

**Ep #48: Epidurals, Inductions & Other Spicy Labor Topics
with Kim Gordon, CRNA**



Full Episode Transcript

With Your Host

Devon Clement

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Are you curious about anesthesia during labor and delivery? Whether you're planning a natural birth or you want to get the epidural and make it a double, we have all that information coming up for you. Stay tuned.

Welcome to *Parenthood Prep*, the only show that helps sleep-deprived parents and overwhelmed parents-to-be successfully navigate those all-important early years with their baby, toddler, and child. If you are ready to provide the best care for your newborn, manage those toddler tantrums, and grow with your child, you're in the right place. Now here's your host, baby and parenting expert, Devon Clement.

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Devon Clement: Hello, hello. We have our monthly Happy Family After webinar today. I think this is also going to go up on the podcast, *Parenthood Prep*. So you might be listening to this on your phone or watching the video. We have a very special guest today on the webinar. It is Kim Gordon, CRNA, not the bass player from Sonic Youth, different Kim Gordon. She does labor and delivery anesthesia and she is also my sister. So hello.

Kim Gordon: Hi, so happy to be here.

Devon: Yes, it's great to have you back. I loved our conversation the last time and I just wanted to update it and go over it again and get it up on the podcast because I think it's so important. The birth side of things, it's so funny because I'm so knowledgeable about what happens as soon as the baby comes out, but everything before that, I have no idea.

You hear epidural, you hear a C-section, you hear, give me the drugs, but you don't actually, you don't actually really know what it looks like or you know what it's like. And you don't really meet your patients until they're in labor, right? Like you're not like the obstetrician, You're not at the office. Can you walk us through, I'm in labor, I'm at the hospital, what happens?

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Kim: Yeah, of course. That's definitely something I want to get into. And the idea is to make everyone feel more comfortable and have more information going in. But first I just want to say a couple things just for my purposes.

Number one, I just want to describe what my job actually is to give you some context about why I know what I'm talking about and why I can answer these questions for you. Because a lot of people are not familiar with my side of the healthcare professional industry, which is I'm a CRNA, which stands for certified registered nurse anesthetist. We're also called certified registered nurse anesthesiologist or sometimes just nurse anesthetist or nurse anesthesiologist. It's a lot of words, it's a mouthful, which I totally understand, but to explain it simply, CRNAs are a type of advanced practice nurses.

So you might have heard most commonly of a nurse practitioner or in this context, a midwife, also types of advanced practice nurses, but I am not either of those things. I specialize in anesthesiology. So my education and training included becoming a registered nurse to begin with and doing critical care, so ICU nursing for a number of years. And then going back for a specific training program where I achieved a Master's degree in anesthesiology. And then I furthered my education to become a doctor of nursing practice.

So I don't use the title doctor in clinical practice and a lot of nurse anesthesiologists don't, just to decrease confusion with our physician colleagues, but I am doctorally prepared and at this point in 2025, I believe that most, if not all, nurse anesthesiology training programs require a doctoral level degree.

So I want everyone to know these things so that they are informed. And if they are in a facility that employs nurse anesthesiologists, which most do, some are exclusively nurse anesthesiologists, some are exclusively physician anesthesiologists, and many facilities in America employ both, and we work together. I want you to have every confidence that your anesthesia provider can provide you what you need in a very difficult time and as we know unfortunately

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a very painful time and help you through the process regardless of their degree in education.

We all practice anesthesia the same way, we have access to the same medications, the same techniques, the same equipment and you should have every confidence asking whatever provider comes to your bedside to administer anesthesia for your labor and for potentially your delivery, that you will feel comfortable with that provider. I also have to say, as I always do, that nothing in this conversation should be considered medical advice. This is a friendly conversation just so I can be approachable and relatable and answer your questions.

I have been doing labor and delivery anesthesia almost exclusively for about eight years. So I don't have the numbers offhand, but I've witnessed thousands of labors and I have done most likely over a thousand epidurals and certainly over a thousand C-sections. So I just want to bring some insight as someone who's there to tell you how the process goes and what your options are so that you feel more comfortable and you can focus on the important things like being a parent and having a baby.

Devon: That's great. That's great. And as I was telling you before we got on the call, I had a call this morning actually with a grandma who's booking some postpartum care for her daughter. And she is an anesthesiologist currently retired. And when I mentioned that you were a CRNA, she was like, oh, I love CRNAs, they're so great, I learned so much from them in my career. And she said, because she did pediatric, it sounds like she did some pretty intensive like stuff. She's like, all of my biggest saves were like with a CRNA working together.

Kim: I have a tremendous respect for my physician colleagues. Physician anesthesiologists do a number of years of training and have many clinical experiences to back up what they're talking about. And yes, they are phenomenal providers. In my facility, we work alongside physician anesthesiologists. Occasionally, I directly provide care with them.

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Occasionally they provide the care without me in the room and occasionally I provide care without them in the room. So really it's called the care team model when physician anesthesiologists and nurse anesthesiologists work together. And it really promotes an environment that, to say it casually, it's a twofer. You get two anesthesia providers that can help you and provide care.

Devon: But in general, especially in labor and delivery, you're doing it on your own and you are totally trained and qualified and everything, experienced.

Kim: Oh absolutely. And like I said, I have a respect for my physician colleagues, but I don't want anyone to not know what a nurse anesthesiologist is, even though the profession has been around since early world wars. And I just don't want anyone to ever make a face like, oh, you're a nurse and not a physician anesthesiologist, because we do have highly specialized trainings and can provide the same level of care in the absolute safest way.

Devon: Yeah, I love that. Also, I just want to apologize in advance. I am getting over a cold, so I may occasionally mute myself to blow my nose or cough. It's that time of year that is happening.

Kim: I was going to say, everybody.

Devon: Yeah, one of my mentors canceled. I had to reschedule our call this week as well because she's also sick. But I'm on the mend, which is great because I'm leaving for a trip tomorrow and I'm very excited.

Okay, so I am always so curious about this because again, I've never given birth, I've never been at a birth, I've never been... I've been to the hospital. I've never been in the environment and hearing you talk about it, I don't think it's something you really think about when you're going into this situation to have a baby. But it's something that's so important, whether you're planning a, I don't know what the terminology you like to use is, drug-free delivery or not, you might end up with a C-section, you might end up needing anesthesia. So tell us, what does that look like?

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Kim: Sure. So I use the term natural birth. That's what we use in our facility. People tend to say natural, even though that can encompass many things. People tend to say natural to mean a medication-free birth.

You want to be in the hospital setting to have the resources available to you that a hospital can provide, all the medical providers, et cetera, but you still would like to labor as if you were at home, say, or in a more natural environment than an American hospital, which is understandable and amazing, whatever choices you make in your labor.

But I like to describe, maybe the best way to answer this question is to describe pain management during labor as a spectrum. There's on one end, absolutely no medications. Absolutely. I want to do this the way my ancestors did it or the way my mother did it or the way before we had all these fantastic scientific advancements to get me through my labor.

And then the other spectrum is, nope, I want to walk in, I hope she doesn't mind me saying this, but our mother, like I want to walk into the hospital and give me the drugs before you even ask me my name. Both hugely...

Devon: A colleague said to me that she's a great postpartum doula, but she'd be a bad birth doula because she's, give her the epidural and make it a double.

Kim: Just do it. Just make it a double. Totally true. And I see parents on every little millimeter of this spectrum and all of them are wonderful and beautifully fine. You came here to have a baby and you know what you need to do.

So considering that we have a spectrum, if you come to, for example, my facility, which is a large hospital in New Jersey, we do a lot of deliveries a year, you really have the option to do anything on that spectrum. So if you come in the door and you're like, I'm not quite sure what I want to do.

