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**AAMC Press Teleconference
Coronavirus: Facts on the Front Lines
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Participants:

David J. Skorton, MD, AAMC president and CEO
Ross McKinney, Jr., MD, AAMC chief scientific officer
Janis Orłowski, MD, AAMC chief health care officer
Alison Whelan, MD, AAMC chief medical education officer
David A. Acosta, MD, AAMC chief diversity and inclusion officer

MODERATOR: Welcome, everyone. The online conference is about to begin. Please note today's call is being recorded. Please stand by. The Association of American Medical Colleges is pleased to welcome you to today's press conference, Coronavirus: Facts on the Front Lines. My name is Sandy, and it is my pleasure to be the facilitator for today's event. Please note today's call is being recorded. When you want to ask a question, please press star 1 on your telephone key pad to be placed into the phone queue. You will still be able to hear the presentation while you are waiting. When the speakers are ready to take your question, your line will be unmuted. Please announce yourself with your name and media outlet. It is now my pleasure to introduce Dr. David Skorton, President and CEO, who will introduce the other speakers for today. Dr. Skorton?

David Skorton, MD: Thank you, Sandy, and welcome, everyone. I thank you for joining us today and thank you for your reporting, which we really appreciate. We remind you our organization's members include all 155 accredited medical schools in the U.S., 17 accredited medical schools in Canada, roughly 400 major U.S. teaching hospitals on the front lines of this crisis including Mass General, John Hopkins, University of Washington, New York Presbyterian, University of Pennsylvania, L'Anfhomme, others, and 80 academic society. Many joined our press conference last Thursday and so much has changed since then. The COVID-19 pandemic has become exponentially more severe and that's why we wanted to share the latest with you today. Last Thursday, there were nearly 245,000 cases and more than 10,000 deaths around the world.

Across the United States, there were more than 13,000 cases and 206 deaths. This morning, those numbers have jumped to nearly 550,000 cases and more than 24,000 deaths around the world. And nearly 86,000 U.S. cases and 1300 deaths in the United States. That means we now have six times as many cases and deaths in the U.S. as when we gathered last. I'm here with four members to share information for those on the front lines of the crisis, as well as our perspective on key issues. First, Dr. Ross McKinney, chief scientific officer and infectious disease officer with research including the most promising vaccines and other treatments tested. After that, Dr. Janis Orłowski, chief health care officer and practicing physician, will talk about PPE shortages, testing, and supply chain issues as well as the latest in telehealth and what can be done to augment the health care workforce. Next, Dr. Alison Whelan, AAMC's medical education officer, will talk about guidance on medical student participation. And then Dr. David Acosta, chief diversity and inclusion officer,

will talk about testing disparities and how this affects the homeless, prisoners, and poor. After that, we will open it up for your question. Let's start, please, Dr. McKinney. Ross?

Ross McKinney, Jr., MD: Okay, thank you very much, David. There are few areas where the science is moving along quickly. One area is in the development of diagnostics. PCR remains the primary way to make the diagnosis of the acute infection and continue to have problems getting a sufficient number of PCR tests available. This will probably continue for the next few weeks. The difficulty is in manufacturing of sufficient supplies, including swabs; so that in most places, rather than being able to test everybody who people would like to test, who physicians would like to test, we are continue trained to only testing -- continue stained to only testing the most ill as confirmation.

This also means that we are underreporting the number of cases that are present in the United States. So that number that David cited of 86,000 or so, which is already exceeding China and Italy, is, in fact, a consider underreporting of the number of cases that are present in the United States. As we move into the next phase of this epidemic, one of the things that will be useful in understanding, the antibody response. So when somebody is infected, we protect ourselves by developing antibodies against the infection, and Dr. Crammar at Mount Sinai Medical School -- developed antibody assays that will be able to be used to identify which patients have developed a good immune response after their coronavirus infection. Knowing which patients have high neutralizing antibody dieters -- which means they can fight the infection well -- will allow us to try the experiment by using Exxon convalescent series yum to treat those in active stages of infection in hopes to make the infection less severe. That's still very preliminary and experimental but is likely to proceed in the very near future. There is also work to be done to develop monoclonal antibodies in the lab that are more tightly targeted and are generated from cells that can produce the specific antibodies against the virus and companies like Regeneron are developing those. It's likely a cocktail of those monoclonal antibodies could be effective and relatively benign treatment. In the meantime, there is still no supporting data for chloroquine for that to be credible. There are studies on going of drugs like FAVIPRAZIR. And I practice, it comes from Fujifilm in Japan. Those drugs are under study at present.

