THE ECONOMIC CLUB
OF WASHINGTON, D.C.

Interview with Dr. Jack DeGioia; Richard Pollack and Dr. David Skorton; and Gail McGovern

John J. DeGioia, Ph.D.
President, Georgetown University

Richard J. Pollack
President and CEO, American Hospital Association

David J. Skorton, M.D.
President and CEO, Association of American Medical Colleges

Gail J. McGovern
President and CEO, American Red Cross

Moderator:
David M. Rubenstein,
President, The Economic Club of Washington, D.C.

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Friday, May 1, 2020

ANNOUNCER: Please welcome David Rubenstein, president of The Economic Club of Washington, D.C.

DAVID M. RUBENSTEIN: Good morning. I'm David Rubenstein, president of The Economic Club of Washington. And I want to thank you for joining us at our ninth virtual event since the corona crisis began. Today we have four presidents that we're going to talk to, presidents of different organizations who are living in the Washington area. And I wanted to let you know who they are. First will be Jack DeGioia, who is the president of Georgetown University. Second will be Richard Pollack, who is president and CEO of the American Hospital Association. Third will be David Skorton, who is the president and CEO of the Association of American Medical Colleges. And fourth, Gail McGovern, who's the president and CEO of the American Red Cross.

We'll spend about an hour with them today, and we'll start in a moment. I just want to give you a couple other announcements before I start with them. First, our next program on Friday, May the 8th – and subsequently we'll do all of our programs, we hope, on Fridays – will be with Mark Warner, the senior senator from Virginia, and with José Andrés, the founder of World Central Kitchen, and Schroeder Stribling, who is the CEO of N Street Village.

We also are pleased today to have many people watching not only who are members of the club, but also member of The Economic Club of Chicago and New York, and members of the diplomatic corps as well. Once again, I'd like to acknowledge and thank the frontline health care professionals who have been very courageous in all the work they're doing in helping all of us make certain that we get the health care treatment that we need. This is going to be broadcast later today, and throughout the weeks, on our website, EconomicClub.org. So, anybody can go to EconomicClub.org as soon as this event is over and watch the whole, or any part, of this interview, if you'd like.

So, with that introduction, let me start with Jack DeGioia. Jack, can you hear me?

JOHN J. DEGIOIA: I hear you. I hear you just fine, David.

MR. RUBENSTEIN: OK. All right. So, Jack DeGioia is the president of Georgetown University. And he's been in this position for 19 years. A very long time for a university president. Obviously, he's doing a very good job. Jack is a graduate of Georgetown University. Got his undergraduate degree there, and his Ph.D. there as well. And he is the first person in the history of the university to be president – [inaudible-]. Jack, you are coming to us from your home today, is that right?

MR. DEGIOIA: I am, David. You're breaking up a little bit.

MR. RUBENSTEIN: OK, can you hear me?

MR. DEGIOIA: Hear you now perfectly, but yes.

MR. RUBENSTEIN: OK. You're coming to us from your home?

MR. DEGIOIA: I am. I am. Not far from campus.

MR. RUBENSTEIN: OK. So, you made a decision a few weeks ago, I guess, to have all your students go home. Was it hard to get them to all leave the campus?

MR. DEGIOIA: You know, it was challenging. You know, we had been tracking the coronavirus since min-January with daily meetings for almost two full months. And we had to make some decisions early in the process to bring students home from China, and then from Italy. Our students were on spring break, and it became very clear that the way in which the trajectory of the virus was moving, we were going to have to move into a virtual learning environment. It was difficult. I think it became more real for students when they saw us have to stop our men's basketball tournament in Madison Square Garden on the second day, and then the cancellation of the men and women's basketball championships, March Madness.

I think that brought it home in a way that was harder – I think it had been a bit of an abstraction, I think, for young people. And so, we made the decision, and then we kind of asked everybody to come to find the best way to move out. We gave some folks time. We handled it in a very appropriate way, over the course of a few – of a few weekends. And we're – at this point, we have about 180 students who really – when we started, we had 5,000 undergraduates living on campus. About 280 living in our law center residence hall. And in both contexts, we've been able to reduce the numbers considerably.

MR. RUBENSTEIN: So, you sent them home. And you said, you're going to learn online. And how has that worked out? Are student happier or sadder with that process?

MR. DEGIOIA: Oh, you know, I don't think we can diminish the real heartbreak of having to break up a university community, all here on our campuses, to break that up in the middle of a semester. And then to have to go home, and to engage in what we call our virtual learning environment. It was difficult. And we don't have any illusion about that. We made the decision and announced it on Wednesday March 11th. And by March 16th, we were putting 3,000 courses, classes, online in that first week. And it was – it was challenging.

MR. RUBENSTEIN: Now, do all students who go home, do they have internet access in their houses? And how do we deal with those who don't have internet access?

MR. DEGIOIA: Well, what we did was – we've worked with all of our community to ensure that they had appropriate capacity to be able to do our virtual learning. For those who did not have direct internet access, we provided hot spots to anyone who needed them. So, we were able to get everybody in a position that they could – they could participate.

MR. RUBENSTEIN: So, the biggest complaints from this process have come from students, faculty, administrators, or parents who have their children home again?

MR. DEGIOIA: [Laughs.] Oh, I think the difficulties have been shared widely by everyone. I think for our faculty, you know, while some have found that students engage just a little bit –

some students engage a little bit differently in the virtual learning environment. And they've been able to see some things that they weren't seeing in the regular classroom. I mean, no one would deny for a moment that they miss that sort of day-to-day immediate interaction. I think for our students, it's the full immersion into a campus community, with all the dimensions – ranging from the classroom, to intercollegiate athletics, to recreation, to student clubs and activities. We've been trying to sustain some of that virtually, but it's a challenge. And I think, you know, it's not a natural act in the middle of a semester for students to go home, and to be home for the rest of the term.

MR. RUBENSTEIN: Well, speaking of that, you have a son who's home with you, from college. How has that experience been working out?

MR. DEGIOIA: It's been terrific for us. He's great company. He's been a great sport. That being said, I have a front-row seat to watching him do online learning, the virtual learning. And it's different. He's finished his courses. He's in his exams now. But I think he's hopeful, like all of us are hopeful, that we'll be able to back on campus as soon as possible.

MR. RUBENSTEIN: Well, that's the big question all university presidents and all students are looking toward: When will you be able to open campus again? And what are you working towards in the fall of this year?

MR. DEGIOIA: Yeah. So right now, you know, there are three factors that have guided us throughout this process. The first is ensuring the health and safety of our community. The second is academic continuity. And the third has been trying to protect the livelihoods of our workforce for as long as we possibly can. In each of those contexts we're engaging with a range of questions right now that will determine how and when we can reopen on our campuses. The most fundamental question we wrestle with is can we – can we honor our public health responsibilities? Our families, our students, all of our workforce, or faculty look to us to ensure that we can provide for their health and safety. There'll be public authorities that will be looking to us to be able to guarantee that. We're trying to determine now what will that entail and will we able to meet those responsibilities.

MR. RUBENSTEIN: So, is there a difference between graduate students and undergraduates? The graduate student experience, you tend to have older people, they live in maybe apartments. Undergrads live in dorms, crowded together. Is there a difference you might do between the two of those type of students?

