National townhall on COVID-19

With a virtual crowd of 4,000 in attendance, the AMA National Physician Townhall covered important areas the Association continues to work on in the face of the COVID-19 pandemic, including access to PPE, clinical clarity on treatment and the CARES Act.

Featured speakers

James L. Madara, MD, CEO and executive vice president, AMA
Patrice A. Harris, MD, MA, president, AMA
Howard Bauchner, MD, editor-in-chief, scientific publications, *Journal of the American Medical Association*
Mira Irons, MD, chief health and science officer, AMA
Aletha Maybank, MD, MPH, chief health equity officer, AMA
Todd Askew, senior vice president, advocacy, AMA

Transcript

American Medical Association Foundation

COVID-19 AMA's National Physician Town Hall

April 9, 2020
Dr. Madara: Hello and thanks for joining us. I'm Dr. Jim Madara, chief executive officer of the American Medical Association.

We've learned during the COVID-19 pandemic that the astonishing, in many ways, no longer astonish us. Our routines have been [inaudible], schools and universities closed, businesses shuttered and much of America is sheltering in place. The last time our country experienced anything like this was in 1918, the H1N1 pandemic that resulted in nearly 700,000 deaths in the U.S. and 50 million deaths worldwide.

Today, physicians, nurses and other health care workers are under intense pressure and also great personal risk not only to themselves but also their families as they care for those stricken with COVID. And these risks are heightened due to shortages in supplies, including basic personal protective equipment. So, this is a sobering time for our profession made more so given the deaths of physicians and other caregivers have already occurred. In honor of them, I want to take a brief moment of silence and acknowledge their sacrifice.

We understand you're frustrated. You're working long days with resource uncertainties and under challenging conditions. Some have been forced to close practices. But even those practicing often have seen massive change to their routine of providing care.

Recognizing the important work needed to support the profession, the AMA is responding to this pandemic with three strategic work paths. First, providing trusted evidence-based resources including guidance to help your efforts on the front lines. Second, ensuring that state and federal leaders hear your voice and fully understand the challenges you're confronting. And third, being your strong advocate for additional supplies, equipment, test kits and economic support that you need.

Joining me today, we have AMA's president, our editor-in-chief of JAMA and three members of our senior management team who are subject matter experts. This group will discuss the ways in which AMA engages our national COVID effort, an effort we engage on behalf of all physicians, but most importantly we want this call to be about you, your needs, your challenges and yes, your insights. So, thanks again for joining and I'll now turn it over to Dr. Patrice Harris, the president of the AMA. Dr. Harris?

Dr. Harris: Hello, Jim, and thank you. We've reached a critical stage in our fight against COVID-19. Cases are soaring by the day and deaths are climbing. Across this country, physicians, nurses and other health care workforce continue to work extremely long hours under intense pressure and sometimes dangerous conditions.

You're exhausted. You're deeply frustrated by the torrent of conflicting and sometimes inaccurate information that discourage the public and our officials from taking this pandemic seriously. And you have already paid a terrible price for our nation's lack of preparation, for its inability to get you the
basic supplies and protective equipment you've been pleading for.

As Jim said, many in our medical community have fallen seriously ill. Some have died. This is the reality as we show up for work today on April 9th facing an enormous public health threat, seemingly with an arm tied behind our back. But you have stood tall. You have arisen to this moment. And you have shown this nation who we should be listening to—physicians, public health experts and scientists.

Time and again, you have answered the call despite breakdowns in leadership, despite conflicting messages and despite severe shortages of resources and life-saving equipment. The coronavirus pandemic presents a challenge our country has not faced on this scale for generations, but let me be clear, you are not shouldering it alone. The AMA has been fighting on your side from the beginning, channeling your collective voices into action. We've been your powerful ally at the White House, at the negotiating table and everywhere that important decisions are being made to get you what you need to fight this pandemic, especially PPE, testing kits and ventilators.

I've met personally with President Trump and his task force to pressure them to alleviate these shortages and to invoke the full powers of the Defense Production Act to accelerate production and resolve supply chain issues, and the AMA will continue to apply pressure until this happens.

