

Trust, gender and personhood in birth experiences in Rio de Janeiro, Brazil

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Abstract

In narratives of birth of two age groups of middle class women in Rio de Janeiro, Brazil, they focused to a great extent on how their experiences had the participation of obstetricians and how trusting them was an important issue. In this article, I want to discuss the recurrent mention of trust in doctor-patient relations, seeking to understand its particular significance in the experiences of birth of the women studied and to contribute to a broader theoretical discussion of trust. Its meaning has to be placed in relation to women's notions and experiences of pregnancy and birth, which are in turn tied to ideas of personhood, body, gender and are affected by their age group, social standing and race. I argue more generally that trust is not only about establishing cooperative relations, as it often appears in many social sciences studies. Treating trust as a moral relational idiom, I specify that it is more fundamentally about how people are thought to be and how they are expected to behave.

Key words: childbirth, trust, doctor-patient relations, personhood, gender.

Confiança, gênero e pessoa em experiências de parto no Rio de Janeiro, Brasil

Resumo

Nas narrativas de parto de dois grupos etários de mulheres de camadas médias no Rio de Janeiro, o foco recaiu em grande parte no modo como obstetras participaram de suas experiências e na importância de confiar neles. Neste artigo, pretendo discutir esta menção frequente à confiança na relação médico-paciente, buscando compreender seus sentidos particulares nas experiências das mulheres pesquisadas e contribuir para os debates teóricos em torno da confiança. Estes significados devem ser entendidos em relação às noções e experiências de gestação e parto destas mulheres, que estão, por sua vez, articulados a ideias de pessoa, corpo, gênero e são afetados pelo grupo etário, posição social e raça. De modo mais amplo, argumento que a confiança não diz respeito apenas à formação de laços de cooperação, como aparece em muitos estudos nas ciências sociais. Ao tratar a confiança como um idioma relacional moral, aponto que esta noção remete fundamentalmente ao modo como as pessoas são pensadas e como devem se comportar.

Palavras-chave: parto, confiança, relação médico-paciente, pessoa, gênero.

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During my research on the experience of pregnancy in Rio de Janeiro, I frequently heard middle class women make anxious comments about finding trustworthy ob-gyns. When I moved on to analyse birth narratives, women focused to a great extent on how their deliveries had unfolded with the participation of obstetricians, whether satisfactorily or not. In these stories, trust was again a prominent factor, now with a greater accent on how it had been lost. These constant remarks contrasted with my previous studies of friendship in London and Rio de Janeiro, in which the category trust was associated with personal relations, marked by ideas of shared intimacy. Indeed, the idea that friends were people one trusted was common but acquired different emphases and meanings in each setting.

In this article, I examine this recurrent mention of trust in doctor-patient relations, seeking to understand its particular significance in the birth experiences of the women studied and to contribute to a broader theoretical discussion of trust. Its meaning has to be placed in relation to women's notions and experiences of pregnancy and birth, which are in turn tied to ideas of personhood, body and gender, and are affected by their age group, social standing and race. These narratives also have to be understood in the context of birth humanization discourses, which have been disseminated in the last two decades.

In the process, I argue more generally that trust is not only about establishing cooperative relations, as it often appears in many social science studies (Giddens 1990, Hart 1988, Luhmann 1988, Simmel 1964), which I review below. Taking up Corsín Jiménez's (2011: 194) argument of trust as a relational idiom, I specify that it is more fundamentally about how people are thought to be and how they are expected to behave, which subsequently makes them trustworthy or not. Thus, trust is inextricably linked to cultural concepts of the person, which may vary with factors such as age, gender, race, and class. In this sense, there is a moral quality to trust, since it entails expectations about how people should behave.

This article is based on birth narratives obtained through interviews I carried out with two different sets of white university-educated heterosexual women in Rio de Janeiro.¹ Seven women were aged between 61 and 69 years old, having given birth to their children in the 1970s and early 1980s. Among these, two were divorced while the others had been married for over thirty years. Most of them had worked during and after their pregnancies, in positions such as medical doctor, psychologist, geographer, and teacher. They had given birth to their first child in their early twenties, soon after marrying, and on average had three children. The second set was comprised by nine women of ages between 37 and 47 years old, who had given birth in the last couple of years. They were all married and held occupations such as architect, designer, art teacher, economist, sociologist and business manager. Most of these women gave birth to their first child in their thirties and had on average two children.

I treat trust as a discursive element in the analysed narratives, inspired by Abu-Lughod and Lutz's (1990) approach to emotion. Instead of seeing emotional discourses as expressive vehicles, they propose to understand them as "pragmatic acts and communicative performances" (1990: 11) to be understood in the context of utterance. In Portuguese, trust and confidence are translated by the same term – *confiança*.

