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BULLETIN

PRESIDENT'S PAGE PG 04

By LINDA FEIWELL ABELS, MD
IMS President

INDIANAPOLIS MEDICAL SOCIETY
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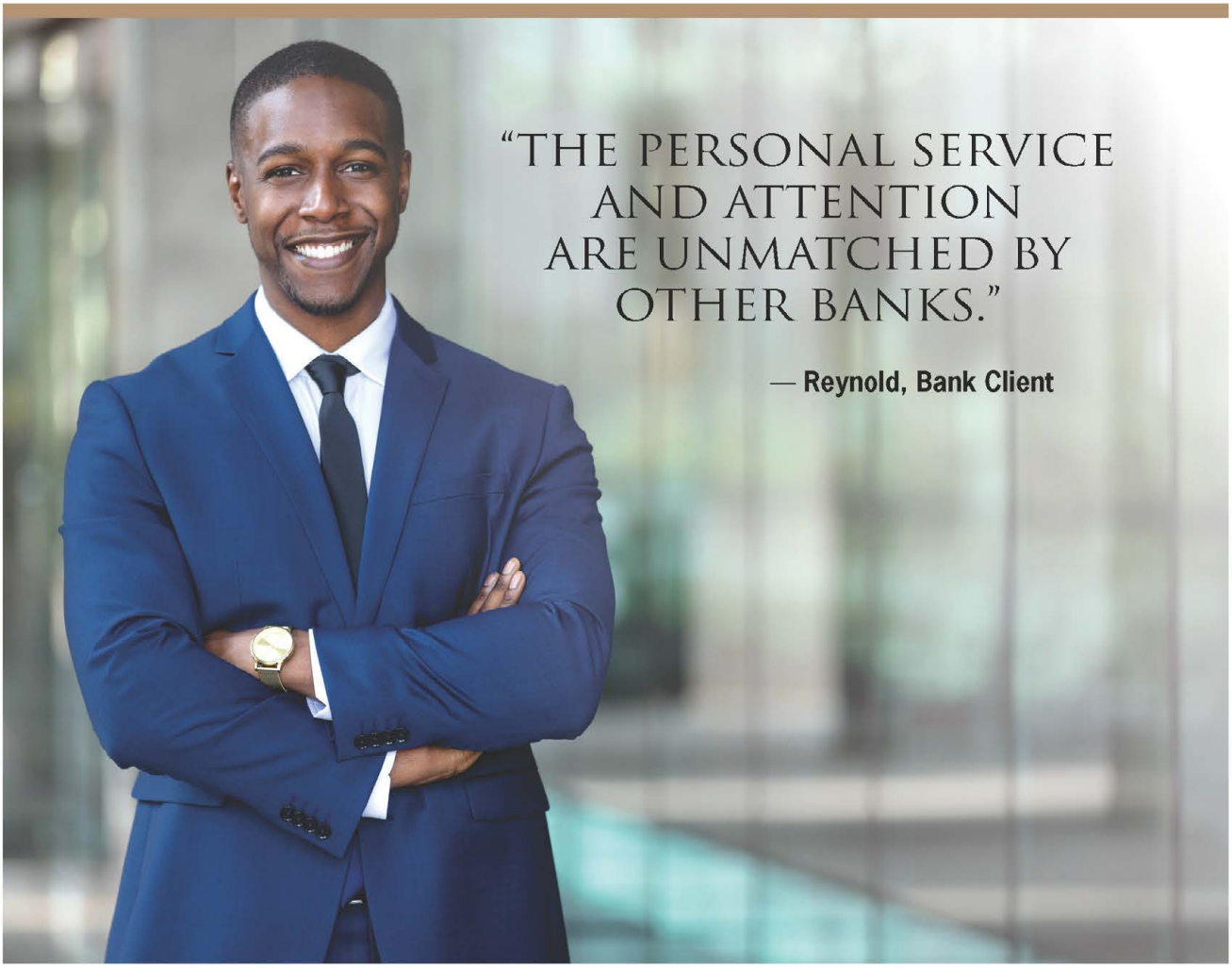

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BULLETIN

INDIANAPOLIS MEDICAL SOCIETY EST 1848

OFFICIAL MONTHLY PUBLICATION OF THE

Indianapolis Medical Society
125 West Market Street, Suite 300
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Ph: 317-639-3406
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LETTER FROM THE EDITOR

Members,

Welcome to the new year! Be sure to check out page 19 of the Bulletin to meet your new IMS leadership. We are excited to welcome our new officers, board members, and delegates for the year. We have several alternate delegate positions yet to fill. If you are interested in serving this advocacy role for the IMS at this year's ISMA Convention, September 10-13, please contact me. We would love to hear from you.

Don't forget to get your COVID vaccine. If you take your picture and post it on any social media sites, be sure to tag the IMS site too.

Stay safe and healthy! Until next month.

Morgan Perrill

Morgan Perrill
Executive Vice President

THE PRESIDENT'S PAGE

LINDA FEIWELL ABELS, MD

Happy New Year. I hope 2021 is a healthier, happier year for all of you. As Covid vaccines become more available, you as health care providers are all eligible for a vaccine. If you have questions about how to schedule, please visit the Indiana State Department of Health Web site website at

https://www.in.gov/isdh/28690.htm

and to register visit:

https://registration.coronavirus.in.gov/log-in/6421a803a24e47368bd7ffdceb950e04.

We look forward to returning to some sense of normalcy with our families, friends, and patients.

I want to introduce myself. I am from northern Indiana and grew up in South Bend. I graduated from Indiana University with a bachelor's degree in nursing and worked as an ICU nurse and later, after completing graduate school, as a faculty member in the IU School of Nursing. I subsequently worked as a nurse practitioner and was encouraged to go to medical school. I completed the prerequisites for medical school and returned to IU School of Medicine in 1985 with four small children under seven. I completed a residency in internal medicine at St Vincent's Hospital after giving up an anesthesia spot at IU. I have been an internist in practice for 31 years. I have worked at American Health Network for the past two-and-a-half years. I have been married for 47 years and have four adult children and seven grandchildren. I've been a member of the Indianapolis Medical Society for my entire career.

I would like to share some of my goals for 2021. It is my hope to continue efforts to increase membership in the IMS. Dr. Tibesar began and was successful in getting a number of new members last year. We have also welcomed all students from Marion School of Medicine and Indiana University School of Medicine. Most recently, IMS has also implemented a program for new members at a reduced rate for their first year. The best method for recruiting new members is through the efforts of our existing members. I hope all of you will try to recruit at least one new member in 2021.

