

Stop Treating POCUS Like Radiology: Make It Part of the Physical Exam

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To the Editor:

Three recent *PRiMER* articles collectively describe family medicine's current POCUS (point-of-care ultrasound) problem: we are teaching it more, valuing it highly, and using it inconsistently. Beduhn et al show that when residents scan more, their scan quality improves, most clearly among those in a longitudinal track with substantially higher scan volume.¹ Ludden-Schlatter et al show that learners and practicing physicians overwhelmingly view POCUS as important, yet report low comfort and multiple barriers that inhibit routine use.² Embers and Yedlinsky demonstrate that students utilize ultrasound as a tool that augments physical examination learning and understanding.³

The most important lesson across these studies is not simply that POCUS is desired, but that its competence requires repetition, and our current systems too often prevent repetition from happening.

In many practice environments, bedside POCUS is treated as if it were comprehensive diagnostic imaging. That framing brings expectations of formal credentialing, minimum scan thresholds, image archiving, billing rules, and separate procedure documentation. Those requirements may be appropriate when ultrasound is used as a standalone diagnostic study. When imported wholesale into routine bedside decision-making, the result is predictable: clinicians avoid using POCUS at all, and learners rarely see it modeled.

Family medicine already understands how examination skills develop. No one expects a trainee to identify a subtle murmur after hearing only a handful of normal heart sounds; we accept that clinicians must hear many normal exams before reliably identifying abnormal findings. POCUS use is analogous. If we require physicians to meet imaging-style hurdles before they can use ultrasound as an exam adjunct, we deny them the very repetition that builds skill and calibration. Beduhn et al demonstrate what access and repetition produce: more scans, better quality.¹

If bedside POCUS is truly an extension of the physical examination, our documentation should reflect that. Exam-augmenting POCUS should be recorded in the physical examination section of the note, alongside inspection, palpation, percussion, and auscultation, rather than relegated to the "imaging" or "procedure" portion of the chart. When findings are integrated with history and exam to inform real-time clinical reasoning, they function as physical exam data, not as a separate diagnostic study. Documenting them as such reinforces appropriate scope and reduces the perception that every scan requires radiology-style oversight.

This distinction is not about lowering standards; it is about aligning expectations with clinical intent. Diagnostic ultrasound used for billing or comprehensive evaluation appropriately carries higher documentation and credentialing requirements. Exam-augmenting POCUS should be enabled like other bedside skills, supported by

training, feedback, and local quality improvement, rather than blocked by disproportionate gatekeeping.

As POCUS expectations expand in training, family medicine must decide how it will live in practice. If we want competent family physicians, we must let them practice, and we must document POCUS use like the physical exam skill it is.

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References

1. Beduhn B, Schoneich S, Saunders W, et al. Point-of-care ultrasound track in an academic family medicine department. *PRiMER*. 2024;8:41. doi:10.22454/PRiMER.2024.363716
2. Ludden-Schlatter A, Kruse RL, Mahan R, Stephens L. Point-of-care ultrasound attitudes, barriers, and current use among family medicine residents and practicing physicians. *PRiMER*. 2023;7:13. doi:10.22454/PRiMER.2023.967474
3. Embers D, Yedlinsky NT. Using ultrasound to augment exam skills among clerkship students. *PRiMER*. 2023;7:39. doi:10.22454/PRiMER.2023.183911

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