

**Oregon Public Health Division
MEDICAL ADVISORY GROUP
Meeting Minutes
February 6, 2007**

Participating: (Attendance list at end of minutes)

Opening:

Susan Allan noted that the MAG is scheduled for 6 meetings; the next scheduled meeting was set for March 12, but on that date the Division will be presenting its 2007 proposed budget to the legislature. It was agreed that the next MAG meeting would be moved to April 30, 8:30 am to 4:00 pm.

Susan indicated that the next two meetings will be used to respond to the following questions:

- Where do we go from here?
- What do we do with the results of the several topics we've discussed
- How does MAG or a subset of MAG continue? Should it continue to meet quarterly, every 6 months, or once a year, for example?

Susan explained that she sees the MAG as

- continuing as an informal ad hoc group to advise on decisions to be made by the Public Health Division
- representing a foundation of knowledge of and understanding about critical issues that the Division may face
- providing information to the members' respective organizations about critically important issues

Ethical Framework:

Discussion followed among members of the MAG about the Ethical Framework, developed at the January MAG meeting and reworked to some degree since then by John Touhey and Division staff. Some of the conversation points included:

- the standards may need to shift during urgent conditions to respond to new information
- the notion of "contextual triage" should be employed during times of extreme emergency... a "MASH" vs. "emergency room" approach. At issue is the magnitude of demand. Include mention of this in the framework, like it is anticipated that contextual triage would be employed during an emergency.
- The military has thought about response to emergencies more than we have. Does Marshall Law get imposed?
- While "Evidence-Based Medicine" is important, the standards will change during emergencies, and mention of this should be included in the framework.
- There is interest in expanding the "Competencies" component to apply beyond just medicine
- Some mention of the principle of due diligence for planning should be included.

- The “context of decisions” should be included in some fashion, noting that there are different levels of decision making, beginning at the “immediate practice site” to the next site.
- Maybe include mention of the Incident Command System approach to emergencies?
- We’ve never really limited care given to patients before; the framework should work well to support that discussion
- Maybe include a section in the framework on the practical application of the principles. Identify the practical importance of the document
- The framework needs to be sensitive to the environments in which it might be applied...for example, dealing with corpses

It was agreed that another elaboration will be done on the framework, with John Touhey providing content leadership, to be shared at the April meeting.

2004 Influenza Vaccine Shortage:

Paul Lewis provided an overview of the 2004 Influenza year experience (copies of the slides have been posted). Highlights include:

- What was initially projected to be a year with adequate vaccine supplies evolved to be one with significant cuts in production
- CDC recommendations were issues to identify priority population groups for vaccine administration
- The Oregon response included
 - Use of the incident management system
 - Collaboration with partners and stakeholders
 - Invoking a statutory authority (ORS 433.040)
 - State purchase of 2nd round of vaccine
 - Facilitation of brokering of vaccine among providers
- Evaluation showed that
 - DHS leadership was timely and strong
 - Strategies for sub-prioritization were not supported well
 - Messages changed frequently and rapidly
 - Providers were frustrated with redundant and mixed messages about vaccine availability and administration guidelines
 - The hotline was expensive and underutilized

In discussion that followed:

- When risks of morbidity and mortality are high, the government should control vaccine supplies to assure high risk groups are reached
- Some of the ethical considerations that were applied (explicitly or implicitly) included
 - Using the vaccine to save the most lives possible
 - Avoiding barriers to access (through use of the sub-priorities)
 - The shift of health care to supermarkets (where much vaccine is administered) is fraught with ethical issues, and challenges the state’s capacity to maintain public order
 - Access to the most vulnerable was precluded in some instances, counter to social justice considerations

- Targeting the vulnerable population vs. stopping the spread of disease represents conflicts in ethical standards, but stopping spread in case of a widespread epidemic directly addresses public order principles

Scenario Work: Small Groups

Three scenarios were worked on by three separate groups, dealing with:

