

Evaluation, Stabilization, and Transfer of Pregnant and Postpartum Patients Presenting to Emergency Departments Without Inpatient Obstetric Services



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More than 50% of rural critical access hospitals in the United States no longer provide inpatient obstetric services. As more hospitals close their hospital-based obstetric services, emergency physicians must still be ready to care for pregnant patients who present emergently for care. Ideally, this will include immediate medical screening examination, stabilization and transfer to a hospital with obstetric services. In other circumstances, it will result in the need to provide basic obstetric emergency care for conditions such as unanticipated delivery, postpartum hemorrhage, eclamptic seizure, and neonatal resuscitation. Emergency physicians working in hospitals without inpatient obstetric services need to have knowledge of both the closest obstetric unit they can transfer a full-term patient for obstetric triage and delivery, and where they can transfer a preterm patient at any gestational age. Level I Obstetrical Units (low-risk units) can typically accept patients with more than 37 weeks gestation. Regional maternal centers (Level III/Level IV) can typically accept any gestational age. It is critical for emergency physicians working in facilities without inpatient obstetrics to be familiar with both resources in their catchment area (eg, nearby low-risk and regional high-risk centers). This article examines the emergency physician's role in evaluation, stabilization, and transfer of pregnant and postpartum patients seeking emergency medical care at facilities without inpatient obstetric services. [Ann Emerg Med. 2026;87:365-373.]

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INTRODUCTION

The ability of hospitals to maintain an inpatient obstetric service in the United States has been steadily declining over the last 2 decades. Between 2010 and 2022, more than 500 hospitals closed their inpatient obstetric services.^{1,2} In 2022, more than 50% of rural critical access hospitals in the United States no longer provide inpatient obstetric services.

As more hospitals close their hospital-based obstetric services, emergency physicians at these facilities are being called on to care for pregnant patients who present for care. Ideally, this care will include an immediate medical screening examination (MSE), stabilization within the capabilities of the facility and then transfer to a hospital with an obstetric unit.

In the United States, there is not currently a robust maternal transport system that parallels the work done with our trauma system. Although work to build these systems continues, this article examines the emergency physician's role in evaluation, stabilization, and transfer of pregnant and postpartum patients seeking emergency

medical care at facilities without inpatient obstetric services. We recommend algorithms for the MSE in a pregnant patient and provide a framework for transfer decisions, referencing published works from the American College of Emergency Physicians, American College of Obstetricians and Gynecologists (ACOG), and Agency for Healthcare Research.

THE EMERGENCY MEDICAL TREATMENT AND LABOR ACT

In a legislative response to cases of inadequate stabilization and delayed care of patients presenting to emergency department (EDs), the Emergency Medical Treatment and Labor Act (EMTALA) was enacted in 1986.^{3,4} The word "Labor" is in the title of the legislation and there is no doubt that EMTALA also applies to the evaluation and stabilization of pregnant patients.

The essential legal requirements of EMTALA with consideration of pregnant patients published by the Agency for Healthcare Research and Quality⁵⁻⁷ and recent

clarifications from the Department of Health and Human Services⁸ are:

- **Perform a MSE to determine if a person has an emergency medical condition including active labor.** In the case of a pregnant patient, this examination must take into account both the pregnant patient and the fetus. As the MSE is typically done by obstetric staff at hospitals with Labor and Delivery units, emergency physicians may have limited exposure to this skill during training.

- **If an emergency medical condition is found, the patient must either be stabilized prior to discharge or transferred to a higher level of care after stabilization within the capabilities of the transferring facility.** In the case of a pregnant patient, transfer to a facility that can assess for maternal and fetal wellbeing is likely necessary if they have any medical issue that may be pregnancy-related. The suggestion or recommendation for pregnant patients to travel by private vehicle to nearby facilities with obstetric services is generally not acceptable.³ Of the 94 posted enforcement actions on the Officer of the Inspector General website for the Department of Health and Human Services between 2013 and 2024, 12 cases involved pregnant patients.⁹ The majority of actions (66%) were the result of failure to arrange transfer to a facility with inpatient obstetric services.

