R
ural health care is in crisis around the country, but Texas is suffering the most. At least 20 small-town hospitals have closed since 2013. More than one-fifth of Texas’ 254 counties have only one doctor or none at all. State lawmakers have the tools to slow or reverse the trend, but they’ve mostly neglected to use them. The result? Without nearby medical services, many of Texas’ rural residents end up traveling hours for care—and because of this, people are dying. ¶ Towns are too. Rural communities need health care in order to attract businesses and create jobs. But newly graduated doctors are often averse to working
in tiny, down-on-their-luck communities. No doctors means no hospitals, and no hospitals means few businesses. The vicious cycle goes on. ¶ Much has been written about medical deserts, but we’ve rarely heard from the people who call them home. This series highlights the stories of rural Texans without access to care—and explores what can be done to reverse this troubling trend. The Texas Observer will continue reporting on rural health care in the coming months; in the following pages, we start by examining hospital closures in East Texas, as well as the Panhandle’s doctor shortage. // By CHRISTOPHER COLLINS and SOPHIE NOVACK
When a rural hospital dies, the community around it starts to follow suit.

By CHRISTOPHER COLLINS and SOPHIE NOVACK

On the evening of December 28, 2014, Kourtney Bogan got an urgent call from her younger brother in Clarksville, a rural town of 3,200 bordering Oklahoma in far northeast Texas. Their mother, Gayla Bogan, who'd been fighting a respiratory infection over Christmas, was in bad shape. Kourtney jumped in her car and drove over. “When I got there, she was gasping for air, like she couldn’t breathe or something was blocking her airway,” Kourtney said. “I was panicking. She kept saying that she couldn’t breathe.”

Kourtney and her brother, Bristian, tried sitting Gayla upright in a chair, but it didn’t help. A minute later, she became “nonresponsive,” Kourtney said. She called 911. Within five minutes, an ambulance had arrived at the house, and workers loaded Gayla into the vehicle. They sped off to the nearest emergency room—a 30-minute drive to Paris Regional Medical Center in neighboring Lamar County.

Kourtney didn’t know it at the time, but Gayla, a 47-year-old who served as a church usher and worked as a nurse at a local nursing home, was having a heart attack. As the ambulance sped northwest on a thin strip of oak-lined highway, paramedics tried desperately to revive her.

The timing couldn’t have been worse.

If Gayla had gone into cardiac arrest just two weeks earlier, the travel time to the nearest hospital would...
have been only a few minutes. East Texas Medical Center had operated a rural hospital with an emergency room in Clarksville. But in December 2014, ETMC shuttered the Clarksville hospital along with two other facilities in surrounding Gilmer and Mount Vernon—casualties of low patient volumes, cuts to reimbursement rates from Medicaid and Medicare, and the cost of treating the uninsured. The closures rocked the small communities, upending what had been reliable sources of health care for decades.

More than 20 rural hospitals have closed in Texas since 2013, nearly double the number of closures of any other state, and about one-fifth of the total closures around the country in that time period. Many of the approximately 3 million Texans living outside the state’s major metros are left scrambling for care when emergencies crop up. Some of the approximately 160 rural Texas hospitals that have managed to keep their doors open have done so by cutting crucial services such as emergency care and maternity wards. According to health analytics group iVantage, 75 of Texas’ small town hospitals are at risk of closure.

Though the reasons for rural hospital closures are numerous, the root cause is financial. According to hospital administrators, physicians, and health care experts across the state, the Legislature has hamstrung the facilities and helped seal their fates by failing to relieve some of the financial pressure with a simple fix: expanding Medicaid through the Affordable Care Act. Doing so would extend health care coverage to 1.4 million uninsured Texans and provide much-needed revenue for hospitals, which shoulder the burden of treating the uninsured. Emergency rooms have to see patients regardless of their ability to pay, sometimes pushing hospitals teetering on the financial brink into insolvency.

In East Texas, as the ambulance rushed from Clarksville to Paris, Kourtney tried to keep up, trailing the vehicle in her own car. When she arrived at the hospital, friends and other family members had already begun to crowd into a waiting area in the emergency room. Some were so worried about Gayla that they’d left work, still wearing uniforms from their jobs.

Then a few minutes later, around 10 p.m., a doctor told the crowd of 50 people packed into the waiting room that Gayla had died. She never made it to the hospital alive; her heart gave out in the ambulance, shortly before arriving in Paris.

“When the doctor came in and told us she didn’t make it, it was just a lot to take in,” Kourtney, now 29, recently told us. After the initial shock wore off, she began to wonder whether the outcome would have been different had the Clarksville hospital remained open. “I always feel like the ‘what ifs’ are in our head. Like, ‘What if we had a hospital where she could have gotten stable?’” Kourtney said. “We don’t know. But us not having a hospital close started what I feel like is a string of people not getting to the hospital fast enough.”

According to Dr. Bacharanianda Muthappa, who runs a clinic next door to the old hospital and is the only full-time physician still practicing in Clarksville, longer travel times to Paris may have contributed to 10 patient deaths since December 2014. Experts say that patients see higher survival rates from medical emergencies such as heart attack and stroke when they receive care quickly. This year, the National Bureau of Economic Research found that rural hospital closures caused mortality rates in surrounding areas to rise nearly 6 percent.

Rural populations tend to be older, poorer, and in worse health than those living in urban areas. Nearly 30 percent of Red River County’s more than 12,000 residents are 62 or older. Without a hospital here, Muthappa and others interviewed for this story predict more preventable deaths.

“You’re looking at extended transport times with a critical patient. It can be a bad outcome,” said Clifton Brown of LifeNet Emergency Medical Service, which provides ambulances in the region and transported Gayla. “If you got somebody in cardiac arrest with a 30-minute transport, that’s a long way and a long time. We’ve either got to resuscitate on the scene or they’re not getting resuscitated.”

When the Affordable Care Act was passed in 2010, part of the law required states to expand Medicaid to adults with incomes up to 138 percent of the federal poverty level. Knowing this would rankle conservative states, the federal government said it would cover the full cost of the expansion for the first three years, then 90 percent thereafter. But with a carrot came a stick: If states didn’t expand Medicaid to cover all newly eligible individuals, they would lose all federal funding for Medicaid. Predictably, a consortium of states—including Texas—subsequently filed a lawsuit against the federal government. The U.S. Supreme Court eventually upheld the rest of the ACA but found that the threat of pulling Medicaid funding was unconstitutional. States could now choose to opt in or out of the expansion.