MR. DEGIOIA: We're exploring, you know, a range of options. The fundamental difference between undergraduate and grad is our undergraduate program is almost fully residential. About 90 percent of our students live in our residence halls. The density that characterizes undergraduate residential education does not lend itself to the kind of social distancing that we were required to honor back in March and to sustain to the present day. Graduate students, our law students, our medical students, I think have different dynamics that we're wrestling with.

What we're doing right now in terms of the learning environment is trying to imagine a range of modalities and timeframes in which we might offer those modalities. And it really is on

this continuum between being fully residential, fully on campus, with everybody back, or fully virtual. And then what are the – what the kind of options we can create between those two? And then how might we manage the timeframe of – we're a two-semester university. Maybe we have to suspend the normal 14-week framework of a semester and think about it a little bit differently, where we might be able to do some virtual, some on campus, and many iterations of this.

MR. RUBENSTEIN: So, let me ask you about the financial situation. Obviously, you have to run a university. You got a physical plan. You got employees that you presumably still have on your payroll. How are you going to cover the costs of dealing with online, if you have to do that, or not bringing all the students back, not getting the tuition from them. What are you going to do?

MR. DEGIOIA: Yeah, that's a big question we're wrestling with right now. The immediate impacts, beginning in mid-March to the present day, cost us about $25 million to be able to, you know, return some of the costs that people had already paid for their room and board. They weren't going to be able to be on campus, so we gave back those fees. We had to help students – a number of students get home. We had to put things in storage. We had to manage a whole range of issues that cost us in unanticipated costs in our community about $25 million. As we try to get to the end of our fiscal year, we're looking at probably a negative – a negative performance in the range of $30-40 million for this fiscal year.

It will depend, David, on what modality we use and how we – how we structure the fall semester and, if we need to, you know, our winter and spring experiences. We don't yet know what form we're going to be in, so we can't yet predict what the economic impact will be. We know, however, that we will be challenged in a way that we've never been challenged before.

MR. RUBENSTEIN: Well, the federal government in the CARES Act did provide some money for some colleges. Some of them have decided not to take it. Have you gotten any money from the federal government and do you intend to keep that?

MR. DEGIOIA: Yes. We were given $6 million from the federal government through the CARES Act. We intend to keep it. You know, half of that money would go directly to our students with financial need and the other half comes to the university to help us address some of the – some of the cost impact. So, we're going to work with every possible option we can to meet our financial obligations as we go forward. You know, so far, we've been able to, you know, maintain our full workforce. We haven't had to conduct any layoffs. We haven't had a furlough. All of our – all of our activities in terms of delivering our academic mission have been sustained. So, so far, we've been able to hold it together. But now we're looking at what the challenges of the fall will look like depending on the modality that we use.

MR. RUBENSTEIN: Well, some universities have laid off people who work in cafeterias, or restaurants, or who work in dorm-related projects. You have not had to furlough those people yet?

MR. DEGIOIA: Not yet.

MR. RUBENSTEIN: OK. And let me ask you about athletics. You were on the NCAA board. So, you cancelled March Madness.

MR. DEGIOIA: Yes.

MR. RUBENSTEIN: That cost a lot of money.

MR. DEGIOIA: Yes.

MR. RUBENSTEIN: So how are universities now going to pay for their athletic programs, because March Madness paid for a large part of the entire athletic program of many colleges?

MR. DEGIOIA: Well, certainly, you know, there are two fundamental sources for most athletic departments. Football revenue, for the big football-playing schools, and then the share, 80 percent of March Madness, roughly the billion dollars that is earned through March Madness, 80 percent of that gets shared among a couple hundred NCAA institutions. It's an important piece, but it's not determinative for a place like Georgetown, for example. It's important, but it isn't the difference-maker in terms of sustaining our program.

MR. RUBENSTEIN: But leaving even the finances aside, can you really have – even if you have students come back online or even some on campus, can you really have kind of athletic programs, where a lot of time there's physical contact, and so forth?

MR. DEGIOIA: This is – this is the fundamental question. We had NCAA board meetings this week. And this is a question we know will confront us as we move into the next – in the next couple of months. When you think back on the decision in mid-March to cancel the men and women's basketball tournament, there was another decision that we made at that time, which was to suspend spring championships. It's important to remember, the NCAA really only manages championships. So, conference play is a decision made by conferences. The championships is a NCAA decision. And the decision we made it was a two-part decision over the course of about 24 hours.

The first was to go without spectators in the March tournament. The second was to suspend the whole tournament, and to suspend spring championships. And if you remember what was going on at the time, the first decision really about spectators came when San Francisco and Washington, D.C. said you couldn't bring more than 1,000 people together. Well, that meant we couldn't have spectators. But when the young man in Utah who played for the Utah Jazz testing positive for coronavirus, and the NBA made the decisions we could no longer have the kind of contact – I mean, there's no social distancing in our sports. How do you manage your public health responsibilities under those circumstances? That will be what will drive our decision for fall.

MR. RUBENSTEIN: So, you've been an advisor to the Vatican on some things. And is the pope calling you for advice on this matter?

MR. DEGIOIA: The holy father Pope Francis put in place a special commission just a few weeks ago on COVID-19, bringing together all the resources of the Vatican and of the Roman Catholic Church. That commission is operative. And we were asked to help support that commission. We have a couple of members who are working on committees that are a part of that commission. We have a number of members of our faculty who are supporting the work of those committees.

MR. RUBENSTEIN: What does cura personalis mean to you, and why is that relevant in the way you're operating the university?

MR. DEGIOIA: Oh, thank you. Cura personalis, the Latin term, comes out of the Jesuit tradition. Georgetown is our nation's oldest Catholic and Jesuit university. And cura personalis is a term that is translated, care for the person. It's a commitment we have to provide deep care for each person that we come into contact with. Particularly relevant in this moment, the motto for our medical school and our medical center, is guided by this commitment to cura personalis. And so, in this moment, when we try to assess what are our public health responsibilities, sort of the guiding principle for us is to ensure we can provide that deep care for each individual.

MR. RUBENSTEIN: So, as I mentioned at the beginning, you've been the president for 19 years. Is this the biggest single challenge you've had in your 19 years?

MR. DEGIOIA: Yes. You know, I was in this job on 9/11. I was in this job during the financial crisis in 2007-2008. But nothing has brought together the convergence of as many elements as this one. We have this public health challenge. We have this need to ensure we're contributing to the public good of public health. We have to ensure our academic continuity at a time when this move to virtual has shown where we have exceptional strengths, but also some weaknesses in our ability to deliver our academic mission in this environment.

But most importantly, you know, we are, David, the largest non-public sector employer in Washington. If you take all of the universities in Washington, we probably have, you know, 60,000 students or more, in a population base of 600,000. You know, we recognize that per capita we have more college students per population here in the District than any city in the nation. The presidents of the universities like to refer to ourselves as America's college town. We're inextricably linked to the recovery of this city. And so, our ability to protect livelihoods is a dimension to this that is critical.

MR. RUBENSTEIN: So, is there anything the federal government can do to help you, at this point? I guess, other than give you money. Are you seeing any help from the federal government, or you're basically on your own with your trustees and your students?

MR. DEGIOIA: Well, where we're going to have the most significant challenge – I've described meeting our public health responsibilities. Concretely, what will that mean? Well, generally the framework that is being used in this discussion right now is, you know, test, trace and isolate. What kind of testing regime will we need to have in place when we bring people back to our campus? Will we be able to test? Will we be able to test in a timely way? We're going to have to test asymptomatically if we bring people back because the timeframe from

when somebody might be carrying the disease to when it might manifest itself in an individual will not be helpful for us. We're going to need to test more broadly than anybody could imagine testing right now.