- **The benefits of transfer to a facility with inpatient obstetric facilities should be documented in the medical record and be easy to understand.** In most cases, the benefits of transfer to a facility with inpatient obstetric services far outweigh the risk of transfer for both mother and fetus.

THE MSE OF A PREGNANT PATIENT

The medical screening examination of a pregnant patient with more than 20 weeks' gestation with a potentially obstetric-related condition should focus on immediate stabilization and ideally preparation of that patient for transfer to an appropriate facility with obstetric services (Figure). Direct communication with the accepting obstetrician should not be delayed for laboratory or imaging examinations.

The list of presenting complaints that may be related to pregnancy is long and may include signs and symptoms such as headache, vision changes, shortness of breath, edema, chest pain, abdominal pain, cramping, vaginal discharge, vaginal bleeding, contractions, and decreased fetal movement.

If the presenting complaint may be pregnancy-related, our recommendation is a prompt evaluation to assess for the stability of the pregnant patient for transport. This should include a process to rapidly triage pregnant patients to assure prompt evaluation by a provider. Ideally, a goal would be for completion of nurse triage within 10 minutes and for a clinician to complete their initial evaluation within 20 minutes, so as not to delay transfer to a higher level of care. Although rapid assessment and stabilization is a goal, we recognize that there are competing demands with other acutely ill patients in an ED, which can cause delays on clinician time to initiate MSE.

The MSE should include a targeted obstetric history (eg, expected due date/estimated gestational age, gravity, parity, prior cesarean delivery, is this pregnancy a singleton or multifetal gestation, any known complications with this pregnancy, fetus or placenta) that will allow for rapid communication to the obstetric provider at the accepting inpatient facility. Our recommendations are also for rapid assessment of maternal vital signs, fetal pulse rate through a handheld Doppler or bedside ultrasound, and a pelvic examination for cervical dilation. Digital examination to assess for cervical dilation is acceptable in the absence of vaginal bleeding or known preterm prelabor rupture of membranes. Digital examination should never be performed in any patient with a known obstetric complication of vasa previa or placenta previa; thus, clinicians should inquire about these during patient interview prior to an examination. Speculum examination is an acceptable alternative in any patient to assess stability for transfer, and is preferred in cases of vasa previa, placenta previa, and preterm prelabor rupture of membranes. Emergency clinicians practicing in settings without inpatient obstetric services should remain proficient in the assessment of cervical dilation. Laboratory values, including a urine analysis (if patient is able to void), complete blood count, and comprehensive metabolic panel, may be considered, but should not delay initiation of a transfer request with an obstetric facility.

ESTABLISHMENT OF FETAL WELL BEING

Obstetric triage requires the ability to assess the stability of a pregnant patient and assure fetal wellbeing. The ability to assess both patients (mother and fetus) requires consistent volume and practice to achieve and maintain competency.

For certain types of fetal assessment, such as continuous fetal pulse rate monitoring and nonstress tests, abnormal results may necessitate immediate delivery through cesarean delivery. However, it is not expected that emergency physicians maintain the competency to initiate

