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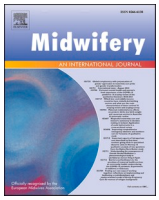

The PRIMROSE project: What is 'physiological birth'? Exploring the perceptions of care providers and birthing persons in Australia: A qualitative descriptive study

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ABSTRACT

Background: 'Physiological birth' as a term, lacks consistency, and the current definition from the World Health Organization in 1997 does not consider the viewpoint of women/birthing persons. Differences in individual interpretations of physiological birth may complicate care provision and the advocation of physiological birth.
Aim: To explore the contemporary understanding of physiological birth from the perspective of women/birthing persons, midwives, obstetric doctors, and doulas in the Australian setting, and identify important elements to include in a consensus statement of 'physiological birth'.
Methods: A qualitative descriptive study was undertaken using focus groups and interview. Data was audio-recorded, transcribed verbatim, and was thematically analysed using NVivo software.
Results: Ten participants took part in this study. Three aggregate themes were identified: (1) Connection to the natural process of birth, (2) Elements of decision, and (3) Challenges in the birthing setting. Participants agreed that 'spontaneous onset' and 'vaginal birth' were important terms to include in a consensus statement of physiological birth. Women/birthing persons, midwives and doulas believed physiological birth was a natural process, uninterrupted by intervention; however, the use of the term 'intervention' was amorphous. Antenatal education about physiological birth was identified as lacking, and physiological birth was considered not to be a 'woman's term'. Participants acknowledged a fear-based narrative around childbirth, and that 'red tape' within the hospital setting could challenge maternal choice.
Conclusion: Trusting in instinctive labour and birth is an important element of physiological birth. Multiple understandings of the term 'physiological birth' extend into the terms used to define it.

Introduction

The World Health Organization defines physiological birth as "spontaneous onset, low risk at the commencement of labour, and continuing so for the remainder of labour and birth. The infant is born spontaneously between 37 and 42 weeks of pregnancy with a cephalic presentation. Following birth, both mother and infant are in good condition." (World Health Organization, 1997) This definition of 'physiological birth' offers little consideration of the lived experience of women and their care providers and has not been updated since 1997.

A fundamental component of 'Midwife Standards of Practice' in Australia is to 'promote normal physiological childbirth'(Nursing and Midwifery Board of Australia, 2018, p. p2), however, it is evident that there are varying interpretations of this concept among maternity care providers and women/birthing persons. Definitional ambiguity of 'physiological birth' could influence clinical care, the development of policy and the understanding of birth outcome (Henshall et al., 2024a). In the previous stage of the PRIMROSE Project, a quantitative study demonstrated a change in language in the Australian contemporary maternity care setting, with terms such as 'normal', 'low-risk' and 'gestational term' being viewed as contentious in the setting of defining 'physiological birth' (Henshall et al., 2025b). That study also demonstrated a range of perspectives with interventions used in labour and birth, with some interventions being viewed as incongruent with

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physiological birth, depending on role or profession of the individual in the birthing space. Regardless of whether a 'physiological birth' was achieved, women/birthing persons have demonstrated a desire for a physiological approach to labour and birth, that valued shared decision making and explicit communication (Hall et al., 2022). This suggests a disconnect between institutional definitions and the values held by those giving birth, reinforcing the need for greater conceptual clarity of 'physiological birth' in maternity care. Proactively cultivating an ethos that empowers care providers to deliver evidence-based and woman-centred care, will in turn, aid a culture of respect, dignity, and support, enabling women to have a safe birthing experience (Brady et al., 2024).

Therefore, the aims of this study are to:

- Explore the contemporary understanding of physiological birth from the perspective of women/birthing persons, midwives, obstetric staff and doulas; and
- Identify elements considered important in a consensus statement of physiological birth.

The context of this study

This research is part of the PRIMROSE (*P*hysiological B*i*rth: A M*i*xed *M*ethod Explanat*o*ry Framew*o*rk with *S*equential D*e*sign) Project, an explanatory sequential design study; exploring the perceptions of physiological birth in the Australian setting. This project encompasses four parts; 1) a scoping review (Henshall et al., 2024a); 2) a quantitative nationwide survey (Henshall et al., 2025b); 3) a qualitative understanding of physiological birth (described herein), and finally, 4) the development of a consensus statement on 'physiological birth'.

Methods

A qualitative descriptive study design was used as it allows for the interpretation of data without losing the richness and individuality of responses (Sandelowski, 2010). Focus groups were used to explore the participants' experiences and attitudes regarding physiological birth. The group format encouraged sharing multiple perspectives and highlighted consensus or discrepancies between focus group members (Nyumba et al., 2018). Homogeneous groups with experience of the phenomenon, can produce quality data in focus groups (Cleary et al., 2014). A sample size of 10 participants with varying roles in labour and birth was deemed appropriate for this stage of the PRIMROSE Project. Participants were invited to relate their perceptions openly. Participation was voluntary, and participants could withdraw their consent up to the point of data analysis.

The group dynamic and interaction among participants were considered an important component of this study's methodology, as it can influence the data collected (Grønkjær, 2011). Where this was not possible in the interview, further discussion between the moderator (BH) and interviewee was considered in the thematic analysis. Evidence sufficiency was reached when all questions had been thoroughly explored in detail, and no new themes were identified in subsequent interview/group (LaDonna et al., 2021).

Recruitment

All participants who completed the survey component of the PRIMROSE Project (Henshall et al., 2025b) were invited to express interest in attending one of three focus groups scheduled between early September and mid-November 2023. Of the 194 participants who consented to be contacted further, 129 participants who met the study were criteria, were contacted by email. Twenty-two participants accepted, with 9 participants attending focus group sessions (3–4 participants per focus group, each participant attending 1 focus group). One interview was held for the obstetric doctor who was unable to attend the focus group session due to time conflicts (overseas at time of interview).

All participants have been involved in intrapartum care in the Australian maternity system within the last 12 months either as a midwife, obstetric doctor, doula or recipient of care. In Australia, an obstetric doctor is a medical doctor who specialises in maternity care, including managing complications during pregnancy and childbirth (Department of Health, 2018). Midwives are registered health professionals who work in partnership with women to give the necessary support, care and advice during pregnancy, birth and the first few weeks after birth (Australian Government, 2024). In the Australian setting, doulas offer emotional, physical, and social support to individuals during the perinatal period, without providing clinical care (Bohren et al., 2017).