I would like to continue virtual educational meetings as begun this past year. It affords us the opportunity to meet virtually and learn and discuss current information. One suggestion is to review the new guidelines for coding that were implemented by CMS this month. Another suggestion is to discuss recommendations for vaccination for Covid 19, including facts and myths. Please feel free to email me if you have any ideas for other topics.

We continue to have a close relationship with The Indianapolis Bar Association. At this time, we are unsure whether the annual medical/legal dinner will occur in 2021. We will keep you posted about this collaborative event.

In addition, I would like to establish a committee to write resolutions for 2021. Please email me if you are interested. Resolutions are due for submission by July. We can help individuals who submit their own resolution as well.

I would also like to work with some members interested in issues pertaining to advanced practice providers. Please email if you are interested in this subject.

I would also like to establish a program that a philanthropic committee that enables IMS to select a yearly project to help a facility/program in the Indianapolis metro area. We have provided support to the medical museum and last year partnered with ISMA to provide PPE to some local hospitals.

And finally, I would explore the possibility of setting up an like to research the possibility of an

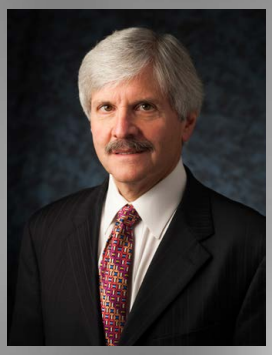
endowment program for IMS.

We continue to encourage you to consider writing articles for our IMS Bulletin. Morgan Perrill, our wonderful executive vice president, works hard to put the Bulletin together. the bulletin.

I want to conclude today by thanking our immediate past president, Dr Eric Tibesar, who worked very hard through difficult times to keep IMS moving forward by adapting to virtual meetings. I hope to be as flexible as he was during 2020.

Linda Feiwell Abels
President
Indianapolis Medical Society

Indiana's Tobacco Tax



By RICHARD D. FELDMAN, MD
IMS Board Member, MHM Board member and Past President, Former Indiana State Health Commissioner

Indiana is one of the unhealthiest states in the country on most any measure. It ranks among the states with the highest prevalence of lung and other cancers, obesity, diabetes, and most chronic diseases. Our state's infant mortality rate is eighth highest, and our 13.5 percent maternal smoking rate is well above the national average. Indiana's overall health ranks 12th worst in the country. Meanwhile, the Hoosier state ranks 49th lowest in public health funding.

Hoosier adult smoking rates are unacceptably high, ranking 10th highest among the states - 19.2 percent as compared to the national rate of 13.7 percent.

Our cigarette tax is 38th lowest in the country at $99.5 cents per pack and has not been raised since 2007. Surrounding states have higher per-pack cigarette taxes: Wisconsin $2.52; Michigan $2.00; Illinois $2.42; Ohio $1.60, and even the tobacco state of Kentucky maintains a tax of $1.10.

What a pathetic situation.

Indiana's finances are stressed, and our state-budget crafters are looking for funds to replace decreased revenue due to the COVID-19 pandemic. What better time to increase the cigarette tax to improve the health of Hoosiers and improve the workforce and business environment.

There will be non-health related proposals on uses for an increased cigarette-tax revenue. But there must also be consideration for additional funding for public health-related purposes including opioid treatment, increased programming to reduce infant mortality, added support for the expanded Medicaid program and the Healthy Indiana Plan, and increased funding of the state's tobacco control prevention and cessation programs. Once funded at $35 million a year, tobacco control programs are now only allocated $7.5 million, which is insufficient to effect the needed reduction in tobacco use. This is especially true for our children who continue smoking and vaping their way into lifelong nicotine addiction and eventual premature death. The COVID crisis compels us to also address the dire need for bolstering state and local health department infrastructure and crisis-preparedness capacity.

Despite the great advances in tobacco control in the past half-century, even in Indiana, tobacco is still our greatest public health challenge, continuing as the leading cause of preventable disease and premature death. The Hoosier state is mired in the human and economic losses due to tobacco use. One in five Hoosiers die as a result of smoking (11,000 yearly) while 4,100 kids start smoking every day. Tobacco use results in $7.6 billion in total state economic losses yearly in health-care costs and lost productivity. This includes $590 million in state Medicaid costs and an additional cost of $5,800 to business and industry for each smoking employee yearly. An unhealthy workforce is a drag on business and a barrier for economic development.

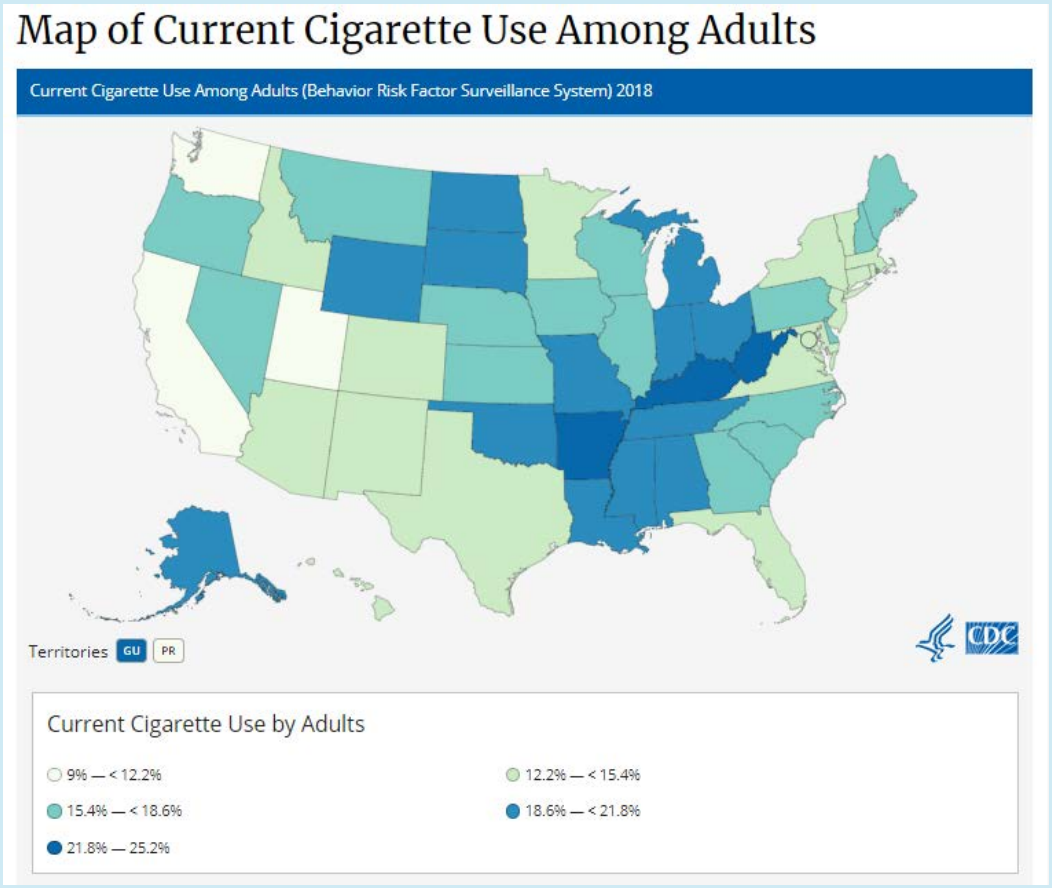
"For every 10 percent increase in the cost of a pack of cigarettes, smoking is reduced about seven percent in children and four percent in adults."

