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Submissions to the July/August 2024 Newsletter should be received by the Chapter office no later than August 1, 2024.

FROM THE PRESIDENT

This past year at Winter assembly, I ran into my former residency Program Director, Dr. Sanford Vieder. We spent some time catching up, and we discussed the state of emergency medicine and MCEP's projects and goals.

As we were discussing the current challenges in emergency medicine and our at times slow progress in addressing them, which can be frustrating to all of us, he used a great metaphor. After getting permission from him, I would like to share this with all of you. He told me that sometimes as we fight for our profession, progress can be like pushing a football sled.

For those of you who don't know, a "sled" is a training device that is used by linemen to work on their blocking skills. It is a heavy metal object designed to slide on the ground when an individual hits a pad connected to the device. The sled can have anywhere between two and seven pads and can weigh up to 1800 pounds!

Michael Fill, DO, FACEP

As you can imagine, a large seven-person sled can be very difficult to push. It is possible for one person to push this type of sled if they start at one side of the sled, move it slightly, then go to the opposite side of the sled and move that slightly. This would take a lot of time and effort, but eventually the sled would move.

However, if seven people get together, pick a signal that would lead them to come out of a football stance at the same time, and then hit their assigned pad, the sled will move much more easily. The sled may move slowly at first, but as the players continue pushing as a team, the sled moves faster and easier the longer the players push. But, if one player decides that they are not going to continue to push, the sled could spin in one direction, either moving in a circle or to one side.

Over the past year, MCEP has experienced several "wins" for our specialty. We have pushed our violence bills across the finish line, increased state Medicaid reimbursement, worked to prevent mandatory nurse staffing ratios, and engaged with ACEP on a host of issues. We have certainly begun to "push the sled" in the right direction. As I pass the torch to our incoming president, Dr. Therese Mead, I encourage all of you to continue to push on these and other issues.

As I have learned over the years, sometimes conditions will be perfect, and the sled will move easily, but, more often than not, the sled will hit a rock, will stick in mud, or will be parked at the base of a hill and will be very difficult to push. However, if everyone pushes together, and if there is a line of individuals to provide support and take over pushing the sled when the first group tires, the sled can now move in any condition.

I would like to thank you all for allowing me to serve as president this past year and for supporting MCEP. §

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REFLECTION AND GRATITUDE

Sara Chakel, MD, FACEP

June and July are a time of transitions in the medical world. In emergency medicine, we celebrate the graduation of senior residents, and we welcome the arrival of new interns. At MCEP News and Views, we also have an impending transition. This is my last column as your editor, after five years at the helm either as editor or co-editor of this publication. I'd like to take my last editorial column as an opportunity to thank you all for trusting me with the printed voice of the organization and to reflect on the past five years, with an eye to the future.

When I started as co-editor in 2019, the world felt like a different place. Coronavirus was one of a number of seasonal cold viruses. Covid-19 didn't exist. Emergency departments were busy as the safety nets of the healthcare system, but we had (and still have) one of the best jobs around, with some of the best nurses, residents, and medical students working together as a team. Active issues for MCEP before the pandemic included physician well-being, violence against healthcare workers, and fair reimbursement.

The pandemic struck during my first year as editor, and things changed dramatically on the front lines of healthcare. Emergency physicians suddenly attained hero status, and we quite literally showed up to work, placing ourselves directly in front of the virus, at a time when everything else became remote, virtual, or quarantined. We did this without fully knowing about the virus, yet understanding there was significant risk to ourselves and likely our loved ones. We helped one another to obtain PPE, learned about donning and doffing, and helped our patients through some of the most truly awful moments in healthcare in living memory. We were celebrated as healthcare heroes, and our communities rallied around us in support. At MCEP, thanks in no small part to our amazing Education Committee chaired by Drs. Therese Mead and Jennifer Stevenson, we pivoted from in-person conferences to a year of high-yield, engaging, and interactive virtual conferences, including a virtual wine and cheese tasting fundraiser, a virtual coffee-themed social event, and plenty of interaction despite our physical distance from one another. We were also one of the first medical organizations to emerge from the pandemic in 2021 with the Michigan Emergency Medicine Assembly in-person conference at Grand Traverse Resort, and we proved that an in-person conference could be done, and done safely.

Over the next few years, the world developed pandemic fatigue. Patients returned to our emergency departments in droves, but instead of remaining healthcare heroes, it often felt like we had become healthcare zeroes. Boarding, a problem that long pre-dated the pandemic, reached new levels of crisis. Violence against healthcare workers continued and escalated. Burnout reached record levels, and nursing staff and ancillary staff began to leave the emergency department for other opportunities. We saw escalating mental health and well-being struggles within our profession, with much attention focused in particular on emergency physician Dr. Lorna Breen. Yet, we've also seen an increased focus on physician well-being and mental health, with Michigan emergency medicine physician and MCEP member Dr. Stefanie Simmons leading as the chief medical officer of the Dr. Lorna Breen Heroes' Foundation, whose "mission is to reduce burnout of healthcare professionals and safeguard their well-being and job satisfaction."[1] MCEP members worked alongside ACEP members from around the country to advocate for the Dr. Lorna Breen Health Care Provider Protection Act, which was signed into law in 2022.

We have upped our advocacy and engagement game at MCEP during the past five years. We fought hard, again and again, for legislation to better protect front-line workers from violence in the workplace, and Governor Whitmer signed House Bills 4520 and 4521 into law last December. We continue to advocate for fair reimbursement from all payors while taking the patient out of the middle of surprise building, and we have achieved significant victories on these fronts. More work remains, but a lot has changed in the healthcare finance landscape during my tenure as editor. Similarly, MCEP has amplified its voice at ACEP Council, regularly submitting resolutions for the past few years. We've also worked across organizational lines, especially with the Michigan State Medical Society, on issues important to all physicians, such as concerns with the role of private equity in healthcare organizations and the corporate practice of medicine.

