I would like to personally welcome all of you to the opening session of the 43rd annual meeting of the American Burn Association (ABA). This has been an exciting year of challenges, opportunities, and advancements. During the past year we have

- rewritten our Association’s by-laws,
- established the opportunity for long-term funding of our Department of Defense/ABA research by adding a line item to the Defense Appropriations budget for burn research,
- reached out to the American College of Surgeons Committee on Trauma (COT) with the establishment within the COT of a burn section,
- reopened meaningful discussions with Homeland Security on the needs of burn disaster planning and our joint concerns for true disaster planning, and
- expanded outreach partnerships through the International Relations Committee with a first effort of working with Operation Smile to add burn resources and Advanced Burn Life Support courses to their overseas trips.

Last fall I had the opportunity to visit the five regional burn meetings—the Eastern Great Lakes Regional Burn Meeting in Cincinnati, the Western Regional Burn Meeting in San Francisco, the Midwest Regional Burn Meeting in Madison, the Northeast Regional Meeting in Providence, and the Southern Regional Burn Conference in Memphis. Each has its own unique flavor and approach to providing an opportunity for scientific discussion and collegial networking. All allowed time for intellectual and social interaction which only a small meeting can accomplish. Most of these meetings lasted a day and a half to two days, and many were within driving distance of the represented burn centers.

Eight hundred sixty-one individuals attended these sessions (Figure 1). Forty-two percent were nurses, 19% were physicians, and 39% were other members of the burn team (Figure 2). For many people, this was their first opportunity to present before an audience outside their own institution. For others, it was their first time to attend a burn meeting. For some, it was an opportunity to present a paper in anticipation of having it accepted at the annual meeting of the ABA. I’m sure that the input of the attendees at the regional meetings was quite valuable to the authors. All sessions allowed ample opportunity for discussion of the papers presented.

The regional meetings held closer to home and for a shorter period of time than the annual meeting of the ABA allow for more members of the burn teams to attend a burn-specific continuing education conference and time to network with other burn centers. These regional meetings have taken on more importance during these hard financial times and have the full support of the Board of Trustees and the Central Office. Although they will never replace the annual meeting of the ABA for breadth and depth of offerings, in these days of tight budget restraints, regional meetings offer an opportunity to many who cannot or would not be able to afford 4 or 5 days off work with the accompanying travel and lodging expenses. I would strongly encourage those of you who do not live in areas serviced by these five regional meetings to consider either joining one of them or starting your own. The ABA staff and Board of Trustees support these regional meetings and stand ready to help in any way possible in expanding this educational opportunity to more of our membership.

One of the themes I have touched on at the regional meetings is the obligation of membership. A first step is the recognition of those new members and first-time attendees of this ABA annual meeting. For this opening session, the first several rows of the auditorium are reserved for members of the Board of
Trustees, past presidents, staff, and their spouses. Usually, new members hide in the back few rows. This year I am starting a “new” tradition. We have reserved the next several rows of the auditorium for new members and first-time attendees. You should know who you are by the orange and aqua ribbons on your name tag. I would like to ask all new members and first-time attendees to stand and be recognized. An obligation of membership is serving on ABA committees. I ask all of our members to get involved in the committee structure of the ABA.

We have an obligation as members to serve and promote our chosen profession, burn care. Not only does this include advancing our own personal education and encouraging new staff members to become involved in the ABA, but it is important to know our history and contributions not only to burn care but also to the general medical community.

Zora Janzekovic (Figure 3), who is this year’s Special Achievement Award winner, wrote an article published in the *Journal of Plastic, Reconstructive & Aesthetic Surgery* 3 years ago in which she made the following comments about her start in Burn Surgery and Medicine in the 1960s¹:

> “Once upon a time—that’s how a fairy tale usually begins. Today’s fairy tale, however, is about the Cinderella of surgery, the burn. Far too long it was excluded from the program of surgical management of injuries. Relinquished to spontaneous healing, which was the domain of dermatologists, it only found its way to the operating table in the final phase that required the covering of the resulting defects.

> The horrible suffering of burn patients, the
helplessness of therapists and medical science—they were all the consequence of a firmly established way of thinking about the nature and the value of spontaneous healing of burn wounds. But sooner or later, changes had to occur."

Well as they say, you’ve come a long way baby. Modern burn surgery is taking its place as a recognized specialty, and it is important for each of us to fully appreciate the contributions that have been made to our burn patients and to the greater medical community over the years by our predecessors to properly promote our specialty and to encourage the next generation of burn care givers.

The history of modern burn resuscitation can be traced back to observations made after large urban fires at the Rialto Theatre in New Haven, Connecticut, in 1921 and the Cocoanut Grove nightclub in Boston, Massachusetts, in 1942. Reading the Official Fire Marshall’s report of the Cocoanut Grove fire is very interesting. On November 28, 1942, a huge fire occurred at the Cocoanut Grove Night Club in Boston. 492 people perished in total. The Cocoanut Grove was originally a speakeasy—an illegal bar during alcohol Prohibition—and some of its doors were bricked up or bolted shut. The main entrance to the club was only a revolving door. There were flammable decorations throughout the building including cloth drapery and paper palm trees. The club had a licensed capacity of 500, and on the night of the fire there were about 1000 people in the building. All of the above contributed to the tragedy.

