# Preface

MY CHILDREN and I arrived in the Netherlands on a cold, clear January day. I had come to study how Dutch babies get born. My children, mildly intrigued by the idea of living in Europe, agreed to come along, making my sabbatical a family affair.

We spent those first few mid-winter days exploring our new surroundings. We bicycled through the Dutch countryside along canals and past cows, farmhouses, and cafes. We visited the schools my children would be attending and became familiar with the bus routes we would travel to and from work and school. We rode the trains from Hilversum—the nearest city to our new home—to Amsterdam and back, learning how to negotiate the stations, schedules, and conductors. We tasted a variety of new and exotic foods, cuisines that found their way to the Netherlands from Indonesia, Turkey, and Morocco.

All the while I watched my children closely, eager to see their response to their new home. I had been to the Netherlands before and expected that they, like most tourists from the United States, would be impressed by the canals, the windmills, and the church towers. But these children, aged 11, 14, and 16, were no tourists: They were well aware that they would be living here for the next 12 months. For them, the most remarkable feature of the Netherlands was its smallness. In this tiny country everything seemed to be half-sized: the roads, the cars, the street signs, the grocery stores. They were most impressed (perhaps I should say *depressed*) by the size of our new living quarters. We had rented a typical Dutch home, a row-house, referred to in Dutch as an *eengezinswoning* (literally, "one-family living place") a label that caused my children, as it would most Americans, to scoff. By American standards, these houses are, at best, large enough for only half a family: The bedrooms are tiny and lack closets, the kitchen has the feel of a galley on a sloop, the single toilet is squeezed into a room so small one cannot turn around when the door is closed, and the living room serves also as the dining room.

Impossibly small for Americans, the architecture of Dutch homes makes sense in a small country with many people. Interior design is the art of efficiency, maximizing space and light. Not one square centimeter is wasted: Front-loading washing machines are tucked under kitchen counters; stairways appear from ceilings; clotheslines are stretched in hallways. Windows are used liberally. Nearly every home in the Netherlands has a large window in the front and in the rear, allowing a flood of natural light, giving small spaces a more open feel.

To the casual observer these cute Dutch homes are nothing more than practical adaptations to limited space. Had we not lived in the Netherlands, I would have been satisfied by that simple syllogism: tiny country = tiny homes. However, after a few months in our Lilliputian house, I came to understand that Dutch homes are not just about economizing on space; they also reflect and reinforce peculiarly Dutch ideas about the importance of the nuclear family. In accommodating to our new home we discovered we were spending more time together than we did in our much larger house in Minnesota. Small homes force families to live together in a way inhabitants of large American houses can avoid. The combined living and dining room of the *eengezinswoning* becomes the hub of family life. Here the children do their homework, parents read and chat, and the family plays games or watches television. Bedrooms are sleeping rooms (*slaapkamers*), and living rooms are really rooms where life is actually *lived.* Stroll down the street in the Netherlands at dusk, just before the curtains are drawn, and you will see framed in each large front window the Dutch family living together.

Our deeper understanding of the meaning of Dutch architecture was hard won: It took some time for us middle-class Americans to find ways to share bedrooms, bathrooms, and living rooms. American teenagers are used to having separate bedrooms, places of refuge from annoying siblings and parents. American parents are *not* used to having to wait in line for the toilet and the shower.

The shortage of space weighed heavily on me. My research was generating expanding piles of notes, documents, language tapes and books, and I had nowhere to work. Lacking room elsewhere, it became my habit to colonize the dining area after we had finished our dinner. My books and papers began in neat, organized piles, but somehow they would slowly march out to occupy not only the table, but also the seats of the encircling

chairs. One evening, a few months after our arrival, I was hard at work amidst these piles, complete with frazzled hair and perplexed look, when my 14-year-old son wandered over to marvel at the chaos. He looked over the tangle of government reports and graphs describing Dutch maternity care, and, after a few minutes, he shook his head, slapped me on the back, and walking away, said—with the candor of youth—"Dad, I hate to tell you this, but no one cares about birth in the Netherlands."

