

Point-of-Care Ultrasound: A Trial for Our Specialty

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Over the last decade, point-of-care ultrasound (POCUS) has become widely available and dramatically less expensive. Undergraduate medical schools are rapidly expanding curricula in POCUS,^{1,2} and American Board of Family Medicine data suggest that over 90% of family medicine residencies have at least one resident who wants to perform POCUS in practice.³ Moreover, of those who intend to perform POCUS, about half are practicing POCUS 3 years after graduation.³ Thus, the question now is not whether, but how our specialty will support dissemination of POCUS in practice. This is a trial of our specialty's fundamental ability to evolve our clinical practice in meaningful ways.

An important first question is whether POCUS improves patient clinical outcomes and cost-effectiveness in the continuity setting. Increasing numbers of studies suggest that POCUS alters the diagnostic trajectory and improves outcomes in emergency^{4,5} or inpatient settings.⁶ In the continuity setting, anecdotes abound (eg, “Did you hear about the case of endocarditis discovered on routine scan?”) but relatively few studies rigorously examine the effectiveness of POCUS in improving the outcomes of care in specific populations or for specific clinical indications. There is progress, however. In addition to more general studies of patient reactions and program evaluation,^{7,8} there is beginning work for a variety of conditions, including screening for abdominal aortic aneurysm (AAA),⁹ detection of carotid plaque,¹⁰ first trimester obstetrical care,¹¹ and intrauterine device insertion.¹²

This will be a trial of the effectiveness of our specialty's research enterprise. Importantly, our specialty's major journals have begun to publish empirical studies, with special issues devoted to POCUS in *JABFM*, this issue of *Family Medicine*, and specific trials in *Annals of Family Medicine*. Moreover, to help

meet the need for empiric research on POCUS in continuity settings the ABFM Foundation has funded 13 pilot studies on the impact of point-of-care ultrasound on patient outcomes and cost effectiveness. These pilot studies address a variety of clinical questions, including the accuracy of POCUS for outpatient indications such as deep venous thrombosis, pneumonia or left ventricular hypertrophy, program evaluations for ultrasound service lines, and evaluations of different training strategies. A key feature of the funded proposals was the variety of clinical contexts of continuity care, from university departments to community residencies to federally-qualified health centers.

Another important research strategy is to collect experience systematically on POCUS practice in family medicine settings nationally. As an example, the POCUS Research, Innovation, and Medical Education (PRIME) Learning network is developing a national POCUS network dedicated to family medicine and primary care-focused education as well as research on applications in primary care.¹³ The strengths of such networks lie in the shared knowledge and experiences of their members. They can provide shared learning and problem-solving as the specialty navigates the challenges of broader POCUS implementation.

For family medicine residencies, perhaps the most important question is what POCUS examinations should be taught to residents. Over the last year, the Society of Teachers of Family Medicine has assembled a task force to recommend consensus curriculum and assessments for POCUS in family medicine. They used Delphi studies to decide which POCUS examinations should be included in family medicine practice and placed them in five tiers according to their clinical usefulness and facilitation of clinical

skill development. They recommend that the first tier—abscess/abscess drainage, cellulitis, bladder volume, knee effusion, and fetal presentation—should be taught in residency. The recommendations have been presented on multiple occasions at national meetings and are now published in this issue.¹⁴ It will be critical for the clinical leaders of specialty to weigh in about the appropriateness of the task force recommendations and the validity of the Delphi studies underlying the selection of examinations and the tiering process.

A key facilitating factor for POCUS implementation in family medicine residencies will be the ABFM requirement of competence in POCUS for ABFM board certification. In 2022, the ABFM identified POCUS as one of its priorities in health and health care,¹⁵ signaling that questions involving POCUS images would be included in high-stakes exams, and the recent ACGME Family Medicine Review Committee major revision lists POCUS as a detailed requirement.¹⁶ In the spring of 2023, ABFM included POCUS competence as part of its policy implementing core outcomes¹⁷ and set a tentative attestation date of 2027. As this editorial is being written, however, that date is now under review by the ABFM with input from the specialty. The tension is between the significant practical challenges of implementing POCUS teaching across over 800 residences with the need to signal to medical students and health system leaders that family medicine embraces POCUS as obstetrics, sports medicine, emergency medicine, and internal medicine already have.

