REVISTA BRASILEIRA DE MEDICINA DE FAMÍLIA E COMUNIDADE
RBMFC

www.rbmfc.org.br
ISSN 2179-7994

Essays

Regional proposal for essential competencies and training strategies for Family and Community Medicine in the 21st century

Propuesta regional de competencias esenciales y estrategias formativas para la Medicina Familiar y Comunitaria del siglo XXI

Proposta regional de competências essenciais e estratégias de formação para a Medicina de Família e Comunidade do século XXI

Maira Alejandra León[1], Thomas Meoño[2], Karin Kopitowski[3]

[1]Universidad Pedagógica y Tecnológica de Colombia, Escuela de Medicina, Facultad de Ciencias de la Salud – Tunja, Boyacá, Colombia.
[2]Caja Costarricense de Seguro Social – San José, Costa Rica.
[3]Hospital Italiano de Buenos Aires, Servicio de Medicina Familiar y Comunitaria – Ciudad Autónoma de Buenos Aires, Argentina.

Abstract

Introduction: Family and Community Medicine (FCM) is recognized as a cornerstone of sustainable, people-centered health systems. However, emerging health challenges in Ibero-America require an updated professional profile that integrates technical, ethical, community, and digital competencies. **Objective:** To present a regional proposal for essential competencies for 21st-century FCM, together with coordinated pedagogical strategies and the incorporation of Entrustable Professional Activities (EPAs) as an assessment framework. **Methods:** A mixed, participatory methodology was applied: (1) a regional Delphi consensus involving FCM experts; (2) AI-assisted structural refinement to standardize and streamline the competency corpus; (3) a critical comparative analysis of the professional profile developed at the 2022 Guatemala Summit; and (4) the development of pedagogical strategies grounded in international frameworks and previous evidence. **Results:** Nine professional roles were defined — Clinician, Relationship Facilitator, Manager, Educator, Researcher, Ethical Professional, Community Actor, Rights Advocate, and Digital Health Professional — each described through clear, action-oriented competencies. Five pedagogical pillars (participatory curriculum design, active methodologies, authentic assessment, in-service training, and continuing education) and an initial set of common and optional EPAs for the region were proposed. **Conclusion:** This integrated proposal provides an operational framework for the development, evaluation, and continuous improvement of FCM training programs, thereby strengthening primary care and promoting health equity and social justice throughout Ibero-America.

Keywords: Family practice; Professional competence; Professional training; Primary health care; Educational Measurement.

How to cite: León MA, Meoño T, Kopitowski K. Regional Proposal for Essential Competencies and Training Strategies for Family and Community Medicine in the 21st Century. Rev Bras Med Fam Comunidade. 2026;21(48 Suppl 1):5451. https://doi.org/10.5712/rbmfc21(48)5451

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Contributors:
Carolina Jara (Chile), Carmen Cabezas (Ecuador), Cecil Quant (Dominican Republic), Clara Niz (Uruguay), Diana Cáceres (Chile), Digna Estévez (Dominican Republic), Elizabeth Salvatierra (Bolivia), Gabriela Di Croce (Argentina), Isabel Martins (Venezuela), Javier Maure (Cuba), Jaqueline Ponzo (Uruguay), Johana Montalvo (Ecuador), Leonardo Savassi (Brazil), Liliana Villegas (Colombia), Lucia Marrero (Uruguay), Luis Cantor (Mexico), Maria da Costa (Venezuela), María Geaneli Villagra (Uruguay), Miguel Suarez (Bolivia), Milagritos Fernández (Peru), Octavio Pons (Mexico), Otto Hamann (Colombia), Ronit Hernández (Dominican Republic), Rosemary Moscoso (Peru), Said Montufar (Mexico), Yomely Quintero (Venezuela), Angela Tulipano (Panama), Alejandro Villalobos (Chile), Isabel Mora (Chile), Johanna Montalvo (Ecuador).
Corresponding author:
Maira Alejandra León
E-mail: maira.leon@uptc.edu.co
Funding:
not applicable.
CEP Review:
not applicable.
TCLE:
not applicable.
Origin:
not commissioned.
Associate Editor:
Maria Inez Padula Anderson.
Peer review:
external.
Received on: March 28, 2026
Approved on: June 25, 2026

Resumen

Introducción: La Medicina Familiar y Comunitaria (MFyC) es reconocida como un pilar de los sistemas de salud sostenibles y centrados en la Atención Primaria de Salud (APS). Sin embargo, la creciente complejidad de los desafíos sanitarios en Iberoamérica demanda un perfil profesional actualizado que articule competencias técnicas, éticas, comunitarias y digitales. **Objetivo:** Presentar una propuesta regional de competencias esenciales para el ejercicio de la MFyC en el siglo XXI, junto con estrategias pedagógicas articuladas y la incorporación de Actividades Profesionales Confiables (APROC) como herramienta evaluativa. **Métodos:** Se empleó una metodología mixta y participativa: (1) consenso Delphi regional con referentes de la especialidad; (2) asistencia estructural mediante herramientas de inteligencia artificial generativa para homogeneizar y depurar el corpus de competencias; (3) análisis comparativo crítico con el perfil profesional de la VIII Cumbre de Guatemala (2022); y (4) diseño de estrategias pedagógicas basadas en marcos internacionales y evidencia previa. **Resultados:** Se definieron nueve roles profesionales — Clínico, Facilitador del vínculo, Gestor, Educador, Investigador, Profesional Ético, Actor comunitario, Defensor de derechos y Profesional en salud digital —, cada uno con competencias claras y orientadas a la acción. Se propusieron cinco ejes pedagógicos (diseño curricular participativo, metodologías activas, evaluación formativa y auténtica, formación en servicio y educación continua) y un marco inicial de APROC comunes y optativas para la región. **Conclusión:** Esta propuesta integral ofrece una guía operativa para diseñar, evaluar y actualizar programas de formación en MFyC, fortaleciendo el primer nivel de atención y promoviendo la equidad social y la justicia sanitaria en Iberoamérica.

