

## Books

**J. Eric Oliver. *Fat Politics: The Real Story behind America's Obesity Epidemic*.** New York: Oxford University Press, 2005. 240 pp. \$28.00 cloth.

U.S. surgeon general David Satcher declared obesity a major public health problem in his 2001 *Call to Action*. He warned that “overweight and obesity may not be infectious diseases, but they have reached epidemic proportions in the United States,” causing “approximately 300,000 deaths a year in this country” (U.S. Department of Health and Human Services 2001: xiii). Without corrective action, he added, “overweight and obesity may soon cause as much preventable disease and death as cigarette smoking” (ibid.). The media, politicians, and the public responded to these warnings by increasing attention to the “obesity epidemic” in the early 2000s. Numerous federal agencies within the U.S. Department of Health and Human Services (DHHS)—such as the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Office of Minority Health—launched initiatives specifically targeted at obesity. Arkansas governor Mike Huckabee made obesity one of the highest priorities of his administration, placing Arkansas alongside twenty-five other states with obesity at the forefront of their health policy agendas (Oliver 2005: 179). By the early 2000s, obesity was an issue whose time had come (Kingdon 1984).

Public attention to social problems rarely corresponds to real changes in the threats posed by those problems but is instead manipulated by strategic actors who seek to advance their own private agendas (Edelman 1964). Obesity and the obesity epidemic are no different. In *Fat Politics*, J. Eric Oliver forcefully argues that alarms of an obesity epidemic have been sounded by public health officials, interest groups, pharmaceutical manufacturers, and weight-loss companies as part of “a politically orchestrated campaign to capitalize on America’s growing weight” (x). According to Oliver, the campaign against obesity fosters an unhealthy preoccupation with weight, often inducing people to undertake starvation diets and gastric-bypass surgeries that do more harm than good to their bodies. Instead, Oliver argues, Americans are well advised to turn their attention away from weight specifically and toward healthier diets and more exercise as mechanisms for improving their overall health.

Oliver joins a growing number of academics — such as Campos (2004, 2006) and Gard and Wright (2005) — who question the urgency of and science behind the obesity epidemic. *Fat Politics* stands out from this set through Oliver’s masterful weaving of evidence from the biological and health sciences with research and insights from the social sciences. In the best tradition of the public intellectual, Oliver renders a deeply informed product that engages with and is accessible to a wide range of audiences. At the same time, his dismissal of the potential links between obesity and mortality is overstated and premature. With respect to explicating the politics of the obesity epidemic (rather than the causes of obesity as a health phenomenon), the book comes up short, especially with its discussion of interest group politics.

Oliver’s modus operandi is to raise significant doubts about the chains of causality that connect obesity with individual and public health problems. His most vulnerable target is the body-mass index (BMI)—the ratio of weight to height that health professionals use to assess obesity. An individual with a BMI of thirty or greater is considered obese. However, BMI fails to account for fitness, heart rate, fat distribution, sex, or other significant differences among individuals that lead to variations in health outcomes (21). The conventional wisdom holds that higher BMIs are less healthy than lower BMIs, but Oliver points out that the association between BMI and mortality actually follows a U shape: individuals at the low and high ends of the scale are at higher risk than those in the middle. Among the elderly, higher BMIs are correlated with better health. Among heavier people who have a higher risk of mortality, scientific evidence does not clearly establish that body fat per se is the source of that risk.

Instead, poor diet and physical inactivity, rather than obesity, may be the causes of their health problems.

If BMI is a flawed measure at the individual level, its misuse has been amplified at the social level by proponents of the obesity epidemic. Oliver details how researchers at the CDC produced a series of maps that graphically depicted the spread of obesity in a way that exaggerated its increasing prevalence (38–43). The wide replication of these maps in government reports and newspapers fueled the perception that obesity had reached epidemic proportions. According to Oliver, the greatest gains in weight are not among average Americans—who have gained only modest amounts of weight (seven to nine pounds) in the past two decades—but among already heavy individuals who have the greatest biological susceptibility to being fat (110).

