

Delivering Discourse: How Flemish First-Time Mothers Engage with Medicalized Discourse in Narrating their Birth

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Abstract

Childbirth represents a paradigmatic case of medicalization. Yet second-generation medicalization theories, which emphasize greater patient involvement in healthcare, are less evident in obstetric care. The micro-discursive processes through which women engage with medicalized discourse, which could enhance our understanding of this, remain both theoretically and empirically underexplored. This thesis aims to address this gap by examining how women engage with medicalized discourse in their birth narratives, and how subject positions and power relations are articulated within this process. Thirteen semi-structured, in-depth interviews centered on women's birth experiences were conducted with Flemish women who had given birth within three months prior to the interview. The data were analyzed using Fairclough's three-dimensional framework for Critical Discourse Analysis. The findings indicate that each birth narrative reflected a coherent pattern of interdiscursivity, of which three distinct patterns were identified. In the first pattern, which characterized the majority of the narratives, medicalized discourse was predominant, and respondents constructed themselves as patients of medical care. In the second pattern, both medicalized and alternative discourses were articulated; however, the latter remained confined to more personal domains of experience, while the former narrated performed medical-obstetric care. In the third and least prevalent pattern, a midwifery-oriented discourse was mostly drawn upon, through which medicalized discourse became an explicit object of critique. Across all patterns, an epistemic hierarchy emerged in which biomedical knowledge was privileged over women's embodied forms of knowledge, thereby appearing to constrain women's perceived possibilities for participation in obstetric decision-making. These findings illustrate women's reflexive, discursive engagement with medicalized discourse, reproducing medicalized understandings of birth to different degrees. Agency in obstetric practice seemed more narrowly bounded by interactional and institutional dynamics sustaining the epistemic hierarchy. Overall, results underscore both the multidimensional and multilevel character of medicalization processes and their pervasive nature, as no narrative reflected a complete distancing from all dimensions of medicalization processes.

Key words: medicalization; childbirth; birth narratives; critical discourse analysis; medicalized discourse; obstetric care; interdiscursivity

Abstract (NL)

Bevalling vormt een paradigmatisch voorbeeld van medicalisering. Toch zijn tweede-generatie medicaliseringstheorieën, die een grotere betrokkenheid van patiënten bij hun gezondheidszorg benadrukken, minder zichtbaar binnen de obstetrische zorg. De micro-discursieve processen waarmee vrouwen zich verhouden tot medicaliserend discours, die ons begrip hiervan zouden kunnen verdiepen, blijven zowel theoretisch als empirisch onderbelicht. Deze masterproef beoogt meer hierinzicht over te verwerven door te onderzoeken hoe vrouwen beroep doen op medicaliserend discours in hun bevallingsverhalen, en welke subjectposities en machtsverhoudingen daarbinnen worden gearticuleerd. Dertien semigestructureerde, diepte-interviews gericht op de bevallingservaringen van vrouwen werden afgenomen met Vlaamse vrouwen die in de drie maanden voorafgaand aan het interview bevallen waren. De data werden geanalyseerd aan de hand van Fairclough's driedimensionaal model voor Kritische Discoursanalyse. De bevindingen tonen aan dat elk bevallingsverhaal een coherent patroon van interdiscursiviteit weerspiegelde, waarvan drie afzonderlijke patronen werden geïdentificeerd. In het eerste patroon, dat de meerderheid van de verhalen kenmerkte, was gemedicaliseerd discours dominant en construeerden respondenten zichzelf als patiënten van de medische zorg. In het tweede patroon werden zowel gemedicaliseerd als alternatief discours gearticuleerd; het laatste bleef echter beperkt tot meer persoonlijke ervaringsdomeinen, terwijl het eerste de uitgevoerde medisch-obstetrische zorg beschreef. In het derde en minst frequente patroon werd voornamelijk een op verloskunde georiënteerd discours ingezet, waarmee gemedicaliseerd discours een expliciet object van kritiek werd. Doorheen alle patronen tekende zich een epistemische hiërarchie af waarin biomedische kennis werd bevoorrecht boven de belichaamde kennisvormen van vrouwen, waardoor de ervaren mogelijkheden voor participatie in obstetrische besluitvorming lijken te worden ingeperkt. Deze bevindingen illustreren de reflexieve, discursieve omgang van vrouwen met medicaliserend discours, waarbij gemedicaliseerde opvattingen over bevalling in verschillende mate worden gereproduceerd. De handelingsruimte in de verloskundige praktijk leek nauwer begrensd door interactionele en institutionele dynamieken die de epistemische hiërarchie in stand houden. De resultaten onderstrepen zowel het multidimensionele en multilevel karakter van medicaliseringsprocessen als hun alomtegenwoordige aard, aangezien geen enkel verhaal een volledige distantiëring van alle dimensies van medicaliseringsprocessen weerspiegelde.

Sleutelwoorden: medicalisering; bevalling; bevallingsverhalen; kritische discoursanalyse; medicaliserend discours; verloskundige zorg; interdiscursiviteit

1 Introduction

Childbirth constitutes one of life's most existential events, marking a liminal space of one of the most significant biographical transitions in social roles that people can universally undergo. Less universal are the forms of care and meanings through which childbirth is practiced and experienced across time and space (Cheyney & Davis-Floyd, 2022; Sharma et al., 2016). In the past century, childbirth in the Global North has undergone profound medicalization (Clesse et al., 2018). In Britain, for instance, only a century ago 15% of women¹ gave birth in a hospital, rising to 99% by 1990 (Loudon, 2008; Oakley, 2016). These developments are not historically isolated but are embedded in a broader shift in the logic of late modernity, where risks are understood as manageable through expertise and technology rather than as hazards outside human control (Beck, 1992; Scamell, 2014). Around the turn of the 21st century, second-generation medicalization literature describes changing power relations within healthcare, where patients became more informed and active in advocating for their rights, needs and preferences (Clarke et al., 2003; Conrad, 2005; Timmermans, 2020).

Rising movements to *patient-centered care*, embracing principles of respectful care and *shared decision-making*, have also been translated into the context of obstetric care as *woman-centered care* (Fontein-Kuipers et al., 2018). Despite its policy adoption, woman-centered care experiences difficulty in being implemented in practice (Gregory et al., 2025). Shared decision-making and informed consent remain insufficiently practiced in obstetric care, with evidence suggesting that in Belgian context about half of medical procedures lack informed consent (Kuipers et al., 2025; Plateforme Citoyenne pour une Naissance Respectée, 2021). Importantly, research shows that insufficient information provision, lack of informed consent, and disrespectful maternity care are associated with negative to traumatic birth experiences (Freestun et al., 2025), with documented consequences for maternal mental health, parent-infant attachment, and broader family wellbeing (Ahmadpour et al., 2023; Delicate et al., 2018; Seefeld et al., 2021). In light of this evidence, the World Health Organization has acknowledged the quality of women's experiences of maternity care as a global public health concern, noting that approximately one in three women worldwide experience their birth as traumatic (Ayers, 2024; World Health Organization [WHO], 2018).

Literature on medicalized discourse points towards how childbirth is collectively predominantly understood as inherently very risk-laden and requiring medical-technological assessment and management (Mauadie et al., 2022; Scamell, 2014). This constitutes unequal subject positions within obstetric care, positioning obstetric care providers as authoritative in handling birth, while a responsible mother is expected to remain compliant to medical care, which ultimately contradicts calls for women-centered-care (Healy et al., 2016; Mauadie et al., 2022). Both theoretical and empirical medicalization literature has devoted little attention to women's micro-discursive engagement with medicalized discourse on birth. Yet, gaining more understanding of how women personally engage with medicalized discourse to make sense of their birth experience, and how this engagement makes certain subject positions seem more available or restricted to them is a productive step forward to understanding of why the shift toward woman-centered care has proven resistant to practical realization.

This dissertation therefore aims to advance understanding of how the accounts of Flemish women who recently gave birth draw upon, negotiate and contest medicalized discourse at the level of language, subject positioning and interpersonal and institutional power dynamics.

¹ While the term 'women' or 'mother' is used throughout this thesis to refer to individuals with the biological capacity to conceive, experience pregnancy, and give birth, it is acknowledged that these capacities are not exclusive to people who identify as women. This terminology is adopted to maintain consistency with the reviewed literature, while it is not intended to exclude or diminish the gender diversity of people's reproductive experiences.

2 Literature Study

2.1 Conceptualization of Medicalization

Medicalization as a concept can be traced back to discussions in the works of Parsons and Foucault, yet it only became formally defined in the early 1970s through authors such as Zola and Illich (Oakley, 2016; Smeenk & Ten Have, 2003). Since then, various conceptualizations of medicalization have circulated within medical sociology, each emphasizing different dimensions of this process and building upon each other. Christiaens and van Teijlingen (2009) distinguish four conceptualizations and divide these into two generations (see Table 1). While these distinctions are not sharply delineated in practice, they provide a useful analytical framework.

Table 1

Integration of meanings and levels of medicalization

	1 st generation			2 nd generation	Example
	Origin (Freidson; Foucault)	Imperialism (Zola; Conrad)	Iatrogenesis (Conrad; Illich)	Optimalisation (e.g., Barilan; Clarke)	
Micro	-	Doctor-patient interaction	Social iatrogenesis	Individual bodies	Obstetrical vs. midwifery practice
Meso	Institutionalization of care	Institutional	Clinical iatrogenesis	-	Biomedical vs. women-oriented ideology
Macro	Professionalization	Conceptual	Structural iatrogenesis	Definition of normality	Medical versus social model

Note. From 'Four meanings of medicalization: childbirth as a case study' by W. Christiaens and E. van Teijlingen, 2009, *Salute e Società*, 8(2), p. 127. In the public domain.

Authors of the first generation of medicalization literature share an emphasis on medicalization as the expansion of medical authority, while also recognizing its potential limits. Within this body of work, three distinct conceptualizations of medicalization can be identified. The first concerns the emergence of the medical care model, through which medical knowledge expanded, medicine became institutionalized, and care increasingly professionalized (Christiaens & van Teijlingen, 2009). Within this conceptualization, Foucault (1963) analyses how medicine constitutes a distinct form of knowledge and power through *le regard médical*, the clinical gaze through which bodies become objects of medical knowledge, enabling surveillance and normalization. Foucault (1975, 1976) later extends this analysis by theorizing disciplinary mechanisms as part of broader relations of biopower, through which populations become objects of governance and regulation. In a similar vein, albeit with a different emphasis, Freidson (1970) conceptualizes medicalization as the growing professional dominance and institutional authority of medicine, including its capacity to define disease and treatment. Despite their different analytical lenses, both Freidson and Foucault highlight the institutionalization of medicine as a key precondition for the expansion of medical knowledge, enabling medicine to regulate and discipline bodies. This contributed to broader rationalization processes (Shilling, 1993) in which the body became increasingly viewed as a machine (e.g., Davis-Floyd, 2001; Martin, 2001). Within this framework, medical authority also gained moral legitimacy to define what is 'normal' or 'abnormal', and by extension 'desirable' and 'undesirable' (Christiaens & van Teijlingen, 2009).

The second theorization of medicalization, introduced by Conrad (1992) and Zola (1972), is *medical imperialism*. It refers to 'a process by which nonmedical problems become defined and treated as medical problems, usually

in terms of illnesses or disorders' (Conrad, 1992, p. 209). In this sense, medicalization captures the expansion of medical authority into an increasing range of everyday experiences and social behaviors, which come to be interpreted through the lens of health and illness and consequently fall within the domain of medical concern. Since medicine can be understood as an institution of social control, the expansion of medicalization also broadens the range of social behaviors that can be regulated and normalized through medical authority (Parsons, 1950; Zola, 1972).

A third dimension of medicalization focuses on *iatrogenesis*, developed by Illich (1976), and further incorporated by Conrad (1992). This concept captures the negative or health-damaging effects of increasing medical management, of which Illich distinguishes three types (Branckaerts, 1982; Illich, 1976). First, *clinical iatrogenesis* refers to adverse outcomes arising directly from medical interventions, such as treatment-related complications. Second, *social iatrogenesis* concerns the process by which framing human problems in medical terms obscures their social and political origins, thereby depoliticizing suffering and reinforcing the status quo (Branckaerts, 1982; Zola, 1972). Third, *structural iatrogenesis* refers to the erosion of individuals' capacity for self-care as dependence on medical systems increases. In this sense, iatrogenesis functions as a critical concept that foregrounds the limits of medical management, calling an ever-expanding reliance on medical solutions into question (Illich, 1976).

From the 1980s onward, a second generation of medicalization theories emerged, recognizing that power relations among actors in medical encounters had shifted with patients, insurers, pharmaceutical companies and governments gaining influence (Conrad & Leiter, 2004; Filc, 2006; Timmermans & Kolker, 2004). In the context of the U.S., Conrad (2005) argues that traditional physicians' authority has become less central, while biotechnology (specifically the pharmaceutical industry and genetic research), along with consumers and managed care have emerged as key players. It should, however, be noted that this is only partly transferable to the context of Western Europe, where stronger state regulation and more universalist healthcare systems limit the market-driven dynamics observed in the U.S. (Ciulla et al., 2023). Alongside this, Clarke et al. (2003) argued that from the mid-1980s onward a new form of medicalization has emerged: *biomedicalization*. They argue that medical knowledge has been transformed through the rise of technoscience, the corporatization of healthcare and research, and increasingly decentralized forms of knowledge production beyond professional medicine. Consequently, medicine increasingly focuses on optimization, risk and surveillance, reshaping identities and bodies in socially stratified ways.

At the same time, critics have questioned the value of biomedicalization as a distinct concept. Busfield (2017) raises two main objections. First, she questions whether the changes since 1985 are substantial enough to mark a genuine break in American medical history, arguing that the distinctions Clarke et al. (2003) draw between the two eras are often asserted rather than demonstrated. Second, following Williams et al. (2008) and Conrad (2013), she contends that the framework casts too wide a net, ultimately obscuring rather than clarifying what medicalization itself means. For the purposes of this thesis, the term biomedicalization will therefore be reserved for contexts in which risk rationality, optimization or technological surveillance are specifically at issue, while medicalization serves as the broader umbrella concept.

These shifting power relations among actors in medicalization processes over time are also reflected in the gradual reshaping of doctor-patient interactions (Timmermans, 2020). Around the middle of the previous century, following the professionalization and institutionalization of medicine and emergence of many medical treatments (e.g., antibiotics, vaccines, medical imaging, etc.), physicians were at the peak of their power, a time referred to as the '*golden age of medicine*' (Greene, 2007; McKinlay & Marceau, 2002). During this time, medical systems relied on doctors upholding an authoritarian and paternalistic communication style, holding decision-making power over the passive patient (Parsons, 1951). Doctors were perceived as and acted as gatekeepers to medical information, advice, and treatment; a position supported by the disparity in medical information between doctor and patient (Timmermans, 2020). Critically, this paternalistic communication style relied on the collaboration of patients themselves, by for instance patients asking few questions (Timmermans, 2020).

Over time, however, this paternalistic model came under increasing pressure as the balance of power within healthcare systems began to shift. A convergence of bottom-up and top-down forces challenged the authority of physicians and paternalistic communication style, including legal pressures around bioethical principles (Office of the Secretary, 1979) and consumer rights movements (Boston Women's Health Book Collective, 1973). This led to new ideals of *patient-centered care* and *shared decision-making*, which involves providing patients with all pertinent information, engaging them in decision-making and building a therapeutic alliance based on shared power and responsibility (Barry & Edgman-Levitan, 2012; Institute of Medicine, 2001; Mead & Bower, 2000). Parallel to these changing ideals, it is described how subject positioning of patients in the medical encounter have changed. Patients have become more actively involved in their own healthcare through for example asking more questions, suggesting possible diagnoses or even lobbying for particular medication or diagnostic tests (Gill & Maynard, 1995; Stivers, 2002, 2007). Consequentially, medicalization literature describes how once passive patients, have transformed to '*consumers*' (Reeder, 1972), '*empowered patients*' (Andreassen & Trondsen, 2010), '*expert patients*' (Fox & Ward, 2006) or '*engaged patients*' (Timmermans, 2020).