Palabras clave: Medicina familiar y comunitaria; Competencia profesional; Capacitación profesional; Atención primaria de salud; Evaluación educacional.

Resumo

Introdução: A Medicina de Família e Comunidade (MFC) é reconhecida como um pilar de sistemas de saúde sustentáveis e centrados na Atenção Primária. No entanto, a crescente complexidade dos desafios sanitários na Ibero-América exige um perfil profissional atualizado que articule competências técnicas, éticas, comunitárias e digitais. **Objetivo:** Apresentar uma proposta regional de competências essenciais para o exercício da MFC no século XXI, juntamente com estratégias pedagógicas articuladas e a incorporação das Atividades Profissionais Confiáveis (APROC) como ferramenta avaliativa. **Métodos:** Utilizou-se uma metodologia mista e participativa: (1) consenso Delphi regional com especialistas da área; (2) apoio estrutural por meio de ferramentas de inteligência artificial generativa para homogeneizar e depurar o conjunto de competências; (3) análise comparativa crítica com o perfil profissional da VIII Cúpula da Guatemala (2022); e (4) desenvolvimento de estratégias pedagógicas baseadas em marcos internacionais e evidências prévias. **Resultados:** Foram definidos nove papéis profissionais — Clínico, Facilitador do vínculo, Gestor, Educador, Pesquisador, Ético, Ator comunitário, Defensor de direitos e Profissional em saúde digital —, cada um com competências claras e orientadas para a ação. Propuseram-se cinco eixos pedagógicos (currículo participativo, metodologias ativas, avaliação autêntica, formação em serviço e educação continuada) e um marco inicial de APROC comuns e optativas para a região. **Conclusão:** Esta proposta integral oferece um guia operacional para o desenho, avaliação e atualização de programas de formação em MFC, fortalecendo o primeiro nível de atenção e promovendo a equidade social e a justiça em saúde na Ibero-América.

Palavras-chave: Medicina de família e comunidade; Competência profissional; Capacitação profissional; Atenção primária à saúde; Avaliação educacional.

INTRODUCTION

Family and Community Medicine (FCM) is the medical specialty that promotes comprehensive, anticipatory, continuous, accessible, and person-, family-, and community-centered care.[1] Its practice is not limited to addressing clinical problems but is grounded in a holistic understanding of the health-disease process, which is strongly influenced by social, cultural, economic, environmental, existential, and political factors.[2] This approach recognizes health as a human right and health care as an ethical, context-specific, transformative practice deeply committed to social and health equity.

Recognized by the World Health Organization (WHO), national and international scientific societies, and successive regional summits (San José 2016, Guatemala 2022), FCM has been identified as one of the key specialties for advancing sustainable health systems oriented toward Primary Health Care (PHC) and centered on people.[3] In particular, the San José Charter reaffirmed the strategic role of FCM and General Practice in strengthening primary care as the structural foundation of the health system.[4] The update to the professional profile promoted by the VIII Ibero-American Summit in Guatemala (2022) defined eight areas of competence for family physicians, integrating conceptual and regulatory contributions from international references (Table 1).[5,6]

Table 1. Comparative analysis between the document from the VIII Summit in Guatemala (2022) and this regional proposal (2025).

Aspect	Guatemala Document (2022)	Montevideo Document (2025)
Organization	Areas of Competence	Professional Roles
Approach	Curricular and Training	Operational and Practical
Prioritization	Includes levels of priority and responsibility	Nonhierarchical; adaptable to different contexts
Writing style	Mixed, with some general formulations	Clarity, using third-person action verbs
Thematic overlap	Some competencies are repeated across different areas	Refined and systematized competencies
Orientation	Focused on residency training	Applicable to education, management, assessment, and clinical practice
Cross-cutting approaches	Presented as specific areas	Integrated across disciplines and defined according to professional roles
Contextualization	Institutional references within the health care system	Emphasis on territorial and community-based work

However, the world and the Ibero-American region face new and increasingly complex challenges: health crises, structural inequities, migration, ecological collapse, population aging, rapid technological transformations, the erosion of social ties, changing epidemiological profiles, and emerging diseases. In this context, the practice of FCM requires professionals who are not only technically competent but also capable of leading care processes in diverse contexts, as well as proposing, educating, managing, and sustaining long-term relationships within collaborative and intersectoral networks.

This document presents a proposal for essential competencies for the professional practice of FCM and Primary Care in the 21st century, accompanied by a coordinated set of pedagogical strategies for their training and assessment. A complementary framework of entrustable professional activities (EPA) is also proposed for the near future as a tool for the operational synthesis of these competencies, facilitating their practical application in real-world scenarios.[7] The content presented here is the result of a participatory, rigorous, and multistage process, and its purpose is to guide the training of professionals capable of practicing with clinical excellence, ethical commitment, regional sensitivity, and social responsibility.

RATIONALE

The Ibero-American region faces significant health challenges: inequality in access to health care, fragmentation of care, underfunding of public policies, increasing medicalization, the weakening of primary care, and the loss of the centrality of the therapeutic relationship. In response, FCM offers a comprehensive, longitudinal, person-centered model that integrates individual, family, and community care and proposes a territorial, interdisciplinary, anticipatory, and transformative approach.[8]

The Ibero-American region has seen decades of sustained progress in FCM education: the creation and expansion of residency programs and university departments, the consolidation of national scientific societies and the Ibero-American Confederation of Family and Community Medicine (*Confederación Iberoamericana de Medicina Familiar* – CIMF), successive Ibero-American summits (San José 2016, Guatemala 2022, Montevideo 2025), and the development of competency frameworks and pioneering initiatives — such as competency-based curricula and the recent Framework Zero for EPA developed by the Brazilian Society of Family and Community Medicine[9] — demonstrate a collective effort and tangible achievements in strengthening the specialty. Nevertheless, challenges remain. In some contexts, curricula

are fragmented, integration between theory and practice is insufficient, community engagement is weak, on-site supervision is limited, and tools for authentic performance assessment are lacking. In addition, some settings continue to replicate traditional biomedical models that prioritize technique over the patient-physician relationship, the specialist over the generalist, and the hospital over the community. This proposal does not start from scratch but seeks to build on what has already been achieved and contribute to its continuity.