We have been your powerful ally with Congress fighting to protect your practices from the financial impact of this pandemic. AMA fought for billions in loans and direct financial support for physician practices and ensured that it was part of the CARES Act passed by Congress earlier this month. And this includes $100 billion, which is often portrayed as a hospital-only fund, but which does include support for physicians to cover cost of treating COVID-19 patients and recoup losses that practices have sustained.

We have been your powerful ally with CMS working closely with them to significantly expand telehealth coverage, ease MIPS requirements, and fast track new CPT® codes so you could get paid for COVID-19 testing. We have been your powerful ally by keeping the focus on science.

We have created resources to help you make the best decisions on patient care, to help you manage your practices and take care of yourself and for all of us to adapt to this new reality. The AMA and JAMA have been the leaders to whom others look for must have information on our websites, illuminating the challenges you're facing on the front lines to a global audience via articles, videos, podcast, email and social media.

The AMA has been a powerful ally in strengthening our physician response, urging federal officials to ensure that international medical graduates who are non-U.S. citizens can continue to fill critical gaps in this effort. The state department has since announced it would expedite the visa process for IMGs.
We've arrived at an all hands-on-deck moment in the fight against COVID-19. We need everyone and every resource available to turn the tide. The AMA is leveraging the power of your voice at the highest levels so that you can focus on the job at hand, taking care of your patients and saving lives. We are your ally in this battle and we're fighting for your safety, your peace of mind and your livelihood.

So, it's critical that we continue to hear from you. We want to hear what frustrates you and what concerns you. We want to hear about the obstacles you're facing and how we can help remove them. We want to know how we can better support you and all that is on your shoulders. So that's what this town hall is about.

We've gathered some of our AMA experts to answer your questions, to lend a helping hand, to provide insights and perspectives and to help you get whatever resources you need.

As our host mentioned at the top, your lines are muted for this webcast, but if you'd like to ask us a question, you can submit them at any time using the Q&A box on your screen. The box should be in the lower righthand corner of your screen. But before we move on to your questions, let me first introduce one of the most trusted voices in medical research and analysis, Dr. Howard Bauchner, editor-in-chief of the *Journal of the American Medical Association*.

Dr. Bauchner will talk about the latest research and scientific understanding of COVID-19 and help us better understand what's ahead. After that, we'll open it up to Q&A. Howard, I'll turn it over to you.

**Dr. Bauchner:** Thanks, Patrice. It's a privilege to be here. I want to thank both you and Jim for the invitation. My comments are based upon a number of sources, so I think that'd be important to mention, firstly, what we've published, what I read, and then the various podcasts and live streams I've done. And my comments are going to occur in three different areas. First, I want to talk a little bit about what we've been seeing at *JAMA*. Then I want to go onto some public health observations and then finish with some clinical observations.

So, what's happened at *JAMA*? Well, first is just the numbers have been staggering in terms of submissions. So, since January 1 we've had 500 research letters submitted. That's January 1 through April 1, 500 research letters submitted that are related to COVID-19. We've had about 1,100 original research reports, opinion pieces, clinical reports and about 300 additional queries.

So, about 2,000 papers have come across our desks and I really need to acknowledge four people that have made our publications possible. Jody Zylke is our letters editor and it's been a huge lift for her. Stacy Christiansen has ensured that we can publish manuscripts in two, three or four days, which is really a tremendous change. And then I'd be remiss not to mention Tom Easley who's my counterpart in publishing.
This is a team effort, editorial and publishing, getting out our content. And lastly, just like telemedicine is the analogy. Leslie Weber’s group in information technology has done a fabulous job. We are beginning to move towards working more from home, but because of Leslie and her group, we've been able to do that for over 250 people within a period of one week when we began working from home and I really want to acknowledge them.

Of those 2,000 manuscripts, we've published 60 papers. They are online ahead of print. They are free to the world, and they've resulted in 15 million views. And those views include podcasts, live streams and the articles. It's a wealth of information. And I have many, many people to thank, but I particularly wanted to highlight Jody, Stacy, Leslie and Tom.