In sum, through capturing the historically and culturally situated 'process by which nonmedical problems become defined and treated as medical problems' (Conrad et al., 2010, p. 1943), medicalization literature highlights the socially constructed nature of the realms that we perceive falling under medical authority (Christiaens & van Teijlingen, 2009). Medicalization is thus not a fixed state, nor a unidirectional process; it is better understood as a dynamic and continuous negotiation between different actors (Halpin & Cortez, 2025), which can also result in demedicalization, the process whereby conditions or behaviors move away from being seen as medical problems (Conrad, 1992; Halfmann, 2011).

While Christiaens and van Teijlingen's (2009) framework usefully maps conceptualizations of medicalization processes, it does not account for the possibility that these processes may unfold unevenly or in opposing directions across dimensions simultaneously. This is more directly addressed by Halfmann (2011), who revised and elaborated Conrad and Schneider's (1980) typology, arguing that (de)medicalization is inherently multidimensional and multilevel in nature, distinguishing three dimensions and three levels. A first dimension is *discourse*, referring to the use of (bio)medical concepts and vocabulary (e.g., *disease*, *symptom*, or *normal function*) to define a problem. The second is *practice*, referring to the application of biomedical technologies and interventions including *testing*, *measurement*, *normalization*, and *surveillance*. The third is *identity*, referring to the extent to which actors adopt biomedical roles or labels such as *physician*, *high-risk patient* or *hospital*. These dimensions manifest at the *macro* level through legislation and institutional discourse, at the *meso* level through organizational procedures and policies, and at the *micro* level through interpersonal interactions and the identities individuals construct or are assigned.

2.2 Childbirth as a Paradigmatic Case of Medicalization

Many domains once understood in social, moral, or everyday terms have increasingly come to be medicalized. Importantly, this process has not been gender-neutral: women's bodies have particularly been subject to medicalization, especially in relation to reproduction and reproductive health (Cahill, 2001; Conrad, 2005; Nisha, 2022).

Particularly childbirth serves as a paradigmatic example of medicalization, as each of its conceptualizations becomes clearly visible within obstetric care. In line with the first, childbirth became increasingly embedded within an institutionalized and professionalized medical system starting across the nineteenth century, decisive across the twentieth (Christiaens, 2008; Scamell & Alaszewski, 2023; Schepers, 1989). Parallel to this, childbirth increasingly came to be understood and handled as potentially pathological and thus risky, reflecting the second conceptualization of medicalization (Christiaens, 2008; Oakley & Houd, 1990). Childbirth also illustrates the third dimension of medicalization through different forms of iatrogenesis. Clinical iatrogenesis is reflected in the physical and psychological harms associated with obstetric interventions performed 'too much' and 'too soon'

(Miller et al., 2016). Structural iatrogenesis is illustrated by the relocation of childbirth to hospital settings, which has progressively displaced intergenerational and communal knowledge of physiological birth from everyday life and may thereby contribute to fear of childbirth through cultural unfamiliarity (Christiaens & van Teijlingen, 2009; Weiss et al., 2022). Social iatrogenesis is evident in the tendency to frame childbirth primarily as a medical problem, shifting attention away from the broader social and structural organization of obstetric care (Christiaens & van Teijlingen, 2009). Finally, reflecting biomedicalization, childbirth has increasingly become subject to medical-technological monitoring, surveillance, and intervention in pursuit of managing risks and optimizing birth (Christiaens & van Teijlingen, 2009; Scamell, 2014).

Childbirth is thus a particularly applicable site for studying medicalization. Not only because it illustrates the different conceptual aspects of its process, but also because it concentrates them into a single, time-bound moment of intensive medical management and decision-making. In this one event, macro-level medical authority, meso-level institutional structures, and micro-level interpersonal interactions all come together. Moreover, this convergence makes an important tension visible.

Second-generation medicalization theory emphasizes a shift toward more active patient roles (Timmermans, 2020). However, this shift has not unfolded uniformly across medical domains. In practice, persistent asymmetries in power between physicians and patients continue to shape clinical encounters (Elwyn et al., 2000; Légaré et al., 2018). This gap is particularly pronounced in contemporary obstetric care. Although patient-centered ideals have been translated into *woman-centered care* frameworks and increasingly incorporated into policy, a persistent disconnect remains between these normative models and everyday clinical practice, where such ideals are only partially realized (Gregory et al., 2025).

In the Western European context, evidence suggests that shared decision-making and informed consent remain insufficiently implemented (Abiola et al., 2025; Kuipers et al., 2025; López-Toribio et al., 2021). Large-scale questionnaire research in the Netherlands and a citizen-led survey in French-speaking Belgium found that nearly half of obstetric interventions were performed without consent being sought, and explicit refusals were not always respected (Plateforme Citoyenne pour une Naissance Respectée, 2021; Van der Pijl et al., 2024). While both studies carry methodological limitations (e.g., self-selected samples and retrospective recall bias) and were not conducted in Flanders, where this study is situated, they represent the closest available approximation of a phenomenon for which no systematic data collection currently exists. To better understand why these persistent power relations have proven more resistant in obstetric care to rising normative ideas and policy changes, it requires narrowing our focus to how the medicalization of childbirth is reflected in how childbirth and the social roles surrounding it are understood, framed, and communicated through medicalized discourse.

2.3 Beyond Obstetric Practice: Medicalized Discourse and Identity Formation

Central to medicalized discourse on birth is the notion of risk, which functions as a central organizing principle within contemporary obstetric care, orienting care toward continuous risk surveillance and medical management (Armstrong, 1995; Mauadie et al., 2022). Importantly, this risk-oriented logic is not unique to the event of childbirth. Scamell (2014) draws on Luhmann (1993) and Beck's theory of *Risk Society* (1992) to argue that the way we perceive potential danger in obstetric care reflect broader conditions of late modernity. In this context, potential dangers are no longer perceived as *hazards* outside our control, but as manageable *risks*, that can and should be controlled through expertise and technology. Within this framework, risk is not only a neutral calculation of probability but also a moral force that shapes acceptable decisions (Heyman, 2010). Obstetric care providers are granted the mandate and responsibility to assess and manage risk through expert knowledge and use of medical technological interventions (Brubaker & Dillaway, 2009; Scamell & Alaszewski, 2023). Importantly, this is no form of overt or coercive power aimed at controlling women's bodies or deliberately undermining autonomy. Rather, it operates as a form of disciplinary power, exercised through implicit social roles and professional mandates (Mauadie et al., 2022).

The notion of risk therefore implies not only a mandate for obstetric care providers but also structures the positioning of mother and child. Risk is conceived as twofold, threatening both mother and child, yet culturally, discursive emphasis predominantly rests on the safety of the unborn child (Liscum & Garcia, 2021; Scamell & Alaszewski, 2023). Within this framework, the baby is framed as the central protagonist through whose wellbeing medical decisions are culturally justified (Christiaens & van Teijlingen, 2009). Literature describes how in this framework the female body is cast as fragile and potentially unreliable: an ‘inefficient machine,’ in rationalized terms (e.g., Davis-Floyd, 2001; Martin, 2001), in need of repair by qualified technicians who ultimately ‘save’ both child and mother. The maternal body is thus understood as requiring careful management in order to produce healthy outcomes (Christiaens & van Teijlingen, 2009; Mauadie et al., 2022; Scamell & Alaszewski, 2023). Medical-technological innovations, such as ultrasounds and fetal heart-monitoring devices, have contributed to constructing the fetus as a distinct and individualized subject, while simultaneously positioning the mother as a potentially harmful influence on fetal wellbeing should she fail to comply with medical advice (Lupton, 1999; McNaughton, 2011). Thus, a responsible mother grants a degree of control and appropriation over her body to the obstetrician (Mauadie et al., 2022; Van der Waal, 2025). Consequently, women’s bodies become subject to a rational, technological, and mechanical model of thinking, legitimizing standardized medical management and transforming the maternal body into an object of social control and governance (Davis-Floyd, 2001; Fassin & Memmi, 2004).

Essentially, these medicalized social roles in the obstetric encounter are interdependent upon each other. Healthcare professionals experience a strong sense of responsibility to control every conceivable risk, increasingly shaped by fears of litigation and professional accountability in a context of heightened public expectations (Johanson et al., 2002; Scamell & Alaszewski, 2012). Women, in turn, may internalize this risk discourse, fostering fears of their bodies failing their babies, and themselves, further amplified by moral expectations of being a responsible and ‘*good mother*’ who prevents adverse outcomes and thus partakes in risk-minimizing practices. These dynamics generate mutual dependencies that reinforce medicalization: women rely on healthcare professionals for safety and reassurance (Chanial, 2010; Courtial & Le Dreff, 2004; Smeenk & Ten Have, 2003), healthcare professionals rely on women’s compliance to mitigate legal risk (Healy et al., 2016).

Crucially, medicalized discourse is co-(re)produced at the micro level by actors involved in the obstetric encounter. Gynecologists reproduce medicalized discourse on birth by framing pregnancy as pathological and risky, using medical-technical language, structuring talk and consent processes around professional authority more than women’s autonomy (Afulani et al., 2020; Mauadie et al., 2022). Similarly, midwives prioritize communicating biomedical information concerning institutional procedures and risk management over more experiential or woman-centered topics in prenatal consultations. In doing so, they may position women as individuals who ‘have to subordinate oneself to the staff of the maternity unit’, normalizing medical hierarchies and the use of dictating hospital protocols (Olsson et al., 2000, p. 127; Pollard, 2011). Similarly, laboring women contacting hospital staff to request admission during early labor apply medicalized discourse through speaking in terms of the timing and regularity of contractions, rather than embodied pain intensity or emotional distress, in an attempt to enhance credibility of their concerns and request to be admitted (Eri et al., 2010).

Taken together, these findings suggest that a movement toward woman-centered care carries deeper contradictions with contemporary obstetric care’s risk-saturated discourse (Scamell, 2011). Second-generation medicalization theory and patient-centered care presume a more autonomous and active patient, one whose subjective experience and preferences carry weight in decision-making. By contrast, obstetric risk governance constructs the pregnant body as an object of expert surveillance, legitimizing professional control in pursuit of optimal outcomes.

If we are to understand why women do not take on more active roles, it is valuable to gain more insight in how women internally make sense of childbirth and their social positioning within it through drawing on, negotiating or contesting medicalized discourse. Such engagements may shape the extent to which certain subject positions

are perceived as more accessible or restricted. Yet it is precisely at this point that theoretical and empirical gaps come to the surface.

2.4 Toward a Micro-Discursive Analysis: Medicalized Discourse in Birth Narratives

Christiaens (2008) proposes theoretically that mothers occupy both active and passive positions within the process of medicalization, continuously mitigating between the two. From the perspective of the ‘good mother,’ women submit to medical authority and technological intervention in the perceived interests of the child. Simultaneously, however, they act as active consumers who deliberately request interventions, such as pain relief, in pursuit of personal goals related to comfort, safety, and control. Medical technology therefore functions not only as an instrument of social control, but also as a potential source of empowerment for women.

Although empirical research examining how women engage with medicalized discourse remains limited and has primarily focused on specifically biomedicalized risk discourse, existing studies do reflect this mitigating dynamic. These demonstrate that women actively draw upon, negotiate, and resist aspects of biomedicalized discourse in constructing accounts of childbirth (Chadwick & Foster, 2014; Possamai-Inesedy, 2006; Westfall & Benoit, 2008). Medical authority is negotiated through strategies such as rationalizing medical decisions, reconstructing their birth story to resist medical framings, and making reluctant compromises between their own preferences and medical demands (Westfall & Benoit, 2008). In addition to biomedicalized discourse, women mobilize alternative discursive resources such as embodied experiential language and naturalistic discourses representing birth as a natural occurrence for which women’s bodies are capable (Chadwick & Foster, 2014; Possamai-Inesedy, 2006; Westfall & Benoit, 2008). These alternative frameworks are interwoven with biomedicalized discourse, producing accounts that both reproduce and partially destabilize dominant medicalized meanings of birth. Possamai-Inesedy (2006) does observe that regardless of birth setting (hospital-based, home-based or midwifery-led birth center), childbirth narratives do remain largely organized around an imperative to manage risk. Importantly, this discursive work is closely tied to processes of identity construction. Birth narratives function as sites in which women position themselves as reflective patients, empowered agents, informed patients or ‘good mothers’ who acted responsibly in managing risk (Westfall & Benoit, 2008).

Taken together, these findings establish that biomedical discourse is actively employed by women to narrate their birth. The birth story in this light can be understood as a site where medicalization processes of childbirth is reproduced, reworked, or resisted (Chadwick & Foster, 2014; Westfall & Benoit, 2008). In this sense, birth stories constitute a particularly fitting site of analysis, as women draw upon culturally available discourses to make sense of birth, constructing what constitutes as normal, which emotions are considered legitimate, and which subject positions become more or less available to them. Birth narratives therefore not only reflect ascribed meanings but also actively construct women’s birth experiences and serve as a vehicle through which meanings of birth are socially transmitted (Akrich & Pasveer, 2004; MacLellan, 2022). Yet the specific discursive mechanisms through which these processes unfold remain empirically underexposed.

Medicalization theory has also insufficiently theorized this micro-level terrain, as several authors have argued. Christiaens (2008), for instance, contends that medicalization theory lacks a theory of action to account for these dynamics. She states that literature on medicalization has thus far remained overly abstract and has failed to translate macro-sociological insights into the micro-sociological dynamics of the delivery room. In the same vein, Halpin and Cortez (2025) challenge process-based conceptualizations of medicalization (e.g., Conrad, 2005) for being too static, deterministic, and post-hoc, arguing that such approaches obscure the role of concrete actors by attributing medicalization to impersonal forces. Instead, they propose a relational framework in which medicalization is understood as an activity carried out by specific actors, such as patients, embedded in unequal power structures. Central to their proposed framework is the concept of the *medicalizing dividend*: all participating actors benefit from medicalization, which helps explain why they actively engage in it. Lastly,

Halfmann (2011) argues that medicalization scholarship has not yet adequately captured the multilevel and multidimensional nature of medicalization processes, with especially the micro-level having not been paid as much attention to. Yet, this distinction is crucial, as medicalization at one level and dimensional configuration may coincide with demedicalization at another. Moreover, the effects and driving forces of medicalization may differ substantially across levels and dimensions (Halfmann, 2011).

Taken together, these critiques point towards the need for a more fine-grained analysis of how women themselves discursively engage with medicalized constructions of childbirth. Therefore, this thesis aims to advance our understanding of how medicalized discourse structures the accounts of women's births at the level of language, subject-positioning and described power dynamics through asking the following research question: *How do Flemish women who recently gave birth draw upon, negotiate, and contest medicalized discourse in their birth narratives, and what described subject positions and power dynamics are associated with these discursive practices?*

3 Methods

This master's thesis employs a qualitative research design grounded in a constructivist-interpretive epistemology with critical elements. The central analytical framework is Fairclough's (1992, 1995, 2003) three-dimensional model of Critical Discourse Analysis (CDA), which allows for systematic examination of how medicalized discourse is reproduced and reworked in language, along with how subject positions and power relations are linguistically constructed. Given that CDA is more conventionally applied to policy documents and media texts, the analytical procedure was adapted for interview data with reference to Dahlborg et al.'s (2023) procedural guide for applying Fairclough's model to care contexts, Needham's (2025) empirical application of CDA within obstetric care, and Jørgensen et al.'s (2020) application of the three-dimensional model on interview data.

3.1 Data collection

3.1.1 Participants and sampling

Participants were recruited through a multi-pronged purposive sampling strategy. A study flyer was distributed across several channels: four hospitals in Flanders (including one university hospital and three general hospitals, two of which held a BFHI label), one midwifery practice, and two independent midwives working in postnatal care who informed eligible patients about the study. The flyer was additionally distributed across online forums and groups targeting new parents on Facebook, Reddit, and Baby24, and through the master student's personal network via social media and family contacts. To minimize recruitment bias, participants recruited through the personal network were required to be of sufficient social distance from the researcher. Interested individuals could register via a Microsoft Form linked to the flyer or post, after which an interview was scheduled.

