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PRESIDENT'S PAGE

Looking Backward, Forging Ahead

By Thomas G. Latiolais, M.D.

Happy New Year! Yes, I know we are already well into 2021, but does your 2021 have a similar look and feel to 2020? Feel like you have not REALLY celebrated starting a new year because everyone is still "following CDC guidelines" at work, at home, while shopping, at schools, etc.? As I am writing, it is the dead of winter, for what it is worth, in North Louisiana. It is cloudy, damp, cold (most days), rainy and there is still only about ten hours of daylight each day. The holidays are over, and it appears Mardi Gras will not be celebrated the same as in years past. Bleak!!

I am sorry, but "that's how I roll", as the young people say. My father was always, always, waiting for the other shoe to drop. He was born in 1922, grew up during the Great Depression and was part of the Greatest Generation, serving his country for freedom in Europe. Others sacrificed on the Pacific front and many Americans sacrificed at home. My father never talked about his time in the service during WWII, but the effects of the depression and of the war were clear by his hypervigilance, seriously taking his responsibilities as a husband and father of five. He, a chemist at a refinery in southwest Louisiana, and my mother, an elementary school teacher worked and saved diligently. He saved for the inevitable "rainy day", when a car needed repair, or a child got sick, always cautiously watching for another problem to crop up. That is one side of who I have become.

The other side, my mother, was the irrepressible optimist. No matter how dark, damp and cold the winter or how hot and dry the summer, she was the family's Pollyanna. Eleanor Porter wrote a series of over a dozen books in the early twentieth century about a child who saw the good side of even the worst situations and brought out that spirit for the betterment of all. That was my mother, and as most physicians, we want to bring out the good in our patients, even during trying times. Whether by using our skills to make the patient feel better physically or by a gentle touch or soft smile to show compassion for those for whom we care, we give hope. So, for every dismal situation, there are opposite ways how a person may choose to react.

THE SKY IS FALLING-waiting for the other shoe to drop
EVERYTHING IS GOING TO BE JUST FINE-Pollyanna

I propose we react to 2020 with something in between as we begin 2021.

BE PREPARED-assess the situation, plan, take action
LOOK ON THE BRIGHT SIDE-celebrate the wins, be grateful

The Physician Revitalization Program along with Christus Shreveport-Bossier Health System will be sponsoring a series which will set up local physicians for much more success and happiness in the year ahead. We will look back to assess the learning and celebrate accomplishments made in 2020. I am certain all of us learned a lot and accomplished a lot. But we are so busy in our day-to-day lives that we do not notice these things until we slow down and look back. This series will take stock of what was learned about ourselves and our practice either despite of or because of the past chaotic year.

The series will allow participants to take time to set goals to make 2021 the best year yet. Planning some concrete goals, writing down the first steps AND scheduling the time on the calendar will be central to reaching those goals. Which new skills we would like to learn, with whom we would to like to have a closer relationship, what do we need to let go of and what steps are needed to have more success and happiness ahead will all be envisioned in this series. Stay tuned for more details coming soon.

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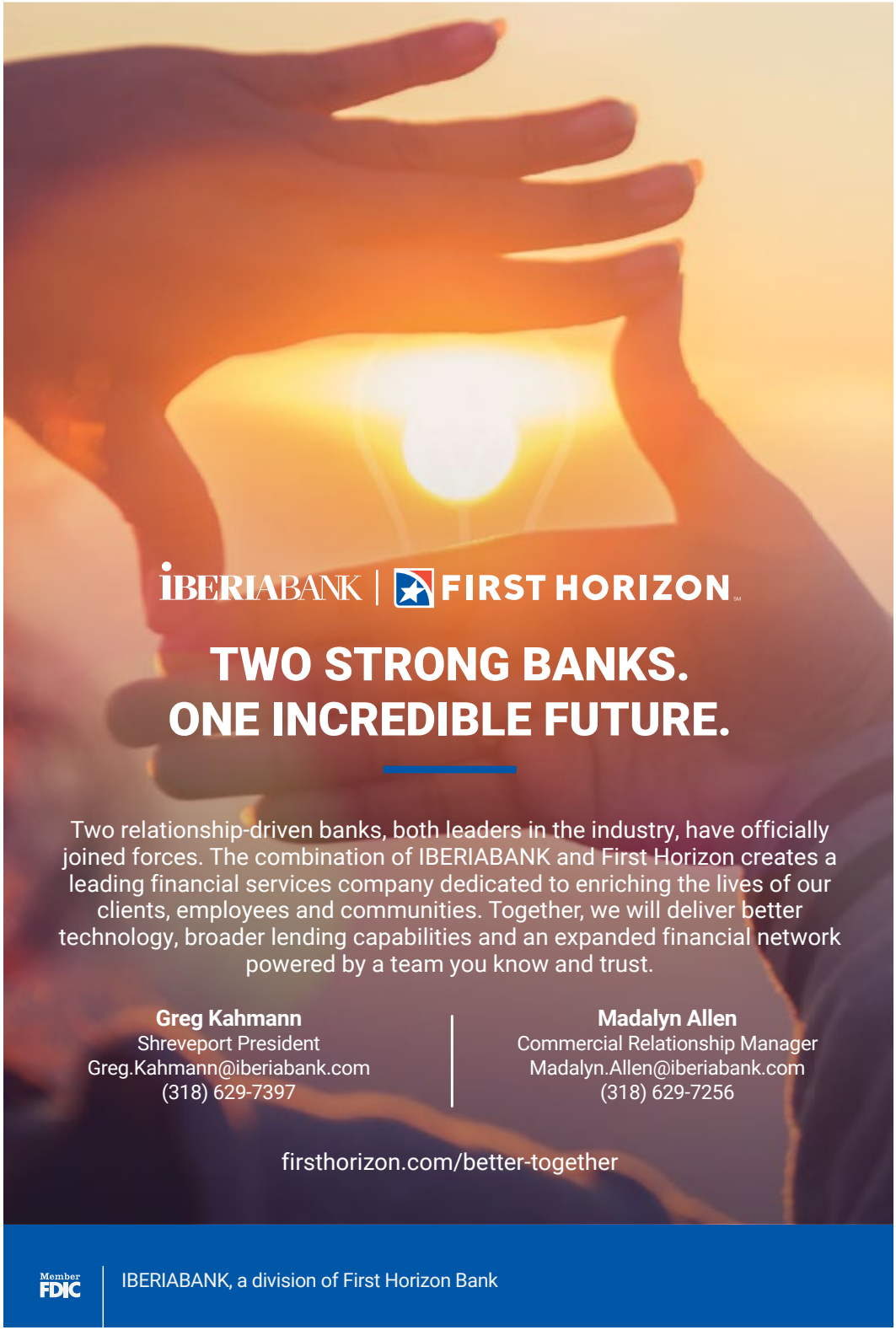
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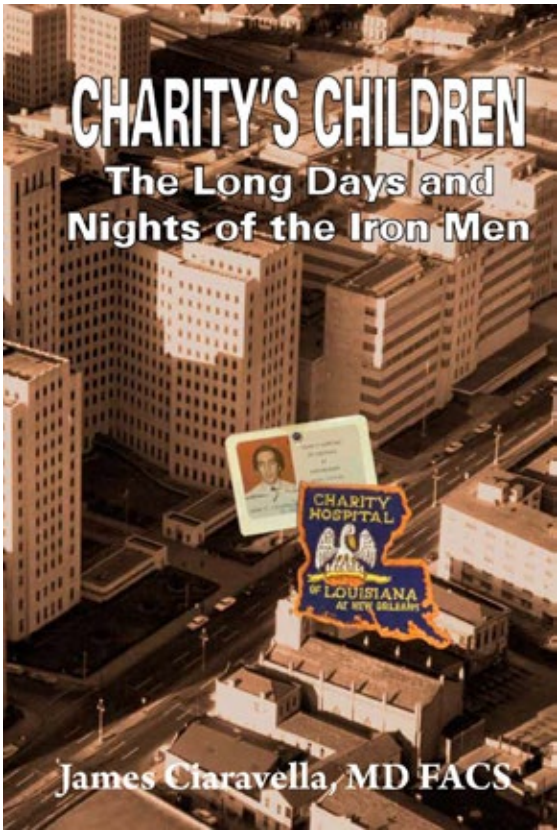

