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Influential Leadership

As a society we have become enamored by the term "influencer." After a few challenging yet successful months at the AMCNO, I cannot help but think of the connection that exists between leadership and influence, and between influence and advocacy.

We are in the middle of a trying time for science. Public trust in science is polling the lowest it has been since the 1970s. We are fighting a war of misinformation against lifesaving vaccines amidst a pandemic. Indeed, according to a recent poll by *The Economist*, 1 in 5 Americans believes the US government is using the COVID-19 vaccine to microchip the population.

This anti-science and conspiracy-riddled rhetoric is not only rampant on the internet and on television, but in the halls of local and state governments. AMCNO President Dr. Kristin Englund, an infectious disease expert from Cleveland Clinic, recently testified against HB 248—a dangerous bill that would make it illegal for any business or entity to mandate vaccination in Ohio, and not just against COVID-19 but also childhood immunizations.

We in the scientific community know that vaccines have saved millions of lives every year, especially children's lives, throughout the past century. But it is not enough to know. We must continue to lead, to advocate, to help our patients understand the science behind these tools, because, if not us, then who will? I am grateful to Dr. Englund and those of you who have joined her in this effort to combat misinformation.

AMCNO Executive Director Jen Johns and Members Dr. Bruce Cameron (L) and Dr. Steven Shook (R) participate in the SB 6 bill signing with Gov. Mike DeWine.

As of press time, HB 248 is no longer moving, but some language from the bill was inserted into an unrelated bill by the legislature and passed into law, which makes it illegal for schools and colleges to mandate vaccination if the vaccine has been approved under emergency-use by the FDA. Although it can be hard to see this less but still dangerous bill as a "win," it is important to recognize that it is proof that advocacy works.

We were also successful in supporting the passage of SB 6, the Interstate Licensure Medical Compact, which will make it easier for physicians to practice and be licensed in multiple states. Because of our advocacy, we were invited to participate in the bill's signing with Governor Mike DeWine (photo above). Participating in the ceremony was a testament to the Northern Ohio medical community and its leadership. Let it be the fuel we need to keep moving, to keep fighting, for the health of our patients, and society. ■

Jen Johns, MPH
Executive Director, Academy of Medicine of Cleveland & Northern Ohio

Academy Archives: Theodore J. Castele, MD

As part of our efforts to celebrate the AMCNO's history as we head toward our bicentennial, we are starting a new series for each *Northern Ohio Physician* issue, called "Academy Archives."

All of our AMCNO members, past and present, are accomplished physicians who have contributed much to the patients they treat and this organization they are part of. The member list is long in our 197-year history, but in this series, we look to highlight some of them.

For this issue, we are focusing on Theodore J. Castele, MD—better known as Dr. Ted Castele or TV Ted. Dr. Castele was a radiologist at Lutheran Hospital. He was best known, however, for his daily appearances on WEWS Channel 5, starting in 1975; he would become the country's first local television physician. He is also a past president of the Academy, from 1974 – 1975. A portrait of him continues to hang on the wall in the AMCNO office.

Dr. Castele joined the Navy in 1946 during World War II, then came to Cleveland to study at Western Reserve University. He earned his medical degree in 1957 from Adelbert College, and he completed his residency at University Hospitals. He practiced at Lutheran Hospital, St. Vincent Charity Medical Center and St. John West Shore Hospital. Dr. Castele was a Case Western Reserve University trustee, and an assistant clinical professor of radiology there.

As pictured in this article, we also recently shared on Twitter the 1975 photo of Dr. Castele with the pollen collecting equipment for the AMCNO Pollen Line, a resource that has been supporting the community for more than 50 years. We continue to provide daily pollen counts, through our partnership with Allergy/Immunology Associates. In fact, we recently attended the training session at their offices (pictured at right). To obtain the daily pollen reports, call (216) 520-1050, visit our website at www.amcno.org, or follow us on Twitter @ AcademyMedCLE.

Dr. Ted Castele stands with the pollen collecting equipment for the AMCNO Pollen Line in 1975.

Dr. Castele died in 2015, at the age of 87. Today, we continue to honor his legacy.

Allergy/Immunology Associates residents learn how to collect and read the pollen samples at a training session in July.

If you know of a physician you would like to see featured in the Academy Archives series, please email Tara Camera, our Director of Communications, at tcamera@amcno.org with the details. ■

AMCNO Presents to UH Anesthesia Residents

In June, AMCNO Executive Director Jen Johns and AMCNO Legislative Committee Chairman John A. Bastulli, MD, FASA, presented to University Hospitals (UH) staff anesthesiologists and physicians in training at the Tavern of Little Italy in Cleveland.

John A. Bastulli, MD, FASA

Dr. Bastulli is also an AMCNO Past President and a member of the Board of Directors of the Ohio State Medical Association. In addition, Dr. Bastulli serves as Director of the Division of Anesthesia and Medical Director of Surgical Services at the St. Vincent Charity Medical Center. Dr. Bastulli discussed his long-standing service as a physician advocate, including on the issues most critical to practicing anesthesiologists, such as scope of practice and payment reform.

Ms. Johns spoke to the Academy's current legislative agenda, the changing political dynamics, and the need for resident physicians to get involved. Particularly at the state and local level, building relationships with elected officials is key to influencing legislation that impacts the practice of medicine.

Thoughtful discourse with the residents followed the formal remarks. AMCNO welcomed the group, as it does to all area residents, to sign up for free AMCNO membership to help jumpstart their careers as advocates. ■

A Pandemic of Long COVID: Are We Ready?

