Teaching Point-of-Care Ultrasound in Medicine: a scoping review

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Abstract
Point-of-care ultrasound (POCUS) is an important tool for diagnosis and management across medical specialties. This scoping review consolidates POCUS education literature, examining how curricula are developed, implemented, and assessed. We identify literature gaps, explore directions for further research, and provide recommendations for curriculum development, implementation, and improvement.

Methods
We conducted a scoping review per the framework outlined by Arksey & O’Malley. A systematic search of the MEDLINE, EMBASE, Cochrane, ERIC, Web of Science, and Scopus databases was conducted to identify published, English language literature, on POCUS education in undergraduate or graduate medical training.

Results
Of 6164 articles identified, 421 were analyzed in depth. Curricular content included diverse diagnostic and therapeutic applications, varying significantly by specialty. Teaching modalities included in-person didactics (74%), human models (58%), simulation (33%), and web-based didactics (18%). Several studies showed better outcomes for structured vs. apprenticeship curricula, hands-on teaching vs. didactic lectures, and human models vs. simulators. Web-based didactics were as effective as in-person didactics and conveyed benefits in reusability, cost, and instructor time. Dedicated electives and boot-camps were identified as effective. Few curricula assessed knowledge retention (5%), clinical decision making (3%), learner behavior (12%), or patient outcomes (6%).

Conclusion
Scholarly POCUS education literature is expanding. Curricular content varies and should be tailored to specialty needs. Structured curricula utilizing hands-on learning, electives, and boot-camps can enhance educational outcomes. Higher-level outcomes such as knowledge retention,
Point-of-care ultrasound (POCUS) has become a valuable clinical tool for the delivery of patient care across medical specialties. It is inexpensive, non-invasive, portable, and studies support its ability to improve patient care by providing timely and accurate diagnoses,\(^\text{12}\) guiding clinical management,\(^\text{3,11}\) and increasing success rates of bedside procedures.\(^\text{12-17}\)

Ultrasonography was first proposed as a clinical tool in the late 1950s.\(^\text{18}\) Over the subsequent decades, technological advances made ultrasound more portable and affordable, paving the way for its use at the bedside. Initial viability studies in trauma literature of the 1980s-1990s\(^\text{19-21}\) demonstrated POCUS’ clinical benefits and led to its expansion across medicine. While POCUS has become increasingly validated and widespread in clinical use, numerous studies detail that clinical training in POCUS is often lacking or highly variable.\(^\text{22-28}\) Additionally, our understanding of what constitutes educational best practice in POCUS is incomplete.
POCUS is often taught through apprenticeship models whereby learners undergo “on-the-job” training in clinical settings by more experienced practitioners. This creates a dependency on educators’ abilities to convey skills and knowledge, identify weaknesses, and assess competency, making this model highly variable. Furthermore, little data is showing its efficacy. Recent literature has shown the benefits of structured teaching curricula over apprenticeship models in POCUS education.29-31

Educational bodies32-35 have established recommendations for content knowledge and competency in POCUS, but do not provide direction regarding other key aspects of POCUS education, such as optimal teaching modalities, and methods of learner assessment and training evaluation. The International Federation of Emergency Physicians (IFEM)36 provides some recommendations on curriculum delivery and learner assessment, but these are minimal compared to their guidelines on content.

There is a robust body of primary literature on POCUS education, but it is diverse in scope and methodology. Various reviews have attempted to summarize this literature. Scoping reviews by Birrane et al.37 and Tarique et al.38 focus on undergraduate medical education literature and identify themes in curricular content and learner assessment. A scoping review by Meadley et al.39 focuses on POCUS education in paramedics to examine curricular structure. Our scoping review asks: what content is being taught in POCUS education curricula and how does this differ between specialties; what training methods are effective; how are learners evaluated; and what are the gaps in the POCUS education literature. Our review differs from those above in that we assess POCUS education literature in both undergraduate and graduate medical education. Additionally, our review takes a more specific look at the exact content that is being taught across specialties. Finally, we look specifically at and summarize comparative studies to better understand the relative merits of various teaching modalities. We excluded studies that solely focused on central line insertion, as this topic has been studied extensively and summarized in other reviews.40-42 This was done to ensure the number of included studies was kept at a manageable number and allowed us to focus more closely on other aspects of POCUS education. The goals of our study are threefold: (1) contribute to the understanding of current practices in POCUS curriculum development, implementation, and assessment, (2) provide specific recommendations to educators to aid in the design of POCUS curricula, and (3) discover gaps in the POCUS education literature and explore directions for further research.

