Q1 2020 Earnings Call

Company Participants

- Calvin Darling, Intuitive Surgical
- Gary S. Guthart, Chief Executive Officer
- Marshall L. Mohr, Chief Financial Officer

Other Participants

- Amit Hazan, Analyst
- Bob Hopkins, Analyst
- David Lewis, Analyst
- Larry Biegelsen, Analyst
- Larry Keusch, Analyst
- Matt Taylor, Analyst
- Rick Wise, Analyst
- Tycho Peterson, Analyst

Presentation

Operator

Ladies and gentlemen thank you for standing by and welcome to the Intuitive Surgical Q1 2020 Earnings Release. At this time, all participants are in listen-only mode. Later we will have an opportunity for your questions, instructions will be given at that time. (Operator Instructions) As a reminder today's conference is being recorded.

I would now like to turn the conference over to Calvin Darling, Senior Director of Finance, Investor Relations for Intuitive Surgical. Please go ahead.

Calvin Darling {BIO 17664656 <GO>}

Thank you. Good afternoon and welcome to Intuitive's first quarter earnings conference call. With me today we have Gary Guthart, our CEO and Marshall Mohr, our Chief Financial Officer. Before we begin, I would like to inform you that comments mentioned on today's call may be deemed to contain forward-looking statements. Actual results may differ materially from those expressed or implied as a result of certain risks and uncertainties. These risks and uncertainties are described in detail in our Securities and Exchange Commission filings, including our most recent Form 10-K filed on February 7, 2020.

Our SEC filings can be found through our website or at the SEC's website. Investors are cautioned not to place undue reliance on such forward-looking statements. Please note that this conference call will be available for audio replay on our website at intuitive.com on the Latest Events section under our Investor Relations page.

Today's press release and supplementary financial data tables have been posted to our website. In addition, this quarter we have also posted charts illustrating da Vinci procedure trends in Q1, which are intended to provide additional perspective and detail regarding the impact of COVID-19 on our business. Today's format will consist of providing you with highlights of our first quarter results as described in our press release announced earlier today, followed by a question-and-answer session. Gary will present the quarter's business and operational highlights. Marshall will provide a review of our financial results, then I will discuss procedure details and finally, we will host a question-and-answer session.

With that I will turn it over to Gary.

Gary S. Guthart {BIO 3429541 <GO>}

Thank you for joining us today. Our first quarter 2020 performance reflects the rise of COVID-19 and the global response to it. On this call we'll describe our experience in the quarter, our framework for engaging those who rely on us and our priorities and actions in these challenging times. Our focus now and in the past is the safety and well-being of patients, care teams, our communities and our employees. For the first 2.5 months of the quarter, procedure performance was at the high end of our expectations with procedure trends consistent with the prior quarters. General surgery in the United States was strong as was urology outside the United States. As we disclosed previously, recommendations by surgical societies and healthcare organizations to delay certain surgeries to conserve resources for COVID care are having a material impact on surgery broadly, including robotic-assisted surgery.

We support government and hospital policies to direct resources to COVID care and recognize these policies vary greatly by region and by hospital system. We are analyzing customer procedure deferrals in response to COVID. Patients undergoing da Vinci procedures do so in response to an underlying disease. While these procedures may be delayed in the short term, without treatment of some sort, the disease and its impairment persist and often worsens.

Said simply, the vast majority of these patients will ultimately seek treatment. We are analyzing both the clinical drivers of return to treatment and customer plans and processes to recover. The categories of benign disease and cancer are not entirely predictive of the urgency of surgical intervention. Clearly aggressive cancers require treatment and are delayed at significant risk to patients. Likewise, some benign conditions require timely intervention as well. We're working internally and with customers to understand their needs to restart surgery for those patients whose condition requires action.

The effect of COVID on the surgical market has impacted different regions differently. Starting with China, procedure performance was impacted by COVID earliest with sharp declines in surgery as resources were diverted to respond to COVID care. Procedures in China have been recovering steadily since that time. However steep declines in procedures that can be deferred are occurring in other regions, particularly Europe and the United States. For the quarter, procedures grew 10% over Q1 of 2019, given early strength followed by sharp declines in the last two weeks of the quarter. I refer you to the materials we posted to our website prior to this call to get a better picture of the dynamics in Q1.

With regard to systems, our total number of placements for the quarter was below our expectations in spite of having strong capital performance in the first two months of the quarter. In March, rapid changes by hospitals delayed some system placements and are likely to significantly impact system contracts and placements in future quarters. Financial pressures exerted on hospitals in response to treating COVID patients and deferring other care are likely to be significant and are unlikely to resolve quickly. Marshall and Calvin will take you through procedure and capital dynamics in the quarter in greater detail later in the call.

To help articulate our priorities and actions during this period of change, we have adopted the phased framework described in the American Enterprise Institute's, national Coronavirus response. In Phase 1, which is the slow the spread phase of Coronavirus response, Intuitive's priorities are as follows: first, we are focused on the health and safety of all those we serve; our customers, our communities, our employees and our suppliers, implementing early and continuous updates to our health and safety policies and processes. Second, we are supporting our customers according to their priorities; clinical, operational and economic. Third, we're focused on continuity of supply by working with our suppliers and distributors. To-date, our delivery capability and inventory positions are on firm footing. Fourth, we are securing our workforce economically. We have built an outstanding team over the years and we believe their strength will be essential in the recovery that follows. Fifth, in partnership with our Intuitive Foundation, we are contributing material, product and volunteers to the frontlines of COVID support. We've designed, produced and delivered PPE to local hospitals and our staff have volunteered in several communities. And sixth, we are eliminating avoidable spend during the stop the spread phase of the virus.