Research shows that states that opted in have seen increased coverage, more access to care, state budget savings, and economic growth. Hospitals in

More than 20 rural hospitals have closed in Texas since 2013, nearly double the number of closures of any other state.
expansion states were about six times less likely to close than those in states that opted out, a gap that is even wider in rural areas, according to a study published in *Health Affairs* last year. In states that expanded Medicaid, research shows uncompensated care costs—service costs that poor patients can’t pay and that hospitals are on the hook for—dropped 47 percent in the years following ACA implementation, compared to just 11 percent in states that didn’t.

Despite having the highest uninsured rate in the nation, Texas opt[ed out of Medicaid expansion. State data shows that caring for uninsured patients cost hospitals $6.66 billion in 2014. That year, the state paid $329 million to reimburse rural hospitals for these costs. As the Texas Health and Human Services Commission (HHSC) put it, “uncompensated care costs continue to increase and funding is inadequate to attenuate the deficits hospitals face.” (The gap narrowed on October 1, when HHSC announced a 25 percent increase in general federal Medicaid funding to reimburse those costs statewide.)

In Red River County, where Clarksville is the county seat, the uninsured rate for people under age 65 in 2017 was 19.6 percent, just higher than the state average of 19.4 percent that year. In Upshur and Franklin counties, home to Gilmer and Mount Vernon, the uninsured rates were below the state average but still nearly double the national rate. Caring for uninsured patients cost the three ETMC hospitals in those towns $2.9 million collectively in fiscal year 2014.

The ongoing crisis led advocates and medical professionals to flood the Texas Capitol this spring to implore Republican lawmakers, who hold all executive leadership positions and control both chambers of the statehouse, to expand Medicaid. Texas is one of just 14 states that continues to reject the expansion, which would bring an estimated $100 billion in federal funds to the state over the next decade. The decision is driven in part by cost concerns and the fear that the federal government will renege, leaving the state to foot the bill. But it’s also largely
motivated by politics—the same politics that have led congressional Republicans and the Trump administration to continue fighting Obama’s signature health care law a decade later. This adversarial stance is unlikely to change soon, especially since rural residents overwhelmingly elect conservative lawmakers—politicians who advocate say vote against their constituents’ interests on this issue. “Rural Texans have been faithful to Republican lawmakers; they need to be faithful to them,” Douglas Curran, a physician in Athens, Texas, and then-president of the Texas Medical Association, told the Observer earlier this year.

Things may soon get worse, advocates say. Some money to help shoulder the cost of uncompensated care comes through Texas’ Medicaid 1115 waiver, a $25 billion deal between Texas and the federal government that’s been used as a Band-Aid in the absence of Medicaid expansion. This waiver funding is set to expire in 2021, leaving hospitals with one fewer financial tool to stay solvent.

In a March committee hearing on a bill that would expand Medicaid coverage, the first hearing on such a measure in years, Anne Dunkelberg, who oversees health policy for the Austin-based Center for Public Policy Priorities, said passing some kind of coverage expansion “is one of the most powerful tools we have to hold on to that funding.” Curran also testified, warning that the rural hospital crisis could be just the beginning. “The canary in the coal mine is our rural hospitals. Bigger hospitals are going to start having the same issues. ... The strain on the system is going to continue,” he said. “We need to draw down every federal dollar we can, to move in a direction where we can take better care of our people.” Curran implored lawmakers to call Medicaid expansion whatever suits them politically but to do what’s best for their constituents. “We’re Texans. We solve problems. We need to solve this problem.”

The bill failed. Four others that would let voters decide whether to expand Medicaid in Texas didn’t get a committee hearing. Meanwhile, the U.S. Census’ most recent data shows that the state’s uninsured rate increased for the second year in a row in 2018, following several years of steady decline—a reversal due at least in part to the Trump administration’s attempts to weaken the ACA. An ongoing national lawsuit led by Texas and backed by the White House seeks to eliminate the health care law, which could kick millions more Americans off their insurance.

When a hospital shuts down, everyone in the community loses—the insured and uninsured alike. The hospitals in Clarksville, Gilmer, and Mount Vernon, which closed simultaneously in December 2014, are now in various stages of disrepair. The Clarksville building is a mere skeleton; the steel support beams and concrete floors are all that remains of the three-story structure. It’s an apt symbol for the town of Clarksville, where factories and manufacturers have packed up and moved to other towns with better highway access. Even the Walmart on Highway 82 is vacant. Local public officials say it’s difficult to recruit businesses to set up shop in a town with no functional hospital. In Gilmer, an hour southeast of Clarksville, what was once a hospital is now an empty lot; the building has been ripped out, foundation and all. What was once a clinic sits vacant on the lot’s north side. Mount Vernon’s old hospital building still looks the part, save the vines creeping up the walls and underneath the window frames. Franklin County is trying to sell it as retail or office space.

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Against all odds, Clarksville could be the first small Texas town to get a brand new hospital amid the current closure crisis. On a scorching August afternoon, Dr. Arjumand Hashmi picks his way through a waterlogged patch of dirt on Clarksville’s far western edge, finally finding shade under the roof of the former ETMC-Clarksville. There’s not much here now: The building is so bare-bones that local residents say you can tour the place simply by driving past. But Hashmi, a cardiologist and former mayor of Paris, has made the empty space mapped out for years.

The doctor’s efforts to resurrect Clarksville’s hospital began in 2014, after ETMC announced the hospital’s pending closure. Back then, Hashmi’s bid to reopen the place was one of two; the other was made by Paris Regional Medical Center. The hospital authority board chose the nearby hospital over Hashmi, but after months of back and forth, Paris Regional pulled out. About a year went by before the board tapped Hashmi for the project.
Texas has the highest uninsured rate in the nation. Expanding Medicaid would extend coverage to 1.4 million Texans.

When he resumed plans for the 35-bed facility, he got bad news. The board had surrendered the hospital’s license to the state, thus revoking the grandfathered status for building codes. He’d have to tear down and rebuild nearly the entire structure. He’s run into other headaches, too, including a bank withdrawing its funding and repeated construction delays.

For years, Hashmi has reassured community members that he’s as dedicated as ever to the project, but his patience is wearing thin. It’s been “one thing after another thing after another thing,” Hashmi said. What was originally intended as a renovation has dragged into a yearslong, multimillion-dollar project that’s tested the will of Hashmi and his local supporters. Some residents, including Kourtney Bogan, are increasingly doubtful that they’ll ever see a hospital in Clarksville again.