Methods
Our decision to utilize a scoping review methodology was made after a first look at the literature revealed a study base that was too heterogeneous in methodology, study population, and objective to be adequately captured by a systematic review. We decided that a scoping review would better allow us to capture and understand the full depth and breadth of the primary POCUS education literature. We used the scoping review framework outlined in 2005 by Arksey & O’Malley43 and expanded on by Levac et al.44 Our strategy is summarized as (a) identifying the research question (described above); (b) identifying relevant studies; (c) study selection; (d) charting the data; (e) collating, summarizing, and reporting the results. This scoping review methodology was chosen to systematically capture the full depth and breadth of the existing literature.

Identifying Relevant Studies
A comprehensive search strategy was developed by a medical librarian (AOC) to identify published, English language literature on ultrasound education for medical trainees. The initial search strategy was developed for Ovid MEDLINE by using a combination of database-specific subject headings and text words; this was then customized for each subsequent database search.

Searches were conducted between March 9 and 15, 2017 in the following databases: Ovid MEDLINE, Ovid MEDLINE Epub Ahead of Print and In-Process and Other Non-indexed Citations, Ovid EMBASE, Cochrane Database of Systematic Reviews (Ovid), Cochrane Central Register of Controlled Clinical Trials (Ovid), ERIC (EBSCOHost), Web of Science Core Collection, and Scopus. No date limits were applied. See Appendix I for the full search strategy.

After the initial database search, duplicates were removed, and an initial title and abstract review were performed (AM), whereby exclusion criteria were used to eliminate irrelevant articles. Then, a full article review to assess the viability of the remaining studies was independently performed (AM, WW), and disagreements were resolved by consensus.

Inclusion and Exclusion Criteria
Research Methodology
We included primary research (RCTs, cohort studies, and cross-sectional studies). We excluded review articles, surveys, case reports, textbook chapters, conference proceedings, research in progress, letters to the editor, comments, and unpublished literature.

We did not assess for study quality as our goal was to capture the full breadth of existing POCUS education literature. Additionally, current practice in scoping reviews is to not assess for study quality.43,44

Point-of-Care Systems
Studies investigating the use of POCUS were included. We defined POCUS as a "portable ultrasound intended for use at
the patients’ bedside for immediate diagnostic or therapeutic purposes.” This definition includes “handheld” and “pocket-sized” ultrasound. We excluded non-POCUS systems, such as trans-rectal ultrasound, trans-esophageal echocardiogram, formal transthoracic echocardiogram, radiology department ultrasonography, endoscopic ultrasound, and endo-bronchial ultrasound.

**Educational Intervention**

Studies that investigated an educational intervention or training curricula were included. We excluded studies in which there was no defined educational intervention, or where the educational intervention was disconnected to the study in question.

**Study Population**

We included studies that involved undergraduate medical learners, residents, or fellows. Articles that focused solely on allied health professions or practicing clinicians were excluded. Studies that involved combined training of medical students, residents, fellows, and allied health care or clinicians were included.

**Central Line Insertion Studies**

We excluded studies that had a sole focus on central venous access procedures. This topic has been studied and summarized extensively in prior literature.\(^40\)–\(^42\) We felt that the inclusion of these studies was unnecessary and could potentially dilute the value of the other studies. Additionally, the inclusion of these studies would substantially increase the number of studies in this review to an unmanageable degree. However, we decided to include studies that involved central venous access education as part of a broader POCUS curriculum, to ensure we did not unjustly eliminate valuable studies on POCUS curricula.

**Charting the Data**

Prior to the study analysis, we devised categories under which study data could be tabulated. These categories were: study date, journal of publication, study design, type of learner, curricular content, teaching modality, instructor type, learner assessments, and training evaluation. Data about these categories were extracted from the selected articles.

Decisions related to which aspects of POCUS education to explore in further detail were borne out of patterns that emerged during a review of the literature, and topics that the authors found interesting. Given the scoping review methodology we used, and heterogeneity of the studies included, we did not assess study quality, nor did we perform statistical analysis on any of the studies. Instead, we performed a narrative summary of the studies to help map the landscape of the existing literature base, form preliminary conclusions on the data found within, and explore directions for further research.

