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**AAMC Press Teleconference  
Coronavirus: Latest Facts on the Front Lines  
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**Audio available here:** <https://vimeo.com/403781635>

**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  
Frank Trinity, JD, AAMC chief legal officer  
Alison Whelan, MD, AAMC chief medical education officer  
David A. Acosta, MD, AAMC chief diversity and inclusion officer

**MODERATOR:** The Association of American Medical Colleges is pleased to welcome you to today's press conference, AAMC Read the Coronavirus Latest Facts on the Front Lines. My name is Sandy and it's my pleasure to be the facilitator for today's event. Please note that today's call is being recorded. When you want to ask a question please press star one on your telephone keypad 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's 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, and thank you everyone in the press for your hard work and your professionalism in keeping the public informed during this evolving and frightening pandemic. This is the third press conference the AAMC has hosted since the COVID-19 pandemic began and will continue to share in real time what we're hearing from the front lines as the situation evolves. As you may know, our members include roughly 400 major U.S. teaching hospitals on the front lines, including several in New York City, such as New York Presbyterian and NYU Langone Health. Across the country, our members include institutions, such as the University of Texas Southwestern, the Cleveland Clinic, Mayo Clinic, Mass General, Johns Hopkins, University of Washington, University of Pennsylvania, and many others. We also represent all 155 accredited med schools in the U.S. and 17 in Canada, as well as 80 academic societies. This is obviously a stressful, frightening and challenging time for the country.

Since last Friday, when we held our last press conference, the number of COVID-19 cases in the U.S. has tripled and five times more people have died from the virus in this country during that

week. Around the world there are more than a million cases and over 54,000 deaths and in the U.S. we have more than 245,000 cases and over 6,000 deaths, more than double the number who died on 9/11. Before introducing our distinguished speakers today, I'll like to make three quick points about where we are in the current crisis and where we are headed. First even though we are in the throws of fighting this pandemic and will be intensifying our efforts as we reach the peak in more areas of the country, we must also start preparing for what lies ahead. The next pandemic will happen without a doubt and there are lessons we have learned and steps our country can take now to prepare us better. I shared some specific suggestions on that in Op-ed just published this morning that I can share with you and I'd be happy to answer your questions during the Q&A if there is interest in what we can do to look ahead.

Second, we also need to start paying more attention as a nation to the impact that this pandemic on marginalized groups, such as those who are poor or homeless. I want to emphasize that the most important thing everyone can do, all of us, each of us, is to stay home as many local governments have recommended. But following a stay-at-home order is not easy. For those who don't have a place to go, and during the Q&A session, I'll refer to my colleague, Dr. David Acosta, our chief Diversity and Inclusion Officer to elaborate on this. Finally, we are very grateful to Congress and the administration for passing a third supplemental relief bill that will provide \$100 billion to hospitals. All hospitals and their physicians and health care workers need support right now most especially in hot spot areas. And now I want to introduce four of my colleagues who will share the latest facts front lines of this crisis. We will start with Dr. Ross McKinney, the AAMC's Chief Scientific Officer and an infectious disease expert, who will share the latest information on the medical research front. And then my colleague Dr. Janis Orłowski, our Chief Healthcare Officer and a practicing physician will talk about how hospitals and health care workers are faring as well as the latest conversations she and her team are having with the centers for Medicare and Medicaid services or CMS. Next, we will hear from Frank Trinity, the AAMC's Chief Legal Officer will discuss an important immigration issue that could help with our current doctor shortages as well as the issue of DACA health care workers. And then Dr. Alison Whelan, the AAMC's Chief Medical Education Officer, will talk about our latest guidance on medical student participations. Also, will be sure to leave plenty of time to take your questions. Let's start with Dr. McKinney. Ross, it's all yours.

