

NARRATIVE ESSAY

Building a Home for Point-of-Care Ultrasound in Family Medicine Training

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We first noticed it in passing between teaching sessions, in clinic hallways, and during casual conversations between residents and faculty. Point-of-care ultrasound (POCUS) was everywhere and nowhere at once. Machines sat plentiful in outpatient clinics. Most teaching happened in the moment in emergency departments, critical care units, sports medicine rooms, and obstetric evaluations. When POCUS did appear in family medicine education it was often a one-off session: energizing, useful, and fleeting.

What we lacked was not interest, or even equipment. What we lacked was space. Space in the schedule, space in the curriculum, and space to learn together.

Those early conversations around building longitudinal POCUS education in our family medicine residency felt hopeful, but tentative. We did not have a dedicated curriculum or regularly scheduled protected time to refine this skill. Still, residents and faculty kept asking the same question: *What could POCUS education look like here?* We wondered whether an interest group might offer a starting point—something intentionally low stakes where curiosity could lead rather than competency checklists.

The logistics were surprisingly human. Where would we meet? Would we have access to machines? Who would show up? With support from clinic managers and residency leadership, we formed a partnership with our outpatient clinics to share ultrasound machines when they were not in use for patient care. Our classroom space next door became a place where learning could shift easily from discussion to hands-on practice. This collaboration, built on trust and shared purpose, made the idea feel possible.

In the fall we scheduled monthly evening meetings and sent invitations widely. Interest was affirmed through enthusiastic conversations with both residents and faculty, as well as survey responses that confirmed high interest but low comfort and confidence across most POCUS applications. Attendance to these evening sessions told a different story. Initially we only had a few attendees due to logistical difficulties as our residency program is geographically dispersed, with residents and faculty balancing clinical demands across multiple sites. Enthusiasm alone could not overcome structural barriers. This was not a POCUS problem. Any optional activity scheduled outside of protected time would have faced the same headwinds.

After one early session, standing in a nearly empty room with an ultrasound probe in hand, I wondered: *is there a better way to meet the need?* That question turned out to be generative. In parallel, conversations continued, advocacy deepened, and program leadership began exploring creative solutions. The uncertainty in the moment quietly became the catalyst for something better.

As spring approached, interest group time was added to the residency didactics schedule. That shift was subtle, but profound. Although this was still an optional activity, attendance increased by at least three-fold. Protected time signaled that this work mattered. It also meant that other interest groups gained space to grow. A win for one became a win for all.

Sessions followed a deliberate progression beginning with the fundamentals of ultrasound and probe handling and advancing through clinical applications like Cardiac, Lung, Focused Assessment with Sonography in Trauma (FAST), and Obstetrics; each with their cardinal views. Asynchronous online prelearning was made available but not required. We collaborated with colleagues who are champions of POCUS in their specialties, from pediatric emergency medicine to pulmonary critical care. Their generosity with their expertise reminded us we were not learning in isolation. In the

sessions our goal was twofold: for learners to leave with hands-on familiarity obtaining the relevant core views, and with at least one clinical pearl they could carry directly into practice. What we did not anticipate was how naturally the sessions would become personalized. As participants shared patient encounters from the week, conversations would shift from technique to integration. We discussed how to incorporate POCUS into a specific evaluation, what a finding meant in context, and how to act on what the image revealed. This structure gave us a foundation while personal experiences gave us purpose.

Didactic time is sacred in our program. As a residency that is spread across many clinical sites, this is the time we return to our family medicine family. Being together feels grounding, like biting into a warm, gooey brownie topped with ice cream after a long day. Adding ultrasound to that space transforms learning into something playful and communal, uplifting both learner engagement and skill development.

This experience taught me that teaching POCUS in family medicine is about encouraging curiosity and the systems that support learning. For me, this interest group served as a living complement to formal didactics: a space to revisit skills, collaborate with peers, and practice imperfectly without the weight of evaluation. Looking forward, this group is a building block to create a formalized POCUS curriculum aligned with American Board of Family Medicine (ABFM) requirements with a pathway toward documented competency. As POCUS becomes a core procedural requirement for our specialty, that progression feels not just inevitable, but necessary.

Ensuring quality experiential learning will be key to promote the intentional use of POCUS in diverse family medicine settings. At the end of the day, we learn best together: hands-on, relationally, and with space to grow.