**Results**

**Search Results**

The screening and review process is outlined in Figure 1 using a PRISMA diagram framework.\(^45\) The initial search identified 12,647 articles. After duplicates were removed, 6164 abstracts were screened. On the initial screen of abstracts, 4,954 articles were excluded. The remaining 1,210 studies underwent full review by two independent investigators (AM, WW). The kappa statistic for agreement between evaluators was 0.663, indicating good consensus. Disagreements were resolved through discussion, and 421 studies were included for analysis.

The papers explored in further detail are cited in the body of this paper. A listing of all studies included in the review is shown in Appendix 2.

**Study Demographics**

**Types of Studies**

There were 269 prospective cohort studies (63.9%), 89 randomized controlled trials (21.1%), 51 cross-sectional studies (12.1%), and 12 retrospective studies (2.9%).

**Journals**

The included studies were published in 166 individual journals (Table 1).

**Date of Publication**

Dates of study publication revealed major increases in publications from 1991 to 2017 (Figure 2).

**Specialty**

Studies were categorized by the specialty of the trainees involved. Studies involving internal medicine and subspecialty trainees (nephrology, rheumatology, and cardiology) trainees were grouped under “internal medicine.” Studies involving surgical trainees (all specialties) were grouped under “surgery.” Specialties with few publications, including radiology, pediatrics, physical medicine and rehabilitation (PM&R), and family medicine, were grouped into “other.”

We plotted the relative frequency of publications by trainee specialty over time (see Figure 2). The earliest learners of POCUS were surgical trainees in the early 1990s. Over the next decade, the literature on emergency medicine trainees was the most published. In recent years, the share of publications in internal medicine, anesthesiology, undergraduate medical education (UME), and obstetrics and gynecology (OBGYN) has increased, while the share in emergency medicine has
Curricular Content

Determining relevant content is essential in developing effective curricula. We analyzed the content of the 421 included studies. Content included ultrasound ‘fundamentals’ (226 studies, 54%), cardiac (188, 45%), abdominal (141, 33%), pelvic (122, 29%), vascular (111, 26%), procedural (104, 25%), pulmonary (80, 19%), MSK (62, 15%), genitourinary (62, 15%), head and neck (39, 9%), and ocular (17, 4%) ultrasound. A detailed breakdown of specific content and the variation between specialties is shown in Appendix 3 and Appendix 4.

Anatomy/Physiology Learning

Fourteen studies employed POCUS to teach anatomy or physiology. Nine studies revealed improved anatomy and physiology knowledge after POCUS teaching. Four studies only looked at subjective measures such as learner satisfaction and confidence. Five studies employed control

deprecated. Currently, the largest share of POCUS education literature is in UME.

Figure 1. There were 12,467 records were identified from databases MEDLINE, MEDLINE epub & in-process, EMBASE, Central, ERIC, Web of Science, and Scopus. There were 6843 duplicates, and 6164 titles were screened. We excluded 4954 records based on title review. We assessed 1210 articles in-depth, of which 421 were included in the final analysis.
groups, comparing ultrasound to cadavers, and traditional anatomy teaching programs. These studies did not find a significant improvement in anatomy and physiology knowledge with ultrasound training compared to controls.

### Teaching Modalities

Teaching modalities are how content is delivered. We were interested in which modalities were being used to teach POCUS and their comparative efficacy. Fifteen teaching modalities were identified (Figure 3). Commonly employed modalities were in-person didactics (313 studies, 74%), human models (244, 58%), simulators (140, 33%), web-based didactics (76, 18%), live demonstrations (76, 18%), and clinical exposures (72, 17%). Many studies analyzed the comparative effectiveness of various teaching modalities. We took a narrative approach to discussing these comparisons.

### Structured Training versus Apprenticeship Model of Learning

Structured training and apprenticeship training were compared in 12 studies. Outcomes included knowledge, image acquisition, image interpretation, procedural skills, and confidence. Ten studies showed significantly better outcomes with structured training curricula than apprenticeship models, while one study showed a trend towards improved outcomes, and one study did not find any difference.

### Web-Based Didactic versus In-Person Didactic Training

Web-based and in-person didactic training was compared in 9 studies. Outcomes included knowledge, image acquisition, image interpretation, procedural skills, and confidence. Eight studies found no difference in outcomes between web-based and in-person didactics. The remaining study found no difference with novices, but inferior outcomes for web-based training with more experienced learners.