By AMCNO President Kristin Englund, MD

As we head into the fall, the number of acute COVID-19 cases is quickly rising. And rising. We are better prepared for this wave of the pandemic, and hopefully more Americans will make the decision to get vaccinated and prevent this disease from spreading. Are we ready for the other medical complications of this pandemic, though? The pandemic of Long COVID?

Kristin Englund, MD

Long COVID, or Post Acute Sequelae of SARS CoV-2 (PASC), is a persistence of symptoms at least 28 days beyond the initial diagnosis of COVID-19. Symptoms can include fatigue, shortness of breath with exertion, chest pain, diarrhea, cognitive dysfunction, depression, sleep disturbances, dizziness, diarrhea, persistent lack of smell or taste, postural orthostatic hypotension syndrome (POTS) and numerous others.

Although the acute viral disease is gone, patients are left with an unclear inflammatory or auto-immune type process that can affect almost every organ system. Numerous studies have found that approximately 30% of COVID-19 patients will have at least one persistent symptom. Long COVID affects those who were not ill enough to be hospitalized as well as those who required hospitalization acutely. These symptoms can be quite debilitating, leaving patients unable to return to work, or, in some cases, even to perform activities of daily living.

Numerous Long COVID clinics have been developed all over the world, with several here in the Northeast Ohio area. To date we are finding:

1. There is no one phenotype or genotype to the patients. They present with a variety of underlying co-morbidities.
2. There is no magic bullet treatment. Each patient must have a personalized treatment plan based on their symptoms.
3. A variety of rehab programs (physical, pulmonary, cardiac, brain) are needed.
4. Behavioral health programs and support programs are important for recovery.

At the time of this article, there have been 194 million cases of COVID-19 worldwide, 34.5 million cases of COVID-19 in the United States. If we assume 30% of all patients will have some degree of Long COVID, that means 58 million Long COVID cases worldwide and more than 10 million Long COVID cases here in our country. And that is even before this next wave of new infections.

The cost to the medical system and the economic impact overall will be astounding, and could last for years to come. Studies are underway to try to understand the biologic basis of the process and how best to treat Long COVID patients. Still, the very best way to prevent it is to prevent the disease initially. Vaccination is key to preventing not only the acute COVID infection, but also the persistent Long COVID disease. ■


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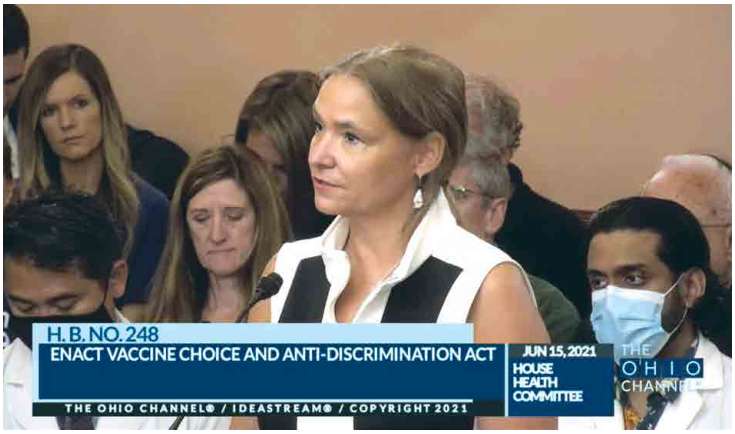
AMCNO President Testifies Against Dangerous Vaccine Legislation in Columbus

On June 15, AMCNO President Dr. Kristin Englund traveled to Columbus to provide opponent testimony for HB 248—a dangerous bill that would make it illegal for any business or entity to mandate vaccination, and not just against COVID-19 but also childhood immunizations. Dr. Englund, an infectious disease physician and Director of the reCOVer Clinic for Long COVID patients at Cleveland Clinic, joined a panel of expert physicians from Ohio's children's hospitals testifying against the bill.

AMCNO is a proud member of the Ohio Champions for Vaccines (OC4V) coalition established by the Ohio Chapter of the American Academy of Pediatrics. OC4V members are a coalition of medical and public health groups, parents and caregivers, and other invested stakeholders to reduce barriers to vaccines; distribute accurate, science-based immunization information; and encourage evidence-based vaccine policy.

Despite facing a tense Health Committee, Dr. Englund was steadfast in her comments about the importance of vaccination. She discussed the incredible economic and moral consequences of life without vaccinations, including the deaths of more than 600,000 Americans to COVID-19 during the past 18 months.

Dr. Englund also noted that there is no question that vaccines are the greatest public health invention of our time. They have allowed us to diminish and, in some cases, eradicate the threat of fatal infectious diseases. She also shared that there is no question that routine childhood immunizations have helped save lives. The World Health Organization estimates that vaccines annually prevent almost 6 million deaths worldwide. And in the United States, there has been a 99% decrease in incidence for the nine diseases for which childhood vaccines have been recommended for decades.



AMCNO President Dr. Kristin Englund, an infectious disease physician, provides opponent testimony for HB 248.

Dr. Englund and her fellow physician expert witnesses should be recognized for their unwavering advocacy. As of press time, movement has stalled on HB 248. ■

AMCNO Joins Amicus Brief

The AMCNO, along with the Ohio Hospital Association, the Ohio State Medical Association, Ohio Osteopathic Association, Ohio State Chiropractic Association, Ohio Alliance for Civil Justice, the Ohio Insurance Institute, and the Ohio Radiological Society, signed on as amici curie in *Cynthia Clawson v. Heights Chiropractic Physicians LLC.*

The case concerns whether a corporate employer of a physician can be held secondarily liable for a physician-employee's malpractice. The brief urges the Ohio Supreme Court (OSC) to reverse the Second District's decision, because it misinterprets this Court's decision in *Natl. Union Fire Ins. Co. of Pittsburgh, PA v. Wuerth.* As stated in the brief, "only physicians—not other licensed professionals such as nurses or corporate entities such as hospitals—have the unique and independent role of diagnosing disease, illness, and other medical conditions, and prescribing treatment plans for their patients, they are (and should be) treated differently than other employees when it comes to imposing vicarious liability because their corporate employers do not and cannot control these activities." The brief also reiterates that the amici assert that decades of legal precedent in Ohio show that only individual physicians can commit malpractice—not employers. ■

Gov. DeWine Signs Interstate Medical Compact Legislation into Law

On July 1, Governor Mike DeWine signed SB 6, the Interstate Medical Licensure Compact, into law. The compact is an agreement among participating U.S. states to work together to significantly streamline the licensing process for physicians who want to practice in multiple states.