The current situation in hospitals responding the viral care is fluid and the depth and duration of this disruption is difficult to predict. New issues are arising with respect to surgery that will require mitigation in time. Some hospital customers and some of our suppliers will experience significant financial stress in this period. Regulatory agency priorities and resources are shifting globally as they devote their resources to infectious disease detection and treatment needs. And lastly, surgeons are being dedicated to frontline COVID work or being idled by a lack of resources in this period.

We are adjusting quickly to the issues described and we're confident in both the need for surgery and in our products as the response to COVID evolves. We're planning for Phase 2, the return to surgery for those patients who cannot wait. Those countries that have

been managing the disease the longest have returned to da Vinci surgery steadily over time or have been able to maintain da Vinci surgery concurrently with COVID care.

We are analyzing the order in which different procedures are likely to return and the strategies likely to be employed by hospital systems to manage surgical practices, while still providing COVID care. For example, some health systems are dedicating specific sites to COVID care, while operating rooms for outpatient surgeries are dedicated in other locations.

We will support customers closely as they bring capabilities back on line. We're also adapting our training in Intuitive telepresence capabilities to support team training and skills retention in a Phase 2 world. We're optimizing our R&D facilities and methods to allow us to progress on important innovation programs, while employing up to date workplace safety guidelines. Lastly, we look forward to accelerating clinical trial activities and the associated regulatory work as trial sites increase their surgical volume.

In constructing our financial plans in the current environment, we're balancing five objectives that reflect our priorities mentioned above. They are first, customer-focused economic policies that meet their needs during this disruption. Second, employee policies that secure our valuable workforce needed for hospital recovery and to drive our innovation. Third, securing and stabilizing critical supply chain resources. Fourth, eliminating spending that is not effective during this period. For example, pausing hiring and volume-related roles and spend on projects that cannot progress in the current phase and finally shareholder policies that don't interfere with the priorities mentioned above.

We remain in close contact with our customers, our community representatives, our employees and our suppliers during this period. While the depth and duration of the current challenges are difficult to predict, the need for both COVID and non-COVID care is clear, given time and resources, health systems have continued to choose da Vinci. The collaborations and solutions orientation among our stakeholders is clear and inspiring. I believe our long-term opportunity is substantial and our business is well positioned financially and organizationally to weather this COVID outbreak.

I'll now turn the call over to Marshall, who will take you through financial matters in greater detail.

Marshall L. Mohr {BIO 5782298 <GO>}

Good afternoon. I will describe the highlights of our performance on a non-GAAP or pro forma basis. I will also summarize our GAAP performance later in my prepared remarks. A reconciliation between our pro forma and GAAP results is posted on our website. Procedures and shipments are consistent with our preliminary press release of April 8th. Key business metrics for the first quarter were as follows: first quarter 2020 procedures increased approximately 10% compared with the first quarter of 2019 and decreased approximately 9% compared with last quarter. Procedure growth continues to be driven by general surgery in the US and urology worldwide. Calvin will review details of procedure growth later in this call.

First quarter system placements of 237 systems, increased 1% compared with 235 systems last year and decreased 29% compared with 336 systems last quarter. We expanded our installed base of da Vinci systems by 11% to approximately 5,669 systems. This growth rate compares with 12% in the last quarter and 13% last year.

Utilization of clinical systems in the field, measured by procedures per system, declined approximately 2% compared with 6% growth last quarter and 5% growth last year. Let me walk through the impact of COVID-19 pandemic on procedures and system placements and how it varied by market. Prior to the spread of COVID-19, we experienced procedure growth trends consistent with those experienced in the fourth quarter, including strength in general surgery, growth in mature procedures in the US and growth in OUS urology.

We also saw early strengthen in capital placements, particularly in US with over half the systems placed in the quarter being arrangements, where the sales cycle was mostly completed in the fourth quarter. Beginning in January, we saw a substantial reduction in da Vinci procedures in China and by early February, procedures per week in China had declined by 90% compared with the weekly rates experienced in early January.

As the COVID-19 subsided in China in March, da Vinci procedures began to recover and by the end of the quarter, China procedures per week were approximately 70% of the early January rate. We saw varied impacts on da Vinci procedures in some other early countries affected by COVID-19. COVID-19 had little impact in Korea, in Japan in the quarter and severe impact in Italy. In summary, the COVID-19 disruption to da Vinci procedures varied by country and the disruption to worldwide da Vinci procedures was not significant through the middle of March. As the pandemic spread to Western Europe and to the US, we experienced a significant decline in da Vinci procedures in the last half of March. Procedures per week in the US, which represented approximately 70% of our procedures in 2019, declined approximately 65% relative to earlier in the quarter.

Procedures in France, Germany and the UK also declined, but to a lesser extent than the US. We've provided you with supplemental information on our website to enable you to understand the magnitude of the impacts on procedures and the variation between countries. As I indicated, most of the sales cycle for approximately half of the system placements in the quarter were completed in the fourth quarter.

As we progressed through the quarter and the impact of the pandemic progressed, customers deferred decisions to purchase or lease systems in the future quarters and in some cases indefinitely. The depth and extent to which COVID-19 will impact individual markets will vary based on the availability of testing capabilities, PPE, ICUs and ORs, medical staff and government interventions. As COVID-19 continues to spread, it is likely that da Vinci procedures will decline from those experienced in the first quarter. In addition, we would expect that system placements will follow the decline in procedures.

