Volume 30, Issue 2 **Summer 2021**

# EMpulse

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

**The 49th Annual INACEP Emergency Medicine Conference was a great success.**

**Stay tuned for the 2022 Conference dates and location!**

## Inside this Issue



## A View from the Top

***Lauren Stanley, MD, FACEP (INACEP Board Immediate Past President)***

Emergency Medicine is at a crossroads.

Whether you have heard it on social media, ACEP publications/presentations, chatter at work, or rumors from EM friends in other counties or states, you have almost certainly heard about it. Our specialty is facing what is projected to be a significant excess of Emergency Physicians within the next decade, which could be disastrous on many levels, from the individual physician (new residency graduate or seasoned EP) to independent EM groups to the specialty as a whole.

The reasons we got to this place are multifactorial. Certainly, the workforce issue is tied in with another hot-button topic: scope of practice for non-physician providers. There is ongoing discussion about the influence of contract management groups and private equity on the EM landscape. The proliferation of EM residencies has played a role. Just as the problem is multifactorial, the solutions will need to be multifactorial. I will leave the discussion of specific solutions to another time. My goal is simply to call all of you, the Emergency Physicians of Indiana, to tune in and stand up.

Let's reclaim our specialty. Let's decide that care provided by Emergency Medicine residency-trained physicians is not only the gold standard but should be the expectation for every single medical facility in Indiana that calls itself an Emergency Department.

***It has been an honor to be your Indiana ACEP President over the last year. I have seen the grit and determination that you all brought to the table in the face of a pandemic; I have also seen the creativity, flexibility, and sense of humor that make EPs truly unique. Thank you for your dedication to providing great patient care even in the most challenging of times.***

Let's protect our workforce: 1. let's keep our jobs and our hours (for those of us who have been out of residency for some time), 2. let's give small-to-medium independent groups the tools they need to stay independent, and 3. let's work to assure that there will be jobs for the EM residency grads who are graduating, ready and eager to take excellent care of patients but finding that the land-of-milk-and-honey of EM jobs is now a field of scattered positions, with multiple applicants for each job.

Let's identify our shared goals as Emergency Physicians and unite our efforts in a way that is effective. I have heard such divisiveness about how we address the issues outlined above, who is at fault, etc. Let's get back to what we do best as EPs: identify the highest-priority actionable problems, create solutions that are discreet, effective, and measurable, and move on to tackle the

*continued on page 10*

# *Case Study:* A Severe Sympathomimetic Toxidrome from Rectal Body Stuffing

*by Nicole Carpp, MD, PGY-II, Indiana University Emergency Medicine Residency (Board Member)*

## Overview

A 28-year-old male with a history of substance use disorder presented to the ED after reportedly ingesting an unknown substance immediately prior to presentation. He was asymptomatic and initially told the clinician that he had swallowed an unknown quantity of methamphetamine. He denied any other ingestions. The Indiana Poison Center was consulted and recommended screening labs, EKG, chest x-ray (CXR) and abdominal x-ray (KUB).

## Findings and Workup

**Physical exam:** Unremarkable. No acute distress. Vital signs all within normal limits.

**EKG:** Sinus rhythm, no ST or T wave abnormalities, normal intervals.

**Labs:** CBC, BMP, and creatine kinase were within normal limits. Ethanol, acetaminophen and salicylate levels negative.

**Imaging:** CXR with no acute cardiopulmonary processes. KUB with concern for a 3cm by 5cm foreign body in the rectum.

## Management

The patient denied having a rectal foreign body and declined a rectal exam. He was monitored on telemetry and observed in the emergency department for passage of the suspected foreign body. Approximately 5 hours into his ED stay, he became agitated, pulled out his IV and attempted to remove monitoring leads. Repeat physical exam was significant for agitated delirium, diaphoresis, tachycardia (HR=160bpm), mydriasis and sustained ankle clonus.