State medical boards, recognizing that physicians would increasingly practice in multiple states because of telemedicine, began actively discussing the idea of creating an interstate medical compact in 2013, with the goal of trying to help streamline traditional medical-license application processes. Since then, 29 states, the District of Columbia, and Guam have joined the compact.

The mission of the compact is to increase access to health care—particularly for patients in underserved or rural areas. The agreement makes it possible to extend the reach of physicians, improve access to medical specialists, and leverage the use of new medical technologies, such as telemedicine. And because of the COVID-19 epidemic, the demand for virtual health care has risen substantially.

The compact also strengthens public protection by enhancing the ability of states to share investigative and disciplinary information. States that participate in the agreement can streamline licensure by using an expedited process to share information with each other that physicians have previously submitted in their State of Principal License (SPL)—the state in which a physician holds a full and unrestricted medical license.

The AMCNO had been an early proponent of this legislation, working alongside the Cleveland Clinic, University Hospitals, Summa Health, Akron Children's Hospital, and the Ohio State Medical Association.

AMCNO testified in support of the legislation in both the House and Senate.

Because of our advocacy, we were invited to participate in the bill's signing. In attendance were Executive Director Jen Johns and AMCNO Past President Dr. Bruce Cameron. AMCNO Member Dr. Steven Shook also participated in the bill signing on behalf of Cleveland Clinic.

The AMCNO will keep you informed of the implementation plan for the compact, as well as the go-live date, once the Ohio State Medical Board releases further guidance throughout the next year. ■

AMCNO Members Drs. Steven Shook (left) and R. Bruce Cameron (right) participate in the signing of SB 6.

Gov. DeWine Signs Biennial Budget into Law

On June 30, Governor Mike DeWine signed into law HB 110, the state biennium budget bill, funding the state government for Fiscal Years 2022 and 2023.

Highlights of the bill include:

- **Medicaid coverage for mothers** up to 200% of the federal poverty level for a full year after giving birth.
- Increased funding for Help Me Grow, Ohio's **evidence-based home visiting program**. The program serves more than 8,200 families, encouraging early prenatal and well-baby care, as well as parenting education to promote the comprehensive health and development of children. Home visiting is proven to reduce infant mortality and promote child development and school readiness.
- Continued support of the **procurement of Ohio's managed care system** to improve wellness and health outcomes while emphasizing a personalized care experience. This next generation of managed care includes a package of reforms and cost savings measures, including the implementation of a new and innovative specialized managed care program for children with complex behavioral health and multi-system needs.
- $250 million in broadband funding, with $2 million specifically for **telehealth**.
- $2 billion in **tax cuts** and the minimum amount an Ohioan can earn before they begin paying income tax is $25,000.

- Increased support for the **lead hazard control programs**, $25 million, to make Ohio's homes and communities lead-safe. The Ohio Department of Health will conduct lead hazard control and abatement services on hundreds of Ohio homes, conduct public outreach and education, and increase the number of lead hazard workers.
- $4.4 million for **the FQHC Primary Care Workforce Initiative**, which addresses the need for more qualified health professionals by providing medical, dental, behavioral health, advanced practice nursing, and physician assistant students with clinical rotations in Federally Qualified Health Centers that are recognized as Patient-Centered Medical Homes.
- Continued funding for **Recovery Ohio**, which aims to fight the opioid epidemic in Ohio, including:
  - Expanding early identification programs, $4.5 million, to increase screening, provide early intervention, and connect people to treatment.
  - Supporting forensic services, $3.5 million, to reduce the stress on the hospital and criminal justice systems that interact with people with serious mental illnesses and expand treatment capacity for those incarcerated with critical mental illnesses by providing access to the medicine they need.
  - Expanded investment of more than $11 million to strengthen cross-system collaboration and expand access to services and supports that promote continued stability and recovery outside of institutions for adults with serious mental illness.

The AMCNO had asked Gov. DeWine to veto a dangerous "Medical Practitioner Conscience" clause that was inserted into the budget at the last minute. The language, which allows a medical provider to deny care that conflicts with their "moral, ethical or religious beliefs," would leave patients, particularly those in underserved areas with limited access to providers, without protection and opens the door to discrimination in health care. Unfortunately, the language was not vetoed and was included in the final bill.