The epidemiologic aspects of the disease -- it has been proposed we may move to a system where counties are rated as high, medium, or low risk of coronavirus and use of PCR testing to be able to help track patients more likely would be able to allow us to do that risk assessment. I will note that seems to be a bad idea because we don't have sufficient testing to make it work. Second, if you were living in a high- risk area, what would be the first thing to come to your mind? It would be to move to a low-risk area. So setting up a triage is destined to fail. The other thing destined to fail is the experiment of trying to get herd immunity by not trying to flatten the curve. That was originally proposed in England and I think that they have decided it was a bad idea, unfortunately, before that was concluded. We learned today Boris Johnson became infected with coronavirus. So I think there are concerns about some of the epidemiologic strategies used and at the moment, social distancing is critical. We need to continue it. We need to continue it for the foreseeable future and that once the infections start to become fewer in number, we'll be able to move to the next phase of the control. And with that, I'd like to hand it off.

Janis Orlowski, MD: Thank you. Thank you. Good morning. This is Janis Orlowski. Thank you for the opportunity to make a few comments. First of all, in regards to shortage, despite all the work that is being done in this area, we continue to hear that PPE remains the biggest, most critical area of shortage among our health care centers. The statistics are that in a normal year, the United States uses between 15 million and 22 million N95 respirator masks so that's on an annual year, looking at the flu and others that we use N95 for. It is estimated that we are going to need five to ten times that number, and if we take a look at U.S. manufacturers, U.S. manufacturers made about 10% -- to maybe about 1.5 to 2 million of those masks. They have increased their production by 400%, but even still, even increasing it by 400%, we have not filled the gap. The national strategic stockpile has been utilized. The Pentagon has provided supplies, and we are told that there are going to be shipments from China very shortly, but these have not. Confirmed yet. So PPEs remain in shortage. Ventilators -- I spoke to Northwell Health System in New York a day ago.

They're very concerned they're running out of ventilators. That an example of what we're hearing for those areas that have the highest volume. Ventilator care is being changed very rapidly where people are looking at opportunities to use a single ventilator with more than one person. We're also seeing ventilators being converted from -- in different term that we have and so the ventilator shortage is of concern and there is tremendous innovation in that area be the biggest thing is trying to conserve PPE to the best of our ability so gowns and masks are being conserved and reused as necessary.

Let me go on to telehealth. We are appreciative of CMS waiving significant amount of regulation when it comes to telehealth. It can be allowed in any location, including home. The waivers allow physician to provide telehealth by Skype, FaceTime, a variety of platforms, and we're seeing fast utilization. For example, the University of South Florida went from no telehealth usage to telling us about 15% to 20% of their usual ambulatory clinic was now up and on Tallet Health. Columbia told us they had a year's worth of telehealth visits in the last two weeks so we're seeing quickly expansion of telehealth. That leads me to the third issue, a physician licensing. Unfortunately, there is still no way that there is a national medical license. It's being done state by state. We continue to work with the Federation for State Medical Boards. This is a cumbersome process for physicians to get licensed in these areas and you see variations. New York sent out a one-page form essentially having individuals able to identify they have an unexpired license in another state. Other states are changing the ways to obtain a license in their state, but it's being done state by state and including the districts.

That brings me to my fourth comment, workforce expansion. What we are seeing is opportunity to expand workforce. Individuals work at the top of their license. The accreditation subtle for residency programs has expanded the ability to use residents and fellows. We also see there is a call for recently retired physicians and nurses to return to practice. People say, "Aren't they

vulnerable to the disease?" There's an opportunity to bring these highly qualified individuals back into the workforce and to utilize them where they're not front line in the ICUs but maybe an ambulatory setting or other areas. So the work force expansion continues and shortly will hear about medical students.

