MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

MAY 2020

The Development of a Surgeon
Part 5

Sunday, May 10th

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Dr. Waldo Lorain Cain was a long-term private practicing surgeon in southeast Michigan and in the Detroit Medical Center. Throughout the years, he was a tremendous help in the technical and cognitive training of surgical residents. Each year, the residents would choose their favorite private practitioning teacher-surgeon who would receive a special plaque. This award was won by Dr. Waldo Cain so many times that the plaque is now described as the "Cain Award".

Recently, Dr. Joseph Sferra (WSUGS 1991) uncovered some information regarding a University of Michigan Medical School project entitled "Documenting the Health Care Experience of African-Americans in Southeast Michigan, 1940-1969." A wise man once said, "Knowing where you've been helps determine where you are going." The following is a continuation of excerpts from that interview.

When asked by the interviewer how he would approach the medical school process, Dr. Cain responded:

How would you approach it? Getting into medicine, going to be a doctor? My best advice is sort of all-encompassing advice that would be true for any discipline. You have to decide that you are going to work hard. You have to dedicate yourself to study and you have to try to give it your very best and do the best that you can and make sure that you enjoy what you're doing. If you don't' enjoy what you're doing, you're not going to be very good at it. But if you like it and you have fun at it, then you look forward to the next day, to going to work. But, in order to do that, in order to get to the place where you can do that, you have to sacrifice. You have to study, you have to work hard. You can't just go through the motions.

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I have used myself as an example to kids. Until I was in medical school, when I was in college, I was just going through the motions. I was going to college because everybody went to college. Until I got to premed and I found something I was interested in, I was no longer just going to college to be going to college. I was going to college to prepare myself to go to medical school. When I got to medical school, we, Hayward Maben and I made the conscious decision, "We're going to be doing this the rest of our lives, man. We're not studying just to pass examinations. We're studying to learn this stuff." That was a concept that we had at that time as medical students. I say, you've got to enjoy it. If I had to go to an office and sit down and work in an office all day, every day, and listen to people's stories and talk to them, I'd get myself another job!

Have you had experiences with alternative healers, or the non-traditional health care providers like folk healers, chiropractors, spiritualists, during the time that you practiced, between 1940 and 1969? *I have to say, at the outset, that I believe that chiropractic medicine is a cult. I don't believe it's science. I don't believe there's any scientific basis for what they claim. I have seen people to whom they do harm. It doesn't make any sense to me and I haven't seen any positive results from anybody who's been manipulated by a chiropractor. Chiropractors believe that everything is due to malalignment of the spine. From my perspective, and I think the perspective of any scientist physician, that's a lot of baloney. They can find something wrong with everybody's spine. Patients say, "Well Doc, he showed me the x-ray." I had a guy in my office, I just dictated the letter on, or just signed the letter today. A guy was sent to me to remove a lymphoma from his arm, because he went to his family doctor and he complained of symptoms, that to me, were kind of classic for a sensory root compression in his neck. He wanted this thing removed from his arm because he thought he was sleeping on his arm, and sleeping on his tumor, and that was what was causing it. He had been to his chiropractor. The chiropractor had told him that he thought that he could adjust his spine. Now, the chiropractor did one thing right. The chiropractor told him he thought his trouble was in his neck. He showed him some x-rays and said his spine was out of line. His spine wasn't out of line. He's got bone spurs in his cervical spine and he had compression of his sensor root in his neck. He'd wake up in the night and his*

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arm would feel dead, it'd feel like it had gone to sleep. "I'd have to shake my arm to make it come alive, Doc." He thought it was due to this damn little tumor, and his chiropractor wanted to take his neck and adjust his neck and make it get better. The man needs an operation on his neck so he can get the bone spurs off of his sensory roots. But the chiropractor doesn't know any better. He thinks he can fix him by adjusting his spine. I have a lady, right here in this building, that lives up on the 8th floor, married to a good friend of mine. Two or three years ago, she was having a terrible pain in her back. Oh, God, she was hurting so bad. I'm up in their apartment and down here, and she stated telling me about this terrible pain she was having in her back and she had been to the chiropractor and how he was going to manipulate her back and make her pain go away. So, I told her, "Girl, you better leave the damn chiropractor and you go see a doctor." I gave her the name of a doctor to go to see. The woman's backbone is bent almost like that and she got a cancer in the vertebrae body. I could just visualize what would've happened to her if the chiropractor started trying to straighten her damn bone out and break it, and she'd be paralyzed for the rest of her life. Anyway, she went to the internist and the internist sent her to the neurosurgeon. The neurosurgeon had to remove the whole vertebrae body and put in a new metal piece in there. But the chiropractor, he would have killed her.

I hope you don't go to chiropractors. I have no faith in chiropractors. I think the idea of everything in your body being due to what they call, a subluxation of your spine, has no validity at all.

How about spiritualists? Or herbalists? *I have no contact with spiritualists. Herbalists, I don't have any quarrel with, because they don't do any harm. I recognize that a large percentage of the effect of medicine is a placebo effect. Patients will get better, no matter what you give them, if they believe in you. You give them some pills and tell them it's going to get better", they're going to get better, a high percentage of them will get better. I don't care if you give them a sugar pill. If they really believe that you're the greatest doctor in the world, that this medicine is the greatest stuff in the world, they're going to feel better. Truly.*

Do ministers have the same effect? *I don't know. I would think so. I think that there is a large…., an undefined portion of getting well is faith.*

