

Patients in Contemporary Russian Reproductive Health Care Institutions Strategies of Establishing Trust

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Abstract: Russian reproductive health care systems have undergone many changes since the 1990s. These changes have given users new opportunities, and users have become more demanding and knowledgeable. At the same time, patients distrust health care institutions and practitioners, which remains one of the Russian reproductive health care's most significant problems. The authors focus on public and private reproductive health care encounters from the patients' perspectives, concentrate on the women's experiences during pregnancy and delivery, explain patients' distrust of medical institutions, and examine the coping strategies patients develop to establish trust. Young, active, educated women do not want to be treated as Soviet patients—disciplined, ignorant, and obedient. They want to find a trustworthy doctor and receive reliable, comfortable, and proximate medical service.

Keywords: distrust, health care, reproduction, Russia, strategies, women

Russian reproductive health care systems have undergone enormous changes since the 1990s. These changes reflect the economic breakdown of the state health care system, the commercialization of medical services, and attempts to solve Russia's demographic problems.

These changes have not only given users new choices and opportunities but have also created unequal access to quality medical services. Russian attitudes toward reproductive health practices have also changed. Women have become more demanding and knowledgeable: they are consciously involved in family planning, including contraceptive use and the exploration of health care options on the Internet.

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However, patients' widespread distrust of both health care institutions and individual practitioners remains one of Russian reproductive health care's most significant dilemmas.¹ The issue of trust in medical institutions has been analyzed, starting with Talcott Parsons's classical model of clinical encounter,² but there have been few previous studies about this problem in the Russian reproductive health system.³ Here, we focus on encounters in public and private reproductive health clinics from the patients' perspectives, concentrating on women's experiences during pregnancy and delivery.

Following a bottom-up strategy of grounded theory (the "systematic inductive guidelines for collecting and analyzing data for middle-range theoretical frameworks that explain the collected data"), we reconstructed the leitmotif (master code) using thematic in-depth interviews.⁴ This leitmotif is: "We do not trust/believe our medicine/doctors." The leitmotif is exacerbated by patients' experiences in reproductive health care institutions.

We also examine how women cope with needed medical assistance despite the trust deficit. We investigate patients' trust in public (insurance-covered and for-fee) and private (commercial) reproductive health services. We find that although women distrust both, they still confront the medical institutions and develop strategies to establish trust when seeking health care.

Field data collected in 2005–6 consists of five participants' diaries and twenty-two in-depth interviews with female reproductive health service clients. (See appendix for the sample's description.) Our subjects were mostly middle-class women of reproductive age who had a postsecondary education. Most were private-sector professionals or ran their own small business.

In this article, we discuss the reproductive health system reforms, providing institutional context for the clinical encounters. We then operationalize the concept of "trust" for our research purposes. We look at reproductive institutions, maternity-care institutions, and practitioners (gynecologists and obstetricians) as subjects of "trust." We analyze different medical encounters in reproductive health institutions. We use this material to portray (1) women's distrust of these institutions; (2) trust-establishing strategies; and (3) new reproductive health patients' construction of their identity as patients.

The Institutional Context of Reproductive Care Reform

Russia's public reproductive health care system consists of two levels. The primary level includes women's consultations, medical centers' gynecological departments, and family planning centers or clinics that provide primary outpatient care. The secondary level includes maternity homes, multiprofile clinics' gynecological departments, and specialized gynecological clinics.

Commercial reproductive health services were legalized in the early 1990s. Private clinics and some state medical centers provide the commercial services. The medical center's administration determines the prices, although prices differ somewhat from one institution to another, depending on the supply-to-demand ratio and the institution's reputation. Institutions regularly revise their lists of commercial services and prices. Since 1994, insurance companies have played a role in the health care system, but the system remains unstable. State-provided mandatory medical insurance (MMI) does not cover all types of medical treatment. Corporations and wealthy clients increasingly use privately owned, voluntary insurance programs.

In 2006, the Russian government launched the Healthcare National Project. President Putin formulated its ideology in his 2006 address to the nation, in which he stated that Russia's worrisome demographic situation—"the most acute problem facing our country today"—stems from three causes: mortality, migration, and fertility.⁵ The National Project on Demographic Policy focuses on reproductive care and pronatal policies, especially encouraging parents to have a second child. The program adopted a policy of financial benefit, termed "maternal capital." A mother receives a substantial sum when her second child turns three years old. The money may be invested in the mother's loans, housing, pension funds, or the child's education.⁶ Birth certificates are another measure aimed at improving the reproductive health system's performance.⁷ However, state efforts to solve demographic problems cannot be successful if Russian women do not change their attitude toward reproductive health institutions. Our research helps explain patients' distrust of medical institutions and explores the strategies that women seeking to establish trust employ.

"Trust" as a Theoretical Tool in Reproductive Health Care Encounters

We interpret trust as a cultural resource necessary for the stable and predictable operation of social institutions.⁸ It is a "routine background to everyday interaction through which the predictability, eligibility, and reliability of collective order is sustained, while the perception of its complexity and uncertainty is restricted."⁹ Targets of trust include institutions, professional roles, and individuals. There are structural factors that determine a society's climate of trust. Social strain and structural uncertainty are conducive to distrust. However, a trust deficit's consequences are not necessarily total disorder. They can result in social change and new solidarities. In a climate of distrust, individuals develop strategies to promote predictability, diminish risks, and gain access to necessary resources and competent services.