### Didactic Training versus Hands-On Training

Hands-on training included training with human models, simulators, clinical training, or cadavers, and was included in 96% of studies. Hands-on training was compared to didactic training in 8 studies. Measured outcomes included knowledge, image acquisition, image interpretation, procedural skills, and confidence. Four studies found that hands-on training alone, or hands-on training combined with didactic training had better outcomes than didactic training alone. One study found that hands-on training alone was equivalent to didactic training plus hands-on training. One study found that didactic plus
Figure 2. Total number of publications in POCUS education (vertical bars) and the share of publications by specialty (lines) from 1991 to 2017. The number of publications in POCUS education has increased exponentially from 1991–2017. Over that time, the share of POCUS education literature has shifted from surgery and emergency medicine to undergraduate medical education (UME), internal medicine, and anesthesiology.

Figure 3. Teaching modalities identified in the 421 analyzed studies. In-person didactics, human models, and simulators are the most commonly used teaching modalities.
hands-on training was superior to hands-on training alone, and two studies did not find any difference in outcomes. No studies found that didactic training alone was superior to hands-on training alone.

**Simulation Training versus Human Model Training**
Simulators and human models were compared in 11 studies. Outcome measures included knowledge (all studies), image acquisition, image interpretation, and confidence. Overall, one study showed superior outcomes with simulation, six showed no difference in outcomes, and four showed superior outcomes with human models. Several studies found that human models conveyed superior outcomes in image acquisition, even when there was no improvement in image interpretation or knowledge. Found that learners trained on human models had superior outcomes in image acquisition and interpretation than their simulation-taught counterparts when tested on a human model, while the opposite was true when tested on a simulator. Training with human models and simulators together versus one modality alone was assessed in three studies, and no differences were found in image interpretation, time to completion, or biometric measurements.

**Simulator Fidelity**
High-fidelity and low-fidelity simulators were compared in three studies. In one study, the high-fidelity simulator was associated with better learner feedback. In the other two studies, there was no difference in learner feedback or procedural skills.

**Instructors**
Ultrasound instructors included attending physicians (348 studies, 83%), residents or fellows (28, 7%), medical students (17, 4%), and allied-health staff (4, 1%). Fifty-six studies (13%) did not specify the type of instructor.

**Self-Directed versus Instructor-Led Training**
Self-directed training was compared to instructor-led training in four studies. One study demonstrated significantly improved outcomes with self-directed learning but did not have a comparison group. The remaining three studies employed comparison groups. Of these, two found worse outcomes with self-direct learning, and one found no difference.

**Peer-Led versus Expert-Led Training**
Peer-led training was evaluated in 18 studies. Fifteen studies used medical students as teachers, two studies used residents, and one study used a fellow. Twelve studies did not use comparison groups, of which eleven found positive outcomes.

Six studies compared peer-led training to expert-led training. Of these, four studies found no difference between peer-led and expert-led education outcomes. Two studies found worse outcomes with peer instructors compared to expert instructors in learner feedback, time to acquire images, and OSCE scores.

**Curriculum Length**
Of the 421 studies analyzed, 341 involved curricula of less than one month (81%), and 71 were one month or greater (17%). Nine studies did not specify curriculum length (2%). The average curriculum was 1.94 months. Three studies assessed whether curriculum length impacted learner outcomes, and found that longer curricula led to better outcomes in image acquisition, image interpretation, and knowledge retention.

**Feedback**
Three studies compared whether providing feedback during training led to improved outcomes. All three studies demonstrated improved outcomes when learners were provided with feedback. Farjad et al. found that addressing errors and providing correctional advice was associated with improved skills compared to simply designating whether a procedure had been performed correctly.

**Electives/Boot-Camps**
Dedicated electives and boot-camps were employed in 24 out of 421 studies (5.7%). All studies reported positive outcomes, including confidence, knowledge, image acquisition, and interpretation, and number of scans performed.

Eight studies compared dedicated electives or boot-camps to standard training. Five of these revealed better outcomes with electives. In two separate studies, Jang et al. found that elective groups performed a threshold number of scans in a significantly shorter time frame, and had equivalent image acquisition and interpretation scores compared to standard training. Maskatia et al. found that fellows trained in an intensive three-day “boot-camp” had superior image acquisition and interpretation scores than historical cohorts trained over a longer time.

**Novel Educational Methods**
Two studies introduced novel methods of POCUS education in the form of ultrasound competitions and an educational conference. The educational conference led to improved...
scores in knowledge, image acquisition, and image interpretation. The ultrasound competition compared image acquisition skills in medical students and selected winners for each content group.

