The 1999 Presidential Address
Burn Care in the 21st Century: Present Needs and Future Solutions

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Welcome to the 31st Annual Meeting of the American Burn Association. This is the first general session of this year’s meeting and the first opportunity for the entire membership and guests to meet together. As President, I have two responsibilities at this time. One is to deliver the President’s Address, which has varied through the years from very personal autobiographies to erudite scientific treatises. My second duty during this session is to recognize, by the Association’s most prestigious awards, the true giants of American burn care. In addition, the winner of the Burn Prevention Poster Contest and the Westaim Fellowship Award will be announced. Finally, we have a special presentation for Dr. Charles R. Baxter, to whom this meeting is dedicated.

These next 90 minutes will be full. To begin with, I would like to thank the Association. Being elected as your President is the biggest honor of my professional life. I deeply appreciate all of your support and kind words during my membership in the ABA. Many people are responsible, for better or worse, for my standing before you today, and they have had major influences on my career. Because time is short, I will recognize just a few of the many appreciated persons whom I have encountered in my life. My most influential mentor has been Dr. Basit A. Pruitt, Jr., whom I first encountered when I was a partially trained surgical resident at the US Army Institute of Surgical Research Burn Center in 1972. Because of Dr. Pruitt and his Institute, I am a burn and trauma surgeon today and not a cardiothoracic surgeon. Next, I would like to thank my two partners during my civilian phase, Dr. Michael Madden and Dr. Jerry Finkelstein. They introduced, I think successfully, this North Carolinian from a small farm town to the city of New York. My 12 years in this most unique of cities were like living here in Disney World—every day was a “Tomorrow Land.” Our partnership was focused on and dedicated to the New York Hospital Burn Center where we worked, and I offer special thanks to its staff and patients. I also want to give a special “thank you” to my staff at the Institute of Surgical Research; they are true professionals in every sense of the word and have always supported me 100%. Finally, I thank my family: my wife, Susan; my daughter, Claire; my son, Brian; and my parents. Many past Presidents have thanked, in jest, their long-suffering spouses, but in fact, most of us reached this podium by frequently placing family second to the job. What’s worse, we were having the time of our lives.

The responsibility for coming up with a presidential address is a difficult one, at least for me. The two addresses I most remember, even today, were made by Dr. Gil Ward in 1989 and Dr. Glenn Warden in 1993. Both were extremely personal and reflected the role of burn centers and the professional fulfillment that comes from taking care of our special patients. So, with the year 2000 just about here and an entire millennium about to begin, I have chosen to reflect on our current situation and to offer new directions that I feel this American Burn Association should pursue. Susan has told me that I sound like a preacher, so I will also use a few accompanying slides to offset any over-seriousness.

So, where are we? Fifteen years ago, Paul Starr wrote a book entitled The Social Transformation of American Medicine. Because I was taking several public health courses at the time, I read the book. To me, Starr’s future of medicine was awful and, anyway,
had no chance of happening. Well, it did happen, and today we have managed care. At one pole, medical care has been commodified, and the Secretary of Health and Human Services is offering our patients bounties to turn us in to the authorities. At the other pole, we have unique opportunities to improve the efficiency and precision of our professional activities. Our health care delivery system is transforming from the model of disease treatment to that of preventive medicine and wellness, but we must not forget the injured and our responsibility to practice ethically and competently. The ABA is in a unique position to expose that which doesn’t work and to provide solutions for what must work in this new millennium of burn care. Since I have been an officer of the ABA, I have found a low-grade sense of turmoil and confusion about where the Association should go and what it should be. I have suggestions for the former, but no answer for the latter.

A major casualty of managed care and its emphasis on hospital profit centers is the decline of research dollars in the department of surgery of teaching hospitals. Burn injury quintessentially is a surgical disease, and most physicians and investigators in the burn community have been supported by departmental surgical research funds. With the exception of the Shriners Burns Institutes, the Army Institute of Surgical Research, and a very small number of major university programs, financial support for burn research has dried up. Even in my own institute, funding for burn research has the lowest priority of casualty care needs for injured soldiers. The young researchers of all professional disciplines, potentially hoping for a career in burn care and burn research, will be our biggest loss.