**Ross McKinney, Jr., MD:** Okay, well good morning to everybody. I'm going to focus my comments on three areas this morning, masks, testing, and some predictions about where I think the epidemic is likely to go. First, in regards to masks. I think there has been a lot of confusion about the whole issue of what to do with masks. It came because of the shortage of PPE. Recommendations were made about general populous wearing masks that really reflected the fact that people were worried that we're not going to be enough surgical masks available where they were most needed, in the hospital. As a result, I think we were a little bit too doctored and people were confused. The answer on masks is that masks help limit transmission by people who are infected to other people. The mask is not as protective for the uninfected person as it is protective because the person who is infected, and may not have any symptoms yet, is not spewing out virus as efficiently. So, basically whereas immunity we wear masks The asymptomatic infected people are wearing masks because everyone is wearing a mask and then

it's got a real benefit for everybody because they are not putting as much virus into the air. So this notion that we should be wearing masks is reasonable, we probably could and should have been wearing masks from the beginning. I think it is appropriate that we are moving in that direction now.

The next issue is testing. In terms of testing we're now going to have serologic tests available. There's one that was authorized by the FDA yesterday produced by Zalicus Incorporated that uses both, that finds both the IG and IGM antibodies against SARS COVID-2. There's also a Becton Dickinson assay that I'm aware of and Dr. Florian Krammer at Icahn Mount Sinai in New York has been working on serologic testing as well. And what the value of serology is, is to tell you who was infected because serology does not become positive until about the tenth day of an infection. And one of problems with serology is people would say, "oh I got the COVID test." Well if the COVID test was a PCR, it really is whether you have the virus and are shedding at that particular moment and time. Serology tells you whether you're immune to the coronavirus and it occurs late. So it's not a good idea to get a serology to establish whether somebody who is in the mist of the infection is infected with COVID or has influenza. It's not a very good test for that. Its main use will be to know who is in the community immune to coronavirus.

And then finally, predictions. It is almost impossible to know when this epidemic is going to abate. It's pretty clear we're going to continue to have a rising number of cases, and a rising number of deaths into April nationally. And projections look like there will be some states that will still have significant number of cases and significant number of deaths into June and July. Those states that had been delayed in doing social distancing may see themselves having later continuing epidemics, which might have economic ramifications particularly for states like Florida where delaying social distancing may mean places like Disneyland can't open until later into this season. What we are going to see next as we start to get sufficient abatement of the epidemic will be a transition to individual quarantine and testing and case contact tracing. So we will slowly but surely be able to move to where only those people who are either infected or those people who are exposed are in quarantine and will be able to use more PCR testing because PCR testing is still not as available as it needs to be. We need to be able to be freely able to test asymptomatic people to know whether they're in that asymptomatic shedding phase or not. So we will be testing more people.

And the other thing that will become true is that more people, slowly but surely, will have recovered from the infection and will be able to, those people will be able to move into society freely without having to worry about the possibility that they're a vector for other people or that they'll be reinfected because our best belief is that people will remain protected against the virus for a period of time after having been infected. So what we are going to see is a wave and then smaller waves that are regional, a shift from general social distancing to quarantine of individuals- with quarantine of infected people and contacts and slowly but surely, we'll move back towards a more normal way of being. It will be slow and it'll be regional and it's going to take us probably well into the summer. And with that, I'm going to hand it to Janis Orlowski.

**Janis Orlowski, MD:** Thanks so much Ross and good morning to all of you. I appreciate the

opportunity to make some brief comments. First of all, I'm going to speak about supply chain. And I know that all of you have heard about PPE. I know it's been covered very widely. Let me just reemphasize it. PPE the lack thereof is a major issue for our hospitals and for our health care workers. Yesterday I was on a telephone call with the CEOs of some of the largest teaching hospitals across the United States and clearly a major portion of the call revolved around PPE, not having enough and really the dramatic concern about the exposure of health care workers not having sufficient PPE. I can tell you a number of the larger institutions, Dartmouth one of them, took a look at the reuse of PPE and whether things can be sterilized with ultraviolet or sterilized with hydrogen peroxide. And they were making recommendations to their colleagues to go with the hydrogen peroxide and sharing that information. So it looks like we're not only short and we are conserving, but that we are having to innovate sort of on the run of how we can reuse PPE.

Second is ventilators and we appreciate the President using the Defense Protection Act, ventilators are a shortage. And then what we're seeing and this is something that we had spoke with Asper about is the shortage of what I would call ICU drugs, so the anesthetics, the drugs that we use to make people comfortable when they are on ventilators. And there is a shortage as well of the hydroxychloroquine. So we're starting to see the shortages and continuing to work with Asper and with CMS and with FEMA about how we can continue to increase production on these drugs. These were expected shortages because we can you know look into the future and see where drugs were going to be used. And we've already put pressures on those manufactures to step up their production.