Perhaps the worst exaggeration by champions of the obesity epidemic was the number of annual deaths attributed to obesity. If, as Satcher claimed, 300,000 people in the United States died each year because of obesity, it would indeed be the most urgent health crisis currently facing the nation. These estimates were widely criticized as unrealistically high, such that by 2006 DHHS had downgraded its estimate to 112,000 deaths per year (U.S. Department of Health and Human Services 2006). Still, Oliver favors other figures reported by Katherine Flegal of the National Center for Health Statistics that estimated the number of deaths from “weighing too much” at approximately 26,000 per year, though he does not explain why he thinks that estimate is superior (25).

While Oliver persuasively pokes holes in claims about an obesity epidemic, his categorical rejection of some claims reaches beyond what a fair reading of the evidence would allow. Because of the correlation among obesity, physical inactivity, and poor diet, it is difficult to establish that obesity, rather than physical inactivity or poor diet, leads to early mortality. Oliver is right to assert that causality from obesity to mortality has not been established conclusively. However, it is also erroneous to conclude—as Oliver does—that obesity does not cause early mortality. The ultimate cause could reside in diet and exercise, but it still could be linked to obesity. Thus, Oliver’s admonition “to stop worrying so much about our weight” is premature, although his advice to start caring more about diet and exercise is sensible. Oliver cites promising research by Reavan, Strom, and Fox (2000) on the links between diet and insulin resistance as a potential explanation for a noncausal relationship between obesity and mortality. Nonetheless, a more conservative position would be that there is heterogeneity within the population in terms of the dangers of obesity.

It is possible that for many individuals with healthy diets and regular exercise routines, excess body fat may be nonproblematic or even helpful. But some individuals may face genuine health threats directly from obesity. It is prudent to caution against crash diets and risky surgeries, but discounting weight entirely would be unwise.

The relatively minimal attention Oliver devotes to childhood obesity is a sign that he has overstated his case. The first mention of children's health does not occur until page 147 (of 189 pages of prose). He states that "the biggest concern with obesity in America is with regard to our children" (161), noting that estimates of childhood obesity range between 15 and 37 percent of the population. The limited discussion on this topic is devoted to whether the true causes of childhood obesity are junk foods, television, or poor parenting, with Oliver favoring the poor parenting explanation. First, the reader must immediately question why this critical public policy discussion is buried in one of the final chapters of the book. Second, the reader must consider the implications of childhood obesity trends for Oliver's arguments about adult obesity. If obesity metrics are sufficiently precise to observe trends in childhood obesity, then why are they insufficient to measure adult obesity (as Oliver claims)? If there is indeed an obesity epidemic among children, why is it so difficult to believe the same about the adult population? At the very minimum, the book could have benefited from devoting additional attention to this issue. Beyond that, more extensive consideration of what childhood obesity tells us about adult obesity (and vice versa) would have enriched his argument.

Oliver devotes scrupulous attention to the evidence supporting or disputing causal relationships among physical activity, diet, weight, disease, and mortality. His consideration of causality among political variables, however, does not approach the same level of rigor. In particular, when explaining why the perception of an obesity epidemic arose despite weak scientific evidence, he rests heavily on the explanation of interest group influence, ignoring the fact that he examines no systematic evidence that ascertains the power or impotence of particular groups. For example, Oliver levels partial blame on the American Obesity Association (AOA) for creating the perception that obesity is a "serious, chronic disease" (47). Oliver is right that the AOA is more of an industry-sponsored lobbying group than a grassroots citizen advocacy organization. However, he is wrong to imply that it has much influence in Washington. The sole piece of evidence of AOA's influence introduced by Oliver is a fairly benign list of accomplishments posted on the organization's Web site. This puts AOA in good company with thousands of other small organizations that want to

play the influence game but do not have the clout to do so (Salisbury 1990). According to the U.S. Senate Office of Public Records (2006), the AOA does not pay any contract lobbyists in Washington or undertake significant lobbying operations on its own behalf. According to LexisNexis (2006), AOA has testified before Congress only three times in its decade-long existence. In an exhaustive study of interest groups with influence over health policy matters, I uncovered no evidence that the AOA is regarded as an influential player by health policy elites (Heaney 2006).

Oliver's ethnographic account of the 2004 meeting of the North American Association for the Study of Obesity (NAASO) illuminates the nature of the antiobesity research community. He notes that, in attending the meeting, his skeptical comments and questions about the obesity-morbidity connection were met with befuddled looks, suggesting that such an organization exists only to promote a preordained view of obesity (51). The result of this adventure is not that surprising, in that it seems a little like showing up at a church retreat to ask people about evidence that questions the existence of God. The more important question is whether NAASO is shaping policy in Washington. Oliver does not present any evidence that it is, and, with only two thousand professional members, there is no indication that politicians are likely to succumb to NAASO pressure tactics (NAASO 2006).

