Date: April 30th, 2025
Subject: Multi-society joint statement in response to 2025 EM ACGME proposals

Dear Members of the Emergency Medicine RRC and leaders of the ACGME,

We are writing as the elected representatives of emergency clinical ultrasound organizations from the Emergency Ultrasound Section of the American College of Emergency Physicians (ACEP), the Academy of Emergency Ultrasound of the Society for Academic Emergency Medicine (AAEM), the Emergency Ultrasound Section of the American Academy of Emergency Medicine (SAEM), and the Society of Clinical Ultrasound Fellowships (SCUF) to provide the perspective of the emergency clinical ultrasound community on the recent EM ACGME proposals. We commend the committee for the focus on point-of-care ultrasound (POCUS) as a specialty within the field of emergency medicine and the need for robust training during residency. The language used in 4.4.c to reflect POCUS as a diagnostic modality aligns well with the advocacy our community has sought in the past decades. We further applaud the committee for including additional diagnostic and therapeutic POCUS modalities eg, ultrasound guided regional analgesia to existing core POCUS curriculum [4.11.f.4.a.] and to advocate for faculty qualified to lead resident ultrasound education. We share your vision to ingrain POCUS as an inseparable component of emergency medicine residency training and to elevate it to safeguard rigorous training requirements, ensure competency, and preserve patient safety. POCUS has become a cornerstone of emergency medicine residency training due to its recognition as a distinct set of training skills–one that requires continued support from specific ACGME guidelines. As the members of the education community that serve to actualize resident ultrasound education, we suggest the following adjustments to the current ACGME proposals to achieve our common goal.

1. **POCUS should not be described as part of the physical exam**
    i. 4.11.f.4.a POCUS should be documented as a separate diagnostic procedure, archived for quality review, and recorded within the medical record

2. **Reinstate POCUS into the KIP**
    i. 4.5.j Residents must demonstrate competence in performing the following key index procedures:
    ii. 4.5.j.9. emergency department bedside ultrasound; (Core)
        a. 4.5.j.9.a Residents must use ultrasound for the bedside diagnostic evaluation of emergency medical conditions and diagnoses, resuscitation of the acutely ill or injured patient, and procedural guidance. (Core)

3. **POCUS should be a required rotation**
    i. 4.11.f.4.a Residents must have hands-on dedicated rotation for deliberate practice of image acquisition, interpretation, and application of findings in the clinical setting

4. **POCUS Faculty requirement**
    2.7.a. Residents on ultrasound rotation should be supervised by POCUS faculty who are ABEM FPD-AEMUS certified, or have completed at least one year of dedicated training in the field of emergency ultrasound, or possess specialty qualifications that are acceptable to the Resident Review Committee.

Our rationale for each recommendation:

4.11.f.4.a [POCUS and the physical exam]
We would advise against the proposal that POCUS will, or should be, encompassed in the physical examination. The American College of Emergency Physicians has long held that point-of-care ultrasound is a separate diagnostic test and not a component or extension of the physical examination. Rather, it provides clinically significant data that cannot be obtained by inspection, palpation, or other physical examination maneuvers. By way of example, one cannot detect hydronephrosis or an early intrauterine pregnancy via the physical examination. Rather, these are separate, unique diagnostic tests that the emergency physician must be trained in with regards to both imaging acquisition, interpretation, and clinical application.

POCUS is also a unique test or procedure that involves a significant amount of regulatory guidance. CMS has stated that records of imaging services must be maintained, to include a signed report of imaging interpretation by the practitioner who performs such service. The language here applies to both radiology performed imaging, as well as imaging by "other practitioners." This clearly separates regulatory guidance surrounding ultrasound examinations from standard physical examinations. Similar to many other procedures listed on the ACGME EM minimum procedure list, POCUS involves the application of specific CPT codes and associated reimbursement pathways. There are detailed requirements for image storage and report generation required by CMS, and attention to these details is necessary to ensure compliance with these regulations. Whether it is radiology performing the ultrasound or an EM physician, the same rules apply. Combining ultrasound imaging with the physical examination would run counter to the established regulatory guidance surrounding diagnostic imaging.

Furthermore, unlike the physical exam, there are specific legal requirements to maintain archived images for quality assurance, ensure standard of care, and promote patient safety. Like any diagnostic procedure, it contains billable CPT codes separate from the primary visit and exclusive of the physical examination. Combining POCUS into the physical exam undermines the value of POCUS and could be a threat to program funding and to department/hospital billing. We highly advise keeping this a diagnostic procedure that can be performed by any medical professional as endorsed by the AMA. Additionally, the viability of POCUS as a valuable test for care of the critically ill patient at the bedside is dependent on maintaining it as a separate procedure. Compliance with the above measures for POCUS ensures hospitals have adequate incentive to provide life-saving equipment in the ED and ensures that the ED will continue to offer POCUS in a sustainable form.

Lastly, while ultrasound is an accepted and safe imaging modality, there are significant patient safety variables that must be considered. Ultrasound examinations, including POCUS, should be clearly documented in the medical record as a diagnostic procedure with images archived for

quality review. This is important to meet regulatory guidance as noted above, but it is equally important from a patient safety perspective. It is common for many different physicians to care for patients following an ED visit, either as part of a subsequent hospitalization or on a follow up outpatient visit. A POCUS examination and its associated findings should be clearly documented in the medical record to ensure accurate communication of results. The philosophy of POCUS as a simple extension of the physical examination may discourage this rigorous practice and instead incentivize the brief, undocumented ultrasound exams that so often lead to confusion amongst patients and their subsequent health care team members. In addition, one must keep in mind that diagnostic ultrasound has known associated bioeffects, including thermal and mechanical side effects. Treating POCUS as a simple physical examination adjunct may reduce the focus and understanding of these important safety bioeffects when employing diagnostic ultrasound in patient care.

