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AAMC Press Teleconference

Coronavirus: Reopening the Country

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MODERATOR: The Association of American Medical Colleges is pleased to welcome you to today's press conference, *Coronavirus: Perspectives and Principles on Reopening the Country*. My name is Sandy and it is 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, press star-1 on your telephone keypad to be placed into the phone cue. You'll also able to hear the presentation while you are waiting. When 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 of the AAMC, who will introduce the other speakers for today.

David Skorton, MD: Good morning everyone, and welcome.

I want to start with a special note of thanks to all the members of the media joining us today. Last weekend, as you know, we celebrated World Press Freedom Day. It made me reflect on the importance what each of you does. Thank you for sharing the truth during uncertain times.

Now the AAMC has been hosting a series of press conferences since the early days of this public health crisis. We're sharing what we hear from our members on the front lines, as well as the latest in research and overall, including important information on patient care, research, education, and our communities. AAMC's members include roughly 400 major teaching hospitals and health systems across America, many of which are on the front lines of this pandemic, including for example, Mass General, Newark Beth Israel Medical Center, New York Presbyterian. University of Iowa hospital. University of Michigan hospital, and many others. We also represent all 155 accredited medical schools in the US and 17 in Canada, as well as 80 academic societies.

Today we'd like to provide insights on one of the topics that's taking up so much mind space for all of us: a strategy for reopening the country.

It is helpful to first understand the numbers. As of this morning, there have been 3.9 million cases reported of Covid-19 globally, with more than 270,000 deaths, and we know that both numbers are probably higher. In the US we've had one and a quarter million confirmed cases and 76,000 deaths. And again, because of the lack of sufficient testing, the actual numbers are certainly higher. This is nearly twice as many cases as we had the last time we convened a press conference, on April 17th. Though it's critical to understand that in the United States we are averaging roughly 25,000 new cases each and every day, along with 2,000 deaths.

States are relaxing social distancing guidelines and planning to reopen beaches and businesses. My AAMC colleagues and I would like to share thoughts about how we might reopen the country in a safe and science-based way.

As a nation, as you know, we faced a choice about whether to implement a coordinated national plan for reopening or to take a more decentralized approach led by individual states and even cities and counties. There are advantages and disadvantages to each approach. So what appears to make the most sense at this point is a hybrid approach. One of the great strengths of our nation is its diversity. Life in rural Iowa is different from life in an East-coast city, I can tell you. And that's a hallmark of the US.

Our strategy for opening and reopening needs to recognize that reality. In this pandemic we are seeing a significant amount of variation in the strategies taken among the states and even within states sometimes from county to county. This is based on population density, the presence of disease, the burden of chronic disease in a community, as well as other factors. That means we will need a variety of approaches.

Agreement on national guidelines that has specific advice we can all use as an overarching framework, as well as the ability to interpret this guidance according to local conditions while applying sound and scientific principles in every location. Even so, coordination among states on a regional basis, as well as within states in communities is essential.

This is already happening in areas such as the DC metro area. In other areas, different local approaches to reopening are seen. I believe it is essential for communities to work together to develop a coordinated strategy for their entire regions if we're to prevent a major resurgence of the virus. This is important because of the mobility that is so much a part of American life. So following some nationally agreed upon scientific guidelines would undoubtedly be very helpful.

I will offer briefly, three principles to guide decision makers as they grapple with difficult questions about how to reopen their economies in a science-based and safe fashion.

First, take it slowly. We know people are getting tired of social distancing, and the economic cost of the changes we have undertaken are devastating as underscored dramatically by today's job report. From a scientific perspective we can't just flip a switch and go back to pre-COVID days overnight.

We will still need to avoid large gatherings and open communities up step by step in phases. In addition, masks will be needed for a long time. Masks need to be depoliticized as they are for the common good, that will buy us more time for the health care system to make even more resources available. Such as the testing capacity that is so crucial for communities to open up responsibly.

Second, in every community there are those who are particularly vulnerable because of their health or their life circumstances they may have preexisting conditions, or be homeless, incarcerated, poor, or uninsured. Any plans to reopen need to include a specific approach to ensure protections are in place to control the spread of the virus among these vulnerable populations.

Third, and this may be hardest of all, leaders need to be prepared to reverse course and return to shutdowns if there is a major surge in cases after reopening. That is because there is a significant risk for asymptomatic spread of this virus. Even though it might not be politically desirable, sometimes the smart thing to do is to be being flexible. That may even mean going backwards in terms of social distancing measures, which will take both personal and political courage, but would be the right thing to do. This pandemic will likely evolve and our approach to reopening may need to evolve as well.

