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Perspective

The Case for the Safe Re-Opening of Student-Run Free Clinics during COVID-19

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Abstract

Coronavirus disease 2019 (COVID-19) has presented a unique challenge to student-run free clinics (SRFCs), with many closing for several months and all needing to find ways to adapt to the new "normal" of the pandemic. While the prospect of new variants and higher surges continues to threaten our ability to keep SRFC doors open to serve the neediest patients among our community, we present here arguments from need, practicality, safety, and ethics that COVID-19 is the ideal time to maintain—and, even expand—the services SRFCs provide. With so many patients relying on SRFCs for their primary care and with the ability to use precautionary measures to safely see and treat patients, SRFCs should play a vital role in helping the overburdened healthcare system continue to function and provide needed care, despite the devastating impacts of COVID-19.

Introduction

At the end of February 2020, the Mollie R. Wheat Memorial Clinic (MWMC), a student-run free clinic (SRFC) in Terre Haute, Indiana, closed its doors to protect its volunteers and patients from the acute threat of the novel coronavirus. Faced with an uncontrolled contagion and the threat of clinics as a nidus of infection, medical school administrators implemented a short-term solution: they shut down all SRFC operations. In October 2020, MWMC reopened, employing student-written infection control protocols to again provide necessary care to its community. In a compromise with medical school administration, who were concerned with the safety of their students, MWMC would not have students in patient-facing roles This essay, written and submitted during one of the peaks of the pandemic, makes an argument in four parts for opening SRFCs sooner rather than later during a public health crisis, using the coronavirus disease 2019 (COVID-19) as its example.

The COVID-19 pandemic seems to be waning in America, though the threat of new variants and new surges—as we saw with delta and omicron—loom. Whether or not this is the big pandemic of our lives, over time, there will be other pandemics. The authors hope this essay will provide some future guidance to SRFCs and their medical school administrators for how best to work together to continue serving their communities during a pandemic.

An Argument from Need

Currently, 106 United States (US) medical schools run SRFCs; additionally, more than 1000 non-student operated free clinics serve patients in every state in the US.[1] Combined, these clinics care for 1.8 million vulnerable Americans each year.[2] The majority of these patients are uninsured with few other options for truly free healthcare.[2] The Institute of Medicine released a statement that uninsured Americans "get about half of the medical care of those who are insured, and as a result, those without insurance tend to have more illness and shorter life expectancy than those with health insurance."[3] The pandemic has only amplified this issue. An estimated 7.7 million Americans have lost jobs with employee-sponsored health insurance plans that

had also covered 6.9 million dependents.[4] That is a total of 14.6 million individuals affected by loss of health insurance and access to health care since March 2020.[4] SRFCs are unable to fill this void while closed.

SRFCs function as the primary care provider for many uninsured patients and are crucial for those requiring uninterrupted care for chronic conditions.[5] Despite being managed by students and despite the many disadvantages faced by their patients, SRFCs repeatedly demonstrate success in helping patients manage their chronic conditions. Several studies indicate that SRFCs attain equal or better results when compared to national guidelines for the management of diabetes, hypertension (HTN), preventive counseling (such as smoking cessation and cancer screening referrals), and depression.[6-10] Additionally, research has shown that when chronic conditions are managed appropriately in an outpatient setting, such as in an SRFC, the burden on hospitals significantly decreases.[11]

Studies further suggest that underlying chronic conditions that SRFCs are adept at treating—diabetes, HTN, cardiovascular diseases, smoking, and chronic obstructive pulmonary disease (COPD)—are common in the sickest COVID-19 patients.[12] People with these comorbidities are at higher risk of becoming ill with COVID-19, needing hospital-based critical care such as mechanical ventilation, and ultimately dying of the disease.[12] Furthermore, minority populations in the US face higher morbidity and mortality from COVID-19 due to higher rates of comorbidities and lack of access to reliable healthcare.[13] Patients with these poor social determinants of health, who are the primary focus and beneficiaries of SRFCs, are more likely to have underlying conditions that remain uncontrolled and, thus, are predisposed to more severe disease from COVID-19.[12,13]

Hospitalizations from COVID-19 have peaked five times since its emergence in 2019.[14] Healthcare facilities across the country, urban and rural, were repeatedly overwhelmed, as their COVID-19 patient-counts regularly exceeded the number of available beds. SFRCs are a vital piece of the healthcare landscape, and they must re-open and remain open to offset the strain faced by healthcare systems during such times. SFRCs can manage chronic conditions, like diabetes, HTN, and COPD, helping to avoid unnecessary hospitalizations for diabetic ketoacidosis, myocardial infarction, and COPD exacerbation, and to reserve critical hospital beds for treatment of, for example, COVID-19 patients.

