

Dr. Howard Herrell

Greenville, Tenn.

OB-GYN

Dr. Howard Herrell, an OB-GYN who has practiced in rural Greenville, Tenn. for eight years, has seen firsthand the impact of the spread of hospital closures and maternity deserts on remote communities like his. In its report released in 2024, The March of Dimes found that in rural areas like Greenville, 55% of women live more than 30 minutes from a birthing hospital, compared to 25% of women in urban areas. Below, Herrell spoke with Communications Coordinator Lacey Lyons about the vital role rural hospitals play in their communities.

What attracted you to medicine as a profession?

“I think medicine is a unique opportunity to help people and be of service in a way that many other professions don’t offer. Growing up, there was this idea of the well-rounded physician that was a pillar and an important member of the community, an idea that came mainly from television. OB-GYN was appealing to me, because if you do it the way I try to do it, you have an opportunity to have a lot of continuity of care with people, to be involved in multiple stages of their lives. OB-GYN was most compatible with this TV-based idea of medicine. That vision of OB-GYN is dying away. More and more, it’s just available in rural settings. Medicine has shifted to less continuity of care. But the thing that I enjoy about medicine is the relationships with patients.”

Why did you decide to practice in Greenville, rather than travelling to a larger city to work?

“I started in an academic program, but if you practice OB-GYN care in a larger city nowadays, increasingly, you’re not going to find an opportunity to have a relationship with your patients. The model in larger cities is one of laborists at hospitals who are shift workers who do the deliveries. It’s unusual in larger city settings that you’ll see a physician take care of a patient for nine months and be there at the delivery. I think that’s one of the reasons midwifery is increasingly appealing to patients. The thing that midwifery offers is continuity of care, some expectation that the same midwife will be available at each of your prenatal visits and will be the person who delivers your baby. Even in midwifery, that’s changing. In a rural setting, with fewer partners and no laborists, the model that we provide is continuity of care. We see our patients for all of their prenatal visits and try to deliver our own patients. I’ve delivered my own patients 95% of the time.”

How has your practice, and the practice of obstetrics more broadly, changed over the years?

“When I started 20 years ago, a private-practice model was the norm. Now, it’s the rare exception. That’s happened in medicine in general, but has happened very quickly in OB-GYN. In the ‘90s, women frequently picked their physician. They would have 10 visits with that physician, and that was who was going to deliver their baby. Now, that’s very much the rarity. People don’t pick a physician anymore; they pick a hospital or a group. The corporate model has promoted the interchangeability of physicians. That’s changed the face of obstetrics.”

How has your practice been affected by rural hospital closures in and around Greenville?

“One of the things working in a rural setting does to you is that it makes you concerned about the viability of your job in the future, particularly when you look around and see so many rural obstetrics units closing. You think about how deep your roots are going to go into the community when you’re perpetually worried that there might not be a job for you in some number of years. When I moved here, there were two hospitals that had labor-and-delivery units, and there were six doctors delivering babies. Now, there is one hospital and three doctors. In one sense, some of that was a necessary contracture. (2020 Census data revealed a median household size of two in Greenville. In 2021, when the data was last updated, only 5% of women of childbearing age had given birth in Greenville during the past year.) But at the same time, that means a smaller pool of doctors. That’s just been in the last seven years. Now, it’s a sustainability push to maintain what we have. We find it difficult to attract a fourth partner. These concerns don’t exist in busier units and bigger hospitals in larger cities.”

What are some of the factors that lead to rural hospital closures?

“For the most part, closures revolve around economics. (Nurses and doctors) always have to be ready, in case somebody walks in in labor. There’s a minimum number of deliveries a hospital needs to do to have the appropriate amount of malpractice coverage, in case something goes wrong. The last 10 to 15 years in healthcare have been years of mergers and acquisitions. Scale helps. If you are a bigger hospital that buys a smaller hospital and you can move patients from one hospital to another, you can spread some of those costs over more patients. With obstetrics, there’s a need to do a Caesarian delivery fairly rapidly 24 hours a day. That affects anesthesia coverage. That affects OR staff. There are a lot of expenses, so it just makes sense on the bottom line to cut and combine these units. What’s lost when that happens is the importance of obstetrics to the communities. They’re often the best employer in the community. They entice people to stay in the community or move to the community.”

What have been some other results of hospital closures that you have experienced, in terms of unintended consequences?

“Corporate employers are fairly reticent to move to a community that doesn’t offer a full-service hospital. Closures have a domino effect on the community. Tennessee, like a lot of states, is expanding the number of maternity deserts we have. One of the things that we see with maternity deserts is that women access care less. Women who have to travel an hour and a half to access basic cancer screenings are less likely to do it than if they have to travel 15 minutes. We work really hard to adjust to change and buffer the negative consequences. The question is, ‘When does it bust?’ When it busts, the hospitals close. It’s a philosophical question of whether we should be interested in preserving rural communities.”

What would your dream bill or bills to improve rural health care look like?

“Where lawmakers have an opportunity to help rural healthcare access is by understanding the economic forces that are driving hospitals out of rural communities and making it harder for physicians who practice in rural communities to sustain their practices. One of the things that’s closing rural obstetrics units is the inability to pay malpractice coverage. If legislators understand the unique problems of rural hospitals, there’s an opportunity to subsidize premiums. Medicaid coverage also has direct impacts on obstetrics. It could be that Medicaid deliveries pay more in rural ZIP codes.”

You also mentioned legislative solutions that seemed like “low-hanging fruit.” What are some changes policymakers could enact that would be relatively simple?

For medical students, the scholarship programs or loan-repayment programs that have been state-sponsored in the past don't really reflect the current cost of medical school. They need to be updated and made more competitive so that a new graduate out of residency would consider moving to a rural area to obtain loan repayments. Those programs exist, but they're not really adequate. We have a problem recruiting young physicians to rural settings. Often, in their medical schools, they don't have access to opportunities to see what rural medicine looks like. There's some anxiety about it, in terms of going to a place that doesn't have all the support services. Many OB residents have never been in a setting where neonatology wasn't immediately available, or where anesthesia services weren't available 24 hours a day. A lot of the folks who end up practicing in rural areas are from rural areas. But the key to improving access is having residents train more where they are needed. Medical schools could embed students here for two years. Residents could also have rural rotations or fellowships. Exposure is key."

What do you want the general public to know about the issues facing rural healthcare?

"Maternity deserts are a growing problem. They affect every woman, pregnant or not. Rural hospitals that offer a full array of basic services, including delivering babies and doing surgeries, are essential parts of our communities. People should not have to routinely drive more than an hour to access high-quality, basic healthcare."

As he closed the conversation, Herrell said that if formularies and other economic factors favored rural hospitals, "you'd see the opposite trend. Hospitals would be interested in delivering more babies in rural areas. They'd be building up these units, rather than closing them down."