For patients, medical encounters—and the medical system in general—represent risk, uncertainty, and the imbalance between medical professionals' authority and patients' lack of control. The medical system is structurally conducive to distrust in all societies. Conversely, patients consistently desire physicians that they can trust because medical services provide "credible goods"—services that do not have immediately evident utility or effects that can be assessed before the patient has paid the doctor. Patients' faith in their physician's professional competence is essential to medical service, "because in the course of treatment patients deliberately put themselves in the hands of the doctor and follow his/her instructions, which will in turn supposedly lead to an improvement in their health."¹⁰

Reproductive health's symbolic value in the context of gender identity lends additional relevance to doctor-patient trust. There are meaningful differences between patients' expectations of obstetricians and other specialists. Women are extremely sensitive to issues of sexuality and reproduction, which are culturally defined as essential to their gender identity. Reproductive health services are invasive—during a gynecological examination, the patient must undress and the doctor examines her intimate parts on the gynecological chair. Women expect obstetricians and gynecologists to provide professional help and, equally important, empathy and respect to the future mothers. Russian femininity is traditionally connected to motherhood, and women are more sensitive and demanding with gynecologists than other doctors.

Doctors have significantly more power when they provide medical services—they are in a dominant position; the patient is dependent. The face-to-face encounter between the doctor and the patient takes place inside a medical institution, which imposes the rules and the frame of interaction. The medical center's physical environment, its technological renovation, the doctor's workload, and many other organizational circumstances structure the encounter. Diagnostic and treatment technologies, commercialization, new or unknown organizational rules, and fragmentation and bureaucratization of services all contribute to doctor-patient interaction.¹¹

Institutionally, Russian reproductive health monitoring services direct women to doctors according to their residence. According to new patients' rights legislation, women are allowed to select their clinic and doctor, but this option is expensive and requires the woman to navigate through the bureaucracy. Recently, women have become extremely sensitive to the Russian health care system's quality because of new opportunities for public and private reproductive care choice.

A Pregnant Woman's Institutional Trajectory: The Chain of Encounters in Reproductive Health Care

Every pregnant Russian woman deals with reproductive health care institutions. A woman's clinical encounters begin as soon as she makes a decision regarding childbirth or finds herself with an unplanned pregnancy. This is often a troublesome and emotional time for a patient. Based on proximity to her residence, a woman is assigned to a municipal women's consultation (WC), which offers primary gynecological care, when she starts displaying signs of pregnancy. The WC views a pregnant woman as both a client and a countable unit. She is registered, examined, and supervised throughout her pregnancy. She receives the necessary prescriptions and treatment, official papers entitling her to receive pregnancy leave and maternity leave, and other medical certificates. She must be registered at a WC to receive the free care and social benefits for which she is eligible. Pregnant women are expected to visit their WC monthly and meet regularly with the same doctor and nurse, enabling them to establish long-term relationships. If there are reproductive complications or risks, patients are hospitalized in a prenatal clinic. WCs also refer women to maternity homes, which often belong to the same prenatal center as the WC.¹² By law, women are allowed to choose their maternity home. In 2007, clinics started receiving a fixed sum from the state for every birth certificate they present. This was intended to improve the WC's quality by providing clinics a financial incentive. If a woman changes clinics because she is dissatisfied with the service, the WC administration will be unable to present the birth certificate, and she will therefore be ineligible for the fixed sum.

Women usually give birth in a public maternity hospital. Legally, patients have a right to arrange for delivery in a separate ward. This service is supposed to be free, but the woman usually must pay because of the scarcity of wards equipped for family services.

Patient-doctor trust issues arise at each of reproductive medicine's numerous stages. We examined women's encounters with WCs, prenatal gynecological clinics, commercial diagnostic centers, and maternity homes, concentrating on patients' perceptions. Their complaints are symptoms of institutional and individual trust deficits.¹³

Women develop strategies to control their reproductive health and make the institutional environment more reliable and accountable and its services more satisfying,

thereby empowering the reproductive-care clients. However, their scope correlates with social position and is framed within the urban setting (e.g., St. Petersburg, Samara, and Chelyabinsk).

Public Reproductive Health Institutions: Complaints Regarding the Physical Environment, Bureaucratic Inefficiency, and Alienated Patients

Before a woman even meets her doctor, she first encounters the clinic's physical environment. The WC (the primary care unit) may be renovated or need repair. Throughout her stay, the client interacts with registrars, wardrobe nurses, medical nurses, and cleaners. She undergoes the diagnostic screening and testing procedures. If she is being treated in a prenatal clinic, she stays in a ward, usually sharing it with several other patients. Our empirical data allow us to reconstruct leitmotifs of the female patients' complaints.

Women are sensitive to the quality of their environment. Our interviewees described the clinics' spatial arrangements and interiors in detail. They compared the public and private medical centers, and some informants contrasted Western standards of medical service, from personal experience or media perceptions, with domestic standards. The comparisons are not always favorable to public reproductive care institutions, despite the influx of state money. One woman, Nana, describing a private diagnostic center, writes: "It is clean there. The stairs are new; the building is repaired in *eurostandards* [meaning an international quality of repair work]."¹⁴ But female patients using public health institutions often observe poverty and decay corresponding to their image of Soviet health care institutions.

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Describing a public reproductive health center, Masha, a medical student, writes in her diary:

MH [Maternity Hospital] and WC belong to the large complex of separate five story buildings with no connecting pathways—a so-called decentralized complex. These are old buildings dating from the second half of the 19th Century. The only new building—an Orthodox chapel—was built at the end of the 1990s. . . . The territory of the complex is surrounded by a fence. Everything around the complex is dirty. There is a lot of garbage on the ground and there are no garbage cans in the area. In the building there are neither elevators for patients, nor special tracks for wheelchairs. Elevators are available only for the medical personnel and for medical equipment. Near the entrance the watchperson is on duty—usually a nurse or a retired person, who cannot actually provide security in case of emergency. At the cloakroom (which is often closed) visitors are supposed to leave their overcoats and to change their boots or buy hospital slippers. . . . The paths connecting the buildings are icy and slippery. Neither salt nor sand is spread on the pathways. A couple of days after a snowfall it became simply impossible to get to the maternity house, which is in the middle of the complex (it is especially uncomfortable for pregnant women, sick people and women with baby carriages who visit the gynecological consultation and medical center).¹⁵

Masha's diary allows us to reconstruct the patient's encounter with a hospital's uncomfortable environment: the leitmotifs here are the filth and the client's insecurity. Although religious corners with icons and candles are now common in medical centers, they do not help diagnostics and treatment. Women may buy snacks, drinks, prescribed medicine, and hygiene products from the clinic's drugstore, but these market achievements do not effect change in the doctor-patient relationship—the core clinical encounter.

