MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

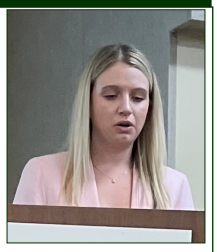
WAYNE STATE

MAY 2025

SURGICAL GRAND ROUNDS

June 15th

Inside this issue:



Dr. Amanda (Dooley) Romero (WSUGS 2025)

The **Surgical Grand Rounds on April 2, 2025** was presented by **Dr. Amanda (Dooley) Romero** who is completing her residency in General Surgery this Spring. The title of her presentation was "**The Surgeon's Role in the Opioid Epidemic."** Dr. Romero discussed the opioid crisis in a period of "waves" or time periods, with the first time period extending from 1990 through 2010. Opioids during this time period were prescribed much more frequently for patients who did not have cancer. They were being described for patients with chronic pain due to multiple etiologies. One of the popular prescription medications was "Oxycontin," which provided for "extra strength" and rapid onset so that the alleviation of pain was present within one hour. Other medications that became very popular included Vicodin and Hydromorphone. As a result of this advertising push on the radio, TV, and on billboards, many people became addicted to these medications.

This eventually led to public and governmental recognition that laws were being broken and that people were being encouraged through private industry to market products which were claimed by industry to not be addictive but which were clearly addictive, and the addictive properties were well known by the companies who marketed these drugs. Purdue Pharmaceuticals faced many legal battles because of defrauding the U.S. government, the FDA, and the so-called "Cosmetic Act" and were involved in "kick back" schemes with physicians who would help market these drugs as being non-addictive. Thus far, the settlements have exceeded 8.3 billion dollars for encouraging therapeutic use of these medicines without medical reasons. The Sackler family members who owned Purdue Pharmaceuticals gave up over $225 million in order to close the case and stay out of jail.

The paper, "Kindness Kills: The Negative Impact of Pain as the Fifth Vital Sign," which was authored by Drs. Lucas and Ledgerwood, was discussed. This manuscript reviewed deaths which were identified by the Performance Improvement Committees at the trauma centers which

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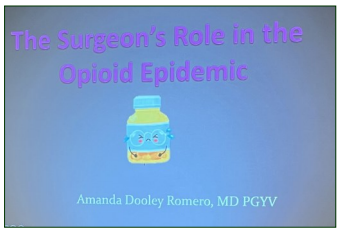

were visited by Dr. Ledgerwood or Dr. Lucas as part of the American College of Surgeons Verification program. During the mid-1990's, the federal government, under the auspices of Medicare and Medicaid, identified that re-accreditation of hospitals had to focus on pain control using the rating system of the "Visual Acuity Score" which is the score based upon facial appearance that ranged from 1 to 10, with 1 being a smiling face and 10 being a face displaying great pain. Any patient who had a 5 or greater had to have documentation in the record that there was a discussion with the nurse or physician or that the pain medications were increased. As a result of this policy, the trauma centers that were visited for verification by Dr. Ledgerwood or Dr. Lucas had an increase in deaths identified as being due to over medication, almost three times as frequent compared to the years prior to the federal mandate.

The next "wave" presented by Dr. Romero extended from 2009-2011 where Hydromorphone became the most common medicine that was being used, and when people became addicted and were unable to get refills, this led to the tendency to advance to heroin addiction which was associated with an even greater increase in over dosage and death.

During the era from 2013-2019, the synthetic narcotic, namely Fentanyl, became the popular opioid resulting in a Fentanyl epidemic and a true public health emergency.

The next period or wave four dealt with the treatment of patients with narcotic addiction and heroin addiction. The use of heroin is thought to have quadrupled during this time period and was associated with many deaths due to overdose from either prescribed narcotics or heroin utilization.

The county of Wayne began to be more compulsive about collecting accurate data and has tried to identify ways to reduce this problem. The media suggests that surgeons are the "gatekeepers" and described narcotics following operation. Unfortunately, somewhere between 6% and 15% of patients who were naïve to narcotics become continuous users, following their initial prescription for narcotics provided after some type of operative procedure. Likewise, many of the patients who are addicted to heroin began their narcotic exposure because of prescriptions written in the postoperative period. There has been excessive writing for narcotic pills following operations in order to avoid return visits to the hospitals and calls to the physician office. As a result, about two-thirds of the narcotic pills are never utilized so there has to be some way to encourage the patients to discard these extra narcotic pills.