¹ This article results from a research project supported by grants from the ProCiência Program at the State University of Rio de Janeiro and the Brazilian Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq). Some of the arguments presented here also appeared earlier in a paper, "Trust between women and their obstetricians," given at the 54th International Congress of Americanists, 2012, in Vienna. The interviews analysed were carried out in 2016. I thank Maria Claudia Coelho for her comments.

Because the idea conveyed by the women studied is that of a feeling of reliance on someone that can be 'lost,' I prefer to use trust in my analysis, since confidence appears in the literature as stronger and less vulnerable.

Finally, I am dealing with narratives of experiences, which are different from the experience as lived. As Bruner proposes, people interpret their experiences in particular expressive forms, which in turn structure experience. As such, "every telling is an arbitrary imposition of meaning on the flow of memory" (1986: 07), and in it, people re-live and re-create their experiences. The fact that these stories were told to a female researcher studying birth, in a particular time when it has become the focus of much attention, as I explain below, certainly affected what I heard. Women signed informed consent forms and were thus aware of my comparative focus, which prompted the older interviewees to comment on changes. Some women belonged to my social network and these in turn referred me to others close to them. I talked to them when it was convenient for them and in places they chose – at their homes, at coffee places, at work, often meeting their children as well. Most stories were emotionally charged – some women had tears in their eyes when talking about their experiences and I felt transported to their birth scenes by all the stories. This is therefore, the context in which these narratives were produced.

Trust in social theory

Trust is a theme that has been approached by various disciplines, with less attention from anthropology. These studies often focus on the definition of the concept and, as Broch-Due and Ystanes (2016) point out from an anthropological perspective, they tend to assume problematic universal views of the conditions in which trust appears and to treat the trusting subject uniformly as well. In this section, I review various sociological analyses of trust that formally define the term in order to propose an alternative, anthropological view.

Early in the twentieth century, Simmel (1964) saw confidence, which in the English translation of his work was used interchangeably with trust, as one of the most important synthetic forces of social life. Given that "all relations which people have to one another are based on their knowing something about one another" (1964: 307), confidence reflects, according to him, an intermediate position between having complete knowledge and being completely ignorant, both of which dispense trust. Confidence thus has an intellectual basis – knowing something about the other person – and an affective component.

More recently, Luhmann (1988) and Giddens (1990) have distinguished trust from confidence. Luhmann argues that both refer to perceptions of familiarity and expectations which may lead to disappointment, but they relate differently to choice. Confidence entails considering no alternatives, while trust requires a prior assessment of the risks involved. A feature of modern times, the idea of risk implies some notion of agency and choice, even if these concepts vary culturally and historically. Because "the perception and evaluation of risk is highly subjective" (Luhmann 1988: 100), trust is also an internal, subjective calculation of the external conditions that produce risk.

Giddens (1990), on the other hand, sees trust as a more or less continuous state, rather than a particular conscious assessment in specific situations. For him, trust is a form of confidence that arises when there is a lack of full information – about what people feel and think, about how they will behave, about the claims made by knowledge systems, about what will happen in the future. Trust has to contend with the risks involved in the absence of complete knowledge. Thus he defines trust as "confidence in the reliability of a person or system, regarding a given set of outcomes or events, where that confidence expresses a faith in the probity or love of another, or in the correctness of abstract principles" (1990: 34).

Hart (1988) adds the notion of faith to the discussion of trust and confidence. While faith demands no evidence and “confidence is a strong conviction based on substantial evidence or logical deduction” (1988: 187), trust relies on partial knowledge and contends with some uncertainty and risk. Faith is highly emotional, whereas confidence mobilizes less intense feelings because of its reliance on outcomes. Trust stands in the middle: it involves strong feelings despite uncertain proof. He sees them as types of belief associated with distinct forms of social relations: faith is found in kinship, trust in associations such as friendship, and confidence in the contract-based relations of civil society. However, from an anthropological standpoint, he observes that “real social organization depends on creative mixture of creative combinations of the types” (1988: 192).

Whereas these authors tend to see trust as an element of interpersonal relations not regulated by contract, Daniel (1999) considers it particularly relevant to the understanding of the relationship between medical doctor and patient – a situation that is at once interpersonal and formalized by protocols and ethical codes. When people have confidence in medicine as an expert system, trust in the practitioner becomes a way of dealing with their own inadequate knowledge. But Daniel stresses that this reliance is “emotionally tense, albeit rationally determined” (1999: 213). The decision to trust may be rational, but, given the instability of the patient’s situation, small details can disrupt it. If a professional dresses, speaks or behaves in a way that differs from conventional expectations, clients may be suspicious of his or her competence and, therefore, can feel mistrust. With the prevalence of education and the spread of knowledge, particularly so with the internet, Daniel identifies a decreasing public trust in science and the medical professions.