Masha writes that approaching such a building makes a woman seeking reproductive care feel vulnerable and helpless. This public health institution's spatial organization is not conducive to the clients' needs: old and unrenovated buildings, structurally outdated patient wards, lack of stroller and wheelchair access, lack of electric lighting, and problematic heating systems. In many cases, medical equipment is obsolete; modern diagnostic equipment is available in only a small number of clinics. Nurses and cleaning staff positions offer only small salaries, causing staff shortages.

In the medical center, WC, or polyclinic (a municipal hospital's primary outpatients' department), women schedule visits with their assigned gynecologists at the lobby desk. Doctors usually work from a set schedule. A gynecologist registers each woman, then gives a primary examination and diagnoses the pregnancy if applicable. Gynecologists provide clients with information about pregnancy options, describe the tests and medical specialists' overall examination processes in different fields, and explain the course of pregnancy monitoring and bureaucratic procedures. Nurses usually assist the doctors in explaining which tests are covered by MMI and what must be paid out of pocket. Information on the commercial medical services provided by the WC is available in the lobby, but women often fail to understand the difference between covered and noncovered services. According to Nana: "The rules of commercial services are not clear. I never know what is covered by MMI and what I have to pay for."¹⁶

Many working women are concerned about balancing their work schedule and clinical routines.¹⁷ Flexible working hours are necessary to fit into the medical practitioners' schedules. This is not always possible, especially with small businesses.

Throughout the course of pregnancy, women must visit medical specialists. In the public medical care system, it is extremely difficult to access these doctors. They usually work in the WC part-time, so there is a waiting list for the visits. The line of patients waiting to see the doctors often extends down the corridor. Sometimes there is not enough available seating. Women in earlier stages of their pregnancy give seats to those in their last trimester. Some patients enter the doctor's office ahead of the line, claiming a special arrangement or emergency situation. As a rule, women in the line silently agree to let them pass. The lines are created by a confluence of organizational inefficiency, rigid and hyperintensive doctors' shifts, and the practice of doctors working (sometimes several) secondary jobs. Nana describes her experience with the registration bureaucracy:

In order to get a "ticket" to an ophthalmologist I came to the polyclinic on Monday and scheduled a Friday visit for the registration. I did not manage to arrive early and my time on Friday was 2 p.m. I wanted to come as early as possible because if you are among the first on the list you have a chance to see the doctor earlier in the month. On Friday I got an appointment. It was in one and a half weeks! It could be worse. Those who came later were scheduled for the last day of the month! When I finally came to visit the doctor I waited in line for almost 2 hours! I was tired and felt really bad! But what could be done? The doctor receives up to 30 patients a day. Her shift lasts 7 hours and according to the rules she has 10–15 minutes for a patient.¹⁸

Organizational deficiencies in scheduling visits at public reproductive health care clinics are preludes to the medical visit itself. Women with complications and pregnancy disorders undergo treatment in the secondary prenatal care institutions. However, in the public clinics, the majority of patients stay in the regular wards. Their treatment is covered by MMI. If clients demand more comfortable conditions, they may stay in commercial rooms for one or two patients. These wards are rare and may be expensive. Clients usually choose to remain in public wards. Katya and Vera wrote diaries describing clinical encounters during their pregnancy. Both women are highly educated; both were in their early thirties and considered older pregnant women by Russian standards. They were assigned to the at-risk reproductive health group and received special pregnancy monitoring. Vera describes the ward in which she stayed: "The hospital is very old with huge wards. In the ward there are eight beds. The bed was awfully hard and uncomfortable and it was very difficult to sleep on such a bed."¹⁹

Katya's description very much resembles Vera's: "It was really quite cold in the ward. A heater that the relatives of one of the patients had brought was constantly used to warm the room. There was just one common toilet in the corridor. There was no separate place to wash. In addition the toilet could not be locked. The lock had broken long ago and there was no hope of it being fixed. In all 'private areas' there are either no locks or the locks are broken. It is almost impossible to guarantee privacy. In addition, anyone may enter the ward at any time without knocking."²⁰

Visitors, often patients' family members, help fix the electricity, bring heaters and televisions for the ward, and generally help compensate for the ward's poor conditions. The lack (or misuse) of material resources in the public medical system necessitates this pseudovolunteerism.

Interviewees described the lack of privacy as routine in medical visits. They frequently criticized this in their diaries. During various aspects of medical care—examinations, treatments, and regular doctor visits in the ward—patients lack privacy. Interviewees often discussed their desire that the staff respect their intimate physiological needs and complained about the unhygienic facilities.

The doctor, often accompanied or followed by the nurse, is at the core of clinical encounters. Patients recalled their encounters with medical professionals in diverse ways. Interviewees described the medical examinations as an important procedure in obstetrics and gynecology. However, they viewed the vaginal examination as a disruption of their bodily integrity and, therefore, not routine. The doctor's and nurse's every word and movement may influence their sensitivity. Many young women feel intimidated and uncomfortable, even if the doctor and nurse are females.

