Table 3

Advanced Procedures Within the Scope of Family Medicine

	B: Require focused training in residency	*C: May require additional training beyond residency or fellowship*
Skin	Allergy testing Botulinum toxin injection Non-surgical cosmetic aesthetics Skin flap advanced closures	
Maternity care	Amniocentesis Cesarean delivery External cephalic version Forceps-assisted delivery	Cervical cerclage Vaginal twin delivery
Women's health	Contraceptive implant insertion and removal Dilation and evacuation Loop electrical excision procedure (LEEP) Non FNA breast biopsy Tubal ligation	Hysteroscopy Laparoscopy
Musculoskeletal		Acupuncture
Urgent care and hospital	Bone marrow biopsy Cardioversion Chest tube insertion, management, and removal Exercise stress test Nasorhinolaryngoscopy Peritonsillar abscess incision and drainage Swan-Ganz catheter insertion and management Tooth extraction	Bronchoscopy Myringotomy (PE) tubes Sleep study—perform and interpret Tonsillectomy
Gastrointestinal and colorectal	Endoscopic gastroduodenoscopy (EGD)	Appendectomy Anal fissure surgical management
Genitourinary	Emergency dorsal slit procedure	Non-neonatal circumcision
Anesthesia	Intrathecal anesthesia	Epidural anesthesia

PE—pressure equalizing tubes (tympanostomy)

technology and the needs of patients and communities, we envision these lists as dynamic. Family physicians will incorporate new technologies into their scope of practice. These may replace older procedures as standard of care, and obsolete procedures will need to be deleted. Family medicine leaders will need to define our scope of practice in procedural care as well as create an ongoing system for periodic updates as change occurs. The STFM Group on Hospital Medicine and Procedural Training is currently reviewing these lists yearly. The list could also be updated using trends identified by AAFP membership surveys and surveys of current procedural training in residencies. The AAFP Commission on Education is a well-placed potential vehicle for vetting procedural training and scope of practice educational recommendations due to its broad representation (family medicine organizations, students, residents, and community practicing physicians) and its interface with the RRC.

In addition, the STFM Group on Hospital Medicine and Procedural Training advocates for uniform training standards and criteria to determine competency. Many privileging committees currently use specialty certification and/or a minimum number of procedures performed (which may be more or less arbitrarily chosen) to award privileges to perform procedures independently. However, performing a minimum number of procedures may not be necessary or sufficient to ensure competency. Further, many procedures involve overlapping skills, allowing physicians to apply their existing surgical and procedural skills to rapidly attain proficiency at new procedures. In addition, some are quick learners while others need more practice to achieve the same level of performance. The STFM Group on Hospital Medicine and Procedural Training is actively working to develop valid measures to assess competence in procedural care; such tools will ensure that credentialing for procedures is based on competence, rather than numbers of procedures. Family medicine organizations such as the RRC and ABFM should establish uniform curricular and proctoring requirements to ensure adequate training and optimal patient care quality.

We anticipate that procedurally focused residencies, which often prepare family physicians for rural or international practice, will continue to offer training