# Hugo's 7 Rights of Informed Induction of Labour

The Maternity Consumer's Guide to Recognizing Obstetric Negligence


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MATERNITY CONSUMER NETWORK

This Guide was published by
the Maternity Consumer Network

# Table of Contents



# Dedication

This guide is dedicated to Hugo McGregor, who died 5 days after an augmented birth due to medical negligence. He will be forever loved and remembered by his mum and dad, Jenna and Andre McGregor.

# Acknowledgments

The MCN would like to extend our deepest thanks to Jenna and Andre Mcgregor who have allowed us to use baby Hugo to create Hugo's 7 Rights of Informed Induction of Labour and permitted us to use baby Hugo's photos. We hope baby Hugo can become a beacon for safety for all birthing women in Australia. We would also like thank the many midwives and an anonymous obstetrician who helped contribute valuable information to this guideline on what is safe medical practice during Induction of Labour.

This guide is not a replacement for legal or individual medical advice and should not be used as such. This guideline does not absolve a medical provider of their legal informed consent obligations, codes of conduct and ethics nor is to be used to blame patients for birth outcomes due to failures to give informed consent.

# What is Induction of Labour?



Induction of labour is a method to initiate contractions for childbirth. This is supposed to be recommended when continuing the pregnancy may pose risks to the mother or baby. While various methods exist, this guide specifically discusses the use of Syntocinon for labour induction.

Syntocinon is a synthetic drug that mimics the natural hormone oxytocin. Oxytocin naturally stimulates uterine contractions during labor. In medical settings, Syntocinon is often referred to interchangeably with oxytocin. The drug is typically administered through an intravenous (IV) drip placed in the arm.

In Australia, around 1 in 3 women (34%) undergo labour induction, with this figure rising to 44% for first-time mothers, according to the Australian Institute of Health and Welfare (AIHW, 2021). These statistics pertain to planned inductions and do not include instances where medication is used to augment labour that has already commenced naturally.

Induction of labour is a common procedure, but it is sometimes inappropriately used. While there are clear and valid medical reasons for induction in certain situations, there are concerns that it is occasionally recommended based on provider convenience, agendas, or beliefs, rather than woman-centered care.

# Why is it recommended?



Induction of labour is generally recommended for two main reasons: addressing medical concerns and potentially reducing stillbirth in low-risk pregnancies.

**Medical Concerns**
Inducing labour due to medical concerns is often necessary when continuing the pregnancy poses a risk to the mother or baby. Some of the key medical conditions include:

- **Pre-eclampsia**: A condition characterized by high blood pressure and potential damage to other organs, most often the liver and kidneys. Induction may be necessary to prevent complications.
- **Diabetes**: Both pre-existing diabetes and gestational diabetes can lead to complications if not well managed. Induction might be recommended to reduce risks to both mother and baby.
- **Intrauterine Growth Restriction (IUGR)**: If the baby is not growing at the expected rate, inducing labor may be safer than continuing the pregnancy.
- **Other Conditions**: Situations like placental insufficiency, oligohydramnios (low amniotic fluid), or chronic high blood pressure may also warrant induction.

Source:

# Why is it recommended?



For low-risk pregnancies, some research suggests that induction of labour might slightly reduce the risk of stillbirth and cesarean sections. However, this is a contentious topic within the medical and consumer community, with some professionals advocating for this approach while others caution against its routine use.

The evidence in supporting inducing low risk pregnancies implies:

Stillbirth Prevention: Inducing labour at 41 weeks in low-risk pregnancies has been associated with a small reduction in the risk of stillbirth (Wennerholm et al 2019).

Reduction in C-Sections: Some studies suggest that elective induction at 39 weeks may lower the rate of cesarean sections compared to waiting for spontaneous labor (Grobman et. al 2018). However, this finding is not universally accepted

Ultimately, the decision to have an induction is yours. It's crucial to discuss all your options with your doctor or midwife, ensuring you have all the information needed to make a confident choice. You should also endeavor to educate yourself by reading available health consumer information sheets on the topic, clinical guidelines if you have the ability and health literacy to do so and the package insert of the drug Syntocinon. Your healthcare provider should give this information to you upon request.

# Risks of Induction



## For mothers

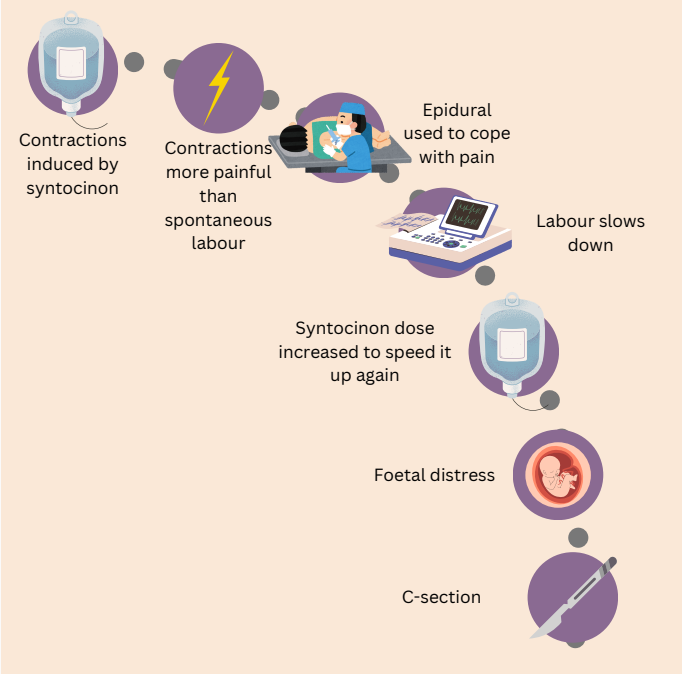
- **Heavy bleeding after birth**
- **Uterine atony** (where the uterus doesn't contract firmly enough after birth to stop bleeding)
- **Uterine rupture**
- **Needing an instrument to deliver your baby (like forceps or vacuum)**
- **C-section**

## For babies

If induction isn't managed carefully, it can lead to a lack of oxygen to the baby (hypoxia), which could potentially cause serious complications such as stillbirth, neonatal death, or disability. The risk of fetal hypoxia can arise due to medical negligence, such as improper monitoring of the syntocinon drug, high dosage or inadequate checks on the mother's uterus and fetal heart rate. (Aboshama et. al, 2020, Brotanci et. al 2017)

## Cascade of Interventions

Women who have labour induced are more likely to experience a series of interventions during childbirth according to some medical experts. This is called a "cascade of interventions," where additional procedures are done to address problems caused by the previous intervention. It is more likely to happen in private hospitals (Dahlen et. al, 2012) An example of this is shown to the right.



# Understanding the evidence



The best way to understand the risks of induction is to compare research findings to real-world experiences in maternity wards as what is in research and what happens in reality can be vastly different,

Evidence regarding induction of labour is determined by:

**High-Quality Research (Randomised Trials)**
Randomised Trials:

- Controlled Environment: These studies are conducted in controlled settings, with strict protocols and close monitoring of participants.
- Comparison Groups: Groups of women who receive induction are compared to those who do not.

    - Reduced C-Section Rates: Studies like the ARRIVE trial indicated that inducing labor at 39 weeks can lower the likelihood of a cesarean delivery in low-risk first-time mothers.
    - Lower Complication Rates: Controlled trials often report fewer instances of maternal and fetal complications when induction is performed under optimal conditions.

**The reason for the difference?**
Real-world situations can be more complex than research studies. For example, women who get induced in a hospital might have different health factors compared to those who go into labor naturally or certain hospitals have different cultures as well as policies and guidelines than another.

**Real-World Studies:**

- Everyday Maternity Settings: These studies follow women who undergo induction in typical hospital environments or analyze hospital birth statistics
- Complex Variables: Real-world settings involve a variety of health factors, practitioner practices, and hospital protocols that can affect outcomes.
- Findings: Some Australian specific cohort studies and statistical comparisons show poorer maternal birth outcomes compared to those observed in controlled trials such as an increase in caesarian birth and other interventions (Butler et. al 2024), (Fox et. al 2021).