Will we have access to those kinds of tests? Will we be able to do it in a routine way? And what does contact tracing mean in a community as dense as a residential university community? We're going to need to wrestle with that piece. And then we'll have – I imagine we'll be able to manage the isolation but depending on how big the numbers could get. Managing public health responsibilities will be on each of us, but it requires all of us. And we do need some federal support and federal guidance as we get into that.

MR. RUBENSTEIN: Now, can you see a situation where some students might come back, maybe graduate students, professional students, and undergraduates might come back later? Can you see a bifurcation that way?

MR. DEGIOIA: Yes. That's what I meant earlier when I was referring to modalities and timeframes. Yeah, you could imagine that – you know, some students may not want to come back at all, because they might have an underlying health condition that they don't want to be, you know, exposed to the risk here. So, will we be able to do our classrooms in a way that would be able to honor those who want to be away, and those who want to be in the classroom? And then can we manage the classroom in way that, you know, honors our public health responsibilities?

MR. RUBENSTEIN: When your drop-dead date for making a decision on all of this?

MR. DEGIOIA: You know, right now we don't have one. We want to be respectful to our students, and their families, and our faculty to ensure they have a sense of what we need to be prepared for this fall. I hope in the course of this conversation you've seen some of the factors that we'll be considering. I don't know that we have a definitive date that – well, we don't have a definitive date yet on what we'll do this fall.

MR. RUBENSTEIN: And what is your view on the concern of some students that if you're going to be online that you shouldn't charge the same tuition as you charge if they're in on campus? There have been some protests and at schools about the fact that tuition should be lower. Now, obviously you're suffering financially. So how do you deal with that issue?

MR. DEGIOIA: Again, I think it's going to depend on how we ultimately move forward. What kind of modality? What kind of framework? How will we be structuring this? I could imagine that some of the possibilities we're looking at would be exceptional learning opportunities in ways that perhaps we would not have imagined if we weren't under this kind of pressure. So, I think the issue of cost and price will factor into our decisions as we go forward, but I think right now we're just trying to imagine the range of possibilities that we have to be prepared for.

MR. RUBENSTEIN: So, as you look forward at Georgetown's situation, do you think the biggest challenge you will have is actually making a decision to come back or not come back, and then dealing with it financially? Is that the biggest challenge?

MR. DEGIOIA: I think the biggest challenge we'll face, first and foremost, is can we meet our public health responsibilities? Because if we can't do that, then we have to look at the range of options in a very different way. If we can meet our public health responsibilities, then it is a question of how soon can we bring people back, in what form, how will we need to space them, how will we be able to manage the multiple dimensions of a university community.

MR. RUBENSTEIN: Now, Georgetown's a very popular university, and you have thousands of applications. I think this year you accepted about 16 percent of your applications. But I'm told that some universities are afraid that there will be a lot of melt from those people you've accepted, who either they can't afford to come now, or maybe their family – they have to help their family more. What do you think is going to happen with those you've actually accepted?

MR. DEGIOIA: Can't be sure yet. Today is the deadline for students to commit to coming to Georgetown. We were tracking very strongly to previous years. So, we're hopeful that we will have a full class. And then I think we've got to evaluate as we move forward, and we make the final choice as to how we will handle the fall. My sense is, David, we won't know how we'll be able to handle the whole year when we make the decision about the fall. So for example, if we made a decision to go forward in the fall, you've heard some of our leading public health experts – Dr. Redfield, Dr. Fauci – indicate that it's not unusual that a – that a virus would have a second surge. We have to be prepared for that possibility. So, we may have – I think it's – without question, we're going to have a more challenging and disruptive year. But I don't know that the decision for the fall indicates exactly what we might do winter and spring.

MR. RUBENSTEIN: So, if I was a senior at Georgetown this year, I was going to have a big graduation event. Now I'm not going to have that. What are you going to do for me?

MR. DEGIOIA: So, we – I announced almost immediately after the decision to go online, because that was, I think, probably question number one among our community. And what I announced immediately was we would not cancel commencement. We would postpone it until a time when we can bring everybody together in a safe environment. We will do some virtual events in two weeks, which would have been our normal graduation weekend. We'll do some virtual events. I will confer the degrees. But we will have a formal commencement later in – later in the year.

MR. RUBENSTEIN: And how are you and your family, you know, social distancing and keeping care of your own health? What are you doing?

MR. DEGIOIA: Well, we're all here in the house. And, you know, we're not leaving the house, for all intents and purposes. We're really here. I go to campus one evening a week, on Sunday evenings. We've been broadcasting livestream Roman Catholic mass from our chapel. And I've participated in those services. But otherwise, we're all right here. And we're just – we're with each other. And we're taking care of one another. And it's been an opportunity for us to be able to spend this time together.

MR. RUBENSTEIN: So, do you have a theory that God is looking more favorably upon your university, because of your connection to the church, than other universities? Is that true or not? I've heard that rumor.

MR. DEGIOIA: [Laughs.] No, that's not an article of our faith. We're all in this together.

MR. RUBENSTEIN: I see. Well, Jack, I want to thank you for coming on this morning and letting us know what Georgetown is going to do. And good luck with these decisions. They're not easy to make, I know.

MR. DEGIOIA: Thanks very much, David. It's an honor to be with you today.

MR. RUBENSTEIN: Thank you.

We're now going to have two individuals who are really experts on health, among other things. One of them is Rick Pollack, who is the president and CEO of the American Hospital Association.

Rick, can you hear me?

RICHARD J. POLLACK: Yes, I can.

MR. RUBENSTEIN: OK. Rick is a graduate of New York State University, but also – State University of New York – and also has a master's degree from American University. He's been at the American Hospital Association for 38 years, as CEO for the last five years.

And we have David Skorton, who I've worked with before at the Smithsonian. David was previously the president of Cornell, also the president of University of Iowa. He is a cardiologist by training, graduate of Northwestern and Northwestern Medical School. And he is now, as I mentioned earlier, heading up the American college of hospitals. And – well, Medical hospitals, I should say. The correct title is – let's see – David, I should have – Association of American Medical Colleges is the correct title. And the David is the CEO of that. And both of you can hear me, is that correct? And you can see me? OK.

So, Rick, can I ask you first, the American hospitals, you have about 5,000 are in your association, is that right?

MR. POLLACK: Right.

MR. RUBENSTEIN: OK. Are all of them financially stressed right now because they can't do the elective surgery that seems to be more profitable than the kind of things they have to have? Or is that wrong?

MR. POLLACK: No, absolutely. Right now, hospitals are facing what I would call a triple whammy. We've got the increased expenses associated with having geared up to prepare for and care for COVID patients. So, a lot of increased expenses. To your point, very little revenue

coming in in terms of regular operations. And by the way, when we say elective surgery, it's really scheduled procedures because elective sometimes sounds like it's only cosmetics. There are a lot of scheduled procedures that are lifesaving. And they have virtually stopped. So, there's no revenue coming in. And the third part of the triple whammy is covering the uninsured. Because as we see the economic situation developing in the way we do, we have an obligation to take care of the uninsured. And the expenses from that side is going to increase as well. So, we're really stressed. In fact, we're probably facing the biggest financial crisis in our history.