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EDITOR'S PAGE

What's Up with Generic Medications??

By Richard J. Michael, M.D.

"It is not the strongest of species that survives, nor the most intelligent, but the one most responsive to change."

– Charles Darwin

Something changed on 1/1/2021 regarding generic medications. Or maybe I was not paying close enough attention and it started in the last quarter of 2020, but generic medications can no longer be assumed to be cheap or covered by any particular patient's Pharmacy Benefits Manager (PBM). Maybe this is something that is affecting primary care more than subspecialists, but I bet everyone who is practicing medicine right now can commiserate about this issue or some other similar payment issue that is controlled by our third-party. Sure, we can send our patients to GoodRx or BuzzRx for cheaper medications outside of their insurance coverage, but these programs do not work for every generic drug and add steps in the process of prescribing and acquiring medications. And I do not want anything to interfere with the rant I am about to formulate.

My nurse has started to leave more and more communications from PBMs on my desk in 2021. "We gave your patient a 30-day supply of their sertraline (Zoloft), but you need to find a drug that is on their formulary." What?? You want generic fluoxetine (Prozac) or citalopram (Celexa) instead of the generic sertraline? No on simvastatin (Zocor), but yes on atorvastatin (Lipitor) or pravastatin (Pravachol)?? You have got to be kidding me?? What doctor's office has time to micromanage generic medications like this? I have accepted as normal getting the PBM communications about non coverage of a branded statin (Livalo) or other cholesterol drug (Repatha), or a branded antidepressant like Trintellix, unless the doctor's office can provide dates of attempts at prescribing at least 3 generic drugs, how much time the patient took the medication before they gave up, and what were the detailed side effects that the patient had before they gave up. But now generics too? Et tu, Brute? This is full on psychologic warfare waged on the medical profession by the PBMs and medical insurance industry. And it HAS TO STOP.

And this does not address the calls I am now getting to tell me the patient would like a new prescription because their allopurinol costs $65. Or that their amitriptyline costs $77. Or that their doxepin costs $85. What happened to the $4 dollar drug lists that Wal-Mart started and every pharmacy mirrored?? It seems like the PBMs and insurance companies have evolved to shut down those benefits and find a new source of profit in generic medications. Of course, the pharmaceutical companies share some blame here. But you know who does NOT share blame or deserve this stress?? Patients and their physicians/health care providers, that is who!!

I get a quarterly report from a few of the PBMs/medical insurance payors in which I participate. They are informing me how I compare to my colleagues in primary care in prescribing generic anti-hyperlipidemic medications, anti-hypertensive medications, anti-depressants, etc. I should call them "shame reports." Dr. Michael, "you only prescribe 93% of your anti-hyperlipidemic medications as generic statins, while your colleagues in primary care prescribe 96%!" No attempt is made by the PBM, as far as I know, to review my charts and see why I have my patient on Livalo or Repatha. Maybe I have documented intolerance to simvastatin, atorvastatin, and rosuvastatin because of myalgias??!! Maybe my patient is a vasculopath and has had multiple cardiac events and stents or multiple TIAs and/or strokes and needs a LDL cholesterol of <70 mg/dl??!! Or maybe the patient's cardiologist communicated to me they want a patient's LDL cholesterol at =/< 50 mg/dl??!! Instead of assuming I am just a bad doctor and paying some people to generate a report based on pharmacy fills and refills, PBMs should do a chart review and see that there is a thoughtful note that explains why this patient requires treatment with a non-generic medication. Novel idea, I know, but it would contribute greatly to stopping a specific assault on physicians and health care providers that leads to poor morale, physician burnout, and physician "morale injury". It is time for insurance companies and PBMs to start being part of the solution instead of a big piece of the problem. I suspect they could easily do this and maintain their yearly hefty profit margins.

And I have yet to address the torture we must go through to get a patient authorized to receive the benefit of a wheelchair, a piece of equipment like a cervical traction device or a nebulizer machine, a referral to a specialist, a CT scan or MRI scan, or a surgery. We have diluted down the autonomy and decision-making ability of the physician and put all the power in the hands of the payors. This harms the patients the most, but let us not minimize the effect on physicians and their morale. And unfortunately, we physicians just put our heads down and say, "yes sir/yes ma'am, can I have another obstacle to overcome, please." All the while, we get graded on our outcomes, our "efficiency" (interpretation = how much we spend), and how happy we make patients (while in the background, we are dealing with all the previously presented distractions that limit our delivery of patient care).