Next, I'd like to turn to the idea of expansion of hospital beds, sort of the hospitals without walls which Administrator Burma has been talking about. First of all, CMS has really helped by getting rid of many of the conditions of participation so that there is the ability to have hospital beds beyond walls. We spoke yesterday with the and this morning actually with a number of institutions that are expanding their hospitals. You see it in a couple of areas. First of all, you see folks like Ohio State University that is working with two other health systems in Ohio where they are going to put in a 1,000-bed hospital within one of their public spaces and each one of the systems are going to share and manage those beds. We also see for example, Temple University, taking over one of their rehab buildings and making that into a 200-bed COVID hospital. And we spoke with the University of California at San Francisco that is utilizing a space that they just moved out of within the last year, going back in and putting beds in that area. So we are seeing expansion of hospital beds throughout the nation.

The issue when you expand beds is where does the workforce come from because you know we don't clone workforce. And so again, discussions of how we do this, Temple had a very clear idea where they had CRNAs. And CRNAs are nurses who are anesthetist and work with anesthesiologist and others in the operating room. But they are nurses, they are critical care nurses and they have really great expertise on the use of respirators. So Temple has moved their CRNAs out of the OR. They have coupled them with their critical care ICU doctors and their pulmonary doctors and they've made teams in order to deal with the expansion of beds. And so our CEOs are sharing how we can continue to expand the workforce, how we can draw folks

who work in ambulatory care centers or ambulatory surgery centers and how we can draw them in.

Next, I'd like to make sure you are aware that the AAMC has put together a critical guidance. I believe you have received the URL for the Web site. We are working with some of the leading experts across the country and we are gathering policies and protocols and we will begin to have concessive statements. This is something that our members, quite frankly, the academic centers have said we need to have a spot where we can begin to collate these protocols and where we can have a common voice. I'd like to turn now to the hundred-billion-dollar fund. We-- I have sent [INAUDIBLE] to HHS and others regarding the appropriate use of the hundred-billion-dollar fund. Probably I can capsulize this in a couple of ways. First of all, we believe that the money needs to go directly from the feds to our hospitals, our health systems, and physicians. And that's who we are prioritizing. We have given some thoughts regarding the dollars going to areas where there is increased complexity, where there is increased vulnerable population, where there is the capacity for high number of ICU beds, but also that hot spots get money directed to them.

And finally, at our last press conference, I spoke about some anticipated changes in Telehealth, a request we have made to CMS and I'm delighted to say that CMS has moved forward with an expansion in the ability for residents to provide care through Telehealth and this continues to expand our workforce. I think at this point, I'll stop and pass it to my colleague Frank Trinity. Frank?

**Frank Trinity, JD:** Thank you, Janis. As we heard from Dr. Orłowski, we need all hands-on deck. The outcome of the COVID-19 pandemic will depend, in part, on whether the surge of patients outstrips our physician workforce. Because roughly 25% of our physicians are from another country, I'm going to talk about several immigration-related challenges we face right now. Two categories: visa processing and Deferred Action on Childhood Arrivals (DACA).

More than 10,000 of our medical residents are here on visas, typically J-1 or H-1B, and many are working in medically underserved areas of the country. The suspension of visa processing has created significant barriers for thousands of practicing physicians, more than 4,200 incoming medical residents who successfully matched last month into teaching hospital residency programs, and countless other health professionals and scientists who either want to remain in the US or enter the US at this most critical time.

Separate from the visa challenges, more than 27,000 health practitioners will lose work authorization if Deferred Action for Childhood Arrivals (DACA) is rescinded.

The AAMC is pleased that the Department of State last week encouraged medical professionals to request emergency visa appointments and yesterday endorsed flexibility in deploying J-1 residents where they are needed most.

However, several steps still remain to ensure that these professionals are able to stay in the US or enter the US at this critical time. These include

- (1) expediting the entry of the more than 4,200 physicians from other countries who matched to U.S. residency programs, so they can start their programs on July 1;
- (2) prioritizing and acting quickly on visa extension or adjustment requests filed by physicians currently in the US so they can continue to save lives; and
- (3) maintaining the DACA program.