He was moved to a resuscitation bay, given repeated doses of IM lorazepam and attempts to externally cool with ice bags to the groin and axilla were made. Despite repeated dosing with a total of 28mg of lorazepam over the course of 1 hour, he remained tachycardic, agitated, and subsequently had a seizure. Rapid Sequence Intubation was performed with etomidate and rocuronium, and he started on propofol and lorazepam infusions. Initial bladder temperature was 38.8 degrees. The foreign material, consistent with body stuffing, was able to be removed and supportive care with ice bag external cooling, IV fluid hydration, mechanical ventilation, and continued GABA-A agonists was continued. He was admitted to the ICU where his toxicity cleared over the course of 12 hours and he was able to be extubated successfully.

## Discussion

Ingestion of drugs to evade detection occurs in two patterns: body packing (well-coordinated for the purpose of drug smuggling) and body stuffing (ingestion of drugs to evade detection). This is a classic case of body stuffing through an uncommon route. While most patients orally ingest a small quantity of poorly packaged substance, at risk for perforation and subsequent toxicity, in this case, the item was concealed rectally. In additional to perforation, toxicity can occur through semipermeable, intact packaging. If identified on history and physical, removal of the substance may prevent toxicity. However, since the packaging can be damaged during removal processes, the risks and benefits of retrieval must be weighed. Additionally, since the locations of concealment can be sensitive, patient consent for such exams must be obtained. GI decontamination with activated charcoal may decrease absorption of some substances but risks aspiration in an awake, non-intubated patient. If the substance is inaccessible, it remains prudent to monitor patients for development of clinical toxicity. While most sources recommend clinical observation for 6-8hours, consultation with the local Poison Center is beneficial for managing these patients.

In this case, the patient developed a sympathomimetic toxidrome which was refractory to frequent, high doses of benzodiazepines. This was complicated by difficulty with safely obtaining IV access in this agitated patient. Repeated doses of GABA-A agonists, including benzodiazepines and phenobarbital, may be needed to treat the agitated delirium and supportive care remains the mainstay of treatment. While a cohort of 132 patients published in 2017 noted a 2.3% rate of surgical intervention with no deaths, several case reports of fatalities have also been published.

## Conclusion

Rupture of illicit substances concealed in the GI tract can result in acute toxicity, morbidity and mortality. Early recognition and intervention in these cases is necessary.

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***Acknowledgements:*** *My thanks to Mary Wermuth, MD and the Indiana Poison Center for their assistance with this case.*

# Indiana ACEP New Executive Director and 2021–2022 Officers

Welcome new Executive Director of Indiana ACEP

**Cindy Kirkhhofer**

At the INACEP Annual Meeting held April 15, 2021 the following new officers were elected:

President
**Tyler Johnson DO, FACEP**

Vice President
(and Education Director)
**Dan Elliott MD**

Secretary/Treasurer
**Lindsay Zimmerman MD, FACEP**

Immediate Past President
**Lauren Stanley MD, FACEP**

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Organizations or individuals that want their message to reach emergency physicians in Indiana will find the ***EMpulse*** their number one avenue.

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# Participate in the 2021 National Pediatric Readiness Assessment May–July 2021

The National Pediatric Readiness Project (NPRP) is a multi-phase quality improvement (QI) initiative to ensure that all U.S. emergency departments (EDs) have the essential guidelines and resources in place to provide effective emergency care to children. The project is supported by the American College of Emergency Physicians, the Emergency Nurses Association, the Federal Emergency Medical Services (EMS) for Children Program, and the American Academy of Pediatrics.

The NPRP Assessment is a national assessment of America's EDs to determine progress in pediatric readiness, identify existing gaps, promote quality improvement (QI) efforts in hospital EDs around the country, develop national collaboratives to address common and critical gaps, and identify best practices.