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I don't know what proportion it is, but I do believe that what a patient thinks, and how they believe, affects how they get well. I know that I can sit and talk to patients before an operation and explain in, not graphic detail, but tell them what's going to happen, how it's going to feel, and how it's going to come out, what we expect to happen. I tell all the good things — don't tell them any bad things — tell the good things that are going to happen, and then emphasize that you're going to have some pain, but it isn't going to be all that bad. I give them just a little speech. They do a lot better than people that you don't have any contact with before operation. A guy comes in and he's got a strangulated hernia and you don't really know him. They get along a lot better when you have a talk with them. They hurt less. They walk better. They feel better. I'm sure that's all in the mind. Now, I've had patients who have cancer and discontinue their chemotherapy because somebody had told them about the macrobiotic diet, or some other kind of diet. They go on these diets and they die. They die on time. So, I think herbalists might do some good if they're dealing with some of the diseases that are not malignant. Herbalists might do some good when dealing with hypertension. Who's to say whether those herbs have something to make blood pressure come down. But see, I deal with a lot of cancer. All of these so-called natural remedies, this holistic stuff, it doesn't do anybody's cancer any good and I know it doesn't. Don't tell me, "I ate garlic and my cancer went away." Baloney! Garlic has so much publicity now that people think garlic is good for everything. So, they think garlic may make your blood pressure go down. Now, I can't say it does, I can't say it doesn't, because I haven't followed people with hypertension who start eating garlic. But I know garlic will not make a cancer go away. I know that whatever you want to eat is not going to make this cancer go away. I had a guy in the parking lot, a couple of weeks ago, ask me, "Dr. Cain, do you eat a lot of antioxidants?" I said, "No. I just eat the same stuff I've been eating all my life. I don't eat that." He asked, "You don't take vitamin E?" I said, "No, I don't take vitamin E." "Well, you ought to be taking those antioxidants", (he's a parking attendant now) "You ought to be taking these antioxidants!" He said, "Man, that'll make you live a long time." I joked with him. I said, "Hell, I'm already old. What would I need antioxidants for?" Now, I don't say that antioxidants do nothing. They may do something. I don't know what they do. But, I don't believe that I would allow somebody to treat me with any kind of herbs unless I know what's in the herbs. Now, traditionally, you think about one drug that I'm

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taking now, just started taking last week: digitalis. It's nothing but an herb. Comes from Foxglove. It's a plant. Penicillin; nothing but a fungus. We just discovered that the fungus is good. So, there's some stuff out there in some of these herbs that may be doing something and we just don't know how it's doing it or what it is, so I don't have anything against them. The only thing I discourage, because as I said, such a high percentage of our patients have cancer, I tell them what I know works and what I know doesn't work. I discourage some people who want some cancer chemotherapy. I tell them, "It's not going to do you a bit of good. All it's going to do is make you sick." A lot of my colleagues disagree with my philosophy. I've got people who have cancer that no therapy known to man is going to alter the course. I tell people that. Some of my colleagues say you shouldn't ever do that because then patients have not hope. I tell the oncologist, "All you really got to sell is hope." I tell them that right to there head, "If you guys only treated the people that you could really do some good, you'd starve to death because there are not that many people out there where you can do some good." But they like to tell everybody…..we only had one medical oncologist in the entire medical center who would tell a patient, "I can't help you." He had to leave because he was starving to death. He was a guy from South America. But the professors, I see them all, and I've watched them for the past 40 years. They give people drugs when I know they know that this drug is not going to do them a damn bit of good. But they treat them anyway. I personally don't think that's right. But their philosophy is the patient must not lose hope. I say, "Well, it's better to let them go home and pray. It does them just as much good as giving them this poison."

What medical associations or professional affiliations are you involved with now? *I'm a member of the Detroit Medical Society, which is a local black medical society. I am a member of the Wayne County Medical Society, the Michigan State Medical Society, the American College of Surgeons, the Society of Military Surgeons, and the American Society of Abdominal Surgeons.*

American Medical Association? *I'm not a member of the AMA. I was a member of the AMA for many years, but the AMA's politics is too far right for me, and I got out of the AMA. I got out of the AMA, maybe 20 years ago today.*

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When did you join the AMA? When were you a member? *From the time I came home in 1963 until, I'm not quite sure when I got out of the AMA.*

Did you have a problem with becoming a member? *No, I had no problem getting in. You'd just sign up and join. See, but at one time when I first came here, when I first started trying to get on the hospital's staffs, you had to belong to the local medical society, the state medical society, and the AMA. So, I belonged to all of them because I didn't want them to have any king of reason to say, "You don't qualify." But, as the years went by, when the AMA….the political stand was too far right for me. The AMA was opposed to Medicare. It was opposed to Medicaid and a whole lot of things. I said, "I can't belong to this organization." So, I just stopped paying dues. So, I'm not a member of the AMA. I still get all of the AMA literature and they send me a journal, but I'm not a member. But everything else. As I said, I'm a member of the College of Surgeons, local and national.*

What about the National Medical Association? *Yes, I belong to the NMA. I'm an emeritus member of the National Medical Association and what is equivalent to being an emeritus member of the College of Surgeons. Of course, you turn 70, you just automatically become a paid-up member. You don't have to pay dues anymore and you don't have to pay any fees for anything in the College of Surgeons. The National Medical Association requires that you must apply. I gave them hell, because I said, "Why should I…. You guys have been in existence this long and you know I've been in this thing. I've been on these committees, I've been doing all of these things all of these years, and then you got to tell me that I have to apply and then submit the names of people to recommend me for emeritus classification and I'm submitting the names of four people I practically raised." But I had to go through that.*

It's a formality? *Yes, a formality you go through in order to get declared emeritus But the College of Surgeons didn't do that. I turned 70, they just automatically sent me all of this stuff and said that you are…..the first thing they sent….somebody must have objected to it because it was a class that implied that you'd been turned out to seed. They changed the designation. Now, they just say you are a fully paid member. They don't call you emeritus. They say you are a fully paid member. You don't pay dues.*

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You don't pay registration fees. You don't do anything. Well, the same thing is true because you're emeritus. But it's just automatic with a big institution like the College of Surgeons.