If there were ever a time when we needed the Administration to take all necessary actions to maintain and reinforce the healthcare workforce, now is that time.

**Alison Whelan, MD:** Good morning. I want to give you a brief update on where things stand with medical student education. As Dr. Skorton mentioned, we've renewed our guidelines related to student's direct patient contact in care. Because there remains a National Imperative to flatten the curve, and because of the continued shortage of PPE. And because of the continued shortage of testing. We've continued to strongly suggest that students not be involved in direct patient contact. Unless there is a severe healthcare worker shortage. And if there is, then we've issued guidelines primarily around protecting--patient's safety through making sure there's sufficient supervision in training for the activities that students will be involved in. This doesn't mean their education is ending, it doesn't mean it's even on pause. Our schools have rallied and have submitted to share among themselves over 100 different ways in which they are redeploying students to continue to their education virtually. To learn about Covid, to learn about pandemics. And to serve their healthcare assistant as well. They're calling back test results to patients who have had Covid testing, they are manning the health lines with triage people calling hospitals, wondering if they should get testing and looking for information on Covid. They're participating in telehealth under supervision, of physicians-- and in some places that are conducting clinical trials related to Covid, the students are--screening in both the phone calls and the emails to identify people who might be relevant for those tests. Students have both through curricular and non-curricular activities--really have stepped up and participating both in continuing their education and inviting the Covid pandemic. Last weekend we talked, there were schools that were considering early graduation. At this point we know that at least 11 schools that are planning-- offering early graduation to all of their students. And 11 planning to offer it to at least some of their students. The New York City schools together have developed a process in which students will be offered early graduation through the state of New York will be offered a special license. They will be voluntarily allowed to participate as a special service roll to booster the health care work force during this time. The expectations is that they will move on into their residencies in July. Massachusetts 4 schools are undertaking a very similar process. Other schools are considering this throughout the country. The last thing I wanted to say as we build the workforce. We need to continue to look ahead of the workforce. The next step that both medical schools, program directors, and residencies and hospitals are looking at is how do we get the next class moving. How do we get new medical students into their schools safely and how do we transition the graduating students into their residency programs in July? Thank you.

**David Skorton, MD:** Thank you, very much. All my colleagues, and we are now ready to shift to the Q&A portion. Where we will be joined by a few additional experts from the AAMC. As always, if there are questions, we do not get to or things that you come up that you would like to ask us after it is done please send them to email [press@aamc.org](mailto:press@aamc.org). Thank you, Sandy we are ready for your questions. Any and all.

**Moderator:** OK, very good Dr. Skorton, and just as a reminder to our participants to ask a question just press star one on the telephone keypad. to be placed into the phone cue. 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. And the questions will be answered in the order that we receive them. We are waiting for our first question to come in Dr. Skorton. We don't have any at this moment. If you have anything else that you want to add I will keep you updated as soon as we get a question in.

**David Skorton, MD:** Thanks very much Sandy. While our colleagues are formulating questions, Dr. David Acosta, who the chief Diversity and occlusion officer. David, I was wondering if you could share some brief thoughts with us about the extra challenge based by our neighbors, in the vulnerable populations. David please.

**David Acosta MD:** Thanks David. As you said from the beginning, the lock down is not as easy for those that are homeless, that's where I'd like to concentrate and just highlight a few important points for us to remember. What we know there is more than 560,000 people that are homeless in the US on any given night in 2019. People that experiencing homelessness may be at a considerable risk for infection during this pandemic because of the environmental conditions where they reside. Studies has showed us compared to the general population the homeless are at higher risk of contracting COVID-19. Because of their higher incidents of chronic health conditions like hypertension, diabetes, asthma, and mental illness. For many that are homeless COVID-19 can be life-threatening and difficult to contain. Homeless individuals will be twice as likely hospitalized, two to four times to require critical care and two to three times to die than the general population. We know that the lack of housing contributes to poor health outcomes focus on stable housing should continue to be a priority for all of us. As the national health care for the homeless council states housing is a health care. The good news there are some preventative measures showing us they can be some cities are adopting and showing us that they can be implemented. For example: it is recommended not to clear encampments until there are individual housing units available. In the past, clearing it can cause people to disperse throughout the community. It breaks the connection that they have with service agencies and providers but increases the risk for diseases such as COVID-19. Public health guidelines have been published and available and have things to ensure these encampments, when they are set up to insure there is a 12x12 foot of space for individual. That the city should ensure that the restroom facilities thereby that have functional water tabs at the stop and hand, hygiene materials, bath tissue and they remain open to people experiencing homelessness 24 hrs. a day. If the facilities are not available to -- some cities are providing access to portable latrines with handwashing facilities for encampments of for more than 10 people. Some cities are even expanding and extending moratoriums on evictions during the pandemic to ensure that more people did not

