The Burn Doc at 21
Coming of Age

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This is the twenty-first year of the American Burn Association—its coming of age. It is also the time for the coming of age of the burn doctor. We have grown into adulthood and are ready to take our place, make our way, and claim our rights. Contrary to the opinions of our surgical colleagues, we do real operations and we are real physicians. I am puzzled that some feel they can be self-appointed judges, commenting about our work, never doing it, never wanting to do it, and without having the slightest ability to recognize quality when they see it, even if it came with a tag from God Almighty! There is more to life than a gallbladder! Burns don't recur like a hernia! They don't metastasize like cancer! If our fellow surgeons cannot speak with intelligence, they can speak best with silence!

That's what I would like to say—but I can't—at least not in public.

Brook Astor said it best when he spoke of his developing ego. “It was not until I was of age that I was able to go into a room and say to myself, ‘What do I think of these people?’ Before that, I had always thought ‘What do these people think of me?’ I said to myself, ‘You are either a whole person now, or you never will be. Believe in yourself.’”

I didn’t realize how hard the job is; at least I didn’t realize it when I started doing it. Most of the medical world still doesn’t know how hard our work is or exactly what we do. It isn’t just people who are distant from our practice. From a heart surgeon I could understand; but, for instance, take my anesthesiologists—please! How many times have I heard them say, “Oh, it’s just a little burn case. They’re only going to do a little debridement.” Just a little debridement... Already I know we are in trouble. This guy has no idea at which end to pass the gas. And sterile technique... Sterile technique to an anesthesiologist is right hand to eat. And consultants... Have you ever watched one come to the burn unit to see a patient? Ophthalmologists are blind to their surroundings... Three drops into each eye every 15 minutes. That’s between the cardiac outputs and wedge pressure readings and throughout the 1-hour dressing changes that take three nurses! Orthopedists have crippling concepts: it never occurs to them that a burn wound can’t be treated when it’s under a cast. It takes more than an every 6 week dressing change. Psychiatrists aren’t much better. What do you do with an opinion that the patient is “depressed because he’s burned?” I get depressed when these people show up on the unit.

We have a tendency to be defensive about our work, particularly when someone asks, “When are you going to do surgery again?” Because our field is evolving, there has been nothing with which to compare it. The only measure of our worth has been the patients. But when you think about it, isn’t that the only measure worth bothering with? As burn doctors we care for patients from the time they are injured until they are back in the community, for better or for worse. Along the way, we care for their families and for ourselves.

WHAT IS A BURN DOC?

Tom Meeker, President of Churchill Downs said, “There are people who make things happen. There are people who watch things happen. And, there are people who don’t know what the hell is going on!”

At one time or another, a burn physician is one of these people. He must be a psychologist, social worker, nurse, therapist, scientist, “preventionist,” fundraiser, father, husband, beggar man, thief, doctor, lawyer, and Indian chief. If there is a Renaissance man, it’s the burn doc.

The Burn Doc as Psychologist and Social Worker: The Most Underrated Components of the Job

All patients with burns are injured in two spheres: physical and mental. The physical sphere is obvious, but the mental sphere is not always so. At the be-
beginning of the burn injury the priorities of the patients and their families are: (1) cosmetics, (2) function, and (3) survival.

The priorities of the burn team are the exact opposite. They are concerned about the patients’ survival; how they look is the last of their immediate priorities. However, in time, the patients’ priorities change. It is difficult for them to deal with burns from the start, but the issues have to be addressed early on by patients and their families. A burn is a family problem; everyone is affected and everyone has to be considered when planning recovery. The injury stresses all relationships, personal and interpersonal. It is not like tempering metal; that is a romantic concept. A burn does not build character; it tests it—to the core.

Therapy begins when the patient is first seen and continues throughout life. It is needed long after what may seem necessary to those not in touch with a victim. There is a delightful and entertaining book that has been on the recent best-seller’s list, written by George Burns about his wife, Gracie Allen. As a child, Miss Allen was burned by scalding water in a kitchen accident; how many similarly injured children have we treated? Gracie was always conscious of the disfigurement and wore long sleeves or gloves to hide the scars. She once told George the one thing she wanted most in life was to wear a strapless gown. One night during the quiet moments of being together, she thanked him for never saying anything about her “bad arm.” “Which arm is that?” he replied. Therein is the entire tale. She was famous throughout the world with material wealth beyond dreams, yet she felt insecure about herself because of her “deformity.” She never escaped the feeling. Yet, the person closest to her never saw it as a deformity.