Data was last collected in 2013 and re-assessment begins May 1st. ED Nurse Managers will receive several postal and email notifications with a link to the web-based assessment. Since **only one NPRP assessment per ED can be completed, we encourage you to collaborate with your ED leadership to participate in the NPRP assessment**. The NPRP assessment asks questions about hospitals and EDs from categories like: infrastructure, resources, personnel, the administration and coordination of care for children, policies, equipment, and more. Indiana EMSC strongly encourages ED Nurse Managers to download and print a PDF copy of the NPRP assessment and review before submitting their responses online.

The NPRP assessment helps ED personnel to be better prepared to provide quality care for all patients of all ages by evaluating the QI process of EDs over time. Hospitals with high ED readiness scores demonstrate a **4-fold lower rate of mortality** for children with critical illness than those with lower readiness scores; thus, improving pediatric readiness improves outcomes for children and their families.

**For more information visit:**
**pediatricreadiness.org and Indianaena.org.**

EMSC is a federally funded program whose core mission is to decrease child and adolescent death and disability through advocacy, education, and research. Facility Recognition for pediatric preparedness in Indiana helps fulfill a substantial portion of this mission. Indiana's program began in 2018 and 2 hospital Emergency Departments have been recognized.

Facilities in Indiana may be recognized as "Pediatric Ready" or "Pediatric Advanced." Criteria for recognition are based on national standards that improve the care of children. "Pediatric Ready" represents the minimum requirements to ensure an emergency department is prepared to care for any child. "Pediatric Advanced" includes slightly higher standards for pediatric preparedness in the emergency department.

If you wish to receive an application, please conact iEMSC Program Manager Margo Knefelkamp, via email: margo.knefelkamp@indianapolisems.org.

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# Emergency Physician Burnout

*by Justin Ritonya MD, FACEP (Board Member)*

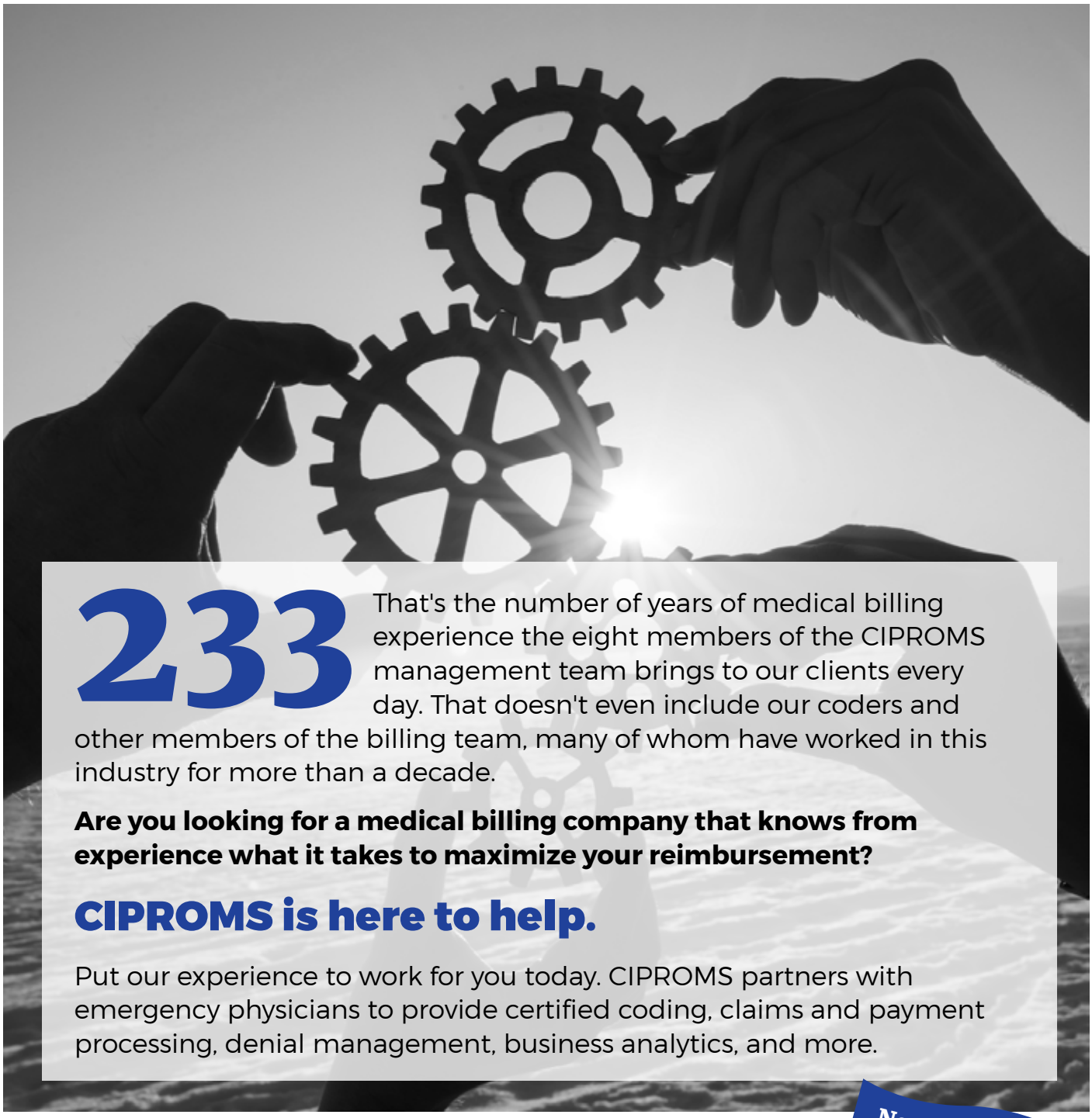
I have tried desperately to avoid the stereotypes of a budding physician throughout my career thus far. Begrudgingly, I am fairly certain I have hit most of the major check points. From a timid intern, to an over-confident second year (perhaps simply euphoric from not being the low person on the totem pole any longer), to a frightened senior feeling ill-prepared to be released upon the world as an independent physician. But the truth is, I never fully allowed most people to believe I was going through those milestones. Sadly, I, like many, chose to keep most of those feelings to myself. Never wanting to share those struggles with others because of feelings of weakness. I think most of who read this can relate to at least some of what I am saying and will discuss here in a moment. Or perhaps it is only me, but either way I hope to at least let this serve as a cautionary tale of the realities of one major problem with being a physician. I am talking about burnout.

