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LETTER TO THE EDITOR

More Than Staffing: Rural Labor and Delivery Nurses as Foundational Infrastructure for Maternity Care

Dear Editor,

Rural maternity care in the United States remains under strain. Over the past two decades, hundreds of rural hospitals have closed obstetric units, contributing to expanding maternity care deserts marked by longer travel distances, delayed prenatal care, and worsening maternal and neonatal outcomes (Hung et al., 2016; Hung et al., 2017; Kozhimannil et al., 2018; Wouk et al., 2026). In response, national and state efforts have prioritized reopening low-volume maternity units to restore local access (Health Resources and Services Administration [HRSA], n.d.; Kozhimannil et al., 2025). Yet experience across many rural communities suggests that reopening a unit is only the first step; sustaining it is the greater challenge.

This letter draws on our shared, practice-based experience to highlight a central but often underrecognized reality: the durability of rural maternity care depends on the stability of the labor and delivery nursing workforce. In policy and operational discussions, nurses are frequently treated as a staffing variable and adjusted in response to volume. In practice, they are the infrastructure that allows the system to function.

When we worked to reopen a Level I maternity center in rural North Carolina, we encountered familiar structural barriers, including low projected volumes, financial uncertainty, and skepticism about long-term viability. Clinical protocols were in place, and physician coverage could be arranged. What proved more difficult and ultimately more consequential was building and sustaining a stable team of experienced labor and delivery nurses.

Without that team, safe care was not possible. Periods of staffing instability quickly exposed the fragility of the unit. When census declined, pressure to float nurses to other departments increased, disrupting continuity and eroding team cohesion. As stability weakened, so did confidence in the unit's future. Closure, once theoretical, became a tangible risk.

What ultimately sustained the unit was not a new program or external intervention, but the nursing team itself.

In this setting, nursing practice extended well beyond conventional role boundaries. Nurses led triage, managed intrapartum and postpartum care, stabilized newborns, coordinated transfers, and responded to emergencies often in environments where other clinicians were not immediately available. They also built the systems that made care possible: developing workflows, cross-training for neonatal resuscitation, and maintaining shared situational awareness across teams with limited redundancy. These patterns are consistent with longstanding descriptions of rural nursing practice, in which clinicians work at broad scope shaped by community need and constrained resources (Bushy, 2002; Hassmiller et al., 2022).

This breadth is not incidental, it is foundational to safety. Obstetric emergencies are unpredictable and time-sensitive, requiring rapid recognition and coordinated response (Mann et al., 2006; Pettker et al., 2009). In small units, that capacity often resides within a core group of experienced nurses whose clinical judgment, shared experience, and familiarity with local systems cannot be readily replaced. The loss of even a single nurse can disrupt this balance, with immediate implications for care delivery.

At the same time, the role of rural nurses extends beyond clinical care. Labor and delivery nurses are often the most consistent presence patients encounter, from initial presentation through delivery and postpartum care. In communities where hospital closures have eroded trust, these relationships shape how patients perceive safety and where they choose to seek care (Armstrong et al., 2007; McCarthy et al., 2021). As continuity within the nursing team strengthens, so too does community trust, reducing rural bypass and reinforcing the viability of local services (Rayburn et al., 2012).

In our experience, this relational continuity was not ancillary; it was central to sustaining the unit. Patients stayed, not simply because services were available, but because care felt known, consistent, and trustworthy. In this way, nursing continuity functioned as both a quality attribute and a structural determinant of system survival.

Despite this, many policies and operational models remain misaligned with the realities of rural obstetric care. Staffing decisions are often tied to average volume rather than the need for continuous readiness. Nurses are routinely floated during periods of low census, interrupting continuity and eroding specialized expertise. Investment in rural nursing pipelines remains limited even as workforce instability persists (NSI Nursing Solutions, 2023; Skillman et al., 2006). These approaches may offer short-term efficiency, but they undermine the conditions required for safe and sustainable care.

What became clear in our setting was that the future of the unit depended less on increasing delivery volume than on stabilizing the nursing workforce. As this recognition took hold, the framing of the problem shifted—from whether the unit could justify itself through volume to how it could ensure readiness, safety, and trust for the patients it served.

Rural maternity units rarely fail for a single reason. More often, they erode when systems are not designed around the realities of care delivery. In this context, the nursing workforce is not one component among many—it is the foundation that enables all others.

Efforts to strengthen rural maternity care will remain incomplete unless this reality is reflected in how services are designed, financed, and led. For those shaping health system strategy, workforce policy, and resource allocation, the implications are clear: sustaining rural maternity care requires intentional investment in the nursing workforce that delivers it. Policies that focus solely on reopening units or expanding access, without addressing the conditions necessary to retain and support nurses, risk reproducing the same instability that led to closures. By contrast, approaches that center nursing—through protected staffing models, readiness-based reimbursement, and sustained investment in rural training and retention—offer a more durable path forward.

Labor and delivery nurses in rural settings bring not only clinical expertise, but a deep understanding of the communities they serve and the systems within which they work. Their perspective is essential to designing care that is both safe and sustainable. Recognizing nurses as

leaders in this work is not simply a matter of professional acknowledgment; it is a practical requirement for building maternity care systems that communities can rely on.

Sincerely,
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