In other Columbus news, Gov. DeWine did veto Substitute Senate Bill 113, legislation that would have legalized the discharge of consumer-grade fireworks, including bottle rockets, firecrackers, and missiles 24 hours a day around the times of 14 holidays each year, with only minimal safety restrictions in place. AMCNO, as a member of the Ohio Fireworks Safety Coalition, opposed this legislation. Proponents of this bill are expected to immediately continue attempts to legalize dangerous discharge of consumer fireworks. ■

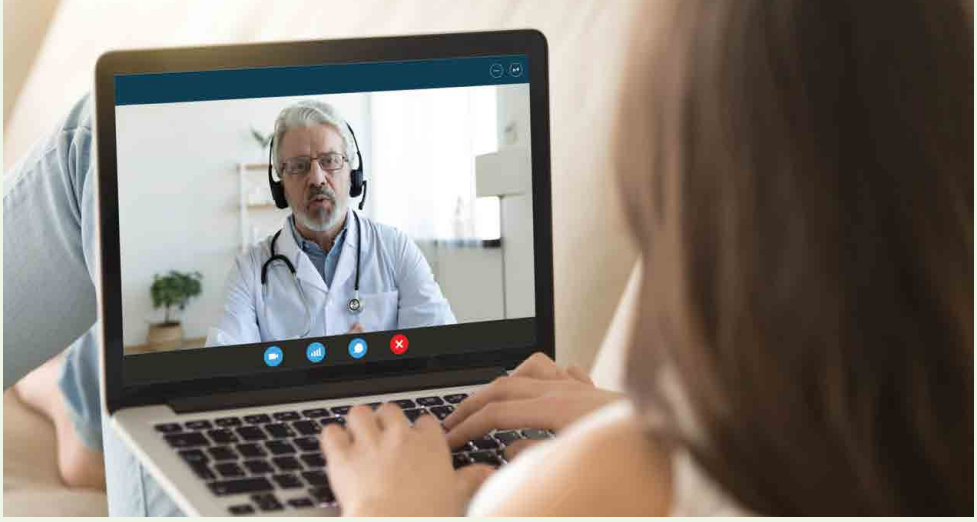
The AMCNO Welcomes NOMS Physicians as New Group Members

We are pleased to announce the addition of new group members, from NOMS Healthcare! NOMS is a large and rapidly growing group of independent providers who represent more than 30 specialties and subspecialties. The more than 130 physicians in this group practice across Northern Ohio, with locations ranging from Toledo to Youngstown.

AMCNO Executive Director Jen Johns was instrumental in personally reaching out to the leaders of this group to discuss the many benefits of membership within our organization. AMCNO Board member Dr. Mary Frances Haerr was key in setting up the introductions.

Please welcome these new physicians into the fold! We hope to host future events (in person and virtual) so they can meet and connect with our current and long-standing members. And, NOMS members, please let us at the AMCNO know how we can better serve you and your patients. We are happy to help.

Once again, welcome *NOMS Healthcare!* ■



Academy of Medicine Education Foundation Receives Grant

The Academy of Medicine Education Foundation (AMEF) was recently awarded The Telehealth Initiative (TTI) grant from the American Medical Association (AMA) and Physicians Foundation. AMEF was one of four winners from across the country—alongside the Iowa Medical Society, Medical Society of the State of New York, and Montana Medical Association.

During the height of the pandemic, telehealth became the main way for patients to access care. And while many health care professionals were ready, others were not. As it became clear that telehealth is here to stay, the AMA and Physicians Foundation wanted to collaborate with state and regional medical societies to help build and improve upon telehealth infrastructure. With this grant funding, the AMCNO will be working to make sure that Ohio physicians who offer these services, or want to offer them, have the resources and support to do so and succeed.

As part of the second cohort for the project, the AMEF and AMCNO will continue the work established by the first cohort, which consisted of collaboration between medical associations in Massachusetts, Florida and Texas. The project strategy is to continue to build infrastructure for telehealth services, and determine best practices that can be then replicated by physician practices across the country. As part of this initiative, our organization will be the liaison for practices, whether they are just beginning the telehealth process (or want to) or are looking to enhance their current processes.

That's where you, our physician members, come in. Where are you on the scale of telehealth services—do you offer them? Did you implement them during the height of COVID-19 in 2020? Do you want to offer them but are unsure how to? We will be using surveys to determine each practice's usage level. All these answers will help show a clearer picture of where our physician members are and how we can help build this technology in Northern Ohio.

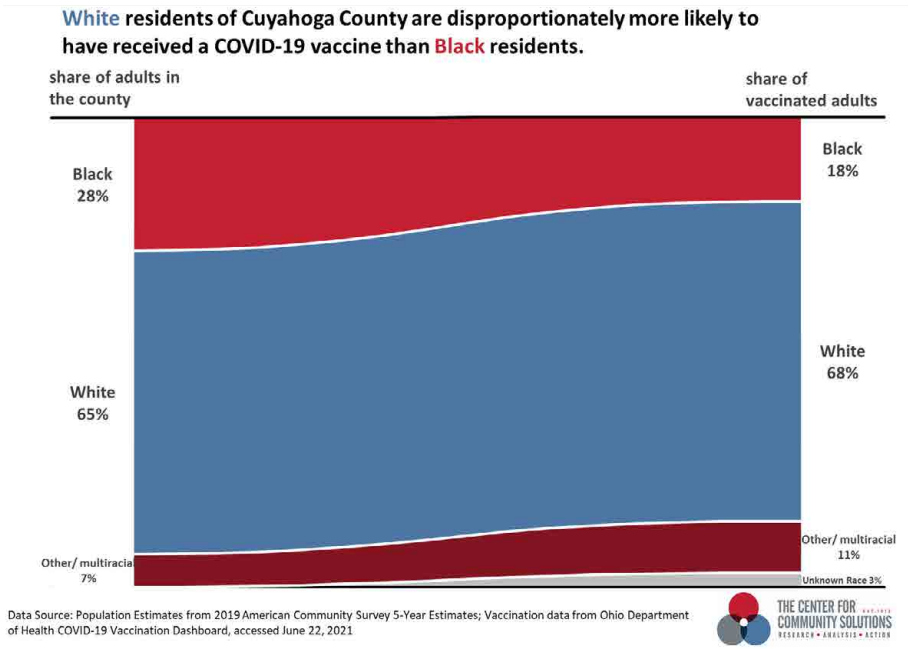
Please notify AMCNO Director of Communications Tara Camera at tcamera@amcno.org if you are a solo practice or part of a small group practice and would like to be involved in this initiative. Participants will receive a stipend.