Perhaps Oliver targets AOA and NAASO because they fit his model of an obesity epidemic driven by self-interested scientists, industries, and government agencies attempting to leverage the obesity epidemic as a way to finance their laboratories, bolster their profit margins, or augment their ever-threatened budgets. Oliver might be more likely to find evidence of interest group influence from the activities of the nation's largest voluntary health organizations (the American Cancer Society, American Heart Association, and American Diabetes Association), which have reputations as comparably more influential actors on Capitol Hill (Heaney 2006). Each of these organizations embraces claims that the obesity epidemic causes innumerable deaths by highlighting the incidence of cancer, heart disease, and diabetes, respectively. Yet with their large, genuine grassroots membership bases and credible scientific boards, they do not conform with Oliver's model of opportunists out to gain at the expense of the public interest. Similarly, the respected Center for Science in the Public Interest—which is mentioned by Oliver—registers concerns about a growing trend toward obesity but stands invulnerable to the charge of manipulation by pharmaceutical manufacturers and weight-loss companies.

A more systematic account of interest group involvement on the obesity

issue is rendered by Saguy and Riley (2005). They probe the discourse of four communities of activists—antiobesity researchers, antiobesity activists, fat acceptance researchers, and fat acceptance activists—for indications of success in framing the public debate. Contrary to Oliver's argument, Saguy and Riley report that the fat acceptance community—rather than the antiobesity community—has achieved considerable success in reframing the debate in favor of its interests (907). According to Saguy and Riley, the fat acceptance community has gained legitimacy for itself, helped to temper the most outrageous claims about the obesity epidemic, and mollified how some health professionals talk about weight with their patients.

Paradoxically, Oliver's book is itself strong evidence of the influence of the fat acceptance community to the disadvantage of the antiobesity community. He notes in the acknowledgments that he began the research with the assumption that obesity was a "major health problem" (ix). He found himself nonplussed with shaky scientific evidence for the dangers of obesity but highly impressed with fat acceptance activists, who are among "the most courageous people" he has ever met (xi). Oliver's predilection for disputing the motives and credibility of antiobesity researchers and activists is a common tactic used by advocates in this arena (Saguy and Riley 2005: 914). In his inadequately brief two-page concluding section, "Real Solutions," the only proposal Oliver has to offer is the recommendation of fat activists Marilynn Wann and Lynn McAfee to stop worrying so much about weight (188–189). In short, Oliver has abandoned the position of a neutral observer and joined the debate on behalf of the fat acceptance movement.

Oliver's political discussion is incomplete in that it attributes too much importance to the role of industries and organized interests and too little significance to the part of political parties. Oliver is perceptive to point out that, in keeping with their conservative ideology, Republicans frame obesity primarily as a matter of individual responsibility. But there is more to the story. As Stone (1989) argues brilliantly, the success of an issue on a policy agenda depends in part on the emergence of a plausible causal story that allows the problem to be solved through policy intervention. Recognizing the high salience of health issues to the electorate, Republican Party elites are desperate to narrow the gap between their party and the Democrats on health policy trustworthiness. The obesity epidemic is a plausible causal story that allows the Republican Party to begin to address health issues in a manner consistent with its small government, conservative ide-

ology. If health costs and premature deaths are being driven up largely by obesity, and obesity is essentially under individual control, then the best government health program is one that encourages the individual to take responsibility for her or his own health. This position allows Republicans to be seen as “doing something” about health without having to create the massive new government bureaucracies that they despise. While capitalizing on the obesity epidemic is by no means antithetical to the interests of politicians in the Democratic Party, it presents a special opportunity to Republicans. Specifically, the obesity epidemic allows Republicans to present themselves as proactive on a major public health issue when it is ordinarily difficult for them to do so on ideological grounds.<sup>1</sup> Further consideration of partisan logics along these lines would have strengthened the book substantially.

