Why Surviving the Virus Might Come Down to Which Hospital Admits You

In New York City's poor neighborhoods, where patients have inequities in understaffed hospitals, with substandard equipment, it was a different story in Manhattan's private medical centers.

Erin Schaff/The New York Times

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In Queens, the borough with the most coronavirus cases and the fewest hospital beds per capita, hundreds of patients languished in understaffed wards, often unwatched by nurses or doctors. Some died after removing oxygen masks to go to the bathroom.

In hospitals in impoverished neighborhoods around the boroughs, some critically ill patients were put on ventilator machines lacking key settings, and others pleaded for experimental drugs, only to be told that there were none available.

It was another story at the private medical centers in Manhattan, which have billions of dollars in endowments and cater largely to wealthy people with insurance. Patients there got access to heart-lung bypass machines and specialized drugs like remdesivir, even as those in the city's community hospitals were denied more basic treatments like continuous dialysis.

In its first four months in New York, the coronavirus tore through low-income neighborhoods, infected immigrants and essential workers unable to stay home and disproportionately killed Black and Latino people, especially those with underlying health conditions.

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Now, evidence is emerging of another inequality affecting low-income city residents: disparities in hospital care.

While the pandemic continues, it is not possible to determine exactly how much the gaps in hospital care have hurt patients. Many factors affect who recovers from the coronavirus and who does not. Hospitals treat vastly different patient populations, and experts have hesitated to criticize any hospital while workers valiantly fight the outbreak.

Still, mortality data from three dozen hospitals obtained by The New York Times indicates that the likelihood of survival may depend in part on where a patient is treated. At the peak of the pandemic in April, the data suggests, patients at some community hospitals were three times more likely to die as patients at medical centers in the wealthiest parts of the city.

Underfunded hospitals in the neighborhoods hit the hardest often had lower staffing, worse equipment and less access to drug trials and advanced treatments at the height of the crisis than the private, well-financed academic medical centers in wealthy parts of Manhattan, according to interviews with workers at all 47 of the city's general hospitals.

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"If we had proper staffing and proper equipment, we could have saved much more lives," said Dr. Alexander Andreev, a medical resident and union representative at Brooklyn University Hospital and Medical Center, a struggling independent hospital in Brooklyn. "Out of 10 deaths, I think at least two or three could have been saved."

At Brooklyn University Hospital and Medical Center, three doctors said that many patients on ventilators had to remain for days or weeks in understaffed wards. Sarah Blesener for The New York Times

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Inequality did not arrive with the virus; the divide between the haves and the have-nots has long been a part of the web of hospitals in the city.

Manhattan is home to several of the world's most prestigious medical centers, a constellation of academic institutions that attract wealthy residents with private health insurance. The other boroughs are served by a patchwork of satellite campuses, city-run public hospitals and independent facilities, all of which treat more residents on Medicaid or Medicare, or without insurance.

The pandemic exposed and amplified the inequities, especially during the peak, according to doctors, nurses and other workers.

Overall, more than 17,500 people have been confirmed to have died in New York City of Covid-19, the illness caused by the coronavirus. More than 11,500 lived in ZIP codes with median household incomes below the city median, according to city data.

Deaths have slowed, but with the possibility of a second surge looming, doctors are examining the disparities.

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At the NewYork-Presbyterian Hospital, the city's largest private hospital network, 20 doctors drafted a letter in April warning leadership about inequalities, according to a copy obtained by The Times. The doctors had found that the mortality rate at an understaffed satellite was more than twice as high as at a flagship center, despite not treating sicker patients.

At NYU Langone Health, another large network, 43 medical residents wrote their own letter to the chief medical officer expressing concerns about disparities in hospital care.

Both networks said in statements that they deliver the same level of care at all their locations.