Finally, I wanted to address the other thing the AAMC is developing, a centralized online covid-19 clinical guidance repository. We're path forget content from academic medical centers that are developing experience in treating covid-19 and providing this as a resource for clinicians and places around the country. The goal is to highlight, summarize, and identify clinical practice during the epidemic and share this up-to-date information for treatment and management guidance. And with that I am happy to turn this over to my colleague, Dr. Alison Whelan.

Alison Whelan, MD: Good morning. As you just heard, there remains a national imperative to flat the curve through social distancing. We continue to have a shortage of PPE, and we continue to have a shortage of testing. These are the primary drivers of our current guideline documents medical students not be involved in direct patient care. I want to be clear that does not mean that students' education has stopped. They're continuing their didactics virtually and schools are creating new, meaningful clinical work they can be involved with that does not require direct patient contact.

In surge areas, there's a local imperative to expand the health care workforce. Medical students can be involved with this, again, off the front lines through non-direct patient care in many cases, but in some of our communities and hospitals, there is a critical need for medical students to come back to direct patient care settings. We've provided some guiding principles in how schools should be thinking about this, keeping in mind the unique role and position of a student and a learner with an emphasis on student safety but most importantly, appropriately, supervision and patient safety. Always it's an individual school decision based on local policy, local mission, and particularly with this pandemic, local need. Likely you have heard some medical schools are looking at early graduations to allow students to get in the workforce.

LCME, the accrediting body for medical schools, released guidelines schools must follow and it's important to recognize that a students graduate with an M.D. degree, they're ready for supervised practice, not independent practice. So the appropriate setting they could have appropriate supervision will be necessary. And at close of one thing -- as we have talked with our schools across the country, they are doing a tremendous job of balancing the public health needs, local patient care needs, and their student learning and safety needs in facing this unprecedented challenge. Each school is responding differently, which is a reflect of the different challenges they face. Thank you. And now I will turn it over to Dr. David Acosta.

David Acosta, MD: Thank you, Alison, and thank you for this opportunity, David; and others as well. Historically we have learned that marginalized communities suffer more during a pandemic. These communities we're talking about are racial and ethnic communities and LGBTQI community, the disability community, and those with special needs, those who live in poverty, the immigrant, refugee, asylee community, and unsheltered homeless community as well. As we know, these communities are unusually under resourced and underserved. A key point is it's important to note any health inequity and health care disparities these communities experience will only be exacerbated by this coronavirus pandemic. Our teaching hospitals has served as safety net hospital and play a major role in playing for medically and socially vulnerable groups.

Despite these efforts, health inequities prevail and place these communities at higher risk during the pandemic. They still have poor access to primary and specialty care and health Carolina utilities both within and outside of the community. Certainly, this is due to lack of insurance or ability to afford a high co- pay but due to limited access to transportation, cost of transportation.

In addition, when I think about our rural communities, the lack of anonymity of where folks are being tested impacts their decisions of whether to be tested or not. Accessibility to interpreter services is certainly another concern during this time, and as a reminder, remember, one in five U.S. residents speaks another language at home other than English and impacts how information about the virus is communicated. Inadequate access to the Internet in some remote areas challenges the ability for these vulnerable communities to receive information. Also, during this stressful time, social services, mental health services needs will rise. They're usually unavailable to these communities.

The third point is the number of high-risk patients with comorbidities are more susceptible to covid-19 is higher in vulnerable population groups due to higher incidents of diabetes, diseases, hypertension, and cardiovascular disease. The fourth point is that it is difficult for some of our vulnerable populations to follow the CDC guidelines as their stigma exacerbate issues. For example, shelter in place has no meaning for inadequate number of shelters available and lack of housing. Social distancing is a challenge in some of the encampments out there. If housing isn't available, overcrowding in houses and worms by multiple family members and friends extends the composure of coronavirus. Many of our vulnerable communities are also located in food deserts, limiting healthy food choices and other household item.

Lastly, stigma associated with coronavirus placed an added burden on populations. Fear and anxiety about a disease can be overwhelming without access to proper information. For example, we have seen a rise in xenophobia and anti-Chinese sentiment with this pandemic. The stigma affects the emotional and mental health of stigmatized groups in the community they live in, and this, in turn, leads to further social avoidance, rejection, denials of health care,

housing, or employment, and in some cases physical violence. Fear of deportation for some is an additional concern, leading to avoidance of accessing health care services altogether.

