



The Future of AI in Emergency Medicine

Not so much what to think, but *how?*

AACEM/AAAEM Annual Retreat

March 2026

Why I'm Here and Who Am I?

Clinician-First

- *Practicing emergency physician at Kaiser San Francisco*
- *Former ED Assistant Chief and CMIO*
- *Clinical Informaticist for KP — Over ED and Urgent Care flows*

Innovation / AI Insight

- *Creator of MDCalc*
- *Editor of The Physicians' Charter for Responsible AI*

Academic / Educational Vision

- *Speaker and Writer about Emergency Medicine (EM News columnist 2011-2021)*
- *Podcast Host, How I Doctor*
- *Simulation Medicine fellow @ Stanford 2011-2012*
- *Residency St. Lukes'-Roosevelt 2008-2011*

Why you should care about AI

- *AI is moving from novelty to workflow reality*
 - *Not whether AI will have an impact, but what the impact will be*
- *The question is not just what AI **can do***
- *The question is how academic EM **should think about it***

Overview of My Talk

- Innovation is at the heart of emergency medicine
- What is AI?
- How should we think about AI with SAEM's Tripartite Mission:



Clinical Care

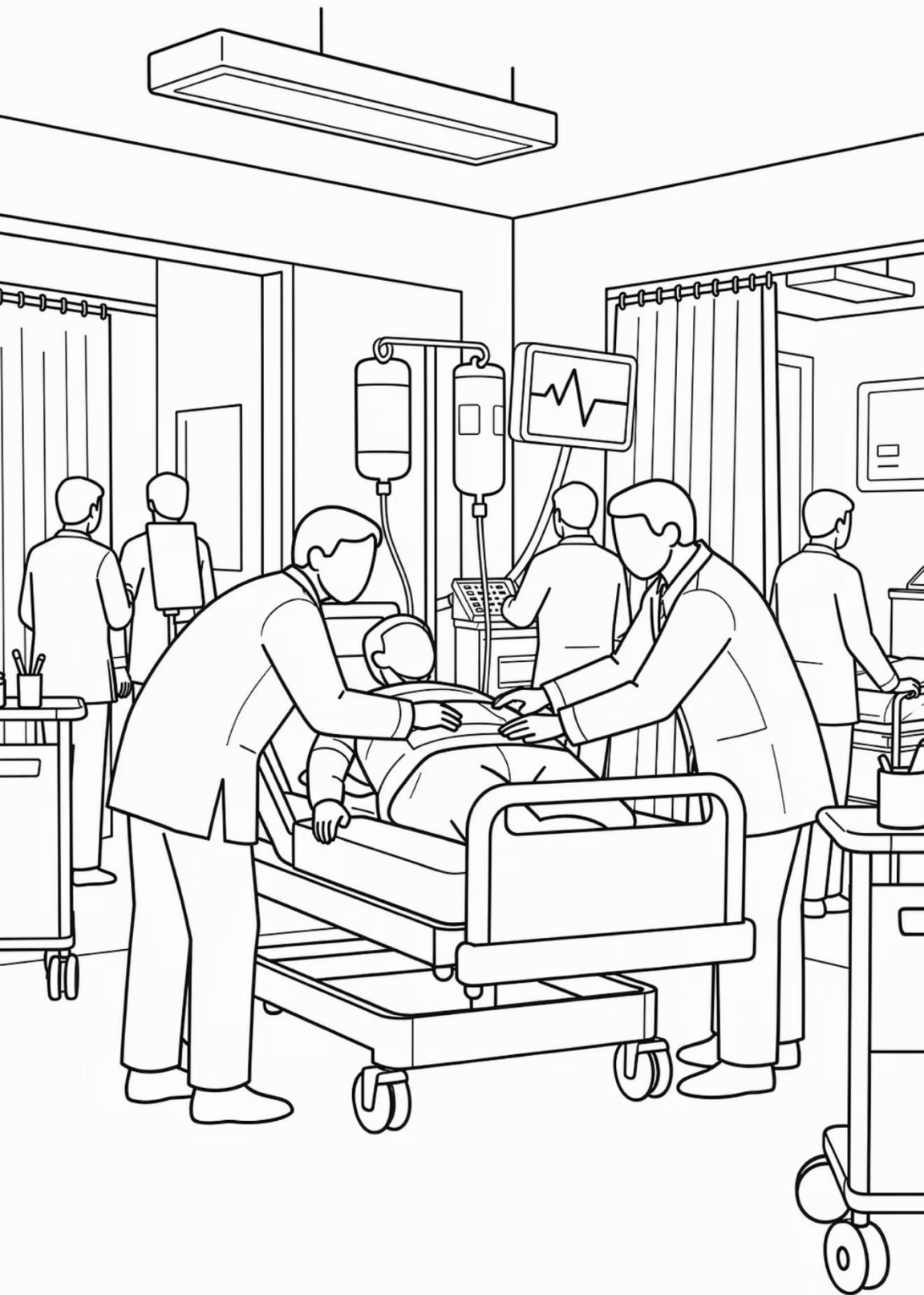


Education/Training



Research

- Leadership, vision, and the future of the specialty



We are a specialty built for change



EM has always led operational adoption of new tools



We are always asking: *Is there a better way to do this?*

Emergency Medicine's Advantages

Our specialty attracts high-agency, innovative, adaptable clinicians

Emergency Medicine's Challenges

Every industry wants high-agency, innovative, adaptable people

Today's Emergency Physicians Have:

1

Increasing alternative options

Career paths outside traditional clinical practice

2

A more-challenging-than-ever environment

Boarding, hallway medicine, lack of primary and specialty care access, patient expectations

3

Questions about their commitment to our specialty

Emergency physicians my age and younger are leaving

My call to action for this audience:

- *We have to keep adapting to ensure outstanding emergency care in the United States.*
- *EM has a unique opportunity to lead in leveraging AI to create a **better, more sustainable practice environment for all.***

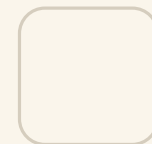




Hands up #1



Who's used AI in the past month for anything at all?



Who's used any AI tool for anything **clinical** in the past month?

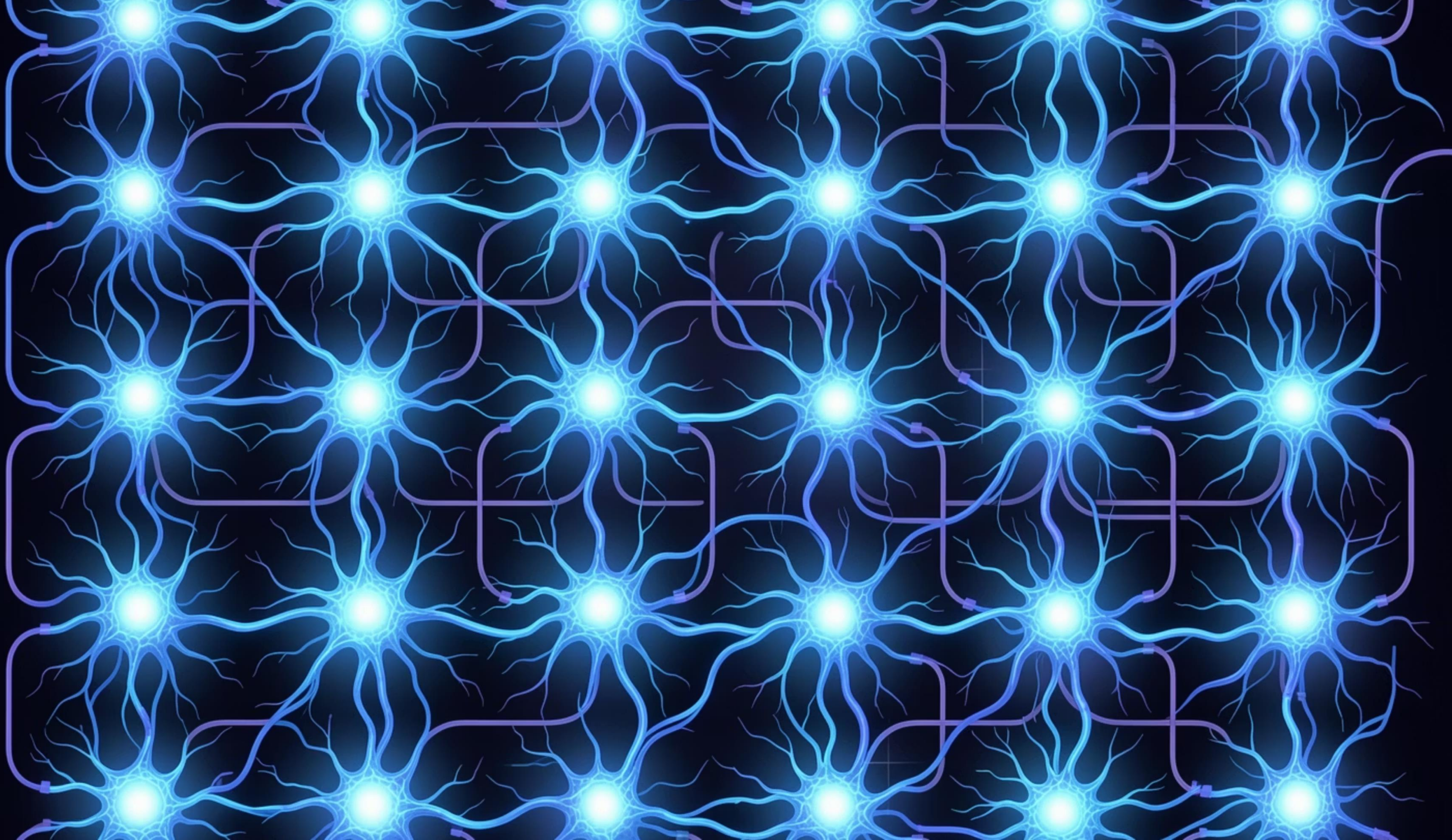
What is AI?