This is a topic that has been brought up sporadically throughout my short career, thus far. However, I never really paid attention to or appreciated burnout. To be fair, why would I take it seriously so early in my career? I always figured this was something I would contend with years down the road. I think we all have encountered at least one seasoned veteran. Battle hardened from years serving their respective communities on the frontlines in the emergency department. But again, I always figured that I had ample time to prepare for such a point in my life. However, I am now starting to realize that I was distracted from this reality by the other many growing pains of becoming an attending. Distracted by either the fear of being on my own or the adrenaline brought on by the excitement of what we do every day. So, for the longest time I ignored much of the advice from my mentors. Advice such as, "you have the rest of your life to work" or "be certain to make time for yourself." I figured that because I was used to the rigors of medical school and residency, I could sustain that long term into my future. Working a "resident schedule" while I am young and able-bodied. These past few years have illustrated how wrong I was.

In late 2019 our community was shaken by the tragic suicide of one of our local physicians. This marked the first time I witnessed firsthand the devastation left in the wake of a physician suicide. I asked myself the same questions everyone else does when something like this occurs. How could no one have noticed any signs? Why would someone who had so much resort to this? I already noted previously how I never really wanted to share my struggles with others. Choosing only to deal with the stressors of a life in medicine on my own. Much of what we do is on our own. We are trained to be independent and to "figure it out." Knowing this, it becomes clear to see how something like this can happen over and over again. I feel as though the culture that drove this attitude in medicine is starting to shift, but we definitely have a long way to go. Physician suicide is still a major problem to the tune of hundreds of lives per year. For better or worse, COVID has helped to bring this to the forefront.