Even Hashmi’s fans seem incredulous of his determination to bring a state-of-the-art facility to Clarksville, where there are more than 80 abandoned buildings ready for demolition and where city leaders have tried fruitlessly to recruit new businesses and create more jobs. “Anyone else would have given up,” said Red River County Judge L.D. Williamson. “He’s moved heaven and hell.”

The ongoing process has reinforced a health care truism: It’s far more difficult to open facilities than to close them. Even if Hashmi were to finish the project today, the whole ordeal would still have eaten up nearly five years. In that time, more than a dozen hospitals closed across the state. This summer, at least three shuttered, including a hospital in Chillicothe in the southern Panhandle and another in Grand Saline, less than two hours south of Clarksville.

So why should Hashmi’s hospital succeed where others have failed? He hopes an extensive cardiology department will help fund less lucrative services, including losses from uncompensated emergency care, and that the sweeping new facility will attract patients and doctors from miles away.

The people of Clarksville are counting on him: Each hospital closure forces rural Texans to cope with the real-life impacts. Those include a dearth of doctors, long travel times for emergency care, and, in some cases, death. Both Muthappa and Hashmi say they know of several patients who, like Gayla, died on the half-hour drive to Paris Regional. James Wood, a member of the hospital authority who once ran a local funeral home, does too. “I’ve buried them,” he said.

When a hospital closes, doctors tend to leave too.
Muthappa says he was one of eight doctors in Clarksville when he arrived 40 years ago. Now, it’s basically just him. The doctor, who says he’s “over 70,” thinks often about retiring but worries about leaving people stranded. Besides Muthappa’s 8-to-5 practice, there’s a daytime urgent care clinic staffed by nurse practitioners. Another doctor in Clarksville practices only on Mondays and Tuesdays. No medical services are available on the weekends.

“Trying to recruit a physician to Red River County without a hospital is very difficult,” said Rob Riley, executive director of Clarksville Nursing Center, where Muthappa is the medical director and Kourtney now works as a nurse. “Three years or five years from now, if there’s not a hospital for physicians to anchor to or call home, will there be physician services in Red River County?”

Clarksville Mayor Ann Rushing hopes the new hospital will be a “saving grace” for the town that’s been withering since its “boom” in the ’80s. Each rural hospital closure means an average of 170 jobs lost, according to the Texas Organization of Rural and Community Hospitals. Closures have a domino effect on businesses, schools, and the local economy. Even the jail won’t house inmates in Clarksville anymore without a hospital nearby, Rushing says, costing the city lucrative contracts.

In June, Hashmi got the loans and approval to finally start construction for the new hospital. If all goes according to plan, construction should be complete and the hospital open by next winter. He and local leaders are optimistic. “It’s incredible we could expect this here,” said Wood, the former funeral director. Sitting on a couch in his mobile home on a corner lot on Digger Road, across the street from a cemetery, he added: “We’re thrilled to death.”

In Gilmer, about 70 miles southeast of Clarksville, public officials have also scrambled to bring services back to the town of 5,200 since its hospital closed five years ago. It seems unlikely that the town will ever have a traditional hospital again. But there may be a middle ground to restore some services: Community leaders are talking to hospital operators about opening a 24/7 health clinic, where specialists such as cardiologists could provide services once or twice a week.

But there’s no Hashmi in Gilmer to raise capital; any health care facility that comes to town will likely need to be supported by tax dollars. A tax as little as 5 cents per $100 property valuation could generate millions of dollars, which would go a long way, said City Manager Greg Hutson. But levying taxes here could be problematic. It took years of failed attempts before the school district was able to pass a $35-million bond to replace the aging Gilmer High School that was built in 1948. (The football team suits up in lavish locker rooms, however.) Residents are so tax-averse that county commissioners once swatted down a 50-cent tax on vehicle registrations to provide car seats for indigent children. “People will say they’re on a fixed income and can’t afford any more taxes. I understand that. I don’t like taxes either,” said Mayor Tim Marshall. But having a hospital, or at least a clinic, he said, would be worth it.

Rural hospitals have increasingly turned to taxpayers to try to make ends meet, usually through propositions to create new taxing districts. The results have been mixed. In several cases, such as in Bowie and La Grange, anti-tax forces converged to bat down such propositions, even when it meant not having a hospital in the county. Hutson expects the same would happen in Gilmer, but he wants a vote anyway—if for nothing else, so people will stop yammering about the hospital.

Red River County Judge L.D. Williamson's fight for a new hospital in Clarksville is personal. CLOSTER NELL

just before 7 a.m. on a rainy August morning, L.D. Williamson is on his second cup of coffee at the Clarksville McDonald’s. Tall, with a flash of white hair, Williamson outdresses anyone else there in a lavender button-down shirt and striped purple tie. The McDonald’s is an early morning gathering spot for farmers, county officials, and city workers; other than the Sonic and Dairy Queen, Clarksville has few eateries. This has become something of a ritual for the 82-year-old county judge: Every morning for the last five years, he’s come for two cups of watery coffee, some breakfast, and an earful from local residents about the hospital.

Today, Williamson is joined by a few white-mustached men near his age in baseball caps and jean shorts. Rainwater leaks through the fast-food joint’s
roof, forming small puddles on the floor near their plastic table. One of their favorite pastimes is waxing nostalgic about Old Clarksville, where gas stations stayed open all night, cars “zip zip zipped” on the highway through town, and storefronts bustled on the main square. Now things are different, they say. Motorists prefer to zip by on Interstate 30, which bypasses downtown. The square went from bustling to barren. Young people tend not to stick around after graduating from high school since few jobs are available. With no hospital, the men drive to Paris, Tyler, even Dallas to see their doctors; they worry the ambulance service, stretched thin and overwhelmed, could be the next service to fold. Before LifeNet came along, the funeral home ran the only ambulance service in town.

“This is a dying town,” said Dan Williams, a local man the others call “Dangerous Dan.” He wears a white T-shirt and dark overalls and has a nasty scrape near his eye. “If something don’t happen here in Clarksville,” Williams said of the hospital closure, “the only people that’s going to be making money here is the undertakers.”

The subject of the hospital comes up at McDonald’s every morning, and people are evenly split on whether it will ever actually be built, Williamson said. He doesn’t blame them. “It’s become a standing joke at the McDonald’s: People ask how long the new hospital will take and I say two-and-a-half weeks,” he said. “I’ve been saying that for four years.”

Some of Hashmi’s plans seem peculiar for a poor rural town that has struggled to keep even basic businesses open; Williamson is skeptical of the gourmet restaurant planned for the hospital lobby, for one.

**SCENES FROM A HOSPITAL’S FINAL DAY**

Chillicothe Hospital closed its doors on July 22.

