations and conclusions. As we, their descendants, fight our way through the great pandemic of our time, these lessons are their legacy to us. When all is said and done and our descendants write of us, may it be said that we upheld that legacy.

1. Oakland Cemetery Preservation Society, “Yellow Fever Victims,” <http://www.oaklandcemeteryla.org/Tour/Tour-Stop-1.aspx>, 2013.
2. “The Terrible Two Months of Life in Shreveport,” *The Miami Republican*, November 29, 1873.
3. *Ibid.*
4. H. C. C. Ziegler, *The Daily Shreveport Times*, November 25, 1873.
5. Henry Smith, *Report of the Yellow Fever Epidemic of 1873, Shreveport, LA* (New Orleans: L. Graham & Co., 1874), 11.
6. Francis A. Walker, *Ninth Census: Volume 1. The Statistics of the Population of the United States, Table XXV* (Washington: Government Printing Office), 645.
7. *The Daily Shreveport Times*, November 22, 1873.
8. *The Nashville Union and American*, November 20, 1873.
9. *The Fayetteville Weekly Democrat*, November 1, 1873.
10. *Ibid.*
11. W. T. D. Dalzell, “Sermon on the Epidemic,” *The Daily Shreveport Times*, November 18, 1873.
12. “Pestilence, Germs, and Quarantine,” *The Norfolk Virginian*, November 22, 1873.
13. Joseph Jones, “Yellow Fever of 1873, in Shreveport, LA,” *Boston Medical and Surgical Journal* 90, no.3 (January 15, 1874): 73-74, & no. 6 (February 5, 1874), 151-154.
14. A. B. Snell, et al. *The Report of the Committee on the Yellow Fever Epidemic of 1873 at Shreveport, Louisiana* (Shreveport, LA.: Howard Association, 1874).
15. “Yellow Fever Epidemic of 1873 at Shreveport, Louisiana,” *The American Journal of the Medical Sciences*, no. 134 (Philadelphia: Lea & Blanchard, April 1874), 480-481.
16. *Ibid.*

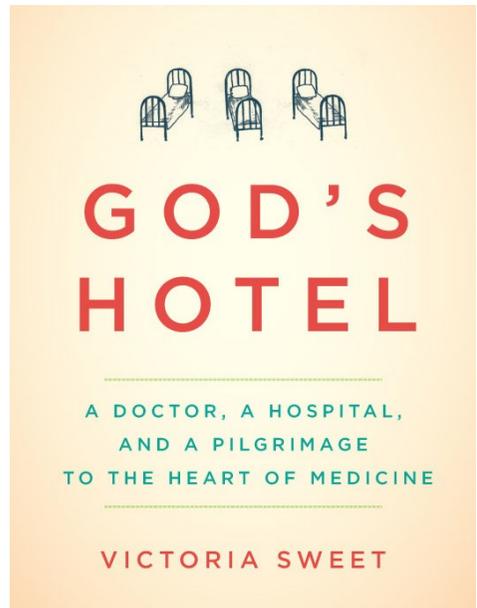


NLMS BOOK CLUB REPORT

By Margaret M. Crittell, M.D.

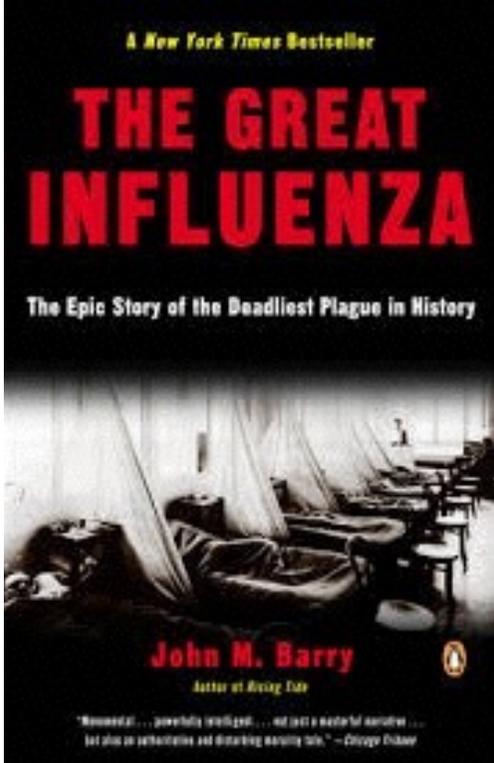
The Book Club met in September and discussed “God’s Hotel: A Doctor, a Hospital, and a Pilgrimage to the Heart of Medicine” by Victoria Sweet, MD. The book was an homage to Laguna Honda hospital in San Francisco, which is an Almshouse, the last one in the country, for the indigent of California. The author, Dr. Sweet, worked at Laguna Honda through its transition from an imposing monstrosity of a building that was a