From this perspective, it becomes essential to move toward a training model that not only defines competencies but also translates them into observable, reliable, and relevant professional tasks that address current challenges, in which diversity and uncertainty are ever-present. Therefore, this proposal incorporates the possibility of exploring the framework of EPA, which allows multiple competencies to be integrated into meaningful professional activities, facilitates their contextualized assessment, and guides training processes toward outcomes and progressive autonomy.

The rationale for this document is also grounded in the region's accumulated experience. The VIII Summit in Guatemala proposed an update to the professional profile of FCM, based on eight areas of competence. Although valuable, that proposal contained thematic redundancies and conceptual overlaps and lacked operationalization. The present initiative builds upon and honors that precedent while advancing its depth through functional categorization by roles and integration with pedagogical tools.

Finally, this document was drafted between January and May 2025 as a technical and policy contribution within the framework of the CIMF's preparatory work for the IX Ibero-American Summit on Family and Community Medicine, held in Montevideo from May 21 to 24, 2025, under the slogan "More Necessary Than Ever." That Summit culminated in the Montevideo Declaration, which reaffirmed the strategic role of FCM and primary care in advancing toward universal, resilient, and people-centered health systems.[10] This proposal aligns with that direction and seeks to operationalize it in the educational sphere by providing a framework of competencies and pedagogical strategies to guide undergraduate education, residency training, continuing professional development, accreditation, faculty development, and professional performance assessment throughout the region.

OBJECTIVE

The overall objective of this document is to present a comprehensive and up-to-date proposal for essential professional competencies in FCM in the 21st century, collectively developed by leading experts in the Ibero-American region and aligned with situated and contextualized pedagogical strategies that ensure their development, cultivation, and assessment throughout the educational process and professional practice.

Furthermore, it aimed to align the competencies presented in this document with the regional proposal for EPA, thereby facilitating consistency among regional proposals and the achievement of objectives aimed at improving specialist training in the region — objectives that translate these competencies into observable and assessable clinical, educational, community, and management tasks in real-world contexts.

This proposal seeks to contribute to the strengthening of primary care, continuous professional development, and the consolidation of health systems centered on care, equity, and social justice.

CONCEPTUAL CONTRIBUTIONS

The conceptual framework underpinning this document is organized around five interrelated pillars. These pillars were not defined *a priori* but emerged from the thematic analysis of the experts' contributions

throughout the Delphi rounds (see Section Methodological Contributions). By systematizing the competency statements that emerged from the consensus, five cross-cutting foundations were identified inductively that underpin and give meaning to the proposed set of competencies:

a) A person-, family-, and community-centered approach.

FCM recognizes each person as a whole individual, with a history, relationships, context, and rights. Care cannot be separated from the social, cultural, and environmental conditions in which it takes place.[11] The therapeutic relationship, continuity of care, cultural relevance, and respect for diversity are fundamental pillars of professional practice.[12]

b) Health as a right and ethical practice.

Health is not a commodity but a fundamental human right.[13,14] Medical practice must be guided by the principles of social justice, solidarity, clinical bioethics, and public responsibility. FCM professionals act not only on the clinical level but also as a political agent, educator, advocate for rights, and agent of social change.

c) Situated, relational, and transformative education.

The teaching of FCM must take place in real-world settings, with a high degree of integration between theory and practice and sufficient mentoring by family practice physicians. From the perspective of situated learning, professional knowledge is constructed through progressive participation in communities of practice and in the real-world contexts in which that knowledge is applied.[15] In-service training enables the development of relevant, ethically grounded knowledge adapted to the specific characteristics of the local context and is aligned with a transformative approach to the education of health professionals aimed at strengthening health systems.[16] Mentoring promotes reflective guidance, the development of clinical judgment, and the fostering of professional autonomy.

d) Competency-based model and the shift toward entrustable professional activities.

Competencies make it possible to organize the curriculum and guide training toward outcomes.[17,18] However, they often remain concepts that are difficult to apply or assess. For this reason, we propose moving toward a complementary model based on EPAs, which integrates multiple competencies into complete, observable, measurable, and meaningful professional tasks.[19,20] EPAs make it possible to assess the level of trust that the training environment places in trainees to assume certain responsibilities, offering a progressive, flexible, and practice-centered tool.[7,20]

e) The paradigm of complexity and the transdisciplinary approach.

Health and illness cannot be understood through a reductionist lens. They require a complex perspective that integrates biological, psychosocial, cultural, ecological, and political dimensions. FCM draws on multiple disciplines and fields of knowledge, including clinical practice, epidemiology, pedagogy,

ethics, anthropology, management, social work, and public health. This transdisciplinary approach is not a mere sum of these fields but rather a critical integration oriented toward the concept of care.[21]

METHODOLOGICAL CONTRIBUTIONS

The development of this proposal for competencies and pedagogical strategies was structured around a rigorous and participatory mixed-methods approach designed to ensure regional representativeness, content validity, and practical applicability. This process took place from January through May 2025. It included four complementary components:

1. regional consensus among experts using the Delphi methodology;
2. structural support through generative artificial intelligence (GAI) tools;
3. critical comparative analysis with the professional profile from the VIII Guatemala Summit (2022); and
4. integration of pedagogical strategies and previous frameworks.

a) Regional consensus using the Delphi methodology

A Delphi methodology was implemented to develop the framework of essential professional competencies. Participants were identified through the academic and scientific network of CIMF, an organization that brings together the scientific societies of FCM from Ibero-American countries. The call for participants was disseminated through the CIMF's national representatives and academic leaders associated with undergraduate and graduate training programs, ensuring that all member countries received an invitation to participate.