Inside a tiny frontier hospital at the Texas Panhandle’s southern boundary, Judy Borpon is hunched over the same gas stovetop that she’s cooked on for the past 47 years. This summer morning, Borpon is right on schedule: She’s simmering hamburger steaks, grabbing canned green beans from the pantry, and whipping up a bowl of powdered mashed potatoes for the few remaining folks on the local Meals on Wheels program. “I don’t want to brag, but I’m known for my rolls,” she says. Borpon apologizes for not making a batch today. There’s just hardly anyone around to eat them anymore.

Borpon used to be one of two cooks at Chillicothe Hospital, a health care hub in this town of about 700 people, an hour northwest of Wichita Falls. For years, the pair had stayed busy making meals for the doctors, nurses, patients, and their families. Now, all the doctors are gone. All but one of the nurses have retired or been let go. There hasn’t been a patient in the hospital for several months now.

Soon, Borpon will be out of a job too.

It’s July 22, and Chillicothe Hospital is closing. Built around 70 years ago, the hospital has been forced to accept fewer and fewer patients because there aren’t enough nurses to see them. This trend is mirrored in the surrounding town of Chillicothe, which has hemorrhaged half its population in recent years. With so few patients to bring in revenue, the hospital can’t make ends meet. Recently, visitors who do come have been met with a paper sign taped to the front door, directing them to the closest hospitals about 20 minutes away.

Inside, the exam rooms are dark. The waiting room is empty. Emergency management workers from Wichita Falls will clear everything out later this afternoon—hopefully they’ll be able to sell most of the equipment, says Bill Barnes, a former hospital administrator who was brought on by the hospital board to help close down the facility. Last week, he had to lay off most of the staff; the hospital took out a loan to make the payroll. Now, state workers are taking down the hospital signs on the highway, and a hospital employee is trying to pry the ER sign out of the front lawn.

The closure reverberates through the community in unexpected ways: Alcoholics Anonymous had been holding evening meetings at the hospital, and now they have to find somewhere else to go. The future of Meals on Wheels in Chillicothe is uncertain. As we stand in a hallway, someone pushes a shopping cart full of frozen ground beef, part of a cache of emergency food supplies that the hospital had stored for the town in case of a disaster. It’s now been sold to the local school.

The clinic attached to the hospital is staying open for now, but Barnes doesn’t know how long it’ll last. In the waiting room is a man who traveled with his elderly mother from Frederick, Oklahoma, a town that also lost its hospital, to see the doctor here, only to learn that the hospital is closing. If she needs to be admitted today, it won’t be in Chillicothe. As he waits, Barnes passes through the clinic, sticking his finger in the soil of a vine planted along one wall. “This needs water,” he remarks, before opening the door and leaving.
And he wishes they’d picked a new, more inspired name than Clarksville General Hospital. But it’s too late to change. Hashmi has already ordered boxes of china plates for the restaurant, each embossed with “CGH” in gold across the center. Williamson rolls his eyes and chuckles. But he credits Hashmi for his persistence. “If we can get it done, it will be the best thing to happen in this part of the world.”

For Williamson, the fight for a new hospital is personal. On July 22, 2015, seven months after the Clarksville hospital closed, Williamson’s wife, Margaret, walked into the living room of their home complaining of a bad headache. She’d had headaches before, but none this severe. Thinking of the cost and time it would take to wait for an ambulance, Williamson drove her the 30 miles to Paris Regional Medical Center.

Margaret and L.D. met in high school in southeast Texas and married young: Margaret was 17, L.D., 19. In 1975, they moved to Clarksville, where L.D. worked for years at an old-timey dime store that he says sold “a little bit of everything and a whole lot of nothing.” Margaret operated machinery at the Campbell’s soup factory just outside town. The couple had opposite but complementary personalities: Margaret was shy and reserved; L.D. affable and magnetic. When L.D. got into local politics a few decades ago, Margaret avoided the limelight. Still, the couple was practically inseparable during their nearly 60 years together.

As they drove to the emergency room on that July day, Margaret seemed to be holding up OK. Just after crossing the county line on the way to Paris, they made a quick stop at a gas station in Blossom for a Sprite to settle her stomach. Fifteen minutes later, they pulled up to Paris Regional Medical Center and hurried into the emergency room. Luckily, Williamson says, it was less crowded than usual, and doctors saw her quickly. Then, a troubling discovery: Physicians found bleeding caused by a ruptured brain aneurysm. Margaret was sent by helicopter to a hospital in Plano for more advanced treatment. Shortly after, she lost consciousness.

Margaret never woke up. Five days after that fateful drive to the closest hospital, Williamson and their five children decided to disconnect her from life support. She was 76.

Williamson still feels guilty for driving Margaret to Paris instead of calling an ambulance: maybe paramedics could have prevented some of the damage. But mostly he wonders whether things would have been different if the Clarksville hospital had still been open. “We’d have gotten there much quicker. The damage would have been a lot less,” he said.

It’s something on the minds of everyone in Clarksville, where residents are linked by one or two degrees of separation. With an aging population, and nursing homes and funeral homes outnumbering just about everything but churches, the fear of not making it to a hospital is top of mind. “[People] didn’t die in Clarksville; they died somewhere between here and Texarkana, here and Mount Pleasant, here and Paris,” said James Hodgson, a Clarksville resident, over a McDonald’s breakfast. “The obituaries today for Clarksville [might as well] say, ‘died in transit, died on the road.’”

Williamson has his plan set. If he ever needs to, he’ll move to the nursing home down the street, where Kourtney Bogan works. He’ll be buried by the same funeral home as Margaret. His headstone, complete with name and birth date, is already in the ground next to hers. Meanwhile, he brings white roses to her grave at least once a week. He eats breakfast at McDonald’s—a new routine since Margaret died. And he’s doing everything he can to see a new hospital in Clarksville open in his lifetime. Margaret had said it would never happen, Williamson recalls with a smile. “We’re going to prove her wrong.”

Kourtney isn’t so sure. The myriad setbacks and delays have caused her frustration to boil over. “We’re coming up on five years since the hospital closed, and we still have nothing,” she said on a recent lunch break from work at Clarksville Nursing Center. “These people need it. The people outside of these walls need it. We need a hospital.”

Around New Year’s Eve in 2014, as Kourtney started to make arrangements for her mother’s funeral, she found a stack of unopened Christmas presents in Gayla’s closet. Gayla died just three days after the holiday, and because she was sick, she hadn’t gotten around to giving them out. One of the gifts was an enormous stocking filled with candy and toy trucks for Kourtney’s then-3-year-old son, Kingston.