So what is the take-home message for us? I think academic medical centers, non-academic medical centers, and private hospitals must be intentional in recognizing the needs of our vulnerable communities, and they need to partner together to share the load. That is -- it's not the responsibility of one institution alone doing the work. In some communities, partnerships are in place. Secondly, our health systems must ensure equity and inclusion are applied not only to those tested but to provide culturally and linguistically responsive medical care and mental health service to all patients, including the most vulnerable. And lastly, health systems need to partner with the local health department to address socially determinants and engage with local communities they are part of and serve. Also being involved with community agencies and organizations and consider them equal partners to devise partner solutions to meet the needs of these vulnerable communities. With that, thank you for the opportunity.

David Skorton, MD: Thank you very much, Dr. Acosta, and all my colleagues. I will open it up for the question- and-answer period. There may be some other colleagues from the AAMC who can offer authoritative comments. Before I turn it over to moderator Sandy to manage our portion, let I remind our friend in the press, if there are questions we do not get time to answer today, please send them to us by e-mail at press@aamc.org. Sandy, we're ready for questions.

MODERATOR: Okay, thank you, Dr. Skorton. And just a reminder, to the participants -- to ask a question, all you need to do is press star 1 on your telephone keypad to be placed into the phone queue. You will still be able to hear the presentation while you are waiting. And when the speakers are ready to take your call, your line will be unmuted. Please do announce yourself with your name and media outlet. The questions will be answered in the order that we receive them. Our first question today is from Lauren clayson with CQ Roll Call. Lauren?

REPORTER: Hi, thank you for holding the call. I was just curious, Dr. Orlowski -- you said there was tremendous innovation in the ventilator space. If you could talk more about that -- I am interested to know what kind of machines can be converted into ventilators and how safe that, considering ventilators seem to be rather touchy anyway. And then, you know, like -- are any health systems leading the charge on this?

Janis Orlowski, MD: Sure. So what we're hearing from the field is that there is innovation going on in ventilator work. For example, I had mentioned that there is reports right now of ventilators able to take multiple patients and so how do we take one -- you know, respirator and put multiple patients on that? The other item that with every. Talking about -- we have. Talking about is there are ventilators used for other means. For example, there are anesthesia machines used in the operating room and what we're doing is taking those anesthesia machines

and turn them into chronic ventilators. And then this morning there was a report for a simplified ventilator coming out of South Carolina, and this is an innovation from a company there. So I would say we are seeing innovation in multiple ways, and quite frankly, they are novel, simplified vents being produced.

MODERATOR: Okay, very good. Thank you. And our next question comes from Tucker Dougherty at Politico.

REPORTER: I wanted to ask a question for either Dr. Orlowski or Dr. Whelan, however they would like to answer. I was wondering, besides the licensing issue, what are some of the other financial and legal frictions for integrating retired doctors and students into these surge workforces? I've heard of some instances of, for example, malpractice insurance companies willing to take on the former members they have covered; but I was wondering if you have seen sort of other similar challenges.

Janis Orlowski, MD: So I'll address the initial part, and then I will ask Alison to talk about medical students. So what we have seen is physicians coming back online. So, first of all, making sure that they have a medical license and that it's not encumbered and they are ready to practice. I will tell you, secondly, we are looking at physicians coming back in who have been retired only a couple of years; and the reason is we want to make sure they're current with medical knowledge. I know some states have said two to three years. New York has gone out to five years, and that's basically just trying to draw in a wide pool. In regards to medical malpractice and benefits, it would be very difficult for a physician to start up their own medical practice -- again, especially if it's been closed. So what we're looking at is whether these individuals can be hired as temporary employees by some of the hospitals, health systems, and large physician groups; and then be placed on their medical liability insurance. I would say everyone's trying to move as fast as they can, and there has been, for example, in New York where the situation is particularly dire, they are looking at waiving some of the liability requirements in order to get folks in as quickly as possible. And Alison, maybe any comments about medical students?

