Student-Run Free Clinics Stand at a Critical Junction Between Undergraduate Medical Education, Clinical Care, and Advocacy

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Abstract

Student-run free clinics (SRFCs) act as primary care providers that bring health care to populations in need and are an important source of undergraduate medical education (UME), guiding trainees through the art of history taking and physical examination. However, they are also social justice and advocacy initiatives—addressing disparity in access to care and educating medical trainees with firsthand exposure to socioeconomic determinants of health as well as language and medical illiteracy barriers. Here, the authors review academic literature examining the impact of SRFCs in their 3 roles: as medical care providers, as components of medical education, and as advocacy organizations. Based on the evidence of that literature and decades of direct SRFC leadership experience, the authors make the case that SRFCs are an undersupported means by which UME institutions contribute to correcting health care disparities and to serving social justice reform.

Student-run free clinics (SRFCs) act as safety nets for the U.S. medical system, providing free primary medical care to underserved populations who would otherwise seek medical care through emergency and urgent care settings.[1,2] The overarching mission of SRFCs is twofold: first, to provide health care to the 35 million uninsured individuals in the United States[3] and, second, to educate and empower the next generation of medical trainees to care for that population via a service-learning mechanism.[4–8] As of the last major published survey of member institutions of the Association of American Medical Colleges in 2014, at least 140,000 patients were seen annually at 208 SRFC sites, and at least 75% of accredited medical schools supported at least one SRFC.[9]

SRFCs have long stood at the junction between medical education and underserved communities. Beyond the service learning they provide, education regarding racial justice and social reform takes center stage at SRFCs. We argue that SRFCs deserve a preeminent position in the critical conversation on integration of social justice into the undergraduate medical education (UME) curriculum and are an existing structure through which the medical community can, and should, productively engage in advocacy efforts. We believe such a discussion is timely as the COVID-19 pandemic has highlighted the health care inequities faced by underserved, minority-dominant communities. At the time of this writing, participation in such service learning is not a Liaison Committee on Medical Education licensure requirement for medical schools; integration of such opportunities varies on an institution-by-institution basis. Specifically, medical schools are required to provide access to service or community learning opportunities,[10] but the degree to which medical students are encouraged to engage in these opportunities varies, and students are generally not required to participate.

In this article, we interpret the primary literature, examining the clinical care SRFCs provide, the educational value of SRFCs, and the role these clinics play in advocacy based on our diverse sets of experiences leading SRFCs affiliated with 3 academic institutions in New York state. We have over 20 years of literature that we collected by conducting PubMed literary searches in August 2020 and again in December 2020, using keyword searches of *student-run free clinic(s)*, which included one or more of these terms: *service learning*, *free clinic*, *activism*, *volunteerism*, *advocacy*, *patient advocacy*, or *undergraduate medical education*. Our search was limited to papers written in or translated to English, those pertaining to SRFCs based in the United States, and those with publication dates ranging from 1993 to 2020. Of the articles garnered by these searches, 25 were excluded. Reasons for excluding a potential source fell into the following categories: (1) Literature that fell outside the scope of our definition of an SRFC (i.e., we excluded clinics run by nursing, pharmacy, occupational therapy, physician assistant, and other nonmedical student populations). (2) The content of the article was outside of the scope of our discussion (e.g., telemedicine). (3) The article's focus was on quality assurance measures for care at an existing SRFC. (4) The source was not a primary source. (5) Our existing citations already substantially supported the source's thesis. Our interpretation of this literature was contextualized by our own direct experience across SRFCs associated with 3 academic institutions in New York. We used the results of our literature review to argue for the value of medical institutions investing resources into SRFCs for the benefit of the communities they serve both within and outside of their academic walls and to make the case that these clinics greatly need financial, administrative, and institutional support.

