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.

Steven Zweig, Chris Matson, Mike Magill, Tom Campbell, Ardis Davis

References

1. Mallon WT, Grigsby RK. *Leading*. Washington, DC: American Association of Medical Colleges; 2016.
2. Gmelch WH, Miskin VD. *Department Chair Leadership Skills*. 2nd ed. Madison, WI: Atwood Publishing; 2011.
3. Quillen DA, Aber RC, Grigsby RK. Interim department chairs in academic medicine. *Am J Med*. 2009;122(10):963-968.
4. ADFM has a process to counsel potential interim chairs, even before they accept the job from the dean. Call ADFM for a referral.
5. Spinelli WM. Turning physicians into "Heartwood". *Mayo Clin Proc*. 2015;90(9):1176-1179.

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.

The requirement of 1,650 patient encounters should not be dismissed as being without worth, however. Competency-based assessments are still very much in fledgling form, with educators striving to understand how to capture the data necessary for such evaluations in a manner that is accurate, reproducible, and doable. Competence requires experience so that a learner may begin to appreciate the common and not-so-common presentations of disease. The 1,650 requirement provides a surrogate marker of adequate experience to allow residency educators to begin to make an in-depth assessment of competence once adequate experience has been attained.

In our zeal to pursue competency-based assessments, it would be a grave mistake to discard all requirements based upon experience. In order to appreciate the breadth of family medicine, a resident must see a variety of patients. One does not learn all there is to know about diabetes from seeing 1 patient with diabetes. Adequate experience is key to ensuring an appreciation of the varied presentations of health and disease in patients across the spectrum of age and condition. An appreciation of the subtleties of the art of medicine cannot develop after seeing only a single example of pathology.

It would be a similarly serious error to consider the completion of 1,650 patient visits to be the sole indicator that a resident is prepared to enter practice. We ask our graduates to take on responsibility for patients, families, and communities with outstanding skills in diagnosis and treatment of disease as well as proficiency in communication, interpersonal skills, and systems-based practice. It is not enough to deem them competent after seeing a specified number of patients when what we ask of them is that they appreciate the complexity and context of each individual who presents with a given diagnosis and attend to their unique experience of health and disease in a continuous trusting relationship. A simple number can never tell us if they are prepared to undertake this critical and complex task.

Seeing 1,650 patients is a necessary but incomplete picture of a resident's preparedness to embark upon unsupervised ambulatory practice. One thousand, six hundred and fifty patient visits provide experience in which the resident can develop competence in the art of medicine. Only when experience is coupled with careful assessments of competency performed by faculty and program directors can we ensure our graduates are truly prepared for the task they undertake as family physicians.

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From the North American Primary Care Research Group

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DISSEMINATION AND IMPLEMENTATION RESEARCH IN PRIMARY CARE PRACTICE-BASED RESEARCH NETWORKS

2016 PBRN Conference Highlights

The 2016 NAPCRG Practice-Based Research Network (PBRN) Conference brought together the energy of 196 participants from the United States, Canada, and the United Kingdom in Bethesda, Maryland on July 11-12, 2016. Conference co-chairs Rowena Dolor and L. J. Fagnan provided the welcome and orientation for this AHRQ-sponsored conference.

Rebecca Roper MS, MPH, lead scientist for the PBRN initiative at the Agency for Healthcare Research and Quality (AHRQ), gave a short overview of the centers (P30s) and the new certificate program for practice-based research methods (PBRMs). In its inaugural year (September 2015-July 2016), 16 fellows graduated from this program. For the second year, there are 54 fellows (46 mentors) from the United States and Canada enrolled. A 2-day convocation sponsored by AHRQ was held prior to the PBRN conference to evaluate the PBRM certificate program and potential modifications for the upcoming year. Roper thanked the course co-directors, James Werner, PhD, and Lyle J. Fagnan, MD, for their leadership.

Arlene Bierman, MD, Director of AHRQ's Center for Evidence and Practice Improvement, highlighted AHRQ's primary care areas of interest and achievements produced by PBRNs. She also shared some practical tools for ambulatory care clinicians, composed of a suite of point-of-care resources for the clinician team and researchers. AHRQ recognizes the critical role that PBRNs have played in creating and sustaining the viability of these tools.

Josh Tepper, MD, MPH, MBA, delivered the first plenary on "Getting to 'Better' in Ontario's Primary Care System," where he described Ontario, Canada's framework for quality and its application to primary care, the role of large scale data and reporting efforts, and the use of quality improvement (QI) plans and capacity building in QI to help improve care.

The second plenary started with the patient perspective of Vincent Dumez, MSc, on his journey developing the patient and professional partnership for primary health care collaborations. His talk was supplemented by the physician-research perspective from Antoine Boivin, MD, PhD, from Montreal, Canada.