A $2 increase per pack that would generate $360 million in the first year and $2 billion over five years. Not chump change for a state budget in COVID-19-induced financial strain.

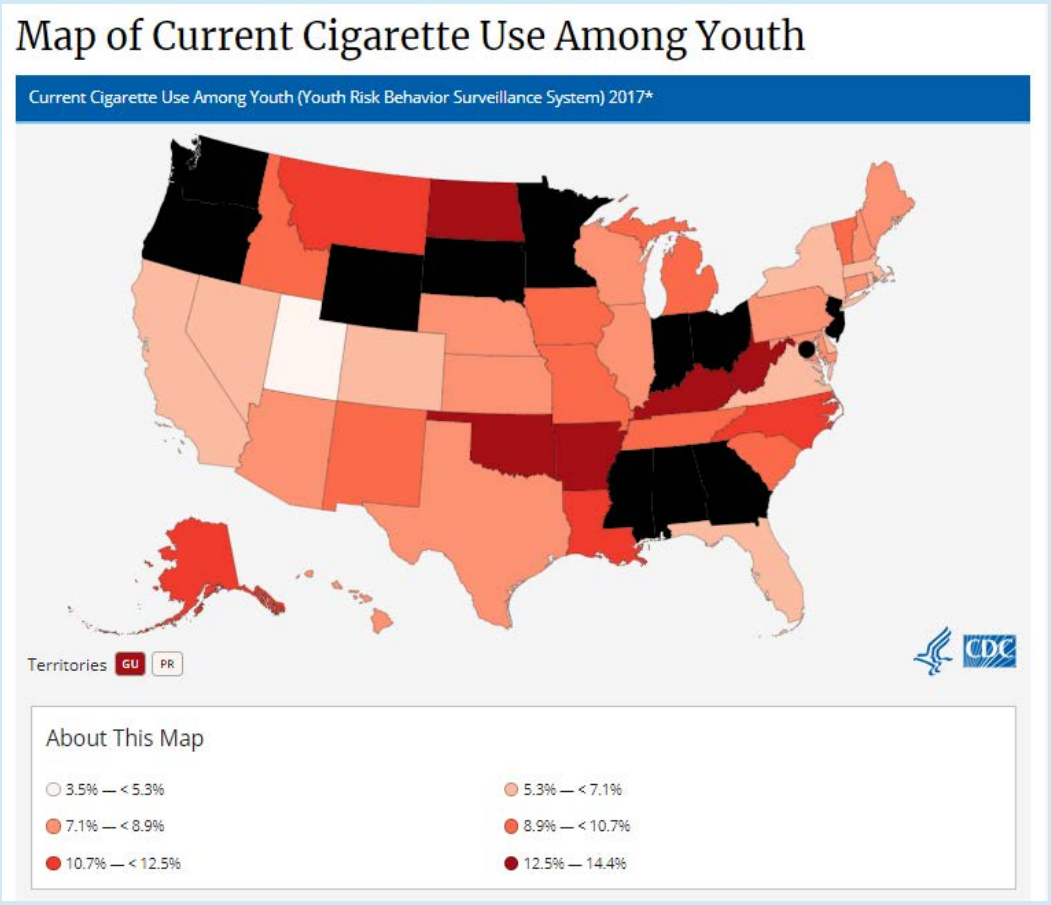
We know that raising the cost of tobacco is the single most effective strategy in reducing tobacco use. For every 10 percent increase in the cost of a pack of cigarettes, smoking is reduced about seven percent in children and four percent in adults. A $2 a pack increase would induce 142,000 smokers to quit and would save a portion of the 151,000 children alive today who are anticipated to eventually die prematurely of smoking-related diseases.

Will we finally increase the cigarette tax this legislative session? It would be big medicine for Indiana's health and economics.

