uses administrative and not manually abstracted clinical data to measure quality. We believe that the most cost-effective alternative to manually abstracted clinical data is to extract structured clinical data from the electronic medical record. To that end, the American College of Obstetricians and Gynecologists (Washington, D.C.) and the American Society of Anesthesiologists (Schaumburg, Illinois) have partnered to create the Maternal Quality Improvement Program[4] (now renamed the Birth Registry) to serve as a national platform for measuring and improving childbirth outcomes. The data elements in the data dictionary for the Birth Registry have been incorporated by some leading electronic medical record vendors and will eventually serve as the backbone of the Birth Registry. These clinical data elements can then be extracted directly from the electronic medical record without the need for manual abstraction by trained data collectors. Our goal in "Measuring Childbirth Outcomes Using Administrative and Birth Certificate Data" was to examine the feasibility of using *lower-quality data* (hospital administrative and birth certificate data) to create risk-adjusted outcome measures for childbirth outcomes while we await broad-based penetration of Birth Registry–compliant electronic medical records. Because hospitals collect administrative and birth certificate data on all births, such data could be used to provide expectant mothers with information on which to base their choice of providers, as well as providing clinicians with actionable performance feedback—while we await more robust clinical data based on the electronic medical record.

Competing Interests

Drs. Glance, Dick, and Hasley served on the Steering Committee for the Maternal Quality Improvement Program (now renamed the Birth Registry). Dr. Hasley serves as the Chief Medical Information Officer at the American College of Obstetricians and Gynecologists (ACOG; Washington, D.C.) and has spoken to sales managers at AbbVie Inc. (North Chicago, Illinois) concerning the future of health information technology. The remaining authors declare no competing interests.

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References

1. Glance LG, Hasley S, Glantz JC, Stevens TP, Faden E, Kreso MA, Pyne SG, Wissler RN, Fichter J, Gloff MS, Dick AW: Measuring childbirth outcomes using administrative and birth certificate data. Anesthesiology 2019; 131:238–53
2. National Vital Statistics System: Birth Data. 2018. Available at: https://www.cdc.gov/nchs/nvss/births.htm. Accessed November 12, 2019.
3. Howbert JJ, Kauffman E, Sitcov K, Souter V: A simple approach to adjust for case-mix when comparing institutional cesarean birth rates. Am J Perinatol 2019 [Epub ahead of print]
4. Butler T, Hasley S, Currigan SM, Levy BS: The maternal quality improvement program: A clinical data-driven national registry for maternity care. Obstet Gynecol 2017; 129:934–8

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Labor Epidural Education and Hispanic Ethnicity: Comment

To the Editor:

I have read with interest the article entitled "Education Program Regarding Labor Epidurals Increases Utilization by Hispanic Medicaid Beneficiaries" by Togioka *et al.* in the October issue of Anesthesiology.[1] The intervention group in the Hispanic arm saw its epidural rate increase from 60 to 80%, while the non-Hispanic arm had a nonsignificant rise from 82 to 86%.

Here, the population previously familiar with the benefit of labor epidurals has the same epidural utilization rate as the postintervention group. What the authors have actually demonstrated is that marketing works.

But we already knew this: Almost no American women shaved their legs prior to 1915, when Gillette created the Milady Décolleté razor and launched it with an advertising campaign. By 1964, 98% of young women were shaving their legs.[2,3]

Any subpopulation not yet marketed to will be expected to respond to an educational campaign—and in this regard, labor epidurals are behaving similarly to other goods. The Hispanic subset of the population was not captured by previous marketing, so the investigators focused on reaching them with a targeted marketing campaign. We can make similar statements about educational programs regarding hydration with carbonated cola-flavored sugar water or cancer prevention with vaccination for human papilloma virus. Further, we can look

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at the lessons provided by direct-to-consumer advertising of prescription medications: Marketing works, but utilization does not always equal a health benefit, as the many papers on "natural childbirth" in the nonanesthesia literature might argue.

Competing Interests

The author declares no competing interests.

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References

1. Togioka BM, Seligman KM, Werntz MK, Yanez ND, Noles LM, Treggiari MM: Education program regarding labor epidurals increases utilization by hispanic medicaid beneficiaries: A randomized controlled trial. Anesthesiology 2019; 131:840–9
2. Hope C: Caucasian female body hair and American culture. J Am Culture 1982; 5:93–9 doi:10.1111/j.1542-734X.1982.0501_93.x
3. Komar M: The sneaky, manipulative history of why women started shaving. Bustle, December 14, 2016. Available at: https://www.bustle.com/articles/196747-the-sneaky-manipulative-history-of-why-women-started-shaving. Accessed February 11, 2020.

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Labor Epidural Education and Hispanic Ethnicity: Reply

In Reply:

We appreciate Dr. Wecksell's comments on our article, "Education Program Regarding Labor Epidurals Increases Utilization by Hispanic Medicaid Beneficiaries."[1,2] Dr. Wecksell asserted that the marked improvement in epidural rates for the educational intervention group in the Hispanic arm, coupled with no significant difference for the intervention group in the non-Hispanic arm, was a demonstration that "marketing works." One might reasonably argue an educational intervention and a marketing campaign can be similar in *how* they deliver information to individuals, but the likeness should end there, lest one embarks on an equivocation fallacy.