Nevertheless, Corsín Jiménez (2011) remarks critically that there is more to trust than its relation to cognitive and knowledge structures. Rather than striving to define it, he argues that trust as an anthropological object should be thought in terms of the work it does. In his discussion of a theory of corporate public trust, he refers to anthropological analyses of the allocation of responsibility and argues that “relations appear as risky only under certain systems of moral accountability” (Corsín Jiménez 2011: 188). In this theory of corporate trust, morality emerges not as an element of human relationships but as an aspect of the infrastructure of information, the risks of which are seen as dispersing responsibility. In this case, information becomes “a blaming-resource used by society to reallocate its funds of responsibility” (2011: 187).

In his article, therefore, Corsín Jiménez makes an important contribution by linking trust to culturally specific notions of risk, responsibility and morality. But I also wish to retain the sociological discussion about the partial knowledge involved in the trusting act, in order to stress that underlying all are concepts of the person. In this sense, I see trust as doing the work of a relational idiom about personhood. How are people seen in terms of their transparency or occultation of motives and intentions? How is their agency considered to be and how is their behaviour explained? And how do gender, age, race and social position affect these notions? I examine these questions next, with reference to my study of women and their relations with ob-gyns.

Pregnancy and birth in biomedical contexts

Biomedical discourses on bodily processes articulate regimes of truth, strategies for intervention and modes of subjectification (Rabinow & Rose 2006). The inclusion of pregnancy and birth within this biomedical frame means that these physiological events have become matters of health and illness (Carneiro 2015), understood through the lens of medical science and treated with its technological apparatus. Martin (1987) has explored how the metaphor of work labour now organizes the medical

imaginary of birth. Doctors play the role of the supervisor of a process in which the woman's body is seen as a machine over which they themselves have little control. Davis-Floyd (1993), examining American forms of birth, further stresses how hospitals deal with them according to a technocratic model, full of repetitive procedures, hoping to deliver the perfect baby within the appropriate time. In this process, health professionals are responsible for monitoring women's bodies and their experiences of birth become secondary concerns.

The issue of control is also taken up by Lupton (1999) through a focus on risk in pregnancy. Biomedical discourses on gestation, she claims, become normalizing forces in a context in which value is placed on self-regulating individuals who maximize opportunities and minimize the risks to which they are exposed. Lupton adds that expert knowledge and technologies, such as ultrasound scans, produce ambivalent feelings since patients are faced with greater choices about which tests to take, whilst re-situating women as mothers responsible for the care of their unborn babies. Seen in this light, pregnancy entails dealing with anxiety and fears about the woman's own health as well as that of her foetus.

Notwithstanding the force of biomedical discourses, I stress that local concepts of the body, the person and motherhood affect how people understand and relate to pregnancy and birth.² In Brazilian society, pregnancy and birth became, over the course of the twentieth century, largely the object of biomedicine (Rohden 2001, Tornquist 2004). The medical framework coexists with different perceptions and ways of treating these bodily processes in urban, rural and indigenous areas.³ Furthermore, class and race affect women's insertion into Brazil's healthcare system, divided into public and private sectors, and hence influence how they live childbirth.

McCallum and Reis (2008) studied young lower-class, mostly Black women's experiences in a public maternity hospital in Salvador, Bahia. As in many other public hospitals, vaginal deliveries are more common and the rate of caesarean sections varied between 10 and 30%. In contrast to home birth, hospital delivery was valued by women, perceived as 'safe' and 'modern' because of the access to medical expertise and technology. As a consequence, they were largely compliant with procedures such as trichotomy, episiotomy and the use of synthetic oxytocin to speed up labour, which medical providers themselves re-examined. Instead, women attributed much of their suffering during childbirth to the lack of humane treatment by health professionals. Denied the presence of a companion and the administration of analgesia, women's experiences of birth were marked by solitude and the need to endure pain in order to avoid being treated as hysterical patients (McCallum & Reis 2006).

This analysis contrasts sharply with experiences of birth in the private health sector, generally those of middle class women (Cardoso & Barbosa 2012, Carneiro 2015, Hirsch 2015) who are mostly white.⁴ This system is organized by variously structured and priced health insurance plans, which cover medical appointments, laboratory tests and hospital care to be selected from a specific range of options. In 2017 only 24.5% of Brazil's population (Agência Nacional de Saúde Suplementar 2017)⁵ could afford to pay for private healthcare, with 61% of users living in the southeast region of the country, where Rio de Janeiro is located, and 53% being women. In contrast to the public system, users of health insurance plans can choose where to be treated and who will treat them.

