Presenting to you today is a highlight of my life, but it’s also pretty intimidating, because I know how hard it can be to interest an audience as diverse as you are. I am not like other presidents for whom this office was merely a stepping stone to more exalted honors. I’m stuck as a burn doctor; and this—probably fortunately—will be my only chance to speak my mind.

I will begin by saying that I was initially drawn to surgery by the remarkable and unforgettable people I encountered and the amazing things they said. One quote has been especially important in my subsequent career, and so I’ve entitled my talk today “N.P.D.G.B., and Other Surgical Sayings.” I also want to use this presentation to recognize some friends who have helped me and some people who are important to this association. I know this is risky, because I’m sure I’ll forget someone. So I will ask for your understanding if I leave you out. My list is not a complete one.

First is my only living relative—that I will admit to, anyway—my brother, Michael. He was my first and continues to be my most enduring role model. Growing up was far easier with him breaking trail; growing old is a lot less unpleasant knowing he’ll be with me, and he means more to me with every passing year. People say we look alike—which I have never understood—but I do have one request. If you encounter at this meeting a short, chubby, bearded, middle-aged man who looks at you without recognition and answers you unintelligibly, that will be me. If you should encounter Michael, please be nice to him. Mike is a stranger in our very strange land.

A Russian proverb says that “to marry well is half of life.” I believe I married superbly. My beloved Susan is my friend and companion on every adventure and a totally loyal—sometimes my only—supporter. On more occasions than I can count, I have arrived home at the end of the day disappointed, stressed out, and ready to quit, and by the next morning, through her magic, she has restored me. Whereupon she sends me back out into the world, filled with fresh, hot air, shirt newly stuffed, for another day of jousting with windmills.

There are lots of memorable sayings about surgery. I like to remind my residents that “surgery is no profession for a gentleman,” which is attributed to William Osler. Or that “a good set of bowels is worth more to a man than any quantity of brains.” With advancing age, I realize the truth of that statement.

As a surgical resident, I was advised that “if it ain’t broke, don’t fix it,” and frequently told that “all bleeding stops.” And it does. Surgeons, of course, believe that “a chance to cut is a chance to cure,” but you should also remember another Osler-ism: “When all else fails, examine the patient.” There are lots of other popular sayings, and many of them—most of them, actually—are too vulgar to quote in this dignified assembly. But if you’re interested, talk to me later.

I met Dr. Glenn Warden in 1976, when I was a green intern. I thought that he was the best surgeon I ever saw, and my career decision derived from a pathetic ambition to be just like him which, fortunately for both of us, failed. Glenn told me that “you can learn 90% of burn care in six months, and it takes the rest of your life to learn the other 10%.” I believe that’s true. At present, I think I’m up to about 91%.

Another favorite person has been Dr. Alan Dimick, who—along with Dr. Jordan—has been my guardian angel and have subjected me to many unwarranted acts of kindness. Like Alan himself, his favorite quotation is unpretentious and homespun and devastatingly accurate: “The problem with young turks is that
they turn into old turkeys.” A major satisfaction in using it is that it gives me an opportunity to show all of you a picture of him.

But the most memorable thing I ever heard in surgery was in 1982, when I was a traveling burn fellow on the East Coast, and I was sent on rounds with the residents. The intern presented a 65-year-old man. He was homeless, and he lived—literally—in a cardboard box, which he had set afire while trying to keep warm. He had burns of over 70% TBSA. And an inhalation injury. And active AIDS. And endocarditis. He was on a ventilator, a dopamine drip, and dialysis. This is a true story. And when I expressed my horror over this poor fellow’s hopeless condition, the junior resident laughed. “Well, Dr. Saffle”, he told me, “you know what they say: N.P.D.G.B”

“N.P.D.G.B?” Was that some complex East-Coast acronym for his medical condition? I asked, and I was told:

“N.P.D.G.B. That stands for ‘normal people don’t get burned’.”

Normal People Don’t Get Burned!

That line was delivered with the sort of callow self-assurance of which only a really inexperienced person can be capable. But ever since that day, I’ve heard this surgical saying time and again. When the driver of a tanker truck checked the level of diesel fuel with a lighted match: N.P.D.G.B. When a 25-year-old man with crab lice poured kerosene on himself while smoking a cigarette, when a methamphetamine lab blows up, when babies are abused by drug-addicted parents: N.P.D.G.B. Everybody on my burn team says it. And, I’ll confess: Sometimes the person who says it is me.

