Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

experiential learning liable to bring a great many people to discover the overlooked existential experience of dyspnoeic patients. We believe that this offers a unique opportunity to raise public awareness of what it means to be constantly aware of, and bothered by, one's own breathing. This phenomenon could be leveraged by foundations and charities that promote lung health or by teams engaged in the field of disability studies as a communication tool about the dyspnoeic experience that is lived by patients afflicted by chronic respiratory diseases, to, in the end, achieve better levels of comprehension and empathy. Meanwhile, let us have a thought for these patients when breathing through a facemask bothers us.

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Juntos en la pandemia de COVID-19 (together in the COVID-19 pandemic): health-care professionals and the Latinx community

The burden of illness from COVID-19 is strikingly disproportionate among racial and ethnic minorities in the USA. This disparity is well illustrated in Latinx populations, who bear 2·8 times the number of cases and 4·6 times the age-adjusted hospitalisation rate from COVID-19 compared with non-Hispanic whites. As health-care professionals caring for Latinx patients affected by COVID-19, we share here what we have learned and highlight critical considerations for the health-care system and community during the ongoing pandemic.

The first line of defense for COVID-19 care is infection prevention. For Latinx immigrants, a number of factors pose challenges to prevention. The lack of language-concordant care, and in particular the lack of reliable and consistent public health information in Spanish, potentially delays critical messaging at a time when recognition of symptoms and precaution application is vital to reduce transmission. The development and dissemination of public health messages related to COVID-19 in Spanish is critical to COVID-19 prevention among Latinx with limited English proficiency. A well established model of care is to leverage the expertise of promotoras, or bilingual and bicultural community health workers trusted by the community. This model includes active linguistic and culturally tailored community outreach by medical professionals and via partnerships with community leaders. Use of bilingual contact tracers might also help build trust within Latinx communities and reduce viral spread when cases are identified.

Even with optimal dissemination of information, social, economic, and political factors, specifically housing and employment, make it difficult to follow infection control recommendations. Congregate housing is common, and 25% of the Latinx population live in multigenerational housing, compared with 15% of non-Hispanic whites, making self-isolation more difficult. Financial pressures and the absence of paid sick leave or disability benefits might directly conflict with the need to quarantine or isolate. Additionally, Latinx might serve in frontline jobs that cannot be done via telework and require in-person attendance of all staff, worsening COVID-19 occupational hazards (eg, COVID-19 outbreaks in meat or poultry processing facilities). Provision of alternate housing solutions in the setting of infection might reduce community and household spread but requires proactive reassurance of altruism without repercussion to the individual (eg, revealed immigration status). Resources to maintain finances and employment status during illness are essential but not uniformly available. Many immigrants work in informal economies where paid sick leave is not provided, and undocumented immigrants (vulnerable to work exploitation) are not eligible for unemployment benefits or stimulus checks. State and federal provisions must be strengthened to ensure occupational health protections and adequate personal protective equipment provision is enforced, with resources for employers to institute safe practices for all workers in all work environments.

The proportion of people uninsured is higher among Latinx than among any other racial or ethnic group in the USA. Undocumented immigrants are excluded from the Affordable Care Act, often leaving them

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For more on **COVID-19 in the USA** see https://www.cdc.gov/coronavirus/2019-ncov/covid-data/investigations-discovery/hospitalization-death-by-race-ethnicity.html

For more on **COVID-19 hospitalisation data in the USA** see https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/index.html

For more on reaching the **Hispanic community about COVID-19** see https://www.cdc.gov/pcd/issues/2020/20_0165.html

For more on **COVID-19 in Spanish** see https://www.hopkinsmedicine.org/coronavirus/espanol/index.html

For more on **bilingual community health workers (promotores)** see https://www.cdc.gov/minorityhealth/promotores/index.html

For more on **multigenerational households** see https://www.pewresearch.org/fact-tank/2018/04/05/a-record-64-million-americans-live-in-multigenerational-households/

For more on **health insurance in the USA** see https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=3&lvlid=64

For more on **undocumented US immigrants and COVID-19** see *N Engl J Med* 2020; **382:** e62

For more on **Medicaid enrolment** see https://www.kff.org/report-section/impact-of-shifting-immigration-policy-on-medicaid-enrollment-and-utilization-of-care-among-health-center-patients-issue-brief/