MR. RUBENSTEIN: The federal government has allocated a large amount of money to hospitals. I assume the hospitals have gotten that money by now, and maybe there's more coming. That hasn't solved the problem?

MR. POLLACK: No. The CARES legislation, the first three segments of it, did in fact commit $175 billion to an emergency fund for providers. It's not just hospitals. It's all providers. Of the $175, $50 billion has been allocated. Hospitals have gotten less than half of that amount thus far. It may sound like a lot of money, but we have a tremendous need out there given the fact that we're facing a pandemic of – that's unprecedented in this country. So, you know, there will undoubtably need to be more as we go through this whole process of relief, recovery, and rebuild.

MR. RUBENSTEIN: Do you think hospitals in the United States, many or some of them will have to declare bankruptcy because of this?

MR. POLLACK: You know, even before COVID, one-third of the hospitals in the country were on a negative margin in terms of operating margins. So, this is going to get much more – much more acute. There's no question that hospitals' viability is going to be threatened. And we will see closures as a result of this unless we're able to get the kinds of assistance that's necessary.

MR. RUBENSTEIN: David, can you hear me?

DAVID J. SKORTON, M.D.: I sure can, thank you.

MR. RUBENSTEIN: OK. Now, your association, the association deals with medical colleges as well as medical teaching hospitals. Are medical schools still going to be operating in the fall? And are they operating now? Can you really teach doctors to be doctors now?

DR. SKORTON: We sure can. I want to just let everybody know what the Association of American Medical Colleges does. We represent all of the accredited medical schools in the U.S. and in Canada, and the 400 major teaching hospitals in the country are members of our institution. And I want to take just a moment to tell you that it's great to be on here with Rick Pollack. When the chapter is written about this pandemic, I think we'll say that the American Hospital Association was part of the reason that we came out as well as we did. So, I do want to have kudos to Rick, even though he has a nice backdrop that says AHA and I just have my clothes folded up.

MR. RUBENSTEIN: Yeah. Richard, where's your backdrop? Can't you afford a backdrop?

DR. SKORTON: David, I'm trying to answer the question, please. So, it is true that just like Dr. DeGioia was discussing in terms of undergraduate and graduate and professional education at research universities, the great medical schools in our country are having to revamp how they do things. And we've been issuing some guidance through the offices of our chief medical education officer, Dr. Alison Whelan, in which of course we acknowledge that the local situation may be different from place to place in terms of the burden of coronavirus, how much personal protective equipment or PPE is available, and so on. But in general, we have issued guidelines suggesting that when possible students should be separated from exposure to patients with COVID, partly for their own health and partly not to have competition for the PPE.

So, the schools have on their own locally, they get all the credit for this, they have developed tremendous innovations in being able to continue the education that we're counting on for future doctors. Some of it online, some of it dealing with patients through so-called telehealth – you know, using technology. And the instructors and the deans of those schools of medicine are really doing an amazing job. So, yes, we are doing our best. It's not perfect. It's not like it would have been otherwise. But we're doing a very creditable job, not thanks the AAMC but thanks to the member institutions who are doing these innovations.

MR. RUBENSTEIN: Well, you're a medical doctor, as I mentioned earlier. And I'm just curious, do you have any insights on when you think we might get vaccines or might get more tests available for people to be able to determine whether they have the virus?

DR. SKORTON: Well, the troubling thing for this particular pandemic which you're referring to indirectly is that what we've had up to the minute has been largely been what the doctors call supportive care. So, you ask someone to rest. You ask them, of course, to self-quarantine. If they don't have – if they don't have sufficient lung function you give them oxygen. If things go really in a bad way, you put them on a ventilator. These are all supportive things. They don't directly destroy the virus. They don't prevent the virus from coming in.

So, testing is enormous. And like Dr. DeGioia was saying, tracing is very, very important as well. But there is hope across the horizon on both vaccines and antiviral therapy. And we've had some pretty good news in the last few days. And on the vaccine front, David, there's really a lot of – a lot of irons in the fire, a lot of things going on. Perhaps our listeners and those who are participating today have heard about the trials from Oxford University in the U.K., and things coming out of Pfizer and other companies. So, there's a lot of work going on. I believe we will see vaccines hopefully within a year, maybe a bit less than that, hopefully. And also, some approach to antiviral therapy.

MR. RUBENSTEIN: Antiviral therapy, explain what that is.

DR. SKORTON: Sure. So, if you have a bacterial infection – you know, pneumonia, let's say, from a bacterium, you use antibiotics. And they will suppress the growth of it. And then the body's immune system, along with the antibiotic, will help you get past that insult. Antiviral therapies have been developed in the past for different viruses. As you know, effective antiviral

therapy has changed HIV/AIDS, for example, from something that had just a horrendous prognosis at the beginning to more of a chronic disease in many, many, many cases. And so, we're looking forward to having that kind of antiviral therapy against the coronavirus.

One that we've all heard about in the last just couple of days is remdesivir, which has been shown to be suggestively helpful in a relatively small group of patients, but bigger than some earlier studies, to shorten the course of the infection and, perhaps, to make it a bit less lethal. There will also be other approaches that could be based on the use of monoclonal antibodies. So, these are therapies that would either interrupt the ability of the virus to cling to our cells and cause infection, or to actually do things to stop the virus from reproducing.

MR. RUBENSTEIN: Rick, can you explain for people watching, if you go to a not-for-profit hospital or a for-profit hospital is there any difference in the way you get treated with respect to this type of virus we now have?

MR. POLLACK: No. There's no difference. And, by the way, thank you, Dr. Skorton, for your kind comments. It's been a privilege to partner with you and our academic medical centers as we have tried to fight this battle.

So, to your question, you know, roughly 60 percent of the hospitals in this country are private nonprofit. Twenty percent are investor owned. And the remainder are government owned, public hospitals, if you will. The only difference that I detect in what has occurred throughout this whole situation is a little bit of a difference between those hospitals that are part of larger systems as opposed to freestanding, independent hospitals. Some of the systems have had more resources to draw on and move around within their system than those that are on their own. And that is the biggest distinction. Less ownership than how they're organized.

MR. RUBENSTEIN: Now, if I don't feel well and I go to a hospital today in the United States can I get a test that tells me whether I have the virus or not? Or is it not that easy to get?

MR. POLLACK: It's not that easy to get. And it's very, very uneven. And certainly, priorities are for those that are symptomatic, for our frontline health-care workers and for first responders. But it's been a very uneven situation. And you know, it's not just the machines, of course. It's the swabs, the reagents, and all of the supplies that go with it.

MR. RUBENSTEIN: Speaking about that, have you been surprised at how dependent our medical supply system is on supplies coming from China? Did you realize that in advance, or – and do you think anything will change as a result of this?

MR. POLLACK: You know, there are a lot of things that are going to change as a result of this. And we're learning a lot of things. And one of them is the diversification of the supply chain. And you know, there have been books that were written, that I was advised to read – that unfortunately I didn't – about eight months ago with regard to how not only for supplies but also for the ingredients for pharmaceuticals that we are way overdependent on China and certain countries. And we have to diversify. The other lesson we're certainly learning is the utility of telehealth. And that will certainly change.

MR. RUBENSTEIN: But are you spending time dealing with members of Congress now, and saying: We need a lot more financial aid out of the new legislation? Do you expect you'll get more aid out of Congress?

