

Oregon Public Health Division
MEDICAL ADVISORY GROUP
Meeting Minutes
January 9, 2007

Participating:

Members Present:

Dana Braner, Oregon Health Sciences University Pediatrics, Critical Care; Oregon Pediatric Association, ICU, Disaster Preparedness
Thomas Dodson, Oregon Psychiatric Association
Melissa Doherty, Emergency Medicine and EMS
George Gerding, Senior Care Specialist, Oregon State Pharmacy Association
Roberta Hellman, Council of Local Health Officials; public health administrator
Jere High, PA, Oregon Primary Care Association
Jim Jensen, Oregon College of Emergency Physicians
Csaba Mera, Medical Director, ODS Health Insurance
Dane Nichols, Director, OHSU Fellowship Program; Society of Critical Care Medicine, OHSU Intensive Care
Anne Peltier, Local Gov't Advisory Committee, Public Health Program Manager
Bob Shoemaker, Public Health Advisory Board, OR Assoc. of Attorneys
Jim Shames, Family Physicians, Local Health Officer
Jennifer Soyke, Lane Co. Medical Society, Medical Director, Lane Co. Adult Corrections, Palliative Medicine, Medical Ethics, Emergency Medicine
John Tuohey, Providence Medical System Center for Ethics
Larry Wallack, Dean, PSU College of Urban & Public Affairs, Public Health communications and media
Bill Zepp, Executive Director, OR Dental Association

Oregon State Public Health Staff:

Susan Allan, Director
Paul Lewis, Medical Epidemiologist
Brian Mahoney, Public Health Planner, Public Health Emergency Preparedness
Katherine Bradley, Director, Office of Family Health
Gail Shibley, Administrator, Environmental Public Health

Facilitators:

Casey Milne, Milne & Associates, LLC
Tom Milne, Milne & Associates, LLC

Members Absent:

Margaret Carley, Deputy Director & Legal Counsel, OR Health Care Association, Nursing Homes / long-term care / community-based care / senior housing in-home care
Roberto DeCastro, Chair, OR Section, American College of OB/GYN
Joe Finkbonner, NW Portland Area Indian Health Board, Oregon Native American Tribes
Judge Steven Grasty, County Judge, Association of Counties
Heather Hue, staff physician, Legacy Meridian Park, Oregon Medical Association

Opening:

Susan Allan explained that today's meeting is the first discussion by the MAG of ethical frameworks for making decisions regarding allocation of scarce resources and altered standards of care. This meeting is the first of several that will focus on topics that have ethical components, so specific purpose of this meeting was to provide an introduction that will aid further discussion at subsequent meetings.

Background:

John Touhey provided a background on ethic principles and frameworks, and how they are currently being applied in planning for medical and health emergencies around the country. He noted that in emergencies, people will be asked to do things for which they are not well-grounded. There is often a disconnect between ethical conversations and practical considerations. The challenge is to integrate ethics into the conversation and emergency planning. Application of ethical principles can inform decision making. Going into a pandemic with a good framework with a few principles will guide the discussions that arise.

John explained that the word "ethics" comes from the Latin *ethos* meaning "barn" ... creating a safe place to live, or "we're in this together." Thus, ethics is the art of discerning our relationships, understanding our obligation in the context of the broader community. The outcome measure is the quality of relationships. Key questions to ask include

- How will doing things this way build community?
- How will we assure people know what we are doing?
- How can we build trust?

A caution is that medical ethics is usually focused at the individual patient level, not at the community level, so while medical ethics is still very much an evolving and vaguely defined field, there is even less experience with applying it to community emergencies.

Beginning Ethical Framework:

John outlined a broad ethical framework using "professionalism" itself as an example of broad ethical principles. He noted that the following 3 principles as part of medical professionalism.

1. Social Good: The medical community sees itself as serving the social good by helping to create a healthy society. Attributes of the Social Good include
 - Public Order
 - Safety
 - Access to services
 - Trust in institutions
2. Consistency with Rigorous Competencies: High quality facts and assessment tools need to be used transparently in decision making for it to be acceptable. For example, if SOFA (sequential organ failure assessment) guidelines, or any other guidelines are to be used to determine when to move patients off ventilators then the tool must be well validated and accepted by the professional community.

3. Principle of Justice: Attributes of justice that apply for population level healthcare decisions during an emergency include:
- Absence of inherent bias in the decisions
 - Equality – all “equals” are treated the same under the same set of circumstances
 - Difference Principle – is used to justify treating groups differently when needed to balance disparate impact on those who are most vulnerable.
 - Important to assure that society benefits, that the “We’re in this together” principle is satisfied.

Another principle discussed was that of Subsidiarity – decisions need to be made at the most local setting possible.