TRIAGE OF PREGNANT PATIENTS IN EMERGENCY DEPARTMENTS WITHOUT OBSTETRICAL SERVICES

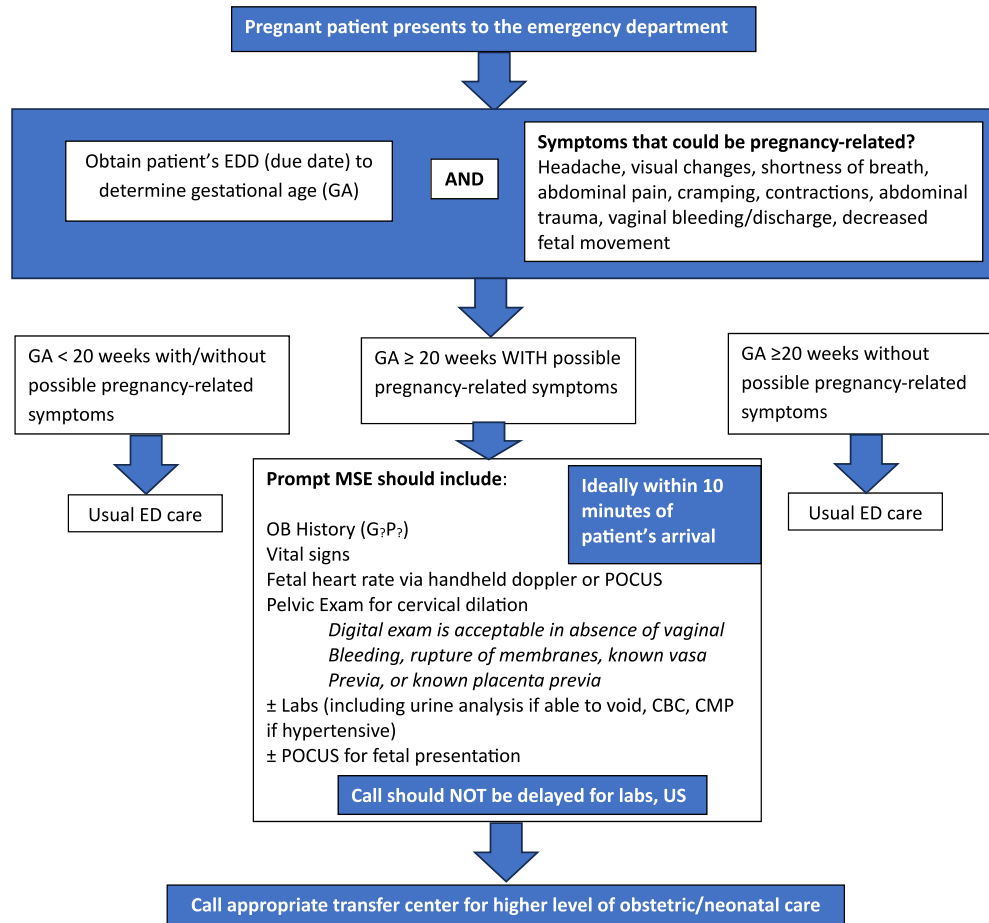


Figure. Triage of pregnant patients in EDs without obstetric services. *EDD*, estimated due date; *GA*, gestational age; *G*, gravid; *P*, parity; *POCUS*, point-of-care ultrasound; *US*, ultrasound, *CBC*, complete blood count; *CMP*, complete metabolic panel.

and interpret these types of fetal assessments. Similarly, it is not expected that an emergency physician has the capacity to safely perform an emergency cesarean delivery in response to nonreassuring fetal testing. As a result, our recommendation is to delay this type of testing until the patient arrives at the accepting obstetric facility as this best balances the risks and benefits for both mother and child. Attempts at fetal monitoring may cause delays in definitive care and testing, as it requires experienced interpretation. If real-time obstetrics consultation is remotely available for interpretation of testing through secure telehealth platforms, and an obstetrician may determine that fetal testing will affect the urgency or location of patient disposition, then remote interpretation of locally administered fetal testing may be considered.

Additionally, although point-of-care ultrasound may be helpful for assessment of fetal pulse rate and fetal

presentation, our recommendation would be to not delay a transfer by obtaining a formal obstetric ultrasound.

STABILIZATION AND TRANSFER

ACOG states that a pregnant patient “*in labor is considered unstable from the latent phase through delivery of the placenta if there is inadequate time to safely transfer her to another hospital before delivery or if that transfer may pose a threat to the safety of the pregnant patient or her fetus.*”⁷

It is important to remember that if adequate time exists, transfer to a higher level of care, especially a facility that has obstetric services is often in the best interest of the pregnant patient or her fetus, especially while in latent labor. In the case of a preterm delivery, antenatal transfer to a higher level of care is always recommended if time allows, as preterm infants born at higher levels of care have

better outcomes. Therefore, transport determinations should always be done with consideration of the risks and benefits for both patients.

Emergency physicians working in hospitals without inpatient obstetric services need to know the closest obstetric unit they can transfer a full-term patient for obstetric triage and delivery, and they also need to know where they can transfer a preterm patient at any gestational age.¹⁰ Level I Obstetrical Units (low-risk units) can typically accept patients with more than 37 weeks gestation. Regional maternal centers (Level III/Level IV) can typically accept any gestational age. It is critical for emergency physicians working in facilities without inpatient obstetrics to know the closest type of both facilities for transfer.