“The stocking was as big as him,” she said. Others were for residents at the nursing home where Gayla worked. “I knew I had to give those gifts,” Kourtney said. “They bawled their eyes out. It was so sweet.”

In 2016, spurred by Gayla’s death, Kourtney went back to school. She was already working as a certified nurse’s assistant at the time, but she applied for a more advanced nursing program in Iabel, Oklahoma, just across the state line from Clarksville. On the application, Kourtney cited her mother’s death as her primary motivation. “I felt like I couldn’t let her die in vain,” Kourtney said.

Inside a spartan conference room at the nursing home, Kourtney wipes tears from her eyes. A clock on the wall ticks away, words at its center reading, “Time spent with family is time well spent.” Kourtney wishes she had gotten to spend more time with her mother. On special occasions, to remember Gayla, Kourtney wears one of the dresses she inherited from her mom. Kourtney’s favorite—one that she coveted as a child—is black with ruching at the top and a blue jacket, the perfect choice for church functions. “It makes me feel like her. Like she’s right there with me,” Kourtney said. In December, for Gayla’s birthday, Kourtney likes to make banana pudding using her mom’s recipe. Soon, Kourtney will have another reminder of Gayla around: She’s due to give birth to a girl in November. She hasn’t decided on a name yet, but one she’s considering is Kayla—a tribute, of course, to her mother.
DRIVING MY LIFE AWAY

As physicians leave small towns, rural Texans must travel farther and farther for health care.

By CHRISTOPHER COLLINS and SOPHIE NOVACK

Yolanda Narvaez knew something was very wrong when she heard the crackling in her neck—“Like when you put milk in Rice Krispies.”

Yolanda was working the cotton fields just outside Memphis, a small town in the Texas Panhandle, when it happened. It was 2001, and her job was to navigate the claustrophobic paths between rows of cotton, checking traps for boll weevils—beetles that feed on the plants and are one of the state’s most destructive agricultural pests. Rain had poured down the night before, making a mess of the fields. Driving a pickup and looking sideways out the window for weevils, Yolanda didn’t see that the path in front of her had been washed out. The truck’s front end plunged, lifting Yolanda in the driver’s seat and whipping her head toward the roof.

Yolanda later learned that she had ruptured three discs in her neck, setting off a cascade of medical problems and years of chronic pain that would upend her and her family’s lives. Now, nearly 20 years later, there’s not much she can do without significant pain. “Just talking about it makes me want to cry,” she says. That means no more playing backyard football with her kids and grandkids. No more gardening. No more pickup basketball. No more of a lot of things she once did with ease and joy. The 63-year-old feels depressed—and she feels pain. All the time.

Living in rural Texas only exacerbates Yolanda’s condition. There’s no doctor in all of Hall County, population 3,000, where she’s lived for decades with her husband, Angel Narvaez. There was a physician in town until recently, but he died this spring. The health clinic in Memphis shuttered two years ago, when the nurse practitioner who ran it retired. The empty clinic sits in front of the old hospital, which closed in 2002. The closest medical center is in Childress, 30 minutes away, but even there, there are no specialists who can administer the regular injections and other procedures Yolanda needs for her neck pain.

Because the injury left Yolanda unable to drive beyond town, she relies on Angel to take time off from his job doing maintenance and cleaning at the Hall County Courthouse to drive her to doctor appointments. About once every month the couple drives 300 miles to Lubbock and back, five hours round-trip, for an appointment with Yolanda’s pain specialist. Early appointments sometimes require spending the night in a motel, another expense on top of gas. Once, they drove nearly eight hours round-trip for a doctor visit in San Angelo, only to find out when they arrived that it had been canceled. These surprise cancellations happen a couple times each year, and when they do, it’s a full day wasted. Also, Yolanda’s workers’ compensation—which covers her injury and is her only health insurance—won’t reimburse for mileage of canceled appointments.

The Narvaezes are used to traversing long distances for medical care. It’s sort of a sad family tradition, one memorialized by a small teddy bear that sits on their dashboard, stitched with the name Ian, their grandson who was born with a rare, life-threatening liver disorder. For years, his condition required regular trips to see specialists in Amarillo, Dallas, even Florida. Once, when Ian was very sick, the ambulance took so long to arrive to their house that his dad drove him the 30 minutes to Childress himself, where Ian was put in a helicopter and flown to Amarillo for more advanced care. Angel and Yolanda’s daughter, Margie, a nurse, got fed up with the lack of medical care and moved the family to Bridge City, two hours east of Houston, a city with some of the best hospitals in the country. The experience also inspired the Narvaezes’ son, Nick, to become an EMT in Memphis—but the ambulance service is still severely understaffed. While the county has two emergency vehicles, there are only enough EMTs to run one at a time. If one is out taking a patient to the hospital, it could be occupied for hours, leaving the entire county without emergency transport.
“It’s just the way it’s always been,” Yolanda said. “We don’t have enough help.”

Neither does a lot of rural Texas, which is facing a critical physician shortage. Two decades ago, 14 of the state’s 254 counties had no doctor. Today, that number has jumped to 33. More than 20 other counties have just one. In 2018, Texas had about 54 primary care physicians per 100,000 people, according to research from the Robert Graham Center, affiliated with the American Academy of Family Physicians—one of the lowest ratios in the country and far below the national ratio of 76 per 100,000. More than a quarter of Texans live in an underserved county like Hall, with fewer than one primary care physician per 2,000 residents. For years, medical professionals have been sounding the alarm, but they say lawmakers are still not doing enough to bring services to far-flung Texas—and that the problem is only getting worse. Statewide, the primary care physician shortage is expected to grow from about 2,000 to nearly 3,400 in the next 10 years.

The Panhandle is particularly emblematic of Texas’ doctor shortage crisis. Projections show the area’s residents need roughly 140 more primary care doctors to meet demand; by 2030, they’ll need 185 more, according to the Texas Department of State Health Services. Hall County, where the Narvaezes live, sits in a cluster of eight doctorless counties. Several of these also have no nurse practitioner or other medical staff.

Rural populations also face economic barriers to accessing medical care. They tend to be poorer—or older and on a fixed income—and have higher uninsured rates than their urban counterparts. Yolanda’s brother and sister-in-law in Crosbyton, 40 minutes east of Lubbock, sometimes don’t have money for gas to get to the doctor, so they cancel their appointments and reschedule when the social security check arrives. Other Texans pay their neighbors to drive them. Many forgo care altogether.