MR. POLLACK: We hope so. We think that it's not just the assistance in terms of dollars, but it's the assistance in terms of policy changes. And I also have to say that CMS[1] has been very responsive in providing us with regulatory flexibility that has enabled us to cut through red tape and respond in a quick and decisive manner to certain things relative to this pandemic.

MR. RUBENSTEIN: Suppose I was scheduled for elective surgery. My hospital now calls me and says: OK. You can come in now. We're doing elective surgery. Should I be worried that I'm going to get the virus because it might still be hanging around the hospital somewhere?

MR. POLLACK: You know, no. No need to be worried, because we're taking all the precautions that are necessary to transition back to doing those non-emergent procedures. There are guidelines that were issued by the American College of Surgeons, as well as the American Association of Operating Room Nurses, the American College of Anesthesiology, the government has also looked at these guidelines. And we're going to make it as safe as possible. We won't start up those procedures until certain guidelines and markers have been met. Once they are met, we're taking also sorts of precautions in terms of universal masking in the facilities, screening everyone that walks into our building, separating out COVID and non-COVID areas of the building. So, we will take all those steps to make sure that we're ready to care for anyone that walks through the doors.

MR. RUBENSTEIN: OK. David, there was a report in New York the other day of an emergency room physician, a woman, who committed suicide, in part because, I guess, the stress of dealing with this crisis was just overwhelming. Have you heard of a lot of other similar stories? And are you worried about health care providers not either getting adequate equipment, or not feeling that they have the emotional strength to be able to deal with this problem?

DR. SKORTON: Yes, to all the above. And as in the case of some of the factors that Rick was talking about, concerns about clinician wellbeing started long, long before the pandemic. Medicine can be a very, very challenging profession. And there's been work – good work done by the National Academy of Medicine and others along with the AAMC on this issue. Then fast-forward to the pandemic, and I think there's at least two factors that have made this especially stressful for physicians and other health workers on the frontlines.

One has been the fact that they themselves are at risk of getting sick, bringing it home to their families. And so, there's that tremendous fear, again, as I mentioned earlier, because there is not right now an improved antiviral therapy that can be used. And so many of the cases of people getting sick and dying are actually health-care workers. So that's part of it. That's one thing. And the second thing, there's the enormous stress of seeing so many people get sick and die. And doctors are used to having the tools available. There's a lock, you know, which is a certain disorder, a certain problem. And then we have the key to turn that lock and open the door

[1] Centers for Medicare & Medicaid Services a part of the U.S. Department of Health and Human Services

to better health care. And so far in this particular pandemic, it's been a very tough situation. So, doctors are upset because they can't do better for their patients. And they're under enormous, enormous strain.

In addition to all those things there's the financial strain that Rick talked about so eloquently. And some of our member institutions, I'm sure this is true across the board for Rick's larger number of hospitals, are losing millions of dollars per day – per day! And so, the stresses of whether the institution itself will keep afloat and whether things will go forward, coupled with their fears for themselves and their families, coupled with the inability to do what they wish they could do for their patients. This has been very tough. And the suicide of that wonderful physician in New York was a wake-up call.

And I want to mention in that regard that all of us through this pandemic, those of us at home, those in The Economic Club who are leading organizations, those of course on the frontline of the pandemic, we have to find a way to take care of ourselves, to ask for help, including psychological or psychiatric help when we need it. It would be a sign of great strength to ask for help rather than get to the point of no return.

MR. RUBENSTEIN: So, some people say that the statistics about the death that's occurring because of the virus are not accurate. Some say the numbers are higher, but we're not accurately reporting them. And some say they're lower because people are dying and they're attributing it to the virus. Do you have any insights on whether these numbers are accurate?

DR. SKORTON: This is a really good question, David. And it's hard because the data are not all in. You know, we call this thing the novel coronavirus. It's something new and different. One of the things different about it is it appears to be quite a bit more lethal, maybe an order of magnitude or more, more lethal, for example, than influenza. And the second is this peculiar if not unique, quite unusual circumstance that asymptomatic people can be spreading the virus. In fact, they may be asymptomatic throughout their course.

So as just the testing, for the reasons that Rick mentioned, have not been where they need to be. And, by the way, right up to the minute, they're not where they need to be. We don't really have enough data about, if you will, what the denominator is, how many people in the community actually have the disorder. So, I have to skirt that question a little bit. I can't actually tell you the answer to that.

MR. RUBENSTEIN: OK. Your organization is also responsible for the MCATs, which is what you have to take in order to go to medical school. So, you've postponed them. Suppose I want to go to medical school, when am I going to be able to take my exam? And am I going to do it in person, or how is that going to work?

DR. SKORTON: We're working all those things out now. Stay tuned to the AAMC. We are rescheduling times for the MCAT to be taken. We're making some changes where they are necessary. The country needs more physicians, not just now for the pandemic, but we're projecting – our organization is projecting, David, as many as 100,000 or more shortages of

physicians going forward over the next decade. And I want to take the moment to mention one other thing in terms of workforce.

I'm very concerned about the potential DACA[2] rescission, a decision that's going to be made by the highest court in the land. And we estimate about 30,000 health-care workers in this country are DACA recipients. And it would be a pretty terrible time, in my view, to remove work authorization from those 30,000 health-care workers in the middle of this crisis. And so, I'm hoping that we will do everything we can to keep doctors, international medical graduates, in the country, to retain the work of those health-care workers who are DACA recipients. We need all hands-on deck.

MR. RUBENSTEIN: What about the people that take the MCATs? What percentage of them, who then come to American medical colleges and universities, are foreign students? Is it a high percentage? Ten percent, 20 percent?

DR. SKORTON: No. It's a relatively low percentage, but it depends on the school and it depends on the situation. Whatever the percentage is locally, we need all hands-on deck. And as you know, and you and I have talked about it on earlier occasions, ours is a country largely of immigrants, except for Native Americans. And we really need to continue to have our arms broadly open for all kinds of reasons – social justice reasons and others. But we also need to have our arms open right now because we need the health-care workforce of all types.

MR. RUBENSTEIN: OK. Rick, can I talk to you about nurses? How are nurses faring in this situation? They often bear the brunt of some of the hardest assignments in the hospitals. How is the nurse workforce holding up in this pandemic?

MR. POLLACK: Well, you know, it's – of course, physicians, nurses, respiratory therapists, and the people that clean the rooms and deliver the food – we worry about all of them. If they're not kept healthy and they're not protected, the whole system will collapse. You know, it's been a real struggle. And we know that people have had a tough time. And as Dr. Skorton said, we had issues with resiliency prior to COVID-19 that will only get exacerbated as a result of this. I think that what we have seen is that in the heavily impacted areas, whether it was Seattle, or New York City, or some of the other areas, thanks to the bravery of those health-care workers on the frontlines, they've held the line. And I think we have seen them do heroic work.

MR. RUBENSTEIN: What would you suggest that people watching or people around the country might be hearing of this? What can average people do to help hospitals right now? Should they make financial donations? Should they make volunteer contributions? What should they be doing?

MR. POLLACK: Well, you know, all of the above in many ways. We do have a site called Protect the Heroes that was set up by the Association of Health Philanthropy and the Creative Coalition. And it allows people to make donations to their hospitals of their choice. Major

[2] Deferred Action for Childhood Arrivals is a U.S. immigration policy that allows some individuals who were brought to the country as children to receive a renewable two-year period of deferred action from deportation and become eligible for a work permit.