Much more has happened over the past five years, and it has truly been my honor to reflect back to you, through the lens of this column, what I see as the current and seminal events of our specialty and the current challenges in emergency medicine in our state. Along the way, I have tried to be a voice of optimism and hope for the MCEP organization and our profession and to also reflect some of the human challenges we encounter as physicians and as people.

Going forward, MCEP News and Views is in experienced and capable hands with incoming editor Dr. Andrew Taylor. Dr. Taylor has served alongside me as co-editor this year in preparation for full editorial duties starting with the next issue. As I finish this, my 21st editorial column, I look forward to joining all of you as a regular reader of MCEP News and Views while still working in other capacities to support MCEP's ongoing mission of "advancing quality emergency medical care, supporting the interests of Emergency Physicians, and promoting the values of Emergency Medicine."[2] Thank you for working with me to support emergency physicians and emergency patients in Michigan. §

1 https://drlornabreen.org/about-the-foundation/, accessed 6/28/24.
2 https://www.mcep.org/about-us/, accessed 6/28/24.

LEGISLATIVE COLUMN

FISCAL YEAR 2024-25 STATE BUDGET UPDATE

Governor Whitmer presented her sixth budget in February to kick off the Fiscal Year (FY) 2024-25 budget cycle. After the Governor's budget gets presented, the legislature takes several months to have hearings on individual items and adopts their own spending plan. In mid-May, the Consensus Revenue Estimating Conference takes place, providing the House, Senate, and Governor's office with an accurate estimate of funds the state has to spend in the FY 2024-25 budget. Under current law, a balanced budget is required to be presented to the Governor by the end of June. We expect that to happen after a long month of negotiations between the House, Senate, and Executive Office.

SB 279 – LEGISLATION TO ALLOW NURSE PRACTITIONERS TO OPERATE INDEPENDENT OF PHYSICIANS

Legislation that would allow registered nurse practitioners to receive controlled substance prescription licenses and supervise registered and practical nurses without the oversight of a physician has received a committee hearing in the Senate Health Policy Committee. Michigan's current laws require nurse practitioners to be licensed under a supervising physician who fills prescriptions and orders certain treatments for the nurse practitioner's patients. SB 279 received significant testimony in March 2024 from numerous stakeholders regarding its potential impact. The bill is sponsored by Senator Jeff Irwin (D-Ann Arbor). No further action has been taken on the legislation since the committee hearing in March.

MICHIGAN COLLEGE OF EMERGENCY PHYSICIANS

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HOUSE AND SENATE HEALTH POLICY COMMITTEES KEEP BUSY

Bret Marr, Lobbyist
Muchmore, Harrington, Smalley & Associates

The Health Policy Committees in the House and Senate have kept busy the last several months since their Easter recess. MCEP has attended numerous hearings and supported a package of bills from the House dealing with the signing of death certificates and simplifying that process. The committees have also passed bills allowing Michigan to enter into both the physical therapy multistate compact and the occupational therapy multistate compact. Both of those bill packages reside in the Senate now and will have hearings in late June.

While those policy committees hold hearings every week on various topics, the legislature has been consumed with competing proposals from the House and Senate on economic development and business attraction. Both proposals are based on allocating state resources to attract and/or retain large employers to the state. We do not expect these proposals to reach consensus prior to the end of June summer recess.

AUGUST 6TH STATE ELECTION PRIMARY

Michigan electors will be able to go their local polling location or cast their absentee ballot for the Tuesday, August 6th, state primaries. The main races on the ballot are the primaries for the open U.S. Senate seat being vacated by long-time Senator Debbie Stabenow. Democrats are expected to select current Congresswoman Elissa Slotkin, and Republicans are leaning towards former Congressman Mike Rogers. There are also multiple state House primaries that will have an impact on the fall's general election races. Michigan's House is currently a 56-54 Democratic majority. §

