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**EXAMINER**

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**The Impact of Pay-for-Performance Beyond Quality Markers—A Call for Bioethics Research**

By David Satin, MD

What if your doctor's salary depended on whether you quit smoking, lost weight, and lowered your cholesterol? It already does. Pay-for-performance (P4P) models of physician reimbursement have been around in some parts of the country for more than 15 years. Medicare and Medicaid are about to adopt the strategy nation wide. Although the particulars of each payment scheme vary by insurer, P4P can be summed up as "the use of incentives to encourage and reinforce the delivery of evidence-based practices and health care system transformation that promote better outcomes as efficiently as possible."<sup>1</sup> That is, clinicians are paid more if their patients score well on a particular set of health care quality markers.

The past year has yielded an explosion of studies investigating the efficacy of P4P,<sup>2,3</sup> yet few have examined its safety or net effect. Evaluating the

adverse effects from the perspectives of disciplines such as ethics, psychology, sociology, economics, epidemiology, public health, and clinical medicine is exactly the kind of interdisciplinary research bioethicists ought to be doing. I propose the following research questions necessary to examine the safety and overall impact of P4P programs.

**RESEARCH QUESTION #1:**

**HOW DOES P4P AFFECT ACCESS TO HEALTH CARE?**

All forms of physician reimbursement can impact access to health care. For example, under capitation (fixed annual payment per patient), "both physicians and hospitals have been found to attempt to select healthier patients... to maximize net revenues."<sup>4</sup> Under our current fee-for-service model, "maximizing net revenues" increasingly involves

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**David Satin, MD – Faculty Profile**

Dr. Satin currently holds the positions of Post-Doctoral Fellow at the University of Minnesota's Center for Bioethics and Assistant Professor in the University's Department of Family Medicine and Community Health. He practices family medicine at Smiley's—a Family Medicine Clinic serving the inner-city Minneapolis community and its homeless. He completed his Family Medicine residency at the University of Minnesota, following a medical degree from the University of Western Ontario (Canada), a Robert Jones Scholarship in philosophy to the University of St. Andrews (Scotland), a philosophy degree from the University of Western Ontario and a health sciences degree from Marianopolis College in his home town of Montreal, Canada.



David Satin, MD

Dr. Satin has been the recipient of multiple clinical, teaching, and research awards including most recently: The Minnesota Academy of Family Practice Resident of the Year Award, The Society of Teachers of Family Medicine's Resident Teacher Award, The American Academy of Family Practice Award for Excellence in Postgraduate Medical Education, and The University of Western Ontario's first prize in Bioethics. As a medical student, Dr. Satin co-authored an ethics text in *Obstetrics and Gynecology*. During his medical residency, Dr. Satin was the primary investigator of an NIH grant investigating

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**PUBLICATIONS**

**Recent Faculty Publications**

**BOOK CHAPTERS**

**Elliott C.** Disillusioned Doctors. In Kenny N, Shelton W (eds.) *Lost Virtue: Professional Character Development and Medical Education*. Amsterdam: Elsevier, 2006.

**Tauer C.** Making Decisions About Genetic Testing. In Hamel R (ed.) *Making Health Care Decisions: A Catholic Guide*. Liguori, MO: Liguori Publications, 2006.

**ARTICLES**

**DeVries R, Elliott C.** Why Disclosure? *Journal of General Internal Medicine* 2006;21(9):1003.

Illes J, et al, **Wolf SM**, and members of the Working Group on Incidental Findings in Brain Imaging Research. Incidental Findings in Brain Imaging Research. *Science* 2006;311(5762):783-784.

**Lemmons T, Elliott C.** Commercial IRBs Have a Fundamental Conflict of Interest. *PLoS* 2006; available at <http://medicine-plosjournals.org/perlserv?request=getdocument&doi=10.1371/journal.pmed.0030309>.

