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ADFM Association of Departments of Family Medicine
VISION, VOICE, LEADERSHIP
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STEPPING THROUGH: THE TRANSITION FROM DEPARTMENT CHAIR

As the average tenure of department chairs grows shorter and the opportunities after being a chair expand, the question of life after being a department chair becomes more common. Family medicine departments are beginning to see the second generation of family physician leaders, often the first ones to have experienced residency training in family medicine, begin to "step through." At a recent session of the Association of Departments of Family Medicine, 3 transitioning chairs spoke of their decisions and motivations for this change. Several developmental tasks were described: deciding when it's time for a change, determining the right time to announce and transition, recognizing what is lost and gained, and deciding what to do next.

Time for a Change

"I found myself slouching more in department chair meetings."

In the recently published AAMC book *Leading* by Mallon and Grigsby,[1] the authors include a self-assessment for incumbent department chairs[2] that asks one how commonly she/he demonstrates leadership behaviors such as showing enthusiasm, working without resentment, dealing with conflict, delegating to others, giving praise, and supporting organizational goals. This form of self-reflection can also come from other sources such as consulting with colleagues or family members, working with a coach, journaling, or mindfulness training.[1] Competencies specific to chairs of departments of family medicine[1] include a series of subcompetencies in personal development relevant to knowing when it is time to step through.

Determining the Right Time

"I would like things to be stable so I can hand off the ball rather than drop it."

It may be hard to find the right time to transition. The challenges of academic medicine and the changes demanded of family medicine departments have never been greater. Once a decision has been made, when does one announce? Most agree one's boss, the dean, should know first in order to help plan succession. In fact, competencies for chairs of departments of family medicine[1] include how to optimally manage leadership transitions, including between a chair and dean or other boss. But when should those inside and outside the department find out? A "lame duck" chair may not be effective in a department or medical school filled with divisiveness. Should one set a stop date to push the search process or should an interim chair be recommended?[3,4] If there is no appointment by the stop date, is this an opportunity to negotiate an extension? Have we done our work to plan for succession, not only for an emergency but also for the long term? Are circumstances right to enable a large investment in the department by obtaining new leadership?

Recognizing What is Gained and What is Lost

"I don't have to go to the gym at 5am" vs "I will miss the relationships with the faculty."

Trying to anticipate what will change and then trying it on to see what it will feel like is probably a helpful

exercise. The successful department chair has made a great commitment to this role and her/his department. Changes in role have implications; many will be perceived as losses. There will likely also be a significant reduction in income. The transitioning chair should be as prepared as possible to deal with these changes in a realistic and proactive way. This assessment may also help in deciding next steps.

Deciding What to do Next

"It's important to find something that will get you up at 4 am." There are many variations in next steps and hopefully these will emerge from the self-reflection process. Some chairs wish to retire completely. Some may seek another administrative challenge such as becoming a dean or a leader outside academic medicine. Others want to return to the faculty as clinicians, teachers, or scholars, contributing to the strength of the department as 'heartwood,'[5] just as the heartwood core of trees contribute to their structural strength. Cutting back to the things one loves most about one's job seems like the right combination. Appropriately those choices should also reflect the needs of the department and will be appreciated by the new department chair. No former chairs desire or should make life miserable for their successor.

Stepping through is an important developmental task in the life of a department chair and the history of a department. Done well it can be an incredibly helpful milestone for both the individual and the department. Those of us in family medicine should learn from each other and from our colleagues outside our discipline to best prepare for this process.

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AFMRD Association of Family Medicine Residency Directors

From the Association of Family Medicine Residency Directors

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IN PURSUIT OF 1,650

Many words can be used to describe the work that a family medicine residency program director does during a typical day: teacher, administrator, counselor, coach, cheerleader, and, of course, tabulator of patient encounters. Of the visits a program director counts, perhaps none is more famous than the 1,650 continuity patient encounters required in the family medicine practice site before a resident may graduate. Many a program director has wondered if evidence exists that 1,650 patient visits is the best marker for knowing a potential graduate has achieved adequate experience in ambulatory care during residency.

At the simplest level, the requirement for 1,650 patient visits can be viewed as an arithmetic calculation based upon the concept that experience will lead to expertise. Assume that residents progress in both number of sessions in the office and number of patients per session throughout residency and also assume that residents see patients for 44 weeks per year to allow for vacation or away rotation. The calculation is simply:

$$(1 \text{ session per week} \times 3 \text{ patients per session} \times 44 \text{ weeks per year}) +$$
$$(3 \text{ sessions per week} \times 4 \text{ patients per session} \times 44 \text{ weeks per year}) +$$
$$(4 \text{ sessions per week} \times 6 \text{ patients per session} \times 44 \text{ weeks per year}) = 1{,}716$$

The ACGME Program Requirements exist to set minimum standards of education, thus, the 1,650 requirement is best understood as a baseline to ensure that the resident has appropriate patient volume and frequency of sessions.

A literature review reveals no studies that suggest a count of 1,650 patient visits confers the competence to practice ambulatory family medicine. Perhaps 1 resident is prepared for ambulatory practice after only 1,200 visits while another will require over 2,000. Determining competence is a much more nuanced process, requiring frequent observations of the resident. Feedback about performance of component skills as well as the integration of skills into a global whole rather than simply completion of a number of visits. A count of experiences cannot be an adequate substitute for thorough, frequent observations when the goal is determining competence.