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AMCNO Files Amicus Brief, Ohio Supreme Court Rejects Attack on a Jury Verdict

By Brian D. Sullivan, Esq., Reminger Co., LPA

On July 23, 2020, the Ohio Supreme Court issued a decision rejecting a dissatisfied plaintiff's attack on a jury verdict in favor of a physician in a medical malpractice lawsuit. *Jones v. Cleveland Clinic Foundation*, Ohio Supreme Court Slip Opinion 2020-Ohio-3780. In so doing, the Supreme Court reversed the Eighth District Court of Appeals that had vacated a defense verdict based on its belief that lengthy jury deliberations warranted a mistrial. The Academy of Medicine of Cleveland & Northern Ohio ("AMCNO") joined in the physician's efforts to convince the Ohio Supreme Court to affirm the jury verdict in his favor.

The *Jones* case involved a jury verdict rendered late on a Friday evening in favor of the defense in a medical malpractice matter. After the trial was over, one of the jurors wrote a letter to the court expressing regret for her vote and a statement that she had compromised her true beliefs to avoid having to return to continue deliberations the following week. The trial court refused to consider the letter and denied the plaintiff's motion for a mistrial. The court of appeals, however, reversed this determination concluding that the letter should have been considered by the trial judge and supported plaintiff's request for a new trial. AMCNO filed an amicus brief (or friend of the court brief) in support of the physician's efforts to reverse the decision of the appellate court.

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AMCNO Applauds City Council for Passing Legislation to Keep Kids Healthy

The AMCNO is pleased to announce that Cleveland City Council unanimously approved the healthy default drinks policy supported by the AMCNO. This legislation ensures that kids' meals offered in Cleveland restaurants include healthier drinks as the default options, not sugary drinks. Mayor Frank Jackson signed it into law the same day.

As we reported in our March/April issue, this legislation was spearheaded by the American Heart Association and a broad coalition of local and regional organizations (including the AMCNO) to support the Cleveland Healthy Kids' Meals Campaign. This campaign was created to increase awareness around sugary drink consumption, and call for policy changes that can lead to better outcomes for kids.

This community-based initiative addresses the epidemic of sugary drink consumption among Cleveland's kids, and the resulting risks of chronic health issues, including diabetes and heart disease. Several healthcare representatives testified before City Council, and the AMCNO submitted written testimony in support of this important legislation.

The legislation will require restaurants, by the end of January 2021, to provide children with a healthy beverage option such as milk, water or juice. This legislation is similar to measures adopted in other cities, and will still allow customers to obtain sugary drinks, if they so desire, through a separate purchase.

Restaurants that don't comply with the ordinance could face fines, and the Department of Public Health has been charged with enforcement.

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In *Jones*, the plaintiff presented to the emergency department of a local hospital complaining of chest pains. He was evaluated by a cardiologist and ordered to undergo a stress test. The stress test was performed, and the cardiologist interpreted the results as negative. Two weeks later, Mr. Jones died of a heart attack. Plaintiff alleged that the cardiologist was negligent in failing to obtain a cardiac catherization that would have found Jones' blocked coronary artery and enabled doctors to save his life.

After a week of trial, the jury began its deliberations on Friday morning. After approximately 1½ hours of deliberation, the jury asked the trial court for clarification on a jury instruction and noted that their votes were equally split. Several hours later, the jury submitted a second note indicating that they were still undecided and not sure what to do. The jury was instructed to keep deliberating.

Later that evening, a juror was excused due to a family emergency. An alternate juror was summoned, and the entire jury was instructed to restart their deliberations. After another hour of deliberations with the replacement juror, the jury advised the trial court that it was once again deadlocked. They were once again instructed to continue their deliberations. About an hour later, the trial court received another note indicating that the jury was tired, cranky, and deadlocked. They wanted to know if they needed to continue to deliberate before they could go home. By this time, it was around 9:30 pm.

The trial court, with the agreement of counsel, decided to send a note to the jurors saying that they could leave for the evening and return on Monday morning to resume deliberations. After delivering the message to the jury, the bailiff reported that a couple of jurors reacted to the judge's note by stating, "Come back for what? We are not going to change." In response, the trial court determined it would read the standard jury instruction relating to deadlocked deliberations and was discussing with counsel whether it should be read that evening or on Monday morning. As the trial judge was discussing this issue with counsel, the jury announced it had reached a verdict. The jury returned to the courtroom and announced it had reached a 6 to 2 verdict in favor of the defense. Plaintiff promptly moved for a mistrial.

One month after the trial, the trial court received a letter from a juror. The juror explained that her jury service had been stressful and that she had ultimately agreed to a defense verdict to avoid coming back the following week. She further explained that she felt very strongly that the plaintiff was correct in the case and that the physician was negligent. After disclosure of the letter to all parties, the trial court concluded that it could not consider the juror's letter. It did so because the rules of evidence preclude the use of a juror's testimony to attack a verdict unless the testimony suggests a threat, bribe, or impropriety by an officer of the court, and the letter did not suggest that any of the exceptions to the prohibition against juror testimony was applicable.

On appeal to the Eighth District, the appellate court concluded that the trial judge mistakenly refused to consider the letter. The appellate court further found that, given the totality of the circumstances surrounding the jury's deliberation, the trial court abused its discretion in refusing to grant a mistrial.

On appeal to the Ohio Supreme Court, AMCNO argued that relitigating the validity of trial court decisions under these circumstances undermined the integrity and finality of our time honored jury system. The AMCNO argued that the appellate court decision risked opening "Pandora's box" and permitted Ohio courts to re-examine verdicts on the basis of a juror's unsworn, post-trial statements about their personal motivations for their vote. To that end, the AMCNO argued that, if the Supreme Court allowed jurors to undermine the validity of private, candid jury deliberations, medical professionals across the state would be unduly burdened by the obligation to relitigate medical malpractice cases. Finally, AMCNO argued that, if the appellate court decision was left to stand, jurors would likely be subject to harassment from litigants dissatisfied with verdicts. Unsuccessful litigants would be incentivized to question jurors to determine if any of them were tired, hungry, dissatisfied or otherwise have regrets about their decision. This harassment would not only unduly burden jurors, but also threaten to extend litigation in an otherwise settled matter.

The Ohio Supreme Court reversed the decision of the appellate court. In so doing, it concluded that the Rules of Evidence prohibit juror testimony to impeach a verdict unless the testimony relates to jury misconduct and when the evidence of that misconduct arises from a source outside the jury or the testimony relates to "any threat, any bribe, any attempted threat or bribe or any improprieties of any officer of the court." The Supreme Court concluded that neither exception to the prohibition against jury testimony was applicable under the facts of this case. Indeed, the Supreme Court concluded that a juror's impression of deliberations is not "outside evidence" and that conjecture that jurors felt pressured to change their votes because of a desire to avoid further deliberations did not amount to "outside influence." The Supreme Court observed that what plaintiff complains of was exactly the type of internal juror dynamics that the rule prohibiting juror testimony was designed to keep sacrosanct. Based on this analysis, the Supreme Court concluded that the trial court properly refused to consider the juror's letter when reviewing plaintiff's request for a mistrial. The court further found there was no basis on which plaintiff was entitled to a new trial and remanded the matter to the appellate court to consider other issues related to admission of certain trial testimony. ■

AMCNO COMMUNITY ACTIVITIES

AMCNO Applauds City Council for Passing Legislation to Keep Kids Healthy

(Continued from page 1)

The final ordinance calls for restaurants to provide water or sparkling water, nonfat or 1% milk, in servings with no more than 150 calories, or up to 8 ounces of 100% fruit juice, with no added sweeteners, as the default drink on their menus for children's meals.