While some markets like China appear to be recovering, it is possible that a recurrence of COVID-19 will negatively impact da Vinci procedures and not all markets will recover at the same pace. Additional revenue statistics and trends are as follows: utilization of the installed base declined by 2% compared with the fourth quarter of 2019, reflecting the

impact of the pandemic on procedures, coupled with the fourth quarter system placement strength. When procedures increase, customers will first look to utilize existing da Vinci capacity, which is likely to depress capital placements.

First quarter placements included a higher concentration of multiple system arrangements with hospitals and IDNs, seeking to standardize on fourth generation systems. Many of these replacements were completed as capital leases. As a result, first quarter trade-ins were higher and operating leases were lower as a percentage of total placements than in the fourth quarter of 2019.

We would anticipate in an environment of COVID-19 as economic pressures increase more customers will seek leasing or alternative financing arrangements than purchases. Trade-in activity can fluctuate and be difficult to predict. However, given the impacts of COVID-19, we expect the number of trade-ins to decrease. We recognized $12 million of lease buyout revenue in the first quarter compared with $34 million last quarter and $12 million last year. There were no returns of da Vinci systems for leases that ended in the quarter. Lease buyout revenue has varied significantly from quarter-to-quarter and will likely continue to do so.

Instrument and accessory revenue per procedure grew to just over $2,000 per procedure compared with $1,980 in the fourth quarter of 2019, reflecting instruments and accessory purchases prior to the decline in procedures. We expected as hospitals adjust inventory levels for lower surgery volumes, instrument and accessory revenue will decrease. Three of the systems placed in the first quarter were SP systems, reflecting both our measured rollout of SP and the impact of COVID-19. Our rollout of SP surgical system will continue to be measured, putting systems in the hands of experienced da Vinci users, while we pursue additional indications and optimize training pathways in our supply chain.

Given the impact of COVID-19, our ability to perform a clinical trial associated with an SP colorectal procedure is likely delayed. We placed eight Ion systems in the quarter. Ion system placements were also impacted by COVID-19. Ion system placements are excluded from our overall systems count and will be reported separately. Procedures and other information associated with Ion are excluded from our prepared remarks and will be reported separately when they become material. Our rollout of Ion will continue to be measured, while we optimize training pathways in our supply chain.

The completion of the PRECISE study will be delayed due to COVID-19. We cannot predict when the PRECISE clinical study will be completed. Outside the US, we placed 55 systems in the first quarter, compared with 81 in the first quarter of 2019 and 140 systems last quarter. Current quarter system placements included 25 in Europe, 10 into Japan and nine into China, compared with 49 into Europe, 13 into Japan and three into China in the first quarter of 2019.

Moving on to gross margin and operating expenses. Pro forma gross margin for the first quarter was 69.7% compared with 71.2% for the first quarter 2019 and 72.2% last quarter. The decrease compared with the first quarter of 2019 and last quarter primarily reflects product mix, higher fixed costs on lower production and costs associated with SI product

transitions, partially offset by cost reduction. As revenues are pressured by COVID-19, we will reduce production levels, which will result in higher labor costs and under-absorbed overhead and a significant reduction of product margin.

Pro forma operating expenses increased 15% compared with the first quarter of 2019 and decreased 8% compared with last quarter. Spending in the first quarter reflected normal business activities into March and then a curtailment of costs associated with the impact of COVID-19. While certain spending will decrease in the second quarter as a result of the reduction in revenue and activities limited by the pandemic, much of our spending will continue.

Major categories of spending and likely trends for the second quarter are as follows: We will continue to support our customers. We will continue to invest in innovation focused on the quadruple aim. We will invest in manufacturing and our supply chain to ensure supply for our customers. We will ensure we are prepared for periods when the spread of COVID-19 is contained. Certain costs will decline as underlying activities are restricted by COVID-19, including travel and related expenses, clinical trials, surgeon training and customer data collection.

We will eliminate spending that is ineffective due to COVID-19 like surgeon and hospital events. We are pausing the hiring volume-related roles like sales reps and manufacturing employees. We continue to believe that we have a unique opportunity to expand the benefits of computer-aided surgery and acute interventions around the world and will continue to invest in the business for the long term.

Our pro forma effective tax rate for the first quarter was 20% compared with our expectations of 20% to 21%, reflecting geographic mix. Our actual tax rate will fluctuate with changes in geographic mix of income, changes in taxation made by local authorities and with the impact of onetime items. Our first quarter 2020 pro forma net income was $323 million or $2.69 per share compared with $312 million or $2.61 per share for the first quarter of 2019 and $417 million or $3.48 per share for last quarter.

I will now summarize our GAAP results. GAAP net income was $314 million or $2.62 per share for the first quarter of 2020 compared with GAAP net income of $307 million or $2.56 per share for the first quarter of 2019 and GAAP net income of $358 million or $2.99 per share for last quarter. The adjustments between pro forma and GAAP net income are outlined and quantified in our website and include excess tax benefits associated with employee stock awards, employee stock-based compensation and IP charges, amortization of intangibles and acquisition-related items and legal settlements.

We ended the quarter with cash and investments of $5.9 billion, compared with $5.8 billion at December 31 2019. Cash generated from operations was partially offset by stock repurchases and investments in working capital and our infrastructure. We repurchased approximately 192,000 shares for $100 million at an average price of $522 per share. Our current thoughts on capital deployment are in the following order: we recognize the hardships that COVID-19 places on our customers and we'll work with customers to ease the burden of lower da Vinci utilization, including providing customers with more flexible

financing. We will work to secure supply chain and build appropriate levels of inventory to ensure customer supply, particularly as procedures resume. We will invest in securing our employees. We will continue to our open market repurchase program. Consistent with our prior practice.