League Baseball Players Association came out and endorsed it just yesterday. And that's a way to channel funds that will be used for personal protective equipment for our heroes on the frontlines.

MR. RUBENSTEIN: Now, when you're the head of the American Hospital Association, you have 5,000 hospitals you can pick from, if you ever have to go to the hospital, what hospital do you pick? Then will the others get upset?

MR. POLLACK: Well, you know, I love all my members. And we're blessed in this area that I live in as well as having great organizations. You know, generally, let's face it, most people make that choice based upon what their physician recommends. And I rely on my local community hospital here in North Arlington as a personal matter for a lot of things. But we have great organizations in this area.

MR. RUBENSTEIN: OK. Let me ask David a final question in this section. David, what can people do to support your organization? Are there volunteer or financial contributions that you are seeking, or you think would be helpful?

DR. SKORTON: We're not so much personally looking for that, but I think that supporting hospitals, as has been mentioned. And I want to talk just for a moment about something a little bit tangential, but I think is very important. Vulnerable populations throughout our country suffered from health inequities decades, generations before the pandemic. They're really, really, really suffering now. And so I would hope that people listening to this, members of The Economic Club, and really everyone will do what they can to help feed their neighbors, to help make sure that people are getting some sort of help right now.

And, you know, one of the very difficult parts of the situation in our country in the way health care is financed is that a lot of it, although there's a lot of government input of course, but a lot of it is based on employer contributions to health insurance. And with the millions and millions and millions of people out of work, those who had health benefits are now largely without it. And both the American Hospital Association and the Association of American Medical Colleges are working with the federal government to try to have some rational way to have coverage for these people.

But I would hope that people would think about their own community, their own neighbors. And right in our fair city of Washington there's a lot of people suffering disproportionately because of health equities. And helping them to eat, and any kind of help that we can give in that way I think would be the number-one priority, for my mind.

MR. RUBENSTEIN: David and Rick, thank you very much for your time and your participation, and your kind words.

MR. POLLACK: Thank you.

MR. RUBENSTEIN: I'd now like to go to Gail McGovern. Gail, can you hear me?

GAIL J. MCGOVERN: Can you hear me?

MR. RUBENSTEIN: OK. Gail is, as I mentioned earlier, the president of the American Red Cross, a position she's held for 12 years. She is a graduate of Johns Hopkins and Columbia Business School. She has taught at Harvard Business School. She's been a senior officer at Fidelity, senior officer at AT&T. And I've come to know her over the years through my daughter's interest in the Red Cross, as well as my own interest. So, Gail, thank you very much for appearing today.

MS. MCGOVERN: Thank you for having me, David. I really appreciate being interviewed by you.

MR. RUBENSTEIN: So for people who may not be that familiar with the American Red Cross, tell us just briefly, the organization – what's the size, how many employees do you have, where do you get your money from?

MS. MCGOVERN: David, you're clipping in and out, but I think I know what you just asked me. So, the American Red Cross is a nonprofit, one single nonprofit. We have a board of governors who has fiduciary responsibility for the American Red Cross. We have 19,000 employees, and we have 300,000 volunteers. And that's reason we can do what we do. Our mission is to alleviate suffering during emergencies.

And there are four major parts of what we do. First of all, we respond to disasters, which probably all of your viewers know. But what most people don't realize is we respond to about 60,000 disasters every year. These are largely home fires that are caused by cooking accidents. And every eight minutes we are responding to a disaster. We provide about 40 percent of the nation's blood supply to hospitals around the country. We also provide training – first aid, CPR, babysitting, learn to swim, lifeguarding. And finally, we do a lot for the men and women in the armed forces. We handle about 480,000 calls every single year. Remember –

MR. RUBENSTEIN: Your revenue comes from what? Is it contributions you get most of your money from, or is it government sources?

MS. MCGOVERN: So, we do not get government sources, except for some of the work we do for the armed forces. And that's a $24 million contact. It costs us about $30 million to be able to do it. Everything we do is because of the generosity of the American public. So, our budget is between $2.5 and $3 billion every year, depending on how many large natural disasters we have. And those are from financial contributions, and when we collect blood, we charge our hospitals basically what it costs us to collect blood.

MR. RUBENSTEIN: So, in the 12 years you've been the president of the American Red Cross, is this the biggest single challenge you've had?

MS. MCGOVERN: Absolutely. Nothing has come even close. I mean, we had a year in 2017 where we had back-to-back-to-back hurricanes, Harvey, Irma, and Maria. And I thought that was the peak of a crisis. But there's been nothing like this. I mean, this is impacting every

single county in our country. And, you know, we have employees and volunteers in every county dealing with this. And every part of our mission has been turned upside down as a result of it.

MR. RUBENSTEIN: So, you provide, as you said, 40 percent of the blood provided in the United States. For the COVID-19 crisis is blood needed as much as normal? Or more than normal?

MS. MCGOVERN: This is an excellent question, actually, because when the virus began the elected officials were telling people: Do not go outside unless it's for pharmaceuticals or groceries. And we were beginning to face a very severe blood shortage because people weren't coming out to present and donate. And as it turned out, enough people gave us shoutouts and told people, no, it's OK to give blood. And so, w narrowly averted the shortage. But now that the hospitals are dealing primarily with COVID patients, and as you heard earlier all surgeries are being postponed for the most part, we're now seeing a severe drop in demand. So, it's been quite the rollercoaster ride.

MR. RUBENSTEIN: So, if somebody wants to give blood to the Red Cross, where do they go? And do they get paid for it? Or is it just a contribution they give because they're – [inaudible].

MS. MCGOVERN: Believe it or not, every single day about 15,000 people come and donate blood at the American Red Cross. And they are rolling up their sleeves, and just doing this out the goodness of their heart. And when they walk out, they feel great about themselves because they know they just saved somebody's life. So that is done voluntarily. And if they're interested in going, they can go to our website, RedCross.org, and see where they can potentially donate blood.

MR. RUBENSTEIN: Now, certain types of blood cannot be given to other types of recipients, that have different types of blood. Should everybody know their blood type? And is it important that you know your blood type if you're donating blood?

MS. MCGOVERN: So, when you come to donate blood, we will determine your blood type. And we match donors with their blood type, so – and the recipients with the blood type. So, it's not necessary to know it when you come in. When you come out, you will know your blood type. And we're very careful on how we label it to make sure the right kind of blood goes to the right kind of recipient.

MR. RUBENSTEIN: Some people have said over the years that you might get blood that might be infected with the disease, or something. But if you give blood, there's no problem in your getting harmed by giving blood, right? There's no health problem associated with giving blood, is there?

MS. MCGOVERN: Yeah. Giving blood is safe. And that's why so many people do it. And we test – we collect your blood, and then we also save some of it and run all sorts of tests for so many different diseases. You know, hepatitis, HIV/AIDS, Chagas, all kinds, TRALI, every

single disease you can possibly imagine that can be tested through blood serum, we test. And if anything comes back positive, we discard the blood and we don't ship it to the hospitals.

MR. RUBENSTEIN: Have you been surprised at how much we are dependent on medical supplies from other countries in the course of this crisis? Or did you already know that?

MS. MCGOVERN: I think everybody was surprised by what the supply chain looks like. And you know, we don't use heavy medical equipment like hospitals do, but we were scrambling to get masks, to get gloves, to get sanitizer for our phlebotomists that are on the frontline collecting blood every single day. And fortunately, we have enough supply now, but it was really quite a challenge for a while for us to make sure we have what we needed.

