Journal of Student-Run Clinics
Original Study

Student-Run Clinics: A National-Scale Needs Assessment

David Lee, MD[1]; Felicia Fong[2]; Kaitlyn Quach[2]; Kurt Wharton, MD[3]

[1]Division of Urogynecology and Reconstructive Pelvic Surgery, Department of Obstetrics and Gynecology, Northwestern University Feinberg School of Medicine, Chicago, Illinois, USA
[2]Oakland University William Beaumont School of Medicine, Rochester Hills, Michigan, USA
[3]Department of Obstetrics and Gynecology, Oakland University William Beaumont School of Medicine, Rochester Hills, Michigan, USA

Corresponding Author: David Lee, MD; email: david.lee@alumni.med.wmich.edu

Published: October 4, 2025

Abstract

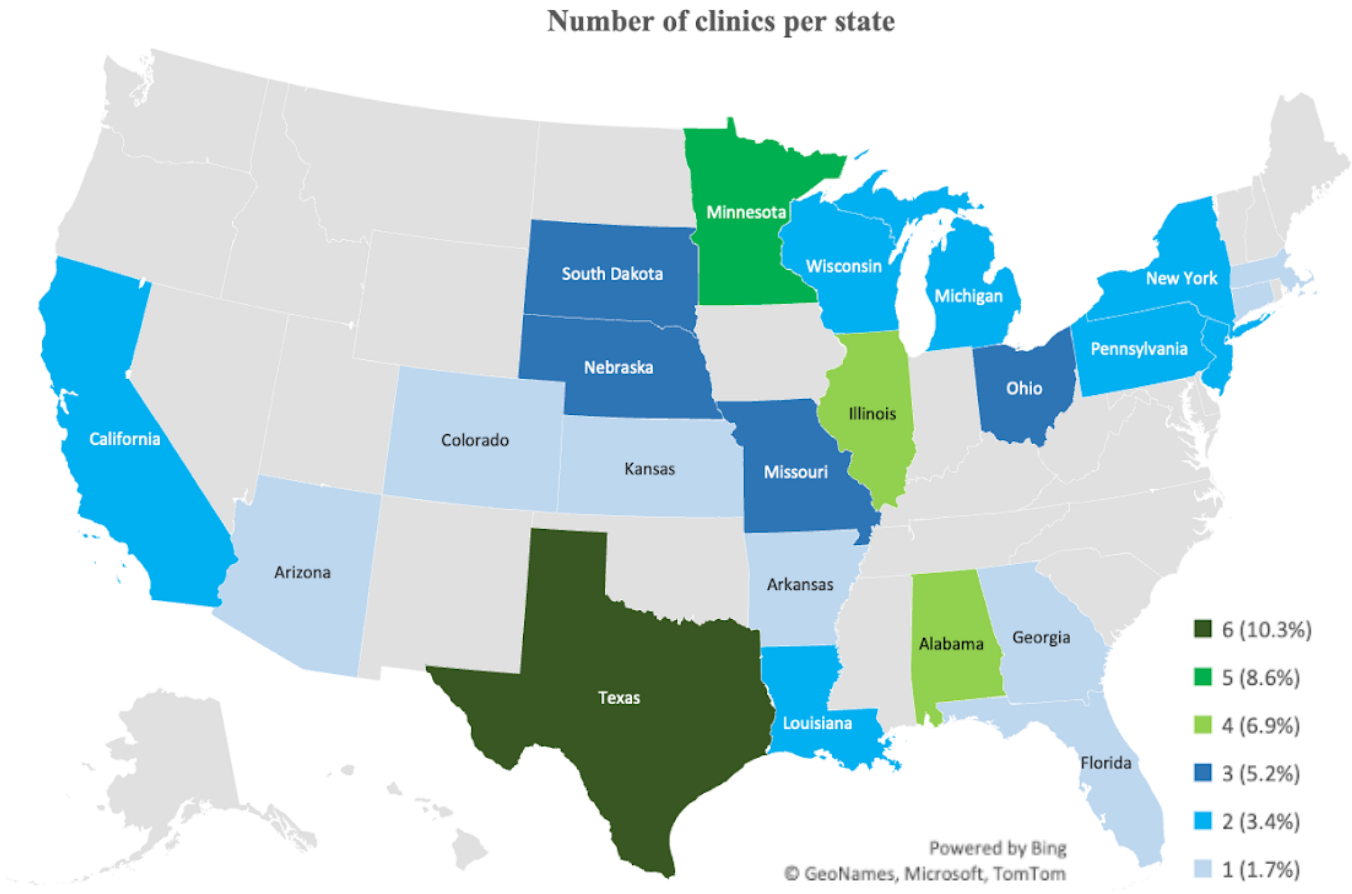
Background: Student-run clinics (SRCs) provide underserved individuals with critical healthcare access. They also enable a service-learning mechanism for students and are instrumental to health equity, social justice, and advocacy efforts. As health system complexity continues to rise, how SRCs are evolving in response to patient care needs remains unclear. This study assesses the status of SRC operations at the national level with regard to which services they provide, as well as what innovations, breakthroughs, and limitations they have experienced.
Methods: An electronic survey was distributed to registered attendees of the 2023 Society of Student-Run Free Clinics (SSRFC) annual conference who were invited to participate anonymously via survey links provided within SSRFC pre-conference and post-conference email correspondence. Information sheets with the survey QR code were also posted throughout the conference grounds. Additionally, survey participation reminders were sent each day of the conference through the conference app.
Results: The survey was distributed to 400 registered conference attendees and 58 responses were received. These 58 responses represented 58 SRCs, 49 institutions, and 24 states. A total of 45 respondents indicated their SRCs primarily served adult patients with a predominance of limited English proficiency amongst SRC patient populations and offered patients indicated screenings, though screening completion rates varied. There were 46 respondents who involved postgraduate trainees within their SRCs with varying specialties represented. Finally, 23 SRCs responded that at least half of their patients needed referrals to other specialties, and only 13 SRCs noted that at least half of referrals made were successfully completed.
Conclusion: This study provides a vital update in the status of SRCs across the United States, including their current resources, challenges, and potential opportunities for growth. SRCs will continue to play a critical role in caring for society's underserved and uninsured until a definitive and sustainable solution can be identified.