The following inclusion criteria were applied: being a physician specializing in FCM with more than three years of experience in teaching, patient care, management, research, or community work, and being available to complete the successive rounds. In addition, the inclusion of professionals with experience in medical education, curriculum design, competency assessment, residency program development, and academic leadership was encouraged to maximize regional representation and diversity of expertise.

Thirty-two leading FCM physicians from 16 countries in the region participated in three Delphi rounds with iterative feedback, organized through the analysis of three subgroups and discussions in group meetings conducted via videoconference. Consensus criteria were established as an agreement rate of greater than 75% and a dropout rate of less than 5%.[22–24] This strategy made it possible to collect, organize, and validate multiple perspectives, generating an initial corpus of approximately 200 competency statements.

Although this set was rich in conceptual diversity, it contained redundant formulations, varying levels of abstraction, and thematic overlaps that hindered its practical application and curricular use. For this reason, it was decided to proceed to a second methodological stage to consolidate the material without losing its depth or representativeness.

b) Structural Assistance Using Generative Artificial Intelligence

The second stage consisted of applying GAI tools — Chat GPT-5, OpenAI — to provide technical assistance in processing the corpus. This technology was used for four specific purposes:

1. detecting semantic duplications and merging equivalent formulations;
2. standardizing the language by using the third person and action verbs;

3. classifying competencies according to professional roles; and
4. organizing the document according to a coherent pedagogical logic, in line with recent recommendations on the use of GAI in medical education.[25]

At no point did artificial intelligence (AI) replace critical review or human validation; rather, it functioned as a structural tool that improved the efficiency and quality of the analysis. Specific instructions (prompts) were used, such as:

- "Identify duplicates or redundant phrasing in this list of competencies."
- "Rewrite each competency in the third person, using a clear action verb and specific language, without ambiguity."
- "Organize this list into thematic categories based on the professional role of the family physician (clinical, community-based, educator, manager, etc.)."
- "Merge these three formulations, which express similar ideas, into a single competency."

The result of this process was a systematized, clear set of competencies organized by professional roles, which subsequently underwent human validation. Three researchers independently reviewed each AI-processed competency, comparing it with the original wording using categories of questions consistent with the founding values of FCM and aligned with contemporary training needs. Discrepancies were resolved by consensus.

The language models were used exclusively as a support tool for organizing, preliminary synthesis, and linguistic harmonization of the documents generated by the working group; they did not participate in conceptual decision-making or content definition. Given that these models may reproduce cultural, linguistic, or data-driven biases stemming from the data used to train them, all generated outputs were independently reviewed by experts from various Ibero-American countries. Discrepancies were discussed and resolved through human consensus, prioritizing regional relevance, conceptual fidelity, and the representativeness of different educational contexts. Consequently, AI was used as an assistive tool rather than as a source of evidence or a substitute for expert judgment.

c) Comparative Analysis with the Guatemala Summit Document (2022)

The comparative analysis with the competencies document developed at the VIII Ibero-American Summit in Guatemala revealed several useful insights. First, strategic alignments were identified: both documents share the principles of person-centered care, the importance of clinical communication, an ethical approach, the need for teaching and research in FCM, and the inclusion of perspectives on gender, diversity, and interculturality.

However, redundancies and overlaps were also identified in the structure of the Guatemala document, such as the repetition of the idea of "first contact" across multiple areas and the distribution of communication tools across unintegrated sections. The new proposal sought to consolidate these elements into functional categories to provide greater clarity. The detailed comparison is summarized in Table 1.

d) Integration of pedagogical strategies and existing frameworks

In parallel with the development of the competency framework, a set of pedagogical strategies was developed based on inputs from the Delphi process, previous institutional documents (such as the

Guatemala 2022 professional profile), and international frameworks. These strategies were not conceived as an isolated list of educational techniques but rather as a cohesive proposal that recognizes the need for training in real-world contexts, with community participation, active supervision, and critical, inclusive, and transformative methodologies.

Regarding the structure of this document, the competencies are organized by professional roles, written clearly in the third person, and presented without internal hierarchies, thereby facilitating their applicability across diverse educational and practice settings. This approach aligns with the goal of creating an operational, practical document that is consistent with a vision of FCM as a complex, integrative, ethical, and situated practice.

Supplementary materials — including the complete Delphi questionnaire, the prompts used with GAI, and the detailed comparative matrix with the 2022 Guatemala document — are available upon reasonable request from the corresponding author.

PROPOSALS

As a result of the methodological process described above, the main structural proposals of this initiative are presented below. These proposals are intended to serve as a guide for the design of training programs, assessment tools, and professional development strategies in FCM throughout the region.

a) Essential 21st-century competencies, organized by professional roles

The proposal identifies nine professional roles of the family physician, based on which the essential competencies are grouped in a structured, operational manner consistent with real-world practice.[26] Each role is conceptually defined below, and its operational breakdown into competencies is presented in the following section.

1. **Clinician:** The core identity of the specialty; provides comprehensive, longitudinal, and person-centered care, integrating biomedical and psychosocial knowledge to address undifferentiated health problems under conditions of uncertainty.
2. **Facilitator of Clinical and Community Connections:** Views relationships as a therapeutic tool; builds bonds of trust and meaningful communication with individuals, families, teams, and communities, in both in-person and digital settings.
3. **Manager:** Organizes and coordinates care and resources within the assigned territory, coordinating the care network based on the principles of equity, efficiency, sustainability, and collaborative work.
4. **Educator:** Views teaching as an integral part of the specialty, supporting the learning of peers, teams, individuals, and communities as a driver of social transformation.
5. **Researcher:** Generates and applies relevant, context-specific knowledge to improve practice and services, integrating research into daily work.
6. **Ethical Professional:** Guides practice according to the principles of dignity, rights, and justice; deliberates in the face of ethical dilemmas, questions medicalization, and resists external pressures.
7. **Community actor:** Recognizes the community as the subject of care; participates in health assessment, planning, and governance from a territorial and intersectoral perspective.
8. **Rights advocate:** Actively promotes equity; incorporates gender and intercultural perspectives and takes a stand against structural inequalities and violence.

