

MARCH 2021



Creativity in Our Medical Graduates



*Daylight Saving
Time Begins*

Sunday, March 14

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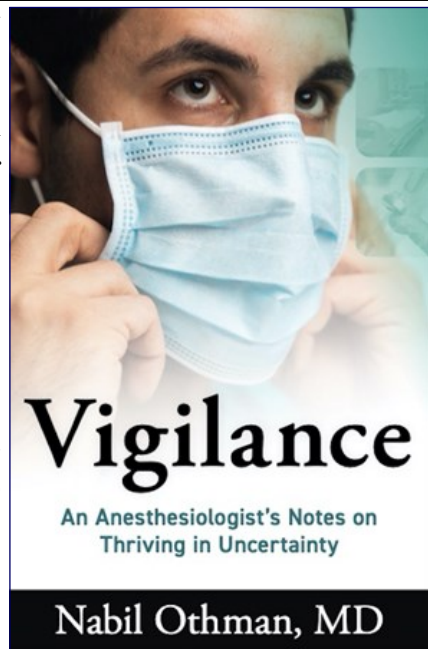
Resident Member:

Peter Cmorej (WSU/GS 2021)

Many of our graduates from WSU Medical School have a need to be creative in areas outside of their special training. The surgical clan has over ten members who have published one or more books, which often have nothing to do with the medical profession. One of our medical students, Dr. Nabil Othman (WSU 2017), is finishing his Anesthesiology residency at Cedars-Sinai in Los Angeles. Subsequent to that, he plans to do a Critical Care fellowship at the Texas Heart Institute followed by a Cardiac Anesthesia fellowship.

This year, he wrote a book about anesthesiology for the general public; this is entitled "Vigilance: An Anesthesiologist's Notes on Thriving in Uncertainty." This book talks about many of the experiences he had during his medical school training and talks about the relationship he had with two of his teachers. All of us, at one time or another, shared these emotions regarding those who were able to help us learn about the broad field of medicine, and you will be infused by memories of your own experiences during these formative years. Chapter two of this new book is incorporated into the Monthly Report to help you recall some of your positive experiences in your early years.

You can learn more about Dr. Nabil Othman at <https://airwaybagelcoffee.com/>





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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

Chapter 2: Expertise, a Solution

"To study the phenomenon of disease without books is to sail an uncharted sea, while to study books without patients is not to go to sea at all"

-Dr. William Osler

"Incompetence is certainty in the absence of expertise. Overconfidence is certainty in the presence of expertise"

-Malcom Gladwell

When I applied to medical school in 2012, the three best known medical schools in Michigan were Wayne State in Detroit, University of Michigan in Ann Arbor, and Michigan State in Lansing. After I started my medical education at Wayne State, I heard a popular anecdote about my school's philosophy towards medical education:

"Three medical students arrive at the bedside of a dying patient. Their attending physician asks them what should be done. The first medical student from Michigan State is still talking to the patient about his life. The second medical student from University of Michigan can recite the most up to date research but has no idea what to do. And the third medical student from Wayne State has no idea what is wrong with the patient but knows exactly what to do about it."

The story is not meant to put down the University of Michigan or Michigan State. I consider graduates from both programs to be valuable colleagues. The point of the story is to emphasize Wayne State's philosophy of medical education. Wayne State emphasizes experiential learning. Looking back, I think the three medical students from the story represent the three things required for true expertise: knowledge (University of Michigan), metacognition (Michigan State), and experience (Wayne State).

In this chapter, we'll explore the reasons physicians are considered experts. For the purpose of this book, I define expert as "a person who, over the course of many years, accumulates knowledge, metacognition, and experience that enables him or her to make consistent accurate predictions in uncertain real-life situations." True experts possess an expanded perspective enabling them to successfully navigate uncertainty.

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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

§ Lucas and Ledgerwood §

I began to understand expertise as a medical student during my trauma surgery rotation when I met Drs. Charles Lucas and Anna Ledgerwood.

Anna Ledgerwood has a powerful personality. Don't let her innocent-looking tuft of white hair or Midwest accent fool you. She trained in an era when woman traditionally did not become surgeons so she had to work twice as hard to get half as much as her male counterparts. Her mind has only become sharper with age. When she walks into a room everyone knows who is in charge. Dr. Ledgerwood expects her residents and medical students to perform at her level whether they like it or not. Her green eyes can read your thoughts before you speak. Her kindness is as boundless as her anger. She will hug her patient one minute and erupt at her residents the next.