Five inclusion criteria were applied. Participants had to (1) be 18 years of age or older, (2) be residing in Flanders, Belgium, ensuring all participants fell under the same regional and national guidelines, (3) have given birth within the three months prior to the interview, so that memories remained more detailed, participants were likely still on parental leave, and the interview fell within a period during which birth stories are more naturally shared in everyday social interaction, (4) be speaking Dutch or English, and (4) births had to be of a first child. This criterion rests on theoretical grounds: first-time mothers cannot draw on personal prior experience when constructing the meaning of their birth and are consequently more reliant on external discursive sources (Westfall & Benoit, 2008).

In total, 13 participants were recruited for in-depth interviews. All presented as white, cisgender women of Belgian descent. All gave birth in a hospital and evaluated their overall birth experience as positive. More information on respondents is presented in Table 2.

Table 2
Demographic information respondents

Pseudonym	Age	Education	Age baby at interview	Contact
Noor	31	Master	4 weeks	Baby24 forum
Julia	28	Bachelor	5 weeks	Personal network
Tess	36	Bachelor	16 weeks	Baby24 forum
Olivia	33	Bachelor	9 weeks	Baby24 forum
Margot	28	Secondary Education	12 weeks	Baby24 forum
Esmée	36	Master	5 weeks	Midwifery practice
Anna	36	Bachelor	10 weeks	Baby24 forum
Lisa	28	Bachelor	15 weeks	Baby24 forum
Victoria	29	Bachelor	13 weeks	Baby24 forum
Louise	31	Master	19 weeks ²	Baby24 forum
Lore	29	Bachelor	7 weeks	Baby24 forum
Emma	24	Secondary Education	7 weeks	Baby24 forum
Liv	30	Master	5 weeks	Baby24 forum

3.1.2 Data Collection Procedure

Data were collected through semi-structured in-depth interviews using an interview guide with open-ended questions (see Appendix). All interviews, except one, were conducted in person at the participant's home. Prior to recording, the researcher explained the information sheet in detail and obtained written informed consent. Each interview opened with two introductory questions: a self-introduction and a reflection on the participant's expectations and hopes. Participants were then invited to narrate their birth story in their own words – from the moment they considered labor to have begun to the moment they considered the birth to have ended – as they

² One participant was interviewed at 19 weeks postpartum, exceeding the three-month window. Initial contact was made within the inclusion period; however, scheduling delayed the interview beyond this threshold. Given that the participant remained on parental leave at the time of the interview and that her narrative remained directly relevant to the research questions, the interview was retained in the dataset.

would recount it to close family and friends. Any demographical items from the interview guide not addressed during the interview were collected through a brief drop-off questionnaire administered after the recording ended. Interviews lasted between 40 and 90 minutes, with an average duration of 60 minutes.

3.2 Data Analysis

3.2.1 Transcript and Preparation

Interviews were transcribed from audio recordings using a combination of Whisper and Microsoft Word's AI-assisted transcription tools, both GDPR-compliant, followed by manual correction. Field notes, reflections, and relevant background information were appended to each transcript. All transcripts were imported into NVivo for further analysis. As interviews were conducted in Dutch, fragments cited in the results section were translated into English with priority given to preserving the participant's original wording and intended meaning.

3.2.2 Analytical Framework and Phases

Fairclough's (1992, 2003) three-dimensional model distinguishes three analytical levels: (1) the textual level, (2) the level of discursive practice, and (3) the sociocultural level. The analysis was organized into four sequential phases. In the first phase, coding was conducted at the textual level, addressing aspects of grammar, modality, vocabulary, and metaphor. Later during analysis, possessive forms and figures of speech were incorporated into this first phase, as these proved analytically relevant, although these are not part of Fairclough's original specification. In the second phase, discursive practice was analyzed. Transcripts were examined for participants' engagement with medicalized discourse in their birth narratives, for the identitarian positions women occupied within those narratives, and for evidence of recontextualization of medicalized discourse into the postpartum period. This phase was guided by an abductive operationalization of medicalized discourse (see coding tree in Appendix). In the third phase, discursive practices were connected to broader sociocultural processes of medicalization: how birth narratives contributed to ideological reproduction of birth as a medical event, and what relations of power emerged from this. In the fourth and final phase, findings across all three analytical levels were integrated into a coherent interpretive account for each birth narrative.

3.3 Quality of the Research Process

Quality assurance was pursued in accordance with the criteria for trustworthiness in qualitative research established by Lincoln and Guba (1985). *Credibility* was supported through peer debriefing: initial coding and interpretations of the first transcript were discussed with supervisors to assess whether they were sufficiently grounded in the data and aligned with independent readings (Van Dijk, 1997). Preliminary conclusions and summary case analyses were similarly reviewed by supervisors at later stages. *Transferability* was fostered through purposeful sampling, the use of thick descriptions in the interview data, and an as comprehensive as possible documentation of the research context, methodological procedures, and findings in the thesis, in order to facilitate an assessment of the applicability of the results to other contexts. *Dependability* was secured through an audit trail: analytical decisions and reflections were recorded in a dedicated research diary, and the meaning of codes was systematically documented throughout the analytical process. *Confirmability* was pursued through ongoing reflexivity, documented through researcher notes and written reflections recorded at multiple points during the study.

3.4 Ethical Considerations

This study received ethical approval from the Ethics Committee of UZA prior to the start of recruitment (Identification number 8242). All participants provided written informed consent after reviewing an information

sheet that outlined the purpose of the study, the use of audio recording, procedures for confidential data handling, and their right to withdraw at any time or to pass over certain questions (see Appendix). Participant identities were protected through the use of pseudonyms throughout all stages of analysis and reporting.

Given the potentially sensitive nature of childbirth experiences, trauma-informed interviewing principles were consistently applied, both in pre-interview communications and during the interviews themselves. At the close of each interview containing emotionally charged content, after the recording had ended, participants were asked how they had experienced the conversation as an emotional check-in.

3.5 Position of the Researcher

Reflexivity was maintained throughout the research process in recognition of the ways in which the researcher's social positioning may have shaped both data collection and interpretation. EG, who conducted the interviews, presented as a white, cisgender woman from a middle-class Belgian background. Since EG has personally never given birth before, respondents may have been more inclined to moderate disclosure of negative aspects of their birth experience in order to avoid discouraging a potential prospective mother from having children (Earle, 2003; Muir, 1970). Conversely, EG's inexperience may have prompted more elaborated accounts, as participants sought to ensure comprehension (Clancy et al., 2022).

EG's personal understanding of childbirth has been shaped by two contrasting influences: popular media representations of birth as medically precarious, dangerous or gruesome, and familiarity with a non-medicalized birth context through her mother's home births. This duality informed a heightened attentiveness to the social constructed nature of how birth is represented.

EG's class and educational background introduced additional relational dynamics during home interviews with participants of lower educational attainment. In these interactions, EG remained attentive to power asymmetries such as made visible through markers such as clothing or university-branded consent forms. In those moments, EG found herself trying to bridge the perceived distance by communicating respectful interest and increased member checking by paraphrasing and checking whether participants' meanings were correctly understood.

3.6 Use of AI

Generative AI tools were used throughout the research process in various capacities, including as a source of ideas, a learning tool, a search aid, an assistant for writing, and to enhance efficiency. More specifically, ChatGPT, Claude, Gemini, Consensus, Elicit, and NotebookLM were all used for certain tasks, such as brainstorming, discussing ideas, enhancing understanding of literature, correcting APA referencing, and evaluating written text and providing feedback. A more detailed overview is provided in the Appendix.

4 Results

Medicalized discourse was present across all thirteen birth narratives, although the extent to which it functioned as the dominant discourse varied. Each birth narrative fit into three identified distinct patterns of interdiscursivity, which refers to the ways in which different discourses are combined and interact. For analytical clarity, these interdiscursive patterns are presented as distinct categories, though they are more accurately understood as imperfectly demarcated positions along a continuum. As the dominance of medicalized discourse increased, other discourses occupied less space within the narratives, and vice versa. At the same time, the interaction between these discourses differs qualitatively across the three patterns, warranting their separate discussion. The following sections examine each pattern in depth, followed by an analysis of the interactional and institutional dynamics described by respondents that shed light on how these discourses relate to clinical practice.

4.1 Three Patterns of Interdiscursivity

4.1.1 A First Interdiscursive Pattern – Medicalized Discourse as Predominant

In a first set of narratives, representing the majority of respondents, medicalized discourse functioned as the dominant framework through which birth experiences were articulated. Other discursive registers explicitly appearing were limited to an embodied register through which respondents described their physical sensations, emotional states, and thoughts during labor and birth. However, rather than operating as a competing epistemological framework, this embodied register coexisted with medicalized discourse without generating tension. Olivia's account illustrates this dynamic:

By around nine o'clock that morning, it was really getting difficult. I couldn't sit anymore, I couldn't stand anymore. I thought, what is this? Then I thought, okay, these are real contractions. So, I asked, can you give me an epidural?

- Olivia

In this excerpt, Olivia seamlessly connected an embodied register, centered on internal experience of pain, immobility, and disorientation, to its medical management through the request for an epidural. No tension emerged between the two registers; rather, they operated alongside one another. Whereas the embodied register gave voice to internal and affective experiences, medicalized discourse provided the interpretative framework through which these experiences are defined, understood, and acted upon. The following subsection examines in greater depth how medicalized discourse was precisely mobilized and expressed within these narratives.

4.1.1.1 How Medicalized Discourse Manifests in Birth Narratives

At the lexical level, medical terminology was frequently adopted throughout the birth narratives, often through references to medical interventions (e.g., epidural, induction, or cesarean section), monitoring devices (e.g., CTG-monitor, scalp electrode, or simply 'the monitor'), and occasionally chemical substances (e.g., Misoprostol or Cytotec). In Noor and Anna's narrative for example, clinical terms and descriptions of medical interventions are seamlessly integrated to recount the progression of events.

At 37 weeks I went to the gynecologist, and he checked me and he was like, yeah, there's still no dilation, it's nicely closed. If it stays like this, we'll do the induction with, yeah, a balloon catheter and misoprostol.

- Noor

I'd already had the epidural, so I was quite comfortable. They checked again, and that's when they realized she was a posterior baby. Even though at 38 weeks we'd had a check-up and an ultrasound, and she was in the perfect position for birth then.

- Anna

Noor and Anna's accounts illustrated how clinical language travels beyond the circle of obstetric care providers and institutions. The use of medical terminology to narrate birth without explanation or contextual framing suggested a degree of familiarity with these terms. From this perspective, it may be interpreted as indicating how medical terminology is discursively reproduced as a seemingly self-evident way of describing birth.

Another way in which birth was discursively constructed as a medical event was through metaphors, comparisons, and expressions. Through these, birth was often conceptualized by respondents as a purely physiological and mechanistic process, with the birthing body perceived as too unreliable or incapable to undergo unassisted. Respondents in the first interdiscursive pattern expressed, both implicitly and explicitly, limited trust in their body's capacity to give birth without medical intervention. Consequently, continuous medical supervision and intervention were framed as necessary and inevitable by respondents. For example, Noor described how, as her due date approached, her delivery was already being discussed in terms of requiring medical oversight. This may have contributed to her expectation that she would likely undergo a caesarean section, despite this conflicting with her preference for a more 'natural' birth. Reflecting on the discrepancy between her preference for an unassisted birth and what she perceived as the probable reality, she stated:

Just because you play the Euromillions and build dreams around it, doesn't mean you actually expect to win. You know, there's a big difference between your personal wishes and reality.

- Noor

The Euromillions metaphor positioned a medically unassisted birth as analogous to a lottery win: desirable, yet statistically improbable, and dependent on chance rather than bodily competence. This can be read as a reproduction of a risk-laden perspective of childbirth, in which the body requires medical surveillance because its proper functioning cannot be assumed. At the same time, the metaphor may also reflect an anticipation of medical assistance, whereby the prospect of intervention is already being rationalized as a means of aligning one's expectations with what is perceived as likely to occur. Notably, this expression emerges in the respondent's anticipation of labor, which suggests that discursive constructions of risk can operate prospectively. Through contributing to expectations prior to any actual clinical event and potentially giving rise a sense of an 'insufficient' body before it has been clinically established as such.

Furthermore, from a grammatical perspective, respondents alternated between active and passive sentence constructions, indexing shifts in subject positioning throughout the birth experience. In active sentences, respondents positioned themselves as grammatical subjects through the use of first-person active constructions: *I decided, I asked* or *we chose* (referring to her and her partner). This discursively positioned one as agentive within the birth process. In passive sentence constructions, respondents would grammatically position themselves as objects of an action performed outside of them, often done by obstetric care providers: she said *to me*, they did *to my body*. Crucially, an inclusive first-person plural construction positioning

respondents and obstetric care providers as shared subjects (*'we, together'*) were notably absent across all birth stories.

Moreover, this grammatical distribution of active and passive sentences underwent a consistent transformation in narratives where medicalization intensified during labor. Typically, as clinical interventions accumulated, respondents increasingly positioned themselves as the objects of medical care rather than agents of their own experience. Lore's narrative illustrated this shift. At the onset of labor, her account is characterized by many active sentence constructions:

I'd already had some bleeding for a few days, so we were kind of on our guard. And during the night I woke up and I was in so much pain. So apparently, I had back labor contractions first.

- Lore

As her labor progresses and becomes increasingly medically supervised, with labor-inducing drugs administered upon arrival in the delivery room, followed by her water being broken and the placement of an epidural, her narrative shifts toward more passive constructions:

Yes, the nurses really had to keep me down because I needed to relax. So, they were there, the two of them, pushing on me. They puncture, first time. The epidural wasn't placed; they couldn't get it in.

- Lore

This shift illustrates how, as medical interventions become more frequent and intense, narrative voice is increasingly given to care personnel's actions, constructing respondents as more passive. A key nuance in this pattern, however, is that adopting a more passive patient role and being under increased medical supervision could also be an active choice, one that respondents sometimes experienced as relieving, for example when responsibility for making the 'right' decision could be delegated, or when medical interventions such as an epidural provided comfort.

Despite medical discourse being predominant in this interdiscursive pattern, it was apparent that terms such as 'medical' or 'risk' were never explicitly mentioned. Though, risk seemed to function as an implicit organizing logic behind virtually every described care decision and action. The absence of these terms from the vast majority of narratives might therefore not indicate an actual absence of medical framing or risk but rather signal its discursive dominance. In this sense, the biomedical risk framing of birth appeared to have become so thoroughly embedded that it no longer required explicit articulation.

4.1.1.2 Subject positioning

Within this first interdiscursive pattern, respondents consistently positioned themselves as patients within a medical system, placing trust in obstetric care providers to manage the birth process on their behalf. Rather than explicitly articulating a loss of control, this positioning was expressed as a form of trust and surrender to clinical expertise. Notably, the more respondents positioned themselves as passive, compliant recipients of care, the less their birth experiences were linguistically framed as personally owned, as evidenced by a reduced use of possessive pronouns such as *'my room,' 'my gynecologist,'* or *'my delivery.'* Julia's account illustrates this dynamic:

The gynecologist decided for me that we would do it this way. [...] To call in the anesthesiologist for the epidural.

- Julia

This stands in contrast to respondents such as Noor, who adopted a more actively engaged patient position, which is reflected in a stronger sense of ownership expressed through possessive pronouns:

My gynecologist also knows that I need that, to know the different scenarios. [...] I'm going to wait until nine o'clock for my epidural.

- Noor

Those adopting a more engaged patient role actively participated in their care by asking questions, seeking information, and expressing preferences or expressing evaluations of provided care, while still complying to decisions made by obstetric care providers. Their engagement thus remained in adherence to the guidance and decisions of obstetric care providers, but the birth process was discursively framed more as their own by these respondents.

4.1.1.3 Internalization and Recontextualization

Medicalized discourse in this first interdiscursive pattern did not only structure how birth experiences were narrated. In several accounts, it also seemed to operate as an internalized interpretive framework, with which respondents would for example draw on risk rationality, hospital norms or customs, medical categories and protocols to reason about options, assess situations, and determine appropriate courses of action. This made clear how medicalized discourse functioned as a basis for interpretation, meaning-making and decision-making for respondents.