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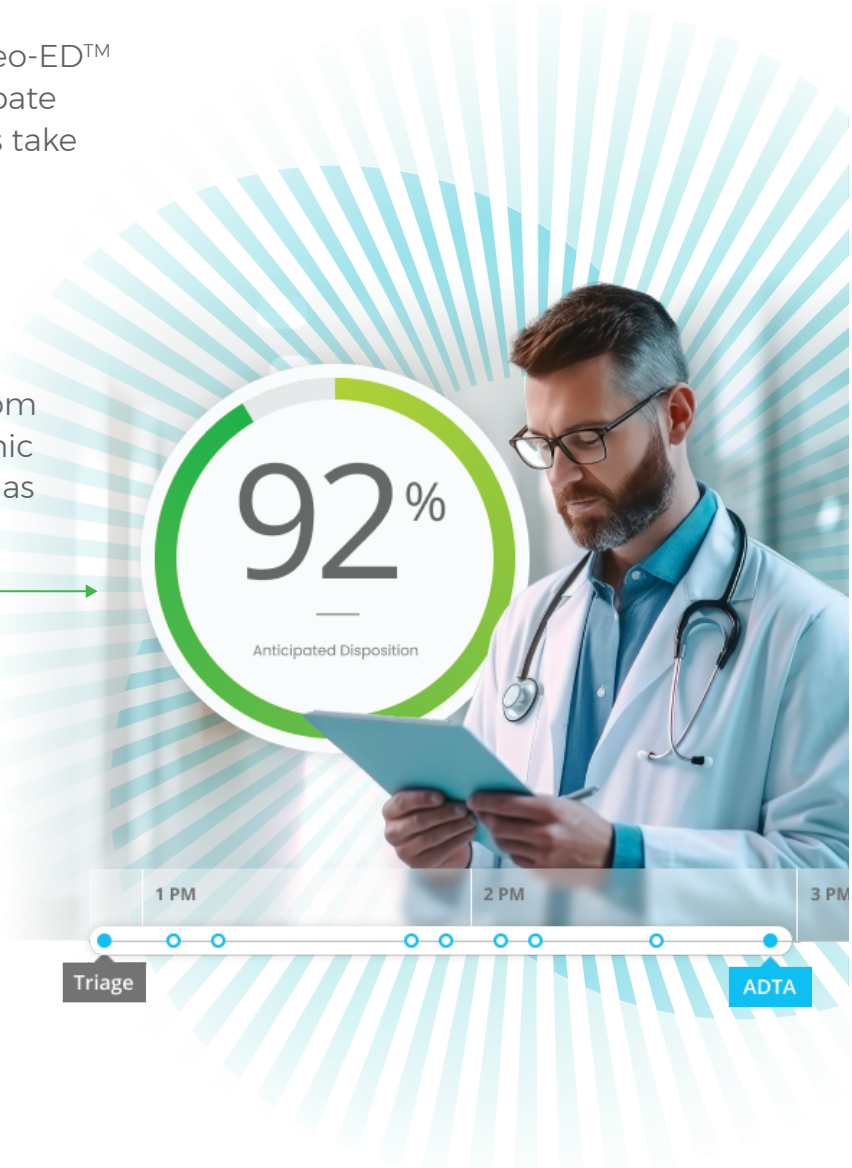

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DON'T BLOW THE DIAGNOSIS: A CASE PRESENTATION OF WEBER SYNDROME

Kevin Killian, DO; David Ishiyama, MD; Max Jones, DO Candidate of Henry Ford Health, Jackson, MI, Corewell Health, Grand Rapids, MI and Wayne State School of Medicine, Detroit, MI.

INTRODUCTION:

The initial rapid assessment of acute neurologic dysfunction includes a brief history from the patient and EMS but also heavily relies on the physical exam. Specific exam findings can mobilize resources early, including thrombolytics, anticoagulation reversal, and neurology and neurosurgery consultations. This case demonstrates an acute presentation most often seen with catastrophic intracranial hemorrhage but, in this patient, found to be an embolic phenomenon that was amenable to early administration of thrombolytics. Awareness of this patient's presentation may allow for a broader differential of oculomotor dysfunction with neurological decompensation.

CASE PRESENTATION:

The patient is a 56-year-old male with a pertinent past medical history of immune thrombocytopenic purpura (ITP), hypertension, hyperlipidemia, prediabetes, and common variable immunodeficiency (CVID). Per EMS report, the patient was driving when he began having double vision, pulled over, and called 911. On EMS arrival, the patient had decompensated to having right-sided paralysis and mixed aphasia/dysarthria with a "blown" pupil. The patient was activated as a stroke prehospital, and, upon arrival to the emergency department, he was evaluated at the stroke spot. Pertinent findings included right hemiparesis and sensory loss, hemineglect, mute speech, gaze paresis to the left, and a left non-reactive dilated pupil with a right constricted pupil. GCS was calculated at 11, and NIHSS was 26. Bedside POC glucose was 88 mg/dL. Neurology and neurosurgery were contacted. A catastrophic intracranial hemorrhage was the initial suspected diagnosis due to the above neurologic symptoms and the patient's rapid decompensation. On return from CT, the patient was obtunded and drooling, with a GCS of 8, and he was subsequently intubated. CT head without contrast showed no acute or chronic process. CBC results showed no thrombocytopenia, and the remainder of lab work was non-contributory. With intracranial hemorrhage ruled out, the decision to administer thrombolytics was made via shared decision making with the patient's wife, the ED physicians, and neurology. CTA of the head and neck showed no large vessel occlusion (LVO), and, therefore, there was no need for thrombectomy. The patient was admitted to the ICU for further management. Prior to transfer to the ICU, the patient was moving all four extremities, his pupillary defect had resolved, and he appeared to be following simple commands. The patient was extubated a few hours later in the ICU, and he maintained a GCS of 15 with no appreciable neurological deficits. Subsequent MRI imaging revealed a thalamic stroke. Echocardiogram showed a large patent foramen ovale (PFO). The patient was discharged on dual antiplatelet therapy to follow up with his care team out of state for further management.

DISCUSSION:

Weber syndrome is a rare midbrain stroke presenting with superior alternating hemiplegia due to corticospinal tract involvement. The syndrome is due to the occlusion of a branch of the posterior cerebral artery, which leads to dysfunction of the oculomotor fascicles in the interpeduncular cisterns and presents as an ipsilateral third nerve palsy with contralateral hemiparesis. Occlusion of the perforating branches of the basilar bifurcation can also cause Weber syndrome through a similar mechanism as above. Treatment is the same as for any embolic stroke syndrome.

