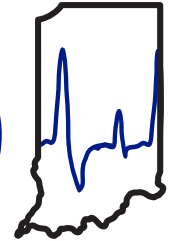


# EMpulse

*Official Publication of the Indiana Chapter of American College of Emergency Physicians*



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## Inside this Issue

This is Our Lane .....	3
New INACEP Members .....	3
Conference Update .....	4
Reflections of a New EM Doc .	5
A story of Salt and the Lives It Saves.....	6
Legislative Update.....	8
Case Study—How'd That Get In There.....	10

## A View from the Top



**Christian Ross, MD, FACEP (INACEP President)**

Things are continuing to chug along here at INACEP. As per my normal “View From the Top” columns, here are your updates on our most active projects.

**1. INACEP 2019 Conference** – Our conference has been announced and the slate of speakers has been finalized. It should be very educational and entertaining. If you haven’t already booked your registration for our conference April 17-18, go to our website (<https://inacep.org/register/>) and do so now. It’s super quick. Late registration begins on March 26th so make sure to register before that date. See you all there!

**2. Legislative Issues** – Hooray! It’s legislative season. The statehouse is buzzing with activity and it turns out that there’s quite a bit being tossed around that affects us Hoosier Emergency Physicians. To be honest with you, as a frontline Emergency Department doctor, it’s tough to keep up with all the proposed bills. Fortunately, we have a fabulous lobbyist and liaison to the statehouse, Lou Belch, who keeps us informed and has roped us into the conversation on these topics. Probably the one I’m asked most about is the Advanced Practice Registered Nurse (APRN) “scope of practice” bill introduced in the House and the Senate. The gist of the bill is to eliminate the need for a collaborating physician for APRNs (allowing them to practice independently) after three years’ experience out of school. Per those in support of the bill, arguments put forth highlighted using APRNs as rural PCPs and for providing mental health services. However, as expected, testimony was robust in opposition with many of the medical specialties and ISMA testifying. The bills were subsequently put on hold in hopes that the physician and nursing groups could work together to come up with a compromise. This, however, has been very difficult. As it

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for APRNs (allowing them to  
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*continued on page 8*

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# This Is Our Lane

by Lauren Stanley MD, FACEP (INACEP Board Secretary/Treasurer)

The topic of gun violence has been hotly debated in recent months, as media coverage of various violent acts has shed light on the issue and drawn strong opinions from all sides. The question of how to prevent or reduce gun violence is heavily laden with political, ideological, cultural, religious, and even socioeconomic implications, setting the stage for heated dialogue. Physicians as a group were thrown into the mix in November when the NRA released a tweet that said (in part) "Someone should tell self-important anti-gun doctors to stay in their lane," prompting a reaction from multiple physicians and physician professional organizations that belied physicians' typically-quiet role in such politically charged conversations. The responses were quick and powerful, illustrating how gun violence is, indeed, in our lane.

Among physicians, we as Emergency Physicians are particularly involved in the aftermath of gun violence. We are at the front door, literally and metaphorically, when the victims of gun violence need care. We grow up in our residency training speaking and writing the letters "GSW" as casually as we say our own names, and we continue to treat the effects of gun violence regardless of what type of practice environment we choose. We can and should have a voice in the conversation about gun violence.

One of the skills which we as physicians are most called upon to use is reason. We use this skill every day to approach clinical

problems, both on an individual patient level and on a broader epidemiological level. Gun violence should be no exception. Let's change the conversation from an emotionally-driven, reactionary, quick-fire debate to one of logic. Let's approach the issue as we would any other clinical conundrum: by conducting credible research and applying the findings to creating a viable solution. The US has seen great success in decreasing fatalities from MVC's, without forcing law-abiding citizens to give up their right to own/drive a car; can we attempt to do the same for gun violence?

There are organizations that are already pursuing this strategy. A few examples are The American Foundation for Firearm Injury Reduction in Medicine (AFFIRM), the National Physicians Alliance's Gun Violence Prevention project, and Doctors 4 Gun Safety. If supporting or participating in an organization isn't your cup of tea, consider letting your voice be heard by simply contacting your local legislator individually to relay your professional experiences with the effects of gun violence, and to express the importance of allocating funding to research into commonsense gun violence solutions. We as Emergency Physicians are in this lane. Let's move on from rhetoric and use our well-honed problem-solving skills to find a solution.