So, I'd like to move on to some public health observations and some clinical observations. I think in hindsight it's clear China's quarantine worked. Many people thought of it as being draconian, but in hindsight, I think without doubt, they were able to limit the spread within a country of 1.4 billion people to perhaps 100,000, 200,000 or 300,000 people who've been reported to have been infected. It's a remarkable accomplishment.

Taiwan, Hong Kong, Singapore and Korea have clearly had tremendous success in identification, tracking, tracing and quarantine. It's always difficult to compare the U.S. to Taiwan, Hong Kong or Singapore. They're much, much smaller countries with a different health information technology system, but they clearly have shown success and actually may point the way to what we have to begin to do as the current pandemic wanes and we face the fall season. Korea mounted a different type of response, which I'll come back to.

China gave the world three or four weeks, some people say six or eight weeks, to begin to understand what it would face. And unfortunately, I think it's quite clear that the U.S. for many different reasons squandered that time. The lack of rapid testing, which has been in the press repeatedly for six or eight weeks has led to organizational and logistical nightmares and it has clearly fueled health care worker infections, probably has led to increase disease amongst patients and certainly has created enormous problems. And what I mean by testing isn't a three-day delay. I mean rapid testing where response times are a few hours and not a few days.

Protecting health care workers and everyone else involved in the efforts, so, for example, we just got a viewpoint about how do we protect people who are delivering food to grocery stores, so protecting health care workers is critical. We can increase ICU bed numbers, but it won't be possible to staff them without health care workers.

I believe the U.S. is managing well. There's four or five hotspots—Detroit, Chicago has been difficult, obviously Boston and New York. But the other major metropolitan areas are doing generally well. In part, they have less disease with enormous resources. And I'm pleased that just over the last week or so, it's been very clear that the projected ventilator shortage may not occur. The critical issue is to
move ventilators to the critical place rather than necessarily try to create just more ventilators.

I'd like to move a little more to the clinical observation. There's tremendous tension over the use of unapproved therapies. I can't emphasize enough the remarkable support I have for Patrice's comments publicly. She's been relentless in commenting about the need for science and evidence and science. It is likely that we don't know the best treatment for Ebola because we never conducted the appropriate randomized clinical trials. They are the key to understanding how we can more effectively treat these patients. And I can't emphasize again my support for Patrice's comments.

There's an ACE and ARB question. People have confused the question, even the drugs that are used to treat hypertension, and there's two different questions. First, are people who have hypertension and are on those drugs, are they more likely to become infected or develop serious disease? That is an unanswered question. The second question is if they become infected, should they come off of those drugs? Again, unanswered, but the major professional cardiology societies have said based on the data to date, patients should not come off ACE or ARBs and they should continue to be treated for hypertension if they're admitted to the—admitted to the hospital.

Why are so few children impacted? Either they're not getting infected or if they're getting infected, they're not having serious disease. This is very, very different than influenza and it remains unclear why this is the case.

Much in the news about [inaudible] root of spread and masking. It's interesting it took us a bit longer than perhaps it should have to get to masking. Unfortunately, in Paris, New York and London, underground subway Metro, we had the perfect vector for spread of asymptomatic disease from patients who are asymptomatic, and I think there's real reasons why those three cities have had such substantial problems.

Vertical transmission, pregnant woman to child, we've published a number of papers on that issue. It likely occurs. There's just not enough data to know how serious the consequences are.

Passive protection, interestingly enough, again, JAMA published an article. It's had close to a million views on the use of convalescent serum. It's become increasingly popular around the country. It's already entered clinical trials. This combined with understanding the serology, IgM and IgG response will be the key to resuming normal business schooling, college and other activities come the fall.

