

Lessons From the Delta

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In Mound Bayou, Mississippi, physicians are like undifferentiated stem cells. In a time of medical specialization, they are the primary care providers, emergency medicine consultants, and rounding inpatient physicians. For the pediatrician I worked with, he is also the newborn nursery, NICU, PICU, and pediatric subspecialists all rolled into one. I watched him round on newborns in the hospital and discuss asthma prevention with his patients in clinic. He answers pediatric questions for the nearby emergency department and directs care for children in the local ICU. When needed, he also makes home visits and hand-delivers paper scripts to the local pharmacy. Mississippi has one of the lowest physician-to-patient per capita ratios in the country.^{1,2} With the nearest academic health care system to Mound Bayou being 2 hours away, a “quick” referral to a pediatric specialist or a transfer to a dedicated children’s hospital requires thoughtful care and coordination.

When I walked into “Kyle’s” clinic room at the Delta Health Center in Mound Bayou, I was prepared to discuss nutrition and exercise. Although childhood obesity is on the rise nationally, the Mississippi Delta region has some of the highest rates of obesity, poverty, and poor health outcomes in the country.³⁻⁵ Prior to the visit, I was told Kyle was a social preteen. Instead, I was met with a boy who barely spoke or made eye contact. As it became clear that Kyle was struggling with depression and suicidal thoughts, the appointment quickly changed from asking about snacks and sodas to assessing safety and plans of intent. I wanted to provide resources for local therapists, psychiatrists, crisis hotlines, and psychiatric hospitals—resources I had access to back home. I was met with the realization that extensive resources simply didn’t exist in this region. The pediatrician *was* the resource.

The Delta Health Center is a community health center that practices health equity and provides world-class primary care to the most vulnerable populations.⁶ First established in 1965 by Dr H. Jack Geiger, a physician activist, and John Hatch, a social worker and community organizer, the Delta Health Center aimed at addressing social determinants of health within this historically underserved

community.⁷ Notably, it was the first rural community health center in the United States, paving the way for federally qualified health centers across the country.

As a future primary care pediatrician, I found myself on an elective rotation in Mound Bayou at the end of my residency training. While there, I watched a team of clinicians exemplify the very essence of what it means to be a medical home—a patient-centered, comprehensive, primary care center. These medical clinicians give everything, including time away from their own loved ones and families, to provide the highest quality of care to children and families who are often overlooked and forgotten.

However, intertwined with my admiration for the clinicians themselves was also a feeling of disappointment in the system that fails to support them and their patients. I questioned why the pediatricians needed to advocate to obtain albuterol spacers for their patients. I struggled to understand the systemic barriers preventing women from accessing IUDs and Nexplanon. I was saddened that the mental health resources that are so desperately needed simply do not exist. While these struggles are not unique to Mississippi, the state is leading the way for many negative health outcomes nationally. The racism embedded in this area helps to explain the staggering statistics. In 1955, Emmett Till was lynched in a town not far from Mound Bayou. In March 2022, 67 years later, the Emmett Till Antilynching Act was finally signed into law.⁸ In another nearby town in the Delta, the local high schools were recently desegregated in 2017, a mere 6 years ago.⁹ Every barrier that the clinicians encounter only fuels the negative statistics. I found myself asking—have we as a health care system, and more importantly as a society, really accepted health inequity as a standard of care? I also cannot help but wonder, am I part of the problem?

I am now a chief resident at a renowned children’s hospital, with every pediatric subspecialist and resource at my fingertips. While my own resident clinic serves the underserved population in my city, I never have to worry about my clinic’s internet going out. I never have to worry about having enough albuterol spacers to give to my children. In a health care system that underappreciates preventative medicine and provides the lowest compensation to pediatricians,¹⁰ what are the incentives to work in

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rural America? Knowing the broken health care system in which these rural physicians are operating and the immense stress of working in a low-resource area,¹¹ would the incentives alone even be enough?

The physicians in Mound Bayou epitomize what it means to be primary care physicians. After my rotation ended, Kyle continued to meet with his pediatrician regularly, and at one point, was communicating with him via email in between office visits. Kyle is getting the support and care he needs because he has a trusted pediatrician who provides excellent care despite living in a low-resource area. I want that career where I am making a difference in the lives of patients who otherwise would not receive quality health care. I want to be the pediatrician who advocates for policy changes, fights for resources, and takes care of patients like Kyle. But I also cannot say that I am ready to move from my city in the Northeast where I have direct access to a plethora of mentors and subspecialists to the rural region of Mississippi after this year. If I'm truly being honest with myself, that leap into such a high need, under-resourced, and isolated area simply seems too daunting.

American author William Faulkner once said, "to understand the world, you must understand a place like Mississippi."¹² While I cannot pretend that I now understand a place so different from where I was raised and trained after spending only 2 weeks there, I have found myself being more critical of our medical training system and our health care system at large. We do not need to cross a border or an ocean to find extreme health disparities. But if we want physicians to take that leap and move away from the academic centers in which they train, we need to better equip them with the tools and resources to do that. We need to restructure medical education to provide more accessible, targeted, and longitudinal opportunities for trainees to experience health inequities first-hand. We need to expand loan repayment programs for physicians working in rural communities, programs such as the National Health Service Corps and the Mississippi Rural Physicians Scholarship Program. We need to provide dedicated advocacy and policy education to trainees, giving them the tools to implement change within our complex system. Perhaps most importantly, however, is that our health care system needs to better value and incentivize preventative medicine and primary care. I am hopeful that as we continue to create a stronger medical education system, provide better support to physicians, and improve our health care system overall, we can provide more equitable care to all Americans. We must.

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