**Valapour M.** Donation after Cardiac Death: Consent is the Issue, Not Death. *The Journal of Clinical Ethics* 2006;17(2):137-138.

**Wolf S.** Doctor and Patient: An Unfinished Revolution. *Yale Journal of Health Law, Policy & Ethics* 2006;6:485-500.

**Wolf S.** Introduction: Debating the Use of Racial and Ethnic Categories in Research. *Journal of Law, Medicine & Ethics* 2006;34:483-486.

**Wolf S.** Symposium on the Responsible Use of Racial and Ethnic Categories in Research: Where Do We Go from Here? *Journal of Law, Medicine & Ethics* 2006;34:483-558.

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**BIOETHICS**



**AcademicHealthCenter**  
UNIVERSITY OF MINNESOTA

*"The Center is dedicated to the advancement and dissemination of knowledge concerning ethical issues in health care and the life sciences."*

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excluding patients with medical assistance insurance. Although a healthy infusion of P4P dollars into medical assistance programs may reverse this trend, some data already suggest that sicker patients have a harder time accessing care when clinicians are rewarded for healthier patients under P4P.<sup>5</sup>

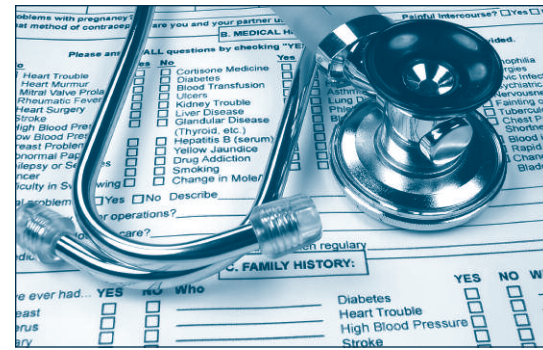
But can one predict who will be a sicker patient? In some cases, we can. Rural, minority, and low socioeconomic status patients all have, on average, worse health outcomes.<sup>6</sup> Unlike Britain and New Zealand, American P4P programs do not adjust for these factors, putting clinics that disproportionately care for such patients at a disadvantage.<sup>7,8</sup> These clinics are often smaller, less profitable inner city or rural practices that may find the upfront investments required to meet P4P goals difficult if not impossible. The need to invest in an electronic medical record, re-train staff, and create tracking systems may render small or poorly financed clinics unable to compete. The financial pressures mount as many insurance companies do not offer true P4P bonuses, but rather withhold a proportion of the fee-for-service reimbursement and redistribute the withheld dollars to the clinics meeting the P4P goals.<sup>9</sup> This ‘reverse Robin Hood’ strategy may result in the loss of smaller, less profitable clinics and could leave poor inner city and rural patients with even less access to health care.<sup>7</sup>

When the Centers for Medicare and Medicaid release their nation wide P4P program, will these patients appear financially more or less attractive to clinics? What sorts of practice and use patterns are emerging as a result of P4P? Can the scope and impact be quantified? What safeguards might reduce the risk of adverse effects on access to health care?

**RESEARCH QUESTION #2:**

**HOW DOES P4P AFFECT PATIENT-CENTERED CARE?**

When a version of P4P was introduced into elementary school systems, many educators soon began “teaching to the test.”<sup>10</sup> Medical P4P programs not only tell clinicians the subjects in which they will be tested, but tells them the questions that will be on the test. For example, Minnesota Governor Tim Pawlenty’s “QCare” initiative for primary care in Minnesota will soon announce the measures upon which physicians will be judged. Many clinicians expect that it will include items like how many of their diabetic patients are non-smokers, have LDL cholesterol under 100, have blood pressures under 130/80, have A1C blood sugar measurements under 7,



and take an aspirin a day.<sup>11</sup> Under these P4P criteria, clinicians would have a financial disincentive for investigating a diabetic patient’s back pain, as it would take time and effort away from collecting the P4P quality markers. In this way, P4P has the potential to create incentives that undermine patient-centered care. The clinician must choose between addressing the patient’s issues and addressing the criteria by which reimbursement will be determined.