An Argument from Practicality

The closure of SRFCs, as has occurred during COVID-19, deprives a generation of medical students the opportunity to learn practically, and also deprives the healthcare system of extra, eager hands that might help relieve some of the strain caused by a pandemic. Medical students sometimes feel like their place in academic medicine is simply to study and observe without an active role in patient care. However, SRFCs challenge the mentality that medical students cannot contribute early in their education.[15] By encouraging medical students to learn experientially in a safe and supervised environment, they will be better prepared for clinical rotations, residency, and professional practice.[16] When medical schools fail to recognize the value of early experiential learning, students are left at a significant disadvantage.[17] Clinical experiences early in medical education help students master clinical skills, build self-confidence, and increase comfort working in an interprofessional team.[18]

In addition, volunteering in an SRFC provides an opportunity for real life, problem-based learning. Used for over 50 years in medical education, problem-based learning has helped motivate generations of medical students with the sense of self-fulfillment that comes from learning autonomously.[19] Working in an SRFC places the responsibility for learning and integrating information from multiple courses on the student, who is interacting with real patients in authentic situations.

The healthcare system cannot afford to make SRFC student volunteers bystanders for the continuing COVID-19 pandemic or future health crises. SRFCs are equipped with the staff to relieve overburdened healthcare systems and ultimately to help mitigate rationing of care as has occurred in the ongoing pandemic.[20,21] Beyond this, there is a moral imperative for SRFCs to resist abandoning their patients under challenging

circumstances, especially when SRFCs can design effective solutions to re-open safely.

An Argument from Safety

When COVID-19 limited hospital services and canceled elective procedures in March 2020, the CDC recommended prioritizing acute visits.[22] This response, focused on preventing transmission of the virus, included closing SRFCs and led to the underuse of chronic care services.[22] As more was learned about the virus, the importance of resuming care for chronic conditions while still preventing physical interaction among patients became clear. In August 2020, the American Association of Medical Colleges (AAMC) recognized this need for healthcare to return to full capacity. They published a change in guidance, recommending that medical students could return to direct patient care, provided that the infection-control guidelines were followed. These guidelines easily apply to the re-opening of SRFCs. However, despite AAMC's leadership, at almost a year after the onset of the pandemic, many SRFCs remained shut by their universities and their vulnerable patient populations remained uncared for.[23,24]

Because SRFCs are essential to providing free medical care to those most vulnerable to COVID-19, it is vital to open with a plan that prevents transmission of the virus and protects not only patients but also students and faculty. While studies have shown that those in healthcare settings are at increased risk for COVID infection, researchers have also demonstrated that this risk is mitigated by availability and proper use of PPE and distancing protocols, as well as vaccination.[25,26,27] However, the most important consideration when creating a re-opening proposal is that it must remain amenable to modification. Information about COVID-19 is continually changing, so scheduling frequent meetings, working with local health departments, and making adjustments as new evidence emerges is required for keeping an SRFC open.[28]

Overall, the safest way to keep open SRFCs is to establish telemedicine services, and this has recently been a popular topic of investigation, because it eliminates physical contact with patients entirely.[22,29,30] However, this option may not be

Table 1. Safety considerations for re-opening a Student-Run Free Clinic (SFRC)

Category	Safety Considerations
PPE Considerations	Face coverings required: masks for patients and properly fitted (according to Occupational Safety and Health Administration standards) N95 respirators for students and clinic faculty.[2]
	Face shields available upon request.
Infection Control	Hand sanitizer and handwashing stations placed throughout the clinic to accommodate Center for Disease Control (CDC) handwashing guidelines.[31]
	Patient screening with standardized symptom questionnaires upon entry to the clinic and when scheduling appointments.
	Temperature checks upon entry to the clinic.
	Use of CDC-approved disinfectants after each patient in clinic areas that experience heavy traffic, including exam rooms.[31]
	Plexiglass barrier added around registration.
	Use of CDC-approved disinfectants to clean the entire clinic at the end of the day.[31]
Staffing	Procedure for contact tracing and quarantining exposed students and faculty.[28]
	At this point, because of the availability of coronavirus disease 2019 (COVID-19) vaccines for SRFC volunteers, clinic volunteers are required to be vaccinated.
	Plan to maintain adequate staffing with an on-call volunteer position, in anticipation of the temporary loss of clinic volunteers due to COVID-19 quarantine.[28]
Clinic Flow	Closed waiting room; patients wait in cars or outside until their room is ready
	Patients escorted immediately to their rooms to limit patient-to-patient exposure.
	Patients remain in the examination room for laboratory procedures (bring a mobile lab to patient rooms to minimize patient contact while waiting by/in the lab).

feasible for every clinic. The cost of implementation, for instance, may be prohibitive for some clinics. Also, telemedicine may further alienate patients already disenfranchised by the healthcare system and who are most negatively affected by social determinants of health. For example, some SRFC patients might lack access to the Internet or to electronic devices, making telemedicine impossible for them. For these reasons, even if telemedicine could be quickly implemented, a plan must still be made to re-open the clinic physically.