We propose that pregnant patients requiring interfacility transfer fall into the following 3 general categories, based on the likely need for intervention en route:

- 1). Stable with low risk for delivery and/or deterioration—generally pregnant patients with cervical dilation less than 6 cm.
- 2). Unstable with some potential for delivery and/or deterioration but the risk of transfer is less than nontransfer.
- 3). Unstable to the extent that the risk of immediate transfer is more than further local stabilization.

The active phase of labor in a pregnant patient is defined as a cervical dilation of 6 cm or more.¹¹ Although progression in labor is often unpredictable, in nulliparous patients in spontaneous labor, the average time to delivery from the start of active labor was 2.3 hours (5th to 95th percentile 0.6 to 9.4 hours) with less than 5% of patients delivering within 36 minutes. In multiparous patients, the average time to delivery from the start of active labor was 1.4 hours (5th to 95th percentile 0.3 to 7.9 hours) with less than 5% of patients delivering in less than 18 minutes.¹² Therefore, we propose that, in general, pregnant patients with cervical dilation less than 6 cm be considered stable with a low risk for delivery and/or deterioration during transport. Although pregnant patients with cervical dilation of 6 cm or greater may be unstable, transport is still feasible and should account for patient presentation, diagnosis and time course, especially in the setting of preterm labor which can arrest. The transfer of an unstable patient to a higher level of care is acceptable when the benefits of transfer outweigh the risks of transfer and the transferring facility has attempted to stabilize the patient to their maximum capabilities. These decisions would depend on distance, geography, and weather as well as the

availability of ground and air transport. Similar to trauma patients, transfer should not be withheld solely on the basis of the acuity of the patient. If adequate time for transfer prior to delivery does not exist, calling specialized neonatal transport teams to the transferring facility to assist in the resuscitation, stabilization and transport of the baby, especially in preterm infants, is recommended if this service is available. Transfer decisions should be made to best balance the risks and benefits of the transfer to higher level of care for both the pregnant patient and the fetus and recommended to be a joint discussion between the physician at the transferring facility and the receiving obstetrician/gynecologist.

Transport team composition is highly variable. Some transport teams include 2 basic emergency medical technicians whereas other teams may include a paramedic. Some specialized transport units include a registered nurse in the team complement (typically critical care interfacility transport). When there is some potential for delivery en route, we recommend that the transport team include 2 individuals in addition to the driver/pilot. We further recommend that at a minimum least one member of the transport team have Neonatal Resuscitation Program certification, Basic Life Support in Obstetrics or equivalent education or experience. Basic Life Support in Obstetrics is designed for out-of-hospital care providers, emergency clinicians and nurses and includes obstetric training for care of normal labor, emergent prenatal assessment, postpartum hemorrhage, maternal resuscitation, malpresentation, shoulder dystocia, hypertensive emergencies, preterm labor, and neonatal resuscitation. In lieu of these certifications, individuals (nurses, advanced practice providers, and/or physicians) experienced in obstetrics may be helpful. In both Mississippi and New Hampshire, Health Resources and Services Administration Rural Maternity and Obstetrics Management Strategies grant funds are being used to provide training and support for physicians in EDs without obstetrics, nurses, paramedics, and emergency medical technicians (EMTs), out-of-hospital health care providers. Over the last 2 years, the program in Mississippi has held more than 60 classes and trained more than 1,000 team members.

Specialized issues, unique to the transport of obstetric patients to be considered, are the following¹³:

- 1). **Positioning**—The obstetric patient with more than 20 weeks gestation should be transported in the left lateral recumbent position to maximize perfusion.
- 2). **Intravenous magnesium sulfate**—The 2 indications for magnesium sulfate are severe preeclampsia/eclampsia and prior to anticipated preterm delivery for fetal

neuroprotection.¹⁴ Magnesium sulfate is considered a high-risk medication due to a narrow therapeutic window and risk of toxicity. Calcium gluconate 10% (1 g) should be readily available to treat magnesium toxicity, which may present as respiratory depression, lethargy, loss of deep tendon reflexes, or cardiac arrest.