Alison Whelan, MD: Sure. What are the consideration for early graduating medical students? Number one, they are, as I said before, the M.D. degree gives them the ability to have supervised practice, not independent practice. So creating the appropriate supervision will be necessary. They will also require a special license because they cannot have an independent license, but with the flexibility that many states and Federation of State Medical Boards have been providing in this crisis, that is an issue that will be easily resolved. And then as they move from student status to employee status, the expectation is they would likely be joining the the hospital or health system in which they have. Training. The usual things in thinking about health insurance, long-term disability insurance, malpractice insurance, will have to be sorted through with their new employer. It's important to note that these students recently through the

match program so they have a contractual obligation to begin residency by June or July so thinking about what they need to do to transition at the end of this special time of special employment to be ready to meet their contractual requirement to really begin the next step of critical training will be something that both the individuals, their new employers, and their residency programs, will need to consider together. Thank you.

MODERATOR: Okay. The next question comes from Joyce Friedan with Me Page Today.

REPORTER: Hi, thanks for taking my question. A question for Dr. Orlowski -- when you talked about how the current system of licensing state by state can be kind of encumber some in situations like this, what are your thoughts on a national licensing system?

Janis Orlowski, MD: Thanks for your question. So, what are we thinking about regarding a national licensing system? I can tell you there's been quite a bit of talk about this. I know in discussion where the federation of state medical boards, they have put together a uniform application that can be used across the States. On one hand, I would say many people are supportive of a national license, and issue will be the monitoring and oversight and discipline of the physicians and that will need to be sorted out. I would put that into sort of the category of things that we need to work out as we make it through this crisis. I think that is an important national discussion that we need to have, and we need to have a better solution than we have right now.

MODERATOR: Okay. Our next question comes from Maria Castellucci with Modern Healthcare. Maria?

REPORTER: Hi, thank you guys for taking my call. I'm wondering if the AAMC or hearing or seeing from members they're asking clinicians, physicians, nurses, who wouldn't typically care for covid-19 patients like those specialized in cardiology or orthopedics, they're being asked to help treat the influx of patients of this condition; or just to things outside their usual scope to help because I know a lot of routine procedures and appointments have been postponed so those doctors are likely not -- can likely step in and help. I don't know if you're helping from members doing that.

David Skorton, MD: Dr. Orlowski, could you comment on that, please?

Janis Orlowski, MD: I sure will. So the question is, are we seeing individuals who are from various specialty coming forward and participating in the treatment of covid-19. So the first thing that he would say is that all physicians have a foundational understanding of medical practice, and our expectation is active physicians keep this knowledge up. Yes, we are hearing there are individuals from other specialties who are being train into clinical care, care they may not do on a day-to-day basis. For example, at some of the hospitals in D.C., I have seen very

quick training programs to get people back up to speed in the use of PPE, use of ventilators, some of the things to be careful and be cautious about. And so there is quite a bit of just-in-time training that is being done for individuals who are may not be busy with their "Usual practice." So we are seeing that occur. Thank you.

MODERATOR: Okay. Our next question comes from Jamie Descharme with "Time" magazine.

REPORTER: Thank you for taking my call. I wanted to go back to the innovations in the ventilator space and the implications for patients who need these machines. Is there any evidence, for example, putting multiple people on the same ventilator leads to worse outcomes for patients?

Ross McKinney, Jr., MD: Actually, there are several preliminary studies looking at the use of the same ventilator on one or more patients, but it's very preliminary. It's a strategy you use in desperation so I would consider it in the investigational category. Just like the relatively simplified ventilators being developed at universities like Mississippi, UTMV, and University of California-Davis, all of those are --, I would say, in the early phases of investigation as potential relief valves for the traditionally very complex ventilators that we're using primarily.

Janis Orlowski, MD: This is -- sure. Thank you. So what we would add to Dr. McKinney's comments is that there are number of things that we are doing with on-the-spot clinical management and so as we put individuals on these newly developed respirators, these different functions, clinicians, physicians, nurses need to be at bedside, monitoring the patient, and there are parameters that we measure. What are the number of breaths per minute? What's their oxygenation status? Is there adequate ventilation, or is there a rise in abnormal rise in their CO2? So there are clinical tests that we check to say, is this person being adequately ventilated? And those are being done at the bedside as they use these techniques. And so this is an example of the medical community having to figure things out right now as they're practicing. You know, I had mentioned earlier that we're having clinical guidelines or repositories together. Many of us know how to treat coronavirus. We know how to treat respiratory illnesses. We're very -- you know, we're very well versed on treating complex patients at our large academic medical centers, and what we're doing is taking all that knowledge that we've had in the past and saying, "How do we bring it to bear today?" So are we learning as we practice medicine? Yes. Are there parameters that we're watching? Yes. Will we need to do studies as Dr. McKinney said? Yes. but quite frankly, we're trying to keep people alive right now, and we're using the best test and the best clinical knowledge that we have to be able to innovate and use these types of respirators.