Katya emphasized the lack of privacy during her examination:

The door to the examination room is always open when they are taking blood or giving injections. None of the patients attempt to complain. Entering one by one for an injection, no one closed the door. It was almost like an unwritten rule. . . . Intimacy was neglected even during the doctor's examination. All examinations took place publicly. In the ward the doctor would discuss results of the analyses in front of everyone, your diagnosis and—this really bothered me—to demonstrate just how much blood was being lost he would publicly show the sanitary towel. In the examination room there are three beds, and as a general rule three doctors would give examinations or provide treatments at the same time. That is to say that it is not a confidential consultation with the doctor—instead it is a public event. To make matters worse the doctors

talk to each other, discussing diagnoses and treatments. . . . Having undressed in the corridor, you proceed almost naked through an enormous hall to the bed and climb up onto it.²¹

Women view public consultations and practices in maternity homes as extremely dehumanizing, authoritarian patterns of physical control. The environment makes a woman feel alienated and objectified. Women often call their medical care “Soviet and inhuman.” Women see the consultation as an unfriendly, bureaucratic machine with unclear rules. Katya describes a doctor who disciplined a patient that disobeyed instructions by “reducing [her] to tears with threats to her pregnancy and baby.”²²

Nana writes: “The only thing I want when I go to the clinic is a gentle and empathic doctor who is ready to explain everything to me in a way that I can understand, not with this professional language. And without being rude.”²³

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The physical environment, the medical services bureaucracy, and public institutions’ lack of privacy frustrate women. They are often uncomfortable working with doctors and medical personnel. According to our interviewees, a doctor’s attitude is based on an esoteric level of medicine, which is incomprehensible to patients, and the

bureaucracy. Doctors often neglect to develop personal relationships with their patients.

Many patients try to rationalize this bedside manner or avoid analyzing their attitudes. They describe the doctor’s workload, the chain of bureaucratic chores he or she must implement, the administrative hierarchy among medical personnel—all the aspects of a doctor’s daily routine—rationalizing that the patient will be treated as a consumer in the overcrowded marketplace at best. The situation is usually worse, however. Patients generally view nurses as people who do not want to be emotionally involved with the people they treat. Patients frequently complained about their inability to find a kind, empathetic, “velvet” doctor. Interviewees emphasized how much they appreciated the low-level medical personnel’s politeness and specialists’ attentive attitudes, despite the poorly organized interactions.

Medical experiences rarely meet patients’ expectations. Our interviewees stressed four main complaints with public reproductive health centers: (1) lack of comfort and privacy; (2) emotional neglect and objectification; (3) the professional staff’s paternalism; and (4) organizational disorder.

Women avoid public medical services because they distrust them.²⁴ Interviewees believe that the Soviet patterns of clinical interaction remain. Those with resources look for more reliable services, particularly private health care services. The less wealthy have limited choices.

Commercial Reproductive Health Centers: Dramatized Diagnoses and Extortion

Wealthy, reflective, demanding, and educated women prefer private clinics. Nana writes: “I compared WC and the commercial diagnostic center. The former is less expensive. But

the cost in both emotional stress and time is too high to go there. My emotional resources are diminishing. I have to preserve what is left. I chose the private clinic."²⁵

Private reproductive care services involve specialized medical examinations (including STD and genital-infection tests), deliveries, abortions, and professional consultations by highly qualified specialists. Medical centers and clinics provide better conditions commercially. Patients consider paid services to be more reliable and better organized. The environments are more comfortable; time and space are more effectively used. They do not spend as much time waiting, and facilities are better equipped for waits. Sometimes magazines, medical advertisements, and even tea are available in the lobbies. Women expect attention and comfort, less bureaucracy, and an individual, personalized approach from the medical staff. In her diary, Katya explains "what she paid for": "My investment was linked, first and foremost, with a desire to buy the attention of the doctors—to buy communication and explanations of things."²⁶

However, our informants do not think that the doctors' professional skills differ between public and private clinics; the same gynecologists work in public and private clinics.

The system of commercial services remains operationally unreliable and lacks transparency. Consumers often do not understand how the system operates, even though every clinic posts price listings. The ambiguity as to which services MMI covers leads to patients paying unnecessary expenses, which leads to further institutional distrust.²⁷

Patients can pay officially at the cashier or unofficially to the doctor ("tax free" or "in the pocket"). Doctors receive more money from unofficial payments, and patients can negotiate their price. Some patients prefer to pay the doctor (or nurse) directly because it saves time (and often money) and helps to cultivate the relationship with the doctor. Others follow the official rules and reject tax-free payments as illegal.

The consequences of reproductive health care's commercialization are contradictory. Patients who can afford private care are treated as clients who pay for services, and their physical, emotional, and social demands are more likely to be met. However, this is accompanied by a decline in the quality of free medical services, which highlights the growing social inequality in health care.

Despite greater concern for patients' emotional needs, the trust deficit is also a problem in the commercial sphere. The treatment of genital infections illustrates patients' distrust of private medical services.²⁸ Such tests are usually administered before or during pregnancy.

One interviewee, Anya, was a businesswoman who lived with her partner and planned on becoming pregnant. She wanted to make sure that she did not have a sexually transmitted disease before she stopped using contraceptives. She writes, "I want to be sure that I am absolutely healthy before I become a mother."²⁹

The examination and treatment of genital infections is not covered by MMI and is provided only on a commercial basis. Anya was examined in a commercial diagnostic center, and the tests revealed that she had a genital infection. She received an expensive treatment and subsequently underwent several more tests, which showed that she was still infected. The doctors prescribed more paid treatment. Anya became upset and desperate and began questioning the medical opinions. She believes that she was the victim of "hidden" extortion. Her comments were full of anger: "Doctors are . . . monsters. . . . It's quite possible that I never even had anything that serious, not even something that is sexually transmitted. They simply want to extort money. . . . They demand money for everyday procedures, for consultations. . . . I don't know whether I really had an infection or not."³⁰

Natasha provided a similar account. She realized that the commercial service was not a guarantee of quality and went to another doctor she found through personal networks. This doctor did not detect any infection:

When they found ureaplasma . . . I went to a private clinic, to a specialist with a female friend. However I had some doubts about their competence. . . . They told me that a whole number of tests needed to be carried out. They offered me blood radiation, which also costs money. At that point I said: okay I'm going to find a different health center, though again through acquaintances. I didn't want to go to a private clinic, so I went for a gynecological consultation in a regular [public] medical center where an acquaintance of mine works. The doctor carried out her examination and told me that I was "completely clean," that is, healthy. She asked me where I had been previously. I told her, "V. L.," and she said, "Oh, you know it's not the first time I've heard such an evaluation from that clinic."³¹

Many patients suspect that doctors are dishonest and careless. Diagnoses are often considered false or exaggerated. Patients interpret exaggerated, or even fabricated, diagnoses as their doctors' strategy for reinforcing their declining authority or as a means of improving their financial situation. Many interviewees suspected that their doctors manipulated diagnoses to extort money for additional tests and treatments. Physicians are generally viewed as unprofessional and frequently mistaken in their diagnoses and treatments.