The coalition was pleased to have worked with the Ohio Beverage Association, the Ohio Restaurant Association and the Ohio Dairy Producers Association in developing this legislation.

TOP 5 KIDS' MEALS HEALTHY DEFAULT DRINKS "NEED-TO-KNOW" KEY POINTS:

1. The Kids' Meals Campaign worked to pass a healthy default drinks policy that would ensure that kids' meals offered in Cleveland restaurants include healthier drinks as the default options (not sugary drinks).
2. The policy would affect only restaurants in the City of Cleveland, and only those restaurants that have kids' menus with beverages included (not retail).
3. The policy doesn't restrict choice; parents could still order anything they want for their kids from the menu.
4. Healthy default drinks policies are already active in local schools and at early childcare centers.
5. Beyond the City Council policy, the Kids' Meals Campaign is working to build awareness and engage community members around the health impact of sugary drinks.

The Healthy Kids' Meals Campaign aims to make restaurant kids' meals healthier by ensuring that healthy drinks like water and low-fat milk are included as default options instead of sugary drinks. This policy has been effective in cities around the U.S. in helping parents make healthier choices while eating out, and it can lead to better outcomes for Cleveland kids.

By offering further protections for kids, healthier restaurant kids' meals support our work as physicians and advocates for our patients. Again, we applaud the City of Cleveland for passing this important legislation! ■

The AMCNO Board of Directors and Staff wish you and your family Happy Holidays and a Healthy New Year!

Ohio Expands Immunity for Healthcare Providers

By Erica James, Esq., and Ray Krncevic, Esq., Tucker Ellis LLP

On Sept. 14, 2020, Ohio Governor Mike DeWine signed into law House Bill 606, also known as the "Good Samaritan Expansion Bill." The new law stands as a much-needed expansion to existing protections for Ohio healthcare providers responding to the unprecedented COVID-19 pandemic. The bill builds on current federal and state level protections, ensuring that providers will not face liability for good faith decisions necessitated by COVID-19.

The significant number of COVID-19-related fatalities raises concerns that healthcare providers will eventually be the target of litigation. In the early days of the pandemic, many jurisdictions, including Ohio, put a moratorium in place for non-essential surgeries and procedures, creating fertile ground for suits related to delay of diagnosis and/or treatment. Additionally, the standard of care associated with the diagnosis and treatment of COVID-19 has shifted on numerous occasions, and it will continue to shift as scientific knowledge regarding the presentation and optimal treatment of the disease continues to evolve. Prior to the passage of HB 606, the existing federal and state level protections have not been adequate to address these challenges.

Federal Protections

The existing federal protections do not extend to many facets of medical practice. On March 17, 2020, the Secretary of Health and Human Services issued a declaration under the Public Readiness and Emergency Preparedness Act for Medical Countermeasures Against COVID-19 that provides immunity to certain individuals and entities against claims of loss associated with the manufacture, distribution, administration, or use of certain medical countermeasures to COVID-19. Retroactive to Feb. 4, 2020, this declaration provides some protection for providers who utilize certain diagnostic or treatment measures to address the COVID-19 pandemic. But importantly, it does not address the medical decision-making associated with the care of COVID-19 patients, including triage, assessment, and treatment course.

The Coronavirus Aid, Relief, and Economic Security (CARES) Act, enacted on March 27, provides limited immunity for volunteer healthcare professionals during COVID-19 emergency response. The CARES Act states that healthcare professionals providing care on a volunteer basis in response to the COVID-19 public health emergency cannot be held liable for professional malpractice as long as they were acting within the scope of their licenses and in good faith. The CARES Act immunity does not apply to care provided outside the scope of volunteer work, and also does not apply in cases of willful or criminal misconduct, gross negligence, or intoxication.

Current Ohio Protections

An Ohio statute enacted in 2019 provides some limited protection to healthcare providers responding to the COVID-19 pandemic. Ohio Revised Code 2305.2311, effective March 20, 2019, provides that a healthcare provider or emergency medical technician that provides emergency medical services, first-aid treatment, or other emergency professional care, including the provision of any medication or other medical product as a result of a "disaster," is not liable in damages to any person in a tort action for injury or loss to person or property that allegedly arises from an act or omission in his or her provision of those services or that treatment or care. "Disaster" explicitly includes an epidemic that is declared to be a disaster by the federal government.

Ohio Revised Code 2305.2311 does not grant immunity for actions that are outside the scope of the healthcare provider or emergency medical technician's authority or constitute reckless disregard for the consequences so as to affect the life or health of the patient. Most notably, Ohio Revised Code 2305.2311 applies only to the provision of emergency medical services, first-aid treatment, or other emergency professional care. It does not apply to care provided on a non-emergent basis and also does not apply to tort actions alleging wrongful death.

New Protections Under HB 606

HB 606 provides temporary immunity for healthcare providers in both tort actions and in professional disciplinary actions, if those actions arise from a disaster or emergency, inclusive of an epidemic. The bill explicitly supersedes Revised Code 2305.2311 for events taking place from March 9, 2020, through Sept. 30, 2021. And, unlike Revised Code 2305.2311, it provides immunity from wrongful death actions.

In the bill, "healthcare provider" is broadly defined, encompassing not only physicians and nurses, but an entire list that includes athletic trainers, licensed counselors, dental hygienists, federally qualified health centers, home health, long-term care, and hospice services, among others. The immunity applies to any healthcare services provided "as a result of or in response to a disaster or emergency," whether for "an act or omission" in providing care, any "decision related to the provision" of care, or any [c]ompliance with an executive order or director's order" issued in response to the disaster/emergency. Importantly, the bill provides immunity for claims arising because the provider was unable to treat, diagnose, or test a patient for a condition "due to an executive or director's order or an order of a board of health…issued in relation to an epidemic or pandemic." It expressly covers elective procedures that were delayed or canceled.

Tort immunity and immunity from professional discipline will not apply in situations where the healthcare provider's actions constituted reckless disregard for the patient's health, intentional misconduct, or willful or wanton misconduct. Immunity also will not apply if the provider acted beyond the scope of his/her training, unless done "in good faith and in response to a lack of resources caused by a disaster or emergency." In addition, immunity from professional disciplinary action will not apply if the provider's actions constitute "gross negligence," defined in the bill as "lack of care so great that it appears to be a conscious indifference to the rights of others."

The new law takes effect on Dec. 13, 2020. At this point, it is uncertain whether the law will face any legal challenge. But in the meantime, as the stresses and uncertainties associated with COVID-19 continue, passage of HB 606 should help alleviate some of healthcare providers' fears of being second-guessed. ■

Editor's Note: *The AMCNO strongly supported HB 606 and we are pleased that it will become law.*

AMCNO Pollen Line – 2020 Review

By Maaz Jalil, DO; Craig Sewell, DO; Katheryn Birch, DO; Kelsey Graven, DO; Ryan Shilian, DO; Reimus Valencia, DO; Robert Hostoffer, DO; Devi Jhaveri, DO; Haig Tcheurekdjian, MD; and Shan Shan Wu, DO

Allergy/Immunology Associates is committed to serving our community of the Greater Cleveland area by providing daily pollen counts every year through the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Pollen Line. We use a Rotorod Aeroallergen device to obtain samples of air, which we use to calculate daily pollen levels throughout the season.