*The views expressed in this article are mine, and are not intended to represent the opinion of the Indiana chapter of ACEP.*

## Welcome New INACEP Members

### ***New Members:***

James Davidson MD FACEP  
Laura Gilbert MD  
Gladys Lopez MD  
Thomas Nelson MD

### ***Medical Students:***

Candice Anusewicz  
Jacob Bledsoe  
Amy Clark  
Wesley Gallaher  
Bonit Gill  
Sofia Gillum MD  
Aida Haddad  
Arvind Haran

Ian Keith

Matt Kening  
Quinton Nannet  
Michael Pergola  
Joseph Quinlan  
Kayley Rainey  
Kathryn Schilling  
Amanda Smith  
Justin Staley  
Cody Williams

### ***Resident Members:***

John Gall MD  
Joseph Jenkins MD  
Jonathan VonDerHaar MD

## Upcoming Events

### ***INACEP Annual Conference***

Indianapolis  
**April 17 – 18, 2019**

### ***Leadership & Advocacy Conference***

Washington DC  
**May 5 – 8, 2019**

## 2019 INACEP Conference Update

by Bart Brown MD, FACEP (INACEP Vice President & Education Director)

The 2019 INACEP Conference will be here before you know it! Register soon to be part of our 2019 Extravaganza!

We have an all-star lineup. We have top national leaders and speakers, local leaders, returning favorites, and 2 hands-on courses. Jen Walthall will kick off day 1 with the latest on opioid treatment and an FSSA update. ACEP President Vidor Friedman will speak about quality and combating burnout followed by a national ACEP update. We will also have our own JT Finnell, recently elected to the national ACEP Board of Directors. Back by popular demand, Elizabeth Weinstein and Andrew Stevens return for the latest in EMS and pediatric topics. Kristine Nana-gas rounds out the day with a timely toxicology topic.

Following the day 1 CME activities, we are excited to add a 1 hour Medical Director's meeting. This will be a great opportunity to meet with fellow directors and INACEP leadership to collaborate on statewide issues impacting our departments. Day 1 closes with the valuable resident's forum.

Robert Muelleman, current ABEM president, will open day 2 with "Frequent ED Users" followed by an update of ABEM policies. The always entertaining Joe Martinez returns for the latest in abdominal surgical emergencies. Michael Kauffmann will discuss community paramedicine and provide an update on new initiatives he is taking as the state EMS director. US guru Srikar Adhikari will discuss point of care ultrasound in the hypotensive patient. This will be followed by a hands on course with live models to learn how to rapidly scan the hypotensive patient. This year we have a simultaneous hands on course option for RNs and other interested attendees. Chad Denney will present a difficult IV techniques course, including US guided IV placement.

The conference is open to all levels of training including RNs, APPs, and anyone interested in Emergency Medicine. Please consider sponsoring and sending a team of providers including physicians, nurse practitioners, physician's assistants and nursing staff to this year's conference. I hope to see you all at the North Sheraton on April 17-18th. Register online at <https://inacep.org>. We look forward to seeing you.

## 2019 INACEP Conference Fees & Location

The 2019 INACEP Conference Registration will be online this year. go to [inacep.org](https://inacep.org) to register. Registration is open.

### CONFERENCE FEES:

Fees have remained the same as last year!

#### Two-Day Registration:

ACEP Member Physician .....	\$325.00
Non-ACEP Physician .....	\$375.00
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Medical student .....	\$20.00
Late fee if after 3/25/19 .....	\$25.00

#### One-Day Registration:

	Wed	Thurs
ACEP Member Physician .....	\$200.00	\$160.00
Non-ACEP Physician .....	\$230.00	\$180.00
PA/RN/LPN/NP/ Paramedic .....	\$140.00	\$100.00
Medical student .....	\$10.00	\$10.00
Late fee if after 3/25/19 .....	\$25.00	\$25.00

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#### Sheraton Indianapolis Hotel at Keystone Crossing

A block of rooms has been reserved at the Sheraton Indianapolis Hotel at Keystone (8787 Keystone Crossing, Indianapolis, IN 46240) for the special rate of \$159.00 per night. This hotel is within easy walking distance to theaters, restaurants and popular nightspots.

To reserve your room please call the Sheraton directly at 317-846-2700. Identify the group as "Indiana Chapter of American College of Emergency Physicians"

**HOTEL WILL ONLY HOLD ROOMS THROUGH MARCH 25, 2019 SO PLEASE REGISTER EARLY!**



# Reflections of a New EM Doc

by Dan Elliott MD (INACEP Board Member)

I walked into the trauma bay at my new Emergency Department to a patient just arriving via EMS. I'd barely introduced myself to the nurses and techs before I was called to my first patient room of the evening. He was a frail middle aged man from a local ECF presenting for altered mental status and was found to be febrile, hypotensive, and tachycardic. Medics tried unsuccessfully to get IVs on the way in, so all we had was an IO placed just prior to arrival. He vomited as he was wheeled in, and had to be suctioned. I walked into his room and everybody stopped and looked at me for direction. For a split second, I wanted to turn around and look to my attending for initial guidance. Alas, I quickly knew that the time had come for me to take full charge. The team worked to get an adequate IV started to run in fluids while setting up for intubation. I completed that procedure, and then realized the IV blew after RSI meds and we were going to need a central line. I had barely put my coffee and bag down, and I was already starting pressors, completing multiple procedures, verbally giving orders to nurses I had not officially met, and calling consultants to get the patient admitted to the ICU. My training had armed me with the knowledge and skills to practice well, but nothing could have truly prepared me for that first night on my own.