Something must change! Enough IS enough. Somehow, the medical profession must stand up and demand change!! And not in the form of Physician Wellness Programs, though they are important and useful for current stressors in our profession. But rules and expectations must change. Maybe doctors need to run for elected offices and populate state legislative bodies and Congress to a significant level and make real world changes in health care laws and delivery. In the process, we would need to make sure we effectively police ourselves so that utilization is appropriate and profit does not drive our decisions.

Next quarter, I hope and plan to tackle the elephant in the hospital…the 'silent' killer of physicians and health care providers. What I have talked about today is partially responsible for this issue. Stay tuned.

ECONOMICALLY SPEAKING

What Will Biden's Answer Be?

By Alan B. Grosbach, M.D.

In January, British Prime Minister Boris Johnson announced a new UK lockdown due to the threat posed by the more communicable strain of COVID-19. That raises the question of how the incoming Biden Administration will address the pandemic.

Biden has announced that the entire vaccine supply will be distributed as it becomes available. That's a departure from the Trump strategy of holding a supply in reserve for planned second doses to optimize protection. Biden's announcement is at odds with the CDC's recent recommendation against committing all available vaccine to first doses potentially leaving single-dose recipients inadequately protected. While the case can be made for giving at least one dose to as many people as possible, if subsequent research demonstrates that single doses never raise protection above the initial 50% level (compared with over 90% after two) or if protection rapidly wanes without the second dose, single dose recipients will have to be re-vaccinated. That would waste millions of vaccine doses.

Last year, Biden told Americans he planned to invoke a universal mask mandate at a time when mandates were already in effect on airplanes, trains, and mass transit as well as in many states and localities. By late summer, about 80% of Americans were under mask mandates. Sweden's leading infectious disease expert has characterized the evidence supporting masking-wearing as, "astonishingly weak," and Dr. Anthony Fauci once referred to masks as, "largely theater." So, are mask mandates effective?

A December 27th report from the Heritage Foundation by Doug Badger and Norbert Michel ("Mask Mandates: Do They Work? Are There Better Ways to Control COVID-19?") presents the data and offers recommendations.

In July, CDC Director Robert Redfield said, "I think if we could get everybody to wear a mask now, I think in four, six, eight weeks, we could bring this epidemic under control." Data proved him wrong. In the weeks that followed, case numbers soared, and 97 of the country's 100 counties with the most new COVID-19 cases were already under county or state mask mandates. In 87 of those 97 counties, mask mandates were in place before the surge in cases began.

The world's only controlled trial found that among 6,000 Danes, half of whom wore masks with a 98% filtration rate, the one-month rate of COVID-19 infection was 1.8% for mask-wearers compared with 2.1% for non-wearers, a non-significant difference.

Italy imposed a national mask mandate in early October. Within one week infection rates nearly tripled. After five weeks, the rate had increased by a factor of more than ten. Nearly all Italians (99%) reported wearing masks always, sometimes, or often. Ninety-two percent of Americans reported wearing masks in late October. Nevertheless, new U.S. case rates increased rapidly in October and November, surpassing those in Italy by November 26th. The difference in mask-wearing between the two countries, 99% versus 92%, while statistically significant, is hardly a ringing endorsement for mask effectiveness.

Badger and Michel recommend less emphasis on masks and more on protecting nursing home residents who represent only about 0.5% of COVID-19 cases but 39% of deaths. Testing nursing home personnel and visitors, plus making available rapid home test kits for everyone followed by appropriate isolation procedures are more likely than masks to control COVID-19.

Mass Vaccination for Polio

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

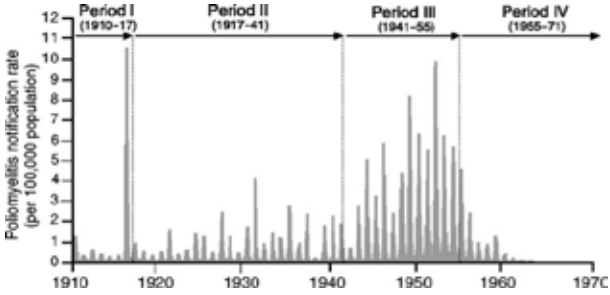

Figure 1. Polio Case Notification Rates per 100,000 Population in the United States, 1910 - 1970 (Trevelyan, Smallman-Raynor, Matthew and Cliff 2005), with permission.

Though likely present since antiquity, poliomyelitis remained an episodic and unusual disease throughout the world until the 20th century. The disease was first reported in the United States in Louisiana in 1841, when Dr. George Colmer of Livingston Parish attended an infant with a recovery from paresis, amidst a local outbreak of about ten similar cases.[1] Excepting the large epidemic in New York & New Jersey in 1916 (case rates about 130 per 100,000 population) and a lesser epidemic in New England and the Mid-Atlantic states in 1931 (maximal case rates about 60 per 100,000), polio remained endemic and sporadic throughout the U. S. until the end of World War II, with annual case rates generally no more than 5 per 100,000.[2] However, coincident with the end of the War, polio rapidly transitioned into an epidemic stage throughout all regions of the country, with annual case rates tripling or quadrupling to the range of 15 to 25 per 100,000.[3] By the early 1950s there were tens of thousands of annual cases nationwide, with a paralytic rate at about 35%.[4]

Although the peak year of polio incidence in the U.S. was 1952, polio struck Caddo Parish particularly hard in the summer of 1951, with 248 cases, at a rate of 140 per 100,000, being what the Shreveport Times termed "an enemy against which no defense as yet has been discovered anywhere in the world."[5] In May 1951 the Shreveport Charity Hospital opened a 45 bed polio center to centralize the care of area cases, with Dr. S. George Wolfe as medical director.[6] As the epidemic worsened, the National Foundation for Infantile Paralysis (now known as the March of Dimes) supplied the center with five "iron lung" respirators.[7] By July the center was near capacity, and plans were made to overflow to other hospitals.[8] Upon petition by the Shreveport Medical Society (SMS) and Dr. Wolfe, and with the assistance of Congressman Overton Brooks, plans were made for emergency overflow to the newly opened Shreveport Veterans Administration Hospital.[9] A

48 bed isolation ward opened on July 12 and received 29 patients in transfer from Charity Hospital on July 16.[10] By mid-August, this ward was at capacity and an additional 50 beds were opened, with a total VA census of 120 polio patients.[11] A total of 14 iron lung respirators were deployed.[12] One case became nationally prominent as a medical first – a 23 year old woman who underwent Cesarean section two minutes after her death while in the respirator, delivering a healthy six pound baby boy.[13] By the end of September, the great polio epidemic had faded. The Shreveport Chamber of Commerce issued formal commendations for many involved, including Dr. Wolfe and his staff, and the Veterans and Charity Hospitals.[14]