**Learner Assessments, Outcomes, and Training Evaluation**

Outcome evaluation is essential to determine curriculum effectiveness and make improvements. Educators must decide how and what outcomes to measure, and ensure that these outcomes provide insight on the value their curriculum is trying to create.

**Learner Assessment Methods**

Learner assessments included questionnaires and surveys (179 studies, 43%), non-procedural practical examinations (160, 38%), pre-and-post intervention assessments (134, 32%), comparisons to control (118, 28%), written examinations (110, 26%), procedural skills assessments (62, 15%), comparisons to gold-standard tests (54, 13%), comparisons to experts (49, 12%), OSCEs (33, 8%), and review of archived images (30, 7%).

**Learner Outcomes and Training Evaluation**

We assessed learner outcomes by using the Kirkpatrick model139 of training evaluation (Figure 4). This model assesses measured outcomes to determine the efficacy of a training program, assigning a numerical score as follows:

- **Kirkpatrick I**: The degree to which participants find the training favorable, engaging and relevant to their jobs
- **Kirkpatrick II**: The degree to which participants acquire the intended knowledge, skills, attitude, confidence and commitment based on their participation in the training
- **Kirkpatrick III**: The degree to which participants apply what they learned during training when they are back on the job
- **Kirkpatrick IV**: The degree to which targeted outcomes occur as a result of the training

Studies that elicited learner enjoyment or satisfaction with the curriculum were designated as fulfilling Kirkpatrick level I. Kirkpatrick II was accorded to studies that assessed confidence, knowledge, image acquisition, image interpretation, knowledge retention, procedural skills, clinical decision making, anatomy knowledge, and physical exam skills. Kirkpatrick III was accorded to studies that assessed learners’ use of ultrasound by monitoring the number of scans performed or through self-reports. Kirkpatrick IV was accorded to studies that measured end-outcomes, including changes or improvements in diagnostics, changes in patient management, procedural success rates, and patient satisfaction.

Overall, Kirkpatrick I outcomes were assessed in 141 studies (33%), Kirkpatrick II outcomes in 398 studies (95%), Kirkpatrick III outcomes in 50 studies (12%), and Kirkpatrick IV outcomes in 27 studies (6%). We took particular interest in

![Figure 4. Learner and program outcomes assessed in the 421 analyzed studies, divided by Kirkpatrick levels of training evaluation. The majority of studies assess Kirkpatrick levels I-II outcomes. Few studies assess Kirkpatrick III-IV outcomes. Even within Kirkpatrick II, few studies assess knowledge retention and clinical decision making.](image-url)
outcomes that we believed were of value, but understudied, and from which we could present data-driven conclusions; these are summarized below.

Knowledge Retention

Knowledge retention (Kirkpatrick II) was assessed in 22 studies (5%).3,9,31,63,80,83,90,100,106,115,116,140–151 These studies varied in terms of curriculum length, time to follow-up, method of assessment, and rates of retention. Twelve studies found that knowledge was maintained,3,9,31,63,100,106,116,141–146 seven found a decline in knowledge,90,115,140,147,148,150,151 and three had mixed results.80,83,149

Of the 12 studies in which learners maintained knowledge, the average time to follow-up was 5.2 months and the average number of teaching modalities used was 2.83. Outcomes included knowledge,9,31,63,100,106,116,141–146 image interpretation,9,106,116,141–143,145,146 image acquisition,3,106,141,144,145 learner confidence,141 psychomotor skills,63 and procedural skills.100 However, two studies found a trend towards knowledge decay.31,144

Of the seven studies that showed a decline in knowledge retention, the average time to follow-up was 11.75 months, and the average number of teaching modalities used was 3.0. Measured outcomes included knowledge,9,31,63,100,106,116,141–146 image interpretation,9,106,116,141–143,145,146 image acquisition,3,106,141,144,145 learner confidence,141 psychomotor skills,63 and procedural skills.100

Of the studies that showed a decline in knowledge retention, the average time to follow-up was 2.9 years for practicing physicians who had been trained in a 36-month curriculum, to the point where the average learner would not have passed their final competency test after only one year of non-use. Hempel et al.151 found that medical students retained only 20% of knowledge at two weeks after a didactic presentation. Dulohery et al.148 found that residents had a significant decline in their ability to differentiate fluid from air at 22 months after a one-day ultrasound course.