Once again, we are excited about this project, and we look forward to working on it with our members! ■

Federally Qualified Health Centers are key to racial equity in COVID-19 Vaccine Access

By Alex Dorman and Kate Warren, The Center for Community Solutions

As of July 2, more than 5.5 million Ohioans have received at least the first dose of a COVID-19 vaccine. As there has been with testing and transmission, racial equity concerns about vaccines continue.



Black adults in Cuyahoga County, home to Cleveland, are still less likely than white residents or people of other races to have received a vaccine, although considerable progress has been made in recent months. The reasons for the disparity are layered and include access issues around the locations of vaccination sites, transportation challenges and even the fact that the phased vaccine distribution began with health care professionals, followed by the oldest Ohioans. Due to life-expectancy disparities, Black Ohioans are less likely to live past age 80, making them under-represented in that strata of the population.

Relatedly, our recent research identified a correlation between the ZIP codes in Cuyahoga County where higher rates of hourly workers lived, and lower rates of vaccination. This finding tracks with nationwide data that found a "top concern across groups has been the potential side effects of the vaccine, including a substantial share who are worried about missing work due to side effects." Black workers are far more likely than white workers to be paid minimum wages, and are far more likely than white workers to be receiving wages that keep them below the federal poverty guidelines. Hourly workers are also less likely than their salaried counterparts to have paid time off. A federal tax credit was made available to businesses to cover paid time off for employees who needed time to recover from the potential side effects of the vaccine, but many have not implemented this policy.

However, despite these very real barriers to vaccine access for Black Americans, some health officials and policymakers have relied on the "Tuskegee scapegoat" as a primary explanation for vaccine inequity. The United States Government's 1932-1972 experiment on Black men infected with syphilis in Tuskegee (in which researchers, among other things, actively hid the treatment for syphilis) was abhorrent. A prevailing notion is that this experiment is the primary explanation for why Black Americans are wary to engage in new medical science and research. Reality is different.

Findings from a large study published in the *Journal of Health Care for the Poor and Underserved* found that Black participants were indeed 1.8 times more hesitant than white participants to engage in medical research, but there was ultimately no difference in Black participants' willingness to participate. That distinction is important; **hesitancy does not equal refusal**. Dr. Rueben Warren, director of the National Center for Bioethics in Research and Health Care at Tuskegee University in Alabama, unequivocally states, "If you want Black people to trust doctors and trust the vaccine, don't blame them for their distrust. The obligation is on health institutions to first show they are trustworthy: to listen, take responsibility, show accountability and stop making excuses. That means providing information about the vaccine without being paternalistic and making the vaccine easy to access in Black communities."

Then what can help? Federally Qualified Health Centers (FQHCs) are an important player in combatting vaccine inequity among Black Americans. FQHCs are well-equipped to reach vulnerable populations—including Black, Latino, low-income and immigrant populations—given their historical and legal obligations to serve medically underserved areas. As the map on page 9 indicates, nearly

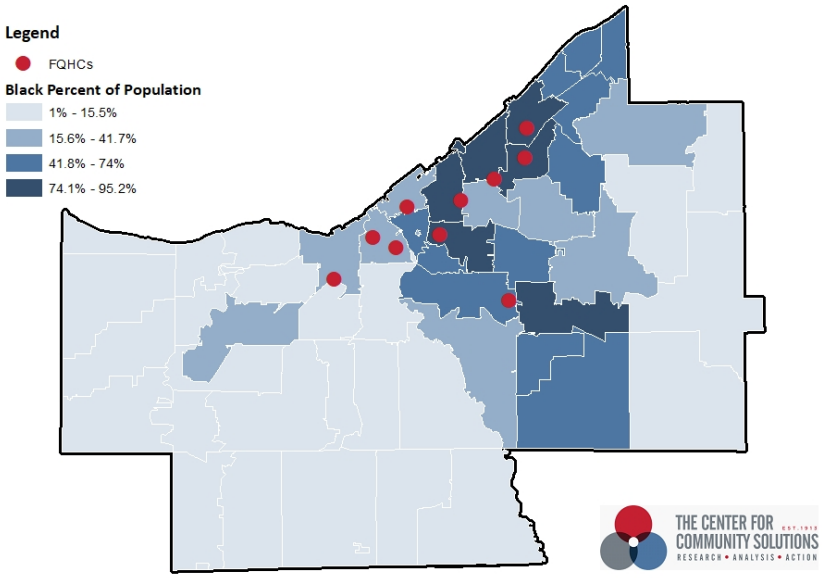
all FQHCs are located in, or adjacent to, Cuyahoga County ZIP codes with a majority Black population. This strategic positioning allows Black residents to have more immediate access to receiving the vaccine in their neighborhoods.

FQHCs have become a key part of Ohio's strategy to address equity concerns. Indeed, recent data from Better Health Partnership indicate that FQHCs in Cuyahoga County have been successful in more equitably distributing the COVID-19 vaccine. More than a quarter of all vaccines distributed by FQHCs have gone to Black residents, and 15 percent have gone to Hispanic/Latinx residents, larger shares than among all other non-FQHC providers in Cuyahoga County.

FQHCs are not only conveniently located, they are established entities who are trusted by many in the communities they seek to serve. This trust is critical in overcoming vaccine hesitation. The Black Doctors COVID-19 Consortium, a leader in efforts to vaccinate underserved populations, has stated clearly: "Those left unvaccinated will prefer to get their shots by or around people they know," regardless of their reason for hesitancy or other barriers. The role of FQHCs to vaccinate Black Ohioans stands to grow in importance as supplies are now more readily available and recruitment becomes paramount.