I had worked to reach that night for the better part of a decade! With years of school and training finally in the rearview mirror I was ready to practice medicine independently. Residency was tough and demanding but in the end, my co-residents and I all knew it would make us better EM doctors. The 24hr calls in the PICU would put us at ease when we had our own pediatric arrest once in the community setting. Our trauma rotations would prepare us for the worst of the worst, brought to us while we're single covered and an hour away from a trauma center. The overnight shifts in constant care, managing 15 critically ill patients at a time, would prepare us for the inevitable surge each shift.

In a lot of ways, residency prepared us for the worst of the worst. But even so, it was a shock to finally be on our own. That first pediatric arrest post residency always sticks with you. Mine came in October of my first year out. It was a mess.

Unfortunately, it was going to be futile regardless, but how I ran that code still sticks with me. And then there's the gunshot to the chest that my partner took care of at a non-trauma center which arrived via private vehicle. They did everything possible to help that patient, but in the end, we can only do so much. And there's the bad MVC with multiple injuries and unstable vitals which I did everything in my power to keep alive and stabilize while waiting for that helicopter to show up, knowing that was their only definitive hope.

Then there's the complicated medical cases. I would have thought during residency at a large academic center, we had seen it all. And then I get a lead poisoning in an adult which decompensates, or a massive MCA stroke in a 16 year-old with no medical conditions. Or the febrile postpartum patient who ends up having endocarditis and goes into multisystem organ failure. Or the refractory Torsade's from a drinking binge with a potassium of 1.2 and magnesium of 0.6. Every week it's something new and we begin to think that even 15 years of residency wouldn't be enough to see it all.

Emergency Medicine is an amazing and demanding specialty that allows us to see the absolute best and worst that medicine has to offer. We're the front door of the hospital, the crossroads of medicine, and the only option for millions of patients. My first 18 months out of residency has been a humbling, challenging, and rewarding experience that I wouldn't trade for anything. It has been exactly what I thought it would be and at the same time completely different. There have been great shifts and horrible ones. The politics of medicine can start to wear you down. It can start to feel like a chore to go into a shift, but then you have one of those days where you walk away knowing you made a massive difference in someone's life. Those shifts are what makes it all worth it. You again begin to realize why we got into this specialty. Every shift, I try to identify one patient encounter where I feel like I made a difference, and as long as I can continue to identify those encounters, this career will be well worth it. Here's to 30 more years in this crazy, demanding, rewarding, and always challenging specialty!



## A Story of Salt and the Lives It Saves

by Louis Profeta MD, FACEP

About twenty years ago, after an ice storm hit our city, our Emergency Room physicians recognized a gap in our community's public health awareness and safety preparedness and set about trying to make a difference through a very creative partnership with the Indianapolis Department of Public Works and our Emergency Department.

A city of a million people can count on at least a thousand of its residents to be sent to the ER for every day of snow or ice. So, taking into account all the ERs, Med Checks, and clinics that operate in a city this size, a level 1 trauma center can easily expect to see at least a hundred new patients coming to the ER during the 24 hours immediately following an ice

storm and nearly the same amount each day of ice that remains following the initial storm. It may surprise you to hear that most of these injuries are slips and falls and not a result of motor vehicle accidents. Most car accidents during those days are very low impact, people creeping along driving bumper to bumper and gently sliding off the road or into each other. Thus, those injuries tend to be mostly minor.

The amount of broken bones, and severe brain trauma due to falls, however, can be staggering, often requiring emergency surgery, clogging up the operating rooms and intensive care units, and taxing ERs that are often in the full throes of influenza during the same winter months. Many of these people, especially the elderly on blood thinners, suffer incredible injuries and will ultimately die from their simple falls. In addition, many will be brain damaged, paralyzed, and permanently disabled. It is one of the most unappreciated public health issues in America. Thus, began the "Erase" (Emergency Response Awareness Safety and







Education) salt project. Our goal was two-fold: to provide a simple and proven safety adjunct to the community we serve in the form of bags of road salt, and to create a yearly media campaign highlighting the dangers of ice.

