

COMMENTARY

Two Patients at Every Birth: Elevating Neonatal Readiness as Core Scope of Practice in Family Medicine Training

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ABSTRACT

Family medicine residency and fellowship programs have made substantial progress in strengthening maternal and operative obstetric training. Yet neonatal preparedness, particularly prolonged stabilization, procedural skill proficiency, team leadership, and interfacility transfer remain frequently conceptualized as certification-based rather than as a longitudinal professional competency. In rural maternity care settings, where family physicians often serve as both obstetric and neonatal providers without immediate pediatric backup, this educational gap carries meaningful implications for patient safety, workforce sustainability, and scope of practice readiness. Neonatal readiness must be elevated to an explicitly-taught and assessed component of family medicine training. Reframing neonatal competence as multidimensional and encompassing resuscitation, stabilization, procedures, leadership, transfer, and family-centered communication aligns education with real-world rural practice. Preparing future family physicians to manage both maternal and newborn emergencies strengthens community trust, enhances professional confidence, and supports sustainable rural maternity care. Neonatal readiness must be taught with the same intentionality and rigor as obstetric emergencies.

MATERNAL STRENGTH, NEONATAL BLIND SPOT

Family medicine has long defined itself by comprehensive, community-responsive care. Over the past two decades, residency and family medicine obstetrics (FMOB) fellowship programs have appropriately expanded training in advanced maternal care, operative obstetrics, and intrapartum emergencies.^{1,2} These efforts have been essential as rural communities face continued obstetric unit closures and widening maternity care deserts.^{3–5}

However, while maternal preparedness has rightly received sustained educational investment, neonatal readiness has often remained implicit or assumed to follow from certification rather than cultivated as a distinct and longitudinal competency. In rural maternity settings, where family physicians may be the only clinicians immediately available to care for

both mother and newborn, this distinction matters.

TWO PATIENTS, ONE TEAM

Rural hospitals that maintain obstetric services commonly lack on-site pediatricians or neonatologists.^{6,7} In these settings, family physicians often lead neonatal resuscitation, stabilization, and transfer coordination alongside small, interdisciplinary teams. Transport delays are common, requiring clinicians to sustain advanced newborn care for prolonged periods before transfer occurs.^{8,9}

Regionalized neonatal systems appropriately centralize intensive care resources at tertiary centers.⁹ However, this structure makes early recognition, stabilization, and leadership in neonatal emergencies core responsibilities of rural practice rather than rare exceptions. Expanded neonatal knowledge may also strengthen anticipatory risk assessment and shared decision-making regarding

maternal transfer before delivery when neonatal compromise is anticipated. In these settings, preparedness extends beyond resuscitation alone and may help facilitate timely access to specialized personnel, equipment, and higher levels of neonatal care.

Despite these realities, neonatal training in family medicine often remains centered on episodic certification, particularly the Neonatal Resuscitation Program (NRP).⁸ Although NRP provides an essential, evidence-based foundation, certification alone may not fully prepare clinicians for prolonged stabilization, interfacility coordination, advanced procedures, and family-centered communication during high-stakes neonatal emergencies.

NEONATAL READINESS AS CORE SCOPE OF PRACTICE

The role of family physicians in rural neonatal care extends well beyond initial resuscitation. Neonatal preparedness in rural family medicine must be conceptualized as a multidimensional professional competency rather than a certification-based milestone. In practice, family physicians working in rural communities assume responsibility not only for initial resuscitation but also for sustained stabilization, procedural intervention, team leadership, transfer coordination, and real-time communication with families. This leadership role often includes sustaining collaborative interdisciplinary care teams in settings with limited subspecialty support.

This expanded scope reflects the realities of regionalized neonatal care systems, where rural clinicians may manage respiratory support, thermoregulation, glucose instability, and sepsis evaluation for extended periods while awaiting transport.^{6,8} Neonatal emergencies are therefore not merely technical events but complex leadership moments requiring clinical judgment, systems navigation, and emotional presence.

Competency-based medical education emphasizes that readiness develops through repeated practice, direct observation, and longitudinal reinforcement rather than episodic credentialing alone.¹⁰ Yet neonatal preparation in many programs remains narrower in scope compared with maternal emergency training.

Procedural skill decay further complicates readiness. Advanced neonatal airway management and umbilical venous access are infrequent but potentially lifesaving interventions.

Evidence demonstrates that without deliberate practice and simulation-based reinforcement, procedural competence deteriorates over time.¹¹ In low-volume rural settings, this risk is amplified.

Equally central is family-centered communication. Neonatal emergencies unfold near parents, often without subspecialty buffering. Family physicians must simultaneously provide clinical care while explaining evolving risks, coordinating transfer, and maintaining trust. Communication is not ancillary to neonatal readiness; it is integral to safe, ethical practice.