MR. RUBENSTEIN: So many people are told to stay at home during this crisis, but I would think the Red Cross people would be saying that they have to come to the office. Or is that not true?

MS. MCGOVERN: So, of our 19,000 employees, we have about 8,000 that are on the frontlines every day, either collecting, and manufacturing, and distributing our blood products. And, you know, we put people in shelters when there are large disasters. And right now, so many tornadoes ripped through the country. And we had at the peak about 1,500 people in hotels because we don't want them in these large congregant shelters. And our volunteers are out there also helping people. And we're doing a lot virtually, David. It's kind of amazing. We're doing mental health counseling, case management, all through virtual means so that we can keep our people safe.

MR. RUBENSTEIN: So, what lessons would you say you have taken away from this crisis so far?

MS. MCGOVERN: Well, the American Red Cross is built to deal with crises. And we certainly – this is what we do. But what I've learned through this is people can really step up when it is required of them. And I am so proud and amazed at how our Red Crosses have been handling this. And as everybody that's dealing with it, you know, people are getting a bit frayed, they're getting stir-crazy. Our folks on the frontline are exhausted from collecting blood. But at the end of the day, I think we all feel that it's an incredible privilege to be part of the American Red Cross right now, because we know we're saving lives every day. And not a lot of people get to say that.

MR. RUBENSTEIN: So, what do you expect to make – what changes might you expect to make in the way the Red Cross operates in the future as a result of this? Or do you expect you don't have to make changes?

MS. MCGOVERN: Well, I think we're learning a lot. First of all, we're learning a lot can be done virtually. And, you know, there's nothing like face-to-face communications for real, but I'm learning that a lot of the travel that we're doing for internal meetings and the like can be done virtually. And, you know, people are very much used to it, and they can handle it. I'm also learning that – you know, I'm kind of a natural optimist. But this is the time where we really

have to model optimism so that, as leaders, people don't lose faith and hope. And I'm also learning that we have to all be very empathetic, because this is difficult times, and people might snap at each other, and we have to forgive ourselves when we do that, and we have to forgive others when we're the recipient of it. So, we're definitely learning a lot.

MR. RUBENSTEIN: I can't see you snapping at anybody. I don't see that. You're doing that, right?

MS. MCGOVERN: No. I'm trying very hard not to do it.

MR. RUBENSTEIN: So how is your family dealing with this? Are you all isolated together somewhere in the Washington area?

MS. MCGOVERN: Well, my husband and I are in the Washington area. I have a daughter and two stepsons. And I miss them all terribly. They're also practicing good social distancing in the cities in which they live. And, you know, like everybody else, it's rough. But every day I am just thankful for the fact that I have a wonderful job, and working with incredible people, and I'm trying not to go stir-crazy.

MR. RUBENSTEIN: So, if you ever go to the hospital, do you tell people: I'm the head the American Red Cross, you better do a good job on me?

MS. MCGOVERN: [Laughs.] No. I wouldn't do that. But I imagine that they do know I'm the head of the American Red Cross, because you have to fill that out on your patient form. I hope they take good care of me. [Laughs.]

MR. RUBENSTEIN: And do you always have to wear red every day if you're the head of the American Red Cross?

MS. MCGOVERN: We don't have to, but I like to. And I like wearing my Red Cross pin too. And I have to tell you, David, that when I'm wearing this pin and I am traveling or I'm out and about, people stop me and tell me a Red Cross story. It's extraordinary. And –

MR. RUBENSTEIN: It's like – I would just say, nobody doesn't like Sara Lee. Nobody doesn't like the American Red Cross, right?

MS. MCGOVERN: Well, that's how I feel. And I also feel like everybody has a Red Cross story. You know, they say one in five people have been directly touched by the American Red Cross. And, you know, it feels to me like everybody has in one way or another.

MR. RUBENSTEIN: As I mentioned, you've been a professor at Harvard Business School. You've been at AT&T. You've been at Fidelity, a wide range of things. How do you compare this job to the others you've had?

MS. MCGOVERN: So, at AT&T I was running a $26 billion P&L, the largest in the organization. And at Fidelity Investments, I had about a half a trillion dollars under asset

management because I was running the personal investments business. And they were hard jobs. But this is by far the hardest job I've ever had. And I quickly hasten to add, it's the best job I ever had. You know, you wake up in the morning, you know you're doing good things, you know you're making a difference. And it affords me the opportunity to be able to not only lead with my head, but also lead with my heart. And even during this crisis, I feel privileged to be a part of it.

MR. RUBENSTEIN: So, let me conclude by asking you, if somebody wants to do something to help the American Red Cross, they can either go donate blood or they can make a financial contribution. Is that what you mostly would like them to do?

MS. MCGOVERN: Yeah. I mean, even pre-COVID-19 we always are seeking three things. As you said, donate blood – and we always need blood. It's a critical need. Make a financial donation. And, David, I have to tell you, I have seen million-dollar gifts come in, I have seen a crumpled-up dollar bill in a letter from a child that said: This is from the tooth fairy, can you use it to help people? Every gift is appreciated. And then the other gift that people can give is the gift of time. Because, as I said, we have 300,000 volunteers. And some of them volunteer for an hour a week. And others are full time with us. And, you know, the gift of time is really special too.

MR. RUBENSTEIN: There was a child who asked a question whether the tooth fairy could come during the virus. And what is your answer to that?

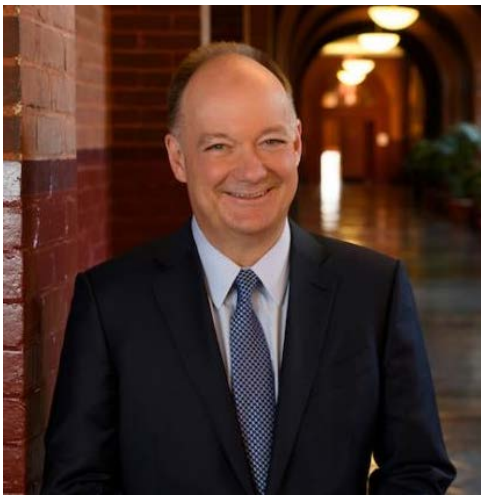
MS. MCGOVERN: The tooth fairy is absolutely immune to this virus. And we're all very grateful for that immunity.

MR. RUBENSTEIN: Thank you very much, Gail. I appreciate all the work you're doing. And thanks for coming this morning.

MS. MCGOVERN: Thank you, David.

MR. RUBENSTEIN: Bye.

So that's our program today. We have another program on next Friday with José Andrés and Senator Mark Warner. I'd like to thank all of our sponsors for supporting us. And, again, this show will be on our website right after the show is completed – EconomicClub.org. Thank you all for joining us today.



John J. DeGioia, Ph.D.
President
Georgetown University

John J. DeGioia is the 48th President of Georgetown University. For nearly four decades, Dr. DeGioia has worked to define and strengthen Georgetown University as a premier institution for education and research.

A graduate of Georgetown, Dr. DeGioia served as a senior administrator and as a faculty member in the Department of Philosophy before becoming president on July 1, 2001. He continues to teach an Ignatius Seminar each fall, which is part of a program offering first year students the opportunity to encounter unique courses of study inspired by the Jesuit educational theme of cura personalis ("care for the whole person").

