

# “Failure to Progress”

(or in some cases cephalopelvic disproportion)

***“We will give it an hour. If there is no change, we will need to look at getting things moving.”***

Medical doctors follow the **Friedman’s curve** for assigning a time frame to a mom in labor—from the beginning of active labor through delivery of the baby. In a “normal” progressing labor, moms in **active labor**, according to this curve, should be dilating:

- 1 1 centimeter every 2 hours in first time moms
- 2 1 centimeter every hour in subsequent deliveries

The general time allowed to most moms in pushing is 3 hours.

## **Is there medical reason to support this?**

NO! Friedman’s Curve was not developed to assign a “normal” vs. “abnormal” diagnosis, but to determine an **average**—taking into account labors which included both sides of extremes—long, drawn out labors and short, precipitous labors—and those which fell between these extremes. The diagnosis of “failure to progress” is deemed by many birthing experts as “failure to be patient”, as there is no true justification for speeding up a birth that is taking its time. Babies have lots of rotating, maneuvering, and molding to do and, just as each baby grows at his/her own pace, each baby will take different amounts of time to complete the process. Throw in the fact that each mom’s cervix also changes in its own time (softening, moving anterior, effacing, and dilating), and it is no wonder how vast the time variances in women’s labor can be!

## **Accepted Medical Theory in regards to Friedman’s Curve:**

The theory behind using Friedman’s curve in obstetrics is that a slow or halted labor may be an indicator of *cephalopelvic disproportion*-CPD. Whereas this is a common diagnosis in the medical field, true CPD is an extremely rare diagnosis, and mostly seen if the mother has a pelvic deformity, has rickets, or has had a substantial pelvis injury. Most labeled cases of “CPD” occur because of poor fetal positioning and often seen in moms delivering in semi-sitting/reclining position. (Gupta J, Glanville J, Johnson N, et al. The Effect of Squatting on Pelvic Dimensions. Eur Obstet Gynecol Reprod Biol 1991;42: 19-22.)

True CPD will manifest itself in the form of fetal distress. In a normal birth, the baby’s head will mold to fit the mother’s pelvis. In cases of true CPD, the baby’s head will also attempt to mold and squeeze through the mother’s pelvis, but much more severely. This severe compression will show up in the baby’s heartrate—indicating that there is a problem. (CPD is not the only factor which can precipitate fetal distress; the vast majority of the cases can be traced to other things—especially pharmaceutical labor induction and augmentation drugs.) All in all, cases of CPD will be detected eventually if left alone. Using pharmaceutical augmentation will make the labor harder on mom and baby—only to give you answers you were going to find out anyway.

80% of moms will report that augmented contractions are more painful than natural contractions, and babies are much more likely to suffer from fetal distress with augmentation. Fetal distress is not common with natural labor contractions and those instances can often be remedied by position changes and extra care to remember to breathe at the onset, during, and after contractions.

In mothers who have experienced rupture of membranes (either spontaneously or artificially) there is some increased risk of infection (if membranes have been ruptured for >24 hours and if combined with frequent vaginal exams). For this reason, typically, once your bag of waters are broken the “cesarean clock” starts ticking down from 24 hours. However, this in itself, is not the “medical reason” for augmentation used primarily, for many providers will suggest augmenting a “slow” labor regardless of whether her bag of waters is still intact or not.

## **Problems with the Accepted Medical Theory of Friedman’s Curve:**

Recent studies have also shown that Friedman’s Curve may not be entirely accurate and may be “too stringent in current practice”. (Zhang 2002) (See attached study.) Current studies are seeing an AVERAGE of 5.5 hours for progression from 4-10 centimeters dilation, instead of the 2.5 hours allotted by Friedman. (Zhang 2002) Following Friedman’s curve wholeheartedly has undoubtedly led to multiple unnecessary cesarean sections because of the medical field’s “need” for labor to fall within Friedman’s time parameters.. Even the developer of the Friedman curve has warned that his study is being misused.....

Dr. Emmanuel Friedman (Harvard Medical School, Beth Israel Hospital, Boston) asserted that the Friedman labor curve, which he developed, “is being abused more than it is being used appropriately. ....Dr. Friedman termed today’s high cesarean rate an “iatroepidemic” [a physician-caused epidemic].....[stating] that 70 percent of cesareans for prolonged labor and 50 percent of cesareans for arrest disorders [where progress stops] are unnecessary.

*Robbie Davis-Floyd, Birth as an American Rite of Passage*

“Failure to progress” is a primary reason for pharmaceutical augmentation (Pitocin, Cytotec, etc.) and THE leading cause for cesarean sections. Both augmentation and cesarean sections present multiple risks to the mother and the baby.

Saying that a woman’s labor which deviates from the median average (12-14 hours for first time moms) is “abnormal” is the equivalent of saying that a 6 pound baby is “abnormal” in comparison to a 7 ½ lb. (average) baby! Just as every woman (and baby!) is unique, so will her labor be unique as well.