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At NYU Langone's flagship hospital in Manhattan, about 11 percent of coronavirus patients have died, according to data obtained by The Times. Jonah Markowitz for The New York Times

Gov. Andrew M. Cuomo and Mayor Bill de Blasio have spoken throughout the pandemic of adding hospital beds across the city, transferring patients and sending supplies and workers to community hospitals, implying that they have ensured all New Yorkers with Covid-19 receive the same quality care.

"We are one health care system," Mr. Cuomo said on March 31. The same day, he described the coronavirus as "the great equalizer."

In interviews, doctors scoffed at that notion, noting, among other issues, that government reinforcements were slowed by bureaucratic hurdles and mostly arrived after the peak.

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"There was no cavalry," said Dr. Ralph Madeb, surgery director at the independent New York Community Hospital in Brooklyn. "Everything we did was on our own."

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In a statement, Dani Lever, the governor's communications director, said Mr. Cuomo has repeatedly pointed out inequalities in health care. The state worked during the peak to transfer patients so everybody could at least access care, she said.

"The governor said Covid was the 'great equalizer' in that it infected anyone regardless of race, age, etc. — not that everyone would receive the same level of health care," she said. "The governor said we are one health system in terms of ensuring that everyone who needed it had access to a hospital."

A spokeswoman for Mr. de Blasio, Avery Cohen, said the mayor agreed that the pandemic had exposed inequalities, and the city had worked to address disparities.

"From nearly tripling hospital capacity at the virus' peak, to creating a massive testing apparatus from the ground-up, we have channeled every possible resource into helping our most vulnerable and remain undeterred in doing so," she said.

Weill Cornell, part of the NewYork-Presbyterian system, is one of the more prestigious health care facilities in New York City. Stephen Speranza for The New York Times

New York has never had a unified hospital system. It has several different hospital systems, and in recent years, they have consolidated and contracted, through mergers and more than a dozen hospital closures.

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Today, most beds in the city are in hospitals in five private networks. NewYork-Presbyterian, which has Weill Cornell Medical Center and Columbia University Irving Medical Center; NYU Langone; the Mount Sinai Health System; Northwell Health; and the Montefiore Medical Center.

These networks are wealthy nonprofits aided by decades of government policies that have steered money to them. They also rake in revenue because, on average, two-thirds of their patients are on Medicare or have commercial insurance, through their employer or purchased privately.

Collectively, they annually spend $150 million on advertising and pay their chief executives $30 million, records show. They also pay their doctors the most, and score the highest marks on industry ratings regarding safety, mortality and patient satisfaction.

The city has 11 public hospitals. This is the city's safety net, along with the private networks' satellite campuses and a shrinking number of smaller independent hospitals, which have been financially struggling for years.

At the safety-net hospitals, only 10 percent of patients have private insurance. The hospitals provide all the basic services but often have to transfer patients for specialty care.

Most of the private networks are based at expansive campuses in Manhattan, as are some of the public hospitals. (Montefiore is based in the Bronx; many of Northwell's hospitals are outside of New York City.)

The hospital closures have largely been outside of Manhattan, including three beloved safety-net hospitals in Queens in just a few months in 2008 and 2009.

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There are now five hospital beds for every 1,000 residents in Manhattan, while only 1.8 per 1,000 residents in Queens, 2.2 in Brooklyn and 2.4 in the Bronx, according to government data.

Yet in a cruel twist, the coronavirus has mostly clobbered areas outside of Manhattan.

Manhattan has only had 16 confirmed cases for every 1,000 residents, while there have been 28 per 1,000 residents in Queens, 23 in Brooklyn and 33 in the Bronx, the latest count shows.

Over all, more than 17,500 people have been confirmed to have died in New York City of Covid-19. Erin Schaff/The New York Times

These areas have lower median incomes — $38,000 in the Bronx versus $82,000 in Manhattan — and are filled with residents whose jobs have put them at higher risk of infection.

"Certain hospitals are located in the heart of a pandemic that hit on top of an epidemic of poverty and stress and pollution and segregation and racism," said Dr. Carol Horowitz, director of the Institute for Health Equity Research at Mount Sinai.