Introduction

The United States has roughly 30 million uninsured individuals.[1] These uninsured individuals tend to possess poorer health literacies and health histories. They also tend to present with more advanced disease states compared to their insured counterparts. Unsurprisingly, the unmet needs in these patients contribute to increased morbidity and mortality.[2,3]

Student-run clinics (SRCs), sometimes referred to as student-run free clinics, student-led free clinics, or student-driven free clinics, are part of a greater network of pro-bono healthcare services which contribute to providing relief to the otherwise unmet healthcare needs across the country. In a 2014 survey conducted by the Association of American Medical Colleges, an estimated 140,000 patients were seen annually across 208 SRC sites, with approximately 75% of accredited medical schools

Figure 1. Geographic map of responding student-run clinics nationally (N = 58)



Note: two Canadian clinics are not shown.

supporting one or more SRCs.[4] SRCs serve a triple function.[5] They provide uninsured, underinsured, and other low socioeconomic status patients with a medical home.[3] They also enable a service-learning mechanism for health-profession students to care for patients for whom they would otherwise have limited to no access. Finally, SRCs spearhead the integration of health equity, social justice, and advocacy as critical components of the health professional education curricula.

The roles of SRCs have grown since their initial inception. Their volunteers have increasingly taken on new roles, such as health navigators and care managers, to contend with the array of complex pictures and contributing factors SRCs patients often bring including lack of insurance, difficulties affording medications, and low health literacy rates.[2,6,7] These patients also tend to have worse control of their chronic health conditions compared to their insured counterparts. Thus, ensuring access particularly for these individuals to SRC services including behavioral counseling, chronic disease screening and management, and vaccinations remains high-priority.[8–10]

Given their reach within groups that may not otherwise interface with traditional healthcare infrastructure, SRCs are in a privileged position to provide their patients with platform and agency in addressing outstanding concerns within their communities.[11,12] SRCs may also function as a safety zone for asylum seekers as a significant proportion of SRC patients screen positive for histories of torture, trauma, and displacement.[13,14] Over time, some SRCs have achieved sufficient operational success that they have drafted guidance for others interested in establishing new clinics and or in expanding their existing clinics.[15,16]

However, SRCs continue to face multiple challenges. Most SRCs are solely equipped to provide single-specialty care, with only a limited number positioned to provide access to sub-specialty services

Table 1. Student-run clinic (SRC) patient characteristics

Characteristic	N (%)
a) Age of patients served, years, n=58	
Less than 18	5 (8.6)
18-26	9 (15.5)
27-54	9 (15.5)
55-64	9 (15.5)
65 and older	9 (15.5)
I don't know	45 (77.6)
b) Level of English proficiency, n=58	
All are proficient	5 (8.6)
Most are proficient	21 (36.2)
Some are proficient	19 (32.8)
Few are proficient	12 (20.7)
Patient is proficient, but family is not	1 (1.7)
c) Percentage of insured patients, n= 21	
Less than 25%	19 (90.5)
25-49.9%	2 (9.5)
50-74.9%	0 (0.0)
75-100%	0 (0.0)
d) Percentage of underinsured patients, n=19	
Less than 25%	14 (73.7)
25-49.9%	3 (15.8)
50-74.9%	1 (5.3)
75-100%	1 (5.3)
e) Percentage of uninsured patients, n=26	
Less than 25%	0 (0.0)
25-49.9%	2 (7.7)
50-74.9%	5 (19.2)
75-100%	19 (73.1)

a) Patient age distribution, b) English proficiency, c) Insured patients at SRCs, d) Underinsured patients at SRCs, e) Uninsured patients at SRCs

and referrals to hospital or other community free clinic resources. Even fewer clinics can directly connect their patients with surgical or procedural interventions.[17,18] Finally, most SRCs remain challenged by limited financial resources, frequent turnovers in SRC student leadership and patient follow-up duration, and inconsistent access to supervising healthcare profession faculty.[4,19]

As both burden of patient health problems and complexity in health system navigation across communities continue to rise, particularly in light of proposed health policy changes, the full extent of how SRCs are evolving to continue meeting patient care needs remains unclear. The purpose of this study therefore is to assess the status of SRC operations at the national level, assess what services they provide, and determine what innovations, breakthroughs, and limitations they have experienced while diversifying health professions education and expanding patient access to care.

Methods

An electronic survey housed on Oakland University William Beaumont School of Medicine's (OUWB) Qualtrics database was distributed to registered attendees of the 2023 Society of Student-Run Free Clinics (SSRFC) annual conference with the approval of the SSRFC's leadership team.

Table 2. Student-run clinic (SRC) operations

Characteristic	N (%)
a) Interpreter services, n=58	
In-person	37 (63.8)
Over-the-phone language line	37 (63.8)
Translator software *(Google translate, etc.)*	12 (20.7)
Video-based language line *(via iPad, laptop, Martti, etc.)*	7 (12.1)
None	2 (3.4)
I don't know	2 (3.4)
b) Advertisement and promotion methods, n=58	
Referral by other patients	40 (70.0)
Referral by health professionals who are school faculty	32 (55.2)
Other media *(flyer, newspaper, magazine, etc.)*	30 (51.7)
Non-paid social media	29 (50.0)
Referral by programs not affiliated with the school *(government, community, etc.)*	27 (46.6)
Referral by health professionals outside of the school	21 (36.2)
SRC participation in local programming or events	18 (31.0)
Only our respective specialty clinics advertise	3 (5.2)
Paid social media	2 (3.4)
Other*	3 (5.2)
Not applicable: SRC doesn't engage in advertising or promoting services	3 (5.2)
I don't know	1 (1.7)
c) Financing methods, n=58	
Grants *(external to school or education institution)*	44 (75.9)
Donations directly to the SRC	37 (63.3)
Annual budget provided through school or educational institution	31 (53.4)
Gala or fundraiser proceeds	27 (46.6)
Grants *(within school or education institution, but not included within an annual budget)*	21 (36.2)
I don't know	4 (6.9)
Other†	3 (5.2)
d) Volunteer recruitment methods, n=58	
Email announcements	53 (91.4)
Word-of-mouth	47 (81.0)
Student body newsletter announcements	35 (60.3)
Social media postings	25 (43.1)
Orientation or class presentation	6 (10.3)
Other‡	3 (5.2)
e) Benefits or incentives, n=58	
School volunteer hours	34 (58.6)
No benefits or incentives offered	24 (41.4)
School elective curricula course credit	13 (22.4)
School required curricula course credit	6 (10.3)
Other**	4 (6.9)