There are times when the burn doc has to be a mind reader. This usually happens about 2 to 3 months after the patient goes home from the hospital. Friends and relatives are not acting like they used to and the patients don’t understand why. They only know they are unhappy, when before they had happily anticipated going home. Get ready to slice an hour out of the clinic. Lots of emotions will well up and out when the source is tapped; these are abscesses that need draining then and there.

All these people need psychologic support for full recovery. Some need only a word of encouragement and a suggestion; others need a detailed outline on how to turn a doorknob.

One last word on being a burn shrink: expect to fail sooner or later. This applies particularly to teenagers who have the misfortune of not only being burned, but being burned during their rebellious phase. They are not going to do anything you want them to, at least not until it’s too late. Wasted therapy and unworn pressure garments are the tragedies of teenage burns. I’m not suggesting you give up; always try. Some, mercifully, get the message early.

The Burn Doc as a Nurse

You have to know how to change a dressing, a big dressing—one of those dressings that takes 20 people and 20 hours on a 20-ton patient. Until you’ve done one, asking to have the freshly changed dressing taken down for a “quick look” just does not mean anything. You have to be a pillow fluffer, and you have to know how to wipe a bottom.

You have to know how to work with and fix the equipment. There are IVs to regulate, cardiac outputs to shoot, beds to adjust, and observations to record. You have to know what a nurse does before you ask him to do it. You have to understand care plans and the orderliness of a day to understand the impact of changing the routine.

How many patients are too much? Better know this or you will turn around and the staff will be gone. Don’t take sides. Suggest that people work it out themselves, or the mandated solution may not be acceptable to anyone, including yourself.

Stand up and be counted for your staff. Protect them against all outside enemies—except husbands and wives. Just keep telling yourself that pregnancies are not punishment directed toward medical directors.

Rehabilitation Therapists

After survival is ensured, the burn doc must consider how patients will integrate into the community. What are the problems and how can they be solved? This involves more than providing visiting nurses; it may mean training the patient for a new job and a new life. Forget about life-styles of the rich and famous, what about the life-style of the person to whom scratching the nose is an accomplishment?

I know historically there is a difference between a physical therapist and an occupational therapist. But, in burn care the lines of distinction get blurred. I see one of each on the sides of a patient, holding him up as he walks down the hall. I see one of each putting on and adjusting splints. Therapists are a group of people with a collection of outstanding talents directed toward the noble goal of getting the patient in working order. Getting out of bed, getting dressed, getting into the kitchen, sitting down, and eating make up one continuous process.

You, as a burn doctor, have to be prepared to see patients for years. A few will do well and return to
a seemingly normal or even supernormal life-style. These are rare. Keep them in mind when looking for people for your future patients to emulate. The majority, however, will have problems and will have to come to grips with losses. The caregiving system is also going to have to come to grips with the patients and their problems. So far, it is having trouble getting its administrative priorities straight. I speak here of the insurance companies and the government agencies that ask incessantly for evaluations and more evaluations. They don’t go away any faster than the patients. Our colleague, Roger Salisbury, is beginning to make some headway toward solving this problem.

Scars always have to be dealt with, scars that are seen and unseen. I mentioned the inward scars, those hidden from the crowd. But there are public scars that have to be distinguished from being ugly versus being physically and/or mentally destructive. Both types need treatment, and when and where to begin is different for each patient. The important thing is to begin. Don’t expect miracles in a day. In fact, don’t expect every day to be a good day. Patients have bad days just like the rest of us. Every day is not a success, but keep trying.

Scientist

A burn doc observes and asks, “Why?” We cannot be afraid to question established precepts or to turn questions upside-down and look at them from a different angle. A burn doc cannot be afraid to try something new or to accept good ideas from someone else.