At the pandemic's peak, ambulances generally took patients to the nearest hospital — not the one with the most capacity. That contributed to crushing surges in hospitals in areas with high infection rates, overwhelming some hospitals and reducing their ability to care for patients.

In Manhattan, where many residents fled the city, hospitals also found patient release valves. Mount Sinai sent hundreds to a Central Park tent hospital. NewYork-Presbyterian sent 150 to the Hospital for Special Surgery.

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In all, the census at some emergency rooms actually declined.

At Lenox Hill Hospital, a private hospital on the Upper East Side, Dr. Andrew Bauerschmidt said on April 8 — near the city's peak in cases — that the hospital had more patients than usual, but not by much.

"Nothing dire is going on here, like the stories we've heard at other hospitals," he said.

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People waited for hours in long lines outside of Elmhurst Hospital Center in Queens to be tested for coronavirus in late March. Dave Sanders for The New York Times

Personnel at Mount Sinai Hospital in Manhattan experienced a more calm atmosphere compared to facilities in the other boroughs. Hilary Swift for The New York Times

After weeks battling the virus at the Elmhurst Hospital Center, a public hospital in Queens that was overwhelmed by Covid-19 deaths, Dr. Ravi Katari took a shift at the Mount Sinai Hospital.

When he arrived at the towering campus just east of Central Park, he was surprised to see fewer patients and more workers than at Elmhurst, and a sense of calm.

Dr. Katari was a fourth-year emergency medicine resident in a program run by Mount Sinai that rotates residents through different hospitals, to give them varied experiences.

In interviews, seven of these residents described vast disparities during the pandemic — especially in staffing levels.

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At the height of the crisis, doctors and nurses at every hospital had to care for more patients than normal. But at the safety-net hospitals, which could not deploy large numbers of specialists or students, or quickly hire workers, patient-to-staff ratios spiraled out of control.

In the emergency room, where best practices call for a maximum of four patients per nurse, the ratio hit 23 to 1 at Queens Hospital Center and 15 to 1 at Jacobi Medical Center in the Bronx, both public hospitals, and 20 to 1 at Kingsbrook Jewish Medical Center, an independent facility in Brooklyn, workers said.

"We could not care for the number of the patients we had," said Feyoneisha McGrath, a nurse at Kingsbrook. "I worked 16 hours a day, and then I got in my car and cried."

Nurses at Kingsbrook Jewish Medical Center said the ratio of nurses to patients was 20 to 1 during the peak of the coronavirus epidemic. Demetrius Freeman for The New York Times

In intensive-care units, where patients require such close monitoring that the standard ratio is just two patients per nurse, ratios quadrupled at some hospitals, including at Interfaith Medical Center in Brooklyn, an independent facility, and at NewYork-Presbyterian's satellite in Queens, workers said.

The city's public hospital system disputed those ratios cited by workers. It added that during the pandemic, it recruited thousands of nurses and streamlined monitoring, including by opening doors to patient rooms. The chief executive of Kingsbrook and Interfaith also disputed the ratios at those hospitals.

Research has shown that staffing levels affect mortality, and that may be even more true during this pandemic because many Covid-19 patients quickly deteriorate without warning.

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At Brookdale, the independent hospital, three doctors said that many patients on ventilators had to remain for days or weeks in understaffed wards because the intensive-care unit was full. Amid shortages in sedatives, some patients awoke from comas alone

and, in a reflexive response, removed the tubes in their airways that were keeping them breathing. Alarms rang, and staff rushed to reintubate the patients. But they all eventually died, the doctors said.

A hospital spokesman, Khari Edwards, said, "Protocols for sedation of intubated patients are in place and are monitored by our quality improvement processes."

Similar episodes occurred at Kingsbrook, the Queens Hospital Center and the Allen Hospital, a New York-Presbyterian hospital in Northern Manhattan, according to workers.