Dr. Lucas has a different style. He's tall and thin with pale blue-grey eyes and walks slowly with his hands comfortably folded behind his lower back. He can communicate complex thoughts with a single look. He's the kind of person who doesn't speak many words, but when he does everyone listens. Dr. Lucas has a different effect on his trainees. Even though you might meet him only a few times in your training, he feels like your most trusted mentor. He is the father-figure you never knew you had. With Ledgerwood you fear her wrath; with Lucas you fear his disappointment. I remember watching him examine a patient before taking her into the operating room. When she shuddered at his touch, he moved his right hand to his chest, produced a rare smile, and said: "Cold hands, warm heart." And that was all the patient needed to know she'd be okay.

Rounds with "the Ls" were quite different from other rotations. My first time rounding with Dr. Ledgerwood, she was appalled I didn't know where my patient went to high school. Medical students are expected to be encyclopedias of their patients, but I was still surprised by her level of expectation. From that day forward, I knew I had to buckle up and brace myself. My schedule was as follows: read the night before about my patients' pathologies, arrive at the hospital at 5:30am, prepare my presentation for rounds, and then be "pimped" during rounds by Dr. Ledgerwood.

If I didn't know the answer within five seconds I was in trouble. Dr. Ledgerwood would then ask the residents detailed questions about pathophysiology. The best medical students could answer all of her questions so the residents could relax in the background. If our whole team didn't know the answer, Ledgerwood would yell, "THIS PATIENT NEEDS A DOCTOR! ARE YOU THAT DOCTOR? ARE YOU THAT DOCTOR? BECAUSE RIGHT NOW I DON'T SEE ANY DOCTORS!" She looked us in the eyes individually as she'd say this, and when she felt especially offended she would turn around and walk away in disgust.

Rounding with Ledgerwood was intense-intense, whereas rounds with Lucas were calm-intense. When medical students didn't know the answers to his questions Lucas would sigh, look down at his feet, and shake his head. The sense of disappointment was overwhelming, especially because we knew he wouldn't let us finish our presentation. Instead, he'd ask the chief resident to summarize the rest and move on.

¹Many theories of knowledge exist. Mine describes how physicians think about uncertainty. There is more than one model of expertise - mine might serve the practical purpose of defining who is credible based on their ability to interpret uncertainty.



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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

After rounds I spent the rest of my day assisting in the operating room or carrying out floor work. My job was to be helpful in any way possible: from holding a retractor for hours in the operating room to faxing paperwork. Of course, I also wanted to learn from my patients. I remember many of their cases with great detail

One of them was a dangerously thin elderly African-American man with a short beard streaked with grey. His eyes were deep and brown as though they had endured a difficult life. I saw him in the emergency room because he was coughing up blood. He had a distinct black, shiny, foul-smelling stool called melena, which suggested a bleed in the esophagus or stomach. I passed a nasogastric tube into his nose, past his palate, arriving in his stomach. Immediately, 500cc of blood was suctioned out. He was then admitted to our general surgery service for management of a presumed stomach bleed.

Over the next day he received blood transfusions and an endoscopic exam of his stomach. His stomach biopsy showed a rare tumor called Gastric MALToma, a cancer of the white blood cells in the stomach

wall. This cancer is usually caused by a bacterial infection called *Helicobacter pylori* and is the only cancer that can be treated with antibiotics in the early stages. In this case, the cancer was eroding the wall of the stomach but had not metastasized. He would require radiation and possibly chemotherapy in addition to antibiotics.

During his five-day hospital admission, we walked laps together in the ward hallway every day. I learned everything about his medical history, histology, pathophysiology, staging, chemotherapy, radiation, and eligible clinical trials. I also learned about him as a person: his strained relationship with his family, past heroin use, intermittent homelessness, and how he slept in an abandoned attic for the last month.

On the last day of my rotation I was rounding with Dr. Ledgerwood. This time I knew everything about my patient including his medical history, social history, treatment options for his stomach cancer, and where he would go after discharge. Despite the fact I spent three hours preparing the night before my presentation lasted a mere two minutes. After I answered all of her questions, her eyes narrowed, she huffed air from her nose, and then stormed off without another word. As soon as she turned the corner, I danced in the hallway. I had received the highest compliment a third-year medical student on her service could receive: her lack of criticism.

With Lucas and Ledgerwood, I learned expertise is built on a foundation of knowledge. Experts are most likely to find the correct answer if they have a comprehensive knowledge of their subject. Missing a single detail could be the difference between life and death. This lesson would be confirmed over and over again in my anesthesiology residency training.

§ Knowledge §

Medical students are knowledge sponges. Every three months of medical school is approximately one undergraduate science degree. After two years of book learning students take an eight hour cumulative exam. Then in the third year of medical school students rotate in different specialties. They are tested once per month on their clinical knowledge. After third year they take another eight-hour cumulative exam. The overwhelming amount of knowledge acquired in medical school is commonly described as “drinking from a fire hose”. For perspective, I learned an entire semester of undergraduate immunology in 12 days.