Amidst these epidemics, defenses to polio were rapidly being developed. By 1952 Dr. Jonas E. Salk began human trials of a novel inactivated poliovirus vaccine (IPV) with formaldehyde-treated strains of poliovirus types 1, 2, and 3, and in 1953 he reported induction of antibody levels comparable to those of natural infection[15]. Between April and July 1954, a massive and unprecedented placebo-controlled double-blinded Field Trial of the three-injection Salk IPV was conducted, funded by the the National Foundation for Infantile Paralysis and overseen by the Poliomyelitis Vaccine Evaluation Center at the University of Michigan.[16] Four hundred thousand grade-school children received the vaccine and two hundred thousand received placebo.[17] Extensive educational meetings for parents were held at schools throughout Caddo and Bossier Parishes, and locally about 2,600 children participated in the Field Test.[18] On April 12, 1955, the Vaccine Evaluation Center in Ann Arbor released the trial results to the nation – the Salk polio vaccine was "safe, effective, and potent."[19] Shortly thereafter 200 cases of polio were contracted from lots contaminated with live virus (the Cutter Incident), resulting in a May 7, 1955, moratorium on polio vaccination.[20] U.S. Surgeon General Leonard A. Scheele conducted a rigorous review of all manufacturing of the vaccine, issued amended standards for production and testing, and in August 1955 commended the vaccine to the nation.[21] Following mass vaccination, the 1957 polio case rate in the U.S. plummeted to 3.2 per 100,000.[22] Between 1955 and 1962, over 400 million doses of the IPV were distributed in the United States.[23]

Simultaneously to the efforts of Dr. Salk, Dr. Albert Sabin was pursuing an oral polio vaccine (OPV) utilizing attenuated live virus mutant strains.[24] In an incredible feat for the times, Dr. Sabin supplied his viral strains to Dr. Mikhail P. Chumakov, Director of the Moscow Institute for Poliomyelitis Research of the U.S.S.R. Academy of Medical Sciences. The Soviets then manufactured 263 million doses of the Sabin OPV in the U.S.S.R. and in 1959 & 1960 carried out uncontrolled mass vaccination trials of a three dose sequential schedule, ultimately administering Sabin OPV to more than 200 million persons.[25] Case rate results showed a near-

complete elimination of cases of polio in vaccinated regions.[26] On August 24, 1960, U.S. Surgeon General Leroy E. Burney declared that live poliovirus vaccine was suitable for use in the United States, and authorized licensure for manufacturing of OPV from Sabin strains of poliovirus types 1, 2, and 3.[27] Following an extensive safety review of the manufactured vaccines, U.S. Surgeon General Luther L. Terry endorsed all three Sabin vaccines for use in the United States on December 19, 1962, and urged communities to proceed with immunization campaigns.[28]

After successful initial mass vaccination programs in Cincinnati and Phoenix in 1960 and the approval of the vaccine for general use in late 1962, medical societies throughout the nation organized "Sabin On Sundays" (SOS) in which large numbers of persons were systematically vaccinated with OPV in a compressed sequential timeframe.[29] In January 1963, the Shreveport Medical Society quickly took up the challenge. Under the leadership of the President, Dr. Charles L. Black, Sr., Dr. James Cotter, Chairman of the Polio Advisory Committee of the Society, Dr. H. Whitney Boggs, Coordinator of the Program, Dr. Albert Hand, Chairman of the Public Relations Committee, Dr. James Shipp, Chairman of the Supply Committee, and Dr. Donald Mack, Chairman of the Manpower Committee, the Society declared the OPV "completely safe" and devised an ambitious plan for vaccinations in a network of 83 improvised clinics in churches, schools, and other public facilities, with vaccination dates set on Sundays in February 1963 for the Type I vaccine, March for Type II, and May-June for Type III.[30] With Dr. Black's stated goal of the eradication of polio in northwest Louisiana, the program was designed to simultaneously cover the residents of Caddo, Bossier, Webster, DeSoto, Claiborne, and Red River Parishes.[31] Each clinic had a local physician as medical director, with volunteer nurses, dentists, and pharmacists as medical personnel, and the clinics were supported by 10,000 support volunteers recruited from a broad swath of community organizations.[32] The vaccines were administered free of charge to all comers with costs underwritten by the Shreveport Medical Society, although a 25 cent donation was requested.[33] When all was finished in June 1963, the Society had overseen the vaccination of about 200,000 persons, nearing 70% of the population.[34]

By 1966, polio had been eliminated in Louisiana.[35] The last cases of indigenous wild-type polio in the U.S. were in 1979, and in the Western Hemisphere in 1991.[36] Although poliomyelitis

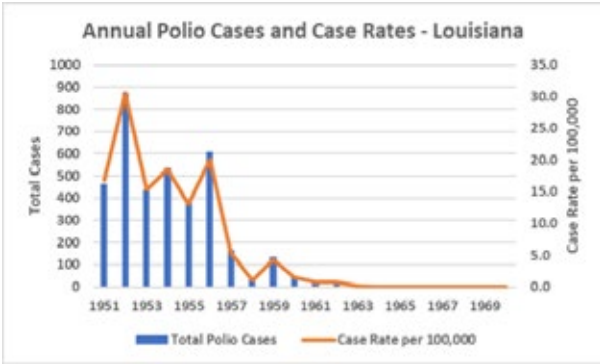

Figure 2. Data source: Morbidity and Mortality Weekly, "National Notifiable Diseases: Infectious Annual Tables," 1951-1970

has been eradicated throughout most of the world, scattered cases still occur in sub-Saharan Africa and the disease remains endemic in Afghanistan and Pakistan.[37] The story of polio is a story of the victory of mass vaccination over a deadly epidemic disease. The vaccines were safe and effective, but imperfect. Keys to victory were the transparent governmental oversight of vaccine manufacturing and safety, the vigorous support of vaccination efforts by the medical profession, the forthright education of a fearful public on vaccine benefits and risks, and the effective design and implementation of community mass vaccination programs. These are lessons that still speak to us today.

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NLMS BOOK CLUB REPORT

By Margaret M. Crittell, M.D.

The NLMS Book Club met on Thursday, December 10, 2020 to discuss "The Great Influenza" by John M. Barry. We were delighted to be joined by Dr. Gary Joiner, who is a Professor of History at LSUS and has authored over 30 books, as well as his wife, Marilyn Joiner, who is a knowledgable historian herself. Dr. Joiner is an acquaintance of John Barry, who himself is a professor at the Tulane University School of Public Health and Tropical Medicine, and Dr. Joiner's vast knowledge of the 1918 pandemic really made for a very enjoyable evening.

