ACGME International

Advanced Specialty Program Requirements for Graduate Medical Education in Family Medicine

Revised: 9 May 2025, Effective: 1 July 2026
Reformatted: 1 April 2022
Revised: 1 February 2020, Effective: 1 July 2020
Revised: 8 December 2017, Effective: 1 July 2018
Revised: 12 December 2015, Effective: 1 July 2017
Initial approval: 10 January 2011

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Int. Introduction

Background and Intent: Programs must achieve and maintain Foundational Accreditation according to the ACGME-I Foundational Requirements prior to receiving Advanced Specialty Accreditation. The Advanced Specialty Requirements noted below complement the ACGME-I Foundational Requirements. For each section, the Advanced Specialty Requirements should be considered together with the Foundational Requirements.

Int.I. Definition and Scope of the Specialty

Family medicine is a primary care specialty that demonstrates high-quality care within the context of a personal doctor-patient relationship and with an appreciation for individual, family, and community connections. Continuity of comprehensive care for the diverse patient population family physicians serve is foundational to the specialty. Access, accountability, effectiveness, and efficiency are essential elements of the discipline. The coordination of patient care and leadership of advanced primary care practices and evolving health care systems are additional vital roles for family physicians.

Int.II. Duration of Education

Int.II.A. The educational program in family medicine must be 36 or 48 months in length.

I. Institution

I.A. Sponsoring Institution

I.A.1. Since family medicine programs are dependent in part on other specialties for the education of residents, the ability and commitment of the Sponsoring Institution to fulfill these requirements must be documented.

I.B. Participating Sites

I.B.1. Participating sites should not be at such a distance from the primary clinical site that they require excessive travel time or otherwise fragment the educational experience for residents.

II. Program Personnel and Resources

II.A. Program Director

II.A.1. Qualifications of the program director must include:

II.A.1.a) a minimum of five years of clinical experience in family medicine; and,

II.A.1.b) if the length of the program's accreditation allows, at least two years as a core faculty member in an ACGME-I-accredited family medicine residency program.

II.A.2. The program director must maintain clinical skills by providing direct patient care.

II.B. Faculty

II.B.1. The resident-to-faculty preceptor ratio in a family medicine practice (FMP) site must not exceed four-to-one. (Moved from II.D. Resources)

II.B.2. All family medicine physician faculty members must maintain clinical skills by providing direct patient care and role modeling competence in their respective scope of practice.

II.B.2.a) ~~Family medicine physician faculty members should have a specific time commitment to patient care.~~

II.B.2.b) Some family medicine physician faculty members must see patients in each of the FMP sites used by the program.

II.B.3. The program must have family medicine physicians or other qualified physicians as faculty members providing or teaching care for each of the following:

II.B.3.a) maternity patients;

II.B.3.b) inpatient adults; and,

II.B.3.c) inpatient children.

II.B.4. Instruction in ~~the~~other specialties must be conducted by faculty members with appropriate expertise.

II.B.5. There must be faculty members dedicated to the integration of behavioral health into the educational program.

II.B.6. The program, in partnership with its Sponsoring Institution, must ensure that there is ~~There must be~~a structured program of faculty development that involves regularly scheduled activities designed to enhance ~~the effectiveness of~~faculty members' skills in administration, leadership, scholarship, clinical practice, ~~behavioral components~~ professionalism, and teaching effectiveness, including evaluation, assessment, and curriculum development.~~of faculty members' performance.~~

II.C. Other Program Personnel

II.C.1. The program must have a program coordinator.

II.D. Resources

II.D.1. There must be at least one FMP site to serve as the foundation for educating residents and to provide residents with family medicine physician role models.

II.D.2. FMP site(s) must support continuous, comprehensive, convenient, accessible, and coordinated care to a panel of patient families.

II.D.2.a) There must be agreement with specialists in other areas/services regarding the requirement that residents maintain concurrent commitment to their patients in the FMP site(s) during these rotations.

