

# **Ten Year Follow Up of a Psychiatry Residency Program Merger**

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The authors would like to thank Maj. Matthew D. Faubion MD USAF, MC, and Lt. Col. Catherine Bobenrieth MD USAF, MC. without their help this paper would not have been possible.

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The opinions expressed in this paper are solely the authors' and do not necessarily reflect that of the United States Air Force or the Department of Defense.

## Abstract

*Objective:* To report on the successful merger of a civilian and military psychiatry residency. *Methods:* The reasons for and the history of the merger between the University of Texas Health Science Center at San Antonio and Wilford Hall Air Force Medical Center psychiatry residencies is described. *Results:* After some false starts, a bottom-up approach was implemented by first merging seminars, then rotations. *Conclusions:* Combining two psychiatry residencies in order to capitalize on both their strengths can yield a product even greater than the sum of their two programs and the key to a lasting merger is to start with two independently successful programs with different and complementary strengths.

Word Count:

Key Words: merger, psychiatry residency

## INTRODUCTION

Mergers have become a part of the corporate world. Mega-mergers and smaller mergers occur, with some lasting years and some dissolving rather quickly. Financial interests seem to drive these mergers (1-3, 6).

In medicine, mergers have been occurring with increasing frequency during the last two decades. Managed care systems and hospital systems merge for financial gain, to corner larger shares of the market, and to provide a broader range of services (4,6).

This trend has also been occurring within Psychiatric Education, particularly in psychiatric residency programs. During the last fifteen years, a number of mergers between residency programs have been planned, with some of these proceeding (5). A small number have managed to last and become stable. Reasons for merging include development of stronger and more diverse programs, financial advantages in consolidation of leadership and administrative positions, making accommodation for new regulations (such as the 80-hour duty limits) easier to meet, making programs more flexible if a resident needs a leave of absence due to medical illness, pregnancy or family concerns, and making programs which have more strength against the vicissitudes of current regulations and economics.

This paper discusses a merger between the Wilford Hall Air Force Medical Center Psychiatry Residency Program (Wilford Hall) and the University of Texas Health Science Center at San Antonio Department of Psychiatry Residency Education Program (UTHSCSA). Discussion includes reasons for the merger, process of merging, advantages and disadvantages of the merger, and current and future prospects.

## WILFORD HALL MEDICAL CENTER PSYCHIATRY PROGRAM

The military began considering the idea of military medical residencies towards the end of World War II. Many of the nation's top medical specialists were brought into the military during and soon after the war. The military became concerned about recruitment of physicians into the service. In 1946, Col. Floyd Wergeland proposed the idea of establishing resident training programs. The idea was implemented by Col. Raymond Duke, Director of Education and Training at the Office of the Surgeon General (7), in the late 1940s.

Military residencies in general offer unique training opportunities because of the mission to provide optimal medical care to the troops and their families. Psychiatry in the military, in particular, offers distinctive experiences. In addition to education, training, research and patient care, an Air Force psychiatrist must also be knowledgeable about military specific requirements such as flight status and deployments to austere locations.

Wilford Hall Medical Center (WHMC) was founded November 16, 1957 and is the flagship hospital of Air Force Medicine. With a staff of 4,500 and a maximum bed capacity of over 1,000 in wartime, it is one of the Air Force's largest medical facilities(8).The Psychiatry Residency Program at WHMC, approved by the Air Force in 1962, actually began in 1967 with six residents in its first year of ACGME accreditation(9). WHMC has the largest inpatient psychiatry unit in the Air Force (8). It is common to have patients with first break psychosis, Post Traumatic Stress Disorder (PTSD) and aeromedical evacuation patients from all over the world. The depth and breadth of types of patients, including new onset psychosis, provided an exceptional experience for the medical students and residents. The program developed an acclaimed Consultation-Liaison Service and offered distinctive forensic psychiatry experiences, with requests for Sanity Boards and Fitness-for-Duty Evaluations. The Psychology Department at WHMC had a robust health psychology program and a psychology internship training program, with a strong emphasis on Cognitive Behavioral Therapy modalities. Another unique aspect of Wilford Hall psychiatry was the Distinguished Visiting Professor (DVP) program. Psychiatrists and psychologists of national stature came to Wilford Hall annually for a several day stay, during which time they participated in formal presentations, extensive bedside teaching, case conferences, evening journal clubs, and individual one-on-one conferences.

The Air Force now typically has six residents per class in the merged UTHSCSA-WHMC program. The program has over 120 graduates, and a number of Wilford Hall graduates are now in positions of national prominence.