²“Pimping” is the Socratic Method applied in medical education. The Socratic Method is a form of cooperative argument where both parties stimulate critical thinking in the other. In medical education attendings ask medical students and residents about their fund of knowledge and thinking process to expose gaps in their knowledge or flaws in their reasoning. The trainees try to make their attending run out questions. It’s like psychological chess.

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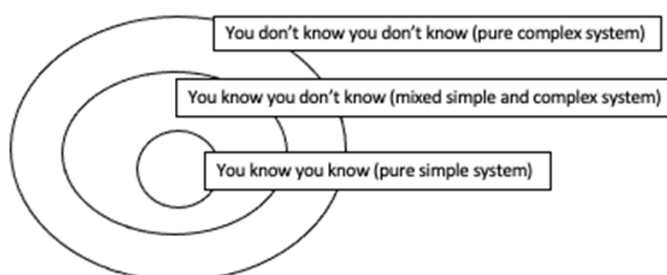


REPORT FROM THE OUTFIELD

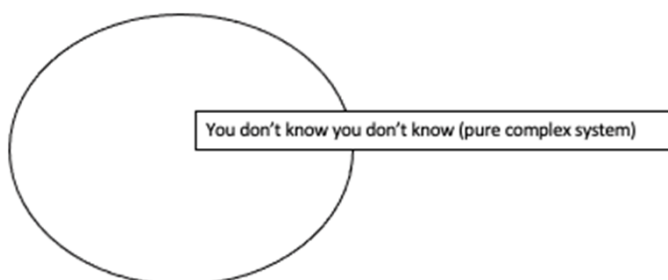
Creativity in Our Medical Graduates, cont..

Knowledge is the first component of expertise. To become a true expert, one must divide their knowledge into three layers: things they know, thing they know they don't know, and things they don't know they don't know. A diagram of this 3-layer model is below:

The following are diagrams for a medical student (start of training), resident (middle of training), and attending (fully trained).



Medical student knowledge:



³These cumulative exams are called USMLE (United States Medical Licensing Exam) STEP1 and STEP2. The amount of material covered is approximately 5,000 textbook pages each. Learning how to memorize then organize this volume of information is a skill in itself.

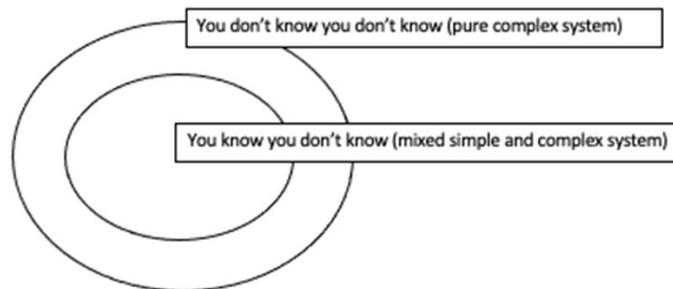
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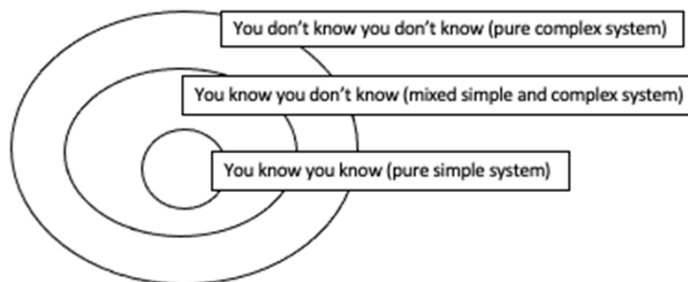
Creativity in Our Medical Graduates, cont..

Resident:



To residents, the world is a complex system that includes some cause and effect. They are trained to be cautious, especially when encountering new situations, so they don't cause preventable complications. There is always an attending physician immediately available just in case. That same attending also told me: "Make all your mistakes as a resident because you will have no one to correct them when you are an attending". Residents are usually frustrated because this learning occurs through years of tedious trial and error with an attending constantly micromanaging you...ask me how I know!

Attending:



Attendings have all three layers and can differentiate between them. They know when they are comfortable with a situation (first layer), when they are capable but need to be extra focused or acquire additional attainable knowledge (second layer), and when they do not have the expertise to properly evaluate a situation (third layer). At this point, they might consult another expert. No physician is an expert in everything...but they know what they don't know. True experts understand the limits of their knowledge because they can accurately triage data into the three layers, then give an informed opinion about how external data relates to their internal knowledge.

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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

Physicians must also learn how to weigh different kinds of knowledge. Lucas and Ledgerwood wanted to know if their medical students could differentiate between subjective and objective knowledge. Subjective knowledge exists in the mind of an individual-- it may or may not exist in objective reality because it consists of one person's limited perspective. Objective knowledge exists regardless of perception. Some examples of objective knowledge are bacteria, the sun, and gravity. They are independent of human perspective; that is, if all humans became extinct tomorrow they would still exist. Bacteria existed before humans could see them with microscopes. The Sun was around before humans existed. Gravity works whether you believe in it or not. Subjective knowledge exists in the fallible perspective of a single individual, objective knowledge can be observed by anyone.