*a) Types of interpreter services provided by SRCs, b) Methods for advertisement and promotion by SRCs, c) Methods for financing SRC operations, d) Methods for recruiting volunteers by SRCs, e) Benefits or incentives offered for volunteering by SRCs. *Located within a school, Mexican consulate and Spanish-speaking churches, website. †Ministry of the Sisters of St Joseph of Carondelet, Physician billing to local public health care system, physician office leadership provides equipment and manpower. ‡Mandatory part of curriculum, reaching out to specific student groups, student sign up. **Community involvement/credit for residency applications, free dinner, leadership opportunities, interprofessional education credit*

A survey comprised of 68 questions was created primarily to assess the current breadth of healthcare services offered by SRCs and the geographical spread of these services with a secondary aim of collecting information on the training statuses of individuals involved in SRCs and to better qualify and quantify access to specialty and subspecialty services directly through SRCs or through relationships with their healthcare institutions.

Registered conference attendees were invited to participate anonymously via survey links provided within SSRFC pre-conference and post-conference email correspondence. Survey information sheets with a QR code were also posted throughout the conference grounds. Additionally, survey participation reminder messages were sent each day of the conference to all registered participants through the conference app.

Only fully-completed submissions were considered valid for analysis, and partially-completed and blank survey submissions were excluded. Descriptive statistics through Excel were used for analysis. This study was deemed exempt by the OUWB Institutional Review Board.

Results

The survey was distributed to 400 registered conference attendees, and 137 survey responses were received. Of these, 79 responses either had no data entered or were incomplete and were removed, leaving 58 fully completed submissions for the analysis. A total of 58 SRCs, 49 institutions, and 24 states plus Canada were represented (Figure 1). Of these, 43 respondents classified their SRCs as operating in urban communities, 11 in suburban communities, and 4 in rural communities (Appendix).

Respondents commented on the characteristics of the patients they served. Most SRCs served adult populations, with only 5 SRCs noting they served pediatric patients (Table 1a). Thirty-one SRCs reported a predominance of limited English proficiency amongst their patient populations (Table 1b). SRC patients also had varying degrees of insurance status, with 24 clinics reporting more than half of their patient populations being uninsured (Table 1c-e).

Respondents described their clinic operations as well. SRCs most-commonly utilized in-person interpreters and phone language lines for interpretation services (Table 2a). SRCs advertisement and promotion were commonly achieved through word-of-mouth from patients or health professionals within the community (Table 2b). As for financing operations, 37 SRCs reported receiving donations directly to their respective clinics and 31 SRCs received an annual budget through their educational institution (Table 2c). Recruiting volunteers for SRCs was most-often conducted through email announcements with 34 SRCs also offering school volunteer hours as an incentive for volunteering at SRCs (Table 2d-e).

Respondents additionally shared what SRC services they offered. A large breadth of specialties were represented at SRCs with the three most common being Family Medicine, Internal Medicine and Pharmacy (Table 3a). Forty-five SRCs performed screenings for social determinants of health concerns and 44 SRCs offered routine health, lab, and imaging-based screenings (Table 3b). The three most common screenings offered were diabetes, lipid profile and hypertension (Table 3c). Thirty-four SRCs offered indicated screenings at least most of the time whereas 22 SRCs completed indicated screenings at least most of the time (Table 3d-e). Vaccines were offered at 40 SRCs, with the three most common being Influenza, coronavirus disease 2019, and Pneumococcal (Table 3f-g).

SRCs were further queried on their involvement of postgraduate trainees, which may be referred to elsewhere as advanced trainees. A majority of SRCs reported having some level of postgraduate trainee involvement, with medicine, social work, and behavioral health being the top three disciplines represented (Table 4a-b). Specific duties included supervising, teaching, research, and filling in roles at other specialty SRCs. The respondents also shared barriers to postgraduate trainee involvement including institutional policies, logistical barriers, and lack of time, interest, and/or incentives.