become homeless at this critical time. So priority should be to increase capacity for more shelters to get the unsheltered off the streets, and try to increase isolation housing for those at higher risk. Such as are homeless elderly of those with chronic diseases and those with confirm the possible COVID-19 who don't warrant patient hospitalization. Some great examples are the city of San Francisco created a \$5 million fund to provide trailers for people experiencing homelessness in order to reduce the exposure to COVID-19. Oakland now the city is leasing hospitals and converting rooms for people counter-rally in homeless encampments. Seattle, Washington was created over 100 additional shelter spaces has created designated building types to create new shelters. And last communicating advocating the homeless is vital survival. Public health departments have helped in this as well as other not-for-profit agencies. But also their leaders leveraging those that are influential within the homeless community. They could be homeless themselves by educating or partnering with these community liaisons who can help communicate with others in these encampments about coronavirus how to avoid getting infected. If they are exposed where can they reach for help. Insuring partnership with the local public health department, local health systems to make -- it will be critical at this time. Thanks David.

**David Skorton, MD:** Thanks very much Dr. Acosta. Sandy, any questions?

**MODERATOR:** Yes. Our first question is with Maria Castellucci with Modern Healthcare.

**REPORTER:** Thank you very much for your time. In terms of reusing PPE. I know the FDA recently approved a decision. I know health systems are looking how to reuse PPE especially the N95 masks. Are there are any concerns about reusing them and the methods being used? Do we have evidence that some of these methods are good and safe? I know we have health systems exploring and re-purposing devising into ventilators any safety concerns with that as well. So Dr. McKinney and Dr. Orlowski could you please both comment on that.

**Janis Orlowski, MD:** Sure. I'll start on the mechanics. So first of all, there are concerns. Thanks for your question. Mass General yesterday spoke about they looked at UV light vs. Hydrogen peroxide and made the decision to go with hydrogen peroxide. Dartmouth also has that is been looking at hydrogen peroxide as well. They have been doing two things. Even though it is time intensive. They will be cleaning it and returning it to Dr. Smith other institutions just don't have the time to do that. And there was a discussion about the metal clip around the nose and some of the other sort of the mechanical whether the N95 will fit enough after it goes through multiple cleanings. There are concerns. People continue to test this and you know I think it's and 95 respirators is better than none but again. We are putting our health care workers at risk by not having adequate PPE and I'm having to go through these methodologies. Ross?

**Ross McKinney, Jr., MD:** One of the critical things about the N95 it has to be precisely fit. For years the OSHA has required annual fit testing to make sure somebody's face hasn't changed or they have grown a beard. The worry is when the N95 goes through this process of being either UV or the hydrogen peroxide will lose its seal. It is not ideal to reuse N95s but it is what we can do at the moment. I think it is probably safe in terms of the organisms being killed. Those



standards are being established by doing testing. I think we are clear it can work but you do lose the shape and it is obviously less ideal than having new equipment to use.

**MODERATOR:** The next question comes from Jayne O'Donnell from USA today.

**REPORTER:** The big question I have is what you folks think is best policy and most common policy. So, when workers, nurses, doctors become infected do you inform -- should you as a hospital administration inform it works with them and the public. You might have seen they had a nurse die. There is an uproar there. What are the best practices? Can we expect them to keep alerting the hospital -- the workers?

**David Skorton, MD:** That's a great question. I'm going to turn it over to the doctor. Even though we are in the public health crisis. We have to remember the principals of privacy. But doctor, please share your thoughts.