4.5.j/4.5.j.9/4.5.j.9.a [Reinstate POCUS into the KIP]
Despite significant advancements in emergency ultrasound over the past few decades, variability in POCUS instruction still exists among training programs. Many residency faculty members completed their training prior to residency POCUS requirements were in place. Unlike skills such as ECG and radiology study interpretation, **it is currently premature to assume that all emergency residencies over the country can provide adequate, uniform POCUS training to residents without an accountable, number-based standard.** From our collective experience, residents who have performed 300 or more POCUS studies over the course of their training/residency demonstrate consistent overall ultrasound competency in image acquisition and interpretation. This is congruent with the opinions of surveyed emergency medicine residents. Overall, published POCUS literature has also affirmed the median range of 25-75 scans per application to achieve competency in emergency ultrasound.

Furthermore, removal of required POCUS performed/ POCUS procedure log may lead to unintended consequences. It could create confusion in hospital privileging and credentialing bodies and result in denial of privileges for graduates of emergency medicine residencies who did not maintain an ultrasound procedure log. It might remove an incentive for residents to archive POCUS findings during patient care, and lead to incomplete documentation as well as potential missed findings that would have otherwise been identified during expert image review. Fewer documented scans might lead to decreased billing, decreased departmental revenue, and potentially less resources to fund POCUS programs and faculty.

Lastly, removal of POCUS from the key indexed procedures in Emergency Medicine is internally inconsistent with ACGME recommendations of other programs e.g., diagnostic radiology (ACGME Program Requirements for Graduate Medical Education in Diagnostic Radiology: IV.B.1.b).(2).(a).(iii).(a).(i))). This may further lead to uncertainty in the privileging/credentialing process for new EM graduates. POCUS requires the same documentation, image archival platforms, workflow solutions, quality assurance processes, privileging/credentialing, disinfection procedures etc. as diagnostic radiology in addition to the "clinical correlation" that remains the cornerstone of POCUS. POCUS is an essential component of emergency practice with the skill set and infrastructure required of diagnostic radiology as well as the expertise of a clinician. Maintaining POCUS as a core emergency medicine procedure promotes consistency and standardization of ultrasound training in residency. We strongly advocate that the ACGME, at a minimum, retain the previous standard of 150 scans as an objective benchmark for resident ultrasound experience. We would further recommend increasing the required ultrasound KIP to 300, to reflect the growing application of ultrasound in emergency care.

4.11.f.4.a [POCUS should be a required rotation]
Given the inherent nature of POCUS requiring mastery of both imaging acquisition and interpretation, this skill differs greatly from modalities such as electrocardiography and radiographic imaging interpretation which require no acquisition by the clinician interpreting the image. Ultrasound imaging acquisition is a skill that takes mechanical practice and hands-on repetition to successfully achieve, which places it in a different category from the aforementioned diagnostic tests. The change to a "structured experience" which may be satisfied with "didactic series, real or simulated time caring for patients, or the completion of focused educational materials such as readings or modules", raises concerns that the hands-on experience to gain image acquisition skills will be lost. This runs counter to the 2023 ACEP Ultrasound Guidelines Appendix 4. *Recommendations for an EM Residency Clinical Ultrasound (POCUS) Educational Program*, which advocates for a defined rotation to ensure dedicated hands-on practice and instruction.

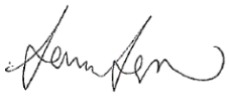
Furthermore, the move away from a defined rotation is at odds with the ACGME Program Director Survey results which demonstrated that ultrasound was one of the rotations "that the respondents felt must be in the curriculum as rotations outside of the ED." The lack of required hands-on experience may be insufficient to prepare residents for the new ABEM 2026 Certifying Exam, not to mention, their future clinical practice.

2.7.a [POCUS Faculty requirement]
A key barrier to long-term use of POCUS by residents is understanding its integration into clinical practice. Emergency medicine residents require not only a comprehensive curriculum, but also qualified faculty members to teach and supervise POCUS. Faculty should possess administrative and program management expertise to ensure effective ultrasound program implementation, optimizing patient care and resource utilization. Additionally, POCUS faculty must be skilled in teaching, mentoring, and fostering a culture of continuous learning to promote high-quality clinical ultrasound practice.

In section 2.7a, the proposal states faculty should have "background and focused experience in ultrasound," without defining clear criteria for qualification. Our specialty has invested significant effort in developing accredited Advanced Emergency Medicine Ultrasonography (AEMUS) Fellowships and an ABEM Focused Practice Designation (FPD) certification in AEMUS. While residency-trained emergency physicians acquire basic ultrasound knowledge, AEMUS FPD certification or similar specialty training includes education in ultrasound teaching, image quality assurance, proper documentation of studies, management/administration of ultrasound programs, and maintenance of ultrasound equipment–critical components for keeping patients safe and providing quality medical treatment. Faculty that are specialty trained in emergency ultrasound allows residents to perform statistically significantly more ultrasound scans, utilize POCUS for more advanced applications and contribute more research. Therefore, we suggest the revision of this statement to "POCUS faculty who are ABEM FPD-AEMUS certified, or have completed at least one year of dedicated training in the field of emergency ultrasound, or possess specialty qualifications that are acceptable to the Resident Review Committee."

We appreciate the opportunity to provide feedback on the proposed EM ACGME guidelines and kindly ask you to consider our recommendations, as discussed during the recent RRC meeting at the Council of Residency Directors assembly. Our organizations are united in our commitment to advancing emergency care for patients while maintaining high-quality, effective education for our trainees. We look forward to collaborating on these important considerations.

Respectfully,



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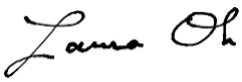

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