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Access to narcotics in patients who have become addicted over half the time results in getting the pills from "a friend" with the prescription of the narcotic pills being the causative factor in less than 20% of patients. Less than 5% of the narcotic pills come from a stranger or from a narcotics dealer. Most patients who have an operation do not need narcotics but can simply be managed with over-the-counter medications without the risk of addiction. Physicians tend to provide less and less hard narcotics as they become more experienced and recognize that narcotics are often not needed and are potentially dangerous. In a training program, the junior residents are the ones who are usually writing for the prescriptions, and there has to be an educational program which emphasizes the importance of not overdosing the postoperative patients. The ACGME in 2020 added a mandate to the training program that instructs residents about over dosage and provides some guidelines about how many narcotic pills are needed for different types of operative procedures. Part of this education includes having a discussion with a patient and pointing out that no one is "pain free" after an operation, but there has to be a healthy balance between ameliorating pain and overdosing. This educational program must also instruct residents on the signs and symptoms of excess narcotics and how to treat patients who have overdosed.

There was a thorough discussion following this very comprehensive presentation.

The **Surgical Grand Rounds on April 9, 2025** was presented by **Dr. Matthew Georgis (WSUGS 2023)** who is completing his Vascular Fellowship this Spring. The title of his presentation was **"Aortic Dissections and More."**


Dr. Matthew Georgis

Approximately 10 in 100,000 people will have this complication some time in their life. The Stanford classification of aortic dissection was defined, which includes Type A-ascending aorta and Type B-more distal aorta. Two-thirds of aortic aneurysms are Type A. Patients who have Type A aortic dissection often need urgent surgical intervention in that they present with an acute crisis. Pertinent anatomy was described, including the fact that the right carotid artery comes off of the right subclavian artery, whereas the left common carotid artery arises directly from the distal part of the aortic arch. A Type A thoracic aortic aneurysm may well involve the right subclavian artery. The onset of the

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dissecting aortic aneurysm usually occurs in the morning and is more frequent in patients who have bicuspid aortic valves. Some of the patients may have disease of the media section of the aortic wall, such as is seen in patients with Marfan syndrome; these patients tend to have cystic medial necrosis.

The symptoms include very severe pain which is described as the worst that the patient has ever experienced. The diagnosis may be suspected by the severity of pain followed by evidence of mediastinal widening on chest x-ray. A thoracic CT scan is the gold standard for making the diagnosis, and a transesophageal echo may provide supplemental information when the diagnosis is in doubt. Distinguishing between what is the true lumen vs. the false lumen may be helped in the operating room by the use of ultrasound.

The different temporal types of aneurysm including the hyperacute which have been present for less than 24 hours, the acute ranging from 1-14 days, the subacute ranging from 15-90 days, and the chronic which is present for more than 90 days. Mortality with this entity is related to location which is much worse in those who have a Type A rupture of the ascending aorta. Once the dissection occurs when the intima is ruptured and blood flows into the media section, the dissection may occur proximal or distal. The proximal dissections may be associated with an acute myocardial ischemia due to compromise of the coronary arteries or even cardiac tamponade due to rupture into the pericardial sac. The distal dissections lead to many other syndromes depending on how far the dissection occurs. With the Type B aneurysms, the dissection may occur throughout the length of the aorta, and the segments of the aorta were described from 1 to 10, with 1 being the ascending aorta and 10 being the junction of the aorta with the iliac vessels.

The Law of LaPlace was discussed, which relates to the radius of the ruptured segment and how that is associated with increased dissection pressure. In the uncomplicated dissections, one must get "impulse" control which means control of blood pressure. When that cannot be done, the patient is a candidate for immediate operation. Patients who have organ function compromise associated with the dissection require urgent operation.

When the patient is reasonably stable, the medical treatments include impulse control with maintenance of the systolic blood pressure less than 120 and the pulse of less than 60. This is often accomplished in hypertensive patients with vasodilators, such as Esmolol or calcium channel blockers. Nitroprusside is also a popular agent at this time. This is important to

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reduce the pressure on the dissecting aneurysm, but even when control is achieved, there may be a 30-day mortality exceeding 10%. Patients who have an aneurysm which is stable can be observed non-operatively, but if the aneurysm grows, they are candidates for intervention.