MODERATOR: Okay. And I just want to give a reminder to our participants to ask ask a question press star 1 on your telephone key pad to be placed into the phone queue. You will

still be able to hear the presentation while you're waiting, and then we'll unmute your line when we are ready. So our next question comes from Robert King with Fierce Healthcare.

REPORTER: Hi, thanks for taking my question. I wanted to see -- I heard so much some academic medical centers putting together their own in-house testing. I'm wondering if you can tell me if you have. Seeing that and kind of how that has been helping with the response to the outbreak.

Ross McKinney, Jr., MD: So the question is about whether academic laboratories are developing their own tests and how is it helped or hurt. It's helped a lot. We have quite a few of our laboratories -- when the FDA gave permission on February 29 to allow labs to use their own lab-developed tests for three business weeks while they sorted out and verified their valid if I, our labs that knew how to do this kind of work let into action so there are lot of parts of the country where the primary system of making the diagnosis is a locally developed test. Well, what's the catch? Many of those local tests use the same reagents as the commercial kits, and at the moment, many of the reagents are in short supply, particularly the RNA extraction kits. The means of obtaining samples by swabs, unfortunately the swabs come from northern Italy so they're in short supply. So even though we have local labs doing these very important tests, there are still barriers to doing it as frequently and as often as we'd like to.

David Skorton, MD: Thank you very much. Sandy, do we have another question?

MODERATOR: At the moment, our queue is empty right now. Just a reminder to our participants -- star 1 will put you into the phoneme to ask your question to the speakers.

David Skorton, MD: Okay, thank you. I want to take a moment, while other members of the press are formulating questions, to just make a general comment. When we're thinking about all of the things that are happening around the country in health care, I would like all of us to remember there are two different kind of activities going on. One is the crisis management, things being done all over to save lives, especially in places with high case loads and enormous surge of patient care. The second activity, which is critically important, is preparedness response; and this is happening in areas that have not yet had the huge surge and she even areas that are. We're thinking of the next things, whether it's ethical or scientific things. So I think it's important for us to remember these two very important phases of what we're doing that need to be done at the same time -- preparedness for what may come next, and dealing with the current crisis. Sandy, do we have any other people in the queue right now?

MODERATOR: Yes, we have a couple of follow-up questions. Jamie Descharme from "Time" magazine has another question.

REPORTER: Yes, thank you. I appreciate that opportunity for a follow-up. I want to ask because of the warnings from Italy ahead of the outbreak has been morbid, saying hospitals will have to make tough choices as they reach capacities issue and more patients are coming in. I wanted to ask if you've heard anything from your members about that already happening in the U.S. or emergency departments already being at that point as being overwhelmed and having to make very difficult choices.

David Skorton, MD: Thank you for that very good question. I will turn it over to Dr. McKinney in a moment. I want to mention this is a great example of what I was talking about just a minute ago. You want our hospitals to be thinking about these issues before they come up. You want us preparing for things becoming worse. You don't want us to think about those things while we're dealing a current crisis. So I will turn it over to Ross, but my feeling is it's important to do these preparedness discussions long before they're needed. Ross?