By doing this, we were able to create a public awareness dialogue that encourages people not to venture out and asks more capable neighbors to help the elderly by bringing in their mail, getting their groceries, etc., but we also were able to promote a sense of volunteerism in local school groups, who jumped at the chance to assist us.

More than twenty years later, with the help of local youth volunteers and ER staff, who take over our ambulance bay for a few hours, we have now assembled and distributed more than 120,000 five-pound bags of road salt. Salt meant to improve the traction on porches, sidewalks, and walkways, especially for the elderly.

We really have no doubt that countless lives have been saved because of this initiative. The salt is donated by the Indianapolis Department of Public Works. Our ER buys the printed bags and—save for a few dozen donuts, some door prizes, a couple radios playing holiday music, folding chairs, plastic scoops, and a couple borrowed pickup trucks—the cost, time, and planning expenditures are negligible.

Imagine if your ER, your school, your church, your civic group city did the same.

Sometimes the simple solutions to public health and safety just require just a bit of imagination, a few dozen motivated student volunteers, and about ten dozen donuts. Give it a try in your community. We can accomplish so much by just being creative and working together.

*Dr. Louis M. Profeta is an emergency physician practicing in Indianapolis. He is one of LinkedIn's Top Voices and the author of the critically acclaimed book, The Patient in Room Nine Says He's God. Feedback at [louerm@att.net](mailto:louerm@att.net) is welcomed.*

## BULLETIN BOARD

Organizations or individuals that want their message to reach emergency physicians in Indiana will find the **EMpulse** their number one avenue. The **EMpulse**, published four times per year, is mailed to members of the Indiana Chapter of the American College of Emergency Physicians. This highly focused group includes emergency physicians, residents and students.

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## Legislative Update

by Lou Belch, Lobbyist for INACEP

Several of the bills are being monitored for their impact on Emergency Medicine. While the information in this article is current as it is being written, things change quickly at the General Assembly.

### Advanced Practice Registered Nurses

HB 1097 and SB 394 seek to remove the requirement that an APRN collaborate with a physician. Both bills have been heard in their respective committees and await amendment and vote. One of these bills will likely pass over the objection of organized medicine. The bill does not prevent employers from putting in place requirements limiting practice.

### Physician Maintenance of Certification

SB 203 prohibits a hospital from denying hospital privileges to a physician solely based on participation in maintenance of certification. It also prohibits the licensing authority or insurers from requiring maintenance of certification. JT Finnell MD, FACEP represented INACEP in opposition to the bill. The bill has passed the Senate and awaits further action in the House.

### Sepsis Treatment Protocols

HB 1275 as introduced, would have required hospitals to adopt sepsis treatment protocols and report on sepsis to the State Department of Health. Chris Ross MD, FACEP participated in meetings on this bill. The bill was amended to create a task force at the Department of Health to study sepsis protocols for all settings. There will be an emergency physician on the task force. All but 5 hospitals in the State have sepsis protocols, but many schools, long term care facilities, and home health agencies do not. The bill will likely pass the House.

### Emergency Care Payment

HB 1441 requires insurers to cover and reimburse expenses for care obtained by a covered individual in an emergency. It uses the prudent layperson standard for emergency. The bill has been assigned to the House Insurance Committee.

Above is a small sampling of bills that are of interest. INACEP lobbyists and leaders are monitoring the session very closely and will act when appropriate in the interest of Indiana Emergency Physicians.

## A View from the Top

*continued from page 1*

stands currently (as of this writing), the bill is moving forward in a modified format. We're working extremely hard at INACEP to make it as EM friendly as possible. I've been sending out frequent updates on the INACEP engagED forum so please go there to join the discussion and keep track of this and all pending bills. The signup can be found under the "About ACEP" tab on the ACEP homepage ([acep.org](http://acep.org)).

**3. Health Information Exchanges** – Now that we've made some strides with the Medicaid Managed Care payment issues (which we are still keeping our eye on, don't worry), our next big hope was to help straighten out health information exchanges (HIEs) here in Indiana. The biggest player in Indiana is IHIE, known to most as Careweb. The information in IHIE is robust when available, but participation amongst some hospital systems and in some regions of the state is lacking. IHIE has been working with us to try to bring this additional

info on board. In addition to IHIE, we have been looking into an ACEP-endorsed national HIE product called EDIE. EDIE is an ED-specific national HIE database that is focused on our needs as emergency physicians. It has already rolled out in several states, including Virginia, Washington, Florida and Kentucky with a great reception by Emergency Physicians in those states. What EDIE aims to do is to digest information into a one-page summary of pertinent information and push it to your ED. This would work not only with information across the state, but across the country as well. They hope to be the "front page" of HIE for us here in Indiana. However, with or without EDIE, we plan to work hard to improve our HIE system in a meaningful way. Definitely more to come on this issue.