Pollen counts are useful data for both patients and practitioners; it allows individuals to correlate symptoms with an objective measurement. Practitioners can use trends in the data to optimize timing of therapy and confirm suspected diagnoses. Tree, grass, and ragweed pollen are the main culprits most responsible for allergies in the Northern Ohio region. They cause allergic conjunctivitis, allergic rhinitis, and/or asthma. By quantifying the amount of pollen in the air and observing trends, we can offer targeted therapies and prepare our patients to improve their overall quality of life.

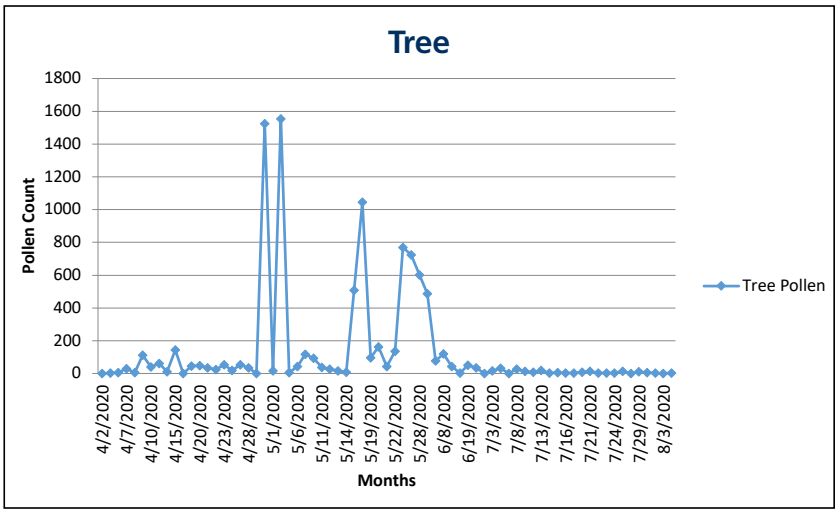
This year's allergy season was unique due to the COVID-19 pandemic that arrived in the United States in March 2020. Public officials and state guidelines mandated quarantines and closures of local businesses, parks, schools, and retail stores. Thus, fewer people were outdoors during the start of the spring season, causing fewer symptoms. However, as businesses reopened in early summer, our allergy practice noted worse allergy symptoms.

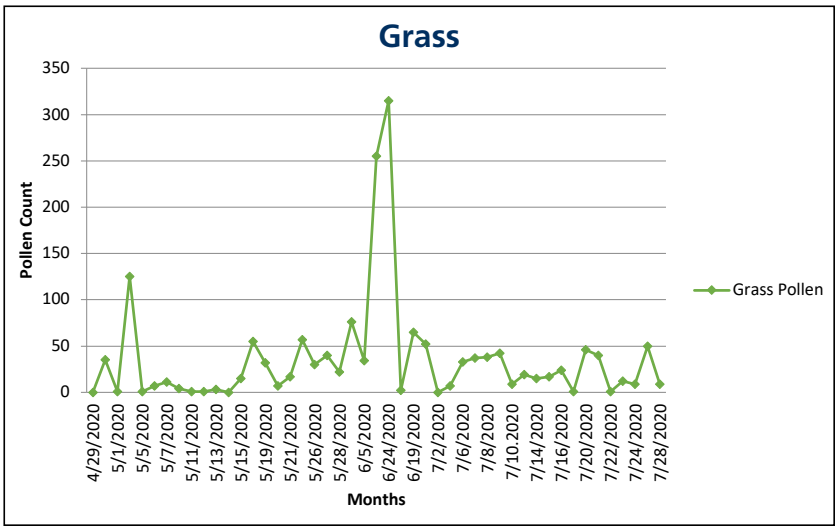
The pollen season begins with the blooming trees in spring. This year, tree pollen started appearing in mid-April, but remained relatively low until a sudden peak at the end of April/beginning of May. A second peak was also seen in mid- to late-May. Compared to last year, the pollen did not reach as high of a level—1555 vs 5000. Last year, there were a few peaks in early April that were not seen this year.

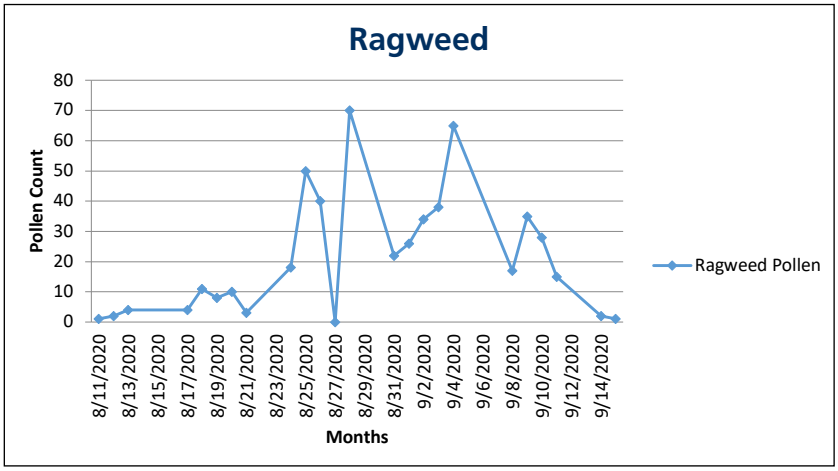
As the weather gets warmer and summer arrives, grass pollen begins to appear. This year, grass had an intermediate peak in the beginning of May, but then remained relatively low until its main spike in mid-June. Compared to last year, grass pollen reached higher levels—315 vs 260. Last year, grass pollen was in the high range for the majority of May, but it was less severe this year.

As autumn arrives, we begin to see ragweed. Similar to last year, we started seeing ragweed in mid-August and noted a peak at the end of August into September. Ragweed did not peak as high as it did last year—70 vs 570.

Each year, Allergy/Immunology Associates, in coordination with the AMCNO, is honored to provide the pollen count for the Greater Cleveland area from April 1 to October 1. The counts are available daily through the Pollen Line at (216) 520-1050, and they can be found online at www.amcno.org. ■