And also if your water broke spontaneously and you weren't planning on coming in until next week and you're really not, I didn't think about it yet. I was going to talk to my OB at my final appointment or my appointment next week, or I had

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planned an induction in three days and now we're not doing that. So now I'm totally unprepared. It's totally fine to walk into the hospital unprepared for how your labor pain will be met.

Devon: Pausing for a second, is it something that comes up at the OB appointments? Do they bring it up? Do they ask you about it? Or do they expect you do ask?

Kim: Good question. So I find that most of my patients, and I wish I could speak more to this, I should ask some of the very knowledgeable labor nurses that I know. It is discussed ahead of time and people tend to do pre-birth classes, right? About breathing and the experience and how your partner can be involved in those things.

So I do think it comes up, but I guess it depends on what resources you have and who's coaching, how much they get into it. A lot of parents, I think, ask their OB at the pre-birth appointments. They may be someone who says, yes, I can answer any specific questions you have, but it's really better to talk to your anesthesia provider at the hospital, which I'll get into that. So I don't know. I feel like some people have more information than others, but either way you can come in totally unprepared, so to speak, or with a lot of questions.

And when you encounter the anesthesia provider, that's the time to discuss those things. So we love when people have information. We love when people have specific questions. I don't love it, but I appreciate when patients are afraid because I know that I can help them through it and give them all the information they need to make them less afraid for that situation. So back to your original question.

Sorry, we're sisters. We can do this all day long. Back to your original question of what does it look like when you come into the hospital? Typically, maybe you have some background information on anesthesia, maybe you don't. You come into the hospital, they admit you to the labor and delivery unit, the labor and delivery nurse will check you in if there's time.

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Sometimes there's really not. And sometimes you push the baby out and then we ask you, do you have any medical history? Very rarely, but sometimes it happens. Let's be real.

Devon: I have heard a lot of birth stories, even if I've not actually experienced it first or secondhand, but there's been some doozies.

Kim: Yes. There, we call it multigravida patients that have had many pregnancies and deliveries in the past. So sometimes the sixth or seventh kid doesn't really wait for you to get out of the car. That's nature. But most of the time you get checked in. 99% of the time, unless you have a birth plan that really excludes it, you are going to get peripheral IV, which is an IV in your arm so that you have access to give you medications in an emergency, access to give you fluids to keep you hydrated during labor, access to give you a blood transfusion should you need it in case of an emergency and accepting.

I can only speak for the few hospitals that I actually work at but I'm going to assume that most hospitals are going to explain the benefits of getting an IV even if you want to have a more natural labor. They'll take your medical history, get you comfortable in a labor room, and then start talking about the labor process with you.

Babies get monitored with external monitors most of the time. Again, your birth plan may exclude that and continuous monitoring, but most likely the provider is going to request that you at least get monitored every hour, every few hours, depending on your situation, just so that we can all keep an eye on the baby during labor, meaning the baby's heart rate, and just make sure that the baby is tolerating labor and we don't need to employ any of the resources that are in the hospital. Or if we do, they are available and we can do the right intervention.

After that happens, if you do choose to get medication for your labor pain, what often happens is earlier in labor, meaning before active labor, which typically is around five to six centimeters, the early phase of labor is before that, and you can get IV pain medication. So if you're like, I'm not really sure about the

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epidural. I want to be able to really experience labor, but this is just too much and I can't even catch my breath. Then there are some IV pain medication options which range from ivitamine to morphine, which is a narcotic. Some people get nervous about that. It is researched and considered safe for laboring mothers, but I will say that some people still don't, are not interested in getting a narcotic medication.

So that's an option that you can choose to do or not. And then of course, there are many alternative methods of pain management like warm compresses, physical activity. The labor nurses have all kinds of equipment, which is the closet where all the equipment is stored. It looks really fun. It looks like preschool. There's bouncy balls that you can bounce on or like rings that you can do or pressure squeeze stress balls.

Devon: There's a big parachute that everyone can go under.

Kim: Exactly. Everybody just runs under. You run to the other side. Yeah. Yeah. Blocks, whatever you're like. No, but there are many options for you in the hospital. I don't feel like anyone should go into the hospital thinking, now I'm here, I have to get the IV and get the drugs and I'm not going to be aware for my labor. It's not like that at all, thankfully, in most facilities. So there are options also alternative to the epidural that you can use before you even decide whether you feel like getting an epidural or not.

Devon: That's great to know. I'm curious about inductions, but I want to keep talking about this and then we'll go back to that because I know that's a different situation because obviously you're coming into the hospital when you're not yet in labor.

Kim: In a more controlled situation.

Devon: Right, to be induced. So, okay, so now I'm in active labor, now what?

Kim: Okay, so let me just say, you have these other payment management options before active labor, but if you are a person who chooses to get an

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epidural, it's really based on your provider. Some obstetricians or midwives still have, based on their professional experience and training, they may talk to you when you want to get an epidural, they will talk to you first. Okay, tell me when you're ready for the epidural. Okay, I've been having contractions for a little while and I'm just not, I feel like I can catch my breath. I'm getting tired.

I just feel I'm not experiencing this with my partner the way I want to. I feel like we need to talk about some options. I feel like we're getting to that point. So you talk to your obstetrician and they might be like, you're one to two centimeters dilated. Let's try to give it some time. Did you try this? Did you try that?

Some providers do that. And maybe they not discourage you, but maybe they're saying, if we can wait a little longer on the epidural, let's try that, or let's make a plan. A really good provider will say, let's make a plan together about how you want to do this. And here's why I'm bringing my information to the table and then you tell me how you're feeling about it.

Devon: I think, wait, I just want to put a pin on that for a second because I think that's so important just in general. Like a really good provider will say, let's make a plan together, just across the board in everything to do with birth, even in postpartum, lactation, anything. Let's make a plan together. I'll give you the information. You ask your questions. We'll make a plan together.

Kim: Absolutely. And I definitely try to guide my practice that way because it makes, and when we talk about actual epidural medication, I'll remind me to touch on that because it ties in. So hopefully your obstetrician is doing that. And hopefully you've gotten to this point with your obstetrician. A lot of people go into their obstetrician and they're with the same person for their whole labor and maybe have been for previous kids or that was their gynecologist.

So I hope that there's a relationship with your provider that's respectful both ways. It should be that way. So in some cases, the obstetrician may say, you're a little earlier than I, I would like to see you progress a little more. Let's try something before we consider the epidural. Maybe some providers are like, yep,

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it's your choice. When do you want it? Let's get it. And some patients do get the epidural at one time.

Devon: And is that because the epidural can slow things down?

Kim: That's a great question. So I've been practicing anesthesia, including my training for over 10 years, if you can believe that. I mean, you as my sister, cause it feels like yesterday.

Devon: I still remember when you left for school a hundred years ago.

Kim: God, I know. A hundred years ago. Even in the beginning of my training, I feel like more of the research articles we're discussing, like, yes, there's a possibility that epidurals slow down labor. Recently, I've been very happy to see more research on how does pain affect labor?

If you can imagine like back in the day, if you're about, if you're at term and you're being chased by a saber-toothed tiger, right? The classic example of fight or flight. Is your body like, oh, it's a good idea to drop a baby now? No, of course not. So labor pain is our modern version of fight or flight, right?

So the article doesn't imply that epidural speed up labor, but it does gently suggest, let's do more research on this because pain may slow down labor. And just totally anecdotally, I can speak to, I asked labor nurses a couple of questions in preparation for this webinar, and they were like, I don't know, I feel like some women get the epidural, they finally relax, they take a breath, and then they just open up. They dilate from three to 10 centimeters and they never would have otherwise. Totally anecdotal. That's not based on research, but I'm just saying we can't make the assumption that epidural slow down labor at all.