The involvement of the oculomotor nerve in Weber syndrome can present with ptosis as well as a "down and out" position of the affected eye due to the unopposed contractions of the lateral rectus and superior oblique muscles. In comparison, intracranial herniation and an increased intracranial pressure can also lead to oculomotor dysfunction due to transtentorial uncal herniation, presenting as a dilated, "blown," ipsilateral pupil. With both herniation and Weber syndrome presenting with neurological dysfunction, rapid clinical deterioration, and ipsilateral oculomotor dysfunction, bedside diagnosis is not reliable without first utilizing diagnostic imaging. This is particularly important in utilization of resources and time management in regard to the colloquialism "time is brain" when considering thrombolytics. A "blown" pupil and coma may still be an embolic process requiring thrombolytics, and the practitioner's bedside differential should include embolic processes until proven otherwise.

Interestingly, on MRI of the brain, this patient's stroke was found to be in the deep left thalamus, whose location and morphology is most consistent with small vessel disease. Review of thalamic vascular territories show obstruction of the paramedian artery can cause coma and aphasia while obstruction of the inferolateral branches can cause hemiparesis and sensory loss. With further discussion with the neurologist, the most likely explanation was migration of the clot after the effects of thrombolytics, leading to a more distal lesion found on MRI. This patient was diagnosed with Weber syndrome, and he is without any neurological sequelae from his stroke after treatment.

This case reminds the physician to consider ischemic stroke as well as herniation in the differential diagnosis for a blown pupil with acute neurological decompensation. §

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National Institute of Health Stroke Scale

1a. Level Of Consciousness	1-->Not alert, but arousable by minor stimulation to obey, answer, or respond
1b. LOC Questions	2-->Answers neither question correctly
1c. LOC Commands	2-->Performs neither task correctly
2. Best Gaze	2-->Forced deviation, or total gaze paresis not overcome by the oculocephalic maneuver
3. Visual	0-->No visual loss
4. Facial Palsy	3-->Complete paralysis of one or both sides (absence of facial movement in the upper and lower face)
5a. Motor Arm, Left	0-->No drift, limb holds 90 (or 45) degrees for full 10 secs
5b. Motor Arm, Right	4-->No movement
6a. Motor Leg, Left	0-->No drift, leg holds 30 degree position for full 5 secs
6b. Motor Leg, Right	4-->No movement
7. Limb Ataxia (not due to weakness)	0-->Absent
8. Sensory	1-->Mild-to-moderate sensory loss, patient feels pinprick is less sharp or is dull on the affected side, or there is a loss of superficial pain with pinprick, but patient is aware of being touched
9. Best Language	3-->Mute, global aphasia, no usable speech or auditory comprehension
10. Dysarthria	2-->Severe dysarthria, patients speech is so slurred as to be unintelligible in the absence of or out of proportion to any dysphasia, or is mute/anarthric
11. Extinction and Inattention (formerly Neglect)	2-->Profound hemi-inattention/extinction more than 1 modality
Total NIHSS Score =	26 [redacted]

Figure 1: NIHSS scoring upon arrival to the emergency department

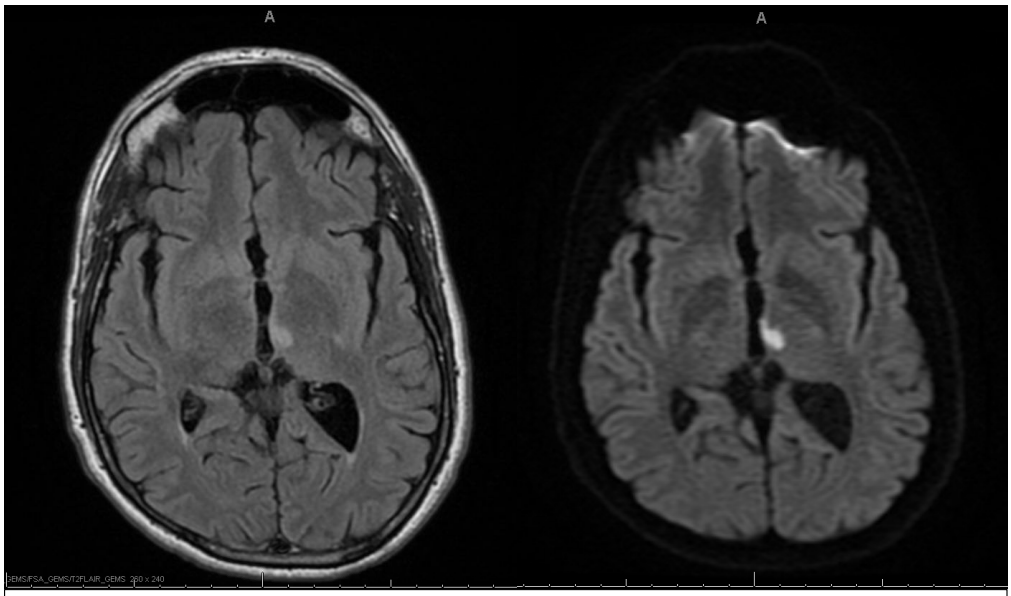


Figure 2: MRI with and without contrast images showing the acute infarct after thrombolytics therapy and normalization of NIHSS. Radiologist's impression: Acute infarct involving the left medial thalamus greater than 6 hours age.

EMRAM PRESIDENT COLUMN

IT'S GOING TO BE EMRAM'S BEST YEAR YET

Brittany Garza, DO

I am very excited to be addressing you as your incoming EMRAM president for the 2024-5 academic year! Last year, I had the great opportunity of serving as your EMRAM secretary where we made tremendous efforts to increase resident engagement while facilitating fun and educational programs for all. I am excited to take the work we have started and amplify it to make this the best year EMRAM has ever seen!