Opioid Consortium Welcomes Admiral Brett Giroir to Virtual Meeting

Camille Zalar, MHA, BSN, RN, CARN

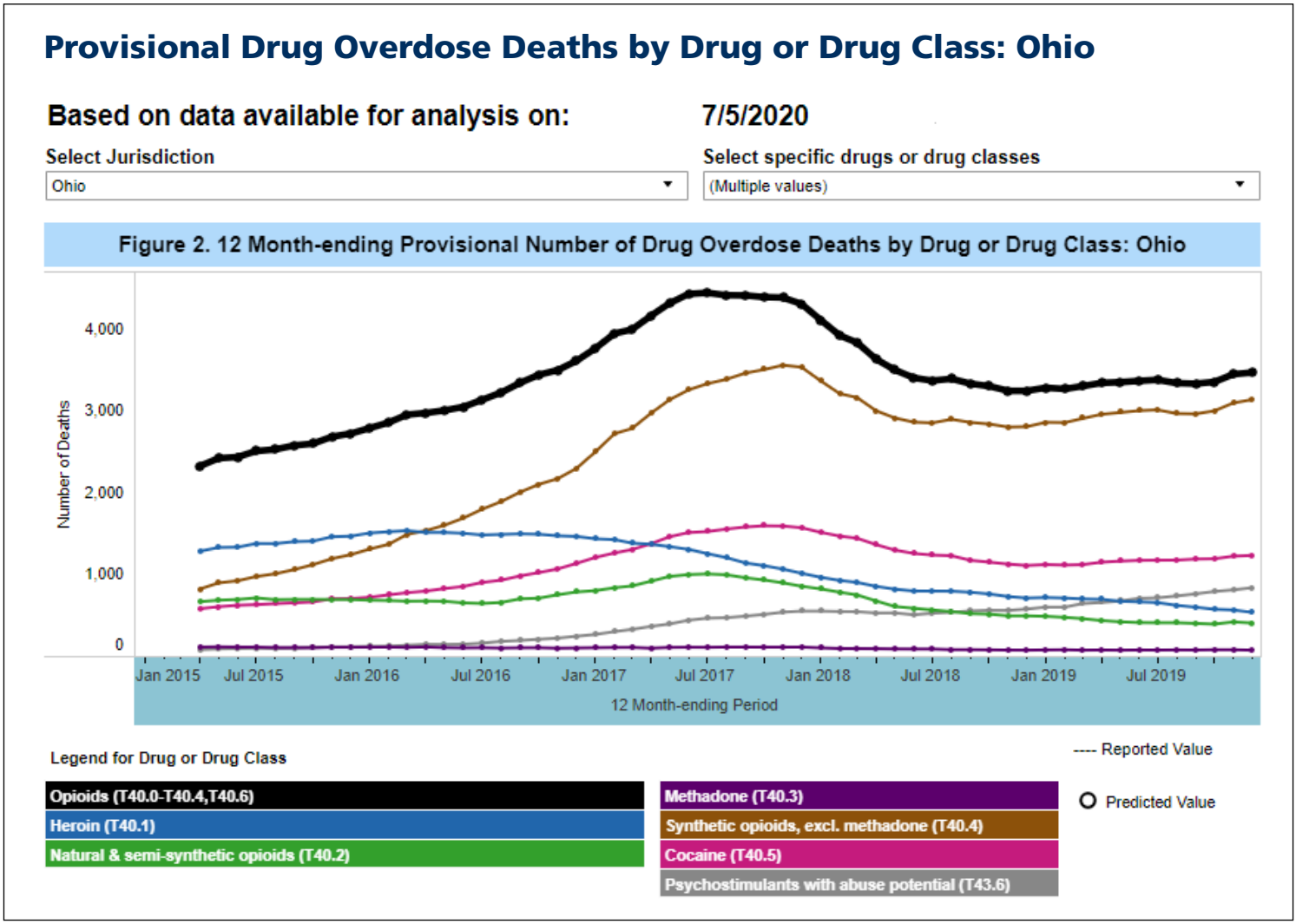
Director, Education & Initiatives, Northeast Ohio Hospital Opioid Consortium
The Center for Health Affairs

The Northeast Ohio Hospital Opioid Consortium welcomed Admiral Brett Giroir, assistant secretary for health at the U.S. Department of Health and Human Services (HHS), to its quarterly membership meeting held virtually in August.

As the primary public health and science advisor to HHS Secretary Alex Azar, Adm. Giroir's work includes coordinating HHS' efforts across the administration to fight America's substance use crisis as well as overseeing COVID-19 testing efforts. In his remarks to Opioid Consortium members, Adm. Giroir shared recent data on substance use disorders, offering insight on what's happening nationwide as well as factors that are unique to Ohio.

Based on national data from the Centers for Disease Control and Prevention (CDC), the headway that had been made in 2018 and early 2019 on the opioid crisis has reversed. Nearly 72,000 people died in 2019 of overdose nationwide, a 4.8% increase over 2018. In Ohio, the increase was even greater, at 6.9%. Synthetic opioids—mainly fentanyl and fentanyl analogues—were the most common causes of overdose. Adm. Giroir pointed out that a differentiator in Ohio is the presence of carfentanil, which is not as prevalent in other states.

Dr. David Streem, physician chair of the Opioid Consortium and chief of psychiatry and medical director of alcohol and drug recovery services at Cleveland Clinic, shared that prior opioid epidemics generally have been followed by stimulant epidemics, which was borne out by the data shared by Adm. Giroir. At the national level, cocaine as a cause of overdose had been trending downward. However, more recently that trend has reversed and overdose attributable to cocaine, along with psychostimulants, primarily methamphetamine, once again has been on the rise.



Impact of COVID-19

According to data shared by Adm. Giroir, COVID-19 has exacerbated challenges for the 47.6 million Americans with a mental or behavioral health disorder and the 20.3 million individuals with a substance use disorder. An analysis of urine screen data from Millennium Health indicates illicit use of fentanyl, methamphetamine, and cocaine has increased when compared to pre-COVID timeframes. According to the Overdose Data Mapping Application Program (ODMAP), which issues alerts when there are spikes in the incidence of overdose, there were nearly double the number of spike alerts in April 2020 compared to April 2019.

Although these statistics are grim, there are some glimmers of hope. Thanks in great part to the concerted efforts of those in health care, deaths attributable to prescription opioids have declined. And the federal government continues to prioritize this issue, for example through the HEALing Communities study and opioid response grants. Due to the rise in the use of methamphetamine, federal agencies are also increasing funding and attention to researching new treatments for related substance use disorders, which are lacking.

At the same time, under COVID-19, the provision of services using telehealth has been unfettered, allowing opioid treatment programs to provide therapy and counseling with audio only, for example. Adm. Giroir reiterated what's been heard from other federal officials, including Centers for Medicare & Medicaid Services Administrator Seema Verma, regarding an ongoing commitment to telehealth and an intention to maintain many of the expansions implemented under the public health emergency declaration.

Opioid Consortium Expands Education Initiative

The Opioid Consortium appreciated that, especially during such an incredibly busy moment for the nation's public health system, the Admiral made the time to share his insight and assure members, even in the shadow of COVID-19, of the continuing prioritization of the opioid and substance use disorder crisis facing the country. His insights reinforced the importance of efforts by area physicians, hospitals and others working in the region to address the crisis.

A significant component of the Opioid Consortium's work throughout the last year has been related to launching and expanding an online education portal. The initiative began with the four-part program that went live in November 2019 for nurses and was expanded this summer with a course for healthcare support staff. This new course is designed to provide an increased understanding of opioid use disorder to enhance patient care and reduce stigma. Developed in collaboration with nurse education partners within each Opioid Consortium hospital system, it is intended for ancillary staff who work in various healthcare environments that serve patients, and it aims to teach healthcare support staff about the disease of addiction, and how to communicate with empathy, use verbal de-escalation techniques, and implement tools to help patients and families receive needed services.

Additional enhancements to the education portal are in development, funded through a grant from the CDC received through a partnership with the Cuyahoga County Board of Health, The MetroHealth System and others. Through this work, the Opioid Consortium is adding opioid mitigation online tools and resources for member hospitals and other providers, including a Peer Review Model Toolkit, which is in development in partnership with The MetroHealth System's Office of Opioid Safety. This is a step-by-step guide to creating and implementing a peer review model that can be used by Opioid Consortium member hospitals. It will include opioid mitigation resources for physicians, pharmacists and other providers as well as an academic detailing section that incorporates train-the-trainer resources for Opioid Consortium hospitals.

To date, more than 3,100 participants have registered with the online education portal, and more than 5,000 nursing CEUs have been delivered this year.

Looking Ahead

Currently, the Opioid Consortium is in the final months of its three-year strategic plan. Work is underway to develop a new plan, which will carry the collaborative work through 2023. The new three-year plan is expected to be finalized by the end of 2020.