Devon: I also put a lot of credence in anecdotal stories of people who've been there a million times. A lot of my stuff about babies and newborns and sleep and things like that is anecdotal, but it's true.

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Kim: The majority of the time, this is what happens. Let's not make a big deal out of it. It's just that, of course, especially in human science, whether it's newborn care or you have to go with the research to make a real statement, but yes, it's true. And that's I'm here to tell you what I've done in my 20 years.

Devon: Everyone is different and everyone has different experiences and things like that. But yeah, I could definitely see that. There's also some research that a little bit of early formula supplementation helps improve breastfeeding outcomes because they're not like the baby's getting fed and they're not so stressed and they're not starving and everyone's not like losing their minds because early breastfeeding is really hard. If you can grease the wheels a little bit, you end up in a better place. And I could see that relating here. I'm in a lot of pain.

Kim: And I didn't know about that, but yeah, it's also, oh, let me focus a little bit and remember what I came here to do. And when you're in labor pain, like you can't. Your brain is just, you can't do it.

Devon: It sounds horrible, honestly.

Kim: It's rough, it's rough.

Devon: Okay, so that's interesting, that's interesting. So your provider is the one to make the call of when to bring you.

Kim: In most cases, like I said, it should be a plan. And it's not to say that if you are like, "No, I hear what you're saying, but that's it. I'm doing the epidural." I think most providers, obstetric providers at that point would be like, "OK, if that's what we're going to do, that's what we're going to do." And that's fine. No judgment.

So at that point they called me and the provider calls me or the nurse calls me on behalf of the provider and says, "Hey Kim, I've got this lady in 228. She's a G3P0, meaning she's been pregnant three times, but this is her first delivery for whatever reason. And she's three centimeters and she's asking for an epidural."

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Okay, great. And I'm like, "Okay, I'll be right there." Whatever. "What's her medical history," or I'm going to look it up on the chart myself.

And then come to your room as a patient and introduce myself. Every single provider that walks into your hospital room should introduce themselves. And if you don't hear them, or if you're contracting while they say that, and you're like, "I'm sorry, what? Who are you?" Or "Give me a minute." Please say that. Please say that. You have every right to say that. "I'm clearly breathing and sweating here. My face is tomato. Could you give me a minute?" Yes.

And I usually, this is my little speech that I say, "Hi, I'm Kim Gordon. I'm an orthostatic sociologist. I came to do your epidural. I have a couple of quick questions for you. Then we'll talk about the plan. And then you can let me know whatever questions you both have." And I usually gesture to the support person because that person is absolutely involved and should ask questions as well.

Typical questions, it's not a top quiz, midterm exam. It's just "Tell me about your medical history. Have you had an epidural in the past? Have you had a delivery in the past? Have you had anesthesia in general in the past?" And some people are like, "No." And I'm like, "Did you ever have your wisdom teeth pulled?" And they're like, "Yeah." And I'm like, "Okay, that counts too." Just so that we know if there's anything we should be aware of or medication reactions or any problems like that.

Then we talk about the plan for the epidural, which I'll explain when we're ready for that part of the conversation. And then I always leave it open to questions. Most women, of course, are like, nope, just no questions, where's the paper, let's go, which I totally understand.

Devon: How often, what percentage of the time would you say does the partner ask, do you have any drugs for me?

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Kim: Oh, it's getting better. It's getting a lot better, whatever. It's getting lower, but yeah, 20 to 30%. When they see like the magical difference of the relief, they're like, oh, can I get some of that? And I'm like, okay.

No, it's funny, the partner aspect of labor, because it's like, of course, they want to be involved. And we have to be very patient focused. But it's also really important to know that the partner is doing all they can and they've been here for all these contractions so far and they're exhausted too. And I get it. I get it. It's just what I'm saying. Everyone wants to be involved and really only the patient can really know what's going on.

Devon: I remember I read recently or I don't know maybe it was a while ago, Kelly Ripa and I know that her relationship with her husband is amazing. That's why this is so funny. But for their like third baby, it was like a post on Instagram. What did your partner say to you during labor? And Kelly Ripa commented, this looks like it's going to be a while. Can I go to the batting cages?

Kim: Step outside for a minute. I'll see you later. I will say some of the women that have four or five kids and then it's like, oh, the baby's coming. They're like, oh wait, my husband went home to sleep. Can we just try to wait? We live 10 minutes away. Can we just wait? They're just home. Just hope something exciting is happening. Do you want me to go on to talk about the epidural procedure?

Devon: Yeah. So I've signed the form. I'm ready.

Kim: Oh, and let me just back up one second to say that if at any point you're in the hospital, maybe you're not ready for the epidural yet. If you have questions and you wanna talk to an anesthesia provider, you can always ask. I can't guarantee that they'll be there immediately because they're doing other epidurals or surgeries or trauma or intubating people in the hospital, but you can always ask your labor nurse or your provider, anyone who's at the bedside with you, like, I just would feel more comfortable having a conversation with

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anesthesia before I'm in the throes of contraction pain. So could we make that happen? And they should be able to.

That's very important. We are absolutely allowed to ask that question. So you have some background, you've done this before, you did a class, you talked to someone, you're comfortable, you're ready to sign the consent and asked about the risks, which we can talk about in a minute. And I've answered all your questions, so you're ready for the epidural.

Basically what happens is positioning is really important. So again, 99% of the time, there are rare cases where we can do the epidural lying down but that depends on your anesthesia provider and it's technically more difficult. So most providers are going to suggest that you sit up on the edge of the bed and kind of, we always say, we curl over your baby.

What are some of the analogies I've heard? Kiss your knees or kiss your baby through your belly button or like doing a cannonball in the pool. The idea for positioning. And I always tell people to visualize like spreading your vertebrae, which is the bones in your spine, spreading your vertebrae apart, right? So if you can imagine like your back, like the letter C, I'm doing it, can't really do it sideways right now, but your back, like the letter C, relax, like slouching.

Basically the only time a medical provider is gonna tell you to not have good posture is during an epidural or a spinal. And we clean off your back with some sterile cleaning solution. The whole procedure is sterile, which is why sometimes we ask your partner to sit down or leave the room.

Some facilities ask the partner to leave the room because it is technically a sterile procedure and we want to minimize the risk of contamination. Also, sometimes partners aren't so happy about needles and they see one and then we have two patients in the room. So there are reasons that we do that. It's not because we don't want your support person here. It's because it makes the experience more efficient and safer.

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So then we clean off your back with some cold cleaning solution, and then you get the numbing medicine. Many people have at least had a cavity filled at the dentist. So you get that Novocain and it, it sucks. Let's be real. That's usually the worst part of the procedure. So there's like a pinch and a burning in your back and then we do the actual epidural procedure. And that procedure does require a needle, but again this is behind you. So if you're a person with a needle phobia, it's typically tolerated.

The labor nurse is going to be in front of you holding your hand, you can lean on her or him. I don't think I've ever worked with a male labor nurse. I feel like they would get their hands broken, but I do think that there are and I'm sure they're very good at what they do. But the labor nurse is going to be in front of you and helping you breathe and letting you focus.

I put the epidural needle in your back, low in your spine, and then thread the epidural catheter through. So it's like getting an IV in the sense that the needle introduces the plastic catheter. A catheter, a lot of people think catheter is for urine, that's also for urine, but the word catheter just means a plastic or rubber tube. So we use a very tiny tube, I describe it as a guitar string, my husband is a musician and it looks exactly like a guitar string, that's how thin it is, that goes through the needle and stays in your back so that we can have access to give you the epidural medication.