Three studies had mixed results. One study found that anesthesia residents tested at three weeks follow-up were able to obtain simpler ultrasound views of the spine, but had a significant decline in the ability to identify more difficult views.60 Another study found that theoretical knowledge declined at three months, but found no decline in procedural skills.149 Finally, one study compared pre-intervention knowledge and image interpretation to the same outcomes at six months but did not include an immediate post-intervention test.83

Learners in curricula that were one day or less tended to have more knowledge decay than those in curricula more than one day. Of the former, seven studies revealed a degree of decay in outcomes (58%), while five did not. Of the latter, two studies revealed a degree of decay in outcomes (22%), while seven did not.

Clinical Decision Making

Clinical decision making (Kirkpatrick II) represents the transition from acquiring and interpreting images, to make clinical decisions based on them. Clinical decision making was tested in 12 of 421 studies (3%).72,126,152–161 Learners’ decision-making skills were assessed through OSCEs,126,154,156–158 and written tests.72,152,153,155,159,161

Joziwa et al.160 asked residents to perform bedside echo on ICU patients and graded their hemodynamic diagnosis and management plan. All studies found improvements in clinical decision making after POCUS curricula.

Changes in Behaviour

Changes in learner behaviour (Kirkpatrick III) was evaluated in 50 studies out of 421 studies (12%).3,6,7,9,10,61,67,68,114,121,124,125,128–130,132,141,142,162–193

The majority of these studies measured learner behaviour by determining the amount of POCUS scans performed after the training period had finished (42, 84%),3,7,10,67,68,114,121,124,128–130,132,141,142,162–167,169,186,189–193 or through surveys and questionnaires (8, 6%).3,6,9,112,141,168,187,188

Major barriers to continued practice of POCUS included difficulties in obtaining and using equipment, time constraints,10,170,179 lack of adequate supervision or continued feedback,6,187 and learner motivation and confidence.10,172,187

Twelve studies used ongoing formal assessments,7,114,121,124,128,162,166,167,169,172,178,184 including web-based upload and review strategies114,121 to encourage ongoing POCUS use. Five studies61,68,114,129,141 found that formal POCUS training encouraged subsequent use when compared to no training,114,141 and apprenticeship models,61,68,129 and one study found no difference between formal training and apprenticeship models.67 One study found that longer training curricula led to more use than a shorter curricula.174

Changes in Diagnoses or Patient Management

Changes in diagnoses and patient management (Kirkpatrick IV) were assessed in 11 out of 421 studies (3%).3,6,11,137,138 All studies demonstrated striking improvements in diagnostics and patient management (Table 2). Specifically cited diagnostic improvements included finding new evidence of heart failure,3,4,11,137 cardiomyopathy,3 valvular disease,3,4,11 left ventricular hypertrophy,3,4 previous MI,3 liver metastases,3 and cholelithiasis3; diagnosing the etiology of dyspnea3,4; verifying the presence of soft tissue abscesses194; and finding new diagnoses in ICU7 and peri-operative settings.9 Cited changes in management included changes in the immediate management of cardiac diagnoses,4,11 change in management of dyspeptic patients,8 change in referral practices,6,11,6 ordering of formal studies,4,11 changes in perioperative management,9 and changes in the management of ICU patients.7
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Change in management: 71% of patients |
Change in management: 37% of patients |
| Lung ultrasound in internal medicine: training and clinical practice. | Mozzini C, Fratta Pasini AM, Garbin U, Cominacini L. | Change in management: 59% of patients  
Change in immediate management: 33% of patients |
| Focused bedside ultrasonography by clinicians: experiences with a basic introductory course. | Hillingso JG, Svendsen LB, Nielsen MB | Clinicians reported changing clinical approach: 47%  
Clinicians reported changing workup/diagnosis: 44%  
Clinicians reported changing referral patterns: 23% |
| Diagnostic influence of routine point-of-care pocket-size ultrasound examinations performed by medical residents. | Andersen GN, Graven T, Skjete K, MjÅ, Jstad OC, Kleinau JO, Olsen Å, Haugen BO, Dalen H. | Change in, verification of, or additional diagnoses made: 41% of patients |
| A pilot study of the clinical impact of hand-carried cardiac ultrasound in the medical clinic. | Croft LB, Duvall WL, Goldman ME. | Diagnostic improvements made: 14%-39% of patients  
Management decisions reinforced: 36% of patients  
Management decisions changed: 40% of patients. |
| Focused cardiac ultrasound by unselected residents-the challenges. | Ruddox V, Norum IB, Stokke TM, Edvardsen T, Otterstad JE | Diagnoses changed: 30% of patients |
| ABSCESS: applied bedside sonography for convenient evaluation of superficial soft tissue infections. | Squire BT, Fox JC, Anderson C | Diagnoses changed: 17% of patients  
(correct in 94% of these cases) |
| Focused cardiac ultrasound is feasible in the general practice setting and alters diagnosis and management of cardiac disease. | Yates J, Royse CF, Royse C, Royse AG, Canty DJ | Management changed: 15% of patients |
| Impact of pocket ultrasound use by internal medicine housestaff in the diagnosis of dyspnea. | Filopei J, Siedenburg H, Rattner P, Fukaya E, Kory P. | Improvement in diagnostic accuracy: 5% |
| Impact of high-fidelity transvaginal ultrasound simulation for radiology on residents’ performance and satisfaction. | Ahmad R, Alhashmi G, Ajlan A, Eldeek B | Reduction in repeat scans needed  
(8/month to 1/month)  
Decreased referrals to attending physicians (4/month to 1/month) |
Procedural Success Rates
Fifteen studies (4%) measured the success rates of various ultrasound-guided procedures (Kirkpatrick IV) completed by residents after undergoing POCUS education. Procedures included ultrasound guided regional anesthesia, paracentesis, vascular access, and renal biopsy. Eleven studies found improvements in procedural success after an ultrasound curriculum compared to controls, and two found no difference in outcomes compared to controls, and two found positive outcomes, but did not use controls. Specific improvements in outcomes included rates of successful anesthesia, fluid aspiration, vein and artery cannulation, tissue retrieval, time to procedure completion, errors or complications, number of insertions or attempts, amount of anesthetic used, and patient feedback.

