Communication with medical team in emergencies

Why emergency communication matters in birth

Birth emergencies are clinically distinctive because two patients may be affected at once: the birthing person and the fetus or newborn. Conditions such as postpartum hemorrhage, shoulder dystocia, hypertensive crisis, fetal bradycardia, umbilical cord prolapse, sepsis, or neonatal respiratory compromise can require rapid assessment, role allocation, and coordinated action. In these moments, communication is not a courtesy layered on top of care; it is part of the safety system.

Research on emergency teams consistently links communication quality with patient safety. In critical situations, unclear role assignment, incomplete handover, unacknowledged instructions, and assumptions about who is doing what can contribute to delayed or unsafe acts. For a family in the room, this may look like many people arriving, equipment moving quickly, and short clinical phrases being exchanged. The speed can feel frightening, but the goal is coordinated intervention, not exclusion.

Hospital emergency response frameworks also emphasize accurate internal and external communication, leadership approval for messaging, and coordination across services. In maternity care, that may mean nurses, midwives,

obstetricians, anesthesiology, neonatology, blood bank, operating room staff, and emergency transport working from the same shared picture. The patient and support person do not need to control this system, but they can help by giving concise information, asking for clarification when possible, and identifying the correct decision-maker or support contact.

Prepare before urgency changes the conversation

The easiest emergency conversation is the one partly prepared before anything happens. During prenatal visits or admission, ask how the unit handles urgent events, who usually leads communication, and how to reach maternity triage urgent call services after discharge. This is also the right time to discuss emergency warning signs around birth, including symptoms that should prompt immediate assessment rather than watchful waiting.

Keep essential information accessible: gestational age, allergies, medications, major medical conditions, blood type if known, prior uterine surgery, pregnancy complications, Group B Streptococcus status, relevant ultrasound findings, and the preferred emergency contact. If the patient has preeclampsia, diabetes, cardiac disease, placenta previa, prior postpartum hemorrhage, clotting disorders, or significant mental health history, those details should be easy for the team to verify. The point is not to self-diagnose but to reduce the time needed to establish context.

Birth preferences can still be useful in an emergency if they are written in a flexible way. Instead of framing them as rigid instructions, consider a short section such as, "In an emergency, please explain the concern, the recommended action, and whether there is time for alternatives." Include preferences for professional interpreter support, blood products, anesthesia concerns, newborn care, religious or cultural needs, and who should receive updates if the patient cannot speak comfortably. A support person can keep this information available while staying out of the clinical workspace.

Use closed-loop communication when seconds count

Closed-loop communication means that a sender gives a clear instruction, the receiver repeats or confirms it, and the sender verifies that the message is correct. In emergency care, this can reduce missed tasks and ambiguity. For

example, a clinician may say, "Start a second IV and draw labs," the receiver repeats, "Second IV and labs," and the clinician confirms. Observational emergency-team research suggests that closed-loop communication appears more often in high-priority actions such as medication, equipment, and procedural tasks, where misunderstanding could matter quickly.

Patients and support people can use the same principle in a simple way. If a clinician says, "We are moving to the operating room because the fetal heart rate has not recovered," a useful response may be, "I hear that the baby's heart rate is still concerning and you recommend moving now." This does not delay care; it confirms understanding. If there is no time for a long explanation, ask for the shortest safe version: "What is the immediate risk?" or "What are you doing first?"

In a sudden labor emergency, the support person should avoid competing with team commands. The most helpful approach is to speak to the person designated as the communicator, often a nurse, midwife, or physician near the head of the bed. Short statements are best: "She has a severe penicillin allergy," "Her last blood pressure medication was at 8 a.m.," or "She wants an interpreter if there is time." If the team asks for silence during a critical maneuver, that is usually to protect concentration and ensure commands are heard.

Share clinical context without slowing care

In emergencies, the medical team needs information that changes risk, management, or consent. A practical structure is situation, relevant history, current concern, and requested clarification. For example: "I am 39 weeks, my water broke two hours ago, the fluid was green or brown, and the baby has moved less than usual." Or postpartum: "She delivered 30 minutes ago, the bleeding suddenly increased, and she feels faint." These statements are not diagnoses; they are clinical signals that help triage urgency.