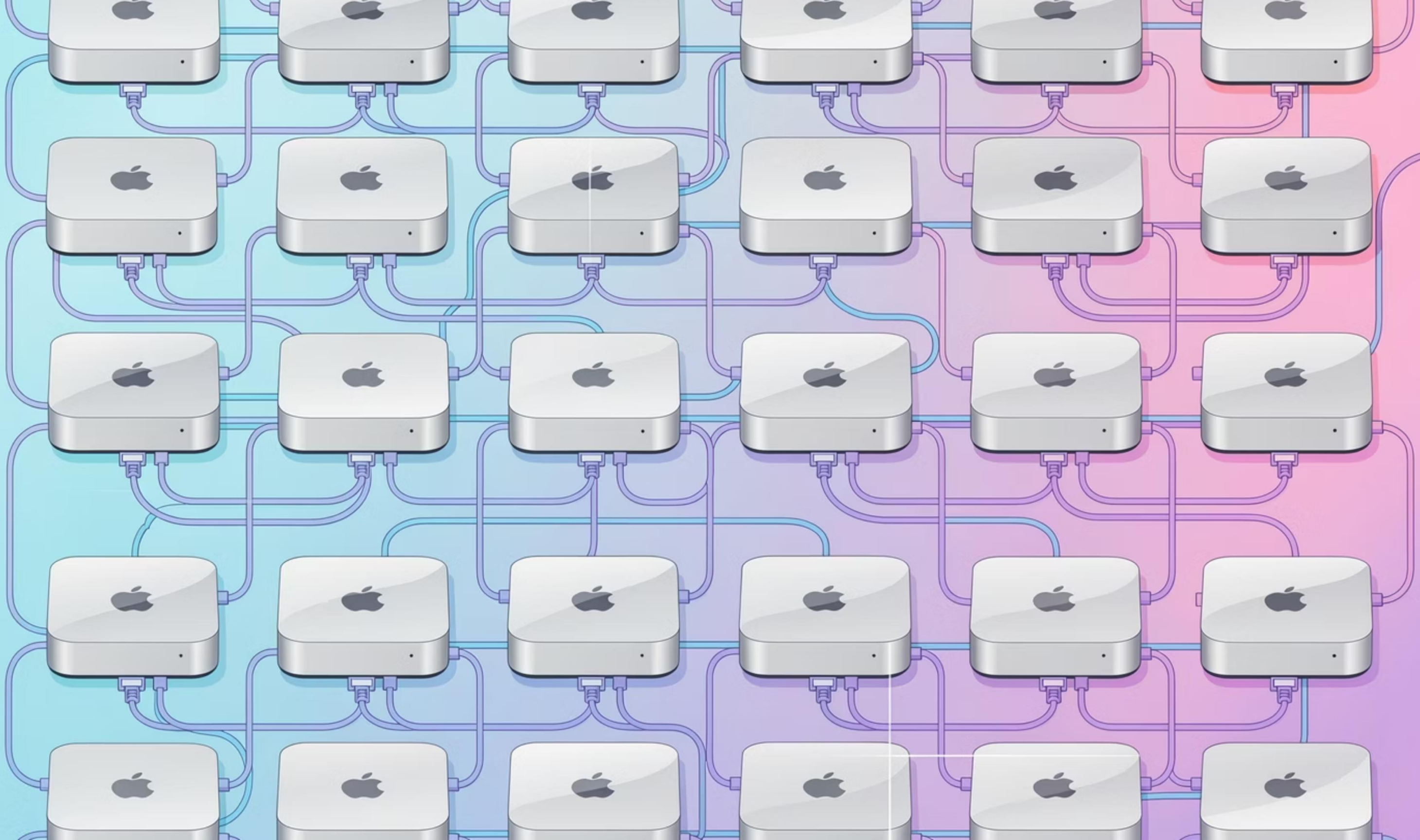
Vast numbers of software processes (or, computers in the cloud) running even vaster mathematical calculations to try to:

1) Find patterns

2) Make predictions

(Note: That's what the human brain is constantly doing, too)





It's not just ChatGPT or Generative AI.

PREDICTIVE MODELS (Machine Learning)



Data-driven forecasting for clinical risk and operations.

COMPUTER VISION



Automated, large-scale image interpretation and pattern recognition.

LANGUAGE AI



From understanding clinical text to generating documentation and reasoning.



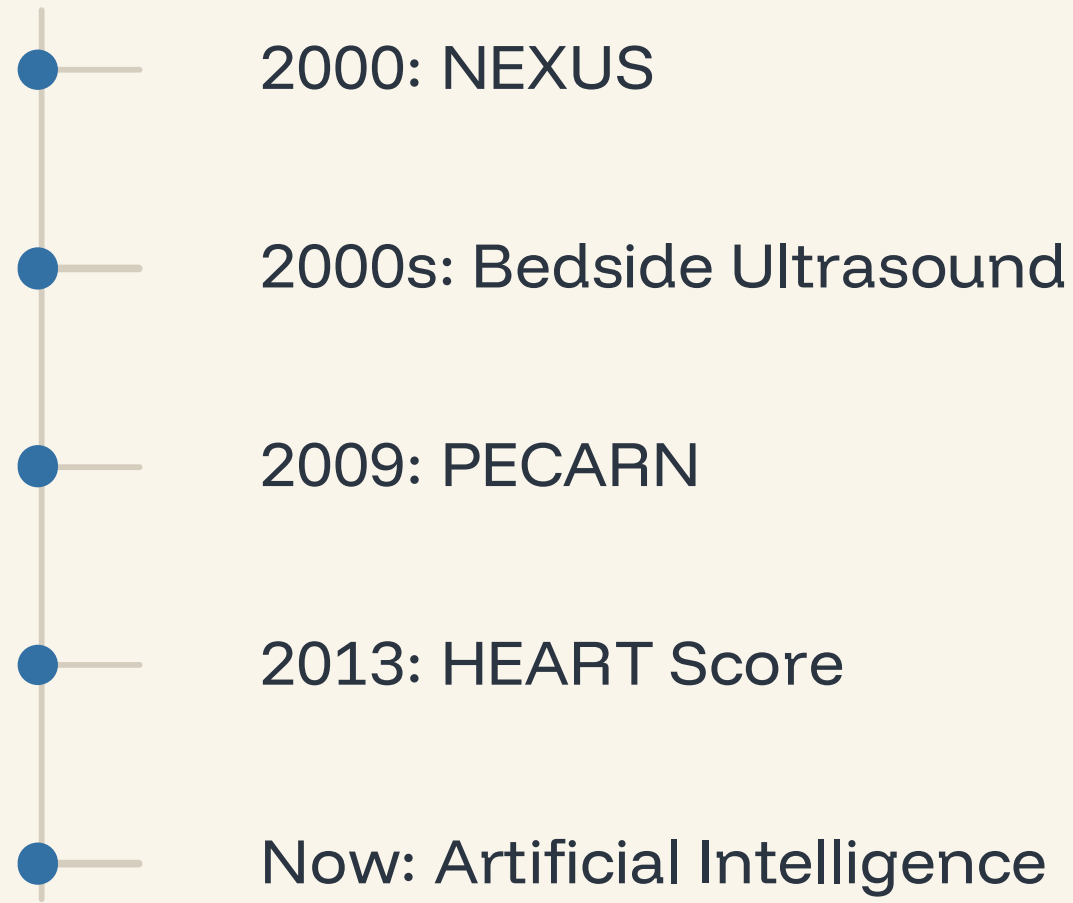
But AI is not some new-fangled idea or technology.

AI is just an extension of what we in medicine have always been doing.

And specifically emergency medicine.