How were blacks viewed in the research arena? In other words, how did African Americans impact the health sciences in southeastern Michigan during the 1940s throughout 1969? Were they respected in that area? *Well, first of all....the basic word is, "I don't know." The only person that I know who was doing any kind of research at all, a black person, was Dr. Charles Whitten. He did a lot of research on Sickle Cell disease. He's highly regarded, everywhere. But for basic research, I don't know of anybody else, black, who was doing any fundamental research.*

What we wanted to do was ask you some questions in regards to some health issues in Detroit during the 1940s throughout 1969. What was the perception of many of your black patients, and other blacks with regard to chronic illness, understanding what it is, following the treatment regimen, and also mental health issues? So, it's a two-part question. *I don't have an opinion about mental health issues. I find that patients will follow treatment plans provided you make sure they understand. If you have the proper vocabulary and you can speak to people in terms that they understand, they will follow. I think where you have difficulty with a lot of physicians, be they black, white, or whatever, a lot of them talk in terms that patients really don't know what they're talking about. Or, as patients tell me, they don't talk to the patients hardly at all. One of the big complaints that I see, and I have a pretty narrow practice, a referral practice, is that physicians don't talk to their patients. They don't sit down and talk to them and explain to them what's going on. I had a patient who got cancer referred to me and the doctor knows they have cancer. That's the reason he sent him to me. The patient didn't know it.*

Did they do a better job back in the 1940s through the 1960s than they do today? *No. No, I think right now, and it has always been true, and I don't know whether it's just true of us, or if it's true of the white doctors, because I rarely get a patient from white....I get some referrals from white doctors, but very little. But, a high percentage of patients, who are sent to me don't really understand what's going on with them. It's not because they don't have the ability to understand, it's because they've never been told.* Continue page 8

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They've never been told in language, in words that they understand. Now, I'll tell you one other thing about what I believe about health care, particularly among internists and primary care people, particularly as it has to do with seniors. I have patients come to me with a brown paper bag full of medicine. They put all of this medicine out on the table and say, "I take this one twice a day, I take this one three times a day, I take this one so and so…." and they're maybe taking seven or eight different kinds of medicine every day. There's no way in hell the patient is going to be compliant. Right now, I take three kinds of medicine and I take it all in the morning after I brush my teeth. Once in a while, I forget and I've got to go back to the bathroom after I've sat down at the table and had breakfast, go back and take my pills. There's no way in the world you can tell me that a senior citizen is going to take eight different kinds of medicines at different times, different intervals, every day. No way! So, they're following directions? No. The doctor's not getting the kind of result he expects from his treatment. You're not getting results because the patient's not taking the medicine. The patient's not taking the medicine because they've got too many different schedules of medicine to take. You just think about it, if you have eight different kinds of medicine, taking them at different times, two hours, three hours, six hours, you spend all you day thinking about when am I going to take my next drug And people don't do that. So, talk about compliance, they're not complying because they're taking too many drugs and some of them are not complying because they just don't understand because the doctor didn't take the time to explain. You see, a lot of us so-called educated people, I think we don't give the uneducated people enough credit. We think if he's just barely got out of high school, or didn't get out of high school, he doesn't understand. Hell, they understand. They might not understand all the words that you would ordinarily use, so you break it down to words that they know, and they understand. They will be compliant if complying is not too complicated. See, complying can get to be complicated, so your regimen has no effect. That's just another personal pet peeve of mine.

So, do you think that between the 1940s through the 1960s, that African Americans in particular, had a very clear understanding of the nature and seriousness of things like diabetes and heart disease? *No. No, I think they have a better understanding now. I think that there are still people out there, and I know there were back in those days,*

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who believe that hypertension could be cured. They'd take some medicine and they'd say, "I went to my doctor. My blood pressure's down," and they stopped taking their drug. Back in those days there were many people who used to believe, I don't think they believe it now, there were diabetics who believed that if they get their sugar under control , then they can stop taking their insulin. There were people who believed that. I don't think they believe that nowadays, but I think they used to believe that. People who are diabetic will understand that diabetes can't be cured, but the doctor has to sit down and tell them. Maybe not tell them once, but tell them twice, tell them three times. "You've got a disease that can't be cured, but you can live with it if you respect it and you do this and do that." It's just like, all black folks know about hypertension, but the vast majority of black people who are past 50, will think and will say, "If I don't eat any pork, my blood pressure would be alright." They believe that. That's a belief that has been handed down for generations and generations because salted pork is bad for you Makes your blood pressure worse. For years and years we would cure pork in salt. You eat that pork, you get overloaded with salt and then makes you blood pressure worse. But people start getting to the point where they believe it's the pork. They don't think of it as being just the salt. They believe, "If I don't eat pork, I'll be alright. My blood pressure will be alright."

What was the community health status like back in the 1940s through the 1960s? When I say community, I mean the black community. Would you say the health status was good, fair, or poor? *Overall, I would say poor.*

What were some of the most common problems that black patients had during that period? *I can't really say because I've never been exposed to the common problems. All I've been exposed to is surgery. So, I have no exposure beyond my own field.*

What about the most serious problems, even outside your field of surgery? *The most serious problems are probably the same kind of problems there are today outside of surgery. Our most serious problems are hypertension, diabetes, and obesity. Just as I think about it now. When I say hypertension, I mean heart disease. I don't know that I can say that lung disease, lung disease is probably… I don't know how cancer of the lung and bronchial disease and those various kinds of lung diseases fit in there, but the most serious problem we have is hypertension, then diabetes, and as a result of the*

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hypertension and/or diabetes, kidney disease.