9. **Digital Health and Technology Professional:** Incorporates information technologies and AI into care with critical judgment, safeguarding quality, safety, equity, and the clinical relationship.[27]

Essential 21st-Century Competencies for Family and Community Medicine

A. As a clinician

• Provides comprehensive, continuous, accessible, and person- and family-centered medical care throughout the life course, taking into account biological, psychological, social, cultural, spiritual, and ecological dimensions.
• Addresses undifferentiated health problems, manages uncertainty with clinical judgment, and avoids hasty diagnoses or unnecessary interventions.
• Applies principles of evidence-based medicine, prioritizing cost-effective, culturally relevant interventions with a focus on quaternary prevention.
• Diagnoses and treats prevalent diseases, both acute and chronic, in various settings.
• Carries out activities related to health promotion, disease prevention, recovery, rehabilitation, and palliative care, coordinating with health care teams and the community.
• Develops and implements comprehensive care plans tailored to the individual's circumstances and the local context.
• Performs diagnostic, therapeutic, and minor surgical procedures in accordance with the range of services offered.
• Uses basic and specialized family-centered tools for the assessment and care of the families under their care (genogram, ecomap, APGAR, etc.).
• Provides care to populations with specific needs (*e.g.*, migrants, sexual minorities, incarcerated individuals).
• Provides home care, taking into account the environment, resources, and needs of the individual and their family.
• Establishes a long-term, empathetic, and trusting doctor-patient relationship.

B. As a facilitator of clinical and community connections

• Communicates clearly, empathetically, and respectfully with individuals, families, and teams, adapting to diverse contexts.
• Establishes therapeutic agreements and shared decision-making based on mutual understanding.
• Uses clinical communication strategies that promote adherence, autonomy, and empowerment.
• Ethically manages interactions in digital environments and on social media, ensuring privacy and accuracy.
• Uses language free of sexism, stigma, and unnecessary technical jargon.

C. As a manager

• Leads the collaborative work of the interprofessional team within the regulatory framework of the profession and the health care system
• Manages the health of the assigned population using clinical, social, and community-based tools.
• Efficiently coordinates the care network and referrals, ensuring continuity and quality.
• Use epidemiological and clinical data to evaluate and improve care processes.

- Leads local management processes using an intersectoral and territorial approach.
- Promotes sustainable practices and environmental responsibility in the health sector.
- Recognizes personal limitations and coordinates with other resources within the system, optimizing care and preventing professional burnout.

D. As an educator

- Participates in the training of professionals, health care teams, and communities.
- Applies active, inclusive, and culturally relevant teaching strategies.
- Conducts individual and community health education activities.
- Ensures the use of non-sexist language and respect for rights throughout the educational process.
- Uses education as a tool for social and community transformation.
- Employs self-regulation strategies for continuous professional development.
- Demonstrates compassion, empathy, and respect for all people, adapting to the needs of individuals in diverse contexts.

E. As a researcher

- Formulates research questions relevant to clinical, educational, and community practice.
- Designs, conducts, and leads research projects using appropriate methodologies.
- Participates in data analysis using statistical and epidemiological tools.
- Disseminates findings in academic, institutional, and community settings.
- Integrates research findings into the improvement of professional practice and services.
- Applies ethical principles throughout the research process.

F. As an ethical professional

- Respects the dignity, diversity, and rights of all people without exception.
- Advocates for care free from stigma, discrimination, violence, or coercion.
- Applies bioethical principles in decision-making and resource management.
- Promote appropriate care, avoiding the medicalization of life.
- Critically evaluates external influences (*e.g.*, the pharmaceutical industry and market forces) on medical practice.

G. As a community actor

- Recognizes the local context and the characteristics of the population under their care.
- Conducts participatory and context-specific community assessments.
- Plans and implements health interventions using a territorial and intersectoral approach.
- Participates in local health governance, coordinating with social actors.
- Promotes community empowerment and social participation in health.
- Promotes the formation and integration of networks.

H. As a rights advocate

- Applies a gender and intercultural approach in daily practice.
- Identifies and addresses situations of violence at all levels.
- Promotes equality within health care teams and among the population served.

• Participates in networks and systems that provide comprehensive care to vulnerable individuals and groups.
• Takes an ethical and political stance against structural inequalities.

I. As a digital health and technology professional

- Uses information technologies to improve access, quality, and continuity of care.
- Uses tools such as electronic health records, telemedicine, and georeferencing systems.
- Applies AI in health care with responsibility and clinical judgment.
- Critically evaluates the benefits, risks, and biases associated with the use of new technologies.

b) Progressive Incorporation of Entrustable Professional Activities

The goal is to initiate a regional process for the development, validation, and implementation of EPAs in FCM as a pedagogical and assessment tool complementary to the competency model.[18] EPAs enable the following:

- Integration of multiple competencies into meaningful professional tasks.
- Assessment of performance in real-world contexts with varying levels of supervision.
- Facilitation of training progression and the transition to independent practice.
- Adaptation to the territorial, institutional, and epidemiological realities of each country.

It is recommended that a set of mandatory common EPAs, applicable throughout the region, and a set of optional EPAs, tailored to the specific characteristics of each health system or community, be developed.