Related to this internalization was the recontextualization of medicalized discourse to the narration of the postpartum period. The technocratic risk-monitoring and -management logic emerged also as an organizing principle in accounts of the first weeks after delivery, particularly through references to weight thresholds, sequential routines and temporal intervals structuring infant care. The infant's body, much like that of the birthing body in the obstetric encounter, is thus frequently approached through measurements and evaluated against normative parameters. Noor's account offered a particularly clear illustration of this dynamic. Describing her use of a device for monitoring her newborn's heartbeat, she explicitly invoked institutional forms of legitimation:

I don't really have that issue with Owlet, actually, because it provides data. Also, it's certified in the EU as a medical device and FDA-approved for medical tracking of... So, you know, it's not just some gimmick.

- Noor

The legitimacy of home monitoring was here established through the same authoritative knowledge systems (scientific certification and medical approval) that underpin clinical monitoring during obstetric care. Notably, the extent to which medicalized discourse was recontextualized appeared to be associated with the emotional tone of the postpartum experience. In accounts where this logic was strongly extended into the home context, the postpartum transition is more frequently described as uncertain or anxiety-inducing:

Still a bit on guard, definitely. [...] We came home the first night, and at every little sound we would jump up and check. You no longer had those alarms telling you everything was okay. So those first two or three nights especially, we were constantly standing over the crib thinking, okay, is everything still alright? Because, well, you just don't know.

- Lore

There is, however, an interpretive logic underlying this pattern. When respondents positioned themselves as patients of care during birth, decision-making authority was largely delegated to obstetric care providers, who were constructed as the primary arbiters of safety and risk. Upon returning home, the withdrawal of this institutional monitoring may therefore have been experienced as increased uncertainty. Having relied on obstetricians during birth and in the process, respondents may subsequently have found themselves with a fragile basis for trusting their own assessments in the postpartum context. At the same time, the opposite relationship may also hold true, whereby those who felt more anxious about birth were also more likely to have positioned themselves as a patient and opting for a more medicalized approach to care.

4.1.2 A Second Interdiscursive Pattern – Medicalized Discourse in Frictionless Coexistence with Alternative Discourses

A second interdiscursive pattern was characterized by the integration of multiple other discourses alongside medicalized discourse. Medicalized discourse was integrated in similar ways as described in the first interdiscursive pattern. Yet, parallel to this, respondents drew on a broader discursive repertoire that included elements aligned with a midwifery model of birth (framing birth as a normal physiological process), an empowerment-oriented discourse (presenting birth as strengthening and transformative), and occasionally a more spiritual or experiential register (connecting birth to a higher sense of womanhood). Embodied descriptions of sensations, thoughts, and emotions were also more prominent and centrally positioned than in the first pattern. Through combining these alternative discourses with medicalized discourse, respondents seemed to internally negotiate meanings and representations of childbirth.

Through engaging with alternative discourses, respondents expressed forming a more trusting relationship with their bodies, something respondents contrasted to a more risk-oriented wary and watchful stance they perceived as more culturally dominant. Tess' account illustrated this dynamic. She described a deliberate reorientation away from narratives foregrounding potential medical complications during childbirth toward more positive ones:

And because of that, I felt really ready for my labor. So, I went from being very anxious because of my entourage to feeling very confident. Simply by, I sort of, [laughs briefly], by tuning out all those stories. All those negative stories and really focusing on the positive ones. And I have to say, that helped me a lot. Because of that, I wasn't nervous at all about giving birth. I was like, okay, when the time comes, I know what to expect. I'm looking forward to it. And I also felt like, I'm going to make something beautiful out of it. I'm going to take control myself and make something beautiful out of it.

- Tess

What was analytically significant is the discursive work involved in this shift. Confidence was not presented as inherent to Tess, but as something actively managed through selective engagement with reassuring narratives. In this way, this other discourse operated as a resource for reconfiguring the meaning of birth, from something to be managed medically to something that can be shaped subjectively. The result is a subject position in which she was not the recipient of a birth experience but its protagonist, someone who will 'take control' and 'make something beautiful.' Birth is framed by these respondents not as a medical event to be undergone and feared but as an experience to be directed, to be made enjoyable and meaningful. Respondents often described the birthing body as capable, responsive, or trustworthy, sometimes referring to notions of inherent bodily knowing, as in Margot's statement:

You'll know when it's time to push. It will be an instinct.

- Margot

Through drawing upon the word *instinct*, respondents framed their body as an entity having the innate capacity to know how to give birth. In that sense, their body became portrayed as a knowledgeable source of information, one can rely on. While the alternative discourses allowed respondents to internally negotiate and rework medicalized meanings of birth and their bodies as unreliable or risky, they simultaneously introduced new normative and potentially pressuring expectations, such as the idea that birth should be intuitive, empowering, and approached with confidence.

What was apparent, however, is that in this second interdiscursive pattern, the use of alternative discourses remained confined to domains of preparation for, attitudes toward, and coping during birth. What they did not so much enter or shape, were the narration of care practices and decisions during birth itself. Standard procedures, such as monitoring, interventions, and clinical judgements, were accepted without explicit negotiation. Through the compartmentalization of medicalized discourse from the alternative discourses across distinct domains of the birthing process, the integration of alternative discourses thus resulted in a non-conflictual or frictionless coexistence with medicalized discourse in the birth narrative and in obstetric care interactions.

Tess' account offered an illustration of this distinction. While her preparation towards birth was shaped by alternative discourses embracing a more faithful attitude, this did not translate into interactional negotiation or resistance within the hospital setting. Standard monitoring procedures, the placement of a screw electrode on the fetal head and an epidural were performed and narrated into the birth story without any negotiation. One single moment of more explicit counter-positioning occurred internally, at the suggestion of an emergency caesarean:

But then at a certain point, her [the baby's] heart rate went very high a few times, [...] And then they said, well, if that happens again, we'll have to do a C-section, an emergency C-section. But at that moment I was like: no, that's not my story. [laughs] That's not my story.

- Tess

'*That's not my story*' occurs within Tess' inner monologue, not within her exchange with clinical staff, illustrating how other discourses structured her narrative meaning-making and self-regulation. They did not enter the domain of clinical decision-making or tried to alter the course of obstetric care.

This pattern of compartmentalized coexistence of these alternative discourses with medicalized discourse might be ideologically functional. It may produce a sense of competence and self-determining autonomy, together with a sense of control or security through leaving the standard structures of obstetric care and decision-making intact. Seen in this light, this second interdiscursive pattern did not contest medicalization of care in practice but rather may have rendered it more tolerable.

This discursive compartmentalization extended into respondents' subject positioning. Internally, in respondents' own experience and in their produced narrative, respondents positioned themselves not as patients but as autonomous subjects actively shaping their birth experience. Externally, in their account of interactions in the hospital, their behavior appeared to be more in line with engaged patients: actively participating in their care, yet consistently following decisions made by obstetricians, even when clinical decisions did not align with their own preferences or interpretation of the situation.

4.1.3 A Third Interdiscursive Pattern – Contestation and Resistance of Medicalized Discourse

A third pattern, representing the minority of respondents³, is characterized by narratives in which a midwifery-aligned discourse functioned as the central discourse drawn upon to narrate the birth story, and against which the medicalized discourse was explicitly contrasted and contested.

A distinctive textual feature of this third pattern was its more explicit use of terms such as ‘medical,’ ‘medicalization,’ and ‘risk,’ which turned assumptions that remained implicit in other patterns into more explicit objects of reflection and critique, rather than leaving them to function as unquestioned common sense. This naming practice is evident in Esmée's account:

If it can just follow its natural course, the birth will generally go well, without all those medical interventions. And that is what I mainly wanted to start from, the strength of simply being a woman, or simply the natural process of bringing a baby into the world, is not something that needs to be medicalized.

- Esmée

In this third pattern, the respondent's trust in ‘the natural process’ and their bodily competence was more explicitly positioned against biomedicalized framings of birth. The body's capability was articulated by the respondent as a counterargument to the organizing risk-laden logic of obstetric care. At the same time, formulations such as invoking ‘*natural processes*’ or ‘*the strength of being a woman*’, seemed to be drawn upon in the birth narrative not as straightforward claim about biological reality. Rather, these seemed to function more as discursive resources that the respondent mobilized to challenge predominant medical dominance.

Another feature of this pattern is that discursive contestation did not remain confined to the domains of preparation, attitude, or internal experience. It also traveled to practice: through an active choice for midwifery-led care, through including a doula during the birth, and through declining specific medical interventions in the hospital. Critically in this shift, risk as a guiding principle of care choices was not rejected as relevant by the respondent. The risk calculus itself was reformulated in this interdiscursive pattern. The dominant medical framework was critiqued for the risks it may fail to account for; namely potential iatrogenic risks associated with medical management and intervention itself. For this respondent, a genuinely risk-conscious approach to birth would require taking seriously the risks of over-medicalization alongside the risks of under-medicalization, with contemporary care being framed as over-medicalization. Remarkably, moments of refusal of obstetric care practices made the institutional structures of decision-making visible. For example, Esmée refused the placement of a scalp electrode on her baby's head to improve heart rate monitoring:

And then at a certain point, I think they came to ask three times. And then they said, well, if you really don't want that, that's possible. But then we had to sign a document in which we formally distanced ourselves from the hospital protocol. Which is, I think, quite intense, in that context.

- Esmée

³ Only one respondent exhibited this distinct interdiscursive pattern in the sample. After methodological reflection, this third pattern was ultimately retained, because it clearly differed from the previous two patterns and published literature had identified its discursive dynamics (Chadwick & Foster, 2014; Possamai-Inesedy, 2006).

This response illustrated how deviation from hospital protocol can be managed institutionally. The document registered Esmée's refusal primarily as a potential legal liability. Practical rejection appeared formally permitted yet constrained through subtle pressures of repeated questioning and legal procedures that shift responsibility onto the respondent herself. Moreover, in Esmée's case, her ability to sign was not simply a matter of individual conviction but also depended on access to alternative authoritative sources of knowledge and guidance – namely, the presence of her independent midwife and doula – as well as social support in the form of a partner committed to the same position. This third interdiscursive pattern thus corresponded with a subject position in which the respondents internally and externally embraced a *self-directed birthing subject* role, self-directing her own birth, with clinical staff occupying a supporting or at times antagonistic role.

4.2 Interactional and Institutional Dynamics in Obstetric Care

Across all respondents, an underlying epistemological hierarchy appeared to structure interactions between respondents and obstetricians. Respondents frequently referred to embodied forms of knowledge, including felt pain, previous experiences with medication, personal preferences, intuition, emotional states and bodily sensations. Within the birth narratives themselves, these forms of knowledge were often presented as meaningful and significant for navigating care preferences and choices. Yet, when respondents described interactions with clinical staff, this embodied knowledge appeared to occupy a more marginal position in relation to clinical decision-making. Instead, decisions were predominantly narrated as being based on forms of knowledge external to the birthing woman, such as technological monitoring, measurable physiological indicators, medical-scientific expertise, or institutional protocols.

For example, during Olivia's birth, her request for an epidural was initially denied by the obstetric care staff, who assumed that she had not been in the hospital long enough to have progressed sufficiently for an epidural. This was despite her reporting that the pain had become unbearable and that she could no longer stand or move properly. Only after repeated requests, the obstetrician reconsidered, but first performed a more thorough examination:

And then they inserted the epidural. Only after they first checked how far along we were. So, at that moment I was four centimeters dilated.

- Olivia

In this account, embodied pain alone did not appear to function as sufficient grounds for intervention. Rather, external measurement of her dilation became the decisive basis upon which clinical action is legitimized. Interestingly, this prioritization of external observation to base clinical action on is reproduced by respondents themselves, for example in Lisa's narrative: although she felt that the baby's head was already crowning, she nevertheless sought confirmation from obstetric staff before beginning to push:

And then in the end I said, I do want that, I want you to check after all. And when she checked, I was at 10 centimeters dilated and his head was already basically ready to be born. Yeah, then I thought, see, I knew it!

- Lisa

Here, embodied sensation became retrospectively validated through clinical assessment. Such accounts may suggest that obstetric staff were interactionally positioned as possessing privileged access to authoritative forms of medical knowledge, particularly through their ability to interpret medical measurements, protocols, and technological outputs. Within this configuration, respondents often appeared to position themselves as dependent on external confirmation before their own perceptions and knowledge became actionable.

This epistemological hierarchy also appeared to shape how decision-making is linguistically organized within clinical encounters. Although informed consent formally remains a legal requirement, respondents frequently described interventions as communicated through declarative statements rather than negotiated proposals, with consent often appearing implied rather than explicitly solicited. Julie's account illustrates this dynamic:

At one o'clock the gynecologist came back in for the second time. And then he said, 'I'm going to call the operating room. We're going to look at doing a C-section.' They didn't really ask, 'is that okay with you?'.

- Julia

Importantly, majority of respondents did not experience this dynamic as coercive. Particularly within the first interdiscursive pattern, clinical authority was often framed as legitimate, necessary or even relieving. Several respondents framed decisions imposed by obstetric staff as their own active choices. Other respondents, more so in the second and third pattern, did express a felt distance between the formal right to explicitly agree or refuse care and the interactionally experienced possibility of participating in shared-decision-making. For example, Lisa noted that she found it peculiar that, although she considers herself a decisive and assertive person in everyday life, she did not present herself that way within obstetric care. When asked why she thought that was, she reflected:

I think it's because I was quite insecure and sort of thought, well, the midwife will handle it. I mean, I'm kind of the subordinate here, so to speak. [...] And now sometimes I think, of course I didn't know that at the time, how much my gut feeling could be worth. But now I do.

- Lisa

Lisa's reflection illustrates how interactional dynamics in obstetric care can constrain experienced agency. Yet, the epistemic hierarchy and asymmetrical positions within clinical decision-making seemed not only reproduced through interpersonal interactions but also appeared to be institutionally embedded. Esmée's account of declining a fetal scalp monitoring illustrates part of this, as her refusal was managed through institutional documentation procedures formally distancing her care from the hospital protocol. Such responses may indicate that while refusal remains formally possible, institutional arrangements can nevertheless function to reinforce medical authority, through redistributing responsibility onto the birthing woman herself.

Moreover, protocol-driven practice in which clinical-decision-making largely relies on medical-technological measures external to the women to establish a (legally) defensible basis for care, which seemed to contribute to this epistemic hierarchy. In addition, most respondents were attended by obstetric staff whom they had not previously met, as maternity care settings in Flanders predominantly operate through shift-based systems. This limits the possibility of developing continuous care relationships in which informed consent and shared decision-making can be meaningfully practiced. Practical constraints such as time pressures and logistical demands described by respondents may additionally reinforce asymmetrical epistemic positions between obstetric staff and birthing women. In sum, interactional and institutional factors in tandem seemed to undermine the conditions necessary for informed consent and shared decision-making to be regarded as reasonable and achievable practices by respondents.

5 Discussion

5.1 Synthesis of Key Findings

Using Fairclough's three-dimensional framework for CDA, this thesis examined how thirteen Flemish women who recently gave birth draw upon, negotiate, and contest medicalized discourse in their birth narratives, and how these discursive practices are intertwined with subject positions and power relations within obstetric settings.

Overall, the findings indicate that medicalized discourse, representing childbirth as a risk-laden event that should be medically managed, is predominant in birth narratives, yet not in a uniform or unidirectional manner. Its dominance does not reside solely in the degree to which it is expressed, but also in how it interacts with alternative discourses within the narrative. Three distinct patterns of such interdiscursive interplays were identified, through which birth narratives variably reproduce, nuance, or contest biomedical framings of childbirth.

In the first pattern, which characterized the majority of accounts, medicalized discourse functions as the dominant discourse drawn upon to narrate one's birth, which consequently represents birth as an inherently risk-laden medical event, positioning women primarily as patients. In the second pattern, medical discourse coexists with alternative discourses that foster embodied competence. However, these alternative discourses largely remain confined to personal domains and appear to exert limited influence on obstetric practice. Birth was thus simultaneously constructed as a natural event that can subjectively be given shape, while ultimately remaining within a medical framework as a patient in which medical professionals retain decisive authority. In the third and least frequent pattern, a midwifery-oriented discourse predominates, rendering biomedicalized discourse visible and open to critique. Birth is framed as a natural and holistic process that may be compromised by excessive medical intervention. Within this configuration, respondents position themselves both internally and in practice as self-directing subjects of their own birth.