Of course he was right. *I* was fascinated with the way the Dutch organize maternity care, but who else aside from a few birth activists, a handful of midwives, and an occasional obstetrician would be? This tiny country with its tiny houses, tucked in the swampland north of France and west of Germany, is little noticed on the world stage. News from the Netherlands rarely finds it way into newspapers in other countries. Every once in a great while you might find a story about Dutch drug policy or euthanasia on the third page, or perhaps some quaint personal interest story in the B-section. Not atypical is a report from the Associated Press that appeared in my local paper: "Marijuana Now Legal in Dutch Pharmacies" (*Minneapolis Star Tribune*, 18 March 2003, A7), or this piece from the *New York Times*: "The New Reefer Madness [in the Netherlands]: Drive-Through Shops" (*New York Times*, 28 May 2001, A4). When the Dutch Prime Minister visits the White House in Washington, it is not front-page news. Who in the United States can even *name* the Dutch Prime Minister?

Who, indeed, cares about birth in the Netherlands?

But social research often proves the wisdom of the biblical aphorism, "the foolish things of the world . . . confound the wise" (1 Corinthians 1:27). Thus a political scientist can go bowling (who cares about *bowling*?) and discover important truths about American social life (Putnam 2000). Similarly, we will see that birth in the Netherlands has a resonance that reaches far beyond the borders of this small country. In studying the peculiarities of the Dutch way of birth, we will learn how health systems are formed and how they can be successfully reformed.

I had come to the Netherlands for both personal and professional reasons. My name, De Vries, betrays my personal interest. Impossible for most Americans to spell, let alone pronounce, De Vries is perhaps the most common name in the Netherlands, the Jones of the lowlands. I am, in fact, a third generation Dutch-American. My grandparents, all four, were immigrants from the Netherlands, part of the flood of

Europeans that arrived at Ellis Island at the beginning of the twentieth century. They settled in the Dutch neighborhoods of northern New Jersey, from whence their descendants, in good American fashion, spread out to the corners of the continent.

I grew up hearing a very funny language traded back and forth among aunts and uncles, a secret code for communicating above the heads of us monolingual children. My knowledge of Dutch was limited to the names of certain household items: I was six or seven years old before I learned that not everyone called a dustpan and brush, the "fayghee and blek." I was, as my parents wished me to be, 100 percent American. And yet I remained curious about my roots in a different land, interested in the practices and ideas that made the De Vries and Greydanus families distinctive. I had been to the Netherlands a number of times—first as part of the backpacking tour of Europe that was nearly obligatory for American college students in the early 1970s, and thereafter for a few professional meetings. But I longed for a chance to live there, to become familiar with the language and the everyday life of the land where my ancestors had lived for countless generations.

Had my interest in the Netherlands been *only* personal, the book you hold in your hands would be a travelogue or a personal history rather than a piece of social and cultural analysis. My *professional* interest in the Netherlands grew out of my graduate school research on the sociological dimensions of birth practices. I began this work unaware of any connection it might have to my family history. To my delight, while digging through references on midwifery and obstetrics, I kept finding articles that described the Netherlands as "unique," "the exception," "a system worthy of emulation."

What caused this commentary? What made Dutch maternity care so peculiar? One simple fact: Unlike women in every other country in western Europe, unlike women in the United States, Canada, and the developed nations of Asia, women in the Netherlands continued to have their babies at home. According to some accounts I read, Dutch women were actually *encouraged* to have their babies at home. This was, and remains, very unusual. It is true that in the middle and late 1980s some women in developed countries were choosing to give birth at home, but data from the Dutch government showed a home birth rate of more than 30 percent through the 1980s and into the 1990s. At that time no other country with a sophisticated, highly technological medical system had more

than 2 *percent* of births occurring outside the hospital,[1] and most of those births were precipitous deliveries, births that occur so fast that the laboring mother is unable to make it to the hospital.