Map of Current Cigarette Use Among Adults



Map of Current Cigarette Use Among Youth

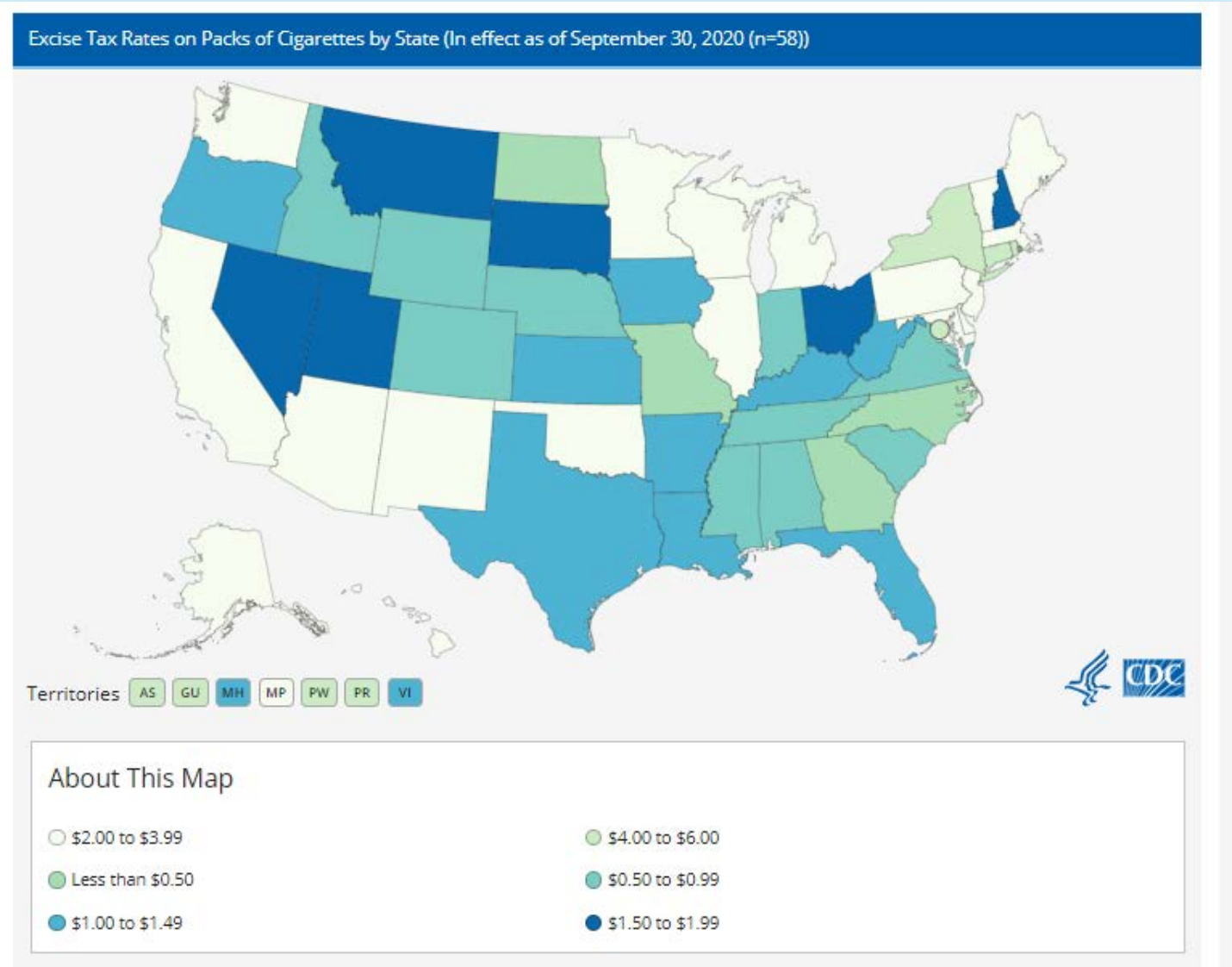


Source: Center for Disease Control and Prevention Website, https://www.cdc.gov/tobacco/index.htm

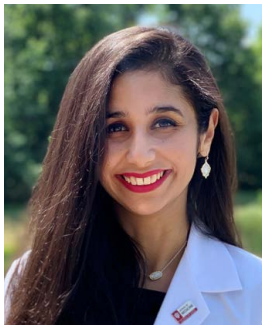
STATE System Excise Tax Fact Sheet

Taxes on Tobacco Help Reduce the Number of Tobacco Users

In the United States, tobacco use is the leading cause of preventable disease, disability, and death.[1] More than 480,000 people die prematurely in the United States annually and another 16 million have a serious illness caused by smoking or exposure to secondhand smoke.[1] Each year, smoking costs the United States nearly $170 billion in direct medical costs and more than $156 billion in lost productivity.[1,2] The Centers for Disease Control and Prevention's (CDC) Best Practices for Comprehensive Tobacco Control Programs concludes that the more states spend on comprehensive tobacco control programs, the greater the reductions in smoking.[3] However, in fiscal year 2020, states will receive $27.2 billion from tobacco taxes and tobacco industry legal settlements, but will only spend $739.7 million—less than 3% for tobacco control programs.[4] In 2018, the tobacco industry spent $8.401 billion on advertising and promotion of cigarettes. This translates to more than $23 million every day, or almost $1 million every hour.[5] States reaching recommended levels of investment in tobacco control is an integral component of meeting the Healthy People 2030 objective to reduce current cigarette smoking among adults to 5% or less by the year 2030.[6]



Patient Advocacy in the Classroom



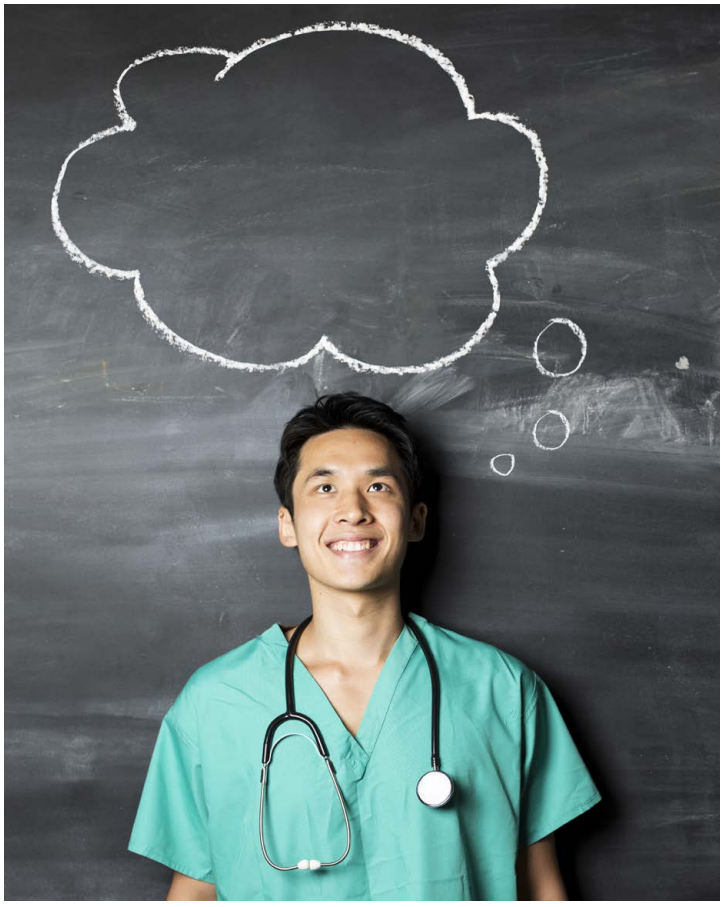
By SALMAN QURESHI, OMS-3, NAHMAN NADEEM, MS2
Marian and Indiana University Medical Students (respectively) and IMS Board Members

Approximately two years ago, we started medical school. To say the least, our very first week was a rush; a rush of unpredictable, overwhelming newness. At the end of that week, we attended our first medical society meeting. There we got to step out of the box of facts and science and got to experience the human side of medicine. So much of the first two years of medical school are focused on learning the basics of medical science and passing exams that the connection between physician and patient gets buried deep. In this way, the first two years of our education jumps over a valuable role physicians play in society as patient advocates. In the larger scheme, physicians have the responsibility to act on behalf of their community as advocates when it comes to health and medicine related policy. In medical school, including training on this topic can foster a greater level of professionalism and empathy. Additionally, intertwining this with our first two years of classroom education can cultivate a more realistic picture of the roles and responsibilities of a physician.