Once that's done, the needle comes out, so the only thing left in your back is the plastic catheter. There's no needle, nothing sharp in there. We tape everything up to secure it and then lie you back down and get you comfortable. So now we have this access, again, like the IV, that we can give you epidural medication in the epidural space throughout your labor, which is really great.

And the technology is fantastic. And it really allows for more control of pain for a long procedure such as labor, unlike when you're getting a surgery that has a pretty finite amount of time and you have a different type of anesthesia.

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Devon: So you put the medication in, but then you would potentially put in more if it went on for a longer period and things like that. So after you set that up, you leave.

Kim: So most of the time what happens is we give an initial dose of medication, a small amount, just to make sure the catheter is in the right place, the epidural catheter is in the right place, and there are no adverse effects to the medication. So some women are very nervous because they're like, I've never had an infusion medication before. What if I have a terrible allergic reaction to this? We're going to give you a little bit first, and we're going to wait five minutes and see, hey, is there a problem with this?

Devon: It's like when you're doing a transaction and they send you like two cents just to make sure it goes through.

Kim: Exactly, yes. This is definitely your bank account.

Devon: Or you like spot check a cleaning product or something.

Kim: Yes, exactly. Yeah. We do that while I'm in the room still and making sure that if there were any reactions that we need to treat with emergency treatment, we can do that. It rarely happens. The risks of an epidural are very small, but then after, okay, everything is good, maybe I'll give you a little more of the pain medication right away just to be like, hey, are you noticing a difference?

But some anesthesia providers just set up the infusion pump, which most epidurals have nowadays. I would say most facilities do that. And basically, again, like the IV, you get fluid dripping in all the time. The epidural medication is set up on a pump that connects to the epidural catheter, and we set it at a certain rate so that you get pain medication through the epidural throughout your entire labor.

Devon: Oh, interesting. So it's just automatic.

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Kim: Yes. So this is what I was going to touch upon before. I can't even remember. Oh, making a plan with your provider and being involved. A lot of epidural infusion pumps also I'll set a rate that's always gonna give you medications. When I walk out of the room, you don't have to think about it ever again. If you're fine, if you feel good, if you're like, I can tolerate, this is great. Even if it's 12 more hours, I'm going to get ready. We're going to dilate. I'm going to take a nap and then I'm going to push the baby out.

You also get a button to press. We call it patient-controlled epidural analgesia. And analgesia is just the word for pain management, not to the degree of anesthesia. And you get a button to press that's set a certain way so that you can give yourself extra medicine if you feel like you need it.

So sometimes I tell patients, okay, I just gave you some of my medication. We started the pump. You just got the epidural. Let's let it settle out for 10 to 15 minutes. You'll be feeling much better by then. I always tell patients it takes about 10 or 15 minutes to be 100% effective, but each contraction should feel better and better, but you have the option to, so you might get comfortable for a couple hours, and as the baby moves lower, or you dilate more, the intensity can increase again, and then you can press the button to give you extra medicine if you feel like you need it.

The machine won't let you overdose. We set it a certain way so that you don't have to remember, oh my God, I feel like I just pressed this. What if I give myself too much? It locks out at a certain time for a certain timeframe. But the point that I'm trying to make is having control over your own pain management actually adds so much to the experience, much like making a plan with your provider or your postpartum doula. When you feel involved and you feel like you have control, your brain actually interprets that as stress relief. It's the same kind of endorphins that I'm sure everyone can relate to that in some aspect of their lives.

But when you feel like, okay, if I want to press this button, if I want to give myself extra medicine, I don't have to call anybody. I don't have to tell anybody. I can do

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it on my own. And that has been researched well and proven to alleviate labor pain to an even greater degree than the actual chemical medicine does, which is awesome.

Devon: That's great. Yeah, I've heard that. Even just people who feel more informed, even if they've had a traumatic delivery or something has, like crazy has happened, if they felt like they were in control of the process, their psychological after effects are so much better and they rate the experience so much better and their overall interpretation of things versus like you could have the smoothest labor in the world, but if you didn't feel like you were in control of anything and people are just telling you what to do, that can be really difficult and traumatic.

Kim: Yeah, absolutely. Absolutely. And I see that every day. So it has a situation that has been researched. And also I can say that is absolutely been my experience in all the years that I've been doing that.

Devon: Yeah, that's great. So I didn't know that they had a button. That's so cool.

Kim: Yeah. I've done labor and delivery anesthesia and analgesia in three, four facilities on both coasts, California and New Jersey, and everyone has had that. So it really is a useful tool.

Devon: And so what if you come in, I'm pretty early on or early stages of active labor, but I feel good, I'm maybe not sure I wanna get it. What's like the window of opportunity?

Kim: That's a great question and one that I get quite a bit. So in theory, you can get an epidural anywhere from your cervix is close to 10 centimeters fully and the baby's come down. The logistics are what changes.

So number one, so we're talking about maybe, oh, I really don't want to get an epidural. My friend or my sister had all her babies naturally and I want to do the same thing. I want to experience labor. I want the whole experience, but now I'm

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stuck at nine centimeters or this is just too long or whatever. There's a million good reasons to just be done with labor pain. And now I should have gotten the epidural, right? You can get an epidural, fully dilated.

The things that your provider will talk to you about are, there is unfortunately an increased risk of adverse events later in labor. And I can get into the biology, but keep this brief just to say that some of the things we worry about with epidurals, like the needles, can sometimes go to the wrong spot. It can go too far and you can get a leak of cerebrospinal fluid. It eventually resolves on its own. It sounds a lot more dangerous or a lot scarier than it is. It is everything that's an adverse event is dangerous, but the chances of those types of things happening do go up later just because of the way your body and your back changes throughout labor.

It's also a possibility I've had some women who get an epidural close to the end and the medicine does take a little time. I always say it's medicine, it's not magic. I wish it were. I wish I could wave a wand on your back and you suddenly feel better, but it does take a little time. So sometimes I have been in situations where I'm doing an epidural and the woman has been like, nope, never mind, I gotta push this baby out, I gotta push. And they lay down and push the baby out. So there are times when I finish the epidural, tape it up, give the medicine, and then they're like, nope, gotta push. And then unfortunately, they don't get the relief from the medication anyway. So these are things that can happen towards the end.

That being said, again, it should be a plan with your provider. I would say that some anesthesia providers do hesitate. I have met and worked with some anesthesia providers do hesitate to do the epidural after eight-ish centimeters just because of these risks, but it's highly situational. It's your first baby, and we think you probably have a little time between 8 and 10 centimeters. Your sixth baby, once you're 8, you're probably gonna be 10 and push the baby out pretty soon.

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That's just typically how it happens, depending on the situation, but the risks go up. So it's definitely a conversation to have if you are even remotely considering getting an epidural or you're saying, I'm thinking about this, I really don't want to, so please don't talk me into it. But I want to know ahead of time when I should ask for it. That's definitely something you should address in your individual situation.

Devon: Okay. I like that. I'm remembering that television program Mad About You and she was having the baby and she wanted the, they were like, no, the window is closed, Mabel. And she was like...

Kim: Yeah, that's definitely something to provider dependent and patient dependent, situation dependent. So it's definitely a conversation you should have.

Devon: Plus on TV they always make things more dramatic than they need to be. So what about if you end up needing to have a C-section? You've got the epidural, maybe something's happening, the baby is decelerating or something's happening or it's just been too long, you've been pushing, they decide you need a C-section. What does that look like?