As President, Dr. DeGioia is dedicated to deepening Georgetown's tradition of academic excellence, its commitment to its Catholic and Jesuit identity, its engagement with the Washington, D.C. community, and its global mission. Under his leadership, Georgetown has become a leader in shaping the future landscape of higher education and has recently completed a $1.5 billion campaign dedicated to enhancing the lifelong value of a Georgetown education.

Dr. DeGioia is deeply engaged in addressing broader issues in education. He is a Past Chair of the Board of Directors of the American Council on Education (ACE), and is Chair of the Board of Directors of the Forum for the Future of Higher Education; he also serves as a member of the Board of Directors of the Carnegie Corporation of New York, and the National Association of Independent Schools. He also serves on the NCAA Board of Governors, the NCAA Division 1 Board of Directors and is Chair of the Division I Committee on Academics, and he previously served as a commissioner on the Knight Commission on Intercollegiate Athletics. He is a member of the World Economic Forum's (WEF) Global University Leaders Forum.

Dr. DeGioia earned a bachelor's degree in English from Georgetown University in 1979 and a Ph.D. in Philosophy from the University in 1995.

Prior to his appointment as president in 2001, Dr. DeGioia held a variety of senior administrative positions at Georgetown, including Senior Vice President and Dean of Student Affairs.

He has been presented with a Lifetime Achievement Award for Excellence in Academia by the Sons of Italy, and the "Catholic in the Public Square Award" by Commonweal (2012). He was honored as a "Brave Thinker" by The Atlantic (2012), and as "Washingtonian of the Year" by Washingtonian magazine (2008).

He has received Honorary Degrees from Miami Dade College (2008); Loyola University, Maryland (2009); Queens University, Belfast (2009); Sacred Heart University (2011); Mount

Aloysius College (2015); and Seattle University (2016). He has also received an honorary fellowship at Glyndŵr University (2010), as well as the "Esteemed Friend" award from Sophia University in Tokyo (2014) and was elected a member of the American Academy of Arts and Sciences (2010).

Dr. DeGioia spent his early years in Orange, Connecticut, and Hanford, California. He and his wife, Theresa Miller DeGioia, a Georgetown alumna, and their son, John Thomas, live in Washington, D.C.

Richard J. Pollack
President and CEO
American Hospital Association

Rick Pollack was elected president and CEO of the American Hospital Association in May 2015.

He began his career in D.C. in 1976, when he went to work as a legislative assistant to Rep. David Obey of Wisconsin. Rick left Capitol Hill and entered the health care field to work for the American Nurses Association as their legislative representative in the 1980s.

He joined the AHA in 1982, where he has been a member of the advocacy team for over three decades. He served as associate director for legislation, and then vice president for federal relations and deputy director of the AHA Washington Office.

In 1991, Rick was named the association's executive vice president and began his successful efforts to create a sophisticated political and grassroots infrastructure, enabling the hospital advocacy agenda to be effectively communicated before the Congress and federal agencies. The AHA has been cited by numerous national publications as one of the most influential and effective advocacy organizations in Washington.

Under his leadership, the AHA launched AHAPAC, now one of the largest health care political action committees in the U.S., supporting congressional candidates who support hospitals and patients. Through his vision, the AHA also helped found in 2000 the Coalition to Protect America's Health Care, a group of providers, businesses and other stakeholders dedicated to ensuring the financial viability of our nation's hospitals from the threats of federal cuts in reimbursement for hospital payments.

Rick also has been a leader in efforts to expand health coverage in the U.S., taking part in many broad-based national coalitions that ultimately led to coverage expansion under the Affordable Care Act.

Rick holds a bachelor's degree in political science and communications from the State University of New York's College at Cortland. He also earned a master's degree in public administration from the American University.

Dr. David Skorton
President and CEO
Association of American Medical Colleges

David J. Skorton, MD, is president and CEO of the AAMC (Association of American Medical Colleges), a not-for-profit institution that represents the nation's medical schools, teaching hospitals, and academic societies.

Dr. Skorton began his leadership of the AAMC in July 2019 after a distinguished career in government, higher education, and medicine.

Most recently, Dr. Skorton served as the 13th secretary of the Smithsonian Institution, where he oversaw 19 museums, 21 libraries, the National Zoo, numerous research centers, and education programs. Prior to that, he served as president of two universities: Cornell University (2006 to 2015) and the University of Iowa (2003 to 2006), where he also served on the faculty for 26 years and specialized in the treatment of adolescents and adults with congenital heart disease. A pioneer of cardiac imaging and computer processing techniques, he was co-director and co-founder of the University of Iowa Adolescent and Adult Congenital Heart Disease Clinic.

A distinguished professor at Georgetown University, Dr. Skorton is an elected member of the National Academy of Medicine, the American Academy of Arts and Sciences, and the American Philosophical Society, as well as a lifetime member of the Council on Foreign Relations and a fellow of the American Association for the Advancement of Science. He also served on the AAMC Board of Directors from 2010 to 2013 and was the charter president of the Association for the Accreditation of Human Research Protection Programs, Inc., the first group organized specifically to accredit human research protection programs.

Throughout his career, Dr. Skorton has focused on issues of diversity and inclusion. A nationally recognized supporter of the arts and humanities, as well as an accomplished jazz musician and composer, Dr. Skorton believes that many of society's thorniest problems can only be solved by combining the sciences, social sciences, and the arts and humanities.

Dr. Skorton earned his BA from Northwestern University and MD from Northwestern University Feinberg School of Medicine. He completed his medical residency and fellowship in cardiology and was chief medical resident at the University of California, Los Angeles. He is married to Robin Davisson, PhD, an award-winning scientist, who is a professor of molecular physiology at

the Cornell University College of Veterinary Medicine and Weill Cornell Medicine, as well as a professor of medicine at Georgetown University and an emerging visual artist.

Gail J. McGovern
President and CEO
American Red Cross

Gail McGovern joined the American Red Cross as President and Chief Executive Officer in 2008, and has taken a strong leadership role at the nation's leading emergency response and blood services organization.

Under her direction, the Red Cross has become more effective in fulfilling its mission and is better prepared to face current and future challenges. Her transformational initiatives have led to improved financial stability and have expanded the reach of lifesaving Red Cross services. McGovern has initiated extensive modernization projects at the Red Cross. Among them are an overhaul of Red Cross IT systems and the growth of the organization's leadership in social media and mobile technologies – including the introduction of a series of free apps that put lifesaving skills at people's fingertips during emergencies.

During her tenure, McGovern has overseen the American Red Cross response to multiple high-profile disasters across the country and around the world, including Hurricane Sandy in 2012, Hurricanes Harvey, Irma and Maria in 2017, as well as the multitude of tornadoes, hurricanes, floods, wildfires, home fires and other local disasters that affect our country each year.

Prior to joining the Red Cross, McGovern was a faculty member at the Harvard Business School and earlier had served as President of Fidelity Personal Investments, a unit of Fidelity Investments. She was also Executive Vice President at AT&T for the Consumer Markets Division, the company's largest business unit, and was responsible for its $26 billion residential long-distance service.

She earned a Bachelor of Arts degree from Johns Hopkins University and an MBA from Columbia University, and has since been recognized as alumna of the year from both universities.

McGovern is currently a member of the board of trustees for Johns Hopkins Medicine. She also serves on the board of directors of DTE Energy and PayPal.

McGovern was recognized by Fortune magazine in 2000 and 2001 as one of the top 50 most powerful women in corporate America.