"If we do not enter this landscape of policy and decision making, we will be left with a future that may not be what we really want."

Primarily, teaching our medical students how to be patient advocates from the beginning allows them to further develop their professionalism and teamwork abilities. For example, we attended our first national AMA meeting in the summer of 2019. There we learned one very critical thing. One individual person may not be able to accomplish a lot on their own, but with a group or a whole organization the opportunities are limitless. Pooling resources, having debates, and making connections through these types of organizations allow for medical students like us to have our opinion heard. If we do not enter this landscape of policy and decision making, we will be left with a future that may not be what we really want. Through these meetings we met colleagues from all over the country. Together we discussed our individual experiences and problems and worked together to positively contribute to the topic at hand. As such, we were doing our professional duty to serve our community through our experience.

Furthermore, promoting advocacy instills the importance of empathy in the patient physician relationship. Like we mentioned before, much of our first two years of medical school is exam oriented. As such, oftentimes the human connection of medicine gets lost amidst the facts and science. Surely, these first two years are critical to establishing a knowledge base, but that time may feel disconnected from the actual clinical aspects of medicine. Teaching advocacy earlier on can help teach us that our patients aren't looking for doctors who are just providing a diagnosis and treatment plan. Conversely, they are oftentimes looking for reassurance, compassion, care, and most importantly, empathy.



Lastly, looking back now at our past experiences as third year students now we wish we had been exposed to the roles and responsibilities of a clinician sooner. Early on in the third year, we learned that being a clinician is far more complicated than it looks at a glance. For example, during our first internal medicine rotation we had an elderly patient who required physical therapy. During a conversation with him he kept mentioning how important his family was for him. Through this experience, it was evident how critical it is to understand your patient's priorities and values. As a result of our discussion, we were able to advocate for him so that he could receive outpatient physical therapy rather than transferring him to a nursing home care facility. While this action may seem small, this advocacy is a prime example of the impact it can have for patient's satisfaction.

In conclusion, advocacy training early on in medical school education provides a platform for students to develop their skills as clinicians. Specifically, it helps build professionalism, instills empathy, and allows us to be ready for our future from the start of our careers.

NP and PA Collaboration:

One Physician's Review of Indiana Law

By Mercy Hylton, MD
IMS Board Member, Founding Member of "Indiana Physician's Lounge"

Can an employer of a physician (hospital or otherwise) mandate that a physician collaborate with, sign a collaborative agreement with or co-sign the charts of employed non-physician practitioners (NPPs) including nurse practitioners (NPs) and physician assistants (PAs)? I present here my review of our state's laws related to this question. Keep in mind that I am not an attorney, and these are my interpretations.

Review of Indiana Statutes

Indiana law IC 25-22.5 defines the practice of medicine, in part, as the "diagnosis, treatment, correction, or prevention of any disease, … injury, … or other condition of human beings… without limitation."

IC 25-22.5-1-2 on Exclusions (to the practice of medicine) states that an employment contract between a physician and entities including "a hospital" and "health care organizations" … "does not constitute the unlawful practice of medicine under this article if (emphasis mine) the entity does not direct or control independent medical acts, decisions, or judgment of the licensed physician."

Indiana law IC 25-27.5-5-2 requires that a physician assistant (PA) "must engage in a dependent practice with a collaborating physician" and that "the duties and responsibilities that are delegated by the collaborating physician… are within the collaborating physician's scope of practice."[1] "Supervision of Physician Assistants", included in IC 25-27.5-6, states that during the first year of PA prescriptive practice at least 10% of patient encounters by the PA be must be reviewed by the collaborating physician or designated physician (and thereafter a percent to be determined to be reasonable and stated in the collaborative agreement) within 10 business days. Furthermore, IC 25-27.5-6-7 states that the legal responsibility for a PA's patient care activities falls on the collaborating physician, regardless of whether the PA is employed by the physician, by a physician group or by a health care entity such as a hospital.

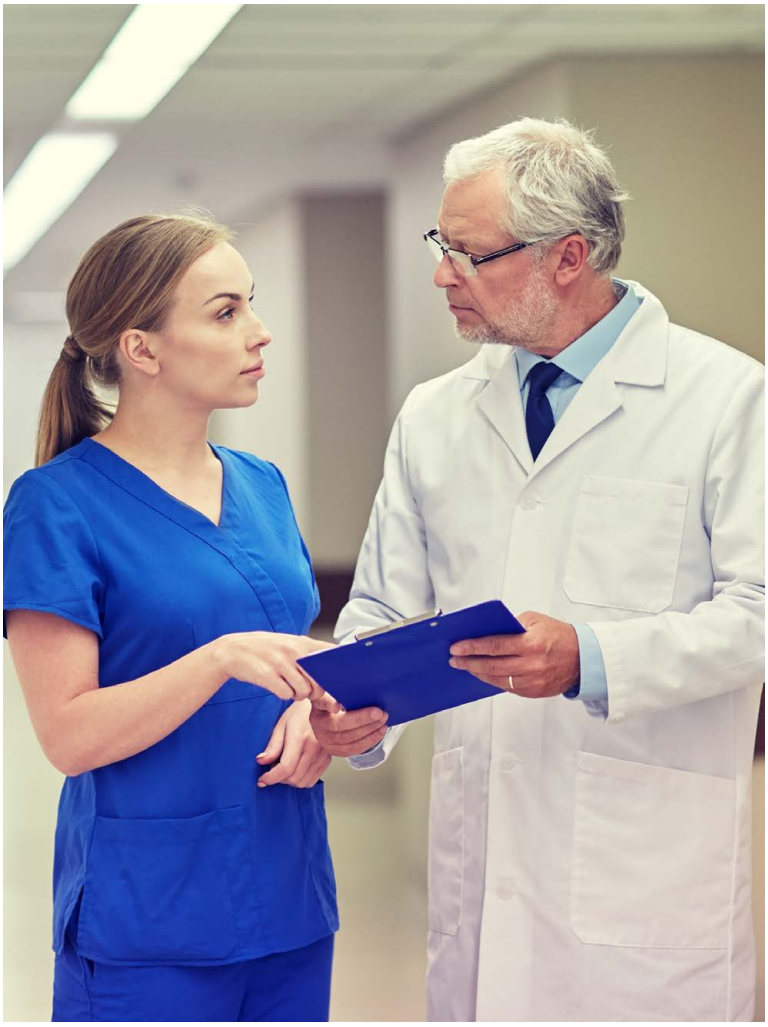
In Indiana nurse practitioners are licensed as registered nurses and their oversight is by the Board of Nursing. An NP may also have a license for APRN Prescriptive Authority which is delegated by a collaborating physician. Registered nurses assess health conditions to derive a nursing diagnosis which is defined as "the identification of needs which are amenable to nursing regimen."[2] Under 848 IAC 4-2-1 regarding the "Competent Practice of Nurse Practitioners," NPs are authorized to "assess clients by using advanced knowledge and skills to… diagnose health problems… develop and implement nursing treatment plans… (and) collaborate with or refer to a practitioner in managing the plan of care."[3] NPs must operate under a written "practice agreement," with a collaborating licensed practitioner (generally a physician; excludes oth