This movement already has specific regional models. In Brazil, the Brazilian Society of Family and Community Medicine (*Sociedade Brasileira de Medicina de Família e Comunidade* – SBMFC) published the document National EPAs in Family and Community Medicine: Ground Zero in 2025, which defines 15 national EPAs for residency training. These were developed through a rigorous methodological process with national validation via a Delphi study and linked to the current competency framework. The document represents a collective and historic effort and serves as a leading reference for the region.[9] In residency training, the experience of Hospital Italiano in Buenos Aires (Argentina) offers detailed examples of EPAs,[28] and similar initiatives can be observed in other Ibero-American countries. This proposal draws on this background and aims to move toward a regional set of common and elective EPAs while respecting the specific characteristics of each health system. Table 2 presents a detailed example.

c) Coordinated teaching strategies

Five strategic pillars for training in FCM have been identified:

1. **Participatory, flexible, and context-specific curriculum design:** with a modular, critical-social approach, developed with the participation of students, faculty, communities, and administrators.[29]
2. **Structure based on key competencies:** including clinical, community-based, reflective, and technological competencies.[17,26]
3. **Active and innovative methodologies:** problem-based learning, simulation, fieldwork, action research, gamification, and digital tools.[30]

4. **Formative and authentic assessment:** using diverse tools (rubrics, portfolios, case studies, Mini-CEX, critical incident analysis, and ECOE), involving multiple stakeholders, and providing structured feedback.[31] These strategies enable the assessment of performance in real-world or simulated contexts, promoting reflective and learner-centered learning.[32]

Table 2. Example of an Entrustable Professional Activity (EPAs) developed in the region: palliative care for adults (Family Medicine Residency Program, Hospital Italiano of Buenos Aires, 2025).[29]

Entrusted Professional Activity — Providing palliative care to adults

Specifications and limitations. Participates as part of an interdisciplinary team in the provision of palliative care to adults from a perspective of rights, diversity, interculturality, and shared decision-making when appropriate. This includes adopting a patient-centered approach to managing common symptoms (including pain) using appropriate tools, recognizing palliative emergencies, providing support during the grieving process, and demonstrating the ability to address psychosocial, cultural, religious, spiritual, and existential aspects.

Elements included in this activity:

- Conducting the clinical interview and compiling the problem-oriented medical record (POMR).
- Performing a physical examination when appropriate.
- Establishing differential diagnoses in accordance with the principles of clinical reasoning.
- Ordering relevant diagnostic tests and interpreting their results.
- Ordering appropriate treatments.
- Requesting consultations with other specialists when appropriate.
- Building trusting relationships with the patient and their family.
- Providing clinical care that respects the patient's self-perceived gender identity.
- Communicating bad news sensitively.

Limitations. Does not include the care of children and adolescents requiring palliative care.

Risks associated with inadequate performance:

- Increased physical or emotional suffering due to poor management of common symptoms.
- Failure to recognize or address palliative emergencies.
- Breakdown of the therapeutic relationship.
- Creation of unrealistic expectations among patients or family members due to poor communication of the prognosis.

Relevant areas of expertise:

- Medical Expert.
- Communicator.
- Collaborator.
- Health advocate (does not apply to managers/administrators).

Required knowledge:

- Objectives of palliative care.
- Strategies for managing common symptoms (pain, shortness of breath, nausea, constipation, anxiety, delirium).
- Relevant aspects of conditions requiring palliative care (cancer, end-stage COPD, renal failure, etc.).
- Delivering bad news.
- Ethical principles applicable to end-of-life care.

Expected skills:

- Active listening.
- Clear and empathetic communication.
- Clinical and emotional management of difficult situations.
- Identification of the patient's needs.
- Assessment of suffering in all its dimensions.

Expected attitudes:

- Proactivity and responsibility.
- Clinical and ethical integrity.
- Collaboration within an interdisciplinary team.
- Recognition of personal limitations and seeking help.

Required experience: Participation in the care of at least 30 adult patients requiring palliative care.

5. **Continuing education and professional development:** accessible, ethical, context-based, and focused on self-regulation, mentoring, and ongoing professional growth.[33]

RECOMMENDATIONS

The main recommendations derived from this process are summarized below to guide institutional, academic, and policy decisions regarding FCM training in the region:

1. Adopt a consensus-based regional framework of essential competencies for 21st-century FCM, focused on comprehensive, proactive, ethical, continuous, and context-specific care for individuals, families, and communities, with an emphasis on rights and social justice.
2. Organize competencies around clearly defined professional roles, using clear, action-oriented language, to facilitate their application in training programs, assessment, and continuing professional development.
3. Ensure that gender, diversity, interculturality, and ecological sustainability are integrated throughout all levels of the training process, from the curriculum to clinical and community practice.
4. Promote the development of leadership skills within health care teams so that family physicians can positively influence their environment, strengthen collaborative work, and contribute to transforming the health care system.
5. Promote and conduct research in FCM as an integral part of training and professional practice, strengthening the capacity to generate useful, applicable, and context-specific evidence that improves primary care.
6. Strengthen in-service training as the main pillar of education, ensuring direct and continuous supervision by family physicians who serve as mentors, role models, and guardians of a person- and family-centered approach.
7. Promote participatory, modular, and context-specific curriculum design, developed collectively with the participation of students, faculty, communities, and administrators, and adapted to regional and epidemiological needs, as well as to the well-being of trainees.
8. Develop specific teaching competencies in FCM through programs in pedagogy, ethics, and digital health for those who mentor and teach in primary care.
9. Apply active, participatory, innovative, and transformative pedagogical strategies, such as problem-based learning, clinical simulation, action research, and intersectoral community projects.
10. Implement mechanisms for formative and authentic performance assessment, with structured feedback, the participation of multiple stakeholders, and the use of tools such as rubrics, case studies, and digital portfolios.
11. Promote regional networks for academic cooperation that foster the joint development of competency frameworks, EPA, pedagogical strategies, and assessment mechanisms adapted to the realities of Ibero-America.
12. Incorporate EPAs as complementary tools to the competency model, enabling the assessment of clinical, community, and management tasks in real-world contexts, as well as evaluation of the level of proficiency trainees have attained to perform such activities independently and safely, with varying levels of supervision and progressive delegation.