Everything would be easier for the Narvaezes—for all of Hall County, really—if the health clinic in Memphis were still open. The nurse practitioner there couldn’t do much for Yolanda’s neck, but the clinic
saved them hours on the road for basic services like flu shots and allergy treatment. But the building sits vacant; old medical reference books are still tucked away in cabinets, dust and dead bugs gathering in corners. County officials have been trying to find a nurse or doctor to reopen the clinic. When anyone comes to tour, Angel cleans the facility, part of his second job running a cleaning service in town to make ends meet. Yolanda helps as much as she can manage. But the couple tries not to get their hopes up.

“I guess it just comes from living in a small rural community—you don’t get access to too much of anything,” Yolanda says during a recent trip to Lubbock, as she watches cotton fields blur by. “It’s hard living in a small town. But at our age, I don’t know that we’d make it anywhere else.”

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In February 1989, a nine-member task force handed over a 140-page report on rural health care to then-Governor Bill Clements. The task force crisscrossed the state for 10 months, taking in 100 hours of public meetings, before reaching a determination: The health care system for rural Texans was utterly broken. Rural hospitals faced a wave of closures. Small-town doctors were retiring or dying with no one to replace them. In some rural areas, health care was all but disappearing. The task force excoriated public officials for letting things get so bad.

“More and more of our fellow Texans are traveling further and further for even the most basic health care services, or worse, simply doing without,” the task force wrote. “If this sorry state of affairs were brought before a grand jury, there might be an inclination to indict the state and federal governments of gross negligence.”

The task force recommended financial incentives for doctors willing to practice in rural Texas and suggested emphasizing primary care instead of other specialties during medical training—solutions that health care advocates still espouse today. With some creative funding, the report said, Texas could “reverse disturbing trends limiting availability and
access to health care in rural areas.” But 30 years later, the problems persist. Rural hospitals are still closing. Older doctors are retiring; younger doctors are staying in the cities where they were trained.

“This has been a problem for a very long time,” said Tom Banning, CEO of the Texas Academy of Family Physicians, an Austin-based trade group representing family doctors. “What we’re talking about right now is the same damn thing they were talking about in 1987.” He and scores of other health care experts generally agree on why rural counties have increasingly gone doctorless: Training spots for medical school graduates are limited in Texas; graduates leave school burdened with crippling student loan debt—sometimes up to $400,000—prompting them to select high-paying specialties in urban areas; and the state has done a miserable job of enticing physicians to set up shop in small towns.

In theory, there should be enough doctors to go around. Texas is producing more medical school graduates than ever: 1,735 in 2018 compared to 1,447 the previous year. That number is expected to grow even higher after the University of Houston and Sam Houston State University open new medical schools next year. But before those future doctors can see patients without oversight of another physician, they’ve got to attend a three-to-seven-year residency program. That’s where the bottleneck happens—Texas has plenty of medical school graduates but too few places to train them. The result is that recent graduates move to other states, like California, with more residency spots.

“We’ve been exporting medical school graduates because we don’t have adequate slots,” said Dr. Dana Sprute, director of the family medicine residency program at Dell Medical School. In 2018, the state had an estimated shortage of 200 residency slots.

Sprute says it’s imperative that the state increase the number of residency slots, especially since the doctors who train here tend to stay here—in 2016, nearly 60 percent of doctors who had their residencies in Texas stayed in-state. And those who do residency work in rural Texas are also more likely to practice in a small community than those who don’t, experts say.

Residency programs in Texas are mostly funded through an annual $10 billion Medicare appropriation distributed nationally that has barely budged in two decades. The state doesn’t supplement much beyond the federal dollars, and in fact, the current doctor shortage crisis can partially be traced to a particularly austere legislative session in 2011. That year,

In Texas, 33 counties have no doctor.
Hall County Judge Ray Powell keeps a folder of news clippings on his desk with examples of other Texas communities that have brought back health care.

SOPHIE NOVACK

lawmakers slashed the budget for training family medicine doctors by 72 percent. At the time the cuts were made, Dr. Bruce Malone, former president of the Texas Medical Association, warned that defunding today would exacerbate doctor shortages tomorrow. “There is a long queue for that training, so if you cut the people at the beginning of the training process, there’s no way you can make them up quickly,” he told the Texas Tribune that August. In the years since, some residency programs have been forced to cut services and accept fewer applicants. Last year, the 40-year-old family medicine training program in Wichita Falls was shuttered for lack of funds.

But even with sufficient residencies, medical school graduates are still typically saddled with hundreds of thousands of dollars of debt. State officials set up the Physician Education Loan Repayment Program, which promises doctors up to $160,000 in loan repayment if they agree to work in an underserved area, but that program has been haphazardly funded by lawmakers. Loan repayment appropriations have tumbled by 25 percent, from a peak of $33.8 million in the 2016 to 2017 biennium to $25.4 million in 2018 and 2019.

In 2019, only 27 percent of Texas doctors receiving loan assistance through the program went to rural areas, compared to 52 percent in 2014. Lawmakers further watered down the program by adding an “alternative pathway” that cuts the requirement for doctors to work in underserved areas in order to be awarded funds. The trend really doesn’t seem to fit with the intent of the program, says former state Representative Warren Chisum, who helped secure the program’s first major funding source in the 2009 session.

The Legislature has also damaged other, smaller initiatives to get doctors into rural areas, like already meager stipends for family medicine trainees who do rotations in rural settings. In 2010, state funding provided a total of $180,000 for this purpose; this year, money for the program dropped to $105,000, effectively halving the trainee class size.

“Every biennium, you’re just sitting on pins and needles. They can zero out funding for those programs just like that,” said Dr. Frederick Onger, who directs the family medicine residency program at Texas Tech’s Lubbock campus. “So you fend for yourself or just perish.”

Physician shortages extend beyond the state’s borders. According to the National Rural Health Association, rural U.S. communities have just 40 primary care doctors per 100,000 people, compared to 53 per 100,000 in urban areas. A national survey conducted by health care advocates and NPR this year found that more than one in four rural Americans have not gotten care when they needed it in recent years. The gap is expected to get worse: Data from the Association of American Medical Colleges projects a shortage of as many as 55,000 primary care physicians and 65,000 specialists nationwide in the next decade or so. The U.S. Senate is exploring a bill to expand residency slots nationwide—a strategy that could trickle doctors down to rural areas—but Texas senators John Cornyn and Ted Cruz have not signed on as co-sponsors.