Given that P4P quality markers represent a small sampling of overall quality, clinicians who “treat to the test” will not fully serve the needs of their patients. It will be important to understand to what extent clinicians are striving for this year’s P4P quality markers to the exclusion of others not rewarded. Can P4P programs safeguard against “treating to the test,” and what ought to be the relationship between P4P and patient-centered care?

**RESEARCH QUESTION #3:**

**WILL SICKER PATIENTS GET WORSE CARE UNDER P4P?**

The vast majority of current P4P programs focus on the percentage of a clinic’s patients achieving the highest quality standards. For example, within diabetes, most P4P programs provide bonuses for achieving a certain percentage of patients with excellent blood sugar control as measured by an A1C blood test of less than 7.<sup>9</sup> Such programs provide little incentive to improve a diabetic patient’s A1C that is hopelessly far from goal (e.g. A1C greater than 12). As a result, some clinics participating in P4P have special programs to lower the blood sugar of diabetics who are close to the goal (e.g. A1C between 7 and 8), despite the knowledge that risks of diabetic complications are exponentially greater for the patient with the A1C greater than 12.<sup>12,13</sup> A recent ethics article in the journal *Medical Economics* asks whether non-compliant diabetic patients ought to be “discharged” in order to preserve the doctor’s P4P bonus.<sup>14</sup> The

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**Calendar of Events**

**Oct 26-29**

American Society for Bioethics and Humanities (ASBH) Annual Meeting, Denver, CO. 10/26 Susan Wolf, JD, will participate on a panel “Issues Raised by Pediatric Biobanks”; David Satin, MD, will speak on “Pay-For-Performance Update: Americans Should Learn From Britain and New Zealand.” 10/27 Jeffrey Kahn, PhD, MPH will participate on a panel presentation “Bioethics and Public Health Ethics: Theory Building in Policy”; Carl Elliott, MD, PhD, will participate on a panel “Pharmaceutical Marketing and the Medicalization of America.” For information, visit [www.asbh.org](http://www.asbh.org).

**Oct 28**

Jeffrey Kahn, PhD, MPH, will participate in a panel presentation “The Ties that Bind? Academic Medical Centers and Industry” at the AAMC Annual Meeting, Seattle, WA. For information, email [sdunmore@aamc.org](mailto:sdunmore@aamc.org).

**Oct 28**

Dianne Bartels, RN, MA, PhD, will speak on “Current Bioethical Challenges: From Stem Cells to Plan B” at the American College of Clinical Pharmacy, St. Louis, MO. For information, call 612-624-9440.

**Nov 3**

Steven Miles, MD, will speak on “Human Rights and Emerging Infections” at the University of Minnesota Medical School 12th Annual CME Conference “Emerging Infections in Clinical Practice and Public Health,” Minneapolis, MN. For information, visit [www.cme.umn.edu](http://www.cme.umn.edu).

**Nov 6**

Steven Miles, MD, will speak on “Prisoners of War on Terror: Public Health in a Post Geneva World” at the American Public Health Association (APHA), Boston, MA. For information, visit [www.apha.org/meetings](http://www.apha.org/meetings).

**Nov 9**

Jeffrey Kahn, PhD, MPH, will speak on “The Ethics of Creating a Stem Cell Donor” at the UCLA Center for Society and Genetics, Los Angeles, CA. For information, visit <http://www.socgen.ucla.edu/colloquium.htm>.

**Nov 9**

Susan Wolf, JD, will speak on “Incidental Findings in Human Subjects Research” at Vanderbilt University Law School, Nashville, TN. For information, call 612-624-3482.

**Nov 10**

Susan Wolf, JD, will participate in a symposium on “Human Embryonic Stem Cell Research” at the American Philosophical Society, San Francisco, CA. For information, call 612-625-3482.

