But when Mrs. A. answers my question why, she doesn't mention teaching material or guinea pigs. She doesn't dread amateurish invasions of her privacy or the frustration of answering the same questions again and again. She doesn't allude to dark rumors about unsupervised residents run amok. She talks about her late husband's final hospitalization at another academic center. There, she heard often about Mr. A.'s team of doctors, but she never saw them all together. When an intern or student or senior physician popped in, he or she usually came alone and was always in a hurry. Mrs. A. couldn't tell whether they talked to each other because often one didn't know what another one did. And each time her husband needed help at night, a different stranger came.

An audio interview with Dr. Reilly is available at NEJM.org

I transfer Mrs. A. to the nonteaching service, wishing her well. I don't tell her how my team conducts itself here, so differently from what she saw elsewhere. My residents and I will go off service tomorrow, our 4-week rotation over, and I can't promise that the new team will run their show as we run ours. Nor can I promise that the nonteaching service will satisfy her more. After all, her aversion to the teaching service has nothing to do with teaching.

But tomorrow, other patients will ask more pointed questions. Having embraced patient-centeredness with gusto, they'll want to know how clinical teaching benefits them. How should I answer? Will I say that clinical teaching, like its subject matter, is more art than science (and thus lacks gravitas in academic centers today)? Will I admit that this art dances to different drummers (no two teachers teach alike) refereed by recondite rules (no one teacher inarguably better or worse than another)? Will I claim that these are strengths, not weaknesses, and that effective clinical teaching is all about listening (hard to measure), adaptability (hard to judge), and impromptu exploitation of "teachable moments" (hard to plan)?[5] And after we've had our mature dialogue, will these patients buy my assertions? Or will my customers be a hard sell?

Learning hospitals would do well to learn more about these things.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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Restoring Trust in VA Health Care

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It has been nearly 20 years since the Veterans Health Administration (VHA), the subcabinet agency that oversees the Department of Veterans Affairs (VA) health care system, implemented a series of sweeping reforms that markedly improved quality, boosted access, and increased efficiency.[1,2] Recent revelations about long wait times for veterans compounded by systematic coverup by VHA administrators make it clear that reforms are again needed. Apparent manipulation and falsification of wait-time data at more than 40 facilities indicate a serious systemic problem.

To some observers, the VA's problems confirm that government cannot manage health care. To others, they tell a simple story of insufficient funding: the VA needs more money to care for the large number of veterans returning from the wars in Iraq and Afghanistan and for aging Vietnam veterans. Unfortunately, neither narrative adequately captures the challenges facing this organization or provides guidance on how we might address them.

Inadequate numbers of primary care providers, aged facilities, overly complicated scheduling processes, and other difficult challenges have thwarted the VA's efforts to meet soaring demand for services. For years, it has been

no secret that the VA's front lines of care delivery are understaffed for the needs. And though there can be no excuse for falsifying data, we believe that VA leadership created a toxic milieu when they imposed an unrealistic performance standard and placed high priority on meeting it in the face of these difficult challenges. They further compounded the situation by using a severely flawed wait-time–monitoring system and expressing a "no excuses" management attitude.

Without diminishing the seriousness of the problems of data manipulation and prolonged wait times, we would argue that these are symptoms of deeper pathology. Quite simply, the VA has lost sight of its primary mission of providing timely access to consistently high-quality care. Although it has garnered less attention than the wait-time problems, a disturbing pattern of increasingly uneven quality of care has also evolved in recent years. To be sure, the quality of health care provided by VA hospitals is, on average, similar to or better than that in the private sector.[1-3] When VA hospitals are compared with top-tier integrated delivery systems, however, their quality advantage diminishes. Some VA hospitals excel, but others are struggling with the basics. The Phoenix VA Medical Center — ground zero of the wait-time scandal — has mortality rates for common conditions that are among the highest within the VA and higher than those in many private hospitals. Its rates of catheter-related bloodstream infections are nearly three times the national average.