At the state level, lawmakers made small steps in addressing rural doctor shortages in the 2019 session. A bill authored by state Senator Charles Perry, a Lubbock Republican with a large rural constituency, will help rural hospitals recoup Medicaid underpayments. As it stands, the insurance program only pays a fraction of what hospital services cost. Another measure, by state Representative Trent Ashby, a Republican from Lufkin, encourages more doctors to train in rural Texas. The new law grants money to universities that are creating residency spots in “rural and nonmetropolitan” areas of the state. Last year, the University of North Texas partnered with a hospital group to create 500 new residency slots. The university also now sends four premed students to shadow physicians in Midland. According to the Texas Medical Association, three out of

Pauline Johnsey, the former board president of the Hall County Hospital District, is trying to find a health provider to take over the empty clinic in Memphis.

SHIAE WILLIAMS
four residents who train in rural areas end up practicing there. On a large scale, such initiatives could go a long way toward solving the state's doctor shortage.

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On an August afternoon in Memphis, Hall County Judge Ray Powell sits behind a sturdy desk piled with an array of paperwork. Instead of his name, the placard on his desk reads "I'M BUSY."

"I've got more stuff than I can say grace over," Powell said. He and Pauline Johnsey, who until this fall ran the Hall County Hospital District—a government entity that levies taxes to pay for health services like indigent care and the local ambulance—have been trying to recruit a physician assistant or nurse practitioner to take over the town's idled clinic. No dice, at least so far.

For Powell, who also happens to be Angel Narvaez's boss, bringing some sort of health care back to Memphis is a personal mission. Powell's wife, Lera Kate, was diagnosed with lung cancer in January 2018. For a year and a half, they drove three hours round trip to Amarillo every three weeks for bloodwork and chemotherapy. When she started seeing a radiologist, they made the drive every day for a week.

"We put a lot of miles on the car," Powell said. Fortunately, their trips have come to an end—as of this August, she's cancer-free.

Powell worked on recruitment with Carole Ward, the nurse practitioner who ran the clinic from 2005 to 2017 (see sidebar, p. 29), administering basic care to an average of 15 patients a day. She retired at 64 to spend more time with family. But when Ward, Powell, and Johnsey tried to locate a successor to take over the clinic, the pickings were slim. The few people who expressed interest in running the place backed out after looking at the grim balance sheet. "People want to make money," Ward said. County officials have been talking to a nurse practitioner who may want to take over, but they haven't reached an agreement. In the meantime, the empty clinic is actually costing the cash-strapped county money. Over the last couple years, Johnsey estimates the hospital district has paid a few hundred dollars each month for gas, electricity, cleaning, and yard work as they hold out hope that someone will want to reopen it one day.

Powell is also exploring the possibility of obtaining a mobile health unit for Hall County, essentially an RV outfitted with equipment to provide basic health care services. He keeps a folder full of news clippings behind his desk—examples of other places, like Amarillo and parts of East Texas, that have started similar programs. Even if he found the funds to buy the vehicle, it would raise the same problem as the county's empty clinic and second ambulance: Who would staff it?

The quest to bring health care back to this part of Hall County is playing out, in some form or fashion, all over rural Texas. Sixty miles south of Memphis, the dusty oil town of Paducah is going on eight months with no doctor, no clinic, no anything. About 1,100 people live in this scrubby, flat patch of the southern Panhandle, by far the biggest town in Cottle County, situated halfway between Lubbock and Wichita Falls. The people of Paducah had a health clinic here until March, but like many others in the state, it was a money-loser. The clinic now sits empty on the edge of town, in the shadow of Paducah's hospital, which closed in 1985.

The clinic was handy for 61-year-old Irless Brooks, who lives in Paducah and has multiple sclerosis (MS). The blood thinners Brooks takes for MS require frequent blood testing, which he could do at the clinic just five blocks from his home. Now that it's closed, he must drive 30 miles north to Childress for routine blood work and other medical services, a difficult task for an older man whose wife, like Powell's, has cancer.

The quest to bring health care back to this part of Hall County is playing out, in some form or fashion, all over rural Texas.
that the rural doctor shortage is so tied to the decline of small rural towns makes it a more complex problem. For many rural Texans, it feels like lawmakers—far, far away under the pink dome in Austin—aren’t hearing their concerns. “If you stick a pin in Amarillo and a string, and draw a radius around, do you know how many state capitals are closer to Amarillo than Austin?” said Dr. John Howard, who runs a health clinic in Donley County, directly north of Hall. “Santa Fe, Oklahoma City, I think Denver is closer, Topeka it’s awfully close, even Little Rock would not be too much further,” he said, laughing. “Austin’s a long way away.”

Howard’s clinic in Clarendon, the county seat of Donley, is the only one in at least a thousand square miles, and Howard, a retired Marine Corps flight surgeon, is the only physician in the county, population 3,300. He’s also the county judge, the emergency management coordinator, the de facto budget officer, an attorney, and a Sunday school teacher. Twenty years ago, after graduating from Tulane University and doing medical stints in Louisiana and across Texas, Howard set about figuring out where he would practice for the long haul. He examined a map of Texas and a database from the Texas Medical Association that showed the distribution of doctors in the state's 254 counties, looking for a place where he could make a real difference, a community in desperate need of a doctor. He landed on Clarendon, an hour southeast of Amarillo. Unlike in some nearby Panhandle towns, the highway splitting Clarendon is populated with businesses that are mostly still open: gas stations, fast food joints, and lodging with names like the It’ll Do Motel. A sign outside an auto parts supply shop informs passersby, “God loves you always has!” Another advertises Clarendon with a town slogan: “Stay all night! Stay a little longer!”

Clarendon is situated on a busy highway on the Dallas-to-Denver corridor; motorists with medical emergencies would be out of luck if Howard weren’t here. At his clinic, Clarendon Family Medical Center, Howard and a few mid-level providers try to stabilize patients before they travel the hour to hospitals in Amarillo or Childress. Now, with the Memphis clinic closed 30 minutes away, Howard sees more traffic from Hall County too. Patients’ conditions run the gamut from the flu to diabetes, farming injuries, snake bites, cancer, and heart attacks. “Because we’re the only provider in a county that doesn’t have a hospital, we’ll see just about anything,” Howard says as he walks us around the clinic, which he designed and built in 2001.

The clinic comprises nine exam rooms, an X-ray room, and a lab that can do basic testing. It’s clean and bright inside. Howard too is carefully polished; tall, with bright blue eyes and a dark suit, he looks the part of a former Navy officer. Dark wood frames the windows in his office, where books line one side

for getting fatalistic. As one uninsured shopper at Moore’s Thriftway, the only grocery store in Paducah, advised: “Eat good, exercise, and pray.”