Data collection

A semi-structured focus group schedule was developed specifically to explore salient issues (Doyle et al., 2020) identified in the previous stages of the PRIMROSE Project (Henshall et al., 2024a, 2025b). The focus group guide was piloted with midwives and research academics who provided feedback on the questions' scope, clarity and the lead author's interview technique.

The focus group sessions and interview were conducted and recorded via the Zoom online platform. Audio recordings were transcribed verbatim, and the transcripts were checked by all authors for accuracy. The data and field notes collected from the focus groups and interview were deidentified and uploaded to NVivo 1.0 for analysis (NVivo, 2018).

Before the focus groups and interview, participants were sent the focus group guide (Table 1) ahead of time via email, and invited to ask questions/raise concerns before commencement.

Data analysis

Inductive thematic analysis was used to identify, explore, and generate themes from the data, following four steps (Green et al., 2007):

1) data immersion through rereading transcripts and checking against audio and fieldnotes;
2) coding, including researcher discussions and theme refinement;
3) category creation by collapsing and expanding codes; and
4) theme identification through repeated analysis, with intervals for reflection.

A cyclical process of listening to and viewing the recorded focus groups and interview, reading transcripts, and note-taking was undertaken (Willig, 2013). All transcripts were deidentified and assigned pseudonyms. Two authors read each transcript, considering field notes alongside. This iterative process involved regular meetings to discuss codes and themes, with conflicts resolved by a third author reviewing transcripts and audio. Three themes were identified, each illustrated with verbatim quotations.

Data adequacy (Vasileiou et al., 2018) was assessed continuously. By the third focus group and interview, no new themes were apparent, indicating sufficiency (LaDonna et al., 2021). This was confirmed through team discussions and literature review, ensuring contextual relevance and theoretical grounding. The team then ceased further data collection for this stage of the PRIMROSE Project.

COREQ guidelines ensured rigour, including reflexivity, study design, analysis, and reporting (Tong et al., 2007). Validation techniques included data triangulation from diverse maternity care roles and investigator triangulation through multiple coders (Carter et al., 2014). An audit trail documented decisions, coding, and theme development, enhancing transparency and reliability (Wolf, 2003).

Table 1
Focus group guide.

1. What does the term physiological birth mean to you?
2. What criteria excludes a birth from qualifying as physiological?
3. From the survey component of the PRIMROSE project, results indicated; that words to include in a consensus statement of physiological birth were:
   – spontaneous onset, spontaneous delivery/birth, vaginal birth, minimal intervention and no intervention.

Words to exclude from a consensus statement of physiological birth were:

– low-risk, normal and gestational term.*
Are there any other words you'd like to see in a consensus statement about physiological birth, or words you'd like not to see?
1. What else is important for me to know, that you'd like to talk about?

* In the first stage of the PRIMROSE Project, participants in a nationwide survey were asked to consider what terms they would like to see included in a revision of 'physiological birth' rating terms on a scale of 0 'Disagree' – 100 'Agree'.

Reflexive statement

All researchers are midwives, with the moderators' (BH) occupational background, gender (female), and credentials (RN/RM/MMid/PhD candidate) disclosed to the participants at the beginning of the session. The observers of the sessions (HG, JD and CE) are midwifery academics, with HG and JD having experience in qualitative research including focus group facilitation. There was no prior relationship between any of the authors and the participants. It is acknowledged that the interpretation of the data may be biased, based on the researcher's profession and experience. This could influence coding and theme development.

Ethical consideration

This research project has been approved by a university Human Ethics Committee (Ethics approval number HEC23252). Participants received an information sheet before the focus groups. This included the researchers' contact details and information about resources to support participants if they experienced any emotional discomfort as a result of participation. Support services included 24/7 hotline numbers to Perinatal Anxiety & Depression Australia and 'Beyond Blue'. Written consent was obtained before commencement, and verbal confirmation was also gained at the start of each session.

Findings

Of the 22 participants who agreed to attend the scheduled focus groups, nine ultimately did so. One interview was conducted (Fig 1. Recruitment). Reasons for non-attendance included being unable to make the session times ($n = 3$), or no reason was given/non-attendance at scheduled focus group time ($n = 9$). We did not reschedule focus groups for non-attendees. The focus groups were conducted in English, lasting an average of 60 min. The focus groups were conducted through videoconferencing, from October- November 2023 with 1 interview conducted with 1 participant in December 2023.

All participants identified as female and were based in Australia, with the majority from the state of Victoria (60 %). Midwives had a median of 3 years of experience in midwifery. Of the six maternity care providers, one worked in a primary hospital setting, three worked in a secondary setting, two worked in a tertiary hospital setting, including the obstetric doctor. All the women/birthing persons in this study had two or more birthing experiences (see Table 2).

The data from the focus group discussions and interview were compared and categorised. This assisted in the identification and development of 22 first-order codes, and seven second-order codes which were grouped into three themes. These themes are presented in Table 3 and illustrated with quotations from participants in Supplementary Table 1.

Analysis of the focus group and interview transcripts identified three themes:

– Theme 1: connection to the Natural Process of Birth
– Theme 2: elements of Decision
– Theme 3: challenges in the Birthing Setting

These themes can be understood to represent participant understanding and experience (perceptions) of the phenomena 'physiological birth'. Lastly, the elements important in a consensus statement of 'physiological birth' were discussed.