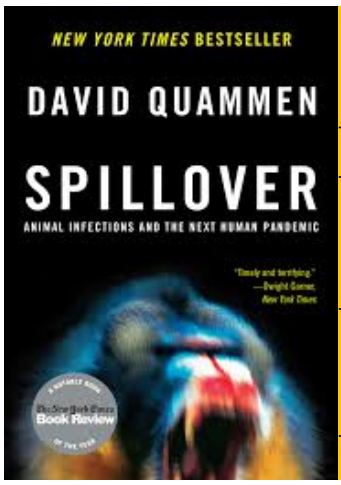
The book opens up as a history of medicine in the United States. We are introduced to several of the pioneers of scientific research, in essence, the Great Grandfathers of Evidence Based Medicine. There is much focus on the opening of Johns Hopkins, often referred to as "The Hopkins" in the early 20th Century. Now, as someone who graduated from medical school at the closing of the 20th Century, I knew that Johns Hopkins was considered the first truly rigorous medical school in the United States, but I had never considered that this tradition was rather a new phenomenon. I just assumed there were stressed out medical students from time immemorial. An interesting fact that was imparted by the Joiners involved the means by which "Doctors" were recruited to fight in the Civil War. They actually would elect a doctor from among the soldiers and it often came down to a popularity contest. They were given a field manual and a set of instruments and did their best to help their fellow soldiers. Hopefully they had plenty of Morphine and a Bible in their kit, because that seems about as helpful as anything else. At any rate, as we are learning about the progression from discouraging literacy among medical students, to requiring a basic understanding of chemistry for entry into medical school, we also get simultaneous lessons in virology as well as a review of the role that the United States played in World War I. As many are already aware, the term "Spanish Flu" is a misnomer, because while there is not a true consensus on where exactly the virus first emerged, in is very unlikely that it emerged in Spain. However, as Spain was neutral in the War, it was reporting on a strange illness spreading across Europe, while all countries involved in the fighting were mainly publishing propaganda and avoiding letting on that there was a mysterious illness ravaging the troops. John M. Barry presents an argument that the strain of Influenza that emerged in 1918 actually was first spread in Haskell County, Kansas and was introduced to Europe by way of Camp Funston, which was a Cantonment where roughly 56,000 men would report for training prior to shipping overseas. The book continues to highlight the responses of different cities and government agencies to the unknown killer as well as the ongoing futile struggle of scientists to create an effective treatment for the disease that killed one fifth of the world's population. These pioneers of medicine were fighting a match while blindfolded as they all labored

Gary D. Joiner, Ph.D.

under the flawed theory that the disease was a bacterial illness, namely Bacillus influenza (now referred to as Haemophilus influenza) rather than a virus, which were poorly understood infectious particles that were nearly impossible to isolate with the techniques they had at their disposal. They were desperately injecting horses with bacterial and bleeding them for serums which were administered as hopeful treatments.

When comparing the pandemic of 1918 with that of 2020, we can find areas of commonality as well as areas of divergence. For starters, the Influenza was highly deadly in among young adult victims. The theory behind this is that a robust immune system would actually hasten death in the victims while elderly patients were often spared the worst outcomes. As compared to the SARS Coronavisus-2 which hits the elderly with an especially deadly impact. But we have all heard of the "cytokine storm" which has been seeming to strike at random, turning young, healthy adults into terribly ill patients in a matter of hours. The incubation of the 1918 virus was, for better or worse, much shorter than our current illness, but from what I can gather, that lightening quick spread combined with the continuing mutation of the strain of flu to a less virulent strain, led to the resolution of the disease and a return to "normal" life. Unfortunately, the coronavirus mutates at a much slower rate and the longer incubation has just led to frustration, confusion and anger over length of quarantine time and what is considered a risky behavior. Hopefully the speed at which we're able to produce a vaccine will be our saving grace in this battle. While we will never have all the answers, it is fascinating to consider that just 100 years ago we had so little understanding of diseases, and it really makes me wonder how history will judge us 100 years from our current pandemic.

For our next book club selection, we are sticking to our Pandemic-theme and reading "Spillover: Animal infections and the Next Human Pandemic" by David Quammen. This book was highly recommended by Dr. Joiner and is a deep dive into the science of zoonotic diseases. We are planning to meet Thursday, March 11 at 6pm at Chiante Restaurant and we will have Dr. Andrew Yurochko, a virologist with the Department of Microbiology and Immunology at LSU Health Shreveport help lead the discussion of this book.



NLMS BOOK CLUB

Dr. Andrew Yurochko, Department of Microbiology and Immunology at LSU Health Shreveport will lead.

Thursday, March 11, 2021

6PM
Chianti Restaurant
6535 Line Avenue, Shreveport
(Private Room)

RSVP
www.northwestlouisianamedicalsociety.org
or call (318) 675-7656

Seating is limited in order to comply with Covid-19 guidelines

No Charge to Attend - Dutch Treat Event

ENVISION RESEARCH
A division of BRF

ENVISION RESEARCH SEEKS LEAD PRINCIPAL INVESTIGATOR

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MINIMUM QUALIFICATIONS AND EDUCATION REQUIREMENTS

Active M.D. or D.O. License in Louisiana with authority for prescriptions, DEA license or ability to obtain, and unrestricted ability to participate in federal programs. Minimum one year of experience as Principal Investigator, or minimum of five years of experience as Sub Investigator in clinical trials is required.

ESSENTIAL FUNCTIONS

- Serve as Principal Investigator on clinical trials managed by Envision Research.
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- See the link to the full job posting at the bottom of this page for more essential functions.

If interested, contact Vassia Roulia, Executive Director, vassia.roulia@brfla.org

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COVID-19 VACCINE DRIVES

LSU Health Shreveport, Region 7 Department of Public Health, and the National Guard are leading the state in vaccination efforts. Under the direction of Dr. John A. Vanchiere, the Covid-19 Strike Team has administered 18,000 doses — the average now is 5,000 per week. Vaccine efforts have been bolstered with the help of CHRISTUS Shreveport-Bossier Health System, Willis-Knighton Health System, and medical students from LSU Health Shreveport, Bossier Parish Community College (BPCC) and Southern University Shreveport Louisiana (SUSLA). The partnership plans to administer 20,000 vaccines per week once enough vaccines are allocated to Northwest Louisiana.