The crucial difference between the two allows physicians to separate knowledge into the three layers. We even communicate with each other in terms of subjective and objective quantities: Unmeasurable quantities (subjective knowledge) include the patient's perspective of his or her suffering and the physicians perspective of the patient. Measurable quantities (objective knowledge) include the physical exam, labs, and imaging studies. We weigh each factor differently depending on the individual situation. Diagnosis is not following an algorithm. We need to see thousands of patients in a variety of clinical scenarios before we develop expert-level judgement.

§ Metacognition §

Lucas and Ledgerwood were correct to treat me with healthy suspicion. Even with the proper knowledge medical students initially struggle to understand what knowledge is most relevant. Rounds help medical students organize their knowledge into subjective and objective components. This process is called *metacognition* defined as "thinking about thinking." Metacognition, the second element of expertise, is the mechanism by which experts arrange knowledge into the three layers.

This process requires *abstraction*, which is the transformation of unrelated things into a common idea. Abstraction is a metacognitive language that allows humans to quickly communicate relationships between objects. Similes and metaphors are common examples. A boat is to the water as a car is to the...? (Road). A boat could be called a "water car" just as a car could be called a "road boat". Both are different objects but share the abstract quality of transportation. Metacognition can be separated into intelligence (abstraction with facts) and empathy (abstraction with feelings).

Intelligence is the measure of how well an individual reconciles their individual perspective with objective reality. For medical students this is measured by standardized tests and clinical performance. We must reconcile

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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

our imprecise perceptions with the objective anatomy, physiology, and pathology of our patients. Those who can adapt their perception to an external set of facts and/or patterns are typically considered intelligent. Examples include an engineer designing a machine consistent with the laws of physics, a poet writing poetry consistent with the existential conflicts of human nature, or a medical student diagnosing disease consistent with his patient's symptoms.

Empathy is abstraction relating human feelings. It allows us to recognize other humans as an extension of ourselves. Humans tend to become upset after hurting someone else unintentionally because we recognize the pain they feel as our own pain. Abstraction with feelings allows us to communicate patterns of relationships across a wide variety of experiences. For example, the Greeks had six words for "love" describing different ways people could be empathetically related. Agape means seeking the best for others regardless of circumstance, eros means romantic love, philia means friendship, storge is affection between parents and their children, philautia is loving oneself, and xenia means reciprocal hospitality between hosts and travelers. Expertise is by definition a human creation and therefore only exists in the context of human problems.

Lucas and Ledgerwood taught empathy in unique ways. I especially remember how Ledgerwood would make us present her patients during rounds. Before rounds started at 6:30am, we had to get our patients out of bed, sit them up in a chair, and place a clean white bedsheet folded in half in their lap. Their hospital gown and face needed to be clean. If her patients were not perfectly presented, she would accuse us of not caring about them and question our motives as doctors. After aggressively testing us for intellectual abstraction during rounds, she would walk into each patient's room and act like she had just seen her long-lost friend. She would sit next to them and talk with them about their pain, their feelings, and their family. She wanted her trainees to recognize their humanity in their patients.

Another one of my memorable patients was an exceedingly pleasant African-American man in his 70s. I ended up meeting him because his wife forced him to see a doctor after he saw blood in his urine. The workup included a CT scan of his abdomen which revealed a cancer in his right colon. Luckily for him, the cancer had not spread to the rest of his body yet. The thing I remember most about this man was his smile. He was kind to everyone around him no matter what happened. He had a bald shiny head, and the only wrinkles on his face were at the corners of his eyes and lips, presumably from a lifetime of smiling.

When he was first admitted to the surgical ward, I took his history and examined him. As I asked him about his history he quickly noticed my speech impediment. He told me he also had a stutter growing up. We spent an hour talking about how we overcame our difficulties: he read poetry out loud and I went to speech therapy. His wife and daughter were relieved he "finally went to the doctor after all these years". I quickly learned their patience had finally grown thin. Their family banter was a constant source of amusement.

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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

After two days of planning we took him to the operating room to remove his colon cancer. I assisted in the operation and even felt the edge of his liver for possible metastases. The edge was warm, soft, and smooth. It had the texture of cold butter and the temperature of warm bathwater. After his surgery we walked laps around the surgical ward every day as he recovered.

I updated him and his family every day of his progress. I checked on him twice a day: once before rounds and once in the afternoon. When he left the hospital, our connection had grown. His wife, ever the pragmatist, told him to “stop being weird” as she gently wheeled him towards the elevator. Empathy had built trust, and trust had built a (student) doctor-patient relationship.