2 Ivry's (2010) comparative ethnography on pregnancy is an interesting example. She shows how Japanese and Israeli women attribute different meanings to ultrasound scans and other tests, emphasizing that medical knowledge and technologies fit into local cultural webs of meanings, including what is understood as risk.

3 See Dias-Scopel (2015) for an ethnography of pregnancy and gestation among the Munduruku Indians, in the Amazon region, undergoing a process of medicalization.

4 In the last decade, the percentage of Black people in the middle class has increased, even though it is still a minority in relation to white people (Scalon and Salata 2012).

5 Due to the country's recent economic recession, this percentage has been decreasing in the past four years.

One of the issues women have to contend with in their choice of obstetrician is the type of birth practiced. The rate of caesarean birth in private hospitals is over 80%, way above the 15% considered adequate by the World Health Organization (Ministério da Saúde 2016). Caesarean births require less time and, therefore, mean higher productivity and greater profits for both hospitals and obstetricians, who moreover experience less physical and emotional strain (Cardoso & Barbosa 2012). Paradoxically, those professionals widely known to practice vaginal births typically do not accept health plans, thus making prenatal care and birth extremely costly.

The frequency of caesarean births is one of the arguments underlying the rise of birth humanization discourses in Brazil in the 1990s, initially centred on the *Rede de Humanização do Nascimento* (Network of Birth Humanization). Generally critical of the power relations endemic to the dominant obstetric system, these discourses specifically question a number of medical interventions routinely practiced on women during labour and birth, such as the use of synthetic oxytocin, episiotomy, and the administration of anaesthesia (Carneiro 2015, Hirsch 2015, Tornquist 2004). They advocate that women's wishes should be respected and call for a less asymmetrical relationship with health specialists. These discourses combine feminist and liberal demands for equality of rights and individual autonomy and have become more widespread through social and cyber activism, organized by various groups of women users of the private health system who strive to become the 'protagonists' of their births. Although these discourses initially emerged in a middle class milieu, there are now public health institutions, such as the Casa de Parto in a lower-class suburb of Rio de Janeiro, which militate for women's right to a humanized birth (Hirsch 2015).

The growing significance of birth humanization discourses can also be linked to changing views of motherhood among the middle classes. While in previous generations getting married and becoming a mother were the 'natural' paths for women, over recent decades they have also come to value work as an important source of identity (Almeida 1987, Araújo & Scalón 2005, Barros et al. 2009). Moreover, motherhood has become more of a project, often consciously planned by the couple (Rezende 2015, Salem 2007). Seen from this angle, birth is the object of careful preparation, often involving the help of pregnancy support groups and doulas, and guided by ideas of a 'return to nature' (Tornquist 2002). Treated as a unique event in women's lives, then, birth in these humanization discourses has undergone a process of idealization and aestheticization (Carneiro 2015).⁶

This recent focus on birth and the possibility of choosing health professionals forms the backdrop to the narratives I heard. Despite the diversity of experiences narrated, there are many common features, particularly within each age group. All women became pregnant after marriage. Only one woman had children by different husbands. Some of the older women were surprised by the confirmation of their first pregnancy – they had been recently married, were still studying at university and had not intended to have a child at that time. Younger women, on the other hand, consciously planned with their husbands when to become pregnant, at a stage when both were professionally established and owned their homes.

In both groups, pregnancy was generally described as a good phase, even if there had been morning sickness and other discomforts. Only one woman had bed rest until the seventh month of her gestation. Most of them worked until the final weeks of pregnancy. Particularly among the younger women, some pursued additional forms of care, such as yoga classes, pregnancy support groups and accompaniment by a doula or obstetric nurse in the final months of gestation. Younger women also resorted to internet sites, more than books, to learn about gestation and birth. They sought to prepare themselves mostly for labour and birth, and were then surprised by post-partum difficulties, such as breastfeeding, particularly with their first children.

⁶ In Brazil, pregnancy support groups have become quite common in major urban cities since the 1980s. Initially based on the painless birth approach proposed by Leboyer, Odent and Kitzinger (Salem 2007), they have become more varied in form in the last decade. Often combining yoga and relaxation exercises, they also seek to provide information on labour and types of birth, as well as a space for the expression of doubts and feelings.

