## Emergency decision-making during labor

### What makes a labor decision an emergency

An emergency is generally a situation in which delay could significantly increase the risk of serious harm to the pregnant patient, the fetus, or both. The word does not describe a single diagnosis or guarantee that a cesarean birth will be required. It describes the urgency of assessment and treatment. Some situations are immediately life-threatening, while others are urgent but allow time for additional tests, discussion, transfer, or a trial of corrective measures.

Clinicians commonly consider four overlapping domains: maternal stability, fetal condition, labor progress, and the underlying cause of the change. Maternal concerns may include major vaginal bleeding, severe hypotension, respiratory compromise, seizure, sepsis, or suspected uterine rupture. Fetal concerns may include a persistent fetal heart rate abnormality, recurrent decelerations, prolonged bradycardia, or a pattern suggesting inadequate oxygenation. Labor-related concerns can include obstruction, malpresentation, cord prolapse, or failure of descent in a setting where continuing labor is no longer considered safe.

These findings must be interpreted in context. A single abnormal measurement

may prompt repositioning, medication review, intravenous fluids, or further assessment rather than immediate delivery. Conversely, a rapidly worsening pattern or maternal collapse may require simultaneous resuscitation and preparation for birth. The goal is not simply to act quickly, but to act proportionately while reassessing whether the intervention is improving safety.

**Assessment, monitoring, and escalation**

Emergency decisions usually begin with a focused assessment of the patient and fetus. The team may review vital signs, symptoms, bleeding, contraction pattern, cervical examination, fetal presentation, medication exposure, and the timing of any change. Continuous cardiotocography may be used when clinically indicated to evaluate the fetal heart rate and uterine activity. Clinicians also consider the limitations of monitoring: a tracing can be difficult to interpret, and an apparently reassuring tracing does not replace assessment of the patient.

Labor monitoring tools such as the WHO Labour Care Guide support regular documentation and escalation when observations move outside expected parameters. Escalation may involve calling a senior obstetrician, anesthesiologist, midwife, neonatal clinician, or operating-room team. It may also involve transferring care from a birth center to a hospital or moving from routine observation to continuous monitoring. This structured approach reduces the chance that a concerning trend is overlooked, especially during a busy clinical period.

When a possible emergency is identified, clinicians often address reversible contributors while evaluating whether birth should be expedited. Examples may include changing maternal position, stopping a uterotonic infusion, treating hypotension, correcting hypoxia, or relieving cord compression when possible. These measures are not substitutes for delivery when delivery is necessary. They are part of the effort to stabilize the situation and gain the information needed for a sound decision.

In some cases, the team will use the phrase decision-to-birth interval. This refers to the time between deciding that birth should occur and the birth itself. The appropriate interval depends on the emergency, but the principle is that preparation should proceed without avoidable delay while necessary safety

checks continue.

**Communication when time is limited**

Clear communication is a clinical safety intervention. During a rapidly evolving event, one clinician may lead the assessment, another may communicate with the patient, and others may arrange anesthesia, surgery, blood products, neonatal support, or transport. Teams may use closed-loop communication, in which instructions are repeated and confirmed, to reduce misunderstandings. Names, roles, the working concern, and the next planned steps should be stated plainly.

For the patient, the most useful explanation may be concise rather than comprehensive: what has changed, what the team is worried about, what action is being recommended, how urgent it is, and what alternatives remain. Medical terms should be explained briefly. For example, a clinician might explain that a fetal heart rate pattern suggests the baby may not be tolerating labor and that assisted vaginal birth or cesarean birth is being considered. The patient should be told what would happen next and given an opportunity to ask a short question when time allows.

A support person can help by listening, repeating key information, communicating previously stated preferences, and asking who will provide updates. They should not be expected to make a medical decision for a patient who has capacity unless the patient has specifically delegated that role or lacks decision-making capacity. Cultural, language, hearing, cognitive, and trauma-related needs should be addressed as far as the emergency permits, including use of an interpreter when feasible.

Stress can make it difficult to process information. Asking the team to repeat the immediate concern, the proposed intervention, and the consequences of waiting is reasonable. A calm clinical tone does not necessarily mean there is no urgency, and a busy room does not necessarily mean that the team has lost control.

