

clinician well-being can yield strong return on investment.³ Additionally, as the COVID-19 pandemic has tested the resilience of the anesthesiology workforce and challenged both organization and clinician financial solvency, we need to take steps forward to identify those at high risk and prevent the serious ramifications of clinician burnout.

Fiscal solvency and clinician well-being are not mutually exclusive. But to attain both, practicing clinicians need a louder voice at the table.

Competing Interests

The authors declare no competing interests.

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Availability of Inpatient Pediatric Surgery: Comment

To the Editor:

On behalf of the American College of Surgeons (Chicago, Illinois) Children's Surgery Verification program, we wish to clarify some of the statements in the

article by McManus and França¹ entitled "Availability of Inpatient Pediatric Surgery in the United States," and the accompanying editorial by Ambardekar and Schwartz.² Though we completely agree that there has been consolidation of pediatric surgery toward high-capability pediatric centers, we disagree with the statement that "the American College of Surgeons launched its Children's Surgery Verification Quality Improvement program to promote regionalization." Regionalization is defined as the "integrated organization of a healthcare system, wherein regional structures are responsible for providing and administering health services in a specific region."³ This was never the intent of the American College of Surgeons Children's Surgery Verification program. In contrast, the program strives to provide care in appropriate settings without the need for consolidation by developing standards not only for Level 1 but also for Level 2 and 3 centers and defining optimal pediatric surgical care within the scope of practice of the institution and providers. The clearly articulated vision of the American College of Surgeons Children's Surgery Verification is that "every child in need of surgical care in North America today will receive this care in an environment with resources optimal for his/her individual need." While there is some intrinsic correlation between patient volume and available resources, the American College of Surgeons Children's Surgery Verification program has focused on defining optimal resources and assuring that the right resources are available at the bedside at the time of a child's need. One of the lessons learned from the early years of the program has been that even premiere dedicated children's institutions have required change in order to meet the 24/7/365 expectation of having the right resources for infants and children at all times.

An essential component of a Level 1 American College of Surgeons Children's Surgery Verification–verified center is the engagement with all acute care facilities, designated centers, and nonspecialty hospitals within the referral area in the performance improvement process.⁴ As part of the verification process, Level 1 centers must show that they provide leadership in education, research, and system planning and the provision of technical assistance and education to regional hospitals and providers for the purpose of improving system performance. As a part of this, investigators have recently begun the process of defining low-risk pediatric surgical procedures to determine when surgery can be safely provided closer to home or by adult practitioners. This is illustrated by a recent study from Lawrence *et al.* demonstrating better outcomes after pediatric laparoscopic cholecystectomy with higher hospital or surgeon laparoscopic cholecystectomy volume rather than surgeon pediatric subspecialization.⁵

We agree with the concern that “overconsolidation of services could produce access barriers and other unintended consequences,” especially in rural areas of the country. We contend that the best way to optimize children’s surgical care is to provide a team approach that emphasizes system building by forging alliances with other surgical specialties (including anesthesiology), pediatrician and family practice colleagues, and administrative entities that can provide the essential infrastructure in rural hospitals that care for children.⁶ System building is a relatively new concept, different from regionalization, that has the potential to optimize pediatric surgical care even in the face of uncontrolled consolidation.

Competing Interests

Dr. Oldham is the Chair and Drs. Houck, Barnhart, Deshpande, and Fallat are members of the American College of Surgeons Children’s Surgery Verification Committee, Chicago, Illinois.

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The corresponding author of the original article referenced above has read the letter and does not have anything to add in a published reply.

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Obesity and Positive End-expiratory Pressure: Comment

To the Editor:

We read with great interest the recent article by Simon *et al.*¹ In this study, the authors have shown that individualized positive end-expiratory pressure (PEEP) exerts lower driving pressure.¹ This in turn proved the redistribution of ventilation toward dependent lung areas, as measured by electrical impedance tomography. These sound results imply great notions regarding intraoperative respiratory management. However, we highlight four concerns regarding the methodology used.

First, the study combined data from a multicenter² and a single-center trial. This was likely to cause selection bias. The inclusion periods were separated at 4-yr intervals. The authors divided the combined cohort into three treatment groups: individualized PEEP, fixed low PEEP, and fixed PEEP of 12 cm H₂O. The differences in the patient characteristics were unclear. The Assess Respiratory Risk in Surgical Patients in Catalonia (ARISCAT) score greater than 44 was noted in one patient (4%) in the individual PEEP group, which is less in comparison with the other two groups. We would like to know whether preoperative pulmonary function (forced expiratory volume in 1 s/forced vital capacity), oxygenation, and partial pressure of carbon dioxide differed among the groups. We question this because capnoperitoneum time and duration of an operation are basic information for considering postoperative pulmonary complications. To us, it seems that these might have influenced the results.

Second, the results clearly demonstrated that the individualized PEEP group needed larger amounts of fluid infusion and doses of vasoactive medication than the other two groups. There was no doubt as to whether these discrepancies were related to pulmonary management