To outsiders Dutch birth practices seemed to be caught in a nineteenth century time warp. In the late 1970s obstetricians in the United States had dismissed home birth as child abuse. Could birth at home be safe for babies and mothers? Here was a second curious fact about birth in the Netherlands: This seemingly archaic system was producing some of the lowest morbidity and mortality rates in the world.

What was going on over there? Why hadn't the Dutch conformed to the standards that dictated that modern women give birth in the hospital surrounded by the safety of high technology and the comfort of pain-relieving anesthesiology? And why did the Dutch system work so well?

No one seemed to be able to explain the Dutch difference. Several had tried. The journalists, physicians, historians, and social scientists who wrote about Dutch obstetrics felt obliged to offer reasons for the persistence of home birth there, but their explanations were unconvincing. Some believed it was Dutch stubbornness; others saw it as backwardness. Some credited the geography of the lowlands; others associated Dutch birth with Calvinism. Still others suggested that Dutch women were better suited to birth at home because they were bigger and healthier than women elsewhere. Interesting explanations all, but most were conjectural, based on scant, or no, evidence.

One *might* argue that the peculiarity of Dutch maternity care is nothing more than a cultural flourish. It is well-known that there are cultural variations in the way societies treat disease, so should we be surprised to discover that different countries treat birth differently? Well, no and yes. For if we look closely at the different forms of medical treatment offered in different modern nations, we find that they are, in fact, all mere variations on the theme of allopathic medicine. Yes, rates of surgery and patterns of prescription drug use vary between countries. Underlying these treatments (and nearly all treatments in modern nations), however, is the single, unvarying allopathic principle that the proper response to disease is medication and surgery. Modern medicine is active and interventionist. Obstetrical practice in the

1. The home birth rate in the United Kingdom went above 2 percent in 1997. See Declercq, De Vries, Salvesen, and Viisainen (2001).

Netherlands is especially odd because it is *watchful and reactive*, violating the fundamental premise of modern medicine.

The more I read about Dutch maternity care, the more I saw that it was an *exceptional* exception and not just a quaint custom practiced by people with wooden shoes. While the rest of the modern world was captivated by the wonders of new technology and eagerly applied this technology to the "problems" of birth, this small country, which is otherwise sympathetic to technology, continued to insist that birth is a healthy process best accomplished free from drugs and machinery in the comfort and safety (!) of the mother's home. Something was going on over there that promised to teach us, not just about the way we do birth, but more generally, about the way we think about and organize health care.

I had to get to the Netherlands. Finishing my studies of birth in the United States, which issued in several articles and a monograph on making midwives legal (see De Vries 1985, 1996), I began to seek the means for an extended stay in the land of my ancestors. I was naively optimistic about getting funded: After all, maternity care in the Netherlands was extremely interesting, and it had not been carefully described in the English language literature. The few reports of the system that existed were broadly descriptive, based on a one- or two-week fact-finding tour: just enough time to gather some (not always reliable) statistics. Furthermore, granting agencies would surely notice that the distinctiveness of Dutch obstetrics offered a perfect opportunity to do a quasi-experiment. Here was one country among a number of like-situated countries that had a different outcome. By comparing these countries and working backwards from the present systems to the conditions that generated them, I would be able to isolate the cultural and social variables that explained birth care in the Netherlands.

My early attempts to get funding failed. Perhaps it was because my proposals were poorly conceived, perhaps it was because of the perceived insignificance of the Netherlands. I persisted, applying to a wide range of private foundations and public agencies. Finally, in 1993, reviewers for the Senior International Fellows program of the Fogarty Center of the National Institutes of Health agreed there might be something to learn in the Netherlands, and I was awarded the funds necessary to begin my research.

My family and I left America for the Netherlands in early 1994, a temporary and comparatively advantaged reversal of the immigration story

played out by my grandparents nearly one century ago. The Netherlands proved to be richer ground for sociological research than I had imagined: another way of saying that I soon realized my tidy little study would remain neither tidy nor little. I started with a simple question: Why is the Dutch way of birthing children so different? But this simple question led, ineluctably and almost immediately, to larger questions. What is the place of maternity care in the larger health care system? How is government policy on health care made? How does the political system influence health care? Who pays for health care and who profits from health care services? What elements of Dutch culture (for example, ideas about the body, about gender, about families) support their particular health care system?