In the final analysis, Oliver’s book lives up well to its subtitle but not as well to its primary title. As a study of “the real story behind America’s obesity epidemic,” the volume performs quite admirably, dissecting the complex chains of causality surrounding obesity. As a study of “fat politics,” however, it falls short. Beyond the concerns about its treatment of interest groups and political parties, already mentioned, Oliver could have probed more deeply into congressional and bureaucratic attention to obesity. Oliver tells us, for example, that NIH and CDC researchers strive to exploit obesity to support their agencies. While this is certainly true, it glosses over the complexity of institutions layered with career researchers who have deep commitments to public health and the public interest. Had these dynamics been addressed more directly and systematically, Oliver would have offered a major contribution to the politics of obesity. These criticisms notwithstanding, *Fat Politics* is an elegantly written and thoughtful book that will likely contribute constructively to public discourses about the obesity epidemic.

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1. Consider, for example, the political difficulties faced by President George W. Bush within his own party for supporting the Medicare prescription drug benefit in 2003, given that it would require massive new spending and expansion of the bureaucracy of the Centers for Medicare and Medicaid Services (Iglehart 2004).

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**Janet Golden. *Message in a Bottle: The Making of Fetal Alcohol Syndrome*.** Cambridge, MA: Harvard University Press, 2005. 232pp. \$25.95.

At first glance, it is hard to argue with public policy that is designed to protect the health of some of society's most vulnerable citizens: pregnant women. However, a closer look at what is said covertly with these policies reveals unsightly seams. Most pregnant women today are aware of the surveillance that seems to be everywhere, practiced by many with whom they come in contact. This scrutiny is not doled out by ominous Big Brother types concerned with their safety, but by the local waitress, barista, or other self-appointed "fetal advocate" looking to slap the cuffs on potentially dangerous behavior that might harm an innocent, unborn baby. Being warned about everything from consuming coffee to engaging in exercise, pregnant women are constantly reminded by others that they are carrying precious cargo that they are responsible for delivering safely. The irony in this culture of potential pregnancy perils is that those who are warning were most likely born to mothers unaware of this advice because it had yet to exist. One of the major areas of pregnancy surveillance, drinking and its effects, is the focus of Janet Golden's book. However, the subtitle alerts potential readers that they will be offered an account of Fetal Alcohol Syndrome (FAS) that goes beyond the ubiquitous warning labels.

Golden announces that this book is a "biography of a diagnosis," and as such the reader is presented with the history of FAS from its discovery to the present. Golden's aim is to alert us to what a diagnosis is, what it can do, and what kind of power it has depending on the social circumstances. In sum, "Diagnosis is power—the power to explain behavior and experiences," and the FAS diagnosis and the authority of those who diagnosed it reflected the prevailing norms. FAS was identified and named in 1973, "discovered" by doctors who noticed a similar set of physical characteristics among the children of women who were known alcoholics. These children were found to have suffered serious brain damage before birth and would have limited mental capabilities and functioning skills as they got older. Golden makes the point that this was the same year as the *Roe v. Wade* decision and marshals convincing data that there were ideological reasons why the diagnosis has changed over the past thirty years from a medical problem to a public health issue to a legislative and policy issue to a source of media and moral panic to a courtroom drama. Golden looks at the "medicalization and de-medicalization of FAS" throughout this period, which parallels how the notion of alcoholism has gone from a

moral failing to a disease to an addiction that is connected to the strength (or weakness) of character to overcome it.

The idea of FAS developed slowly at first, struggling to be accepted as a legitimate medical entity. The physicians responsible for its initial identification as a syndrome did not discover something new, as there have been children born to women who drink alcoholic beverages during pregnancy throughout history. They were able to establish FAS as a legitimate birth defect by documenting and—more significantly—publishing their findings in established peer-reviewed medical journals. Golden argues that although there was some skepticism over the epidemiological nature of FAS, it found favor due to the political maneuverings over the legal status of the fetus as a political actor. The abortion debate clearly informed the argument that the actions of the mother had effects on the (unborn) child and raised the question of where one's freedoms end and the other's begin.