...and those are the highlights I have for you all. As always, keep me posted on what's affecting you in your ED and what INACEP can do for you. Now, go take care of some Hoosiers!



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# How'd That Get In There? Creative Solutions to Removing Stuck Parts

by Devin Doos, MD and Sarah Kennedy, MD

## Overview

HPI: A 52-year-old right hand dominant male without significant past medical history presented with his left third digit wedged in a car gas spigot. The patient had reportedly dropped an object in the tank and, when he reached in to retrieve it, realized his hand was stuck. Upon EMS arrival, the first responders needed to cut through the gas tank at the fuel filler neck to free him from the rest of the car. He was then transported to the ED with a portion of the steel tank still attached to his finger (*Figures 1, 2*). His only complaint was pain around the finger secondary to swelling.

## Exam Findings and Workup

Physical Exam: VS: HR 73. RR 16. BP 154/103. Temp 97.9

On initial exam, the patient's middle finger was trapped in the tubular steel gas spigot just proximal to the PIP joint. Any attempt to pull or manipulate digit resulted in increased discomfort. We were unable to visualize the entrapped portion of the finger secondary to the small opening. Radial pulses were 2+ bilaterally and sensation was intact.

## Management

The patient had the sensation of something wedged around the end of his finger, however we were unable to visualize what was pinning his finger in the device. Initially we

attempted to readjust the finger with soap, ultrasound gel, and ice water but had no improvement in finger mobility. It appeared a spring-loaded flap had entrapped the finger. We used Mayo needle holders in an attempt to free the finger, however every time the flap was manipulated, the patient reported increased pain. We then called the Indiana Fire Department for their equipment and expertise. A Sawzall was used to cut down the distal portion of the gas pipe to achieve better visualization and we were able to see his finger tip. The patient then insisted on using pliers himself to bend the metal flap that had entrapped his finger. He was able to free himself from the gas spigot with a small amount of manipulation. Hand x-ray was negative for fracture or foreign body. The wound was inspected and found to be superficial, so it was cleaned and dressed.

## Discussion

After our initial attempts were unsuccessful, we looked for tools available in the ED and looked at schematics of the car's gas tank for ideas. A quick look at Environmental Service's tools found pliers, but without better visualization of the digit, this was not helpful. We discussed calling the OR, but we were unsure of what was available, how long it would take to get the equipment needed, or if it would even be effective. During our initial assessment there was some concern for using power tools, as the metal would be contaminated with potentially



Fig. 1



Fig. 2

flammable material. It became apparent, however, that we could not remove the gas spigot without power tools. Finally, we chose to call the local fire department as they are experts in heavy machinery and cutting techniques. They set up two IV bags running wide open to keep the material cool and took frequent breaks while using the Sawzall (*Figure 3*). Once the metal tube was shortened and the finger was visualized, pliers were successful in freeing the patient's digit (*Figures 4, 5*).

Once removed from the spigot, he was found to have two superficial lacerations along the bilateral distal aspect of his finger without nail fold disruption (*Figures 6, 7*) and had a minimal subungual hematoma with overlying stellate deformity to nail. He was neurovascularly intact in all three nerve distributions and had full range of motion at his joints.

There are no case reports on this type of injury. There are several news articles of similar situations, usually related to using a gas additive. A majority of these individuals were able to have their hand freed on scene however the articles did not comment on whether these individuals followed up in the emergency department.

## Conclusion

We were able to safely remove the gas spout. Patient had a superficial laceration to his finger that was cleaned and bandaged. We updated his tetanus and gave him clindamycin

for prophylactic coverage. He was discharged home without further complications.

Injuries around the nail bed should be carefully inspected as they can require additional repair and leave patients with poor cosmetic result if not appropriately managed. This case was unique that it required additional resources not typically used in the Emergency Department.

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Fig. 3



Fig. 4

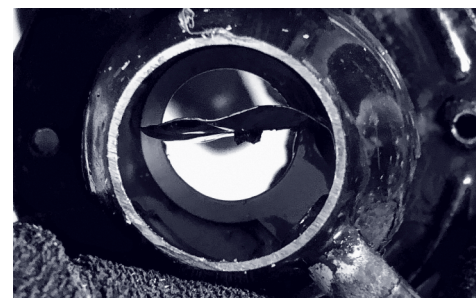


Fig. 5



Fig. 6



Fig. 7






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