So, things like sexually transmitted disease weren't a problem back in the 1940s throughout the 1960s? *They were a problem but they didn't make you really sick. Back in the 1940s and 1960s, practically every young man growing up had gonorrhea at least once, sometimes two, sometimes three times. In those days, we didn't know a thing about chlamydia.*

How about syphilis? *Syphilis...I don't think the incidence of syphilis....well, I don't really know about that, but my guess would be that the incidence of syphilis has probably gone down a whole lot just with the advent of using condoms. I remember when I was in medical school, we had a whole book, a course called syphology; and there wasn't a white person, or a white picture, in that book. A whole book on syphilis and all pictures and illustrations and everybody in there was black. The book was written by white people.*

Does the book come out of a part of the Tuskegee study? *No. No, the Tuskegee study was ongoing, I'm sure, at that time, but this was just a book written on syphilis. All of the illustrations of the primary lesions of syphilis, the secondary lesions of syphilis, what syphilis does to the brain and to the heart and to the blood vessels and to the skin, every illustration in that book was black. There were no white people in that book at all. Of course, everybody at Meharry in the medical school recognized this. Damn, you'd think white folk don't get syphilis!*

What about tuberculosis during that period? *Yes, tuberculosis. I don't know how the incidence of tuberculosis has changed. I don't really know whether the incidence of tuberculosis has gone down. I know tuberculosis used to be very common. I guess Herman Kiefer Hospital was full of people all the time, but I think Herman Kiefer Hospital is not full of people now because they have so many drugs to treat tuberculosis with that you can take on an ambulatory basis. So, as far as the incidence of TB is concerned, I don't really know. I heard on the news reports that the incidence of TB is going up. But I don't know if that applies to just one ethnic group, or to everybody.*

Do you think that during that period from 1940 through 1969,that there was a certain understanding within the African American community about how illnesses were caused? *Do you mean, when you say... you don't mean in the*

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African American medical profession?

No, outside of the medical profession. *No, I don't think that the man on the street believed that there was any difference in the cause of disease in blacks than it was in whites.*

And in the medical profession you didn't find that to be the case? *No.*

What about the long-term care of the elderly? Are you familiar with, or were you familiar with, during that period of time, nursing homes or homes that were specifically geared to care for the aged, and the mentally ill? *The first answer is, and I'm not really familiar with any competence, but for long-term care, nursing homes, I don't think they really existed to any extent probably prior to the early 1960s. Dr. McClendon had a hospital. It was a TB hospital and I think they eventually converted it into a nursing home.*

How were most elderly black patients cared for during the 1940s through the 1960s? *At home. I think a high percentage of black elderly patients I've cared for are at home now. I don't mean people who are totally incapacitated. I mean people who are just old and can't take care of themselves adequately. Somebody who can sit up, and eat, and can walk around, but can't handle himself. I think most of this is done at home. I don't know whether black people are any different than white people, but I think we are very reluctant to put our people in a nursing home. I don't know whether this has anything to do with past history, or why it's true, but I think that black families, black children, are less likely to put their parents in nursing homes than the white population. This may be just a perceived ethnic difference on my part.*

When I think of my sister, who I told you just recently died, she was 97 and she'd been incapacitated for at least 10 years. She has a son and, fortunately, she had enough wherewithal that she could have a 24-hour companion to be with her. It never occurred to him to put her in a nursing home. As long as she was able to feed herself and didn't have to be waited on 23 hours a day, she stayed at home. I think that, had her background and her son's background been different, had she come from a different ethnic background, or maybe a different family background, she probably would have been in a nursing home a long time earlier.

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What was your greatest source of support and strength as a practicing surgeon? *I can say that I have received great support from the medical community, from family, from friends, from everybody. As I said, the medical community accepted me and supported me with referrals from day one.*

You're speaking about both black and white professionals? *No. The white professionals rarely did. I get very few patients from white professionals. Very, very few. I remember I used to get patients from a man down in southwest Detroit, whom I've never met. He had a Hispanic name. The man's name was Pedro Martinez. Anyway, this guy used to send me patients when I was working down at Burton Mercy Hospital and I'd never met the man. I talked to him on the phone, I would write him letters and talk about his patients, but never saw him. I used to get a few patients, but as a general rule, the white practitioners support their people. But so far as our own group was concerned, I had just outstanding support from the very beginning.*

Tell me again about your appointment to the Wayne University Medical School. *I remember this Anglo-Saxon American (Dr. Charlie Johnston) who denied me a faculty appointment and along comes a South African Jew (Dr. Alec Walt) and he invites me onto the faculty and, since then, I must have at least three or four teaching awards, and the first guy didn't want me on the faculty.*

When were you denied? *When I came home in 1953. I went down to Wayne Medical School and called for an appointment with the professor. I went down to have an interview with the professor to seek a faculty appointment. The professor was in Japan on a lecture tour. I met with the vice-chief (Dr. Nicholas Gimbel) who was a full-professor. He told me I was going to be appointed instructor and what my duties were going to be and when I would have to work down at Detroit Receiving Hospital, which was fine by me. But he called me about 10 days later and told me, "The professor is back from Japan and the professor said 'No'." That was it. The professor didn't know anything about me except that I was black. He knew I was a board certified general surgeon. His only reason for denying it was that I was black. See, at that time, there had never been anybody black trained in the university medical system. Nobody. He had never trained a black surgeon. I think, a*

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couple of years after that, he took Tom Flake Sr., MD, who is the father of one of my junior partners now. Tom Flake was the first black surgeon that ever trained downtown. He was my contemporary in age, but he, Tom, went to Wayne. He must have gone to Wayne maybe five or six years after I went to Meharry. So, medically, he was five, or six years younger than I was. But Dr. Johnston, they just didn't, had not ever accepted anybody black.