I would like to introduce four of my AAMC colleagues, who will share their perspectives and insights about what is needed to reopen the country.

We'll start with Dr. Ross McKinney, the AAMC chief scientific officer and an infectious disease expert who will share his views on what is needed from the scientific perspective.

Following that my colleague Dr. Janis Orlowski, who is our chief healthcare officer and a practicing physician, will talk about how hospitals are planning to reopen and begin elective procedures.

Then Dr. Alison Whelan, the AAMC's chief medical education officer, will talk about how the medical education community is planning for the start of medical school again in the fall.

You may have heard that this week we had technical issues for the registration process for MCAT exam students need to take to apply for medical school. That meant there was a delay yesterday where examinees were unable to register for the exam. We worked quickly to address the problem and within a few hours the system was open and we are continuing to register students for the MCAT. Despite the disruption we are encouraged by students' strong interest in registering for the exam.

You'll hear more from Dr. Whelan, and from Gabriel Campbell, our chief services officer, during the Q&A. We're already starting to see early hints of strong interest in people entering the field overall, even though it is early in the medical school application process. That is a great sign if that the preliminary trend continues, because our country needs more doctors.

Finally, Dr. John Prescott, AAMC's chief academic officer, will share a broad perspective on medical school operations including how they're looking reopen other functions, beyond medical education, such as research labs, and clinical work. There'll be plenty of time for questions at the end.

Let's start please with Ross McKinney. Ross, it's all yours.

Ross McKinney, Jr., MD: Thank you very much David. I thank you all for being here today. I would like to talk about three issues.

First, there has currently been controversy about how remdesivir, the antiviral drug, is being distributed. As part of its emergency use authorization approval process, Gilead Sciences donated its current 100,000 to 200,000 courses to the federal government. That sounds like a lot of drug but in fact with 25,000 new cases every day, it is about a 6-day supply of remdesivir.

Antiviral drugs are best used early in disease to suppress viral replication and give the immune system extra time to respond. But remdesivir is an IV-only drug. Making early treatment very inconvenient, even if there had been an adequate supply. As used currently late in the disease, it is not a life-saving drug, as clinical studies have shown.

The main issue that this current problem about distribution illustrates is that where federal government has exclusive control of remdesivir distribution. That allocation system should be transparent, and the algorithm used to release drugs made clear to be understood by the community. We had the same concern about the federal allocation of scarce testing supplies. This has been a problem that should be addressable.

Second, I would like to commend you an excellent article from the notable science journal the Harvard Business Review, published May 1st by Ron and others. They offer a sensible middle ground to reopening society, despite inadequate testing. By using an approach based on increased use of improved face masks. It’s somewhere between N95 respirators and repurposed T-shirts, and a more structured approach to appropriate distancing. The ideas are very good and it's worth your time to read.

As Dr. Skorton noted, it is time to depoliticize masks. They are a tool to keep people healthy. They are not a political statement. Finally, I'd like to note that part of our current crisis is the failure of broad acceptance of public health ethics. In America, we've placed a high value on individual autonomy. We have in general accepted that when individuals pose risk to others, whether because they are holding a hand grenade, or infected with contagious diseases, they do have restraints on their freedom and their autonomy.

The collective good in that situation matters more than the autonomy. I hope we can recall that goal in these difficult times. And I fear that many of the issues that we've seen reflect our over prioritization of individuals over the collective good.

In a related issue, we can use clear national policies to help guide the reopening process as David Skorton said. All 50 states are not equally equipped to handle a whole range of issues associated with phasing out of full social distancing nor should they be. Because there is a lot of technical expertise necessary. This should be a role for the federal government, for its special experts to offer guidelines that states can adapt to fit their needs, and individual circumstances. That concludes my comment.

Thank you for listening. I'll hand this off to Janis Orlowski, our chief healthcare officer.

Janis Orlowski, MD: I will address three items.

First, reopening. All leaders, teaching hospitals and health centers are preparing to begin to open for more medical care. As we talk to medical leaders, what we are hearing is that some urgent cases have become more emergent and those are the first cases that will start to see in the hospitals. As we talk to the leaders, I can tell you there is a number of principles that appear to be coalescing around how and why and when hospitals should be opening.