Kim: Yeah, great question. If you have a functioning epidural, which sometimes I'll address another question I get often in this briefly, sometimes people say, "Oh, I heard about my friend got an epidural and it stopped working at the end." Or, "Oh, I had an epidural before and I was only numb on one side and it's not working." Like I said, it's the catheter that looks like a guitar string. So when we thread it in the back, it gets longer and longer up there and it can curl this way or that way sometimes. And sometimes the medicine goes more one side than the other. In that case, we have a couple tricks and troubleshooting that we can do to straighten it out.

Sometimes the perception of pain changes as the baby moves lower. Epidurals are not designed to get rid of pressure, the sensation of pressure. They're designed to get rid of contraction pain. So if I were standing, I'd show you like

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under the breast to just below the hip bone is what the epidural is essentially designed to cover. So you're like, "Oh, but that's not where the baby comes out. How come it doesn't cover the bottom?" It does you feel better? It's more tolerable.

But technically the way the medication works is not that I'm just saying take anything any crazy epidural story or any crazy labor story you hear with a grain of salt. Because people will be like, "Oh yeah, it was like super comfortable, I was sleeping for 15 hours, and then it stopped working right at the last moment when I needed it." It didn't necessarily stop working. It can happen, it can get disconnected, it can whatever, but it didn't necessarily stop working. It just maybe wasn't covering those nerves as densely as it was covering your contraction pain. And everyone's perception of pain is different.

So in regards to a C-section, that's what you need. You need coverage here. So if you have a working epidural that you still feel numb, you may not feel numb enough for surgery, which is fine. That's not what we expect. But then I can give you a stronger medication, so a stronger concentration of epidural medication through that epidural catheter to the point where you don't feel anything but touch and pressure in the area of the C-section, in essentially your whole abdomen.

Your legs may get so numb to the point that you can't move them. It's temporary. It's super hard to bend your knees. You may not be able to wiggle your toes. That's all normal. And that's what we expect to be anesthesia for a C-section.

Devon: So if you're just, if you just have the epidural, you're just laboring normally, you can still feel your legs and move your toes and stuff. You can't get up and walk but...

Kim: Everybody's different. At most places that I've worked, no, you're on bedrest once you get the epidural. Some places have what we call a walking epidural, which is like a lower concentration of medication that they give a

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certain dose so that your legs are strong enough. But most places for safety will have you on bedrest after the epidural.

Devon: But you can bend your knees and move your legs.

Kim: You should be able to. Perfect epidural is you don't feel anything in your, if you can imagine where you feel your baby moving around, that's where your uterus is. Contraction pain, the perfect epidural, you don't feel contractions or you're like, am I having a contraction? And your partner looks at the monitor and says, yeah, that looks like a contraction. You're like, I think I'm having a contraction.

But you can still bend your knees. You can still shift yourself around in bed to get comfortable. You can still do labor exercises, stretching your hips or manipulating yourself on all that preschool equipment we were talking about. Theoretically, you are still able to move and have a sensation that something is progressing, something is going on. And then towards the end of labor, like I was saying, the baby moves lower and we call it erectile pressure.

It really is a feeling like you have to poop. We want you to feel that because then you know when it's time to push. We want it to be a relief to push. So the epidural is designed to not make you dead leg numb. It does happen sometimes. There's nothing wrong with that. It's just, again, your perception, your body type, how tall you are, how short you are, that's okay. That's allowed. But as long as your blood pressure and heart rate are okay, as long as the baby's heart rate is okay, then it's a safe epidural.

Devon: Okay. So then, but then if you have a C-section, that numbs you completely basically from belly down.

Kim: So then if you have a C-section, obviously you're having surgery. I do like to remind people, yes, we came here for a joyous event and you want to be awake for the birth of your baby. You are here for it, but you are having surgery awake. It's not natural. So we give a much stronger medication in the epidural

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so that you don't feel any of the surgical sensations. You still feel sensations like pushing, pulling, tugging. Again, if you've had dental work, it's similar to that, of course in a greater area, but it's more like...

Devon: I thought that was so crazy. Somebody told me that before we listened to you, like you feel pressure, but I'm like, what are you talking about? And then it was just like you felt like pushing on your teeth.

Kim: You can feel like moving around, but I don't know what type of person you are, but if you ever want to look at a YouTube video of a C-section, you're not feeling that. It's much more intense than what you're feeling. It's uncomfortable at some points, Absolutely. I'm not diminishing that. Again, it's surgery that you're awake for. It's not natural. But we do a risk versus benefit. And the benefit is you get to be awake for the birth of your baby. We minimize exposure of anesthesia medications to your baby. Overall, it's a lovely experience.

So you would get more numbing medicine in the epidural. We of course give you that stronger numbing medicine in the epidural, wait the appropriate amount of time to make sure it's working, and test before we start the surgery. And if you're like, nope, I still feel pinching. I just feel like this isn't, nope, it's not enough. Okay, then we can move on to other options.

We may take the epidural out and give a spinal, which is also an injection in your back, but it's a much more concentrated medication in an area that concentrates the nerves a lot more so that you are absolutely numb. So you're different. And again, not to get too sciencey, but basically from the patient's perspective, it's similar. That's an injection in the same area in your lower back, but the medication goes to a different part that just creates a more denser nerve block. So it coats the nerves more significantly and you feel less and you likely cannot move your legs at all with a spinal as opposed to an epidural and that's expected. It's temporary.

Or there is a possibility that we have to do general anesthesia, which means you have to go to sleep and have a breathing tube put in and go on the ventilator,

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again, temporarily to safely deliver your baby and make it safe for you. And we do try to avoid that, but occasionally, depending on the situation and what kind of time we have and what specifically is going on, that is an option. But the goal is always that you as the patient are comfortable and you and your baby are safe.

And I like to say a little plug at this point that your anesthesia provider is the person that is there for you. And you are there for your baby, right? You're like, take me, just make sure my baby's okay. But I am there for you, specifically the baby, everyone else in the room, there might be eight other people in the room, they all care about what's going on with baby. I care about what's going on with you. That's my job. That's literally my job.

And I'm only allowed to have one patient at a time. So your baby, as much as I think they're adorable and love them already, is not my patient. You are. Just know that you have someone there in any situation with any type of anesthesia.

Devon: It's interesting actually that call I was telling you I had earlier with the retired anesthesiologist, she started out doing OB and then switched over to pediatrics. And she said way back in the day that she was the only one there for the parent and the baby and that it was like very chaotic, but she's now they've got pediatricians in there and pediatric and all that stuff. So she can focus on the parent.

Kim: Of note, there are situations where I am a pediatric anesthesia provider. I've been doing the OR in the OR room that day that has newborns or pediatric patients, but no, in a labor and delivery situation, the anesthesia provider is there for the parent and either the NICU or the nursery providers are there for the baby.

Devon: The anesthesia providers are for the parent. You said baby.

Kim: Oh, yes. I'm sorry. Yes, correct. Is for the parent and the nursery is for the baby.

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Devon: Yeah. I remember you saying that a lot of times the attention, once the baby's out, everything fully shifts that way. Even the partner runs over to see the baby and then the birthing person is, what's going on? And you've got this curtain, you can't see anything.

Kim: You've got a drape, your arms are probably out because we're taking your blood pressure and you're doing the IV and you're stuck and you're just like, hey, is my baby okay? What's going on with my baby? And I'm the one that's going to come over and remind you like, hey, how are you doing? How are you feeling? Are you nauseous? Do you need a bucket? Oh, they're just checking him or her out. They're just looking at him. He's crying. Yeah, exactly.

They're just keeping him warm over there for five minutes, in the C-section especially. They're just checking him out, make sure he's transitioning to the air okay, and that person does try to be there for you.