1 Indiana Code Title 25. Professions and Occupations, Article 27.5 Physician Assistants
2 Indiana Code Title 25. Professions and Occupations, Article 23 Nursing
3 Indiana Administrative Code, Title 848 Indiana Board of Nursing Articles 4 and 5

er Advanced Practice Registered Nurses, PAs and veterinarians) or by hospital privileges, which sets forth the details of how an NP and a physician must "cooperate, coordinate, and consult with each other in the provision of health care to their patients." These practice agreements are supposed to set "the type of collaboration" and what constitutes the physician's "reasonable and timely review" of the prescribing practices of the NP. The minimum constraints are that the NP submits documentation of one's "prescribing practices" to the physician within 7 days, and that the physician perform at least 5% random prescriptive review of the NP's charts.

Review of Case Law

The legal responsibility for an NP's patient care is not clearly codified in Indiana, as compared to the legal responsibility for a PA's patient care. However, there is Indiana case law in which the legal responsibility for an NP's patient care falls to the physician who has signed a collaborative practice agreement (CPA).[4] In the 2015 case of Collip v. Ratts, the Indiana Appeals Court affirmed and remanded the trial court's judgment that physicians who enter a contractual relationship with an NP pursuant to a CPA "owe a duty to the nurse practitioner's patients to fulfill their contractual obligations with reasonable care." In 2006 Dr. Collip had entered into a CPA with nurse practitioner Barger which required a 5% weekly prescriptive review of Barger's prescribing practices. He did not fulfill this requirement but did engage in a more limited review which caused him to become concerned about the amount of narcotic medications being prescribed by Barger. He recommended that the NP attend a narcotic-prescribing seminar, but never followed up if any actions were taken by the NP to remedy the problem nor did he take any steps to terminate the CPA. In 2009 the death of Ratts, a patient of NP Barger, was attributed at least in part due to a mixed drug reaction from multiple narcotic and psychoactive drugs prescribed by Barger. In 2013 Ratts' mother filed a complaint with the court against Collip, despite Dr. Collip having no direct relationship with the deceased, nor ever having received or reviewed



any of Ratts' medical records prior to the litigation. The Appeals Court's decision highlighted Section 324A of the Restatement (Second) of Tort[5] which states that a party which renders services to a second party, which are considered necessary for the protection of a third party, can be held liable by the third party if they suffer harm as a result of a failure to exercise reasonable care in the performance of the duty owed to the second party.

In the 2003 Supreme Court of New York case, Quirk v. Zuckerman, an emergency physician (Zuckerman) was found liable for medical malpractice pursuant to a verbal consultation from an NP in the fast-track area of the emergency department.[6] The court denied Dr. Zuckerman's

4 Collip v. Ratts, 49 N.E.3d 607, 2015 Ind. App. LEXIS 780 (Court of Appeals of Indiana December 31, 2015, Filed). https://advance-lexis-com.proxy.ulib.uits.iu.edu/api/document?collection=cases&id=urn:contentItem:5HRJ-91M1-F04G-5087-00000-00&context=1516831.

5 § 324A Liability to Third Person for Negligent Performance of Undertaking. Restat 2d of Torts, § 324A https://advance-lexis-com.proxy.ulib.uits.iu.edu/api/document?collection=analytical-materials&id=urn:contentItem:42JH-HP60-00YF-T0F5-00000-00&context=1516831.

6 Quirk v. Zuckerman, 196 Misc. 2d 496, 765 N.Y.S.2d 440, 2003 N.Y. Misc. LEXIS 837 (Supreme Court of New York, Nassau County June 30, 2003, Decided). https://advance-lexis-com.proxy.ulib.uits.

claim that at physician-patient relationship did not exist since he did not examine the patient himself, and rather found that an NP's authority to diagnose is only through collaboration with a physician and the ultimate responsibility for diagnosis and treatment falls to the physician. In 2019, the Supreme Court of Minnesota reversed a judgment by the Appeals Court, in Warren v. Dinter, thereby finding a physician Dr. Dinter (hospital-employed hospitalist) liable for medical malpractice against a third-party (patient Warren) despite no physician-patient relationship and the non-existence of a CPA with the second party (outpatient NP Simon), based on a non-recorded phone conversation between the physician and NP.[7] The Court found that, based on Minnesota law, an express physician-patient relationship is not necessary to find malpractice when a tort duty has been created by foreseeability of harm to the patient.

These legal cases illustrate the increased risk of liability faced by physicians who interact with NPs in any capacity, whether (1) both parties are independently practicing with a written collaborative practice agreement, (2) functioning as a collaborating or consulting physician as a result of being employed by the same hospital as the NP, or (3) in the setting of providing what could be construed as medical advice to an NP with whom there is no direct or indirect, nor formal or informal collaborative relationship.

Discussion

Physicians are now dealing with this relatively new (NPP) legal minefield with the backdrop of decreased physician autonomy due to record rates of physician employment (by health care entities) and ever-increasing health system utilization of NPPs to perform health care duties which were once the exclusive domain of physicians. Health care entities may hire NPPs to perform duties outside of an appropriate scope of practice for their training, and increasingly with less oversight by physicians. Physicians who are mandated by employers to nominally supervise or collaborate with NPPs bear the brunt of the legal liability for any medical mismanagement, based on the reviewed statutes and case law.

Conclusion

I ask again, can an employer of a physician mandate that the physician "supervise", "collaborate" with, maintain a "collaborative agreement" with or "co-sign" charts of NPPs? In Indiana, only licensed physicians can practice medicine "without limitation." Based on their independent medical judgment, physicians can delegate parts of their professional duties to other health professionals. NPPs can perform these delegated duties as long as they are performed adhering to the legal requirements of their own professions, which includes physician collaboration.

