

Note:

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Some examples of the kinds of errors to be found in the transcripts are provided below.

Filename	PDF Version Page	Error
jmf_int_transcript_Williams_2_2_1976.pdf	20	“Parkalnd”
jmf_int_transcript_Foster_2_2_1976.pdf	2	“trememdous reseurce”
jmf_int_transcript_Neaves_1976.pdf	6	“Andreas Baselius”
jmf_int_transcript_Schermerhorn_1976.pdf	18	“Moreove”

BAXTER

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The , of course our major objective, or our number one goal in burn treatment, is to remove the burn and to convert at the same time we convert an open and necrotic wound into a closed clean wound.

And we've always known that the only ~~to~~ way to improve mortality is to be able to accomplish this. So the things that have allowed us to approach this goal, at least more closely, is first adequate burn shock resuscitation and a patient that is well physiologically, to be able to prevent the complications of infection and malnutrition that gives us a patient who's a good surgical risk.

The surgery then permits us to take off the wound and the skin bank to close that wound because the patient can't withstand , both, nor has the donor sites or has his own skin available to do it.

And you know that we're really showing here the multidiscipline involvement and requirements of anesthesiology, adequate anesthesia for such big procedures, the availability of blood, in untold quantities that, it does require a lot and the unlimited availability of skin to close even the largest wounds. acutely. And with all this the mortality rate is reduced another 10 or 15%. And that's ~~esent~~ essentially the story.

Ultimately we look forward to universally compatible skin , at the one end of research. This will be a permanent graft. . . .

The second goal is to develop either non surgical or very atraumatic surgical techniques for removing the burn wound early and of course improving the patients' condition to be able to withstand it. . Those are the ultimate goals that we're aiming for and it's going to take a lot of research and I don't know how many decades

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to get there, but we will get there.

We and we have a research organization that involves hematologists for blood
element changes as well as for blood banking; bacteriologists in infection and
immunology ; biochemists- we're working with cellular respiration and seeking the
cause of the extremely elevated metabolic rate in burns, and we just got a good
break through- a most interesting one; cardiovascular respiratory research
because we have problems with the heart and its response;; and of course the pulmonary
end of things is principally surrounding smoke inhalation and direct lung damage and
death from inhalation injury. So that it's a multidisciplinary type of research person or
persons that are involved in all of the important aspects of the research.

You know no man can be everything and ... in each of these areas instead of me
being the expert I'm hiring a basic scientist who has the depth and the technology
to go deeper into them and I know enough smattering to be able to coordinate
and help him design his experiments and get ~~th~~ to the depth of the problem.

Now that wouldn't be important if you were just talking about burns but . . .
all of these ~~principl~~ principles apply to surgery per se and the answers that lie
in burns answer the other problems. Cause burn wraps up everything. You
know the worst you can expect in a patient's pathology in every organ system
is 4plus deranged in a burn patient. So that's why they are a prototype of surgical
injury. Many of the things that we have, infection for example is a universal problem
in surgery. So is ~~woul~~ wound healing a universal problem. So that we are
you ask what kind of person is silly enough to think that you can get after all of these
things I think this illness makes you know a great deal about a number of organ
systems and know how, and what to look for. You just need the technology to look
for it.

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We've put together that crossbreed and . . .

... (discussion of nutrition institute and Trowbridge anesthesiologists.

The problem has always been not only to get the burn wound off but to get the coverage

While we've know we could do that with living human skin, but the problem was

people don't die when this patinet needs the skin, and by the time you find the

skin then this patient ~~is~~ is past the point that it's of any aid.

So we've known for a long time that we needed a constant, ready and amply

supply of of human skin. There were no techniques for preservation so that the

best we could hope for was to take it and put it up in the ice box ... if we used it

in a couple of days fine, if we didn't we had lost it all. That;s a horrendous operation

because you've got to mobilize people ...

So along comes a development in Boston by ^{Bonedack} and + ^{BURKE} of skin preservation

... that we could freeze human skin and and thaw it ~~akx~~ and still have it to be

~~lab~~ viable after six months of storage. So that the ingredients for human skin

bank was there. Then came the ^{logistical} problem of ~~the~~ (getting enough skin to have your bank.

Cause then we had the technique to do it... The almost universal need made us

increase our increase our numbers so that we can furnish skin to other burn

centers as well as meet our own need. And this had now grown into the concept

of hopefully a national network of skin banks.