When calling before arrival, state the location, gestational age or postpartum day, the main symptom, whether the patient is conscious and breathing normally, and whether there is heavy bleeding, severe pain, seizure activity, chest pain, stroke-like symptoms, fever, or decreased fetal movement. If there is concern about when to call 911 or go to hospital immediately, err toward emergency services rather than waiting for routine office hours. Follow local emergency

instructions and the advice of the clinician or dispatcher.

Inside the hospital, try to separate facts from fears while still naming both. A fact might be, "She has soaked two pads in 15 minutes." A fear might be, "She is scared because she hemorrhaged in a previous birth." Both matter, but the clinical fact helps immediate action while the emotional context helps the team communicate respectfully. Communication with doctors during labor may involve several layers of handover, so repeating key details when a new clinician enters can be appropriate if done briefly.

Protect consent, interpretation, and dignity

Urgency can limit the amount of time available for discussion, but it does not erase the need for informed consent during labor and birth whenever consent is possible. In a time-sensitive situation, a clinician may use focused language: the concern, the recommended intervention, the main risk of waiting, and whether alternatives are safe. For example, explanations about operative vaginal birth, emergency cesarean birth, manual removal of placenta, blood transfusion, magnesium sulfate, antihypertensive treatment, or neonatal resuscitation may be necessarily brief but should still be understandable.

If the patient uses a language other than the clinical team’s working language, professional interpreter support is especially important. Family members may help identify preferences or urgent facts, but they should not be forced into interpreting complex risks, consent, or emotionally charged decisions when professional interpretation is available. In true immediate threats, the team may need to act while arranging interpretation as quickly as feasible.

Dignity also means acknowledging pain, fear, exposure, and loss of control. A patient may be fully medically literate and still unable to process complex information while hemorrhaging, shaking after delivery, receiving anesthesia, or hearing that the newborn needs resuscitation. Clear explanations and consent-based care can be brief: "We are concerned about heavy bleeding. We are giving medication to help the uterus contract and calling additional help. I will explain each step as we go." This kind of communication supports safety and emotional containment at the same time.

Coordinate roles with the support person

A support person can be a powerful communication bridge if their role is clear. They can keep track of explanations, hold the patient's hand, repeat preferences, call family, confirm allergies, and ask for updates at appropriate pauses. They should not block staff movement, touch sterile equipment, interrupt closed-loop team commands, or argue during a critical maneuver. If disagreement or confusion arises, the most effective phrase is often, "Who can answer one urgent question for us?"

Before birth, it helps to agree on a few communication priorities. The patient might ask the support person to request explanations before procedures when time allows, remind the team about anxiety triggers, protect privacy, or request that the newborn's status be described clearly if the baby is taken to a warmer or neonatal team. In an unplanned out-of-hospital delivery or emergency transport after birth, the support person may need to relay dispatcher instructions, note time of birth, keep the newborn warm as instructed, and report whether the newborn is breathing normally.

The support person should also know when to step back emotionally. Emergencies can involve alarms, urgent voices, visible blood, rapid transfer to the operating room, or separation from the newborn. A calm phrase to the patient, such as "I am here, they are treating the bleeding, and I will keep listening," may be more useful than repeated questions. After the event, the support person can write down what was said, what procedures occurred, and what follow-up questions remain.

Debrief after stabilization

After an emergency, many families remember fragments: a sudden change in fetal monitoring, a hemorrhage call, a rush to theater, a newborn who did not cry immediately, or medication names spoken quickly. Once the patient and baby are stable, ask for a postnatal debrief after emergency birth. This can be informal at the bedside or more structured later, depending on the hospital. The goal is to understand what happened, not to assign blame in the moment.

Useful questions include: What was the clinical emergency? What signs led to the decision? What treatments or procedures were performed? Were there complications? What monitoring is needed now? What symptoms after discharge

should prompt urgent review? Does this event affect future pregnancies or birth planning? If the newborn needed resuscitation, ask what support was required, how the baby responded, and whether neonatal observation or follow-up is recommended.

Documentation matters. Request that key events, estimated blood loss if relevant, medications, operative notes, anesthesia notes, neonatal information, and discharge instructions are explained in plain language. Emotional recovery matters too. Some people feel grateful and shaken at the same time; others feel angry, numb, guilty, or frightened by memories of the event. If intrusive memories, panic, persistent low mood, or inability to sleep continue, ask a healthcare professional about postpartum mental health emergencies and trauma-informed support.