In this issue of *JECT*, Charrière et al. (1) report the results of the fourth retrospective perfusion safety survey since Stoney et al. (2) and Kurusz et al. (3) published their survey results in 1980 and 1986, respectively. As a bonus in this issue, Mark Kurusz comments (4) on Charrière’s article and their “carefully collected data.”

Searching the keyword “survey” in the *JECT* article database yields seven publications reporting retrospective results in the areas of education, safety, research, pediatrics, extracorporeal membrane oxygenation (ECMO), equipment, and devices. Only one safety-related survey (5) has been published in *JECT* prior to this issue.

In 1987, Romana Schabel, a student at Oakland University’s perfusion education program, worked with several of her clinical instructors (who were PSICOR, Inc., clinicians) to author preventive and corrective actions for the most commonly identified perfusion problems at the time (6). Ms. Schabel and her coauthors built on the sentinel survey work of Stoney and Kurusz, and their coworkers. And, isn’t it regretful that we have not yet eliminated the majority of these perfusion problems today?

Schabel’s article supplements an early gap in the pre-2000 *JECT* body of knowledge regarding safety survey results. The authors of this issue’s classic article leveraged PSICOR’s corporate policies and procedures to share their approach to preparing for and avoiding high-probability clinical perfusion problems. Schabel’s team moved beyond just counting clinical incidents to planning how to decrease the occurrence of the events.

Considering today’s environment and desire to reduce medical errors, Schabel and her coworkers were ahead of their time. Considering perfusionists are still experiencing some of these problems in our modern practice . . . there is still more work to be done. Reviewing our classic article is a reminder of how to apply survey information and good patient care department team behaviors (quality meetings, incident-reporting, checklists, etc.) to avoid and be prepared for possible perfusion incidents.

Schabel’s Figure 1 is an early perfusion team model for applying today’s accepted failure mode and effect analysis, human factors analysis and Six-Sigma process improvement strategies from defining problems to monitoring the success of protocol changes (7,8).

The time for prospective reporting of perfusion incidents is here. Despite Charrière’s good and timely work, there is little reason to ever publish another retrospective perfusion incident survey. All perfusion safety surveys should be prospective. Perfusion teams should have protocols in place to electronically capture equipment and patient-related incidents and events—then retrospective surveys would not be needed.

The Society of Thoracic Surgeons just posted their Cardiothoracic Safety Reporting System (http://ctrs.ctsnet.org/) where The Cardiothoracic Surgery Network (CTSNet) members may contribute an incident vignette so that others may learn with the goal to improve outcomes. The Australian and New Zealand College of Perfusionists supports a prospective perfusion incident reporting system based on the work described by Jenkins, et al. (9) and described by Baker and Wilcox (10). A national contract group (11) and study groups like the Northern New England Cardiovascular Disease Study Group have successfully designed prospective reporting systems (12). The International Consortium for Evidence-Based Perfusion (13) and AmSECT know that U.S. perfusionists should be participating in a prospective incident reporting database.

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Conflict Statement: Mr. Riley served as Director of Quality and Education at PSICOR, Inc. and was editor of JECT when this article was published. PSICOR, Inc. was a co-sponsoring institution for the Oakland University perfusion education program.
The next multi-institutional national perfusion safety survey results we read in *JECT* should come from cardiac surgery teams participating in a prospective incident reporting system and employing Six-Sigma process improvement activities such as those described twenty years ago by Schabel and her coworkers.

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**REFERENCE**