II.D.3. If multiple FMP sites are used for resident education, each must meet the criteria for the primary practice and be ~~approved by the Review Committee-International~~ reviewed by the family medicine program and approved by the Sponsoring Institution prior to use by the program.

II.D.4. Each FMP site must have a mission statement describing its dedication to education and to the care of patients within the practice as relates to the greater community served by the program.

II.D.4.a) The mission should be shared with all education and training sites to ensure alignment and consistency in educational goals.

II.D.5. ~~The resident-to-faculty preceptor ratio in an FMP site must not exceed four-to-one.~~ (Moved to II.B. Faculty)

II.D.5. Each FMP site must be sufficiently staffed to ensure efficiency of operations, adequate support for patient care, and fulfillment of educational requirements.

II.D.5.a) The staff should include nurses, technicians, clerks, administrative personnel, and other health professionals.

II.D.6. ~~Other physician specialists should not see patients in an FMP site unless their presence enhances the experiences and learning of the residents~~Each FMP site must encourage other physician specialists and health care practitioners who provide care within the setting, such as nurses, paramedics, pharmacists, and physiotherapists, to contribute to the educational experiences of the residents.

II.D.7. Each FMP site ~~must~~ demonstrate the use of outcome data to improve ~~involve all members of the practice in ongoing performance improvement and demonstrate use of outcomes in improving~~clinical quality, patient satisfaction, patient safety, and financial performance.

II.D.7.a) The following data should be assessed: clinical quality for preventive care and chronic disease; demographics; health inequities; patient satisfaction; patient safety; continuity with a patient panel; referral and diagnostic utilization rates; and, if applicable, other non-clinical audits, such as financial performance

and waiting times.

II.D.8. Each FMP site must have adequate space and resources to effectively conduct the educational program, including:

II.D.8.a) contiguous space for residents' clinical work and education;

II.D.8.b) readily available computer access to electronic resources;

II.D.8.c) adequate space to conduct private resident precepting sessions, teaching conferences, group meetings, and small group counseling; and,

II.D.8.d) faculty members' offices, either in the FMP site or ~~immediately~~ adjacent to the FMP site.

II.D.9. Each FMP site should receive advice from those outside the program on the health needs of the community.

II.D.9.a) Those advising the program should be demographically diverse and have experiences that are representative of the community.

II.D.10. ~~Each FMP site must be available for patient services at times commensurate with community medical standards and practice.~~

II.D.10.a) ~~When an FMP site is not open, there must be a well-organized plan that ensures continuing access to each patient's personal physician, substitute family physician, or care from a physician with access to the patient's health records.~~

II.D.10.b) ~~Patients of an FMP site must receive education and direction as to how to obtain access to their physician, a substitute family physician, or another physician for continuity of care during hours the FMP site is closed.~~

II.D.11. ~~Inpatient facilities must have occupied teaching beds to ensure a patient load and variety of problems sufficient to support the education of the number of residents and other learners on the services.~~

II.D.12. ~~Inpatient facilities must also provide physical, human, and other resources for education in family medicine.~~

III. Resident Appointment

III.D. Eligibility Criteria

See International Foundational Requirements, Section III.A.

III.E. Number of Residents

III.E.1. The program must have at least ~~four~~two residents at each educational level.

III.E.2. The program should have a total of at least ~~12~~six on-duty residents.

III.F. Resident Transfers

See International Foundational Requirements, Section III.C.

III.G. Appointment of Fellows and Other Learners

See International Foundational Requirements, Section III.D.

IV. Specialty-Specific Educational Program

IV.A. ACGME-I Competencies

IV.A.1. The program must integrate the following ACGME-I Competencies into the curriculum.