The Northeast Ohio Hospital Opioid Consortium was formed in 2016 when the region's health systems came together to develop a hospital-specific response to the crisis. It is a physician-led, member-driven partnership of Cleveland Clinic, The MetroHealth System, St. Vincent Charity Medical Center, University Hospitals, and the VA Northeast Ohio Healthcare System, along with The Center for Health Affairs and The Academy of Medicine of Cleveland & Northern Ohio. Together, these organizations are working to significantly reduce the impact of the opioid epidemic in Northeast Ohio by sharing and implementing evidence-based practices, promoting policy changes, and increasing prevention efforts. ■

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First Year Cleveland — AMCNO Report, September 2020

By Bernadette M. Kerrigan, MSSA, LISW, SPHR, Executive Director, First Year Cleveland

First Year Cleveland (FYC) is pleased that AMCNO is our partner in reducing infant deaths in Cuyahoga County, with a focus on Black infants, who die at a disproportionately higher rate than white infants.

Cuyahoga County is facing two pandemics — racism and COVID-19. We recognize the tremendous efforts of the front line, leadership teams and all levels of healthcare systems. Words cannot adequately convey our appreciation for all you do. ***Thank you.***

FYC is a collective impact organization with a **community-wide network of more than 500 partners**, across all sectors and including parents and individuals who have experienced infant loss — all committed to reducing infant deaths. FYC has activated a three-year public policy and engagement strategic plan, and our 11 action teams are focusing on areas proven to reduce infant deaths: racial disparities, extreme prematurity and sleep-related deaths.

Our community has made progress:

- The **overall infant mortality rate** decreased from 10.51 in 2015 to 8.61 in 2019.*
- The **Black non-Hispanic** infant mortality rate decreased from 18.45 in 2015 to 16.34 in 2019.*
- The Black to white **infant mortality inequity rate** decreased from our baseline of 6.7 in 2017 to 4.17 in 2019.*
- The **overall preterm birth rate** decreased from 12.14% in 2015 to 11.62% in 2019.*

As we know, racism plays a key role in the high Black infant death rate. FYC was one of the first organizations in the state to lead a call to action on declaring racism a public health crisis. Now, 30 Ohio counties have joined us. The time for each AMCNO member to lead and execute antiracism efforts is now. If you would like to deepen your involvement in this important work, please contact FYC Executive Director Bernadette Kerrigan at Bernadette.Kerrigan@case.edu or (216) 368-6870.

We thank all the AMCNO members who contributed to FYC's recent achievements:

- FYC was one of the first infant mortality collaboratives in Ohio to highlight **structural racism** as a key factor contributing to Black infant deaths. Since our initial efforts, strategies were executed which led to Cleveland City Council and Cuyahoga County passing resolutions **declaring racism a public health crisis**. Advisory Councils, at both city and county levels, have been formed, tasked with providing recommendations to reduce racial disparities in wide-ranging areas.
- FYC partnered with healthcare providers to meet the increased needs of new and expectant parents due to the **COVID-19 pandemic**. Working with our partners, key initiatives were implemented to target and reduce the disparity in health outcomes in our Black communities.
- FYC received a $100,000 grant from the **Cleveland Foundation's Rapid Response Fund,** which enabled us to provide Doppler fetal monitors, BP cuffs and more to labor and delivery units, as well as care packages for new mothers with or at high risk of COVID-19.
- FYC's Action Team 2 launched **Our Wellness Network** in June. Comprised of Black therapists, parents, and lay leaders, OWN stresses the importance of mental health and provides services to Black families who have experienced a miscarriage, stillbirth, or infant loss. Individuals may call 888-505-7245 for help and healing.
- FYC's Action Team 4, comprised of local hospitals' OB and NICU leaders, has been studying **premature births**, resulting in priority areas for intervention. FYC Action Teams 4 and 5 are also jointly identifying interventions focused on **access to obstetrical care and triage** in emergency departments.
- More than 15,000 **Safe Sleep Heroes** have been trained as a sustainable effort to reduce sleep-related infant deaths. The "heroes" teach the ABCDs of Safe Sleep: **A**lone, on their **B**ack, in a **C**rib and **D**on't smoke.
- FYC secured $4.8 million through the **Ohio Department of Medicaid Healthy Moms and Babies** grant to support local, effective home visiting programs, community doulas and Centering®. Call Bright Beginnings to refer a parent who could benefit from home visiting or a community birth doula – (216) 736-2673.
- In June, Ohio's governor signed **House Bill 11** into law. HB11 is focused on reducing infant mortality through increased access for pregnant women to dental cleaning, smoking cessation, lead safety information, and group prenatal care services. FYC's **Engagement and Public Policy Committee** was integral to the passage of this bill.
- This same committee identified three public policy priorities for 2020-2021: funding, equity, and access. The committee will closely follow policy decisions across the state that will inform and impact its initiatives, including those focused on paid family and medical leave, recognition of doulas and perinatal support professionals as essential staff in labor and delivery, and the expansion of anti-racism training.
- FYC is **presenting at conferences and seminars**, leading discussions on **reducing racial disparities** and **addressing structural racism**. FYC's executive director now serves on the NY State Department of Health Maternal and Child Equity Improvement Planning Team, where strategies for improving equity in maternal and birth outcomes will be shared.
- FYC has begun an **equity-based strategic planning process**. Outputs will include an equity assessment of FYC; a 2021-2023 strategic plan centered in equity; clearly defined priorities and goals; an implementation plan with measurable deliverables; and an evaluation process to ensure the plan contributes to reducing Cuyahoga County's infant mortality rate, specifically the Black infant mortality rate.
- FYC continues its relationship with **Case Western Reserve University (CWRU) School of Medicine**. CWRU serves as FYC's parent organization, providing in-kind resources including accounting, human resources and technology services.

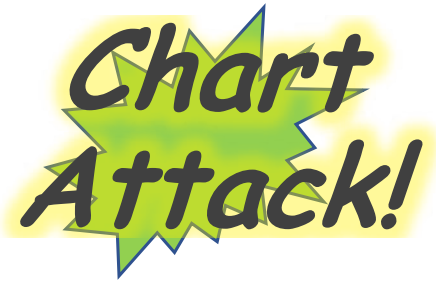
FYC calls on AMCNO members to do everything in your power to address racism in the healthcare system. Please ensure you and your colleagues have taken a racial bias test and are actively attending training to address biases. Lead a review of all HR policies and procedures using an equity lens. Host showings of the film "Toxic: A Black Woman's Story," followed by panel discussions on racism faced by expectant and new parents of color, with executable action steps to stop it.

We must continue to work strategically and collectively in leading both system changes and scaling effective programs for Black parents and expectant parents to achieve our goals, save our babies and eliminate racial inequities. We appreciate your efforts to ensure continued progress.

**2019 data are preliminary and unaudited.* ■

Preventing Chart Attacks

By Gerard Isenberg, MD, MBA



Some local electronic health record chart attack examples across specialties and institutions:

"Patient discharged yesterday. Patient presented to ER today after suffering cardiac arrest, dead on arrival. Most likely patient had PE as patient was not given appropriate DVT prophylaxis by hospitalist."

"Patient transferred to our service because patient inappropriately got cath done there resulting in bleeding."

"Surgery refuses to do cholecystectomy despite evidence-based recommendations including the following articles…."

"Note misplaced subclavian central line on CXR. Typical July new resident issue; discussed with primary service."

"Dr. X does not seem to understand situation and TOTALLY missed test results that show diagnosis."

"Nurse Y still has not put in I's and O's despite being told to."