Theme 1: connection to the natural process of birth

The notion that physiological birth was 'natural' was considered throughout the focus groups and interview:

> Straight away as soon as you see natural you don't think of medical things. You think of a natural progression. Aria, #7, doula, VIC

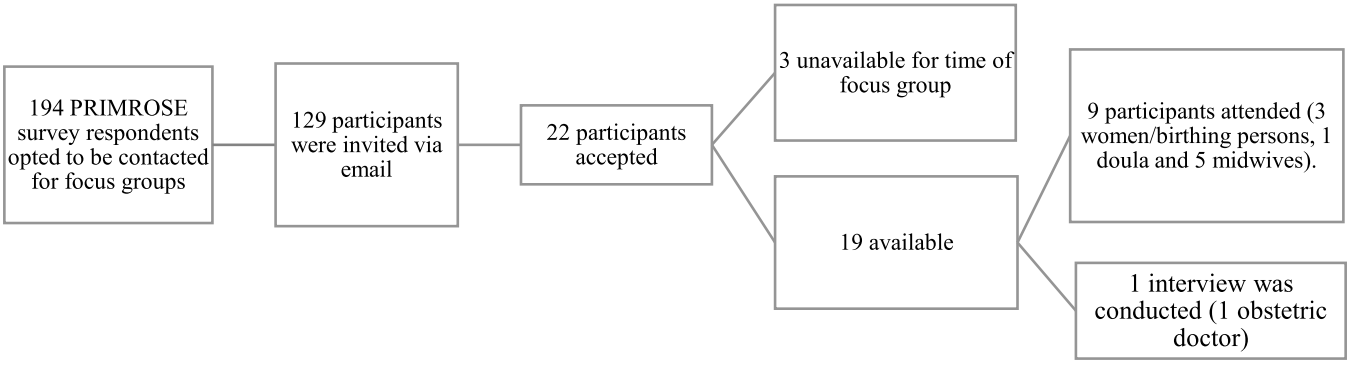

Fig. 1. Recruitment.

Table 2
Characteristics of participants.

Participant Number	Pseudonym	Gender	Location	Category (self-selected)	Years of maternity experience	Type of hospital setting	Number of children
1	Gaia	F	New South Wales	Midwife	3.5	Secondary	N/A
2	Emily	F	Queensland	Midwife	15 years nurse/7 years midwife	Primary	N/A
3	Ellen	F	South Australia	Midwife	3	Tertiary	N/A
4	Hazel	F	Victoria	Midwife	2	Secondary	N/A
5	Elsa	F	Victoria	Midwife	3	Secondary	N/A
6	Jane	F	Victoria	Obstetric Doctor-Registrar	9	Tertiary	N/A
7	Aria	F	Victoria	Doula	N/A	N/A	N/A
8	Hannah	F	New South Wales	Woman/Birthing Person	N/A	N/A	3
9	Rose	F	Victoria	Woman/Birthing Person	N/A	N/A	2
10	Chloe	F	Victoria	Woman/Birthing Person	N/A	N/A	2

Table 3
Coding template.

First-order Codes	Second-order Codes	Aggregate themes
A natural process, uninterrupted by intervention	Instinctive labour and birth	Connection to the natural process of birth
Trusting the natural process of labour and delivery		
Traditional birthing methods of past generations		
Recognising birth as normal rather than a medicalised event		
Sanctuary/Protected space in labour	Importance of support	
Caring role from support people and midwives		
Maternal preferences	Choice	Elements of decision
Embracing technology		
Choice in birth and alternatives for pain relief and interventions		
Autonomy		
Education in physiological birth		
Exposure to physiological birth		
Red Tape	Normality threshold	
Fear-based narrative around childbirth		
Interruption		
Respect and recognition that each experience in unique and personal	Balance and imbalances	
Widespread use of medical interventions	Provider bias and attitudes: Medical intervention	Challenges in the birthing setting
Fighting a system that supports intervention		
Prejudice and prerogative		
Institutional practice norms and reluctant acceptance		
Guardians of physiological birth		
Physiological Birth: A Loaded word	Interpretation	

> Physiological, is like the process of something happening like in nature, I don't like to use the word natural- But it's like that's it's kind of necessary. Jane, #6, obstetric doctor, VIC

There was also the interpretation of physiological birth being solely a biological process;

> Physiological to me is just like the normal biological processes of cells- and so in birth that would be like the process of oxytocin binding to its receptors, causing contractions and the expulsion of the baby like, that's all it would mean to me. Jane, #6, obstetric doctor, VIC

As they discussed and engaged with each other in the focus groups, their experiences of 'being with woman' and receiving care became evident in the responses to define physiological birth. Many of the participants highlighted that maintaining the connection to 'natural' occurred in the absence of intervention:

> For me, physiological birth means having a natural birth from start to finish, spontaneous onset with, no intervention really. Like your body is supposed to do everything on its own. Including birthing the placenta as well. Rose, #9, woman/birthing person, VIC

> I think about it as the body doing what it's made to do. A physiological process, in the absence of any pathology. So a normal and natural process without interventions, that [could] disrupt. Hazel, #4, midwife, VIC

And that 'natural' birth was linked to how women may have birthed in the past:

> [It's] how our great grandmothers would have birthed back in the day. Hazel, #4, midwife, VIC

Women and midwives also highlighted the importance of having support in the birthing space to facilitate physiological birth:

> Your partners and your people around you. And that impacts some of your decisions, too, on what interventions you will have or not have. Rose, #9, woman/birthing person, VIC

> I think it's very important to have a doctor and midwife. Because even though birth is meant to be natural and physiological, there are still things that can go wrong… And you know, if there weren't people around to help, then you could have complications. Chloe, #10, woman/birthing person, VIC

All three women/birthing persons shared their experiences of birth in the focus groups, noting that they considered themselves 'lucky'.

> My births were pretty straightforward. Which was lucky, I think. Chloe, #10, woman/birthing person, VIC

> Luckily, I had a very fast labour, so didn't have much time to think about what the hospital setting was going to do. I need[ed] to make a quite scary journey in a car, to a place that has bright lights, and people asking me questions- people I don't know- in an environment that doesn't feel safe in comparison to your own home. And so, it has started to play on my mind the idea of a physiological birth… Can it happen in a hospital setting? Hannah, #8, woman/birthing person, NSW

…They wanted to induce me. And I said, 'Yeah, Yeah, that's fine'… and fortunately I did just go into labour with both of them and had them both before any induction. Rose, #9, woman/birthing person, VIC

Theme 2: elements of decision

As the focus groups progressed, the factors that establish choice in the labouring process were discussed, with maternal preference and birth preparation being seen as key components to decision-making in labour and birth, especially in physiological birth.

It depends on what the woman wants. Emily, #2, midwife, QLD

It does come back to education at the end of the day. Antenatal education. To get proper informed consent…talk women through their options and what they can and can't do through labour. When we're talking about 'choice' people don't always know their options. Elsa, #5, midwife, VIC

The participants emphasised the importance of individual choice and autonomy in the labouring process and the need for healthcare providers to respect and support women's preferences and decisions during childbirth. However, informed decision-making was seen as a challenge from all perspectives, due to the culture of hospital-based maternity care.

