Professional control of 'practice': physicians and teachers

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At the book signing for Wy Spano and Virginia Gray, of all things, I'd run into George Halvorson from HealthPartners. I told him that Joe Graba and I are working on professional options for teachers, and said we'd be curious to know how that works in an organization like his (where the professionals (doctors) are employees, as in a school district. He said he'd set us up with Dr. George Isham, the chief health officer for HealthPartners. On March 29 Joe and I spent better than an hour with Dr. Isham, going through the professionals' role in decisions about 'practice'. The discussion was in fact full of implications for K-12 education. It went about as follows:

- Professional authority is of course the tradition in this institution. The training is university-based, followed by internship and residency in a specialty. Professional specialty boards admit a new doctor to practice. There is licensing, at the state level. There is an ethic of self-development; and a tradition of teaching others. For a long time physicians owned their practice; hiring nurses and others. Many clinics are still owned by physicians, in groups.

- Professionals control admission to practice in HealthPartners. We have two divisions. One is the Medical Group, which we have traditionally owned; the other is a set of clinics with which we contract. In our Medical Group the medical director, himself an M.D., approves new physicians. Who in practice much at the interviewing is done at the level of the medical-department.

- A doctor joining HealthPartners must also be 'admitted' to practice at every hospital s/he will use. At the hospital, too, admission to practice (and to 'staff privileges') is a responsibility of the medical staff at the hospital. We own one hospital — Regions Hospital, in downtown Saint Paul — and we buy hospital care from other community hospitals.

- Guidelines for practice are now developed through ICSI, the Institute tar Clinical System Improvement. This is a separate nonprofit corporation in which we participate along with the Mayo Clinic, HealthSystem Minnesota and perhaps soon other major health-care operators. It predates the Business Healthcare Action Group but has been strongly supported by the payers/buyers. Representatives of the payers participate on the ICSI board and in some of the work-groups; but ICSI is largely built out of physician, clinical experience. The work-groups look at practice; look for best practice; set down guidelines (protocols) for clinical practice.

- In our contract division the only thing different is that the 'hiring' is by the individual clinic. The decision to 'admit' is by the physicians in that clinic. This means that doctors have options. They can be in private practice; solo or in a single- or multi-specialty group, where they are owners. They can be employees; as in a clinic owned by a hospital (Fairview, for example) or in a medical group like HealthPartners.

- Physicians . . . professionals . . . also control the quality of practice. Education and training for the improvement of practice is a 'given' . Dealing with problems in practice is harder. Measurement is uncomfortable for everybody: Nobody likes to be compared. It is for doctors, too. It's possible only by associating it with the desire of professionals to improve their practice; with professionalism. It needs to be a 'team' activity. It needs to be kept separate from the personnel operation. Needs to be kept confidential. So in HealthPartners an administrator could not dismiss a doctor for

anything related to the doctor's professional work. For absence from work, yes; for embezzlement, say, or for other conduct not a part of professional work. But anything in the medical area would be a responsibility for our professional side. Graba: What about a case of sexual harassment? Isham: If it happened with another employee that would be handled by the administrative side; if with a patient, that would be handled by the professional side.

At the end — again, interested in parallels with public education — we had some discussion about how 'patients' become a part of the process. In education students are not often consulted about the 'treatment' to be provided: How is it in this organization? Isham: We have a Patient Education Group in HealthPartners. We find that the people our doctors work with fall into three groups. Some just want to be told what to do; what medicine to take, etc. pretty much as in the past. Another third do participate: work with the doctor with respect to what's-wrong, and help with treatment. About a third come in with printouts from the Internet and want to tell the doctor what they need. We do run focus groups with patients and members, asking how they feel about their ailment and their treatment, and we feed this information back to our doctors. The doctors are not wild about what might be called "market research" but they have learned some things from this activity.

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At the end, Dr. Isham mentioned that his wife is a teacher. So he has a sense for the different models we're talking about.

In medicine the professionals have traditionally been in charge; the administrators have worked for the doctors. Professional management appeared as clinics and hospitals got larger, but developed as a parallel structure alongside the professional leadership. Most areas we think of as professional have this dual structure of leadership . . . visible in Dr. Isham' s description of HealthPartners.

In districts and schools it is the other way 'round: The professionals have traditionally worked for administrators. There is a single structure of leadership: The assumption is that a single individual will be both administrative manager and instructional leader. In clinics and hospitals there is a chief administrator and there is a chief of the medical staff.

Joe and I asked if Dr. Isham would be willing to continue this discussion, perhaps with some teachers and teacher-union people thinking about professional roles for teachers. He said that, yes, he would enjoy that.

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