The endovascular technique (TEVAR) for treating these aneurysms has become more successful and more popular. The technique of using endovascular stents was described, including the "landing zone" in order to be sure that the graft is secured. The use of ultrasound was also discussed in order to better define the safe location for the endograft. The TEVAR techniques continue to improve. The grades of dissection are categorized into types with Type 1 being a tear, Type 2 being an intramural hematoma, Type 3 being an aneurysm, and Type 4 being a rupture into the periaortic tissues.

One of the complications with the endovascular technique is occlusion of the left subclavian artery which is often associated with ischemia to the left upper extremity. This should be treated with a carotid artery to subclavian artery bypass.

There was a good question-and-answer session. The editor was reminded that Dr. Ringer from the Poultry Division of the Michigan State University Veterinary School published an article in 1961 showing that sweet pea seeds contain a substance (lathyrus odoratus) best known as beta (N-gamma-L-glutamyl) aminopropionitrile (BAPN) which had previously been associated with development of dissecting thoracic aortic aneurysms in rats, and he described the same phenomenon in turkeys. This study was stimulated by the fact that there was an epidemic of sudden death in turkeys in a turkey farm in north Wisconsin which led to an investigation demonstrating that the turkeys that died were all located in the northwest part of the turkey farm where they had the ability to lean over the fence and eat sweet peas. Based upon this finding, the editor was given the assignment by Dr. Raymond Reed, a very prolific Professor of Surgery at WSU, to recreate this phenomenon in a canine model. The editor placed ameroid (plastic) constrictors on the descending aorta which would lead to post stenotic increased pressure on the aortic wall and also provided this model with sweet pea seeds as part of the diet. This led to aortic aneurysms and sudden death by bleeding, usually in the early morning hours. After the project was completed, the editor was informed that he still had an animal in the research lab that had been there for a number of months. Necropsy on that animal demonstrated that there was a dissecting aneurysm with re-entry into the aorta below the renal arteries.

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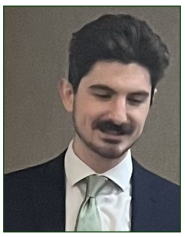
Dr. Alex Lynch

The Surgical Grand Rounds on 4/16/25 was presented by Dr. Alex Lynch who is completing his General Surgery residency this Spring. The title of his presentation was "Non-Technical Skills of Surgery," which dealt with the different types of leadership styles, including the role of mentoring. In the business world, there is early training with introductory features which gradually progresses, and in the progress, leads to the attainment of an MBA in students who become executives. It is important to teach empathy and teamwork with feedback loops to enhance the maturity of the early trainee. The training in medicine does not rely on the same principles of education but rather on the approach of trial and error with learning occurring from errors. The emphasis on surgical training is often excessive in terms of technical skills with less emphasis placed upon the cooperation with team members and the importance of appreciating that all operations are done by a team. The operative approach to certain crises was discussed and how the leader eventually gains confidence while leaning on the mentor during the learning years. The negative aspect of the mentor was when the mentor is an autocrat.

Dr. Michael DeBakey, the famous heart surgeon from Texas, has been identified as a strict authoritarian, leaving little room for deviation from his approach to surgery. This has led to great success in his hands in that he developed great fame as a surgical leader. Dr. Denton Cooley was also discussed; he was at the same institution as Dr. DeBakey and had much less of an autocratic approach to training surgical residents. Although the two were very close physically (working in the same institution), they were far apart socially, and it was not until later years that they resolved their personal disagreements. The leadership identified by Dr. Thomas Starzl would allow for the mental freedom to make important unusual decisions during operation but still expected to have excellent results and became famous for his successes in transplantation.

The importance of surgical mentors was emphasized in terms of leadership and teamwork; this is often best identified by the Tumor Board where physicians from multiple specialties are coming together in order to discuss the optimal treatment of patients with different types of malignancies. Just like the Tumor Board has a specific agenda to follow, so should the surgeon in the operating room follow an agenda which is based upon collaborative teamwork. Dr. Paul Farmer was known for emphasizing teamwork in his writings, and Dr. Devi Shetty from India emphasized the important mentoring on how to provide a high volume surgical career while providing care at low cost so that poor people can receive the benefit of this care.

