



From the Association of
Departments of Family Medicine

FAMILY MEDICINE RESIDENCY AND ACADEMIC MEDICAL CENTER

Many academic medical centers are under siege as Medicare reimbursement and state support decline. Family medicine departments are not immune from these pressures and are being forced to restructure and reevaluate their priorities and programs. Although these changes are painful, they provide an opportunity to craft new programs that build on the strengths of the old. The story that follows describes the saga of one department in crafting a new combined residency in the face of severe budget shortfalls

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The UCLA Experience

In 1994 UCLA purchased Santa Monica Hospital, a 75-year-old community hospital experiencing severe financial problems. Located 4 miles west of the UCLA Medical Center, it had sponsored a well-regarded "unopposed" family medicine program for 25 years. At the time, UCLA was stable financially with respectable operating margins despite a most competitive market.

By mid-1999, UCLA faced serious operating deficits. The provost-dean made it clear that he could no longer support a subsidy of \$4 million for 2 separate family medicine programs 4 miles apart. We were advised to either close 1 program or merge and downsize them.

The UCLA faculty was torn. They had begun at an off-campus center located above a fish market, gaining respectability when they moved to the new on-campus building in 1990, where they developed a robust practice serving university employees. Four miles away, the Santa Monica group believed that the unopposed community model was the best to train family physicians. Clearly, we had 2 different cultures.

The medical students had a different perspective. In focus groups with UCLA senior medical students, we learned that 70% thought a move off campus would be positive; 30% were uncertain; none were opposed. (The UCLA program had not matched a UCLA medical student in the previous 8 years, so the students and faculty had different responses.)

Several UCLA family medicine residents told us that many campus-based inpatient rotations had excellent teaching, but not all were relevant to family medi-

cine. For instance, the intensive care unit experience was primarily involved in taking care of sick liver transplant patients, whereas the pediatric ward was disproportionately populated by children with rare genetic diseases and neoplasms.

Cognizant of the Institute of Medicine's definition that primary care be in the "context of the community" and aware of the Kerr White and Larry Green ecology of medical care models,^{1,2} we developed a hybrid model that focused on the broader community, not just the hospitalized patient.

During the past 2 years we merged the 2 rival UCLA programs of 24 each into 1 smaller program of 36 residents. This new program has a community track based at our Santa Monica center and an urban underserved track based at a county office. Our teaching clinic on campus was reduced by two thirds to allow for a small faculty practice; the remaining space was allotted to the liver transplant service for a posttransplant clinic.

All residents will rotate through the core 25-month curriculum, involving 3 UCLA teaching hospitals, including Santa Monica. Our goal is to utilize the teaching resources of the large teaching hospitals for the early rotations, then move into the less structured community hospital. Our family medicine inpatient service will be at Santa Monica/UCLA.

This 2-year journey has been made difficult by an inherent clash of cultures. These conflicts will ease when the residents from the original separate programs graduate. The merger has been positive from a student perspective; we have now matched UCLA students, including underrepresented minority students. Furthermore, the number of UCLA medical students who chose family medicine increased more than 20%, counter to the national trend.

Despite consolidation, budget concerns remain. California faces a deficit exceeding \$30 billion, and 2.5 million uninsured persons in Los Angeles County lack access to health care. Both factors have an impact on UCLA and its public support. Family medicine will survive as a relevant discipline at UCLA only if we can address unmet needs, such as a population-based approach to primary care for the epidemic of chronic diseases. In doing so, we will attract some of the best and brightest residents regardless of our location. That is the local ecology of family medicine in Los Angeles.

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References

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2. Green LA, Fryer GE. The ecology of medical care revisited. *N Engl J Med* 2001;344:2021-2025.