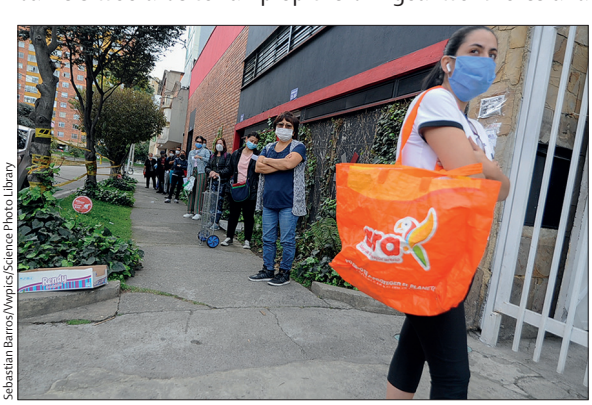
For more on **risk factors for COVID-19** see *Ann Intern Med* 2020; published online Sept 22. DOI:10.7326/M20-3905

For more on **long-term outcomes after discharge from the ICU** see *Crit Care Med* 2012; **40:** 502–09

For more on **symptom resolution in COVID-19** see https://www.cdc.gov/mmwr/volumes/69/wr/mm6930e1.htm

without primary care providers. The Public Charge Rule, which went into effect in February, 2020, has created additional disincentives to care by including use of Medicaid coverage as a programme, which would negatively impact immigrants applying for a green card or citizenship. This led to marked distrust and avoidance in Medicaid enrollment, creating an additional barrier to affordable care. Patients reported to us their reluctance to come to the emergency department due to their insurance or immigration status, despite escalating symptoms consistent with COVID-19. Delayed presentation contributes to more advanced respiratory failure or hypoxaemia on arrival to hospital in many of our Latinx patients, a now described risk factor for mortality in COVID-19. Continued COVID-19 relief funding should occur throughout the pandemic to provide health-care coverage for Latinx patients. The financial relief that this funding provides to uninsured patients, along with confidentiality of immigration status, must be communicated proactively, and might help decrease hesitancy to present to the hospital. During this pandemic it has become even more obvious that treatment without regard to immigration status is a public health necessity.

In the emergency department and while inpatient, necessary isolation precautions create challenges. For example, third party translation, which is necessary to facilitate improved communication with Latinx patients, is challenging due to communication barriers present when using personal protective equipment and limited availability of in-person interpreters on site. Direct communication with qualified bilingual providers is ideal to help build rapport and streamline communication, however, these roles are only available in limited capacity. In addition to isolation precautions, the volume of Latinx patients admitted and time of admission (after business hours) contributes to this communication challenge. Earlier in the pandemic, family visitation was restricted or prohibited, and strict limitations remain. Family visits can provide considerable support for hospitalised patients as well as cultural insight, particularly for patients already in a vulnerable position. A consideration to mitigate such barriers would be to ramp up the bilingual work force and support systems in anticipation of needing to serve this vulnerable population.



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For many of our Latinx patients, illness in the setting of COVID-19 represented their first presentation to the health-care system. Pre-existing health issues were frequently identified by health-care staff during Latinx in-patient admissions for COVID-19, requiring medical management beyond hospital discharge. Hospitalisation and sequelae, particularly the need for intensive care resources, confers risk for lingering functional, cognitive, and psychiatric impairments (eg, post-intensive care unit syndrome and post-hospital syndrome). Longer-term consequences specific to COVID-19 are incompletely described, but a growing body of literature supports delays in symptom resolution. Engagement in primary care, and connection with resources (eg, insurance, assistance programmes, local free or sliding scale clinics with language proficiency, subspecialty care including mental health care and physical and occupational therapy) to ensure provision of care beyond the initial viral illness is essential. Dedicated post-COVID-19 clinics must account for the additional needs of Latinx patients, link patients with case management, social work, and translator services, and proactively advocate for continued medical access. Patient education materials should be translated, and access to nurses, physicians, and testing via phone or electronic health applications should be provided in language-concordant fashion.