**Nov 15**

Carol Tauer, PhD, will speak on “Ethical Decisions at the End of Life” at North Memorial Medical Center, Robbinsdale, MN. For information, email [molly.kundinger@northmemorial.com](mailto:molly.kundinger@northmemorial.com).

**Nov 16**

Jeffrey Kahn, PhD, MPH, will speak on “Ethical Issues at the End of Life” at the Annenberg Center for Health Sciences at Eisenhower Grand Rounds, Rancho Mirage, CA. For information, call 760-773-4506.

**Nov 27**

Steven Miles, MD, will speak on “Pharmaceutical Costs and the CPA” at the Tennessee Society of Certified Public Accountants 2006 Healthcare Conference, Franklin, TN. For information, email [crhea@tscpa.com](mailto:crhea@tscpa.com).

**Dec 1**

Steven Miles, MD, will speak on “Human Rights Based Approach to Global HIV and AIDS” at the 2007 University of Minnesota, School of Public Health Roundtable, Minneapolis, MN. For information, email [vegoc001@umn.edu](mailto:vegoc001@umn.edu).

**Dec 3**

Debra DeBruin, PhD, will participate as a panelist “Re-thinking Clinical Research Ethics: From Protocol Design to Everyday Practice” at the US Department of Health 2006 ORI (Office of Research Integrity) Conference on Research Integrity, Tampa FL. For more information, visit [www.cme.hsc.usf.edu/research\\_integrity/](http://www.cme.hsc.usf.edu/research_integrity/).

**Jan 26-27**

Steven Miles, MD, will speak at the International Intelligence Ethics Association 2nd Annual Conference “Intelligence and Ethics 2007,” Springfield, VA. For information, visit [www.intelligence-ethics.org/](http://www.intelligence-ethics.org/).

**Jan 31**

Jeffrey Kahn, PhD, MPH, will speak on “Innocents Abroad? The Ethics of ‘Outsourcing’ Clinical Research” at the McLean Center for Clinical Medical Ethics, University of Chicago, Chicago, IL. For information, email [msiegler@medicine.bsd.uchicago.edu](mailto:msiegler@medicine.bsd.uchicago.edu).

**Jan 31**

Barbara Koenig, PhD, will participate as a commentator at the “The Science of Human Identification: From the Laboratory to the Courtroom,” Deinar Memorial Lecture on Law and Medicine, Minneapolis, MN. For information, visit [www.jointdegree.umn.edu](http://www.jointdegree.umn.edu).

## Bioethics at the Fair—2006

By Jeffrey Kahn, PhD, MPH



Jeffrey Kahn, hosting the AHC stage, "Chew on This" at the Minnesota State Fair.



J.B. Eckert and audience participants on "Chew on This" at the Minnesota State Fair.

This summer, Center faculty and staff spent the first Sunday of the Minnesota State Fair working at the Academic Health Center's booth. We've come to appreciate our ability to literally reach out to the public at the fair, and this year was no different. Since it was a beautiful summer day and the first weekend of the fair, we enjoyed an unprecedented number of visitors to the booth (nearly 1,000). We assume that they were attracted by our large signs suggesting "CHEW ON THIS," but it may have been the free packs of gum (sugar-free) and University logo gifts. In return for their choice of prize, visitors to the booth were asked to answer one of the three "Chew on This" questions:

**1. SHOULD PEOPLE PAY HIGHER HEALTH INSURANCE PREMIUMS IF THEY HAVE UNHEALTHY BEHAVIORS?**

Yes-84%; No-16%

**2. WOULD YOU BE WILLING TO WAIT LONGER FOR A TOTAL KNEE REPLACEMENT SO THAT MORE PEOPLE COULD HAVE ACCESS TO HEALTH CARE? IF SO, HOW LONG?**

Yes-84%; No-15%; Unsure-1%, the majority who said yes indicated that they'd be willing to wait for up to six months.