Well, I don’t need to explain medical humor to this audience. You understand that it’s unpretentious, and even crude, because it’s used to relieve the stress of situations that are themselves often brutal and terrifying, situations in which the only sane alternative to laughing is crying.

This is a picture of my team at the Intermountain Burn Center (Figure 1). These are delightful, mostly sane people who could get easier jobs in clinics or carry clipboards for insurance companies. The therapists could work in sports medicine, manipulating the limbs of attractive athletes—jobs with regular hours and no weekends—maybe I shouldn’t be telling them this. But they don’t take those jobs. Instead, they empty bedpans and wipe off snotty Silvadene and comfort unendurable pain. They watch over desperately sick people through endless nights. And they are—you are—to me, heroes. And it’s because of them that I won’t apologize to the burn patients in the audience: You, of all people, know we’re just as human as you are, and if we haven’t convinced you that we care about you, we never will. When my team says “N.P.D.G.B” it’s kind of like laughing about your children: you might do it, but you love them, and it certainly doesn’t mean you’ll let anybody else get away with it.

Figure 1. Dr. Saffle’s team at the Intermountain Burn Center. It is representative of all the burn teams in the United States, which are unique in their multi-disciplinary makeup, their camaraderie, and their commitment to excellent patient care.
Besides, I think patients themselves learn quickly just how effective a healer even this sort of dark humor can be. Carl Sandburg said about the people, “you can’t laugh off their ability to take it.” Well, they can take it, and fortunately, they can also laugh it off, and it’s amazing to me how often they do.

The problem lies in a broader usage of the saying “N.P.D.G.B.” in a prejudice that affects our practice, and will affect our future. It isn’t just that burns occupy a unique place in the public imagination as the most horrible of injuries or that burn victims are portrayed as monsters, villains, or misanthropic loners. Those stereotypes remain a real problem for us. But I think we’ve done a lot to fight them, by advocating for patients, through survivor’s organizations like the Phoenix Society and, I think most importantly, by turning out burn survivors who are so obviously healthy, capable, and self-assured.

The problem lies, I think, in a more widespread, societal mind set. Putting it simply: Our patients are unpopular because they’re a lot of trouble, they cost a lot of money, and they have visible, disturbing injuries. Our specialty is unpopular because it’s labor-intensive, far from glamorous, less remunerative than many others, and—face it—because it sometimes hasn’t kept pace with the newest trends in academia. These are the issues I’d like to examine in more detail, to show you how worrisome they can be.

First of all, who really gets burned? We know that some segments of our population get burned more than others and that burns aren’t always entirely random. I’ve had my share of bank presidents, lawyers, and doctors as patients, but we know burn injuries are concentrated among the very young, the very old, the poor, and patients with disabilities.

Let’s examine an example in a bit more detail. In an excellent study in last year’s New England Journal of Medicine, injuries from house fires in Dallas County, Texas, were found to be common at the extremes of age, three times as common in blacks as whites, three times as common in patients over 65. And—amazingly—the same study showed that house fires were twenty times as common in households with mean incomes below $10,000, caused partly by the absence of smoke detectors in low-income homes. These sorts of statistics have been verified over and over again in independent samples and in other studies describing “burn-prone” patients. I’ll summarize the question of “who gets burned” by saying what we already know: Anybody can get burned, but not everybody is at the same risk of getting burned.

What many of these patients have in common is NOT that they are abnormal but that they are disenfranchised and underprivileged. They have little representation, attract little attention from policy makers, and receive less than their share of societal benefits, like health insurance. Ironically, although their scars make them repugnant to some segments of society, their lack of audible representation makes them invisible at the same time. And that’s not the only problem. Burn professionals, and burn centers, are often disenfranchised and often invisible as well.

This is a good place to mention the American Burn Association (ABA). We began in 1967 as a society that collected dues and held an annual meeting. That’s all most medical societies do. Our association is unique in being truly multidisciplinary and in the amazing number and complexity of programs it supports. Burn prevention has been one cornerstone of our association. In recent years, Janet Cusick and Ernest Grant have done terrific work chairing our prevention committee. They’re currently involved in turning down residential water heaters, trying to enforce stricter laws on the flammability of children’s sleep wear, and developing a fire-safe cigarette.