Brandi Gaitan, NLMS Executive Director has spent a few days volunteering at the vaccine drives. She is working with Dr. Vanchiere and LSU Health to keep NLMS members informed. If you have any questions about getting yourself, healthcare staff or patients vaccinated, contact Brandi.

Shelly Raley, RN & Dr. John A. Vanchiere, leading the Covid-19 Strike Team

Dr. John A. Vanchiere & Brian Crawford, WK Chief Administrative Officer pictured with National Guard Soldiers at vaccine drive site

Dr. Joseph A. Bocchini Jr., WK administering vaccines

Dr. T. Steen Trawick, CHRISTUS CEO administering vaccines

Drs. Ghali E. Ghali, LSU Health Chancellor & T. Steen Trawick, CHRISTUS CEO

Double doses for the Drummond twins!

CHRISTUS SHREVEPORT-BOSSIER Health System

WILLIS-KNIGHTON HEALTH SYSTEM

LSU Health SHREVEPORT

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 675-7656 or online at www.northwestlouisianamedicalsociety.org .

- Join Dr. Margaret Crittell and the NLMS Book Club at Chianti Restaurant on Thursday, March 11, 2021 at 6:00 PM to discuss *Spillover: Animal Infections and the Next Human Pandemic* by David Quammen. Dr. Andrew Yurochko, a virologist with the Dept. of Microbiology & Immunology at LSU Health Shreveport will help lead the discussion. 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 2021 LA Regular Legislative Session will convene at noon on Monday, April 12th and will adjourn no later than Thursday, June 10. As customary, watch for email alerts that will be forwarded to NLMS members to advocate for medical-related policies that benefit patients, the physician-patient relationship, and the medical profession. Please see pages 28 & 29 for contact information.

- The LSMS White Coat Wednesday at the Louisiana State Capitol is scheduled for Wednesday, April 21. Physicians are encouraged to wear their white coats and lobby their legislators! Contact the LSMS for more information.

- The LSMS House of Delegates Meeting is scheduled to be held August 6-7, 2021. The LSMS has created the Membership Virtual Engagement Portal (MVEP) to streamline the resolution process. They are looking for volunteers to serve on different councils that will review the resolutions submitted through this new process. For more information go to https://lsms.org/page/MVEP.

- The NLMS Board of Directors continues to monitor the Covid-19 Virus and hopes to resume Quarterly Meetings in late spring of 2021. Covid-19 gathering guidelines will be followed in order to keep participants who choose to attend safe. Please refer to the website www.northwestlouisianamedicalsociety.org for schedules or call Brandi Gaitan (318) 510-3138 with questions.

Welcome New Members

Matthew S. Mosura, M.D. **(Active)**

OFFICE: Pain Care Consultants, Bossier City

SPECIALTY: Pain Medicine

GRADUATION: LSUHSC-Shreveport, 2002

TRAINING: Univ. of TX-Galveston, 2006
MD Anderson Cancer Center, 2007

Richard A. Owings, II, M.D. **(Active)**

OFFICE: Delta Pathology

SPECIALTY: Pathology

GRADUATION: Univ. of Arkansas, 2009

TRAINING: Univ. of Arkansas, 2013
Brigham & Women's Hospital, 2014

Andrew G. Patton, M.D. **(Active 1st Yr.)**

OFFICE: Orthopaedic Specialists of LA

SPECIALTY: Orthopaedic Surgery

GRADUATION: LSUHSC-Shreveport, 2012

TRAINING: Univ. of Tennessee, 2013
Univ. of TX, Galveston, 2019
Univ. of MO, Kansas City, 2020

Paul E. Perkowski, M.D. **(Active)**

OFFICE: Ochsner LSU Health

SPECIALTY: Vascular Surgery

GRADUATION: SUNY Upstate Medical Univ., 1996

TRAINING: LSUHSC-Shreveport, 2002
Arizona Heart Institute, 2003
LSUHSC-New Orleans, 2004

Welcome Aboard!

Interstate Medical Licensure Compact

By Senator Barrow Peacock

This article was written with the assistance of Rick Masters, The Council of State Governments

In the second extraordinary session of 2020, I authored Act 35, which passed unanimously, that enacts the Interstate Medical Licensure Compact. This allows Louisiana to join a multi-state compact for physicians to obtain multi-state license privileges to practice in participating compact states to enhance the portability of a medical license and ensure the safety of patients.

The genesis of the compact occurred in 2013, when the Federation of State Medical Boards worked with its member state boards and special experts to study the feasibility of an interstate compact model to support medical license portability nationwide. The advent of COVID has underscored the need for cross border practice by physicians, both telehealth and in person.

The compact creates an alternative pathway for expedited medical licensure that will expand access to care, streamline the licensing process for physicians and facilitate multi-state practice and telemedicine for those physicians and states that voluntarily choose to participate.

The compact was drafted by multiple state medical board representatives. Throughout the two-year drafting process, input and feedback was received and incorporated from state medical boards, provider organizations, patient advocacy organizations, hospitals and telehealth industry. Since the final model legislative language was released in 2014, 31 states have formally enacted the compact and five more are considering it, including Texas. The compact is supported nationally by the American Medical Association.

The compact does not supersede the state's autonomy and control over the practice of medicine. On the contrary, it is the ultimate expression of state authority. States continue to maintain control of the practice of medicine through a coordinated legislative and administrative process. In the compact, the practice of medicine is defined as where the patient is located, not where the physician is located. As such, all initial disciplinary actions will be handled by the board of the state where the patient is located, just as it is conducted today.

The Compact Commission which has already been meeting since October 2015, serves as an administrative clearinghouse of licensing and disciplinary information among participating member states. The commission does not have regulatory control over physicians or the practice of medicine. It does not issue licenses nor does it revoke licenses. Its only purpose is to facilitate interstate cooperation and the transfer of information between member states. Regulatory control remains with the respective medical boards. The Compact Commission began processing applications in 2017 and since then more than 12,000 have been processed.

The compact is a testament to the work of medical regulatory boards, physicians and other key stakeholders to reach consensus in support of a state-based solution that will simultaneously expedite state medical license portability while ensuring the protection of the public. I hope you will look at and take advantage of the long-range benefits that this legislation will have on expanding access to care and streamlining the licensing process for physicians in Louisiana

QUARTERLY MEETING - LEGISLATIVE UPDATE

On Thursday, November 12, 2020, the Northwest Louisiana Medical Society along with the Louisiana State Medical Society offered a Legislative Update during the Quarterly Meeting. Maria Bowen, VP of Governmental Affairs at LSMS led a discussion with Senator Barrow Peacock and US Congressman Mike Johnson. Congressman Johnson joined the meeting via zoom. The meeting was held at CHRISTUS Highland Medical Center. The staff at CHRISTUS Shreveport-Bossier Health System went above and beyond to provide a safe and comfortable meeting venue. The food and service was excellent. Thank You!