From the commissioner’s report:

"From all the evidence before me I am unable to determine the original cause or causes of this fire. I find no evidence of incendiariam. A bus boy, aged sixteen, employed by the Cocoanut Grove on the night of the fire, testified to lighting a match in the process of replacing an electric light bulb in the corner of the Melody Lounge, where the fire started, and dropping the match to the floor and stepping upon it. After a careful study of all the evidence, and an analysis of all the facts presented before me, I am unable to find the conduct of this boy was the cause of the fire. I have investigated and carefully considered, as possible causes of the fire, the following suggested possibilities: alcoholic fumes, inflammable insecticides, motion picture film scraps, electrical wiring, gasoline or fuel oil fumes, refrigerant gases, flame-proofing chemicals. There is no evidence before me to support a finding that any of these or any combination of them caused this fire. Many people died trying to exit through the revolving door—pushing from both sides and preventing escape. Some diners in the restaurant never even had a chance to leave their seats, having been asphyxiated by smoke and toxic gases. This fire will be entered in the records of this department as being of unknown origin."

This official report absolved any single individual but did identify a number of building code violations that contributed to the deaths such as the locked doors at the top of stairwells (Figure 4). The report suggests that the gases and carbon monoxide from the incomplete burning wood, film, decorations, and paper products resulted in the large number of deaths. Unfortunately, similar findings were made in the Beverly Hills Country Club fire in 1977 and the MGM fire in 1980. Our goal is to prevent such catastrophes in the future.

At that time, physicians noted that some patients with large burns survived the event but died from shock in the observation periods. Underhill identified the concept of thermal injury-induced intravascular fluid deficits in the 1930s and 1940s, and Evans soon followed with the earliest fluid resuscitation formulas and works in a number of areas of burn care during the 1940s and 1950s. Before these advances, burns covering as little as 10 to 20% of TBSA were associated with high rates of mortality.

The next significant step in the development of burn surgery came in the late 60s when a number of burn surgeons came together to form the ABA. The ABA was founded in 1967, following a series of national burn

Figure 4. Locked door at the stairway of basement in Cocoanut Grove nightclub fire.
seminars sponsored by leading institutions in the field of burn treatment. Since its inception, the Association has been dedicated to stimulating and supporting burn-related research, education, care, rehabilitation, and prevention. To advance these goals, the ABA sponsors educational programs, fellowships, research, teaching, and publications, including the leading peer-reviewed, scientific journal in the burn field, the *Journal of Burn Care and Research.*

These founders wanted to establish an inclusive society of surgeons, nurses, dietitians, therapists, and researchers dedicated to improving the care of the burned patient. This team concept is at the core of burn care and the ABA. I would venture to say that in most of your hospitals, the only truly functional multidisciplinary health care team remains the burn team. From small annual meetings with one or two sessions, one clinical and the other research, the annual meeting of the ABA expanded. Additional sessions were added over the years until we reached our current format of breakfast sessions, correlative sessions of a number of topics, plenary and special presentation with more than 1000 attendees, and extensive commercial and scientific exhibits.

In the early 70s, bleeding stress gastritis was almost a weekly topic of debate at surgical Morbidity and Mortality conferences. Should the patient have a vagotony and antrectomy or was the stomach an end organ of stress requiring near-total or total gastrectomy? From within the burn community came the concept that 3 L of sugar water was not a satisfactory nutritional support of these critically injured patients, and with improved and appropriate nutritional support, the incidence of bleeding stress ulcers has almost disappeared. Most believe now that this stress gastritis was a result of the loss of the gastric mucosa barrier as a result of malnutrition in the intensive care unit. Nutritional support of the burn patient was an early wide area of active research in the burn community, and many from within the burn community were founders of the American Society of Enteral and Parenteral Nutrition (ASPEN).

John Burke of Boston was a visiting professor at my surgical residency program in the early 70s and he spoke of the development at the Massachusetts General Hospital and Massachusetts Institute of Technology of an artificial skin. Although many of the glowing projections of an off-the-shelf skin replacement were not met, this bilaminate artificial skin substitute continues to be quite beneficial in selected patients and with selected sites. The hunt goes on with the development of dermal replacements, cultured keratinocytes, and new application process including the “skin gun” which recently went viral on the Internet and “stem cell generators” which are currently in clinical trials.

The standard of care for burn patients in the 1950s and 1960s was to allow the eschar to separate by bacterial lysis of the necrotic base of the eschar resulting in the terrible smell of burn centers and the high mortality rates. Burn clinicians developed topical antibiotics from silver sulfadiazine cream to the plethora of silver-impregnated products currently on the market to protect against infection in multiple forms. The establishment of early excision of the burn wound was championed by Dr. Janzekovic and has led to shorter hospital stays and better functional outcomes. Long-wear silver-containing wound products have also allowed for earlier discharge and a move to wider outpatient care of the burn patients. Many of these products can be left in place for 7 to 10 days and have made more widespread ambulatory care possible.