## **What are my options if I don’t want to be pharmaceutically augmented, or worse, have a cesarean section?**

- 1 First, your doula will suggest ways to naturally augment the process without the harmful side effects of pharmaceutical methods. (gravity, position changes, nipple stimulation, acupressure, etc.)
- 2 Allow your body and baby the time to progress at the pace they are supposed to. Baby has to do a lot of maneuvering to get in that right position for birth. Give him/her the time and freedom to do so, unless he/she shows signs of distress.
- 3 Ask your doctor for a medical reason supporting the augmentation and a medical study which supports his/her position—and get it in black and white—not just verbally. If the baby is in fetal distress with natural labor contractions, it should be suspected that they will have an even HARDER time with augmented labor contractions.
- 4 You have the right to say NO—or “not yet” ! ☺ Whereas many women do not want to go “against medical advice”, if baby and mom are showing no danger signs, you may politely say “I’d like some time to think this over....” Who knows maybe by the time you are done “thinking” your body will have given the doctor the progress he/she is content with!
- 5 As a preventative measure, stay at home during labor as long as possible. If you remain where you are relaxed the most (HOME), your labor will be less likely to stall. Progress in labor will come much easier and faster if you work with the contractions instead of against them. Relaxation in labor is key to letting your body take over. Try to stay home *at least* until active labor!

## Definitions of labor protraction, arrest challenged - Reassessment of Friedman Curve

[OB/GYN News](#), [March 1, 2002](#) by [Nancy Walsh](#)

NEW ORLEANS -- Current definitions of labor protraction and arrest may be too stringent, Dr. Jun Zhang said at the annual meeting of the Society for Maternal-Fetal Medicine.

And the long-accepted Friedman curve may not be an accurate description of normal labor progression, according to a new analysis of data from 1,329 nulliparous women aged 18-34 undergoing singleton, vertex presentation deliveries following spontaneous labor, said Dr. Zhang of the National Institute of Child Health and Human Development, Bethesda, Md.

For the past half-century obstetric practice has followed the description of normal labor set out in a landmark 1955 study by Dr. Emanuel Friedman. Based on his observations of 500 women, Dr. Friedman divided labor into four phases: latent, acceleration, maximum slope, and deceleration.

He also established a series of definitions commonly used to this day. (See box.)

From his data he derived a curve that bears his name predicting the normal course of labor, charting hours of labor against dilation of the cervix measured in centimeters.

But this curve has never undergone rigorous testing, and much has changed in the last half century, Dr. Zhang said. There have been changes in obstetric practice such as the increased use of epidural anesthesia and oxytocin and the decreased use of forceps.

Maternal and fetal weights also have increased.

"We wanted to know if these changes affect labor progression in current practice, and if Friedman's definitions are still valid," Dr. Zhang said during the meeting, which was cosponsored by the American College of Obstetricians and Gynecologists.

Patients who underwent cesarean section and those whose fetuses were macrosomic were excluded from the study. Epidural analgesia was used by 49%, and 53% used oxytocin with a median maximum dose of 6 mU per minute.

Based on the speed of overall labor progression and current cervical dilation, Dr. Zhang and his colleagues calculated the expected traverse time for the cervix to reach the next centimeter and the expected rate of cervical dilation at each phase of labor. (See graph.)

"Our curve is very different," Dr. Zhang said, pointing out that on his curve the average was 5.5 hours for progression from 4 cm to 10 cm, compared with 2.5 hours on the Friedman curve.

"We also didn't see a deceleration phase," he said, noting that in 1978 Friedman modified his curve, but the distinctive sharp upturn remained, as did the deceleration phase.

"Our data suggest that most women enter active labor at different times, mostly between 3 cm and 5 cm dilation, and even in the active phase the speed of progression varies from person to person," he further explained.

The median time for cervical dilation to progress from 4 cm to 5 cm in the present study is 1.7 hours. And for fetal descent, it could take 3 hours to progress from station +1 to +2, and an additional half hour from station +2 to delivery, he added.

"Therefore, the definition of protracted descent or arrested descent appears to be too stringent in current practice," according to Dr. Zhang.

The study had limitations, including the subjectivity of cervical dilation measurements.

"The decision on cesarean section may have been influenced by the prevailing concept of labor arrest, and we excluded all the C-sections," Dr. Zhang said. Also, because cases of macrosomia were excluded, the 95th percentile estimate may have been too low, he said.

"Finally, our findings may not be applicable to induced labor," Dr. Zhang added.

[Graph omitted]

RELATED ARTICLE: [Friedman's Definitions](#)

Pioneering American obstetrician Emanuel Friedman established the following definitions of labor progression in 1955--definitions that remain in use but may be too stringent, Dr. Zhang said:

- 1 Protracted active labor: less than 1.2 cm/hr.
- 2 Active phase at rest: no dilation for 2 hours.
- 3 Protracted descent: less than 1 cm/hr.
- 4 Arrested descent: no descent for 1 hour.

Source: Dr. Jun Zhang

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