Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

Letter to the Editor: Two Perspectives on the COVID-19 Pandemic Nobody Is Talking About—and It's Costing Lives

Letter:

The 2019 novel coronavirus disease (COVID-19) pandemic has resulted in many deaths globally. We are inundated with media reports and a constant stream of numbers—infections and deaths to date—a barrage that can numb the mind, especially in the context of the average unaffected citizen who simply yearns to return to work, make a living, and provide for their family. But there are 2 critical considerations that have not received the attention they need.

Hospitals are hurting financially, too. We have all heard about the need to provide financial stimulus for the cruise ship industry and bartenders' associations, among others. People outside the health care industry assume that during a pandemic, hospitals are in firm standing. After all, hospital doors are open, patients are pouring in, providers are still needed at work, so business must be good. This notion could not be further from the truth. For a hospital in a hot zone in New York City, for example, while the intensive care units and emergency departments may be bursting at the seams with patients with COVID-19, elective surgeries and other procedures have been cancelled for weeks. These interventions requiring highly skilled subspecialists and the downstream imaging, laboratory, clinic visits, and consultations they entail represent the biggest contribution to financial margins for a hospital. Hospitals with large endowments can survive in this state longer than others, but without this source of revenue, a hospital cannot be financially solvent, and it is only a matter of time until it collapses and closes its doors. For hospitals in less populated regions, such as Charleston, South Carolina, which has so far been spared from the feared surge of COVID-19 patients, preparations have nonetheless been in place for weeks as well. These hospitals that "prepared for the worse while hoping for the best" now find themselves at half capacity, with half of the hospital beds empty and elective surgeries postponed. In addition to the loss of revenue for the hospital, being at half capacity results in patients being consolidated together and entire units shut down. This means that nurses, respiratory therapists, and other providers for that unit who rely on a paycheck reflecting 40 hours a week of work are being sent home without pay. For example, at my institution, a state-funded tertiary care center, 900 hospital employees were furloughed (temporarily laid off) on a single day. Scores of others including doctors and nurses face 15%–20% salary cuts, even while they continue to work on the frontlines, risking their health and the health of their families. We are not the exception but rather the norm—this is happening throughout the United States. We must remember that the squeaky wheel does often get the grease. Doctors and nurses are genuinely altruistic people with a strong desire to help others, even at their own expense. This self-sacrificing trait is our own worst enemy at this time of need. Hospitals need to unite in sharing their stories of financial hardship, and the state and federal governments need to bail out these institutions that heal our community. Where will we all be if hospitals close their doors or these workers refuse to return to work?

A pandemic does not stem the flood of other, highly morbid and common diseases. We are beginning to realize that our preoccupation with this singular disease, at the expense of every other disease, will have its ramifications. These are harder to pinpoint and do not make for TV news ratings as do a pandemic, but we fear they will be very profound and long lasting. In severely affected regions where the health care systems are overwhelmed, the relative neglect of other emergent care may be due to limited capacity—lack of hospital beds, resources, and providers. In other regions with relative sparing from COVID-19, significant decreases in provision of care likely reflect fears and anxieties of would-be patients and their families in bringing their loved one in for medical evaluation. The same fears that have resulted in social distancing compliance and other measures, resulting in us flattening the curve as a society, are keeping many at home when they should be seeking urgent medical evaluation. In Montevideo, Uruguay, the most heavily populated area of the country, we have seen zero thrombectomy candidates for acute stroke since the outbreak. In the United States, in smaller urban cities such as Charleston, South Carolina, despite a very low incidence of COVID-19 infection and transmission, an immediate and sustained >50% reduction in stroke consultations and transfers was observed immediately once the state was declared to be in a state of emergency and its citizens were advised to avoid leaving their homes. Similar trends have been observed for the coronary corollary to stroke: ST elevation myocardial infarction, or heart attack. From the hard-hit Lombardy region of Italy at the Humanitas Research Hospital in Milan, and from the Hospital Universitario12 de Octubre, Madrid, we learned that ST elevation myocardial infarction admissions were down 70% and 80%, respectively. Likewise, decreased prevention for chronic diseases and increased delay for scheduled operations have had unfortunate effects, for example, an abnormally high rate of appendiceal abscesses and a sharp drop in consultations for chronic diseases, among others. Delays in providing surgeries for patients with cancer and postponing routine cancer screenings represent another area where ongoing cancellations and delays in providing care will have consequences in months to come, when effective treatment may not be possible. History will judge us not solely by how many deaths result from COVID-19 infection itself, but rather by how many deaths not related to COVID-19 could be averted during this time period and beyond. This may be, perhaps, our greatest challenge. The time to act is now.

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