The explanations for the difference in these studies can include:

- Inconsistent Monitoring: Variation in how closely patients are monitored can impact the safety and effectiveness of inductions.
- Health Factors: Women who are induced might have underlying health issues that complicate their pregnancies and outcomes.
- Resource Constraints: Differences in hospital resources, staffing, and adherence to best practices can influence the success of inductions and research outcomes.
- Syntocinon dosage may be continuous rather than intermittent

**So what is the issue?**

The research seems to suggest some benefits to induction, while others suggest the opposite. However, it's important to consider the Australian context.

# Understanding the evidence



In Australia, the high rates of labour induction (nearly 1 in 3 women overall and nearly half of first-time mothers) contrast with the steady national rates of stillbirth and newborn death over the past 20 years (Alderson, 2024) This period also shows a consistent increase in birth interventions, birth trauma and neonatal morbidity (Dahlen et al 2020). To make sense of these trends, it is important to analyze the interplay between medical practices, outcomes, and broader healthcare implications.

One theory to explain the research discrepancies is that clinicians participating in randomized control trials might be more careful to adhere to hospital policies. They might be stricter about following safety guidelines, obtaining informed consent, and monitoring women and babies closely. This extra attention could lead to fewer complications and less need for interventions like C-sections, which is what some research studies show.

In everyday maternity wards, things are different. Some providers may be lax with clinical checks, do not follow the Australian Charter of Healthcare Rights and/or have problematic attitudes toward women and their rights to medical safety.

# How Induction is misused



Labour induction is supposed to be offered under specific circumstances to meet the individual woman's needs. However, there are troubling reports of women feeling coerced into induction. This coercion can take several forms:

**Emotional Manipulation:**

- Focus on Stillbirth Risk: Some healthcare providers emphasize the small risk of stillbirth if induction is refused, using fear to manipulate women into consenting.
- Guilt and Responsibility: Women might be made to feel personally responsible for potential adverse outcomes, increasing pressure to agree to induction.

**Not being aware of their choices**:

- Some women are scheduled for induction without fully understanding their options or right to refuse.
- Some women are scheduled for induction without their knowledge and when told they have been booked are unaware they can decline.

**Threats:**

- Some women are threatened with child protective services if they do not agree to be induced.
- Sometimes child protection get illegally and inappropriately involved in women’s medical choices.

**Induction during labour:**
Sometimes, medication to speed up labour (augmentation) might be used without a woman's full knowledge or consent. This can happen because the medication is added to the existing IV fluids hydration line. This is illegal.

# Why Induction is misused



- **Scheduling convenience:** Scheduling convenience in maternity care can sometimes lead to unnecessary inductions, where the primary motivation is not medical necessity but rather the convenience of healthcare providers or institutions.

- **Understaffing:** In understaffed hospitals, the pressure to manage bed space and workload can sometimes lead to recommendations for induction that prioritize operational convenience over patient needs. This practice has significant implications for patient care and outcomes.

- **Rushing deliveries:** Some healthcare providers might use higher doses of Syntocinon or other interventions to speed up an induction so they can finish their shift on time and fail to adhere to guidelines.

- **Misinterpretation of research:** Some healthcare providers and policymakers might strongly believe induction benefits all pregnancies, but the research isn't always clear on this. Hospitals often have incentives to reduce stillbirth rates, and induction might be seen as a way to achieve that. Agendas by health services are sadly sometimes prioritised over women's safety and wellbeing.

- **Racial profiling:** Medical guidelines suggest offering induction earlier to pregnant women of colour or those from certain backgrounds. This is based on statistics that show higher health risks in these groups. However, according to Human Rights in Childbirth, these disparities are due to social inequalities. Induction isn't a solution to a health disparities and women of colour do not need more aggressive treatment because of their ethnicity (HRiC, p. 20, 2019).

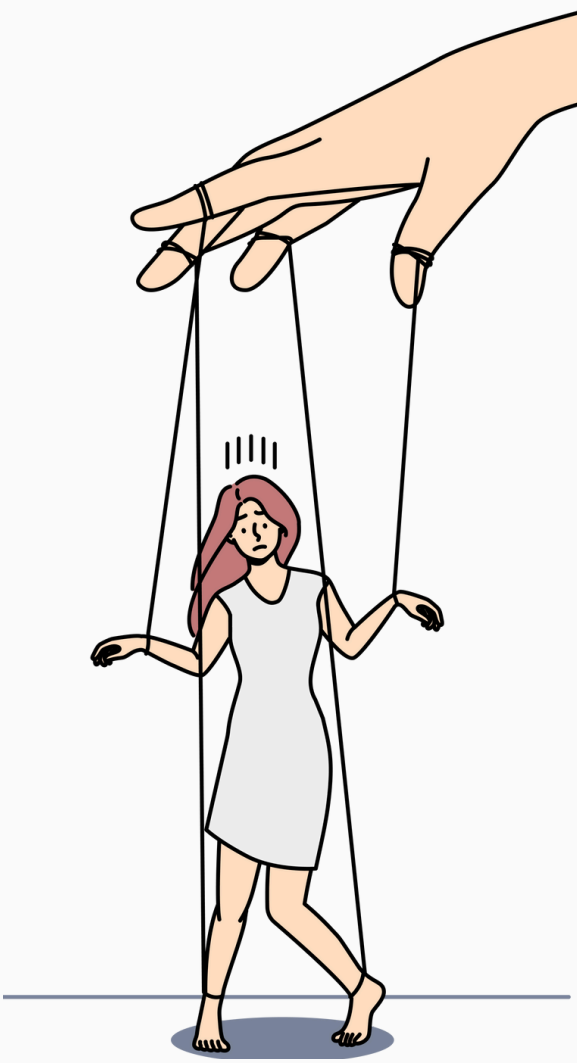
# Why induction is misused



- **Power and control:** Women are easier to control and manage in induced births. They may be easier to pressure into additional interventions because they are now considered “high risk”. Interventions that reduce women’s mobility, such as epidurals, encourage some providers who are abusive to be opportunistic about forcing interventions.

- **Poor hospital culture:** Some hospitals have a negative environment, marked by disrespect, poor communication, and a disregard for women’s needs. This results in numerous issues:

- Some clinicians hold the problematic belief that “all that matters is a healthy baby”, which normalizes disrespectful care practices.
- Ineffective communication between care providers can compromise patient safety.
- Unconsidered power dynamics can cause some clinicians not take the concerns of colleagues, especially midwives, or the concerns of women themselves, seriously.



The Australian Medical Association does yearly surveys called the Healthy Hospital Check and provides valuable insights into the working conditions and overall culture in hospital across the state. This information is important to consider when choosing when and where to give birth. Each AMA per state has this survey available on their websites every year.

# Protecting Yourself During Induction of Labour



## Preparation

A medically managed birth is something ideally women and their birth support should be thoroughly prepared for. However, it is not a requirement in order to receive respectful maternity care. An induced birth can be very positive and empowering for many women, but very much depends on the adherence to guidelines and respect for women from the providers overseeing the birth. We encourage women to read the MCN's perinatal trauma prevention guidelines to better understand the informed consent and respect women are supposed to receive. This guideline is in the resource section at the end of the guide.

## Informed Consent

In order to prepare for an induced birth, it is important for women to be educated and ask for informed consent on particular aspects of induction.

- Ask for Details: During your antenatal care appointments, specifically ask for detailed information about the risks associated with using Syntocinon for induction. This includes potential complications for both you and your baby.
- Understand the Risks: Make sure you understand the risks involved, such as uterine hyperstimulation, fetal distress, and the potential risk for additional interventions such as a forceps delivery, episiotomy etc.
- Clarify Adjustments: Inquire about the criteria for adjusting dosages and how often fetal monitoring will be done to assess the need for changes.

Prepare for possible Augmentation of Labour when planning a natural birth

- Informed About All Possibilities: Even if you plan for a physiological birth, ask about the procedures and dosages for labour augmentation in case it becomes necessary and you choose consent to this.

- Review Consent Forms Carefully: Be cautious with consent forms that might be used as blanket consent for all procedures. Hospitals sometimes use these forms to cover a range of interventions to use them as automatic consent to all procedures, which is not legal and violates your human rights in birth.