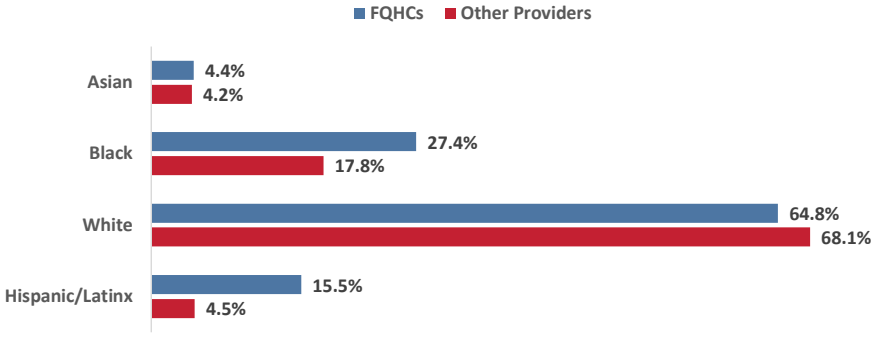
Despite the success of these FQHCs in distributing the COVID-19 vaccines more equitably, the proportion of Black residents of Cuyahoga County who have received the vaccines is still lower than that of the county's white residents. While many more Cuyahoga County residents have received the vaccine since the data were analyzed in February 2021, in the intervening months the demographics of who has been receiving the vaccines have remained unchanged, still skewing white. Given what we know about the benefits of FQHCs, coupled with the barriers Black Americans have faced historically and currently with being underserved by the medical community, FQHCs have been and will continue to be instrumental in vaccinating Black Ohioans. ■

Cuyahoga County FQHCs and Percentage of Black Population by Zip Code



Source: Census American Community Survey 5-year estimates 2019; Ohio Health Care Association

Percentage of Vaccines Distributed by Provider Type and Race/Ethnicity



Source: Better Health Partnerships

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Artificial Intelligence, COVID-19, and the Future of Pandemics

By Richard E. Anderson, MD, FACP, Chairman and Chief Executive Officer, The Doctors Company and TDC Group

Artificial intelligence (AI) has proven of value in the COVID-19 pandemic and shows promise for mitigating future healthcare crises. During the pandemic's first wave in New York, for example, Mount Sinai Health System used an algorithm to help identify patients ready for discharge.

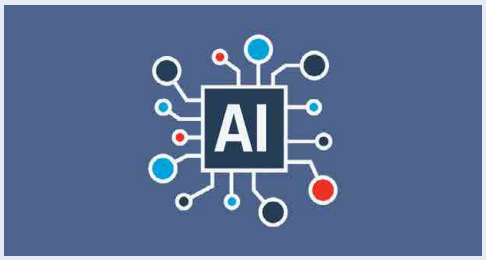
Pandemic applications have demonstrated AI's potential not only to lift administrative burdens, but also to give physicians back what Eric Topol, MD, founder and director of Scripps Research Translational Institute and author of Deep Medicine, calls "the gift of time."

Like any emerging technology, AI brings risk, but its promise of benefit should outweigh the probability of negative consequences—provided we remain aware of and mitigate the potential for AI-induced adverse events.

AI's Pandemic Success Limited Due to Fragmented Data

Innovation is the key to success in any crisis, and many healthcare providers have shown their ability to innovate with AI during the pandemic. For example, AI has been used to distinguish COVID-19-specific symptoms: It was a computer sifting medical records that took anosmia, loss of the sense of smell, from an anecdotal connection to an officially recognized early symptom of the virus. This information now helps physicians distinguish COVID-19 from influenza.

However, holding back more innovation is the fragmentation of healthcare data in the U.S. Most AI applications for medicine rely on machine learning; that is, they train on historical patient data to recognize patterns. Therefore, "Everything that we're doing gets better with a lot more annotated datasets," Dr. Topol says. Unfortunately, due to our disparate systems, we don't have centralized data. And even if our data were centralized, researchers lack



enough reliable COVID-19 data to perfect algorithms in the short term.

AI Introduces New Questions around Liability

While AI may eventually be assigned legal personhood, it is not, in fact, a person: It is a tool wielded by individual clinicians, by teams, by health systems, even multiple systems collaborating. Our current liability laws are not ready for the era of digital medicine.

AI algorithms are not perfect. Because we know that diagnostic error is already a major allegation in malpractice claims, we must ask: What happens when a patient alleges that diagnostic error occurred because a physician or physicians leaned too heavily on AI?

AI in Healthcare Can Help Mitigate Bias—or Worsen It

Machine learning is only as good as the information provided to train the machine. Models trained on partial datasets can skew toward demographics that turned up more often in the data. Already during the pandemic's first waves, multiple AI systems used to classify X-rays have been found to show racial, gender, and socioeconomic biases.

It's critical that system builders are able to explain and qualify their training data and that those who best understand AI-related system risks are the ones who influence healthcare systems or alter applications to mitigate AI-related harms.

AI Can Help Spot the Next Outbreak

More than a week before the World Health Organization (WHO) released its first warning about a novel coronavirus, the AI platform BlueDot, created in Toronto, Canada, spotted an unusual cluster of pneumonia cases in Wuhan, China. Meanwhile, at Boston Children's Hospital, the AI application Healthmap was scanning social media and news sites for signs of disease cluster, and it, too, flagged the first signs of what would become the COVID-19 outbreak—days before the WHO's first formal alert.