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO  
PSYCHIATRY PROGRAM

UTHSCSA Medical School began in 1967 with the acceptance of third and fourth year students. The psychiatry residency began in 1968 with four residents in the first year of the ACGME accredited program. During the 1970s the length of a psychiatry residency was increased from three to four years per ACGME requirements. The number of residents grew to six residents, and then eight during the early 1980s. During the remainder of the 1980s it grew to 12 residents per year. The Child and Adolescent Psychiatry Fellowship was appealing to the General Psychiatry residents since it often filled the fellowship with candidates from the General Psychiatry program.

The program was a community based program with inpatient rotations at the Audie L. Murphy Veterans Administration (VA) Hospital, which opened in 1974, and the Bexar County Hospital. Outpatient rotations included the VA Clinic, the Bexar County Hospital Outpatient Clinic, and the Mental Health-Mental Retardation Center. Consultation-Liaison rotations were at the VA and County Hospitals. Child Psychiatry rotations were at a child guidance clinic and a children's psychiatric hospital. During the 1970s and early 1980s, the residency had a strong inpatient orientation, as did most residency programs. In the late 1980s the emphasis of the program was shifted towards an outpatient-oriented program. The program kept pace with the increasing requirements

for specific rotations such as substance abuse, geriatrics, emergency psychiatry, and forensic psychiatry.

The program leadership has been viewed as quite stable with three Residency Education Directors in over 40 years—the first for five years, the second for 12 years, and the third for 25 years. The psychiatry faculty grew from four physicians initially to more than eighty in the merged program. There are more than two dozen psychologists involved in psychiatry residency education.

As the Psychiatry Residency program grew, a Psychology Internship program was started, followed by a Child and Adolescent Psychiatry Fellowship, Geriatric Psychiatry Fellowship, Addiction Psychiatry Fellowship, and five non-ACGME approved fellowships in psychopharmacologic research, mood disorders, thought disorders, psychiatric genetics, and brain imaging.

## ISSUES CONTRIBUTING TO A MERGER

The demise of most federally funded community mental health centers has seriously cut into funding for psychiatry residency training(6). There is a paucity of available funds for resident stipends, especially when part of the stipend is designated for education and psychiatry training. This limits the time available for residents and faculty to interact with non-patient care activities such as supervision and seminars.

Managed care entities, in an attempt to provide patient care at the least possible cost, has cut into educational time with residents. Increasing regulations, documentation, and oversight responsibilities have also led to reduced patient care and teaching time. As medical faculty are required to earn higher percentages of their salary seeing patients, there has been a decrement in the effective time available for teaching. In some areas, the financial requirements are so great and reimbursement so scarce that teaching becomes a few moments between patients, whether more is needed or not.

As hospitals, the traditional funding source for residents, have been dealing with decreased profits, increased regulations and increased public scrutiny, they have increasingly required resident stipends to be used primarily for patient care, and education as a secondary goal. These needs have led to the increasing use of “body count” systems to insure residents are seeing patients to help the hospital’s bottom line(4). Hospital and federal regulations increasingly cut education activities from the activities counted in the “body count.” This requires education to occur on the run or be paid for by other means. It is regrettable that pro-education hospitals are being driven to curtail education to keep the hospital afloat financially.

Currently programs are required to comply with the ACGME requirements for night call—no more often than every three nights, an eighty hour work week limit, no more than thirty continuous work hours, and ten hours off between duty periods. These new work hour limitations and a growing interest in maintaining work-life balance during



residency have led to the need for innovative approaches to provide adequate coverage in the event of medical or family leave absences (6). Larger programs feel resident absences less acutely. There is pressure to enlarge residency programs to moderate this effect; but increased funding to support this is not always readily available.

Since it is financially difficult to start new psychiatry residency programs, entities which desire to have residents in their institutions to provide patient care and/or education occasionally have to rely on non-hospital paid stipends. These then add to programs having to increase their size.

Programs may merge to provide clinical experiences which may not otherwise be available. The key to a lasting union is two very different and independently successful programs complementing each other. This offers improved clinical and educational experiences to the psychiatry residents. The UTHSCSA program was strongly based at a county hospital and a (Veterans Administration) VA hospital, which provided a patient population which was both indigent and employed and acutely and chronically mentally ill. The WHMC program was based on a strong government organized managed care system which provided an insured neurotic population as well as uniquely military pathologies. Improved rotations in forensics, CBT, (cognitive behavioral therapy), and Consultation-Liaison were attractive to UTHSCSA. For WHMC, stronger rotations in community psychiatry, child and adolescent psychiatry, county hospital Consultation-Liaison psychiatry, and substance abuse were now readily attainable. Combining two

residency faculties made seminar teaching more diverse and richer by having more expert individuals teaching and co-teaching.

The 1991 Persian Gulf War had an impact on psychiatric resident education at Wilford Hall. Psychiatry faculty were deployed to the war zone, reducing available faculty for education and supervision at Wilford Hall. Meeting clinical needs and providing education seriously stretched the non-deployed faculty. The retention of faculty was impacted, partly due to possible future deployment or from increasing work demands as part of reduced staffing at WHMC. By the mid 1990s the possibility of a merger as a way to address some of these concerns was quite attractive to the Air Force.