Patient Feedback
Patient feedback (Kirkpatrick IV) was elicited in four out of 421 studies (1.0%). These studies looked at patient satisfaction nerve block procedures, and patient comfort with transvaginal ultrasound. All studies demonstrated improved feedback when ultrasound was used compared with controls.

Discussion
This scoping review assesses the current literature on POCUS education for medical trainees. We describe the specific content taught to learners across medical specialties, the teaching modalities used – with a focus on studies that compare modality efficacy, learner assessment methods, outcomes assessed in training evaluation, and trends in the literature.

POCUS education literature has increased substantially over the past few decades, especially in UME, anesthesiology, and internal medicine. This pattern is reflective of POCUS’ increasing use and validation across clinical settings. For example, Lichtenstein’s work in the late 1990s to study and validate pulmonary ultrasonography opened up an entire field of diagnostics that is now widely taught in internal medicine and critical care. We believe there is room for continued growth in specialties with relatively little published POCUS education research to date, such as family medicine and PM&R.

In developing POCUS curricula, educators must first identify clinically relevant content specific to the target specialty. Our review summarizes the content being taught across specialty, identifying significant variation. Curriculum designers can use our review as a starting point to identify appropriate content for new curricula or to adjust existing curricula.

Educators must decide on the modalities of education delivery. The majority of studies in our review show that structured curricula perform better than apprenticeship models. Didactic training is the most commonly used modality, but we have found that hands-on training is important for the transfer of physical skills. Web-based didactic learning is non-inferior to in-person didactics in most studies comparing the two, which is appealing given its low cost, receptability, and instructor time savings. Simulators and human models are the most commonly applied hands-on methods; both appear to be equivalent for teaching image interpretation and knowledge. However, human models appear to be superior for teaching image acquisition. This may be because most simulators are built to present images as they appear under ideal conditions. Variations in patient anatomy and physiology alter ultrasound acoustics and confound images. Teaching hands-on skills with human models allow for a more accurate representation of the conditions present in real patients. The disadvantages of human models include increased cost and the absence of clinical pathology. Clinical electives, and using standardized or real patients with known pathologies, are potential solutions.

Curricula in our review ranged from half-day sessions to longitudinal programs of four years. Although longitudinal curricula appear to be associated with better outcomes, they come with increased cost, time commitment, and organizational challenges. Promise has been shown with short-term, intensive programs (i.e., boot-camps) and clinical electives as less resource-intensive alternatives. Attending physicians are the primary instructors in POCUS. Although self-led and peer-led teaching is appealing, we found mixed outcomes. Further research in this area is warranted.