And with that, I'd like to turn it over to Calvin who'll go over procedure performance.

Calvin Darling {BIO 17664656 <GO>}

Thank you Marshall. Our overall first quarter procedure growth was approximately 10% compared to 18% during the first quarter of 2019 and 19% last quarter. Our Q1 procedure growth was driven by 9% growth in US procedures and 11% growth in OUS markets. Our lower first quarter 2020 procedure growth rates were a direct result of hospitals reallocating resources to meet the increasing demands of managing COVID-19. Hospitals postponed deferrable surgical procedures to make more resources available to treat COVID-19 patients.

Impacts to da Vinci procedure volumes were first felt in China in January and moved to other OUS markets as the quarter progressed. As of mid-March, our overall procedures were trending towards the higher end of our expectations, including the benefit of an extra working day in Q1 2020. At this stage of the quarter, the impacts of COVID-19 in the earlier impacted countries were offset by strength in US general surgery and mature procedures. Beginning in mid-March, we saw significant declines in procedure volume in the US and Western Europe.

On a worldwide basis, weekly procedures performed exiting Q1 were approximately 50% lower than the run rate through mid-March. In the US, weekly procedures exiting the quarter were approximately 65% below the run rate through mid-March. Procedure categories realizing significant declines were hernia repair, benign gynecology and bariatric procedures. Lesser impacted procedures were thoracic and colorectal surgeries.

Outside of the United States, weekly procedures exiting the quarter were approximately 25% below the run rate through mid-March. The lower OUS decline primarily reflects procedure volume recoveries in China, offset by broad declines in Western Europe. In Q1, procedures in Japan were less affected by COVID-19. Growth in Japan procedures continued at a growth rate over 40%. We provide these data points to inform investors of the procedure dynamics experienced during the first quarter, which were unprecedented due to the uncertain scope and duration of the COVID-19 pandemic and uncertain timing of global recovery and economic normalization, we withdrew our financial and procedure guidance on April 8th. And these Q1 procedure results aren't necessarily indicative of any forward-looking trend.

That concludes our prepared comments, we will now open the call to your questions.

Questions And Answers

Operator

(Operator Instructions) Our first question will come from David Lewis with Morgan Stanley. Please go ahead.

Q - David Lewis {BIO 15161699 <GO>}

Good afternoon. Can you hear me?

A - Gary S. Guthart {BIO 3429541 <GO>}

We can.

A - Marshall L. Mohr {BIO 5782298 <GO>}

Hi David.

A - Gary S. Guthart {BIO 3429541 <GO>}

Hello? Operator?

Operator

David, your line is open.

Q - David Lewis {BIO 15161699 <GO>}

Can you hear me now?

A - Gary S. Guthart {BIO 3429541 <GO>}

Yes.

Q - David Lewis {BIO 15161699 <GO>}

Okay, sorry about that (inaudible) happened. So, Gary just wanted to talk about capital cycle a little bit. I mean I know we're going to get specifics on 2020, but if I think about the 2008 financial crisis, the strain on hospitals is certainly different today than it was back in 2008 and your business model frankly is very different today than it was back in 2008, how would you compare and contrast sort of the impact on your business to COVID-19 relative to what we saw in the last major financial crisis, impacting hospitals? And I had a quick follow-up.

A - Gary S. Guthart {BIO 3429541 <GO>}

Yeah, thank you. I'd start with, I think there apples and oranges from underlying costs. So, clearly this is healthcare-related and policy-driven in terms of deferrals. As a result, a little bit hard to predict how the capital cycle will recover. You had mentioned and it's true. We have a lot more flexible approaches that are available to us with regard to making systems available. Marshall mentioned in his script although consume existing capacity first as they go. We've been in contact with our customers routinely.

There is a backlog growing for surgery. These folks are going to need surgery and really our opportunity -- our job as a company is to make sure we can support them however we can in terms of access to systems or a motion of systems to allow them to use what they have out there and as those systems become full again, we can think about how to increase capacity going forward and we have a few tools in the toolkit. Marshall anything you'd like to add?

A - Marshall L. Mohr {BIO 5782298 <GO>}

No, I think you hit it. I think you'll see more financing, more leases and alternative financing arrangements.

Q - David Lewis {BIO 15161699 <GO>}

Okay, that made perfect sense. Maybe just a quick follow-up on capital, Marshall for you. You talked about in your script a couple of things, but you talked about certain orders that are being delayed or canceled versus sort of pushed indefinitely. Can you give us any sense from a percentage perspective what percent of the order book was in your mind delayed versus sort of what was either canceled or indefinitely delayed?

And then you just mentioned leased rate hovering around that 40% level. Is it reasonable to assume we should see a more material step up in the lease rate? You said it would fluctuate as it has normally, but my view would be that lease rate could hike up more materially now because you're incentivized to provide flexible financing for hospitals to get these systems in. So, any color there would be very helpful and I'll jump back in queue. Thank you.

A - Gary S. Guthart {BIO 3429541 <GO>}

Sure. For leasing, in the quarter, what happened, we had a number of customers that has started the sales cycle back in Q4 and we're interested in standardizing on fourth generation systems. And it still happens that a number of those customers wanted to do -- wanted to structure the arrangements such as they were purchases -- that were accounted for as purchases. And as a result, we had fewer leases this quarter. So I don't think this quarter's an indicative of our normal sort of run rate for leases as a result. Leasing going forward probably is more akin to what we were experiencing more in the 38% range. That's under normal circumstances and I actually believe given the COVID virus and its impacts that it will increase from there.