I do not think it takes a medical professional to see the dangers of a "do-it-yourself" culture in medicine during a global health crisis with mandated isolation. Unfortunately, over the course of this global health crisis, we would see many more physicians take their own lives. I can only imagine how much burnout played a part in this. I think it is important as well to also note the tremendous toll this has taken on all walks of life. It feels as though the sharp increase in psychiatric crises and drug overdoses has gone largely unnoticed. Fueled by the isolation driven by mass hysteria that is COVID. A hysteria that still dominates the headlines and draws attention away from a myriad of other issues, including the mental health of our medical professionals. I know this may be hard to believe right now, but not everything is COVID related. We need to ensure we are not neglecting everything else because of COVID, including ourselves. Eventually, COVID will be gone, yet all other problems will still exist.

With all of this in mind, it is hard to think how anyone could not have experienced burnout after this past year. As physicians, we all have an internal drive and need to want to help in this time of crisis. I certainly felt this way, and perhaps I was so distracted by COVID that the past year did not feel particularly taxing initially. I thank God often for my amazing wife, family and colleagues who have supported me. But despite all the measures I have in place to protect my mental health, I still recently felt burnout sneak up and grab hold. So, I had to take a step back and realize that I need to take time for myself and my family. I had to remember that in order to continue to help others through their own struggles, I needed to be at the top of my game. We are all susceptible to burnout. And if you think you somehow are not, I promise you, I have seen some of the biggest rock stars in emergency medicine fall prey to it. So, I implore you (especially residents) to pay close attention to any and all advice you receive with regards to maintaining your overall health. And be sure to pay attention to, and support, your colleagues. Because this job is, and always will be, very demanding.



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# Surviving the Democratic Group Reckoning

*by Chris Ross MD, FACEP (Ex Officio Board Member)*

EM groups, especially those of us in small democratic groups, have been through some serious trials and tribulations over the past several years. Declining or stagnant reimbursement, surprise billing and scope of practice fights and the looming threat of CMGs swooping in to take your contract have been ever-present and growing. On top of that, COVID has sent many of us scrambling to adjust staffing, adjust pay and do whatever we can do to make sure ends meet. It feels like we've been on our heels, rolling with the punches to stay upright. Despite this, now more than ever, I think we can still swing the pendulum in our favor. Over the past year, I stumbled into a couple of bright spots that could help democratic groups come out of this mess in better situation. Without further ado, here they are:

## *Emergency Medicine Business Coalition (EMBC)*

EMBC (pronounced "embassy") is the brainchild of Lisa Maurer along with other likeminded democratic group leaders that's aimed at bringing our ideals and numbers together to create a bigger force in the business world. Typically, the smaller democratic groups of us don't get a fair shake in negotiations with insurers and vendors because of our lower numbers (and possibly higher risk in the insurance world). EMBC brings all the groups together under one umbrella to negotiate via collective purchasing and get more competitive rates for services. After one year in existence, EMBC has 16 democratic groups signed on representing 8.8 million patient visits per year. That number is growing month over month as the word is getting out. Currently, they've negotiated for disability, dental, vision and cybersecurity benefits. The group I work in, Medical Associates, is one of those 16 groups and have already found savings three times above our EMBC dues investment. Future projects for the EMBC collaborative include malpractice and health insurance among other potential non-insurance group needs like revenue-cycle management, advocacy efforts, etc. Along with collective purchasing, you get access to a co-op of democratic groups to bounce ideas off that you may be uncomfortable with sharing in the greater EM community. EMBC meets monthly as a membership and regularly hosts guest speakers to help boost your revenue and stay competitive in the EM market. For more details, you can visit the EMBC website at https://embusinesscoalition.org/. It's definitely an overdue and much needed service for the smaller groups to get fair representation in what's becoming a contract managed group heavy market. Think of it as having the leverage of a CMG in several areas while staying as an independent democratic group. The sky really is the limit with EMBC.

