The authors reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Normandy—we are the "next great generation." Paris is in the distance; Berlin is our goal. It is our duty to carry on—the cost of failure is too high.

Michael E. Bowdish, MD, MS[a,b,c]
Stephen F. Sener, MD[a,c]
[a]*Department of Surgery*
Keck School of Medicine of USC
University of Southern California
Los Angeles, Calif
[b]*Department of Preventive Medicine*
Keck School of Medicine of USC
University of Southern California
Los Angeles, Calif
[c]*Los Angeles County + University of Southern California Medical Center*
Los Angeles, Calif

Reference

1. Hastie J, Sutherland L, Takayama H, Furuya Y, Hochman B, Kelley N, et al. Low rate of healthcare–associated transmission of coronavirus 2019 (COVID-19) in the epicenter. *J Thorac Cardiovasc Surg*. 2021;161:e235-7.

https://doi.org/10.1016/j.jtcvs.2020.07.081

REPLY: SAFE HARBOR DURING PANDEMIC STORM

Reply to the Editor:

As the pandemic avidly set foot in New York in March 2020, the well-being of health care workers facing mushrooming censuses of COVID-19 patients garnered considerable attention. Issues surrounding inadequate personal protective equipment supplies, physical and mental exhaustion, likelihood of acquiring the disease, furloughing, and self-isolation from family, among others, raised concerns and public expressions of support. With regard to infectivity, the conversation was unidirectionally focused—protecting health care workers from the inpatient onslaught of coronavirus. The possibility of health care–associated transmission on the other hand, was not foremost in discussions, perhaps because most of the intensive care unit and floor beds in New York City were already occupied by viral victims. In fact, as efforts centered on identifying, securing, and repurposing space to create "COVID" units, it became imperative—and more onerous—to establish "COVID-free" units to care for the immunocompromised and other uninfected patients receiving acute care, particularly those undergoing emergency surgery.

In the report in this issue of the *Journal* by Hastie and colleagues[1] from New York Presbyterian Hospital in Manhattan, the subject of health care–associated transmission to uninfected patients allocated to COVID-free units is discussed. A multipronged strategy was established, which included dedicated nursing staff, ubiquitous and mandated mask use at all times, negative-pressure ventilation, and appropriate signage with restricted traffic. Among 311 patients cared for in 2 such COVID-free units, 18 had positive polymerase chain reaction test results for SARSCoV-2. On thorough review of clinical course and timing of potential exposures in and out of the hospital, only 3 of these 18 patients were considered to have possibly or likely acquired the disease *during* their stay in these designated units. This very low rate of putative health care–associated transmission (less than 1% during the study period) was achieved despite the rotating nature of respiratory therapists and physicians in and out of these units and the physical contiguity of the units to COVID-only patient care spaces.

The lessons learned from this experience carry important ramifications for society at large. First and foremost, the success in preventing in-hospital transmission should provide confidence to the public that our institutions are a safe harbor when the need for urgent or emergency care arises. The troubling observation that hospitalizations for emergency conditions such as heart attacks, strokes, and even appendicitis fell drastically during the height of the pandemic[2,3] and that excess mortality skyrocketed suggests that fear of acquiring infection kept the gravely ill from seeking desperately needed medical care. In fact, during March 11 through May 2, 32,107 deaths were reported to the NYC Department of Health and Mental Hygiene; of these, 24,172 (95% confidence interval, 22,980-25,364) were found to be in excess of the expected seasonal baseline, of which 5293 (22%) were identified as neither confirmed nor probable COVID-associated deaths.[4] Second, at a time when the effectiveness of behavioral interventions to stem transmission—masking, distancing, and handwashing—are the subject of intense debate and politicization, the information conveyed by Hastie and colleagues[1] lends further credence to the beneficial impact of adherence to basic public health recommendations in controlling this growing pandemic in the United States.

The author reported no conflicts of interest.

The *Journal* policy requires editors and reviewers to disclose conflicts of interest and to decline handling or reviewing manuscripts for which they may have a conflict of interest. The editors and reviewers of this article have no conflicts of interest.

Daniel J. Goldstein, MD
Heart Transplantation and Mechanical Assistance Programs
Montefiore Medical Center
Albert Einstein College of Medicine
New York, NY

References

1. Hastie J, Sutherland L, Takayama H, Furuya Y, Hochman B, Kelley N, et al. Low rate of health care–associated transmission of COVID-19 in the epicenter. *J Thorac Cardiovasc Surg*. 2021;161:e235-7.
2. Lange SJ, Ritchey MD, Goodman AB, Dias T, Twentyman E, Fuld J, et al. Potential indirect effects of the COVID-19 pandemic on use of emergency departments for acute life-threatening conditions—United States, January-May 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69:795-800.
3. Wong LE, Hawkins JE, Langness S, Murrell KL, iris P, Sammann A. Where are all the patients? Addressing Covid-19 fear to encourage sick patients to seek emergency care. *NEJM Catalyst Innov Care Deliv*. May 14, 2020 [Epub ahead of print].
4. New York City Department of Health and Mental Hygiene (DOHMH) COVID-19 Response Team, Olson DR, Huynh M, Fine A, Baumgartner J, Castro A, Chan HT, et al. Preliminary estimate of excess mortality during the COVID-19 outbreak—New York City, March 11-May 2, 2020. *MMWR Morb Mortal Wkly Rep*. 2020;69:603-5.

https://doi.org/10.1016/j.jtcvs.2020.07.065