**Janis Orlowski, MD:** Sure. Hi, Jayne. What I would tell you -- sort of on a broader issue. The health care -- hospitals and health care systems anyone who is pregnant or anyone that is compromised they remove from the front lines. Secondly, as far as an exposure let's say a health care worker has an exposure. We are using the WHO criteria of surveillance and so what it requires is to not to remove that health care worker for 14 days but rather that they have a constant surveillance twice a day. They have temperatures, they remain masked throughout the day and there are a couple of other questionnaires. We are doing the WHO guidance for any health care worker that may have been exposed. As far as a health care worker who has the disease, well, they are to the best of their ability the hospitals are trying to notify and contact the people who work with the individual and then those people all need to go to the WHO guidelines for strategically surveying the health care worker twice a day. That is the current protocol and happy to pass it along.

**MODERATOR:** The next question comes from Tanner Lindsay from the AP. I'll read this. What does AAMC know about some hospitals especially in the New York City area developing new DNR protocols for gravely ill Covid-19 patients? In some cases, without consulting the families. And what is then AAMC guidance on that and will it be changing?

**David Skorton, MD:** Thanks very much Tanner for the important question. I'm going to ask Dr. McKinney to comment on this in just a moment. These bio-ethical concerns are massively important in medicine all kinds of ways and I for one think it's very reasonable for hospitals under duress which some of these hospitals are to be having ethical conversations in advance of any particular patient's case to figure out a general approach to dealing with what we hope will never happen but what may happen in these are decisions that the doctors hoping never ever have to make so. I think it is a two-step process. It would be good to have processes and procedures. What to do if such a decision is forced? Secondly the individual decision. Dr. McKinney you're really an expert in this area, could you comment?

**Ross McKinney, Jr., MD:** The particular issue has to do with utility and relative risk. DNR going through compressions in somebody who is in late stage COVID probably is largely futile to exercise. The reasons people die are a combination of oxygen duct deprivation and cardiac arrhythmia due to myocarditis. Sometimes to encephalopathy the largest causes of death or oxygen deprivation and cardiomyopathy. And neither of those are likely to recover if somebody is given a short-term recovery by just compressions and resuscitation. There is risk to the staff in the resuscitation process. They are often those resuscitations are often bloody. There is an issue of resuscitation. It is entirely reasonable that in some cases, it is not worthwhile to engage in the full resuscitation effort in having that predefined seems reasonable. But it is critical it will truly be a situation where utility is apparent. Where the failure of organ systems is so great or prognosis is so poor that the decision is made on that basis absent futility. If we know the patient is younger or milder disease and has a -- you would hope they would be resuscitated and not absolute rule, a rule based on probabilities of utility. It is a risk to the staff and the low probability that will lead to recovery with this kind of disease.

**MODERATOR:** I just want to remind everybody how to submit a question. Make sure you press star one to be placed into the cue. Your line will be unmuted when we are ready to take your call. It is star one to signal you want to say your question. Next question from Robert King with Fierce Health Care. Robert?

**Reporter:** Hi, thanks for taking the question. I wanted to talk about the workforce issue. We are seeing hospital systems furloughing workers because they don't have any money, because they are losing from elected procedures. How do you expand workforce when the hospital system doesn't have any money?

**David Skorton, MD:** Thanks. Tough question. Very important question. I'm going to turn this over to Doctor Orlowski in a second. One comment I would like to make to think about workforce beyond the physicians, and to think about nurse practitioners experience to a physician assistance who can be extremely effective as caregivers. Beyond the current scope of practice. But doctor Orlowski, if you could get to the meat of the question that would be great.

**Janis Orlowski, MD:** This is a critical question. A number of hospitals across the United States have low cash on hand. 40 days cash on hand. What you are seeing is you are seeing they have followed government instructions to decrease elective cases they have utilized services and resources to get ready for COVID. And they find themselves in financial straits. I spoke with one CEO within the last 24 hours who is furloughing but wants to be able to bring the folks back as soon as possible. Another CEO who said it is the absolute worst business decision ever, for us to keep our staff here. But he said "I have argued with my leadership team, and the CFO; it is the right thing to do, we've got to keep them ready and I know we are burning through money." It circles back to the point that out of this \$100 billion fund we need get dollars right down to hospitals as soon as possible. They have lost revenue, they've expended money getting prepared, and we need to give them money. When we talk to HHS is whatever they can do to have a rapid disbursement of these dollars. I will say this: your question is very important about how do we sustain this.