SRFCs as Medical Care Providers

SRFCs primarily serve patients of low socioeconomic status, targeting communities where up to 45% of the

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population falls below the federal poverty line[11] and where the prevalence of unemployment and part-time employment is high.[12] These underserved populations disproportionately represent Black, Latinx, and/or immigrant communities who speak English as a second language.[13] SRFC patients are more likely to have multiple diagnoses and suffer from chronic conditions, such as hypertension, obesity, and diabetes.[12] SRFCs fill unmet medical needs by providing preventive, primary care, and specialist referral services. As shown by the recent closure of SRFCs in March 2020, following recommendations by the Association of American Medical Colleges, this ecosystem is more fragile and vulnerable to disruption than hospital-based systems.[14,15]

Preventive medicine and primary care

SRFCs provide preventive and primary care services with an efficacy similar to that of typical primary care providers, as reflected in the national averages.[16] The scope and impact of this health care are statistically equivalent to those of typical care providers as measured by outcomes following the implementation of screening interventions, e.g., HIV testing[17]; care for sexually transmitted infections[18]; fasting lipid panels[19]; fasting blood glucose and hemoglobin A1c values[20]; vaccinations[21,22]; mammograms[23]; Papanicolaou tests[24,25]; prenatal care[26]; and substance abuse, anxiety, and depression screenings.[13,27–29] Predictive models estimate such preventive care saves tens of thousands of lives.[1] In addition to longitudinal primary care, SRFCs often deliver preventive medicine through ad hoc events, such as vaccine clinics and blood pressure screening clinics. These events are a means of grounding the SRFCs within the community because they are held at common gathering places, including grocery stores, farmers markets, churches or other religious sites, public parks, libraries, or community centers. These events are instrumental in providing patient education, increasing medical literacy, and allowing SRFCs to reach new patients.

SRFCs also provide effective longitudinal management of chronic disease; outcome studies suggest that SRFC care is effective in meeting common treatment goals. For example, a multisite examination of hyperlipidemia demonstrated that more than half of patients treated reached their low-density lipoprotein (LDL) goal, with a mean decrease of 34.5 mg/dL in LDL levels from baseline.[19] Another study reported successful metabolic outcomes in at least half of patients within the following measures: LDL, high-density lipoprotein, triglyceride levels, and microalbumin/creatinine ratio. These measures improved significantly over time and met or exceeded published outcomes of insured and uninsured diabetics.[30] Such findings reflect well on SRFCs' ability to provide effective longitudinal care. Interestingly, a recent study suggests that health outcomes are not necessarily reflected in the frequency of SRFC visits alone.[31] Rather, the establishment of a trusted relationship between SRFCs and the populations they serve is paramount for retaining and providing longitudinal care for those patients. This is particularly relevant given that the marginalized populations SRFCs serve have long and complicated histories with the medical system that have led many to mistrust the medical system.[32] The ability to cultivate this relationship and provide continuity of care subsequently leads to more effective preventive care, attenuating overuse of emergency room services.

Economic impact

The treatment cost for managing chronic diseases continues to increase as a function of physician time, equipment use, and hospitalization costs. SRFCs ease the pressure on our modern health care system by providing preventive care and chronic disease management through a doing-more-with-less approach. These preventive and primary care efforts reduce the burden on emergency room facilities and cut down on the need for urgent care.[33] Introducing free clinics into communities lacking medical resources or access has demonstrated benefits to the overall health, health care use, and subsequent health care costs in those communities.[2,34,35] Arenas et al estimated that the $50,000 operating cost of the SRFC that was the focus of their research saved its associated hospital system $850,000 annually.[2] However, others have found that SRFCs do not contribute to a health care system's bottom line.[36] This variability in findings is likely a product of a disparate distribution of disease burden, the endpoint measures used, and the limited sample sizes associated with SRFC practices. This discordance further demonstrates the need for continued rigorous study of the contributions of SRFCs and active discussion about maximizing SRFC benefits through better integration into the existing medical structure. Specifically, because SRFCs have a variety of structures, institutions should consider the extent to which further integration of financial, administrative, and educational support is feasible and a win–win dynamic can be struck between serving patients, educating trainees, and fostering a relationship between the community and the medical institution.