# How misuse of induction causes harm



## Inductions are not monitored properly

improper monitoring during labour induction is a significant concern that can lead to serious harm for both women and babies.

**Over-Reliance on Continuous Monitoring Traces:**

- Limitations of Machines: Continuous Cardiotocography (CTG) monitors track fetal heart rate and uterine contractions, but they cannot provide a complete clinical picture. They may miss subtle signs of distress or complications that require clinical judgment and physical assessment.
- False Security: Providers sometimes rely solely on these machines, which can create a false sense of security, leading to missed opportunities for early intervention when problems arise.
- Incompetence: Some providers lack the required competency and are not able to pick up concerning readings, leaving babies in danger.

## Inductions are rushed

Inappropriate dosing of Syntocinon (oxytocin) during labor induction can pose serious risks to both the mother and baby. When providers do not adhere to established guidelines and escalate doses inappropriately, particularly around the end of shifts or before non-work days, it can lead to significant birthing complications for both women and babies.

A rushed induction that is also without proper monitoring is extremely dangerous.

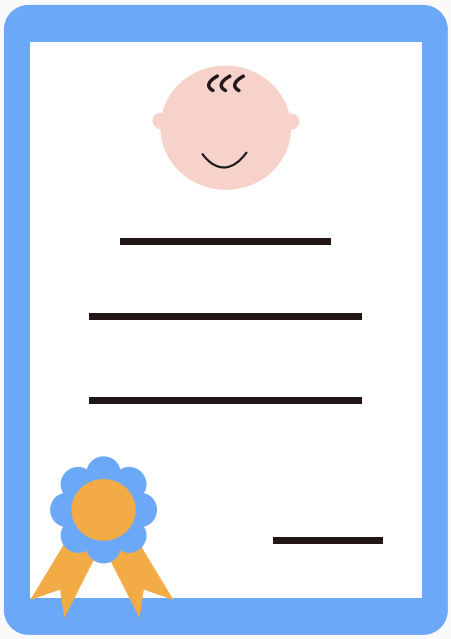
Too high a dose of syntocinon can cause your uterus to contract too much, which can cause harm to your baby. In extreme cases it can result in your baby's death. It can also result in maternal morbidity (birth injuries).

Too many contractions will eventually result in a tired uterus, which reduces its ability to clamp down and stop you from bleeding excessively after your baby is born. This results in hemorrhage, which can endanger your life.

So  what strategies can be utilized to minimize the risks of harm during induction?

# Protecting Yourself During Induction of Labour

## An Advanced Healthcare Directive



The best option besides informed consent, to help reduce the risks of negligence in an induced birth is having an Advanced Healthcare Directive. An Advanced Healthcare Directive is a legal document for formalizing your birth plan and ensuring that your preferences are respected. Here's how it can be used effectively:

- Document Agreements: Request written documentation from your healthcare provider confirming their agreement to follow your preferences as outlined in your directive.

Prepare for interventions

- Clear Instructions: In your Advanced Healthcare Directive, include a section specifically addressing your preferences for birth interventions. For instance, you might write, "In the event of an operative vaginal birth, I consent to the use of a vacuum extractor only. Forceps are not to be used under any circumstances unless explicitly agreed upon by me in writing."

- No Exceptions Clause: Emphasize that there are no exceptions to your preferences unless explicitly discussed and agreed upon with you.

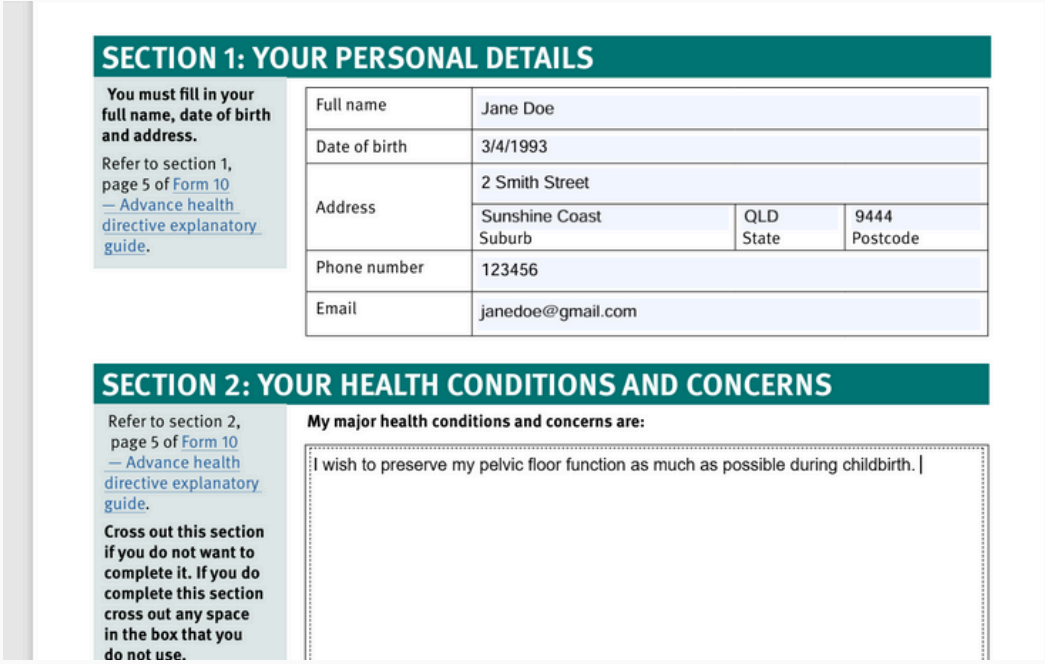
These forms normally require a witness or two to sign to confirm your mental capacity. Some states require a doctor to confirm such capacity.

You should retain the original and certified copes given to your provider by 36 weeks in pregnancy. Alternatively, you can email your directive to the patient liaison of the hospital.

# Protecting Yourself During Induction of Labour



## Sample Advanced Healthcare Directive from Queensland



**SECTION 1: YOUR PERSONAL DETAILS**

**You must fill in your full name, date of birth and address.**

Refer to section 1, page 5 of Form 10 — Advance health directive explanatory guide.

| | | | |
|---|---|---|---|
| Full name | Jane Doe | | |
| Date of birth | 3/4/1993 | | |
| Address | 2 Smith Street | | |
| | Sunshine Coast<br>Suburb | QLD<br>State | 9444<br>Postcode |
| Phone number | 123456 | | |
| Email | janedoe@gmail.com | | |

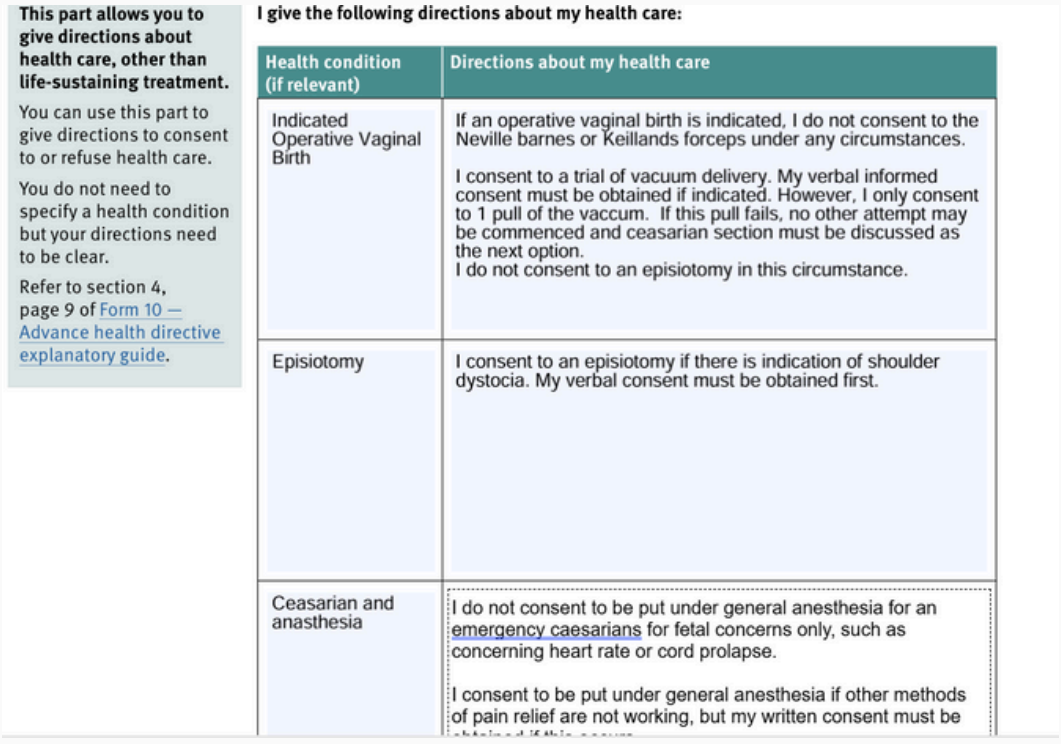
**SECTION 2: YOUR HEALTH CONDITIONS AND CONCERNS**

Refer to section 2, page 5 of Form 10 — Advance health directive explanatory guide.