You find out more about people's perspectives by asking them, and I think we're pretty bad at it. Jane, #6, obstetric doctor, VIC

I think if you want interventions, you don't usually have any issues getting them. Rose, #9, woman/birthing person, VIC

They don't know they can decline certain interventions because it's not always offered as an option. We don't always explain the benefits and the risks to everything we do which we should be doing. Elsa, #5, midwife, VIC

I think it's a bit of a sad reflection on our birthing culture. That- that we've got to the point where women feel like they have to ask permission to do what they want. We need to support women to do whatever they want to do. And I think… we sometimes find it challenging to separate what we think someone should do, versus what they want to do. Hazel, #4, midwife, VIC

Theme 3: challenges in the birthing setting

An inherent distrust of physiological birth by care providers and women was perceived to lead to more intervention in labour and birth, supported by a lack of exposure to physiological birth in the hospital.

There's no way I've ever seen a physiological birth- like; working in a hospital…I've been doing this for 3 1/2 years. I've only seen 2 physiological third stages. Gaia, #1, midwife, NSW

I've never heard someone be like, 'Oh yeah…. I've had a full physiological birth from start to finish', like; I don't think anyone's had that story. Chloe, #10, woman/birthing person, VIC

Working in a hospital system, we're confined to policies and procedures. Elsa, #5, midwife, VIC

Other midwives echoed this sentiment with a discussion of ineffective hospital policies or 'red-tape' restricting care that promotes physiological birth, favouring a risk-management approach to birth.

If you want an intervention-free birth or physiological birth the safest way for you to do that is to stay at home as long as possible. Because, like when you come in, we're gonna be all over you. Gaia, #1, midwife, NSW

So if it's a low-risk woman [labouring] spontaneously, when she arrives within the first hour, it does say 'offer' a vaginal examination, and then four hourly, thereafter… it tells you what to expect…what is 'slow progress' and what's 'good progress'… That's the guidelines that we work within. Emily, #2, midwife, QLD

One of the midwives in the focus groups discussed a conflict of philosophy when approaching physiological birth, among obstetric doctors and midwives:

Only in the recent times where we've had more obstetric input into birthing, we're starting to see more medical [births] and we've started to look at birthing as being a risky thing.

We've started to look at birthing as it's something that we need to save women from. Hazel, #4, midwife, VIC

The doula in the focus group agreed that a risk management approach to labour and birth care had become more commonplace in hospital births.

I have had my own children, so I look back now and think I was actually one of the lucky ones that got out of it. Scott-free. No major dramas or interventions. I think it's getting worse now though…. it's a lot more monitored now. Like straight away onto the CTG (cardiotocography) and getting a VE (vaginal examination). [To] see where you're at… Aria, #7, doula, VIC

A consensus statement about 'physiological birth'

As the focus groups progressed, many participants felt that the term 'physiological birth' was not a term used by women: it could also be contentious, and undermine the experience of birth for women.

I think you need to be really careful about exchanging physiological and normal and natural- like; they don't mean the same things- and it's really dangerous to confuse them. Jane, #6, obstetric doctor, VIC

The only time that I ever had people specifically talking about physiological birth to me was when I did like [the] hypnobirthing course. I would say that regular people aren't using the term. Chloe, #10, woman/birthing person, VIC

I feel like it could be a sensitive topic for women. Women [have] gone in with expectations of how they wanted things to go, and then they didn't get their physiological birth. It could be quite triggering for some women. Ellen, #3, midwife, SA

And that the understanding of 'physiological birth', would be difficult to generalise to the Australian context, as it can be influenced by cultural and contextual factors.

The way that people have given birth differs from state to state, and place to place. And so location, and what people have access to might change their perspectives on what a 'physiological birth' is in their culture… their background might also change how they define and consider physiological birth. Rose, #9, woman/birthing person, VIC

In the interview, it was also noted that a revision of 'physiological birth' has its challenges.

I understand that it's important for some women to walk away saying 'they had a physiological birth'. It has social status. It has implications for mental health…it's an important thing for some people to be able to say. But I also think you can't change the definition of words to suit your social standing. Jane, #6, obstetric doctor, VIC

The question of what should be included in a consensus statement of physiological birth was discussed. Participants agreed that 'spontaneous onset', 'spontaneous delivery/birth', 'vaginal birth' and 'minimal intervention' should be included, but cited that 'minimal intervention' was difficult to include, without first defining the term, "intervention".

Most participants agreed that 'low-risk' should not be included, but that it also inherently described 'physiological birth'.

> What is an intervention? Does it have to be a good intervention? A bad intervention? What about clary sage? Like, is that an intervention? I just don't think that word describes what people intend for it to mean. Jane, #6, obstetric doctor, VIC

> I would lean more towards minimal intervention or low intervention…but then- that's hard, too, because that's hard to define, I suppose… what is a minimal intervention. Rose, #9, woman/birthing person, VIC

> And I thought particularly the removal of low risk. Because women with all risk can have a physiological birth. Emily, #2, midwife, QLD

There was also confusion with the inclusion of 'gestational term' in a revision of 'physiological birth';

> …I think that the idea of 'term' describes a statistical phenomenon… I think the idea of 'full-term' is a work in progress. Jane, #6, obstetric doctor, VIC

> For a woman that spontaneously goes into labour at 35, 36 weeks. Her body, you know, has [done] what we are defining, a physiological birth, and the baby's fine. She's fine. Her body and her baby have chosen to deliver, and you know- is that physiological for her? Isn't that when her baby was meant to be born? Hazel, #4, midwife, VIC

Discussion

This novel study explored the contemporary understanding of physiological birth from the perspective of women/birthing persons, maternity care providers and a doula, and has highlighted key terms and elements for a consensus statement of physiological birth for the Australian setting. By exploring the experiences of care providers and women, the data demonstrates that the understanding of 'physiological birth' varies by profession. While there is some agreement on certain elements of 'physiological birth' much remains contentious. This study is one of a few to incorporate perspectives from midwives, obstetricians, doulas, and birthing persons in shaping the definition of 'physiological birth.'