Virus transmission can be limited by following safe practices inside the clinic and by preventing it from entering the clinic in the first place. Members of the MWMC's executive board did extensive research and implemented the following safety procedures listed in Table 1. Adoption of these practices will allow for SRFCs to continue providing free medical care during a pandemic while also emphasizing transmission reduction and safety.

An Argument from Ethics

Having established that SRFCs are an essential part of community medicine and that keeping them open is practical and safe, what remains is to explain why keeping them open is not just an idealistic possibility but an ethical obligation. Understanding why reopening these clinics is not optional but necessary requires thinking about the nature of the ethical duties that belong to the SRFC and its administration.

Understanding ethics is so integral to medicine that the Liaison Committee on Medical Education includes ethics as its own category in the content standards for medical school accreditation in the United States.[32] One way of understanding these standards, which medical schools often teach as "professionalism," is in terms of virtue-based ethics.[33,34] Others elsewhere describe these virtues in greater detail, but some examples relevant to medicine include justice and truthfulness, compassion, integrity, self-effacement, self-sacrifice, and always courage.[33,34]

The medical virtue of self-sacrifice plays an integral role in the SRFC even under normal circumstances. For student volunteers, SRFCs help cultivate appropriate clinical techniques and attitudes for patient care, but they are also a place for students to enact the ethical standards of their chosen profession. The verb "enact," rather than "practice," is used here because to treat the SRFC as a rehearsal space for the virtues of medical professionalism would be to exploit the SRFC's vulnerable patient population and bring to grotesque fruition one of the fears about such clinics—that students should be "practicing on," rather than definitively treating, those who can't afford other care.[33] Because the goals of SRFCs are twofold—to teach students and to care for patients—one of the implications of this "practicing" is that students' education might be placed above the needs of the patients. Buchanan and Witlen seem to have this concern in mind when they suggest, "the heightened vulnerability of [SRFC] patients implies a greater responsibility on the part of those who care for them."[35] This greater responsibility falls primarily on the student volunteer who must be continually conscious of this responsibility and act deliberately to "keep self-interest systematically secondary."[36] This action is self-effacing and self-sacrificing—two of the virtues of medicine—and it prevents patients from being treated as a means to an end.[33] This responsibility becomes of even greater concern for the SRFC during a pandemic, as it has throughout the COVID-19 pandemic, as the twofold goals of the clinic seemingly come into conflict with each other.

When SRFCs closed in March 2020, not enough was known about SARS-CoV-2 to prevent unchecked transmission within the clinic. Even as the virus became better understood, proper protective equipment was unavailable and physical modifications to clinic space were still needed for effective infection control. In the early stage of the pandemic, to prevent virus transmission and to therefore prevent potentially life-threatening acute disease, the good of a complete closure of clinics for both students and their vulnerable patient population by far outweighed the bad of delaying continued care for patients with chronic, non-COVID-19 conditions.

As more became known about SARS-CoV-2, extensive infection-control guidelines were established that allowed the re-opening of other community clinics.[37] These new guidelines made complete closure of SRFCs less obviously the

necessary good as, at the same time, acute exacerbations of patients' chronic conditions began to loom. Despite this, most SRFCs remained shut by their universities and their vulnerable patient populations remained uncared for almost a year into the pandemic. These sustained closures created not just practical medical problems, but they also suggested that SRFC patients are valued primarily as pedagogical tools instead of as legitimate patients in their own right.

The obligation to keep SRFCs open is thus an ethical one. Meeting this obligation requires a set of calculated risks and sacrifices willingly taken to provide ethical care. In addition to the promise of educating medical students, by accepting patients with chronic conditions, SRFCs implicitly promise those patients a continuity of care. After a year of closure, it benefited neither the students nor the patients to remain closed, or to re-close in the face of future spikes in cases.

Thus, student volunteers must be willing to take certain physical risks—mitigated by the strategies provided in the discussion above—and make pedagogical sacrifices. For the authors of this essay, just such a pedagogical sacrifice was necessary to re-open their clinic, which did so initially with students only in administrative roles and not as patient-facing volunteers. In this way, SRFCs must have the strength to forgo certain educational opportunities for medical students in favor of providing essential care for their patients. To remain closed when it is at all possible to open safely is to fail to meet the ethical obligation owed to SRFC patients.

Conclusion

The COVID-19 pandemic has waxed and waned as new variants emerge, and future public health crises—related to COVID-19 or not—will certainly develop. During those times, it is up to SRFCs to demonstrate the courage, compassion, and self-sacrifice that drove their volunteers towards the study of medicine in the first place by advocating for the continued care of patients in fully-functioning SRFCs. Furthermore, such crises can be opportunities for medical schools, to strengthen the bonds with the communities in which they are rooted through their SRFCs. There is a need in those communities that SRFCs can fill, but only if they are open. Because infection control guidelines can make it possible to protect both SRFC volunteers and patients, all that remains is to fulfill the professional and ethical imperative of SRFCs to continue their patients' care. Nobody else is coming to help these patients—their chance at sustained health is up to SRFCs, and SRFCs are designed to meet that challenge, whatever the circumstances.

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