**Cross out this section if you do not want to complete it. If you do complete this section cross out any space in the box that you do not use.**

**My major health conditions and concerns are:**

I wish to preserve my pelvic floor function as much as possible during childbirth.



**This part allows you to give directions about health care, other than life-sustaining treatment.**

You can use this part to give directions to consent to or refuse health care.

You do not need to specify a health condition but your directions need to be clear.

Refer to section 4, page 9 of Form 10 — Advance health directive explanatory guide.

**I give the following directions about my health care:**

| Health condition (if relevant) | Directions about my health care |
|---|---|
| Indicated Operative Vaginal Birth | If an operative vaginal birth is indicated, I do not consent to the Neville barnes or Keillands forceps under any circumstances.<br><br>I consent to a trial of vacuum delivery. My verbal informed consent must be obtained if indicated. However, I only consent to 1 pull of the vaccum. If this pull fails, no other attempt may be commenced and ceasarian section must be discussed as the next option.<br>I do not consent to an episiotomy in this circumstance. |
| Episiotomy | I consent to an episiotomy if there is indication of shoulder dystocia. My verbal consent must be obtained first. |
| Ceasarian and anasthesia | I do not consent to be put under general anesthesia for an emergency caesarians for fetal concerns only, such as concerning heart rate or cord prolapse.<br><br>I consent to be put under general anesthesia if other methods of pain relief are not working, but my written consent must be |

# Protecting Yourself During Induction of Labour



## Cannulas and Medication Administration

If you are a woman planning a non-induced physiological birth or an epidural without augmentation, consider being mindful of your options regarding the insertion of a cannula.

- You may choose to decline a cannula entirely if you are having a non-induced birth. You can also opt for one that is not attached to a IV line.
- Epidural without Augmentation: A cannula is typically necessary, but it is important to be mindful of what drugs are going through your IV line.

Have a thorough informed consent discussion with your provider about the risks and benefits of not having a cannula inserted or removing while drugs are being administered if you withdraw consent. This ensures you are fully aware of any potential complications and can make an informed decision.

There is unfortunately a practice where some providers might administer drugs through an IV line without the woman's knowledge or consent. This includes medications like Syntocinon and opioids, which might be misleadingly presented as hydration fluids.

A submission by Human Rights in Childbirth to the Australian Human Rights Commission in 2019 highlighted cases where migrant women were given sedatives in their IV lines without consent, leading to non-consensual caesareans. It has been our experiences during advocacy where women who have had epidurals or only consented to hydration fluids, have had their labours augmented with Syntocinon without their knowledge.

The six rights is a mnemonic used by health professionals to safely administer medication. If you do ultimately consent to induction, augmentation or IV fluids, it is a good idea to request the provider go through the 6 rights with you or your birth support to ensure you are being given the right medication you have consented to.

Source:

# Protecting Yourself During Induction of Labour



## Midwifery Ratios

Having a dedicated midwife throughout the induction process is a must for ensuring your safety and receiving personalized care. In order to stay stafe you should check the following:

**Ensuring One-on-One Midwifery Care**

1. Ask About Midwife-to-Patient Ratios:
   - Contact the Unit Manager: Before consenting to an induction, ask to speak with the midwifery unit manager. Inquire about the midwife-to-patient ratios, especially during induction procedures.
   - Request Specifics: Ensure there will be a dedicated midwife assigned to you for the duration of your induction.
2. Confirm One-on-One Care:
   - Dedicated Midwife: Verify that a midwife will be physically present with you in the room throughout the entire induction process. The midwife is not to leave the room and if she needs to do so for any breaks, someone is to replace the midwife.
   - Avoid Separate Monitoring Stations: Ensure that the midwife is not observing the birth from a CTG monitoring station. She must be in the room at all times for observations and quick hands on clinical examinations.
3. Address Staffing Concerns:
   - If One-on-One Care Isn't Available: If the hospital cannot guarantee one-on-one care due to staffing issues, consider the following steps:
     - Speak with Patient Liaison: Contact the patient liaison or hospital administration to explain your concerns and your decision to withdraw consent based on inadequate staffing ratios.
     - Request Re-Booking: Ask to be re-booked for induction at a time when adequate staffing and one-on-one midwifery care are available.
4. Never Consent Without Adequate Staffing:
   - Ensure Safety: Do not consent to an induction if the hospital cannot provide a dedicated midwife for you. Proper staffing is essential for safe and effective care during an induction with Syntocinon. One on one midwifery care must also commence if a natural  labour is augmented with your informed consent.

# Protecting Yourself Against Unnecessary C-Section



Inducing labour can possibly increase the chances of needing a C-section. But it's important to know that consenting to induction **doesn't mean you automatically have to have a C-section** if one is recommended. Here are two things to keep in mind when planning an induced birth:

- Sometimes, labour induced with medication might not start ("**failure to induce"**) or progress quickly enough ("**failure to progress"**).

## Failure to induce labour

When faced with a failed induction, it's essential to be aware of all your options and make an informed decision based on your individual circumstances as some providers only recommend a c-section. It is important to consider:

**Options if Induction Fails**

1. Continue with Induction:
   - Extended Time: You may choose to continue with the induction process. Guidelines suggest that waiting up to 18 to 24hours for labour to start does not significantly increase risks (with your waters broken).
   - Regular Monitoring: Ensure that you are closely monitored during this extended period to assess both your and your baby's well-being.
2. Take a Break and Try Again Later:
   - Pause and Reevaluate: You can opt to take a break from the induction and try again at a later time. This option might involve waiting a few days before attempting another induction.
   - Assess Conditions: Discuss with your healthcare provider the reasons for the initial failure and the potential benefits of waiting and retrying.
3. Wait for Spontaneous Labor:
   - Stop Induction: If you prefer, you can stop the induction and allow your body to go into labour naturally.
   - Discuss Risks and Benefits: Understand the implications of waiting for spontaneous labor, especially if there are reasons for concern or if you are past your due date.

# Protecting Yourself Against Unnecessary C-Section

## “Failure to Progress”

Induction can take longer than spontaneous labor. It's important to remember that labour itself can vary greatly in length, and slower progress isn't always a cause for concern.

“Failure to progress” is a term used when healthcare providers believe your labor isn't progressing fast enough. However, it can be a subjective diagnosis, and the current standards used might not be entirely accurate.

## Normal labour length

- First-time mothers: For vaginal deliveries in first-time mothers, the first stage of labour (dilation of the cervix) can take 12 hours or more.
- Mothers who have given birth before: For mothers who have already had children, the first stage of labour may be shorter.
- Pushing stage: The pushing stage, when you actively deliver the baby, usually lasts for up to 1 to 2 hours.

If your cervix is opening at a rate slower than 1cm per hour, you may be offered a c-section. This assessment is based on a very old research study and its evidence is contested by midwifery researchers (Cesario, 2004).

There's a wide range of what's considered "normal" for labour length. Even within these parameters, some women will experience slower or faster progressions. As long as you and your baby are healthy, a slower pace might not be a problem.

