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Of the many contributions *The Cultivation of Resentment* makes to American Indian political scholarship, the most significant is that the work goes much further than previous works on the contentious relationship between Indians and special-rights detractors. The general trend in American Indian social science at large, and exemplified well in previous American Indian ethnic relations literature, is the grounding of its analysis in court decisions and public opinion about court decisions. *The Cultivation of Resentment* could have followed its predecessors and stayed "within the law," so to speak. It does not, and by abjuring from this standard, *The Cultivation of Resentment* elevates the level of indigenous political scholarship a substantial degree. Dudas breaks this mold and creates something rare: a work of contemporary political theory that is well researched, well written, and useful to political scientists and American Indian political scholars alike.

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Diabetes among the Pima: Stories of Survival. By Carolyn Smith-Morris. Tucson: University of Arizona Press, 2006. 210 pages. $45.00 cloth; $22.00 paper.

Having worked periodically as an applied medical anthropologist in the Gila River Indian Community (GRIC) since 1993, I was eager to review *Diabetes among the Pima*. My concern, as with Smith-Morris (also a medical anthropologist), is the diabetes epidemic and what is to be done. My work in the GRIC has been either as an employee of, or under the auspices of, the National Institutes of Health. Hers has been in close collaboration with pregnant women of the GRIC. The literature generated by researchers of all kinds among the Pima is voluminous, breathtaking in its breadth and conceptualization. Despite this research, the prevalence rate of diabetes in the GRIC continues to increase. Given the sheer volume of research and publication, it would be unsurprising for a new publication such as *Diabetes among the Pima* to go unnoticed. Smith-Morris offers a refreshing perspective that is part synthesis, part fresh ideas and approach that could perhaps serve as an antidote to the cultural reification embedded in much of earlier anthropological publication on diabetes in Native communities and the genetic reductionism of medical science.

Diabetes with its myriad interrelated health complications presents Native Americans and tribal governments with the single most pressing health concern facing them in the twenty-first century. It is not a new threat, but rather one that has been bubbling during the past sixty years. Its sweeping and tragic health ramifications have been well documented by the medical, public health, and social scientific research communities. Blame for this epidemic, at its broadest, can be leveled at the US political economy. Dependency, commodity foods, forced assimilation, language loss, unemployment, boarding schools, racism; the list is lengthy. Rising out of this milieu one would be remiss to ignore the role of psychological depression and its attendant issues of social discord that contribute to the disease complex.

Biomedical research suggests that the blame for diabetes in Native communities (at its narrowest) is the result of a maladaptive genotype. The result of the shift in diet and activity levels, from low-fat, high-protein foods to high-fat foods in excessive quantities, and from high to low activity levels, the "thrifty genotype" hypothesis claims that people who were once adapted to a feast and famine way of life are now maladapted to today's way of life. The outcome of this shift has been nothing short of catastrophic. Yet a new hypothesis about fetal origins suggests that one need not appeal solely to a genetic or a political economic explanation. The fetal origins model uncomfortably merges the two, showing promise by suggesting that pregnant women confer metabolic stresses through an intrauterine pathway. Whether the mother experiences under- or overnutrition (political economic factors) during pregnancy, the outcome is the same: compromised metabolic function (micro-evolutionary factors). The compromised fetus often grows into a compromised adult, eventually suffering from diabetes as well as other chronic health conditions. The first two explanations have received much discussion in the literature. Whereas political economy is the domain of various social sciences such as anthropology and sociology, and genetics is the domain of medical science, the fetal origins model promises a unique collaborative opportunity. *Diabetes among the Pima* discusses these important parts of the puzzle, but it is to the latter gestating women, their children, and gestational diabetes mellitus (GDM) that the author attends.