These innovative applications of AI in healthcare demonstrate real promise in detecting future outbreaks of new viruses early. This will allow healthcare providers and public health officials get information out sooner, reducing the load on health systems, and ultimately, saving lives. ■

1) Topol E. *Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again.* New York, NY: Hachette Book Group; 2019:285.
2) Cha, AE. Artificial intelligence and covid-19: Can the machines save us? *Washington Post.* Published November 1, 2020. Accessed November 9, 2020. https://www.washingtonpost.com/health/covid-19-artificial-intelligence/2020/10/30/7486db84-1485-11eb-bc10-40b25382f1be_story.html
3) Reuter E. Hundreds of AI solutions proposed for pandemic, but few are proven. *MedCity News.* Published May 28, 2020. Accessed October 19, 2020. https://medcitynews.com/2020/05/hundreds-of-ai-solutions-proposed-for-pandemic-but-few-are-proven/

Golfers Take a Big Swing for Medical Students at AMEF Outing

The Academy of Medicine Education Foundation (AMEF) held its first Swing for Students Golf Outing on August 9, at Sand Ridge Golf Club in Chardon. Proceeds from the event primarily benefit medical school student scholarships.

2021 AMEF Scholarship Awardee Joseph Laseter (with his guest) is recognized during dinner.

Golfers were welcomed by AMCNO staff at the registration table, then they were invited to test their skills with the booze putt. For $5 per putt, or $20 for 5 chances, a player could call the bottle of liquor they were aiming for, then try to win it by hitting it. All the bottles were won by the end of the night!

Lunch was served on the patio, and attendees were able to practice their swing on the driving range, before the shotgun start at 1 pm. Silent auction items were also on display so participants could start bidding on the baskets they wanted.

Despite the 90-degree heat, the golfers enjoyed their time on the beautiful course. And many of them secured their place at or near the top of the leaderboard! Following is the winners' list; we congratulate all of them on a great game.

- 1st place team: Dr. Mehrun Elyaderani, Richard Below, Adam Bogden, Jeff Roberts
- 2nd place team: Kevin Ellison, Scott Liff, Dave Krusinski, Dean Erickson
- 3rd place team: Dr. Bill Seitz Jr., David Seitz, Jacob Ehlers, Jesmin Ehlers
- Closest to the Pin – Dave Bastulli (on #4)
- Longest Drive – Alex Wolf (on #6)
- Closest to the Pin – Rich Jenkins (on #8)
- Longest Putt – Dr. Mehrun Elyaderani (on #9)
- Closest to the Pin – Michael Shaughnessy (on #12)
- Closest to the Pin – Joe Zabukovec (on #17)
- Longest Drive – Gilbert Gagne (on #18)

We would also like to sincerely thank all the sponsors and participants for their support. We collected $41,000 in sponsorships alone, and we made more than $3,000 from the silent auction items.

Platinum Event Sponsors
Cleveland Anesthesia Group
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AMCNO Past President Dr. Mehrun Elyaderani (second from left) and his team take first place at the outing!

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Former AMCNO CEO/EVP Elayne Biddlestone receives a Distinguished Service Award for her 40 years of work with our two organizations.

We were also pleased to have one of the recipients of the 2021 AMEF Medical School Scholarships—Joseph Laseter—and his guest attend the dinner, where Joseph received special recognition during the formal remarks given by AMEF Golf Committee Chairman Dr. John Bastulli. The top bidders for the silent auction were also announced, and the evening ended with the former AMCNO CEO/EVP Elayne Biddlestone, who retired in 2020, receiving a Distinguished Service Award for her 40 years of work with both organizations.

Our thanks once again to everyone who participated in this fun outing, and we look forward to seeing all of you at next year's event! ■

The AMCNO Shines at Its Website Launch Open House

We would like to thank our members and the many community leaders who joined us for our Website Launch Celebration at Alley Cat Oyster Bar in downtown Cleveland in July. And, a special thank you to our sponsors who helped us put together this fun and successful event: AMCNO President Dr. Kristin Englund, Past President Dr. Bruce Cameron, ChenMed, and Roche.

AMCNO President Dr. Kristin Englund (center) stands with AMCNO Past Presidents who attended the event.

The AMCNO Board of Directors gather together for a photo.

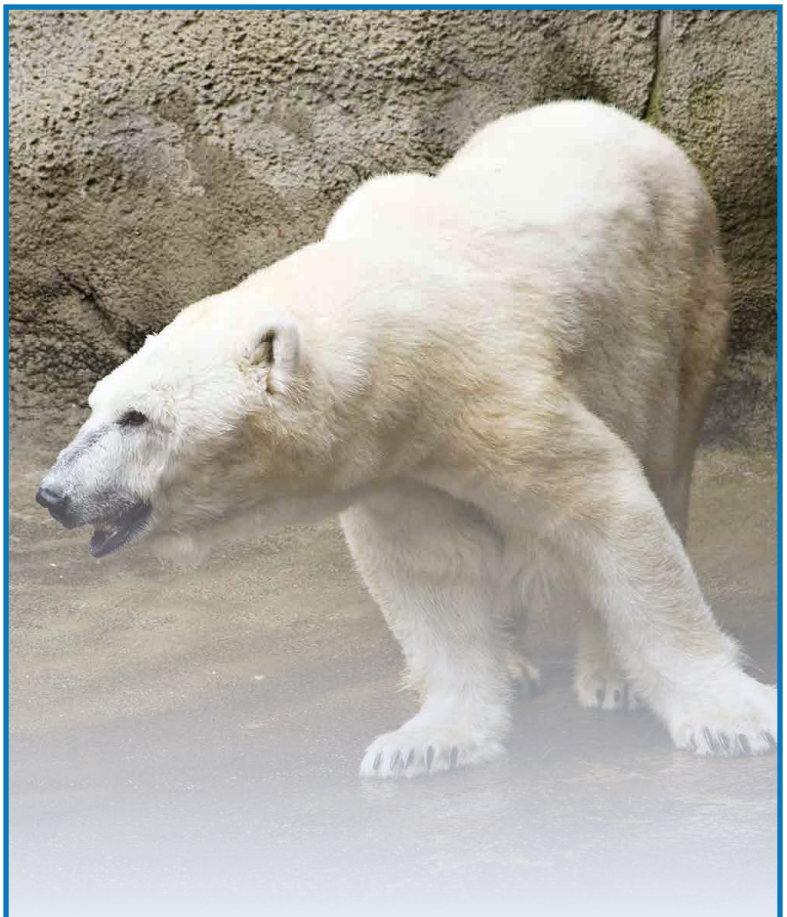
In addition to holding a raffle with some amazing prizes, and sharing delicious appetizers and drinks, AMCNO Digital Marketing and Membership Manager Valerie Yanoska gave attendees a virtual tour of our new website and the features that are currently available. Our website update is part of the process of moving forward as an organization, especially as we gear up toward celebrating our 200th anniversary. Many members commented after the presentation that the website looks great and they look forward to using it.