So and it's -- but it's hard to predict depending on the customer and the circumstances. As far as how many customers may have postponed indefinitely or may have postponed a quarter, the conversations with them are always a little bit "Hey, we're going to postpone." And then they sort of throw in words about maybe another quarter, maybe another couple of quarters and and some say "Well, we'll get back to it.", but we don't have a specific timetable. And for those that say that they don't have a specific timetable, that's what I'm referring to as indefinitely. I don't think that there are customers running from robotic surgery. I think they actually wanted to do robotic surgery and I think that they'll come back some time when COVID virus is handled and the procedures come back.

Q - David Lewis {BIO 15161699 <GO>}

Okay, thank you so much.

A - Gary S. Guthart {BIO 3429541 <GO>}

Next question please?

Operator

Yes. The next question will come from Bob Hopkins, Bank of America. Please go ahead.

Q - Bob Hopkins {BIO 2150525 <GO>}

Sure. Thank you and good afternoon. I want to thank you for the incremental data that you provided this quarter on the trends throughout the quarter by geography, that was very helpful to see. And so, my first question is really on the chart on China. We're showing a pretty nice recovery from trough to where you are right now. I was wondering if you could just walk through your views on how good a proxy China might be for a US recovery? Like why or why not -- how could that be different, just your general thoughts on that would be great. Thank you.

A - Gary S. Guthart {BIO 3429541 <GO>}

Thanks, Bob. Yeah, I know you see in that chart, China, you see other countries as well. Japan and so on and -- which you can really see is that the country policy changes the shape. I think we're encouraged by a couple of things. One is people's interest or customers interest in using da Vinci is durable. That's been great. You would ask a specific question of how predictive is China and I think the answer there is too soon to tell for the rest of the regions. I am encouraged by that. I think it indicates the durability of demand. Having said that, I think policy matters and I think how people allocate their healthcare resources are going to change too. You can see in Japan already that the progress of their approach to the disease is evolving and what that looks like on procedures will evolve. So stay tuned is the short answer. Calvin anything you'd like to add?

A - Calvin Darling {BIO 17664656 <GO>}

No, I think that described it pretty well.

Q - Bob Hopkins {BIO 2150525 <GO>}

Okay and then just one quick follow-up. Just maybe a comment on why Japan has been so resilient and then you did mention in the prepared remarks something about -- I think, I missed it on one of the clinical trials, it's been delayed. I was wondering if you could just highlight or reiterate exactly what you're communicating there? Thank you.

A - Gary S. Guthart {BIO 3429541 <GO>}

Okay. On the Japan side, I think that there -- in general, their system for managing the Coronavirus is a little bit different than we've seen in other countries and it's evolving in time. So to-date hospital operations were relatively likely impacted as it relates to surgery

relative to other countries. What that will look like in the future? I don't know. We'll see how that evolves. It has been interesting and instructive for us to look at data from Japan, look at data from Korea, from China, from Europe and Germany, Italy, UK, France. And that informs us going forward in terms of getting prepared for the reopening of some of those hospital wings and surgical wings as they happen. So too soon to make the final call, but we have I think pretty good real-time information.

I'm going to refer to Marshall, the question about clinical trial.

A - Marshall L. Mohr {BIO 5782298 <GO>}

Clinical trial, What I was referring to was SP. We planned on doing a -- we believe we have to do a clinical trial to get the next indication, which is colorectal. Doing a clinical trial when -- at this point in time is probably not going to happen right away. Having said that, I don't think we had plans to do it right away. We had several steps we had to go through before we got there. So I say it's delayed -- could be delayed and don't know exactly when it will get done.

A - Gary S. Guthart {BIO 3429541 <GO>}

Calvin you had more to add?

A - Calvin Darling {BIO 17664656 <GO>}

Yeah and on the Ion side as well, data capture for the Ion PRECISE study that we've talked about on these calls is currently delayed. We believe that positive clinical data will be important catalyst for broader usage of the platform, but given the lack of visibility, we're not in a position to provide a definitive revised timeline, but it's unlikely that the precise study will read out this year. But if you look at the new platforms both Ion and SP are both in the measured rollout phases of market introduction and early stage utilization rates for both platforms has been encouraging.

Ion commercial procedure rates were up over 110% from Q4 of '19 to Q1 of 2020. SP procedure rates grew 14% from the fourth quarter and they're up about 190% year-over-year. So, really encouraging in these early phases. In Korea, specifically where we have a broad clearance for SP, the utilization per system is at this point in time, higher than it is for Xi.

Q - Bob Hopkins {BIO 2150525 <GO>}

Thank you.

A - Gary S. Guthart {BIO 3429541 <GO>}

Thanks, Bob.

Operator

Our next question will come from Tycho Peterson with JPMorgan. Please go ahead.

Q - Tycho Peterson {BIO 4279327 <GO>}

Hey, thanks. I'm wondering if you could just talk a little bit about procedure mix, the types of procedures that may come back a little bit faster versus others, presumably most core prostate cases may lag and non-emerging hernias may lag. But I'm just curious even based on your experience in China in terms of the procedures that came back a little bit faster, if you could comment on that at all?