What is the best strategy for development of faculty skills in POCUS? A key constraint of dissemination of POCUS is availability of faculty who can use and teach POCUS. Currently widely available are weekend workshops conducted by the American Academy of Family Physicians, state chapters, or for-profit vendors. Typically, they give an opportunity to practice hands-on with a variety of images. They are very popular and can be very useful. Online options for POCUS education exist, but hands-on skills may be best taught by hands-on, in-person instruction. For most potential practitioners, however, as suggested by the experience of the STFM POCUS Certificate Program,¹⁸ the best approach to development of clinical POCUS skills is a longitudinal experience with spaced repetition of item acquisition, image review, and clinical interpretation, probably with a minimum of examinations and ongoing experience in clinical practice.

How should faculty development scale up nationally? There are now more than 800 family medicine residency programs. A promising strategy might be something like advanced life support ultrasound (ALSO) instructorships, in which instructors have an annual meeting, keep up to date, and are certified to lead rigorous POCUS courses. Emergency medicine has had such a course for many years. How many faculty instructors should there be? Perhaps a goal might be one instructor for each residency; as with ALSO and in

sports medicine POCUS training, we can envision collaborative regional training involving many training programs.

It is also clear that there are operational barriers to implementing POCUS practice at scale. An important issue from a liability perspective is to maintain a record of images in the electronic health record (EHR). As we have learned through malpractice litigation in the care of pregnant women, if the image is not available in the chart, courts may assume that there is ill intent in the image not being available. This will require facilitation by hospital systems and EHRs, but fortunately other specialties and many health systems/EHRs have already worked out appropriate procedures. There are also reports of what might be considered cultural barriers—the skepticism of family physician leaders in group practices about the importance of developing POCUS skills in younger family physicians or giving time for POCUS practice and performance.¹ Health systems also may have incentives to keep revenue within imaging departments. These barriers need to be addressed explicitly.

Hospital, health system and payer credentialing is another key constraint; for POCUS to be implemented broadly, there must be reasonable strategies for developing and maintaining privileges to perform POCUS examinations. Here we must look to family medicine department chairs and others experienced in the sometimes political processes of credentialing. The process will vary from institution to institution, but what is critical is that there not be separate credentialing for each of the approximately 52 recommended examinations¹⁴ and inclusion of diagnostic as well as therapeutic scans. The goal should be routine credentialing in POCUS examinations for family doctors, especially once they are board certified with a requirement for POCUS competence as a key component of ABFM board eligibility.

Financing the development of POCUS clinical services is also a significant challenge. The reimbursement environment across the nation and by payers is highly variable, but some version of fee-for-service is dominant. A way forward has been identified at some institutions with the identification of routine examinations (eg, screening for AAA) from which ongoing reimbursement can support the development of the clinical service, including equipment repair and replacement and faculty leadership time.

Beyond technical education, an important question is whether the specialty should promote a fellowship and certification in point-of-care ultrasound administered by the American Board of Emergency Medicine.¹⁹ The fellowship is an intense, 1-year experience on state-of-the-art ultrasound examinations including echocardiograms and other advanced applications. Such a certificate might support family physicians leading POCUS service lines and educational efforts. Obviously, such a certificate would not be appropriate for every clinician who wants to do POCUS, and would require the ABFM to decide to become a qualifying board. Does the specialty need access to this certificate going forward?

Ultimately, the challenge for our specialty is the evolution of clinical family medicine: where do we want our specialty to go? In the current issue of *JABFM* is an extended discussion about what the clinical model of family medicine for the future should be. A key proposed principle is embracing technology such as POCUS. If family medicine is to thrive, if it is to attract students, the specialty must also embrace technology that can make a difference in the outcomes of patients. It is up to us to prove that POCUS can improve outcomes in our continuity practices, that it is financially feasible to develop POCUS clinical practice, and that challenges of liability, equipment, and faculty development are solvable. The dissemination of POCUS will be a trial for our specialty. Onward!

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