John asserted that once a framework is established, it can be applied to any ethical question. He noted that the result of applying a question to the framework may change based on urgency or other variables. But the framework will support the important discussions. He also emphasized that the question of who the decision maker is represents an important consideration. If, for example, the state is the decision maker in general response to an emergency, it can set out a number of policies and guidelines to be followed. However, it is not the decision maker at the physician-patient interface, so cannot change the specific care activities that the professional performs. The framework suggested rests on the assumption that professionals must make decisions within their scope of competency.

Test of Framework:

The full group then tested the framework, using a defined scenario and applying it to the question of to whom should the first doses of pandemic influenza vaccine be administered in a severe shortage situation. The scenario predicted that the greatest death rate would be in children. Considerations discussed included:

- Is the Federal goal of minimizing death and maintaining normal functioning of society acceptable? Or is it really two potentially conflicting goals?
- An alternative suggested was “Minimize spread of the virus”
- Areas of possible focus discussed included
 - On those where the attack rate is highest
 - On those that “have to be out there” (e.g. fire, police, electeds, caregivers)
 - On the population at greatest risk
 - On children
- Relative to targeting children, it was noted that there are many strategies that can be used, including some which would mediate risk of exposure:
 - Protect the infrastructure
 - Priority medical providers, including pediatric intensivists
 - Utilities, fire, police
 - People doing vaccination
 - Parents
 - Teachers

There was general agreement that

- It is important to know who is at greatest risk
- It is important to define clearly who are members of the group(s) to be immunized
- That the elements of the framework laid out by John were useful

Small Group work:

Three other ethical questions were posed for small group discussion, with the intention of testing utility of the framework. The following summarizes the report from each of the groups:

1. Group A: Allocation of scarce resources: mechanical ventilators:
 - The framework was quite useful
 - Recommend providing an overarching theme for the framework: Preservation of Life, and to characterize the framework as "to inform and guide decisions at the front line of care givers during an emergency."
 - Social Good:
 - Suggested adding "need for future resources" as a component of determining social good (e.g. is patient survives but has developed chronic renal failure requiring dialysis then this will be an on-going burden to society)
 - Suggested adding "Continuity/survival of the community"
 - Rigorous Competencies:
 - Suggested adding the point that consideration should be given to not only surviving the acute pandemic illness, but also to patients' potential for long term survivability
 - Justice: it is important to be clear and consistent in defining "equals" in the context of treating equals as equal.
2. Group B: Altered Standards of Care:
 - The framework was useful
 - Considered "Creating good for the greatest number" as an important consideration
 - Withholding care from people with lowered life expectancy (vs. people with better prognoses)
 - To minimize liability/law suits, distribute decision authority to the community (via consensus process)
 - Regarding having predetermined decision process vs. a more temporal process, the group was mixed
 - Make rational decisions vs. arbitrary decisions
3. Group C: Community Containment Measures: Voluntary Home quarantine of exposed people
 - Framework was useful, and members thought they could be more effective in its use with more practice
 - The group addressed the question of whether to make containment measures more restrictive than the national guidelines

- Social Good:
 - A strong case was made for quarantine to benefit the social good
 - A question needing more explanation was raised about who makes sure that those in home containment get food, drugs, needed services.
- Rigorous Competencies:
 - Analysis of 1918 pandemic & other examples demonstrates competencies
 - The Toronto SARS experience may be a model for study
- Justice:
 - This approach would benefit the most-vulnerable by keeping hospitals open longer
 - If schools close, containment strategies become essential
- The group concluded that it would be most useful to begin with the most restrictive containment policies, and then ease up
- The group also mentioned that informing people in advance about what to expect and why – especially before the pandemic – is critically important.

Conclusions about the draft framework:

1. It is very useful
2. The terminology included needs to be expanded and translated so others can understand
3. It may need amplification to be clearer how it applies to community health emergencies.

Miscellaneous Comments during the Meeting:

1. Normally I take care of the medical patients in the ICU. In a pandemic, you are asking me to take care of the community. I need a framework for that shift.
2. A challenge during a pandemic when we are trying to approach decision making within an ethical framework, benefiting the entire population is moving people from the dominant “Yo-Yo” perspective (“You’re On Your Own”) to the “WITT” perspective (“We’re In This Together”)
3. It is tempting, and an increasing practice in ethics, to create new ethical principles in response to each new challenge. Many of these are really “outcome measures”; we should not confuse ethical principles with outcomes.
4. Putting untoward emphasis on planning is of questionable ethics, especially when other real needs are out there.
5. We need to remember the principle stated by Susan at the beginning: “The care people get during a crisis will not be what people are used to; however, they will receive care.”
6. A study of healthcare decision making showed that physicians rely on utilitarian approaches while laypeople employ distributive justice. The ideal is a melting of the two.

Next and Future Meetings:

- February: Tuesday the 6th, 1:00 to 6:00 pm at the Oregon Dental Association
- March: Monday the 12th, 8:30 am to 4:00 pm at ODS
- April: Monday the 30th, 8:30 am to 4:00 pm (place to be determined)