Dr. Dawn Maldonado, a resident doctor at Elmhurst, described a worrisome pattern of deaths on its understaffed general medicine floors. She said at least four patients collapsed after removing their oxygen masks to try to walk to the bathroom. Workers discovered their bodies later — in one case, as much as 45 minutes later — in the bathroom or nearby.

"We'd call them bathroom codes," Dr. Maldonado said.

Lincoln Medical and Mental Health Center in the Bronx had to increasingly use portable ventilators sent by the state to treat patients during the virus peak. Todd Heisler/The New York Times

As the coronavirus raged, Lincoln Medical and Mental Health Center in the Bronx kept running into problems with ventilators.

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Lincoln, a public hospital, had a limited number, and it could not acquire many more, so it had to increasingly use portable ventilators sent by the state. The machines did not have some settings to adjust to patients' breathing, including a high-pressure mode called "airway pressure release ventilation."

Virtually every hospital had to use some old ventilators. But at hospitals like Lincoln, almost all patients received emergency machines, doctors said.

Safety-net hospitals also ran low on dialysis machines, for patients with kidney damage. Many independent hospitals could not provide continuous dialysis even before the pandemic. At the peak, some facilities like St. John's Episcopal Hospital in Queens had to restrict dialysis even further, providing only a couple hours at a time or not providing any to some patients.

While many interventions for Covid-19 are routine, like supplying oxygen through masks, safety-net hospital patients also have not had much access to advanced treatments, including a heart-lung bypass called extracorporeal membrane oxygenation, or E.C.M.O.

For weeks, many independent hospitals did not have remdesivir, the experimental anti-viral drug that has been used to treat Covid-19.

"We are not anybody's priority," said Dr. Josh Rosenberg of the Brooklyn Hospital Center, a 175-year-old independent facility that took longer than others to gain entry to a clinical trial that provided access to the drug.

For weeks, many hospitals, including Brooklyn Hospital Center, did not have remdesivir, the experimental antiviral drug that has been used to treat Covid-19. Victor J. Blue for The New York Times

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Historically, safety-net hospitals have not been chosen for many drug trials.

Dr. Mangala Narasimhan, a regional director of critical care at Northwell, said just participating in a trial affects outcomes, regardless of whether the drug works.

"You're super attentive to those patients," she said. "That is an effect in itself."

Some low-income patients have even missed the most basic of treatment strategies, like being turned onto their stomach. The technique, called proning, has helped many patients breathe, but because it requires several workers to keep IV lines untangled, some safety-net hospitals have been unable to provide it.

Many private centers have beds that automatically turn.

A patient is transferred from NYU Langone Hospital. Hiroko Masuike/The New York Times

At Bellevue Hospital, a doctor gets ready to perform a coronavirus test inside a makeshift hospital room. Brittainy Newman/The New York Times

Near the corner of 1st Avenue and East 30th Street in Manhattan sit two hospital campuses that illustrate the disparities on the most tragic of measures: mortality rate.

One is NYU Langone's flagship hospital. So far, about 11 percent of its coronavirus patients have died, according to data obtained by The Times. The other is Bellevue Hospital Center, the city's most renowned public hospital, where about 22 percent of virus patients have died.

In other parts of the city, the gaps are even wider.

Overall, about one in five coronavirus patients in New York City hospitals has died, according to a Times data analysis. At some prestigious medical centers, it has been as low as one in 10. At some community hospitals outside Manhattan, it has been one in three, or worse.

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Many factors have affected those numbers, including the severity of the patients' illnesses, the extent of their exposure to the virus, their underlying conditions, how long they waited to go to the hospital and whether their hospital transferred healthier patients, or sicker patients.

Still, experts and doctors agreed that disparities in hospital care have played a role, too.

"It's hard to look at the data and come to any other conclusion," said Mary T. Bassett, who led the New York City Department of Health and Mental Hygiene from 2014 until 2018 before joining Harvard University's School of Public Health. "We've known for a long time that these institutions are under-resourced. The answer should be to give them more resources."