Table 3. Student-run clinics (SRC) services delivered

Characteristic	N (%)
a) Specialty type, n=58	
Athletic Training	2 (3.4)
Anesthesiology	0 (0.0)
Behavioral Health	28 (48.3)
Dentistry	9 (15.5)
Dermatology	24 (41.4)
Dietetics	13 (22.4)
Family Medicine	47 (81.0)
Gastroenterology	3 (5.2)
General Surgery	4 (6.9)
Hematology Oncology	2 (3.4)
Internal Medicine	35 (60.3)
Law	2 (3.4)
Naturopathy	0 (0.0)
Nephrology	2 (3.4)
Neurology	7 (12.1)
Nurse Practitioners	9 (15.5)
Obstetrics & Gynecology	23 (39.7)
Occupational Therapy	16 (27.6)
Optometry	7 (12.1)
Ophthalmology	18 (31.0)
Pediatrics	12 (20.7)
Pharmacy	33 (56.9)
Physical Medicine and Rehabilitation	6 (10.3)
Physical Therapy	23 (39.7)
Physician Assistant	17 (29.3)
Podiatry	5 (8.6)
Psychiatry	16 (27.6)
Public Health	3 (5.2)
Social Work	30 (51.7)
Speech/Language/Hearing	5 (8.6)
Sports Medicine	5 (8.6)
Urology	2 (3.4)
Veterinary Medicine	2 (3.4)
Other*	11 (1.7)
I don't know	13 (22.4)
b) Screening types, n=58	
Social determinants of health	45 (77.6)
Routine, General, Lab-based, or Image-based	44 (75.9)
c) Specific screening types, n=58	
Abdominal aortic aneurysm	2 (3.4)
Alcohol use	23 (39.7)
Anxiety-related	24 (41.4)
BRCA-related cancer	0 (0.0)
Breast cancer	13 (22.4)
Cardiovascular disease prevention	24 (41.4)
Cervical cancer	20 (34.5)
Colon cancer	14 (24.1)
Dental caries	4 (6.9)
Depression and suicide risk	29 (50.0)
Diabetes related	40 (69.0)
Drug and substance use	17 (29.3)
Fall prevention	5 (8.6)
Hypertension	35 (60.3)
Infectious Diseases (Chlamydia, Gonorrhea, Hepatitis B, HIV, etc.)	27 (46.6)
Lung cancer	5 (8.6)
Lipid profile	35 (60.3)
Obesity and weight loss	20 (34.5)
Osteoporosis	0 (0.0)
Pregnancy and prenatal-care related	10 (17.2)
Skin cancer	12 (20.7)
Tobacco smoking cessation	23 (39.7)
d) Frequency of screenings offered, n=58	
Always	11 (19.0)
Most of the time	23 (39.7)
Sometimes	7 (12.1)
Rarely	2 (3.4)
Never	5 (8.6)
Unknown	7 (12.1)
Other	3 (5.2)
e) Frequency of screenings performed when due, n=58	
Always	2 (3.4)
Most of the time	20 (34.5)
Sometimes	17 (29.3)
Rarely	2 (3.4)
Never	5 (8.6)
Unknown	9 (15.5)
Other	3 (5.2)
Colon cancer	14 (24.1)
g) Vaccinations offered, n=58	
Yes	40 (69.0)
No	18 (31.0)
g) Types of Vaccinations, n=36	
Childhood vaccinations	3 (8.3)
Coronavirus disease 2019	13 (36.0)
Influenza	29 (81.0)
Hepatitis A	1 (2.7)
Hepatitis B	2 (5.5)
Herpes Zoster	4 (11.0)
Human papillomavirus	4 (11.0)
Monkey pox	1 (2.7)
Measles, mumps, and rubella	2 (5.5)
Pneumococcal	6 (17.0)
Tetanus	1 (2.7)
Tdap	5 (14).0

*a) Specialties included, b) Screenings offered by SRCs, c) Types of specific screenings offered, d) Frequency of screenings offered, e) Frequency of screenings performed, f) Vaccines offered, g) Types of vaccines offered. *Community health workers, diabetic education, Rheumatology, Pulmonology, Endocrinology, Cardiology, Pulmonology, General health advocacy, Immigration, Medical laboratory science, Nursing students, Audiology. BRCA: breast cancer genes; HIV: human immunodeficiency virus.*

Table 4. Postgraduate trainees

Characteristic	N (%)
a) Postgraduate Trainee Involvement, n=57	
Yes	46 (80.7)
No	11 (19.3)
b) Specialties of Postgraduate Trainees, n=46	
Athletic Training	1 (2.2)
Anesthesiology	0 (0.0)
Behavioral health	5 (10.9)
Dentistry	1 (2.2)
Dermatology	12 (26.1)
Dietetics	0 (0.0)
Emergency Medicine	3 (6.5)
Family Medicine	33 (71.7)
Gastroenterology	1 (2.2)
General Surgery	2 (4.3)
Hematology Oncology	0 (0.0)
Internal Medicine	24 (52.2)
Naturopathy	0 (0.0)
Neurology	4 (8.7)
Nurse Practitioners	6 (13.0)
Obstetrics and Gynecology	11 (23.9)
Occupational Therapy	4 (8.7)
Optometry	1 (2.2)
Ophthalmology	6 (13.0)
Pediatrics	8 (17.4)
Pharmacy	1 (2.2)
Physical Medicine and Rehabilitation	1 (2.2)
Physical Therapy	4 (8.7)
Physician Assistant	3 (6.5)
Podiatry	0 (0.0)
Psychiatry	6 (13.0)
Social Work	6 (13.0)
Speech/Language/Hearing	2 (4.3)
Sports Medicine	3 (6.5)
Urology	1 (2.2)
Veterinary Medicine	1 (2.2)
I don't know	1 (2.2)

a) Involvement in student-run clinics, b) Specialties of individuals involved

Lastly, access to referrals and procedures were assessed. Twenty-three SRCs responded that referrals to other specialties were indicated for at least half of their patients, of which 13 SRCs noted at least half of referred patients were then successfully seen by the specialties they were referred to (Table 5a-b). Twenty-seven SRCs noted that less than 25% of patients needed surgeries and only 6 SRCs reported that 50% or more of patients needing surgery successfully obtained it (Table 5c-d). Behavioral health, ophthalmology, and dentistry, respectively, were reported as the top three SRC referral areas (Table 5e).

Table 5. Referrals

Characteristic	N (%)
a) Patients seen at student-run clinics needing referrals, n=58	
Less than 25%	6 (10.3)
25%	13 (22.4)
50%	13 (22.4)
75%	7 (12.1)
Greater than 75%	3 (5.2)
I don't know	16 (27.6)
b) Patients at student-run clinics successfully seen by specialties they are referred to, n=58	
Less than 25%	8 (13.8)
25%	7 (12.1)
50%	7 (12.1)
75%	5 (8.6)
Greater than 75%	1 (1.7)
I don't know	30 (51.7)
c) Patients at student-run clinics that have needed surgery, n=58	
Less than 25%	27 (46.6)
25%	1 (1.7)
50%	0 (0.0)
75%	0 (0.0)
Greater than 75%	0 (0.0)
I don't know	30 (51.7)
d) Patients at student-run clinics that successfully underwent indicated surgery, n=58	
Less than 25%	9 (15.5)
25%	0 (0.0)
50%	4 (6.9)
75%	1 (1.7)
Greater than 75%	1 (1.7)
I don't know	43 (74.1)