IV.A.1.a) Professionalism

IV.A.1.a).(1) Residents must demonstrate a commitment to professionalism and an adherence to ethical principles. Residents must demonstrate:

IV.A.1.a).(1).(a) compassion, integrity, and respect for others;

IV.A.1.a).(1).(b) responsiveness to patient needs that supersedes self-interest;

IV.A.1.a).(1).(c) respect for patient privacy and autonomy;

IV.A.1.a).(1).(d) accountability to patients, society, and the profession;

IV.A.1.a).(1).(e) sensitivity and responsiveness to a diverse patient population, including to diversity in gender, age, culture, race, religion, disabilities, and sexual orientation; and,

IV.A.1.a).(1).(f) adherence to the Sponsoring Institution's professionalism standards and code of conduct, to citizenship, and to other responsibilities.

IV.A.1.b) Patient Care and Procedural Skills

IV.A.1.b).(1) Residents must provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents must demonstrate competence in:

IV.A.1.b).(1).(a) the essential skills/competencies of both productivity and efficiency necessary to meet the expectations of independent clinical practice, including:

IV.A.1.b).(1).(a).(i)	~~ability to~~collecting a complete initial data base ~~and examination~~;
IV.A.1.b).(1).(a).(ii)	~~ability to~~defining and expanding the differential diagnosis list;
IV.A.1.b).(1).(a).(iii)	identifying the most likely diagnoses and establishing ~~of~~a plan for diagnostic and treatment modalities;
~~IV.A.1.b).(1).(a).(iv)~~	~~ability to educate the patient and patient's family about the diagnoses, evaluation, and treatment of the disease; to obtain informed consent; and~~performing appropriate procedures; (Deleted text moved to IV.A.1.e) Interpersonal and Communication Skills)
~~IV.A.1.b).(1).(a).(v)~~	~~ability to practice in a team and with a systems-based approach~~ (Moved to IV.A.1.f) Systems-Based Practice)
~~IV.A.1.b).(1).(a).(iv)~~	~~ability to present data to other members of the team and consultants;~~ (Moved to IV.A.1.e) Interpersonal and Communication Skills)
~~IV.A.1.b).(1).(a).(vii)~~	~~cost-conscious ordering of diagnostic tests and therapeutics~~ (Moved to IV.A.1.f) Systems-Based Practice)
~~IV.A.1.b).(1).(a).(viii)~~	~~construction of a medical record summary with accuracy and in compliance with expected format and the hospital's medical records policies;~~ (Moved to IV.A.1.e) Interpersonal and Communication Skills)
IV.A.1.b).(1).(a).(iv)	formulating short- and long-term goals;
IV.A.1.b).(1).(a).(v)	providing guidance to patients regarding advanced directives, end-of-life issues, and unexpected diagnoses/outcomes; and,
IV.A.1.b).(1).(a).(vi)	addressing suffering in all its dimensions for patients and patients' families.
IV.A.1.b).(1).(b)	providing preventive health care, promoting independent living, and maximizing function and quality of life in the geriatric patient;
IV.A.1.b).(1).(c)	providing longitudinal health care to families, including assisting them in coping with serious

	illness and loss, and in promoting family mechanisms to maintain the wellness of family members;
IV.A.1.b).(1).(d)	assessing and meeting the health care needs of declining geriatric patients; episodic, illness-related care; delivery of health care in the home, FMP site, and hospital; delivery of end-of-life care; and, if available in the country or jurisdiction, delivery of care in a long-term care facility;
IV.A.1.b).(1).(e)	~~managing a normal pregnancy and delivery;~~ providing care to patients who may become pregnant, including:
IV.A.1.b).(1).(e).(i)	diagnosing pregnancy and managing early pregnancy complications, to include diagnosis of ectopic pregnancy, pregnancy loss, and, as permitted in the country or jurisdiction, providing options education for unintended pregnancy;
IV.A.1.b).(1).(e).(ii)	providing low-risk prenatal care;
IV.A.1.b).(1).(e).(iii)	providing care for common medical problems arising from pregnancy or coexisting with pregnancy;
IV.A.1.b).(1).(e).(iv)	performing an uncomplicated spontaneous vaginal delivery;
IV.A.1.b).(1).(e).(v)	demonstrating basic skills in managing obstetrical emergencies; and,
IV.A.1.b).(1).(e).(vi)	providing postpartum care, to include screening and treatment for postpartum depression, breastfeeding support, and family planning.
~~IV.A.1.b).(1).(f)~~	~~managing common problems related to prenatal and postnatal care.~~
IV.A.1.b).(1).(f)	performing appropriate gynecological procedures;
IV.A.1.b).(1).(g)	giving proper advice, explanation, and emotional support during care to surgical patients and their families, including recognizing surgical conditions that are preferably managed on an elective basis;
IV.A.1.b).(1).(h)	diagnosing and managing a wide variety of common general surgical problems typically cared for by family physicians;
IV.A.1.b).(1).(i)	providing routine newborn care, including neonatal