Patients realize that there is no professional solidarity among doctors. Women described how medical professionals attempt to discredit each other, claiming that only their diagnosis is correct, only their prescription will prove effective, and only their institution will provide the proper treatment. Health care competition has undermined the professional ethos of collegiality.

Katya writes: "Almost all doctors are forced to assert and reassert their competency and professionalism through their relationship with other institutions and doctors. It seems to me that this quite often involves the belittling of the others' professionalism. When I was still in a common ward with several patients, one of the patients showed the doctor the results of an ultrasound scan, which she had paid for (she told the doctor that it was a commercial consultation but didn't tell her where). To this the doctor replied, 'And why should I believe these results? For all I know they could be somebody else's!'"³²

Doctors are suspected of putting commercial interests before professionalism. Patients also believe that pharmaceutical companies extort them because doctors receive commissions for selling patients more expensive drugs. Women generally think that the commercialization of medical services creates a crisis of medical professionalism.

In circumstances involving institutional trust deficits, individuals develop coping strategies. In the field of health care, some women avoid health services until the problem becomes an emergency or pursue parallel controls of any service provided (such as multiple medical examinations and visits to different doctors and institutions). However, these strategies are often ineffective. Avoiding clinical encounters makes women ineligible for maternity benefits and other privileges of pregnancy. Parallel control is time-consuming and expensive. Women want access to professional reproductive health care. Most women want to establish personal relationships with their own doctor.

Clinical Encounters in Maternity Homes: Neglect and Uncertainty during Childbirth

The quintessential trust problems in reproductive health care are situations directly connected to childbirth. We interviewed women who had encountered state and commercial reproductive health care institutions. In the realm of reproductive health care, childbirth carries the most risk. Perceived risk is connected to the symbolic value of delivery, possible health complications, and frustrating conditions in maternity hospitals.

Marina reported that she planned her pregnancy and attempted to “organize childbirth” herself.³³ She was not satisfied with the public obstetrics clinic’s services and tried to find other doctors in another clinic. The marketization of health services gave her more options. As responsible consumers, Marina and her husband carried out market research to find a suitable maternity hospital. They used the Internet and a personal acquaintance’s medical expertise. They were especially interested in the reputations of the reproductive care institutions and their doctors. Their expert gave advice concerning maternity homes and told them that the best approach would be to visit the maternity hospital’s director and ask him or her to recommend a good doctor. When they visited the hospital in advance, “the head of the MH was very nice and explained everything.”³⁴ They officially paid for a delivery service in the commercial department, which includes medical help and an individual, comfortable ward for the patient and her husband. Marina had unforeseen health problems, and she was quickly taken to another department for a cesarean section operation. After delivery, Marina found herself in a regular ward for three people, with no furniture suitable for postoperative needs and a fly infestation. This was extremely uncomfortable for her, but she could not do anything about her situation at that time.³⁵ Her rational strategy failed because of unpredicted circumstances, and she was absolutely helpless.

Marina’s experience shows that a patient’s conscientious efforts to control the situation do not guarantee security. She mobilized numerous resources: information, personal networks, expert knowledge, and financial assets. However, nothing guaranteed that she would achieve her goal.

Marina later said in an interview:

It just so happened that I had no choice but to give birth at night [the respondent smiled]. Besides me, there were three other pregnant women in the hall. I had the feeling that they tortured us on purpose. I didn’t like the doctor very much. She didn’t take much notice of our condition. Two hours before it all started the medical staff just disappeared. . . . That is when the pain started, and while I was in labor, there wasn’t a doctor around, not a single soul apart from us in the delivery hall! At that time it would have been nice to have some support, some help, someone to tell you how to breathe properly, etc. But there was nothing! In the end I said to them myself, “Listen, I think the baby is coming,” and they came over and said, “Oh, you’re right, it has started! The doctors are a kilometer away from you.” And the birth itself. . . . Of course in some places they teach you about this, but I wasn’t taught, and, as a result, the delivery was very long. All the time they are commenting, “You didn’t do this or that right,” and threatening that “If you don’t start to give birth properly they’ll take forceps and pull the baby out.” At this point, I almost started to beg them not to get out the forceps. There was horror in my eyes. I can imagine how it all looked. And then, after I had given birth, they said, “Here you go! We have delivered your baby. . . . Say thank you.”³⁶

Marina reported that she initially felt abandoned by and later totally dependent on the doctor and midwife and on luck. The standard organization of childbirth was beyond the

woman's control. She also recognized her own ignorance. There is no hint of the participatory model of clinical visits.

Many interviewees viewed maternity hospitals as authoritarian institutions. Women recalled atrocity stories full of fears about infections, dangers to the health of mother and baby, rude and disrespectful attitudes from doctors and midwives, and medical mistakes.³⁷

Interpreting Interviewees' Distrust

The data show that women are unhappy with clinical encounters in many situations. Women generally distrust the Russian medical system. There are structural and cultural reasons for this trust deficit. However, there are also aspects of reproductive health care that make pregnancy an unknown, and it remains an emotionally charged sphere of intimacy closely related to gender identity.