***EMBC (pronounced "embassy") is the brain-child of Lisa Maurer along with other like-minded democratic group leaders that's aimed at bringing our ideals and numbers together to create a bigger force in the business world.***

## *ACEP Democratic Group Practice Section*

Shamefully, despite being a partner in my democratic group for several years now, I'd never really gotten involved the ACEP Democratic Group Practice (DGP) Section. Around the same time of our enrollment with the EMBC bunch (and after some friendly nudging from a colleague), I signed on to the DGP section to see what it was like. Similar to my experiences with the EMBC group, I found a collaborative of likeminded democratic groups looking to improve their stake in the EM world. I currently serve as the secretary for the DGP section, and along with the other leadership helmed by Jay Mullen, developed a three-part series of discussions surrounding EM group development and leadership dubbed "The Anatomy of a Democratic Group". The series is aimed at delving into democratic group structure and what makes good democratic groups tick. Our first session of the series "Governance" finished up a couple months ago with great success! We had an excellent guest speaker who reviewed different governance structures followed by a robust discussion from our membership about what has worked and hasn't worked in their groups. Our next session "Pay & Equity" is set to go for June and should be another big win. All these sessions are recorded and available to DGP group members if you weren't able to participate or want to join in on the section and catch up on what you missed thus far.

Recent years have been exceedingly difficult on many fronts for smaller democratic EM groups. Fortunately, there seems to be a recent upswing in support for us. I, personally, have found solace and much needed survivability tactics in the two groups mentioned. So, if you're part of a democratic group (or if you're interested in forming one yourself) do yourself a favor and check out EMBC and the ACEP DGP section. Feel free to reach out to me (ctross@gmail.com) with any questions as well.

Take care!

# 2021 INACEP Conference Wrap-Up

*by Tyler Johnson DO, FACEP (INACEP Board President)*

The 2021 Indiana chapter of the American College of Emergency Physicians virtual conference was held via zoom on April 15th. It was a great event with 52 participants. The conference started with a presentation on the use of law enforcement in the emergency department by Tom Rhoades the chief of police at Parkview Health. There were a lot of good questions and discussion. We followed that with an update on heart failure treatment by Dr. Peter Pang, MD FACEP chair of emergency medicine at Indiana University School of Medicine. Next was one of our current national board members and all around nice guy Dr. Ryan Stanton, MD, FACEP who had a good discussion on opioid epidemic in the midst of COVID-19 and where we currently stand. Following this was a current update from our ACEP president Dr. Mark Rosenberg, DO, MBA, FACEP on where we are as a specialty and innovations in emergency medicine. We then spent some time in discussion about the current workforce study.

Lauren Stanley, MD, FACEP led us through the INACEP update. It was an honor to present Jamie Jones, MD with the well-deserved Fred Osborn Award. We recognized our past presidents Bart Brown, MD, FACEP and Lauren Stanley, MD, FACEP with the Past Presidents Award. We then conducted business reviewing the bylaws, financials and activities of the last year for INACEP. After this we recognized and thanked both Sue Barnhart and Nick Kestner for their dedication and service to INACEP as they will both be retiring. We also announced the hiring of a new executive who cannot replace them but will try to fill their shoes in Cindy Kirchhofer. More to come to introduce Cindy and her passion and vision for INACEP.

We concluded the event with presentations on how to stabilize infants with Dr. Richard Cantor, MD, FAAP, FACEP and an update on where we stand with COVID-19 with Lindsay Weaver, MD, FACEP our current Indiana State Department of Health Chief Medical Officer.