All women interviewed received prenatal care in the private health system, either paying directly for consultations or through health insurance plans. In some cases, women sought a different gynaecologist after confirming their pregnancies. Women had both male and female ob-gyns and there was no specific gender preference. Prenatal care differed between the two groups of women, partly due to medical technologies that started to be used in the 1980s. For most of the younger women, ultrasound scans were done as often as once every two months and, in many situations, produced anxiety and concern about possible foetal malformations. In general, women of both ages were often critical of specific professionals and/or procedures, but not of medicine itself. In all narratives, the experience of pregnancy and birth is to a great extent an experience of hospitals, laboratories and medical professionals. The issue of choosing and trusting ob-gyns, however, varies between older and younger women, as I discuss below.

“Not knowing about things”

Ana was 68 years old when she told me about her births.⁷ When she had her first child, at 25 years old, she was living in the northeast of Brazil because her military husband was posted there, while she worked as a primary school teacher. Her first pregnancy was marvellous, she reported. Her obstetrician, also military, was described as a friend of the family, coming to their home on social occasions, and as ‘theoretically trustworthy.’ She went into labour just before Carnival, a time when her ob-gyn liked to drink a bit too much. At the hospital, when the labour pains increased, he gave her ‘something’ to relax, the pain stopped and she dozed off. When she woke up, her baby had been born, pulled out through vacuum extraction, with purple hands and feet. Ana said that neither her husband nor she knew about ‘these things.’ On the following day, when her breasts had become swollen and the baby had difficulty feeding, the doctor came round and decided it would be easier for her to bottle feed her daughter and gave her pills to dry her milk flow. She went home the next day and everything was fine with herself and the baby. But then, Ana remarked, “the worst thing was my stupidity... Because I went on to have another child with this man.” Just before she went into labour with her second child, the doctor had said the baby was in place, but at the hospital, when he examined her, she felt terrible pain. At some point, the doctor told Ana’s husband that the baby was sideways and that it was better to perform a caesarean delivery. This explained why his examination hurt so much – he was trying to turn the baby around. But since the assistant obstetrician never arrived, he then decided that it could be a vaginal birth because he was used to doing pelvic births and could reach the baby’s hand. Ana does not remember exactly what happened next, but the baby was born fine, she said. A few hours later, when she saw her son at the nursery, Ana had a feeling that something was not right and, indeed, he died the following day, due to complications at birth. She recalls that when the doctor came around to explain what had happened, she was so distraught that she called him a ‘murderer’! Ana and her husband moved to Rio a year later and she had two more daughters through caesarean section, having become ‘traumatized’ with vaginal births.

Ana’s narrative is more dramatic than the accounts of the other older women interviewed. But it shares some features with them that shed light on their experiences of dealing with medical professionals. Their accounts of each birth were much briefer than the younger women’s – they remembered what day of the week or time of day that labour began, but did not describe how it evolved, unless there was a particular significant event – an unanticipated procedure applied, something said by the hospital team, an unexpected physiological occurrence. Most older women talked about their doctors without naming them, in contrast to the younger women who named most of the professionals with whom they came into contact. These were rather impersonal and asymmetrical relationships. They did recollect short dialogues with ob-gyns in crucial moments, but otherwise their narratives were much briefer and vaguer, describing succinctly what happened and how they felt.

⁷ I have changed names and other biographical data to preserve the women’s anonymity.

Ana repeated a couple of times that she “didn’t know about things,” as did other older women. This was partly due to her young age when she became a mother, but she also said that at the time, information was not as available and women did not seek it either. Like most of the other older women, she did not talk about pregnancy and birth with her own mother – it was not something mothers and daughters shared, even if birth stories might become part of family lore. Ana and the others were comparing themselves with the experiences of their daughters and daughters-in-law being pregnant during the internet era and planning all the details of their births. By contrast, they married, became pregnant and had their babies, all events that come about with little planning and concern, and often earlier than they expected. Vaginal births were then the default ‘normal’ procedure,⁸ rather than a carefully chosen option as among the younger women.

In this context, they did not mention how they chose their ob-gyns. They appeared in a rather matter-of-fact way. Except for one female obstetrician, all others were male. They did not discuss with patients whether to use procedures such as induction, episiotomy and anaesthesia – these were simply done. Even Teresa, another interviewee, who was a medical doctor, complained that her first ob-gyn decided on interventions without consulting her. Again, some women commented on their experiences, pointing at how different it is now with the humanization discourse that stresses the importance of asking women what they want. In some cases, such as Ana’s, husbands appeared as mediators between their labouring wives and the doctor. They were asked about their wife’s preferred birth and received explanations about the process. As a result, six of the seven older women narrated a first birth that occurred in an unsatisfactory way, leading them to change doctors in their second pregnancy. Ana was the only one who remained a patient of the first obstetrician, even though she had mixed feelings about how the birth had unfolded.