Ross McKinney, Jr., MD: Yeah. In fact, I think you are probably asking two questions. One was about how we make the decision and the other is how often we have to make the decision. In Northern Italy, they obviously had to make the decision frequently; and what you want to have thought through is is the question -- basically, it's an ethics question and want to use the limited supply of ventilators where they need to make a difference. You need to understand which patients are likely to recover, and which are not. And we would love to give ventilator support to everybody, but instead you should have guidelines in place that enable you to start making decisions about who is likeliest to recover if you apply that particular technology. And that will also be troupe of ECMO, an even more expensive extracorporeal oxygen technique used when a ventilator isn't able to support somebody because their lungs or heart is failing. And using those kinds of technologies, you want to use them where they can make a difference. Basically, you need guidelines in place so when the decision comes, it's able to be made in a way that people understand the reason. It's also good to work sometimes by committees and use people who are not not involved in the prognosis and taking care of the patient so the assignment can be more on the basis of fact rather than on the basis of relationship. It's because we're dealing with limited resources and want to use them as wisely as possible.

MODERATOR: Okay. And we have a follow-up question also from Maria Castellucci with Modern Healthcare.

REPORTER: Yeah, thank you for taking a follow-up. Just jumping off of what Janis was saying about being asked to go outside their usual scope, is there any safety concerns with that in terms of patient care? And then, you know, what kind of training is being done? And then for the part about the retired physicians coming back into practice, you said they will be doing work, usually maybe in ambulatory surgery centers? Do you have an example of things they would be doing?

Janis Orłowski, MD: Thanks, Maria, for your further question. So, first of all, in regards to the retired physicians, I don't -- what I would see them working in is in the ambulatory space and so what I mean by ambulatory space is there are individuals who still have chronic medical problems -- high blood pressure, heart disease, whatever, and they need to be seen sometimes by telehealth, sometimes in person. Retired physicians, that would be an area in the ambulatory space we could potentially see retired physicians coming back in. If a physician is a pulmonologist or critical care doctor and have recently retired, you could see them coming back into the ICU work. So that is the retired physicians -- that's what I've heard. That's what I see they're being deployed. In regards to physicians that are getting training in areas that they have some foundational knowledge and experience but no recent work in that area, the reason why we are doing the just-in-time training and checking is to make sure that people are safe to work in that area and is always the physician and people around them's responsibility to make a decision if they're ready to practice in that expanded area. And so safety and quality remains a high priority. The number one priority, even though people are having to work fast, and work smart, safety and quality continues to be our guiding light. Thank you.

MODERATOR: Okay. And another follow-up, this one from Joyce Friedam with Medpage Today.

REPORTER: Hi, thanks for taking a follow-up question. This goes back to the ventilator issue we were talking about before. I have been reading reports that some states and institutions are actually having to compete with FEMA to try to buy some of the ventilator equipment. So I wonder what reports you have been hearing whether or not this is true and whether the federal government has been playing a positive or negative role in procuring equipment for hospitals.

Janis Orłowski, MD: So this is Janis Orłowski, answering your question about how our hospitals and health systems are trying to find ventilators and if they need to compete. We have regular conversations the assistant secretary of disaster assistance and response. They're working with FEMA.

Everyone is doing their best to coordinate the response, and one thing we're trying to get a handle on is where the ventilators are needed. For example, as the New York hospitals talked about the fact they were running out of ventilators, ASPR was working with the military and supplies to sent shipments up there. I think communication is always a challenge in a situation like we're in right now, but I don't see the competition with FEMA but really the continual need for coordination. We continue to work with ASPR and want to be a partner and our institutions are grateful for that as well. So we see FEMA directing areas to where the greatest need is. One other thing I should mention is that we were on a call early this morning with CMS, and administrator Verma is trying to coordinate ICU beds and how many open beds and

how much testing is available. What we see is an attempt to tightly coordinate beds when there's quite a bit of energy and work that needs to be done.

MODERATOR: Okay, very good. Your next question comes from Emma Court with Bloomberg News.

REPORTER: Hi, I was wondering if you could talk a little bit about the clinical trial environment right now. There's been messaging about companies saying they're postponing trials and disrupting on going ones. I was wondering if you could talk about what you're hearing and if you have any sense of whether there are anything across the board.