A great deal, if not all, of science is taking known information and hooking it together in new ways with fresh associations. Sometimes it’s a recombination of old knowledge. Sometimes it’s old plus new knowledge that has become available because of new technology. Whatever happens, remember not to take too much of the credit. The facts have always been true. We didn’t invent the universe or the phenomena that go on therein, we merely make comments about them; the truth has been there all along. All of nature’s ways go on about us whether or not we recognize them. My friend J. J. Bullen said it best: “Not only is the universe more complicated than we imagine, it is more complicated than we can possibly imagine!”

While on the subject of science, I cannot let the opportunity pass without mentioning the JOURNAL OF BURN CARE & REHABILITATION. It is a maturing publication of which the Association can be proud. Its academic standards were established by Charles Baxter. Dr. Baxter has made the JOURNAL a source of information, not just a space-occupying lesion on a shelf. He has given much to this organization, but this is a gift to the whole scientific world. I am proud to have played a role in its becoming our official organ.

Preventionist

Prevention is important both before and after the burn. Prevention before the burn is directed toward preventing fires or the circumstances that lead to burns occurring. Here programs are directed toward individuals and groups in the community. They can be presented as part of fire prevention week or as ongoing school instruction. Schools are always good places to give prevention shows, particularly at the second to fourth grade levels. These children take the information with them and pass it on to their children.

The “burn personality,” does it exist? It does! If a writer ever wants a soap opera script, he only has to visit a burn service. There is enough material to fill three networks with programming. Many of our patients have personality problems, but then again, many do not.

Some patients are true victims of an accident: people caught in a hotel fire.

Some are ignorant and unknowingly place themselves in dangerous situations: the brush used with solvents in cleaning ceramic tile generates enough heat to ignite the solvent.

Some are just plain stupid: immediately filling an empty lawn mower tank while the manifold is hot, which can easily ignite spilled gasoline.

Prevention must also be practiced in the burn unit. Such prevention is usually directed toward infection, keeping patients from getting “bugs” that are already living on the unit or on some patient in a room across the hall. We must also prevent “burn out.” Work has to be kept interesting and up-to-date. The staff has to know what the rest of the world is doing. This has a couple of effects: it keeps them abreast of knowledge and it shows them that their world may not be so backward and bad after all.

The hardest kind of prevention is keeping the burn doc from getting bored. Actually, my problem is keeping my mind in shape and finely tuned. Nothing helps more than another burn doc on whom I can bounce off ideas. Meetings like this one are perfect to get the “sap” flowing.

Fundraiser

There is a group that is frequently forgotten. It is made up of people who work for us but who are never seen by the patients or their families; they are
the fundraisers and the volunteers. These are dedicated friends in the community, tirelessly working to help get money, equipment, and services for projects vital to the continued care of our patients. These folks buy the rehabilitation equipment, build the new burn centers, and support the staff working in the units. Without these wonderful, devoted people, it would be hard to keep up the “good fight.” They spend hours that are never accounted for on a time clock or a paycheck. They believe, as we do, that a job needs to be done and that their efforts can make a difference. And what a difference they make. Anyone is capable of giving. Anyone is capable of being a fundraiser. There are no limits. I am amused when some think that it’s not worth the effort to talk with a group that seems “too small.” The smallest group can have the greatest impact. You never know who can help, who will help, or when they will do it. You may just drop a word to the right person when you need that special door opened. The hardest working volunteer, or the person with the greatest idea, or the president of a company has to be someone; she just might be sitting next to you. A group of four may turn out to do more for your program than a room of 400.

Workers and donors have usually had a personal experience with burn care. A relative or a friend may have had a burn and they want to help others who have had to go through what they did with their loved ones. It’s as simple as that; no one has to convince them of the importance of the work.

The burn doc has to get involved with the fundraising. Until you do, you have no real appreciation of what it takes to bring in the money. Once the money is there, protect it. Remember the story about the ant that planted the field and could get no one to help sow, reap, or bake, but there were plenty to help eat the bread. Guess what? Same story. Chop their hand off if any outsider makes a move for the funds! Once protected, work the money and use it, particularly on people; make their jobs easier and make the care of patients better. It doesn’t do anything in the bank. Dolly Levi said it best when comparing money to manure: “You’ve got to spread it around to do some good.”

Some last thoughts about what not to do with money raised:

- Don’t forget where it came from. Some folks do and it gets them into trouble.
- Don’t turn down any offer. It can grow beyond your wildest dream.
- Don’t be afraid to make mistakes.
- Don’t think small!