The data was obtained from a number of sources, including government agencies and the individual hospital systems.

Many of the sharpest disparities have occurred between hospitals in the same network.

At Mount Sinai, about 17 percent of patients at its flagship Manhattan hospital have died, a much lower rate than at its campuses in Brooklyn (34 percent) and Queens (33 percent).

Dr. David Reich, chief executive at the Mount Sinai Hospital and the Queens site, said the satellites were located near nursing homes and transferred out some of their healthy patients, making their numbers look worse. But he added that he was not surprised that large hospitals with more specialists had better mortality rates.

There have even been differences within the public system, where most hospitals have had mortality rates far higher than Bellevue's.

At the Coney Island Hospital, 363 patients have died — 41 percent of those admitted.

In an interview, Dr. Mitchell H. Katz, the head of the public system, strenuously objected to the use of raw mortality data, saying it was meaningless if not adjusted for patient conditions. He agreed public hospitals needed more resources, but he defended their performance in the pandemic.

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"I'm not going to say that the quality of care that people got at my 11 hospitals wasn't as good or better as what people got at other hospitals," he said. "Our hospitals worked heroically to keep people alive."

At NYU Langone Health, one of the city's large hospital networks, 43 medical residents wrote a letter to the chief medical officer expressing concerns about disparities in hospital care. Demetrius Freeman for The New York Times

On April 17, NYU Langone employees received an email that quoted President Trump praising the network's response to Covid-19: "I've heard that you guys at NYU Langone are doing really

great things.

The email, from Dr. Fritz François, the network's chief medical officer, infuriated residents who had worked at both NYU Langone and Bellevue. They believed that if the private network was doing great, it was because of donors and government policies letting it get more funding.

"When given the ear of the arguably most powerful man in the world — who has control over essential allocation of resources and government funding — it is a physician's duty to take this opportunity and to advocate for the resources that all patients need," they responded.

At the same time, another conversation was happening. It began in late March, when doctors at the Lower Manhattan Hospital concluded their mortality rate for Covid-19 patients was more than twice the rate at Weill Cornell, a prestigious hospital in its same network, NewYork-Presbyterian.

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The doctors saw an alarming potential explanation. In a draft letter dated April 11, they said their nurses cared for up to five critically ill patients, while Weill Cornell nurses had two or three. They also noted staffing shortages at the Allen Hospital and NewYork-Presbyterian Queens.

"What hospital a patient goes to (or that E.M.S. takes them to) should not be a choice that increases adverse outcomes, including mortality," the draft letter said.

Collectively, the hospital networks in New York City annually spend $150 million on advertising and pay their chief executives $30 million, records show. Erin Schaff/The New York Times

It is unclear if the doctors sent the letter. But in mid April, network leaders sent more staff to the Lower Manhattan Hospital, and that gap narrowed.

Another group of network doctors undertook a deeper study and found that some of the gap was explained by differences in the ages of patients and their health conditions. But even after controlling for those issues, they found a disparity, and they vowed to study it further.

In a statement, the network denied that any nurses had to monitor five critically ill patients. "Short-term, raw data snapshots do not show an accurate or full picture of the entire crisis," it said.

Still, one doctor who works at both hospitals said he was disturbed by one episode during the peak at the Lower Manhattan Hospital.

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The doctor, who spoke on condition of anonymity because he had been warned against talking to reporters, recalled he had three patients who needed to be intubated. When he called the intensive-care unit, he was told there was only space for one.

One man was in his mid-40s, younger than the other two, who were both over 70.

"Everyone looked bad, but he had the best chance," the doctor said. "The others had to wait."

The doctor said he did not know what happened to the patients after he left work. Given the high mortality rate at the hospital, he said he was reluctant to look it up.

"What good is it going to do me, to know what happened?" he said.

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