We've Always Done This

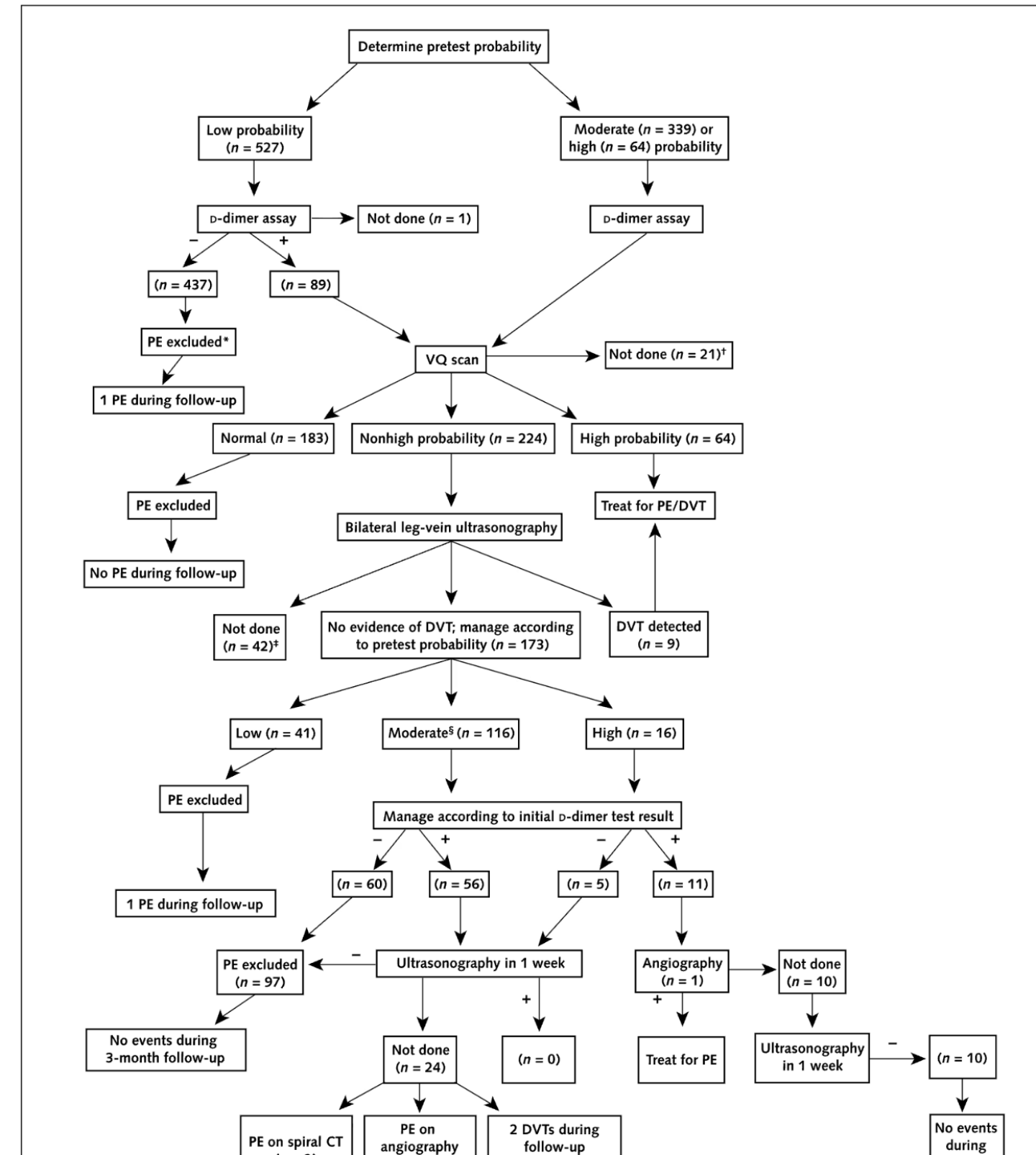
Emergency medicine has always been the specialty that builds tools to make better decisions.



And I'll prove it to you.

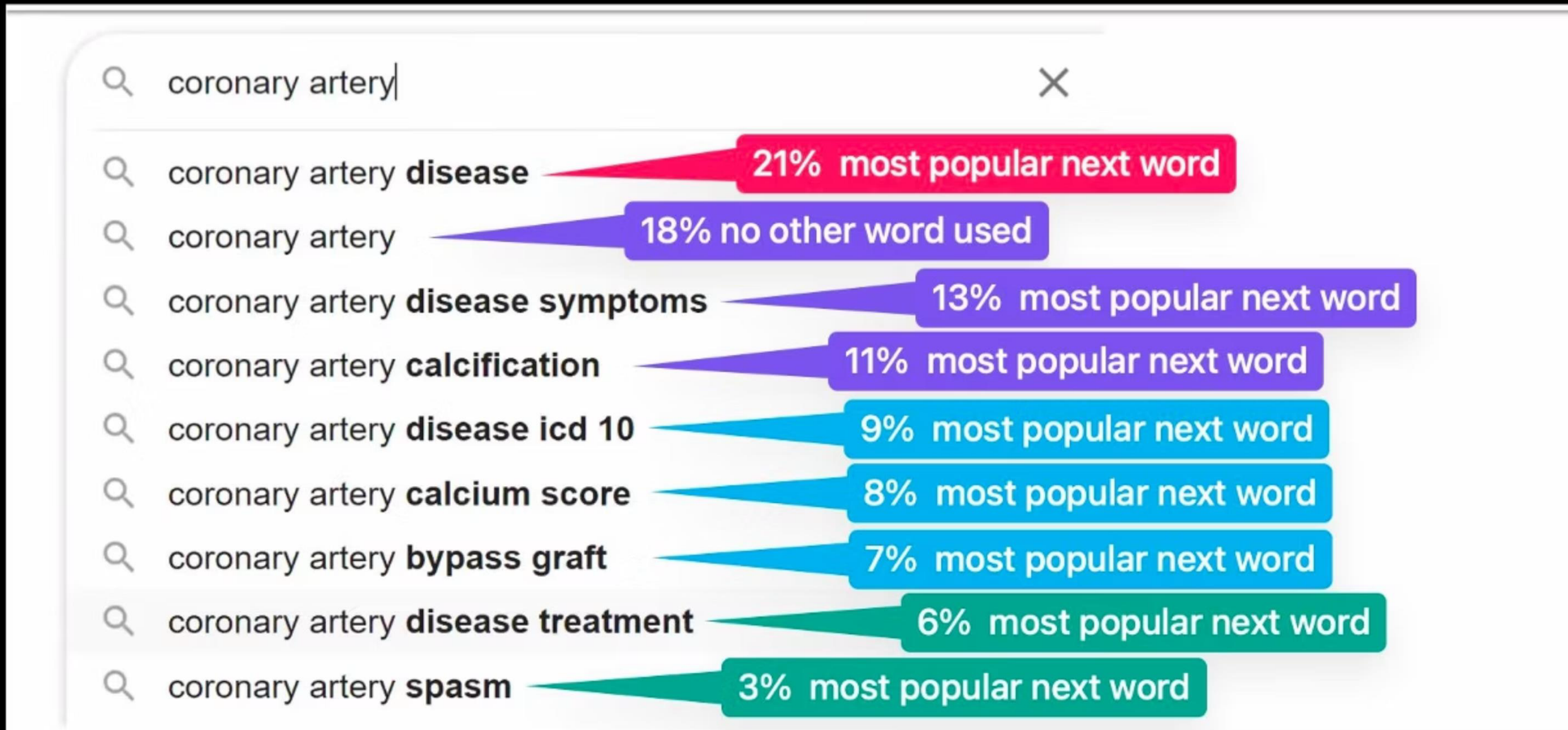
*What is this, if not:
Finding patterns and making predictions.*

Figure 2. Algorithm for patients with suspected pulmonary embolism.



How does GenAI work?

Auto Complete



Dispelling the AI Hype in 60 Seconds

NEXT GEN INVESTING

Bill Gates: Within 10 years, AI will replace many doctors and teachers—humans won't be needed 'for most things'

Published Wed, Mar 26 2025 9:05 AM EDT



Tom Huddleston Jr.



Bill Gates predicts that within 10 years, AI will replace many doctors and teachers—humans won't be needed 'for most things'

A.I. Chatbots Defeated Doctors at Diagnosing Illness

A small study found ChatGPT outdid human physicians when assessing medical case histories, even when those doctors were using a chatbot.



This article is more than 10 months old

Dr Oz tells federal health workers AI could replace frontline doctors

Former TV doctor who leads \$1.5tn Medicare and Medicaid agency also says staff have 'patriotic duty' to stay healthy



Most viewed



Anti-ICE protesters accused of being part of antifa found guilty of support for terrorism in Texas



Kyrsten Sinema says in court filings she had a 'romantic' relationship with guard



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Andrew and Peter Mandelson pictured in bathrobes with Jeffrey Epstein

A.I. Is Making Doctors Answer a Question: What Are They Really Good For?

Many physicians find chatbots threatening, but that doesn't mean they're giving up on medicine.

