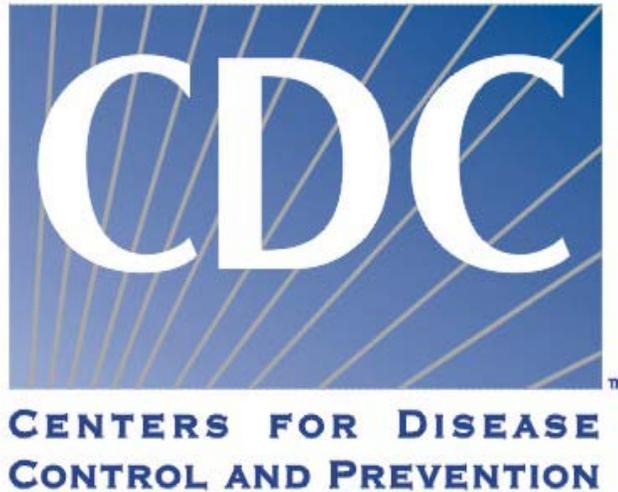


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR DISEASE CONTROL AND PREVENTION /
AGENCY FOR TOXIC SUBSTANCES AND DISEASE REGISTRY**



**Joint Meeting of the Ethics Subcommittee
of the Advisory Committee to the Director, CDC
and the
CDC Public Health Ethics Committee**

June 17, 2010

Minutes

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Acronyms Used in This Report

ACD	Advisory Committee to the Director
APHA	American Public Health Association
ASTHO	Association of State and Territorial Health Officials
CDC	Centers for Disease Control and Prevention
DFO	Designated Federal Official
DPHCP	Division of Public Health Capacity Development
DPHPI	Division of Public Health Performance Improvement
NACCHO	National Association for City and County Health Officials
NIH	National Institutes of Health
NPHPSP	National Public Health Performance Standards Program
OMB	Office of Management and Budget
OSTLTS	Overview of the Office for State, Tribal, Local and Territorial Support
PHAB	Public Health Accreditation Board
PHEC	Public Health Ethics Committee
PHLS	Public Health Leadership Society

**Joint Meeting of the
Ethics Subcommittee of the Advisory Committee to the Director,
Centers for Disease Control and Prevention (CDC) and
the CDC Public Health Ethics Committee
Thursday, June 17, 2010**

Introductory Remarks and Overview of Meeting Goals

**Robert Hood, PhD, Ethics Subcommittee Chair
Florida Department of Health**

Dr. Hood called the meeting to order, welcomed those present, and led everyone in a round of introductions. The first order of business was to ensure that there were no conflicts of interest. For the record, no members of the Ethics Subcommittee declared any conflicts of interest.

Dr. Hood then recognized retiring Ethics Subcommittee member, Vivian Berryhill, who has served as the representative from the Advisory Committee to the Director (ACD). Mrs. Berryhill has made numerous contributions to the Ethics Subcommittee and elsewhere. She is president and founder of the National Coalition of Pastors' Spouses (NCPS), which is a non-profit, non-partisan network comprised of more than 2,500 clergy spouses from various denominations across the country. She has worked to encourage pastors' spouses to use faith institutions as health hubs to improve primary care and to fight illness and disease. She has been honored previously by receiving the prestigious Presidential Service Award for her dedicated service to national and international healthcare initiatives. She has contributed a great deal of work on HIV / AIDS, more recently on diabetes. On behalf of the subcommittee, Dr. Hood expressed gratitude for Mrs. Berryhill's contributions, her keen insights and perspectives, and her input on social determinants of health. Given that the meeting was convened via conference call, a certificate of appreciation was sent to Mrs. Berryhill via FedEx. Drs. Tanja Popovic and Drue Barrett expressed their gratitude as did other members of the subcommittee. Mrs. Berryhill thanked everyone, stressing what a pleasure and honor it had been to work with all of them and noting what a great opportunity it had been to serve on the subcommittee.