So the first is go slow, and David Skorton has already underlined this. Yesterday in a telephone conference with our leaders at the nation's teaching hospitals, Dennis Murphy from Indiana University Health said they were going to increase by no more than 25% the number of patients in their hospital. They were going to stop at that point, they are going to reassess and make a determination. This is some of the thinking that the CEOs are having right now. Start, go slow, then go forward.

The second thing folks are looking at is the burden of local disease, and that is helping them to determine when and if they should start. Third, they are looking at adequate testing. Adequate testing not only right now, but adequate testing for the summer, and for anticipated increase of tests in the fall. Adequate PPEs still continues to be an issue.

We have both Boston and the New York area, Detroit continue to struggle with having adequate PPE available to the hospitals and health workers. One of our CEOs wanted to make sure that as we opened up, the PPE continued to be prioritized for the health system and health care workers that is needed. Another issue that has been addressed by the CEOs is adequate ICU beds. In speaking with Leslie Davis yesterday, who's the executive vice president for health care at UPMC, she said what they are looking at is making sure that there is always an adequate supply of ICU beds as they begin to open for elective cases in the event they have to pivot.

The ability to pivot is the next item on the list. Ability to pivot as needed if there is a local or national surge. In speaking with Rick L., who is the CEO with the University of Cincinnati, he raised issues regarding Ohio's view of the tremendous ability that they've had to flatten the curve in Ohio. But the concern that as they reopen the business, they are seeing an increase in the number of cases. He spoke yesterday not only of preparing for the fall but concerns that if they open too fast and too soon, that there will actually be a surge in Ohio in July or August. They are preparing for that.

Another item that has come up is the well-being of the staff. Kim Walsh at Boston Medical Center has said that she is looking at the 4 Rs which is what they are doing now. Rebound which is what they are hoping to do. Rebuild so they're prepare for the fall, and then re-imagine. This re-imagine, most individuals are saying health care delivery after COVID will be distinctly different.

In this re-imagine of what we can do and how we can deliver care is part of what she is doing. Kate's group needed to actually provide sheltering for homeless people that were COVID positive and couldn't return to their previous shelters. Other way they are helping communities, Indiana University is providing kits for their local manufacturers and businesses about safe ways to reopen. Those are very popular within the community.

Finally, everyone is preparing for what they see as a continuation not only in summer but likely a surge.

Next item is telehealth. There continues to be a wide expansion of the use of telehealth, and an interesting thing is how innovative our institutions are in use of devices in order to enhance the practice of medicine through telehealth. That is an area that is being looked at. In addition, our telehealth providers are talking about how we have best practices and best models to provide telehealth services for those with disability. Finally, we are seeing expansion of behavioral health services through telehealth for those with substance abuse, depression, or other psychiatric illnesses.

Lastly, I want to once again talk about our clinical guidance repository. If you think about this, the United States has probably been in the throes of the COVID-19 epidemic for about 120 days. Yet, what we are seeing is brand new specialty guidelines coming out and tremendous information and sharing of best practices.

One of the things that is coming out is the fact that much of the disease and much of the morbidity that we are seeing with COVID-19 has to do with the inflammation of the lining of blood vessels. There is a cell, the epithelial cell, that seems to be particularly damaged with COVID-19. This inflammation of the epithelial cell seems to be particularly damaged with covid-19, and this inflammation of the epithelial cell is leading to a number of very unusual diseases. It is the renal failure that we are seeing. It's part of the pulmonary process, but we are also seeing, and I know there's been reported Kawasaki Disease, which is the inflammation and damage to blood vessels in the heart of pediatric patients.

What we are beginning to see is a common thread to the pathology, the underlying pathology to the COVID-19. This is being shared and is being used for the guidelines we now have on treating individuals, including treating people with renal failure, people on ventilators and people with renal failure. I think that summarizes the three areas that I want to highlight today.

I thank you very much for the opportunity to speak to you, and have the pleasure introducing my colleague, Dr. Alison Whelan.

Alison Whelan, MD: Thanks Janis. Good morning everyone and thank you for being here. You'll recall that in mid-March nearly all medical schools removed medical students from direct patient care activities. The reasons were to flatten the pandemic curve and to conserve PPE. They've continued with online and virtual learning. Now schools are planning phased-in return to clinical care.