As I pursued these unanticipated questions, I gradually understood that I had *two* stories to tell. The first is the obvious one, about the way children are born in the Netherlands. This story—the story of Dutch maternity care—is a fascinating one, complete with a colorful cast of heroes and villains, political intrigue, and competing professional and scientific interests. The second story is an account of the way health care systems operate. At every step of my research, the facts of Dutch maternity care forced me to rethink and revise the widely accepted stories academics tell about the way health care systems work and develop. This second story is more abstract than the first, but no less interesting and—because it forces us to revise much of the knowledge of health policy and medical sociology that is taken for granted—it is, perhaps, the more important.

This book is my effort to tell these two stories. Taken together, the stories suggest a new way of thinking about health policy. Health care systems are unwieldy beasts. Their size and complexity frustrate individuals who need health services and stymie the most well-intended reform efforts, turning would-be improvements into new inefficiencies. With the constant change wrought by new technologies, new financing schemes, and new political alliances, policy researchers and social scientists are hard-pressed simply to *describe* how these large systems work. If we cannot describe the forces that shape the delivery of health services, we have no hope of improving the quality or reducing the inefficiency of health care. But how can we gain this much-needed understanding? In the following pages I demonstrate that the best way to learn about the operation of complex health care systems is to look at one small slice of health care in one small country. I argue that a rich description of maternity care in the Netherlands allows us to see the many factors at work in the creation

and evolution of health care services, and helps us avoid the problems that plague those who wish to explain the organization of medical care.

When I began my research I was well aware of its policy implications for obstetrics in the United States: We Americans needed to learn how to make birth less medical, using fewer drugs, less technology, and less intervention. But, as you will see, I learned far more than this. Lessons learned from Dutch maternity care have broader application and can help us to find new ways to reform health care and to respond to the high cost and limited accessibility of modern medicine.

The tortured evolution of American health care over the last decade—highlighted by government-sponsored incremental change and unmanageable managed care—has made two things evident: (1) The system must be changed, and (2) we know very little about how to bring about the changes that are needed. If we are to succeed in the reform of health care, we must have a better understanding of the many forces that *form* medical systems. We need to know more than medical sociologists, economists, and health policy analysts have told us: We need to know how medical systems come to take the shapes they do. Study of maternity care in the Netherlands will close gaps in our knowledge of the social and cultural foundations of health care. In turn, this knowledge will serve as the first step in effective reform, not just of maternity care, but also of health systems.

My description and analysis of Dutch midwifery is based on 16 months of research done from 1994 to 1995. During that period, I interviewed midwives, clients, gynecologists, midwife educators, government officials, policymakers, researchers, staff of the association of health insurers, and staff of the professional associations of midwives, general practitioners, and gynecologists.[2] I visited several midwife practices and three schools of midwifery. I read all major government reports on midwifery published since 1940 and read uncounted articles in the professional journals of Dutch midwives, general practitioners, and specialists. I also read popular literature related to birth and midwifery, including articles in newspapers, magazines, and how-to books for new mothers and fathers. Since leaving the field in 1995, I have visited the Netherlands several times, both

2. I draw on these interviews extensively in my analysis. Some of these interviews were done in English and some were done in Dutch. In many instances my interviewees, regardless of the language we were using, would use a Dutch word or expression that is not easily translated. In those cases you will find the words and phrases remain in Dutch, followed by an English approximation.

virtually and physically, updating my data and following developments in health care and midwifery.

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Part I of *A Pleasing Birth* sets the stage for the two stories of Dutch maternity care. After a brief meditation on what makes for a pleasing birth, I go on in Chapter 1 to describe the opportunities afforded by the study of birth in the Netherlands, showing how a careful look at the specific features that make Dutch birth different enhances our understanding of health care systems in general. In Chapter 2, I offer a thorough description of the Dutch system, describing its uniqueness in the modern world.