Physiological birth: A link to the past

Midwives, women, and doulas placed great importance on the 'natural', associating it with past generations, while the obstetric doctor preferred a more scientific view. The research findings support existing literature addressing the competing values in the Australian birth setting (Adams et al., 2017). Describing physiological birth in the context of 'how our grandmothers' and 'ancestors' birthed shows that those involved in birth look to the past for examples of physiological birth, extending to the complexity of culturally safe birthing in the present (Yuill et al., 2020). It was noted that advances in medical practices and technology are an important element of safe birthing in Australia and having trained professionals such as obstetric doctors and midwives is integral to supporting a safe birth, physiological or otherwise, a view well supported by Australian research literature (Faktor et al., 2024).

The element of 'luck'

While discussing physiological birth participants recounted their own birthing experiences, sharing personal details, and highlighting that no birth was the same. Participants emphasised that personalised care, centred on the woman and her family, through shared decision-making, was essential to a positive labour and birth experience. In Australian maternity, this view is carried through continuity of care models, regardless of birthing outcome (Bradford et al., 2022; Fox et al., 2023). Conversely, all the women who shared their experience viewed it as 'lucky'. This choice of wording suggests an underlying perception that a low intervention birth is a rare or exceptional within the broader Australian maternity system. The framing of physiological birth as a matter of luck implies that, for many women, achieving such an experience depends on factors beyond their control. This sense of randomness or fortuity reflects broader systemic issues, where standard maternity care pathways may not routinely facilitate low-intervention birth. National statistics support this perception, indicating that a low-intervention birth, or unassisted vaginal birth, is not the norm (Australian Institute of Health and Welfare, 2023). Participant emphasis on luck reveals a dissonance between the ideal of personalised, empowering care and the realities many women face in navigating the Australian maternity care system.

Without intervention

Statements from midwives show that 'physiological birth' skills and knowledge are being lost through a lack of exposure to physiological birth, and a shifting normality threshold, favouring a risk-management approach to labour and birth rather than a physiological approach (Prosser et al., 2018). This shift in maternity care in Australia sidelines the philosophy of physiological birth, which in turn, can deprive women of the experience. Participants highlighted that physiological birth occurs 'without intervention', however, all participants also agreed that what constitutes an intervention is inherently ambiguous. The perception of risk in labour and birth and its effect on the use of intervention and technology has emerged from an assumption of abnormality (Healy et al., 2016). Risk culture that interprets birth as 'abnormal' can affect how maternity services manage birth, resulting in the ongoing deskilling of midwives, and diminish autonomy in otherwise normal birth (Copeland et al., 2014).

Support in the birthing space to facilitate physiological birth and create a safe environment was highlighted as a protective factor for physiological birth. Integrating support person/s in maternity care through providing a specific role in labour and birth, such as decision-making support, can improve communication in the birthing space between the care provider and birthing person, and improve maternal satisfaction (Nakphong et al., 2023). Doulas have been shown to enhance respectful care and support relationships with care providers (Khaw et al., 2023). Having advocates of physiological birth may reduce the likelihood of interventions promoting a more physiological approach to birth.

Birth preparation

Birth preparation and maternal preference were major factors of decision-making in physiological birth, and participants noted that better antenatal education was needed to support physiological birth. Antenatal education has been shown to lower rates of fear of childbirth (Karabulut et al., 2016), and lower rates of intervention (Ferri et al., 2024; Levett et al., 2016). Motivators for attending antenatal education classes in Australia include women who want to 'better manage the birth' and 'feel more secure as a parent' (Lewis-Jones et al., 2023). Notably, in their study, women who attended psychoprophylaxis classes utilised more non-pharmaceutical pain-relief techniques in labour, in line with a physiological approach to labour, than those who attended birth and parenting classes (Lewis-Jones et al., 2023). The midwives and women/birthing persons in our study felt that the antenatal period was the appropriate time to gain informed consent and provide education for labour and birth, to prevent women coming into labour unprepared.

All participants in this study felt that maternal preference was an important part of birth, physiological or otherwise, including having an appropriate birth space, support in labour, and advocacy based on respectful decision-making and what the birthing person wants.

Ineffective hospital policy

Midwives and women/birthing persons acknowledged a fear-based narrative around childbirth, and that 'red tape' within the hospital setting could challenge maternal choice. An inherent distrust of physiological birth was viewed as routine in hospital policy, affecting the midwives' ability to promote physiological birth philosophy. Midwives and the doula in this study provided examples of restricted access to water immersion in labour, and interventions such as cardiotocography and vaginal examination, being conducted on a set timeframe rather than clinical presentation. These contextual influences point towards the documented fragmented and policy-driven medical models of care within the hospital setting that can affect the midwives' ability to be 'with woman' in Australia (Bradfield et al., 2018; Kloester et al., 2023; Watkins et al., 2023).

The terms in physiological birth

Physiological birth was considered to not be a 'woman's term' in this study, with women/birthing persons stating it was not used commonly, and that they had only heard of the term through self-taught means such as Hypnobirthing classes (Phillips-Moore, 2012; White, 2007), rather than their care providers. Physiological birth was considered a concept that could mean different things to different people, based on their cultural background, and location within Australia. The important elements to embrace in a consensus statement about physiological birth included 'spontaneous onset', 'spontaneous delivery/birth', and the notion of 'low intervention'.

'Gestational term' was contentious, as most participants felt that 'physiological birth' could occur at any gestation, even if the cause of labour was pathologic. Within the research literature, 'gestational term' is well documented with decades of research reviewing neonatal and childhood outcomes based on gestation (Gleason et al., 2022; Lee et al., 2013; Spong, 2013).

Within this study, respect for the woman, her wants in labour and birth, recognition of the hormonal, physical and emotional changes the woman undergoes to birth, and informed consent were viewed as integral for physiological birth, emphasising the well-documented need for shared decision-making in maternity care (Poprzeczny et al., 2020; Shinkunas et al., 2020). These ideals may have a place in a consensus statement about physiological birth for the Australian setting.

