Open-glottis vs directed pushing comparison

What the two techniques actually mean

Open-glottis pushing means the glottis remains open enough for air to move out while the person bears down. The push is usually coordinated with the contraction, but the breath is not held rigidly. Many people describe it as exhaling through the effort rather than bracing against it.

Directed pushing is more explicitly coached. The clinician or midwife gives cues on when to start, how long to push, and when to rest. In many settings, this is paired with a prolonged breath-hold or a Valsalva-style effort, although practices vary. In real labor, the boundary between styles can blur, especially when the team adjusts coaching in response to fatigue, fetal heart rate changes, or progress. Questions about breathing during pushing often arise here because the words used in birth plans do not always match what actually happens in the room.

Neither technique is a moral test of effort. The practical issue is whether the method helps the person work effectively while keeping the baby and mother as safe and comfortable as possible.

Why physiology makes the comparison complicated

The physiologic logic behind directed pushing is straightforward: a closed-glottis, breath-held effort can increase intra-abdominal pressure and may generate a stronger immediate downward force. That can be useful when the clinical goal is a more forceful, well-timed push. The tradeoff is that this style can feel intense, tiring, and sometimes less sustainable over many contractions.

Open-glottis pushing tends to distribute effort differently. Exhaling during the push may reduce the sense of bracing, and for some people it feels more instinctive and easier to repeat. It may also be better tolerated when the person is exhausted, anxious, or working with an epidural and reduced lower-body sensation. Clinicians sometimes prefer it because it can support a steadier rhythm and reduce strain, although the physiologic advantages do not automatically translate into better outcomes for every birth.

In practice, the question is not only how hard someone can push. It is also how well they can repeat the effort, recover between contractions, and stay coordinated with the descent of the fetal head.

What the clinical trials and reviews show

Modern evidence is more restrained than older teaching. A recent randomized controlled trial comparing open- and closed-glottis pushing for vaginal delivery did not establish a simple universal advantage for one approach. It examined operative vaginal delivery outcomes and also reported subgroup results by parity, which matters because nulliparous and parous births do not behave the same way.

The pragmatic EOLE trial also tested whether directed open-glottis pushing was more effective than directed closed-glottis pushing during the second stage of labor. Its real-world design is useful because it reflects the way pushing is managed outside a tightly scripted experiment. Taken together, these trials suggest that the answer is not one-size-fits-all.

Evidence reviews for intrapartum care reach a similar practical conclusion: the data are too mixed to say that one method should replace the other across all births. That is why many clinicians focus less on dogma and more on whether the

chosen style is helping the person progress safely and sustainably. The comparison is real, but the evidence does not support an absolute winner.

When one style may be favored over the other

Technique is usually individualized. A person who is tired, anxious, or struggling to coordinate breath and effort may do better with open-glottis pushing because it is easier to sustain over time. Someone who is well rested, highly coached, or in a setting where the team wants a tightly synchronized effort may be guided toward directed pushing for short periods.

Several clinical factors often influence the choice. Epidural analgesia can change sensation and the ability to sense the most effective moment to bear down. Fetal position, fetal station, and the rate of descent also matter. If the baby is already low and progress is steady, gentle exhaled pushing may be enough. If progress has slowed, the team may try a more structured approach. Open-glottis pushing may be preferred when there is a need to limit prolonged strain, while directed pushing may be used when the team wants a sharper burst of downward force.

Open-glottis pushing can be easier to repeat when fatigue is building. Directed pushing can help when coordination and timing need more structure. Both styles may be adjusted within the same labor if the situation changes.

None of these choices should be treated as fixed rules. They are bedside decisions made in response to the labor unfolding in front of the team.

How to discuss the plan before and during birth

It helps to discuss the general approach ahead of time, but the conversation should stay flexible. A useful question is whether the team usually coaches active pushing or prefers a more spontaneous rhythm. Another is how they adjust when an epidural is present, when the pushing stage starts slowly, or when the mother is becoming exhausted.

Why pushing duration varies is one reason rigid expectations often fail. Two people with similar labors may need very different coaching depending on parity, fetal position, rest level, and uterine contraction quality. That does

not mean anyone is doing anything wrong. It means the second stage of labor is biologically variable and does not reward overconfident assumptions.

If the coaching style in the room is not working, it is reasonable to ask for a change. Many teams can move from directed to more open-glottis pushing, shorten the breath-hold, or build in longer recovery breaths between contractions. The most useful plan is the one that can be adapted without delay when the clinical picture changes.

What this comparison means in practice

The main takeaway is that open-glottis and directed pushing are not competing ideologies. They are tools with different strengths, and the best choice depends on the labor at hand. Open-glottis pushing may be more comfortable, more sustainable, and easier to integrate with the person’s own rhythm. Directed pushing may be useful when the team needs a more deliberate burst of effort or when the birth is moving slowly and structured coaching seems helpful.

Current evidence does not justify telling every laboring person to use one method all the time. Instead, the evidence supports a more measured approach: use the technique that fits the stage of labor, the fetal condition, the mother’s tolerance, and the team’s clinical judgment. That is the most realistic way to think about a comparison that is often framed too simply.

For medically literate readers, the important point is not which label sounds more modern. It is whether the technique improves coordination, avoids unnecessary distress, and supports a safe vaginal birth when that is the clinical goal.