...this is the largest burn center in the country in terms of numbers so that our

needs, quantitatively far exceed most places that treat burns. And with a background

of knowing what to do plus the terriffic clinical need , we just took it upon ourselves

to try and develop a skin bank, and thnaks to the community effort and the press

understanding.. and the medical examiners ~~office~~ cooperation in putting together

a few good people we got a skin bank. And no one else has really been able to do ~~that~~.

that

((omit approx from zero at new start to 400))

In general from the time of healing to the return of work is seven times longer than the acute phase, from injury to skin coverage. We have cut that almost by 70%. As an example a 40% burn used to go back to work in 12-18 months. Today he goes back in 2-3 months. Cosmetically the scarring is much much less. so than the number of plastic surgery and reconstructive procedures has been decreased by a considerable amount. And the functional return of the patient to a near normal life is much closer to good than ever before.

NEW START (VERY PEDANTIC DELIVERY)

The object of care of major or critical thermal burns is the early removal of the wound and its cover with living skin. Currently we are able to achieve often this goal by surgical removal of the burn wound and coverage with living skin from cadaver sources available through skin banking. The patients themselves are prepared for surgery or better prepared for surgery today by advances in the initial care of their fluid resuscitation and from the control of infection from bacteria that colonized the burn wound quite frequently due to its component of dead and devitalized tissue which promotes bacteria growth. Advances in both of these areas allow us to bring to surgery a much larger number of severely burned individuals that can be saved by early removal of their burn wound and coverage with skin. (Bad voice tone) Preparation for the operation is tedious and requires strict control of the burn wound and the patient's physiologic status. The operation itself is of such a magnitude as to be life endangering and involves a large surgical team well developed in controlled anesthesia with close attention to the respiratory and cardiac problems that may attend the very massive blood losses that such surgery entails. The presence and activity of two or more qualified surgeons each with one or more assistants and an operation team of

several individuals supporting the operating team is essential to the ~~accomplishment~~ accomplishment of these large and dangerous procedures. The techniques themselves the operative techniques have been developed in the last few years because more patients can now receive such surgery. The technique of tangential excision of the burn wound, of shaving literally the necrotic tissue down to normal skin elements of the deeper tissue is now a reality and can be carried out when resuscitation and infection control are adequate and physiologic monitoring of all organ systems shows that the patient is a good operative candidate. The operative procedure shown here requires a large and available supply of blood. Since the requirements for excising even one extremity are often four or five pints of blood and many procedures require 10 or more pints the equipment required for excisional therapy is extensive and quite different from most operative procedures. While the removal of skin is the object of the surgical procedure, this is of little benefit to the patient unless a skin cover sealing the open wound from the environment essentially replacing the burn tissue with a skin cover must be accomplished if the surgery is to be a success. Human homograph homograft skin obtained from cadaver sources and frozen in a specific manner and thawed at the time of use that is readily available as a semi-permanent cover for these ^{excised} wounds has made the surgery an essential part of the management of major and critical burns. In addition to sealing the wound the homograft skin provides a basis for better cosmetic and functional result of the burned area. Reducing the quantity of thick and inhibiting scar which often follows the more conservative management of human burns. To these ends, that is the development of ready availability of homograft the human skin bank has ~~arisen~~ originated at our institution in which many cadavers had the other layers of skin removed.

In such an operation as shown here approximately 12-15 square ft, of skin per lower leg are utilized to seal the wound. Thawing of the skin is critical . It must be done in a specific manner in order to insure viability. Skin prepared in this manner will last for a number of days. From two and a half to eight weeks in covering the wound. In the meantime, those areas of the body which were not burned can be harvested for application of the patients own skin and will regenerate so that they may be recropped or taken again to fill the areas when rejection of the homograft occurs.

The skin itself has been rolled in a stiff plastic backing in order to allow for uniform freezing and uniform thawing. Having been taken in long strips from the cadaver donor on his back and legs in strips two and three and four ft long, it can be easily applied to the surface where the burn injury has been surgically removed . This ~~skin~~ skin is only ~~14~~ ~~ten~~ thousandths of an inch thick representing only the outer layers of skin which are taken with a surgical dermatome much as in the operating suite when the patients own skin is used to cover the defect.

Not only does the combination of good resuscitation , infection control, surgical attack upon the burn wound and its coverage increase the numbers of survivors with severe burns, it has significantly reduced the morbidity . and the rehabilitation time of these as well as lesser burns. Today the hospitalization time has been reduced by 1/3 the rehabilitation time has been reduced by 2/3's and both the functional and cosmetic result of the care of burned injuries has been dramatically changed.