In Part II, I begin my explanation of how Dutch maternity care avoided the turn toward technology that characterizes all other modern obstetric systems. In providing this explanation I look to the unique *structural* features of Dutch society. Chapter 3 examines how the infrastructure of Dutch society—including its health insurance system, its health policy process, its educational and professional institutions, and its system of hospitals and roads—sustain the unique Dutch way of birth. In Chapter 4, I explore the political arrangements, both outside and inside of health care, that protect the existing maternity system.

These structural explanations are an important first step in helping us understand the form of Dutch maternity care, but they can take us only so far. In Part III I ask, "Why did the Dutch (and not their neighbors in surrounding countries) *create* and *maintain* the structures that lend support to midwife-assisted birth at home?" Chapter 5 answers this question by looking at the critical role cultural ideas and values played in the creation of the Dutch way of birth. In Chapter 6, I examine the science that informs health policy. Bringing together the themes of Parts II and III, I offer a sociology of obstetric science, an analysis that shows the footprints of structure and culture in the science that has been used to both support and to criticize Dutch obstetrics.

In Part IV, I move to the second story, using what we have learned about Dutch maternity care to explain the way health care systems are *formed* and *re-formed.* In Chapter 7, I look at how changes that are occurring in Dutch society and medicine are threatening Dutch obstetrics, and I discuss the steps the government is taking to protect their unique way of birth. After summarizing the cultural and structural forces that created (and continue to create) Dutch maternity care, I go

on, in Chapter 8, to consider how my research can be used by health activists, medical sociologists, and health policy makers.

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Although I was unaware of it, my lessons about the Dutch difference began during those first days in our tiny home in the Netherlands. We could not help but notice that the Dutch see the world with different eyes. Blessed with boundless space, we in the United States see ourselves as a country without limits. Many of us live in large houses with large rooms, and large yards. The Dutch have spent centuries fighting the sea and rising rivers. Hemmed in by canals and dikes, they have a keener appreciation of limits. As we begin life in the third millennium, we Americans are beginning to discover our limits: Our large houses cost too much to heat, to cool, and to light. And our limitless health care system has created a crisis of cost and confidence. There are better ways to build homes *and* to organize health care. Looking to maternity care in the Netherlands, we can find a way to live within our limits and to create a more just and effective health care system.

## A Note on Language

In order to tell the story of health care and childbirth in the Netherlands, I must put Dutch terms into words that are understandable to an English-speaking audience. In some cases the obvious word is not the best word. For example, use of the word *Dutch* itself. Residents of the Netherlands have grown accustomed to this adjective, but if pressed, most will admit they are not fond of the word. It is a derivative of *deutsch,* or German. In their language the national adjective is *Nederlands(e),* better translated as Netherlandish (as in Finnish, Swedish, Danish) rather than Dutch. In an effort to respect the language and to avoid all the connotations of the word Dutch—"dutch treat," "dutch uncle," wooden shoes, and windmills—I tried using the word *Netherlandish* in this book. In the end it sounded too pretentious; it might work for those in the art world, but it seemed to clutter up this book. Please note, however, that although the use of the word *Dutch* makes for smoother reading, it confuses the translation of many abbreviations of organizations and government agencies: All those Ns become Ds. For example, the Royal Dutch Organization of Midwives

(RDOM) is in fact the *Koninklijke Nederlandse Organisatie van Verloskundigen* (KNOV).

As with all moves from one language to another, it is easy to misrepresent meaning. For example, the Dutch word *welzijn* is most often and easily translated as *welfare.* But the word literally means "well-being," and the Dutch sense of the word is closer to that translation than it is to the heavily loaded (American) English word *welfare.* Because my goal is to get the reader to understand the *concept* represented by the word and not just the word itself, and because one of the central arguments of this book is that health systems must be understood as cultural products, I will ask you, the reader, to become familiar with certain Dutch words and phrases. I do this only when no suitable English word exists or when the common English translation of a Dutch word is misleading. To assist you in gaining a working knowledge of these Dutch words I have prepared a glossary to which you can refer. Because language is an important carrier of culture, it is important for you to become familiar with a few Dutch words and the distinctive meanings they carry. In several places in the text, I include the Dutch word along with the English translation of the word. I do this out of respect for language and to remind you, the reader, that the English translation is only an approximation of the meaning of that word in Dutch. In each chapter the first use of a Dutch word is italicized; thereafter it appears in nonitalicized type.