Latinx patients might continue to face disproportionate challenges following hospitalisation with COVID-19. Telemedicine, applied nationally for infection control purposes during the pandemic, allows for potential expansion of health-care access by eliminating transportation needs, increasing convenience, and reducing time investment by the patient. Video visits are preferred by providers for visual assessment and diagnosis and rapport-building; however, such visits require a computer or smartphone, in addition to digital access, frequently unavailable in lower-income communities. Telephone visits provide access where social and resource-based limitations to in-person or video visits remain, but have substantially reduced reimbursement and therefore they are disincentivised at the system level. Persistence of telephone visits beyond the COVID-19 pandemic might allow providers to continue to engage Latinx as larger solutions to health-care provision are developed. Federal, state, and local policies and funding, informed by patient experiences and provider input, are needed to ensure durable telemedicine health-care access and resources.

Our collective experiences providing care for the Latinx population affected by COVID-19 reflect a magnification of health-care vulnerabilities. Needs are complex and require comprehensive solutions, but it is our undeniable responsibility as health-care professionals, health

systems, and world citizens to address these needs. As Latinx populations have been disproportionately affected by the COVID-19 pandemic, it is essential that we listen to our Latinx patients, address the barriers to care they experience, and continue to adjust processes and resources with the goal of eliminating health-care disparities.

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Essay

An almanac of pandemonium

January, 2020

A New Year had started; a year projected to have many good changes and new beginnings for me. I was into the final months of my radiation oncology residency at a busy tertiary care centre with a dedicated cancer-care facility, with great plans of a much-needed break after my exams, world travel, and subsequently more learning in the later months of the year. Being in a trans-Atlantic relationship for 7 years, during the entirety of which I had been working in demanding departments like oncology and intensive care, our share of holding hands was limited to a few days in a year, and I had started this new year with those.

An itinerary for the year was ready in my mind, and I was going over it, leaning against my partner with a backdrop of the crashing waves of the Indian ocean: "January—you're here. Once I get back, things will get busy again, phew. February, March, April—the last few laps before the exam. May—exams! But exciting parts after that! June, I stay with my parents, but mid-July I come over to you for that Roger Waters concert! Then I just want to live with you the whole of August; idle life. No duties, no pagers, no deaths, no disease. Just you and me. September, when you go for your conferences abroad, maybe I can tag along for short vacations?", and so on, I went, rambling about my "important" plans, so inconsequential in the light of everything that was to follow. But in this moment, we were frozen in time. Around us, the evening beach was abuzz. A lady was selling seashell crafts, I chuckled remembering the English tongue-twister. Endless people were vending their lucrative fare—candies, ice lollies, colourful wind vanes, and so on. A carnival of marine smells, and wafting through it, an aftershave, was making its way into my olfactory memories. In this moment, life was perfect.

My reverie was broken by a phone call from home, 1000 km away. "Hey, some novel virus is apparently spreading like an epidemic in China!" Memories of the SARS outbreak were fresh in everyone's mind, but how do you know which outbreak deserves a panic and which does not? Calmly, just wanting to get back to my perfect evening, I said, "Must be nothing. Don't worry!" Looking back at that moment, I laugh at my own naivety.

The month ended with India recording its first case.

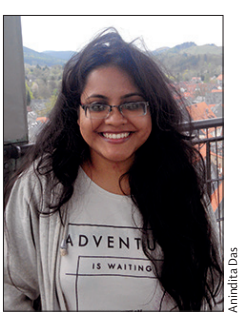
February, 2020

Less than a few weeks later, our worlds had already started changing. More and more people were testing positive all over the world; travel bans were slowly starting to creep in. Masked faces had started appearing here and there. At work, we started to have stringent travel history screenings.

The month ended with only two new cases in India. An entire group of people started their premature celebrations among pseudoscientific theories. The pandemic won't harm India because we are a warm country, because we have more immunity, because we are more resilient, and so on. But the rate at which things were going downhill worldwide, made it pretty evident that it was only a matter of time before the storm hit.

March, 2020

WHO declared the situation a pandemic. Life, as we knew it, had irreversibly changed. Modern day global pandemics were folklores and wild dreams, and yet, here we were! The word exponential started being heard in every nook and corner, as cases climbed to a 1000. Near-complete lockdown was enforced in India, with no transport, dining,



Anindita Das

Anindita is a radiation oncologist from India. In her spare time, she dreams of a world without borders and dabbles with words and ink, often shaping those with her experiences from work.