Rich Man, Poor Man, Beggar Man, Thief; Doctor, Lawyer, Indian Chief

The begging burn doc has to always ask for more. Keep that hand out to the dean, the hospital, and the department. Make them think it’s Sunday and the church is about to go into foreclosure.

- A good burn doc is a good “thief.”
- He steals whenever and wherever he can.
- He snatches patients from deformity.
- He lures them away from self-pity.
- He entices them from inactivity.
- He urges the burn team to excellence.
- He embezzles poor attitudes of self-esteem, leaving only pride of accomplishment in the account.

Physician

Foremost, we are physicians. It is such an obvious thing to say: the one who directs the burn service should be a physician. However, the idea can get lost in the shuffle of the activities of daily living. There are two facets to this job. One is being an informed physician, knowing the subject. That alone is an interesting question. Do burn center directors really know what’s going on in the real world and in their units? The second, and more subtle one, is having the talents and skills of a classic and more gentle time. We are caught up in a revolution of machine and science that at times overpowers the physician and the patient. The caring gets lost in the cacophony of chirping computers and cerebration. We are all guilty, at times, of forgetting that the patient is a person. Nothing revives the memory so quickly as being a patient oneself or being a patient’s family member who has to deal with other physicians.

Lawyer

What can I say? It’s a new world. Why do I always think of Tyrannosaurus rex? Perhaps like the dinosaurs, a welcome cataclysm will occur, maybe a meteor leaving only small ones. There are good lawyers and there are good physicians. We just need to get them together. The rights of the patient must be kept in mind when caring for them. Somehow, we have to get the rights of the physician inserted back into the equation and back into the hospital.

Indian Chief

As the chief of a service and the director of patient care, there are some days when I think I’m brilliant . . . There are days when I think I’m stupid. But there are just enough brilliant days sprinkled among the stupid ones to give me hope and say, “Perhaps tomorrow . . .”
The duties and responsibilities of the “burn chief” can seem insufferable, but they are nothing compared with what a burn patient must do to recover. Recovery does not stop when the patient and family leave the hospital; it goes on. The duties and responsibilities of the burn chief also go on because patients are surviving with multiple-system defects and reconstruction problems that before now were unknown. Although injury by burning is an old problem, today’s survivors are a new problem. We are creating a population with new social and medical puzzles. Unfortunately, we have produced more puzzles than solutions. But that’s not all bad.

Who doomed to go in company with pain,
And fear, and bloodshed, miserable train!
Turns his necessity to glorious gain.

William Wordsworth (1770-1850)
Character of a Happy Warrior

Necessity is the mother of invention; new problems lead us to new and exciting wonders that are undreamed of today. All we need to do is let our minds go and think the impossible. Gershwin set it to music:

They all laughed at Fulton and his steam boat,
Hershey and his chocolate bar.
They told Marconi, wireless was a phoney, that’s how people are.
They laughed at me—

George Gershwin, Ira Gershwin
"They All Laughed"

Well . . . not any more! We’ve come of age! We no longer have to suck hind tit or be concerned how others view our work. We are beholden to no one! The idea that a person who deals solely with burn patients is somehow less than a complete person is a testimony to ignorance. And I speak not only for burn physicians, but for all specialists in the care of burn patients: therapists, nutritionists, social workers, nurses, psychologists, psychiatrists, and researchers. We are a mighty team dedicated to an ancient disease. It is a heritage that links us to the beginning of time. Fire is the classic paradox: good and evil, help and hindrance, benefit and harm, old and new. The burn team is also a paradox. We carry our motto around in our pockets on the coin of the realm. It says E pluribus unum, “one among many.” We are a unique “one,” made up of many disciplines.

We, the burn practitioners have come of age, not by years alone, but by experience.
We have come of age through dedication and commitment.
We have come of age by sheer tenacity and lack of respect for disfigurement.
We have come of age by having failed and not fearing to fail again, begin again.
We have come of age by not letting frustration steer us from our work, but rather making us resolute in our goals and infusing us with determination to go on.

Come of age? Damn right! We’ve had the responsibility, now it’s time for the privileges. Move over surgical world, we’re coming through and here to stay!