In late 1996, we made two brilliant decisions. Because we had too many important projects for a bunch of burn doctors to manage effectively, we decided to set up a permanent central office for the ABA. And, we hired John Krichbaum to run it. The ABA is a very different organization now because of him. As the office has taken on more new projects and maintained old ones, our organization has increased its visibility and its influence in a dozen directions. The staff has grown, too, as you can see (Figure 2). In particular, I want you to know Susan Browning, your Associate Director, who heads up every new effort and keeps all of our irons in the fire. Tom Gorey manages special projects. Jane Burns is our meeting coordinator, Cindy Ramirez works with the journal. I’ll tell you frankly that I don’t who everybody else is, but I do know that this picture has new faces every time I see it.

In 1997, the Office took over the annual meeting, which was a great success at far less cost. They manage our membership services. Susan has developed and manages our Web site, to her enduring regret. The office runs our Directory of Burn Care Resources and helps a great deal with the TRACS/ABA burn registry. That project owes its continued existence to Grace McDonald-Smith, who has toiled thanklessly and endlessly on software development, testing, teaching, and serving as a resource to ignoramuses like me. And I’m delighted to say, that at today’s plenary session, we will FINALLY present data on over 50,000 patient records compiled over the last 10 years. This expensive data analysis will cost you nothing because John and Susan have also obtained a
grant for $100,000 from the Federal Emergency Management Agency for registry development.

It should be clear that burn centers exist to help especially vulnerable people with particularly devastating injuries. So how are burn centers doing? Well, the first thing you should realize is that there are fewer of them than there used to be. In 1981, our Directory of Burn Care Resources listed 185 burn centers in the United States and Canada. In 1985, 161 centers. In the year 2000, that number had fallen to 139—a 25% decrease. Why?

One reason might be the decreasing incidence of burns in the US over the past three decades. In data published by Peter Brigham and Elizabeth McLoughlin, they documented a decrease from 1.2 million burns in the US in 1971, to about 750 thousand in 1991. As you can see, though, the curve is quite flat for the 1980s and 1990s, so I don’t think this is enough to account for the disappearance of a number of American Burn Centers. Over the same period, the number of hospital admissions for burn injury in the United States dropped more dramatically partly, perhaps, as a result of increases in outpatient management. But although burn admissions dropped to about 52,000 per year, the number of burns admitted to burn centers actually increased, so I don’t think these numbers explain the decline in burn centers either.

Another trend that has been clear throughout this period is that burn centers are seeing fewer really big burns. Over the past 30 years, burns of 50% TBSA or greater have declined to only 4% of admissions to US burn centers, whereas burns of less than 10% TBSA constitute over half our admissions (Figure 3). This means that the burns that excite us the most—the ones only we can treat—have not and will not sustain us. We have very little natural monopoly, and we aren’t always the best businessmen.

I also want to point out to you just how small our specialty is. One hundred thirty-nine hospitals, 23,000 admissions per year, but only 4% of those are burns over 50% TBSA—that’s only about 1,000 truly big burns a year in the entire United States. Our niche is literally beneath the radar of big insurers, who don’t support our patients because they don’t have the data to understand them. It’s beneath the radar of federal attention and most NIH funding.

This problem was articulated impeccably by Dr. Roger Yurt in 1999. He pointed out that burn centers sit at the crossroads—or more correctly, the cross hairs—of two disastrous economic trends. First, the managed care movement has focused on immediate gains and often has sacrificed quality for short-term black ink. In addition, because many of our patients can theoretically be treated elsewhere, referring hospitals can send us uninsured and problem patients and keep the easy ones for themselves. This practice—called “skimming,” or “dumping”—places burn centers at risk for financial ruin. I believe that a number of small burn centers have died economic deaths in the last 15 years.
Regarding selective referral, recent publications have documented several facts about trauma that are equally true for burns. First, case mix is critical. Rural trauma among insured patients is lucrative and desirable, whereas urban trauma patients tend to be poor and uninsured.14,15 These uninsured patients have increased length of stay because they’re impossible to place in rehab facilities or extended care facilities.16 One study found that patients were two and one half times as likely to be referred to an level I trauma center if they were uninsured, even after controlling for injury severity.17 At the present time, approximately 41 million Americans have no health insurance—about 14% of our population. But trauma centers admit up to 40% uninsured patients, and so do burn centers, based on data from our National Repository. The irony of this, of course, is that uninsured patients often get better care than insured Americans, and there are good data from trauma centers to prove that. But there are no such direct data from burn centers, and it is sorely needed.