***Please check our inacep.org website later this summer get the date and location for the 2022 Conference. With luck, the next one will be in person!***

## WELCOME NEW INACEP MEMBERS

### *Regular Members*

Rice, Jennifer
Wavle, Nathan

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Hargis, Charles MD

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Brewster, Michael
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Buckman, Zachary
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Harris, Madison
Mark, Natalie
Matella, Andrew
McComb, Randall
Ni, Kevin
Phillips, Emily
Porada, Kristina
Priddy, Conor
Quraishi, Ayesha
Shields, Sanayika
Span, Amanda
Tavel, Sigal

## UPCOMING EVENTS

### *Leadership & Advocacy Conference*

***Washington DC • July 25—27, 2021***

### *Scientific Assembly*

***Boston, MA • October 25—28, 2021***

# Legislative Update

***by Lou Belch, Lobbyist for INACEP***

The 122nd Indiana General Assembly adjourned last week on Thursday, April 22, after final passage of the state's biennial budget. The legislature did not adjourn sine die in typical fashion as they proceeded in a highly unusual year due to COVID-19 protocols. Instead, they adjourned until the fall of the gavel, which means they can return at any time. They did this in order to complete their constitutionally required duty to redraw state legislative and congressional districts once the necessary 2020 Census data is released. It is anticipated they will do this sometime in September.

There were very few new laws that will have an impact on emergency medicine. There were 2 immunity bills related to COVID-19, SEA 1 and HEA 1002. Here is a summary provided by the Indiana State Medical Association:

> *ISMA and other health care industry stakeholders successfully advocated for landmark immunity legislation that is tailored to the heroic response of physicians and members of the health care team.* ***Senate Enrolled Act (SEA) 1 (Civil immunity related to COVID-19)*** *and* ***HEA 1002 (Civil immunity related to COVID-19)*** *provide broad, premises-based protections and specific protections for common situations physicians experienced during the course of the pandemic; these include withholding or delaying care, providing service without adequate PPE or COVID-19 testing, using equipment and medicine in ways not approved by the FDA, and practicing outside of one's expertise or specialty in order to fill workforce shortages. Protections apply to licensed physicians and residents, as well as medical students who were called on to step up in the face of a global pandemic, and extend to administrative licensure actions.*

There were several bills passed the codified some of the Governor's executive orders that were issued in response to COVID 19. Most important among them is SEA 3 which greatly expands the ability of providers to practice telehealth.

It is also important to note what did not happen this year:

- There was no expansion of scope of practice for APRNs.
- There was no change to the surprise billing law from 2020. This means that the federal "no surprises act" will govern in Indiana.

As we move to the interim, there will be several interim study committee topics. INACEP leadership will monitor those committees and respond accordingly.

# View from the Top

*continued from page 1*

next problem. Whether you align with ACEP (as I have, because I see the organization's immense value to my profession) or another reputable EM professional organization, let's be solution-focused instead of getting distracted by conflict. Large parties such as insurers or well-funded lobbying groups love when physicians are divided amongst themselves. Let's form a united front and be a force to reckon with.

On a different note, I wanted to share exciting news with you, our chapter members, about a transition in leadership that is occurring in May. Indiana ACEP has been lucky to have had Nick Kestner as our Executive Director for many years (since 1979!), and Sue Barnhart as Executive Assistant for >25 years. Nick and Sue have devoted countless hours to advocating for Hoosier emergency physicians, and we as a chapter are forever indebted to them for their many years of service. Nick and Sue will be retiring in June. After an extensive search for a new Executive Director, I'm happy to share the news that Mrs. Cindy Kirchhofer will be taking the helm in May.

You may recognize her as Representative Kirchhofer, as she was an Indiana House Representative for about 10 years. For 5 of those years, she served as the Chair of the House Public Health Committee. Her primary work has been as a Risk Manager for a large hospital system. In all of these capacities, she has had extensive interaction with various facets of the healthcare system and has a good understanding of the issues we face as Emergency Physicians. Her unique background and her interest in helping physicians advocate for issues important to them, will be great assets. I look forward to seeing what we can accomplish in the coming years with Cindy as our Executive Director!

It has been an honor to be your Indiana ACEP President over the last year. I have seen the grit and determination that you all brought to the table in the face of a pandemic; I have also seen the creativity, flexibility, and sense of humor that make EPs truly unique. Thank you for your dedication to providing great patient care even in the most challenging of times.