▶ Listen to this article · 11:05 min [Learn more](#)

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 By [Gina Kolata](#)

Feb. 9, 2026

When it's time to have a difficult conversation with a dying patient about whether to insert a feeding tube, Dr. Jonathan Chen, an internist at Stanford, practices first with a chatbot. He asks the bot to be a doctor while he plays the role

Health Advice From A.I. Chatbots Is Frequently Wrong, Study Shows

In part, the problem has to do with how users are asking their questions.

▶ Listen to this article · 7:04 min [Learn more](#)

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But it's not all rosy.

AI

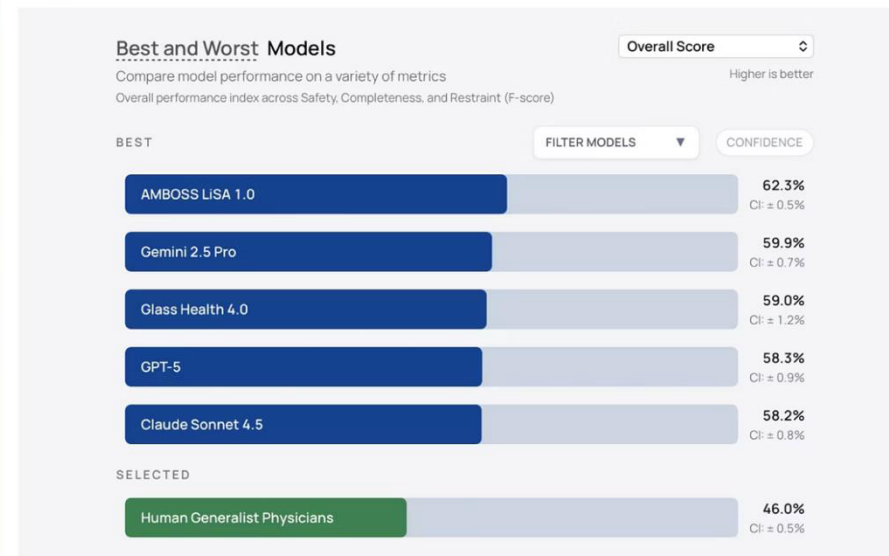
Stanford study finds AI medical models make severe clinical errors in 22% of cases

New Stanford-Harvard research reveals widely used AI models produce harmful medical recommendations at concerning rates, with most errors stemming from omissions rather than bad advice.



Luis Espada

Jan 02, 2026 - 12 min read



AI medical models ranked by clinical safety scores, with top systems outperforming human physicians by 16%.

The most sophisticated artificial intelligence models available today produce severely harmful clinical recommendations in up to 22.2% of medical cases, raising urgent

[Find a Doctor](#)[Our Locations](#)[Patient Care](#)**Press Release**

Research Identifies Blind Spots in AI Medical Triage

First independent evaluation of ChatGPT Health raises questions about safety of consumer AI tools for urgent medical decisions



TECH • AI

OpenAI CEO Sam Altman says A.I. tools are ‘very good at doing tasks’ but terrible at doing whole jobs—for now

 By **Steve Mollman**
Contributors Editor

June 8, 2023, 2:26 PM ET



OpenAI CEO Sam Altman.
JOEL SAGET/AFP VIA GETTY IMAGES



Listen to the article now

00:00

05:46



1.0x

Powered by: [Trinity Audio](#)

OpenAI CEO Sam Altman thinks artificial intelligence is more likely to change your job than steal it, at least in the short term. But either way, you'll have to adapt now that tools like ChatGPT—which his company released last year, sparking an A.I. boom—are readily available.

Here To Stay

Computer Won't Replace Good Doctor, MD Says

Valuable Role Sighted For Machines In Taking Case Histories, Diagnosis

By RAY BRUNER
Blade Science Editor

Computers, which today are being used in growing numbers by banks, industries, and other business firms, and by scientists, technologists, engineers, educators, and statisticians, are now casting a shadow over the medical professions. In a few years they are likely to be an important part of medical practice, as aids in diagnosis, treatment, and research, in doctors' offices, clinics, and hospitals.

Concerned about this, with a fear that computers will dehumanize medical care, some worried MDs are asking: "Will the computer replace the doctor?"

Responding to this question, Dr. Warner V. Slack, University of Wisconsin department of medicine, said: "Any doctor who can be replaced by a machine deserves to be replaced by a machine."

Dr. Slack dropped this remark in concluding an illustrated lecture last night at the annual meeting of the Toledo Hospital medical staff. He meant that a doctor who takes advantage of his experience, training, judgment, and intuition in diagnosing and treating his patients need have no fear of being replaced by a computer or some other data processing device. In other words, nothing can take the place of a competent MD.

New Instrument

Dr. Slack, who described what he called the laboratory instrument computer (LINC), which has been subjected to extensive trials in medical diagnosis at the University of Wisconsin medical department, said it actually did some things better than many doctors. For one thing, it does not scribble notes that are often unreadable on patients' hospital charts.

Also it does not forget to ask all the necessary questions in taking the patient's history or in making a physical examina-

tion. The first question, he is asked: "Do you have any idea what caused your hives?" If his answer to that question is either "no", "don't know," or "don't understand," he may be asked a number of questions that have to do with the appearance of hives, the frequency of their duration, severity, and related questions. If he answers "yes" with regard to what he thought caused his hives, he is asked more questions about agents that might have caused it, and so on.

Many questions

In one sitting in front of the console, the patient may be called upon for similar answers to as many as 250 or more questions pertaining to his medical history.

Answers to questions are stored in the LINC on magnetic tape, and may be retrieved and printed out in detail for the patient's doctor, to help him understand the cause of the patient's complaints.

After the patient records his history on one LINC machine the doctor uses another LINC for recording results of his physical examination of the patient. Occasionally the doctor may neglect to seek answers to all the necessary questions involved in the physical examination. Thereupon, the LINC reminds him of the questions he should ask. The LINC will not proceed until the doctor provides the necessary answers.

Here again, the LINC stores up the doctor's answers on magnetic tape and produces them

Assistant Gives Data



—Blade Photo

COMPUTERS AID, NOT MENACE, PHYSICIANS

Dr. Slack, left, and Dr. David Katchka check picture

FDA Chief Changes Stand To Back Penalties For LSD

Bowed To Administration Arguments On Drug-Use Curbs, Congress Unit Told

WASHINGTON (T-P) — Dr. James L. Goddard, commissioner of the Food and Drug Administration, Monday endorsed the Johnson administration's proposal to make possession of the drug LSD illegal. In so doing, he moved away from his position that penalties for possessing LSD would unnecessarily brand many youths as criminals.

work, and the President supports them in their view. "Their judgment on the need for this provision is one which I respect, and therefore I support the Administration's proposal." However, Dr. Goddard indicated he is dubious about how much the threat of punishment would inhibit the use of LSD. He said use of marijuana is more widespread than use of

Any doctor who can be replaced by a machine deserves to be replaced by a machine.

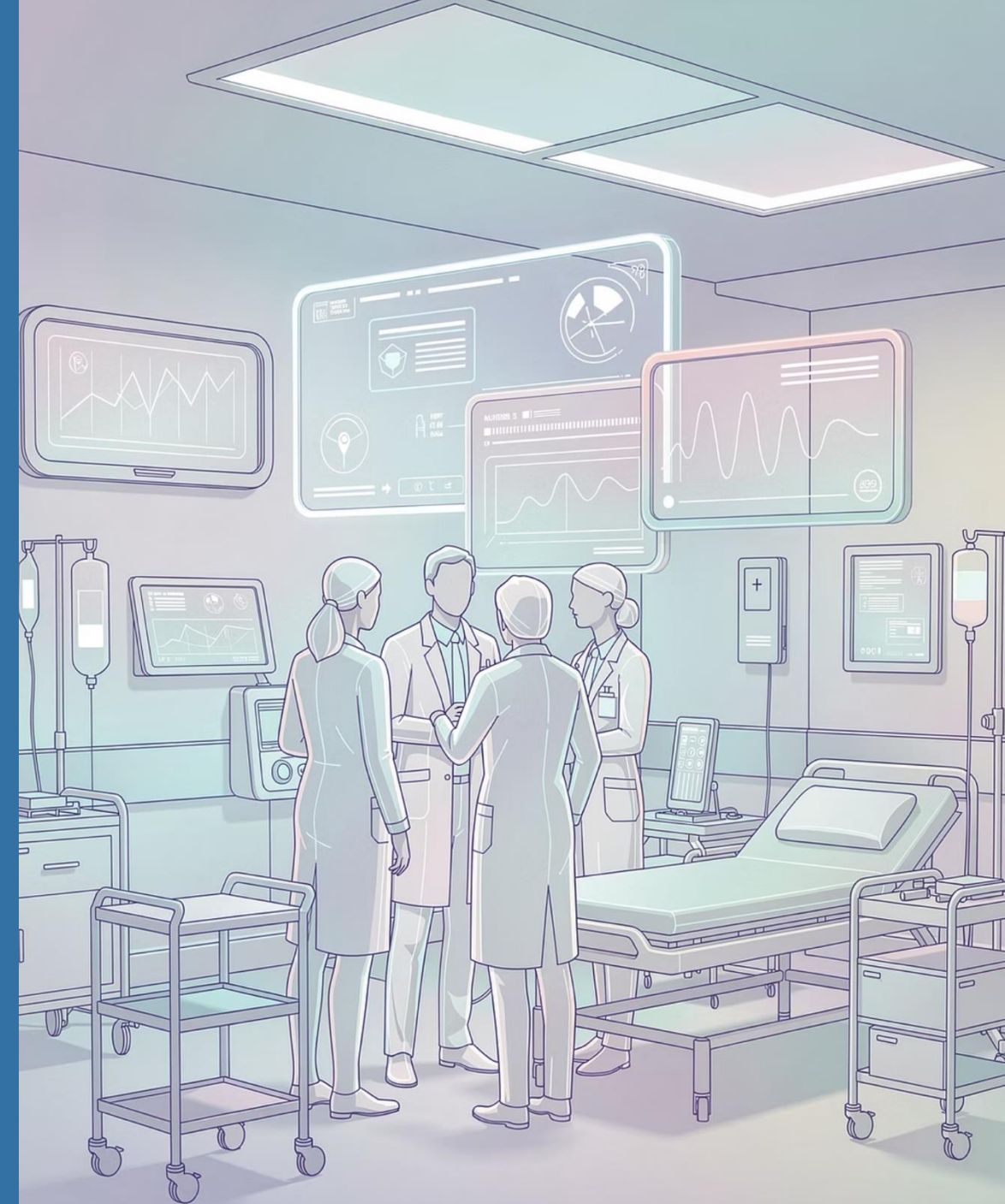
— Informaticist
Warner Slack, MD in 1968