Since I’ve mentioned Dr. Yurt, let me digress for a minute and also mention September 11th. I was personally very proud of the role ABA members played in this tragedy. The New York Hospital Burn Center treated the worst of the 9/11 patients in New York, and The Washington Hospital Center treated victims of the Pentagon attack. Emergency response teams led by Susan Briggs and Rob Sheridan moved rapidly to New York to help in rescue and salvage efforts. Our central office immediately compiled a roster of over 1500 available beds within US burn centers and organized a network of burn center teams to receive patients. And, nurses from a dozen different burn centers—including, I’m proud to say, my own—flew to New York in the weeks after 9/11 to help relieve exhausted staffers and continue superlative care. As a result, national attention was focused on burn center care; the American public saw that manifestly normal people do get burned and that superspecialized, dedicated, labor-intensive care is needed to treat them.

But even with all this, the press couldn’t resist falling back on old stereotypes. An article in the Wall St. Journal on October 1, 2001 carried the amazing statement that “there are no mirrors in burn units,”18 implying, I suppose, that nobody would want to look at our patients, least of all themselves.

Of course there are mirrors in burn units. That’s how I can tell when I need a haircut. A mirror is one of the commonest things patients ask for, and we use them in physical therapy all the time. But this experience illustrates how ingrained is the mindset of N.P.D.G.B. in the public’s imagination and how much work remains to be done.

In an effort to support the concept of burn centers and practice within burn centers, the ABA has developed three projects: The first has been the development of guidelines and a program to verify burn centers in conjunction with the College of Surgeons. Headed by Dr. David Heimbach, this project has helped popularize burn centers and to support them within their regions. Over 60 centers have been verified so far. The second has been the Advanced Burn Life Support Class, lovingly developed and run for years by Bob and Pat Gillespie. ABLS has standardized burn treatment nationwide, and introduced

![Figure 3: Burn size admissions to US burn centers, 1965–2002.](image-url)
thousands of providers to the concept of burn center care. The ABA has recently revised and updated this course—let me say superbly—by a committee headed by Rob Sheridan and Tom Gorey. Finally, to help bewildered burn doctors (like me) understand the gibberish of coding and reimbursement, Dr. Richard Kagan has developed a coding primer for burn care that is being taught at this meeting. I still can’t understand coding, but people who do tell me this primer is terrific.

In the future, it’s likely that much of the impetus for real quality improvement in health care will come from consumers. An article in USA Today reported a large study conducted by a consortium of health care purchasers—including large industries—that found that the presence of an in-hospital intensive care unit physician improved outcomes in intensive care unit patients.19 I think this article illustrates that we need to take our case to patients, employers, and government agencies. And, as this article implies, the concept of evidence-based medicine is critical to this task.

The term evidence-based medicine has become a tremendously influential concept throughout medicine. But I don’t think we’ve kept pace with this so-called revolution in health care. In 1998, a review of recent burn literature to determine the number of randomized clinical trials—widely acknowledged as the best form of evidence for medicine—found relatively few such trials. The author concluded that “little evidence exists for an evidence-based practice for burns.”20

Burn Centers clearly are centers of excellence, a concept that’s gaining widespread acceptance in the medical community but it will require data to produce the preferential reimbursement that we need. As I’ve said, we’re in the small burns business—and to get those small burns, we have to prove that our outcomes are superior. That means shorter lengths of stay, earlier return to work, and better function. And we are just starting to study these outcomes. And, we need to catch up to the rest of the medical world in producing evidence-based outcomes for our treatments. All of this was foreseen by Dr. David Herndon in his presidential address in 1994: “We must take a proactive approach in demonstrating through prospective studies the benefits of our interventions.”21

Well, the ABA has responded to these problematic issues as well. Our Journal of Burn Care and Rehabilitation, edited by Dr. Warden, seeks to present the best in burn research and clinical care. I will add, though, that support for the journal is not what it should be. Too many of our best investigators publish their good results elsewhere, including data from this meeting. We have recently completed an exercise to develop practice guidelines for burn care.22 This first step in evidence-based medicine served primarily to illuminate just how little good evidence there is for many of the things we do. So as a next step, we have formed a multicenter clinical trials group to evaluate our care and perform the sort of rigorous, controlled studies that we need to prove our points. I’m delighted to report that our first randomized prospective study is underway.