A - Gary S. Guthart {BIO 3429541 <GO>}

Sure. Just as a broad brush clearly high risk cancers are things delayed at real risk to patients and (inaudible) benign disease likewise. One caution each country has a little bit different mix of procedures going into 2020 prior to a COVID becoming a bigger issue. So the mixes or a little bit different. Calvin why don't you speak a little bit to what we've seen today?

A - Calvin Darling {BIO 17664656 <GO>}

Yeah and then again procedures, it's early they are following a continuum of urgency that are applied situationally and like you say clearly the aggressive cancers require treatment and and are delayed at significant risk to patients and likewise some benign conditions require timely intervention as well. We're working toward with customers to best understand the segments and our future plans and elaborate we'll elaborate further as those things progressed.

I've mentioned in the prepared comments at least in the ending parts of the first quarter, the more impacted procedures were things like hernia repair, benign gynecology and bariatrics with lesser impacts on things like thoracic procedures and colorectal procedures.

A - Gary S. Guthart {BIO 3429541 <GO>}

On my just personal channel checks, hospitals are now creating large backlog. So patients who are going to meet surgery and they are some encouraged about their commitment to da Vinci as they go through that. So, I think at some point the logistics and availability of PPE and other resources will start to free up a little bit and as they have time, then they'll have to attend to that group of patients and we'll be there to support.

Q - Tycho Peterson {BIO 4279327 <GO>}

And then maybe a follow-up on the capital comments. I appreciate the nature and the time of the discussions may shift more toward alternative financing, but can you just talk maybe to the degree to which hospitals are actually engaging in capital discussions at this point as opposed to still dealing with COVID work? And also curious on your thoughts on Europe just given capital outlook there. Thank you.

A - Gary S. Guthart {BIO 3429541 <GO>}

Like I said in the prepared remarks, capital demand we saw deferral of purchase decisions at the end of the quarter. I would expect that to continue. I would expect also that hospitals as COVID -- as they are able to dedicate resources to the procedures that maybe

in backlog that they'll use up existing capacity and therefore it won't immediately result in capital demand. We still have conversations with some of the hospitals on capital. It's just not possible to predict exactly where it's going to come out for the quarter.

A - Calvin Darling {BIO 17664656 <GO>}

With regard to Europe, any color you want to give, Marshall?

A - Marshall L. Mohr {BIO 5782298 <GO>}

Europe, if we didn't see quite the same level of reduction in terms of procedures at the end of the quarter and that's not -- that doesn't mean to say that, that will sustain itself. It's possible that as the virus spreads that there could be additional pressures on procedures. Having said that, the capital, as you know, we did 25 systems this quarter, which is what I reported in my prepared remarks. That's far lower than we had anticipated for the quarter. And so, we're still -- we are seeing the same kinds of interactions with customers in Europe as we are in US.

A - Calvin Darling {BIO 17664656 <GO>}

Tycho, You've heard us say this before and it's really true in the data that this quarter as well. Europe doesn't act as one. So what's happening in Italy feels and looks different than in Germany from our perspective, from France and from the UK. So each will progress a little bit on a little bit different pathway.

Q - Tycho Peterson {BIO 4279327 <GO>}

Okay, thank you.

A - Calvin Darling {BIO 17664656 <GO>}

Thanks, Tycho.

Operator

Thank you. Our next question will come from Larry Biegelsen with Wells Fargo. Please go ahead.

Q - Larry Biegelsen {BIO 7539249 <GO>}

Good afternoon and thanks for taking the questions. One on procedures and one on just on systems. On procedures, I appreciate the numbers, the percentages you provided us. I think those are exit rates for March and the slides look like those percentages continue to go down. So I apologize if I missed this, but would you be willing to provide any color on what you've seen in the first couple of weeks here in April just to give us a better sense to how to think about Q2? And I did have one follow-up.

A - Gary S. Guthart {BIO 3429541 <GO>}

We're not, not ready to publish what's happened thus far in April. I don't think it's shockingly different from what the beginnings of what you're seeing in the charts we've

given you there. But I'd also say that I don't think the next two weeks are particularly predictive of anything. I think this will flow globally here over the next weeks and months and we're really focused on how to make sure that we're supporting our customers well and flow out of it.

Q - Larry Biegelsen {BIO 7539249 <GO>}

And Gary thinking ahead hospitals are going to be faced with two challenges. I think one is capacity constraints to handle postponed procedures and second moving procedures to alternative sites. I think you mentioned in your prepared remarks like ASCs potentially to isolate non-COVID patients or vice versa. What can you do to help hospitals with these two challenges? Thanks for taking the questions.

A - Gary S. Guthart {BIO 3429541 <GO>}

Yeah. I appreciate it. Well, a couple of things. We are well represented in outpatient departments in hospitals already. We are absolutely able and willing to move systems to locations of care wherever they might be. We do have experience with systems in ASCs to the extent that people want to move into ASC environments. We worked fine in those environments. We will be working on getting training and other resources geographically positioned, where we think that folks can need additional support as they start to ramp up recognizing that we don't think a lot of people will be jumping on planes in Phase 2. So we can sort of forward deploy our resources to help people as they get ready. And lastly, it's staying in touch with our customers and surgery departments and making sure that we have inventory forward deployed for them for the kind of procedures they want to do.

Q - Larry Biegelsen {BIO 7539249 <GO>}

Thanks for taking the questions.

A - Gary S. Guthart {BIO 3429541 <GO>}

Thank you.

Operator

Thank you. Our next question will come from Rick Wise, Stifel. Please go ahead.