3). **Blood products**—In many states, emergency medical services (EMS) providers are not authorized to administer or transport a patient receiving blood products. In cases where transfusion is to occur in transport, this requires the sending facility to send staff (typically a registered nurse) with the patient and would elevate the transport into the “unstable” category.

4). **Antihypertensives**—Hypertensive emergencies (blood pressure of more than 160/110 mmHg) in pregnancy and postpartum patients are defined differently compared with other nonpregnant adults, and require early recognition and immediate action.¹⁵ The goal is not to return rapidly to normotensive blood pressures, but rather to lower the blood pressure out of critical range while transferring to a higher level of care.¹⁵

5). **Safe neonatal transport**—If a delivery was to occur enroute, safe transport is needed for 2 patients (mother and baby) which often requires an additional ambulance with neonatal warmer. Having an EMS-approved neonatal restraint system has been demonstrated to be helpful in these situations to eliminate this need, especially in the case of precipitous out-of-hospital deliveries. One example of an EMS-approved restraint system is the KangooFix

Neonatal Restraint System. The system secures a newborn safely to an adult patient’s chest allowing for skin-to-skin contact during ambulance transportation, allowing the baby to safely travel with their parent.

BASIC EMERGENCY OBSTETRIC READINESS

Although priority should always be to transfer a pregnant patient to an inpatient obstetric facility, every emergency physician should be prepared for a precipitous delivery and be prepared to resuscitate both mother and baby. Kozhimannil et al¹⁶ conducted a survey of critical access hospitals without hospital-based obstetric services on their readiness for obstetric emergencies consistent with recommendations from the World Health Organization publication on monitoring emergency obstetric care.¹⁷ Most were readily able to administer blood, intravenous antibiotics, uterotonic medications, treat maternal seizures and perform neonatal resuscitation.¹⁶ Fewer felt prepared to perform an operative vaginal delivery or had a policy for resuscitative cesarean delivery in the case of maternal cardiac arrest. We recommend that all emergency physicians in facilities without obstetric services be able to respond to basic obstetric emergencies (Table 1). To address rare scenarios, multidisciplinary team training is recommended, ideally, frequent direct on-site simulation training, in the ED with a focus on team communication and latent safety threats.¹⁸

Similar to the specialized equipment demands of pediatric readiness, ensuring that the ED has the appropriate supplies to resuscitate during pregnancy is critical. At a minimum, we recommend maintaining an

Table 1. Basic emergency obstetric readiness for facilities and emergency physicians without inpatient obstetric services.

Responsibility of Facility	Responsibility of Emergency Physician
Maintenance of Obstetrical Emergency Kit	Administer blood products, intravenous antibiotics for maternal or fetal indications, medications for postpartum hemorrhage, and anticonvulsant medications for severe preeclampsia or eclamptic seizure
Sponsor staff training and/or certification in basic obstetric emergencies and neonatal resuscitation	Participate in training and/or drills for basic obstetric emergencies and neonatal resuscitation
Support regular staff drills/team simulations for precipitous delivery, postpartum hemorrhage, hypertensive emergency/eclamptic seizure, and neonatal resuscitation	Perform precipitous delivery
Maintain neonatal warmer and resuscitation supplies	Perform neonatal resuscitation
Policy for resuscitative cesarean delivery in the case of maternal cardiac arrest or maternal death	Perform resuscitative cesarean delivery in the case of maternal cardiac arrest or maternal death
Create transfer pathway for low-risk pregnant patient to nearest inpatient obstetric facility	Know transfer pathway for low-risk pregnant patient to nearest inpatient obstetric facility
Create transfer pathway for high-risk and/or pregnant patient to Level III/IV maternal center	Know transfer pathway for high-risk and/or preterm pregnant patient to Level III/IV maternal center