Congressman Mike Johnson, Senator Barrow Peacock & Maria Bowen, VP of Governmental Affairs at LSMS

Dr. F. Thomas Siskron, IV, 2020 NLMS President

Halen Sumner, MS III, Dr. Paul E. Perkowski, Brittany Wagner, MS III, & Deniz Gungor, MS I

Karen Davis, Dana Smelser & Cynthia LaBorde, CHRISTUS, hostesses for the evening - Thank You!

2021 Legislative Watch

By Maria Bowen, Vice President
LSMS Governmental Affairs

Session is coming…again. 2021's regularly scheduled session starts on April 12 and is fiscal only. However, in a fiscal only session, every legislator is allowed 5 bills on any subject matter, and this year we are expecting some significant legislation that will impact the practice of medicine.

For starters, LSMS plans to bring legislation to eliminate non-compete clauses in physician contracts. Our legislation will seek to void that clause in existing contracts and prevent their use in future ones. Employers will be allowed to incorporate damages or "claw-back" clauses, but they will not be allowed to prohibit you from working in your chosen area. As we are pushing for passage, we are working with legislators to explain the uniqueness of a patient-physician relationship and how these clauses sever that relationship to the detriment of the patient. If you have had a non-compete clause executed on you, please reach out to the LSMS Vice President of Legal Affairs, Lauren Bailey at lbailey@lsms.org.

Scope of Practice is also expected to headline our issues, and it's coming from all sides. To date, we've heard about legislation being proposed by:

- Advanced Practice Registered Nurses to eliminate the Collaborative Practice Agreement and grant themselves full practice authority.
- Physicians Assistants who want to change their employment relationship from "supervised" to "collaborative."
- Pharmacists who would like to practice medicine out of their pharmacies including treating conditions, prescribing and dispensing medications.
- Home Health Agencies who would like to allow any "practitioner," not just physicians, to write orders for home health.

Additionally, we expect many conversations to be held regarding the reissuance of a RFP for Medicaid. At present, the state is operating with the original MCO contracts from several years back utilizing the extension clauses available to them. In a budget year, with limited resources, the legislature is going to take a significant interest in these plans.

All of this, while COVID is still a factor…

At roughly 2 months out, we still don't know how COVID will impact the coming session. Unfortunately, we won't know with any advance warning as COVID continues to spread and vary.

What we do know is that we are planning our Day at the Capitol for April 21! Please save that date and make plans to join us. We will release more information in the next few weeks.

Now for your assignment. Please reach out to your legislators. It is imperative to start now so they know you are interested in being a good resource for them. Make sure they have a way to contact you. Encourage them not to support any legislation that impacts medicine without giving you a chance to offer additional information.

If you've never been involved in advocacy with LSMS before, I implore you to make it a part of your 2021 plans. This session looks to be fast paced and absolutely full of medicine-focused legislation. Look for our alerts and know that you can always contact me (mbowen@lsms.org) for more information.

2021 LOUISIANA STATE LEGISLATURE

Regular Session

AREA STATE SENATORS

LA SENATE – When the State Legislature is in session, Senators may be reached in Baton Rouge by:

Telephone (225) 342-2040
Fax (225) 342-0617

Address letters to:
The Honorable _____
State Senator
P. O. Box 94183
Baton Rouge, LA 70804-4183

(Or Home Addresses below)

Senator Robert Mills (Dist. 36)
105 Harvey's Way
Minden, Louisiana 71055
Tel: (318) 371-5200
Fax:
E-mail: sen36@legis.la.gov
Committees: Education; Insurance; Judiciary A; Retirement

Senator Barry Milligan (Dist. 38)
531 W. 61st Street
Shreveport, Louisiana 71106
Tel: (318) 862-3100
Fax: (318) 862-3102
E-mail: sen38@legis.la.gov
Committees: Senate & Gov't Affairs, Agriculture; Forestry, Aquaculture & Rural Dev; Revenue & Fiscal Affairs; Local & Municipal Affairs

Senator Gregory Tarver (Dist. 39)
1024 Pierre Avenue
Shreveport, Louisiana 71103
Tel: (318) 227-1499
Fax: (318) 227-1058
E-mail: tarverg@legis.la.gov
Committees: Finance; Judiciary B; Local & Municipal Affairs; Senate & Govt. Affrs.

Senator Barrow Peacock (Dist. 37)
1619 Jimmie Davis Hwy.
Bossier City, Louisiana 71112
Tel: (318) 741-7180
Fax: (318) 741-7182
E-mail: peacockb@legis.la.gov
Committees: Insurance; Judiciary A; Transportation, Highways & Public Works; Retirement

Senator Louie Bernard (Dist. 31)
431 Jefferson Street
Natchitoches, Louisiana 71457
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Fax: (318) 357-3184
E-mail: sen31@legis.la.gov
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Senator John C. "Jay" Morris (Dist. 35)
1408 N. 7th Street
West Monroe, Louisiana 71291
Tel: (318) 362-4270
Fax: (318) 362-4277
E-mail: morrisjc@legis.la.gov
Committees: Agriculture, Forestry, Aquaculture & Rural Dev; Commerce, Consumer Protection & International Affairs, Labor & Industrial Relations; Revenue & Fiscal Affairs

AREA STATE REPRESENTATIVES

LA HOUSE OF REPRESENTATIVES – When the State Legislature is in session, Representatives may be reached in Baton Rouge by:

Telephone (225) 342-6945
Fax (225) 342-8336

Address letters to:
The Honorable _____
State Representative
P. O. Box 94062
Baton Rouge, LA 70804-4062

(Or Home Addresses below)

Rep. Tammy Phelps (Dist. 3)
810 E. 70th Street, A
Shreveport, Louisiana 71106
Tel: (318) 862-3080
Fax: (318) 862-3088
E-mail: hse003@legis.la.gov
Committees: Education, Labor & Industrial Relations, Ways & Means; Capital Outlay

Rep. Lawrence A. "Larry" Bagley (Dist. 7)
671 Hwy. 171, #E
Stonewall, Louisiana 71078
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Fax: (318) 925-9590
E-mail: bagleyl@legis.la.gov
Committees: Health & Welfare, Appropriations; Leadership; Economic Recovery; Budget