So, when were you appointed to the medical faculty? *1968. I just got a form to fill out, which I haven't sent out yet, that the tenure promotions committee had recommended that I be made a full clinical professor. I said "Well, I guess they figure you're on your last leg. Boy, you're going to die pretty soon, so we'll make this guy a professor before he dies."*

You've just been through an awful lot and my hat's off to you and all the other warriors out there for fighting against the injustices. *Well, I tell you, I had a lot of fun doing it. I enjoyed myself.*

Who were some of your colleagues that helped you? *The one who used to assist me the most was Dr. Charles Wright. Charles Wright was OB/GYN and he didn't know anything about doing a gastrectomy or a gall bladder, but he'd come and help me. He's got good senses, he's got good hands, and he could help. But I was supposed to be furnished a resident by the hospital. That's why, I told you, I threatened to sue the hospital. They wouldn't give me a resident. I said, "'I'm going to sue you and I'm going to have my patients sue you unless I get an assistant."*

Well, thank you Dr. Cain. We really appreciate you taking this time to provide us with this perspective. *Well I hope it does some good.*

Well, it will do a lot of good and will really add substantial value to what we're trying to do in documenting the historical experience of African Americans. Both you and your wife are a welcomed addition to our oral history collection. Being able to share your experiences with us and with others is just going to be tremendously important, not only to the state of Michigan and to black medical history, but to US history, so, I thank you.

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Peter B. Baute, MD (1934-2020)

Dr. Peter B. Baute

Dr. Peter Brueckner Baute was born in Providence, Rhode Island, in 1934. Following his elementary education, he matriculated at the University of New Hampshire, where he graduated in 1976, and then entered the Hahnemann Medical College in Philadelphia. After the completion of his medical school training and internship at Hahnemann, he went on active duty with the United States Navy and served in Vietnam. Following his contribution to our nation in Vietnam, he entered into a surgical residency in 1964. Prior to finishing his training at WSU in 1969, Pete had many memorable experiences. Pete began his experiences at WSU by working in the "pits," the term affectionately applied to the emergency room (later emergency department) at the old DRH. Although he was in excellent physical condition, the long hours and demanding work made the old man (42 years) realize he wasn't quite as tough as he had been coming to Detroit. He often found an unoccupied cart full of plaster in the old cast room, where he would catch 40 winks until he adjusted to his new demanding schedule. The concept of an 80-hour workweek for residents had never entered anybody's mind at that time, and one had to be very efficient in order to survive; catching 40 winks here or there was one of the methods for survival. During those years, a chief resident worked two months of straight nights and had two four-person teams under him/her. During the first month, one team would work the day shift and the other team would work the night shift; the next month, they would switch. The "pits" became one of Pete's favorite rotations, as he learned from his respected mentors, Dr. Dick Dean, Dr. John Andrew, and Dr. Bob Moffat among others, how to quickly assess a problem and bring about a rapid, logical solution. He was amazed as to how his confidence grew on each rotation, so that by the time that he was the first assistant (first cutter) and later chief, he felt comfortable in dealing with any unusual acute care situations. This background allowed him to develop into a self-reliant surgeon who was able to tackle unusual problems for the rest of his surgical career. Pete has a special remembrance of one of the unusual situations he faced when he was the chief working the night shift in the emergency room. A patient came in with a gunshot of the chest and had active bleeding emanating from the emergency chest tube placement. He was brought in as a police prisoner and was shackled to the cart. The patient needed to go to the operating room for a thoracotomy

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
WAYNE STATE

Peter Baute, MD, cont...
(1934-2020)

and control of bleeding, but was shackled to the cart, and the police officers were nowhere to be found. From the time of his days on the surgical fracture service (General Surgery cared for all fractures three out of seven days a week), Pete still had his heavy shears and was able to cut the chain connecting the patient to the cart so that the patient could be transferred onto the OR table. Following thoracotomy and control of bleeding from a pulmonary injury, the patient had an uneventful recovery. The other half of the story is much more interesting. Some time later, the police found that their chains had been cut and they thought that the prisoner had escaped. The chief police officer in the hospital during the night rotation was extremely upset, resulting in a rather vocal disagreement between Pete and the officer. Anybody who rotated for five consecutive years in "the pits" is not intimidated by anybody short of God, and Pete very loudly proclaimed to the police officer that he would do the same thing tomorrow if that was what was necessary to save the patient's life. Feeling good about himself, Pete left in the early morning hours to get some well-earned sleep and be prepared for the next night shift, which would begin about 5:30 that afternoon. Needless to say, the police officers at the hospital were not about to tolerate this arrogant surgical resident. An embellished version of the episode quickly made it up to the City of Detroit Chief of Police and then into the Mayor's Office. About 9 o'clock that morning, Dr. Alexander Walt, our chairman, received a call from the Mayor's Office. They wanted this resident called Dr. Peter Baute removed from the residency program.

Dr. Charlie Lucas was paged to come to Dr. Walt's office to learn about the now exaggerated episode that occurred. Dr. Lucas, who had just made rounds on the patient, informed Dr. Walt that the patient was doing great and that Pete had saved the patient's life. This defense of Pete caused Dr. Walt to feign more anger as he instructed Dr. Lucas to go get Pete into his office immediately. When Dr. Lucas awoke Dr. Baute at about 10 o'clock in the morning, Pete was full of "piss and vinegar" and self-righteousness and was about to crucify Dr. Lucas for waking him out of a deep sleep. As Dr. Lucas waited around the outside of Dr. Walt's office for Pete to show up, he noticed that Pete was still full of much energy and was about to knock Dr. Walt's head off as soon as he got a chance to go into the office. Once Pete learned that the issue had already gone up to the Mayor's Office, he was convinced to be apologetic that he had caused Dr. Walt so any headaches. Everything was resolved without any further ado. Pete always claimed, "You know, I don't think the chief (Dr. Walt) was too upset, and maybe even a bit pleased by one of his residents definitive, take charge approach."