The American Burn Association should be a major funder of burn research and young investigators. For years, the International Association of Fire Fighters has provided seed grants to dozens of investigators, totaling more than 1 million dollars. On behalf of the Association, I sincerely thank them for their support. Nowadays, however, the cost of research has escalated as the initial startup of a new laboratory now approaches 6 figures. Our past President, Dr Andy Munster, has recruited the Westaim Company to endorse an annual fellowship that provides significant funding for a young investigator, and the first recipient will be presented to you after I finish my sermon. A solution I would like to propose to all of you is the creation of a foundation: the American Burn Association Research and Education Foundation, if you will. The ABA central office and the Board of Trustees have begun to discuss this issue.

Currently our consensus is that a foundation for the ABA offers no special tax advantage given our present financial situation; however, if we are to increase the impact the ABA will have on the practice of burn care and innovative research, I would propose that we expand our vision and develop an aggressive fund-raising effort. This, I feel, is best worked out within the framework of a charitable foundation. One of our fellow and sister organizations, the American Association for the Surgery of Trauma, created a foundation several years ago and is now screening contracts from professional fund-raising organizations. If the ABA decides to pursue a similar course, we all must recognize that it will require a real commitment by us. With the possibility of receiving several million dollars in a successful campaign, the up-front commitment from us can reach the 6-figure range.

Another casualty of managed care is the institutional commitment to the burn team and the burn center. The conversion of the burn center from a cost center to a profit center has generated reductions in staff and services. Long-term follow-up and rehabilitation services are limited to just a very few discharge visits for a disease process that can extend for years—even decades—after the original acute injury. Fewer nurses are left to take care of an increasing proportion of sicker patients. Skill requirements and professional expertise have been ratcheted down to nonlicensed positions with creative titles; unfortunately, the liability and accountability is removed at the top. The ABA offers the tools to maintain our traditional high level of patient care—namely burn center verification and rules-directed practice with monitored outcomes.

I call on every burn center to seek verification under our formal program through the American College of Surgeons Committee on Trauma. The ABA Burn Center Verification is relatively new for us; only a minority of burn centers has been verified, and several are now undergoing the re-verification process. Verification of a level 1 trauma center for the American College of Surgeons Committee on Trauma is accepted by the Joint Commission for the Accreditation of Health Care Organizations as successful proxy compliance for its accreditation surveys. We in the ABA should strive to put our verification process on the same level. This will require general acceptance by the majority of burn centers and a solid track record of fairness and strict compliance with verification requirements; it will also require many of you to participate as site examiners.

The verification standard must undergo continu-
toring burn center performance internally but also comparing individual outcomes to national trends.

The next major area in which the American Burn Association should actively participate is our nation’s emergency preparedness plans. The need focuses most cogently on weapons of mass destruction. Should fighting have taken place in Kuwait and Iraq’s major cities, the number of civilian burn injuries would have dwarfed the number of military injuries. At that time, under Dr Pruitt at the Army burn center and Dr Tony Meyer, the chairman of the ABA Regionalization Committee, all of the ABA burn centers were organized into a nationwide network, and it was agreed at the hospital chief executive officer level that the ABA would provide the needed burn center beds should the direst military predictions come true. Fortunately, casualties were light and these resources were not needed. Undoubtedly the ABA will be called upon again to provide such services, and the ABA must be ready to respond; we must participate with the Federal Emergency Management Agency and with local and regional planning efforts. As you know, the President and Congress have recently appropriated major funding, and they have mandated the development of all infrastructures to manage incidents of mass civilian casualties. The Plenary Session this afternoon, “Managing Burns in Mass Casualties,” will begin to define for the membership where we fit in this infrastructure. Without question the ABA regional chairpersons will be assigned added responsibilities in this area. Such activities should increase requests for the Advanced Burn Life Support (ABLS) courses. The military already has become a major user of ABLS as it reengineers its response planning for mass casualty incidents.