This week 2/3 of our 155 medical schools provided information on their plans. 15% are planning to return students by the end of May. A total of 55% by end of June, and 77% are hoping to return students to their direct to patient contact by end of July. 15% said they are still really finalizing their plans. So as we think about returning students to direct patient contact, just like reopening our communities and hospitals, it is a delicate balancing act. Schools want to get students back to patient centered learning, so they can continue progression toward on time graduation for 2021 and 2022.

But critical considerations, the same considerations as you heard from Ross and Janis, including patient safety and not triggering a second surge need to be considered.

An additional challenge for medical education is making sure there's opportunities for meaningful learning. Depending on where you are in the country there are two barriers. In those places where there remain a high number of COVID patients, the physicians who typically supervise these medical students, may truly have zero time and zero capacity to teach. In those areas, where elective surgeries, and routine office visits have been severely restricted, there may be truly very few patients to learn from and with. This is a challenge that our medical educators are adding to if they continue to think of safety as well.

As hospitals reopen, medical students will be getting back to patient care. Both must be done carefully. In the meantime, students are learning through alternate approaches, and they continue to develop creative volunteer opportunities to serve both their communities and colleagues. I wanted to briefly expand on David's comments about what we have seen a recent interest in medicine. The opening of AAMC's medical school application service this week showed an all-time high of applicant interest in the first 24 hours. Specifically, in the first 3 days this week, we've seen an increase of 50% of initiated medical school applications over the same time period last year. That is 29,245 applications were begun, up from 19,467 last year.

As David said, we can't be certain what the overall numbers of applicants will be for this cycle. One might say these high numbers are just because everyone is home with time on their hands. What I see when I look at social media, is that young people are full of passion, and a desire to help, and desire to change the world. And all the news from the front lines of pandemic, has re-enforced that a career in medicine and all professions affords that opportunity.

The world always wants heroes. While the pandemic has shown extraordinary epic front-page heroic work for health professions, those of us in medicine know that there're quiet moments of courage, bravery, and heroism. in the everyday life of every physician. And what an extraordinary privilege that is. And so we are really looking forward to sharing those stories of quiet heroism, as well as the front page stories of heroic work going on in the pandemic as we welcome our future medical students.

I'd like to turn things over to John Prescott, who will talk about other aspects of opening our medical schools, including clinical care, and the research lab. John?

John Prescott, MD: Yes, thank you very much for the opportunity to address you. I will keep my remarks brief so there's adequate time for questions and answers.

Since we first learned about the novel coronavirus, our nation's medical schools have played a critical role in responding to this pandemic. The highly complex, large in both size and financial impact organizations not only provide optimal education for tomorrows doctors, but also provide advance clinical care and generate new knowledge through research. All with the mission to improve the health of their communities.

Medical schools have had to severely curtail their activities secondary to COVID-19 and opening them back up safely remains a big challenge. As my colleagues have mentioned in many medical schools, labs have been closed. In many medical schools labs have been closed and clinical operations curtailed, education's been disrupted. And on top of this, budgets have been profoundly impacted. And the physical distancing that is required is presenting you a unique challenge in a profession where direct physical contact is often required.

Medical schools are anxious to reopen. They are doing it with a phased-approach that is based on science and fact-based analysis. With decisions that are being made locally by the leadership and in step with governmental guidance. A key component, again, key components in this are the adequate operational support and leadership, as well as a coordination across all the missions. And while this coordination is critical, there's also recognition that the pace of reopening varies by mission.

To enable this work, medical schools have established interdisciplinary mission-based teams to address the logistical, financial, personnel, administration challenges, before them. And to ensure coordination with their numerous partners. The medical schools recognize that there can be no weak links in their reopening. Interdependency is real, and an error or weakness in one area or mission could set back the entire effort for the school. All of you have heard repeatedly that there are basic components for our nation to reopen and having quick and easily available testing, adequate physical distancing, and enough PPE, same holds true for medical schools.

Medical schools recognize that the road to reopening will not be a straight and steady path forward. It is likely to have unanticipated curves that must be navigated. While new approaches and processes are being developed with specific clear and coordinated indicators being followed, that determine the pace to move forward. There is a clear recognition that these strategies might need to be rapidly reversed if there is a resurgence of Coronavirus in their communities. Thank you all. This concludes my remarks. I'd now like to turn this back to Dr. David Skorton.

David Skorton, MD: Thank you very much. We're ready now to shift to the Q&A portion of our conference where we will be joined by a few additional colleagues from the AAMC leadership, depending on your questions. If there are any questions we don't get time for, again, please send them to us by e-mail at press@aamc.org. Thank you. Sandy, we are ready for any and all questions. Thank you.

