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a large academic center in the epicenter of the COVID-19 pandemic. We have also observed that this low rate was present throughout a time period that spans all of the institutional mitigation efforts through the surge of patients with COVID-19. Notably, this very low rate of transmission was achieved in COVID-19-free units surrounded—above, below, and beside—by COVID-19 units.

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coronavirus 2 virus have been strikingly different in Los Angeles and New York, yet the effect and carnage have been equally abhorrent. The huge tsunami of cases and death in New York seem to have subsided, while the unrelenting barrage of coronavirus disease 2019 (COVID-19) on Los Angeles continues. As we now write, our intensive care unit bed census is greater than 90%, and personnel from the Department of Defense are at our doorstep to provide assistance.

While the dynamics have been different, early on, we apprehensively watched and communicated with our colleagues in New York, especially regarding our common desire to safely care for patients with non-COVID-19-related surgical disease. The necessity of this was made apparent to the authors on April 2, 2020, when we learned (while operating) that a patient seen in clinic 2 weeks earlier with multivessel coronary disease presented to the emergency department in cardiac arrest. At first impression, it was hard to believe the cause was COVID-19. But it was; if not for COVID-19, we may already have performed the coronary bypass. The effect of COVID-19 goes far beyond those who have this virus.

Hastie and colleagues¹ from New York Presbyterian/Columbia University Irving Medical Center in New York report that the rate of hospital-acquired transmission of COVID-19 can be kept to very low levels, despite the rendering of care in closed units while being virtually surrounded by viral infection. This is consistent with reports from surgical colleagues in other countries, such as Greece and Italy, where the infection rates were high at earlier time points than in the United States. It appears that carefully crafted infection control efforts within health care facilities do work to limit transmission of viral infection.

Like other facilities, we cancelled all but urgent or emergent operations on March 16, 2020. By the end of April, we implemented universal testing of patients admitted to the hospital. We also started to increase the number of scheduled procedures to include those in which surgeons thought needed to be done within 1 month. It was not until May 26, 2020, that we were able to establish a universal preoperative testing protocol of outpatients for COVID-19. We currently are still limiting scheduled operations to those which need to be done within 1 month, and our operating room volumes are at about 50% of pre-COVID-19 workflow.

Hastie and colleagues should be commended for their pioneering work and dedication to caring for both patients with and without COVID-19 and for facilitating the safe care of surgical patients without COVID-19. COVID-19 may not be a surgical disease, but it is incumbent on every physician, regardless of training, to apply their skills to this pandemic. We challenge everyone to do their part to contribute. This is our

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REPLY: KEEPING SURGICAL PATIENTS SAFE DURING THE CORONAVIRUS DISEASE 2019 (COVID-19) PANDEMIC: LOS ANGELES VERSUS NEW YORK CITY



Reply to the Editor:

The epidemiologic characteristics of the pandemic caused by the severe acute respiratory syndrome

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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.

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<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 colleagues¹ 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 SARS-CoV-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 colleagues¹ lends further credence to the beneficial impact of adherence to basic public health recommendations in controlling this growing pandemic in the United States.