Rep. Samuel L Jenkins, Jr. (Dist. 2)
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Shreveport, Louisiana 71103
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Fax: (318) 632-5972
E-mail: jenkinss@legis.la.gov
Committees: Executive Committee; Civil Law & Procedure; House & Governmental Affairs; Economic Recovery

Rep. Danny McCormick (Dist. 1)
P. O. Box 160
Oil City, Louisiana 71061
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Fax:
E-mail: hse001@legis.la.gov
Committees: Agriculture, Forestry, Aquaculture & Rural Dev; Insurance; Commerce

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900 Pierremont, #119
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Committees: Joint Budget; Agri, Forestry, Aqua & Rural Development; Leadership

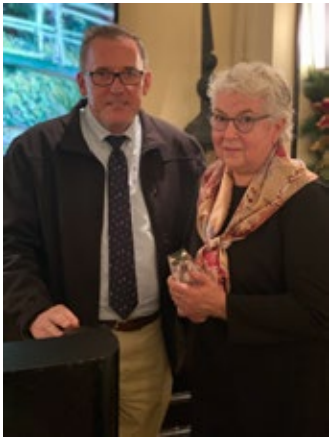
ANNUAL OFFICER INSTALLATION

The Annual Officer Installation was held on Thursday, December 3, 2020. Superior's Steakhouse graciously reserved their entire private wing for the NLMS. This provided our 34 guests ample room to distance, while recognizing both our past and incoming Board of Directors. Most importantly, we also honored our Distinguished Service Award Winner, Dr. James "Gary" Booker.

Dr. James C. Patterson, III presented Dr. James "Gary" Booker with the 2020 Distinguished Service Award posthumously. Mrs. Ruth Booker along with their daughter were present to accept the award. With heavy hearts they were both very grateful the NLMS honored their beloved husband and father. Dr. Booker is the 58th recipient.

Dr. F. Thomas Siskron, IV expressed his gratitude to the 2020 Board and membership for the chance to serve as President in 2020 and then passed the gavel to 2021 President, Dr. Thomas G. Latiolais. Dr. Latiolais presented Dr. Siskron with an engraved crystal award to commemorate his presidency, then proceeded with the Installation of the 2021 Board of Directors. Special thanks to Mr. Gary Moore at Argent Trust for sponsoring the evening.

Dr. & Mrs. Thomas G. Latiolais, 2021 NLMS President



Dr. James C. Patterson, III & Mrs. Ruth Booker

Drs.Thomas G. Latiolais, & F. Thomas Siskron, IV

Drs. Phillip A. Rozeman & Frederick J. White, III

Dr. Ashley White & Dr. Randall White, Jr

Dr. & Mrs. Edward L. Morgan

Gary A. Moore, Argent Trust Company

Richard Conrad Kamm, M.D., Ph.D.
1947-2021

Dr. Richard Kamm was born in 1947 in Earle, Arkansas to Roger and Mary Kamm. He attended Earle High School, Arkansas State University in Jonesboro, Arkansas Polytechnic College in Russellville, Memphis State University at Memphis. He graduated with a Bachelor of Science in Biology and Chemistry. He received his Ph.D. in Experimental Pathology from the University of Tennessee Medical Units, Department of Pathology in Memphis. He received his MD degree from the Louisiana State Medical School at Shreveport in1973. Dr. Kamm attended the National Institute of Health, Division of Computer Research and Technology at Bethesda, Maryland in 1973. He also completed a degree in Medical Technology at LSU in Shreveport in 1976.

At the request of Dr. Albert Smith, Dr. Kamm came to Shreveport to assume the position of Instructor of Pathology at the LSU School of Medicine at Shreveport. Dr. Kamm was also a member of the inaugural graduating class at the Shreveport campus, LSU School of Medicine; a class forever embedded into my mind.

Dr. Kamm received specialty certification in the following areas: Medical Technology from the American Society of Clinical Pathologists in 1976; Anatomic and Clinical Pathology from the American Board of Pathology in 1976; Forensic Medicine from the American Board of Forensic Medicine in 1996; and Disability Analyst from the American Board of Disability Analyst of the American Board of Disability Analysts in 2000.

Dr. Kamm served as Clinical Pathologist at LSU Medical Center, Shreveport; P&S Hospital, Doctors Hospital, Bossier Medical Center, A. J. Mullen Memorial Hospital, Willis Knighton Medical Center, and Christus Schumpert Medical Center. He also later became certified as a Forensic Pathologist and served as a consultant in many venues in that role.

Dr. Kamm was a member of Alpha Omega Alpha since 1973, the American Board of Disability Analysts, a member of the American Academy of Forensic Sciences since 1975, a member of the American Board of Forensic Examiners since 1994, diplomat of the American Board of Forensic Medicine, American Association of Blood Banks, American College of Clinical Pathology, American Society of Cytology, American Society of Law, Medicine and Ethics, College of American Pathologists, Shreveport Medical Society and the Louisiana State Medical Society since 1973, National Association of Medical Examiners, National Association of Interns and Residents, media representative for Pathology, alternate delegate to the Louisiana State Medical Society in 1984, and Sigma Xi: Scientific Research Society.

In closing, Richard was infatuated with model trains. Forty-five years ago, I saw his layout at his home. It ran three lines simultaneously under computer control to avoid crashes.

On January 24, 2021 Dr. Richard Kamm died after a brief illness. He is survived by his wife, Martha Sue Kamm; one brother, Robert Thomas Kamm, wife, Kimberly; three daughters, Kathryn Kamm; Angie Hall, husband, Scott; and Amy Sebald,, husband, Adam; two sons, Dr. Richard Kamm, Jr.; and Joseph Kamm, wife, Rebecca as well as nine grandchildren.

So…this concludes the narrative of Dr. Richard Kamm…a doctor of trains but no longer on the train.

Charles Lester Black, Jr., MD

Northwest Louisiana Medical Society Memorials & Gifts

The NLMS Civic Assistance & Education Fund (CAEF) is authorized under the IRS Guidelines to receive tax deductible memorials and honorary gifts from members of the Medical Society, friends, organizations and businesses. All memorial contributions and honorary gifts so designated, unless otherwise requested by the donor, are credited to the general fund from which allocations are made by the Board of Directors to support community charity and educational activities.

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 Civic Assistance & Education Fund in their annual giving. For more information, please contact the NLMS office at 675-7656.

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