MODERATOR: Great, thanks so much Dr. Skorton. As you can see on your screen if you would like to ask a question, press star-1 on your telephone keypad to be placed in the phone queue. You will still be able to hear the presentation while you're waiting, and when the speakers are ready to take your question your line will be unmuted. We do ask that you please announce yourself with your name and media outlet. And the questions answered in the order we receive them. First question comes from Chris M. with the Pittsburgh Post Gazette. Chris?

REPORTER: Hi. Thank you for the opportunity today and thank you for the presentation. My question is directed to Dr. Janis Orlowski, and maybe also to Dr. David Skorton. As hospitals are gearing up to begin offering non-emergency medical services and procedures, some are offering patients COVID testing. That is, you know, for the confidence of the patient, and also for the medical

staff if you know that you are not bringing a disease into the hospital you are going to have confidence. I am wondering how common that practice is among members in the association?

Second part of the question is how many patients decline to be tested if coming in for non-emergency procedure, surgery, and they're offered to test and they say no thank you. It's painful, I can't get a ride to the testing center, you know whatever the reasons are. Thank you.

David Skorton, MD: Thank you for the question. Janis, would you take the first stab at this?

Janis Orlowski, MD: Sure. Happy to. Chris, thanks for your question. I would tell you that the majority of institutions are doing testing for people electively coming into the hospital.

The reason is there are reports of cases, both in China as well as the United States of people who may have quote-unquote just caught the disease within the last day but are not symptomatic. If they have a procedure, and they go on to have a very stormy post-operative course with increased morbidity. So part of the reason for testing is quite frankly is to make sure that you are not bringing someone in who is going to be having the COVID illness within the next day or two.

Secondly, the reason for testing is to make sure that the patient is treated appropriately for being positive, and most importantly that health care workers understand that the patient is COVID positive and use the appropriate PPE. For certain surgical procedures you may not have to wear a N95 mask. But if the patient is COVID positive many health care workers might make the decision that is what needs to be done based on the kind of surgery.

There are not just what I would call societal issues about isn't it nice that we can test them? There are true medical reasons to test people. As far as members of people who are refusing, I don't have that information. I would say that as a treating physician if I was bringing someone in and felt it was necessary, I would talk about the relative importance of having the test.

David Skorton, MD: Thanks, Janis. I think you covered it really, really well. Thank you very much. Sandy, ready for the next question.

MODERATOR: Very good. Next question comes from Ken Terry with Medscape Medical News. Ken?

REPORTER: Thank you. I was wondering whether medical schools are planning to resume classroom instruction in the fall, or whether that will continue to be done in distance learning?

David Skorton, MD: Thank you. Dr. Whelan, could you answer this one, please?

Alison Whelan, MD: Schools will be looking at local the local amount of pandemic and national and local guidelines. Certainly, if there are still recommendations for social distancing, they won't bring students back into large classrooms. They will be very conservative in bringing students back to in-person classrooms because they found that they've been very successful with the online learning, and in particular over the last month they have been able to not just deliver online learning and online lectures, but create small group teaching as well. When they think it is safe but don't feel a

huge urgency for that because virtual and online and distance learning has been found to be quite effective. Thank you.

REPORTER: Thank you.

David Skorton, MD: Thanks very much. Sandy, ready for the next question.

MODERATOR: Next question comes from Jeffrey Mervis with Science.

REPORTER: Hi. This is a question regarding the funding recommendations from the Ad Hoc Research Group that you and other organizations are a part of. I wonder if Ross or Janis could walk through the parts of that recommendation for the $31 billion. How much of it is for recovery from COVID, and what is the basis for calculating that the need for our recovery? And then how much of it is for improving the infrastructure and just for growing the enterprise?

David Skorton, MD: Thank you. Ross, could you take that and then perhaps Karen Fisher may want to add something. Ross, if you can start that, that would be great.

Ross McKinney, Jr., MD: Yeah. Our calculation was that most of that is to cover all of the agencies not just NIH but all research agencies including NSF and DOE. To cover the gap and cost of shutting down and restarting. By the gap, I'm referring to this period of time where the labs are closed because people are not able to be as productive. They're going to need -- if you have a grant, that's good for 3 years and you have certain goals, you've now had a block of time where you could not work to that goal.