Dr. Hood then reviewed the agenda and goals for the meeting. He welcomed Dr. Judith Monroe, the Director of the new CDC Office of State, Tribal, Local, and Territorial Support (OSTLTS). Prior to coming to CDC, Dr. Monroe served as the Indiana State Health Commissioner. Dr. Hood noted that he first met Dr. Monroe when the Indiana Department of Health hosted a summit of the states to address ethical issues in an influenza pandemic, which he thought was one of the most important efforts on pandemic influenza. She is the immediate past president of the Association of State and Territorial Health Officials (ASTHO) and she serves as Vice-Chair on the Board of Directors for the Public Health Accreditation Board (PHAB).

Overview of the Office for State, Tribal, Local, and Territorial Support

Judith A. Monroe, MD, FAAFP
Deputy Director, CDC
Director, OSTLTS

Dr. Monroe said it was a pleasure to speak to the subcommittee and introduce the new office. This is a very important endeavor and initiative for Dr. Frieden, and is one of his five priority areas that he has outlined for CDC in order to return CDC to some of its roots in terms of support for health departments, which dates back to when CDC first formed to battle malaria. She began with CDC / OSTLTS on March 22, 2010 and started work with the new team that had been formed. The first effort in which they engaged was to think about what the values for the office would be. The role of the office is to support the field, with overriding values of service and stewardship. Internally and externally, it is important to be good stewards, have strong communication, and be a trustworthy and honest office, and they go forth with their work in that spirit.

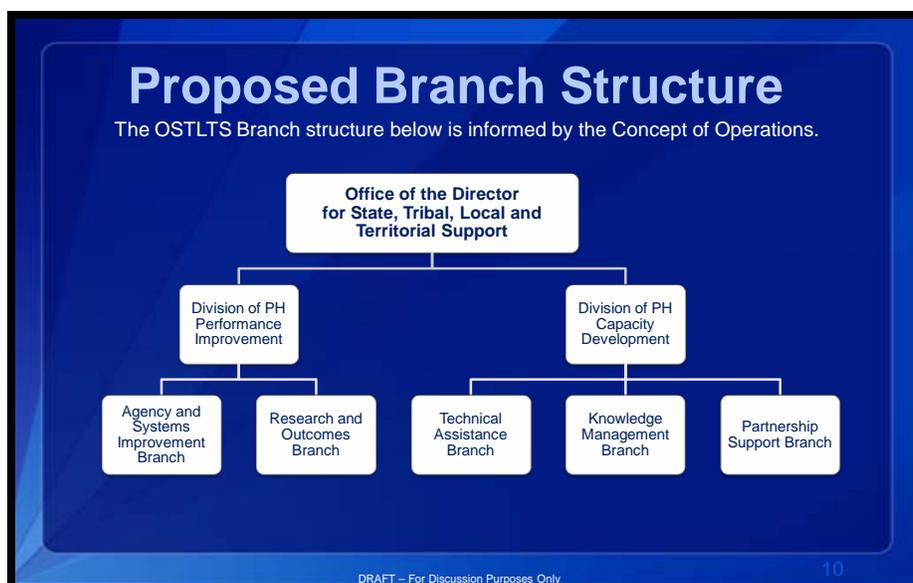
OSTLTS's mission is simply to improve the capacity and performance of the public health system. In terms of the governmental public health system, this includes state, tribal, local, and territorial health departments, and CDC at the federal level. In order to carry out this mission, the office has a working model. They have given a great deal of thought to a concept of operations that has given them their framework and a functional foundation for how to proceed with the office's work. OSTLTS staff members will be working very hard to identify best practices, standards, and policies with which they should be supporting the field. The next task is to validate those, confirming their relevance, quality, and integrity, and then disseminating best practices to ensure that they are adopted in the field. It is important to understand the science, gaps in knowledge, and what is actually occurring in practice.

The office has a process they refer to as "14 and 12." They have set forth 14 goals that they would like to accomplish in the first 12 months of operating the office, which include the following:

1. Best Practices: 5 identified and disseminated via OSTLTS networks
2. Grants Standardization and Optimization: At least 5 improvements identified and made to CDC grants process, guidance, approach, or standards
3. State Health Officer (SHO) welcome packet: System in place to recognize incoming SHOs and trigger a welcome packet from OSTLTS
4. Public Health Advisor Program: Program expanded to add 75 more apprentices in 2010 (total 100)
5. OSTLTS Partner Portal: Established and manage a one-stop information center and service for OSTLTS partners
6. Score cards: 2-3 prototypes developed with health department partners by the third quarter of 2010
7. Field Training: Develop and deliver a training opportunity for CDC field staff and the staffs of state and local health agencies.
8. SHO Orientation: A re-designed, 2-day orientation to CDC will be provided for new health officials (appointed within 2 years)