We aggregated all the instances of distrust into two broad categories: (1) inhumane attitudes in the reproductive care system in general, and on the part of individual professionals in particular, and (2) the unprofessionalism in the health care system. The former refers first and foremost to public reproductive health care. As one interviewee said, "Our medical service is inhuman, it is not for people."³⁸ Women claim that medical services are not patient-oriented, but rather inefficient and self-maintaining bureaucracies that have changed little since the Soviet Union's collapse. Interviewees reported that flawed conditions were a reason for distrust. Further, pregnant women who try to combine their professional work with treatment face administrative barriers. It is very difficult for waged, working pregnant women to fit medical specialists' schedules. Accordingly, women with enough resources sever their relationship with the public reproductive health institutions. Under the pressure of all these patient-unfriendly circumstances, Vera left her prenatal clinic before her treatment was finished.³⁹

The second category is connected to patients' assessments of medical professionals. Women doubt their doctors' professionalism and have little faith in prescribed medical treatments. They consider the time expended and the negative emotions inevitably involved as too high a price for treatment, and they try to avoid using medical services whenever possible. Anya, for example, stopped her treatment for genital infections because she suspected her doctor was dishonest. Women think that a patient-oriented attitude should be part of medical professionalism and that doctors who do not cultivate relationships with their patients are unprofessional.

Strategies to Establish Trust

Despite a systemic lack of trust, most women use the available medical services and develop strategies to establish trust. They are health conscious and want to be treated properly. In the most extreme cases, women prefer alternative practices (e.g., giving birth at home), but we do not include these women here.

The climate of trust in doctor-patient relationships, always fragile, is achieved through conscious effort and must be continuously reaffirmed. Distrust is compensated for by strategies targeted at improvement and control of the medical services. These strategies aim to "find the proper doctor" and "find the proper reproductive health center"—that is, to access high-quality medical services that are reliable, comfortable, and proximate. Following the empirical data, we identified the strategies used to achieve these goals.

The most popular strategy is mobilizing social networks. Women consult their relatives, colleagues, friends, and friends of friends to find a doctor who is recognized as having a good reputation within the network and in the maternity home. This helps women control and personalize visits and transform them into relationships within their social network. This network mobilization is obviously gender-based. Women use mediators to make clinical encounters accountable and transparent. Medical professionals who already belong to the patients' social networks, especially family members, typically act as mediators. "Family delivery" provides new opportunities for fathers to play a role in dealing with medical practitioners.⁴⁰

Another strategy is self-enlightenment. Women empower themselves by obtaining specialized medical knowledge and becoming experts in reproductive health. Popular medical journals, professional medical literature, radio and television programs, and the Internet are all helpful resources for this strategy. The Internet provides women with a community to exchange information about clinics and doctors, give advice on reproductive health issues, and suggest alternative varieties of delivery. Women accumulate expert and lay knowledge, learn as much as possible about their health conditions, use medical and alternative information sources, and conduct market research on the reputations of maternity houses, clinics, and individual doctors. These active patients challenge professional authority, demanding a change in power relations of medical encounters and participatory models of doctor-patient relations.

A third strategy involves "taming" and "seducing" the doctor with economic rewards, combining different forms of payment and gift giving.

Most women use multiple, overlapping strategies. The optimal result is a climate of trust based on the personalized medical encounter. In general, all these strategies have one goal—to find a trustworthy, "proper" doctor who is "velvet" and professional at the same time. A good doctor is often referred to as "my personal doctor," and will belong to the woman's social network. The relationship is sustained by commercial and personal resources, often manifested through favors. Women may have access to the doctor's mobile phone for emergencies. In turn, they do not forget to express their gratitude by using every symbolic occasion to make a gift, and they may recommend the doctor to other women in need. As institutional and personal trust is in short supply, trustworthy doctors are very valuable. Both women and medical professionals confirm that direct relationships are common, efficient, and sometimes evolve into friendship. Our data confirm Michele Rivkin-Fish's findings: "Russians formed acquaintance networks in medical care for more intangible goals: to ensure competent attention and committed care. Patients sought to transcend the bureaucratic framework of doctor-patient relations that worked on the basis of anonymity and fragmented care by personalizing it, transforming the health care setting into an extension of one's personal relations."⁴¹

Conclusion: New Reproductive Care Clients—A New Generation's Demanding Women

Reproductive health care service patients attempt to construct trust-establishing strategies. Although they are not always successful, many women who need medical services want to employ them. Success depends on good luck and available resources. Most of our interviewees belong to a cohort of young, active women who are demanding and ready to fight for their demands. They are rational, highly educated women, often professionals, who live in

large cities. Family planning is not just a slogan but a part of their world. However, the medical system often fails to meet their demands despite reformers' efforts. Path dependency, or dependence on previous development, within the reproductive health care system provokes women's criticisms. Their self-identity and actions openly oppose the Soviet system and Soviet models of patient behavior.

Women describe the health-care system's conditions as morally obsolete, "like the Soviet Union."⁴² They make distinctions between the Soviet-era experiences that they find horrifying and humiliating, and their own demands. New patients perceive health care institutions' Soviet-era discipline as excessive, inhumane, and exclusive. This became particularly clear in stories regarding the treatment of STDs, pregnancy, and childbirth.

Younger women's sexual and reproductive practices differ significantly from their mothers' and grandmothers'.⁴³ The current trend presumes conscious choice of sexual and marital partners, family and childbirth planning, responsible safe-sex behavior, informed contraceptive choice, and control over their own sexual and reproductive health. They intend to be responsible and take control of their lives, including sexual and reproductive aspects. They are highly critical of the available reproductive care services and rely primarily on their own resources and strategies.