Strengths and limitations

As one of a few studies to approach physiological birth from both professional and non-professional perspectives, this study addresses the existing knowledge gap in understanding 'physiological birth' in contemporary Australian maternity care. The COREQ guidelines, data triangulation and an audit trail were used to ensure transparent credible findings. Participants were recruited through the survey component of the PRIMROSE Project, utilising snowballing sampling and social media. This may have contributed to a homogenous sample: Caucasian females with Australian or English backgrounds. To participate in the focus groups and interview, participants required adequate internet connection and access to a computer, unintentionally exclude potential participants. Prior involvement in earlier stages of the project may have introduced confirmation bias, potentially influencing responses and limiting transferability of the findings. Participant credentials were unable to be verified. Only one obstetrician and one doula contributed to this study, so their perspectives may not be representative, potentially affecting evidence sufficiency (LaDonna et al., 2021). The researchers of this project are all midwives and as such, are influenced by the 'Midwife Standards of Practice' which promote physiological birth (Nursing and Midwifery Board of Australia 2018). While conscious attempts to bracket these views were made during data collection and analysis, it is acknowledged that these views may have influenced the findings (Mays and Pope, 1995). While focus groups provide rich and insightful data, conducting them using videoconferencing limits body language observation, as often only the participant's face or upper body is visible (Nobrega et al., 2021). The sample size and data richness can be considered appropriate for a qualitative descriptive study (Vasileiou et al., 2018) however, it cannot be considered broadly representative.

Conclusion

Physiological birth, shaped by both practice and perception, influences the experiences of women and healthcare providers. Trust in birth as an instinctive process was viewed as an important element of physiological birth, yet restrictive policies could undermine a physiological approach to labour and birth care. While participants agreed that 'spontaneous onset', 'spontaneous delivery/birth', and 'vaginal birth' were essential, 'minimal intervention' required clearer definition. Most rejected 'low-risk', though it was seen as implicit, and the inclusion of 'gestational term' in a revised statement of physiological birth remained contested.

Ethical statement

This research project has been approved by the La Trobe University Human Ethics Committee (Ethics approval number HEC23252) on 21/08/2023.

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CRediT authorship contribution statement

Brooke.I. Henshall: Writing – review & editing, Writing – original draft, Validation, Software, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Heather.A. Grimes:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Jennifer Davis:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization. **Christine.E. East:** Writing – review & editing, Supervision, Project administration, Methodology, Investigation, Formal analysis, Data curation, Conceptualization.

Declaration of competing interest

I declare and agree the following; that the article is the author(s) original work the article has not received prior publication and is not under consideration for publication elsewhere that all authors have seen and approved the manuscript being submitted the author(s) abide by the copyright terms and conditions of Elsevier

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.midw.2025.104617.

Appendix 1. Coding template

First-order Codes	Second-order Codes	Aggregate themes	Illustrative Quotes
A natural process, uninterrupted by intervention Trusting the natural process of labour and delivery Traditional birthing methods of past generations Recognising birth as normal rather than a medicalised event	Instinctive labour and birth	Connection to the natural process of birth	"We trust our bodies to do all the other physiological things. We breathe, our heart beats, we go to the toilet, and we don't question it. So physiological birth is just what our bodies are made to do. Trusting the natural process of labour and delivery." Hazel, #4, midwife, VIC
Sanctuary/Protected space in labour Caring role from support people and midwives	Importance of support		"Having the person they want in their birth space. Whether they choose to have a doula or a midwife, or nobody." Emily, #2, midwife, QLD There have always been little things that birth attendants will do to keep a birth on course, whether that's positioning or encouraging movement. Hannah, #8, woman/birthing person, NSW
Maternal preferences	Choice	Elements of decision	"Where do women feel safe? I felt very safe in a hospital, [where] I had physiological births. I remember going into hospital feeling relieved; to be like, 'Oh, I'm in the hospital now. I'm safe. Great! I can just get on with it".- Hazel, #4, midwife, VIC "I think that people are unprepared… I've had a few friends who've been like, 'I'm just going to go to the hospital and let the doctors tell me what I need to do'"- Chloe, #10, woman/birthing person, VIC
Embracing technology Choice in birth and alternatives for pain relief and interventions			"I was doing acupuncture, and I was walking like crazy, and I was doing every spinning baby's position possible. I was drinking the raspberry leaf tea, and I was eating the dates. And… so I think, when we're defining intervention or even implying anything to the labour and birth process, it becomes really blurry about what is natural" Hannah, #8, woman/birthing person, NSW.
Autonomy Education in physiological birth			"Sometimes in the birth setting, [its] not always the best time to discuss pain relief options; that should all be done antenatally, to give women all the choices and options, so they can ask as they need it."- Elsa, #5, midwife, VIC
Exposure to physiological birth			"How many women do we see in a hospital setting, who come in spontaneous labour, heading toward a physiological birth and lay themselves flat on the bed, and then go; 'Oh, gosh! This is painful and very hard to deal with' because that's where they think they should be-not because someone has said so, but because the birth space dictates it, or that's what they've seen in movies." Hannah, #8, woman/birthing person, NSW
Red Tape	Normality threshold		"I think we do forget to trust our instincts. We forget to encourage women to trust their own intuition, which is a huge thing."- Elsa, #5, midwife, VIC
Fear-based narrative around childbirth Interruption			"The line between physiological and pathophysiological is a very blurry one that we often can't see." Jane, #6, obstetric doctor, VIC
Respect and recognition that each experience in unique and personal	Balance and imbalances		
Widespread use of medical interventions	Provider bias and attitudes: Medical intervention	Challenges in the birthing setting	"Unfortunately, people don't always have choices with their labour and their birth. Because we've got so many policies that restrict. If somebody wants to hop in the water, that's not a choice for every woman. Because we've got so, so much red tape around who is 'allowed' and what we will 'let' women do." Ellen, #3, midwife, SA
Fighting a system that supports intervention			"It's very hard for women these days to trust their bodies and their babies… we offer all these interventions, particularly when we get to term…not many women get to go over 41 weeks these days. Which is such a shame because we are missing out on so many potential physiological births." Elsa, #5, midwife, VIC
Prejudice and prerogative Institutional practice norms and reluctant acceptance Guardians of physiological birth			"I think unless someone is striving to have a physiological birth, I don't think that it happens" Chloe, #10, woman/birthing person, VIC
Physiological Birth: A Loaded word	Interpretation		

References

Adams, C., Dawson, A., Foureur, M., 2017. Competing values framework: a useful tool to define the predominant culture in a maternity setting in Australia. Women Birth 30 (2), 107–113. https://doi.org/10.1016/j.wombi.2016.09.005.