In the mid to late 1980s, the diagnosis of FAS went through a growth spurt spurred on by the media's coverage of substance abuse during pregnancy and concern about an apparent epidemic of drug damaged babies. During this time, television news programs aired stories on the public panic over crack cocaine use by African Americans in urban areas and the rash of "crack babies" who were being born addicted to drugs and were subsequently abandoned by their mothers. These children were presented as a burden to society, and Golden argues that this depiction influenced the media portrayal of babies born with FAS. Early news stories on FAS focused on white, middle-class women who were alcoholics while pregnant and were presented as victims of a disease who reformed themselves after their affected baby was born. Later coverage shifted to Native American and African American mothers, who were portrayed as selfish abusers warned by scientific authorities not to drink when pregnant, but who did so anyway. The state would then be left to care for their FAS-affected children who would demand constant interventions throughout childhood and beyond, never to become productive members of society. Various experts then used media outlets to make the case that fetuses should be categorized as separate individuals with their own legal status whose rights needed to be protected from their guilty mothers. Golden convincingly argues that since there were few protests made over the lack of addiction treatment options for these often poor, unsupported women, this change in media coverage was not about protecting fetuses but about controlling women.

The diagnosis of FAS reached maturity in 1988 with the successful federal legislation to label all liquor containers with a warning about the risk of birth defects if pregnant women drink alcoholic beverages. With this decision, the diagnosis moved from the world of medicine to the spheres of public health and public policy. The labeling laws also brought another test of the FAS diagnosis, this time to the courts. Golden dedicates a chapter on a trial brought on behalf of a young boy affected by FAS against a manufacturer of alcohol over the question of who was responsible for paying for the consequences of drinking while pregnant. The prosecution's "failure to warn" argument about the dangers of drinking during pregnancy resemble the arguments used in tobacco legislation and raise the question of where corporate responsibility ends and personal responsibility begins. Via the trial, the chapter explores whether a label would make a difference to a pregnant woman who was about to have a drink, but it sidesteps the less glamorous issue that alcoholic women with FAS children often need more help than labels can provide. Golden misses an opportunity to discuss this failing of the American health care system, where it is often difficult for underprivileged women to obtain insurance coverage or safety nets providing long-term, multifaceted treatment for alcoholism or the care of disabled children. Although it is fair for Golden to focus on the results of the FAS diagnosis, a look at what preceded it would provide a reader unfamiliar with the social determinants of health with necessary background information.

The institutionalization of the FAS diagnosis was tested in criminal court where FAS has been used as a legal explanation of deviant behavior. The implications of the FAS diagnosis for individuals convicted for serious crimes and even sentenced to the death penalty were potentially life changing. The argument is that FAS and its associated brain damage could explain (or to opponents, excuse) antisocial or murderous behavior. Golden states that "[c]ourtrooms become sites for negotiating the meaning of FAS—as diagnosis or excuse—and such negotiations were not infrequent" (158). Golden convincingly points out the limits of the legitimacy of the FAS diagnosis depended on its social context: it is viewed as an acceptable way to regulate women who abuse their unborn children but as unacceptable as a rationale for criminals to get "out of jail free." The introduction of the FAS diagnosis into the legal process came with its own cottage industry—expert witnesses available to testify on behalf of individuals. Ultimately, the FAS diagnosis is found to be stretched beyond its means, its proponents trying to go too far too fast. Though there is little

medical doubt that those who suffer from FAS face significant challenges from the day they are born, once they commit a crime, they stand alone.

Ultimately, this book has more to do with issues beyond the consumption of alcohol during pregnancy. Golden offers the FAS diagnosis as a lens through which to view changes in politics, culture, health, the status of women, and the nature of the fetus as a political player. However, the discussion of FAS diagnosis and its racial disparities (Native American women are a staggering 33 times more likely than the general population to have babies with FAS, and African American women are 6 times as likely than the general population to have babies with FAS) could have been developed more in the text. This book successfully places the issues within a historical and social context that is never weighed down by a parade of facts. The overview that Golden provides is, however, too broad at times, and it suffers from its neglect of individual voices. Though Golden states that it was not her intention to depict personal narratives of FAS, it speaks to the conviction of her arguments that the reader wants to know more about the lives of those who experience FAS.

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**Raymond DeVries. *A Pleasing Birth: Midwives and Maternity Care in the Netherlands*.** Philadelphia: Temple University Press, 2004. 296 pp. \$74.50 cloth; \$24.95 paper.