About 20 to 30 patients, 20% to 30% of patients with COVID ID get hospitalized and about a third need intensive care unit beds. And as I've said, I think there's some evidence in my conversations with Dr. Fauci yesterday, he emphasized that the data they had seen over the last few days suggested that the logarithmic increases in Chicago and New York seem to have been calmer. That is that the curve hasn't inflected, but the rate of rise has declined slightly.
Case fatality rate remains incredibly variable from country to country. And I want to make a few additional comments about it. So, it's being reported at about 10% or 11% in the United Kingdom, Spain, France, and Belgium. Interestingly enough in Sweden where they were pursuing a different approach, it's now grown to 7% or 8%. Korean and Germany remain low and the U.S. is at around 3%. New York city is around 4%. But there's islands within the case fatality rate in which we have very little data. We've now published two reports about potential concerns regarding prisoners. This has been a huge problem in Chicago, and I think we need much more information.

The second group that we know very little about, we don't know very much about the case fatality rate based upon race and ethnicity. This is of increasing interest and I think more and more data will emerge. Some has already emerged from New York city, but I'm hopeful that it will also emerge from other places around the country as well as other places around the world.

My last comment[s] are for us to recognize that successful treatments, even a vaccine does not represent a cure. And we have to be incredibly careful about how we talk about this publicly. A successful treatment will reduce mortality by 20%, perhaps 25%, perhaps 30% but it will not cure the disease. And I want to be careful that we don't mislead the public. Even in the best randomized clinical trial, the best results, the number needed to treat is 5 or 10. And as all of you know, flu vaccine is often not that effective. So even if we have a vaccine, it's not very likely to protect 100% of the population.

And that brings us to the fall. I think people are now just beginning to think as we emerge from this pandemic in every city and in every state, what does the fall look like? What does normalcy look like? How can we ensure a safe working environment so people can go back to work, back to school or back to college? Thank you very much for the time. And again, thanks to Patrice and Jim.

Dr. Madara: As mentioned, we encourage viewers to submit questions in the Q&A box on your screen. We also requested questions via Twitter with our AMA chat hashtag, and I'll be asking those questions today from those two sources.

Dr. Harris: Then I just want to say that the work of you and your colleagues at JAMA has been exceptional as always. Now let's hear from you. We'll get through as many questions as we have time remaining. I will turn it over and hear from our moderator and then I will turn the questions over to our experts as appropriate.

Dr. Madara: As mentioned, we encourage viewers to submit questions in the Q&A box on your screen. We also requested questions via Twitter with our AMA chat hashtag, and I'll be asking those questions today from those two sources.

Dr. Harris, there are many questions and concerns about access to PPE for frontline caregivers. What is the AMA doing? What has the AMA done to ensure all physicians and health care workers have the PPE needed in this crisis?

Dr. Harris: Well, thank you for that question and I'll take the first part of that and then see if Todd Askew has any additional comments. As I said earlier, I had the opportunity to meet with the president early on and definitely raised the issue of PPE with the president. Certainly, hearing from physicians...
across this country on the front lines, the need for PPE, I'm sure we all heard the stories that physicians and other health professionals were reusing PPE. And as I said, many times during a pre-COVID time some of that reuse would have been a violation of our infection control policy.

So, we knew that we needed to get PPE to the front lines and that's why, again, we called on the president to use the full levers of the federal government starting to manufacturer and then more importantly, and most importantly, the distribution of PPE. Certainly, a federal tracking system could identify areas of high demand and higher priority. And so, we also ask for the federal government to coordinate a tracking system.

So, getting adequate PPE has been high priority. I'll say one more thing and then see if Todd has anything else to answer. The AMA also heard from the front lines that physicians were being disciplined, punished, even heard stories of physicians being fired for raising the issue of inadequate PPE. And we said at the time, and we continue to say that certainly we know that institutions need to have media policies to coordinate media responses, but no one should be disciplined in any manner for raising an issue that was already well known to the public. So, Todd, do you have anything else to answer on that?

**Askew:** Thanks Dr. Harris. I think the one thing I would add is we are seeing some progress. There is an air bridge that has been established. Of course, most of this is manufactured in China and much of that capacity was offline for a long period of time. The air bridge is feeding supplies into both the commercial supplies pane and for [inaudible] equipment around the country.