care following birth;

IV.A.1.b).(1).(j) providing preventive health care to children, including for development, nutrition, exercise, and immunization, and addressing social determinants of health;

IV.A.1.b).(1).(k) managing care of ill children, including recognition, triage, and stabilization for common illnesses and injuries;

IV.A.1.b).(1).(l) diagnosing and managing common inpatient problems of adults and children as seen by family physicians;

IV.A.1.b).(1).(m) caring for hospitalized male and female patients with various levels of severity of illness and utilizing appropriate consultation by other specialists;

IV.A.1.b).(1).(n) diagnosing and managing common dermatological conditions; and,

IV.A.1.b).(1).(o) providing supervision to others in the learning environment.

IV.A.1.c) Medical Knowledge

IV.A.1.c).(1) Residents must demonstrate knowledge of established and evolving biomedical clinical, epidemiological, and social-behavioral sciences, as well as the application of this knowledge to patient care. Residents must demonstrate:

IV.A.1.c).(1).(a) knowledge of the broad spectrum of clinical disorders seen in the practice of family medicine; and,

IV.A.1.c).(1).(b) the ability to evaluate evolving medical knowledge and incorporate it into meaningful clinical practice.

IV.A.1.d) Practice-Based Learning and Improvement

IV.A.1.d).(1) Residents must demonstrate the ability to investigate and evaluate their care of patients, to appraise and assimilate scientific evidence, and to continuously improve patient care based on constant self-evaluation and lifelong learning. Residents are expected to develop skills and habits to be able to meet the following goals:

IV.A.1.d).(1).(a) identify and perform appropriate learning activities;

IV.A.1.d).(1).(b) identify strengths, deficiencies, and limits in one's

knowledge and expertise;

IV.A.1.d).(1).(c) incorporate formative evaluation feedback into daily practice;

IV.A.1.d).(1).(d) locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems;

IV.A.1.d).(1).(e) ~~participate in the education of patients, families, students, residents, and other health professionals~~; (Moved to IV.A.1.e) Interpersonal and Communication Skills)

IV.A.1.d).(1).(e) set learning and improvement goals;

IV.A.1.d).(1).(f) systematically analyze practice using quality improvement methods, and implement changes with the goal of practice improvement; and,

IV.A.1.d).(1).(g) use information technology to optimize learning.

IV.A.1.e) Interpersonal and Communication Skills

IV.A.1.e).(1) Residents must demonstrate interpersonal and communication skills that result in the effective exchange of information and collaboration with patients, their families, and health professionals. Residents must:

IV.A.1.e).(1).(a) communicate effectively with patients, patients' families, and the public, as appropriate, across a broad range of socioeconomic and cultural backgrounds;

IV.A.1.e).(1).(b) communicate effectively with physicians, other health professionals, and health-related agencies, <u>including presenting data to other members of the team and consultants; (Addition</u> moved from IV.A.1.b) Patient Care and Procedural Skills)

IV.A.1.e).(1).(c) work effectively as a member or leader of a health care team or other professional group;

