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A Multidisciplinary Response to the Canadian Association of Radiologists' Point-of-Care Ultrasound Position Statement

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In August 2019, the Canadian Association of Radiologists (CAR) published a position statement on point-of-care ultrasound (POCUS).[1] We would like to provide some clarity and address some misconceptions about POCUS that are promoted in the CAR position statement. Point-of-care ultrasound is not a lesser version of conventional consultative diagnostic imaging, as the CAR position statement suggests. Rather, it is defined as the use of ultrasound at the patient's bedside by the clinical provider, performed in real time to answer a focused clinical question or to improve the safety of a procedure.[2] It is a distinct imaging modality, different from technician or radiologist-performed ultrasound.

Through multidisciplinary collaboration, many centers across Canada have achieved safe and effective use of POCUS to improve patient care. While we do not seek governance from radiologists, we celebrate the many constructive and collaborative relationships between POCUS users and radiologists that exist in hospitals throughout this country and in North America. Many of these relationships have been foundational to the development of early POCUS and helped form the basis of current POCUS education, research, and quality, ultimately elevating patient care.

While the CAR position statement repeatedly states the potential of causing patient harm and raises the specter of litigation, the evidence demonstrates the opposite. A recent study identified only 5 malpractice cases in the United States from 2008 to 2012 involving POCUS, and all the cases were related to failure to perform POCUS or to perform it in a timely manner.[3]

With the momentum of widespread clinical adoption, strong evidence base, and robust multispecialty training guidelines, we find the timing and approach of the CAR position problematic in terms of fostering an environment upon which collaboration or scholarship might be imagined. The greatest challenge to aligning our respective views with that of the authors is an existential one: we see POCUS as sufficiently different from radiology-performed ultrasound that we do not look to radiologists for governance over its use. The American Medical Association long ago declared that ultrasound belongs to all specialties, and as such, POCUS has become a powerful clinical tool for countless physicians around the world, including Canada.[4]

We note and welcome the introduction of clinical ultrasound education by medical schools across Canada, with training delivered by clinicians in a collaborative fashion. We look forward to similar collaboration with our CAR colleagues as the use of POCUS continues to grow. Unfortunately, the current CAR position statement does not signal such collaboration nor is it representative of POCUS in Canada today. We will continue to use POCUS in accordance with our respective specialty's guidelines to provide the best possible care for our patients.

This article is respectfully submitted on behalf of the Canadian Association of Emergency Physicians, the American College of Emergency Physicians' Emergency Ultrasound Section, the Canadian Anesthesiologists' Society, the Canadian Point of Care Ultrasound Society, the Canadian Critical Care Ultrasound Consortium, the Society of Clinical Ultrasound Fellowship, the Canadian Internal Medicine Ultrasound group, and the Pediatric Emergency Medicine POCUS (P2) Network.

Authors' Note

Daniel Kim is a member of the medical advisory board of Clarius Mobile Health. Rachel Liu has been a consultant to Philips. Robert Arntfield is a consultant to Fujifilm Sonosite.

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