## Foetal distress

Because induced contractions are stronger than those of spontaneous labours, they can be more difficult for your baby to cope with. This can sometimes be detected by changes in the baby's heart rate on the monitoring. A normal heart rate is 110-160 beats per minute. Both faster and slower heart rates can indicate a problem. Heart rates that fall above or blow a baby's 'baseline' despite being in normal range can also indicate a problem.

If this occurs, you will probably receive a strong recommendation to have a c-section. In cases of mild distress, providers may suggest the following things before reccomending a c-section in according with guidelines:

- **Changing position**: sometimes a particular position you are in is putting pressure on the blood vessels providing oxygen to your baby. Moving can relieve the pressure, and restore sufficient blood flow to the baby.
- **Lowering the dose of syntocinon, or turning it off for a while**: reducing the frequency of contractions can give your baby a chance to rest and recover.

## Uterine Hyperstimulation

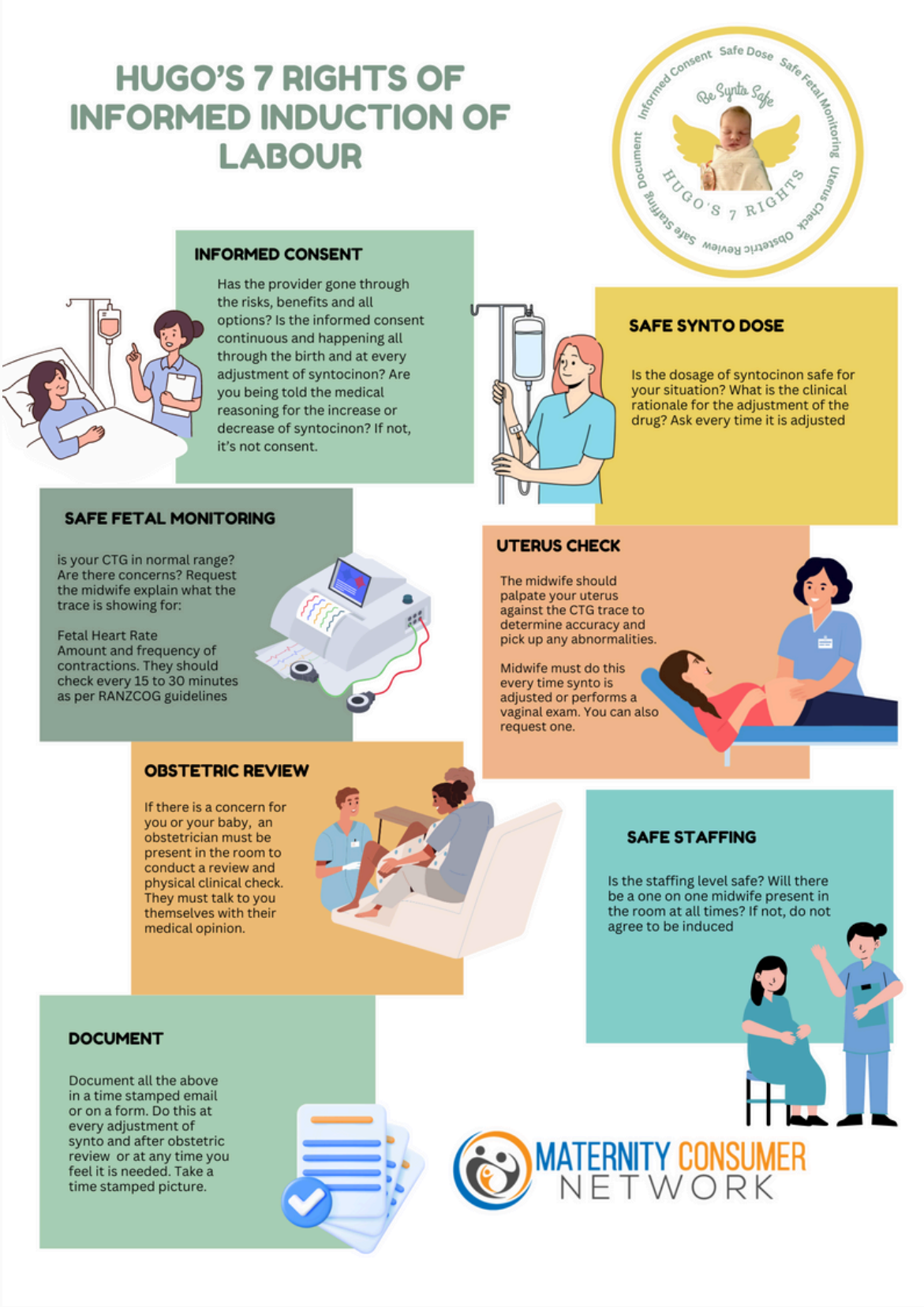
This is when contractions become too long, too frequent, or too strong. This can result in foetal distress, and if not promptly addressed can cause poor outcomes for the baby. It can also rarely result in uterine rupture which can be catastrophic to both mum and baby.

Guidelines recommend giving certain medications to help reduce hyperstimulation or turning down or off the Syntocinon. Unfortunately, some providers do not give women a long enough break or leave women in hyperstimulation in the hopes she will birth before it becomes an issue. This is negligent care hence it is important to follow Hugo's 7 Rights of Informed Induction of Labour to address situations like this.

# Hugo's 7 Rights



An easy  way to help reduce the risks of obstetric negligence during an induced birth and put all this information together is by being an active patient and having active birth support, by following the steps of Hugo's 7 Rights of Safe Induction of Labour.



# Hugo's 7 Rights



The logo of Hugo's 7 Rights can be helpful for visual birth plans. These Rights are not recognized legal rights or part of any hospital or medical policies. These rights have been created for maternity consumers by the Maternity Consumer Network as a guide for women and their birth support to help promote a safe Induction of Labour.

## Why follow Hugo's 7 Rights

In an induced birth, we recommend women and their birth support utilize Hugo's 7 Rights of Safe Induction of Labour as a way to simplify the above information.

It is currently not in medical culture to uphold informed consent in a way that is specific and continuous in induced births. Women and birth support are usually not told when Syntocinon adjustment is occurring or what the CTG trace is showing.

Health regulators do not promote informed consent or accountability especially when it comes to monitoring women's babies and have limited legal power in enforcing hospital compliance to guidelines. Therefore, it is important patients, and their birth support have contingency plans in place to protect themselves due the lack of government oversight on safe maternity care.

Knowing what is going on is important for women and their birth support in order for the woman to make informed decisions.  Following the 7 rights can help up-hold safe and respectful maternity care.

The 7 rights can be documented as below and is available on our website.

MATERNITY CONSUMER NETWORK

**Advocacy Induction of Labour Form for Women**

**Woman's Name:**
**Reason for Induction/Labour Augmentation:**
**Birth Support:**
**Date of Admission:**

| | Time and comment | Provider Name/AHPRA registration number |
|---|---|---|
| Did the provider explain the rate of Syntocinon Dosage Per Hour? What is the clinical reason for dosage? | | |
| Did the provider gain formed consent for Vaginal Exam/Fetal Scalp Monitoring or Breaking your Waters? | | |
| Did the provider gain informed consent for uterus palpitation? | | |
| Did the provider give informed consent for CTG Trace? Foetal Heart Rate, Contraction Length, and Frequency? | | |
| What is the fetal variability, baseline and key features? | | |

## Why document?

Having a designated scribe during labor is important for women to ensure their care is properly documented.

**Creating a Legal Paper Trail:**

- Providers keep detailed records of the care they provide as part of their legal documentation. Similarly, women or familial birth support should maintain their own records to have a comprehensive account of their experiences and decisions made during labor.

**Ensuring Safe and Informed Care**:

- When care is being documented by the woman or her birth support, it can help ensure that providers adhere to guidelines and informed consent obligations. Knowing that their actions are being recorded may encourage particular clinicians who are lax, provide safe and appropriate care.

Keeping records promotes health literacy for the woman and her birth support. If documenting causes significant tension or hostility, you have the right to request a different clinician. However, intentions to utilize documentation should be shared with the birth team prior to labour so they are prepared.