Specialty care

SRFCs have become an important gateway to pro bono specialty services. Patients served by SRFCs are unlikely to access these specialty treatments without an SRFC referral due to the financial cost and the patients' lack of medical literacy. For instance, SRFC-hosted women's health clinics have expanded access to pregnancy testing, mammograms, and screenings for sexually transmitted diseases, leading to downstream referrals to specialists for prenatal care that would otherwise be postponed or not sought at all. Additionally, these clinics play a vital role in guiding patients through the health care system during pregnancy, e.g., by assisting with the application process for public maternity insurance.[26]

Mental health care is another example of specialty care that has become well integrated into SRFC services and a prime example of the unique standing of these clinics in vulnerable, poor, marginalized, and/or primarily Black and Latinx communities. The American Psychiatric Association supports the conclusion that there is a disproportionate mental health burden among individuals with economic instabilities as well as among ethnic/racial minorities[37] due to inadequate financial resources, the cultural stigma of mental health issues, and mistrust of the medical system.[38–40] Thus, in the populations served by SRFCs, the mental illness risk factors of being a member of a minoritized ethnic/racial group and of having a low socioeconomic status inevitably intersect, which speaks to the need for SRFCs to provide mental health care.[41]

One SRFC group identified an 8.8% increase in patients with undiagnosed depression after implementation of a universal depression screening program.[27] More than half of the patients who screened positive for depression at the SRFC demonstrated clinically significant improvement in their symptoms after receiving pharmacotherapy and/or

counseling services provided by the SRFC or through its referral.[27] Such outcomes are particularly noteworthy given the stigmatization of mental illness and the populations SRFCs serve and argue for better use of SRFCs as a bridge between community needs and available service providers. These outcomes speak to the establishment of trust between SRFC care providers and their patient populations. Such trusting relationships are the foundation of longitudinal care and are exemplified by the success of in-house mental health services some SRFCs provide. These conclusions are further supported by small cohort studies that have examined the efficacy of mental health screening and treatment at SRFCs compared with large, commercial health plan providers.[42]

Despite the need for specialty care, most SRFCs lack sufficient resources to sustain direct specialty care practices. Many SRFCs are able to integrate in-house specialty care through rotating specialty-specific clinics.[43] This approach has been shown to work for a variety of disciplines, including otolaryngology, ophthalmology,[44] behavioral and mental health, dermatology, hepatology, musculoskeletal medicine, general surgery care, and women's health.[26,43,45,46] However, the ability of a given SRFC to provide specialty services depends on the extent to which that clinic is integrated into an umbrella academic institution. Without such support, clinics must seek pro bono services from individual practices, a challenge that explains, in part, why not all SRFCs operate on an internal referral system. When an SRFC cannot make in-house specialty referrals, the SRFC can make referrals to its home institution[4] or implement web-based applications for student providers and patients to use to find the most suitable available services for the patient.[47]

SRFCs as a Component of UME

Exposure to medical care

SRFCs provide an environment where medical students readily gain proficiency in basic history taking and physical examination skills. First- and second-year medical students often start their SRFC participation by collecting vital sign measurements and obtaining a chief complaint for each visit. Meanwhile, third- and fourth-year students, equipped with greater clinical experience, practice taking full histories and performing physical examinations, making differential diagnoses, formulating treatment plans, presenting to a supervising attending physician, and writing a patient note. This staging of responsibilities is typical across SRFC structures.[48] Students collaborating at different stages in their education allows for peer-assisted learning that not only increases clinical competence but also provides senior students with valuable experience in teaching clinical skills, a vital aspect of residency training that fosters future clinical educators.[49] Overall, SRFCs increase trainees' independence and confidence in the clinical practice setting.[50]

In the SRFC setting, as in all settings where trainees acquire clinical skills, adequate oversight is key to ensuring successful patient outcomes. The literature examining SRFC clinical outcomes, summarized in the section on medical care providers, evidences strong support for the viability of the SRFC model to provide clinical care that meets standard-of-care measures. However, it is imperative that SRFCs be adequately supported, funded, and staffed to ensure the necessary oversight of trainees.