"We consulted GI for GERD causing atypical chest pain and they did not feel consultation was warranted" (patient was being discharged 5 minutes after consult requested and did not want to stay until GI team was able to see patient as they were attending to a patient in the MICU, so GI suggested outpatient follow up – not documented until later as a chart update by GI team when GI team noted incorrect information put in discharge summary later that evening).

"Surgery called for consult; no response; CALLS BEING IGNORED!"

"Anesthesia mismanaged patient in OR resulting in critical condition."

In my role as Chief Medical Quality Officer for University Hospitals Digestive Health Institute, and a member of several quality assurance committees, I come across multiple other examples of chart attacks. Chart attacks are instances in which providers have either criticized or denigrated other providers or insinuate that sub-standard or poor patient care has been rendered.

A recent *New England Journal of Medicine* article highlighted this problem (Morris NP. Chart warfare. NEJM 2020;382:1392-3). Dr. Morris notes that the electronic health record (EHR) and its technology have weaponized patient records, allowing clinicians to change texts, fonts, underlines, highlights, and deploy templates in their grievances against other providers.

In this day and age of anonymous social media outbursts, providers may feel more empowered to write inflammatory statements in the EHR. These disputes have the potential to entangle patients, attorneys, and administrators in unnecessary battles, and further distance ourselves from our healthcare colleagues, compounding the damage that the EHR has already done in what I call "social-medical distancing." We now place consults and talk to providers by using the chart; we no longer routinely call and/or meet in hallways, rooms, or conferences to discuss patients.

While the person writing such attacks may feel justified or righteous in their criticisms, it does not look well from the perspective of a jury. In addition, the person whom the criticism is directed may feel motivated to retaliate or may also disengage from future optimum collaborative patient care with that provider.

Data regarding malpractice claims generated by chart attacks are not available, but likely are not inconsequential. Data regarding how patient satisfaction is affected by chart attacks have not been studied, but as patients often can more easily access their records via patient portals, such disputes may undermine the confidence that patients have in their healthcare providers, and even question the legitimacy of care they have received. And finally, there are no data regarding how much healthcare provider burnout contributes to chart attacks. To date, local institutions have not trained healthcare providers (from physicians to nurses to technicians) regarding the harms of chart attacks and have not developed institutional programs designed to include conflict resolution between providers with a specific focus on EHR.

Why does this happen?

In many situations, chart attacks occur due to provider egos that get in the way of patient management with skirmishes over whether a particular patient-related care issue is justified. Based on some providers' interviews on why they wrote their attack, many were subsequently dismayed by what they had written. Some comments included:

"I was just angry"

"I did not realize there was more information"

"I felt I was ignored"

"I did not realize there was an alternative explanation"

"I did not know there was an error in the radiology report"

"I guess I was/am burned out"

Physician burnout is increasingly recognized as an important factor in behaviors that are antagonistic, generating frustration, cynicism, and anger. The consequences of burnout are not limited to the personal well-being of healthcare providers. In fact, many studies have demonstrated that physician burnout is detrimental to patient care. Certainly with the COVID-19 pandemic raging on, stress and burnout are higher than ever before.

Some recommendations on what to do when faced with the following:

Conflicting data. Disagreements can and do occur among healthcare members treating a patient. For example, a consultant's recommendations may be at odds with the plans of the primary service attending. Most disagreements can be resolved with discussion and do not need to be documented. If you disagree with a clinical management decision, read the other providers' notes, and reread your own prior notes. Review radiology results (consider reviewing the images with another experienced radiologist) and other clinical reports even if you have already read the films or seen the data. Remember that the retrospective error rate among radiologic examinations is approximately 30% (C.S. Lee, et al. Cognitive and System Factors Contributing to Diagnostic Errors in Radiology. *American Journal of Roentgenology* 2013;201:611-7). Data and information that raises an eyebrow should be verified or rechecked. If you must document a different diagnosis or recommended treatment, objectively state the substance of the disagreement. For example, "Dr. Y's recommendation for antibiotics noted. However, because of patient's stable clinical status as noted by A, B, and C, will not order it at this time. Will follow patient with blood cultures." Do not include negative statements about the ability or

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competence of the other provider. Factually state your opinion and rationale for the alternative plan to be followed.

Arguments/conflicts with other physicians or nursing staff, or other healthcare providers. First, providers should strive to talk with one another, to understand opposing perspectives, and to reconcile differences either in face-to-face or virtual conversations. Second, if the disputes are irreconcilable, these issues should be addressed through the appropriate chain of command, not through the patient's medical record. Certainly disagreements can be documented factually but should be done without emotional overtones. Examples: "Dr. Z has evaluated the patient and does not feel the procedure is warranted. Please see her note for details. Patient is currently stable and will advise her of changes in patient condition" or "RN documentation noted, but I was not aware of low BP until entering room at 2100. IVF bolus ordered immediately." Criticizing another medical provider within the medical record should never be done. Such criticism can strengthen a medical malpractice claim, even if malpractice may not exist.

Recognize signs and/or symptoms of anger and/or burnout. Recognize that disputes sometimes arise because physicians have burnout. A recent study in the ambulatory setting concluded that physicians are spending about 49% of their time on administrative tasks, including EHR entry, and only 27% with their patients (C. Sinsky, et al. Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties. *Annals of Internal Medicine* 2016;165:753-60). Burnout affects physicians at all levels of training and at various stages of their careers: 44-50% of medical students, 66-78% of residents, and 40-51% of attending physicians (TP Reith. Burnout in United States Healthcare Professionals: A Narrative Review. *Cureus* 2018;10:e3681). Burnout is not limited to physicians. It affects all healthcare providers. Clearly, there is a need for improvements, including changes in workload and the environments in which we practice medicine. And clearly, our local institutions need to do more in combating burnout. Useful resources sponsored by the Ohio Physician Wellness Coalition (OPWC), of which the AMCNO is a proud member, include multiple CME-accredited videos: www.ohiophysicianwellness.org/cme. Funding for these courses has been made possible through the generous support of the Academy of Medicine Education Foundation (AMEF) and other statewide associations. CME credit is available through February 2021.

Adverse events. Do not write any finger-pointing or self-serving statements in the patient's medical record. Medical records often reflect differing diagnoses and treatment recommendations among multiple providers. Every provider at one time or another has been faced with patients whose care by other providers appears to be less than ideal. However, criticism of healthcare providers contributes nothing to address the patient's needs. Because patients can access EHR easily, patients may take remarks critical of prior care quite seriously, possibly destroying their relationships with previous providers and/or you. In addition, as all pertinent facts about prior care are rarely available, caution is advised in making judgments and comments if you disagree with a past or current provider. Likewise, basing your opinion of prior care solely on the patient's report of prior circumstances may not actually reflect changes in symptoms and findings over time. In addition, the patient's perceptions and recollections of past events may be inaccurately reported. A factual summary of clinical events and documentation of the discussion with the patient and family, including documentation of their inquiries, are advised when faced with adverse events. Do not make reference to an incident report in the EHR. Do not play the blame game.

Remember: Medical record documentation should never contain assumptions or blame other clinicians. Accurately and objectively document a patient's condition at the time you assume care. This documentation, combined with a thorough review of prior care treatment records, should keep the record straight without pointing fingers or blaming others in case the prior care is problematic. Statements critical of prior and current care may prompt patients to consider litigation, even in the setting in which no negligence has occurred. If you have a concern regarding the patient's care, such inquiries should be resolved with discussion with other providers. Otherwise, they should be made through a quality assurance (QA) review process or through the institutional risk management program if these occur within one organization. Or if outside a particular organization, they should be made through a letter of concern to the Medical Board if one feels obligated in good conscience to expose incompetence. These inquiries should not be mentioned in the medical record.