Drawing from the words of pregnant Pima women of the GRIC, Smith-Morris explores the health- and illness-related knowledge, the perceptions and experiences of women in the midst of a major health crisis. These women's narratives are competently interwoven with and vivify the historical (political economy) and biomedical (genetic and physiological) data and analyses that she adeptly reviews. The narratives not only give voice to the suffering, concern, and outright fear that this disease has embodied in the GRIC but also to the women's personal understandings of the disease and of the hope expressed by them. It is Smith-Morris's contention that it is the gestational period that offers a solid approach to reversing the epidemic. She makes a good case for accepting this contention, dividing the book into five parts.

Like all good medical anthropology, context is what sets this effort apart from public health and biomedical research. In part 1, Smith-Morris rightly justifies her emphasis on gestational diabetes as it arguably has the most profound impact on disease etiology and prevalence. A metabolically impaired fetus is more likely to suffer chronic conditions later than will nonmetabolically challenged fetuses. Moreover, there is an intergenerational and thus cumulative impact that epidemiological studies have reported. Thus, in defending her research agenda to a concerned, even skeptical, tribal councilperson, Smith-Morris explained that targeting pregnant mothers is ultimately about all Pimas, not just women. It is in part 4, however, where the author places the current diabetes epidemic in its historic and economic context. As is now well known, the proverbial stage was set (for the diabetes epidemic) in the late nineteenth century when the Pima's self-sufficient agricultural way of life was transformed with the damming and diverting of the

Gila River. Smith-Morris competently reviews this history, relating it to the rise of commodity foods and the precipitous rise in the consumption of foods with high fat, sugar, and salt content.

The strength of *Diabetes among the Pima* lies in its breadth. Part 4 also addresses obesity and diabetes in the United States and in developing countries. Perhaps ironically, type 2 diabetes is simultaneously a disease of development and of affluence, and diabetes could easily be the quintessential disease of globalization. Smith-Morris reviews how Pima research has served the world even if that research has yet to bring a reduction in diabetes in the GRIC. Her work also serves as a statement of thanks to a community known for this disease.

In parts 2 and 3 Smith-Morris focuses on current diagnostic questions, treatment, and obstacles to treatment. There are plenty of obstacles to the treatment of GDM. Some are related to the patient population and others to clinician culture; they are obstacles at once unique to the GRIC community and more universally applicable. For instance, diabetes has few recognizable symptoms during the early stages of the disease. If one does not feel sick, diagnosis and treatment are likely to prove difficult. For the Pima the diabetes diagnosis is one that is widely feared due to its prevalence in the community. But mundane issues, such as lack of reliable transportation, lack of complete confidentiality (it is a small community) in the hospital, and long waits at the hospital, all reinforce what some consider a passive patient attitude. Moreover, due to the belief that some of the physicians are not fully qualified and are generally unaware of Pima culture and the high turnover of medical staff complicates the so-called compliance picture. It has not helped that clinical culture has waffled over its own diagnostic methods and definitions for GDM. What is accomplished in these two parts of the book is a deepening contextualization of the diabetes problem and how the social worlds of the Piman and clinician cultures are linked. Diabetes is a metabolic disease, but if medical anthropology teaches anything it is that no disease is experienced in a social vacuum.

I highly recommend *Diabetes among the Pima* for medical sociology and anthropology courses, public health specialists, nurses, physicians, dieticians, and physical therapists, that is, anyone who works in Native communities with diabetes patients. It is a book full of insight, and it offers what amounts to hope in an area sorely in need of some. Understanding disease causality is important. That type 2 diabetes is the result of political economy, the thrifty genotype, or fetal origins is meaningless if the message remains at a theoretical level. The Pima I have spoken with have all said as much when they beg medical science for a cure, whether a “magic bullet” or not. But they also deserve understanding and respect. Smith-Morris’s book offers understanding and respect plus a strategy (though no magic bullet) for reducing the incidence of the disease. Her message is to pay attention to pregnant women, intervene with them, and therefore inhibit the cumulative intergenerational affect. What Smith-Morris advocates is a sound start. But there is still a long way to go.

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