The names of any providers in the room should be noted down. If your birth support have time, they should look up the provider's medical registration number on AHPRA's website: [Australian Health Practitioner Regulation Agency - Register of practitioners (ahpra.gov.au)]

## A note for doulas

Doulas should not document clinical details such as Hugo's 7 Rights as it can be interpreted as performing clinical tasks, which is outside their scope of practice. Doulas can still help facilitate good communication regarding the rights with the healthcare team and advocate for them. They can also assist the woman and familial birth support find the provider's AHPRA registration number.

# Understanding Syntocinon, and CTG Traces

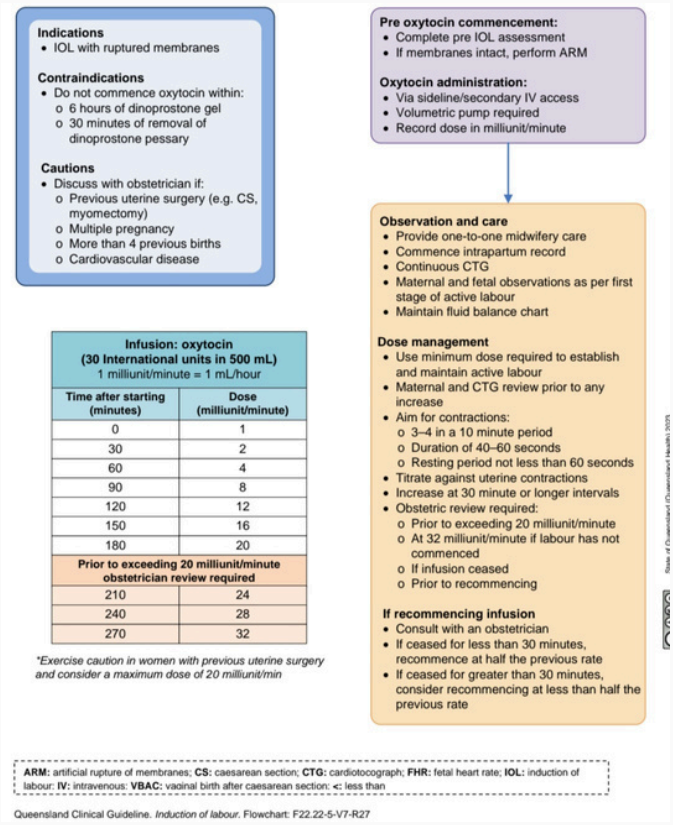
## Syntocinon Administration

Understanding the dosage of Syntocinon (oxytocin) is important for managing its effects and ensuring a safe induction process. Your provider should explain the dosage and why they are adjusting it. Here's a detailed overview based on typical protocols from the Queensland Health Guidelines:

Dosage Rates:
In some hospitals, dosage is measured in milliliters per hour (ml/hour), while others, like Queensland Health, use (milli) units per minute.

Queensland Health Guidelines:

- Starting Dosage: Typically starts at 1 milli-unit per minute. (which will be 1ml/ph)
- Adjustment Intervals: Dosage is usually doubled every 30 minutes until a pattern of 4 contractions in 10 minutes is established.
- Maximum Dosage: The dosage is generally increased upwards for about an hour and a half before being maintained at a steady rate. Further adjustments are made based on clinical needs and physical assessments.



**Indications**
- IOL with ruptured membranes

**Contraindications**
- Do not commence oxytocin within:
  - 6 hours of dinoprostone gel
  - 30 minutes of removal of dinoprostone pessary

**Cautions**
- Discuss with obstetrician if:
  - Previous uterine surgery (e.g. CS, myomectomy)
  - Multiple pregnancy
  - More than 4 previous births
  - Cardiovascular disease

**Infusion: oxytocin**
**(30 International units in 500 mL)**
1 milliunit/minute = 1 mL/hour

| Time after starting (minutes) | Dose (milliunit/minute) |
|---|---|
| 0 | 1 |
| 30 | 2 |
| 60 | 4 |
| 90 | 8 |
| 120 | 12 |
| 150 | 16 |
| 180 | 20 |
| **Prior to exceeding 20 milliunit/minute obstetrician review required** | |
| 210 | 24 |
| 240 | 28 |
| 270 | 32 |

**Exercise caution in women with previous uterine surgery and consider a maximum dose of 20 milliunit/min*

**Pre oxytocin commencement:**
- Complete pre IOL assessment
- If membranes intact, perform ARM

**Oxytocin administration:**
- Via sideline/secondary IV access
- Volumetric pump required
- Record dose in milliunit/minute

**Observation and care**
- Provide one-to-one midwifery care
- Commence intrapartum record
- Continuous CTG
- Maternal and fetal observations as per first stage of active labour
- Maintain fluid balance chart

**Dose management**
- Use minimum dose required to establish and maintain active labour
- Maternal and CTG review prior to any increase
- Aim for contractions:
  - 3–4 in a 10 minute period
  - Duration of 40–60 seconds
  - Resting period not less than 60 seconds
- Titrate against uterine contractions
- Increase at 30 minute or longer intervals
- Obstetric review required:
  - Prior to exceeding 20 milliunit/minute
  - At 32 milliunit/minute if labour has not commenced
  - If infusion ceased
  - Prior to recommencing

**If recommencing infusion**
- Consult with an obstetrician
- If ceased for less than 30 minutes, recommence at half the previous rate
- If ceased for greater than 30 minutes, consider recommencing at less than half the previous rate

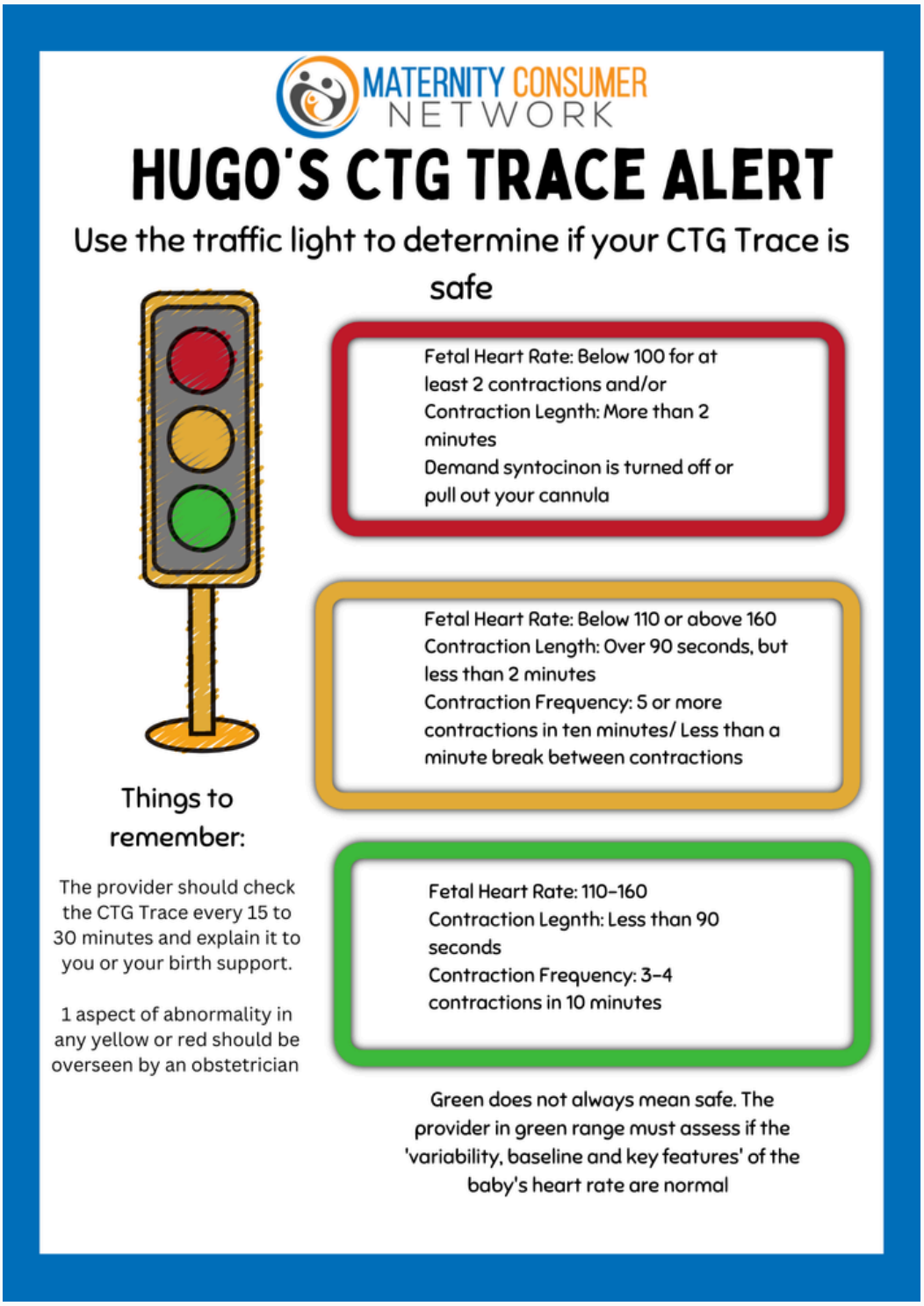
**ARM:** artificial rupture of membranes; **CS:** caesarean section; **CTG:** cardiotocograph; **FHR:** fetal heart rate; **IOL:** induction of labour; **IV:** intravenous; **VBAC:** vaginal birth after caesarean section; **<:** less than