Characteristic (continued)	N (%)
e) Specialists or subspecialists referrals needed for patients seen at student-run clinics, n=58	
Athletic Training	1 (1.7)
Anesthesiology	0 (0.0)
Behavioral health	34 (58.6)
Dentistry	26 (44.8)
Dermatology	25 (43.1)
Dietetics	8 (13.8)
Family Medicine	17 (29.3)
Gastroenterology	23 (39.7)
General Surgery	22 (37.9)
Hematology Oncology	12 (20.7)
Internal Medicine	19 (32.8)
Naturopathy	0 (0.0)
Neurology	22 (37.9)
Nurse Practitioners	1 (1.7)
Obstetrics & Gynecology	25 (43.1)
Occupational Therapy	9 (15.5)
Optometry	12 (20.7)
Ophthalmology	30 (51.7)
Pediatrics	5 (8.6)
Pharmacy	9 (15.5)
Physical Medicine and Rehabilitation	5 (8.6)
Physical Therapy	20 (34.5)
Physician Assistant	2 (3.4)
Podiatry	10 (17.2)
Psychiatry	22 (37.9)
Social Work	23 (39.7)
Speech/Language/Hearing	6 (10.3)
Sports Medicine	3 (5.2)
Urology	13 (22.4)
Veterinary Medicine	0 (0.0)
Other*	1 (1.7)
I don't know	13 (22.4)

*a) Patients needing referrals, b) Patients successfully seen by referred specialties, c) Patients that need surgery, d) Patients that successfully underwent indicated surgery, e) Specialists and subspecialists referral. *Pain medicine*

Discussion

SRCs function as safety nets within our modern healthcare system.[20] They fill care gaps via providing much-needed healthcare services through a doing-more-with-less mentality.[21] This approach contributes to reduced patient utilization of emergency and urgent care services and achieves cost-savings for the greater healthcare system.[22,23] This is of particular importance as minorities and uninsured individuals generally comprise a bulk of SRC patients.[24]

An ongoing challenge of SRCs is delivering preventative and acute care services with outcomes comparable to traditional care settings.[25,26] They provide a variety of services to patients across spectrums of age, language, and insurance status as evidenced by our findings (Table 1, 2a, 3a). Limited studies suggest their potential for effectively bridging disparities in care, particularly in the realm of chronic disease management, and providing patients with an experience comparable to counterparts in traditional care settings.[27–29] Orders for breast, cervical, and colon cancer screenings were also similar in certain instances.[18,30,31] However, patient completion of offered screenings varied and this incomplete adherence continues to be impacted by patient attitudes related to screenings and social drivers of health.[32,33]

Another significant hurdle for SRCs is that as non-revenue-generating entities. Their staffing, operations, and patient base are fueled either almost or entirely through volunteers, fundraising, and community support (Table 2b-d). For many students, their involvement with SRCs is driven by the invaluable opportunities they provide to help the underserved and to gain clinical experience. This aligns with our finding of over 41% of respondents reporting students not being offered benefits nor incentives for their participation (Table 2e).[34] For students who themselves are from underserved or underrepresented-in-healthcare backgrounds, having access to an SRC to serve these populations was particularly critical in their matriculation decision-making processes.[35] These service-learning experiences also influence their future professional trajectories and enable them to hone leadership skills and to partake in quality improvement initiatives.[36-38] Furthermore, SRCs serve as invaluable arenas for implementing and optimizing interprofessional education and collaboration.[26,39] Lastly, SRCs offer avenues for augmenting health equity, cultural competence, and implicit bias curricular components within health profession training programs and for supplementing training in pertinent areas not typically included within established curricula.[40-42] Notably, these opportunities for education in SRCs remain cost-effective.[43]

While most SRCs offer primary care services, access to specialty and sub-specialty-related care is typically limited. One study which surveyed patient interest in specialty care found 34% of their respondents were interested in ophthalmology, 23% in orthopedics, 16% in gynecology, 11% in psychiatry, 7% in pediatrics, and 9% in other services.[44,45] This seeming predominant need for medical-based disciplines likely is influenced by the historic predominance of purely allopathic and osteopathic-affiliated SRCs. However, these figures likely no longer accurately reflect the status quo. Over 30 healthcare specialties and disciplines were represented in our data suggesting the number of interdisciplinary and multidisciplinary SRCs continues to increase. (Table 3a). We anticipate that as these clinics continue to grow and their operations achieve a critical mass, scholarly inquiry can then effectively begin to gauge their impacts on patient care and community well-being as well as to overcome current limitations in SRC research.

Our understanding of impacts from engaging healthcare postgraduate trainees in SRCs is similarly limited.[46,47] Previous calls for their involvement within SRCs steadily increased participation over the years with now over 80% of respondents reporting their presence within operations (Table 4a-b). One potential driver for this is their increased satisfaction from working in the SRC setting compared to their traditional work settings.[48] Given the often-limited number of patients that can be seen in a traditional SRC model, integrating them within SRCs as part of an additional continuity clinic resource may be worthwhile.[46] This arrangement could be particularly valuable for programs with specific training tracks such as rural medicine or migrant health. SRCs also enable unique opportunities for these trainees to teach and supervise students and to reduce administrative burdens of SRC faculty who supervise all aspects of SRC operations.[46,49,50] Additionally, their inclusion may facilitate building relations with their affiliated hospitals and potentially expand SRC referral networks. This then may subsequently provide opportunity for addressing hurdles in patients accessing previously out-of-reach specialties and surgeries which our findings suggest there being significant potential for improvement (Table 5a-e). However, plans for the inclusion of these trainees would need to overcome certain logistical challenges. For resident and fellow physicians, this entails considering

their 80-hour work-week restrictions and limited remaining time not taken up by professional and personal obligations.[46,51] Given the limited literature on integrating these trainees into the SRC setting and on involvement of healthcare trainees within non-medicine disciplines, further exploration in this area is necessary.