They are not satisfied but still attempt to articulate the problem and change the situation. However, the Soviet legacy, lack of resources, and lack of institutional support (education, medicine, contraceptives, etc.) constitute structural barriers undermining responsible, safe practices in reproductive and sexual behavior. This discrepancy results in conflicts and consequent distrust in medical institutions and professionals. These women—demanding reproductive care clients—do not want to be treated as Soviet patients. Nor do they want to behave as Soviet patients: disciplined, ignorant, obedient, silent, and undemanding.

Public efforts to improve reproductive health care's conditions have been mobilized in the early years of the twenty-first century. The state, media, patients, and medical professionals are engaged in this difficult enterprise. These actors' interests, however, are often contradictory. Further research is needed to understand how negotiations are conducted and whether a new participatory model of clinical encounters will develop. There are prospects for improvement for the upper classes, although those in poverty remain unlikely to see their situation improve.

As Russia's economy improves, we expect to find more women demanding responsive medical care. This presents a genuine challenge for the Russian government's pronatal program. If increasing the birthrate is to be the main way to mitigate Russia's daunting demographic situation, prospective mothers' emotional and psychological needs must be taken into account. Without serious attention to improving the care provided during pregnancy and childbirth, no financial incentives will induce educated and empowered women to have a second child, much less to become "hero-mothers."

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NOTES

1. See Michele Rivkin-Fish, *Women's Health in Post-Soviet Russia: The Politics of Intervention* (Bloomington: Indiana University Press, 2005); Anatoly Vishnevsky et al., "Rossyskoe zdra-vookhranenie: kak vyiti iz krizisa" [Organization of Russian Health Service: How to Overcome the Crisis], *Otechesrvennye zapiski* 2006, no. 2 (2006): 6–32.

2. See Talcott Parsons, "The Sick Role and the Role of the Physician Reconsidered," *Milbank Memorial Fund Quarterly: Health and Society* 53, no. 3 (1975): 257–78. For an overview of the sociological research in clinical encounters, see Ellen Annandale, *The Sociology of Health and Medicine: A Critical Introduction* (Malden, MA: Polity Press, 1998); Eliot Freidson, *Profession of Medicine: A Study of the Sociology of Applied Knowledge* (New York: Dodd, Mead and Company, 1970); Deborah Lupton, *The Imperative of Health: Public Health and the Regulated Body* (London: Sage, 1995); Graham Scambler and Nicky Britten, "System, Life world and Doctor-Patient Interaction: Issues of Trust in a Changing World," in *Habermas, Critical Theory and Health*, ed. Graham Scambler, 45–67 (London: Blackwell, 2001); Bryan Turner, *Medical Power and Social Knowledge* (London: Sage, 1995).

3. Research on trust in the Russian medical system includes Julie Brown and Nina Rusinova, "'Curing and Crippling': Biomedical and Alternative Healing in Post-Soviet Russia," *ANNALS of the American Academy of Political and Social Science* 583, no. 1 (2002): 161–72; Rivkin-Fish, *Women's Health in Post-Soviet Russia*; Katja Kesseli et al., "Reproductive Health and Fertility in St. Petersburg: Report on a Survey of 18–44 Year Old Women in 2004" (working paper no. 60, Department of Sociology, University of Helsinki, Helsinki, Finland, 2005); Mary Lrivaara, "Moralnaya otvetstvennost zhenshin i avtoritet vrachei vzaimodeistvia ginekologov i patsientok" [Promoting Moral Responsibility—Gynecologists' Views and Practices on Contraception and Termination of Pregnancy], in *Nobyi Byt*, ed. Elena Zdravomyslova, Anna Rotkirch, and Anna Temkina (St. Petersburg: Izd-vo European University at St. Petersburg, forthcoming).

4. Kathy Charmaz, "Grounded Theory," in *Handbook of Qualitative Research*, ed. Norman Denzin and Yvonna Lincoln, 2nd ed., 509 (Thousand Oaks, CA: Sage, 2000). For more on thematic interviews, see Barney Glaser and Anselm Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Chicago: Aldine, 1967).

5. Vladimir Putin, "President Putin on Russia's Demographic Problem," BEARR Trust, May 10, 2006, <http://www.bearr.org/en/info/putin/demographic> (accessed August 12, 2008).

6. Later in the discussion, the term "maternal capital" was changed to "family capital" for gender balance.

7. Anna Rotkirch, Anna Temkina, and Elena Zdravomyslova, "Who Helps the Degraded Housewives? Comments on Vladimir Putin's Demographic Speech," *European Journal of Women Studies* 14, no. 4 (2007): 349–57.

8. Piotr Sztompka, *Trust: A Sociological Theory* (Cambridge, England: Cambridge University Press, 1999).

9. Barbara Misztal, *Trust in Modern Societies: The Search for the Bases of Social Order* (Cambridge, England: Polity Press, 1996), 97.

10. Bryan Turner with Colin Samson, *Medical Power and Social Knowledge* (London: Sage, 1995), 194.

11. May Carl, "The Clinical Encounter and the Problem of Context," *Sociology* 41, no. 1 (2007): 29–45.

12. According to the official regulations, the current standard workload for public WC gynecologists and obstetricians is as follows: five patients per hour, eight patients per hour in the case of prophylactic observation in an outpatient clinic, 1.25 home visits per hour. This makes the doctor's work conveyer-like, and this method of treatment often lacks an emotional connection with the patient because of the intensification and standardization of the doctor's work. Gynecologists and obstetricians often have secondary jobs, which makes the situation worse.

13. The patients' complaints about Russia's reproductive health care system appear qualitatively different from the "typical" Russian complaint described by Nancy Ries. See Nancy Ries, *Russian Talk: Culture and Conversation During Perestroika* (Ithaca, NY: Cornell University Press, 1997).