A fundamental objective of an educational intervention is to improve knowledge. Properly executed, new knowledge provides a person with skills to make better, more informed decisions, decisions that should be beneficial to the *individual first*. And while a primary objective of a marketing campaign is to inform individuals of a company's or an industry's products or services, the benefits are directed toward the *marketed entity first* (*e.g.,* sales revenue and profits, market share). There may or may not be benefit to the individual; a successful campaign could cause them harm. R. J. Reynolds' Joe Camel advertising campaign[3] is one case in point. Importantly, the goal of our intervention was to create educational equity and promote informed decision-making in a cohort of women (Hispanics) that historically lacked access to accurate information. The educational program was created with the intent to benefit Hispanic women.

In response to the author's statement that "utilization does not always equal a health benefit, as the many papers on 'natural childbirth' in the nonanesthesia literature might argue," we believe that facilitating informed decision-making for the management of severe pain is an end with intrinsic value. Our educational program was evidence-based and avoided value judgments. Furthermore, in an era where nearly one third of births occur by cesarean delivery, epidurals offer a health benefit in certain circumstances.[4]

Last, we did appreciate the account provided to explain why American women began shaving their legs. We warn our audience, however, of the hazards of making causal declarations from observed correlations. We believe a reading of the Bradford Hill criteria for establishing causality from observational data could help avoid future misconceptions.[5]

Competing Interests

The authors declare no competing interests.

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References

1. Wecksell MB: Labor epidural education and Hispanic ethnicity: Comment. Anesthesiology 2020; 132: 1283–4
2. Togioka BM, Seligman KM, Werntz MK, Yanez ND, Noles LM, Treggiari MM: Education program

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regarding labor epidurals increases utilization by Hispanic Medicaid beneficiaries: A randomized controlled trial. Anesthesiology 2019; 131:840–9
3. Federal Trade Commission (1997): Joe Camel advertising campaign violates federal law, FTC says. FTC File No. (P884571)
4. Hawkins JL, Chang J, Palmer SK, Gibbs CP, Callaghan WM: Anesthesia-related maternal mortality in the United States: 1979-2002. Obstet Gynecol 2011; 117:69–74
5. Hill AB: The environment and disease: Association or causation? Proc R Soc Med 1965; 58:295–300

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Superior Trunk Block *versus* Interscalene Block: Comment

To the Editor:

We read with great interests the article "Superior Trunk Block: A Phrenic-sparing Alternative to the Interscalene Block: A Randomized Controlled Trial" by Kim *et al.*[1] The superior trunk block is a promising alternative to interscalene brachial plexus block with diaphragm-sparing. We appreciate the authors' great work, but we do have several concerns. First, the cutaneous innervation of shoulder is provided by brachial plexus and supraclavicular nerves which originate from superficial cervical plexus[2]; therefore, to carry out shoulder surgery solely with peripheral nerve blocks, brachial plexus block must be combined with superficial cervical plexus or supraclavicular nerve block to provide coverage for skin incision and closure.[3] In this study, consequent intravenous sedation was provided intraoperatively, but superficial cervical plexus, supraclavicular nerve block, or local anesthetic infiltration at the surgical sites was not performed. Second, the unit of grip strength measurement in this article was not provided. We speculate that the unit should be kilogram according to their previous study.[4] The grip strength after block was described as change from baseline in this article rather than proportion of baseline by Auyong *et al.*[5] We consider the latter description of grip strength a better strategy to make comparisons. According to their previous baseline data of grip strength, we speculate that the grip strength after interscalene plexus block was about 42% of baseline in this study, which is higher than 27% by Auyong *et al.*[5] It would be hard to preserve such a high proportion of baseline grip strength with 0.5% bupivacaine 15 ml deposited in between C5 and C6 nerve roots. Thirdly, there are existent studies by Aliste *et al.*[6,7] showing that targeting the brachial plexus causes a hemidiaphragmatic paralysis rate of less than 5%. Finally, it is illogical that under intravenous sedation, the intraoperative mean minute ventilation measurements have even increased in the superior trunk group compared with baseline.

Competing Interests

The authors declare no competing interests.

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References

1. Kim DH, Lin Y, Beathe JC, Liu J, Oxendine JA, Haskins SC, Ho MC, Wetmore DS, Allen AA, Wilson L, Garnett C, Memtsoudis SG: Superior trunk block: A phrenic-sparing alternative to the interscalene block: A randomized controlled trial. Anesthesiology 2019; 131:521–33
2. El-Boghdadly K, Chin KJ, Chan VWS: Phrenic nerve palsy and regional anesthesia for shoulder surgery: Anatomical, physiologic, and clinical considerations. Anesthesiology 2017; 127:173–91
3. Tran DQ, Elgueta MF, Aliste J, Finlayson RJ: Diaphragm-sparing nerve blocks for shoulder surgery. Reg Anesth Pain Med 2017; 42:32–8
4. Maalouf DB, Dorman SM, Sebeo J, Goytizolo EA, Gordon MA, Yadeau JT, Dehipawala SS, Fields K: Prospective, randomized double-blind study: Does decreasing interscalene nerve block volume for surgical anesthesia in ambulatory shoulder surgery offer same-day patient recovery advantages? Reg Anesth Pain Med 2016; 41:438–44
5. Auyong DB, Hanson NA, Joseph RS, Schmidt BE, Slee AE, Yuan SC: Comparison of anterior suprascapular, supraclavicular, and interscalene nerve block approaches for major outpatient arthroscopic shoulder surgery: A randomized, double-blind, noninferiority trial. Anesthesiology 2018; 129:47–57
6. Aliste J, Bravo D, Finlayson RJ, Tran DQ: A randomized comparison between interscalene and

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