emergency delivery kit, a postpartum hemorrhage cart, emergency obstetric medications (betamethasone, indomethacin, immediate release nifedipine, magnesium sulfate, oxytocin, methylergonovine, carboprost [15-methyl-PGF-2 α], misoprostol, and tranexamic acid) (Table 2). Carboprost (15-methyl-PGF-2 α) requires refrigeration, and methylergonovine is stable for 14 days at room temperature, so working with the pharmacy to keep these medications accessible, stocked, and ready to use is crucial. The California Maternal Quality Care Collaborative publishes multiple toolkits for obstetric hemorrhage and hypertensive disorders in pregnancy that may be very useful in building obstetric hemorrhage carts and emergency obstetric kits stocked with medications. It is also critical to have developed clinical pathways, policies, and order sets in a usable and easily accessible format for ED staff and clinicians.

Obstetric telehealth services may start to provide additional support to emergency providers who do not have this level of expertise at their own facility. One rural health system in Minnesota implemented a telehealth obstetric service staffed by obstetric hospitalist physicians from the system's level IV maternal center for EDs in their catchment area without obstetric services.¹⁹ In a three-year experience, the telehealth obstetric service was activated 19 times from hospitals without inpatient obstetrics and precipitous delivery occurred 14 times prior to stabilization and transfer. In addition, the telehealth obstetric service was able to successfully support the management of 2 postpartum hemorrhages (one immediate and one delayed) with uterotonics. In Arkansas, since 2001 the ANGLES network staffs a 24-hour call center for obstetric consultation, resulting in more proactively and timely maternal transfers prior to preterm delivery of premature infants.²⁰ Given the success of these telehealth programs for both obstetric and neonatal support, we recommend that working with regional referral centers to develop capabilities and explore ways to provide these services.

Recognition of Obstetric Emergencies in the Postpartum Period

Among developed nations, the United States has the highest maternal mortality of any country.²¹ Two thirds of pregnancy-related deaths in the United States happen in the first-year post-partum.²² Violent deaths (deaths from homicide, suicide and intimate partner violence) are the leading cause of death in the postpartum period.^{23,24} Given this need, having resources readily available for providers in the ED to support postpartum patients with perinatal mood and anxiety disorders and intimate

partner violence is essential. Another focus of attention is the recognition of the immediate postpartum period as a vulnerable time for patients with delayed hypertensive disorders of pregnancy and postpartum cardiomyopathy, the most common causes for postpartum readmission.^{25,26} Delays in diagnosis and misdiagnosis for these patients are common, leading to the recommendation by California Maternal Quality Care Collaborative and The Joint Commission to add questions for patients on presentation for emergency care about current or recent pregnancy.

Collaboration With Hospital With Obstetric Services

Hospitals with inpatient obstetric services are classified by the ACOG, the Society for Maternal-Fetal Medicine and the American Academy of Pediatrics based on their maternal and neonatal levels of care.^{12,27} Level I maternal/neonatal centers are inpatient obstetric services that have the ability to deliver care to low- and moderate-risk pregnancies. The gestational age these centers are able to admit is typically based on the provider complement comfort in neonatal resuscitation and may range between 35- and 37-weeks gestational age. Level II to IV maternal/neonatal centers typically accept increasingly lower gestational ages and higher risk pregnancies. Ideally, these centers would be able to rapidly accept pregnant patients without delays, avoiding the need for the transferring emergency physician to make multiple phone calls to obtain appropriate and timely patient acceptance. Clearly outlined transfer agreements based on perinatal level of care and gestational age in advance of a pregnant patient presenting for emergency care can help to avoid these delays. Additionally, transfer agreements would allow clear contact information for the accepting facility to know what number to call. At many tertiary/quaternary centers, this is through a staffed "call center." At other obstetric facilities (eg, level I or II maternal centers), this may be directly calling the obstetric charge nurse or on-call obstetric provider. Knowing this system in advance will help to eliminate delays in care.

In conclusion, although we continue to see closures of inpatient obstetric units, the need to support the emergency physicians who provide care in the absence of obstetric services is critical.

It is our recommendation that all facilities that do not have immediate access to inpatient obstetric services develop plans to manage patients who present for emergency medical care who are pregnant or recently postpartum. At a minimum, this should include policies and clinical pathways that assure the rapid assessment,

Table 2. Emergency obstetric medication.