It is not enough. It's not going to be enough. And I think HHS and CMS are looking for ideas and looking for best practices for preservation and reuse of PPE, far from ideal, but it's unfortunately where we find ourselves right now. And we will continue to press the federal government to use every lever they have to increase both acquisition and production of PPE.

**Dr. Harris:** Thank you, Todd. Next question?

**Dr. Madara:** Dr. Harris, you described COVID-19 as an all hands-on-deck moment for health care. Still, there are concerns about medical students providing care, retired physicians providing care. What counsel do you have for these students and retired physicians?

**Dr. Harris:** Thank you. And that's an excellent question. And it reminds me to tell the listening audience to please go to our website and look for our COVID-19 resource page. We have all the resources that many of us on this webinar had been speaking about and even more on so many issues that, again, physicians across this country have raised and the AMA have been responsive to. And so, this is one of those issues.
It is an all hands-on-deck moment and I'm sure folks know that some medical students have been called into action of those who were near graduation, and on perhaps the other end of the career spectrum are retired physicians have been called into action. And so, knowing that each of those populations, physician and learner populations would have different needs, the AMA has developed resources specific to those groups.

For the medical students, we've developed a resource guide. We wanted to make sure we were protecting our learners. This is a very difficult time for them. What is the next phase? Certainly, what was going to be the next phase has been disrupted. And so, we have a full resource document on our learners and medical students, and we want to make sure that they are protected as they are volunteered or being called into service.

We also have a resource guide for our senior physicians. Certainly, not surprisingly, our senior physicians who are retired want to answer the call, but we also know that those, in the older age groups are more vulnerable for the more severe health consequences of COVID-19. So, we also have developed a resource page for our retired physicians. So please go to our website and look for those documents. And I will just open it up either for Todd or Mira to add any further comments.

Dr. Irons: Thanks, Patrice, you absolutely covered everything. The evolution of the COVID-19 resource center on the AMA website has evolved as the issues concerning health care providers and the condition have progressed. And so, many of these resources have been added and you're absolutely right. There have been—there are resources with regards to medical students. There are resources with regards to retired physicians and senior physicians, and I believe that there are resources either on the site or about to be on the site that pertain to residents and [inaudible].

Dr. Harris: Thank you, Mira. So, we do encourage everyone to bookmark that page. We are constantly updating that page with the latest information. Next question?

Dr. Madara: There are quite a few questions about drugs that can be used to treat COVID-19. What is the AMA's position on the drugs that are being suggested by the White House? Any preliminary results from the chloroquine and CPAP trials?

Dr. Harris: So, I'll just start that answer and then maybe also turn it over to Howard. But as Howard said, science and the evidence, evidence and the science. And of course, the AMA fully supports rigorous controlled trials so we can really get an answer to these questions.

We know also that the FDA has approved some use, emergency use through their EU, emergency use authorization process. But the most important thing is we really do need to let the process go through regarding randomized controlled clinical trials. I'll turn it over to Howard for any further comment.
Dr. Bauchner: Thanks, Patrice. Just briefly, there’s an incredible tension. You know, patients are really sick. And in the ICU, some are going to go on to die. And people really want to help them. I really appreciate the tension that clinicians feel. And patients want to try something if they realize the potential outcome [inaudible].

But on the other hand, without the appropriate evidence, we’re reaching for straws and there’s been an enormous amount of selective reporting of successful drugs and not just chloroquine, they keep coming across my desk every day. And when we query the authors, they’ll say, "Well, we told you about these five patients." And we'll go, "Well, did other patients receive that drug?" And they go, "Yes, but they didn't do that well." And so, that's what the concern is when you see small case series that are uncontrolled.

In addition, we do know there's [inaudible] side effects. And so, if a patient receives the drug and does well, you assume it was successful. If a patient receives the drug and does poorly, then you say, well, it's the disease without recognizing the possibility of the side effects. So again, I can't emphasize that I strongly support the AMA's position and Patrice's position that to the extent possible decisions have to be based upon science and evidence. In addition, we're doing no service to people who will get infected in the future if we can't resolve some of those issues today.