Devon: Yeah, I think that's great. But you don't think about that. If you don't know what to expect, you might think, oh, my partner is still going to be there with me or my doctor, but your doctor is sewing you up. Everybody else is over with the baby and up by your head is basically the anesthesia person and that's it. Or maybe your partner still if the baby's really crowded, but I think they generally, and you may want them to, if it's a big emergency and they have to rush the baby out, maybe your partner will follow and then you're all alone. You're more than just the bartender.

Kim: Correct. That's why any time a nurse says, just to make patients feel more comfortable, Oh, Kim's a great bartender. I'm like, the reason bartenders are great is because they talk and listen to their...

Devon: It's true.

Kim: That's really why people love their bartenders. So yes, I am that. I do want to address one thing. Cause that's reminding me of something, which is the

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medication itself. So many people, the question I get probably most often are what is the type of medication in the epidural and will it affect my baby?

The epidural medication is first and foremost, a local anesthetic. So you may have heard of Lidocaine or Novocaine. It's similar to those. It's not necessarily that medication, but it's in the same class of drugs. So it's a numbing medicine. It's not necessarily you hear pain medication and you immediately think opioids and controlled substances and things that are dangerous. Primarily, it's a local anesthetic just to numb your nerves so that you don't feel pain.

At the facilities that I have worked at, three of them, so three of the four, the default mixture in the infusion, the epidural infusion, does include a small amount of narcotic. So you may hear people talking about fentanyl, which gets a bad rap on the streets. It is absolutely a dangerous medication. It is absolutely a controlled substance, but administered by a trained provider in an appropriate healthcare facility setting. It is not dangerous to the degree that you hear in the news. And it does help with pain management.

So a lot of patients are like, I don't want to give my baby, he's not even born yet. I don't want to give them drugs, which is legit. That's a legit question. But the amount of medication that goes into the epidural space where we're putting the epidural infusion, it's not right into your bloodstream, the patient's bloodstream. And even the amount that does get into your bloodstream also has to go through the placenta and get to the baby.

So all of the studies, we wouldn't give it at this point if we didn't feel it was safe and have seen many babies born without side effects. But there is an option. Some patients are very much either they have a history of complications from that narcotic medication or something like that. And we can, in most circumstances, have our pharmacy make an epidural infusion bag that does not have the narcotic medication in it. And you can talk to your provider about that.

They may discuss with you the very minimal risk and why there may be a benefit to having that small amount of narcotic medication, not to convince you of

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anything, just to give you more information to continue with your decision making. But it is possible to at least, I encourage people to at least ask, is there a way that I could get this without narcotic? Because I personally have a history or I'm personally uncomfortable with the narcotic medication. And then see what the provider can help you out with in that situation. It's not a left field question.

Devon: I saw something so interesting that was talking about when you get an x-ray, how like you're in the room with the x-ray machine, but then the x-ray provider goes, it was a joke, they were like, goes to Egypt to press the button. So like, how is that safe? And the response was, you get a handful of x-rays in your life and they're in the room with the x-ray machine all day long.

So when you're getting one x-ray, the risk is infinitesimal, but when you're exposed to x-ray all day, every day, and then they made the comparison back to bartending, that if you do a shot with the bartender, you're fine. If the bartender did a shot with every patron in the bar, they'd be dead. Yes, fentanyl addiction is horrible and street drugs laced with fentanyl is terrible, but like a teeny tiny amount in your epidural is not the same thing as...

Kim: In a controlled environment.

Devon: Yeah.

Kim: And it does not, there is no science to suggest that having it in your epidural infusion, even if it's for 24, 26 hours of labor, that you develop a narcotic addiction.

Devon: Sure. I don't see anybody being like, let me get pregnant again because I just really love that epidural.

Kim: Yeah. Yeah. Yeah. But again, it's a very reasonable thing. If you're just not comfortable with it or you don't know enough about it, ask. Talk to your provider. And if whatever provider comes to the room isn't answering your questions appropriately, ask your nurse. Hey, is there someone else I could talk to? I didn't really feel good about that interaction. That's always allowed. I hope that in

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some circumstances, maybe they are the only one and they're just tired or not great at that type of manner and that's unfortunate, but always ask.

Devon: Yeah. And if you're available, we can go a little over time. I don't mind that because I did still want to talk a little bit about induction. And I wanted to ask you about what are some potential side effects or effects that you might experience? I've heard some people say they get, they have a headache after.

Most people say it was wonderful and it was fabulous and they were floating on a cotton candy cloud. But I do think it's important to know what some of the potential more common things could be.

Kim: So the most common thing that happens after receiving epidural medication is your blood pressure drops. A couple things happen. Your pain is relieved, number one. When you're in the throes of contractions, your blood pressure may go up and just that relief that you get this flood of just pain relief, then your blood pressure is gonna go down.

Your positioning for the epidural sometimes just causes - have you ever been in that? You're just overwhelmed and you just get that like flush and sweat and you're just like, I got to sit down like sometimes positioning for the epidural does that. But also the medication itself is designed to lower your blood pressure. It's an unintended effect of it.

But when you have lower blood pressure as a laboring person, you get less blood to your placenta and your placenta gives less blood to your baby and your baby's heart rate can be challenged by that. So it is a known side effect. We try to avoid it, but if it does happen, there are medications to treat that IV medications.

If it's truly an emergency and it just your body cannot recover, cannot compensate, then of course we're going to bring you to the operating room and do an emergency C-section. It's rare that again, that's not the intended effect.

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That's not what happens. But that's why I was saying before, we give you a little bit of the medicine first, then we give you a little bit more.

I stick around. I'm not just going to stick the needle in your back, rip it out and walk away. That's not the way it works in a good facility with a good provider. So I feel like that is the most common thing that happens.

Other things, of course, anyone can have an allergic reaction to a medication or a preservative in the medication. You could just be one of those people that doesn't do well with this type of medication or that type of medication. I don't see it commonly, but that's why we ask, hey, have you had anesthesia before? Any problems? Oh, you got your wisdom teeth out and you got hives? Like, oh, let's think about that and investigate that a little bit more.

Also, sometimes the risks include things that aren't related to the medication itself. But anytime we put a needle through the skin, we're introducing the risk of infection. It's why we make it a sterile environment. I put sterile gloves on, I put sterile cleaning solution on your back before I do it. But anytime you're taking buggies from the outside and putting them into the spinal column, there's a risk for infection, which could lead to meningitis. It could. It's those types of things, but most people I find the risk benefit analysis weighs on the side of benefit.

I will say, if you want to ask about percentages of things people say in the labor room, that should be a podcast. How many times do I go through the risks? I'll never talk to a patient and ask them to do a consent without explaining these risks to them. I have never once explained all the risks and then said, so do you have any questions about that? Do you understand? And the patient said, you know what, nevermind. I don't want it.

Most people understand when you come into the hospital, there are risks. There are always risks to medicine and biology. And again, it's not magic. There are some risks and that's, those are the most common ones. When people talk about a headache or back pain, a lot of times it's, it can be confounded, right? So I just gave you an epidural. Now you don't feel your contractions. Now you're

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about to push the baby. So your legs are up in stirrups. You might be pushing for a while and that's not a good feeling, right?

Like just do it now, not pregnant. Like your legs are stretched out, pulled back and your knees are up by your ears for a couple hours. You may not feel in the moment that hurts. Like it's almost like, I don't know, taking Advil and then going to the gym. Maybe that's masking some of the muscle inflammation that you're getting from overdoing it and you'll feel it till the next day, right?

Devon: Something we say in postpartum is like, it's normal to have any kind of pain, any kind of like a person might come home from the hospital after having a baby and have like foot pain because of something they did. And as long as it improves, as long as it gets better. And you're also reminding me of something else, which is a lot of times when people are learning body feeding or nursing, of course, it's like a new thing and it's uncomfortable. So they'll be like holding the baby and be all like jacked up like this.