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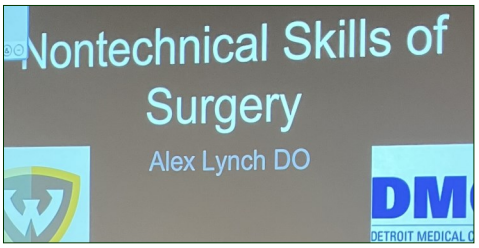
SURGICAL GRAND ROUNDS, cont..



Dr. Lynch praised Dr. Heather Dolman who has always encouraged the residents to grow as surgeons and also Dr. Donald Weaver whom he identified as the "Jedi" in the solving of problems in the operating room.

The laissez-faire approach to surgical training gives more authority to the residents to make decisions and facilitates their growth. There has to be some supervision, however, to be sure the resident decisions are not wrong. Dr. William Halsted, the father of American surgery, emphasized the importance of resident education and resident teaching. Dr. Lynch also made favorable comments about the leadership that he was exposed to, including the occasion when Dr. Larry Diebel drove a patient home when the patient had no transportation, as well as Dr. Andrew Isaacson who has been a wonderful mentor for the medical students, and Dr. David Edelman who has been a strong mentor for the surgical residents.

There are many leadership styles, but all of these techniques must lead to excellence in teaching so that the resident becomes a confident surgeon and is able to make quick and appropriate decisions. Part of this mentorship encourages surgical learning, surgical thinking, and finally surgical skills.

Disruptive behavior has no place in the operating room. Dr. Lynch summarized a report on disruptive behavior, which 90% of the time originates by the responsible surgeon on a particular case. "Intense communication" in the operating room creates discomfort for everyone. When disruptive behavior occurs, there should be counseling which deals with the surgical personality, the stigma of vulnerability, time constraints when a surgeon is overextended, and perception that there is low return on the treatment of a specific patient. Surgical defects were emphasized, including resistance to change, fear of criticism, and lack of being respected as a role model. Application of addressing the above problems should show benefit and help correct the problem of disruptive behavior and facilitate leadership in surgical teaching. The best surgeons are the beneficent leaders of the surgical team.

There was an active question-and-answer period following the presentation.

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Dr. Brian Schneider, MD

Dr. Brian Schneider is a product of the Lone Star State of Texas, having been born in Del Rio, Texas and had his primary education in Amarillo, Texas. His early years gave him exposure to the field of medicine in that his father was an otolaryngologist, and his mother was a registered nurse who worked in the office with his father. During his teenage years, he had the privilege of working as an assistant to his father in his private ENT office. With this background, it is not surprising that he entered the pre-med program at Texas A&M, and during that time, he became exposed to the work of emergency medical technicians and frequently went on EMS runs. Brian continues to have multiple extracurricular activities and includes such diverse things as being involved in beekeeping and banjo playing, and he continues to be involved in home brewing. His need to be a teacher has resulted in his being the instructor in Brewing Science, Brewing Quality Assurance, and Whiskey Tasting at the West Texas A&M University.

Dr. Brian Schneider and his bride, Kate, near their cabin in Colorado

He matriculated at the University of Texas medical school in Galveston and did very well as he had done very well in his pre-medical years. Following completion of his medical school training, he matriculated at WSU in the General Surgery program in 2000 and completed his training in 2005. During his pre-medical years at Texas A&M, Brian was involved in a research program in the Department of Biology and actually had a publication dealing with "Chimeric chemoreceptors in Escherichia coli: Signaling properties of Tar-Tap and Tap-Tar hybrids." This was published in the Journal of Bacteriology. During his medical school years, he was a Hildebrand Academic Scholar and was frequently on the Dean's List. One of his many extracurricular activities was rugby, and he served as the Secretary of the UTMB-Galveston Rugby Football Club during his medical school years. He was also a member of the Phi Chi Medical Fraternity.

Brian has always been interested in the excitement associated with teaching, both in his pre-medical school years and throughout medical school. As part of the Emergency Care Team, he was involved in campus and public health care education. He was also active in training Emergency Medical Technicians, and during medical school, he tutored in the Gross Anatomy Lab. He gave lectures on HIV and AIDS to high school students as a volunteer, but despite all these activities, he found time to be involved in rugby as part of his strong belief that maintaining physical fitness is important for longevity. Additional extracurricular activities have included such things as cooking and brewing of both wine and beer, which gives him some relaxation outside the field of medicine.