Just as family medicine has intentionally expanded obstetric competence to include operative delivery and high-risk management in response to community need, neonatal competence must similarly be elevated from assumed knowledge to explicitly taught, practiced, and assessed scope of practice. These core domains of neonatal readiness and their educational implications are summarized in Table 1.

EDUCATIONAL AND WORKFORCE IMPLICATIONS

Rural maternity care increasingly depends on family physicians practicing at the top of their training. Hospital closures, declining pediatric availability, and geographic isolation continue to expand the responsibilities placed on FMOBs.^{1–4}

Perceived preparedness for neonatal emergencies may influence clinicians' comfort with rural maternity practice, particularly in settings with limited pediatric support. Prior literature has emphasized that workforce readiness and sustainability in rural maternal-newborn care depend in part on adequate training, procedural competence, and ongoing professional support in resource-limited environments.^{12,13} Training environments that intentionally develop competence in both maternal and neonatal crisis management may also strengthen professional confidence, collaborative team functioning, and community trust.

EDUCATIONAL PRIORITIES FOR TRAINING PROGRAMS

Preparing family physicians for rural maternity care requires moving beyond episodic neonatal certification toward longitudinal, practice-relevant training experiences. Neonatal

TABLE 1. Core Domains of Neonatal Readiness in Rural Family Medicine Training

Domain	Educational focus	Practice implications
Resuscitation	Evidence-based ventilation, chest compressions, escalation decisions	Immediate survival and neurologic outcomes
Stabilization	Thermoregulation, glucose control, prolonged respiratory support	Safe extended care during transfer delays
Procedural proficiency	Intubation, umbilical venous access	Life-saving interventions in resource-limited settings
Transfer coordination	Structured handoffs, documentation, emergency medical services (EMS) collaboration	Continuity and safety across systems
Team leadership	Closed-loop communication, crisis role clarity, maintenance of collaborative care teams	High-reliability care in small teams
Family-centered communication	Real-time counseling, shared decision-making	Trust and reduced family trauma

readiness should be intentionally integrated into residency and FMOB fellowship education through competency-based strategies that reflect the realities of rural practice.

Residency and FMOB fellowship programs can support this transition through several practical educational priorities.

1. Define neonatal readiness as an explicit scope-of-practice competency

Training programs should intentionally teach and assess core domains including neonatal resuscitation, prolonged stabilization, procedural readiness, transfer coordination, team leadership, and family-centered communication. These competencies may be incorporated into inpatient obstetric curricula, milestone evaluations, interdisciplinary simulations, and longitudinal assessment alongside maternal emergency training.

2. Expand simulation beyond initial resuscitation

Training scenarios may include delayed-transfer situations, limited staffing environments, evolving respiratory compromise, or coordination with tertiary neonatal teams during transport preparation. Programs may also incorporate the S.T.A.B.L.E. program, a postresuscitation stabilization framework emphasizing temperature regulation, airway management, metabolic stabilization, transport readiness, and family support, to reinforce systems-based neonatal care beyond initial NRP training.¹⁴

3. Reinforce procedural skills through longitudinal practice

Programs may strengthen readiness through periodic procedural workshops, interdisciplinary simulation sessions, deliberate practice models, and direct observation during both residency and fellowship training.

4. Teach neonatal emergencies as leadership and communication events

Educational experiences should emphasize closed-loop communication, role clarity, interdisciplinary collaboration, transfer coordination, and family-centered communication alongside technical resuscitation skills. Practical approaches may include interdisciplinary simulation with nursing and respiratory therapy teams, structured postevent debriefings, supervised participation in neonatal transfer coordination, and direct observation of family communication during neonatal emergencies in both residency and FMOB fellowship training.

5. Align training with the realities of rural practice

Exposure to resource-limited maternity settings remains essential for preparing physicians to provide comprehensive rural care. Rural maternity rotations, longitudinal continuity experiences, interdisciplinary team training, and participation in community hospital obstetric care may better prepare graduates for the clinical, systems-based, and emotional realities of independent rural practice.

Educational investment in neonatal readiness is not merely a curricular refinement; it is an important strategy for

strengthening the rural maternity workforce and sustaining comprehensive family medicine practice.

At every birth, family physicians may be called to care for both mother and newborn. The consequences of limited neonatal readiness are often most visible in rural settings. Yet competencies in neonatal stabilization, interdisciplinary leadership, transfer coordination, and family-centered communication remain essential across maternity care environments, including community and urban hospitals where family physicians provide intrapartum and newborn care. Preparing graduates to lead in both maternal and neonatal emergencies strengthens safety, trust, and the future of comprehensive family medicine.

Neonatal readiness should therefore be taught with the same intentionality and rigor as obstetric emergencies because in many practice settings, particularly rural communities, it is not optional.

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