

How to push safely at the end of labor



Start from the physiology of the second stage

The second stage of labor begins when the cervix is fully dilated and ends with birth of the baby. That threshold matters because pushing before a fully dilated cervix can increase discomfort and does not help the fetal head descend efficiently. Current obstetric guidance places the decision to begin pushing in the hands of the clinical context, not a fixed clock.

At this stage, the uterus still provides the main force, but your abdominal muscles, diaphragm, and pelvic floor coordination influence how that force is transmitted. Some people feel a strong spontaneous urge to bear down as the presenting part reaches the pelvic floor; others, especially those with neuraxial analgesia, may feel less of that reflex. Both patterns are normal. The main safety principle is to push in a way that is coordinated with contractions and responsive to the team's assessment of dilation, station, and fetal status.

The evidence base does not support one routine technique for everyone. Reviews comparing spontaneous and directed pushing have not shown a decisive advantage for one method across major outcomes. That is why labor management should remain individualized rather than formulaic.

Decide when to push with the team, not against the body

A common mistake is to treat pushing like a command that begins the moment labor becomes intense. In reality, the safest moment to start is when the cervix is fully dilated and the obstetric team agrees that the baby has descended enough for effective pushing. If you feel pressure before that point, the team may still want to wait, especially if the cervix is not yet complete or if the fetal head is high.

For people with epidural analgesia, some settings support delayed pushing for 1 to 2 hours so that the fetus can descend passively before active efforts begin. That approach is not universal, but it is an evidence-informed option when the clinical setting can monitor both mother and baby closely. It can preserve energy and sometimes reduce the length of active bearing down.

Directed coaching may still be useful when sensation is reduced or when a short, focused burst of effort helps. Even then, the safest version is usually not prolonged, rigid breath-holding. It is a guided effort that respects the contraction pattern, the maternal response, and the fetal heart rate tracing if one is being followed.

Use breathing to coordinate force, not to fight the contraction

Breathing is a control tool, not a performance test. Many clinicians favor an open-glottis or exhalational pattern because it can help you maintain pelvic floor relaxation and avoid unnecessary Valsalva strain. Others use coached counting or short periods of closed-glottis pushing when that better matches the situation. The main question is whether the pattern helps you stay effective, calm, and synchronized with the contraction.

A practical cue is to inhale, settle the shoulders, then let the contraction initiate the push while you direct air out in a controlled way. Between contractions, recovery breathing matters too. It allows partial re-oxygenation, reduces panic, and gives the pelvic floor a chance to soften again. This is especially relevant when the second stage is long or when contractions arrive close together.

Common breathing problems include bearing down without an actual contraction, holding the breath so long that dizziness develops, and tightening the jaw or throat while trying to push. Those patterns can waste energy. If coached pushing is being used, ask the team to keep instructions short and specific. If spontaneous pushing is working, it is reasonable to lean on the body's own rhythm rather than overriding it.

Choose positions that help descent and reduce strain

Position matters because it changes how gravity, pelvic diameter, and muscle effort interact. Upright positions during labor can assist descent and may feel more intuitive when the body is driving the process. Side-lying, hands-and-knees, and semi-recumbent positions can also be useful depending on fatigue, fetal position, and whether there is an epidural.

There is no single best posture for every birth. A side-lying pushing position may conserve energy and reduce perineal stretch in some people. Hands-and-knees positioning can help when back pressure is intense or when fetal rotation is being supported. Upright positions can give a strong sense of agency and may use gravity to advantage. The most important question is whether the position allows you to relax between contractions and push effectively during them.

If mobility is limited, even small changes can help: a tilted pelvis, supported knees, or a laboring position that reduces tension in the thighs and abdomen. The goal is not athletic effort. It is efficient force with as little wasted tension as possible.

Protect the perineum and avoid harmful pressure

Safe pushing includes protection of maternal tissue. Controlled crowning, slow emergence of the head when feasible, and careful perineal support during birth can reduce unnecessary trauma. Your team may coach you to soften the jaw, pant lightly, or pause briefly as the head crowns so that the tissues can stretch gradually. Those instructions are about tissue protection, not about slowing labor for its own sake.

One practice to avoid is manual fundal pressure during the second stage. WHO guidance advises against it because it can increase risk without clear benefit.

You should not feel someone pressing forcefully on the top of the uterus to push the baby out. If pressure is being applied, it should be part of a clearly explained, clinically justified maneuver, not a routine shortcut.

Forceful, prolonged bearing down in the absence of progress can also be unhelpful. If the baby is not descending, if pain is overwhelming, or if the pattern of contractions is not translating into movement, the team should reassess rather than escalating effort blindly. Safety in labor often means stopping and recalibrating.

Know when the plan needs to change

Sometimes pushing goes well for a while and then slows. That does not automatically mean failure. It may reflect maternal fatigue, rotation issues, a deeply engaged fetal head, or an evolving need for operative assistance. A prolonged second stage is not managed the same way in every setting, but ACOG notes that clinicians should monitor progress and decide whether continued pushing, operative vaginal birth, or cesarean delivery is the better option.

Escalation is also considered if there are concerns about fetal heart rate patterns, significant bleeding, maternal exhaustion, fever, or inability to push effectively. In those moments, the safest action is to let the obstetric team reassess rather than trying to force one more hard push. A different plan can still be a good outcome.

After the baby is born, the work is not over. The team still needs to manage the third stage of labor and check for lacerations or hemorrhage. Good pushing is only one part of a broader birth process that also depends on monitoring, communication, and timely intervention.