



Question: What is Failure to Progress?

Answer: Failure to Progress is an outdated term that refers to slow labor during the first or second stage. The diagnosis of Failure to Progress is one of the most common reasons for Cesareans today, leading to nearly half of all Cesareans in people giving birth for the first time.

Question: Why do so many people have Cesareans for Failure to Progress?

Answer: Until recently, most people in labor were held to a standard called “Friedman’s Curve”. Friedman’s Curve is a graph that some doctors and midwives traditionally used to define a “normal” length of labor. If someone’s cervix does not dilate according to this schedule, they could be assigned a diagnosis of Failure to Progress and given a Cesarean. Though more current guidelines have been developed, research has shown that they are not always followed.

Question: What is Friedman’s Curve?

Answer: In 1955, a physician named Dr. Friedman published a study describing the amount of time it took 500 white birthing people to dilate per centimeter during labor. Although this study was published over 60 years ago, and the demographics and common labor practices were very different from today, it still served as the basis for how physicians defined normal labor until recently.

Question: What guidelines are used today?

Answer: In 2012-2014, several large physician organizations in the U.S. issued new definitions of normal labor and stated that Friedman’s Curve should no longer be used. The new guidelines not only indicate that, on average, labor is slower than what Friedman observed, but they also include flexibility for things like epidurals and medical inductions, which are known to sometimes slow down labor.

Question: What are the new guidelines based on?

Answer: In 2010, Zhang and colleagues studied more than 62,000 people who gave birth at 19 different hospitals across the U.S. The researchers found that, on average, people did not start dilating rapidly at 4cm like in Friedman’s study. Instead, active labor was reached at 6cm. The researchers also noticed that, prior to active labor, some people could go long periods of time without any dilation, and this was within the range of normal for the sample. These patterns occurred in both people giving birth for the first time and those that had given birth before. All of these people went on to give birth to healthy babies showing that, in some cases, labor can be slower/without a regular pattern and still be “normal”.

Please see [page 2](#) for a graphical representation of the results from this study.

Question: Outside of research studies, what is the average length of labor?

Answer: It is not easy to define an average labor because each person has different internal and external factors that can shorten or lengthen their labor. For example, giving birth to your first baby, epidural use, and having a medical induction can all make labor longer. Some things that can make labor shorter are labor positions that use gravity and encourage mobility of the birthing person’s pelvis, ideal positioning of the baby, and engagement of the baby in the pelvis. All of these things can help the baby navigate through the pelvis with more ease (which sometimes means more quickly!).

Question: What is all this talk about the pelvis?

Answer: Historical ideas about varying pelvic shapes can influence peoples’ beliefs about the concept of a baby not fitting through a pelvis. In the 1930s, pelvises were divided into four distinct categories using the Caldwell-Moloy classification system. Although this system is flawed and based on racial and gender stereotypes, it persists today and is still taught in various forms of medical education. Modern research using imaging studies has debunked this type of classification and shown that pelvic shapes are varied. In short, there is no right or wrong pelvis shape for birth-instead, mobility of the pelvis can improve birth outcomes.

Question: When does a labor become abnormally long?

Answer: The American Congress of Obstetricians and Gynecologists and the Society for Maternal Fetal Medicine in the United States both make a strong recommendation that “Cesarean delivery for active-phase arrest in first stage of labor should be reserved for birthing people at ≥ 6 cm of dilation with ruptured membranes who fail to progress despite 4 hours of adequate uterine activity, or at least 6 hours of oxytocin administration with inadequate uterine activity and no cervical change.” The appropriate term is now “labor arrest,” and people should be at least 6 cm dilated and have no cervical change for 4 to 6 hours before being given this diagnosis.

Question: When does a pushing stage become abnormally long?

Answer: Labor arrest in the second stage can be diagnosed if there has been no improvement in the baby’s rotation or descent after:

- ≥ 4 hours in people giving birth for the first time with an epidural
- ≥ 3 hours in people giving birth for the first time without an epidural
- ≥ 3 hours in people who have given birth before with an epidural
- ≥ 2 hours in people who have given birth before without an epidural

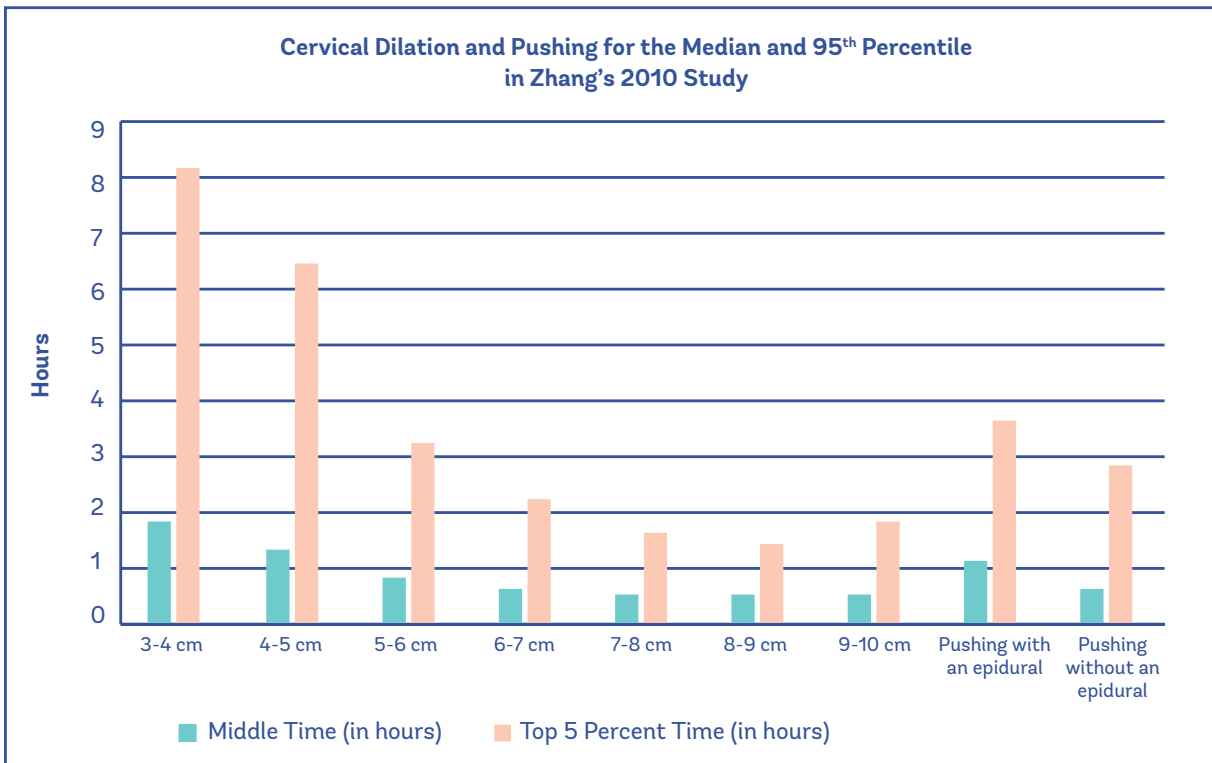




“As long as the laboring person and baby are healthy, and as long as the length of labor does not meet criteria of ‘labor arrest,’ laboring people should be treated as if they are progressing normally.”

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This bar graph shows the amount of time (in hours) that it took for both the middle of the study group and the slowest five percent of the study group to dilate (per centimeter) and to push. Bottom line: the fastest, middle, and slowest times are ALL versions of “normal” labor in this study group!

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