§ Experience §

The third element of expertise is experience. Experience is essential for expertise because it validates knowledge and metacognition in objective reality. Obtaining knowledge and metacognition prior to practicing is helpful because it allows the expert to organize experiences into meaningful patterns rather than simply memorizing facts. Practicing without a basic understanding of principles is like memorizing the sounds of words instead of learning how to read. The memorizer would be unable to read a different text, the literate person would be able to read an unlimited number of texts. The memorizer is not literate but the reader is literate.

In medical education, we don't let medical students touch patients until they prove they have the knowledge and metacognitive literacy to do so safely. The pre-clinical years are for acquiring knowledge, the clinical years for metacognition, and residency is for experience. We need to see thousands of different patients in different settings in order to develop basic medical literacy. My final literacy test will be both written and oral exams administered by the American Board of Anesthesiology. If I pass, I can practice medicine unsupervised as a true expert.

§ True and False Experts §

True experts can organize their knowledge into three layers and differentiate between subjective and objective knowledge. Over time, their performance will improve because they can interpret and adapt to the world around them. Some examples include professional sports players, physicians, and mechanics. False experts are people who claim to be an expert but do not meet the criteria of a true expert. They lack knowledge (do not know basic information), metacognition (cannot meaningfully organize their thoughts), experience (direct interaction with reality), or results (the demonstration of consistent, favorable outcomes).

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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

You can apply this standard to daily life to identify false experts and misinformation. You will recognize a false expert because they exhibit overconfidence even when they are incompetent. Some false experts assume their individual perspective is a perfect representation of reality. They will resort to conspiracy thinking instead of admitting they might be incorrect. These people believe their world is a simple system rather than a complex system. They cannot conceptualize a world where additional actions exist outside of their perspective. They will disagree with known experts about basic facts and claim to have an extensive fund of knowledge without evidence. Some will even claim to “do their own research” but lack the knowledge, metacognition, or experience to confirm their expertise.

False experts often have difficulty differentiating between facts, inferences, and opinions. A fact can be proven beyond a reasonable doubt; it is objective knowledge. An example would be driving faster consumes more gasoline. Inferences are conclusions drawn from facts; they may or may not be true. They are a simple system with a complex component. An example would be driving faster consumes more gas, therefore raising speed limits will increase smog. Opinions can be statements from personal, religious, or political ideologies that cannot be confirmed or refuted. They have nothing to do with analytical thought or a discussion of the truth. An example would be “cars are my favorite kind of transportation.”

Finally, many problems of today’s complex systems rest on a simple premise: those who declare themselves experts are not responsible for the results of their opinions. Lack of accountability for false predictions encourages people to rely on luck rather than skill. False experts might make many vague predictions, hope one of them becomes true by luck alone, then claim they “knew it the whole time”. This is equivalent to someone claiming they had a 100% shooting percentage after making only one of ten free throws. In the other nine instances the person missed. True experts will be correct in the vast majority of their predictions even when their failures are counted.

§ Experts and Complexity §

After a significant amount of knowledge, metacognition, and experience accumulate, a true expert literally sees the world differently than non-experts. Their expanded perspective can quickly triage complications others cannot even perceive. Physicians acquire this cognitive structure in medical school. In anesthesiology I use it every day to manage unexpected events in the operating room and intensive care unit. I’m grateful for Lucas and Ledgerwood’s example of expertise. Ultimately, they showed me how to correctly organize my mind in order to manage complexity and Black Swans.

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REPORT FROM THE OUTFIELD

Creativity in Our Medical Graduates, cont..

Objectively defining our own level of expertise allows us to make better decisions about uncertainty. This cognitive model might be applied outside of the operating room to other situations. By evaluating the limits of our own knowledge, we can figure out how much expertise we actually have instead of becoming a false expert. If we can better evaluate the limit of our knowledge, we can figure out how much credibility to give to our own opinions vs. following the advice of someone with more expertise. Sometimes you will be the teacher, and sometimes you will be the student. Knowledge, metacognition, and experience can be compared between individuals to figure out who is the best qualified to evaluate an uncertain situation.



Dr. Nabil Othman

So far, we've seen how to recognize and classify synergistic interactions and how experts approach their learning in order to prepare for and respond to uncertainty. Next, we will explore the difference between productive and unproductive responses to uncertainty. Years of training are necessary to reprogram our brains to respond appropriately. Our own psychology works against us. Here, we will see why experts need extensive experience to face the ever-increasing complexity in our world.

⁴In order to have constructive interactions, we need to understand the limits of our knowledge. The old saying: "the less you know the more you think you know" is truer today than ever before in history. If we cannot define the limits of our expertise we will have a society of false experts. If you lack expertise in a subject your opinion in that subject area are highly likely to be incorrect. If you think you know more than an expert you should articulate why your opinion is superior despite having less knowledge, metacognition, and experience.