Empathy and cultural competency

In addition to transmitting traditional medical knowledge, SRFCs are an important means of enhancing clinical and practical skills, which are often underemphasized (e.g., science communication, management, and cultural competency) but which are necessary to providing competent medical care. Compared with traditional care settings, the SRFC setting provides an intuitive context in which these skills come to the forefront, allowing for natural discussion among trainees and mentors regarding the social aspects of patients in addition to their clinical situations. Allotting time for the challenging psychosocial elements of care[5] stands in contrast to the narrower teaching focus on disease management that trainees encounter in hospital-based clerkship rotations, necessitated by the careful time management required for the heavy workloads.

While definitive, quantitative evidence of the impact of SRFC training on these critical skills is lacking, observational evidence supports the association between such skills and SRFC involvement. Students who participate in SRFCs have been shown to have a higher level of empathy than students who have not participated in SRFCs.[6] Further, students who volunteer with underserved communities are more likely to return to volunteer and be involved in other SRFCs, i.e., at the level of residency training or beyond.[7,51] This observation suggests that SRFCs breed future leaders in the medical community with a focus on providing medical care for traditionally underserved communities,[8] although measures like specialty selection are not reported to be significantly influenced by SRFC experience.[52–54]

Whether these correlations primarily reflect a self-selection bias or the development of skills in science communication, management, cultural competency, and so on because of SRFC exposure, the opportunity for trainees to engage with patient populations they may not otherwise encounter during their core and elective clinical rotations is valuable. Several studies report that working with underserved populations is associated with continued practice with those populations, demonstrated by data from the National Health Service Corps.[55,56] It is highly probable that such conclusions extend to SRFC settings, although large cohort studies are lacking.

Collegiality and leadership

SRFCs are also a natural setting where medical students can appreciate the skill sets of other health care professionals and build interprofessional communication and collaboration skills on interdisciplinary teams.[49,57–63] Interprofessional SRFCs, originally implemented as a way to diversify clinic services, have many advantages. The incorporation of a wider range of care providers than what is found in traditional clinics—from nursing, nurse practitioner, pharmaceutical, physician assistant, physical therapy, and social work sections—has consistently been shown to improve the quality of care provided.[9,64–66] For example, incorporating social work trainees into SRFCs is a common practice that can help these clinics find affordable care from specialty physicians[67] and guide patients to free community resources, such as for food security, childcare, and needle exchange safety. Furthermore, students report several benefits from working in interdisciplinary SRFCs, including greater perceived clinical abilities and comfort working with others. They also better understand the value of SRFCs as a result of their work experience.[68] Such collaboration is becoming an increasingly

important aspect of modern medicine and medical education.

In addition to enhancing practical teamwork skills, SRFCs are a key means of developing leadership skills.[69] Students in leadership positions within SRFCs are tasked with various administrative duties such as budgeting, volunteer management, scheduling, developing and maintaining electronic medical records, and managing medical supplies and equipment. The skills required to complete these tasks are not typically taught in traditional UME settings, yet they are vital to developing physicians who will go on to be leaders in our health care systems.[70] Further, quality assessments, which are often undertaken at SRFCs, are another crucial element of medical practice that is not generally directly addressed in conventional medical schools. Implementation of these assessments drives home to trainees the importance of patient–provider trust.[13] In gaining experience with such often neglected principles of practice, students leave their SRFCs better prepared for a modern medical workforce.

Finally, leadership opportunities at SRFC-associated organizations, such as the American Academy of Family Physicians, the Society of Teachers of Family Medicine, and the Society of Student Run Free Clinics, allow students to share lessons learned with fellow students and attending physicians at other clinics across the United States. This activity benefits new clinics as well as established clinics that are expanding. This ongoing dialogue fosters shared knowledge pools on potential sources of funding, electronic medical record platforms, medication distribution, and tactics for community outreach. Such networks demonstrate the value of SRFCs in developing leadership and medical communication skills within a relatively flat hierarchy that allows leaders to learn from and teach each other.