modeled after the premodern Hotel Dieu, which were the medieval monastery-based almshouses that dotted Europe and eventually evolved into our modern hospitals, to a more modern Health Care Facility and weaves the history of the hospital in with a history of the Medieval healer, Hildegard of Bingen. Dr. Sweet, in addition to being an internist, also has a PhD in Medieval History, which she earned while working at Laguna Honda. She accepted a job at Laguna Honda precisely for the opportunity it would give her to have a part time position so that she could pursue her PhD. In order to complete her PhD, she had to teach herself Latin and the Medieval vernacular that Hildegard wrote her notes in and then translate those works for herself. While working on her PhD, she also decided to walk the Camino de Santiago. Between the lessons that she learns from Hildegard and the lessons that she learned on the Camino de Santiago, she coins the term “Slow Medicine” (which she writes a book about that I have discussed previously in my column) and illustrates with patient cases, how applying these slow medicine principles to modern medical care will, on occasion, produce a much more satisfactory outcome, both from the patients’ experience, as well as for the physician. She summarizes the practice of premodern medicine as being the three doctors, Dr. Diet (food and nutrition), Dr. Quiet (rest and exercise) and Dr. Merryman (mental health and relationships). I think that a lot can be said for the practice of these slow medicine principles, especially when it comes to most chronic diseases. I think we can all agree that if we have appendicitis, or a heart attack, we would all choose the modern medicine approach to treating these conditions. But maybe for some of our more chronic diseases, like hypertension and diabetes, we need to make a return to the wisdom of the past and focus more on the slow medicine principles prescribed by Dr. Diet, Dr. Quiet and Dr. Merryman. This



leads me to open the discussion on our next Book Club selection, "The Great Influenza" by John M. Barry.

The last few months have been such a fascinating time to be practicing medicine. Frustrating, absolutely, but we can all agree that we are living through one of the most significant medical events of modern history. Since we are all aware that history repeats itself, our next book selection will take us through the last major pandemic and perhaps we will learn some things from our predecessors that we can use to help us get through to the end of our current global crisis. I am excited to announce a change in our Book Club format that I think will add an element that will hopefully help us engage in a deeper discussion of the book. Dr. Gary Joiner, a local historian and Professor of History at LSU is going to come to lead a discussion on the way the Great Influenza affected the Northwest region of Louisiana and I believe that whether or not you read the book, this will be a fascinating discussion and I hope that we will be able to replicate this format for future book selections. Our meeting will be Thursday, Dec. 10 at Frank's Louisiana Kitchen in one of their private rooms. There will be limited seating so please RSVP if you are interested in attending. This will be a dutch treat event but there is no cost to attend and it is open to all members of the Medical Society. I look forward to seeing you there.



NLMS BOOK CLUB

Dr. Gary Joiner, local historian will lead a discussion on how the Great Influenza affected Northwest Louisiana

Thursday, December 10, 2020

6PM

Frank's Louisiana Kitchen
1023 Provenance Place Blvd Suite, 200
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RSVP online

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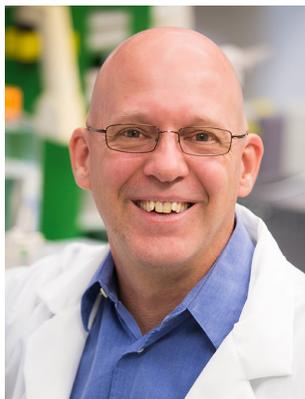
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UPDATE ON SARS-COV-2 VACCINES

By: Andrew D. Yurochko, Ph.D.

Professor and Carroll Feist Endowed Chair in Viral Oncology, Vice Chairman, Dept. of Microbiology and Immunology, Dir. Research, Feist-Weiller Cancer Center, Dir. Research, Center of Excellence for Arthritis and Rheumatology, Louisiana State University Health Sciences Center-Shreveport

Coronaviruses are a family of large RNA viruses that infect mammals and birds and cause respiratory infections and disease. There are 7 known human coronaviruses that originally appear to have come from animals. Of these 7 human coronaviruses, 4 are largely benign and cause ~25-30% of the cases of the common cold. The remaining 3 human coronaviruses are more deadly and include SARS-CoV (Severe Acute Respiratory Syndrome-Coronavirus; caused the SARS outbreak in 2002-2004), MERS-CoV (Middle East Respiratory Syndrome-related Coronavirus, an ongoing infection largely limited to the Middle East), and SARS-CoV-2 (Severe Acute Respiratory Syndrome-Coronavirus-2, the current pandemic virus that causes COVID-19 or Coronavirus Disease - 2019). The current coronavirus pandemic has as of mid-November resulted in >10 million infections and >240,000 deaths in the U.S. alone. With cases spiking in the U.S. and Europe and winter approaching it has been suggested that much of the world is in for a rough winter.