Most grants are pretty tightly tied between the timeline and the expectations of the grant. Basically, this is to cover salaries to complete the projects and cost of restarting. The basis was I might have to say other people did the calculation, the primary basis was looking at the total expenditures of the various agencies taking the block of time that people were not working, which was expected to be about 2 to 3 months. And multiplying the budgets by that gap. It is not supposed to be about a lot of infrastructure. There may be some infrastructure requests, but the real cost is covering the gap. Karen?

David Skorton, MD: So Karen, is there anything to add?

Karen Fisher, JD: Yes. Only thing is, did you mention the number $31 billion, or $26 billion?

REPORTER: Well I wanted you to distinguish those two, because I'm confused about the difference.

Karen Fisher, JD: Right. They are complementary I would say. As Ross mentioned, we believe strongly [indiscernible] there are implications of the COVID epidemic on all of the federal agencies and the $26 billion is a letter that we joined along with other organizations to ensure that the ramp down that has been occurring during COVID is addressed for all of the agencies. Then a group that AAMC convenes, the Ad Hoc Medical Research group wrote a letter that recommended that $26 billion and recommended there be additional money specifically for National Institutes of Health to

deal with many of the issues that Ross talked about, including the ramping up as well as infrastructure needs, and other issues associated with those research issues that are unique to NIH.

David Skorton, MD: That was Karen Fisher, who's the AAMC's chief public policy officer. Sorry, did you have more?

REPORTER: Well I just wanted to clarify. So, the $31 billion is three times the 10 billion that is in the 20s-- for NIH that is in the 26 billion. Is that correct, Karen? So you're saying out of the 30, you are asking 10 billion would be for ramping up, but other 21 billion is for sustaining the enterprise?

Karen Fisher, JD: Yes, that's an estimate on that. It is inclusive of the amount that would be included in the 26 billion as well. We are happy to follow up with you offline on that because there are some technical details we would be happy to follow up with.

REPORTER: Great.

David Skorton, MD: It would be good if you could do that. We will reach the gentleman through the login, thank you. Sandy, next question please.

MODERATOR: Just a reminder to our participants it is star 1 on your telephone keypad if you would like to ask a question. Next question comes from Joyce Freidan with MedPage Today. Joyce?

REPORTER: Yes, hi. Thanks for taking my call. Can you talk a little bit, I really hadn't heard about what had happened yesterday with the MCAT. Can you say a little more about what the problem was, and also talk, again, about the numbers in terms of interest in going into medicine?

David Skorton, MD: Thank you for the question. Gabrielle Campbell is the best one to answer that question. Gabrielle, if you would?

Gabrielle Campbell: Sure of course. Yesterday we opened up the registration for the MCAT program in a new format. We previously had to cancel our testing in March, April, and most of May because of the stay-at-home orders and the concerns about health and safety of examinees.

In doing so, we've reformatted the exam so that we are now testing examinees 3 times per day. And our previously scheduled testing days. We've also added an additional 3 days. That allows us to do 50% capacity within the actual testing center so people will have appropriate physical distancing between them, and they can wear their masks and their gloves, and we'll disinfect between each session. That allows increased capacity by 50%. We will have more than enough testing appointments for everybody who was displaced, and then anybody else who wants to come in and test over the summer.

We knew that we were going to have a high number of people coming in for the opening. In the past we averaged about 10 to 12,000 people to come in on an opening day for registration. We of course knew that the folks that had been displaced in March, April, and May. We ended up having about 62,000 people come in yesterday. That was more than our systems were ready to handle.

We had--in the first 2 minutes after the point we opened we had more people ready to go than we'd ever experienced before. So that actually hit our system in a way that we had to step back, we had to revamp the systems. That took a couple hours to make sure that we could have the testing all deployed. We knew we had one shot to get it right yesterday, and not have to wait more days and put people in greater inconvenience. We took time and got it up and were able to move through the 62,000 people and everyone got testing appointments at the times and place that they wanted. It was a bit of an inconvenience for our examinees.

We are sorry about that. We deeply regret it. But we're happy that we were able to help them move forward with their MCAT registration. In terms of the MCAT numbers, we opened on May 4th, Monday, for people to start their applications. This is just to initiate them to start their application. Start putting in their transcript information, their clinical experiences, voluntary experiences.

We were surprised to see a 50% increase in number of people that initiated applications. Just in the first three days compared to last year as Dr. Whelan commented. We're going to be watching that closely. They can actually start submitting their applications on May 28th. We will be forwarding all of the data to the medical schools on July 10th.