14. Nana, Diary 4, March 9, 2006, 2.

15. Masha, Diary 1, December 8, 2005, 1.
16. Nana, Diary 4, February 1, 2007, 14.
17. Most middle-class women do not express concerns about the prices in commercialized services, although this could be a problem for poorer women.
18. Nana, Diary 4, March 17, 2006, 8.
19. Vera, Diary 3, January 10, 2005, 6.
20. Katya, Diary 2, January 24, 2006, 3.
21. Ibid., January 25, 2006, 10.
22. Ibid., January 24, 2006, 3.
23. Nana, Diary 4, March 12, 2006, 16.
24. Polina Aronson, "Utrata institutsionalnogo doveriya v rossiskom zdravookhraneny kak odna iz prichin otkaza ot professionalnoi meditsinskoi pomoshi" [The Loss of Institutional Trust in the Russian Health Service as the Basis for Refusing Professional Medical Help], *Zhurnal Sotsiologiy Sotsialnoi Antropology* 2006, no. 2 (2006): 120–31.
25. Nana, Diary 4, March 9, 2006, 2.
26. Katya, Diary 2, January 25, 2006, 7.
27. Sergey Shishkin et al., *Rossiskoe zdravookhranenie: Oplata za nalichnyy raschet* [Russian Health Service: Cash Payments] (Moscow: GU-VShE Institut Sotsialnoi Politiki, 2004).
28. Genital infections include genital herpes, condyloma, chlamydia, candidosis, ureaplasma, and mycoplasma.
29. Anya, Interview 7.
30. Ibid.
31. Natasha, Interview 4.
32. Katya, Diary 2, January 25, 2006, 6.
33. Marina, Interview 5.
34. Ibid.
35. Ibid.
36. Marina, Interview 22.
37. Tatyana Tchshepanskaya, "Mifologiya sotsialnykh institutov: Rodovspomozhenie" [Mythology of Social Institutions: Delivery], *Mifologiya I Povsednevnost* 1999, no. 3 (1999): 383–423.
38. Anna, Interview 1.
39. Vera, Diary 3, January 20, 2005, 22.
40. Anna Temkina and Evgeniya Angelova, "Otets, uchastvuushy v rodakh: Gendernoe partnerstvo ili situatsionnyi kontrol" [Father as a Participant of Delivery: Gender Partnership or Situational Control?], in *Nobyi Byt*, ed. Elena Zdravomyslova, Anna Rotkirch, and Anna Temkina (St. Petersburg: Izd-vo European University at St. Petersburg, forthcoming).
41. Rivkin-Fish, *Women's Health in Post-Soviet Russia*, 154.
42. Katya, Diary 2, January 25, 2006, 8; March 1, 2006, 21; Vera, Diary 3, December 20, 2004, 10; January 10, 2005, 6, 8; Nana, Diary 4, January 1, 2007, 12.
43. Anna Rotkirch, *The Man Question: Loves and Lives in Late 20th Century Russia* (Helsinki: University of Helsinki, 2000).

APPENDIX
Description of the Field Data

Diaries (Five Individuals)

1. Masha's diary of her experiences in a gynecological and prenatal clinic was written December 8–21, 2005. Masha was a twenty-one-year-old fourth-year St. Petersburg Medical University student with a middle-class background.
2. Katya's diary was written January 24–April 29, 2006. Katya was a thirty-four-year-old woman in her first pregnancy during observation. She was employed as a researcher and came from a middle-class background.

(appendix continues)

APPENDIX (CONT.)

3. Vera's diary was written November 19, 2004–July 3, 2005. Vera was a thirty-two-year-old researcher from a middle-class background who was pregnant during observation.
4. Nana's diary of regular visits to a gynecologist in the women's consultation was written March 9, 2006–February 12, 2007. Nana was a forty-five-year-old teacher from a middle-class background.
5. Vanya's diary of an emergency visit to a private clinic surgeon was written March 7, 2006. Vanya was a fifty-year-old teacher from a middle-class background.

Interviews (Twenty-two Individuals)

Sixteen interviews were conducted in 2005 in St. Petersburg. The research group consisted of students affiliated with the Gender Studies Program of European University at Saint Petersburg (EUSPb). Anna Temkina and Elena Zdravomyslova coordinated the research. The sample was constructed using snowball techniques oriented on the a priori criteria. All interviewees were middle-class, urban women who had degrees of higher or specialized education. Eight interviewees were eighteen- to twenty-five-year-old women; eight interviewees were thirty- to forty-five-year-old women. The authors designed the interview guide.

Thematic interviews with women were about sexual and reproductive practices; medical treatments in the reproductive sphere (visits to gynecologists, practices of pregnancy, abortions, delivery, and birth control); family planning and contraceptive use; choice of partner; and similar topics.

Sixteen interviews were conducted in St. Petersburg: Temkina conducted four interviews with women in Chelyabinsk in 2005. Chelyabinsk interviewees were found through university networks. EUSPb PhD student Olga Snarskaya conducted two interviews with middle-class Samaran women, ages twenty-four and twenty-five, who gave birth in 2006.

1. Anna, 25, single
2. Tanya, 24, partnership, one child
3. Nina, 19, partnership
4. Natasha, 22, single
5. Marina, 26, civic marriage
6. Katja, 20, separated, one child
7. Anya, 25, single, separated after civic marriage
8. Olga, 27, divorced, one child
9. Vera, 31, unmarried mother
10. Nadja, 37, married, one child
11. Veronika, 30, married
12. Olga, 32, divorced, one child
13. Asya, 28, single
14. Galina, 32, married, two children
15. Varvara, 43, civic marriage, divorced, two children
16. Mira, 29, civic marriage
17. Olya, 25, pregnant, married
18. Ekaterina, 22, divorced
19. Alexandra, 22, married
20. Viktoria, 20, civic marriage
21. Rita, 25, married
22. Marina, 24, married, one child

We focused on younger reproductive care clients. Our interviewees were all middle-class women. This group included two students, four PhD students (combining studies with professional jobs), one office manager, one dress designer, five small business managers, five professionals (a doctor, an NGO administrator, a journalist, a guide, and an artist), two housewives, one cleaner, one worker, and one sailor.