Q - Rick Wise {BIO 1490589 <GO>}

Hi, good afternoon. Hi, Gary. Hi, Marshall. A couple of things. Maybe let's start with thinking about the slowdown in capital you've talked about and obviously related procedure decline. I know I'm looking ahead -- far ahead and you're not comfortable really predicting the next quarter, but I just want to think about the recovery. Gary, how do we think about, let's say if the slowdown in capital persists throughout 2020 or well into 2020, does that suggest that 2020 recovery won't be back to let's say 2019 levels and it's going -- it would take probably possibly until 2022 for us to see you get back at sort of a historical growth because of that slowdown in capital, which might be slower to recover and therefore procedures slower to accelerate overall if you follow what I'm trying to get at?

A - Gary S. Guthart {BIO 3429541 <GO>}

I think the way I'd have you think about it is from the point of view of demand for surgery, demand for robotic-assisted surgery. In that setting, I think the world is queuing up a set of patients who will need care. Makes sense, I understand it, I think conserving of PPE and ICUs and other valuable resources at this time makes sense. As some of those constraints start to loosen I think everybody will have to adjust and adapt to carrying for patients who have other conditions.

That is the demand that will drive everything behind it from I&A and other inventory to access to capital and systems. We are well positioned from an inventory point of view. We are well positioned operationally and financially to move systems where they need to go, to put systems out on lease or usage-based models or other things to support customers the way they want to be supported and we will be quite agile. So on the capital side, you may see shifts in the way capital is deployed, in the way they we're compensated for that capital relative to prior quarters sort of historical norms. But we'll be leaning forward to help people when they need that help. How fast that happens? I think that has a lot to do with government policy and health system policy as to when they pivot to go treat other patients that will determine everything else.

Q - Rick Wise {BIO 1490589 <GO>}

Got you. And as just sort of a separate, but related question, Gary. Several of our ongoing physician conversation suggest that as things recover, actually robotic capacity won't be sufficient to meet demand, which is an interesting thought. And they suggest actually that on a recovery, robotic surgery will lose market share so to speak of some of those deferred patients to laparoscopic surgery to open surgery, I have no idea. I'd be curious to know if you have any high-level thoughts about that -- those physician comments? Thank you so much.

A - Gary S. Guthart {BIO 3429541 <GO>}

Yes. Thanks, Rick. It's possible. I think that folks rotating into open surgery, patients who are great candidates for MIS is doing that set of patients at a service. So, we will see, that may happen, hard for us to control. With regard to our capacity for robotics, remember there are a lot of robots out there and they are right now under utilized. As that flows back, we can help. Will some folks want to use lab? Maybe.

From the point of view of surgeon preference, surgeon comfort what their choices are, just remember surgeons are intentional about the method of surgery they choose. They don't accidentally fall into robotic surgery training. They make those commitments and time investments for a reason and they have a preference. So, if we can fulfill their preference, great, that will be great. If we're unable to do so and they choose lab, because they couldn't get access where they wanted, well, that may happen. But that's really, I think Intuitive's job to make those systems available to them if they would like to use them.

Q - Rick Wise {BIO 1490589 <GO>}

Thanks so much.

A - Gary S. Guthart {BIO 3429541 <GO>}

Thanks Rick.

Operator

Thank you. And our next question is from Larry Keusch, Raymond James, please go ahead.

Q - Larry Keusch {BIO 1504587 <GO>}

Thanks, good afternoon everyone. I guess, Gary to start with, just curious, thinking about R&D. What changes are you making to allow the innovation engine to not stall out here? I'm just curious how you're accomplishing that and what sort of processes procedures you're putting in place?

A - Gary S. Guthart {BIO 3429541 <GO>}

Thank you. First thing has been to employ to ensure to protect the safety of our staff and those who supply us, while we do our R&D. So step one has been to stay up to date on the latest employee work safety methods. We started our incident response team relatively early. We were up and running at full speed in terms of our incident response team in early January. And so they start looking at the best practice, relaying out our on-site facilities as it need to be relaid out, enabling work from home where we can. We were pretty capable at remote work capabilities, just given the distributed nature of our campuses.

So it's really flexing in that regard. And then we've put in place a robust process for allowing on-site work, where we think it can't be done otherwise for training our staff and staying with it. And so we've done that. Of course, there is a loss of efficiency as you go through this and so there is no doubt that in the first weeks of this, you start to slow down and then we're fighting hard to recover. Team attitudes have been fantastic. The agility and creativity of teams to get the work done, their willingness and desire to do so has been really encouraging. So, so far so good.

Some things will go slower to the extent that we have clinical trials out there, and those are being conducted in hospitals that are being impacted by COVID, those things will slow down. The principal investigators in those places are highly committed. First, the patient care and then as a second priority, to doing the research they'd like to do. And so that will come back is as time permits for them to do so.

Q - Larry Keusch {BIO 1504587 <GO>}

Okay, terrific. And then I guess the other question is, you guys are obviously having a lot of conversations with surgeons, with hospitals. I'm just sort of curious if you can comment on what you are hearing relative to maybe some of the bigger geographies in Europe or in the US when they may be able to start to get some of these surgeries going? As you guys have indicated multiple times on this call, there is a continuum and there are procedures that can be deferred, but not for potentially long periods of time. So I'm just

curious, I know it's a fluid situation, but just anything you might be hearing as to when this might start to start up again?