And, through the efforts of Dr. Ron Tompkins, we have just concluded a successful and influential review of outcomes for pediatric burn patients.

There’s one more issue I’d like to address. These are some of the key people who run my burn center (Figure 4). Like many successful men, I spend my days under the total control of women who are smarter, abler, and more competent than I am. Thankfully, these are the most gentle and benevolent of dictators, and they keep our ship on course despite my erratic efforts to steer. I couldn’t survive—our unit couldn’t survive—without them.

My colleague in the burn center is Dr. Stephen Morris. He is the best of fellows, and his good-natured willingness to cover for my meetings and committees is a major reason why I’m here today. My skin grafts don’t take any better than Steve’s, my patients don’t survive more frequently, and the nurses don’t like me as well as Steve—who they universally refer to as “the nice one.” But I flatter myself that I do have him beat in one important way: I have the better partner.

In addition to thanking these people, I cite them as examples of perhaps the most worrisome problem we face: manpower. Where will the dedicated nurse managers, the hardworking therapists, the able burn doctors of tomorrow come from? What we’ve seen so far suggests they’ll be harder to find than ever.

Though most of my data concern physicians, the shortage of nurses is probably even more acute. First, because we need so many more of them. Second, because many nursing careers don’t last a lifetime. Nurses who pursue the elusive mirage of total fulfillment find it nearly impossible to have it all. And finally, many forces conspire to lure our best nurses away from the bedside—into administration, teaching, and advanced degrees, especially because the salaries for those jobs far surpass what even the best patient care providers can earn.

And for physicians, this is nowhere more obvious than in burn care, as an extension of trauma care, and as an extension of general surgery. Recent publications have addressed the dramatic decrease in applicants for surgery training in America.23 Even prestigious training programs often fail to fill their
internship classes; those that do can expect significant attrition. The most obvious scapegoat is the “L” word: lifestyle. Although surgery is perceived as exciting and heroic, the rigors of surgical training—and practice—exceed those of more elective specialties, which offer lucrative and challenging technologies, without the necessity of nightly emergencies and weekend call.

Fewer medical students aspire to surgery, and even those who do are rarely attracted to trauma. Studies from the United States and Canada reveal that fewer than 10% of residents anticipate spending even part of their practice in trauma care, and the reasons cited are the familiar ones: the work is too hard, the lifestyle too confining, and the patients not rewarding to work with, including the remarkable statement by a resident that “They’re all drug dealers anyway”; perhaps the ultimate expression of “N.P.D.G.B.” And within trauma care, burn doctors do not project an attractive image to the residents of today. Burn fellowships routinely go unfilled, and the few fellows who are trained are deluged with offers of employment.

The recent decision by the Accreditation Council for Graduate Medical Education to remove burn care from the ranks of essential knowledge and classify it as a secondary area of expertise, like anesthesia, led to the immediate removal of residents from burn rotations in several hospitals. This gives programs not affiliated with burn centers an excuse to stop farming out their residents for a remote experience. Because the number of training programs exceed the number of burn centers, a significant number of US surgeons may never rotate through a burn center.

In my own unit, admissions and surgical volume have increased steadily over the past 20 years, but house staff coverage has just as steadily declined, our reputation for committed teaching and excellent patient care notwithstanding. Thus, our residents have less opportunity to experience the attraction of burn care, the satisfaction of seeing sick people get well, and pleasure of working in a real team setting. We have less ability to capture their imaginations and elicit their loyalty.

I don’t think plastic surgery has suffered as much attrition. Many dedicated plastic surgeons still care for burn patients. But for residents in training, plastic surgery offers a lucrative, lifestyle-oriented practice that is the antithesis of burn care. Plastic programs now accept more residents with reduced general surgical training, the so-called “three and three” programs. These residents may have little exposure to burn care before entering plastics and require little more afterwards.

I can think of no more eloquent illustration of the disinterest shown to burn care than the recent decisions surrounding the possible closure of the Brooke Army Burn Center. Hidden in this grainy old photograph of ridiculously young people with bad haircuts are four future ABA Presidents, including the granddaddy of them all, Colonel Basil Pruitt (Figure 5).
From 1970 to 2000, Dr. Pruitt trained a couple of dozen burn center directors, many full professors of surgery, and 14 Department Chairman. More than any other place in America, The Brooke Army Burn Center was burn care for the last 30 years. It now appears that Brooke might be saved, although in a very altered and possibly diminished role. It will probably never return to its prominent place in US burn care.