**3. SHOULD THE GOVERNMENT IMPOSE MANDATORY QUARANTINE (LOCKING PEOPLE IN THEIR HOUSES OR IN THE HOSPITAL) IN THE EVENT OF A BIRD-FLU OUTBREAK?**

Yes-64%; No-30%; Unsure-6%

The answers that people wrote on index cards weren't so surprising for the way the majority "voted," but they were interesting for the overwhelming proportion that shared the same viewpoint. The individual comments showed insights, sophisticated comments, and the sort of public engagement that we can usually only dream about. It's heartening to know that the work we do touches a chord with so many, and makes it clear why outreach continues to be an important part of our mission. The Minnesota State Fair brings out millions of our fellow citizens every summer, and it's great to know that so many are willing to exercise their minds in addition to their pocketbooks and waistlines. See you there next year!

## University of Minnesota, the Mayo Clinic and Mayo College of Medicine awarded a Ruebhausen Visiting Professorship in Fall 2007

The University of Minnesota Center for Bioethics and Consortium on Law and Values in Health, Environment & the Life Sciences; and the Mayo Clinic and Mayo College of Medicine Biomedical Ethics Research Program were awarded a \$25,000 grant from The Greenwall Foundation for the Ruebhausen Visiting Professorship. The three programs submitted a joint application to maximize the reach and impact of the Ruebhausen Professor's visit, as well as create additional opportunities for further collaboration between the University of Minnesota and Mayo.

Zach W. Hall, PhD, President, The California Institute for Regenerative Medicine (CIRM) has been appointed to this professorship, and will visit in October 2007. Dr. Hall is the former Director of USC's Zilkha Neurogenetic Institute; Senior Associate Dean for Academic Development in the Keck School

of Medicine of USC; Chancellor at UC San Francisco; and Director, National Institute of Neurological Disorders and Stroke (NINDS), National Institutes of Health.

Dr. Hall's perspective will be important and interesting to faculty, researchers, students, staff, and members of the administration on our campuses, and to members of the public from our communities and across our region. His visit will be a new and important way to collaborate for the University of Minnesota and the Mayo Clinic and Mayo College of Medicine, and will create a platform for ongoing discussion of issues between the two institutions.

Look for details in upcoming issues of the *Bioethics Examiner* as well as on our website at [www.bioethics.umn.edu](http://www.bioethics.umn.edu).

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article goes so far as to provide a multiple choice quiz so that physicians can practice choosing which non-compliant diabetic patients to dismiss.

Will sicker patients receive less care because of their low likelihood of ever reaching a P4P goal? What P4P safeguards could protect the sickest patients and ensure that all patients get an appropriate amount of care? What criteria should determine what is an appropriate amount of care, and who should make that determination?

### RESEARCH QUESTION #4: WHAT ARE THE EFFECTS OF P4P ON CLINICIANS AND THE FIELD OF MEDICINE?

Perhaps most offensive to some clinicians is how P4P programs insinuate that the existing moral and social incentives for providing excellent care are not sufficient—that a financial incentive will succeed where the clinician's professional character failed. Nevertheless, studies demonstrating how a P4P program succeeded in changing clinicians' behavior where years of traditional quality improvement programs failed suggest that financial incentives can work.<sup>3</sup>

Does P4P function by enticing clinicians with the promise of personal financial gain, by providing clinicians with the financial resources to hire much needed support staff and fund quality improvement initiatives, or in an altogether different way? If P4P improves patients' health, does it really matter how it gets us there? What impact will P4P have on medical professionalism? Will medicine under P4P attract a different kind of future clinician? How will P4P affect clinician job satisfaction and rates of clinician burnout? Given the correlation between a medical student's debt load and his or her choice of medical specialty,<sup>15,16</sup> how will P4P programs influence a future clinician's practice patterns and patient interactions?