Based on these warnings, most people are wondering “how do we get out of this pandemic and return to a normal life”. The end goal that has received significant attention is the development of an effective vaccine. Vaccines allow society to safely reach herd immunity that would otherwise be difficult under natural conditions. To date, no dangerous pathogen have via natural infection resulted in herd immunity. For example, the eradication of Smallpox in 1976 was only possible with concerted worldwide vaccination efforts. The same idea holds true for the current Polio eradication efforts, where through the use of an effective vaccine, the world health organization has limited endemic wild type polio to only two countries as of November 2020.

Currently there are >150 SARS-CoV-2 vaccines in clinical trials around the world, with nearly 10 in phase III trials. In the U.S. there are at least 4 vaccines in phase III trials with results on the efficacy of these trials expected in November or December of 2020. The 4 main vaccines in phase III trials in the U.S. are vaccines from Moderna, Pfizer/BioNTech, Oxford/AstraZeneca, and Johnson & Johnson. These different vaccines represent distinct approaches, with the Moderna and Pfizer/BioNTech vaccines being mRNA-based vaccines and the Oxford/AstraZeneca and Johnson & Johnson vaccines being adenoviral-vector-based vaccines. mRNA-based vaccines have been around for more than 20 years, but have come into their own in the last decade. mRNA vaccines represent a new tool in the vaccine arsenal as they can be created quickly (once a viral genomic sequence is known, for example) and tested quickly. mRNA-based vaccines rely on the power of the vaccinated host to translate the mRNA into a protein of interest. For Moderna and Pfizer, their vaccines are focused on the spike protein. All coronaviruses have a spike protein because this is the protein responsible for viral attachment to the infected cell. Nevertheless, there are regions

on a coronavirus' spike protein that are unique to each virus that can be specifically targeted by the immune response to control infection with that virus. mRNA based vaccines are very amenable to rapid production and can be quickly constructed, however, once marketed, to remain stable they must be stored frozen. It appears that this vaccine route requires two separate shots a few weeks apart. The University of Oxford collaboration with AstraZeneca has taken a different approach and is using a non-replicating chimpanzee adenoviral vector that they have experience using in other studies. The vector expresses the SARS-CoV-2 spike protein and thus acts as an immunogen. In initial trials, a second dose increased immunity. Johnson & Johnson is using an adenoviral vector that expresses the spike protein that they hope only requires a single shot. They are using a modified human adenoviral vector that they utilized during their creation of an Ebola vaccine. Other approaches, such as the use of inactivated whole virus are also being used in other vaccine candidates.

It is expected that these vaccines will stimulate a robust humoral and cell-mediated immune response that would provide protection from disease caused by SARS-CoV-2 infection and possibly mitigate some level of infection. Because all available data suggests that infected humans generate an immune response to a coronavirus infection, there is no inherent reason that a vaccine should not provide protection. Arguments have been made as to what type of immunity may be generated. In general, the types of vaccines generate an IgG antibody response and thus should protect the lower respiratory tract. Because IgA is often required to protect the upper respiratory tract, it remains unclear if the vaccines will prevent disease through disruption of infection of the lower respiratory tract or if they will mitigate and/or block infection in general. To exit the current pandemic this is likely unimportant for the vaccinated hosts but could play a role in the length of time of the pandemic, if a large percentage of folks do not get vaccinated. Also not discussed in most press releases is the ability to generate cell-mediated or T cell immunity. T cell-mediated immunity does develop in coronavirus-infected individuals and plays a vital role in host defense. Most studies seem to focus on the antibody response and then the waning of the antibody response. These are all normal processes and because an effective immune response to most pathogens generates immunological memory that lasts from months, to years and even for a lifetime for many pathogens, these vaccines should be able to provide, should they prove to efficacious, strong protection for the vaccinated host. On November 9, 2020, a Pfizer press release suggested that their vaccine was 90% effective in blocking or preventing disease in their trial participants. This release only discussed the outcome in a small number of participants, but it did show the potential of the current crop of SARS-CoV-2 vaccines in current trials.