In these narratives, the issue of trust between women and their ob-gyns rarely surfaced. Ana was the only one to mention having a doctor she initially trusted whose later actions led her to call him a murderer. Trust was associated with the fact that she and her husband knew him well – they belonged to the military social circle – and considered him a friend with whom they socialized. However, his decisions in both deliveries changed these feelings. While he performed the first delivery with a few complications, in the second, according to Ana, his actions produced serious suffering to the baby, who died a couple of hours later. In her later pregnancies, she was treated by a different ob-gyn who performed successful caesarean sections. Thus, in Ana’s narrative, trust was related to positive outcomes – doctors who prevented herself and her baby from suffering. This view was also present in the stories told by the other older women, but differed to some extent to the younger women’s accounts, as I show next.

“Loving my ob-gyn”

Gabriela was a 39 year-old economist and she talked in great detail about the births of her two sons. The older was five at the time and his pregnancy was very much planned and desired. Early on, she realized her previous gynaecologist, a ‘dear’ person, was not sympathetic to vaginal births, which she was aiming to have, and so she sought out others in search of ‘empathy.’ She and her husband finally met Dr. Pedro whom they ‘loved’ and, even better, could be paid through their health plans. But he would be away during her 38th week, so she met his substitute, Dr. Marcia, who was as careful and loving as he was and had a reputation of delivering humanized births. A couple of days later, her waters broke and she went to the hospital the following day, despite the absence of contractions. Dr. Marcia gave her the option of waiting another 24 hours, even though it raised the risk of infection and caesarean birth, or of inducing labour with synthetic oxytocin. Gabriela preferred the latter and began feeling strong labour

⁸ Until recently in Brazil, vaginal births were referred to as ‘normal births.’ Mostly as a result of humanized discourses, it is more common now to see distinct terms used, such as vaginal births, natural births, home births, etc.

pains. Three hours later, she asked for something to ease the pain but Dr. Marcia remonstrated, as she usually worked without anaesthesia. The doctor's reaction made Gabriela lose trust in her and feel that she could not count on her. Due to her insistence, she received a light anaesthesia, but by then she felt very tired and had trouble pushing the baby out. Dr. Marcia began criticizing her for not doing it right and Gabriela became 'rebellious,' not staying in the position she was told, which then prompted the doctor to ask her if she wanted to have a caesarean. In the end, Dr. Marcia made a Kristeller manoeuvre and the baby was born through vaginal birth, in perfect health. Gabriela said it was all very dramatic – she was nervous and the medical team, who had held a great deal of responsibility in their hands, 'had become lost.' Furthermore, she and Dr. Marcia had not really bonded, which made it all the more difficult. Her second birth was the opposite – it all worked out perfectly. Although she chose a different ob-gyn, who again was not going to be present at the estimated time of birth, she 'adored' the substitute doctor who would do nothing to which she did not agree. At the time of birth, there was a doula present, the room was very quiet and peaceful and she delivered the baby in a squatting position, without any anaesthesia. She felt very emotional, "as if the entire universe were inside" her.

This recollection is a heavily summarized version of Gabriela's narrative, extremely rich in details. She recalled and retold everything she did when her first labour began – the day of the week, the time of day, what she did next, what the doctor said, what she ate, how she felt, etc. Because her older son came into the room in the middle of the interview, her description of her second labour was marked by his interruptions and interventions and was briefer in comparison, but still filled with specific details. Gabriela also described how her pregnancies were accompanied by various health specialists aside from the ob-gyn – pregnancy support groups, yoga instructor, psychotherapist, doulas and obstetric nurses – all of which contributed in different ways to the unfolding of both births. Her story is, in this sense, very similar to other younger women's meticulous narratives.

Gabriela and the other younger women knew very much what they wanted. If some had a first birth by caesarean section, it was because they feared vaginal births at the time and chose the surgical form seen then to be safer and painless. Only one woman had a caesarean because of complications during labour. All the others had the type of birth they chose, an option based on the information they possessed, on the experiences of close relatives and friends, and on the ob-gyn who treated them. They actively read about births through books and internet sites, and heard from their mothers, sisters and friends about their own experiences of birth and doctor-patient relationships. Their female kin were in general strongly present in their daily lives – parents often accompanied them to ultrasound scans, contributed through gifts to set up the baby's nursery, and most importantly were references for what counted as good or bad medical and birth experiences. Gabriela's mother was already deceased when she became pregnant, but her experience and sayings figured in her narrative from its very beginning. Some also chose to attend pregnancy support groups in which they prepared for birth both physically and subjectively, by acquiring information and sharing feelings and concerns.