And they'll be like, oh, is nursing supposed to make your shoulder hurt? Is nursing supposed to give you back pain? I'm like, no, but stop doing that. And relax a little bit. And this is why you have back pain because you're jacking your shoulder all up and your back is all tense and you're all in a cockeyed position. Or even just holding the baby. You might be holding the baby in something that's comfortable for 30 seconds or a minute, but you're holding your baby like that for hours. And then you're like, oh, why does my elbow hurt? Why does my shoulder hurt? So get really comfortable and give yourself a lot of support. So I think it's similar to that.

Kim: Totally. And that's the thing with back pain. During labor, most women tell me they had back pain. I always ask, oh, hey, do you have anything going on with your back before we do the epidural scoliosis, have you had sciatica during the pregnancy, just things I want to know ahead of time. I won't prevent you from getting an epidural, but things I want to know.

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So that afterwards, if you tell me, my lower back really hurts, you're like, oh, I have this shooting pain down my right leg. And I'm like, okay, we can explore that a little more, but you did have that sciatica beforehand. So maybe we just need to treat it from that perspective because that might be exacerbated just from the whole experience of pushing another human out of a human.

Devon: It's a lot.

Kim: So not to minimize it, but just to say, oh, I don't want to get an epidural because it causes back pain. Maybe you need more information before you make that decision. And then as far as headaches, so some people do unfortunately get the side effect, it has happened to me when I've been doing epidurals, I've done so many of them, they actually have kind of a joke in my, in my industry. That's if you've never gotten, we call it a wet tap when the epidural needle goes too far and you get that leak of spinal fluid.

If you've never had a wet tap, some people say, I've never had a wet tap. I must be doing it right because I've never had a wet tap. We all say, if you've never had a wet tap, you haven't done enough epidurals. It's a known side effect, it happens, it's unfortunate. It doesn't necessarily affect you in the moment.

You can still get a successful epidural and have relief of labor pain, but most of the time what happens is the leak of spinal fluid causes a headache, like a low headache or a frontal headache, and it's very positional. So you can lie down and feel pretty okay, and then as soon as you sit up, your head is, it's the worst headache of your life. That's really hard when you are breastfeeding and holding a newborn and trying to get back to your toddler or your dog or your whatever, and you just wanna enjoy your newborn baby and you can't even see straight because your head hurts. So if people talk about that kind of headache, that's a known problem.

Devon: I just also wanna flag that if you are having a severe headache after birth and you don't know that you had a wet tap or whatever happened, that can be a sign of blood pressure issues and you need to call your doctor immediately.

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That's a big red flag if you have a severe headache and you don't know that there was a reason for it or even if you do, call your doctor.

Kim: I was actually going to say that. So I know that to be true, but I should say that if you have a severe headache after birth, you should always call your obstetrician first and then they can ask more questions to guide you to the right thing. Typically, we call them spinal headaches or the wet tap headache. Happens while you're still in the hospital. You're not even gone yet and you're like... And then the nurse is probably let's call anesthesia to evaluate you because this is the possibility and we know you had a wet tap. Most of the time we know that it's happened. Sometimes it goes unrecognized but we can make that evaluation depending on your situation.

Devon: Yeah, so things like little tweaks in your neck, shoulder, elbows, whatever, those can be normal, but a bad headache is something you should get checked out.

Kim: We use it for anything like the gauge is like if you can't take care of your baby comfortably. If you can't breastfeed, no one is happy after that's why they have you, right? No one is full energy, thrilled to be like up all night with their baby all the time, every night. But more than just tired, if you're like, I can't, I want to breastfeed and I can't even, I have to put the baby down. If you can't do normal activities of taking care of a newborn by yourself in your normal situation, then that's the time to call your doctor for sure.

Devon: Yeah. Yeah. I had a client a few years ago who called us. I forget if she was having her third or her fourth, but she said, she called us, like I said, with the pregnancy test in hand. I'm due in 9 months, are you available? Yes, we are. She said with her second, she had all these horrible symptoms after.

And finally her mother, like the doctor was just like, wait and see. And her mother forced her to go back to the hospital and thank God, because she had almost died and she was worried she was going to have similar complications after the third, which is partly why she called us, but also because she knew by

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baby number three that getting help and sleep was important. Let's do that. The further along you are in the series of kids, the earlier you call us is something we've discovered pretty anecdotally, but also it's true.

So let's just touch on inductions, because if I'm coming in for an induction, I'm not in labor. At what point am I seeing you? I know sometimes inductions can be painful, even from the beginning. Is that something that you get involved with right from the start?

So the benefit of inductions is that and we're talking about inductions of labor because we also talk about induction of anesthesia. And that's a different thing. So we're talking about induction of labor. Induction just to mean let's urge this along with some medications and start the process for you. Inductions are beneficial from our perspective because we have a controlled environment where the patient is coming in not in labor and kind of able to focus.

And this was planned and we packed our bag and everybody's here that needs to be here. And I came prepared and I'm ready to go. At any point during the admission to the hospital, you can ask to speak to the anesthesia provider. I have a personal opinion that you should speak to your anesthesia provider as early as you want to. Of course, like I said, there's not always someone available to come right away.

But if you know that you want to explore analgesia or anesthesia in the form of an epidural sooner, or if you just have questions, then you should be able to ask for the anesthesia provider, whatever. Let them get your name, print your bracelet out, get you in a hospital gown if that's what you're doing. Let the nurse put an IV in because we actually do require an IV to be placed prior to epidural, again, because if there's a risk and we need to give you emergency medication, you need to have an IV. So those types of kind of administrative things need to happen first. But if at any point after that you want to speak to the anesthesia provider, you should be able to do that.

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If you don't, if you just want to take a nap or if you have other people coming in and out and you're not interested in doing it at that time, that's okay too. At any point during labor, if you are just like, "Hey I have a few minutes, can I talk to the anesthesia person?" Then that is perfectly acceptable and we can have a conversation with you then. If you get to the point where you're like, "Oh, this induction was going really slowly and I fell asleep and now I woke up and I'm six centimeters and this hurts like hell," then you can ask for the anesthesia provider then and we'll talk to you then.

Devon: So typically it would be just basically the same as coming in for labor, but you just have a little more time when you're in your clear headspace to talk about your options. One thing I remember, because I did do a birth to a training, is that there's sometimes a point, I don't know if it's in all labor or just an induction, where you might even want some medication to help you sleep. Is that something that you would do?

Kim: Yeah. So in my facility, no, it's not the anesthesia provider, it's your obstetrician. And actually, let me just say too, because again, I'm picturing it in my head, but people that are watching this don't know the situation. You can also talk to your labor nurse. So your labor nurse is your partner in this whole thing.

And you can talk to your labor nurse about epidural things. I was thinking, why don't more people ask me to come earlier in the process. And it's because they asked their labor nurse, who is extremely knowledgeable about it too. So they might just have a question like, should I get the epidural now? And the labor nurse might say, if you want to, but just remember, you can't get out of bed after.

So if you feel like you want to walk around for two more hours, then don't get the epidural. And then they're like, oh yeah, okay. So they don't have to necessarily talk to the anesthesiologist.

Devon: Oh wait, quick side question. If you have the epidural in and you can't get up, how do you go to the bathroom? Do they do a catheter?

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Kim: Yes, they do a urinary catheter. So considerably, they wait for the epidural to kick in a little bit so you don't have to feel that catheter going in as much. You might be like, oh, something's going on down there, but it doesn't feel like the pressure that you normally would have.

Devon: There's a lot going on.