During the 2023-4 year, the EMRAM executive board expanded our social media platforms to reach more residents throughout the state of Michigan. We hosted a very successful SIMWARS in April where Trinity Health Muskegon was awarded 1st place and Central Michigan University was awarded 2nd place. Congratulations to all the winning team members! We also had one of the biggest years for EMRAM executive board applications, with applicants coming from all over the state! After very close races, we have four new executive board members from four different residency programs! I am excited to announce the new executive board members: Dr. Knisely, Dr. Stone, and Dr. Baribeau.

This year, we have both a highly diverse executive board and strong plans for the upcoming academic year. Our goals include increasing resident engagement throughout the state, increasing sponsorship at EMRAM events, and promoting residency networking opportunities. With such a robust team of residents, I am confident we will accomplish our goals! §

MEET YOUR NEW EMRAM EXECUTIVE BOARD:

PRESIDENT: BRITTANY GARZA, DO

I am a 2nd year resident at Central Michigan University. I am excited to continue my leadership for Michigan emergency medicine residents and make this the best year EMRAM has seen!

TREASURER: PHILIP STONE, MD

I am a 2nd year resident at McLaren Health in Pontiac. I look forward to working with the other members of the executive board to plan, promote, and assist in EMRAM events this upcoming year. Our goal is to increase engagement from all programs at these events and build a close network for everyone.

VICE PRESIDENT: TARA KNISELY, MD

I am a 2nd year resident at Ascension Genesys. I look forward to getting to know many residents from across the state, working on increasing residency program engagement, amplifying resident voices, and planning some fun and exciting events!

SECRETARY: SARAH BARIBEAU, DO

I am a 1st year resident at Trinity Health Muskegon. I'm most looking forward to getting involved in opportunities for physician related political activity as well as meeting lots of new people!

JOIN US AT OUR UPCOMING EVENTS:

Michigan Emergency Medicine Assembly

- July 28-31, 2024
- The Highlands – Boyne, Harbor Springs, MI
- This conference will share information on a variety of topics, including medical-legal information, healthcare issues, and practice updates.

Life After Residency Conference

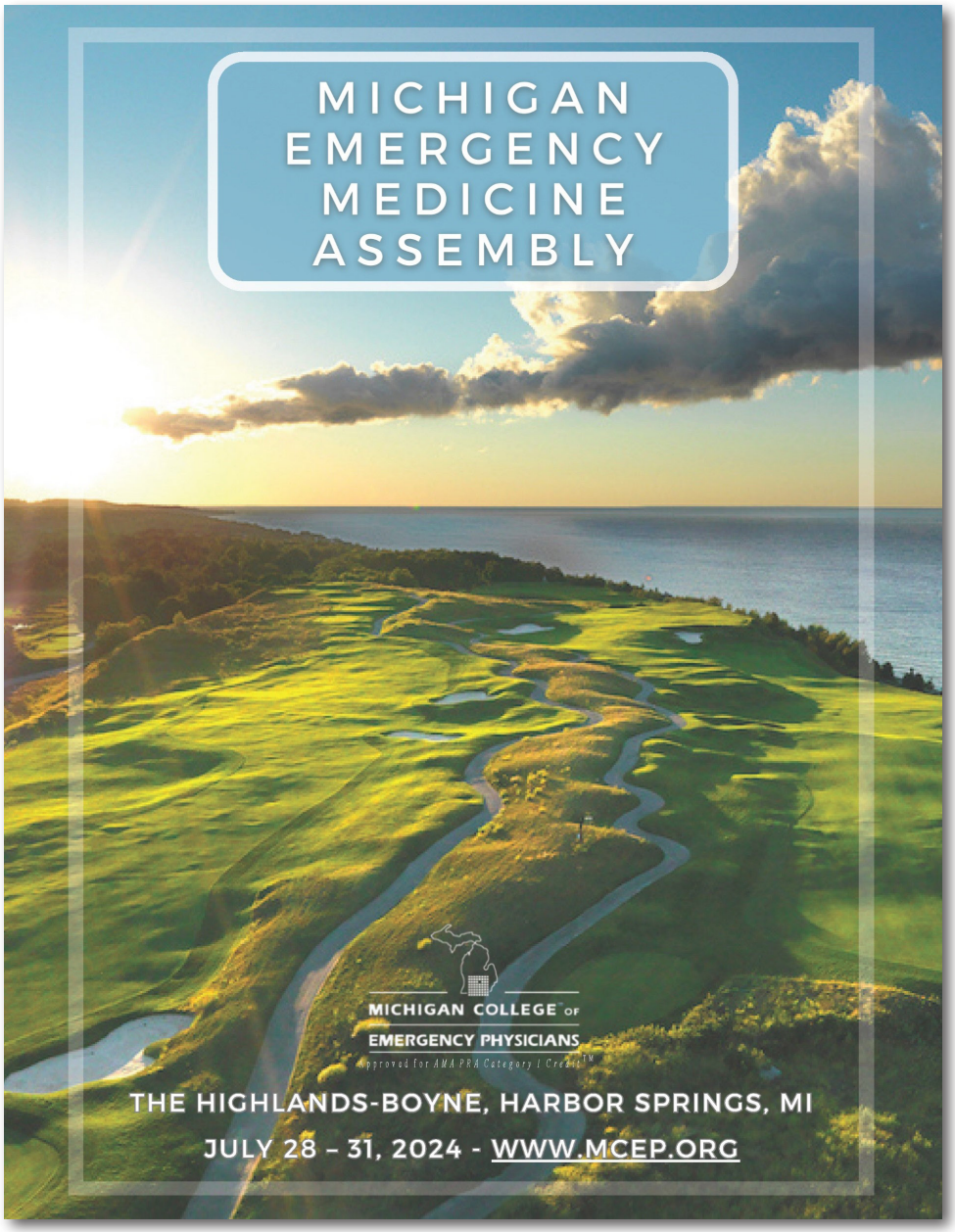
- August 15, 2024
- Somerset Inn in Troy, MI
- This conference is designed for 2nd and 3rd year residents to learn about effective job searching, personal finance issues, and entrepreneurship.