Perhaps the best example of how meaning can be lost in translation is found in the Dutch words for midwife. The Dutch use two different words for midwife. *Vroedvrouw,* literally "wise woman," is the more traditional term; *verloskundige*—"expert in delivery" or "expert in obstetrics"—is the more modern word. In the mid-1970s the official term was switched from *vroedvrouw* to *verloskundige;*[3] but in the common language of the streets both words are used. Generally, the practitioners who favor the term vroedvrouw are those who are actively advocating for home birth and autonomous midwifery, whereas those who prefer verloskundige are midwives seeking to fit their occupation in the modern professional structure. If I simply translated both terms as *midwife,* the nuance that separates activist midwives

3. In 1975, the two existing professional associations of midwives merged and the new association was named the *Nederlandse Organsatie van Verloskundigen*. In 1978, the government replaced vroedvrouw with verloskundige in all laws referring to midwives (Drenth 1998, 81).

from other midwives would be lost (see van der Hulst 1989). Consider this exchange with a midwife educator:

> *I noticed that you use the word* vroedvrouw, *and not* verloskundige. *So you feel that's an unfortunate change of names?*
>
> Ja.
>
> *That happened before you became a* vroedvrouw*?*
>
> Yes, I think in 1975. It happened in the period when I was in training. Op mijn diploma staat nog *Vroedvrouw.* [On my diploma it still says "Vroedvrouw."] So afterwards, a year later it said *Verloskundige* on the diplomas. And it started about 1974, when men came in the profession, that they decided to change the word.
>
> *Who's they? Is that the government again?*
>
> The government, ja.
>
> *I've noticed also on the elevator downstairs it says* Vroedvrouwenopleiding, *[*Vroedvrouw *education] not verloskundige. Has that just stayed the same here, in Amsterdam? Or did you change it? Or . . .*
>
> No. Officially the name of our school is *Kweekschool voor vroedvrouwen* (Vocational school for *vroedvrouwen*). And then people would say, "It's a very old-fashioned name; you should change it. You should change it; you should make it *Akademie voor verloskundigen,* or *Hogeschool voor verloskundigen.*" And we discussed a lot about it, and then we said "No, we have to use that name, because it's a very old name, and it's good to have that old name, *Kweekschool voor vroedvrouwen*."
>
> *Is it still used by other schools,* Kweekschool*?*
>
> No.
>
> *It's not used in any other . . .?*
>
> The school in Kerkrade is called *Vroedvrouwenschool,* and Rotterdam is called *Rotterdamse opleiding tot verloskundige.* So they changed it. And we are still the *Kweekschool voor vroedvrouwen.* And we are not discussing that any more. That's our name, and that's what it is.

# I. Birth Care/Health Care

Among the many interesting things I discovered while studying the Dutch language, none was more fascinating than learning that the verb *bevallen*, means both "to give birth" and "to please." *Een bevalling dat bevalt* is, literally, "a birth that pleases," or, translated more fluently, "a pleasing birth." Given what I knew of birth in the Netherlands, it seemed fitting that in Dutch, "a pleasing birth" would be a redundancy. Of course, not all women agree on the features of a pleasing birth. For some women the ideal birth is one that takes place in the company of family and friends. Other women prefer to be alone. Some women desire analgesia and anesthesia to relieve the pain of labor, others choose to give birth without the assistance of drugs. For some, the most satisfying birth occurs in the security and familiarity of their own home, although others find the hospital the most reassuring place to bring their child into the world. Some birthing women are happiest when attended by an obstetrician-gynecologist; some favor the services of a midwife.

The following birth story-told in Dutch and translated into English-is an account of a pleasing birth in the Netherlands.