Adequate NPP collaboration may include timely physician review of any and all NPP patient care, ability to make timely changes to NPP's patient care plans, the physician's authority to provide consequential professional feedback to NPPs and other practices based on each physician's judgment. If a physician's hospital-employer mandates NPP collaboration without providing reasonable conditions for meaningful collaboration based on the physician's independent medical judgment then that employer's mandate could potentially be in violation of Indiana law.

Dr. Mercy Hylton is a pediatric emergency physician and IMS Board Member with an interest in physician and patient advocacy. She is also the founder of "Indiana Physicians Lounge" a virtual gathering space exclusively for Indiana physicians on Facebook. Dr. Hylton can be reached at mmhylton@gmail.com for comments on this article.

Note from the Editor

This is an opinion written by a physician. None of these statements should be considered in anyway legal opinions. You should contact your own legal counsel regarding all legal matters before acting. IMS does not support nor endorse any editorial piece in this or any Bulletin.

All editorials are opinions of the author and not the opinion of the Indianapolis Medical Society. Editorials are published with the intent to encourage discussion and opposing viewpoints are **welcomed.** Please submit articles for this publication to mperrill@indymedicalsociety.org.

iu.edu/api/document?collection=cases&id=urn:contentItem:490R-GBM0-0039-43X5-00000-00&context=1516831.

7 Warren v. Dinter, 926 N.W.2d 370, 2019 Minn. LEXIS 195, 2019 WL 1646469 (Supreme Court of Minnesota April 17, 2019, Filed). https://advance-lexis-com.proxy.ulib.uits.iu.edu/api/document?collection=cases&id=urn:contentItem:5VX3-5YH1-F57G-S39H-00000-00&context=1516831.

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KEVIN MACADAEG, MD

Dr. Kevin Macadaeg co-published an article in the European Spine Journal: Long-term outcomes following intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: 5-year treatment arm results from a prospective randomized double-blind sham controlled multi-center study.

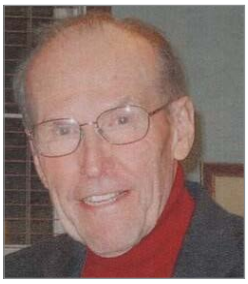
Fischgrund, JS., Rhyne, A., Macadaeg, K., Moore, G., Kamrava, E., Yeung, C., Truumees, E., Schaufele, M., Yuan, P., DePalma, M., Anderson, DG., Buxton, D., Reynolds, J., Sikorsky, M.: Long-term outcomes following intraosseous basivertebral nerve ablation for the treatment of chronic low back pain: 5-year treatment arm results from a prospective randomized double-blind sham controlled multi-center study, European Spine Journal, May, 2020.

STEPHEN W. PERKINS, MD

Stephen W. Perkins, MD of Meridian Plastic Surgeons, was an invited faculty member at the American Academy of Facial Plastic and Reconstructive Surgery 2020 Annual Meeting conducted virtually. Dr. Perkins gave a keynote lecture titled "My Facelift Philosophy and Techniques From a 36-Year Perspective". He presented multiple lectures on the topics of Blepharoplasty, Neck Lifting During Facelift and Upper Lip Dermabrasion. And, he moderated a panel that discussed Preservation Rhinoplasty. Dr. Perkins also participated as a presenter at the European Academy of Facial Plastic Surgery virtual meeting.

IN MEMORIAM

TED LINDSAY GRAYSON, M.D.



Ted was born at home on the Tipton county farm of Silas "Pete" Grayson and Lowey Lindsay Grayson. In 1945 Ted went to Indiana University. At that time IU had opened an extension campus in Kokomo, and Ted was in the first class. Ted's education continued at IU Bloomington (BS '50) and IU Medical School (MD '53). Next came six years in St. Louis, MO where Ted completed his internship and surgery residency at Washington University/Barnes Hospital. His medical training was interrupted for two years when Ted was drafted as part of the "doctor draft" in the Korean conflict. He served in the U.S. Navy as the medical officer on board the USS Navarro.

In 1961 Ted established a thriving private practice in Indianapolis. Ted was in private practice focusing on abdominal and thoracic surgery for 30 yrs. Hundreds of interns and residents trained under him at the operating table through his tenure as a clinical associate professor at IU School of Medicine. He served on the Methodist Hospital Board of Directors. Ted was awarded an IU Bicentennial Medal for distinguished and distinctive service in support of Indiana University's mission. IMS Member since 1961.

CME & CONFERENCES

MONTHLY EVENTS

	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
1st Week of the Month	Community North: Breast Cancer Conf. 7-8 am	Community East: CHE Admin Conf. 12-1 pm Community North: Psychiatry GR 12:30-1:30 pm Community North: Chest Cancer Conf. 7-8 am Community Heart & Vascular: Imaging Conf. 7-8 am		Community North: Forum 7-8 am Community South: South Case Presentations 12-1 pm
2nd Week of the Month	Community East: Medical GR 1-2 pm Community South General CHS 12-1 pm	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: M&M Conf. 7-8 am Community South: Breast Cancer Conf. 8-9 am St. Vincent Simulation Center: Pediatric GR 12-1 pm St. Vincent Womens: Neonatology GR 12-1 pm	St. Vincent: Electrocardiograph Conf. 7-8 am	Community North: Gynecological/Oncology Conf. 7-8 am
3rd Week of the Month	Community North: Breast Cancer Conf. 7-8 am Community South: South Thoracic 8-9 am Community South: South Molecular 5-6 pm	Community North: Psychiatry GR 12:30-1:30 pm Community North: Melanoma 7:30-8:30 am Community Heart & Vascular: CV Conf. 7-8 am	St. Vincent Heart Center: Cardiac, Medical, Surgery 7-8 am	Community North: GU Conf. 7-8 am Community South: South Case Presentations 12-1 pm
4th Week of the Month	Community East: Breast Cancer Conf. 7-8 am	Community North: GI/Oncology Conf. 7-8 am Community Heart & Vascular: Disease Manage Conf. 7-8 am St. Vincent Womens: Perinatal Case 7-8 am		

Annual	St. Vincent Womens:	MFM Ultra Sound Series — Quarterly 1-4 pm
	St. Vincent Simulation Center:	Sim Debriefing Essentials — 12x/Year
	St. Vincent Simulation Center:	PMCH Crisis Management — 12x/Year

WEEKLY EVENTS

Day of the Week	Event
Monday	St. Vincent: General Cardiology 7-8 am
Tuesday	St. Vincent: Trauma Case 12-1 pm
	St. Vincent Womens: Neonatology Journal Club (every other month) 12-1 pm
Wednesday	St. Vincent: CCEP 7-8 am St. Vincent Heart Center: Intervention Cardiology 7-8 am St. Vincent: Advanced Heart Failure 7-8 am St. Vincent: Surgery Didactics 7:30-8:30 am St. Vincent: Surgery M&M 6:30-7:30 am
Thursday	St. Vincent PMCH: Pediatric Cardiothoracic Surgery & Cardiology Conf. 12-1 pm St. Vincent OrthoIndy: Fractures 8-9 am

IMS is not responsible for the events listed. We recommend that before attending any CME/Conference events that you check with the provider to confirm the program is still available.

