

Direct laryngoscopy is still a core skill. This is not a “DL is bad” argument. This is a default-setting argument.

If your goal is safer intubation in critically ill patients, first-pass success has to drive the decision. In the DEVICE trial, first-pass success was 85.1% with video laryngoscopy vs 70.8% with direct laryngoscopy (Prekker et al., 2023). That is a 14.3-point absolute difference. In airway management, that is not small.

The usual pushback is “we can predict difficult airways.” We cannot do that reliably enough. In INTUBE, complications occurred at meaningful rates in critically ill intubations across diverse settings, and risk escalated with repeated attempts (Russotto et al., 2021). So the practical reality is simple: if prediction is imperfect, your default needs to be robust when attempt one matters most.

And attempt one does matter most. With additional attempts, adverse events increase, including hypoxemia, hemodynamic instability, and esophageal intubation risk (Russotto et al., 2021). That is why first-pass success is a patient safety metric, not just a performance stat.

Training is another reason this matters. With DL, the trainee sees the view and the attending often does not. Feedback is delayed. With VL, both see the airway in real time. Coaching improves immediately. Adoption data has shown this pattern before: early resistance, then support after exposure and routine use (Cook and Kelly, 2017; Ahmad et al., 2026).

The DL-skills objection is legitimate. You still need DL for specific scenarios: heavy contamination, equipment failure, and select anatomy. The right answer is not “abandon DL.” The right answer is “default to VL where evidence supports it, and deliberately preserve DL proficiency.” Even recent guidance flags perceived DL skill loss as a major adoption barrier (Ahmad et al., 2026).

There is also a measurement caveat. “First-pass success” is not defined identically everywhere. When definitions include stricter tube-delivery criteria, reported rates can drop by about five points (Trent et al., 2023). That should make us careful with cross-site comparisons, not dismissive of the overall signal.

Bottom line: standards should move when evidence moves. Macintosh laryngoscopy was a major advance. It still has a role. But if we are serious about safety in ICU, ED, and resource-constrained environments, we should stop treating legacy default as sacred and start treating first-pass success as the primary endpoint (Prekker et al., 2023; Russotto et al., 2021).

References

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