> *Mijn tweede zwangerschap was niet zo stralend en vitaal als mijn eerste; vaak verkouden en vermoeid. Wilde graag dat deze tweede op 1 mei geboren zou worden, zo'n mooie datum. Maar op 26 April, na mijn laatste afspraak met de vroedvrouw, voelde ik een kleine wee en een tijdje later weer een kleintje.*
>
> My second pregnancy was not as exciting as my first, I was often tired and had many colds. I was hoping that this child would be born on the first of May, it is such a perfect date. But on the 26th of April, after my last appointment with the midwife, my contractions began. I felt a weak contraction, and then a while later, another small one.
>
> *Besloot om lekker vroeg naar bed te gaan. Als ik kan slapen, misschien gingen de weeën dan wel weg. Dat lukt niet. Ik had nu duidelijk weeën en ging met mijn blote dikke buik bij de warme kachel staan. Wat lekker was. De weeën werden duidelijker en regelmatiger en we belden de vroedvrouw.*
>
> I decided to go to bed nice and early. If I could get to sleep, maybe the contractions would stop. That did not work. I was definitely having

contractions, so I went with my big bare belly and stood in front of the gas heater. That felt great! The contractions became stronger and more regular, and we called the midwife.

*Eerste kwam de co-assistent en daarna de vroedvrouw. Ook Jetske, mijn vriendin, kwam met een grote bos sterk geurende lelies. Buurman Otto kwam toevallig binnen en vroeg of hij mocht blijven. Dat mocht. Tussen de weeën kon ik me nog heel goed ontspannen en als er weer een op kwam zetten, ving ik hem/haar behendig op. Voelde me een bedreven baarster. Ze namen intussen in hoeveelheid en intensiteit toe en binnen de kortste tijd herinnerde ik me weer haarscherp hoe venijnig sommige weeën kunnen zijn.*

First came the assistant and then the midwife. My friend Jetske came with a big bouquet of fragrant lilies. My neighbor Otto happened to come by and asked if he could stay. Sure, why not? Between contractions I was able to relax, and when another came, I was able to handle it easily. I felt like an old hand at this. Gradually the contractions became more frequent and intense, and I suddenly recalled how vicious some contractions can be.

*Ik raakte geïrriteerd en ongeduldig. Ik had er echt genoeg van, ik wilde dit nooit meer. Snel kwamen toen de persweeën en ik moest ze nog even op een afstand houden, wegblazen. Maar ze waren zo machtig dat ik mee moest en tegelijk genoot ik daarvan. De vroedvrouw brak de vliezen. En toen kwam als een enorme opluchting mijn tweede kind naar buiten, een prachtig meisje met donker haar, Rosa.*

I began to feel irritated and impatient. I had had enough of this, I wanted no more. Soon came the urge to push, but I had to keep these strong contractions at a distance, I had to puff them away. But they were so powerful I had to go along with them, and when I did I found that I enjoyed them. The midwife broke the membranes. And then, an enormous relief, my second child arrived, a beautiful little girl with dark hair, Rosa.

*Zij lag veilig en warm naast me, met tussenpozen zachtjes kreunend alsof ze bij moest komen van de tocht naar buiten. Toen iedereen weg was en Frans, mijn man, lag te slapen op de bank en Swaan, mijn dochtertje, in haar bed, en Rosa in mijn arm, veranderde de kamer in een eiland van rust, het middelpunt van het universum.*

She lay next to me safe and warm, softly groaning as if gradually recovering from her journey. When everyone had gone and Frans, my husband, was sleeping on the sofa and Swaan, my little daughter, was in her bed, and Rosa in my arms, the room changed into an island of rest, the center of the universe.