In summary, SRCs have come to represent a welcome addition in health services to our community's underserved patient population. The challenges SRCs and their patients face are complex and tackling them requires innovative and potentially even non-traditional solutions. Similar to traditional health system environments, interdisciplinary collaboration within and across SFRCs is vital to achieving optimal outcomes.[28,44,52-57]

Strengths

One of the strengths of our study is the anonymous nature of the survey which mitigated the potential for identification by peers, colleagues, and faculty. Another strength is that we have centralized information. Individual SRCs may operate in more than one location and some sites may offer multi-disciplinary services. Furthermore, to date there has been limited study on the involvement of postgraduate trainees in SRCs, and our study contributes to the knowledge base regarding extent of engagement by healthcare learners. Lastly, this study touches upon the current status of SRC resources and serves to identify ongoing limitations.

Limitations

Our study is impacted by several limitations. Firstly, our opt-in recruitment methodology, compounded with distribution at a busy conference, likely contributed to our final sample representing only approximately 14% of conference attendees which falls short of previously recommended thresholds for an electronic survey.[58] We are aware of attendees who discontinued survey completion when they learned a colleague from their institution had already submitted a response despite instructions specifically welcoming multiple submissions from a single institution. Secondly, students and faculty in allopathic and osteopathic medicine programs continue to comprise the majority of SSRFC annual meetings attendees. Thus, attendees from other healthcare specialties with SRCs such as dentistry, veterinary medicine, and allied health are more limited which undoubtedly impacted potential respondent diversity. Thirdly, the disproportionate representation of attendees from individual institutions, which may stem in parts from robustness of funding and scholarly activity, may also skew results and therefore limit generalizability. Additionally, competition for time to complete the study potentially limited participation and completion of the survey. Between the conference's busy schedule, cost, and breadth and number of topics being presented, it is likely attendees were more incentivized to attend events rather than complete this survey. Furthermore, no validated questionnaires existed for which to base our survey off of which likely hampers study generalizability. Moreover, a majority of responses for patients successfully seen by referred specialists and surgeons was "I don't know." This potentially reflects a systemic deficiency in SRC operational and clinical performance reviews. While this may be due to a lack of bandwidth of busy faculty, student leaders should take ownership of regularly reviewing these data. This may enable students to understand their patient population more in-depth and implement appropriate interventions. Lastly, the lack of a national SRC contact database precluded us from capturing the full scope of needs of all SRCs given this was only sent to conference attendees, and thus, may not accurately represent the status nationally.

Conclusion

This study provides a vital update in the statuses of SRCs across the United States, including their current resources, challenges, and potential opportunities for growth. SRCs will continue to play a critical role in caring for society's underserved and uninsured until a definitive and sustainable

solution can be identified. As a result, it is incumbent upon SRCs and those operating them to ensure that these patients are provided with world-class care and a medical home.

Acknowledgements

We wish to express our gratitude to the Society of Student-Run Free Clinics, in particular Dr. Jessica Kruger and Dr. Jake Woodruff, for their support in completing this project.

Disclosures

The authors have no conflicts of interest to disclose.