After the VA gained a hard-won reputation for providing superior-quality care 15 years ago, how did cracks appear in its delivery of safe, effective, patient-centered care? We believe there are three main causes: an unfocused performance-measurement program, increasingly centralized control of care delivery and associated increased bureaucracy, and increasing organizational insularity.

How did cracks appear in the VA's delivery of safe, effective, patient-centered care? We believe there are three main causes: an unfocused performance-measurement program, increasingly centralized control of care delivery and associated increased bureaucracy, and increasing organizational insularity.

The performance-measurement program — a management tool for improving quality and increasing accountability that was introduced in the reforms of the late 1990s — has become bloated and unfocused.[4] Originally, approximately two dozen quality measures were used, all of which had substantial clinical credibility. Now there are hundreds of measures with varying degrees of clinical salience. The use of hundreds of measures for judging performance not only encourages gaming but also precludes focusing on, or even knowing, what's truly important.

In addition, the tenor of management has changed substantially over the past decade. During the reforms of the 1990s, decentralization of operational decision making was a core principle. Day-to-day responsibility for running the health care system was largely delegated to the local facility and regional-network managers within the context of clear performance goals, while central-office staff focused on setting strategic direction and holding the "field" accountable for improving performance. In recent years, there has been a shift to a more top-down style of management, whereby the central office has oversight of nearly every aspect of care delivery.[4] Concomitantly, the VHA's central-office staff has grown markedly — from about 800 in the late 1990s to nearly 11,000 in 2012.

Finally, the VA health care system has become increasingly insular and inward-looking. It now has little engagement with private-sector health care, and too often it has declined to make its performance data public. For example, it contributes only a small proportion of its data to the national public reporting program for hospitals, Hospital Compare, and has declined to participate in other public performance reporting forums such as the Leapfrog Group's efforts to assess patient safety.

So how can the VA turn the ship around? We propose a few first steps.

First, after ensuring that all

veterans on wait lists are screened and triaged for care, the VA should refocus its performance-management system on fewer measures that directly address what is most important to veteran patients and clinicians — especially outcome measures. The agency's recently developed Strategic Analytics for Improvement and Learning (SAIL) dashboard, which focuses on 28 meaningful metrics including access to care, mortality rates, infection rates, and patient satisfaction, is a good start that will improve with use and would help hold the VA accountable for results.

Second, conceptualizing access to care in terms of a "continuous healing relationship,"[5] the agency should design a new access strategy that draws on modern information and advanced communications technologies to facilitate caregiver–patient connectivity and that uses personalized care plans to address patients' individual access needs and preferences. Facility-by-facility assessments should determine whether VA facilities are using technology to leverage the best possible "care delivery return on investment" and whether personnel are working at the top of their skills. Perhaps some of the resources supporting the central and network office bureaucracies could be redirected to bolster the number of caregivers.

Third, we believe the VA needs to engage more with private-sector health care organizations and the general public — participating fully in performance-reporting initiatives, expanding learning-and-improvement partnerships with outside entities (as it did in the late 1990s in spearheading national patient-safety improvement efforts[1]), and making performance data broadly available. Transparency may expose vulnerabilities, but it is easier to improve when weaknesses are publicly acknowledged.

VA health care is at a crossroads. We learned from the last round of reforms that the VA's problems can be fixed. The agency continues to employ an army of highly dedicated clinicians and administrators who are deeply committed to providing high-quality care to veterans. New leadership should help them succeed.

The views expressed in this article are those of the authors and do not necessarily reflect those of the Department of Veterans Affairs.

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Improving Health Care for Veterans — A Watershed Moment for the VA

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On May 30, Eric Shinseki resigned as secretary of veterans affairs (VA), taking ultimate responsibility for the falsification of records of veterans' wait times for medical appointments. Two days earlier, an interim report by the VA's Office of Inspector General (OIG) had found that "significant delays in access to care negatively impacted the quality of care" at the Phoenix VA health care system and that "inappropriate scheduling practices are a systemic problem nationwide." An intense political and media spotlight remains focused on the VA during this election year. Will it engender improvements in care for veterans?

Health care is one of three