Practical considerations of UME integration

Despite the increasing number of SRFCs associated with medical schools in the United States, and the benefits of such associations, volunteer work at an SRFC is rarely incorporated directly into medical school curricula. Occasionally, elective options in late-stage undergraduate medical training are provided,[71] but more commonly, students are left to decide whether to volunteer during their personal time. Ironically, lack of integration into the medical curriculum leads to negative personal or academic consequences for students that seek out such volunteerism. Because time is a zero-sum game, students in a rigorous and competitive setting must weigh the opportunity cost of participating in service learning over other endeavors that offer greater potential for professional advancement (such as preparing for examinations or carrying out clinical research) or over personal well-being. To date, there is a lack of large-cohort data measuring such opportunity cost, though previous small datasets suggest no direct correlation or a weakly positive correlation between SRFC participation and academic grades.[72,73]

SRFCs as Advocacy Organizations

Social responsibility and activism have always percolated in the background of UME but are increasingly becoming crucial topics for the physicians of tomorrow.[74–76] Yet, the universal integration of advocacy within medical school curricula has remained elusive.

The authors argue that nowhere do activism and medicine coincide more than in settings where students are confronted, often for the first time, with the realities of medical care access and health disparities. In the service-learning environment of SRFCs, students experience firsthand the public health and systemic issues that negatively and disproportionately affect health outcomes for marginalized populations. For example, SRFCs often serve as a gateway to Medicare and Medicaid enrollment; without assistance, eligible patients might be unable to enroll on their own because of language barriers or insufficient literacy in health care topics or reading.[77,78] Firsthand exposure to vulnerable populations through SRFCs is a critical means of encouraging future providers to educate themselves on medicine-adjacent topics (e.g., public health, social work). This self-education is critical for developing physicians able to care for patients from different cultures.[5] These experiences from the service-learning environment ignite important conversations about access to medicine, racism, ableism, and so on. Student volunteers, regardless of whether they were involved in the leadership of the clinic, have consistently reported SRFC exposure to be a source of education regarding social barriers to health.[64,79,80] Additionally, SRFC case studies that focus on providing care to specific populations (e.g., the homeless or immigrant groups of specific ethnicities) report students have increased awareness of population-specific health disparities after their participation in SRFCs.[81–83] This education is fundamental for addressing common but overlooked population-specific concerns; for example, one SRFC demonstrated the prevalence of food insecurity in its lower-socioeconomic patient population that had not been previously addressed and that had clear, negative clinical consequences.[84] While the UME curriculum can be narrowly systems based, SRFCs arguably put advocacy, law, and governmental politics into close contextual proximity with medicine.[70] Even at the preclinical level, such exposure is reported to increase engagement, learning, and a sense of responsibility for the importance of patient care.[82,85]

Service to marginalized groups is a critical part of the identity of modern-day medical trainees. Now is a crucial time for medical schools to carefully examine their role in training the next generation of health care providers on the key factors that lead to poor health outcomes and the role an associated SRFC can have in achieving these institutions' stated goals. We hope that medical schools will engage in meaningful conversations of what service learning looks like in the context of social justice and advocacy, and we suggest that institutions that do have an associated SRFC consider how best to support those existing opportunities, such as conversion to a longitudinal clerkship model.[86]

Limitations of SRFCs

The current positioning of SRFCs at the intersection of medical volunteerism and education presents complex challenges. First, SRFCs have limited financial resources.[9,34] Each SRFC model varies in its funding support and operational budget. Some SRFCs are hosted within clinical institutions with government support (i.e., federal, state, local) that covers the majority of the financial responsibilities, while others are independent 501(c)(3) (federally tax exempt) entities that seek out their own funding sources.[87] Sponsoring institutions often help with appropriately budgeting operational costs and using assistance programs that help secure discounted medical supplies and pharmaceuticals.[88] Many SRFCs are eligible and compete for grants or carry out fundraising activities to find additional support[88–90]; these

endeavors can be important learning experiences for student leaders looking to address a clinic's funding limitations.