Dr. Harris: Thank you, Howard. And the only other point I will make is that some of the medications that are appropriately being studied are also currently being used for our patients who have lupus and arthritis for an example. And we have heard that they—patients are having trouble in some areas obtaining these medications. There is shortage of these medications at their local pharmacy. So, we have to make sure that we are looking at all of this and looking at all of this in context and for the well-being of all of our patients.

But thank you for that question. Next question?

Dr. Madara: Dr. Harris, there’s a number of questions including from Twitter about many practices have had their financial stability threatened by the pandemic. Some have closed their doors or reduced visits. What support is available for private practice? What is AMA doing to support physicians who are not part of a group or hospital or independent practice?

Dr. Harris: Thank you. And I will have Todd elaborate. But again, from that early meeting, from that first meeting with the president . . . we all raise the issue around the importance of the viability of practices, no matter the practice size. And I think a lot of people don't realize this, but practices from the small ones, the [inaudible] as we call it to the larger practices are small businesses in communities and they have employees and they pay for health benefits and they pay rent.

And so, these are small businesses, and so, we certainly realize that, elevated these levels from the very beginning. You heard me earlier talk about the $100 billion, which I think a lot of folks miss and
think that that was just for hospitals. No. And of course, we also advocated strongly to make sure that practices could take advantage of the support, the financial support through the small business loans. So that's a broad 30,000-foot view, but I'll turn it over to Todd for additional specifics.

Askew: Sure. Thanks, Dr. Harris. So, you mentioned two of the most important ones right off the bat there, the $100 million emergency fund is available for—is they're in the process of deciding how it will be distributed, but it will be available for practices not only for the cost of caring for COVID patients, but for lost revenues that will be suffered because of a sharp decline in office visits and obviously the necessity to cancel so many elective procedures. That will be rolling out very soon. It should be broadly available to most physicians.

And there are efforts already underway to increase that fund even more, recognizing that it's not enough, but there the real emphasis at HHS and at CMS to get that money out and into people's hands so practices can be sustained because health care needs obviously aren't going away.

The SBA loans that were mentioned are very favorable in certain circumstances and are available to practices with less than 500 employees working through their current lender or other lenders that work with the small business administration. These loans for the most part, a large portion of it will be forgivable. It means that it acts almost just like a grant to the practice. They're for the purposes of maintaining payroll and benefits and other overhead costs. It's called a Paycheck Protection Program. And so, that is available.

There is a new program that just came out of Treasury today. The details are still being released, but it is focused on the larger practices and all businesses from 500 to 10,000 employees. That option will provide favorable loan terms through lenders by injecting significant amount of liquidity into the markets. That's $480 billion something that will generate trillions, a couple of trillion dollars in liquidity.

And then the last one I would mention is the opportunity for Medicare Advance Payments. It is a Medicare program where based on your last quarter of 2019's revenue you can receive an upfront payment against future Medicare claims to help with the cost of keeping your practice open. There are some considerations there in terms of those—the recoupment of those claims will start fairly soon, and after 210 days the interest rate is quite high.

We are working with Congress, working with the administration to see if we can make that program—make the terms of that program a little more favorable. So, I think the federal government recognizes the extreme needs that practices have not only those who are dealing directly with the disease, but those who have seen sharp declines in revenue because we've encouraged people to stay home and put off elective needs. And we'll continue to work on your behalf on those—on that issue.

[Edited for clarity]
Justin DeJong [Moderator]: Let's see here. This might be a good question for Aletha—the AMA’s chief health equity officer. There's been a lot of discussion this week, a lot of visibility on communities of color and the impact of COVID-19 on those communities. Aletha, can you provide some perspective on AMA's work on this front?

Dr. Maybank: Yes. Thank you. So, there has been a tension really across the country for the last couple of weeks from a lot of the health equity leaders. And there's been an obvious missing data as it relates to being able to see what is happening across race and ethnicity.