Unlike heart attacks, chart attacks can be 100% prevented.

Gerard Isenberg, MD, MBA is Chief Medical Quality Officer of the University Hospitals Digestive Health Institute, Associate Chief and Director of Clinical Operations of the Division of Gastroenterology and Liver Disease, and Associate Professor of Medicine at Case Western Reserve University and was recently recognized as a Master Clinician by the Department of Medicine. Dr. Isenberg is also a member of the AMCNO Executive Committee and Board of Directors and he chairs the AMCNO Membership Recruitment and Retention Committee. ■

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- You only need a valid email address to subscribe.
- Multiple people/email addresses from your facility can subscribe. We recommend that all staff (clinical, billing, and administrative) who interact with Medicare topics register individually. This will help facilitate the internal distribution of critical information and eliminate delay in getting the necessary information to the proper staff members.

To subscribe to the CGS ListServ Notification Service, go to http://www.cgsmedicare.com/medicare_dynamic/ls/001.asp and complete the required information.

New Court Rules Effective July 1, 2020

By Susan Audey, Esq., Tucker Ellis LLP

Effective July 1, 2020, Ohio state courts have some new rules to follow. As part of its effort over the last two years to bring some of the civil rules in line with civil rules followed in federal courts, the Supreme Court of Ohio's Commission on Rules of Practice and Procedure submitted several new rules that would implement sweeping changes affecting how litigation is conducted in Ohio state courts. This year, however, recommended changes to the rules regarding discovery—that part of civil litigation where parties seek information from each other in an attempt to gather the evidence necessary to prove their respective claims or defenses—received considerable attention from the Supreme Court, practitioners from both the plaintiffs' and defense bar, and even the General Assembly.

It would be helpful to explain a little of the rule-making process to understand the attention these new rules garnered. The rule-making process is a year-long, constitutionally mandated process. The Commission on Rules of Practice and Procedure, whose members are appointed by the Supreme Court of Ohio, consists primarily of judges and lawyers across the state who serve on various Commission subcommittees for the body of rules each subcommittee is assigned—civil, criminal, evidence, juvenile, appellate, and traffic. Each subcommittee studies certain of their rules—sometimes on the recommendations of the Supreme Court, subcommittee members, practitioners, or courts—and then proposes amendments to the studied rules. The amendments as proposed are submitted to the Supreme Court before the first round of public comment begins in the fall of the preceding year the rules would become effective. The first round of public comment ends toward the end of that year, each subcommittee studies the comments received, tweaks the proposed rule if necessary, or pulls it altogether before the second round of public comments begins early the next year. The same process is followed after comments are received after the second round of public comments ends around spring of that year. From there, the Supreme Court decides whether to submit the proposed rules to the General Assembly, with or without changes. The General Assembly then decides whether to take any action on the rules as submitted by the Supreme Court. If it takes no action by July 1, the amendments to the various rules amendments become effective on that date.

As this process relates to the Civil Rules Subcommittee, the two comment periods this past rules cycle generated a slew of comments from practitioners, industry groups, and some courts about the proposed discovery rules. In particular, the proposed rule that discovery be "proportional to the needs of the case." As submitted and now enacted, a court, in determining proportionality, is to consider "the importance of the issues at stake in the action, the amount in controversy, the parties' relative access to relevant information, the parties' resources, the importance of the discovery in resolving the issues, and whether the burden or expense of the proposed discovery outweighs its likely benefit."

This is the precise wording used by the federal discovery rule counterpart enacted as part of the amendments to the federal rules in 2015. And just like the onslaught of comments received by federal practitioners then, Ohio practitioners did the same when proportionality was proposed here. The concern voiced by the plaintiffs' bar was that the now former rule worked well and the new rule requiring proportionality could deny plaintiffs potentially useful information under the guise of proportionality. The defense bar, on the other hand, was generally in favor of proportionality because it avoids scorched-earth discovery tactics that are unnecessary, unfair, and expensive, and proportionality has worked well in the federal system since implemented in 2015. **Like some other defense-affiliated groups, AMCNO submitted a comment letter in favor of proportionality.**

With the concern voiced in the public comments and elsewhere over proportionality (and some of the proposed amendments to the criminal rules), the General Assembly's Senate Judiciary Committee took the not often-used step of hearing testimony on the proposed rules. The Chair of the Civil Rules Subcommittee testified in favor of the then-proposed rule on proportionality, but there was testimony offered against proportionality as well. And from the questions of some state senators, it appeared an open question if proportionality was going be adopted in Ohio.

Despite the attention given proportionality by the Supreme Court, practitioners, and even the Senate Judiciary Committee, the General Assembly took no further action on the rule amendments as submitted by the Supreme Court, and the new rules, including proportionality, became law on July 1, 2020.

But proportionality in discovery, although the most publicly debated, is not the only new rule affecting civil litigation. There are new rules regarding expert witnesses, the exchange of expert reports, and a new provision created for healthcare providers who now can rely on the medical records in lieu of an expert report when they seek to offer expert opinion testimony.

The new rules are good changes for healthcare providers who find themselves the subject of civil litigation. Overall, they bring a sense of fairness and efficiency to discovery process.

If you have any questions about these new rules, please contact AMCNO EVP/CEO Elayne Biddlestone at (216) 520-1000, and she can direct your inquiry. ■

WE'VE MOVED!

As of October 1, 2020, we have a new address.

Please make note of the change:
Academy of Medicine of Cleveland & Northern Ohio (AMCNO)
6111 Oak Tree Blvd., Suite 150
Cleveland, OH 44131

Our phone and fax numbers remain the same, as does our website.
Phone: (216) 520-1000
Fax: (216) 520-0999
www.amcno.org

AMCNO, AMEF Were Proud to Take Part in 2020 First Responder Appreciation Week

September 20-26 was the statewide celebration of First Responder Appreciation Week—one week dedicated to thanking first responders for their care and compassion when responding to overdoses and administering Narcan to save lives.

The AMCNO and our charitable component—the Academy of Medicine Education Foundation (AMEF)—were pleased to once again provide support for the program. AMEF's mission is to enhance health care through education of the medical profession and the community at large.

First responders bring help and hope year-round, so the Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board of Cuyahoga County wanted to find a way to keep the thanks going all year-round. This year, they created a calendar that includes a collection of thank you messages from those in recovery from substance use disorders who wanted to thank first responders for saving their lives and helping them reach recovery. Every police and fire station in Cuyahoga County received a thank you calendar in the mail.

The ADAMHS Board knows treatment works and people recover. They hope these thank you messages help first responders across the county see that too, since they do not usually get to see the people they help living in recovery. Throughout the year, the hope is that the messages of thanks and appreciation give first responders renewed hope and compassion to do the challenging work they do every day.

This project was made possible by donations from the AMEF and Ohio Association of County Behavioral Health Authorities (OACBHA).

The ADAMHS Board created a playlist on You Tube of several short videos: https://www.youtube.com/playlist?list=PLLT3BsBQ3Sbl8EjcuW1ilR4stQR5toZL3

They also posted messages all week on Twitter, Facebook and Instagram, using #BringingHelpBringingHope. The AMCNO posted messages on our Twitter feed as well @AMCNOTABLES. ■

AMCNO Bids Farewell to Longtime Executive Staff and Welcomes New Executive Director

Biddlestone

Elayne R. Biddlestone, who has served as the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) staff member and Executive Vice President/CEO for more than 40 years, will retire at the end of 2020.