ONLINE EVENTS

Indiana School of Medicine

Indiana University School of Medicine is committed to providing valuable educational opportunities. Many of our educational activities usually offered as face-to-face meetings, have now transitioned to a virtual format in an effort to keep healthcare teams connected and engaged during the COVID-19 pandemic.

Live Webinars, visit: https://iu.cloud-cme.com

JAN
21 Breast Cancer Year in Review

Additional virtual events: schedule, visit https://iu.cloud-cme.com
Grand Rounds: Dermatology, Gastroenterology, Medicine, Pathology, Pediatric, Psychiatry, Otolaryngology, OBGYN
Project ECHOs: Cancer Prevention & Survivorship Care, Integrated Pain Management
Education & Research: Child Neurology, Clinical Research Ed, Faculty Devel. Simulation, IU Health Pathology Digital Imaging, Neonatal & Prenatal Ed, Pulmonary Research

To submit articles, Bulletin Board items, CME & events, opinions or information, email ims@imsoline.org. Deadline is the first of the month preceding publication.

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Past Presidents' Council 2021

** Indicates Voting Board Members, Term Ends with Year in Parentheses*

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John C. Ellis
Bernard J. Emkes
Bruce M. Goens
Paula A. Hall
Susan K. Maisel* *(2021)*
Jon D. Marhenke
Mary Ian McAteer* *(2022)*
John P. McGoff
Stephen W. Perkins

Advisory Board Members 2021

Salman S. Qureshi, Marian Student
Maham Nadeem, IU Student

Delegates

Delegates to the Annual State Convention

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Linda Feiwell Abels (2021)
Christopher D. Bojrab (2021)
Ann C. Collins (2023)
Carolyn Cunningham (2022)
Julie A. Daftari (2023)
John H. Ditsler (2021)
Marc E. Duerden (2023)
Richard D. Feldman (2021)
Robert S. Flint (2021)
Bruce M. Goens (2022)
Ann Marie Hake (2022)
Ronda A. Hamaker (2022)
Mark M. Hamilton (2022)
C. William Hanke (2021)
Penny W. Kallmyer (2023)
John E. Krol (2023)
Susan K. Maisel (2022)
Mary Ian McAteer (2023)
Thomas R. Mote (2021)
Mercy O. Obeime (2023)
Ingrida I. Ozols (2023)
Robert M. Pascuzzi (2023)
J. Scott Pittman (2022)
David M. Ratzman (2021)
Jodi L. Smith (2022)
Eric E. Tibesar (2023)
Maureen Watson (2022)
Steven L. Wise (2021)
Crystal Zhang (2022)

Alternate Delegates

Delegates to the Annual State Convention

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Ranai Abbasi (2021)
Laurie L. Ackerman (2022)
Jeffrey L. Amodeo (2021)
Doris Hardacker (2021)
Kyle Jamison (2021)
David A. Josephson (2023)
James Leland (2022)
Christopher Mernitz (2021)
Martina F. Mutone (2021)
Scott E. Phillips (2022)
Richard M. Storm (2021)
Glenn A. Tuckman (2021)

Indiana State Medical Association

Past Presidents

**Indicates deceased*

John P. McGoff 2017-2018
Jon D. Marhenke 2007-2008
Bernard J. Emkes 2000-2001
Peter L. Winters 1997-1998
William H. Beeson 1992-1993
George H. Rawls* 1989-1990
John D. MacDougall* 1987-1988
George T. Lukemeyer * 1983-1984
Alvin J. Haley 1980-1981

Executive Committee

Board Chair
David R. Diaz

Clerk
John C. Ellis

Seventh District

Trustees

David R. Diaz (2023)
John C. Ellis (2021)

Alternate Trustees

Susan K. Maisel (2022)
Robert Flint (2021)

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Robert Flint (2021)

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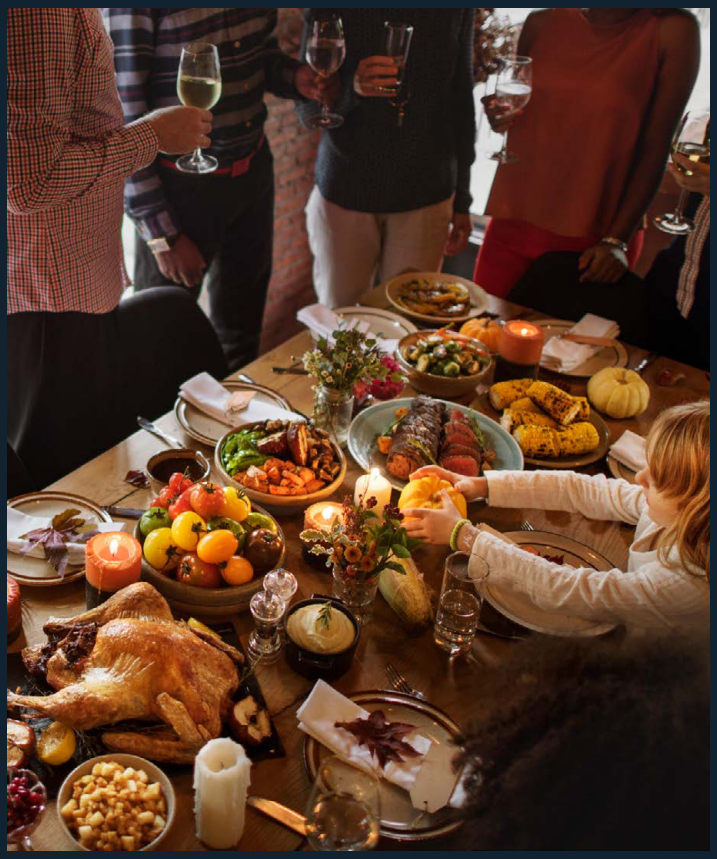

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