Leadership continuity is also a major challenge for SRFCs, with typical leadership roles lasting only a year; frequently changing leadership has been a self-reported weakness of SRFCs.[91] Initiatives within a clinic occur gradually and often require more than a full year to implement and assess outcomes. For example, needs-based assessment is an invaluable tool for setting clinic policies but often requires more than a year to perform properly.[2] Thus, annual turnover of student leadership results in friction from project and operational handoffs. To help alleviate potential negative consequences of frequent handoffs, many SRFCs have a longitudinal faculty advisor who guides students in project planning and execution and other activities related to clinic operations. In addition to faculty guidance, a longitudinal steering committee composed of junior and senior student volunteers and faculty members can help ensure the success of clinic operations and initiatives.[92] For additional best practices, see the recommendations in the practical handbook for health care providers, "The Free Medical Clinic," developed by the American Health Lawyers Association and the American Medical Association Foundation.[93]

Finally, another significant challenge for SRFCs is the shortage of volunteer supervising physicians.[9,34,94] Trainees provide the bulk of the SRFC labor force; however, oversight by faculty or resident supervising physicians is required to manage the care these trainees provide. In a profession with a high risk of burnout and dissatisfaction with the work–life balance,[95] attending physicians may face a significant opportunity cost for donating their time outside of already demanding regular work hours. This understaffing is reflected in patient wait times[96] and may also contribute to a high turnover rate of volunteer physicians. This turnover can have significant consequences for the continuity of care of returning SRFC patients and the quality of mentorship for trainees. Often, the physicians who volunteer repeatedly at SRFCs are medical educators who report a personal interest in contributing to and advancing the education of medical students.[97] This desire for positive impact through mentorship is also reflected in the senior trainees' active involvement in teaching leadership skills necessary for managing the clinic in addition to assisting with patient care.[98] We believe the strength and stability of SRFCs can be improved by adding programs to incentivize participation and decrease the opportunity costs for volunteer physicians. For example, faculty at some institutions receive secondary appointments in medical education departments for their volunteer involvement at a set number of SRFC sessions within a year.[88] The authors hope that stakeholders in UME will examine these challenges and consider how they might be addressed to benefit not only SRFCs but also the teaching faculty and doctors-in-training who form a bridge between the infrastructure of SRFCs and the sponsoring institutions.

Finally, the authors note that the perspective we offer in this article is based on our interpretation of the data; we recognize that additional investigation is needed to determine how best to bring SRFCs under institutional umbrellas.

Conclusions

In this article, we reviewed the scholarly literature to examine the impact of the SRFCs in their role as medical care providers, as components of medical education, and as advocacy organizations. Our review supports the following conclusions: (1) SRFCs deliver quality primary care services to communities of patients who would otherwise go without; (2) SRFCs serve as a bridge between those communities and more advanced health care treatments by improving medical literacy and aiding in the navigation of the complex medical system; and (3) SRFCs give health professions trainees the opportunity to further develop their clinical knowledge and skills, practice interprofessional collaboration, and gain insight into the administrative aspects of medical practice.

Despite these contributions, SRFCs largely remain poorly integrated into medical school curricula and the health systems they supplement, a problem worth reflecting upon at an institutional level. The extent to which an SRFC can foster a productive partnership with its related institutions affects the success of the clinic. Many of the SRFC limitations we have presented here can be addressed through sufficient institutional financial, administrative, and teaching support.[9,34] Development of volunteer physician incentivization programs,[88] navigation of grant opportunities, and advertisement to potential patients are examples of such institutional support. However, we hope stakeholders in advocacy and medical education will continue discussing these issues, spurred by our perspective on how best to move forward.

As SRFC leaders with over 30 years of collective experience, and based on our interpretation of the available literature, we believe investments in SRFCs are beneficial to underserved communities, to medical students, and to the health systems in which they exist. We believe the institutional integration and support of SRFCs are part of the larger effort of addressing health care disparities across the United States and of providing an education to medical students that will enable them to be effective advocates for and health care providers to underserved populations throughout their careers.

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Teaching and Learning Moments
Bearing Witness

A bright and incongruous warmth cocoons the room, sun-streaked windows inadvertently highlighted as we shuffle about, physically distanced even as we gather together. We are assembled around JG's hospital bed, for he remains ventilator-dependent after his liberation from the endotracheal tube; his newfound tracheostomy is carefully trussed but sullied still with dried blood. He is awake—unlike earlier in the week—and sits up with unseeing eyes, intraretinal hemorrhages having robbed him of sight. His hearing seems intact, although it is hard to be certain, as he very likely sustained anoxic brain injury at the time of presentation. His head tilts toward the video monitor, sensing the presence of loved ones as they slip frantically between English and Spanish.

