passage through the pharynx and by elevating its tip, which in turn gets closer to the glottic opening. The ‘trick’ is to gently press the tube shaft with the middle finger of the right hand on a point 2 cm above the dental row into its concave side in the direction of the tube’s convexity, while using the upper dental row (or the upper gums in edentulous patients) as a hypomomichlion (Fig. 1).

This move inevitably causes a more pronounced bending of the entire tube and decreases the curve radius, which is given by its original shape. The resulting forward movement of the proximal tube end reflects the simultaneously occurring symmetrical elevation of the distal tip, thus giving reason to call this move ‘reflective’. Consequently, both ends of the tube approach each other; however, the relevant benefit happens in the pharynx, where the resulting upward move of the tube tip can be translated into an approach to the glottis opening, which in turn facilitates intubation. According to direct assessment, the net effect of this manoeuvre is equal to an improvement of the Cormack and Lehane view by one grade. However, this statement is based only on personal observation of the tracheal tube’s physical behaviour and still has to be substantiated (or rejected) by future investigations.

This simple and unpretentious move became by time an integral part of the regular intubation technique of the author of this article, and it may have substantially contributed to his overall success rate. However, this change in the technique happened intuitively and developed in a natural way while it has never been consciously noticed when it became a standard habit. Therefore, it remained unknown until colleagues, who watched this approach, wondered about the nature of this specific move. This was the initial trigger to produce and publish this report. Hopefully, this herein presented simple and effective method will gain some attention and productive use. A prospective investigation to assess its influence on the outcome of tracheal intubations in patients will follow soon.

Declaration of interest
The author is Board Member and the Treasurer of the European Airway Management Society (EAMS).

P. Biro
Zurich, Switzerland
E-mail: peter.biro@usz.ch

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Working conditions, stress, fatigue, and depressive symptoms among Chinese anaesthetists

Editor—Anaesthetists are exposed to fatigue and many stressors at work, such as long working hours, extended duty shifts, high demand of the job, and the burden imposed by working in isolation and lack of respect.1 2 And mental well-being of anaesthetists needs more attention, since the negative impacts of depression on anaesthetists inducing not only physical problems and the suicide of anaesthetists, but also more medication errors, absenteeism from work, and decreased productivity, all of which may result in patients’ safety suffering.3 However, their mental health status is often neglected by medical management and researchers.4

Our study was aimed to investigate working conditions, work-related stress, fatigue, and depressive symptoms among Chinese anaesthetists.

A cross-sectional survey was carried out in 13 randomly selected grade III hospitals of five cities of China, in 2012. The questionnaires evaluated background, working conditions of anaesthetists (including job rank, salary satisfaction, respect at work, anaesthetist–patient relationship, and turnover intention), fatigue assessed by the Chinese version of Multidimensional Fatigue Inventory (MFI), and work-related stress measured by the Chinese version of the Job Content Questionnaire (JCQ), while depressive symptoms were evaluated by the Beck Depression Inventory (BDI). After univariate analysis, the associations between factors and depressive symptoms were analysed using multivariate logistic regression.

Three hundred and thirty-eight questionnaires were returned by 410 anaesthetists, among which 311 were effective (effective rate, 75.9%). The results showed that 62.1% anaesthetists had depressive symptoms (BDI ≥5). Regarding working condition, 56.8% participants indicated that their salary did not meet the effort they offered at work, while 27.5% anaesthetists reported they did not get the respect they deserved. Meanwhile, 81.1% participants were bothered
by their relationship with patients, and 76.3% anaesthetists wanted to change their work. The mean score of MFI and job demand of our sample were 50.6 (SD: 1.2.5) and 36.1 (SD: 4.1), respectively. Multivariate logistic regression analysis (Table 1) showed that salary dissatisfaction significantly increased the incidence of depressive symptoms with adjusted odds ratio (OR) 1.9 (1.1–3.6). Meanwhile, physical fatigue, mental fatigue, and high job demand were significantly associated with depressive status, where the adjusted OR were 4.4 (2.2–8.7), 2.5 (1.3–5.0), and 2.0 (1.1–3.6), respectively.

Our finding demonstrated that a large percentage of anaesthetists in China faced unsatisfactory working conditions and a higher level of fatigue and job demand compared with normal care workers,5 which could be risk factors of depressive symptoms. It also indicated that nearly two-thirds of Chinese anaesthetists suffered from depressive symptoms. For the sake of anaesthetists’ health and patients’ safety, mental health status of anaesthetists should receive more attention. As countermeasures to reduce depressive symptoms among Chinese anaesthetists, management of work arrangement and education of coping techniques for work stress with the purpose to improve anaesthetists working conditions and mental health should be considered.

### Declaration of interest

None declared.

H. Yang1
Z. Zhang1
Y. Zhang2
K. Zhao3
Y. Zhang1*
1 Hunan, China
2 Henan, China
3 Chongqing, China
*E-mail: zhangyalin@csu.edu.cn

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### Application of emergency trauma score in a hub-and-spoke regional system

Editor—In the article by Raum and colleagues,3 the new proposed emergency trauma score (EMTRAS) correlated with mortality. Moreover, EMTRAS was rapid and easy to obtain considering its four subscores (age, Glasgow come scale, emergency room prothrombin time, base excess: ranging from 0 to 3 each).1 We retrospectively tested the usefulness of EMTRAS in a cohort of 324 patients admitted for major trauma from July 2007 to December 2011 in the intensive care unit of a referral trauma centre (Careggi Teaching Hospital, Florence, Florence, Italy). EMTRAS was calculated in the emergency room and the results were compared with mortality (Table 1).

Table 1: Multivariate logistic regression analysis of factors associated with depressive symptoms (n=311). Values in bold are statistically significant, *P<0.05, **P<0.01, ***P<0.001. 1Adjusted for sex, age, marital status, chronic disease, job rank, and supervisor support

<table>
<thead>
<tr>
<th>Variable</th>
<th>Crude</th>
<th>Adjusted†</th>
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<tbody>
<tr>
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<td>OR (95% CI)</td>
<td>P-value</td>
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<tr>
<td>Working conditions</td>
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<td>Salary satisfaction (no vs yes)</td>
<td>2.4 (1.3–4.3)</td>
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<td>Respect at work (no vs yes)</td>
<td>1.2 (0.6–2.7)</td>
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<td>Anaesthetist–patient relationship (serious vs mild)</td>
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<td>Turnover intention (yes vs no)</td>
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<td>MFI</td>
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<td>Physical fatigue (high vs low)</td>
<td>4.2 (2.2–8.1)</td>
<td>0.000***</td>
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<tr>
<td>Mental fatigue (high vs low)</td>
<td>2.8 (1.4–5.5)</td>
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<td>Reduced motivation (high vs low)</td>
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<td>Reduced activity (high vs low)</td>
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<td>JCQ</td>
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<td>Skill discretion (high vs low)</td>
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