Ross McKinney, Jr., MD: The question is about clinical trial and there are interesting points in the world outside of covid clinical trials and inside the world. Inside the world of covid -- many delays are on hold because who wants to go into if hospital for testing when there are so many patients in with coronavirus infection? So it is has been hard and many clinics, in fact, have cut back routine care and routine patient contact because of concerns about the waiting rooms and the exposure of staff to potentially infected people. So it has slowed up dramatically, the accrual of many different categories of study. I think the ones affected least are cancer studies because many of those are time-sensitive and people are willing to take a chance and the focus is high enough in that area that those studies continue to accrue. But there's still where it's elective, people are just not coming into the clinics. In regard to covid studies, it's very hard to do research when you're running a mass unit. It's hard to maintain the control and precision you'd like to do studies well so we hope we will be able to learn from this experience, but where there is a very heavy patient load, it can become so overwhelming that doing the kind of careful work that's required for a clinical trial for treatment, coronavirus, becomes very difficult and challenging.

MODERATOR: Okay. Very good. Our next question comes from Ilana Kowalski. Can you give us your media outlet? I did not have that.

REPORTER: Oh, "U.S. News and World Report." I want to talk through our to ask about the logistics for medical students who are graduating early. You know, what will their experience be like? You know, I know that some students are allowed to opt in to get a choice so I wanted to talk through what will the experience be like for medical student that are choosing to graduate early and, you know, do this work. And then, you know, just the logistics -- where are students being asked to do this? You know, will they be paying tuition? Will they be considered employees? How will this work for that subset of students?

Alison Whelan, MD: So the question, what are the logistics for students who graduate early. It will be different from community and from health system to health system, depending on really their needs and how things are organized. It's important to know that if they have graduated, they will not pass student status so it will need to be in the employee status. And

with that, the things I had mentioned before that insurance, health insurance, liability, will need to come as an employee.

The important thing to think about is what is the window here. So the schools are talking about graduating students as early as April. They have a contractual obligation to begin their new residency program about the end of June. Some of those are local. Many students go to another part of the country. An important thing to think about is a transition into this special service work is that they need to have appropriate onboarding, and most schools in health systems are thinking about this see that the most efficient way to safely and effectively onboard these new people joining the workforce is to do it locally. They're already been receiving their education within a health system within hospitals so they wouldn't need to learn the system, so that would be a big hurdle that would be lessened. That would allow them to really focus on making sure they had the appropriate skills for whatever assignments they were getting.

And then, of course, the supervision is important. Most schools are still figuring out what they will do that are leaning towards this idea of an employed special service short-term physician. Some schools who are students when they graduate go into their residential programs associated with their health system and are working through the possibility of entering residency early. If they do this, they will be following the accrediting organization for the residency programs for both it will individuals and the programs. It is possible, and those are the two different possible roles. The short-term employee in some ways is more straightforward if they were to enter a program. The rules regarding salary, health insurance, would have to be followed by the already carefully developed guidelines from the ACF&E. Thank you.

David Skorton, MD: Thank you. Sandy, I think we could sneak one more question in if there is.

MODERATOR: Yes, there is one final follow-up question from Robert King.

REPORTER: Thank you for taking my follow-up question. I want to get some more about the repository you talked about and is the AAMC putting that together? Can you give us information on when that will be available for folks?

Janis Orlowski, MD: Yes. so thanks for the question regarding the clinical guideline repository. We were actually approached by Mass General and Johns Hopkins and Beth Israel and Stanford. There's a number of academic medical centers that are developing policies and putting them somaline and what they're noting is there is slight differences in the moll Is and. They asked the AAMC to be a body that collects and brings experts together. It's hard to look at 15 or more different policies on an area so we have a temporary website that has been put together. We are working with an expert panel of physicians from across the United States, and

we are testing this, I would say, sort of behind the -- in the background. We hope to have this up and rolling within the next couple of days, and we just want to make sure our external experts have had a chance to look at it and provide guidance. So that is coming. Thanks.

David Skorton, MD: Thank you very much. We will wrap up. I just want to mention, to Thanks, again, members of the media for coming and thank you for your reporting, which is very, very much appreciated.

We will let you know about future virtual press conferences, and I want to remind you if you have questions that you formulate that did not have a chance to answer today, please send them to us at press@AAMC.org. Thank you very much for coming today. Sandy, turning it over to you to close.

MODERATOR: Thank you. And with that, we must conclude today's program. This session has been recorded, and AAMC Media Relations will post the link to the recording on the AAMC website early this afternoon. On behalf of the Association of American Medical Colleges, thank you.

Have a good day. You may now disconnect.

End of Webinar