The issues I’ve raised this morning point toward our need to reach and influence the government and to develop effective advocacy stances. Here, too, the ABA is acting. First, through the creation of an ABA Foundation. This was established by President John Hunt, and Dr. Andrew Munster leads our ongoing effort to accumulate principal. Eventually, I hope this money can support training grants in burn care, to attract the brightest of surgical talent to this fascinating career.

Second, recognizing the common interests of burn care professionals and burn center hospitals, the Institutional Advisory Council was formed to provide an action arm for the ABA. Over 30 hospitals have joined to date. Dr. David Levinsohn has been the charismatic leader of this group for over a decade. And the group was rewarded for their loyalty in a most tangible way only a month ago, when the ABA held its first Washington Leadership Conference. Burn doctors and nurses, administrations, and our central office staff met with congressional policy makers. The meeting occurred at a perfect time for us to emphasize the role our members played after September 11, and I believe we succeeded in teaching our government that burn care is both a demanding specialty and a precious national resource (Figure 6). And we’re planning to go back next year and tell them again.

As you can see, our future is far from assured, but neither is it hopeless. Although most surgical societies are pedantic and irrelevant to our practical problems, the American Burn Association just might be the salvation of our struggling specialty. Through your association, we are advocating for all the key areas of our specialty, as contained in our logo: patient care, education, rehabilitation, research, and prevention.

Our central office has helped direct our energies, but our most powerful weapon is still our membership. I’ve tried to convince you this morning that our survival requires us to work together as a group, to support our many programs and our patient care mission. In fact, I worry that our central office is so efficient that the rest of you won’t feel the need to remain involved. Please don’t make that mistake. Remember that all of the impressive projects we now manage had their beginnings within committees of the ABA and were conceived and developed by ABA members. And our future directions will come from the same place. I exhort you to support the association, and participate in its programs. Look at all you get (Figure 7).

And if all this doesn’t convince you, or if you think I’ve strayed from the most important thing we need to do, let me introduce two people. First is Leonard. He was burned in 1990 to 56% TBSA. He spent 10 weeks in my unit, 4 weeks on a ventilator, 2 weeks on dopamine. He had eight major operations, lost most
of his fingers and one ear, and left us scarred from head to foot. He was also my first experience with cultured skin. Although 60% burns are considered no-brainers to some of you—at least, to read your publications—Leonard was desperately sick, and I spent the first 2 weeks of his care believing he would die. But I forgot something: Normal people don’t get burned.

Today, Leonard is back to work as the safety officer in his factory. He attended our burn camp river trip as a counselor and wore his garments faithfully in the blistering heat. He’s the bishop of his church. He’s the patriarch of an adoring family. And he is one of the finest people I’ve ever met.

This is Donna. Three years ago, Donna became septic from Group A Streptococcus and developed pur-pura fulminans. She spent 12 weeks in the hospital, had a horrific abdominal compartment syndrome, and suffered amputation of all 10 fingers and both legs below the knee. When this happened, Donna was
65 years old. Well, we all know that a person like this would never walk again. And, she doesn’t walk much, actually; she runs. She ran in the Olympic Torch relay in Salt Lake City February of this year. Her prosthetic legs carried her the half-mile with no trouble, and her stubby remaining fingers held the torch high and proudly.

People like Leonard and Donna are amazing, but we know that maybe the most remarkable thing about them is just how typical they are. Every one of you knows a Leonard, or a Donna, or has received a graduation announcement or a wedding invitation from some kid who spent 2 months on a ventilator and kept you up every night, some patient about whom somebody probably said “N.P.D.G.B.,” but who really proved the absolute truth of another old surgical saying, that “the bravest person in the operating room is the one on the table.”

Some of them probably aren’t normal, these patients of ours; they’re better than the rest of us. And even if you don’t buy all this stuff about disappearing burn centers, diminishing reimbursement, vanishing nurses, lifestyle-obsessed residents, and the need for legislative action, you know how important our patients are. And it is both for them and ourselves that we are compelled to work for the survival of burn centers, to perform not just as clinicians and researchers, but as outspoken advocates for our tiny specialty. For them, so that the best of care can be available and new advances continue. For ourselves, so that the ultimate satisfactions of our careers can inspire our successors in the future.

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