### CONCLUSIONS

In the coming decades, P4P will no doubt exert a greater and greater force on the practice of medicine. To date, the medical literature is focused on measuring improvements in the number of patients meeting a particular set of P4P quality markers. Bioethics researchers can help answer the important but difficult questions about the broader effects of P4P. We are well positioned as interdisciplinary collaborators to help better understand the transformations that have already begun under P4P.

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16. Rosenblatt R, Andrilla C. The Impact of US Medical Students' Debt on their Choice of Primary Care Careers: An Analysis of Data from the 2002 Medical School Graduation Questionnaire. *Academic Medicine* 2005;80(9):815-819.

Perhaps most offensive to some clinicians is how P4P programs insinuate that the existing moral and social incentives for providing excellent care are not sufficient—that a financial incentive will succeed where the clinician's professional character failed.

## Letter to the Editor – Oh, The Water

By Jurrit Bergsma PhD, Em Professor in Medical Psychology, The Netherlands

From several viewpoints Professor Marshall's reflections on the act of killing in extreme circumstances is interesting and in some ways even moving. Nevertheless, as I see it, some important considerations are missing. Besides the fact that American ethicists still like to refer to Nazi conditions they never met, there is more than just a difference in this Katrina case. One of the most important focuses for an ethicist should be in inquiring about responsibilities. The acts of killing Professor Marshall's mentions are basically different from each other if considered on the dimensions of responsibility. Her article is a clear illustration of the inescapable individual intertwining of responsibilities with the context of the actions. Under the Nazi regime power-dependency was the one and only (political, ideological) condition. Killings taking place like those in the case of *Sophie's Choice* were based only on intention: the whole system was set up to kill (certain groups) and nothing else. The Katrina ordeal in New Orleans, what an inspiring place it was, was completely different. The chaos implicitly was the result of governmental incompetence, passivity, denial and may be even more. In the acts of killing, personal acts are never independent from their context. It is clear that in both cases, the Nazi case as well as the Katrina case, responsibilities can be clarified and indicated. The essential difference is in the inapproachable power depending dictatorship during the German (Nazi) occupation in Europe and the open democratic system in the USA which at least suggests the approachability of institutions to openly discuss circumstances.

The Katrina case, consequently, is a complicated situation: a complex picture of responsibilities and co-responsibilities. Those who try to claim euthanasia in New Orleans too easily ignore the important fact of shared responsibility. Those who were inactive, incompetent or too passive on the level of governmental responsibility are as responsible on this point as those healthcare workers who had no care-or-mercy-option left than to free those patients from suffering. The positive aspect of this experience is the illustration of the difference between a dictatorship and a democracy, which we enjoy together with our American colleagues.

The missing but essential issue in Professor Marshall's contribution is the political context when it comes to evaluation of issues like mercy-killing. Medical ethics, certainly not only or especially if it wants to focus on extreme cases like these, should be much more alert to political/ideological contexts. Responsibility is in the personal act, but in the context of that act as well. This has nothing to do with the relativity of values. It has important meaning for thinking about the intertwining of responsibilities in situations where medical actions have to be evaluated, like in our hospitals. If this issue is overshadowed by referring to the Nazis, it has no meaning at all. The Nazi system was primarily a political-ideological system, inapproachable regarding their values. In case of comparisons and evaluations the ethicist should broaden her own focus into the direction of acts and circumstances, deeds and contexts, and clarify and name the responsibilities where they are really located. Don't be afraid Professor Marshall, give the issues the real names they deserve.

Response to article by Marshall M. Oh, the water... it stoned me to my soul. *Bioethics Examiner* 2006;9(4):1-3.

Continued from Page 1 – David Satin, MD - Faculty Profile

"Societal Considerations of New Reproductive Genetic Technologies." He has presented his research findings at international meetings of the World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA Europe); the American Society for Bioethics and Humanities; the Canadian Bioethics Society; and the Society for Teachers of Family Medicine.