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Texas

She retired in 2017.

nurse practitioner, health clinic until

County. He’s also

ran the Memphis

Bottom: Carole

Ward, a former

nurse practitioner,

ran the Memphis

health clinic until

she retired in 2017.

Sophie Novack

Task as MS robbed him of most of the function of his legs. He controls his pickup’s foot pedals with a mechanism mounted near the steering wheel; he drives slowly and feels unsafe in heavy traffic or near construction. Earlier this year, the daunting prospect of travel compelled Brooks to put off an appointment with a neurologist in Lubbock for six months. Still, he said, he counts himself as “one of the lucky ones.”

“There’s people around here who can barely pay their water bill, and a lot of them don’t even have a vehicle to go a long distance,” he said. “There’s a lot of old, sick shut-ins around here.” Unfortunately for Brooks and other Cottle County residents, there’s no indication that the clinic—or health care of any type—will be back soon. It’s hard to blame the aging, left-behind communities here or elsewhere in Texas

The Observer
of the room, and a series of medical, legal, and naval certificates hang on what Howard jokingly calls his “I love me wall.”

Just behind his clinic is the local ambulance service, which takes patients to Amarillo or Childress in an emergency. Next door is the nursing home, built decades ago to be a hospital. By the time construction was finished, the few doctors in town had retired or left, leaving the place unstaffed. It opened as the town’s nursing home instead.

Across the Panhandle, rural counties have retained medical services either through handsome endowments or by individuals’ sheer force of will. In Collingsworth County, east of Hall and Donley, a private foundation has propped up the community hospital. Without Howard, Donley County would likely be in the same situation as neighboring Hall and Cottle counties.

Howard is glad he raised his family in a tight-knit community with wide open spaces. But if he wanted to make the big bucks, he would have taken his degrees in law and medicine elsewhere. He came here to make a difference, not a fortune. In Donley County, where more than 20 percent of residents under 65 are uninsured, Howard estimates that he gives away $50,000 in care each year to patients who can’t pay. “Donley County is by many measures one of the poorest counties in the state, so we have a significant population who face issues with access because of resources and because of transportation,” he says. Even with Howard practicing in their town, some are accustomed to going without care altogether.

Take Scarlet Estlack, a biology professor at Clarendon College who recently replaced Howard as leader of the Clarendon Lions Club. She was attacked by a dog while out for a run one weekend, but when she finally got her leg loose from its grasp, she didn’t go to the emergency room, which would have required a two-hour drive round-trip. Where did she go instead? “Home,” Estlack said, laughing. “I put hydrogen peroxide on it.” That Monday, when Howard’s clinic opened, she went in for a tetanus shot. It’s the general attitude around here, she says: People won’t travel far for care unless they’re basically dying.

THE LAST NURSE IN MEMPHIS

CAROLE WARD, a 66-year-old nurse practitioner who lives in Hedley, ran the Memphis health clinic from 2005 until she retired and the clinic closed in 2017. The clinic offered limited services, but it was better than nothing. In the two years since, Hall County officials have been trying to reopen it, with some advocates suggesting loosening restrictions placed on mid-level practitioners such as Ward. Under Texas law, nurse practitioners and physician assistants can render medical services under the supervision of a licensed physician. In late July, the Observer sat down with Ward to talk rural health care, running a small health clinic, and her decision to leave the facility.

Is there a shortage of health providers in this part of rural Texas? Yes. It’s a low socioeconomic area, so it’s sometimes hard to find resources for people. That was stressful. I think a big thing is just [patient] volume. You just don’t have much volume. Therefore your profits are low.

What kinds of expenses are involved in operating a rural health clinic? Well, it depends on the kind of staff you have. I had an office manager for everything clerical. Then a [licensed vocational nurse] who worked with me. In Texas, nurse practitioners have to have a cooperating physician, and I was blessed to have one that would do that without charging me. A lot of nurse practitioners pay big bucks to get their collaborating physician.

Did you have any regulars? I did have a lot that just came there. A lot of older patients who didn’t need to be driving out on the highway anymore. It was hard knowing [after the clinic closed] they weren’t going to have anyone to take care of them here in town. One of them actually bought my lunch the other day at a restaurant in Childress.

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A backpacker in a sleeping bag." Yolanda chuckles. Then he shares bad news: Workers' comp won't pay for Yolanda's methadone prescription. Fortunately, he says, it's only $20 to $30 per month out-of-pocket, "not too bad."

“Well, not too bad, but when you have to go drive to Childress to get it too..." Yolanda trails off. Hagstrom shares her frustrations with workers' comp, which makes Yolanda, who has struggled to find doctors who will accept her coverage, nervous. "If Dr. Hagstrom decides he doesn't want to take workers' comp anymore, then I'm in deep water. Where am I going to go?" she says.

After 20 minutes, Yolanda's visit is over. She and Angel pile back in the car to head home.

As Angel and Yolanda get older and require more frequent care, they're grappling with a question on the minds of many in Memphis and surrounding rural towns: stay put and risk a medical emergency, or pack up and leave for a place with better health care? Their daughter has been trying to convince them to move to Bridge City, but they worry about leaving the home where they've spent their whole lives, about finding a new job for Angel, about earning enough money, about being a burden on their daughter.

“It's scary to move somewhere else,” Yolanda says. But “I'm tired of working so much to be able to make it here.” She adds quietly: “It's just too much pain for me.”

On the drive home, Yolanda's spirits lift. The long day of travel is reaching its end. The prospect of new pain medication is closer. As Angel drives, Yolanda shows us photos of their grandkids at their vow renewal two weeks before. (A sign they made for the occasion, “Oops we did it again,” now hangs in their garage.) They snack on Mexican pastries from the panadería that's become a regular stop on their Lubbock visits. When we pass a parked motorcycle with a "for sale" sign, Angel jokes they should get it, to save gas money on trips to the doctor. They discuss plans to clean the empty clinic again that week—to sweep up the dust and insects, mop the floors, yank the weeds—in case someone else might be interested in bringing health care back to their small town.

As we near Memphis, the couple gets quieter. It's been nearly eight hours since Angel and Yolanda set off for Lubbock that morning. Yolanda watches the familiar landscape pass: the cotton fields, the abandoned farm houses, the highway that seems to stretch forever. Angel softly drums his fingers on the steering wheel as a classic rock tune plays on the radio: "I'm drivin' my life away, lookin' for a better way for me / Ooh, I'm drivin' my life away ..."