Across all three patterns, interactional and institutional dynamics emerged as crucial contextual factors in understanding medical decision-making. The findings indicate that women's agency in clinical decision-making is not merely a function of individual conviction but is bounded by more structural conditions determining medical forms of knowledge as a more legitimate basis for practicing obstetric care.

5.2 Positioning within existing literature

Overall, our findings align with prior empirical research demonstrating that women do not passively reproduce biomedical discourse, but they actively draw upon, negotiate, and at times contest it in constructing accounts of childbirth as reflexive agents (Chadwick & Foster, 2014; Possamai-Inesedy, 2006; Westfall & Benoit, 2008). Our findings extend previous literature by capturing these discursive mechanisms in greater detail through describing three distinct patterns of interdiscursivity, which Fairclough (1992) conceptualizes as a key mechanism through which hegemonic discourses are reproduced and negotiated.

5.2.1 First Interdiscursive Pattern: reproduction of medicalized discourse

The first and most prevalent pattern aligns with earlier research illustrating that women's reflexive engagement with discourses on childbirth frequently results in the reproduction of dominant understandings of birth as a risk-laden event requiring medical management (Chadwick & Foster, 2014; Possamai-Inesedy, 2006; Westfall & Benoit, 2008). A contribution of the present analysis is that explicit articulation to the words 'risk' or 'medical' by respondents were largely absent. At first glance, this appears to contrast with Possamai-Inesedy's (2006) finding that risk discourse pervasively structures women's accounts of childbirth. However, drawing on

Fairclough (1992), this absence may instead indicate a process of naturalization, whereby a discourse becomes so pervasive and self-evident that it no longer requires explicit articulation or justification. In this sense, the ideological power of biomedicalized discourse may lie precisely in its naturalized presentation as common sense or objective reality rather than as a socially situated framework requiring some explicit mentioning.

Related to this, and perhaps a further manifestation of it, are the internalization and recontextualization of medicalized discourse present in our analysis, which both have been identified in previous literature (Chadwick & Foster, 2014; Clancy et al., 2022; Murphy, 2000; Possamai-Inesedy, 2006; Westfall & Benoit, 2008). This dynamic resonates with Clarke et al.'s (2003) theory of biomedicalization, in which the pursuit of health has become an individual moral responsibility fulfilled through self-surveillance, risk assessment, and prevention. Something that extends well beyond clinical settings into daily life. Foucauldian concepts of disciplinary power and governmentality further illuminate this observation. Building on Foucault's (1977) notion of the panoptic gaze, and its later extensions in relation to pregnancy (Freeman, 2015; O'Malley, 2004, 2009), this internalization and recontextualization of medicalized discourse by women may be understood as forms of self-surveillance, monitoring both their own bodies and those of their infants, consistent with a broader biomedicalized culture in which continuous health monitoring has become an expected and normalized practice.

Importantly, even though respondents in the first interdiscursive pattern largely reproduced medicalized discourse and positioned themselves as patients deferring to medical decision-making authority, this subject positioning was in most cases a reflexive stance rather than one experienced as coerced. In that sense, not actively seeking a role in clinical decision-making can be a conscious and even relieving choice, particularly when delegating responsibility to obstetric care providers was experienced as reducing uncertainty rather than as a loss of agency. However, this specific subject positioning does not straightforwardly map onto existing conceptualizations of the changing patient role. The notion of the *expert patient* (Fox & Ward, 2006), the *empowered patient* (Andreassen & Trondsen, 2010), or the *consumer* (Reeder, 1972) do not apply here, in that sense that these conceptualizations would overstate the specialized knowledge, active participation and bargaining power of women in obstetric care interactions. Timmermans' (2020) notion of the *engaged patient* comes closest, insofar as respondents orienting themselves as responsible health actors, sometimes expressing preferences through birth plans or asking questions. Yet, even this framing overstates the interactional dimension of their engagement, as respondents' engagement remained largely discursive, at the intrapersonal level of meaning-making rather than at the level of interactional negotiation, leaving the decision-making authority in the hands of obstetric care providers. In this sense, their subject position of majority of respondents in obstetric care might be more accurately described as that of a *compliant yet reflexively engaged patient*.

5.2.2 Second and Third Interdiscursive Pattern: Alternative Discourses, Risk, and Agency

In the second and third patterns of interdiscursivity, respondents mobilized alternative discourses alongside medicalized discourse to negotiate meanings of birth. Across both patterns, women discursively constructed their bodies as inherently *capable*, *knowledgeable*, and *trustworthy* in ways that challenged biomedical representations of the body as risky and in need of expert management. This finding aligns with Chadwick and Foster's (2014) observation that women planning home births often positioned themselves in opposition to the 'technocratic body' through narratives of embodied competence and intuitive knowledge.

The third pattern was characterized by an additional discursive feature that explicitly contested biomedicalized discourse. Risk rationality was not only made explicit but also actively reconfigured. Rather than rejecting risk discourse, respondents expanded its scope to include clinical iatrogenic risks, at times using this reframing to justify the refusal of medical procedures. Similar dynamics have been identified by Chadwick and Foster (2014) and Possamai-Inesedy (2006), who found that women who choose home birth do not abandon risk logics, but instead contest their selective application in medical settings. Collectively, this finding suggests that risk continues to function as a dominant interpretive and guiding framework, even when alternative discourses are mobilized

to reconfigure the meaning of birth and women's positioning within it, or when medicalized care is declined in practice (Scamell, 2014).

This points to a broader theoretical implication. Clarke et al. (2010) identify a focus on risk as defining features of biomedicalization. The present findings of a rejection of the use of a biomedicalized monitoring device because of its iatrogenic risks (Illich, 1976) might complicate this theoretical position at first glance. However, movements of demedicalization in *care practices* may co-occur with movements of medicalization in *discourse and identity* according to Halfmann (2011). Through this more detailed lens, it becomes clear how refusing biomedicalized monitoring devices can still be grounded in a self-surveilling subjectivity foregrounding the management of risks in an aim to prevent and optimize health, which does closely align with notions of biomedicalization (Clarke et al., 2010).

The persistence of biomedicalized discursive reasoning even when respondents aimed to avoid biomedicalized practices, can also be situated and understood within Beck's (1992) theory of risk society as the broader context in which medicalization processes unfold. In contemporary modernity, potential dangers are rendered as calculable, manageable and attributable to human decision-making and responsibility. In the context of childbirth, this makes risk difficult to escape discursively, even when contesting medicalization, as women remain compelled to justify choices in relation to the management and prevention of potential harm (Beck, 1992; Possamai-Inesedy, 2006). Crucially, this risk discourse does not operate in a neutral space but is deeply entangled with normative ideals of 'good' and 'responsible' motherhood, whereby women's choices become a reflection of their moral worth as mothers rather than merely personal preferences (Lupton, 2011; Maffi & Gouilhers, 2019). To summarize in Chadwick and Foster's (2014, p. 78) words 'there was thus no pure form of resistance' to medicalization identified in our sample.

5.2.3 Interactional and Institutional Dynamics Constraining Agency

Interestingly, previous literature linked described discursive mechanisms to variations in women's choices for birth settings (e.g., home birth, midwifery-led care, elective caesarean section, or hospital birth; Chadwick & Foster, 2014; Westfall & Benoit, 2008). Our findings nuance this account by demonstrating a similar range of discursive mechanisms within a homogeneous sample of hospital births, suggesting that the incorporation of alternative discourses is not necessarily mirrored in choices for more or less medicalized care. Our analysis highlights that, although women engage in discursive reflexivity, their practical decision-making agency in the obstetric encounter is exercised within an institutional environment in which a primary mandate of risk management through medical assistance seems to shape which forms of knowledge and participation are perceived as accessible, legitimate, and institutionally supported (Brubaker & Dillaway, 2009; Scamell & Alaszewski, 2023).

Results suggested the presence an epistemic hierarchy privileging biomedical forms of knowledge in clinical decision-making over embodied and subjective experience of women. This hierarchy can be conceptualized as an expression of macro- and meso-level biomedicalization (Clarke et al., 2003), as institutional and legal frameworks structurally enforce clinical measurements as the ultimate authoritative knowledge in assessing labor and birth (Halpin & Cortez, 2025; Jordan, 1993). Furthermore, our analysis highlights how this epistemic hierarchy is consistently reproduced at the micro-level, through women themselves internalizing and applying this epistemic hierarchy in narrating their birth stories, particularly in their accounts of asymmetrical care interactions with obstetric providers, who likewise appear to reproduce these hierarchies interactionally. This dynamic has been previously described by Maffi and Gouilhers (2019), who demonstrated how external indicators, such as biomedical measurements, numerical values, and monitoring technologies, tend to overshadow women's embodied experiences in constructing understandings of ones labor.

From Illich's (1976) perspective, this epistemic hierarchy can be conceptualized as a form of both structural and social iatrogenesis. Structurally, it seems to support a loss of faith in a woman's embodied sensations and her

capacity to assess the progress of her labor, fostering a dependence on external clinical measurement (Maffi & Gouilhers, 2019). Socially, the political and power-related implications of this dependency are obscured, as the situation is legitimized and conceptualized as an objective medical necessity. For clinical practice, this epistemic asymmetry sits in tension with the principles of shared decision-making, which require that clinical expertise and patient experiential knowledge are treated as equally relevant within the decision-making process (Lee et al., 2025).

Halpin and Cortez's (2025) relational approach to medicalization can further clarify how subject positions are structurally shaped within an institutional care context. They argue that medicalization unfolds through unequal relations, in which actors derive benefits through a 'medicalizing dividend'. Crucially, the actor holding a hegemonic position, in this case, a medical institution, dictates the 'rules of the game' by exercising control over logistics, clinical protocols, and the interactional conventions, steering how dividends are granted and constrained. This mechanism is distinctly reflected in our findings. Yielding to medical authority within hospital-led care provides significant individual dividends, such as the delegation of moral responsibility for the child's outcome to medical experts, reassurance through expert monitoring, and participation in a framework that legitimizes fears and insecurities surrounding childbirth. By contrast, through a resistance of medical monitoring practices one forgoes this medicalizing dividend and is met with institutional friction and legal pushback when deviating from established protocols. Ultimately, clinical protocols function simultaneously as instruments for minimizing medical risk and as frameworks through which hospitals can legally justify clinical decisions (Brubaker & Dillaway, 2009; Scamell & Alaszewski, 2023). Importantly, this suggests that compliance within obstetric care should not be understood merely as passive acceptance of medical authority. Rather, it can also be viewed as a relational response to or a pragmatical navigation of institutional arrangements that facilitate some forms of participation while constraining others. This intertwinement of micro-level subject positions and meso-level institutional arrangements further highlighting the multidimensional and multilevel nature of medicalization processes (Halfmann, 2011).

Previous scholarship further suggests that resistance to authoritative biomedical knowledge often requires the construction of an alternative epistemic framework that itself requires legitimacy (Davis-Floyd & Sargent, 1996; Jordan, 1993). This process is reflected in our findings in which the only respondent that translated alternative discourses into practical resistance of biomedicalization of her birth, also brought independent caregivers into the hospital setting who embodied alternative forms of authoritative knowledge, aligned with midwifery models of care. However, this also implies that resistance to medicalization does not depend solely upon individual conviction or willingness to contest medical authority. Rather, it additionally depends upon epistemic work and access to alternative sources of epistemic authority, social support, and material resources, conditions that are not equally available to all women. This supports Clarke et al.'s (2003) notion of stratified biomedicalization, insofar as the capacity to customize biomedical care itself depends upon access to social, cultural, and material resources.

Taken together, findings suggest that current models of shared decision-making in obstetric care may remain constrained by interactional dynamics and institutional arrangements that privilege external biomedical information over embodied forms of knowledge. This could foster a felt distance between a legal right to informed consent or refusal and a felt ability to participate in decision making by individual women.

Beck (1992, 1997) argues that the answer to these dynamics in the context of a risk society should not be the rejection of science or (medical-)technology, but the recognition that within the construction of a seemingly apolitical medical protocol lies a deeply normative question: *what risks should be taken into account and at what risk thresholds should we intervene?* As both previous scholarship and our findings suggest, the answer is neither value-neutral nor purely technical, but socially and politically situated, and personally variable.

Thus, if shared decision-making in obstetric care is to move beyond rhetorical aspiration and become meaningfully achievable in practice, greater flexibility within protocol-level definitions of risk constitutes an possible step forward. Such flexibility would not only create institutional space for women's participation in

decision-making but would also provide clinicians with the legal and professional protection necessary to accommodate informed refusals without departing from defensible clinical practice. In the absence of such structural change, woman-centered care risks remaining a discursively upheld ideal that ultimately reaches its limits at the threshold of clinical practice.

5.3 Limitations

Several limitations of this study warrant acknowledgement. Methodologically, three constraints affect the interpretation of the findings. First, the birth narratives analyzed were produced within a specific interactional context, namely an in-depth interview with a younger, unknown student interviewer. What respondents narrated, and how, was inevitably shaped by the uninterrupted interview format, selective recall, and social desirability dynamics such as pressure to present oneself as a good mother and grateful patient. The discursive patterns identified reflect what participants were willing and able to articulate within this interview context. Consequently, the birth narratives analyzed here are therefore best understood as artefacts of a research situation rather than direct representations of how women naturally recount birth experiences in everyday settings.

Second, although the analytical process of the study was conducted in an iterative, transparent, and reflexively documented manner to reduce personal interpretation biases (e.g., confirmation bias, positionality bias, etc.), CDA remains an interpretive method susceptible to these on the part of the analyst. Third and relatedly, the analysis was conducted by a single researcher without independent parallel coding, limiting the extent to which interpretive claims can be independently verified and leaving alternative readings of the data possible.

At the level of sample and context, most respondents volunteered following a post on online fora. These self-selected participants likely differ from women who did not volunteer, which may partly account for the uniformly reported positive birth evaluations. Moreover, all participants identified as white, cisgender women of Belgian descent. The findings therefore remain limited with respect to women with migration backgrounds, non-binary individuals, or those embedded within religious frameworks that possibly organize childbirth differently. Moreover, for minority populations, interpersonal dynamics within obstetric care often encompass more adverse interactions (De Freitas et al., 2020; Peters et al., 2019), and the discursive patterns identified here may not hold. Additionally, all births took place in hospital settings in Flanders. The findings are therefore not directly transferable to other birth settings, care models, institutional arrangements, or national healthcare contexts, and should be read as analytically specific to the contemporary Flemish obstetric context.

Theoretically, the findings speak specifically to how medicalized discourse operates within the birth narratives of first-time mothers. Women recounting subsequent births can draw upon prior personal experience, potentially producing different discursive dynamics. The analytical claims of this study therefore remain confined to uniparous women. Furthermore, although three discursive patterns were identified, theoretical saturation was not fully achieved, as the third pattern emerged in only one narrative. Consequently, the analysis, especially the third pattern, should be interpreted as a preliminary theoretical contribution rather than a saturated account.

5.4 Future research

Future research should examine whether the discursive patterns identified in this study extend to more diverse populations and obstetric trajectories, including multiparous women, women from religious communities, and women giving birth in alternative care settings. In particular, greater attention is needed for the experiences and birth narratives of ethnic minority women, who remain structurally underrepresented in obstetric research despite evidence highlighting that they are structurally more exposed to suboptimal communication with obstetric caregivers, reduced autonomy in care decision-making, and inadequate responsiveness across all

phases of perinatal care (De Freitas et al., 2020; Peters et al., 2019), as well as to care interactions marked by dismissiveness, lack of emotional attentiveness, and insufficient recognition of their cultural meaning systems (De Freitas et al., 2020; Degrie et al., 2020). Exploring how medicalized discourse is negotiated within these contexts may further illuminate how race, class, culture, and institutional power intersect in shaping women's possibilities for agency within childbirth. Additionally, observational research in hospital birthing rooms could offer a valuable complement to interview-based methodologies. By directly analyzing interactions between obstetric care providers and birthing women, such research could provide more direct insight into the interactional mechanisms through which epistemic hierarchies are reproduced in real time, rather than as retrospectively narrated through birth accounts. In addition, future research could investigate how the internalization and postpartum recontextualization of medicalized discourse, particularly an internal devaluation of embodied knowledge and risk-assessment relates to women's psychological wellbeing during the early postpartum period.