This does not necessarily say that there will be more people applying for this entire application year but it is -- we are cautiously optimistic about it. We weren't sure what would happen given the pandemic and people's interest in medicine. between the MCAT registration, volumes and AMCAS application initiation, we are cautiously optimistic.

David Skorton, MD: Thank you very much, and for the questioner just to make sure you know who is who. Gabrielle Campbell is the AAMC's chief services officer. Thanks, so much Gabrielle. Ready for the next question.

MODERATOR: Okay the next question is from Julie Rovner with Kaiser Health News.

REPORTER: Hi, thanks for doing this. I have a question about students who are graduating now, many who graduated early. Are they going to be starting their internships as scheduled, July 1st or some of them staying where they are? Is there difficulty with getting students from finishing medical school into hospitals to start their residencies?

David Skorton, MD: Alison, and then after that, if John has anything to add but Allison if you could start please?

Alison Whelan, MD: Sure. As you know students from over 30 medical schools, a portion of them were given an opportunity to graduate early. The vast majority of those students who did graduate early stayed locally. Were granted special licenses for supervised practices and had been working in a variety of roles within those hospitals.

There is a work group actively working that includes the associations that really think about the transition from medical school to residency. Thinking about all of the safeguards and processes that need to be put in place to assure that the students can safely begin their residencies on July 1st, or whatever the appropriate start date is. That statement should be coming up next week and it will

include broad categories such as things you had pointed out. Transportation to get to the new place thinking if quarantining is necessary. Thinking about orientation and those kinds of things also. So the expectation in the medical education community is that these recent graduates need to enter into their residency programs in a timely fashion so that they can continue their true work which is to become full-fledged members of our profession. Thank you.

David Skorton, MD: Thanks, Alison. John, anything to add at all?

John Prescott, MD: No, I think Dr. Whelan covered it all.

David Skorton, MD: Great, thank you. Thanks for the question. Sandy, we're ready for the next question please.

MODERATOR: At the moment Dr. Skorton that is the last question that we have in our queue. So just a reminder to everyone if you still have a question you want to ask, it is star 1 on your telephone keypad.

David Skorton, MD: Thank you, Sandy. Maybe I can just remind our participants--that is our attendees, if you come up with a question later, we still have about 10 minutes or so left, and we're going to stay the whole hour. If you have questions afterwards that occur you to, you can write to us at press@aamc.org.

You don't have to recall the names of all of the people today. If you just send your question to that. We will quickly get it to the right person and get an answer right back you. And there will also be a follow up from Karen, the chief public policy officer for that question about the calculus for figuring out the 31 billion of request for research money. Any other questions coming up, Sandy.

MODERATOR: No, we don't have any at the moment.

David Skorton, MD: Okay, let me ask if any of the participants, want to add anything that wasn't in your prepared remarks while we have a couple minutes. Any aspect related to reopening. This would be good if you have any additional brief comments. Thank you.

Ross McKinney, Jr., MD: I can make a comment that we were very happy that the FDA took a second look at their regulations regarding antibody testing serology. And the fact that they now require commercial entities to go through the EUA process to demonstrate their antibody tests are, in fact, accurate. There was a lot of garbage out there.

I think it was important for the FDA to start to reign that in. At the same time they allowed academic laboratories that are certified for high complexity testing to be able to develop antibody tests, which is appropriate because it is -- eventually they have to go through a standards process as well. I think it is a very appropriate strategy that the FDA announced on Monday.

David Skorton, MD: Thank you very much, Dr. McKinney. Dr. Orlowski, do you want to add anything? Janis, did you have anything to add to that comment? Okay.

MODERATOR: I just want to make sure her line wasn't muted, Dr. Orlowski. Okay.

David Skorton, MD: Okay. Any other questions, Sandy, so far?

MODERATOR: No. No other questions have come in, sir.

David Skorton, MD: Okay. Well, if everyone is comfortable with this, we can call the conference. We really appreciate your participation. Hope that you find it useful. We definitely find it useful. On behalf of AAMC, I want to thank again, the press, for everything you are doing. We very much are depending on you in many ways hope you all will be safe and your families and have a good weekend. Thank you very much. Sandy, back to you.

MODERATOR: Okay, very good. With that. we will conclude today's program and this session has been recorded and 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. You may now disconnect.

End of Press Conference