IV.A.1.e).(1).(d) act in a consultative role to other physicians and health professionals;

IV.A.1.e).(1).(e) maintain comprehensive, timely, and legible medical records, ~~if applicable~~and <u>construct a medical record summary with accuracy and in compliance with expected format and within the hospital's medical records policies; (Addition</u> moved from IV.A.1.b)

Patient Care and Procedural Skills)

IV.A.1.e).(1).(f) <u>educate patients and patients' families about the diagnoses, evaluation, and treatment of disease, and obtain informed consent when needed; and,</u> (Moved from IV.A.1.b) Patient Care and Procedural Skills)

IV.A.1.e).(1).(g) <u>participate in the education of students, residents, and other health professionals.</u> (Moved from IV.A.1.d) Practice-Based Learning and Improvement)

IV.A.1.f) Systems-Based Practice

IV.A.1.f).(1) Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents must:

IV.A.1.f).(1).(a) advocate for quality patient care and optimal patient care systems;

IV.A.1.f).(1).(b) coordinate patient care within the health care system relevant to their clinical specialty;

IV.A.1.f).(1).(c) incorporate considerations of cost awareness and risk-benefit analysis in patient and/or population-based care as appropriate;

IV.A.1.f).(1).(d) participate in identifying system errors and implementing potential systems solutions;

IV.A.1.f).(1).(e) work effectively in various health care delivery settings and systems relevant to their clinical specialty; ~~and,~~

IV.A.1.f).(1).(f) work in interprofessional teams <u>using a systems-based approach</u> to enhance patient safety and improve patient care quality; and, (Addition moved from IV.A.1.b) Patient Care and Procedural Skills)

IV.A.1.f).(1).(g) <u>order diagnostic tests and therapeutics using a cost-conscious approach.</u> (Moved from IV.A.1.b) Patient Care and Procedural Skills)

IV.B. Regularly Scheduled Educational Activities

IV.B.1. The program must provide a regularly scheduled forum for residents to explore and analyze evidence pertinent to the practice of family medicine.

IV.C. Clinical Experiences

~~*Background and Intent: Clinical practice in family medicine differs throughout the world based in part on differences in medical practice, population demographics, and disease patterns. The goals of the clinical experience requirements in family medicine are to provide flexibility and to maintain quality so that the program educates physicians:*~~

- ~~*for current as well as future practice;*~~
- ~~*to care for families in a comprehensive and caring manner; and,*~~
- ~~*to care for families throughout the continuum of care.*~~

IV.C.1. Educational experiences should be structured to minimize the frequency of rotational transitions, and rotations must be of sufficient length to provide a quality educational experience, defined by continuity of patient care, ongoing supervision, longitudinal relationships with faculty members, and high-quality assessment and feedback.

IV.C.2. Each resident must be assigned to a primary FMP site.

IV.C.2.a) ~~Residents must receive regular reports of individual and practice productivity and clinical quality, as well as the training needed to analyze these reports.~~

IV.C.2.b) ~~Residents must attend regular FMP business meetings with staff and faculty members to discuss practice-related policies and procedures, business and service goals, and practice efficiency and quality~~.

IV.C.3. Residents must be scheduled to see patients in the FMP site for a minimum of 40 weeks during each year of the educational program.

IV.C.3.a) Residents' other assignments must not interrupt continuity for more than eight weeks at any given time or in any one year.

IV.C.3.b) The periods between interruptions in continuity must be at least four weeks in length.

IV.C.4. Experiences in the FMP site must include acute care, chronic care, and wellness care for patients of all ages.

IV.C.4.a) ~~FMP site patient encounters should include care for patients younger than 10 years of age.~~

IV.C.4.b) ~~FMP site patient encounters should include care for patients 60 years of age or older~~

IV.C.5. Individual residents or a team of residents must be primarily responsible for a panel of continuity patients.

