VIEWPOINT

The Disproportionate Burden of COVID-19 for Immigrants in the Bronx, New York

Jonathan Ross, MD, MS
Division of General Internal Medicine, Montefiore Health System, Bronx, New York; and Division of General Internal Medicine, Albert Einstein College of Medicine, Bronx, New York.

Chanelle M. Diaz, MD, MPH
Division of General Internal Medicine, Montefiore Health System, Bronx, New York; and Division of General Internal Medicine, Albert Einstein College of Medicine, Bronx, New York.

Joanna L. Starrels, MD, MS
Division of General Internal Medicine, Montefiore Health System, Bronx, New York; and Division of General Internal Medicine, Albert Einstein College of Medicine, Bronx, New York.

Corresponding Author: Jonathan Ross, MD, MS, Montefiore Health System, Albert Einstein College of Medicine, 111 E 210th St, Bronx, NY 10467 (joross@montefiore.org).

As general internists who work in the hospitals and outpatient clinics of a large safety-net health system in the Bronx, we care for an ever-increasing number of patients with symptoms of coronavirus disease 2019 (COVID-19) who call our clinics to ask for guidance, seek care in our hospitals, and die in our wards. We are distressed by the disproportionate burden of the COVID-19 pandemic for immigrant patients.

The Bronx, a borough of New York City, is one of the most ethnically diverse urban areas in the US and ranked the least healthy of New York State's 62 counties. It has rates of chronic diseases such as asthma, diabetes, hypertension, obesity, and tobacco use disorder—all factors that appear to increase the risk of complications from COVID-19—that are among the highest in the state.[1] Poor health in the Bronx is due at least in part to decades of policies related to housing, education, environmental health, and criminal justice that have perpetuated racial and economic inequality. Unsurprisingly, the Bronx currently has the highest rate of COVID-19 diagnoses and deaths among New York City's boroughs.[2] More than half a million immigrants live in the borough, and most speak a language at home other than English. Immigrants in the Bronx are disproportionately represented in the essential workforce at risk for exposure to severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), including physicians, nurses, nursing aides, home health aides, subway and bus drivers, grocery clerks, and others. The limited sociodemographic data available for COVID-19 cases in New York City show that Hispanic or Latinx individuals, who constitutemost immigrants in the Bronx, are considerably more likely to die of COVID-19 than white New York City residents.[3]

As we care for patients in the community and in the hospital during this crisis, we are deeply troubled by some of the ways in which COVID-19 uniquely affects low-income immigrant patients. In these communities, the combination of high levels of chronic diseases, chronic stress, and less access to preventive health services[4] increases the risk of more severe SARS-CoV-2 infections. Many immigrant patients live in close quarters with multiple generations sharing bedrooms and bathrooms. In these families it is often impossible to isolate older family members, those with asthma or other comorbid conditions, or even those who are ill with COVID-19 from others in the household, including those who must continue to leave home to work.

When conducting telemedicine visits because our clinics are shuttered, we routinely ask about COVID-19 symptoms and answer patients' questions. For immigrants with limited English proficiency, the lack of available translated information about the disease has meant relying on social media to obtain advice that may be erroneous. A man with fever, fatigue, and diarrhea was confident that he did not have COVID-19 because he had held his breath for 10 seconds and had not coughed, repeating a myth that has circulated online in many languages despite being refuted by the World Health Organization.[5] Even with substantial symptoms of COVID-19, patients also fear the immigration-related consequences of going to the hospital. Immigrant patients are highly susceptible to the combination of elevated rates of exposure to SARS-CoV-2, misinformation about its transmission and disease course, and hesitancy to access care.

Caring for hospitalized patients has also revealed particular challenges for immigrants. Because visitors have been barred from hospitals, patients face their illness alone in a foreign space, without families who often serve as cultural mediators between them and the health system. Staff have reduced both the frequency and amount of time they spend in patients' rooms to minimize exposure and conserve personal protective equipment, and doors to patients' rooms are often kept closed. Trying to communicate with anyone while speaking through an N95 mask, plastic face shield, and full personal protective equipment is difficult; to do so via a telephone interpreter with a patient who is short of breath and speaks a different language feels particularly depersonalizing and inadequate. We can only begin to imagine how terrifying the experience is for patients. In addition, with outpatient practices closed, our posthospital discharge plans often seem tenuous for immigrant patients—particularly those who are undocumented, who already have difficulty navigating the health care system, and who may not have a regular source of outpatient care.

In both the outpatient and inpatient settings, COVID-19 has brought added complexity to the use of interpreter services, a crucial means of communication with immigrant patients. Owing to the high transmissibility of SARS-CoV-2, in-person interpreters at the bedside of hospitalized patients are now rarely used. Telephone interpreter services are challenging; we have observed clinical staff trying to avoid touching the room telephone to their face or contaminating their own device. In both inpatient and outpatient settings, it is critical to provide reassurance to patients who are ill or anxious about the pandemic. For those who do not speak English proficiently, using telephone interpreter services further strains our ability to express empathy, and we can only hope that it comes through.

Even before COVID-19, immigrant communities in the US faced numerous difficulties accessing health care, including language barriers, lack of health insurance based on legal status, and fear of accessing medical ser-

vices related to immigration enforcement.[6] Now COVID-19 has exacerbated these barriers and has starkly revealed the inequities of our health care system. Because they are less likely than nonimmigrants to have a primary care physician,[7] immigrants may have more problems accessing medical care by telephone. Additionally, patients with fears about immigration enforcement may not be willing to risk a call to a physician's office or a visit to an urgent care center or emergency department given the increased number of deportations by Immigration and Customs Enforcement during the past several years and the recently revised public charge rules.[8,9] Implemented by the Department of Homeland Security in February 2020, the revised public charge rules have broadened the conditions under which the government can deny admission or visas to immigrants based on their use of public benefits. As a result, immigrants may wait too long to seek care for symptoms of COVID-19, putting themselves and their families at risk.

As of late April 2020, the rate of SARS-CoV-2 infections and deaths was beginning to slow in New York City. Some of the trauma caused by this pandemic was unavoidable given its scale and speed. A more equitable health care system, however, would not have failed immigrants and other vulnerable groups in the ways that we have seen. As the immediate crisis lessens and the country begins to address longer-term pandemic-related goals, a comprehensive and equitable response is necessary. To address the ongoing outbreak, COVID-19 testing and treatment should be accessible to all patients and targeted as needed toward populations, such as immigrant communities, with elevated risk. Testing and treatment will only be effective if immigrants can receive communications in their own languages and can access services without fear of immigration enforcement. One of the legacies of the COVID-19 pandemic should be a health care system that provides access to comprehensive care for all patients in the Bronx and beyond.

ARTICLE INFORMATION

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