# *Fred Osborn Award Winner:* Tribute to James Jones MD, FACEP

*In 2010, the Indiana ACEP board established an annual award in memory of Dr. Fred Osborn who passed away in 2009. Dr. Osborn contributed extensively to the practice of emergency medicine and to his group, hospital, community and the state. As such, an award was established in his memory to be presented annually at the Indiana ACEP Education Conference in the spring.*

*The recipients of the award to date have been as follows:*

*2010 - Peter Stevenson MD, FACEP of Evansville, IN*

*2011 - David VanRyn MD, FACEP of Elkhart, IN*

*2012 - Thomas Madden MD, FACEP of Bloomington, IN*

*2013—Thomas Gutwein MD, FACEP of Fort Wayne, IN*

*2014 - Tom Richardson MD, FACEP of Danville, IN*

*2015 - Randall Todd MD, FACEP of Indianapolis, IN*

*2016 - Chris Burke MD, FACEP of Carmel, IN*

*2017 - John McGoff of Indianapolis, IN*

*2018 - Thomas Heniff MD, FACEP of Boone CO, IN*

*2019 - Chris Hartman MD, FACEP of Carmel, IN*

***2020 – James Jones, MD, FACEP of Zionsville, IN***

The Board of Directors of the Indiana Chapter of the American College of Emergency Physicians announced last summer that James Jones MD, FACEP was the 2020 recipient of the Fred Osborn Memorial Award for Excellence in Emergency Medicine. This award, presented annually, recognizes leaders in Emergency Medicine who have made extraordinary contributions to the EM community in Indiana in terms of leadership, involvement and contributions to their Emergency Medicine group, hospital, and state. Dr. Jones was nominated by Dr. JT Finnell. After a year of COVID 19 postponements, this award was presented to Jamie at the 2021 INACEP 49th Annual Emergency Medicine Conference on April 15, 2021.

I'd like to take a moment to congratulate Jamie Jones on being nominated as the 2020 Fred Osborne award recipient. Many people know Jamie and his numerous accomplishments, I'd like to summarize just a few.

Jamie is a 1976 graduate of DePauw University (Greencastle, Indiana) and a 1979 graduate of the Ohio State University School of Medicine. He completed his residency in Emergency Medicine at Wright State University in Dayton, Ohio in 1982. From 1985 – 1997 he was faculty for the then Methodist-based EM residency, serving as the associate program director from 1993 – 1997. In 1998 – 1999 he was the chair of the Department of Emergency Medicine for Mayo Hospital Arizona. He then returned to Indiana in late 1999 and joined the faculty of the Eskenazi Emergency Department and the Indiana University School of Medicine. From 2001 – 2013 he served as the Vice Chair of the academic department.

Jamie served on the INACEP Board of Directors from 1987 – 1993. He was president of our board from 1991 – 1992.

Within the IU School of Medicine, Jamie is the Chair for Promotion and Tenure Committee (clinical and contracts), serves as a mentor for the Career Development Consultations and is a member of the Curriculum Council Steering Committee. In 2015, he was named an Assistant Dean for Graduate Medical Education with a focus on Residents as Teachers.

On a national level, he was a member of the Board of Directors for the American Board of Emergency Medicine (ABEM) from 2005 – 2015. His ABEM activities included: chair of the Residency Visitation Program Task Force, chair of the Academic Affairs Committee, chair of the Communications Committee, senior editor for the LLSA examination, liaison to the Medical Toxicology sub board, member of the Test Development, Test Administration, and Credentials Committees as well as the Assessment of Practice Performance, Initial Certification, Residency Training Information, and Internal Medicine-Critical Care Task Forces. From 2010 – 2015 he served on the Executive Committee and was President in 2013 – 1014. He continues as an oral board examiner. Since 2001, Jamie has been a manuscript reviewer for Academic Emergency Medicine.

I was honored to introduce Jamie at the 2021 INACEP virtual conference and ended his tribute with this quote: "A true friend will ride the bus with you when the limo breaks down." Jamie Jones is that kind of mentor and true friend.

# EMpulse

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