In this context, choosing the right ob-gyn was an important element in planning the desired birth. Although the women to whom I talked tried to find obstetricians who were covered by their health insurance plans, most did consider paying for consultations since many doctors who did humanized births did not accept such plans. Because of the high rate of caesareans in the private healthcare system, women were keen to distinguish ob-gyns who were pro caesarean ('cesaristas') from the fewer number who practiced humanized births. Not only did they rely on their social network – friends, work colleagues and family – for recommendations on reliable doctors, they also learned to pick up signs of an inclination towards caesarean section. Some women explicitly mentioned internet sites on humanized births that presented information and shared experiences, which helped them evaluate their ob-gyns' behaviour. Thus, they were suspicious of punctuality, which showed that "the doctor doesn't have to rush to attend a patient in labour."

They were tuned in to the choices being made by other patients in the waiting room and, most importantly, they noticed how the doctor reacted when the subject of vaginal births arose. The obstetrician's gender was not a selection factor, but, in contrast to the older women, many of the younger interviewees had female doctors.

Among the younger women, husbands played a significant role in the process of choosing an ob-gyn as co-participants, no longer as mediators. Gabriela talked, as others did, of visiting various doctors with her husband in order to find one that *they both* 'loved.' Having empathy was a minimum requirement and most women described their feelings for their ob-gyns as Gabriela did – 'loving,' 'adoring' her or him. Husbands were present in most prenatal consultations, scans and other exams and participated in births. Despite their presence, when labour began, women were the ones who negotiated with the medical team over what they wanted or not.

For them, trust in their ob-gyns was not just related to medical competence. More significantly, it had a very emotional basis, having to do with empathy, fondness and the establishment of intimacy, which created an affective bond over time. Being able to call the doctor many times during labour, before going to the hospital, was an example of intimacy. It also meant receiving support during labour – speaking in a calm and affectionate manner, getting pain relief or finding the best position, rather than being criticized or having to insist on her demands or needs, as Gabriela recalled. Being attentive in consultations was important, therefore, but it was the doctor's performance during labour and birth that consolidated or broke trust.

Gabriela singled out her second birth as the perfect experience. It had a different medical team present, with an ob-gyn she liked and who had assured her that her wishes would be respected. She mentioned, as others did, that they were all closely in tune and the whole atmosphere was very peaceful. The description of birth in terms of mystical aspects and of the feelings between women and specialists was recurrent, whether the outcome was successful or not. Another woman interviewed, Laura, attributed her difficulties at birth partly to the ob-gyn's and anaesthetist's lack of understanding of the mood she wanted to create in the hospital delivery room. She had prepared herself during pregnancy through a meditation and breathing program to be carried out during labour, also selecting relaxing music to be played during delivery, which in turn became the object of mockery by her ob-gyn. The anaesthetist was 'disgusting' because he insisted on giving her anaesthesia, ridiculing her initial option against it. She later had serious post-partum problems and harboured strong doubts about the doctor's responsibility in the process.

Thus the narratives of successful births among the younger women related less to the health problems that they or their babies had experience. All the nine women interviewed gave birth to healthy babies who went home a day or two later. The perception of what counted as a good or even perfect birth resulted mostly from being able to fulfil expectations and realize a particular project nurtured since the outset of pregnancy. In order to achieve these aims, the interactions between women and the medical team at the hospital were seen as fundamental, hence the importance of trusting ob-gyns.

The significance of trust

In this final section, I want to discuss the significance of trusting ob-gyns in the narratives analysed here, as well as some theoretical aspects of trust. Firstly, the stories presented above have to be connected to the women's gender, age, race and class. As white women with university education and middle-class occupations, there is a significant dimension of agency in their stories about choosing and (dis)trusting ob-gyns. In Ortner's (2006) definition of the concept, agency implies both having a project and being embedded in power relations. Thus both groups of women largely chose to become mothers and selected

ob-gyns to care for them, which nevertheless meant inserting themselves in asymmetrical doctor-patient relations. While they had the privilege of choice in comparison to lower-class women, they were still the weaker party within the power structure of biomedicine.