—"The Birth of Rosa"[1]

1. From *Bevallen and Opstaan,* Spanjer et al. 1994, 366–367.

When we hear stories of labor and delivery it is easy to conclude that every woman has her own idea of a pleasing birth. But is the definition of, or the agenda for, a pleasing birth an individual creation? Can we assume that the decisions we make about how we want our birth to proceed—or the decisions we make about *any* health care service we use—are based on nothing more than our individual preferences? When we look closely at women's preferences for care at birth we find a pattern beneath the variation. The hospital, with its bright lights, gleaming stainless steel, and state-of-the-art machinery, comforts an American mother but terrorizes a birthing woman newly arrived in the United States from rural Laos. A laboring woman from Paris would panic if placed in the simple hut and birthing hammock that reassure mothers-to-be in the Yucatan. The home birth described above—quite common in the Netherlands—seems outlandish and risky to a pregnant woman in nearby Berlin.

No one is surprised to find that women in rural Laos have a definition of a good birth that differs from the definition shared by women who live in the suburbs of the United States. It *is* surprising, however, to find widely disparate conceptions of a pleasing birth in societies that are quite similar. Dutch society is not unlike other European or North American societies, and yet women there have an anomalous conception of a pleasing birth: More than 75 percent of pregnant women in the Netherlands choose midwife care at the beginning of their pregnancy, and more than 40 percent choose to have their babies at home (Wiegers 2002).[2] These numbers stand in stark contrast to the rest of the modern world: In the United States fewer than 10 percent of pregnant woman seek the care of a midwife, and home birth is exceedingly rare in countries with modern medical systems.

This is odd. Medical science and clinical practice are no less sophisticated in the Netherlands than they are in the United States or Europe. Why has midwife-assisted home birth persisted there? The bright light of science is supposed to dispel the mists of folklore and superstition. Medical science put an end to the elixirs, potions, and ointments of traveling medicine men, but in the Netherlands the science of obstetrics has been unable to eliminate old-fashioned birth at home or to standardize the procedures used to accomplish birth.

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2. As we will see in Chapter 2, not all the women who choose birth at home actually deliver there.

If we were to embark on an international study of heart bypass procedures in the countries of Europe and North America, the only variation we would discover would be in the language used in the operating theaters. The setting, the actors, and the techniques are so similar it would be difficult to know if we were watching Finnish or French physicians at work were it *not* for the language. A tour of birthing rooms in these same countries would yield no such confusion. Not only do the *settings* vary—from delivery rooms, to birthing rooms, to bedrooms—but so do the *practices,* which range from very low technology (using only a fetoscope and a blood-pressure cuff) to very high technology (complete with electronic monitoring equipment, surgical tools, infant warmers, and the like). There are also differences in those who attend birth—midwives, general practitioners, gynecologists, obstetricians. More than any other branch of medicine, maternity care is marked by the culture and society in which it is found.[3]

The marks of culture and society on birth care extend beyond clinical procedures to the science of obstetrics. If we were to continue the comparative study of birth practices that we began with our tour of birthing rooms, we would find several distinct "sciences of birth." There is scientific literature that supports maternity care in the Netherlands, with its high rate of home births and low rate of cesarean sections (13.7 percent in 2002), *and* scientific literature that supports obstetric practice in the United States, where less than 1 percent of births take place at home and, in 2002, more than 26 percent of women were delivered by cesarean section.[4] The co-existence of separate and often contradictory sciences of birth forces us to conclude that in the world of maternity care the relationship between science and practice is turned upside down: Rather than science generating medical practice, practice generates science.

Most citizens of the early twenty-first century are aware that science does not exist in some culture-free vacuum: The once revolutionary ideas of Thomas Kuhn (1962)—demonstrating that science proceeds

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3. These marks are visible both *between* and *within* societies. The modal Dutch birth is radically different from the modal birth in the United States, and the modal birth to an upper-class, well-educated woman in the Netherlands will look different from the modal birth for a working-class Dutch woman. For the most part, my concern in this book is with the variation *between* societies.

4. In 2002, the cesarean section rate in the United States was 26.1 percent.

not by the gradual accretion of knowledge, but by leaps between paradigms—are now standard fare in business schools and motivational seminars. But the science of obstetrics is a special case, exceeding what most laypersons, and even social scientists, believe to be the influence of culture on medical knowledge and practice. Obstetrics is best thought of as a "cultured science," a science that is thoroughly embedded in its host culture.