IV.C.5.a) Residents' responsibilities must include integrating each panel patient's care across all health care settings.~~including the home, long-term care facilities, the FMP site, specialty care facilities,~~

~~and inpatient care facilities.~~

IV.C.5.b) Each resident's panel of continuity patients must be of sufficient size and diversity to ensure adequate education, as well as patient access and continuity of care.

IV.C.5.c) Panel size and composition for each resident must be regularly assessed and rebalanced as needed.

IV.C.5.c).(1) Resident panels should be calculated and readjusted for the appropriate size and diversity (demographics and medical conditions) required for optimal education, patient access, and continuity of care every 12 months.

IV.C.5.d) The FMP site should utilize team-based coverage for patients when the continuity resident is unavailable.

IV.C.6. ~~Residents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients.~~

IV.C.6. Residents must provide care for a minimum of 1,650 in-person patient encounters at their assigned FMP site, with at least 150 visits occurring in the first year of the educational program.

IV.C.6.a) The majority of these visits must occur in residents' primary FMP site.

~~*Background and Intent: Patient encounters at the FMP site may include telephone visits, electronic visits, telemedicine visits, group visits, and patient-peer education sessions.*~~

IV.C.7. ~~The program must ensure that every resident has exposure to a variety of medical and surgical subspecialties throughout the educational program.~~ There must be a specific subspecialty curriculum to address the breadth of patients seen in family medicine.

IV.C.7.a) Every resident must have exposure to a variety of medical and surgical subspecialties throughout the educational program.

IV.C.7.b) The curriculum should address any gaps in the clinical experience through other required structured rotations and FMP continuity.

IV.C.8. Residents must have at least 600 hours (or six months) of clinical experience dedicated to the care of hospitalized adult patients with a broad range of ages and medical conditions.

IV.C.8.a) Residents must ~~have exposure to~~participate in the care of hospitalized patients in a ~~critically ill patients~~critical care setting.

IV.C.8.b) The experience should include the care of patients through hospitalization and transition of care to outpatient follow-up.

~~*Background and Intent: Experiences caring for hospitalized and critically ill adults can provide residents with an opportunity to deliver continuity of care to their panel of patients. These experiences also provide residents with opportunities to develop clinical skills, including in initial evaluation, development of a care plan, ongoing evaluation and management, performance of basic procedures of medicine, appropriate consultation, and planning for discharge and continuing care. Additionally, the experience provides opportunities to learn how families deal with critical illness and loss and how to deliver bad news.*~~

IV.C.9. Residents must have emergency department experience that includes care of acutely ill or injured adults.

IV.C.9.a) Residents must have at least 200 hours (or two months) or 250 patient encounters dedicated to the care of acutely ill or injured adults in an emergency department setting.

IV.C.10. Residents must have clinical experiences dedicated to the care of the older patient across a continuum of sites.

IV.C.10.a) The experience must include functional assessment, disease prevention and health promotion, and management of patients with multiple chronic diseases.

IV.C.11. Residents must have at least 200 hours (or two months) of clinical experience dedicated to the care of ill child patients in the hospital and/or emergency setting.

IV.C.12. Residents must have at least 200 hours (or two months) of clinical experience dedicated to the care of children and adolescents in an ambulatory setting, including:

IV.C.12.a) acute care;

IV.C.12.b) chronic care;

IV.C.12.c) newborn patient encounters, to include well and ill newborns; and,

IV.C.12.c).(1) <u>This experience should include inpatient and ambulatory settings, including in the continuity practice</u>.

IV.C.12.d) well-child care.

IV.C.13. Residents must have at least 100 hours (or one month) of clinical experience dedicated to the care of surgical patients, including hospitalized surgical patients.

IV.C.14. Residents must have at least 200 hours (or two months) of clinical experience dedicated to the care of patients with a breadth of musculoskeletal problems.

IV.C.14.a) This ~~must~~should include a ~~structured~~ sports medicine experience.