**Consent and patient participation**

Most people in labor retain decision-making capacity. Labor pain, anxiety,

medication, or fatigue do not automatically remove the right to make decisions. Informed consent normally involves an explanation of the recommended treatment, its purpose, material benefits and risks, reasonable alternatives, and the likely consequences of declining or delaying it. The discussion should be adapted to the level of urgency and the patient's ability to engage.

In an urgent but not immediately life-threatening situation, there may be time for a fuller conversation about options such as continued observation, assisted vaginal birth, cesarean birth, anesthesia choices, or transfer. In a time-critical emergency, the explanation may need to be compressed to the essential facts. Clinicians should still seek consent whenever possible. Emergency treatment without prior consent is generally limited to circumstances in which immediate action is necessary and the patient cannot provide consent, or when there is another legally recognized basis for proceeding.

A patient may accept or refuse a recommended intervention, although refusal can have serious consequences that clinicians should explain clearly and respectfully. A refusal should not be treated as evidence of incapacity merely because the team disagrees with it. If capacity is uncertain, clinicians should assess it directly and involve senior staff. Advance discussions during prenatal care, including preferences about anesthesia, assisted birth, cesarean birth, blood products, and communication, can support decision-making but do not predict every situation or replace a conversation during labor.

Consent is an ongoing process rather than a signature obtained once. If circumstances change, the recommendation may change as well. When there is time, the patient can ask whether the proposed intervention is an emergency, whether there is a short window for reassessment, and what warning signs would make waiting unsafe.

**Choosing between urgent birth options**

The choice between continuing labor, assisted vaginal birth, and cesarean birth depends on the clinical problem and whether the necessary conditions for each option are present. Assisted vaginal birth may be considered when the cervix is fully dilated, the fetal head is sufficiently low and positioned, and the clinician has the required expertise. It may shorten the time to birth without abdominal surgery, but it has its own maternal and neonatal risks and may not

be appropriate if the head is high, the position is uncertain, or there is suspected obstruction.

Cesarean birth may be recommended when vaginal birth is not imminent or is unlikely to be safe, or when maternal or fetal status requires a different route of delivery. The urgency can range from a situation in which there is time for preparation and regional anesthesia to one requiring immediate general anesthesia. Teams consider the suspected cause, fetal station and position, prior uterine surgery, maternal medical condition, anesthesia assessment, and the availability of neonatal and surgical support.

Possible causes such as placental abruption, cord prolapse, severe fetal compromise, or uterine rupture carry different management priorities. The safest plan may change as new examination findings or monitoring information becomes available. A team may recommend one intervention, attempt it, and then move to another if the response is inadequate. This is not necessarily indecision; emergency care often involves sequential reassessment under uncertainty.

Patients may reasonably ask what the team believes is happening, how quickly birth is needed, which options are technically available, and what risks are associated with waiting. The answers may be brief because the clinical window is narrow, but they should remain honest and understandable.

**After the emergency: explanation and recovery**

Once the immediate danger has passed, attention turns to stabilization, newborn assessment, bleeding prevention or treatment, pain control, feeding plans, and emotional safety. Some patients need additional monitoring for anemia, infection, hypertensive complications, anesthetic effects, or surgical recovery. The newborn may require observation or neonatal resuscitation after birth if breathing, circulation, or adaptation was compromised.

An emergency birth can be psychologically difficult even when the outcome is medically good. People may experience shock, grief about a changed birth plan, intrusive memories, anger, numbness, guilt, or difficulty understanding what happened. These responses do not mean that a person is ungrateful or failing to recover. A structured explanation can help restore a sense of continuity. Ask

for a review of the timeline, the indication for intervention, what alternatives were considered, what was done, and what the findings mean for future pregnancies.

A postnatal debrief after emergency birth may be offered by the maternity team, although local terminology and availability vary. A debrief should be more than a brief reassurance; it should allow questions, review of records when appropriate, and discussion of physical and emotional recovery. Support from a midwife, obstetric clinician, primary-care professional, mental-health specialist, or perinatal support service may be useful.

Seek urgent professional help for severe bleeding, fainting, chest pain, difficulty breathing, severe headache or visual changes, fever, worsening abdominal pain, thoughts of self-harm, or concern that the baby is acutely unwell. Postpartum warning signs require assessment even when the birth itself occurred several days earlier.