PROPOSED AMENDMENTS TO THE MICHIGAN COLLEGE BYLAWS

In its recent review of the Michigan College of Emergency Physician Bylaws (last revised in July 2021), the ACEP Bylaws Committee made several recommendations. While many of these changes are "housekeeping" changes to maintain consistency with recent changes in the ACEP's Model Chapter Bylaws, a few warrant specific mention: The first is a provision giving the Michigan College Medical Student Council the option to select a non-voting medical student representative to serve on the MCEP Board of Directors (the Board) (Article VI, Section 2). The term of office for this position would be one year, with a maximum of two consecutive terms (Article VI, Section 4). Additional changes include clarification of how the College handles Councillor resignation and the filling of Councillor vacancies (Article VIII, Sections 7-8), as well as language explicitly stating that a quorum (i.e. a majority) of Executive Committee members have the authority to act on behalf of the Board of Directors (Article IX, Section 2), provided all actions taken are ratified at the next Board meeting. Finally, Article XIV (Ethics) was removed, as it was felt to be adequately covered by the ACEP Bylaws and therefore not requiring specific mention in the Michigan Chapter Bylaws. These Bylaws amendments will be presented to the membership for approval vote at the upcoming annual meeting (July 28-31, 2024) as an amendment by substitution.

Click the link below for further information, including a full copy of the current Bylaws and proposed amendments. §

https://www.mcep.org/2024/05/09/proposed-amendments-to-the-michigan-college-bylaws/



ON THE FAST TRACK: MEDICAL STUDENTS DIVE INTO EMERGENCY PROCEDURES AT CENTRAL MICHIGAN UNIVERSITY

Authors: *Payton Wolbert, Nicholas Paselk*

This past winter marked a transformative day for approximately 30 medical students at Central Michigan University (CMU) College of Medicine. Hosted by the Covenant HealthCare Simulation Center and CMU College of Medicine Emergency Medicine residency program, the Emergency Medicine Interest Group (EMIG) Procedures Day was an engaging event tailored specifically for medical students. Running from 9 AM to 3 PM, this day was not merely a workshop but an in-depth exploration of the essential procedures critical to any emergency medicine professional.

IN-DEPTH SESSIONS AND EXPERT GUIDANCE

Each group cycled through five thoughtfully designed stations, each lasting 45 minutes with brief intervals to facilitate transition and preparation for the next set of challenges. These stations covered a range of vital skills:

- **Advanced Airway Management:** This station was geared toward equipping students with the competencies required to manage complex airway situations, which are frequently encountered in emergency settings. Through hands-on practice with advanced simulation models, students learned to swiftly identify and effectively manage airway obstructions and other critical respiratory conditions that demand immediate and precise interventions.
- **Intravenous/Intraosseous Access:** At this station, participants honed their skills in establishing vascular access, a fundamental yet high-pressure task in emergency medicine. The session included detailed instruction and practical exercises on both traditional intravenous and intraosseous infusion techniques, crucial for administering life-saving treatments during critical care situations.
- **Ultrasound Techniques:** Here, medical students were taught how to perform Focused Assessment with Sonography for Trauma (FAST) exams (Figure 1). Additionally, they practiced ultrasound-guided techniques to accurately diagnose and treat abscesses, thereby significantly enhancing their diagnostic acumen and procedural skills.
- **BLS Scenarios:** This station provided training in Basic Life Support (BLS), focusing on critical scenarios that require quick thinking and

decisive action. Students engaged in simulated emergency situations, using CPR and the automated external defibrillator (AED), along with securing airways and managing unconscious patients, emphasizing the speed and precision necessary to save lives.

- **Critical Care Access:** Participants were immersed in the techniques of placing central and arterial lines, essential for managing critically ill patients (Figure 2). This training covered a variety of catheter placements, including peripherally inserted central catheter lines and arterial catheterization, with a focus on using sterile techniques, understanding anatomical landmarks, and preventing complications during insertions.

ENGAGEMENT AND LEARNING

The event's structure was carefully crafted to foster an engaging and interactive learning experience. Each session was designed to bolster the students' practical knowledge and confidence in managing real-life medical emergencies. The dynamic, rotating format of the day allowed each participant to engage directly with seasoned professionals, enabling them to ask questions and receive immediate feedback on their techniques.

IMPACT ON ASPIRING EMERGENCY MEDICINE PHYSICIANS

As the event concluded, the feedback from the students was overwhelmingly positive. They appreciated the hands-on approach and the opportunity to refine their skills in a comprehensive and supportive setting. The EMIG Procedures Day not only reinforced their existing knowledge but also exposed them to new techniques and procedures crucial in emergency settings.

For those students considering or interested in pursuing a career in emergency medicine after medical school, this event was particularly impactful. It provided a real-world glimpse into the challenges and demands of the field, cementing their interest and preparing them for the fast-paced, critical decision-making environment of an emergency department. This successful event was made possible thanks to the invaluable support and collaboration of the CMU Emergency Medicine Residency Program, whose expertise and dedication were instrumental in providing such a rich learning environment.