Overall the incidence of hospitalizable burn injuries is decreasing, and together with more efficient use of available facilities, burn center censuses will be decreasing. The burn center remains the most expert location for managing acute skin and soft tissue maladies requiring meticulous wound care, often in the presence of major organ dysfunction and the need for critical care support. The ABA needs to review its guidelines and mission and encourage the use of burn centers for such new diseases as toxic epidermal necrolysis, necrotizing fasciitis, staphylococcal scalded skin syndrome, and massive abrasion and degloving injuries; all require surgical expertise and intensive wound care, ideally treated in the burn center, as do all severe diseases and injuries. Continuity of care offers the best opportunity for clinical success, and the burn team is uniquely suited to treat these individuals.
Now that I have proposed several new paths that we might begin to pursue in the 21st century, I ask the question: "What will the ABA look like in the new century?" When the American Burn Association was formed in 1967, it was primarily a surgeons' organization. But even at that time, from reviewing old programs, other scientific and clinical disciplines were included in the program. The bylaws provided that only physicians were eligible for membership and election to office. With time, new categories of membership were incorporated, but the bylaws maintained "physician only officers." I should point out to the nonsurgeons in the audience that this arrangement—a multidisciplinary society—allowed the ABA to be a member of the Board of Governors of the American College of Surgeons. This representation, along with the prestige of your representatives over the years, has maintained the visibility of burn treatment as a major branch of trauma, general surgery, and surgical critical care. As Gil Ward indicated in his Presidential address, the "burn busters" had made it to the big time. Actually, what he really said (to paraphrase) was something to the effect that burn care no longer took breast milk from the least desirable position.

At any rate, during the past 15 years especially, the ABA has evolved into a true multidisciplinary organization—a real team. Associate members are now regular members and entitled to all of the privileges of regular membership, including the opportunity to hold office. The American Burn Association membership beneath the surface has—and at the best—been trying to decide if or where to propose a non-surgeon for the elected officer positions that proceed to the Presidency.

This is not a trivial issue for us, because our choices will determine the direction the ABA takes into the next millennium. Clearly we will not be a single specialty professional organization like the American Association for the Surgery of Trauma or the American College of Surgeons. Would we become more like the American Cancer Society or the American Trauma Society, whose memberships include large proportions of lay members and whose focus is primarily on fund-raising? I think I can confidently say that most ABA members would feel out of place. What then? The American Heart Association is one potentially usable model. It raises funds, but it also generates practice guidelines, education, and training. Its annual scientific meeting is one of the most prestigious in its field.

I don't have an answer about our future, and ultimately our structure will be determined by the votes of the members. While it is tempting to take the coward's way out and to offer no personal opinion, I can't resist my last opportunity to offer my own observations based on 25 years of membership. The burn center, at least as we know it, remains tied to the burn center director. This is not to diminish the roles of nursing, rehabilitation, and the other disciplines. Their importance to the multidisciplinary team is illustrated by the equally important questions about our future. Should burn surgery lose its place and recognition with our parent professional organization, the time and costs for attending our annual meetings may lose priority. Whatever direction the ABA takes, I urge all of our physician members to maintain active roles in the organization. I think a burn-surgeon-led ABA represents the model for the ABA in the next century; however, I cannot hide the fact that a recent survey of burn center directors and associate directors reveals that 72 surgeons are not even members of the American Burn Association.

To close, I point out that a successful ABA will be very busy in the years to come. Summarizing my previous comments, I urge you to vigorously adopt the verification process; to participate in the TRACS® registry; to provide direction and support for practice guidelines and outcomes research; and to participate actively in our national emergency preparedness planning. All of this will require funding, and my solution is an ABA Foundation and a formal fund-raising effort. And finally, join and participate. Send your papers to the Journal of Burn Care & Rehabilitation, attend your regional meetings, and teach an ABLS Course. Whatever we look like 10 years from now, I am confident that the ABA will represent humane and state-of-the-art burn care.

REFERENCE