A - Gary S. Guthart {BIO 3429541 <GO>}

Clearly varies by country and is the reason that we put a couple of those charts on our website for you to look at is just to see the difference in how different countries are doing it. The places that are able to engage earliest have taken strategies where they have put COVID care in one location and allow surgery to occur in a different location or hot and cold zones within their own institutions that have allowed them to manage both concurrently so long as they have staff and PPE to do it.

Giving you a general answer is really not possible at this time because of the puts and takes by region. What I will say is surgeons are there for a reason, they are -- it's impressive. They are both community-oriented and clearly understanding the need to support their communities as they flex into this crisis. At the same time they are surgeons and looking forward to going back to surgery. The backlogs that you hear about are significant and they are concerned about those patients who are surgical patients, who need care. The last comment I'd make is that very few of the procedures that are done using robotic-assisted surgery are easily resolved by non-surgical means that we are in a part of surgery that where surgery is by and large the first choice.

And as a result, I don't think a lot of these procedures are going to dissolve in time just by waiting. I think they're going to have to be done surgically. So it really will be a question of where do they get done, when do they get done and what kind of technology is used to do it.

Q - Larry Keusch {BIO 1504587 <GO>}

Okay, great. I appreciate the thoughts. Thank you.

A - Gary S. Guthart {BIO 3429541 <GO>}

Thank you.

Q - Larry Keusch {BIO 1504587 <GO>}

Thank you. Our next question will come from Amit Hazan, Goldman Sachs. Please go ahead.

Q - Amit Hazan {BIO 6327168 <GO>}

Thanks and good afternoon. Just a quick follow-up on the European system side, just thinking about operating leases out there and how that situation might evolve, can you just kind of maybe remind us of the tendency of certain countries to adopt to the leases out there and whether you are sensing any kind of a change or improvement in that outlook as we think about them being more constrained to spend on capital potentially over the next year or so?

A - Gary S. Guthart {BIO 3429541 <GO>}

Marshall?

A - Marshall L. Mohr {BIO 5782298 <GO>}

Yeah, there were -- there are limitations as to what you could do within each European country, all of them have different rules as to registration with different regulators around financing. Having said that, we really had launched leasing in Germany, in the UK two years ago or so and France, a little bit after that. And we did see a nice uptick in leasing particularly in Germany.

I think going forward, we'll be doing -- you'll see leasing in all those markets we're prepared to be able to offer. We now understand structures we can do and what the requirements are from a reporting perspective, and I think we're set. So I would anticipate given the impact of the COVID-19 that we would see additional leasing there.

Q - Amit Hazan {BIO 6327168 <GO>}

And then just one quick kind of bigger question -- bigger picture longer term one for Gary. It's early days, but how are you thinking if at all about secular changes for hospital systems and healthcare more broadly after this crisis is over? Is it kind of relates to your markets?

A - Gary S. Guthart {BIO 3429541 <GO>}

Yeah, I think it's a little too soon to tell. We certainly are thinking about how customers might adapt and you can think about a few things. I guess I'd focus you on really kind of Phase 2 and Phase 3 of this Coronavirus response. The economy starts opening back up and we have a fair amount of testing, but you're still doing with COVID as it -- as a uncured disease, how do hospitals manage that? I think that's a lot of where our thoughts are now that may have to do with side of care and other kind of flexible ways. We think minimally invasive surgery broadly and robotic-assisted surgery is important in that setting. Keeping people out of the hospital or allowing number recover quickly at home.

These are things that I think are generally good for the healthcare system and there may be some adaptation by health systems to be flexible about how to deliver that. And we're working through that internally and with them and it gets exciting. What happens after that as this goes on a couple of years, I think we'll all have to have to wait and see. Last questioner please.

Operator

Yes, that will come from Matt Taylor, UBS. Please go ahead.

Q - Matt Taylor {BIO 16863940 <GO>}

Hi, Thanks for taking the question. So I just wanted to ask a follow-up question on some of the things you're talking about qualitatively earlier in regards to helping systems when they get back to working normally and helping them be efficient and flex up on the

upside. I know you've done some work there with your internal consulting groups to make systems more efficient. It seems to be working and I was just wondering if you could offer some thoughts on how much more they could flex up in the short run and what are some of the best practices and what are the best systems doing with regards to utilization today?

A - Marshall L. Mohr {BIO 5782298 <GO>}

Yeah, if you think forward, the major things here have been really making sure that teams are consistent teams that know how to work together, work together frequently, they know how to parallelize tasks and they use kind of best practices. It is not limited to robotic surgery, but works really well therein. With regard to how we can help, making sure that training resources are available. We have been investing, as you know in Intuitive telemedicine network. I'm really pleased that we made that set of investments and in the future that allows us to project expertise in at a distance, that means people don't have to be on planes. In a post-COVID world that's probably helpful for us and something that we want to rotate towards as we go. As I said earlier in the call. I think we can forward deploy some of our training resources and help get teams up and running and trained. That would help people work through backlogs as best as they can.

Q - Matt Taylor {BIO 16863940 <GO>}

Thank you very much.

A - Gary S. Guthart {BIO 3429541 <GO>}

All right, well thank you. That was our last question. In closing, we continue to believe there is a substantial and durable opportunity to fundamentally improve surgery and acute interventions. During this period, our continue -- our teams continue to work closely with hospitals, physicians and care teams to support them in their mission wherever that may lead. We believe value creation in surgery and acute care is foundationally human. It flows from respect for and understanding of patients and care teams, their needs and their environment. Thank you for your support. We look forward to talking with you again in three months. Thank you.

Operator

Thank you. And that does conclude your conference for today. Thank you for using AT&T event conferencing, You may now disconnect.