Clinical care

All the AI attention is here

Examples: Ambient AI scribes, GenAI textbooks, pended orders, patient AVS

Mostly generative AI here but predictive AI has massive potential





Audience Poll #2

Who is teaching diagnostic peritoneal lavage?



Audience Poll #3

How about landmark-based U
central line placement?



Audience Poll #4

Who is teaching BVM and backup airway options?



Audience Poll #5

Who's teaching sick vs not sick?

When better tools arrive, four things can happen

1

Replaced

- *DPL*
- *Running your own gram stains*
- *Tactile fremitus*

2

Redefined

- *US-guidance for central lines*
- *Video laryngoscopy*
- *Clinical decision rules (eg pediatric head injuries)*

3

Retained

- *Knowing 2nd and 3rd line sedation meds*
- *Direct laryngoscopy without video*

4

Emphasized

- *BVM technique*
- *Sick vs not sick*
- *Patient disposition*
- *Resuscitation leadership*

Foundational Competencies for EM

Patient Care / Procedural Skills



- *Emergency stabilization*
- *Performance of focused history and physical exam*
- *Diagnosis and suggested orders*
- *Pharmacotherapy*
- *Reassessment and disposition*
- *Multitasking*
- *General approach to procedures*

Medical Knowledge



- *Scientific knowledge*
- *Treatment and clinical reasoning*



Practice-Based Learning and Improvement

- *Evidence-based and informed practice*
- *Reflective practice and commitment to personal growth*



Professionalism

- *Professional behavior and ethical principles*
- *Accountability / conscientiousness*
- *Self-awareness and well-being*



Interpersonal and Communication Skills

- *Patient- and family-centered communication*
- *Interprofessional and team communication*
- *Communication within health care systems*

Systems-Based Practice



- *Patient safety*
- *Systems-based management*
- *System navigation for patient-centered care*

**There is plenty of work to do in
emergency medicine for anyone who
wants to do it.**

Ask yourself these questions:

- 1. If the AI was good enough* at this task, should the AI just do it for the human?*
- 2. If the AI was good enough* at this task, should the AI augment the human?*
- 3. Is this something that should never be delegated to AI?
 - a. If so, could the AI help the human train, rehearse, or practice it?**

** Sorry, but you gotta ask yourself what good enough means, too*

Education and training

The question is not whether learners will use AI...

The question is what competencies must be protected...

How to protect them...

And what new competencies must be developed.



The impact of AI on medical education and training is my number one concern.

I don't have an answer for you.

Here's what the crowd said you should focus on:



Graham Walker, MD · You

Healthcare AI — MDCalc & Offcall Founder — ER Doctor @ TPMG (views are my own, not employers')

1w ·

Next month I'm speaking to the Dept Chairs of Emergency Medicine about AI. And I don't want AI's opinion about AI, I want **yours**.

I can get a thousand polished takes from a model. But I want **human** opinions — the stuff forged from long med school memorization hours, overnight shifts in your training, bad handoffs, near misses, and “this seemed fine until it wasn't.”

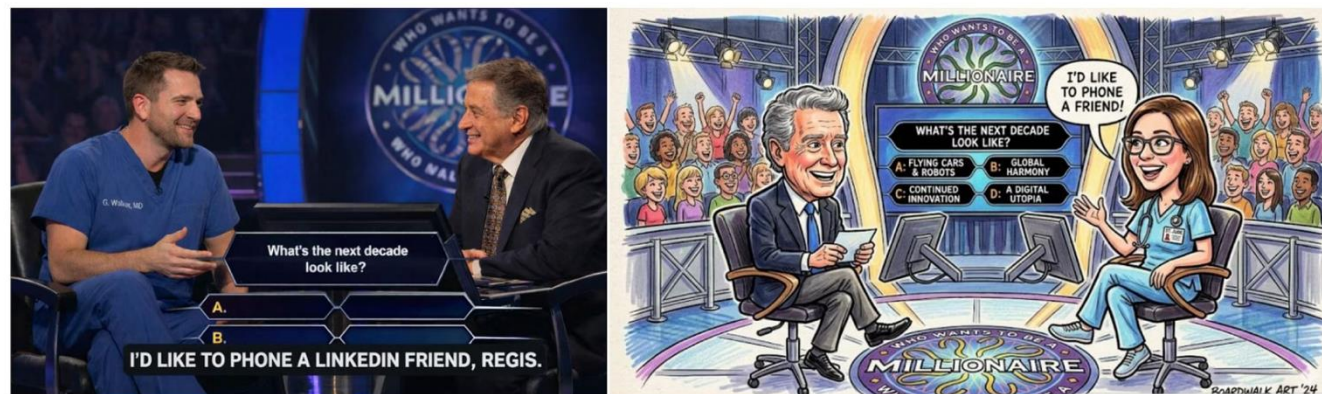
Clinical AI gets all the attention. So I want to help tell the chairs about two other topics they care about:

1) **Training:** What should an EM resident be able to do without AI in 2030? What's dangerous to outsource? How should training and education change in the next decade?

2) **Research:** What happens when “publishable” becomes cheap? How do we protect signal when AI agents can manufacture noise at scale and p-value mine while you're sleeping?

Drop your hottest take in the comments — or your best failure mode. What's your utopia? What's your dystopia?

If you were advising a Chair, what would you put on the “decide this now” list?





Effie Andrikopoulou, MD MBA FACC FASE  · 1st

1w ...

Cardiologist & Systems Architect | AI-Driven Cardiovascular Infrastructure | MD MBA FACC FASE

In general, I don't think there is anything inherently wrong with using AI. The main issue is how and when we use it. On that note, a couple of thoughts:

Given the recent decision by the FDA that at the end of the day, we humans still own accountability for the tools we use when something goes wrong, the key focus and challenge would be to very deliberately ensure we can function under uncertainty. How can we make sure we train our residents to be able to tell when something doesn't look/sound/feel right without having an algorithm nudging us?

From a research standpoint: how do we double down on training our residents to apply methodological judgment themselves so we can critically assess the output of AI generated specific aims and hypotheses. If we drown in a sea of AI-generated proposed ideas, we will need to be on top of our game with respect to Methods assessment. How do we make this part of our everyday training so it becomes second nature?

Like ·  14 | Reply · 3 replies

Assessing AI outputs and applying critical reasoning skills to them



Dave Spatholt MCP, MHI, CCRP  · 2nd

1w ...

Changing the Emergency Medicine experience through data | Ask me about Informatics, AI, VR, Public Health, Clini...

EM is stochastic by design. Managing uncertainty is the specialty, and that generalist nature will outlive the threat AI poses to other specialties.

AI will reduce real cognitive burdens. But winning on efficiency while losing the capacity to learn from uncertainty is a bad trade.

Training: Residents need "AI downtime" competency. What can you do when the AI is unavailable, wrong, or biased against your patient? Automation bias and skill atrophy are the consequence of removing friction from learning, and procedural skills and reasoning skills don't atrophy the same way. Residents need actual informatics literacy; not how to use the tools, but how to interrogate them: distribution shift, model degradation, training data bias.

