The authors describe how a small and relatively low-functioning psychiatric teaching program at a Department of Veterans Affairs (VA) medical center was transformed over a 6-year period into an active and well-functioning program for both medical students and residents. Steps were taken to address trainees' negative perceptions about VA patients and faculty, recruit and support an education-oriented staff, and improve the "user-friendliness" of the system. Efforts were made to integrate education into the missions of a variety of clinical and research programs while emphasizing the convergence of trends in the field of psychiatry with the VA experience. Data are presented indicating improvements in student and resident evaluations. Training was significantly expanded on inpatient units, chemical dependence units, a research unit, and an outpatient clinic. The authors offer suggestions that may be helpful to those developing psychiatric education at other academically affiliated VA medical centers. (Academic Psychiatry 1996; 20:56-63)

Education is one of the specific mandates of the Department of Veterans Affairs' (VA) hospital system. Nationwide, the VA is a major provider of graduate and postgraduate medical education, with over 130 VA hospitals affiliated with medical schools. The VA supports over 14% of all U.S. psychiatry residency slots (1,2). Our service is affiliated with the Department of Psychiatry at the University of Texas Southwestern Medical School at Dallas in a relationship similar to major partnerships between medical schools and approximately 35 full-service, tertiary-care VA medical centers nationwide. Given the magnitude of the VA's role in psychiatric training, relatively little has been written about developing psychiatric education programs at VA medical centers. We describe the transformation of our VA psychiatry service into an active teaching program, and we suggest ways others can use our experience to improve the teaching capabilities of their VA services.

In 1987, our VA service served as an inpatient training site for 3 third-year medical students and 3 second-year psychiatry residents. Six VA faculty psychiatrists participated in teaching on the inpatient ward but had limited involvement in lectures, seminars, or the medical school's education policy and administration. At that time, planning for educational improvements began. The authors, using their multiple roles...
As VA clinicians, academic faculty, educators, and medical administrators, focused on five major areas of concern discussed in the sections to follow. A process of problem identification, development of possible solutions, plan implementation, and results will be described.

ADDRESSING NEGATIVE PERCEPTIONS

At the beginning of the improvement process, the students and residents expressed concerns that psychiatric diagnoses at the VA are seldom seen in "pure" form. In 1987–1988 approximately half of the narrative feedback forms returned by the students and residents included some complaint that VA patients were too old and medically ill, had excessive substance abuse comorbidity, or lacked the social support to be "good teaching cases." The residents often unfavorably compared the VA patient mix with the carefully screened cases they had seen at a private hospital rotation. The themes of the complaints were that VA patients were too complicated, hopeless, and dangerous to engage in treatment. Therefore, we got the impression that the trainees perceived that faculty working with such "hopeless" cases could not be of high caliber.

Having identified a perception problem, we met with our faculty to examine the validity of the feedback. It was clear that many perceptions about VA patients and faculty were distorted or bordered on negative stereotypes. The faculty concluded that these misperceptions derived from trainees' lack of appreciation for the potential rewards of working with chronically mentally ill patients, therapeutic nihilism related to inexperience, or unexamined countertransferential feelings. We believed that such misperceptions would be highly amenable to educational enlightenment.

As a first step in changing resident attitudes, our staff physicians had to examine their own attitudes and abilities. The staff examined the extent to which they were conveying negative feelings about difficult patients. In many cases, it was clear that faculty were not communicating the rewards that come from ongoing therapeutic relationships with chronically mentally ill veterans. We discovered that some faculty had accepted the idea that the only "good teaching cases" were those with pure nonsubstance abuse disorders, although such cases were rarely found in our patient population. In the staff discussions that ensued, these distortions were recognized. The staff acknowledged that they had developed skills in managing difficult cases that required a combination of treatment approaches. They resolved to communicate the message that every case, given the appropriate supervision, can be a good teaching experience.

Having recognized their expertise in conceptualizing treatment models for complicated cases, our VA faculty chose to emphasize the value of training with a challenging population. The management of difficult and complicated patients became a focus of our teaching program. An important step in this process was developing specific written training objectives and methodologies. In objective planning sessions, our faculty focused on developing the trainees' competence in addressing chronic severe mental illness, psychiatric comorbidity with chemical addiction, trauma-related emotional disorders, geropsychiatry, and aggression management. A formal "hands-on" training module for managing psychiatric emergencies on the wards was established as part of the orientation for the students and residents. As a result of this training, the trainees enter the wards prepared to safely run an aggression crisis code and are less anxious about their VA inpatient experience.

To further address the perception problem, our faculty met with groups of residents to let them express their attitudes about working with VA patients. The residents often raised issues related to the patients' social class, compensation seeking, and sub-