"We are with you … you are loved … you will get better…." Their earnest pleas ring into the halls of the intensive care unit (ICU), echoing in my heart. JG has been here for several months, transported to our tertiary care center after he arrested while waiting in the triage at a community emergency room, the demands of oxygenating fluid-filled lungs too much for his middle-aged heart. He was transferred for consideration of extracorporeal membranous oxygenation—a sophisticated bypass that "rests" the heart and lungs and can allow time for healing—but his status was tenuous, and he quickly spiraled into a vortex of complications: pulmonary emboli, respiratory failure, infections, bleeds, and tissue breakdown.

JG is infrequently alert, although the COVID-19 infection he initially harbored is gone—he has been deemed "COVID recovered"—but in its wake it has left a tempest of damage, unveiling itself slowly and erratically. Despite his bedridden tenure, his physique attests that JG was once vigorous and robust; his body reflects years of hard manual labor and long days, and communicates a life story we can no longer elicit. It remains uncertain where he contracted the virus and, in many ways, it is moot, for his anatomy has reluctantly yielded to its devastation.

JG had been working to support his family and children in Central America—this much we know. His daughter is on the Zoom call now, her far-away connection spotty, the skies behind her a disarming blue as she tries to grasp what has happened to her father. It is difficult for JG's loved ones to imagine, through the constraints of the Zoom screen, how extremely ill he is. Explaining the effects of COVID-19 is difficult enough, but its recovery and sequelae can be even more confusing. The grief contained within our ICU is being mirrored globally, on a horrifying scale, as our disbelieving world is thrust into the pandemic. The deaths are irrefutable.

COVID's victims are largely the most vulnerable: the elderly, the frail, the immunocompromised, and the chronically ill. Additionally, the virus has laid bare the schisms of our communities by targeting those who are impoverished with poor health care access; those beholden to crowded housing and public transport; and those who are struggling with mental illness and addiction. Death and illness are magnified in the walls of prisons and other institutions, nursing homes, and communal residences. Those with the least reserve are burdened with disproportionate grief and loss; yet somehow, we continue to be surprised that this is so, alarmed by images of inequity and injustice. Already, the life expectancy in the United States (which, at baseline, is lower than that of comparable high-income nations) has shortened due to SARS-CoV-2.[1] Minority groups are inordinately impacted, with the life expectancy of Blacks lessening by 2.10 years, Latinos by 3.05 years, and Whites by 0.68 years.[1] Gains that had been made in reducing discrepancies in life expectancy between racial groups are being lost, with an abhorrent 39% increase in the Black–White life expectancy gap.[1]

JG's loved ones, overwhelmed by medical information and care nuances, plead with the medical team to press on, desperate for recovery or any semblance of normalcy. JG tires quickly and although his family members continue to cheer him from the screen, he slumps back in the bed, the effort of this meeting already evident. His family is given time to process and absorb the impact of his illness and consider what may lie ahead for him despite our best efforts: long days of being institutionalized, isolation, ventilatory dependence, confusion, blindness, pain, and suffering. Meetings are scheduled with loved ones to check in, but visits are limited by screen availability and unit restrictions.

Ultimately, the family decides against aggressive care as the outlook and prognosis for JG becomes less ambiguous, and local friends and relatives are granted in-person visitation as end-of-life care emerges as the only plausible course. Prayers are recited, remembrances shared, forgiveness and blessings offered. JG is compassionately weaned back from the ventilator and he passes faster than had been anticipated, his body exhausted beyond our comprehension. His wife and children are unable to see him, hold his hand, lean into his cheek, rub his feet, or embrace his ever-thinning frame. Despite his COVID-recovered status, JG remained estranged by the pandemic and isolated by time, resources, and circumstance. But his story was witnessed, and I pray this will prove true for all the stories that must be heard, for compassion and comprehension are necessarily embedded within our ability to behold the humanity of others.

Author's Note: The name and identifying information in this essay have been changed to protect the identity of the individual described.

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