has meaning and value, and it can be measured. We believe that Pisano is making the same important point in a different way, and we appreciate his constructive comments.

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REFERENCES
DOI: 10.1213/ANE.0000000000001016

Dangerous Regulations for a Level 1 Trauma Operating Room

To the Editor

We read the exposé on regulatory fatigue and distraction by Morey et al.1 with interest. As faculty members at the busiest level 1 trauma facility in the nation, we echo their concerns about unintended, dangerous consequences of arbitrary regulations that will negatively impact patient care. We also raise the following points:

1. Their estimated 5- to 10-minute arterial line monitoring system setup time presumes immediate availability of a dedicated technician or anesthesiologist. At our busy facility, especially in after-hours scenarios, this may be longer. Recent data from Pragmatic, Randomized Optimal Platelet and Plasma Ratios (PROPPR) highlighted the first 3 hours of trauma-related mortality,2 and delaying arterial line access for a fraction of these golden hours has the ability to cause patient harm.
2. Direct admissions from the helipad or emergency room frequently occur in <5 minutes and would preclude safe preparation of monitoring systems or necessary medications at that time.

3. As with many academic centers, clinical responsibility is coupled with educational requirements, including a new intake of one-third of the effective resident and one-half of the Anesthesiology Assistant student cohort every summer, coinciding with the busiest period of the trauma season. With new personnel, it is imperative that arterial line monitoring systems, induction, and rescue medications are prepared and immediately available to avoid delay in care.

4. We agree with the plea for evidence-based recommendations. In our collective experience, we have not seen an infection at an arterial line site that was placed urgently or emergently in the operating room. If there is concern for sterility or infection, the arterial line can be safely replaced once the patient is not in extremis.

We appreciate the attention that Morey et al.1 have brought to this topic and trust that leaders in the Trauma Anesthesiology Society and the American Society of Anesthesiologists lead the call for safe, common-sense regulations that will not harm patients.

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REFERENCES
DOI: 10.1213/ANE.0000000000001020