Research: Methodology was already under siege before AI arrived. AI just scales the attack. When information is cheap, curation is everything, and right now nobody with the right incentives is doing it.

The decide-now question is simple: what does it mean to train a physician who has never practiced without AI?

Like ·  13 | Reply · 3 replies

Residents need "AI downtime" competency



Gus M. Garmel, MD, FACEP, FAAEM  · 1st

1w ...

Adjunct Professor of Emergency Medicine, Stanford University Department of Emergency Medicine

Terrific that you're offering your wisdom to Chairs, [Graham Walker, MD](#) . And smart that they collectively seek it. Executives, administrators, clinicians, IT, and staff must remember that patients are INDIVIDUALS, unique in what defines them, what matters to them, and what worries them. AI won't always consider SDOH or other nuanced circumstances, because these aren't always included as data points. Patients are not algorithms, nor should they be treated as such by them. AI-driven algorithms, in addition to chart, vital sign, CC, lab and imaging reviews are important, as is knowing how and when to use these correctly. That said, communication, empathy, active listening, and experience (that "sixth sense") remain essential to healthcare outcomes; they must stay front-and-center in education & training. Healthcare delivery is challenging even when everything lines up. AI won't solve all of healthcare's problems; the goal is for AI to help highly-trained and compassionate humans offer kindness and better care to individuals in need. Good luck with your presentation!

Like ·  6 | Reply · 1 reply

**Humans need to maintain their humanity;
patients aren't algorithms**



Bhav Jain ✓ · 1st

MD Candidate & Knight-Hennessy Scholar @ Stanford | prev: MIT, Truman, Samvid | AI & Policy for Health

1w ...

When will they let the med students use AI on rotations??

Like · 🗳️ 10 | Reply · 2 replies



Graham Walker, MD **Author**

Healthcare AI — MDCalc & Offcall Founder — ER Doctor @ TPMG (views are my own, not employers')

1w ...

Bhav Jain When, not should, in your view?

Like · 🗳️ 1 | Reply | 253 impressions



Bhav Jain ✓ · 1st

MD Candidate & Knight-Hennessy Scholar @ Stanford | prev: MIT, Truman, Samvid | AI & Policy for H...

(edited) 1w ...

Graham Walker, MD I think it's going to be a sufficiently integral part of clinical care delivery that we should get exposure to it during rotations. Obviously need to balance that with learning, but there's opportunity to use it to enhance learning (e.g., have the student come up with a differential and compare against AI, have the student write the note and compare against the ambient scribe). That way they simultaneously learn from AI on how to improve, can develop a critical detector for when AI is wrong, and gain firsthand ...more

Like · 🗳️ 2 | Reply

When will they let med students use AI on rotations?

Near-Term

Education: 1–3 years

01

Learners are **already** using AI

02

Programs need **explicit norms and expectations:**

"No AI" days? Even/odd AI usage times?

03

Skill maintenance is **critically** important

04

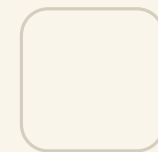
Critique and **calibration** become teachable skills

Longer-Term

Education: 5–10 years



Competence may shift from answer production toward **supervision and override**



Assessment may rely more on **simulation**, oral defense, and observed reasoning



Foundational knowledge may need to be **redefined**, not abandoned



AI-native training models will emerge whether we design them or not

The Impact of Generative AI on Critical Thinking: Self-Reported Reductions in Cognitive Effort and Confidence Effects From a Survey of Knowledge Workers

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Abstract

The rise of Generative AI (GenAI) in knowledge workflows raises questions about its impact on critical thinking skills and practices. We survey 319 knowledge workers to investigate 1) when and how they perceive the enactment of critical thinking when using GenAI, and 2) when and why GenAI affects their effort to do so. Participants shared 936 first-hand examples of using GenAI in work tasks. Quantitatively, when considering both task- and user-specific factors, a user's task-specific self-confidence and confidence in GenAI are predictive of whether critical thinking is enacted and the effort of doing so in GenAI-assisted tasks. Specifically, higher confidence in GenAI is associated with less critical thinking, while higher self-confidence is associated with more critical thinking. Qualitatively, GenAI shifts the nature of critical thinking toward information verification, response integration, and task stewardship. Our insights reveal new design challenges and opportunities for developing GenAI tools for knowledge work.

Confidence Effects From a Survey of Knowledge Workers. In *CHI Conference on Human Factors in Computing Systems (CHI '25)*, April 26–May 01, 2025, Yokohama, Japan. ACM, New York, NY, USA, 23 pages. <https://doi.org/10.1145/3706598.3713778>

1 Introduction

Generative AI (GenAI) tools, defined as any “end user tool [...] whose technical implementation includes a generative model based on deep learning”,¹ are the latest in a long line of technologies that raise questions about their impact on the quality of human thought, a line that includes writing (objected to by Socrates), printing (objected to by Trithemius), calculators (objected to by teachers of arithmetic), and the Internet.

Such consternation is not unfounded. Used improperly, technologies can and do result in the deterioration of cognitive faculties that ought to be preserved. As Bainbridge [7] noted, a key irony of automation is that by mechanising routine tasks and leaving

accountability. Conversely, lower self-confidence may lead users to rely more on AI, potentially diminishing their critical engagement and independent problem-solving skills. This reliance on AI can be seen as a form of cognitive offloading [8], where users depend on AI to perform tasks they feel less confident in handling themselves.

Confidence in AI is associated with reduced critical thinking effort, while self-confidence is associated with increased critical thinking effort. This duality indicates that design strategies should focus on balancing these aspects. The aims are both to improve the quality of AI-assisted tasks and also to empower users to develop their skills and maintain a balanced “relationship” with AI. To address task confidence recalibration, AI tools could incorporate feedback mechanisms that help users gauge the reliability of

The 3 C's of AI in EM Training



Create protected
reps



Calibrate



Critique required

1. Create protected reps



Require human first-pass thinking before AI



Protect clinical reasoning skills

Like DDx, Assessment/Plan, MDM



Maintain resuscitation leadership, POCUS & procedures

High-stakes = Human.

2. Calibrate your own thinking

01

Pre-commit

*Form your own assessment before consulting
AI output*

02

Compare

*Examine where your reasoning and the AI's
reasoning diverge*

03

Own the difference

Take responsibility for the final clinical judgment

3. AI always gets a Critique

What is this missing?

What is this assuming?

What additional information would change this output — and why?

What could happen if I only listen to the AI and do what it recommends?

AI Downtime Competency

Function Without AI

Can the learner function when AI is unavailable?

Recognize Errors

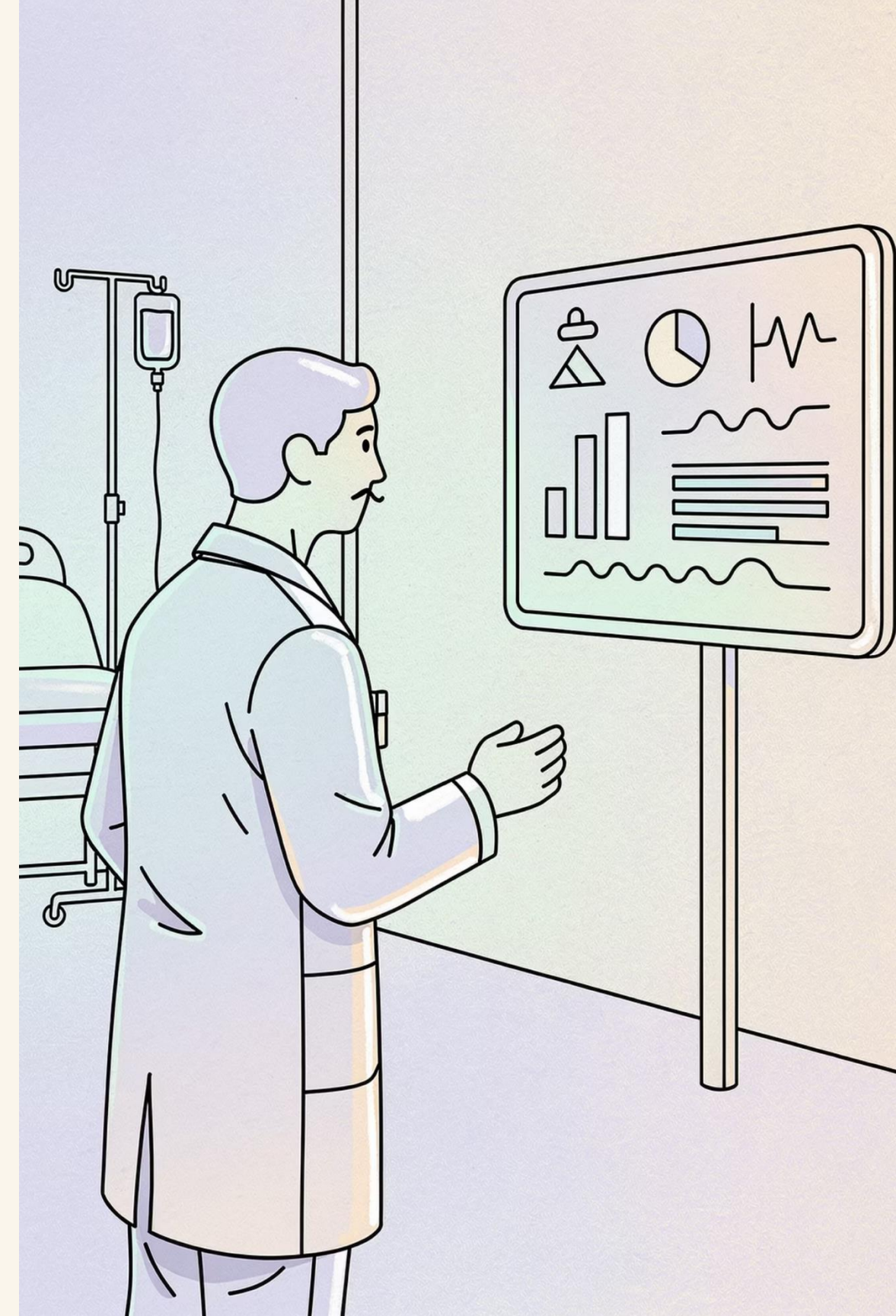
Can the learner recognize when AI is wrong?