6 Conclusion

This thesis analyzed how Flemish uniparous mothers who recently gave birth draw upon, negotiate and contest medicalized discourse, and what subject positions and power dynamics went together with this engagement, by applying CDA to their birth narratives. The findings show that medicalized discourse is ubiquitous in birth stories, but in different ways. Three patterns of interdiscursivity were identified. In the first and most common pattern, medicalized discourse served as the primary interpretive framework, with women positioning themselves as patients who delegate medical decision-making authority. In a second pattern, medicalized discourse coexisted seamlessly with alternative discourses that emphasized embodied competence, but these remained compartmentalized to the domain of personal experience, without influencing practical obstetric decision-making. In the least frequent pattern, medicalized discourse was explicitly contested from a midwifery-aligned discourse, which also translated into practical resistance, a step that required epistemic and social resources.

Overall, the findings indicate that women engage reflexively with medicalized discourse, reproducing but also reworking collective medicalized understandings of birth. Yet, discursive negotiation, contestation and even practical refusal of aspects of biomedicalized care always remained embedded within risk-laden reasoning, underscoring the multidimensional nature of medicalization processes. Women's agency in obstetric care appeared bounded by an interactionally and institutionally upheld epistemic hierarchy that positions biomedical forms of knowledge as more legitimate than embodied experience. This appeared to underpin women's limited perceived opportunities for participation in obstetric decision-making, as their embodied knowledge was experienced as less legitimate, actionable or relevant than biomedical expertise. As long as these conditions remain unchanged, woman-centered care and its shared decision making might stay compromised by these dynamics, remaining a discursively maintained aspiration that encounters its practical limits at the threshold of the clinic.

7 References

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8 Appendix

8.1 Use of AI

Table A1

Overview of Generative AI Tool Usage

Role	Tools	Description
Idea generator	ChatGPT (Sep–Feb), Claude (Feb–May), Gemini	Concretizing the thesis topic, weighing research methods, brainstorming alternative text structures, finding synonyms when search engines yielded insufficient results, creatively thinking about wordplay for a title
Search engine	Consensus, Elicit, Gemini, ChatGPT, Claude	Targeted search for relevant sources; used as a closing search strategy after Web of Science and Google Scholar to ensure no key papers were missed; exploratory search strategy for peripheral questions arising during the writing process (mainly Consensus)
Writing assistant	ChatGPT (Sep–Feb), Claude (Feb–May)	Correcting spelling, grammar and typing errors using standard prompts from Aivoorstudenten.nl; analysis of published articles to generate detailed writing guidelines; assessing written sections based on these published-article-guidelines and generating specific feedback; fact-checking written content
Practice tool	ChatGPT (Sep–Feb), Claude (Feb–May), Notebook LM	Better understanding of articles by requesting explanations of difficult passages
Data analysis	Claude (Feb–May), Word & Whisper	Co-developing appropriate labels for specific codes; transcription; collaborative coding of a sample birth story from an online public forum for exercising the method
Efficiency support	ChatGPT (Sep–Feb), Claude (Feb–May), Gemini, Consensus, Elicit, Notebook LM	Targeted information retrieval within PDFs; generating planning schedules; literature searches; identifying APA formatting errors in reference lists
Designer	—	—

8.2 Informed Consent (NL)

INFORMATIEDOCUMENT VOOR DE DEELNEMER AAN EEN NIET-COMMERCEEL EXPERIMENT OP DE MENSELIJKE PERSOON

Opdrachtgever:

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Beste deelnemer,

U wordt uitgenodigd om vrijwillig deel te nemen aan een interviewstudie met betrekking tot je bevallingservaring.

Vooraleer u toestemt om aan dit onderzoek deel te nemen, is het belangrijk dat u dit formulier leest.

1. Studiespecifieke inlichtingen

Dit onderzoek werd op ... (Datum (.../.../.....)) goedgekeurd door het onafhankelijke Ethisch Comité UZA-Uantwerpen.

Doel en beschrijving van het onderzoek

Dit is een wetenschappelijk onderzoek waaraan, naar verwachting in totaal minimaal 12, maximaal 50 Belgische personen zullen deelnemen.

Deze studie heeft tot doel inzicht verkrijgen in de wijze waarop vrouwen betekenis verlenen aan de bevalling en medisch taalgebruik verwerken in hun bevallingservaring. Dit onderzoek maakt deel uit van de masterthesis van Emilie Gillain.

Dit is een ~~interventionele~~/observationele studie. Dit betekent dat de onderzoeker je interviewt en alleen observeert, zonder dat er iets wordt veranderd of beïnvloed.

Als je deelneemt, word je één keer geïnterviewd over je bevallingservaring. Voor deelname wordt ongeveer 1,5 uur gerekend, waarbij het interview ongeveer een uur in beslag zal nemen. Het interview wordt audio-opgenomen, zodat het nadien nauwkeurig kan worden uitgeschreven.

In dit onderzoek verzamelen we geen medische gegevens zoals medische dossiers, uitslagen, parameters of evaluaties. Tijdens het interview vragen we enkel naar uw persoonlijke ervaring van uw bevalling, zoals u die zelf heeft beleefd en nadien vertelt. U kiest volledig zelf wat u hierover wilt delen. Het onderzoek heeft geen medisch doel: het is geen evaluatie van medische handelingen of zorgverlening, maar richt zich op de persoonlijke betekenisgeving en beleving van de bevalling. Alle informatie die u deelt is subjectief en vrijwillig, en wordt enkel gebruikt voor wetenschappelijk onderzoek in de sociale en humane wetenschappen. De onderzoeker kan niets verifiëren in medische dossiers en voert geen medische handelingen uit.

Tijdens het interview ben je herkenbaar voor de onderzoeker, maar in alle onderzoeksresultaten word je **volledig gepseudonimiseerd** weergegeven. Dit betekent dat uw naam, voornaam, geboortedatum en woonplaats vervangen worden door een code. Alle verdere verwerkingen gebeuren op deze gepseudonimiseerde gegevens. Het verband tussen de code en uw persoon wordt wel bewaard. Deze link wordt enkel gebruikt om in uw eigenbelang bepaalde informatie naar u te kunnen terugkoppelen.

Indien u aanvaardt om aan dit onderzoek deel te nemen en indien u voldoet aan alle voorwaarden voor deelname, dan zullen er geen volgende tests / onderzoeken worden uitgevoerd: *niet van toepassing*. Er zijn geen volgende tests/onderzoeken nodig voor verdere deelname.

Duur van het onderzoek

Zoals eerder vermeld, voor deelname wordt ongeveer 1,5 uur gerekend, waarbij het interview ongeveer een uur in beslag zal nemen.

Voor- en nadelen

We kunnen niet garanderen dat deelname directe voordelen voor jou oplevert, maar jouw bijdrage helpt ons om beter inzicht te krijgen in bevallingservaringen.

Het kan zijn dat sommige vragen als gevoelig of persoonlijk aanvoelen. Je mag altijd weigeren om op bepaalde vragen te antwoorden of pauzeren wanneer je dat wenst.

Trigger warning: In dit interview kunnen onderwerpen aan bod komen zoals pijnlijke of traumatische ervaringen, medische complicaties, verlieservaringen, ervaring met grensoverschrijdend gedrag en ervaren psychologische gevolgen. Laat het me gerust weten als je bepaalde onderwerpen liever vermijdt of een pauze nodig hebt.

Hulplijnen: In geval van aanhoudende onrust, zorgen of behoefte aan een gesprek, kan je altijd terecht bij Tele-Onthaal bij nummer 106 of bij De Kraamvogel voor een ingepland zorgen- en twijfelgesprek. De Kraamvogel is een expertisecentrum en vzw in Antwerpen die zich bezighoudt met ondersteuning rond zwangerschap, bevalling en de periode na de geboorte. Zij bieden gesprekken aan waar je terecht kan met je zorgen en twijfels.

2. Algemene informatie over de deelname aan een onderzoek

Vrijwillige deelname

Indien u toestemt om deel te nemen aan het onderzoek, dient u deze informatiefolder te bewaren en zal er u gevraagd worden het aangehechte toestemmingsformulier te ondertekenen.

U neemt geheel vrijwillig deel aan deze studie en u heeft het recht te weigeren eraan deel te nemen.

U heeft ook het recht om uw deelname aan het onderzoek op elk ogenblik stop te zetten, zelfs nadat u het toestemmingsformulier ondertekend heeft. U mag ook iedere vraag weigeren te beantwoorden. U hoeft hiervoor geen reden te vermelden. Het intrekken van uw toestemming zal geen enkel nadeel of verlies van voordelen met zich meebrengen.

Uw deelname aan het onderzoek kan ook, zonder uw toestemming, op elk ogenblik stopgezet worden door de onderzoeker(s), het Ethisch Comité of de opdrachtgever. Mogelijke redenen voor zulke beslissing kunnen onder andere zijn:

- U houdt zich niet aan de instructies voor deelname aan het onderzoek
- Uw verdere deelname blijkt schadelijk te zijn voor u
- Er wordt tijdens het onderzoek vastgesteld dat u toch niet of niet meer aan de voorwaarden voor deelname voldoet
- het onderzoek wordt om externe redenen stopgezet

Aansprakelijkheid en verzekering

Indien u schade ondervindt als gevolg van uw deelname aan dit onderzoek, zal u of uw rechthebbenden door de opdrachtgever van dit onderzoek vergoed worden voor deze schade, overeenkomstig de geldende Belgische wetgeving. U hoeft hiervoor geen fout aan te tonen.

De opdrachtgever heeft een foutloze verzekering afgesloten die de eventuele schade dekt die zou voortvloeien uit dit onderzoek. U of uw rechthebbenden kunnen hiervoor op elk ogenblik deze verzekeraar rechtstreeks dagvaarden.

Kosten en vergoeding

Deze studie zal voor u geen bijkomende kosten met zich meebrengen. Eventuele reis- en eventuele parkeerkosten die verbonden zijn aan het interview worden echter niet vergoed.

Bescherming van uw persoonlijke levenssfeer

Uw identiteit en uw deelname aan dit onderzoek worden strikt vertrouwelijk behandeld. U zal niet bij naam of op een andere wijze geïdentificeerd worden in dossiers, databestanden, resultaten of publicaties in verband met het onderzoek. Audio-opnames en transcripties worden opgeslagen op een beveiligde locatie en 10 jaar bewaard, volgens de richtlijnen voor goede onderzoekspraktijken. Enkel de onderzoeker en bevoegde vertegenwoordigers van de Universiteit Antwerpen kunnen, indien nodig, de gegevens inkijken om de kwaliteit van het onderzoek te controleren.

Om uw privacy te garanderen met betrekking tot het bewaren en verwerken van de gegevens in het kader van deze studie, worden uw gegevens gepseudonimiseerd. Dit betekent dat uw naam, voornaam, geboortedatum en woonplaats vervangen worden door een code. Alle verdere verwerkingen gebeuren op deze gepseudonimiseerde gegevens. Het verband tussen de code en uw persoon wordt wel bewaard. Deze link wordt enkel gebruikt om in uw eigenbelang bepaalde informatie naar u te kunnen terugkoppelen.

Bescherming van uw persoonsgegevens

Indien u toestemt om deel te nemen aan dit onderzoek betekent dit dat u toestemming geeft tot het gebruik van uw persoonsgegevens die in het kader van dit onderzoek worden verzameld.

U kan de toestemming om uw gegevens te verzamelen en te verwerken op elk moment intrekken. Indien uw studiedeelname voortijdig gestopt wordt, zal uw oorspronkelijke toestemming het gebruik toelaten van de over u verzamelde gegevens met betrekking tot de periode dat u in het onderzoek ingesloten was.

Enkel personen die rechtstreeks bij het onderzoek betrokken zijn, zullen toegang hebben tot uw persoonsgegevens. Uw gegevens worden niet doorgegeven aan derden.

De onderzoekers zullen uw gegevens bewaren gedurende een periode van *10 jaar*.

U heeft het recht aan de onderzoeker te vragen welke gegevens er over u worden verzameld in het kader van het onderzoek en wat de bedoeling ervan is. U kan vragen om bepaalde gegevens te verbeteren of te wissen, of om uw gegevens niet meer te gebruiken.

Alle persoonsgegevens, die over u verzameld worden, zullen worden verwerkt in overeenstemming met de Europese Algemene Verordening Gegevensbescherming (General Data Protection Regulation (AVG/GDPR) – EU2016/679) en de Belgische wet van 30 juli 2018 die deze verordening verder uitwerkt.

De Universiteit Antwerpen is als opdrachtgever van de studie verantwoordelijk voor de verwerking van uw persoonsgegevens. Zij heeft daartoe een functionaris voor de gegevensverwerking aangesteld (contactpersoon: Sarah Van de Velde, sarah.vandevelde@uantwerpen.be).

Wanneer u vindt dat uw rechten met betrekking tot uw persoonsgegevens onvoldoende worden gerespecteerd, kan u steeds terecht bij de functionaris voor de gegevensbescherming die desgevallend de nodige maatregelen zal treffen. U hebt ook het recht om een klacht in te dienen bij de Belgische Gegevensbeschermingsautoriteit.

Meer informatie kan u nalezen op <https://www.uza.be/privacy.html>.

We hopen u met dit document voldoende informatie te hebben gegeven over het onderzoek.

U heeft het recht om op elk ogenblik bijkomende vragen te stellen over de inhoud, het doel of het verloop van het onderzoek, over de mogelijke en/of bekende voor- en nadelen die dit onderzoek voor u inhoudt, enz.. U kunt zich daarvoor wenden tot de onderzoeker(s) *Emilie Gillain*, emilie.gillain@student.uantwerpen.be.

Datum (.../.../.....)

TOESTEMMINGSFORMULIER

Deel enkel bestemd voor de deelnemer:

Hierbij bevestig ik, ondergetekende (*naam en voornaam deelnemer*) dat ik over het onderzoek ben ingelicht en een kopie van het informatiedocument ontvangen heb.

Ik heb de informatie gelezen en begrepen. De onderzoeker heeft mij voldoende informatie gegeven met betrekking tot het doel en het opzet van het onderzoek, de voorwaarden en de duur ervan, en de mogelijke bekende voor- of nadelen die dit onderzoek voor mij kunnen inhouden. Bovendien werd mij voldoende tijd gegeven om de informatie te overwegen en om vragen te stellen, waarop ik bevredigende antwoorden gekregen heb.

Ik ben ervan op de hoogte dat dit onderzoek we geen medische gegevens zoals medische dossiers, uitslagen, parameters of evaluaties verzameld of bevroegd. Het interview zal enkel gaan over mijn persoonlijke ervaring van het bevallen, zoals ik deze zelf heb beleefd en nadien navertel, waarbij ik mag kiezen wat hierover gedeeld wordt. Ik begrijp dat het onderzoek geen medisch doel heeft: het is geen evaluatie van medische handelingen of zorgverlening, maar richt zich op de persoonlijke betekenisgeving en beleving van mijn bevalling.