ADDEDUM TO JANUARY 2021 Monthly Report

The Smith Family

In the January Monthly Report we did not mention the names of the Smith Family in their Christmas greeting. The names in the photos on the card to the right are as follows (left to right):

Photo 1: Steve and Christina

Photo 2: Jenna and Scott

Photo 3: Noah, Anna, Liam and Mark

Photo 4: Julia





"EXCERPTS FROM LOG BOOK" - DOWN MEMORY LANE

Anna M. Ledgerwood, MD

4-18-70: Chief resident, Dr. S. Sukumaran; staff, Dr. T. Grifka

OW--lacerated extensor tendon left leg, tenorrhaphy and short leg cast application

CH—acute appendicitis, appendectomy

LT—intestinal obstruction small bowel due to adhesions, bilateral ovarian cysts, lysis of adhesions, aspiration of cysts and appendectomy

SB—abscess right breast, drained



Dr. Anna Ledgerwood

4-19-70: Staff, Dr. A. Arbulu

BD—acute appendicitis, appendectomy

GH—GSW left thigh with complete transection superficial femoral artery and vein. Repair of vein, arterial repair with saphenous vein graft

4-20-70: Staff, Dr. R. Lucas

LS—post GSW paraplegia with resection transverse colon and multiple perforations of liver/stomach—had fecal fistula, jaundice, did an ascending loop colostomy, a renal biopsy (Dr. Lucas study) tracheostomy

JF—intestinal obstruction post GSW--lysis of adhesions and appendectomy

4-21-70: Staff, Dr. Hartzell

FS—mechanical small bowel obstruction--lysis of adhesions and appendectomy

CC—subphrenic abscess, right suprahepatic and empyema right chest—drainage and tracheostomy

BW—GSW right lobe liver--exploratory lap, cholecystostomy and drainage

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DOWN MEMORY LANE

Anna M. Ledgerwood, MD

4-22-70: Staff, Dr. Kambouris

GB—GSW right arm, hand, upper forearm, right thigh, chest—complete transection right brachial artery in the arm and injury to median, ulnar and musculocutaneous nerves. Operation was debridement, brachial artery repair with saphenous vein graft and posterior splint application, fasciotomy

CD—pneumonia due to aspiration and alcohol, operation was bronchoscopy

4-23-70: Staff, Dr. Hershey

MM—acute appendicitis--found perforation with abscess, did appendectomy and drainage

KC—automobile accident—blunt trauma abdomen, exploratory lap, retroperitoneal hematoma, hematoma small and large bowel mesentery

MP—GSW right flank with perforation right lobe liver, laceration upper pole right kidney, retroperitoneal hematoma. Operation was hemostasis, evacuation of hematoma, and drainage

PL—lacerated median nerve, flexor tendon, left wrist repaired

Note to Dr. Walt: “This has been a productive two months for me in terms of quantity as well as quality. I certainly enjoyed the rotation.” (Sukumaran)

4-24-70: Chief resident, Carlos Carrasquilla; staff, Dr. J.C. Rosenberg

SC—GSW abdomen, eight holes jejunum, resected times two, GSW urinary bladder, GSW lower anterior sigmoid colon, which was tangential--operation suprapubic cystostomy done by GU resident, suture of bladder wounds, closure of anterior wound of the sigmoid with retrorectal drainage and a diverting colostomy





WSU MONTHLY CONFERENCES

2021

Death & Complications Conference
Every Wednesday from 7-8



Didactic Lectures — 8 am
Kresge Auditorium

The weblink for the New WebEx Room:

<https://davidedelman.my.webex.com/meet/dedelman>

Wednesday, March 3

Death & Complications Conference

Carotid Artery Disease

Alison Maringo, MD

PGY-5 Surgery Resident

Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, March 10

Death & Complications Conference

TBD

Cynthia Deaphart, MD

SICU Fellow

Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, March 17

Death & Complications Conference

Opioid Use Disorder

Andrew M. King, MD

Associate Professor of Emergency Medicine/Toxicology, WSU

Wednesday, March 24

Death & Complications Conference

Academic Surgery, Why Not?

Awni Shahait, MD

PGY-5 Surgery Resident

Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, March 30

Death & Complications Conference

The Pregnant Surgical Resident

Kaitlyn Woolley, MD

PGY-5 Surgery Resident

Wayne State University Michael & Marian Ilitch Department of Surgery



Wayne State Surgical Society

2021 Dues Notice

Name: _____

Address: _____

City/State/Zip: _____

Service Description	Amount
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2021 Dues Payment _____ \$200	_____
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My contribution for "An Operation A Year for WSU"	_____
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*Charter Life Member _____ \$1000	_____
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Total Paid _____

Payment by Credit Card

Include your credit card information below and mail it or fax it to 313-993-7729.