References

1. Cohen RA, Cha AE, Terlizzi EP, Martinez ME. *Health insurance coverage: Early Release of Estimates From the National Health Interview Survey, 2021*. National Center for Health Statistics; 2022. doi:10.15620/cdc:115983 LINK
2. Nourse SE, Franco CL, Johnson EH, Williams BC. A case study of complex care management at a student-run free clinic. *J Stud Run Clin*. 2019;5(1):1-7. doi:10.59586/jsrc.v5i1.86 LINK
3. Mootz A, Price A, Elahi C, et al. Retrospective analysis of population demographic characteristics, medical interventions, and resource use at a medical student-run clinic on the Texas-Mexico border. *J Health Care Poor Underserved*. 2019;30(2):519-531. doi:10.1353/hpu.2019.0034 LINK
4. Smith S, Thomas R, Cruz M, Griggs R, Moscato B, Ferrara A. Presence and characteristics of student-run free clinics in medical schools. *JAMA*. 2014;312(22):2407-2410. doi:10.1001/jama.2014.16066 LINK
5. Rupert DD, Alvarez GV, Burdge EJ, Nahvi RJ, Schell SM, Faustino FL. Student-run free clinics stand at a critical junction between undergraduate medical education, clinical care, and advocacy. *Acad Med*. 2022;97(6):824-831. doi:10.1097/ACM.0000000000004542 LINK
6. Cadzow RB, Craig M, Rowe J, Kahn LS. Transforming community members into diabetes cultural health brokers: the Neighborhood Health Talker project. *Diabetes Educ*. 2013;39(1):100-108. doi:10.1177/0145721712465342 LINK
7. Chilukuri P, Williams C, Dowla S, et al. Findings from a qualitative needs assessment of Equal Access Birmingham, a student-run free clinic in the Southern United States. *J Stud Run Clin*. 2021;7(1):1-8. doi:10.59586/jsrc.v7i1.226 LINK
8. Creps J, Kaartinen M, Diebold K. Examination of demographics and chronic health condition management in an underserved population at a pro bono physical therapy clinic. *J Stud Run Clin*. 2017;3(1):1-5. doi:10.59586/jsrc.v3i1.57 LINK
9. Dalrymple N, Hidalgo M, Desai A. Comparison of the health status of uninsured diabetic patients presenting for an initial visit to an urban free clinic to diabetic patients from the National Health and Nutrition Examination Survey. *J Stud Run Clin*. 2020;6(1):1-5. doi:10.59586/jsrc.v6i1.90 LINK
10. Stickel JW, Ngo S, Akshara, Kumar V, Rhodes LA, Zeeman JM. Evaluation of a preventative health consultation service for patients at student-run walk-in health clinics. *J Stud Run Clin*. 2021;7(1):1-9. doi:10.59586/jsrc.v7i1.212 LINK
11. Thorgrimson J, Doble D, Balfour-Boehm J, et al. Going beyond good intentions: needs assessment for student-led health outreach in Northern Ontario. *J Stud Run Clin*. 2016;2(2):1-6. doi:10.59586/jsrc.v2i2.13 LINK
12. Rizzo G, Elkhatib S, Geske J, Menning M, Christiansen H. Is stability sufficient? Challenging the status quo via needs assessment in a 22-year-old student-run free clinic. *J Stud Run Clin*. 2021;7(1):1-7. doi:10.59586/jsrc.v7i1.203 LINK
13. Praschan N, Mishori R, Stukel N. A student-run asylum clinic to promote human rights education and the assessment and care of asylum seekers. *J Stud Run Clin*. 2016;2(2):1-7. doi:10.59586/jsrc.v2i2.18 LINK
14. Pan J, Leader A, Wang E, et al. Screening for torture, asylum, and trauma among patients seeking care in an urban student-run free clinic. *J Stud Run Clin*. 2022;8(1):1-7. doi:10.59586/jsrc.v8i1.240 LINK
15. Tucker S, Jarolimova J, Naushad N, et al. Utilizing a qualitative needs assessment with multiple stakeholders to design a new family medicine student-run clinic. *J Stud Run Clin*. 2019;5(1):1-12. doi:10.59586/jsrc.v5i1.75 LINK
16. Stubbs C, Duvernay D, Omole F. A roadmap to clinic expansion: meeting the needs of an underserved community. *J Stud Run Clin*. 2019;5(1):1-7. doi:10.59586/jsrc.v5i1.124 LINK
17. Evans PT, Ewing JK, Walia S, Miller RF, Hawkins AT. Implementation of general surgery care into a student-run free clinic. *J Surg Res*. 2020;255:71-76. doi:10.1016/j.jss.2020.05.031 LINK
18. Kattih Z, Uhlar C, Perera Y, et al. A model for colon cancer screening at a free community clinic. *J Stud Run Clin*. 2018;4(1). doi:10.59586/jsrc.v4i1.76 LINK
19. Hess MC, Chung SK, Banos JH, Cockrum RH, Van Wagoner N, Hoesley CJ. Predictors of patient retention at a student-run free clinic. *J Stud Run Clin*. 2018;4(1). doi:10.59586/jsrc.v4i1.70 LINK
20. Stone SS, Heil H, Vaghasia J, Thaureaux MR, Badia V, Baal P. Utility of student-run free clinics for underserved individuals during COVID-19 Michigan shelter-in-place order. *J Stud Run Clin*. 2021;7(1). doi:10.59586/jsrc.v7i1.279 LINK
21. Wells A, Zwygart K, Roetzheim R, Gonzalez E. Cost savings of HPV testing alone versus co-testing for cervical cancer screening at a student-run free clinic. *J Stud Run Clin*. 2021;7(1). doi:10.59586/jsrc.v7i1.233 LINK
22. Trumbo SP, Schuering KM, Kallos JA, et al. The effect of a student-run free clinic on hospital utilization. *J Health Care Poor Underserved*. 2018;29(2):701-710. doi:10.1353/hpu.2018.0053 LINK
23. Alhallak I, Williams DK, Eudy R, Puryear E, Clark M. Impact of student-run free clinics in urgent care. *J Community Health*. 2021;46(3):522-526. doi:10.1007/s10900-020-00890-0 LINK