Ik ben ervan op de hoogte dat enkel de onderzoeker en de bevoegde instanties van de Universiteit Antwerpen mijn gegevens kunnen inkijken in het kader van kwaliteitscontrole, en dat deze informatie strikt vertrouwelijk wordt behandeld. Ik begrijp dat mijn gegevens gecodeerd worden en uitsluitend gebruikt zullen worden voor dit onderzoek, en dat alle resultaten volledig gepseudonimiseerd zullen worden gerapporteerd Dit betekent dat uw naam, voornaam, geboortedatum en woonplaats vervangen worden door een code. Alle verdere verwerkingen gebeuren op deze gepseudonimiseerde gegevens. Het verband tussen de code en uw persoon wordt wel bewaard. Deze link wordt enkel gebruikt om in uw eigenbelang bepaalde informatie naar u te kunnen terugkoppelen. Ik weet dat ik het recht heb om mijn gegevens in te zien en te laten corrigeren, evenals het recht om te vragen welke gegevens worden verzameld en met welk doel. Ik ben ervan op de hoogte dat de opname van het interview wordt verwijderd na het uitschrijven van het interview. Ik ben ervan op de hoogte dat ik mijn toestemming tot deelname aan het onderzoek en tot verwerking van mijn gegevens kan weigeren en dat ik de toestemming om mijn data te gebruiken op elk moment kan intrekken, nadat ik de onderzoeker hierover heb ingelicht, zonder dat dit mij enig nadeel kan berokkenen. Mijn oorspronkelijke toestemming tot deelname aan het onderzoek en gebruik van mijn persoonsgegevens zal het gebruik van mijn gegevens toelaten met betrekking tot de periode dat ik in het onderzoek ingesloten was. Ik ben ervan op de hoogte gesteld dat mijn gegevens gedurende 10 jaar zullen bewaard worden. Als ik klachten heb over het beheer van mijn gegevens weet ik dat ik me kan richten tot de onderzoekers of de functionaris voor de gegevensbescherming van de UA, prof. dr. Sarah Van de Velde (sarah.vandevelde@uantwerpen.be).

Ik geef toestemming aan de onderzoeker om mijn gegevens te verzamelen, te verwerken en te gebruiken zoals beschreven in het informatiedocument dat ik ontving en conform de geldende wetgeving. Wanneer de studieresultaten gepubliceerd worden, zal mijn identiteit geheim blijven.

Ik stem geheel vrijwillig toe om deel te nemen aan dit onderzoek en om mee te werken aan alle gevraagde onderzoekshandelingen. Ik begrijp dat mijn deelname volledig vrijwillig is en dat ik op elk moment kan stoppen, zonder hiervoor een verklaring te moeten geven en zonder dat dit enige nadelige gevolgen met zich meebrengt. Ik begrijp eveneens dat ik tijdens het interview vragen mag weigeren te beantwoorden.

Ik erken dat tijdens dit interview onderwerpen aan bod kunnen komen die verband houden met pijnlijke of traumatische ervaringen, medische complicaties, verlieservaringen, grensoverschrijdend gedrag of mogelijke psychologische gevolgen. Ik ben geïnformeerd dat ik bij aanhoudende onrust, bezorgdheden of de behoefte aan verder gesprek terecht kan bij Tele-Onthaal via het nummer 106, of bij De Kraamvogel voor een ingepland zorgen- en twijfelgesprek.

Naam van de deelnemer
Datum (.../.../.....)
Handtekening

Deel enkel bestemd voor het onderzoeksteam

Ik, ondergetekende (naam): _____,
bevestig dat ik de inhoud van het informatieformulier heb besproken met
_____ (naam deelnemer).

Ik heb de deelnemer geïnformeerd over de doelstelling, werkwijze, mogelijke risico's en haar rechten. Ik heb expliciet gevraagd naar eventuele onduidelijkheden en deze beantwoord.
Ik bevestig dat de deelnemer vrijwillig toestemming heeft gegeven.

Datum: _____
Handtekening onderzoeker: _____
Contactgegevens: _____

8.3 Informed Consent (ENG)

INFORMATION DOCUMENT FOR PARTICIPANTS IN A

NON-COMMERCIAL STUDY INVOLVING HUMAN SUBJECTS

Commissioning:

University of Antwerp (UA)
Faculty of Social Sciences
University of Antwerp
Stadscampus – Building M (De Meerninne)
Sint-Jacobstraat 2
2000 Antwerp, Belgium

Promotor(s):

Prof. Dr. Sarah Van de Velde
UA - University of Antwerp
Department of Sociology

Researcher:

Emilie Gillain
University of Antwerp
Department of Sociology
emilie.gillain@student.uantwerpen.be
+32 487 25 79 35

Contact person for information about the study:

Emilie Gillain
University of Antwerp
Department of Sociology
emilie.gillain@student.uantwerpen.be

Contact person for information about collected data:

Emilie Gillain
University of Antwerp
Department of Sociology
emilie.gillain@student.uantwerpen.be

Prof. Dr. Sarah Van de Velde
University of Antwerp
Department of Sociology
sarah.vandavelde@uantwerpen.be

Medical Ethics Committee:

Ethics Committee UZA-UA
UZA, Drie Eikenstraat 655, B-2650 Edegem
Tel. +32 3 821 38 97
Ethisch.Comite@uza.be

Dear Participant,

You are invited to voluntarily participate in an interview study concerning your childbirth experience.

Before you agree to participate in this study, it is important that you carefully read this document.

1. Study-specific information

This study was approved on ... (Date .../.../.....) by the independent Ethics Committee of UZA–University of Antwerp.

Purpose and description of the study

This is a scientific study in which an estimated total of at least 12 and at most 50 Belgian participants will take part.

The purpose of this study is to gain insight into how women attribute meaning to childbirth and how they incorporate medical language into their childbirth experience. This study is part of the master's thesis of Emilie Gillain.

This is an observational study. This means that the researcher will interview and observe you only, without changing or influencing anything.

If you participate, you will be interviewed once about your childbirth experience. Participation will take approximately 1.5 hours in total, with the interview itself lasting about one hour. The interview will be audio-recorded so that it can later be transcribed accurately.

No medical data such as medical records, test results, parameters, or evaluations are collected in this study. During the interview, we will only ask about your personal experience of childbirth, as you yourself experienced and recount it. You are entirely free to decide what you wish to share.

This study has no medical objective: it is not an evaluation of medical procedures or care, but focuses on the personal meaning-making and lived experience of childbirth. All information you share is subjective and voluntary and will be used solely for scientific research in the social and human sciences. The researcher cannot verify information in medical records and does not perform any medical procedures.

During the interview, you will be identifiable to the researcher, but in all research outputs you will be fully pseudonymized (meaning that your name and other identifying details will be replaced by a code or pseudonym, so that you cannot be identified in any reporting of this interview).

If you agree to participate in this study and meet all participation criteria, no additional tests or examinations will be conducted: not applicable. No further tests or examinations are required for continued participation.

Duration of the study

As mentioned above, participation will take approximately 1.5 hours in total, with the interview lasting about one hour.

Benefits and risks

We cannot guarantee that participation will provide you with any direct benefits, but your contribution will help us gain a better understanding of childbirth experiences.

Some questions may feel sensitive or personal. You may always refuse to answer specific questions or request a break whenever you wish.

Trigger warning

This interview may address topics such as painful or traumatic experiences, medical complications, experiences of loss, boundary-crossing behavior, and psychological consequences. Please feel free to let me know if you would prefer to avoid certain topics or need a break.

Support services

In case of ongoing distress, concerns, or a need for conversation, you may contact Tele-Onthaal at number 106 or De Kraamvogel for a scheduled support and consultation session. De Kraamvogel is an expertise center and

non-profit organization in Antwerp that provides support related to pregnancy, childbirth, and the postpartum period. They offer conversations where you can discuss your concerns and doubts.

2. General information about participation in a research study

Voluntary participation

If you agree to participate in the study, you should keep this information document, and you will be asked to sign the attached informed consent form.

Your participation in this study is entirely voluntary, and you have the right to refuse participation.

You also have the right to withdraw from the study at any time, even after signing the consent form. You may also refuse to answer any question. You do not need to provide a reason. Withdrawal of consent will not result in any disadvantage or loss of benefits.

Your participation may also be terminated at any time without your consent by the researcher(s), the Ethics Committee, or the sponsor. Possible reasons for such a decision include, but are not limited to:

Failure to follow study participation instructions

Continued participation is deemed harmful to you

It is determined during the study that you no longer meet the participation criteria

The study is discontinued for external reasons

Liability and insurance

If you suffer damage as a result of participation in this study, you or your legal representatives will be compensated by the study sponsor in accordance with applicable Belgian law. You do not need to prove fault.

The sponsor has taken out a no-fault insurance policy covering any potential damage resulting from this study. You or your legal representatives may initiate direct legal action against the insurer at any time.

Costs and compensation

Participation in this study will not incur any additional costs for you. However, travel or parking expenses related to the interview will not be reimbursed.

Protection of your privacy

Your identity and participation in this study will be treated as strictly confidential. You will not be identified by name or otherwise in any files, databases, results, or publications related to this study.

Audio recordings and transcripts will be stored in a secure location and retained for 10 years, in accordance with guidelines for good research practice. Only the researcher and authorized representatives of the University of Antwerp may access the data if necessary to monitor research quality.

To protect your privacy with regard to the storage and processing of data in the context of this study, your data will be pseudonymized. This means that your name, date of birth, and place of residence will be replaced by a code. All further processing will be carried out on these pseudonymized data. The link between the code and your identity will be retained and used solely to provide information to you in your own interest.

Protection of personal data

By agreeing to participate in this study, you consent to the use of your personal data collected in the context of this research.

You may withdraw your consent for the collection and processing of your data at any time. If your participation in the study is terminated early, your original consent will allow the use of the data collected about you during the period in which you participated in the study.

Only individuals directly involved in the research will have access to your personal data. Your data will not be shared with third parties.

The researchers will retain your data for a period of 10 years.

You have the right to ask the researcher which data about you are being collected as part of the study and for what purpose. You may request that certain data be corrected or deleted, or that your data no longer be used.

All personal data collected about you will be processed in accordance with the European General Data Protection Regulation (GDPR – EU 2016/679) and the Belgian Act of July 30, 2018 implementing this regulation.

The University of Antwerp, as the sponsor of the study, is responsible for processing your personal data. A data protection officer has been appointed for this purpose (contact person: Sarah Van de Velde, sarah.vandavelde@uantwerpen.be).

If you believe that your rights regarding your personal data are not being sufficiently respected, you may contact the data protection officer, who will take appropriate measures if necessary. You also have the right to lodge a complaint with the Belgian Data Protection Authority.

More information is available at: <https://www.uza.be/privacy.html>

We hope that this document has provided you with sufficient information about the study.

You have the right to ask additional questions at any time about the content, purpose, or conduct of the study, as well as about any possible or known benefits or risks. You may contact the researcher(s), Emilie Gillain, at emilie.gillain@student.uantwerpen.be.

Date (.../.../.....)

INFORMED CONSENT FORM

Section for the participant only:

I, the undersigned (participant's full name), confirm that I have been informed about the study and have received a copy of the information document.

I have read and understood the information. The researcher has provided me with sufficient information regarding the purpose and design of the study, its conditions and duration, and the possible known benefits or risks. I have been given sufficient time to consider the information and to ask questions, which were answered to my satisfaction.

I am aware that this study does not collect or request medical data such as medical records, test results, parameters, or evaluations. The interview will focus solely on my personal experience of childbirth, as I experienced and recount it, and I may choose what I wish to share. I understand that the study has no medical purpose: it is not an evaluation of medical procedures or care, but focuses on the personal meaning and lived experience of my childbirth.

I am aware that only the researcher and authorized bodies of the University of Antwerp may access my data for quality control purposes, and that this information will be treated confidentially. I understand that my data will be coded and used exclusively for this study, and that all results will be reported in a fully pseudonymized manner (meaning that my name and other identifying details will be replaced by a code or pseudonym, so that I cannot be identified in any reporting of this interview). I am aware that I have the right to access and correct my data, as well as the right to ask which data are collected and for what purpose. I am aware that the audio recording of the interview will be deleted after transcription. I am aware that I may refuse consent to participate in the study and to the processing of my data, and that I may withdraw consent for the use of my data at any time after informing the researcher, without any negative consequences. My original consent allows the use of my data collected during the period in which I participated in the study. I am aware that my data will be retained for a period of 10 years.

If I have complaints regarding the management of my data, I know that I may contact the researchers or the data protection officer of the University of Antwerp, Prof. Dr. Sarah Van de Velde (sarah.vandevelde@uantwerpen.be).

I give permission to the researcher to collect, process, and use my data as described in the information document and in accordance with applicable legislation. When study results are published, my identity will remain confidential.

I voluntarily agree to participate in this study and to cooperate with all required research procedures. I understand that my participation is entirely voluntary and that I may stop at any time without providing a reason and without any adverse consequences. I also understand that I may refuse to answer questions during the interview.

I acknowledge that this interview may address topics related to painful or traumatic experiences, medical complications, experiences of loss, boundary-crossing behavior, or possible psychological consequences. I have been informed that in case of ongoing distress, concerns, or the need for further conversation, I may contact Tele-Onthaal at number 106 or De Kraamvogel for a scheduled support consultation.

Participant name:

Date (.../.../.....)

Signature:

Section for the research team only

I, the undersigned (name): _____,
confirm that I have discussed the content of the information document with
_____ (participant's name).

I have informed the participant about the purpose, procedures, possible risks, and her rights. I have explicitly asked about any remaining questions and have answered them.

I confirm that the participant has given voluntary consent.

Date: _____

Researcher's signature: _____

Contact details: _____

8.4 Semi-Structured Interview Guide (NL)

Toelichting [informatiebrief en informed consent reeds behandeld]: zoals eerder toegelicht in de informatiebrief, zullen we het vandaag hebben over uw bevalling. Om alles goed vast te leggen en aandachtig naar u te kunnen luisteren, neem ik dit gesprek op. De opname blijft strikt vertrouwelijk en wordt anoniem verwerkt. U kunt het interview op elk moment stopzetten of bepaalde vragen overslaan. Er zijn geen juiste of foute antwoorden; het gaat volledig om uw persoonlijke ervaring. Verder wens ik u alvast te bedanken voor uw tijd en openheid!

Openingsvraag (± 5 min)

- Zou je jezelf kort willen voorstellen?
 - o *Leeftijd, werk, studies, hobby, etc.*

Overgangsvraag (± 5 min)

- Voordat we het over de bevalling zelf hebben, ben ik benieuwd: hoe keek je ertegen aan? Wat verwachtte je? Waar hoopte je op? [Heb je een geboorteplan gemaakt en wat stond er in?](#)

Centrale vraag (30-45 minuten)

Zou je me willen vertellen hoe je bevalling voor jou is verlopen, van begin tot einde, gewoon zoals jij het hebt beleefd?

We hebben een uur de tijd, dus neem gerust alle ruimte om je verhaal te doen met alles wat voor jou belangrijk is. Ik zal vooral luisteren. Soms kan het zijn dat ik tussendoor een vraag stel, maar dat dient voornamelijk om zeker te zijn dat ik zaken goed heb begrepen.

Overkoepelende aandachtspunten voor interviewer

- *Wie bepaalt wanneer een fase 'officieel' start?*
- *Agency: wie is het subject in haar zinnen? ('Ze hebben mijn vliezen gebroken' vs 'Ik besloot dat ze mijn vliezen konden breken')*
- *Evaluaties: wanneer gebruikt ze woorden zoals 'moest', 'mocht', 'gelukkig', 'jammer', 'normaal', etc.?*
- *Hoeveel ruimte is er voor eigen interpretatie door de bevallende vrouw?*
- *In welke mate wordt er over de bevalling gesproken als iets fysiologisch/natuurlijk/etc. en in welke mate/wanneer/waarom wordt het iets medisch/risicovol/monitoring etc.?*
- *Beslissingsmacht: Wie voert besluitvorming uit?, Wie heeft het meeste beslissingsmacht? En wie/wat bepaalt dat? (bv. wnr er geperst mag worden)*
- *Medische hiërarchie: in welke mate geïnterpreteerd als samenwerking tussen gelijke partners? In welke mate en wanneer verschuift leiding van bevallende vrouw naar vroedvrouw naar gynaecoloog?*
- *Wat wordt wel/niet als interventie benoemd of gekaderd? Welke interventies zijn routinematig of indicatiegebonden?*
- *Verandert interpretatie/taal/betekenis wanneer setting verandert, bv. bij verplaatsing van thuis naar hospitaal?*
- *Hoe verhouden ervaringsmacht, expertisemacht/technologische monitoring en institutionele macht zich tegenover elkaar?*
- *Wanneer word iets verwoord als keuze (+van wie?) en wanneer als noodzaak?*

Reflectievragen (voor moesten deze nog niet beantwoord zijn in het verhaal)

- [Hoe waren de eerste weken post-partum? \(Specifiek: de overgang van ziekenhuis naar thuis\)](#)
- Hoe uw ervaring en je geboorteverhaal in de loop der tijd veranderd?