Dr. Satin's current research focuses on ethical issues in pay-for-performance (P4P) models of physician reimbursement. Dr. Satin's interest in P4P arose from two disparate experiences; his academic investigation into the anticipated positive public health effects of P4P, and his clinical experience with the models' potential negative impact on his poor, mentally ill, and homeless patients. He currently sits on the American Medical Association's P4P geriatric task force, and he writes, and speaks on the topic.

Dr. Satin contributes to his local community through his clinical practice, writing an ethics column for a local newspaper, speaking at local churches and libraries, as well as spending much of his time engaged in teaching medical students and residents.

## Center News

**Muriel Bebeau, PhD**, co-author of the book, *Dentists Who Care: Inspiring Stories of Professional Commitment*, was nominated for a Moral Development and Education Outstanding Book Award by the American Education Research Association.

**Debra DeBruin, PhD**, has been appointed to the Minnesota Privacy and Security Project, Minnesota Department of Health.

**Barbara Koenig, PhD**, has been elected to the Committee on Public Policy, American Anthropological Association; and appointed to the Advisory Board, Humanities Center, Stanford University.

**Mary Faith Marshall, PhD**, has been appointed member to the Institute of Advanced Studies, University of Minnesota.

**Maryam Valapour, MD**, has been awarded a five-year career development grant (K23) of \$750,000, from the National Institutes of Health (NIH-NHLBI). This grant is designed to promote Dr. Valapour's development as a scholar in the field of organ transplantation ethics and

He is committed to improving the lives of his patients and colleagues by exploring pivotal issues such as patient confidentiality, consent, cultural issues in health care, practical ethics for the sports-medicine clinician, ethical issues in obstetrics, the impact of genetic technologies on society, advocacy for underserved patients, and the meaning of medical professionalism.

### SELECTED PUBLICATIONS

Satin D. Paying Physicians and Protecting the Poor: Pay-For-Performance Systems Should Protect the Health of Poor Patients and Level the Playing Field For the Physicians Who Treat Them. *Minnesota Medicine* April 2006;89(4):42-44.

Satin D. Maximum-Strength Health Care May Cause Dangerous Side Effects. *Minneapolis Observer* February 2005.

Satin D. More Realism About Informed Consent. *The Journal of Laboratory and Clinical Medicine* 2005;145:292-294.

Stovitz S, Satin D. Ethics and the Athlete: Why Sports Are More Than a Game But Less Than a War. *Clinics in Sports Medicine* 2004;23:215-225.

Stovitz S, Satin D. Professionalism and the Ethics of the Sideline Physician. *Current Sports Medicine Reports* 2006;5(3):120-124.

Satin D. Gut Reactions: An Ethical Analysis of Emerging Biotechnologies. *University of Western Ontario Medical Journal* Fall 1999.

Satin D. Peeping Tom and Prostitution: Ethical Parameters of Patient Centered Medicine. *University of Western Ontario Medical Journal* Spring 1998.

policymaking, by extending her previous training in pulmonary medicine and bioethics.

**Maryam Valapour, MD, and Jeffrey Kahn, PhD, MPH**, are co-investigators on a recently funded National Institutes of Health (NIH-NIAID) grant to study long-term effects of living donor kidney and lung donations. The University of Minnesota is one of five centers chosen by the NIH to conduct this study. Valapour and Kahn will study the quality of informed consent among donors in all five centers of the consortium.

**Susan Wolf, JD**, has been named the McKnight Presidential Professor of Law, Medicine & Public Policy, University of Minnesota.

**Susan Wolf, JD**, Chair, Consortium on Law and Values in Health, Environment & the Life Sciences was awarded a \$1.22 million grant for a 4 year project on "NIRT: Evaluating Oversight Models for Active Nanostructures and Nanosystems: Learning from Past Technologies in a Societal Context." For more information, visit [www.lifesci.consortium.umn.edu](http://www.lifesci.consortium.umn.edu).