Credit Card Number: _____

Type: MasterCard Visa Expiration Date: (MM/YY) _____ Code _____

Name as it appears on card: _____

Signature: _____

Billing address of card (if different from above): _____

Street Address _____

City _____ State _____ Zip Code _____

*I want to commit to becoming a charter life member with payment of \$1000 per year for the next ten (10) years.

Send check made payable to **Wayne State Surgical Society** to:

Charles Lucas, MD
 Department of Surgery
 Detroit Receiving Hospital, Room 2V
 4201 St. Antoine Street
 Detroit, Michigan 48201

MARK YOUR CALENDARS



*Please Update Your
Information*

The WSUSOM Department of Surgery wants to stay in touch. Please email Charles Lucas at clucas@med.wayne.edu to update your contact information.



Missing Emails

Over the years the WSU Department of Surgery has lost touch with many of its alumni. If you know the email, address, or phone number of the following WSU Department of Surgery Residency Program graduates please email us at clucas@med.wayne.edu with their information so that we can get them on the distribution list for the WSU Department of Surgery Alumni Monthly Email Report.

Mohammad Ali (1973)

David B. Allen (1992)

Tayful R. Ayalp (1979)

Juan C. Aletta (1982)

Kuan-Cheng Chen (1976)

Elizabeth Colaiuta (2001)

Fernando I. Colon (1991)

David Davis (1984)

Teoman Demir (1996)

Judy A. Emanuele (1997)

Lawrence J. Goldstein (1993)

David M. Gordon (1993)

Raghuram Gorti (2002)

Karin Haji (1973)

Morteza Hariri (1970)

Harrison, Vincent L. (2009)

Abdul A. Hassan (1971)

Rose L. Jumah (2006)

R. Kambhampati (2003)

Aftab Khan (1973)

Samuel D. Lyons (1988)

Dean R. Marson (1997)

Syed A. Mehmood (2007)

Toby Meltzer (1987)

Roberto Mendez (1997)

Mark D. Morasch (1998)

Daniel J. Olson (1993)

David Packer (1998)

Y. Park (1972)

Bhavik G. Patel (2004)

Ami Raafat (1998)

Kevin Radecki (2001)

Sudarshan R. Reddy (1984)

Renato G. Ruggiero (1994)

Parvid Sadjadi (1971)

Samson P. Samuel (1996)

Knavery D. Scaff (2003)

Steven C. Schueller (1974)

Anand G. Shah (2005)

Anil Shetty (2008)

Chanderdeep Singh (2002)

D. Sukumaran (1972)

David G. Tse (1997)

Christopher N. Vashi (2007)

Larry A. Wolk (1984)

Peter Y. Wong (2002)

Shane Yamane (2005)

Chungie Yang (2005)

Hossein A. Yazdy (1970)

Lawrence S. Zachary (1985)



March 20

Wayne State Surgical Society

The Wayne State Surgical Society (WSSS) was established during the tenure of Dr. Alexander Walt as the Chairman of the Department of Surgery. WSSS was designed to create closer contact between the current faculty and residents with the former resident members in order to create a living family of all of the WSU Department of Surgery. The WSSS also supports department activities. Charter/Life Membership in the WSSS is attained by a donation of \$1,000 per year for ten years or \$10,000 prior to ten years. Annual membership is attained by a donation of \$200 per year. WSSS supports a visiting lecturer each fall and co-sponsors the annual reception of the department at the annual meeting of the American College of Surgeons. Dr. Jeffrey Johnson (WSU/GS 1984) passed the baton of presidency to Dr. Scott Davidson WSU/GS 1990/96) at the WSSS Gathering during the American College of Surgeons meeting in October 2018. Members of the WSSS are listed on the next page. Dr. Davidson continues in the hope that all former residents will become lifetime members of the WSSS and participate in the annual sponsored lectureship and the annual reunion at the American College of Surgeons meeting.