At the recent annual meeting of the American College of Obstetricians and Gynecologists, all attendees received a bumper sticker depicting a stork with a bundled baby in its bill, proclaiming “Home Deliveries Are for Pizza.” Despite the incredible rarity of home birth in the United States (fewer than 1 percent of births happen outside the hospital and many of these are precipitous), this sentiment encapsulates the threat that home birth (which some doctors have even castigated as “child abuse”) represents in the American obstetrical imagination. Indeed, American beliefs about birth are typical of high-income, industrialized societies, where the vast majority of births take place in hospitals under the care of a physician. Midwives, the traditional birth attendants for most of human history, have been relegated to the margins of modern birth.

Imagine, then, the paradox of the maternity care system in the Netherlands, where home birth is valued and encouraged and midwives are

an integral and powerful professional group. This paradox is the subject of Raymond DeVries's *A Pleasing Birth*, an engaging, well-written case study of maternity care in the Netherlands. DeVries describes how women in the Netherlands give birth (or "get babies" in the Dutch idiom) and then uses this case study to extend a compelling set of arguments about the relationship between culture and health care. He begins with the simple observation that the organization of maternity care in the Netherlands differs starkly from that of every other high-income, technologized society; in DeVries's apt phrase, the Netherlands is the "*exceptional* exception" (xi). DeVries extracts two main lessons from this captivating exploration of the Dutch maternity care system: first, that of all the medical sciences, obstetrics is most deeply implicated in culture and, second, that obstetric science follows obstetric practice, inverting the formula that is the foundation of evidence-based medicine.

First the facts. In 2000, 30 percent of births in the Netherlands occurred at home, and 34 percent of births were attended by a midwife. In the United States, 99 percent of births occurred in the hospital and 8 percent of births were attended by a midwife. The cesarean delivery rate was 12 percent in the Netherlands, 24 percent in the United States. And the infant mortality rate was 5.1 percent in the Netherlands and 6.9 percent in the United States. In other words, the Dutch are able to achieve extremely good outcomes for mother and baby alike by organizing maternity care in a manner that would seem unacceptably risky to the typical American or European obstetrician.

DeVries sets out to explain the peculiar characteristics of birth in the Netherlands. Why, for example, has home birth persisted there, while it has all but vanished elsewhere in the developed world? Moreover, home birth in the Netherlands persists not as a fringe, counterculture alternative but as a deeply valued part of the state-organized and supported maternity care system within the Netherlands. What accounts for the staunch societal, professional, and governmental support for this system of care? DeVries divides explanations for the persistence of the "Dutch way of birth" into two types, structural and cultural, although as he astutely recognizes, "cultural ideas are given credence by structural arrangements" (243).

Undergirding the Dutch maternity care system is a distinct philosophy of birth that is in many ways diametrically opposed to the prevailing cultural beliefs and norms governing childbirth in the rest of the industrialized world. One of the axioms of modern obstetrics is that "birth is normal only in retrospect," which is to say that physicians tend to regard

childbirth as a risky pathological process that most safely proceeds in a high-technology (i.e., hospital) environment, often with an array of interventions such as induction, oxytocin supplementation, episiotomy, and surgical delivery. In the Netherlands, in contrast, birth is viewed as a normal process that most safely proceeds in a comfortable and familiar environment (i.e., home) with minimal interventions. More than 75 percent of pregnant women choose midwife care at the outset and more than 40 percent intend to have their babies at home. Only if a woman's pregnancy is deemed high risk by her primary care provider—a midwife or a general practitioner—is she referred to a specialist.

This system is supported by a set of structural arrangements, including governmental regulations that mediate the professional rivalries that elsewhere have allowed obstetrics to dominate midwifery, a reimbursement system that directs women into primary care and away from more expensive specialty care until complications arise, and a physical infrastructure—high population density, excellent network of roads, coordinated hospital system—that facilitates rapid transfer from home to hospital in the event of labor complications. Dutch midwifery, for example, enjoys a legally defined sphere of practice that drastically limits encroachment by obstetrics, a clearly articulated professional identity, and its own distinct educational institutions. One of the most interesting features of the Dutch system is the *Verloskundige Indicatielijst* (VIL), or Obstetric Indications List. By precisely defining what distinguishes a physiological (i.e., normal) birth from a pathological one, the VIL delineates clear boundaries of professional practice between primary care provided by midwives and general practitioners and specialty care. DeVries details the history and evolution of these arrangements, demonstrating that the state has often played a central role in negotiations between competing professional groups, particularly in the case of the *primaat*, which essentially granted a kind of monopoly practice to midwives.