During the 1950s, at a time when there were 19 Shriners orthopedic hospitals, Shriners found themselves able to provide additional services. They became aware of the lack of medical help for the thousands of children who are disfigured or killed by severe burns. In the mid-1960s, 40 years after opening its first orthopedic hospital, the Shrine opened three hospitals specializing in burn care, each with a threefold mission: helping children, conducting burn research, and training medical personnel in the treatment of burns. These Shrine Hospitals for Burn Children have provided an enormous amount of excellent burn care while advancing the science of burn medicine and surgery. Early and vigorous physical and occupational therapy and nutritional support have had remarkable results in improving survival rates and decreasing length of stay for these, some of the most challenging patients to care for. I believe it is important for all of us to help ensure that the next generation of team members will be there by knowing and telling our story.

As this year marks the 10th anniversary of the lethal attack on the twin towers in New York, it became quite clear during my visits to the regional meetings that many local communities and several regions have put a large amount of time and effort into developing burn surge plans. Regional planning is authorized under Section 319C-1 of the Public Health Service Act which requires states to plan for the provision of care to burn patients based on a population ratio of 50 patients per million population. With approximately 125 burn centers in the United States with an average capacity of 10 beds, nationally we only have about 1250 specialized burn beds. The American College of Surgeons in its excellent Disaster Management Course for Surgeons has incorporated the burn triage protocol developed by Past President Saffle. The next major event, when it occurs, will...
involve physical trauma and burns. We, the burn community, will need to rely on our trauma colleagues for initial evaluation and stabilization of the massive numbers of burn patients that might result. Any burn center required to care for hundreds of new burn victims will itself become a disaster. Triage at the scene will be needed to distribute this large number of patients to trauma hospitals for delayed secondary triage 48 to 72 hours after the event.

Eventually, distribution of these patients to several burn centers will be required so that no one center is overwhelmed and becomes a nonfunctioning disaster itself. At this year’s ABA National Leadership Conference, meaningful dialog was started between the ABA and the Department of Homeland Security toward a joint public-private partnership between the ABA central office which can provide communication and decision making regarding the distribution of these victims with the U.S. military providing the transportation. These conversations have continued with the recently held conference cosponsored by the American College of Surgeons and the National Disaster Medical System (NDMS) entitled “Improving US Specialty Care of Mass Disasters” at which the concept of establishing Multi-specialty Enhancement Teams (MSET) composed of groups of specialists who will be needed during national disasters was introduced.

Our closer association with the American College of Surgeons’ Committee on Trauma will provide a better opportunity to dialog with trauma leadership and open the door for effective disaster management planning and cooperation. Over the next year or so, this public-private partnership between the ABA, the COT, and the Federal government should become more firmly functional. Homeland Security and the leadership of NDMS fully understand the very limited nature of the burn community and appreciate the need for vigorous burn surge planning which includes all community resources. Issues such as care across state lines, tracking of patients and their transportation, and the proper positioning of resources need to be addressed. Scene triage, proper communication, and evaluation of the needs and distribution of burn patients to a number of burn centers will be necessary for optimal results for both the patients and the burn centers. Instead of the chaotic response we saw with the Haiti earthquake, a thoughtfully executed program must be in place. We cannot afford for a single burn center to become overloaded and to be taken out of operation and unable to continue to provide care to its local community. Patients must be distributed to a number of burn centers to avoid overloading of any one center and to allow for normal daily functioning of the burn center as the disaster is dealt with.

This has been a wonderful year and I wish to thank all members of the Board of Trustees and our many committees for their hard work on behalf of the organization and in particular those who put this year’s program together and the ABA staff for their many hours of planning. Much of what has been accomplished would not have occurred without the strong support of our Central Office staff who are the most dedicated and hardworking group of people I’ve ever had the honor to work with.

Personally, I have my partners and mentors to thank. Dr. Robert Finley was my surgical program director and the individual who started the burn program in Dayton, Ohio, although I must admit that when I joined him in practice after my Air Force service he told me that he and one nurse would provide the care for the few dozen burn patients admitted annually and that I would not have to become involved in their care. Over 30 years later and under his leadership for most of that time, the program grew from a few specialized beds to a four million dollar plus verified burn center admitting several hundred patients per year. Partners in Dayton included Drs. Larry Jones, Kevin Bailey, and Mike Johnson. The move from Dayton to Columbus was an opportunity to start from scratch and build a verified program where none existed. My associates in Columbus, Dr. Brian Porshinsky, Becky Coffey our Burn Center nurse practitioner, and the members of my Division of Critical Care, Trauma and Burn have been most supportive covering the home front while I have been busy with other duties. Although she was unable to make the trip, I also need to thank my administrative assistant of the past 15 years, Jackie Brown. Most important, my family who suffered through all the years of Dad being gone, the well-trained grandchildren, and my wife, Babs, of 44 years, without whose support, advice, counsel, home-making, and love, I would have been lost long ago. Thank you.

ACKNOWLEDGMENTS

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REFERENCES

2. Reilly WA (Fire Commissioner, City of Boston). Excerpts from “Report Concerning the Cocoanut Grove Fire, November 28, 1942.”