Curriculum designers must evaluate the efficacy of their curricula. POCUS requires users to be able to independently acquire images, correctly interpret those images, and then make the correct management decision or perform a procedure. We believe that a minimum evaluative standard should be to target Kirkpatrick level II outcomes; this ensures that learners gain clinically relevant skills and knowledge. This scoping review shows that a majority of studies assess Kirkpatrick levels I-II outcomes in confidence, image acquisition, interpretation, and knowledge. However, Kirkpatrick II assessments of knowledge retention and clinical decision making are lacking. Ongoing use and practice of skills are essential to maintaining competency and retaining knowledge. Some studies hypothesize that using more teaching modalities leads to better retention, but we did not find this to be true in our review. We have found that longitudinal curricula tend to result in better knowledge retention, and recommend this approach to curriculum designers. Curriculum designers should make knowledge and skill retention a priority, and implement ongoing assessments to ensure that there is adequate retention. Evaluation of clinical decision making as an outcome is also underrepresented in POCUS studies. The
ability to translate knowledge into actionable clinical decisions is essential for patient care, making this outcome one that should be more routinely assessed.

Few studies assess Kirkpatrick level III outcomes (50, 12%), which is an important measure to determine whether learners translate knowledge to clinical use. Further research is needed to determine the best ways to promote ongoing POCUS use. Our study has identified longitudinal programs and ongoing clinical assessments as methods that have been used to promote use, but this comes with increased resource costs. Barriers include time, training expertise and supervision, and equipment constraints. More research is needed to determine how to manage these constraints and how best to promote continued POCUS use.

Studies that assess Kirkpatrick level IV outcomes are likewise underrepresented (27, 6%). These studies are especially important since the intention of POCUS is to be used at the bedside to improve patient care; measuring these outcomes ensures that POCUS education is meeting its intended purpose. We found dramatic effects on clinical outcomes in the few studies that assessed Kirkpatrick IV outcomes. Demonstrating improved patient care as an outcome can help increase institutional buy-in, and obtain more funding and resources. Investigators and educators should make an effort to assess Kirkpatrick III-IV outcomes when designing and evaluating their curricula.

Conclusion
Educators should take into account many factors when designing POCUS curricula, including curricular content, modalities of teaching, learner assessments and training evaluation. Curricular content varies significantly between specialties and must be tailored to fit the needs of its specialty. POCUS should be taught in structured curricula with a combination of didactic and hands-on learning. Web-based didactic methods are cost-friendly and effective. Simulators and human models are both viable methods of hands-on teaching, but human models appear to convey better outcomes in image acquisition. Novel teaching methods such as dedicated electives, intensive "boot-camps," and competitions are promising methods to deliver POCUS education. There is a pressing need to go beyond satisfaction outcomes in evaluating POCUS learning. Educators should target outcomes in knowledge, image acquisition, and image interpretation. Ideally, outcomes in knowledge retention, clinical decision making, learner behavior, and patient care should be sought to provide high-level evidence of the benefits of POCUS curricula.

Limitations
There are several limitations to our study. We did not include studies that focused solely on central line insertion, as this area has been extensively studied and would greatly add to the studies analyzed in this review. However, central line insertion and POCUS studies related to them make up a large portion of the POCUS education literature, and by excluding them, we may have missed out on valuable insights provided by these studies.

Another limitation is in the narrative interpretation of study results. As this is a scoping review, we did not formally assess for study quality. Also, we did not conduct any statistical analysis of between-group comparisons. As such, the conclusions reached when comparing different modalities should not be interpreted as definitive conclusions. Our goal was simply to form a narrative understanding of what these studies showed to better understand the literature, formulate preliminary conclusions, and provide a starting point for further research. We believe that more statistically robust systematic reviews would greatly add to the understanding of POCUS education. Further to this, our study is incredibly broad and attempts to address every aspect of POCUS education. While this serves to capture the full breadth of POCUS education literature, a more focused analysis may have provided more robust conclusions.

Finally, the modalities that we decided to compare and discuss in further depth were borne out of our ideas generated during the review of the literature; based on what we thought was interesting, and what the studies in the literature appeared to be focused on, as opposed to a theoretical framework or established precedent. As such, there may be other interesting areas to analyze that we did not touch on.

References


84. Damewood S, Jeannomod D, Cadigan B. Comparison of a multimedia simulator to a human model for teaching FAST exam image interpretation and image acquisition. Academic Emerg Med 2011;18(4):413–19.