IV.C.15. Residents must have at least 100 hours (or one month) or 125 patient encounters dedicated to the care of women with gynecologic issues, including well-woman care, family planning, contraception, and, as permitted in the country or jurisdiction, options counseling for unintended pregnancy.

IV.C.16. Residents must document at least 200 hours (or two months) dedicated to obstetrics, including prenatal care, labor management, delivery management, and postpartum care.

IV.C.16.a) Residents must care for pregnant patients in the outpatient setting, including providing prenatal care and care of medical issues that arise in pregnancy.

IV.C.16.b) Each resident should care for postpartum patients, including care for parental-baby pairs.

IV.C.16.c) Some of the maternity experience should include the prenatal, intrapartum, and postpartum care of the same patient in a continuity care relationship.

~~*Background and Intent: Experiences in obstetric care can provide residents with an opportunity to deliver continuity of care to their panel of patients. These experiences are also intended to provide residents with opportunities to learn to recognize common problems associated with pregnancy and delivery and provide opportunities for residents to develop competence in making referrals for obstetric care. The requirement can be met through participation in deliveries, providing pre- and postnatal care, and through simulation.*~~

IV.C.17. Residents must have clinical experiences in diagnosing and managing common dermatologic conditions.

IV.C.18. The curriculum must be structured so behavioral health is integrated into the residents' total educational experience.

IV.C.19. ~~There must be a structured curriculum in which residents are educated in the diagnosis and management of common mental illnesses~~Residents must have dedicated experience in the diagnosis and management of common mental illness, including interprofessional education and training in cognitive behavioral therapy, motivational interviewing, and psychopharmacology.

IV.C.19.a) This experience should include identification and treatment of substance use disorders.

IV.C.19.b) Treatment should include pharmacologic and non-pharmacologic methods and an interprofessional team.

IV.C.20. There must be a structured curriculum in which residents address population health, including the evaluation of health problems of the

community.

IV.C.21. The curriculum should include diagnostic imaging ~~and nuclear medicine therapy~~ pertinent to family medicine.

IV.C.22. Residents must receive training to perform clinical procedures required for their future practice in ambulatory and other health care environments.

IV.C.22.a) The program director and family medicine faculty members must develop a list of procedural competencies required for ~~completion by~~ all residents in the program to achieve prior to graduation.

IV.C.22.a).(1) This list must be based on the anticipated practice needs of all family medicine residents.

IV.C.22.a).(2) In creating this list, the members of the faculty should consider the current practices of program graduates, national data regarding procedural care in family medicine, and the needs of the community to be served.

IV.C.23. Residents must have experiences dedicated to health system management.

IV.C.23.a) Residents must attend regular FMP business meetings with staff and faculty members to discuss practice-related policies and procedures, service goals, and practice efficiency and quality.

IV.C.23.b) Residents must receive regular data reports of individual/panel and practice patterns, as well as the education and training needed to analyze these reports.

IV.C.23.c) This curriculum should prepare residents to be active participants and leaders in their panel teams, their practices, their communities, and the profession of medicine.

IV.C.23.d) At some point during the educational program, each resident should participate in a health system or professional group committee.

IV.C.24. Residents must have elective experiences.

IV.C.25. Clinical experiences should be structured to facilitate learning in a manner that allows residents to function as part of an effective interprofessional team that works together longitudinally with shared goals of patient safety and quality improvement.

IV.C.26. ~~The curriculum should prepare residents to be active participants and leaders in their practices, their communities, and the profession of medicine~~.

IV.D. Scholarly Activity

IV.D.1. Resident Scholarly Activity

IV.D.1.a) Residents should complete two scholarly activities, at least one of which should be a quality improvement project.

IV.D.1.b) Scholarly projects should be disseminated through presentation or publication.

IV.D.2. Faculty Scholarly Activity

See International Foundational Requirements, Section IV.D.2.

V. Evaluation

See International Foundational Requirements, Section V.

VI. The Learning and Working Environment

See International Foundational Requirements, Section VI.