We are very clear, historically, in this country and even contemporarily that communities of color, those who are immigrants or undocumented, those who are disabled as well as identify as LGBTQ will experience a greater burden of disease especially during a time of disaster. And there were already reports and stories that folks were not getting access to testing potentially. And so, in order to really fully understand—and also just not even seeking care also because of mistrust of the health system, but also because of current policy and rhetoric that really prevents people who are undocumented from seeking care as well related to public charge.

So, we wanted to have a better understanding of what was—what's happening. And so, we collaborated in partnership with some other physician organizations, The American Academy of Pediatrics, the family physicians, [inaudible] as well as the National Medical Association, the National Hispanic Medical Association, the Association of American Indian Physicians and the National Council of Asian Pacific Islander Physicians. So, we all sent a letter to HHS demanding for this data to be standardized, collected and released. And it's not just for HHS but clearly for its subagencies and really a call to action for all state and local health departments to release this data and the data of what they have.

We were clear there are going to be gaps. Because we know everyone is not getting tested at this time, but gaps in how people already have their systems set up as it relates to race and ethnicity. But we need to see the data. And so, fortunately, we have had about six to seven states now release, publicly release on a daily basis on their websites and about three cities also publicly release their data on race and ethnicity as well.

But we definitely want to see more, and so we're making sure that we are constantly advocating and working with other partners, having our conversations with CDC and others to get this data out and make it available so that we have a better and more clear understanding of what is happening in communities of color and those most marginalized because we cannot completely or work towards really ending the epidemic unless we're very clear about what's happening in our communities as well.

[Edited for clarity]

Dr. Harris: This is Dr. Harris. Thank you, Dr. Maybank. Justin?
**DeJong:** You bet. A couple of questions from Twitter about medical liability. In terms of medical malpractice coverage, how are physicians being protected from the disruption of existing standard of practice during this pandemic time? And if physicians become chronically disabled as a result of occupational COVID-19 exposure, what are a physician's options?

**Dr. Harris:** Thank you. Those are great questions. And again, if you haven't already been to our website, our COVID-19 resource page, we have information about both of those issues. I think we are just, if not already published today, we'll be soon publishing issues around. And so, we urge you to take action.

**DeJong:** A couple of scientific questions. Is there any scientific evidence regarding how long a patient with COVID-19 remains infectious? Is there any scientific evidence regarding when it is safe for a health care worker to return to work after recovering from COVID-19 and no longer be contagious to others? And if there are any, is there any evidence of whether or not a positive antibody to COVID-19 confers immunity?

**Dr. Harris:** Howard, would you take those?

**Dr. Bauchner:** Sure. Return to work based upon the current CDC recommendations is seven days from being well. They've been very clear about that. I think within health care institutions, they may want individuals to become test or PCR negative prior to return to work. But at the time we resume normal business practices around the country, the CDC's recommendation is likely to be the one that people adhere too, which is safe to return to work seven days after someone is well. As I said, that may vary very differently in a health care institution where people may want to be clearer that someone is test negative.

With respect to serology, there's not a lot of data yet on IgG and IgM. Interestingly enough, in my conversations with Dr. Fauci yesterday, he had mentioned that they had not done as much testing post SARS that they had hope. The general feeling now is if people develop IgG, then they will be protected. How long they would be protected for is unclear. This may play a very, very important role as the summer ends and we begin to return to normal practices that as you can imagine, a scenario where large numbers of people will be tested.

So, if they've developed IgG antibody and they were asymptomatic or they had mild disease, you would know indeed that they have some protection. How long that protection will last will be unclear. The general feeling is it's months to years and that may make some activities in the fall months easier to arrange. But with respect to return to work, the recommendation is seven days well, and I think it will be clearer in the future if you're ill, particularly if you have a fever or a cough, you should not go to work.
Dr. Harris: Thank you, Howard. And by the way, thank you for those wonderful interviews that you’ve done with all of your colleagues, but I know you’ve done a couple with Dr. Fauci and they’ve been very illuminating and informative, so thank you again for that.

Dr. Bauchner: My pleasure.

Dr. Harris: Justin, next question?

DeJong: You bet. Dr. Harris, there are reports of physicians being reprimanded by their employer for speaking out publicly about their need for PPE. What advice and counsel do you have for these physicians?