Please be sure to visit us at www.amcno.org, and take a look at all of the changes we've been working on behind the scenes. If you haven't already, be sure to also update the individual profile that has been set up for you, after you've reset your password. To do so, click on the green "Member Login" button on the right side of the home page. That will take you to the login screen, with the option to sign in (if you already have set it up), or either retrieve your username and/or reset your password. If you have any questions or need assistance, please contact Valerie at vyanoska@amcno.org, or call our office at (216) 520-1000.

As we continue to update our website and learn of new features that are available to our members, we will send you email notifications. Please be sure to share your feedback with us, too! Tell us what you like/don't like about the site, and what we can do to help improve it. We want a website that is a trusted resource dedicated to our members.

Additional photos from the Open House are posted on our social media accounts—Instagram and Twitter @AcademyMedCLE, and Facebook at The Academy of Medicine of Cleveland & Northern Ohio. ■

AMCNO staff pause a moment to take in the beautiful views.



How Do You Zoo?

The AMCNO is hosting a Family Fun Day for our members at the Cleveland Metroparks Zoo!

Saturday, Oct. 9
11 am – 3 pm

Discounted tickets are available

Standard Admission, for those aged 2 and up: $12.50 (regularly $16.95)

Under 2: Free

A catered lunch and crafts will be provided in the Primate Pavilion.

If you're interested in attending, please visit our website at www.amcno.org to register.

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SMBO Releases Guidance Related to Telemedicine

The State Medical Board of Ohio (SMBO) recently released a document with 24 frequently asked questions (FAQs) and answers about telemedicine. The compilation was approved by the SMBO on July 14, 2021, and it reflects the laws and rules in effect on that date.

The document's first of five sections focuses on the effect of the COVID-19 pandemic state of emergency status on telemedicine in Ohio. One of the questions is: What did the SMBO do at the beginning of the pandemic regarding enforcement of its laws and rules requiring in-person patient visits in Ohio? The SMBO's answer: On March 18, 2020, the Medical Board issued the following guidance to licensees: Effective March 9, 2020, until Executive Order 2020-01D (declaration of a state of emergency for Ohio for the COVID-19 pandemic) expires, providers can use telemedicine in place of in-person visits, without reinforcement from SMBO. This includes, but is not limited to:

- Prescribing controlled substances
- Prescribing for subacute and chronic pain
- Prescribing to patients not seen by the provider
- Pain management
- Medical marijuana recommendations and renewals
- Office-based treatment for opioid addiction

Providers must document their use of telemedicine and meet minimal standards of care. The Medical Board will provide advance notice before resuming enforcement of the above regulations when the state emergency orders are lifted.

Another question: Since Governor Mike DeWine ended the state of emergency on June 18, 2021, when will the Medical Board resume enforcement of its laws and rules requiring in-person patient visits? SMBO's answer: The Medical Board will resume enforcement on Sept. 17, 2021.

In the licensure section, one FAQ addresses whether a physician needs to apply for a separate telemedicine license. The SMBO's answer: No, there is not a separate license for telemedicine in Ohio. Specific to licensees of the Medical Board, in order to practice telemedicine in Ohio, the provider must be licensed in Ohio as a physician or physician assistant.

Two of the four questions in the "laws and rules for telemedicine in Ohio" section cover the following:

- What are the laws and regulations the Medical Board enforces as to its licensees? Answer: To protect the health and safety of patients, the Medical Board has laws and rules that require an initial and/or periodic in-person patient visit for those medical visits involving the prescribing of drugs. Generally, there is no telemedicine for initial patient visits with a physician or physician assistant involving prescribing as OAC rule 4731-11-09 prohibits physicians from prescribing controlled substances or non-controlled substances to a person on whom the physician has never conducted a physical examination with some exceptions. Also, visits that involve prescribing of specific types of controlled drugs also have initial and periodic in-person visit requirements. These are explained in subsequent FAQs.
- What is the standard of care that applies to telemedicine? Answer: The standard of care for telemedicine must be consistent with the standard of care for in-person medical care. A physician or physician assistant can face disciplinary action for "a departure from, or the failure to conform to, minimal standards of care of similar practitioners 4 under the same or similar circumstances, whether or not actual injury to a patient is established." R.C. 4731.22(B)(6) and R.C. 4730.25(B)(19).

The final two sections discuss visits involving prescribing a drug that is a not a controlled substance and visits that do. The complete FAQ is available on the AMCNO website: https://amcno.memberclicks.net/SMBO_telemedicine ■