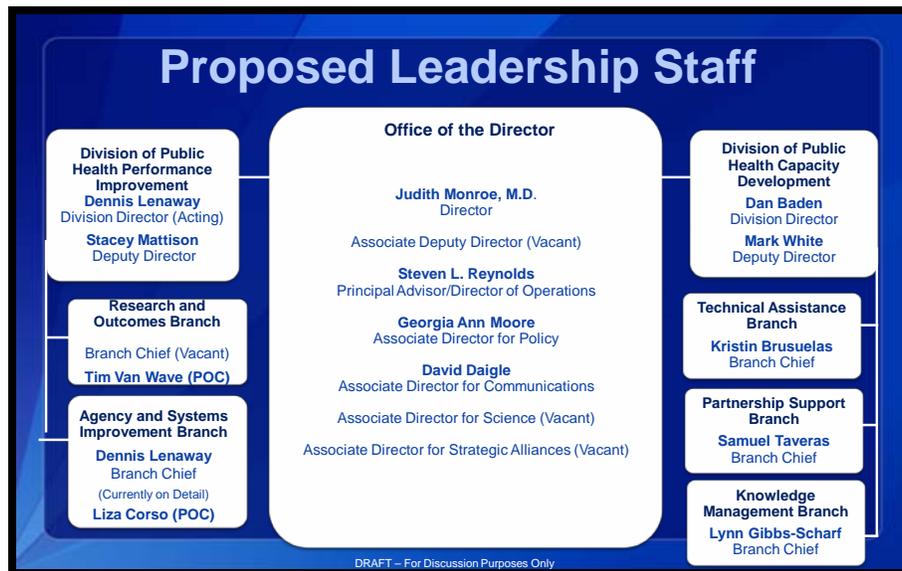
9. Public Health law Training: Develop and deliver the first of a series of public health law trainings for Communities Putting Prevention to Work (CPPW) grantees
10. CDC Organizational Resource Directory: Develop and implement this external portal for OSTLT public health professionals to be able to reach into CDC
11. ACD subcommittee: Establish the subcommittee on public health practice
12. Completion of a “beta-test” of the national accreditation standards, measures, and site visit process
13. Develop version 3 of the National Public Health Performance Standards Program assessment tools for use by state, tribal, and local health departments
14. Deliver an annual training program to 120 National Public Health Performance Standards Program (NPHPSP) & MAPP users from state, tribal, and local health departments

OSTLTS will have two divisions under the Office of the Director: Division of Public Health Performance Improvement (DPHPI) and Division of Public Health Capacity Development (DPHCP), which basically align with the mission of the office. DPHPI will lead standards and best practices identification and evaluation activities, while DPHCP will serve as the implementation, training, and grants management arm of OSTLTS. In addition, the following branch structure is proposed:

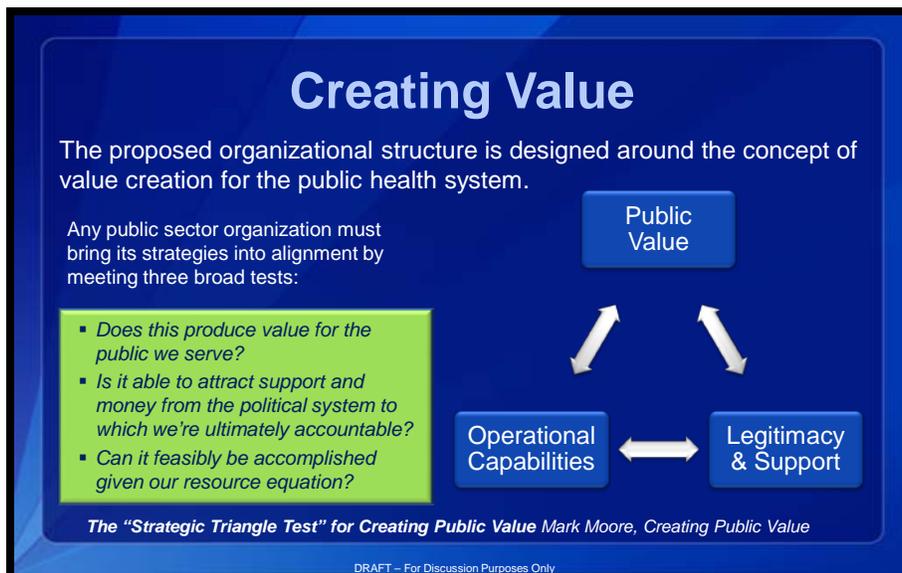


Supported out of OSTLTS is the core funding for 8 public health partners, including such groups as ASTHO, National Association for City and County Health Officials (NACCHO), and the American Public Health Association (APHA), that are critical to the success of public health practice.

The proposed leadership staff are reflected in the following organizational chart:



In conclusion, Dr. Monroe indicated that she learned about a strategic triangle model when she went to Kennedy School of Government that carried with her throughout her tenure as a state health official. She introduced this to model within OSTLTS. The purpose of this model is to determine whether public value is being created, and it is illustrated in the following graphic:



Discussion Points

- Dr. Hood inquired as to how the Ethics Subcommittee might best support the work of OSTLTS in terms of building capacity in states.
- Dr. Monroe responded that it may be a reverse question as well. One of the greatest values OSTLTS has is its connection to the health officials. Thus, early on they are attempting to leverage these connections by disseminating communications, delivering technical support, ensuring that health officials understand what is coming out of CDC, and helping states understand how best they can move policy forward and communicate to stakeholders within the state. As a former state health official, she assured subcommittee members that states truly want guidance pertaining to pandemic influenza, ethics in terms of ventilators, et cetera. Therefore, it is imperative to ensure good communications and well-developed relationships with states. Health officials change over time and sometimes frequently. OSTLTS is in a good position to understand such dynamics and support each of the states in carrying out the important work coming out of CDC. Most health officials want to be good stewards, but sometimes the information is not flowing in a way that they either understand or that catches their attention. In addition to emergency efforts such as occurred with pandemic H1N1, health officials have other pressing day-to-day matters with which they must deal. They need sound communications and support.
- Dr. Barrett inquired as to whether something might be included about CDC's public health ethics activities in the state health official welcome package to be created, and whether the CDC Public Health Ethics Committee (PHEC) and/or the Ethics Subcommittee could serve as a resource on public health ethics issues. With regard to the activities Dr. Monroe mentioned related to accreditation, Dr. Barrett pointed out that a number of Ethics Subcommittee members are very interested in accreditation issues. Her understanding is that the current accreditation process does not include a specific capacity relating to ethics. She wondered whether there might be any opportunities to collaborate with OSTLTS on some of those issues. In terms of the ACD workgroup that OSTLTS is establishing, she suggested that they engage in a discussion about how the Ethics Subcommittee could best coordinate with OSTLTS activities with that workgroup.
- Dr. Monroe responded that the welcome package represented a tremendous opportunity. In terms of accreditation, she indicated that she had to resign from the accreditation board because she came to work for CDC. CDC has been a funder, with funds coming out of OSTLTS, which she now directs. The accreditation effort is starting out broad-based. They need to put a structure in place and begin to develop measures. Many questions have been raised about including more specific modules in a variety of areas such as capacity in ethics. In fact, the accreditation board has conducted some focus groups that they refer to as "Think Tanks." They conduct one-day meetings with these Think Tanks to ponder specific questions. Down the line, it would be interesting to talk to the accreditation board about a specific Think Tank that focuses on ethics capacity. The ACD workgroup is just beginning and is expected to convene for the first time in July 2010.
- Dr. Barrett questioned whether it would be useful to have an Ethics Subcommittee liaison on the ACD workgroup. Dr. Monroe indicated that she would raise this idea with the workgroup.
- Ms. Wolf supported the idea of an assessment tool to determine ethics capacity, which may be related to the accreditation issue. There was a discussion about how to best define

“ethics capacity.” Dr. Hood pointed out that the extensive work on clinical ethics might be somewhat parallel. From his personal perspective working in a health department, ethics capacity means helping members of the workforce develop skills to identify ethical issues, analyze them, develop some sort of a framework / checklist, and work together to develop options that the agency can pursue.