**MODERATOR:** Very good. We have one standing by on the phone from Camilla from CQ.

**REPORTER:** Hi, thanks so much for doing this call. I have a quick question in regards to immigration matters. Someone mentioned how the department is offering flexibility. Can you clarify what kind of flexibility they're offering for J1 visa holders?

**Frank Trinity, JD:** Typically, a visa is tied to a particular location, a particular hospital not an overall health system. And telehealth was not something that was contemplated in these visas. Yesterday the State Department gave J-1 sponsors flexibility to redeploy J1 visa holders within a health system as long they comply with GME accreditor (ACGME) criteria. We are hearing, however that sponsors of H1B visa holders need similar flexibility in redeploying H1B physicians, so we think the government needs to look at that issue for H1B physicians.

**MODERATOR:** The next one is coming through chat from Denise with Diverse Issues in Higher Education magazine. She writes "Looking ahead to the fall semester with regard to student health risks, what should be considerations when closed campuses and dormitories are being used as makeshift hospitals?"

**Ross McKinney, Jr., MD:** I hope by fall, they will be back to dormitories. They have to get them clean, but we hope by fall we are passed the bulk of the wave. So that shouldn't have to be an issue. There will be worries about exposure but I will let Alison talk about those.

**Alison Whelan, MD:** I think it will depend where we are in the pandemic, going back to what the doctor McKinney said at the beginning, it is possible there will still be geographic variation. There will be areas more activity in the fall. So going back to the principles of testing, isolation when needed, and social distancing is something we have to be adapt with. Schools will have to develop policies if students need to have -- limited number of students need social distancing, or quarantining in how they can continue their studies. If it's a larger portion of students, how they can continue to do distance education. I think the principles they are adapting now will need be become more flexible in the fall. That is for universities as well as our medical schools. Thank you.

**MODERATOR:** The next question we have -- a follow-up question from Lindsay Tanner with The Associative Press.

**REPORTER:** Thank you. I just wanted to know if you know of other circumstances where the kinds of DNR decisions, and actions you described have been taken other than COVID?

**David Skorton, MD:** I'll make a comment on that. Thank you for the question. Then I'll ask Ross to talk about it. This kind of discussion of bioethics have been going on in our country for some time. Many medical schools have formal programs in bioethics sometimes linked to medical humanities. The more medical technology gets to the point that we can sustain life what our grandparents expected in their day. We have run into ethical questions. There're any number

of situations in which these kinds of conversations have happened in the past. Ross, perhaps you can elaborate on that a bit.

**Ross McKinney, Jr., MD:** I think It has always been true that there are patients for whom the prognosis is so bad that CPR isn't offered as a therapeutic. Generally, CPR in hospital about 30% of patients who have CPR in hospital, ever leave the hospital. 70% die in hospital. It isn't a wonder therapy. There are a fair number of patients with late stage cancer. Patience with a variety of certain deaths particularly if there aren't available people to provide knowledge of what the individual's desires were before they became sick. Where decisions are made not to offer resuscitation through CPR. So it's -- it is unusual in this case that is as systematic as it is. Unusual that there be such risk to individuals doing the process and that risk to the staff relative to the potential benefits for the individual be the equation that is being considered. Usually it is about the individual's hope for any benefit coming from the CPR process.

**David Skorton, MD:** I might add just one other comment. I suppose it could go without saying, but as a physician I want to say for getting it out there, such a consideration is so much against the general approach to medicine hypocritical that we all take. The idea of doing everything possibly to sustain and maintain human life. Yet, there are situations in which, for a variety of reasons, in this particular case, is partly that the health and safety of the people administering the therapy, that we have to reconsider this. I do want to say that this is a very, very difficult kind of conversation for physicians to be having, as well as families and, of course, patients, you know, who are going into situations like this. It is a very important question. Thank you. Sandy, ready for the next question.

**MODERATOR:** Another question just came in from Marshall Allen. Can you identify your media outlet?

**REPORTER:** Good morning. I'm with Pro-Publica in New York. My question was: given we spend twice as much per person on healthcare than any other developed nation. Given this coronavirus outbreak was not unexpected by health care experts how is it possible that we are short of PPE that we are putting our health care workers at risk of infection, and also spreading infection.