Following his training in Detroit, Pete moved to Kent Hospital in Warwick, Rhode Island,

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
WAYNE STATE

Peter Baute, MD, cont...
(1934-2020)

which he described as being a far cry from Detroit. During his training years, Pete was stimulated by Dr. Irwin K. Rosenberg and the chief (Dr. Walt) to develop a greater interest in cancer surgery as a major portion of his surgical career. This not only related to the operative treatment of patients with cancer but to the postoperative care and counseling of these patients, who need a tremendous amount of support. Pete was very proud that even after almost 10 years since he'd retired from hospital practice, patients still called to get his thoughts and advice when they learned that they had cancer. His interest in cancer during the early years of mammography stimulated him and his favorite radiologist, Dr. Gillian Newstead, to gather data on their own experiences. This led to the lead paper in Surgery, Gynecology and Obstetrics in 1980, when they identified a method for more accurately identifying those patients who required needle localization. Based upon these studies, they were able to reduce the number of patients who did not need needle biopsy and, thus, were able to increase a percentage of positive biopsies from 5% to over 30%. His continued interest in the cancer area led to his hospital becoming the first Community Hospital Cancer Program in Rhode Island approved by the American College of Surgeons Commission on Cancer. This involvement led to Pete becoming a cancer program surveyor for the Commission on Cancer for several years, when he had an opportunity to visit many hospitals in the New England area.

Like all busy surgeons, Pete had a number of anecdotal tales. He especially remembered Olaf, a Scandinavian retired sea captain, who presented with a colon cancer and liver metastasis. Pete saw Olaf late in the afternoon on a busy office day, so that Olaf had to wait a long period. After visiting with Pete, Olaf went back to the waiting area and informed the whole group, "You know he's worth waiting for." What a wonderful compliment! Pete remembered another patient, an old farmer who brought his wife in from some distance from Warwick. She didn't have much to say; he did all the talking. Except for the fact that looking to be about 70 years of age, you would have thought that she was pregnant or had massive ascites. The old farmer, however, insisted that she had not had a bowel movement in about a month. He added, "I knew 'twas an emergency, but I had to get the truck paid for first. I came as fast as I could, and don't you know it, I got stopped for speeding." Working with his nurse, Pete did all he could in the office with little success, so he took the old lady over to the hospital endoscopy

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Peter Baute, MD (1934-2020)

suite. After much work, they hit pay dirt, or as Pete said, "Pay dirt hit us." The room was covered with brown spots all over the floor and many parts of the wall as were Pete and his nurse after they decompressed her volvulus and unleashed a volcano. The next day, the nurses had a banner flying, which awarded Pete "The Dalmatian Award of the Year" for redecorating the endoscopic site.

Pete & Cindy Baute

Like many residents who trained in the old program, Pete always had an interest for missionary medicine. When he came across a small announcement in the Rhode Island Medical Journal about an opportunity to work with the Catholic Medical Missions in rural Honduras, he volunteered and was told it would even be more helpful if he could put together a team. Stimulated by Pete's excitement, he was able to convince two surgeons, two anesthetists, and four nurses to make up the team. The nurses managed to scrounge all sorts of material that would otherwise have been thrown away. They sterilized and packed the materials, including drapes and instruments plus additional materials that were donated by sales representatives. One of the anesthesiologists gathered up an inventory of drugs along with the clearance to transfer them from the USA to Honduras. When they arrived in Jutiapa, there were many patients lined up for a triage visit and, over the next five days, they did 40 operations including many difficult cholecystectomies, which is a common but, unfortunately, often untreated disease in that population. Pete and his team were back there on many occasions, so that it had become a tradition. Pete and his team had also visited one of the mountain villages in Nepal, and he continued to do volunteer work at a free clinic in Providence. Pete stated, "What one does for many of these people who have so little is so rewarding because they are uniformly so grateful."

Pete wished he could teach all of the extended surgical clan about Block Island, a small place of about 1000 hardy souls. Block Island is 12 miles out to sea from the mainland of Rhode Island. Years ago, Pete had the privilege of relieving the island's doctor form time to time. Block Island has a small medical center which, basically, is an outpatient facility with examining rooms and a room for suturing and caring for minor trauma. The Block Island Citizen Board

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WAYNE STATE

Peter Baute, MD (1934-2020)

asked Pete to take a half-time position there in 2000. This turned out to be a good way for Pete to transition into retirement. He became a primary care physician and, because Brown University medical students have a rural care rotation there, he was appointed an Assistant Professor in Family Medicine at the Brown University Medical School. He was the only physician separated by over 10 miles of ocean with a limited ferry schedule, compromised by frequent fog, and there were often anxious and even scary situations ranging from unconscious head injuries, to myocardial infarctions, and once an 8-year-old who arrived with diabetic ketoacidosis.

Pete sometimes had to serve as an emergency veterinarian, since they do not have a veterinarian on the island. His veterinarian cases included removing a fishing plug from the belly of a black lab and treating a forepaw amputation in a cat. He and his wife, Cindy, also gave antibiotic injections to local camels that had infectious problems.

Since being involved in this activity, Pete talked about one special patient that he cared for. This was a 30-year-old hippie-type person married to one of the local fishermen. She was brought in one night with awful abdominal pain. Even though Pete never rotated on gynecology, it did not take him long to figure out that she was about eight months pregnant and was having severe biliary colic. Pete wanted to alert her gynecologist on the mainland but found out that she didn't have one. He was informed that the midwife would be coming over on a ferry when the time for deliver came. Pete had asked, "What happens if the weather is bad and the ferry doesn't run?" She replied, "Then you can do it." When Pete explained to her that he had not delivered a baby in 30 years, she responded, "Don't worry, I'll tell you what to do."