LIMITATIONS

This study has some limitations that should be considered when interpreting its results:

Delphi Method: Although the Delphi method is widely validated, it can lead to groupthink or favor dominant perspectives. This limitation was mitigated by the participation of experts from 16 countries representing diverse roles within FCM.

Use of GAI: Although systematic human validation was applied, AI-assisted processing may have introduced undetected cultural or linguistic biases. This risk was mitigated through independent human validation.

Empirical validation: This competency framework requires validation through implementation in real-world training programs across different countries before its broader applicability can be confirmed.

EPAs under development: The proposed framework for EPAs requires further validation and consensus, and this document should be regarded as a starting point.

CONCLUSION

This document presents an integrated proposal for essential competencies and training strategies for FCM, developed collectively through a critical analysis of previous frameworks, accumulated regional experience, and the use of rigorous and innovative methodologies. Organizing competencies according to professional roles and linking them to context-specific pedagogical strategies supports training that is more relevant, assessable, and aligned with the challenges of the 21st century.

In a health care context characterized by complexity, inequality, and constant transformation, FCM requires professionals capable of integrating clinical, community-based, ethical, and technological knowledge while maintaining a strong commitment to the communities they serve and to social responsibility. To this end, it is essential to transform traditional training models by moving beyond fragmented and prescriptive approaches and adopting frameworks that promote meaningful learning, authentic assessment, and the collective construction of knowledge.

Recognizing that this framework constitutes a starting point requiring validation in real-world training settings, academic institutions, health authorities, and training stakeholders throughout Ibero-America are encouraged to progressively adopt and adapt this proposal to their own contexts, pilot and evaluate it, and collectively provide feedback for its continuous improvement. Conceived as a living, guiding, and evolving tool, its contextualized implementation and evaluation have the potential to strengthen primary care and contribute to the consolidation of health systems centered on people, equity, and social justice.

ETHICAL CONSIDERATIONS

This expert consensus study was deemed exempt from ethical review under Guideline 23 of the International Ethical Guidelines for Health-Related Research Involving Human Subjects, as it involved professionals participating in their capacity as experts and posed no risk to patients.

CONFLICT OF INTEREST

Nothing to declare.

AUTHORS' CONTRIBUTIONS

ML: Conceptualization, Methodology, Formal Analysis, Writing – original draft. KK: Conceptualization, Methodology, Formal Analysis, Writing – original draft. TM: Writing – review & editing. Collaborative group: validation of competencies and critical review of content.