**David Skorton, MD:** I want to take a crack at this, myself. I'll ask any of my colleagues to speak up afterwards. This is the question of the hour. It's a combination of a whole bunch of different factors. It is absolutely true that it is predictable that these kinds of pandemic will come along periodically because of the -- of nature. Things changes, viruses, other microbes mutate. Then the question is are we prepared adequately. Obviously, we were not prepared adequately. I will refer to the op Ed that was put in the media reminder this morning. The idea is that right now, we need to take lessons from what we are going through in COVID-19. Hard lessons. Begin to think about preparedness for the future. As one of my colleges at the AAMC, who is a retired army physician and emergency physician Dr. John Prescott says, "preparedness is not a one and done situation." And so, all kinds of areas of preparedness we were not ready for such a thing happening. I don't want to spend any time looking backwards or pointing fingers. Lack of

preparedness goes back a fair distance. We should take lessons from what we're going through, to think more critically about things like the strategic national stockpile. The health care workforce, both doctors and other non-physician health care workers. You expect me to say this, our investment in basic biomedical research needs to be pumped up more. Especially support for the CDC. We need to think forward not just in the moment in order not to be in this situation again. I ask any of my colleagues to chip in if they would like to add anything to that.

**Janis Orłowski, MD:** So, David, you have really answered the question in an eloquent way. I'm going to add a few business comments to this. Right now, hospitals cannot afford to have stockpiles. It is very expensive to have their drugs, other equipment, everything. So, what hospitals do is they coordinate with supply chains so they can get the supplies they need. When they need it they store a certain amount in the hospital. But they continue to have their supplies. We also have had discussions with state authorities about the states' ability to have supplies for PPE and also the national strategic stockpile. And again, not looking back, looking forward, this idea that hospitals have some, that the supply chain will have some, the states will have some, and the national strategic stockpile will have some. That equation has not worked, quite frankly. I think that the other thing as we take a look at it, after 9/11 and with the Ebola crisis there were moneys given to maintain ventilators to maintain PPE. Those moneys have trickled down to nothing. I think one of the things that David wrote in his op ed today, is that we can't just think about preparedness for the one or two year after we have 9/11 or Ebola. We have to take a look, and say what is the readiness for the health care system in the United States on an ongoing basis. As we go forward that is the question that is before us.

**Ross McKinney, Jr., MD:** The other thing that is a critical factor, it is just in time world. In this particular case, the just in time supply chain led back to China which wasn't able to supply in time.

**David Skorton, MD:** Thank you so much, Ross. As you taught me a few weeks ago, the swabs that are used in collecting nasal specimens to do diagnostic testing for Covid, many were made in northern Italy.

**Ross McKinney, Jr., MD:** Most of them, yes. That is correct.

**David Skorton, MD:** Sandy, I think we have time for one more question if you agree.

**MODERATOR:** Sure. At this moment we don't have any questions standing by doctor Skorton.

**David Skorton, MD:** Okay, Frank Trinity, I'm going to turn to you for the last comment. Telling our colleagues and the press about the names of some of the hospitals that rely the most on physicians with visas. Can you take a minute or two to do that Frank?

**Frank Trinity, JD:** Sure. If you look across the country, of the hospitals that rely on physicians with visas, many are in New York City: Bronx Lebanon, Montefiore, Brookdale, Northwell, St.

Luke's-Roosevelt, Mt. Sinai. And you have Partners in Boston. You have Beaumont hospital in Detroit. You have Mayo Clinic, Cleveland Clinic, and Emory University. Those are some of the hospitals in terms of sponsoring physicians with H1B visas.

**David Skorton, MD:** Thanks very much. Sandy before I turn it back to you, I want to thank our colleagues and the press for sharing the time with us. If you have more questions or questions come up that we were not able to deal with in this hour, send them to us at [press@AAMC.org](mailto:press@AAMC.org). Thank you very much for all that you are doing. Sandy, back to you.

**MODERATOR:** Excellent. Thank you so much. We will conclude today's program. This session has been recorded and the AAMC media relations will post the link to the recording on the AAMC website this afternoon. On behalf of the Association of American Medical Colleges, thank you and have a great day and you may now disconnect.

**End of Webinar**