- Pandemic flu
- A major earthquake
- A large chemical accident

Each group considered information in the scenario, then discussed resources needed to address the scenario, difficult decisions that needed to be made by players at the scene, and the ethical/procedural issues that needed to be addressed. Some of the comments that followed during a debriefing after the scenarios were completed included:

- Physicians involved were used to “doing everything for the individual patient” as opposed to considering the broader community needs. (Influenza)
- Corporations felt the obligation to keep business alive and humming as opposed to being a part of the community as they stockpiled Tamiflu for employees. (Influenza)
- It was a major challenge to control the mob and convince them that they would get care. (Chemical)
- There was a need for long term surveillance of toxics in the surrounding environment (grass, food, etc.) that would result in exclusion of people from contaminated homes and businesses for an uncertain amount of time. (Chemical)
- Asking EMTs to go into the plume to rescue people created ethical challenges (Chemical)
- Difficult to assure the provision of clean water, food, power, and how to manage competing needs. How to deal with reciprocity and subsidiarity. (Earthquake)
- It was a challenge getting the physicians to go provide care. (Earthquake)

Evaluation of the scenarios included the following points:

- The exercise made us question how we’d make decisions
- Knowing the full scenario (as opposed to a “turn the card” tabletop exercise) made use of the framework more difficult
- The reality is that the first that come are the ones that get services and supplies, since the full dimensions of the problem aren’t understood
- The reluctance of physicians to participate seemed to be in opposition to the Hippocratic Oath obligation to prepare or respond to population emergencies. (This led to a lively discussion with the following points:)
 - There is no clear obligation under the Oath for such response
 - This is not in medical school curricula, most physicians weren’t trained to respond to emergencies
 - This would be an excellent consciousness raising training for medical schools - before disasters occur
 - Is medicine changing to being first and foremost a “business”?
 - What is the psychology of medical practice today?

Next Meeting: The next meeting will be April 30 at the Oregon Dental Society, address and particulars to follow. The agenda will go out well in advance.

Participating:

Members Present:

Dana Braner, Oregon Health Sciences University Pediatrics, Critical Care; Oregon Pediatric Association, ICU, Disaster Preparedness
Margaret Carley, Deputy Director & Legal Counsel, OR Health Care Association, Nursing Homes / long-term care / community-based care / senior housing in-home care
Thomas Dodson, Oregon Psychiatric Association
Melissa Doherty, Emergency Medicine and EMS
Joe Finkbonner, NW Portland Area Indian Health Board, Oregon Native American Tribes
Judge Steven Grasty, County Judge, Association of Counties
Roberta Hellman, Council of Local Health Officials; public health administrator
Heather Hue, staff physician, Legacy Meridian Park, Oregon Medical Association
Jim Jensen, Oregon College of Emergency Physicians
Steve Jones, Director, Infectious Disease & Internal Medicine Training Program, Legacy; Infectious Disease Society of Oregon
Csaba Mera, Medical Director, ODS Health Insurance
Bob Shoemaker, Public Health Advisory Board, OR Assoc. of Attorneys
Jim Shames, Family Physicians, Local Health Officer
John Tuohey, Providence Medical System Center for Ethics

Oregon State Public Health Staff:

Susan Allan, Director
Paul Lewis, Medical Epidemiologist
Brian Mahoney, Public Health Planner, Public Health Emergency Preparedness
Paul Ceslak,
Mel Kohn,

Facilitators:

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

Members Absent:

Roberto DeCastro, Chair, OR Section, American College of OB/GYN
George Gerding, Senior Care Specialist, Oregon State Pharmacy Association
Jere High, PA, Oregon Primary Care Association
Roy Magnuson, Medical Director, OHSU; Oregon Association of Hospital and Healthcare Systems
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
Jennifer Soyke, Lane Co. Medical Society, Medical Director, Lane Co. Adult Corrections, Palliative Medicine, Medical Ethics, Emergency Medicine
Larry Wallack, Dean, PSU College of Urban & Public Affairs, Public Health communications and media
Bill Zepp, Executive Director, OR Dental Association