After completing his surgical training, Brian entered private practice at the Hannibal Clinic in Hannibal, Missouri. While at the Hannibal Clinic, Brian was active in administration and became the Vice Chair of Surgery and then later the Chair of Surgery before he decided to move on to Texas Tech University. Although he developed a successful practice in Hannibal, something in his blood told him that he had to get back to the Lone Star State, and he became an Assistant Professor of Surgery at Texas Tech University Health Sciences Center in 2009 where he became a busy general surgeon for the next five years.

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Dr. Brian Schneider, MD, cont…

Dr. Schnieder's bride, Kate (middle, and their daughters, Marie (left) and Evelyn (right) on the Great Wall near Beijing, China

He then accepted a position at the Amarillo VA Health Care Center in 2009 where he worked for the next four years but then returned to his first love, namely, the Texas Tech University. Following his return to Texas Tech, Brian has resumed his role as the Director of the Surgical Clerkship which continues to serve his needs to be helpful to others. Brian realized that he was the only faculty member who never did a Fellowship so he decided to enroll in the Critical Care/Burn Fellowship in Galveston. This resulted in his, at the age of 50, being away from his family every third weekend, but he feels that this sacrifice was well worth it. Following his return to Amarillo, he continued as a general surgeon, critical care surgeon, and even cares for burns. Before Brian did the Critical Care Fellowship, all of their burns were transferred to Lubbock, Texas to the Lubbock Burn Center, but now many of the burns are being treated in Amarillo. Brian keeps active in the care of serious burns in that he has volunteered to cover the Burn Center in Lubbock each month. Thus, he has put into practice the things he learned during his Critical Care Fellowship. Their program has been approved for residency training, and he has become the APD for the upcoming surgical residency which begins in July of 2026.

Brian and his wife have two daughters, Evelyn, age 19, and Marie, age 16. As might be expected with Brian's multiple interests, the entire family enjoys the outdoors and loves to camp and bike together. Recently, he was a guest speaker at the Fort Worth Museum of Science and History as part of their "Public Knowledge" series with a lecture entitled, "A Beer, Booze, and Bees." He is also a volunteer for the Amarillo High School Marching Band and has served as a physician for these events.

June 14th

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

EXCERPTS FROM THE LOG BOOK
DOWN MEMORY LANE


Dr. Anna Ledgerwood

7/2/72 - Staff: Dr. J. Kirkpatrick; Chief Resident: Dr. Ali

1. AU: Debridement of wound right leg.
2. JM: Laceration extensor tendon of forearm with knife, repaired.
3. DL: Prolapse of small bowel through the colostomy site, treated with reduction.
4. LR: Appendectomy in 11yo girl (found to have PID).

7/3/72 - Staff: Dr. A. Arbulu

1. AU: Change of dressing and debridement of muscle.
2. EW: Split-thickness skin graft of both thighs post GSW.
3. MJ: Stab of chest, treated with chest tube.
4. JH: Stab wound epigastrium and right leg with laceration and perforation of stomach and caudate lobe of liver, main hepatic artery ligated.
5. UD: Stab wound abdomen x2 with laceration liver and right femoral artery with resection and end-to-end anastomosis.

7/4/72 - Staff: Dr. Y. Silva

1. AU: Debridement of wound leg.
2. OF: Postop splenectomy with subphrenic abscess, treated with drainage.
3. CS: GSW left thigh, right thigh, and right arm, had thoracotomy and cross clamp aorta and laparotomy, both iliac veins ligated and right iliac artery repaired, right ureter repaired, ascending colon colostomy. Procedure took nine hours and used 18 units of blood.
4. MF: SGW left leg and thigh, treated with fasciotomy and debridement.
5. RC: Stab abdomen, negative exploration.

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"EXCERPTS FROM LOG BOOK" - DOWN MEMORY LANE, cont...

7/5/72 - Staff: Dr. Joe Bassett

1. TM: Perforated duodenal ulcer treated with a patch. This patient was S/P stab abdomen with colon, spleen, and small bowel injury.

