Evidently, during laryngoscopy and tracheal intubation, changing the anaesthetist’s chest level relative to the patient’s face by adjustment of operating table height is a troublesome task.

In our operating room, face-mask ventilation and subsequent laryngoscopic intubation are routinely performed by the anaesthetist sitting on a stool with adjustable height. Before anaesthesia, by adjusting the height of the stool, the patient’s face is initially placed at the level of the anaesthetist’s xiphoid process. During laryngoscopy and tracheal intubation, the height relation of anaesthetist’s chest with the patient’s face can be adjusted momentarily by changing the height of stool by the operator themself, as needed. Our experience suggests that dynamic optimization of the height relation between the anaesthetist’s chest and the patient’s face using an adjustable stool during tracheal intubation is an easy and rapid process.

**Declaration of interest**

None declared.

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**Teamwork in anaesthetics and critical care is possible**

Editor—Dr Brindley’s editorial reminds us of the importance of effective teamwork in anaesthesia and critical care, emphasising the value of crisis management. There are two points it is worthwhile adding. First, while crisis management is a central component of anaesthetic practice, not all mishaps and complications arise from a crisis. Surgical teams with ineffective communication and low levels of situational awareness have higher complication rates. Effective teamwork in anaesthetics and critical care extends beyond the heat of crises to the cooler but equally essential realm of routine care, as the current emphasis on checklists and debriefing demonstrates.

Second, there is encouraging research suggesting that targeted training in teamwork and communication may improve patient outcome. Multidisciplinary training programmes such as TeamSTEPPS have been shown to improve the performance of trauma teams, and in elective surgery to improve patient safety, reduce surgical complication rates, and possibly even reduce perioperative mortality. In this area it can be difficult to find meaningful endpoints and isolate secular trends. Nevertheless, there is emerging evidence that team training can improve hard clinical outcomes as well as measures of team performance. Given the likely benefits to patient safety, the emphasis should be on training entire multidisciplinary perioperative care teams rather than a single specialty or profession.

**Declaration of interest**

None declared.

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**Improving teamwork in anaesthesia and critical care: practical lessons to learn**

Editor—We read with interest the editorial by Brindley discussing the lessons to learn in teamwork training in anaesthesia and critical care. We believe that the challenge faced in the National Health Service perioperative setting is that we work in ‘pseudo’ teams. To create a high-performing team we must understand the reality of the multidisciplinary team, how human factors impact on their performance, and the nature of how the different disciplines work, interact, and train.

Collective multidisciplinary performance is often only valued in terms of efficiency, but to create real gain we must move this team from the potential of high performance to actual high performance where there is an ongoing
commitment to team development. The wider pseudoteam must have a shared concern for quality of care and patient outcomes and have systems to critically appraise their performance. The pseudoteam’s ‘shared mental model’ can be supported and developed to enhance practice in the five team work principles (communication, coordination, leadership, mutual support, and situation monitoring) that are key in effective teamwork.

In aviation, a higher level of operational standardisation is present. This aids the five teamwork principles where operational procedures cover both normal and abnormal situations. They also provide an operational shell and act as a form of impersonal leadership. The introduction of the World Health Organization checklist, crisis checklists, and emergency guidelines (e.g. advanced life support, unanticipated difficult intubation, etc.) has helped to develop a national shared mental model.

At a local level, we, a group of clinicians and educators at the Royal London Hospital (RLH), have developed MATCH (Multidisciplinary Action Training in Crises and Human Factors). This 1 day team-building programme introduces, demonstrates, and consolidates the five teamwork principles. Exemplary team behaviour is explored to promote mutual understanding of the three subteams (nursing, surgical and anaesthesia).

To aid communication, each team develops its own ‘bespoke’ briefing, sign-out, debriefing, and operational formats. Incident reporting is reinvigorated as teams are given the opportunity review their ‘own’ incidents over the previous 3 months. After-action review is introduced as a debriefing process whereby, after an event, a team can explore individual expectations, how they differed from the actual event, and what can be learned. Team members commit to changes and actions to improve teamwork and performance in the operating theatre. Resource folders are created by the teams during the day to support understanding and development. An engagement programme includes an educational seminar series that encourages involvement of the clinical and management teams.

This approach to improving teams, by understanding the culture of care, is endorsed by the reports of Francis, Berwick, and the NHS Never Events Taskforce. Increasing team morale coupled with team empowerment to innovate and educate will improve the culture of perioperative care.

The main lesson the NHS is still learning is that a team of experts is not necessarily an expert team, and our teams require practical development and a deeper understanding to perform as a highly effective team.

**Declaration of interest**

None declared.

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doi:10.1093/bja/aeu481

Re: Improving teamwork in anaesthesia and critical care: perhaps there really is no ‘I’ in ICU

**Reply from the authors**

Editor—I applaud the comments of Hunningher and colleagues and Ford regarding my editorial and their expertise. Attention to teamwork and its domains (communication, coordination, leadership, mutual support, and situational awareness) may benefit patients as much as any pharmacologic discovery or novel device. Their letters illustrate that, while many individuals can resuscitate, intubate, and pontificate, anaesthesia and critical care medicine (CCM) physicians should embrace making a ‘science of that team performance’, a ‘science of managing complexity’, and a ‘science of managing uncertainty’. Medical practice has traditionally argued whether it is best understood as ‘art’ or ‘science’; increasingly it is ‘engineering’, and we doctors are its ‘process safety engineers’.

None declared.