Queensland Clinical Guideline. *Induction of labour*. Flowchart: F22.22-5-V7-R27

# Understanding Syntocinon and CTG Traces



While formal CTG (Cardiotocography) interpretation courses are not available for lay people, you or your birth support can still be proactive in understanding your CTG monitoring by asking the right questions and following a simplified system. Hugo's Traffic Light System is a helpful way to ensure you are receiving safe and effective care. It is your choice whether to consent to CTG monitoring



# Understanding Syntocinon and CTG Traces



You or birth support can ask what the CTG trace is showing for:

- Fetal Heart Rate (inclusive of baseline, variability and key features)
- Contraction Length
- Contraction Frequency

The provider MUST assess the CTG trace every 15-30 minutes for fetal heart rate and contraction length and frequency.

In addition, the midwife SHOULD assess contraction strength by feeling your uterus through the abdomen (palpitation) with your permission. This is important in order for the midwife to pick up hyperstimulation or ineffective contractions and is how the midwife determines Syntocinon dosages and adjustment. Syntocinon should not be adjusted without these checks.

Some providers may try to adjust the Synotcinon without doing the aforementioned, so make sure your birth support questions the provider every time they touch the IV infusion panel and requests they provide informed consent before they adjust dosage.

Birth support should document all this down and assist you with advocacy should you have any concerns about you or your baby's wellbeing.

It is important to note that there is no high-quality evidence that demonstrates that CTG prevents stillbirths or poor maternal outcomes. This technology is in fact associated with unnecessary interventions. ( Alferevic et.al, 2017)

Quality midwifery and obstetric care via physical checks and adherence to guidelines as well as informed consent is what reduces poor outcomes.

Furthermore, if there is a concern and you require an obstetric review, the obstetrician must be present in the room and physically observe you themselves and talk to you. Do not accept communication through intermediaries. The doctor MUST be physically present and communicate to the patient directly and perform their own clinical checks.

If you have planned a natural birth and there is recommendation for augmentation with Syntocinon, we caution this if your CTG has shown evidence of concerns even if the fetal heart rate is within normal range. Such fluctuations can be indicative of a problem which can be exacerbated by Syntocinon and it is important your provider explains their recommendations for augmentation and its safety, thoroughly. Baby Hugo died within an hour of Syntocinon augmentation because the provider had not observed the CTG correctly or sought an obstetric review. Syntocinon may not be safe for a compromised baby.

# Understanding Syntocinon and CTG Traces



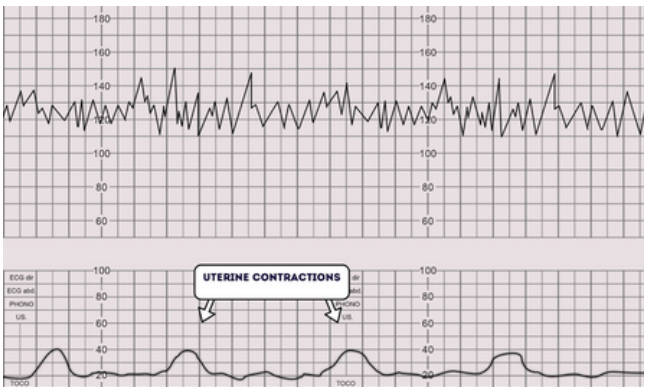
It is important for women to understand that a baby with a heartbeat in a normal range does not always mean the baby is safe or okay if you choose to consent to monitoring. This can sound complicated, but simply asking the provider certain questions about the fetal heartbeat and documenting it can help with the provision of safe maternity care.

When a provider is monitoring the fetal heart beat on a CTG trace they are looking for three things. Key reassuring features, baseline and variability. You or your birth support should ask what these are and if there are any concerns. This should be asked at every CTG trace check the provider does within a 15-30 minute period.

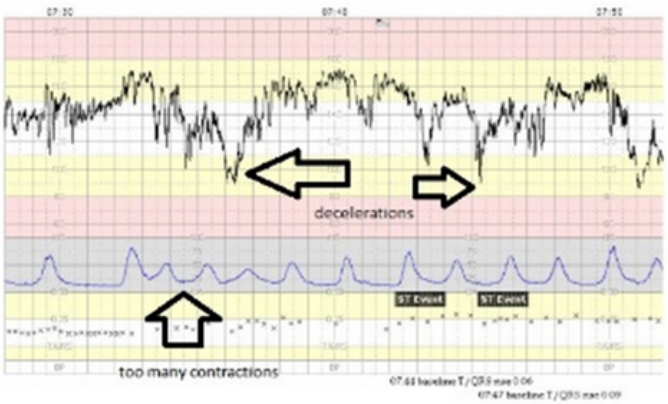
The baby's heartbeat will show abnormal features if there isn't enough 'resting periods' between contractions or if there is too many contractions in the 10 minute period. This below example is part of what your medical provider will be assessing.

Below is an example of a normal CTG and abnormal CTG Trace

Normal




Abnormal



## Neethu's 5 Signs

The current recommendations for the delivery of the placenta is for the provider to manage it with drugs and careful cord traction (pulling on the umbilical cord). The provider needs your consent for this and should explain what they are doing through the process. We recommend women and their birth support utilize Neethu's 5 Signs. Unfortunately, some providers pull on women's umbilical cords before checking if the placenta has separated from the uterus. This is extremely dangerous and can cause a catastrophic hemorrhage if the placenta is ripped from the uterine wall before drugs have taken affect to separate it.

According to standard Clinical Guidelines, the provider should:

1. Get informed consent to administer uterine drugs (syntometrine)
2. Wait a minimum of 3 minutes for the drug to take affect
3. Palpate the uterus by feeling the abdomen to check for signs of separation
4. Wait for contractions to start and for signs that the placenta has separated. (trickling or small gush of blood and lengthening of umbilical cord)
5. With your consent and pushing with the contractions, gently pull on the umbilical cord and carefully ease the placenta out. They should stop if there is resistance or pain.

You have the right to decline a managed birth of your placenta and wait for it to come out naturally. You also have the right to pull your own placenta out and have guidance on this from the midwife.

You can use Neethu's 5 signs for visual birth plans. Your birth support should keep a copy of the logo to remind them to communicate to the healthcare team about your wishes for placental delivery. Information sheet is available on our website under Neethu's 5 Signs.

## Navigating Clinical Concerns

Violence and abuse against women in maternity care is a serious problem. However, advocating for women requires strategy and using appropriate channels to achieve this as hospitals have strict zero tolerance policies for abuse against their staff and sometimes these policies are unfairly weaponized against women's advocates.

There is a safe way to escalate concerns that can minimize threats of the improper use of security against women's birth advocates. Polite assertiveness and using established patient support services is the best way to achieve results.