This day was a clear demonstration of CMU College of Medicine's commitment to providing its students with a practical, immersive educational experience that prepares them for the rigors of emergency medicine. It also underscored the importance of continuous learning and practice in the medical field, particularly in such critical areas as emergency care.

LOOKING FORWARD

The success of this event promises the continuation of such valuable learning opportunities, helping shape the next generation of medical professionals to be well-prepared for saving lives. The anticipation for next year's event is already building, promising even more advanced modules and learning opportunities. This ongoing initiative reflects the university's dedication to nurturing skilled, confident medical professionals ready to excel in emergency medicine. §

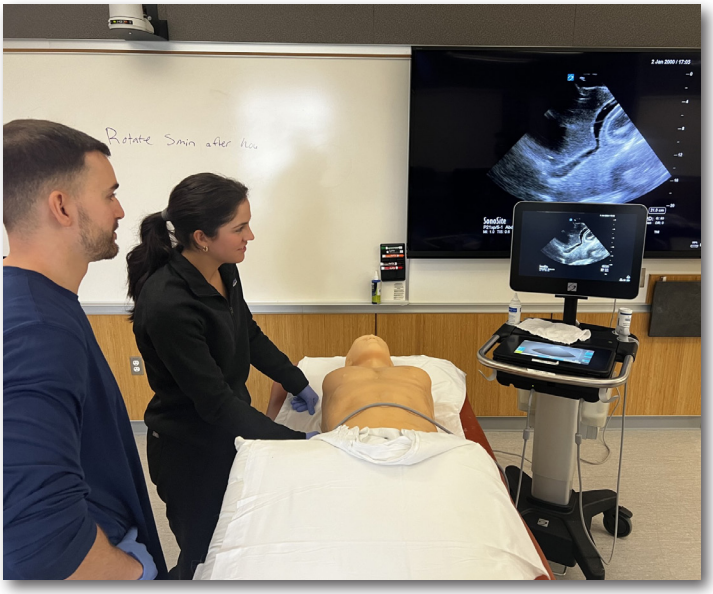


Figure 1. In this image, Logan Gary and Matthew Holtz, second-year medical students at CMU College of Medicine, demonstrate their newly acquired skills in performing FAST exams on a simulation model, thanks to the training provided by resident teachers. They are specifically visualizing the liver, kidney, and free fluid in Morrison's pouch, enhancing their proficiency in emergency ultrasound diagnostics.

Figure 2. In this dynamic learning environment, Dr. Matthew Petruso instructs first-year medical students Rylee Holek and Karen Nguyen on the precise technique of ultrasound-guided central line placement. Here, they are engaging closely with a simulation model to master this critical procedure, enhancing their skills under expert guidance.

THE PROPOSED RESURRECTION OF PRESIDENT GEORGE WASHINGTON

Bradford L. Walters, MD, FACEP

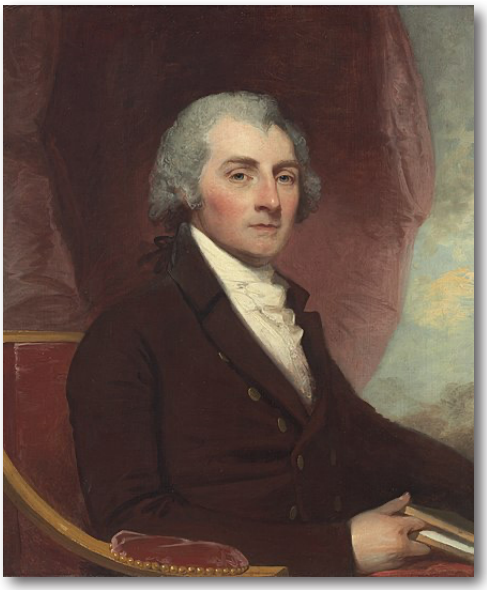
The death of our first president, George Washington, had one of the most unusual aspects in a proposal by a well-respected physician/scientist to resurrect him. I just want you to imagine that you were one of the physicians attending the first president when some consultant came in saying that, while he was dead, here is my recommendation to bring him back to life. This is that story.

Washington was a robust man throughout his life and in good health until just a few days before his death on December 15, 1799. The actual diagnosis was felt to have been either acute epiglottitis or a peritonsilar abscess that resulted in airway compromise, exacerbated by the treatment he was subjected to, leading to his death. Washington was given the best treatment those times afforded. Disease theory had not changed for some 3000 years and revolved around the ancient Roman concept of four bodily humors: Blood, phlegm, yellow bile, and black bile. Disease resulted when these humors became unbalanced, and a physician's task was to restore that balance, often through removing something from the body. As such, Washington's physicians used blistering chemicals, called cantharides, that were applied to his skin to cause painful burns. He was given enemas and purgatives to induce diarrhea and vomiting. And if that was not enough, he was bled on four different occasions for an estimated total of over four liters, some 40% of his blood volume. It did not take long for the first president to develop fatal airway compromise along with shock from fluid loss from the treatments. He died some 48 hours after the onset of his illness at the age of 67, finally begging his physicians to cease any further painful treatments. In hindsight, his death was the result of both the disease itself and the treatments that he was subjected to.

Washington was a rather modest man and did not want a lot of pomp over his death or funeral. On his deathbed he asked, "I pray you to take no more trouble about me, let me go off quietly." It was at this juncture that Dr. William Thornton (1759-1828) arrived, having ridden frantically from Washington, D.C., as soon as news of Washington's illness reached the capital. However, Dr. Thornton arrived after Washington had died.