The following are Dr. Anna Ledgerwood's (WSUGS 1972) thoughts regarding Dr. Baute. Dr. Peter Baute was an outstanding mentor and resource for me as a rotating intern at the Detroit General Hospital. I would regularly seek him out for advice, an opinion, or an assessment of a patient, while I was on the medicine service, and he would always be receptive, responsive, and helpful. I was fortunate to rotate on his service as a first-year surgical resident, and he patiently taught me the basic surgical skills. I looked up to him as an excellent surgeon but, more importantly, a superb doctor. I will never forget the day when we were making rounds on Division II with attendings Dr. Irwin K. Rosenberg and Dr. Yvan Silva. I was the rotating intern,

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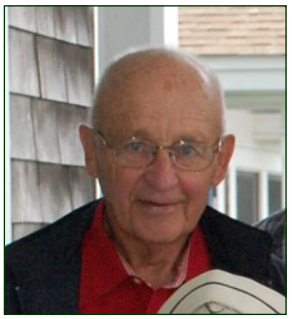
WAYNE STATE

Peter Baute, MD (1934-2020)



Dr. Peter Baute (1934-2020)

and Dr. Stefan Fromm was the chief resident, and Dr. Baute was the assistant chief. The patient being presented had undergone a vagotomy and antrectomy three days prior and, unfortunately, the spleen had been injured and she required a splenectomy. After the patient had been presented, the attending asked (in front of the patient) if she had been told she required a splenectomy. Dr. Baute had been the surgeon, and the patient had not been told. We departed the room and entered the hallways, at which time Dr. Baute chastised the attending for discussing this issue in front of the patient on rounds. He had planned to do this privately with an opportunity for questions after the patient started diet. He informed the attending, in what seemed like a long diatribe, that he was inappropriate. When he finished chastising this attending, he walked out! This poor intern was afraid Dr. Baute had left the program! I was convinced this was true when he did not come to clinic that afternoon. It was only later that I learned he had left to pick up his wife and newborn at the hospital and take them home. Several years later, I "sacrificed" the opportunity to participate in the ACS convocation , where I was to be inducted as a Fellow, in order to have dinner with Dr. Peter Baute—a most enjoyable experience.

After being involved with his volunteer work on Block Island, Pete retired and became more involved in town government. Energy concerns became a major focus for Pete, since the electric utility charges on the Island are more than three times greater than on the mainland. Cindy and Peter were married many years ago. Their union brought together Pete's four children and Cindy's two children. All are grown and doing well on their own. Dr. Peter Baute left us for the next world on April 4, 2020. The extended surgical clan extends their deepest sympathy to Cindy and their family.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
WAYNE STATE

DOWN MEMORY LANE

Anna M. Ledgerwood, MD


Dr. Anna Ledgerwood

It was 48 years ago this week (April 12-18, 1972) that I was the chief resident on the Emergency Surgery Service at the old Detroit General Hospital. The Emergency Surgery Service had two teams. One team covered all patients in-house with daily progress notes, rounds with the attending, and all patient care and any operations that needed to be done during the day. The night team worked from 6:30 p.m. to 6:30 a.m. and was responsible for the history and physical and treatment of all patients who presented during those hours. The chief resident presented to the hospital at 6 p.m. and made rounds with the day team and then rounded with that same team the following morning at 6:30 a.m. There were no work-hour requirements, but each team member had one day off a week. At the end of one month, the day and night teams switched. It was generally thought that the day team took care of all of the complications created by the night team, and there was some truth to that. The attending surgeons for the service were Dr. Charles Lucas (WSU/GS 1962/67) for the first half of the week and Dr. John Kirkpatrick for the last half of the week. Each night was covered by one of the full-time faculty members or by one of the community surgeons who came back to support their program. The attending staff who covered weekends were paid $125 per day/night, and the surgeons who covered the night shift were paid $75/night if they were in-house. The log books, from which this information is obtained, was used to document the attending surgeon's presence in-house and was completed each day by the chief resident. A sample of a week completed 48 years ago is presented.

4/12/72

Staff—Dr. C. Benavides

1. Incarcerated right inguinal hernia, reduced and repaired with orchiectomy.
2. GSW abdomen (age 22), TNT right lobe liver, TNT duodenum closed.

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
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DOWN MEMORY LANE, cont...

Anna M. Ledgerwood, MD

3. Strangled and ? Raped (age 10), fractured larynx, admitted with marked respiratory distress, arrested in OR, intubated, tracheostomy and repair of larynx done.
4. DTs, pancreatitis, pneumonia with respiratory distress, tracheostomy.
5. Upper GI bleed (age 21), vagotomy and antrectomy for gastritis.

4/13/72

Staff—Dr. N. Thoms

1. Dressing change for shotgun wound leg.
2. STSG for a shotgun wound calf.
3. Stab abdomen (age 22), through-and-through transverse colon and left lobe liver, primary closure colon.
4. Stab abdomen (age 22), laparotomy, penetrated, no injury to viscera.
5. Abdominal pain (age 46), pelvic abscess, drained in OR (had perforated ulcer one month ago).
6. Pain right hand (age 26), abscess, drained in OR.

4/14/72

Staff—Dr. Alexander Walt

1. Lacerated carotid and vagus nerve three days ago, tracheostomy.
2. Stab abdomen (age 22), 2cm laceration right lobe lover and right kidney with expanding hematoma, both sutured.
3. Abdominal pain (age 22), appendectomy (normal appendix).

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY
WAYNE STATE

DOWN MEMORY LANE, cont...

Anna M. Ledgerwood, MD

4. Laceration wrist (age 24), repair left flexor carpi ulnaris and left superficialis at 2,3,4,5 and left ulnar nerve.
5. Laceration thumb (age 22), repair lacerated flexor pollicus longus tendon.
6. Stab abdomen, laparotomy, penetrated, no injury.
7. Shotgun wound left thigh one month ago, split-thickness skin graft.
8. Shotgun wound leg, remote dressing change.
9. Blunt trauma abdomen, 5cm laceration liver, sutured, colecystostomy (part of t-tube study).
10. Stab abdomen, two holes stomach, one hold jejunum, all closed.
11. Blunt trauma, multiple rib fractures, tracheostomy.