Members of the Wayne State Surgical Society Charter Life Members

Ahn, Dean	Bouwman, David	Fromm, Stefan H.	Johnson, Jeffrey R.	Montenegro, Carlos E.	Shapiro, Brian	Weaver, Donald
Albaran, Renato G	Bradley, Jennifer	Fromm, David G	Johnson, Pamela D.	Narkiewicz, Lawrence	Silbergleit, Allen	Whittle, Thomas J.
Allaben, Robert D.	Chmielewski, Gary W.	Galpin, Peter A.	Kovalik, Simon G.	Nicholas, Jeffrey M.	Smith, Daniel	Williams, Mallory
(Deceased)	Cirocco, William C.	Gayer, Christopher P.	Lange, William	Novakovic, Rachel L.	Smith, Randall W.	Wilson, Robert F.
Ames, Elliot L.	Clink, Douglas	Gerrick Stanley	(Deceased)	Perrone, Erin	Stassinopoulos, Jerry	Wood, Michael H.
Amirikia, Kathryn C.	Colon, Fernando I.	Grifka Thomas J.	Lau, David	Porter, Donald	Sullivan, Daniel M.	Zahriya, Karim
Anslow, Richard D.	Conway, W. Charles	(Deceased)	Ledgerwood, Anna M.	Ramnauth, Subhash	Sugawa, Choichi	
Antonioli, Anita L.	Davidson, Scott B.	Gutowski, Tomasz D.	Lim, John J.	Rector, Frederick	vonBerg, Vollrad J.	
Auer, George	Dujon, Jay	Herman, Mark A.	Lucas, Charles E.	Rose, Alexander	(Deceased)	
Babel, James B.	Edelman, David A.	Hinshaw, Keith A.	Malian, Michael S.	Rosenberg, Jerry C.	Washington, Bruce C.	
Bassett, Joseph	Francis, Wesley	Holmes, Robert J.	McIntosh, Bruce	Sarin, Susan	Walt, Alexander	
Baylor, Alfred	Flynn, Lisa M.	Huebl, Herbert C.	Missavage, Anne	Sferra, Joseph	(Deceased)	

Members of the Wayne State Surgical Society—2021 Dues

Alpendre, Cristiano V.	Edwards, Ryan	Kosir, Mary Ann	Noorily, Michael	Thoms, Norman W.
Asfaw, Ingida	Fernandez-Gerena, Jose	Lam, John	Paley, Daniel S.	Vasquez, Julio
Bambach, Gregory A.	Gallick, Harold	Larson, Sarah	Phillips, Linda G.	Ziegler, Daniel W.
Baylor, Alfred	Goltz, Christopher J.	Liebold, Walt	Schwarz, Karl W.	Zoellner, Steven M.
Carlin, Arthur	Hillu, John	Lopez, Peter	Shaheen, Kenneth W.	
Dawson, Konrad L.	Jeffries, Christopher	Malian, Michael S.	Siegel, Thomas S.	
Dente, Christopher	Joseph, Anthony	McGee, Jessica D.	Tarras Samantha	
Dolman, Heather	Kaderabek, Douglas J.	Meade, Peter C.	Taylor, Michael G.	
Dulchavsky, Scott A.	Klein, Michael D.	Mueller, Michael J.	Thomas, Gregory A.	



Operation-A-Year January 1—December 31, 2021



The WSU department of Surgery has instituted a new group of alumni who are remembering their training by donating the proceeds of one operation a year to the department. Those who join this new effort will be recognized herein as annual contributors. We hope that all of you will remember the department by donating one operation, regardless of difficulty or reimbursement, to the department to help train your replacements. Please send your donation to the Wayne State Surgical Society in care of Dr. Charles E. Lucas at Detroit Receiving Hospital, 4201 St. Antoine Street (Room 2V), Detroit, MI, 48201.

Albaran, Renato G.	Chmielewski, Gary W.	Francis, Wesley	Holmes, Robert J.	Lim, John J.	Novakovic, Rachel L.	Smith, Randall W.
Anslow, Richard D.	Cirocco, William C.	Gallick, Harold	Huebel, Hubert C.	Lopez, Peter	Perrone, Erin	Sugawa, Choichi
Antonioli, Anita L.	Conway, W. Charles	Gayer, Christopher P.	Johnson, Jeffrey R.	Malian, Michael	Porter, Donald	Sullivan, Daniel M.
Anthony, Joseph	Davidson, Scott	Gutowski, Tomasz D.	Johnson, Pamela D.	McIntosh, Bruce	Sferra, Joseph	Whittle, Thomas J.
Bambach, Gregory A.	Dujon, Jay	Herman, Mark A.	Joseph, Anthony	Missavage, Anne	Siegel, Thomas S.	Williams, Mallory
Bradley, Jennifer	Edelman, David A.	Hinshaw, Keith A.	Ledgerwood Anna M.	Nicholas, Jeffrey	Silbergleit, Allen	Wood, Michael H.

WSU SOM ENDOWMENT

The Wayne State University School of Medicine provides an opportunity for alumni to create endowments in support of their institution and also support the WSSS. For example, if Dr. John Smith wished to create the "Dr. John Smith Endowment Fund", he could donate \$25,000 to the WSU SOM and those funds would be left untouched but, by their present, help with attracting other donations. The interest at the rate of 4% per year (\$1000) could be directed to the WSSS on an annual basis to help the WSSS continue its commitment to improving the education of surgical residents. Anyone who desires to have this type of named endowment established with the interest of that endowment supporting the WSSS should contact Ms. Lori Robitaille at the WSU SOM> She can be reached by email at lrobitai@med.wayne.edu.