Second, as Gershengorn indicates, the decision to intubate a patient with COVID-19 is influenced by many factors, including the patient’s clinical condition, the clinician’s beliefs and expertise, available resources, and patient preference. We believe that mandating criteria for intubation during the early phases of the COVID-19 pandemic without enough knowledge about the disease itself was not feasible simply because there was not enough safety data to inform any specific approach or criteria. Moreover, clinicians’ opinions about and expertise with intubating patients with COVID-19 have evolved during successive waves of the pandemic, which could have undermined the use of explicit intubation criteria.

Third, although we considered adjudicating the indications for intubation events in this trial, we did not pursue this due to the difficulty of blinding the adjudication committee members. Fourth, Gershengorn suggests choosing another primary outcome for our trial. Even with other objective outcomes, it is difficult to exclude the possibility of bias in an unblinded study. A recent systematic review and meta-analysis of 269 critical care trials that reported data on mortality found an association between lack of blinding and a larger reduction in the risk of death. Even though there is not an optimal solution for this issue, we believe researchers conducting clinical trials during the pandemic had to make difficult decisions to ensure feasibility and efficiency without significantly affecting methodological rigor.

Dr and Ms Raghunathan propose that the geographic location of patients in our trial could have affected their adherence to prone positioning and ultimately influenced their clinical outcomes. Although interesting, this remains a hypothesis that needs to be verified. Factors influencing adherence to prone positioning are not well understood, and it remains unclear if there is a dose-response effect with prone positioning. To attribute adherence to prone positioning to geographic location alone is likely an oversimplification. Other factors, such as severity of illness and frailty, may play an important role in adherence to prone positioning. Therefore, rather than conducting an unplanned post hoc analysis of our single trial, a better approach would be to assess the effect of adherence to prone positioning on outcomes in a future individual patient data meta-analysis.

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CORRECTION
Correction to Conflict of Interest Disclosure: In the Viewpoint titled “Remote Patient Monitoring During COVID-19: An Unexpected Patient Safety Benefit,” published in the March 22, 2022, issue of JAMA, and in a related Letter in Reply titled “Remote Patient Monitoring During COVID-19—Reply,” published in the July 19, 2022, issue of JAMA, the authors’ conflict of interest disclosures were incomplete. For the Viewpoint, the disclosures should have read as follows: “Dr Pronovost reported grants from Masimo (collection of data on remote monitoring) during the conduct of the study. Ms Cole reported receipt of grants from Masimo (analysis of data). Dr Hughes reported receipt of a grant from Masimo (analysis of data).” For the Letter in Reply, the disclosures should have read as follows: “Dr Pronovost reported grants from Masimo (collection of data on remote monitoring) during the conduct of the study. Ms Cole reported receipt of grants from Masimo (analysis of data) and from the Federal Communications Commission (FCC) Coronavirus Aid, Relief, and Economic Security (CARES) Act (for purchase of home-monitoring devices).” These articles have been corrected online.


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