(All of above cases done by night crew, finished 1:30 p.m. Two first year residents each did two cases, intern did two cases, third year resident did one case, and senior student from the day shift did the tracheostomy.)

4/15/72

Staff—Dr. Charles Lucas

1. Mycotic aneurysm proximal carotid artery, ligated from carotid artery with evacuation of clots from the cavity.
2. GSW abdomen, two holes rectum closed, hole small bowel, four closed and 3" resected with end-to-end anastomosis, loop sigmoid colostomy.
3. Partial amputation 5th finger, sutured.
4. Stab abdomen, closure, one hole transverse colon.

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MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

DOWN MEMORY LANE, cont...

Anna M. Ledgerwood, MD

4/16/72

Staff—Dr. Ron Krome

1. Auto accident, blunt trauma, laceration of the left lobe of the liver, avulsion falciform ligament sutured, colecystotomy (t-tube study).

4/17/72

Staff—Dr. Tom Flake, Sr.

1. Dressing change for large shotgun wound, leg.
2. Stab abdomen, serosal tear small bowel closed.

4/18/72

Staff Dr. Conrad Bernys

1. Fracture five left ribs and three right ribs with left hemopneumothorax, insertion left chest tube.
2. Abscess neck from heroin, IND done.
3. Perforated duodenal ulcer with 2L pus in peritoneal cavity, Graham patch, irrigated and drained.

Chief Resident, Dr. Anna Ledgerwood (standing second from right) and the graduating class of 1972, with Dr. Alexander Walt (sitting second from right)

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

WSU MONTLY CONFERENCES 2020

Death & Complications Conference
Every Wednesday from 7-8

Didactic Lectures — 8 am
Kresge Auditorium

ALL CONFERENCES DONE VIA WEBEX

(7:30 a.m.—8:30 a.m.)

Wednesday, May 6

Death & Complications Conference

"Steroid Use in Sepsis and ARDS"

Alwyn Harriott, MD. Fellow, Surgical Critical Care

Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, May 13

Death & Complications Conference

Topic to be Determined

Eric Dyson, MD, Fellow, Vascular Surgery

Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, May 20

Death & Complications Conference

"Extra Corporeal Membrane Oxygenation"

Gabriel Bakula, MD, Fellow, Surgical Critical Care

Wayne State University Michael & Marian Ilitch Department of Surgery

Wednesday, May 27

Death & Complications Conference

Topic to be Determined

Amy Somerset, MD, Fellow, Minimally Invasive Surgery

Wayne State University Michael & Marian Ilitch Department of Surgery

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Wayne State Surgical Society
2020 Dues Notice

Name:

Address:

City/State/Zip:

Service Description Amount

2019 Dues Payment _____$200 _____

My contribution for "An Operation A Year for WSU" _____

*Charter Life Member _____$1000 _____

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.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

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. Calzetta (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)

May 25th

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. Brian Shapiro (WSU/GS 1988/93) passed the baton of presidency to Dr. Jeffrey Johnson (WSUGS 1984) 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. Johnson 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.

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

Members of the Wayne State Surgical Society
Charter Life Members

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

May 16th

Members of the Wayne State Surgical Society—2019 Dues

Alpendre, Cristiano
Asfaw, Ingida
Bailey, Colin E.
Bambach, Gregory A.
Baute, Peter B.
Baylor, Alfred E. III
Bucci, Lorenzo A.
Busuito, Michael J.
Carlin, Arthur M.
Cirocco, William C.
Dawood, Moiz
Dawson, Konrad L.
Dente, Christopher J.
Dolman, Heather
Field, Erin
Golden, Roy
Goltz, Christopher J.
Herman, Mark A.
Horness, Mark D.
Joseph, Anthony
Kaderabek, Douglas J.
Klein, Michael D.
Knight, Anna
Kosir, Mary A.
Larson, Sarah
Liebold, Walter C.
Lloyd, Larry
Lopez, Peter
Mansour, Roozbeh
Marquette, Lauren
Marquez, Jofrances
Masood, M. Faraz
Mayuiers, Matthew
McAlpin, Glenn M.
Noorily, Michael J.
Novakovic, Rachel L.
Phillips, Linda G.
Prendergast, Michael
Reilly, Lindsay
Resto, Andy
Shanti, Christina
Siegel, Thomas S.
Spotts-Resto, Josette
Sundaresan, Naresh
Tarras, Samantha
Taylor, Michael G.
Tennenberg, Steven
Thomas, Gregory A.
Thoms, Norman W.
Truong, William
Vaszuez, Julio
Zahriya, Osama
Zerfas, Dorene
Ziegler, Daniel W.

Operation-A-Year
January 1—December 31, 2020

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 you 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.
Anslow, Richard D.
Bambach, Gregory A.
Bradley, Jennifer
Conway, W. Charles
Davidson, Scott
Dujon, Jay
Edelman, David A.
Francis, Wesley
Gallick, Harold
Gayer, Christopher P.
Gutowski, Tomasz D.
Herman, Mark A.
Hinshaw, Keith A.
Holmes, Robert J.
Huebel, Hubert C.
Johnson, Jeffrey R.
Johnson, Pamela D.
Ledgerwood Anna M.
Lim, John J.
Lopez, Peter
McIntosh, Bruce
Missavage, Anne
Nicholas, Jeffrey
Perrone, Erin
Siegel, Thomas S.
Silbergleit, Allen
Sugawa, Choichi
Sullivan, Daniel M.
Whittle, Thomas J.
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*.