Through the use modern techniques and accelerated trials, the hope is to develop a safe and effective SARS-CoV-2 vaccine in 12-18 months. The previous fastest vaccine to market was 4 years and many take 10-15 years to develop, test, and bring to market. Certainly, the current pandemic has spurred rapid action to quickly develop a vaccine. At present the safety profiles look good and there is no evidence that any safety corners are being cut. Our fingers are crossed that one of the current phase III vaccines or current phase I/phase II vaccines will come to fruition and allow large-scale vaccination and us to return to our new normal lives. Lessons learned from the pandemic should spur greater surveillance techniques and through the use of new vaccine development technologies to produce future vaccines to new pathogens quickly.

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NLMS NOTES

- 2021 NLMS Membership Dues renewal notices have been forwarded. You may pay by check or credit card. Credit card payments can be accepted over the phone by calling the office at (318) 675-7656 or online at www.northwestlouisianamedicalsociety.org.
- The Annual Officer Installation is scheduled for Thursday, December 3, 2020 at Superior's Steakhouse Private Dining Wing. Reservations are limited in order to comply with current COVID-19 guidelines. Welcome 2021 Board of Directors.
- Join Dr. Margaret Crittall and the NLMS Book Club at Frank's Louisiana Kitchen on Thursday, December 10, 2020 at 6:00 PM to discuss *The Great Influenza* by John M. Barry. Dr. Gary D. Joiner, local historian, will lead a discussion about the 1918 flu pandemic. Please register online www.northwestlouisianamedicalsociety.org or call the office (318) 675-7656. Attendance is limited. NLMS has secured the venue, food and beverage may be purchased individually.
- The LSMS House of Delegates Meeting that is traditionally held in January has been moved to August 6-7, 2021.

WELCOME NEW MEMBER



Sergio Jaramillo, M.D. (Active)

OFFICE: Radiation Oncology Services

SPECIALTY: Radiation Oncology

GRADUATION: Baylor College of Medicine, 2016

TRAINING: Baylor College of Medicine, 2020

Welcome Aboard!

FOR THE LOVE OF MEDICINE TENNIS MIXER

A tennis mixer is a fun event for both players and non! On Friday, October 16, 2020 the NLMS held its second annual tennis mixer and it was a HIT! It was a perfect fall evening to be outdoors and enjoy tennis, live music and one of the best burgers in town! New to the mixer this year were the kids. Ages 5-12 had a blast playing king of the court and other games with POTC staff. The evening ended with an intense Hit for Prizes competition. Congratulations to Boothe Dugan, who won the Grand Prize, a colonoscopy screening by Dr. John Bienvenu at GastroIntestinal Specialist!

Many thanks to our Sponsors, Prize Donors, the POTC Pros and staff, The Critics Band, and NLMS staff, Brandi Gaitan & Sandy Cagle. Beginners to Pros are welcome. Join us on the court next year and maybe you can take home the Grand Prize!



Medical Students brought their "A" game!



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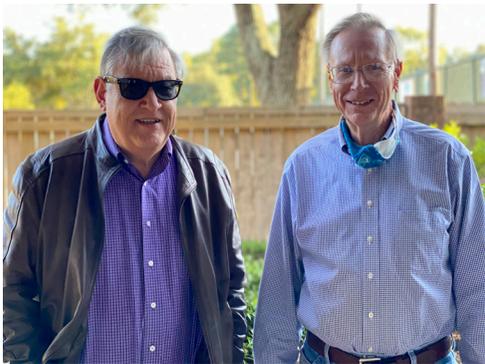
Dr. Christina Notarianni & her daughter, Caroline Werner



The Critics



Dr. Tim Hart & his daughter Alice Sample



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Boothe Dugan, Grand Prize Winner & Kyle Dacdac, medical student

