From the Editor
Observation and Participation

Every 10 years, since 1790, the US government has conducted a census of every living person in the United States. The government is gearing up to launch this decade’s survey on April 1, 2010. A survey of inhabitants of the United States is mandated by the US Constitution and is used to make critical decisions about the distribution of community services, the distribution of Congressional seats, and how $300 billion in federal funds will be spent. Perfusionists seem to have a real affinity for surveys. Updated perfusion practice surveys appear in the literature every two to three years, not by constitutional mandate, desire for recognition or funding, but merely a product of the curiosity of perfusionists.

In this issue of the Journal, we are pleased to feature two surveys: one related cardiopulmonary bypass practices in Australia and New Zealand (1) and one related to extracorporeal life support practices in North America (2). Surveys provide a snapshot of practice at the time they are administered. What should we do with these reports? With this knowledge, we can certainly reflect on our own practice and perhaps make some inferences—are we innovators, early adopters, mainstream, or are we still among those embracing the traditional approach to clinical care? Should the findings be an impetus to change? Consensus does not constitute a foundation for change; rather, these reports provide some sense of the extent to which new technology and new management strategies are being adopted into clinical practice. Given our (normal human) resistance to change, trends in practice typically lag behind the published evidence by an average of seventeen years! However, there are a few exceptions, the report by Brown and colleagues (3), with an accompanying commentary by Hillary Grocott (4), identifies a case of clinical practice getting ahead of science. Use of aprotinin had skyrocketed from 2001 to 2006; it was thought than this drug conferred many benefits, including a reduction in inflammation. This current meta-analysis shows otherwise; the rest of the story is history.

Also in this issue, the report by Wiegmann and colleagues (5) from the Mayo Clinic provides a view of cardiopulmonary bypass from an important perspective. Although most studies focus on the foreign surface–blood interaction, their work focuses on the human–mechanical interaction between clinician and the heart-lung machine, an interface that is equally ubiquitous, far more complex, and far less reliable. They carefully explore the suboptimal attributes of this interface and likewise expose our penchant to “adapt to” rather than “to discard and redesign.” Lack of clarity in communication between surgeons and perfusionists and coordination issues were frequently observed during the study. Strikingly similar, failed communication is described by Malcom Gladwell in his recent book Outliers (6). Gladwell describes the failed communication that may occur between members of an airline crew and the airport tower, a type of failed communication he refers to as “mitigated speech.” Mitigated speech occurs when one downplays or sugarcoats the meaning of what is taking place. Example: “Doctor, I am having a little trouble maintaining the blood pressure,” rather than say, “Please put down the heart, the mean arterial pressure is 25 millimeters of mercury!” What prompts this type of communication? It happens when one is trying to be polite, when one feels intimidated, ashamed, or embarrassed, and when one is being deferential to authority. Mitigated speech is a failure to engage; it is observation without participation.

In 1993, Kevin Carter, a South African photojournalist, trained the lens of his camera on a starving child being stalked by a vulture as the child edged his way toward a food distribution center in southern Sudan. For >20 minutes, Carter inched his way toward the scene, hoping that the vulture would spread its wings. He patiently waited for the precise angle and optimal lighting before capturing the image. He subsequently sold the photograph to The New York Times. The Times ran the photo on March 26, 1993 (7). This striking image got a lot of attention from readers, who contacted the paper, inquiring about the ultimate fate of the child. The photographer had made no attempt to help the child, nor did he follow up to learn of the child’s fate. The photo won the Pulitzer Prize for photojournalism on April 12, 1994. Along with this notoriety, Kevin Carter received harsh and intense criticism. Some described him as an opportunist, no better than the vulture. Like Carter, we too are likely to be judged harshly by future generations for our inactions.

Healthcare is a high stakes industry; reducing the risk for patients involves both observation and participation. We are indebted to the contributors to this issue of the Journal. They have provided us with perspective that requires of us, in the very least, to be mindfully reflective of our work. As Grocott has stated, we must “be prepared to change our mind.”

Robert C. Groom, MS, CCP
Editor-in-Chief

REFERENCES