

Last month, I was with some British midwives touring a high-tech American maternity hospital when somebody asked whether the women who gave birth at the unit had access to birth balls.

The clinical director pulled an apologetic face.

“We’d like to, but we can’t use birth balls here, honey. They haven’t been risk-assessed.”

Quickly, she moved back to more comfortable territory, explaining the intricacies of the hospital’s computer system. It could show you any woman’s CTG trace from anywhere on the labour ward, probably in any colour of your choice and with an accompanying Mozart concerto.

Meanwhile, all sorts of visions twirled through my imagination. I pictured women slipping off birth balls as they dozed during transition, while the escaped ball rolled down the corridor, tripping up unsuspecting obstetricians. Some women in my scenarios got flattened around the ball, as Tom and Jerry always did, and rolled along with it. I imagined their partners suffering broken toes as a birth ball – complete with cartoon-style squashed woman – rolled over them on its way to smash the computer merrily displaying its CTG traces. Realising that these situations were among the most unlikely, I began to consider the possibility of a spontaneous birth ball explosion and the chaos that could result, especially if it happened during some kind of sterile procedure.

But try as I might, I couldn’t think of anything really bad that could happen with a birth ball. The kind of birth ball balancing feats which are routinely performed by fathers-to-be at parenting sessions are, in my experience, rarely attempted by labouring women, who often develop a great respect for gravity during the third trimester. Women usually use birth balls on the floor, where there is little distance to fall, or the bed, where they tend to be anchored by something else. I also can’t see how the risk of infection from a birth ball can be any higher than from a bed; it might even be lower, with no corners or crevices for dirt to hide in and a handily wipe-able surface.

Maybe I’m being a bit too laissez-faire about the risk of puncture or explosion. I know of one case where a birth ball punctured; it deflated quite gradually, giving the woman ample warning, and nobody was injured. I have no problem with the idea of being sensible enough to check that balls are of an appropriate design and strength to be used by a labouring woman, or of checks of the integrity of birth balls that are being used regularly. But people fall off normally shaped chairs and beds too, and I’m at a loss to see how we could prevent anybody ever falling off any piece of labour ward furniture. Unless, of course, we moved the furniture out of the room and gave everybody more space to sit and crawl around on the floor, which might be less risky than expecting women to rock and sway on high, narrow beds. Indeed, if we want to put into place sensible precautions to help women feel secure and get the most out of their birth balls, we could do worse than to install gymnasium wall-bars and ceiling ropes into labour rooms, with which women could anchor themselves.

I am reminded of the experience of Michel Odent (1983) who, when pressed by a journal editor for all of the possible risks of water birth, invented the theoretical risk of water embolism. Twenty years on, this has never happened, and probably never will, yet it is still widely quoted as being a risk of water birth (RCOG 2001). When, in a few months time, you read the NICE guidelines discussing the ‘theoretical risk of spontaneous birth ball explosion’, you can feel smug that you read it here first.

This parallels with the situation where new mothers (and their midwives) were deprived of their toast during the recent fire fighter’s strike. It strikes me as very interesting that risk-management and infection control policies can deprive women of the low-tech things that might help them cope with labour, like birth balls, candles, toast, stereos and, in some cases, baths of water. Yet the same principles do not seem to apply in the same way to medical practices that carry risks of infection or other danger to women and babies; fetal scalp electrodes, epidurals, CTG monitors and

caesarean section. How many units banned diathermy during the fire fighter's strike?

Lots of people have pointed out that life is risky, and a risk-free existence probably wouldn't be nearly as much fun. As I wrote in these pages a few months ago (Wickham 2002), people have accidents with such seemingly innocuous devices as tea cosies; there is no way to assure that you can keep everyone safe at all times. Instead of simply risk-managing the things that might help women in labour, surely what we really need to address is the culture of fear and litigation which has somehow enshrouded pregnancy and birth, and the ways in which we can break this down, for the sake of everybody concerned.

I mentioned to one of the midwives who was on the tour with me that I felt compelled to write about this situation. "Well," she told me.

"That's fine, but you need to understand that it will probably provoke someone, somewhere to realise they haven't risk assessed their units' birth balls and rush out to do so immediately." If so, let's hope their conclusion is to bring in the anchoring ropes and ladders, rather than to remove another low-tech tool which might be helpful to women.

References

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RCOG (2001). **Birth in Water**. RCOG Statement No. 1: January 2001

Wickham S (2002). Number Crunching. **The Practising Midwife**. 5(5): 29.