**Patient Liaison**: Patient liaisons are a useful resource for escalating concerns when you're feeling unheard. They act as intermediaries to help facilitate communication with senior medical staff, even though they don't provide direct advocacy.
Here's a summary of how to be prepared should you require escalation:

Using Patient Liaison Services
1. Contact Information:
   - Find Contact Details: Check the hospital's website under the feedback section or ask staff for the patient liaison's contact details.
2. Role of Patient Liaison:
   - Communication: They can communicate your concerns to senior medical staff and facilitate a review.
   - Not an Advocate: They do not provide direct advocacy but act as messengers.
3. Availability:
   - Business Hours: They are available only during standard working hours, so plan accordingly.
4. When to Call:
   - Obstetric Review: Contact them if you need an obstetric review and feel your concerns are not being addressed.
   - Safety Concerns: If you don't feel safe or comfortable requesting a senior review yourself, they can assist in arranging it.

Having this option in your toolkit can be helpful if you encounter difficulties during your hospital stay.

# Navigating Clinical Concerns for Birth Support

**Clinical Review**:
If a woman feels that something is wrong during labor, it's important to know how to escalate her concerns effectively.

**Requesting a Clinical Review**
1. Direct Request:
- Immediate Action: The woman or her birth support can directly ask to speak with the midwifery unit manager or the overseeing doctor.
- Use Specific Language: Clearly state the need for a "clinical review" to ensure the request is understood as a priority for medical assessment.

2. Patient Liaison:
- Contact Patient Liaison: If immediate staff do not respond, contact the patient liaison during standard working hours for assistance in arranging a review.
- Provide Details: Explain the concerns and specifically request a clinical review by senior staff.

3. Independent Phone Lines (State-Specific):
- Know the Numbers: Be aware of independent phone lines available for clinical reviews in different states. These are displayed in hospitals and can be very effective in urgent situations. They are normally available 24/7.
    - NSW: REACH
    - Queensland: Ryan's Rule
    - Western Australia: Aishwariya CARE Call

- Other States: Not all states have a standard clinical review number. Ask during antenatal visits and note down the specific number and terminology for the hospital where you plan to give birth.

4. During Antenatal Care:
- Preparation: During antenatal appointments, ask your provider for the hospital's clinical review procedures, including any specific numbers or terms used.

- Documentation: Write down this information and keep it accessible during labor.

5. Steps if Escalation is Needed:
- Persist in Requests: If initial requests are ignored, continue to ask for a review through different channels. The woman should be seen within 30 minutes, but she may need to take action herself if there is severe fetal compromise as elaborated on the next page.

## What if they don't listen?

If you feel something is wrong during your labor, whether or not you have an epidural, **you have the right to take action to ensure your and your baby's safety**, as do your birth support with your consent.

**If the provider ignores you, you should take action in order to avoid serious poor outcomes.**

Turning off Syntocinon may alleviate abnormal fetal heart tones and frequent contractions (Boie et al., 2018, Small, 2022).

**Request to Stop Syntocinon:**

- If you believe the CTG trace is concerning or your contractions are abnormal, tell the provider to turn off the Syntocinon infusion immediately, and then ask for an obstetric review.

**Withdraw Consent:**

You can withdraw consent for labor-inducing drugs at any time. **You do not need a specific reason.** If asked for a reason, if you are comfortable to do so, you can clarify that you do not feel that the induction is being managed correctly.

- Inform the provider that you are withdrawing consent and if they won't stop the infusion, **you will**.

You rights to withdraw consent are protected by the Australian Healthcare Charter and various medical case law.

**Take Action if Ignored:**

You can take one of these options to stop the Syntocinon yourself:

- **Remove the Cannula:** Pull out the cannula. Place pressure on the cannula site afterwards to stop any bleeding.
- **Disconnect the Cannula:** Unscrew/pull out the delivery IV tubing line attached to the cannula. The medication may end up on the floor, but that is not your problem to deal with.
- **Stop Infusion:** If you have the medical training to do so, find the stop button on the Syntocinon infusion. (We do not recommend this if you are not familiar with the infusion pump in case the wrong button is pressed).

**After Stopping the Infusion:**

Request Senior Staff:

- Ask to speak with the head midwife or head of obstetrics if available.
- Request a clinical review through patient liaison or independent escalation phone lines if necessary.

Document Actions:

- Ensure your birth support documents that **you** withdrew the infusion to avoid any accusation that they interfered with medical practice.

# Induction of Labour Checklist

- [ ] Induction of Labour Documentation Form
- [ ] Hugo’s 7 Rights Induction Information Sheet
- [ ] Hugo’s CTG Trace Alert
- [ ] Neethu’s 5 Signs of Placental Delivery Logo
- [ ] Advanced Healthcare Directive
- [ ] Patient Liasion/Clinical Review Contact Numbers
- [ ] You are all set!

# Resources

Queensland Induction of Labour Guidelines
https://www.health.qld.gov.au/__data/assets/pdf_file/0020/641423/g-iol.pdf

Queensland Induction of Labour Consumer Information
https://www.health.qld.gov.au/__data/assets/pdf_file/0018/641430/c-iol.pdf

RANZCOG Operative Vaginal Birth Guideline
https://ranzcog.edu.au/wp-content/uploads/2022/05/Instrumental-vaginal-birth.pdf

RANZCOG Operative Vaginal Birth for Consumers
https://ranzcog.edu.au/wp-content/uploads/2022/06/Assisted-birth.pdf

Queensland Placental Delivery Information
https://www.qld.gov.au/health/children/pregnancy/antenatal-information/stages-of-labour/third-stage-of-labour

AMA Queensland Healthy Hospital Check
https://www.ama.com.au/qld/campaigns/resident-hospital-health-check

Queensland Advanced Healthcare Directive
https://www.publications.qld.gov.au/ckan-publications-attachments-prod/resources/56b091a2-4c65-48a0-99e1-01661c4d9e77/form-4-advance-health-directive-queensland.pdf

Western Australia 6 Rights of Safe Drug Administration
https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/safety/PDF/Medication-safety-resources/Six-rights.pdf

Syntocinon Drug Information
https://www.drugs.com/pro/syntocinon.html

Midwifery Reading Material on Induction of Labour:
https://www.rachelreed.website/wim
(Book: Why Induction Matters).

Inducing Labour by Midwife Sarah Wickham
https://www.sarawickham.com/iol/

RANZCOG CTG Guidelines
https://ranzcog.edu.au/wp-content/uploads/2022/05/Intrapartum-Fetal-Surveillance.pdf

MCN Perinatal Trauma Prevention Guidelines
https://www.maternityconsumernetwork.org.au/about-5

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https://www.tandfonline.com/doi/full/10.1080/14767058.2018.1499092

https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/about

Induction of labour at 41 weeks versus expectant management and induction of labour at 42 weeks (SWEdish Post-term Induction Study, SWEPIS): multicentre, open label, randomised, superiority trial - PubMed (nih.gov)

Induction of labour in women with normal pregnancies at or beyond 37 weeks | Cochrane

Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour | Cochrane

A cascade of interventions: A classification tree analysis of the determinants of primary cesareans in Australian public hospitals - Fox - 2021 - Birth - Wiley Online Library

https://humanrights.gov.au/sites/default/files/2020-09/sub_149_-_human_rights_in_childbirth.pdf

https://www.health.wa.gov.au/~/media/Files/Corporate/general-documents/safety/PDF/Medication-safety-resources/Six-rights.pdf

https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/aogs.12091

https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12806

https://bmjopen.bmj.com/content/11/6/e047040

https://www.abc.net.au/news/2024-04-19/stillbirth-rates-have-been-static-but-data-could-help-families/103640182

https://birthsmalltalk.com/2022/04/06/stopping-the-oxytocin-infusion-when-the-ctg-is-abnormal/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3467614/

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6464257/

https://www.sciencedirect.com/science/article/abs/pii/S0884217515342283

# Legal Disclaimer

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The creators of this guideline do not provide medical advice. The content of this guideline is based on general clinical guidelines and is not tailored to the specific medical circumstances of any individual.

Users should not rely on this guideline for making medical decisions.
This guide does not provide legal advice or establish any legal rights or obligations.

While this guide  is intended to support clear communication and informed decision making, there is a risk that its use could lead to conflicts with health care providers, especially if there are disagreements over care decisions. Users are expected to discuss any concerns privately with their health care provider and take all steps to avoid creating tensions during labour.

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Rest in Peace baby Hugo