However, it is not structure alone that accounts for the Dutch way of birth. While acknowledging a deep-seated sociological prejudice against the idea of “national culture,” DeVries foregrounds culture as an explanation in a charming (and self-deprecating) introduction in which he describes moving his Midwestern family into a Dutch household for a year. His observations about the smallness and enforced intimacy of Dutch domestic space—such a contrast to the sprawling American household—lay the groundwork for his later arguments about the influence of culture on maternity care. In a fascinating tour of Dutch social history, DeVries shows us that the Netherlands was the first European society to

experience the nuclearization of the family, which had emerged as an ideal in all classes as early as the sixteenth century. Moreover, women enjoyed independence and an elevated status within the family, a marked contrast to the rest of Europe. This history translated into an abiding emphasis on the private domestic sphere over the public sphere. (Even today, DeVries notes, the Dutch are less likely to “go out” to movies or taverns, preferring to stay at home.) Throughout the twentieth century, Dutch women experienced higher rates of fertility and lower rates of paid labor force participation than their peers elsewhere.

In addition, DeVries points to a Dutch tolerance for pain—in general, the Dutch use fewer pain medications than other European societies—and an intolerance for heroics (which DeVries neatly illustrates through his description of Dutch national monuments). Remarkably, obstetrical specialists in the Netherlands eschew the heroic, even godlike self-image that many American physicians cultivate. “It’s very easy to play the hero . . . but no one is helped by it. . . . It diminishes [the woman’s] own role, of doing a lot of the performance, of the labor, of the work. . . . It’s nonsense” (166), one doctor tells DeVries. A different culture with respect to malpractice prevails as well; although lawsuits do occur in response to bad birth outcomes, DeVries argues that there is both more acceptance of mistakes and a much greater forthrightness on the part of doctors about mistakes when they do happen.

Finally, a broader set of cultural values around thriftiness, social solidarity, rationality, and negotiation has supported and sustained the Dutch maternity care system. DeVries characterizes the policy-making process in the Netherlands as rational, with a careful weighing of costs and benefits (a feature that American readers will surely regard with envy). The Dutch emphasize the *polder* model, a form of politics that prizes conflict avoidance, elite cooperation, and consensus. Moreover, in Dutch politics everything is *bepsreekbaar*, or speakable; that is to say, nothing is outside the realm of discussion. There are no “third-rail” issues in Dutch policy making; DeVries points to the frankness of Dutch policy around euthanasia as another example. This openness facilitates public discussion and grants all stakeholders a voice.

In an especially trenchant final section, DeVries dissects the relationship between obstetrical practice and obstetrical science, as presented in the peer-reviewed medical literature in the Netherlands, the rest of Europe, and the United States. Mainstream obstetric research in the Netherlands produces evidence that supports the existing structure of care and division of labor. Yet there is a dissenting faction within Dutch obstetrics that

allies itself with the orientation and ideology of obstetrics outside of the Netherlands; that is to say, in favor of hospitalized and interventionist birth. This schism yields what DeVries calls the “two sciences” of birth in the Netherlands, a bifurcation that is echoed outside of the Netherlands as well. Mainstream Dutch obstetrical science—that is, research that demonstrates the safety and good outcomes of home birth—is regularly shunned by the leading American medical journals (finding a home instead in nursing journals), while the minority critique finds welcome reception therein. He argues that “accepted definitions of what is normal in pregnancy determine what is accepted as good science” (207) in the Netherlands and in the United States, which is precisely the inverse of what the philosophy of evidence-based medicine would dictate. The engine at work here is not science, but culture—beliefs about how (and where) birth *ought* to happen. Indeed, DeVries (180) quotes Gerrit-Jan Kloosterman, the chair of obstetrics at the University of Amsterdam:

Obstetrics is wider and broader than pure medicine. It has to do with the whole of life, the way you look at life, making objective discussion difficult. You are almost unable to split the problem off into pure science; always your outlook on life is involved.

*A Pleasing Birth* is full of keen observations and thoughtful analysis about far more than birth; as DeVries’s analysis skillfully illustrates, childbirth is a window onto “the whole of life.” Anyone interested in childbirth, professional regulation, the impact of culture on health care, the sociology of knowledge, or health care reform will find this book to be a pleasing read.

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