Override Safely

Can the learner override it safely?

Lead Clinical Care

Can the learner still lead clinical care?



When Evaluation Signals Get Cheap

- *Personal statements written in 5 minutes*
- *Letters of recommendation that become templated and low value*
- *When faculty can automate the evaluation of trainees*

When Everything Is a Signal... Nothing Is

If every student has a glowing letter...

If every applicant sounds polished...

If every answer is optimized...

A close-up photograph of an elderly person's hand, showing wrinkled skin. A bright yellow wristband is wrapped around the wrist, with the words "FALL RISK" printed in bold, black, capital letters. The background is a soft, out-of-focus light blue and white.

AI Reveals a Proxy Problem

Letters, statements, and interviews are not the value.

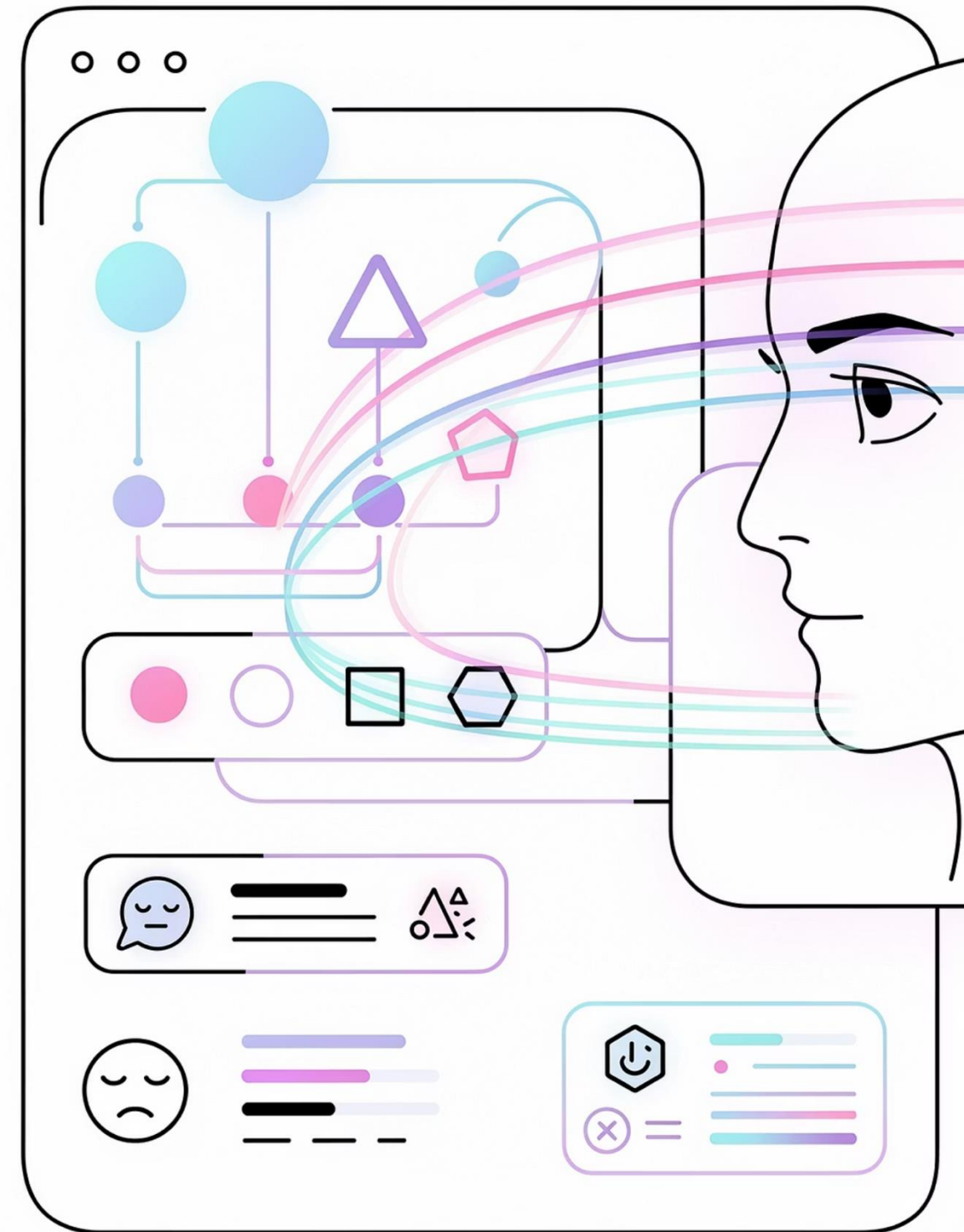
They are proxies for:

Judgment

Character

Potential

Trust



Research: The Third Mission

How AI changes scholarship and evidence

**Accelerate
Generation**

Accelerate Noise

**Accelerate
Knowledge Creation**

AI Will Massively Increase Research Production and Generation



Faster Analysis



Easier Study Design



Automated Writing



AI-Assisted Peer Review

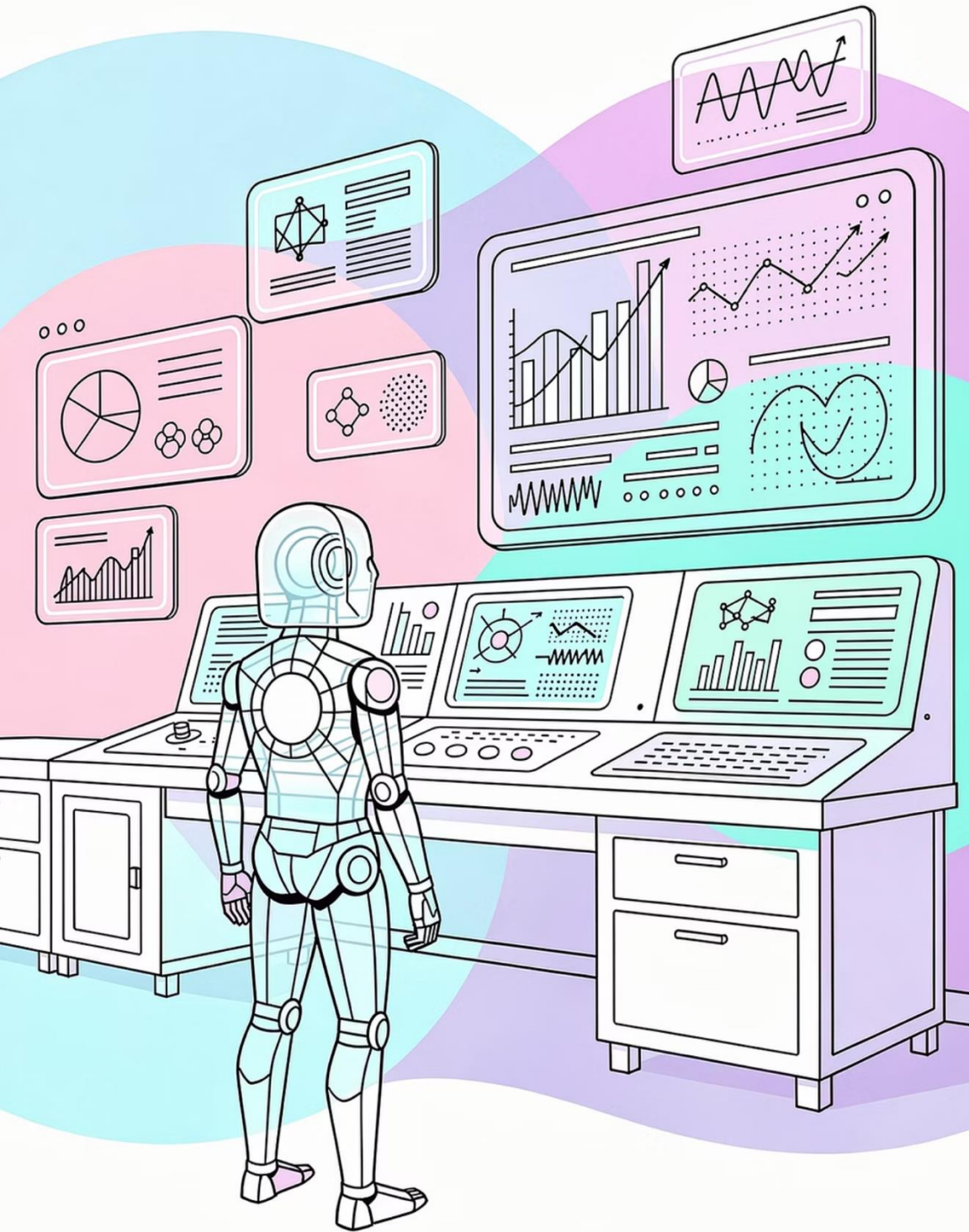
The Bottleneck Moves

Old Bottleneck: Generating Studies



New Bottleneck: Choosing the Right Questions





Good Research Starts With the Question

Not: "Is this statistically significant?"