Australian Government. (2024). *Nurses and midwives.* Retrieved 1 November 2024 from https://www.health.gov.au/topics/nurses-and-midwives/about#:~:text=A%20midwife%20is%20a%20registered,first%20few%20weeks%20after%20birth.

Australian Institute of Health and Welfare, 2023. Australia's Mothers and Babies. Australian Government. Retrieved 13 April 2024 from. https://www.aihw.gov.au/reports/mothers-babies/australias-mothers-babies/contents/summary.

Bohren, M.A., Hofmeyr, G.J., Sakala, C., Fukuzawa, R.K., Cuthbert, A., 2017. Continuous support for women during childbirth. Cochrane Database System Rev 7 (7), CD003766. https://doi.org/10.1002/14651858.CD003766.pub6.

Bradfield, Z., Duggan, R., Hauck, Y., Kelly, M., 2018. Midwives being 'with woman': an integrative review. Women Birth 31 (2), 143–152. https://doi.org/10.1016/j.wombi.2017.07.011.

Bradford, B.F., Wilson, A.N., Portela, A., McConville, F., Fernandez Turienzo, C., Homer, C.S.E., 2022. Midwifery continuity of care: a scoping review of where, how, by whom and for whom? PLOS Glob. Public Health 2 (10), e0000935. https://doi.org/10.1371/journal.pgph.0000935.

Brady, S., Gibbons, K.S., Bogossian, F., 2024. Defining woman-centred care: a concept analysis. Midwifery 131, 103954. https://doi.org/10.1016/j.midw.2024.103954.

Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., Neville, A.J., 2014. The use of triangulation in qualitative research. Oncol. Nurs. Forum 41 (5), 545–547. https://doi.org/10.1188/14.Onf.545-547.

Cleary, M., Horsfall, J., Hayter, M., 2014. Data collection and sampling in qualitative research: does size matter? J. Adv. Nurs. 70 (3), 473–475. https://doi.org/10.1111/jan.12163.

Copeland, F., Dahlen, H.G., Homer, C.S., 2014. Conflicting contexts: midwives' interpretation of childbirth through photo elicitation. Women Birth 27 (2), 126–131. https://doi.org/10.1016/j.wombi.2013.11.004.

Department of Health. (2018). *Australia's future health workforce – obstetrics and gynaecology*. Retrieved 1 November 2024 from https://www.health.gov.au/sites/default/files/documents/2021/03/obstetrics-and-gynaecology-australia-s-future-health-workforce-report.pdf.

Doyle, L., McCabe, C., Keogh, B., Brady, A., McCann, M., 2020. An overview of the qualitative descriptive design within nursing research. J. Res. Nurs. 25 (5), 443–455. https://doi.org/10.1177/1744987119880234.

Faktor, L., Small, K., Bradfield, Z., Baird, K., Fenwick, J., Gray, J.E., Robinson, M., Warton, C., Cusack, S., Homer, C.S.E., 2024. What do women in Australia want from their maternity care: a scoping review. Women Birth 37 (2), 278–287. https://doi.org/10.1016/j.wombi.2023.12.003.

Ferri, A., Levett, K.M., Sutcliffe, K.L., Catling, C., Newman, E., 2024. Antenatal education – putting research into practice: a guideline review. Midwifery, 103960. https://doi.org/10.1016/j.midw.2024.103960.

Fox, D., Scarf, V., Turkmani, S., Rossiter, C., Coddington, R., Sheehy, A., Catling, C., Cummins, A., Baird, K., 2023. Midwifery continuity of care for women with complex pregnancies in Australia: an integrative review. Women Birth 36 (2), e187–e194. https://doi.org/10.1016/j.wombi.2022.07.001.

Gleason, J.L., Gilman, S.E., Sundaram, R., Yeung, E., Putnick, D.L., Vafai, Y., Saha, A., Grantz, K.L., 2022. Gestational age at term delivery and children's neurocognitive development. Int. J. Epidemiol. 50 (6), 1814–1823. https://doi.org/10.1093/ije/dyab134.

Green, J., Willis, K., Hughes, E., Small, R., Welch, N., Gibbs, L., Daly, J., 2007. Generating best evidence from qualitative research: the role of data analysis. Aust. N. Z. J. Public Health 31 (6), 545–550. https://doi.org/10.1111/j.1753-6405.2007.00141.x.

Grønkjær, M., Curtis, T., de Crespigny, C., Delmar, C., 2011. Analysing group interaction in focus group research: impact on content and the role of the moderator. Qual. Stud. 2, 16–30.

Hall, H., Fooladi, E., Kloester, J., Ulnang, A., Sinni, S., White, C., McLaren, M., Yeganeh, L., 2022. Factors that promote a positive childbearing experience: a qualitative study. J. Midwifery Womens Health. https://doi.org/10.1111/jmwh.13402.

Healy, S., Humphreys, E., Kennedy, C., 2016. Midwives' and obstetricians' perceptions of risk and its impact on clinical practice and decision-making in labour: an integrative review. Women Birth 29 (2), 107–116. https://doi.org/10.1016/j.wombi.2015.08.010.

Henshall, B.I., Grimes, H.A., Davis, J., East, C.E., 2024a. What is 'physiological birth'? A scoping review of the perspectives of women and care providers. Midwifery 132, 103964. https://doi.org/10.1016/j.midw.2024.103964.

Henshall, B.I., Grimes, H.A., Davis, J., East, C.E., 2025b. The PRIMROSE Project: what is 'physiological birth'? A quantitative approach to the perceptions of the Australian population. Midwifery, 104375. https://doi.org/10.1016/j.midw.2025.104375.

Karabulut, Ö., Coşkuner Potur, D., Doğan Merih, Y., Cebeci Mutlu, S., Demirci, N., 2016. Does antenatal education reduce fear of childbirth? Int. Nurs. Rev. 63 (1), 60–67. https://doi.org/10.1111/inr.12223.

Khaw, S.M.-L., Homer, C.S.E., Dearnley, R.E., O'Rourke, K., Akter, S., Bohren, M.A., 2023. A qualitative study on community-based doulas' roles in providing culturally-responsive care to migrant women in Australia. Women Birth 36 (5), e527–e535. https://doi.org/10.1016/j.wombi.2023.04.003.