- Waren er momenten tijdens de bevalling die voor jou echt belangrijk waren of die echt anders zijn verlopen dan verwacht?
- Zou u een volgende keer op eenzelfde manier willen bevallen? Waarom?

Besluitende vragen

- We zijn bijna aan het einde van het interview. Is er nog iets over je bevalling dat je belangrijk vindt om te delen, maar waar we het nog niet over hebben gehad?

Dank je wel voor je openheid en vertrouwen. Ik waardeer het enorm dat je je verhaal met me wilde delen. Hoe was het interview voor jou?

Als je achteraf nog vragen hebt, of als je nog iets wilt toevoegen, mag je me altijd contacteren.

Nota's voor mezelf:

Sensitising subjects: risico, risico-management, normaliteit, medisch toezicht, self-efficacy, communicatie, support, 'medisch noodzakelijk', 'veiligheid', 'echt bevallen', 'natuurlijk bevallen', vrouwelijkheid, falen / succes, medische autoriteit, agency / overgave, schuld / opluchting, normaliteit / uitzondering, keuze / noodzaak [nog verder aan te vullen]

Principles trauma-informed interviewing

- Ga uit van een mogelijke traumageschiedenis: wees gevoelig, empathisch en vorm geen oordeel
- Creeër veiligheid en vertrouwen: Zorg voor een rustige, veilige fysieke en emotionele omgeving. Bespreek informed consent duidelijk en transparant.
- Empower participanten: participanten vertellen enkel wat ze willen vertellen, faciliteer een context waarin participanten zich vrij voelen om vragen te weigeren en grenzen te stellen
- Gevoelige vraagstelling: stel je vragen op een zachte en uitnodigende manier, ga voor open vragen, free-recall vragen, reduceer druk of sturende formuleringen
- Culturele en individuele responsiviteit: pas je houding, communicatie en verwachtingen aan culturele achtergrond en persoonlijke noden aan
- Voer geen druk uit: Respecteer het tempo van de participant en forceer geen onthulling van gevoelige informatie
- Veroordeel of moraliseer niet: Blijf onpartijdig en ondersteunend, ongeacht wat gedeeld wordt
- Benadruk vertrouwelijkheid en privacy: Leg duidelijk uit hoe informatie wordt beschermd en wie toegang heeft tot de gegevens
- Zelfzorg voor de onderzoeker: Voorzie training, supervisie en ondersteuning om secundaire traumatisering of overbelasting te voorkomen
- Voorbereiding op toetreding tot de gemeenschap: leer over de gevolgen van traumatische gebeurtenissen en historisch trauma voor individuen en gemeenschappen

1. Latente fase / naderende bevalling → start? Wanneer? Wie bepaalt dat? + hoe wordt ontsluiting bepaald? Wie maakt beslissingen? Fysiologisch: Beginnende weeën, breken van vruchtwater, slijmprop/bloed Mogelijke interventies: breken vruchtwater, oxytocine, monitoring (hartslag) baarmoedermond opent tot ongeveer 4–6 cm Interpretatief: Wanneer maakt dit deel uit van de bevalling? Wat/wie bepaalt dat terugkijkend het 'telt' als start? Betrokkenheid zorgverlener Begint vaak thuis → vroedvrouw/verloskundige wordt gecontacteerd Ziekenhuis: telefonische triage → opname bij <u>voldoende</u> regelmaat/progressie Mogelijke interventies Monitoring & evaluatie: CTG-monitoring (hartslag baby), ontsluitingsgraad, etc. Vliezen breken Oxytocine bij onvoldoende progressie Pijnstilling (bv. lachgas? In BE?)
Actieve fase / ontsluitingsfase Fysiologisch Weeën worden intenser en frequenter in tijd De ontsluiting gaat sneller (vaak 1 cm per uur) en weeën worden krachtiger en regelmatig (elke 3–5 minuten) Interventies: epidurale Betrokkenheid zorgverlener: Actieve aanwezigheid Mogelijke interventies Monitoring & evaluatie: CTG-monitoring, ontsluiting, indaling hoofd, stand van het hoofd, etc. Epidurale
Overgangsfase Fysiologisch Zeer krachtige, frequente weeën Snelle ontsluiting tot 10 cm Vaak: Misselijkheid/braken Beven Drukgevoel Emotionele ontregeling ("ik kan niet meer") Ontsluiting 8–10 cm. Typische betrokkenheid zorgverleners Continue begeleiding Voorbereiding op uitdrijvingsfase Eventueel arts stand-by Mogelijke interventies Bij foetale nood/kritiek moment: versnelde besluitvorming

Soms bijsturen van epidurale
Uitdrijvingsfase
Fysiologisch - Volledige ontsluiting (10 cm). - Actieve persweeën. - Indaling en rotatie van het hoofd. - Geboorte van het kind. Typische betrokkenheid zorgverleners - Actieve begeleiding van persfase. - Continue monitoring foetale harttonen. - Gynaecoloog aanwezig bij verhoogd risico. - Neonatale equipe indien verwacht risico. Mogelijke interventies - Episiotomie (knip) - Kunstverlossing: - Vacuümextractie - Forceps - Sectio caesarea (indien vaginale geboorte niet mogelijk of bij acute nood) - Manuele ondersteuning perineum - Oxytocine na geboorte schouders (actief nageboortetijdperk)
Nageboorte
- Moederkoek volgt nog - Mogelijke interventie: hechting, manuele verwijdering - Monitoring bloedverlies - Start huid-op-huid contact - Gecontroleerde tractie aan navelstreng - Hechten van rupturen of episiotomie - Manuele placentaverwijdering bij retentie - Behandeling postpartum hemorragie

8.5 Drop Off (NL)

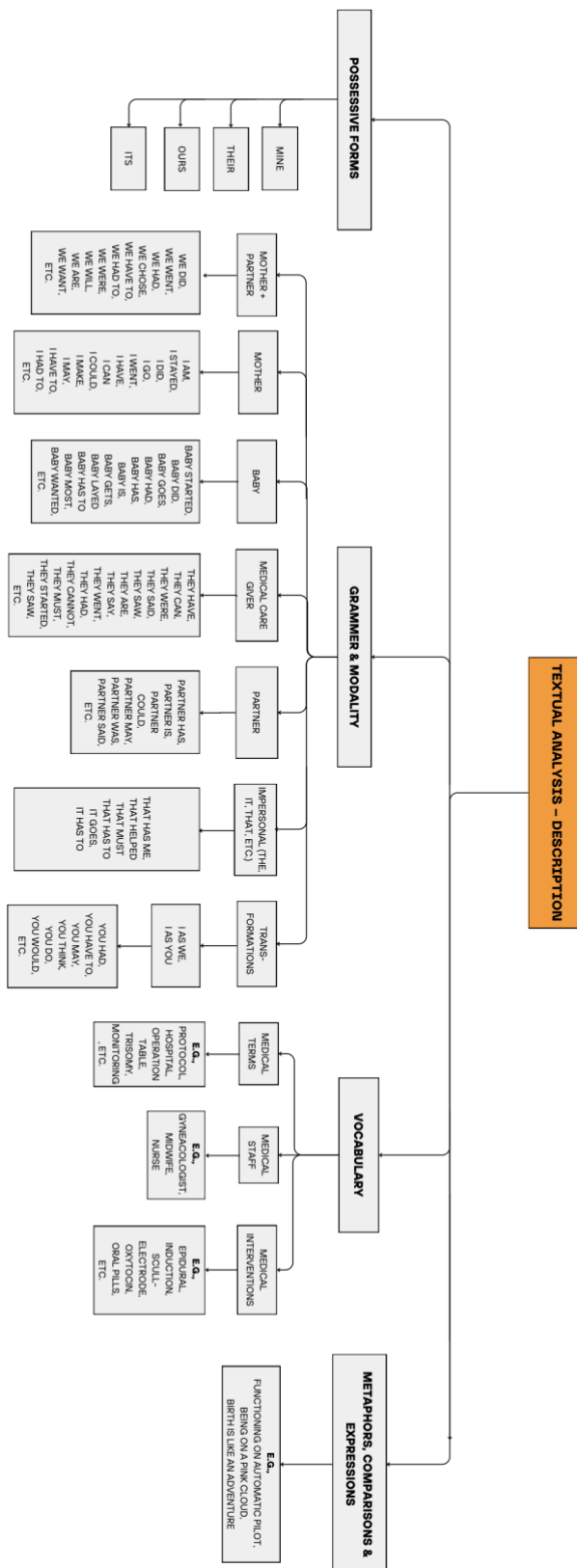


Achtergrondvragenlijst

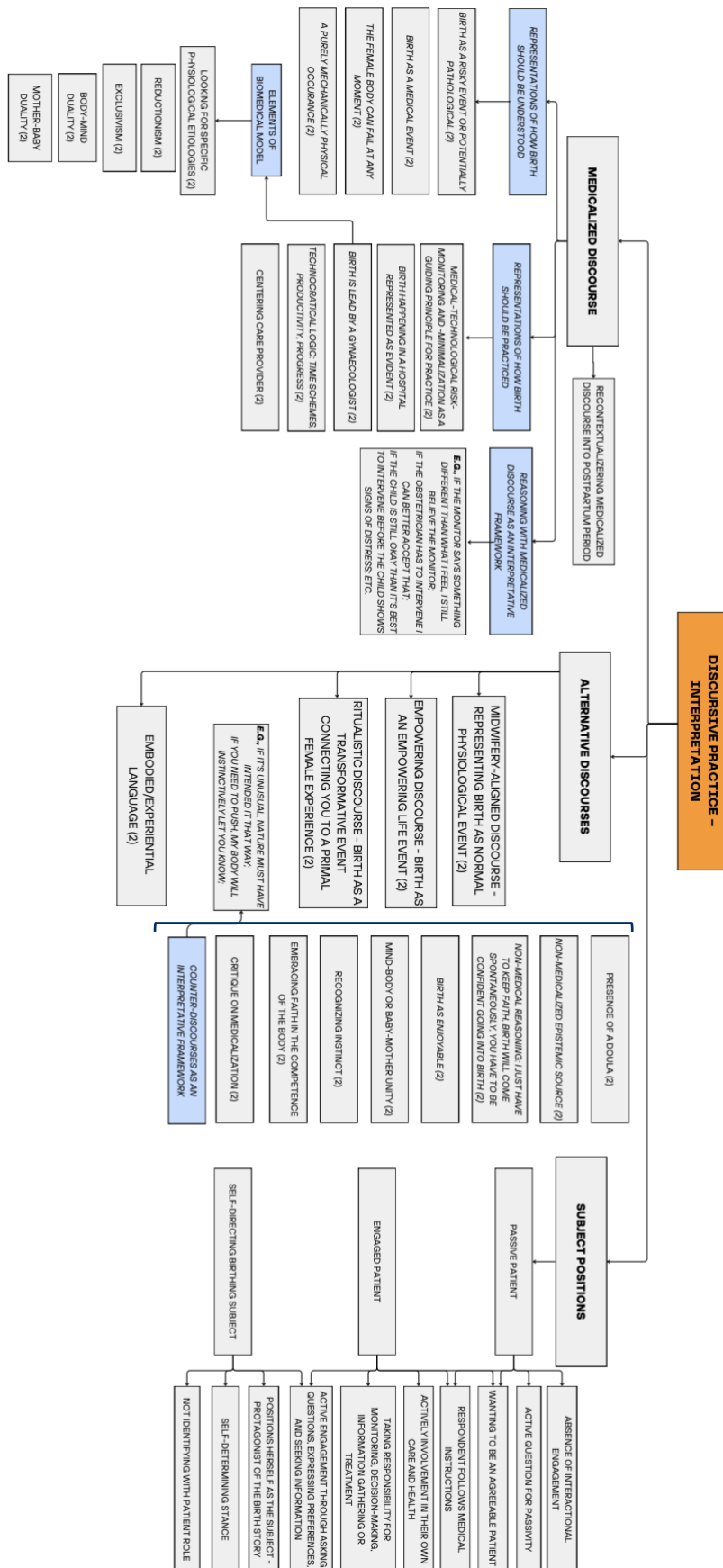
Wat is uw leeftijd?	jaar
Wat is uw hoogst behaalde opleiding?	☐ Secundair onderwijs ☐ Professionele bachelor ☐ Academische bachelor ☐ Master ☐ Wil ik liever niet zeggen
Welke omschrijving past best bij uw woonomgeving?	☐ Stad ☐ Verstedelijke gemeente ☐ Platteland ☐ Wil ik liever niet zeggen
Waar ben je bevallen?	☐ In een ziekenhuis ☐ In een geboortehuis / birthing center ☐ Thuis (geplande thuisbevalling) ☐ Thuis (ongepande thuisbevalling — bevalling begon thuis en was te snel voor ziekenhuis) ☐ Onderweg / in ambulance ☐ Anders/mix, namelijk:.....
Hoe tevreden ben je over je bevallingservaring?	Op een schaal van 1 (helemaal niet tevreden) tot 10 (zeer tevreden):
Met wie woon je samen?	☐ Partner/echtgenoot ☐ Alleen (alleenstaande ouder) ☐ Ouders of andere familieleden ☐ Vrienden / huisgenoten ☐ Anders, namelijk:..... ☐ Wil ik liever niet zeggen
Hoe oud is je baby momenteel?	
Wie was er aanwezig tijdens je bevalling (naast zorgpersoneel)?	☐ Partner / echtgenoot ☐ Moeder ☐ Zus / andere familieleden ☐ Vriend(in) ☐ Doula ☐ Niemand anders (alleen medisch personeel) ☐ Anders, namelijk:

8.6 Coding Tree

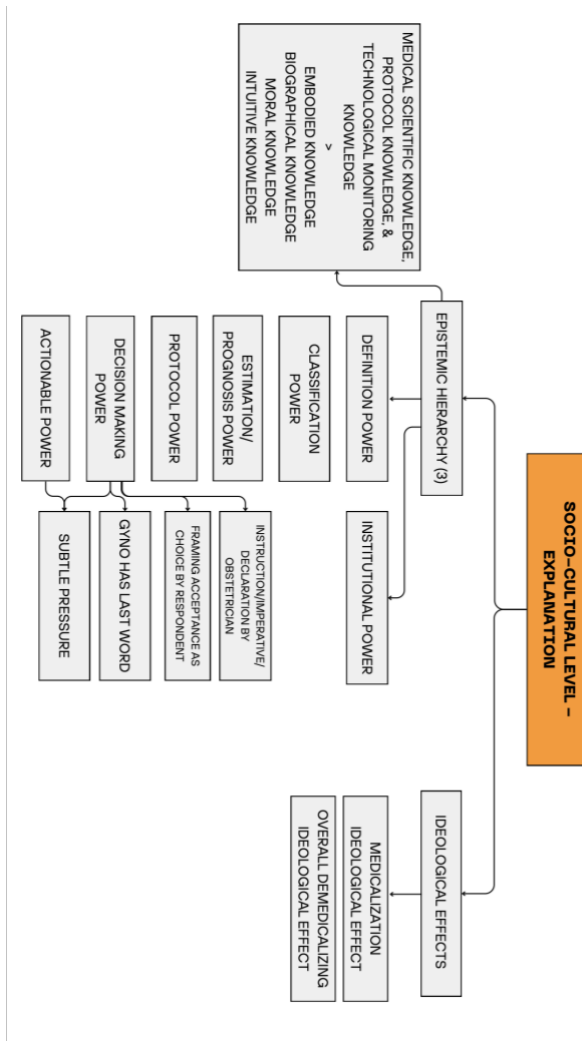
8.6.1 Phase 1 – Textual Analysis



8.6.2 Phase 2 – Discursive Practice



8.6.3 Phase 3 – Socio-Cultural Level



8.6.4 Remaining Codes