7/6//72 - Staff: Dr. R. Threlkeld

1. AU: Change of dressing and debridement.

7/7/72 - Staff: Dr. C. Benavedes

1. AW: Change of dressing.
2. MF: GSW left leg with change of dressing.

7/8/72 - Staff: Dr. J.C. Rosenberg

1. DL: GSW colon, revision and division of exteriorized segment of colon with colostomy and mucous fistula (prior exteriorization of injured bowel).
2. SW: Appendectomy, normal appendix.
3. CR: 25yo with GSW abdomen and in shock. Left thoracotomy, cross clamp aorta, two holes in aorta at bifurcation repaired, two holes in small bowel repaired.

June 21st

MICHAEL & MARIAN ILITCH DEPARTMENT OF SURGERY

WAYNE STATE

WSU MONTLY CONFERENCES 2025

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, May 7
Death & Complications Conference
"Advocate Like a Surgeon"
Madyson Riddell, DO
Graduating Surgical Resident, DMC/WSUSOM

Wednesday, May 14
Death & Complications Conference
"Intraoperative Consults: Ethical and Medicolegal Considerations and a Framework for Responding"
Ryan Rosen, DO
Graduating Surgical Resident, DMC/WSUSOM

Wednesday, May 21
NOTE: LOCATIONS IS SCHOTT HALL, BLUE AUDITORIUM
"Festschrift: WSSS Research Achievements of Surgical Icons
Charles E. Lucas, MD and Anna M. Ledgerwood, MD
Selected presentations by physicians/surgeons highlighting research achievements of Dr. Lucas and Dr. Ledgerwood
Lawrence Diebel, MD, Professor of Surgery, WSUSOM

Wednesday, May 28
Death & Complications Conference
Alexander J. Walt Endowed Lecture
"A Vastly Changed World: Autonomy in Surgery and the Continuum of Safety"
Keith A. Delman, MD
Chief of Surgery, Grady Memorial Hospital, Emory University School of Medicine
Associate Chair, Department of Surgery, Emory University School of Medicine
Professor of Surgery, Department of Surgery, Emory University School of Medicine

KRESGE AUDITORIUM – SECOND FLOOR WEBBER BLDG
HARPER UNIVERSITY HOSPITAL, 3990 JOHN R.
7:00 Conference: Approved for 1 Hour – Category 1 Credit
8:00 Conference: Approved for 1 Hour – Category 1 Credit
For further information call (313) 993-2745

The Wayne State University School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. The Wayne State University School of Medicine designates this live activity for a maximum of 2 hours ***AMA PRA Category 1 Credit(s)***™. Physicians should claim only the credit commensurate with the extent of their participation in the activity."

EVALUATIONS
Surgical Death and Complications Rounds #2024321125, Jan-April 2024 CME Reflective Evaluation:
https://www.surveymonkey.com/r/MJMJNVV
Surgery Grand Rounds #2024321064, Jan-April 2024 CME Reflective Evaluation:
https://www.surveymonkey.com/r/MJWT2XF

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WAYNE STATE

Wayne State Surgical Society
2025 Donation

Name:

Address:

City/State/Zip:

Service Description Amount

2024 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

71st Meeting of the Michigan Chapter of the ACS
May 14-16, 2025
Shanty Creek Resort
Bellaire, MI

Midwest Surgical Association Annual Meeting
July 27-29, 2025
Lake Dawn Resort
Delavan, Wisconsin

84th Annual Meeting of AAST & Clinical Congress of Acute Care Surgery
September 10-13, 2025
Boston, Massachusetts

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

Wayne State Surgical Society

The Wayne State Surgical Society (WSSS) was established during the tenure of Dr. Alexander J. 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. Larry Narkiewicz (WSU/GS 2004/09) passed the baton of presidency to Dr. Joseph Sferra (WSUGS 1991) at the WSSS gathering during the American College of Surgeons meeting in October 2024. There are hundreds of Charter Life Members who have made contributions of well over $10,000 to the WSSS and hundreds of regular Dues-paying members of the WSSS, including many of the above who donate the payment for one operation a year to the WSSS. The residents thank all of these former residents for their support of the surgical program and hope that they will have the opportunity to meet these individuals at the annual American College of Surgeons reunion.

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*.