Kim: I was going to say at that point, people care very little about the catheter. That's not the main concern, but yes, you do get the catheter. And if you have to poop then we put you on the bedpan and you would poop in a bedpan. Not glorious, but we call it the joys of motherhood.

Devon: And from what I've heard, all the nurses and OBs and everyone is very just done, pretend it never happened, not even thinking about it, not telling you about it. The doctor makes eyes at the nurse and she comes over and that's it.

Kim: 100%. There is always a level of like nerves and awkwardness with those kinds of things, but don't worry about it. Try not to worry about it.

Devon: Yeah. And everyone of course is very professional and sees this all the time. I've had mom's parents, like when I'm sleep training or when I'm with them, and they're like, oh, I bet you've never seen anyone who's like as much of a mess as me. Yes, we have. All the time. Constantly. Everyone is a mess. Constantly.

Kim: On that note, I really, I'm not saying I hate it. I just feel for the patients. I get so emotional when patients are apologizing to me for screaming, for moving around during an epidural. And I didn't really talk about that either. You can move around during an epidural. You can't reach your hands back and be wild all over the place because we do have a needle in your back. But you can... People are like, oh, I'm having a contraction. What if I jump? What if I jump? I understand it's a needle in your back. Your body is programmed to jump. I get that. We know how to handle those situations.

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Devon: Even on the phone, people are like, oh, my baby, you might hear my baby in the background. I hope that's okay. I'm like, yeah, that's fine.

Kim: Yeah, we expect that. We expect that. And again, not to minimize it.

Devon: That's why we're having this call.

Kim: I appreciate that you are respecting what I'm doing for you and my time, but please don't apologize to me. That's what I say to people. If it makes you feel better, then do whatever you want, but please don't apologize to me. I know, like you said before, this is your first labor. I've been here 100 million times.

If you are truly uncomfortable, then I need to give you more numbing medicine. I did this to you. I'm the one sticking a needle in your back. So if you are, you don't have to be upset about that. I do, and I have to fix it.

Even if it's just with breathing or comfort or do you need to take a break? Let me stop for a minute and tell you. By the way, the epidural procedure probably start to finish in a perfect scenario takes 10 minutes. There's some like prep with a sterile field, there's some time on the other end where the medication needs to work, but the epidural procedure itself in an ideal situation where there's not difficult anatomy or the patient isn't contracting back to back, no pun intended, and I can just go ahead and do a smooth epidural shouldn't take longer than 10 minutes. You don't have to be in that perfect position frozen for a half hour, just to know, because people really have no idea how long it takes.

Devon: No, that's good to know. That's good to know. I'd be curious as well. Sorry.

Kim: And at the point where you're just overwhelmed and you need a minute, sometimes it's difficult. Sometimes we have to try more than once. If that happens and you're just like, can I just take a breath? You can say that. If you're down there and you're just clenched and so upset and you're like, can I just pick my head up and take a breath? Please ask.

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Devon: Yeah, I love that. Before I started talking about catheters, we were talking about possibly being given some medication to help you sleep if the induction is going along or your labor is going along and not progressing and you're tired. And it can help, I think, to get a little rest during the process.

Kim: So in the facilities I work in, that's more the obstetric providers because they're following your labor hour to hour or minute to minute more closely. They have the latest on what's safe for you, safe for baby. They're better versed in the situations at my facility. Not to say that the anesthesia provider doesn't, or the sleep experts, doesn't take care of that in other situations. But yes, it is a possibility and again, a discussion with your provider and it is encouraged to be as comfortable as possible during labor and ask for what you think you need to be comfortable during labor. Does that answer your question?

Devon: Yeah. No, I love that. I love that. But I think the main takeaways here are don't be afraid to ask to speak to the provider early in the process. Even if you're not sure if you want medication or think you don't want medication, it's still a good idea to connect because you don't want to end up... I say this about people. They call me and they're like, we want to see how things go and then we'll decide if we want to hire.

Don't wait till you're drowning. Let's find out, let's get everything squared away and if you end up not using it, fine, but you're not going to have a good time having this conversation when you're ridiculously sleep deprived and out of your mind. So talk to the provider early. Hopefully your provider will make a plan with you, but you can advocate for yourself.

Kim: Tell your partner ahead of time. I don't know how I'm going to feel when I get there. So these are the things that are important to me. If you could just remember that and that's a really great way to get them involved.

Devon: Yeah. Oh, that's great. Yeah. Yeah. Or if you have a doula or another, a coach or another support person having them and that the labor nurses are your

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friends. And I love what you said about the research showing that the pain support and pain relief can actually help things progress and be good.

Because I know there is some rhetoric out there that it's not. Is there anything else that you can think of that we didn't talk about? I'm looking at our list of questions.

Kim: Sorry, speaking of babies in the background, I don't know if you hear a cutoff, but that's just my dogs scratching at the door because they hear my voice.

Devon: Yeah, a lot of you saw me lean over before, but the cats discovered that the treat container is right here. So then of course, everybody came over and had to have some, so I had to put them out. Is there anything you can think of that we didn't talk about?

Kim: Of course, I could talk in depth on all the things that we talked about. So if I missed anything, yes, the best advice is to ask your provider, be comfortable with the people that are surrounding you during this amazing, wonderful time. Even if there are struggles and challenges throughout, expect there to be, and just know that you have support.

Anything from a traditional standard labor to a true emergency, you should feel like you have some say in it. You should feel like you're part of the plan and you should feel confident saying, "I don't like this. Can you tell me if this is necessary or not?"

Some phrases I encourage people to say are like, "I'm in so much pain, I don't quite understand you. Could you tell me again? Or could you come back in five minutes?" When you remind them what you're going through, then it helps everyone in the room put the focus back on you and be like, "Oh yeah, this isn't - I'm not talking to you over coffee. I'm talking to you while you're in labor."

Let's all remember that and be present for this person who is doing this amazing thing and has already been through an incredible amount of work and who is

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anticipating an incredible amount of work once we are on the other side. So I encourage you to do whatever it takes to make you feel like the VIP because you are.

And you should be, and everybody should be focused on you. If you're going for a job interview and you have a routine in the mirror that you say to yourself, do it to yourself in the car before you walk into the hospital. We may be the experts in our field, but that doesn't mean that you are not the most important person here.

Devon: I love that. I love that. I think anybody who has you do their anesthesia is very lucky. And then I just have one final question for you, which is what is the specific gravity of cerebrospinal fluid?

Kim: Oh my goodness. All right. So this is an inside joke. I am not going to answer that question because after all, she is my sister and I have to give her a hard time.

Devon: She was nervous going into this webinar that we were going to ask her very academic, scientific questions that she hasn't answered since she was in school. And I was like, no, these are people having babies. They want to know what it's going to look like from their perspective when they're in the room with you.

Kim: I just wanted to be well informed and refreshed on the things that in my head are very important.

Devon: Beautifully prepared.

Kim: But I forgot that they are not as important to the audience.

Devon: It's true.

Kim: But if I ever see you in one of my facilities, please say hello and you are welcome to ask me any question. And if I don't know the answer, I will look it up and come back to you.

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Devon: And you can do that. You are allowed to do that.

Kim: Yes, absolutely.

Devon: Thank you so much. This has been so great. I always learn so much when I talk to you about this stuff because it's so funny that we're like on opposite sides of the same situation. Just seeing it straight through. Also with sleep training, I say we both get - our job is to watch people sleep, put them to sleep and watch them do that.

Kim: Yeah, mommy pointed that out. I can't believe that both of my children get paid to watch people sleep.

Devon: Of course, you have the much more difficult job of waking them back up at the end when mine wake up all on their own, sometimes more than we want them to. Yeah. Okay. It was so great to have you. Thank you so much.

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