Throughout the last 40 years, Ms. Biddlestone has served in various positions at the AMCNO and has been in her current role since 1996.

"My time with this amazing organization has been professionally and personally rewarding. When I started here in 1980, I never imagined I would still be here 40 years later – and I could not be more proud to have worked for this truly remarkable organization for so many years. I have been extremely fortunate to have had such a long and rewarding career. This has been a very difficult decision for me to make, but we all know that change in inevitable. I will always cherish my time with the AMCNO, and I will miss working for all of the physicians and their patients in Northern Ohio."

Johns

Following an extensive search process, Jen Johns has been selected to serve as the new Executive Director, effective October 19. Prior to joining the AMCNO, Ms. Johns served as Director of Government Relations for Cleveland Clinic, where she was responsible for leading the organization's state government relations work in Columbus. She also served as founder and chairwoman of the organization's internal opioid task force, working on solutions to the opioid epidemic in Northeast Ohio.

During her eight-year tenure at Cleveland Clinic, she was a key leader in Columbus, tackling issues from prior authorization reform to telehealth expansions, Medicaid reimbursement, addressing the opioid epidemic, and examining scope-of-practice issues.

Ms. Johns also previously worked in Government Relations for University Hospitals of Cleveland and Nationwide Children's Hospital in Columbus.

As a graduate research assistant at the Dartmouth Institute for Health Policy and Clinical Practice, she researched mental health benefits for children enrolled in state CHIP programs. Ms. Johns earned a Masters of Public Health degree in Health Policy and Management from the University of Pittsburgh, and a Bachelor of Arts degree in Political Science from The Ohio State University.

She currently resides in Twinsburg and enjoys attending Cleveland Indians games, cycling in the Metroparks, and spending time with her rescue dog Lola.

The AMCNO congratulates Ms. Biddlestone on her retirement and thanks her for her decades of leadership. We also warmly welcome Ms. Johns and look forward to working with her on issues of importance to physicians and their patients. ■

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Full Name	Complete Mailing Address
The Academy of Medicine of Cleveland & Northern Ohio	6100 Oak Tree Blvd. Ste 440, Independence, OH 44131

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REGIONAL ACTIVITIES

AMCNO Partners with Healthcare Innovation to Present Virtual 2020 Health IT Summit

This year's Midwest Healthcare Innovation Summit, of which the AMCNO was once again a partner, took place online throughout four days, but otherwise followed a similar format to the two-day in-person event from years past. Fittingly, the topics at this summit covered the COVID-19 pandemic and how healthcare systems are continuing to respond to the challenges, primarily through telehealth.

The program covered the following topics:

- How MetroHealth is Improving Care in Patient Populations Across the Region
- Utilizing Social Determinants of Health Data and Other Unique Data Sources to Improve Care
- Change Management Playbook: Leading Change in Healthcare
- 20 Years with Your EHR – What's Next?
- How MetroHealth Deployed a Hospital at Home and Virtual Care Program During Response to COVID-19
- CNIOs and CIOs Work Together to Care for the Workforce and Patients
- Building a Hybrid Cloud
- Clinical Transformation to Improve Operations, Costs and Deliver Better Patient Care

The AMCNO looks forward to partnering with Healthcare Innovation next year and having the event back in Cleveland.

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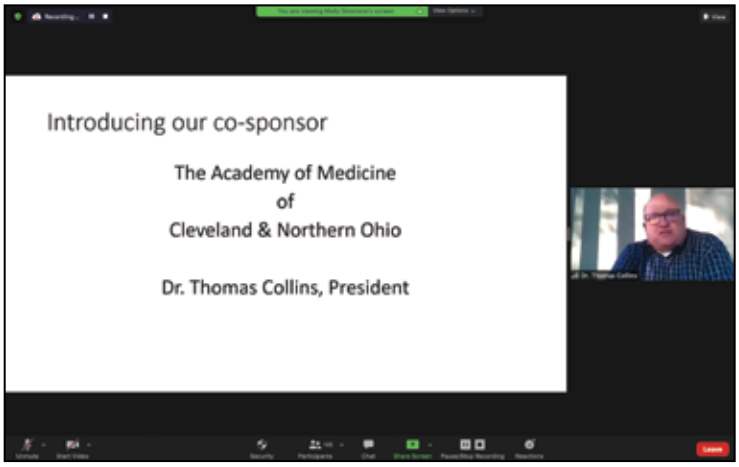
AMCNO, AMEF Host Virtual Speed Mentoring Event with CWRU School of Medicine for M1 Students

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and our charitable component, the Academy of Medicine Education Foundation (AMEF), co-hosted the annual Speed Mentoring event, along with Case Western Reserve University (CWRU) School of Medicine, for two nights in late-September.

This year's program was held virtually, however, because of the COVID-19 pandemic. The format remained mostly the same as in previous years. AMCNO physician members, Case faculty, and first-year medical students were invited to the event.

Each of the two sessions began with a didactic presentation on how to be a good mentor/mentee, provided by the school's Geiger Society Dean Dr. Marjorie Greenfield the first night, and by Robbins Society Dean Dr. Margaret Larkins-Pettigrew the following night.

AMCNO President Dr. Thomas E. Collins provided opening remarks, emphasizing how pleased we were to be co-hosting the event once again this year with Case. He explained to the students the importance of getting involved in the AMCNO and what we do to support our local communities.



AMCNO President Dr. Thomas Collins welcomes the attendees to the event.

The Case tech team then discussed the format of the program—each breakout room featured 1-3 physicians and 4-6 students. The goal was for the physicians to spend 6-7 minutes per room, then move on to the next room. The students were encouraged to ask questions, such as what a typical day is like for the physicians and what they like/don't like about their work/field.

Many students asked about how to achieve work-life balance to counteract feelings of burnout. AMCNO President-Elect Dr. Kristin Englund responded with practical, but essential, advice—focus on what you love outside of medicine. She said for her, that includes her dogs, her children and Taekwondo. She also encouraged the students to find joy every day. AMCNO Board member Dr. Jonathan Scharfstein echoed Dr. Englund's suggestions, adding that students need to let themselves enjoy what they love.

AMCNO Past President Dr. Ronald Savrin discussed his experience as a vascular surgeon and the head of his department, and how he was able to work on research while also on surgical service, after a student expressed her interest in doing both of these aspects of medicine.

Another AMCNO Past President, Dr. Matthew Levy, invited all his mentees to shadow him one day in the office or operating room.

Breakout rooms allow physicians and students to interact in small groups.

Family medicine physician and AMCNO member Dr. Jeff Brown said he loves primary care because he enjoys receiving thank you notes from his patients, which means he has really gotten to know the family.

Feedback from the students and physicians indicate 98% of attendees thought their participation in the program was time well spent. One student said she liked that the physicians were from a variety of fields and points in their careers and that all were friendly and welcoming. Another said the opportunity to speak with real-life physicians about their actual experiences was incredible. One physician responded that he liked meeting the students and hopefully making a difference. Another said she loved having the opportunity to inform students and help them on their path.

We would like to thank everyone for their participation and support. If you would like to participate in next year's Speed Mentoring event, please contact the AMCNO offices at (216) 520-1000. ■

Interested in Running for the AMCNO Board of Directors?

Members of the AMCNO Board of Directors are elected to represent their districts, determined by primary hospital affiliation or at-large for a two-year term.

Board members are responsible for addressing issues of importance to physicians and the patients they serve, and setting policy for the AMCNO.

If you are interested in running for 2021, please contact our offices at (216) 520-1000.

The deadline to apply: Dec. 31, 2020.