Dr. Thornton was a highly respected scientist and polymath who was considered one of the leading lights in the Enlightenment now sweeping Europe and the New World. Not only was he a noted physician in America, but he also designed the Capitol Building now rising in the city that came to be called Washington, D.C. He was well acquainted with Washington and a frequent visitor at his Virginia home. He was aware of reported cases of animals supposedly being revived from being dead and fish recovering from being frozen. He was a member of a cutting-edge medical society founded in 1774, the Royal Humane Society, that advocated mouth-to-mouth breathing as first described by Dr. William Tossach to resuscitate drowning victims. In addition, there was a pervasive concern in those times of taphephobia, the fear of being buried alive. In fact, that was a fear expressed by Washington, and reports of comatose patients thought to be dead and then recovering only fed that apprehension. To prevent the burial of a person who was still alive, it was a common practice to tie a string to the large toe of a corpse that led up

Death of George Washington by Junius B. Stearns, 1853, credit Library of Congress



Dr. William Thornton

to a bell so the person could ring it to signal they were still alive (there are no recorded instances of that happening). Sailors who died and were buried at sea were sewn into a canvas shroud in which the last stitch was placed through the lip. The thought with this practice was that anyone still alive would react to the stitch, alerting their fellow seamen they were still alive. As such, the actual pronouncement of death was often called into question. Thus, could the recently deceased president still be potentially revived?

Thornton's proposal to Washington's family to resurrect the President was a well-considered proposal and far from the fictional descriptions of Mary Shelley's Frankenstein. First, he wanted to rewarm the body that was now frozen in the unusual freezing cold of northern Virginia that winter. Second, he proposed to establish a definitive airway by doing a procedure recently described in the medical literature, a tracheostomy. This would allow Dr. Thornton to insufflate the lungs using a bellows. Finally, he believed that if he could restore the drained blood, then he could correct what had been removed by bleeding. He suggested using sheep's blood, a procedure that had been described and was somewhat successful in the very early days of transfusions.[1] Dr. Thornton was confident he could restore Washington to life and offered that opinion to Washington's family. The following is in Thornton's own words that he penned in 1820:

"(f)irst to thaw him in cold water, then to lay him in blankets, & by degrees & by friction to give him warmth, and to put into activity the minute blood vessels, at the same time to open a passage to the Lungs by the Trachea and to inflate them with air, to produce an artificial respiration, and to transfuse blood into him from a lamb . . . He died by the loss of blood & the want of air. Restore these with the heat had subsequently been deducted, and as the organization was in every respect perfect, there was no doubt in my mind that his restoration was possible."[2]

However, Washington's family, particularly Martha Washington (1731-1802), declined the offer from Dr. Thornton, citing President Washington's request to withhold any further medical interventions and to be buried with little ceremony at his beloved Mount Vernon home. Unfortunately, that desire was altered, as President John Adams (1735-1826) prevailed on Mrs. Washington to allow Washington to be interred in the new Capitol Building that was in the process of being built. After quite a bit of pressure, she did allow him to be transported to the capital, where he was placed in a crypt in the then unfinished Capitol Rotunda that just so happened was designed by Dr. Thornton. Martha Washington eventually followed upon her death in 1802 and was buried next to her husband. However, in 1831, they were both re-buried at Mount Vernon, where their graves still reside to the present day.

As for Dr. Thornton, he went on to a distinguished career as a physician, amateur architect, artist, abolitionist, and leading New World intellectual. He died on March 28, 1828, in Washington, D.C. He never went further with a similar re-animation proposal as he suggested for George Washington. He did continue his involvement with the Royal Humane Society that advocated the early resuscitation procedures that are the historical roots of our modern cardiopulmonary resuscitation. In particular, he paid attention to airway procedures (and for those who know me, that is something near and dear to my heart). §

BIBLIOGRAPHY:

1. Walters BL. History of transfusions, intravenous catheters, and solutions. MCEP News and Views. June 2012.
2. William Thornton, "Sleep" [undated 1820's] (original in the Thornton Papers at the Library of Congress.
3. Klein C. The bizarre plan to bring George Washington back to life. History 2/13/2024.

MCEP CALENDAR OF EVENTS 2024-2025

July 28-31, 2024
Michigan EM Assembly
Boyne Highlands
Harbor Springs, Michigan

July 29, 2024
Annual Membership Meeting &
Board of Directors
Boyne Highlands
Harbor Springs, Michigan

August 15, 2024
EM Career Planning:
Life After Residency
Somerset Inn
Troy, Michigan

September 4, 2024
Board of Directors
Chapter Office
Lansing, Michigan

September 13, 2024
Observation Medicine
Conference
Virtual Zoom Meeting

September 17, 2024
MCEP Councillor Meeting
Chapter Office
Lansing, Michigan

September 27-28, 2024
ACEP Council Meeting
Las Vegas, Nevada

September 29-October 2, 2024
ACEP Scientific Assembly
Las Vegas, Nevada

November 21, 2024
Expert Witness Course
Virtual Zoom Meeting

December 4, 2024
Board of Directors
Chapter Office
Lansing, Michigan

December 10, 2024
$traight Talk
Reimbursement Course
Virtual Zoom Meeting

January 23-27, 2025
MCEP Winter Symposium
Mountain Grand Ledge
Boyne Mountain, Michigan

January 25, 2025
Board of Directors
Mountain Grand Lodge
Boyne Mountain, Michigan

February 12-13, 2025
ITE Review Course
Virtual Zoom Meeting

March 5, 2025
Board of Directors
Chapter Office
Lansing, Michigan

March 20, 2025
Critical Care Course
Virtual Zoom Meeting

April 27-28, 2025
ACEP Leadership &
Advocacy Conference
Washington, DC