#### ATTEMPTS AT MERGING

During the early 1990s, two attempts were made at merging the Wilford Hall and UTHSCSA psychiatry programs. Each time the two Residency Education Directors (REDs), the Wilford Hall Chief of Psychiatry, and the UTHSCSA Department of Psychiatry Chairman agreed that a merger would be beneficial and should be pursued. Each time the Hospital Commander and the Medical School Dean agreed with the concept, and further discussions were planned. When the REDs, Chief, and Chair met with the attorneys of the two institutions, things stalled. The legal impediments which were encountered were so great that the process was stopped under the weight of legal

restrictions. It was not possible to make a dent in these issues, so a merger twice fell by the wayside.

## A SUCCESSFUL MERGER

In early 1996, Sidney Weissman, MD was a Distinguished Visiting Professor at Wilford Hall and at UTHSCSA a Psychiatry Grand Rounds speaker. After meeting with each RED individually and hearing the same story and frustration about failed mergers, he brokered a meeting with the two REDs. Rather than a top-down merger, he suggested that the REDs should merge through a bottom-up approach. The REDs continued meeting through early spring, reviewed ACGME requirements and guidelines, and completed appropriate Letters of Agreement and Teaching Memoranda of Understanding.

The REDs formed an Executive Committee of select faculty from both programs and began to design a combined residency program. The intent was to design a program where all residents, irrespective of funding source, would have the same schedule for the four years of their psychiatry residency training.

When the academic year 1996-97 began in July 1996, the Wilford Hall residents, all funded by the Air Force, were assigned to approved rotations at Wilford Hall and UTHSCSA. Similarly, the UTHSSA residents, predominantly paid by the VA hospital

and the county hospital, were assigned rotations at UTHSCSA and Wilford Hall. As the residents from each program adjusted to the schedule, going to previously unknown sites at Wilford Hall and UTHSCSA proved positive for the faculty at the sites and for the residents who made new friends as well as experienced new rotations.

The seminar schedule was similarly adjusted. The topics remained largely the same, but civilian and military faculty were scheduled as co-teachers whenever possible. This helped convey the idea that the programs and faculties were working together for the residents' clinical and seminar education. Over the first several months, the residents began mixing together rather than having the civilian residents on one side of the seminar room and the military residents on the other.

After six months it was apparent that the sharing of clinical sites and seminar teaching was proceeding successfully. The residents from both sites were generally positive about the shared experiences. It was clear that two separate residency programs could share sites and responsibilities in a successful manner. The Wilford Hall Chief of Psychiatry and the UTHSCSA Department Chairman agreed that the REDs should plan toward a single combined residency program. Attorneys were asked to assist in the process as needed.

The ACGME was advised of the desire of the Wilford Hall and UTHSCSA programs to voluntarily ask for de-accreditation of each individual program and to apply for a single merged program. The Psychiatry Residency Review Committee (RRC) helped the REDs

plan the most efficient way to accomplish this. The RRC set an external accreditation review date of 1 July 97. At that time the Wilford Hall RED gave a letter to the RRC asking for voluntary de-accreditation of the Wilford Hall program. The review evaluated a PIF of the combined programs and indicated that, following ACGME guidelines, the program name was UTHSCSA-Wilford Hall Psychiatry Residency Program, with the civilian RED as the new RED and the military RED as the Deputy RED.

After a six month wait, the new program received notice that it was approved as a single residency program with the designated name. Five year accreditation was given with no citations, evidencing careful preparation of the Program Information Form (PIF).

The resident complement was determined by the RRC by adding the resident complements of each previous program. The complement of seventy-eight residents has never been reached, with the residents usually numbering about sixty. Each resident class usually has six military paid residents and ten civilian paid residents.

#### TEN YEAR FOLLOW UP

After ten years the psychiatry residency program remains strong and merged. Despite the military RED being told that the civilian world was impossible to deal with and the civilian RED being told the inverse, the working relationship is strong. Other programs at the institutions have merged to varying degrees, with a few continuing to do well.

With the positive history of the General Psychiatry merger, a Forensic Psychiatry Fellowship was started with teaching sites, faculty, and stipends from both Wilford Hall and UTHSCSA.

The structure of the residency has become as stable as training programs can manage.

Rotations are the same for each resident, despite funding source, with three exceptions:

1. primary care and inpatient neurology for the military residents occur at Wilford Hall, and those rotations for the civilian paid residents occur at the county hospital and the VA hospital;
2. in the third year continuity-of-care experiences, military paid residents spent two-thirds of their time at Wilford Hall and one-third at the civilian sites, while civilian paid residents spent two-thirds of their time in the civilian sites and one-third at Wilford Hall;
- and 3. military residents did their fourth year four month administrative rotation most often at Wilford Hall, while the civilian paid residents usually spent this time at the VA hospital and the county hospital. The time spent by the military residents at Wilford Hall enabled them to learn about some military specific aspects of psychiatry such as disability and fitness for duty evaluations, flight medicine issues involving psychiatry, and psychiatric issues encountered during deployment.