However, their narratives about these relations varied considerably owing to important social differences related to their age difference. These women belonged to different generations, which affected how they lived pregnancy, birth and their relationship with ob-gyns, associated in turn with different experiences of gender and motherhood (Almeida 1987, Rezende 2011). Motherhood was desired by all but planned mostly by the younger women. They had children at distinct moments of life – in terms of their age and the stage in their marriage and in their professional careers. Whereas husbands in the older generation appeared as mediators or someone who at the most gave support, the younger men were active co-participants during pregnancy and birth, revealing changes in gender roles that have been occurring in Brazilian society (Araujo & Scalon 2005). Families played different roles in each generation, being much more present daily and as references among the younger women. The importance of having access to information and of being well informed was another major transformation, together with the rise of birth humanization discourses, which have critically re-examined the behaviour of ob-gyns, especially their power to decide and their favouring of caesarean births. Hence, all the younger women had babies in a social context that elected birth as a crucial event in their lives – as an individual woman and as part of a couple and a family network. As a consequence, they prepared for birth through various body therapies and the overall attention paid to the relationship with ob-gyns was much greater. Hence trust in doctors became an issue for these women in distinct ways.

Moving beyond these specific meanings concerning patient-doctor relations, these narratives help highlight some features of trust as a relational idiom. First, the sociological literature argues that trust arises in relations and situations defined by partial information on other people's motives and behaviour. Underlying this argument is a view of people whose future behaviour can be predicted based on knowledge of their past experience. For most women in my research, because relationships with ob-gyns were established due to pregnancy, they did not know how these professionals would act in consultations and later during childbirth, save for general ideas regarding the behaviour of health professionals. Despite recommendations from friends and relatives concerning their expertise, women had to contend with a power asymmetry that allowed doctors to make future decisions about which they might not agree. Thus there seemed to be a constant doubt about the ob-gyns' possible actions, which made them less predictable. It was not a coincidence that mentions of trust mostly referred to its fragility and loss.⁹

Nonetheless, partial knowledge of doctors and their unpredictability appeared to be a problem mostly to the younger women, who brought up the issue in their narratives. Ana was the only older woman who talked about it when recounting her experience of the death of her second child. This does not mean that trust was unimportant for the other older women at the time, merely that it was not a subject they recalled in their narratives. They also spoke of ob-gyns in a vague and impersonal manner, as though their personal characteristics did not matter as much as their professional capability. Trust was broken mostly after this expertise had come into question due to their performance during birth, as in Ana's story. In contrast, younger women named their doctors and qualified their relationship in terms of their feelings. Their professional knowledge and reputation were apparently not enough to provide a basis for trust and they sought to establish more symmetrical and personalized relationships with ob-gyns, in an attempt to ascertain that they would support the woman's birth project.

⁹ In my previous study on friendship (Rezende 2002), reference to trust appeared often and positively characterized who friends were – people on whom one could count.

Because trust implies choosing to rely on people's future (unknown) behaviour, sociologists point to the risks deriving from this decision. The understanding of risk varies culturally, socially and historically (Douglas 1992), as does the perception of choice, I would add. Thus, for the older women studied, pregnancies and births happened to them and ob-gyns enter their narratives without any reference to how they were chosen. These women focused on the outcome of the birth – the main source of risk. Bad birth experiences – suffering procedures without any warning or having problems with their babies – led to a change of ob-gyns in future pregnancies. By contrast, younger women planned their pregnancies and carefully chose how they wanted their births to happen. Hence, they selected their ob-gyns attentively, informed by the humanized birth discourse and based on their reputation for practicing certain types of birth, as well as by the experiences of their friends and relatives. The risks resulting from their choice related not only to the possibility of having health problems at birth. Most importantly, they referred to the emotional dimension of the experience – a bad birth signified one that did not unfold as projected and desired.

The fact that, in the narratives, references to trust appeared always in the negative – to a feeling that trust had been jeopardized or lost – point to the emotionality of trust as a relational idiom. Whether in relation to women themselves or to their babies, these references revealed expectations that were frustrated or disappointed by the ob-gyns' actions. These expectations were not seen as deriving from their personal wishes, but from how they thought a doctor should behave during childbirth. For the older women, ob-gyns were mostly expected to exercise their professional expertise and show their patients respect by informing them about their decisions. For the younger women, doctors not only had to possess medical knowledge and practical experience, they also had to consider patients as participants in all their actions and give them emotional support. In this sense, their accusations of unsatisfactory performances from ob-gyns were morally laden.

In sum, these narratives about trust in obstetricians reveal distinct meanings attributed to the notion by two different generations of white middle-class women in Rio de Janeiro. In so doing, they show how gender, class and race affect choice and agency, which in turn lies at the basis of trust. Moreover, they also reveal how trust issues refer to concepts of the person – how they are thought to be and how they are expected to behave. They point to the articulation of trust and responsibility discussed by Córstin Jiménez (2011), in a social context in which morality stems from human relationships, not just from the informational structures that the author studied. In this sense, more than a feeling that promotes cooperation, trust is fundamentally a moral relational idiom.

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