

COMMENTARY

Medical Training in Corinth, Mississippi

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Keywords: rural emergency medicine, rural medical training

<https://doi.org/10.67225/001c.116754>

Journal of the Mississippi State Medical Association

Vol. 65, Issue 3/4, 2024

I train at a rural emergency medicine program that has a vision of training competent physicians to work in underserved locations in the South. Everyone knows there is a shortage of physicians in these areas but not everyone knows what the field of medicine is doing to fix it, so I'd like to share my perspective of what we are doing.

The street that connects my house to the hospital where I train in residency is a skinny two-way strip with a railroad crossing instead of a single red light. On the way to work, I pass by a couple of farms, a couple of trailers, and an emu that likes to hang out in the west corner of his lot if it's early enough. For the 6am shift, depending on the time of the year, I'll catch the emu in his dawn glory, both of us enjoying the country backroad wake up for the day. My single car is the only thing that parts the sleepy fog that has settled onto the road among singing cicadas and frogs that can be heard even with the windows rolled up against the humidity.

Now, I'll be honest: this is not what I pictured arriving to the emergency department (ED) to be like when I was a medical student chomping at the bits for gore and success. I studied in Birmingham where the shouts of unmedicated psychiatric patients rose outside of the ED and drowned the sound of ambulance sirens constantly arriving. Bustling health care workers shoved through hot, greasy steam floating up from sewage drains to hurry past each other and around metal detectors at all hours.

When I walk through the sliding glass doors of the ambulance bay today, I'm greeted by a sleepy security guard on his third retirement job and two night docs sitting in dim lighting. Everything is calm.

Until it's not, and that's what makes this training as good as it is.

We are a 30,000 annual patient volume ED with three training programs: emergency medicine, internal medicine, and cardiology fellowship. We are located in small-town Mississippi where diabetes and heart disease is a "when" not an "if". I do dental blocks, joint and fracture reductions, peritonsillar abscess drains, lateral canthotomies, moderate sedations, vaginal deliveries (the occasional first assist on a c-section), neonatal resuscitations, joint taps.

You name it; I do it. There's no one else here *to* do it. My patients have me, my attending, and a prayer. I have no choice but to step up to the plate because my patients' location shouldn't affect their quality of medical care.

That's the thing about American health care – about 20% of Americans live in rural communities (1). They need doctors to be able to do these things because they don't have the time or resources to get to the ultra-specialized. Although 20% may not sound like a lot, the U.S. Census Bureau designates areas of greater than 5,000 people as “urban areas” (2), so likely more than half of Americans are dependent on small EDs to get them the emergent health care they need. That's where our training comes into play.

A few weeks ago at 3am, the intern and I were running the 20-bed ED. The only active cases were an NSTEMI and a septic shock. The radio called out that they were bringing us an alpha stab wound to the chest who was currently hypotensive. We prepared the nursing staff, called the blood bank, called respiratory, and called x-ray. When the patient was 5 minutes out, I tapped on the attending's door. There were no surgery residents, no anesthesia residents, and no orthopedic residents rushing to the bedside. There was a chest tube tray set up and an ultrasound with gel on it. The patient rolled in, and the intern met him at the door.

“Sir, what's your name?”

When we paused for breath sounds, our small-town team of about six people seemed big.

The patient did well even though no one was fighting for the head of bed and 25 people weren't trying to squeeze into his room. He is doing fine today, even though his “team” of doctors was comprised of two people named Katie and Gigi.

This is our normal.

I pack up at the end of the night shift to head back home. The black has already softened in the sky but the emu still isn't out yet. I float through the dark and wonder if I mismanaged a case and remind myself to read up on something because there was no specialist to take the wheel for me. This is the kind of training I had hoped for and the type of doctors I hope we all are: always growing and always trying to become more competent for our patients regardless of the resources.

Submitted: March 22, 2024 CDT. Accepted: April 12, 2024 CDT. Published: April 19, 2024 CDT.