## OBSERVATIONS AND SURPRISES

1. The original plan was to have the Chief of Psychiatry at Wilford Hall and the

Department Chair at UTHSCSA determine who would be the RED and Deputy RED. This would be done by alternating the titles, or choosing a senior person, etc. However, the ACGME requirement of the civilian RED being the lead RED has proven wise for our program, with the civilian RED remaining for the 10 years of the merger. There has been a succession of four military REDs, each expecting to stay for five years, but averaging only two and one-half years due to a variety of circumstances.

2. If the REDs of two programs like and respect each other and share a common vision, the likelihood of a merger, and a lasting union, are greatly increased. Beginning a merger with executives and attorneys, who have little buy into the success of the mission and who are not well enough acquainted to not be suspicious of the other side, makes merging difficult if not impossible.
3. When residents perceive the education as excellent, faculty at all sites feel appreciated and listened to, and training office personnel (both physician and administrative) like and respect each other, the merger remains strong.
4. When the RED, Deputy RED, and the Associate REDs see all residents, irrespective of funding source, as their responsibility, the program cohesiveness is strong and keeps the unified program intact and functioning.
5. We have been pleasantly surprised that the military residency applicants see

the combination of military/civilian sites and rotations, as well as more diverse faculty, a drawing point to the program. Similarly, the connection to the Air Force, the best functioning managed care system in the world, is a positive recruitment item for civilian applicants. Having a program which is one-third military and one-third county hospital and community psychiatry has been a positive in recruiting for psychiatry.

6. To accommodate the presentation of military specific lectures, those lectures were scheduled as required obligations for all military residents, regardless of which site, as well as for civilian residents on any rotation at Wilford Hall. These are given at the beginning of the Thursday afternoon Psychotherapy Clinic time. This has lengthened the psychotherapy hours to late afternoon and evening. Civilian residents are interested in the military specific lectures, but no civilian resident has accepted the opportunity to participate in the required military camping and firearm activities.
7. The exposure of the civilian residents to the military has resulted in three individuals joining the Air Force during the residency program, with military assignments starting after completion of residency.

## CONCLUSION



Mergers between two large systems can be a tenuous even under the best of circumstances. Much of the success with the merger between UTHSCSA and WHMC was because they were two very different programs. The impetus for many mergers are to take two failing programs that have similar weaknesses and create a larger program. This often leads to one large program that has the same problems that each had prior to the merger. Often times this will double the problems of the merged program, but not necessarily improve the merged program as a whole.

When UTHSCSA and WHMC merged, they were both very strong programs that were able to stand very well on their own. However, there were some prominent weaknesses that each had that limited their abilities to grow. Prior to the merger, UTHSCSA's weaknesses were having difficulty attracting some of the best residents, having difficulty finding staff to teach lectures, and having trouble finding enough residents to fill all the sites that were paying for residents' salaries. The UTHSCSA faculty were experienced and well seasoned, but there were not many young faculty. WHMC on the other hand, had young and energetic faculty who enjoyed teaching many of the basic psychiatry residency lectures. They attracted very competitive residents through the Armed Forces Health Professions Scholarship Program, and all the residents were fully salaried by the military. Some of the weaknesses of WHMC included that they had too few faculty to supervise all their residents and the residents needed more attending time. WHMC also lacked the breadth of experience, and residents needed to see sicker and indigent patients.

Combining the two programs enabled WHMC to give their enthusiastic and bright residents experience in civilian university sites with more senior faculty, brought more young and energetic attendings to the residency program, and improved the amount and quality of teachers available for the lecture series. The merger gave the Air Force the needed stability to survive faculty deployments without jeopardizing the residency program. For the University, the merger enabled it to give the civilian residents a broader patient experience with younger, insured and often higher functioning patients. It also expanded the clinical teaching and exposed them to new faculty and residents.

As can be seen, the merging of two stable programs to expand the educational and clinical experience was positive for both UTHSCSA and WHMC. Over ten years after the merger occurred, the combined program is significantly stronger than either program was individually. It would have been a much more daunting task if either of the programs had been struggling. Much of the success of the merger is also due to the people that instituted the merger and the reasons why it was done. The Residency Training Directors of the two programs created the merger to make a better overall residency program, not to save two programs that were doing poorly. The Training Directors decided that the programs were going to be merged; that trickled down to all the residents and staff—who also believed it. It has made the combined program a wonderful environment for residents, faculty, and staff. And as such education and patient care have been markedly improved.

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