Kloester, J., Brand, G., Willey, S., 2023. How midwives facilitate informed decisions in the third stage of labour – an exploration through portraiture. Midwifery 127, 103868. https://doi.org/10.1016/j.midw.2023.103868.

LaDonna, K.A., Artino Jr., A.R., Balmer, D.F, 2021. Beyond the guise of saturation: rigor and qualitative interview data. J. Gr. Med. Educ. 13 (5), 607–611. https://doi.org/10.4300/jgme-d-21-00752.1.

Lee, A.C., Katz, J., Blencowe, H., Cousens, S., Kozuki, N., Vogel, J.P., Adair, L., Baqui, A. H., Bhutta, Z.A., Caulfield, L.E., Christian, P., Clarke, S.E., Ezzati, M., Fawzi, W., Gonzalez, R., Huybregts, L., Kariuki, S., Kolsteren, P., Lusingu, J., Black, R.E., 2013. National and regional estimates of term and preterm babies born small for gestational age in 138 low-income and middle-income countries in 2010. Lancet Glob. Health 1 (1), e26–e36. https://doi.org/10.1016/s2214-109x(13)70006-8.

Levett, K.M., Smith, C.A., Bensoussan, A., Dahlen, H.G., 2016. Complementary therapies for labour and birth study: a randomised controlled trial of antenatal integrative medicine for pain management in labour. BMJ Open 6 (7). https://doi.org/10.1136/bmjopen-2015-010691.

Lewis-Jones, B., Nielsen, T.C., Svensson, J., Nassar, N., Henry, A., Lainchbury, A., Kim, S., Kiew, I., McLennan, S., Shand, A.W., 2023. Cross-sectional survey of antenatal education attendance among nulliparous pregnant women in Sydney, Australia. Women Birth 36 (2), e276–e282. https://doi.org/10.1016/j.wombi.2022.08.003.

Mays, N., Pope, C., 1995. Qualitative research: rigour and qualitative research. Bmj 311 (6997), 109–112.

Nakphong, M.K., Afulani, P.A., Opot, J., May, S., 2023. Access to support during childbirth?: women's preferences and experiences of support person integration in a cross-sectional facility-based survey. BMC Pregnancy Childbirth 23, 1–14. https://doi.org/10.1186/s12884-023-05962-2.

Nobrega, S., El Ghaziri, M., Giacobbe, L., Rice, S., Punnett, L., Edwards, K., 2021. Feasibility of virtual focus groups in program impact evaluation. Int. J. Qual. Methods 20. https://doi.org/10.1177/16094069211019896.

Nursing and Midwifery Board of Australia. (2018). *Midwife standards for practice*. Retrieved 3rd April 2023 from https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/Midwife-standards-for-practice.aspx.

NVivo. (2018). NVivo qualitative data analysis software (version 12, 2018) computer software.

Nyumba, T., Wilson, K., Derrick, C.J., Mukherjee, N., 2018. The use of focus group discussion methodology: insights from two decades of application in conservation. Methods Ecol. Evol. 9 (1), 20–32. https://doi.org/10.1111/2041-210X.12860.

Phillips-Moore, J., 2012. Birthing outcomes from an Australian HypnoBirthing programme. Br. J. Midwifery 20 (8), 558–564. https://doi.org/10.12968/bjom.2012.20.8.558.

Poprzeczny, A.J., Stocking, K., Showell, M., Duffy, J.M.N., 2020. Patient decision aids to facilitate shared decision making in obstetrics and gynecology: a systematic review and meta-analysis. Obs. Gynecol. 135 (2), 444–451. https://doi.org/10.1097/aog.0000000000003664.

Prosser, S.J., Barnett, A.G., Miller, Y.D., 2018. Factors promoting or inhibiting normal birth. BMC Pregnancy Childbirth 18 (1), 241. https://doi.org/10.1186/s12884-018-1871-5.

Sandelowski, M., 2010. Qualitative description revisited. Res. Nurs. Health 33 (1), 77–84. https://doi.org/10.1002/nur.20362.

Shinkunas, L.A., Klipowicz, C.J., Carlisle, E.M., 2020. Shared decision making in surgery: a scoping review of patient and surgeon preferences. BMC Med. Inf. Decis. Mak. 20 (1), 190. https://doi.org/10.1186/s12911-020-01211-0.

Spong, C.Y., 2013. Defining "term" pregnancy: recommendations from the defining "term" pregnancy workgroup. Jama 309 (23), 2445–2446. https://doi.org/10.1001/jama.2013.6235.

Tong, A., Sainsbury, P., Craig, J., 2007. Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. Int. J. Qual. Health Care 19 (6), 349–357. https://doi.org/10.1093/intqhc/mzm042.

Vasileiou, K., Barnett, J., Thorpe, S., Young, T., 2018. Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period. BMC Med. Res. Methodol. 18 (1), 148. https://doi.org/10.1186/s12874-018-0594-7.

Watkins, V., Nagle, C., Yates, K., McAuliffe, M., Brown, L., Byrne, M., Waters, A., 2023. The role and scope of contemporary midwifery practice in Australia: a scoping review of the literature. Women Birth 36 (4), 334–340. https://doi.org/10.1016/j.wombi.2022.12.001.

White, K., 2007. HypnoBirthing: the Mongan method. Aust. J. Clin. Hypnother. Hypn. 28 (2), 12–24. https://proquest.com/scholarly-journals/hypnobirthing-mongan-method/docview/228262377/se-2.

Willig, C., 2013. Introducing Qualitative Research in Psychology. McGraw-hill education, UK).

Wolf, Z.R., 2003. Exploring the audit trail for qualitative investigations. Nurse Educ. 28 (4), 175–178. https://doi.org/10.1097/00006223-200307000-00008.

World Health Organization, 1997. Care in normal birth: a practical guide: report of a technical working group. Maternal and Newborn Health/Safe Motherhood Unit, Family and Reproductive Health. World Health Organization.

Yuill, C., McCourt, C., Cheyne, H., Leister, N., 2020. Women's experiences of decision-making and informed choice about pregnancy and birth care: a systematic review and meta-synthesis of qualitative research. BMC Pregnancy Childbirth 20, 1–21. https://doi.org/10.1186/s12884-020-03023-6.