REFERENCES

1. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. Milbank Q. 2005;83(3):457-502. https://doi.org/10.1111/j.1468-0009.2005.00409.x
2. World Health Organization. Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health [Internet]. Geneva: WHO; 2008 [cited on Mar 4, 2026]. Available at: https://www.who.int/publications/i/item/WHO-IER-CSDH-08.1
3. Macinko JA, Montenegro Arriagada H, Nebot C. Renewing Primary Health Care in the Americas: A Position Paper of the Pan American Health Organization/World Health Organization (PAHO/WHO) [Internet]. Washington: PAHO; 2007 [cited on Mar 4, 2026]. 33 p. Available at: https://iris.paho.org/handle/10665.2/31083
4. Castro FL, Madrigal MDRS, Kidd M, Anderson MIP, Martin TM. Carta de San José. Rev Bras Med Fam Comunidade. 2016;11(Suppl 2):86-91. https://doi.org/10.5712/rbmfc11(0)1398
5. Confederación Iberoamericana de Medicina Familiar; World Organization of Family Doctors (CIMF-WONCA). Medicina Familiar y comunitaria: Especialidad esencial para la salud en el siglo XXI. VIII cumbre Iberoamericana de Medicina Familiar / Medicina Familiar y Comunitaria (Guatemala, 2022) [Internet]. Barcelona: Sociedad Española de Medicina de Familia y Comunitaria; 2025 [cited on Jun 20, 2025]. Available at: https://www.semfyc.es/images/CIMF%2016-05-25_1748352456.pdf
6. Ng V, Nashat N, Andrades M. WONCA Global Standards for Postgraduate Medical Education [Internet]. Bangkok: World Organization of Family Doctors; 2025 [cited on Jan 8, 2026]. Available at: https://www.globalfamilydoctor.com/site/DefaultSite/filesystem/documents/Groups/Education/WONCA%20Global%20Standards%20for%20Postgraduate%20Medical%20Education%202025.07.20.pdf
7. Brito LAR, Caramori U, D'Abreu NB, Cardoso Filho C, Cunha LO, Bragança JF. Atividades profissionais confiáveis para a residência em Medicina de Família e Comunidade no contexto brasileiro. Rev Bras Educ Med. 2025;49(1):e029. https://doi.org/10.1590/1981-5271v49.1-2024-0198
8. Kringos DS, Boerma WGW, Hutchinson A, Van Der Zee J, Groenewegen PP. The breadth of primary care: a systematic literature review of its core dimensions. BMC Health Serv Res. 2010;10:65. https://doi.org/10.1186/1472-6963-10-65
9. Cunha ATR, Caramori U, Brito LAR, Pacheco RA, Pisco CR, Freitas FL, et al. EPAs Nacionais em Medicina de Família e Comunidade: Marco Zero Tiragem [Internet]. Rio de Janeiro: Sociedade Brasileira de Medicina de Família e Comunidade; 2025 [cited on Jun 20, 2026]. Available at: https://sbmfc.org.br/wp-content/uploads/2025/06/EPAs-Nacionais-em-Medicina-de-Familia-e-Comunidade-Marco-Zero-SBMFC-2025.pdf
10. Bernal D, Segura OJM. CONGRESO CIMF 2025: Una celebración de la medicina familiar y comunitaria en Uruguay [Internet]. WONCA; 2025 [cited on Jun 20, 2026]. CONGRESO CIMF 2025: Una celebración de la medicina familiar y comunitaria en Uruguay. Available at: https://www.globalfamilydoctor.com/News/CONGRESOCIMF2025.aspx
11. Wasim A, Sajan M, Majid U. Patient-centered care frameworks, models and approaches: An environmental scan. Patient Exp J. 2023;10(2):14-22. https://doi.org/10.35680/2372-0247.1806
12. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000;51(7):1087-110. https://doi.org/10.1016/s0277-9536(00)00098-8
13. United Nations. Universal Declaration of Human Rights [Internet]. United Nations; 1948 [cited on Mar 4, 2026]. Available at: https://www.un.org/en/about-us/universal-declaration-of-human-rights
14. Meier BM, Seunik M, Dhatt R, Gostin L. ALMA-ATA at 40: A Milestone in the Evolution of the Right to Health and an Enduring Legacy for Human Rights in Global Health. Health Hum Rights [Internet]. 2018 [cited on Mar 25, 2026]. Available at: https://www.hhrjournal.org/2018/09/05/alma-ata-at-40-a-milestone-in-the-evolution-of-the-right-to-health-and-an-enduring-legacy-for-human-rights-in-global-health/
15. Lave J, Wenger E. Situated Learning: Legitimate Peripheral Participation. Cambridge: Cambridge University Press; 1991. https://doi.org/10.1017/CBO9780511815355
16. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. Lancet. 2010;376(9756):1923-58. https://doi.org/10.1016/s0140-6736(10)61854-5
17. Frank JR, Snell LS, Cate OT, Holmboe ES, Carraccio C, Swing SR, et al. Competency-based medical education: Theory to practice. Med Teach. 2010;32(8):638-45. https://doi.org/10.3109/0142159x.2010.501190
18. Cate OT, Taylor DR. The recommended description of an entrustable professional activity: AMEE Guide No. 140. Med Teach. 2021;43(10):1106-14. https://doi.org/10.1080/0142159x.2020.1838465
19. Ten Cate O. Entrustability of professional activities and competency-based training. Med Educ. 2005;39(12):1176-7. https://doi.org/10.1111/j.1365-2929.2005.02341.x
20. Shaughnessy AF, Sparks J, Cohen-Osher M, Goodell KH, Sawin GL, Gravel Jr J. Entrustable Professional Activities in Family Medicine. J Grad Med Educ. 2013;5(1):112-8. https://doi.org/10.4300/jgme-d-12-00034.1
21. Sturmberg JP, Martin CM. Handbook of systems and complexity in health. Handbook of systems and complexity in health. New York: Springer; 2013. https://doi.org/10.1007/978-1-4614-4998-0
22. Clayton MJ. Delphi: A technique to harness expert opinion for critical decision-making tasks in education. Educ Psychol. 1997;17(4):373-86. https://doi.org/10.1080/0144341970170401
23. Humphrey-Murto S, Varpio L, Wood TJ, Gonsalves C, Ufholz LA, Mascioli K, et al. The Use of the Delphi and Other Consensus Group Methods in Medical Education Research: A Review. Acad Med. 2017;92(10):1491-8. https://doi.org/10.1097/acm.0000000000001812

24. El Rayess F, Filip A, Doubeni A, Wilson C, Haq C, Debay M. Family medicine global health fellowship competencies: A modified delphi study. Fam Med. 2017;49(2):106-13. PMID: 28218935.
25. Preiksaitis C, Rose C. Opportunities, Challenges, and Future Directions of Generative Artificial Intelligence in Medical Education: Scoping Review. JMIR Med Educ. 2023;9(1):e48785. https://doi.org/10.2196/48785
26. Shaw E, Oandasan I, Fowler N. CanMEDS–Family Medicine 2017: A competency framework for family physicians across the continuum [Internet]. Ontario: The College of Family Physicians of Canada; 2017 [cited on Mar 25, 2026]. Available at: https://www.cfpc.ca/CFPC/media/Resources/Medical-Education/CanMEDS-Family-Medicine-2017-ENG.pdf
27. Wong K, Keen M, Zhou T, Bolch C, Ashurst J. Telehealth in Family Medicine Clerkships After Return of In-Person Care: A CERA Study. PRiMER. 2024;8:57. https://doi.org/10.22454/primer.2024.899806
28. Arceo MD, Volpi M, Kemnitz M. Programa de Residencia en Medicina General y/o Familiar: Actividades Profesionales Confiables [documento institucional]. Buenos Aires: Hospital Italiano de Buenos Aires, Servicio de Medicina Familiar y Comunitaria; 2025.
29. Harden RM. AMEE Guide No. 21: Curriculum mapping: a tool for transparent and authentic teaching and learning. Med Teach. 2001;23(2):123-37. https://doi.org/10.1080/01421590120036547
30. Jaganathan S, Bhuminathan S, Ramesh M. Problem-Based Learning – An Overview. J Pharm Bioallied Sci. 2024;16(Suppl 2):S1435-7. https://doi.org/10.4103/jpbs.jpbs_820_23
31. Norcini J, Burch V. Workplace-based assessment as an educational tool: AMEE Guide No. 31. Med Teach. 2007;29(9-10):855-71. https://doi.org/10.1080/01421590701775453
32. Norcini JJ, Blank LL, Duffy FD, Fortna GS. The Mini-CEX: A Method for Assessing Clinical Skills. Ann Intern Med. 2003;138(6):476-81. https://doi.org/10.7326/0003-4819-138-6-200303180-00012
33. Davis D, O'Brien MAT, Freemantle N, Wolf FM, Mazmanian P, Taylor-Vaisey A. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? JAMA. 1999;282(9):867-74. https://doi.org/10.1001/jama.282.9.867