24. Nizamuddin I, Hussain A, Gummi R, Solanki B. Identifying the underserved: an analysis of a free eye clinic's demographics. *J Stud Run Clin*. 2018;4(1). doi:10.59586/jsrc.v4i1.58 LINK
25. Butala NM, Murk W, Horwitz LI, Graber LK, Bridger L, Ellis P. What is the quality of preventive care provided in a student-run free clinic? *J Health Care Poor Underserved*. 2012;23(1):414-424. doi:10.1353/hpu.2012.0034 LINK
26. Swartz MK. The contributions of student-run free clinics. *J Pediatr Health Care*. 2012;26(6):397. doi:10.1016/j.pedhc.2012.07.015 LINK
27. Taylor J, Thomas D, Tornheim J, Meah Y. Hypertension outcomes at a student-run clinic for the uninsured. *J Stud Run Clin*. 2015;1(1):1-8. doi:10.59586/jsrc.v1i1.4 LINK
28. Goldwaser E, Bibber B, Eckert K, Paglinco S, Leroy K, Alaimo D. A chronic disease management program at the Rowan School of Osteopathic Medicine's student-run free clinic implementation and community partnerships. *J Stud Run Clin*. 2016;2(1):1-6. doi:10.59586/jsrc.v2i2.20 LINK
29. Menning M, Nabower A, Medder J, Geske J, Margalit R. The impact of a multifaceted intervention on the rate of preventive services offered in a student-run clinic. *J Stud Run Clin*. 2016;2(1):1-12. doi:10.59586/jsrc.v2i2.14 LINK
30. DiLorenzo MA, Osterbur Badhey ML, Roth L, et al. Intervention to improve mammography screening at a student-run free clinic. *J Stud Run Clin*. 2019;5(1). doi:10.59586/jsrc.v5i1.83 LINK
31. Xiao SY, Major CK, O'Connell KA, et al. Breast and cervical cancer screening rates in student-run free clinics: a systematic review. *Int J Gynaecol Obstet*. 2023;162(2):395-408. doi:10.1002/ijgo.14675 LINK
32. Bhathena S, Moczygemba L, Lawson K. Emergency department use and barriers to health care among homeless and uninsured patients at a student-run free clinic. *J Stud Run Clin*. 2020;6(1). doi:10.59586/jsrc.v6i1.91 LINK
33. Maranets M, Harmer K, Vordenberg S, Thompson A. Pre-visit planning calls conducted by student pharmacists at a student-run free clinic. *J Stud Run Clin*. 2022;8(1). doi:10.59586/jsrc.v8i1.342 LINK
34. Greni S, Radil S, McIntire B, Menning M. Why do physicians volunteer at student-run free clinics? A look into what drives or hinders their participation. *J Stud Run Clin*. 2022;8(1). doi:10.59586/jsrc.v8i1.312 LINK
35. Vanstrum E, Mohan S, Yue J, et al. Exploring the influence of an interprofessional student-run clinic on matriculation to health professional school: a retrospective cross-sectional study. *J Stud Run Clin*. 2022;8(1). doi:10.59586/jsrc.v8i1.307 LINK
36. Mischell S, Yegya-Raman N, Frenchu K, Lin K. Patient expectations and satisfaction when using a student-run health clinic. *J Stud Run Clin*. 2017;3(1):1-7. doi:10.59586/jsrc.v3i1.23 LINK
37. Tang C, Win G, Unangst S, et al. A retrospective study on the influence of participation at a student-run free clinic on medical specialty choice. *J Stud Run Clin*. 2022;8(1). doi:10.59586/jsrc.v8i1.287 LINK
38. Jagadish I, Modi N. Incorporation of standard operating procedures for leadership and volunteer transitions in a student-run free clinic. *J Stud Run Clin*. 2022;8(1). doi:10.59586/jsrc.v8i1.300 LINK
39. White L, Franks A, Ragland D. Establishment of an interprofessional, student-led, community-based, free clinic. *J Stud Run Clin*. 2018;4(1):1-6. doi:10.59586/jsrc.v4i1.65 LINK
40. Gururangan K, Hooda C, Osterberg L. Implementation of an evidence-based health equity curriculum for reducing implicit bias at a student-run free clinic. *J Stud Run Clin*. 2021;7(1). doi:10.59586/jsrc.v7i1.256 LINK
41. Trieu S, Bajpai S. Bridging the language gap in medicine: quality improvement for interpreter services at JayDoc Free Clinic. *J Stud Run Clin*. 2022;8(1). doi:10.59586/jsrc.v8i1.278 LINK
42. Lee D, Chen K, Kruger J. Nurturing future health care leadership with student-run clinics. *JAMA Intern Med*. 2025;185(6):746-747. doi:10.1001/jamainternmed.2025.0081 LINK
43. Mazander M, Rumenapp J, Lee D, et al. Quantifying the educational value of a student-run free clinic. *Fam Med*. 2024;56(3):176-179. doi:10.22454/FamMed.2024.568265 LINK
44. Linson E, Zanganeh T, Korchak M, Lustbader J. Georgetown Eye Health Initiative. *J Stud Run Clin*. 2016;2(1):1-5. doi:10.59586/jsrc.v2i1.10 LINK
45. Downie E, von Hohenberg M, Harrison A, Sick B. Student-run free clinic as a source of meaningful ophthalmologic care for underserved patients. *J Stud Run Clin*. 2017;3(1). doi:10.59586/jsrc.v3i1.46 LINK
46. Fernandez TF, Kraus AC, Olson KM. A call for residents to get more involved with student-run free clinics. *Acad Med*. 2017;92(5):577. doi:10.1097/ACM.0000000000001653 LINK
47. Lee D. Advanced trainees in student-run free clinics: potential bridges to critical gaps in knowledge. *J Stud Run Clin*. 2023;9(1). doi:10.59586/jsrc.v9i1.454 LINK
48. Pincavage AT, Razi RR, Arora VM, Oyler J, Woodruff JN. Resident education in free clinics: an internal medicine continuity clinic experience. *J Grad Med Educ*. 2013;5(2):327-331. doi:10.4300/JGME-D-12-00127.1 LINK
49. Pitre A, Mulla Y, Arboleda B, et al. Contraception use and counseling at a student-run free clinic. *J Stud Run Clin*. 2022;8(1):1-8. doi:10.59586/jsrc.v8i1.280 LINK
50. Lee D, Loh T, Blackmond N, et al. Establishing a gynecology student-run free clinic: a joint medical student and resident physician initiative. *J Stud Run Clin*. 2024;10(1). doi:10.59586/jsrc.v10i1.456 LINK
51. Teal L, Spitz K, Diven D. Establishing dermatologic care for the homeless and underserved at a student-run clinic. *J Stud Run Clin*. 2020;6(1):1-6. doi:10.59586/jsrc.v6i1.150 LINK
52. Taylor K, Willis E, Hitchens J, et al. Campbell University Student-Run Free Clinic: osteopathic medical care for the rural underserved. *J Stud Run Clin*. 2016;2(1):1-6. doi:10.59586/jsrc.v2i1.11 LINK
53. Rayson N, Weiss S, Bellizio J. An organizational model and growth of a free-standing physical therapy student-run clinic. *J Stud Run Clin*. 2016;2(2):1-6. doi:10.59586/jsrc.v2i2.19 LINK
54. Belus JM, Cohen MJ, Givens M, Simirnova N, Myerholtz L. Integrating behavioral health services in a student-run medical clinic. *J Stud Run Clin*. 2017;3(1):1-7. doi:10.59586/jsrc.v3i1.44 LINK

55. Wozniak M, Stablein C, Zuk N, Kreisler R. A student-run free mobile veterinary clinic in the Phoenix metropolitan area. *J Stud Run Clin*. 2018;4(1):1-5. doi:10.59586/jsrc.v4i1.63 LINK
56. Bui T, Kindratt TB, Reddy S, Pagels P. Promoting oral health through manager training and dental referral at a student-run homeless shelter clinic. *J Stud Run Clin*. 2019;5(1):1-7. doi:10.59586/jsrc.v5i1.100 LINK
57. Eton V, Semalulu T, Desruisseaux T, et al. Development and evaluation of a student-led mental health promotion workshop to address community needs for marginalized populations in urban Northern Ontario. *J Stud Run Clin*. 2019;5(1):1-10. doi:10.59586/jsrc.v5i1.51 LINK
58. Wu MJ, Zhao K, Fils-Aime F. Response rates of online surveys in published research: a meta-analysis. *Comput Human Behav Rep*. 2022;7:100206. doi:10.1016/j.chbr.2022.100206 LINK