Dr. Harris: Well, certainly, from the AMA’s standpoint, we’ve made a strong statement about that, certainly, supporting our physician colleagues—and their ability to speak out. The issue [inaudible] definitely want to protect physicians again are publishing some information about employment. And certainly, there’s not a one size fits all approach here and each physician will find him or herself in a unique position, but we want to hear those stories so that we can continue to figure out the best ways [inaudible] to support physicians [inaudible] through this. And Todd, could [inaudible] and as you know, that requires, [inaudible] so far regarding liability protections.

DeJong: And here’s a question. Next question. As I work in the New York City frontline positions, I see that most of us are IMG. What is the AMA doing to help foreign doctors stay legal in this country?

Dr. Harris: Todd Askew, do you want to take that?

Askew: Happy to. We have, initially, we’ve done some work with customs to ensure that those physicians who may have had initial concerns with the travel ban being able to come into the country, we have worked with them to resolve those. And we are always on the look to—look out to help support our IMG workforce, which is such a central part of the health care system in the United States. This is an area where you can help us and where members have been very valuable in reaching out to us with specific problems that they’re encountering and, and letting us work through the problem with them and go to the right officials at the federal level.

So particularly on that area as specific issues arise, please do not hesitate to reach out to us and we will work with you to resolve them.

Dr. Harris: Justin, do we have time for one more question?

DeJong: You bet. What measures are being taken for unmatched U.S. citizens where doctors have passed all required board exams, we need residency spots to help fight COVID-19? Is it possible for hospitals to hire unmatched applicants to help with the pandemic?
Dr. Harris: Yes. This question has come up quite a bit and I know I want everyone to know that we have a strong team at the AMA. Susan Skochelak and her team have been working closely with ACG and me and AAMC and all of the groups regarding this. And I, Jim, did you want to comment on that? And then I don't know if Todd might have anything else to add.

Dr. Madara: Well, no, that's exactly right. What I would do is maybe ask a comment from Mira who's been plugged into our educational activities as well.

Dr. Irons: Thanks a lot, Jim.

Dr. Harris: Sounds great. Thanks, Jim. Mira?

Dr. Irons: Thank you very much. Yes, I, Dr. Skochelak and the Med Ed team are actually looking into this very closely and there is a coalition across medical education that is looking at all of the different backups of this question, because the students need to be protected and they need to be supervised. And so, information will be coming out and will be posted on the resource center.

Dr. Harris: Thank you, Mira. Justin, should we take another question, or should we close?

DeJong: Let's take one more question, Dr. Harris, and then I think we can close.

[Edited for clarity]

DeJong: Let's see here. "I am a 73-year-old clinical neurologist and solo telehealth practice. My question is how can I best volunteer to support the fight against COVID-19 in areas such as New York where I did my undergraduate education?"

Dr. Harris: And any of my colleagues can join. And I do encourage you, doctor. Thank you. Again, not surprised that everyone wants to join in this fight and help. We talked about opportunities in our document regarding retired physicians because, of course, sort of going [inaudible] into the ICU is not the only way. You can talk about volunteering to do telephone triage or volunteering for a telephone consultation.

We know certainly on the—our younger colleagues have done a lot of things like volunteering for putting childcare services together. So, there are a lot of opportunities for colleagues that don't require direct care and certainly direct work in the intensive care unit. So, certainly, appreciate you wanting to serve. I think the best way you're in New York, if I heard you correctly, would be to consult the officials in New York, and they can provide you with more specifics about opportunities to help. And so, I'll leave it there and I open it up to see if any of my other colleagues have any additional comments. Okay.

DeJong: Dr. Harris, let's do final remarks.
Dr. Harris: [Edited for clarity]

Thank you for joining us and for all of your thoughtful questions and for being the heroes that our country needs in this moment. I encourage everyone to check out all of the COVID-19 resources we have for you for free on the AMA website and the *JAMA* website. I hope that you continue to engage with us any constructive criticism as well that you have. We are here to support you, to push down walls when you need it, frustrations and no [inaudible] today.