Antepartum Medications, Administer If Advised By OB-GYN/MFM	
For acute pain	Fentanyl* 50-100 µg IV OR Morphine* 4 mg IV or 10 mg IM OR Nalbuphine* 10 mg IV OR Nitrous Oxide by patient-controlled face mask
For fetal lung maturity	Betamethasone 12 mg IM (preferred) OR Dexamethasone 6 mg IM
For initial tocolysis of contractions	Indomethacin 50 mg PO (only if <32 wks gestation) OR Nifedipine 20 mg PO
For Group B streptococcus (GBS) prophylaxis	Penicillin G 5 million units IV OR Ampicillin 2 g IV OR If low-risk penicillin allergy (eg, isolated rash without urticaria) Cefazolin 2 g IV OR If high-risk penicillin allergy (eg, urticaria and anaphylaxis) Clindamycin 900 mg IV
Magnesium for neuroprotection (for gestational age < 32w0d to decrease the risk of cerebral palsy)	Magnesium sulfate 4 g bolus, followed by 1 g/h Bolus: 4 g in 100 mL normal saline solution, infuse over 15-20 min Maintenance: 2 g in 500 mL normal saline solution, infuse at rate of 25 mL/h
Magnesium for seizure prophylaxis (for preeclampsia/eclampsia at any gestational age or postpartum)	Magnesium sulfate 4 g bolus, followed by 2 g/h Bolus: 4 g in 100 mL normal saline solution, infuse over 15-20 min Maintenance: 2 g in 500 mL normal saline solution, infuse at rate of 50 mL/h
For magnesium toxicity	Calcium Gluconate 10% (1 g)
For acute onset, severe hypertension	Labetolol- 20 mg IV, repeat blood pressure in 10 min Hydralazine- 5 or 10 mg IV, repeat blood pressure in 20 min Nifedipine immediate release oral tablets 10 mg – repeat blood pressure in 10 min
Postpartum Medications, Administer if advised by obstetric-gynecology/maternal-fetal medicine specialist	
At cord clamp	Oxytocin 10 units per 500-1,000 mL normal saline solution OR Oxytocin 10 units IM
For postpartum hemorrhage (blood loss >1,000 mL)	Oxytocin 10-40 units per 500-1,000 mL normal saline solution OR Methylergonovine 0.2 mg IM (avoid with hypertension) OR 15-methyl-PGF2α (Carboprost) 250 µg IM (avoid with asthma) OR Misoprostol 800 µg per rectum AND Tranexamic acid (TXA) 1gm IV for single dose [†]
Magnesium for seizure prophylaxis for preeclampsia/eclampsia	Magnesium sulfate [‡] 4 g intravenous bolus, followed by 2 g/h Bolus: 4 g in 100 mL normal saline solution, infuse over 15-20 min Maintenance: 2 g in 500 mL normal saline solution, infuse at rate of 50 mL/h

IV, intravenous; IM, intramuscular; PO, per os.

*Administration of narcotics within 60 minutes prior to delivery may be associated with neonatal respiratory depression.

[†]Tranexamic acid to be given with first uterotonic.

[‡]If no intravenous access, magnesium sulfate can be given as 10 g IM injection bolus for eclampsia.

stabilization, and transfer of pregnant patients to either the nearest obstetric facility for low-risk patients or the nearest regional Level III/IV facility for high-risk and/or preterm patients and the ability to provide basic emergency obstetric care including blood products, intravenous antibiotics, uterotonics, anticonvulsant medications and neonatal resuscitation.

For emergency physicians, we recommend knowledge of surrounding obstetric facilities including appropriate gestational age ranges for transfer and participation in appropriate and frequent multidisciplinary staff and provider education, certification and simulation on obstetric emergencies and neonatal resuscitation. As emergency physicians are increasingly called on to staff facilities without inpatient obstetric services, continued focus on residency training in emergency medicine to expand beyond the minimum obstetric requirements of 10 deliveries to include enhanced obstetric experiences focused on competence in basic obstetric emergency care, comfort with obstetric triage, and knowledge of procedural skills for normal and complicated deliveries is vital.

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