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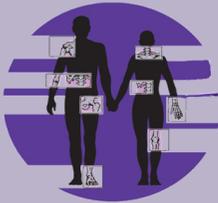
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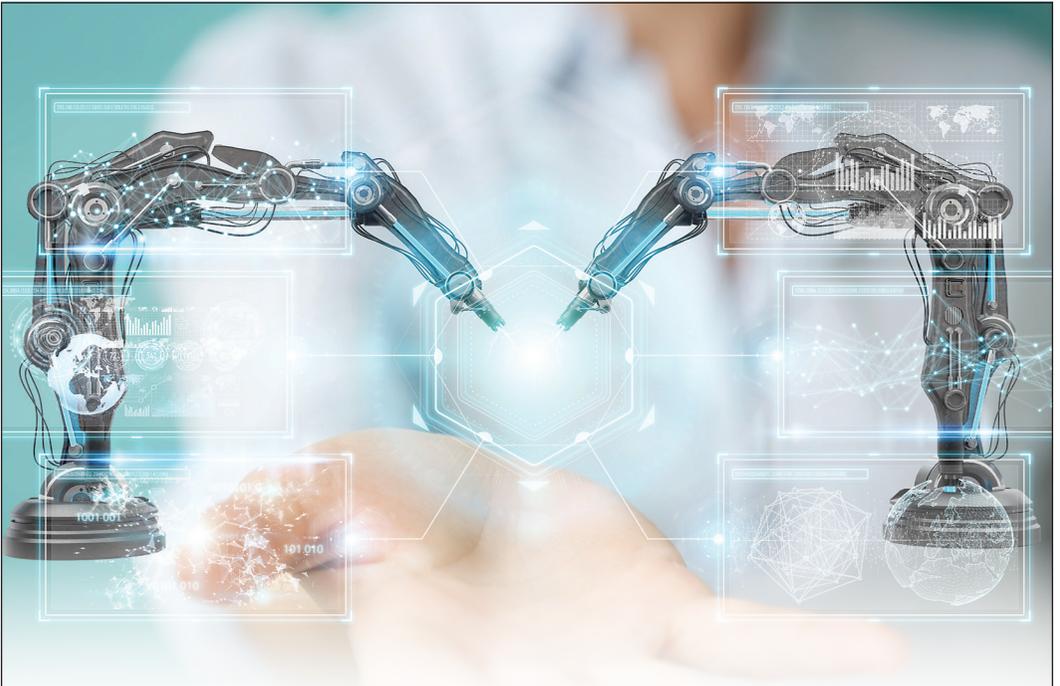
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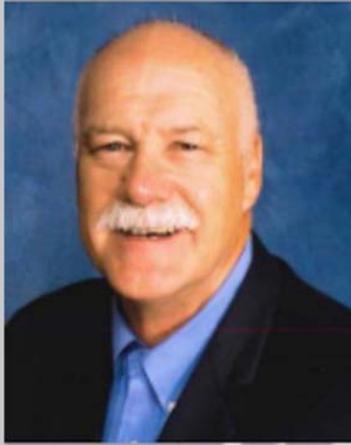
NORTHWEST LOUISIANA MEDICAL SOCIETY

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An appropriate letter will be sent on the donor's behalf to the family of the deceased or to the person honored. The amount of the gift will not be disclosed unless requested.

NLMS members are encouraged to consider the NLMS Civic Assistance Education Fund in their annual giving. For more information, please contact the NLMS office at 675-7656.



*James "Gary" Booker, M.D.
1953-2020*

James "Gary" Booker was born January 22, 1953 in Center, Texas to James Julyn and Sadie Rae Windham Booker. After graduating from high school, Gary proudly served in United States Navy in the Nuclear Power Program. He served as Machinist Mate E6 for six years and subsequently as a Lieutenant Commander in the Medical Corps Reserve. Dr. Booker received his medical degree in 1984 from LSU Medical School at Shreveport. He completed his psychiatric residency in 1988 and then went on to complete a geriatric fellowship at St. Louis Medical School in 1990. Three years later, he was named the Director of Psychiatry Professor at LSU Health Science Center at Shreveport. At the time of his death Dr. Booker was Director of Emergency Psychiatry and Consultation Liaison at Ochsner LSU.

Dr. Booker opened his private psychiatric practice in Shreveport in 1997 where he developed relationships and lifelong friendships with his patients. Dr. Booker was passionate about mental health and his Shreveport community. He truly believed that research was a way to find better treatment options for his patients. In 1992, Dr. Booker was inducted into the Shreveport Medical Society.

On Saturday, August 29, 2020 Dr. James "Gary" Booker passed away so suddenly in an accident which also took his father. Dr. Booker is survived by his mother, Sadie Booker; wife, Ruth Martin Booker; daughters, Dr. Anne Booker and Emily Booker; sister, Charlotte Barber and husband, James; brother, Greg Booker along with a niece and nephews. He was preceded in death by his father. Dr. Booker will be greatly missed by his family, colleagues, students, residents, patients, and his nurse of 21 years.

Do you know what I will remember forever? Those conversations we had in the doctors' lunch room at the Schumpert Hospital many years ago. Dr. Booker always had that sympathetic advice one treasures.

Dr. J. Gary Booker will receive the 2020 NLMS Distinguished Service Honor Award posthumously on December 3, 2020.

-Charles Lester Black, Jr., MD

NORTHWEST LOUISIANA MEDICAL SOCIETY

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