But: "Does this matter to patients?"

The Research Questions for the Future Become:

What do you want from research?

What's valuable? What's not?

Then build that exact system.

It's actually possible with GenAI.



Want a place for people to vote on
which research questions are the most
important?

Okay, build that in 5 minutes.

Want papers being submitted to EM journals to go through an AI review for stats, methods, and clinical impact?

You can build that, too.

Prefer an alternative to **publish-or-perish** that instead rewards "impact on emergency care?"

No problem.

Whatever your values are for research, you can build a system that encourages and supports them.

How should Academic EM Chairs think about the future of EM and AI?

Recruit the Best

Can academic EM continue to recruit the strongest, most innovative clinicians?

Retain Practitioners

Can it keep them practicing emergency medicine?

Lead Adoption

Can it lead all of medicine in thoughtful technology adoption, as it has before?

Final Takeaways

AI Is Here

AI will re-shape medicine, including emergency medicine.

New Opportunities and Challenges

AI will create new opportunities just as it will create new challenges.

Closer to Our Values

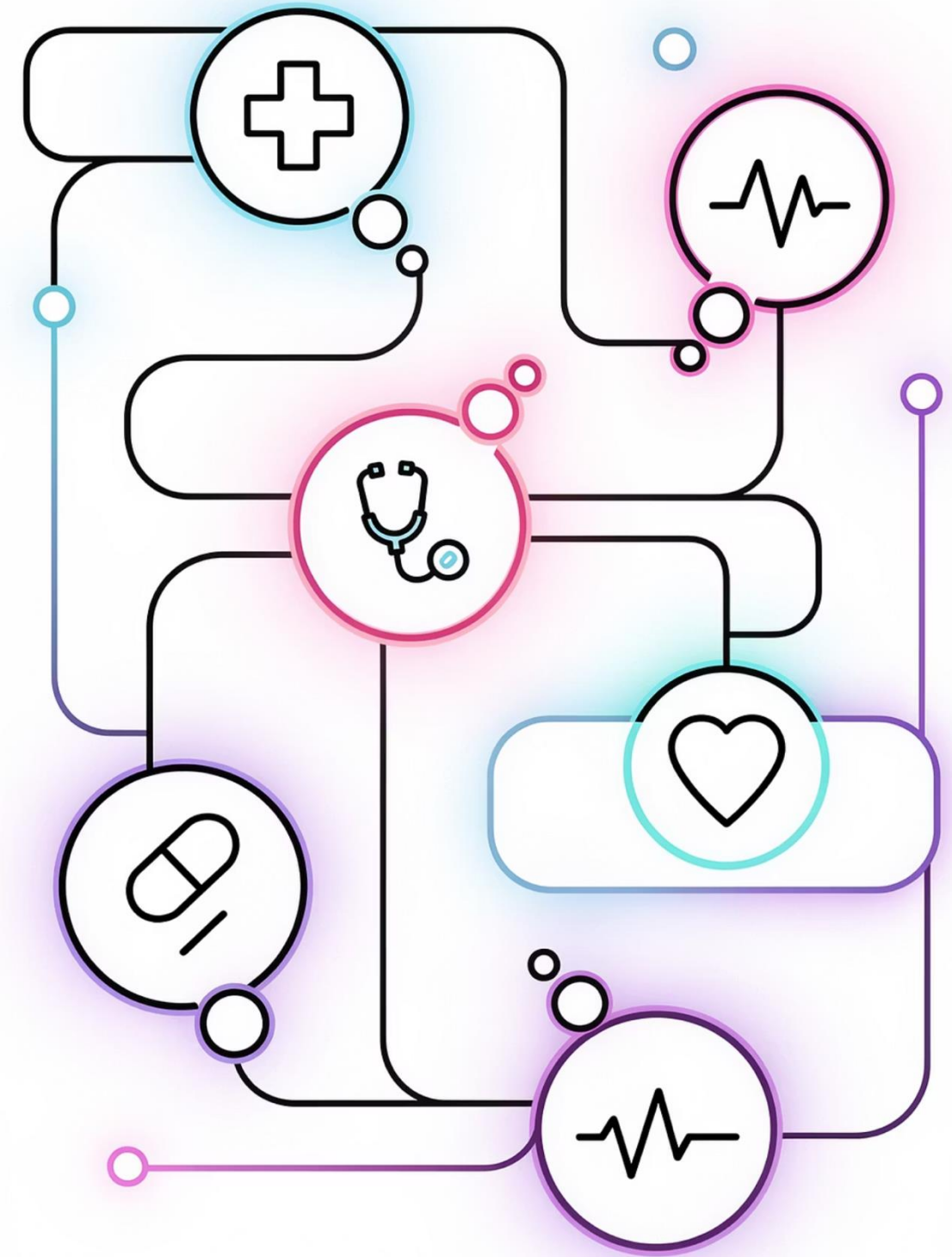
The capabilities of AI can get us closer to our principles and values.

Decide What Stays Human

Some of medicine will change, adapt, or go away — you need to decide what must stay fundamentally human.

Questions?

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Dr. Brian Wai Lin
Emergency Physician
1978-2025

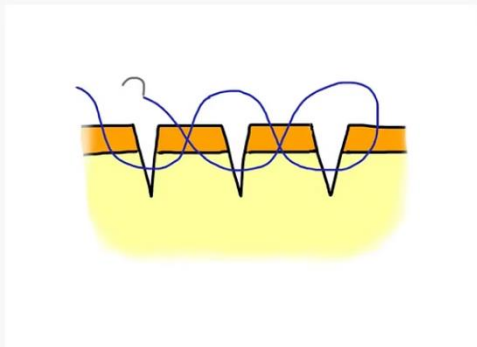
LacerationRepair.com



THE TOENAIL "SPORK" TECHNIQUE

Recently I had an opportunity to perform one of my favorite techniques, the transverse figure-of-eight suture to secure a partially avulsed toenail. The patient was a young man who injured his toe kite boarding. Somehow he managed to lift the nail from its bed, miraculously had no underlying laceration to the bed (just a whole...

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PARAFFIN LACERATIONS



ROAD RASH! PART I

A 9-year-old boy is brought in for evaluation of facial abrasions after falling down in the schoolyard. He unfortunately fell face first on pavement with loose gravel causing this painful abrasion around his left eye. The center of the wound is darkened with dirt and debris from the asphalt still embedded deeply in the wound....

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EVERSION

We are taught the value of everting our wound edges from Day 1 in our surgery rotation in medical school. But just how important is it? Why do we do it? And can we cause harm when we fail to do it? Eversion Eversion is an axiom that has lost its source tag. The theorized...

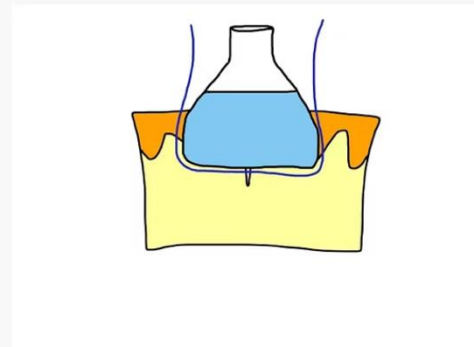
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DOG BITE DOGMA, PART I

Lacerations caused by a dog bite. The upper and lower jaws of the dog are perfectly outlined in this full thickness laceration; the lower laceration is stellate and crosses the vermillion border of the upper lip. A 19-year-old female presented to the Urgent Care for evaluation of a facial laceration due to a bite from...

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THE PERFECT SIMPLE

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If you know a resident, fellow, or young attending who loves lacerations and wound care like Brian did, please reach out.