- Dr. Bernheim thought this was a great working definition. In terms of talking about infrastructure capacity in line with accreditation, a number of people have been working with the Public Health Leadership Society (PHLS). Members have been discussing building not only capacity to substantively deal with such issues as Dr. Hood described, but also to address ways of structurally integrating the capacity to have an on-going group or team of individuals who have the training and ability over time to provide that. Ethics committees are the corollary in hospitals.

Report from the State and Local Support Workgroup

Leslie Wolf, JD, MPH, Ethics Subcommittee Member
Robert Hood, PhD, Ethics Subcommittee Chair
Ruth Gaare Bernheim, JD, MPH, Ethics Subcommittee Member

Ms. Wolf reported that the first couple of meetings of the State and Local Support Workgroup focused on gathering information and trying to decide where their particular focus was going to be. In particular, they wanted to hear what had been done by others, including the Public Health Leadership Society, ASTHO, and NACCHO because they did not want to duplicate the work that had been done by others. They also wanted to seek support and suggestions from these groups. From that, they began to formulate a sense of what they wanted to do in terms of a survey. They crafted a draft protocol to offer a sense of the workgroup's goals, and developed a draft survey to identify the topics. The main goal is to collect information from the state, tribal, local, and territorial health departments primarily to understand their needs. Generally they wanted to understand what issues the Ethics Subcommittee could focus upon that would be most helpful to those in the field. The workgroup identified various question areas / topics, including the value being placed on public health ethics, availability of tools for addressing ethics issues, impact of addressing ethical issues on public health practices, and the importance of public health ethics for improving public health work. The workgroup also wanted to identify the major ethical challenges health departments are experiencing. For this, they were thinking about including closed-ended and open-ended questions. It is hoped that this will also provide information that can be used by the Case Studies Workgroup to develop realistic case scenarios.

The workgroup has been considering when a survey should be disseminated into the field and to whom it should be addressed. The next steps are to obtain feedback on the concepts of the survey to determine whether any issues have been left out, whether there are issues they should not focus on, et cetera. The workgroup is coordinating with ASTHO and NACCHO because they do not want this survey to interfere with other work they have on-going, nor do they want people to be burned out on surveys and not want to respond to theirs.

Discussion Points

- Dr. Hood thought a strength of the approach was the strategy of trying to identify the kinds of topics / problems / dilemmas that people in the field perceive as ethical issues from their perspectives, as well as trying to understand organizational structures and mechanisms that support examination of ethical issues.
- Given the lengthy anticipated Office of Management and Budget (OMB) approval time, Dr. Bayer wondered about the possibility of the survey being organized out of a school of public health rather than from CDC. This sounded like a three-year process and he wondered whether they would be serving the interest of public health and advancing an agenda of the ethics of public health by taking so long to obtain approval.
- Dr. Barrett responded that her understanding was that the OMB rules are that it does not matter who is administering the survey. If data are being collected on behalf of the federal government, OMB clearance still applies. They have engaged in discussions with staff in the Office of the Associate Director for Science who oversee OMB clearance issues at CDC. There are some new rules about social media, but unfortunately any time a structured survey is administered to more than 9 members of the public, the OMB Paperwork Reduction Act comes into play. They could put out a general call through the *Federal Register* requesting input on a strategy to support state and local health departments; however, if they want to ask more structured questions, they will have to seek OMB clearance.
- Dr. Hood viewed this as a good opportunity to think about what they want to ask and the best way to ask it. He stressed the importance of timing and that state and local health officials frequently receive surveys, so they must make sure that theirs is not distracted by others.
- Dr. Barrett requested further information from Dr. Monroe about the strategy for reaching out to state and local health departments in terms of sampling strategies, communication methods, contacts, et cetera. This is potentially complicated, given that there are some 2,800 local health departments.
- Dr. Monroe replied that if she had to reach out to local health departments immediately, she would do so through NACCHO for local health officials. For state health officials, CDC is beginning to send direct communications via email. The ultimate intent of her office is to be able to communicate directly with all health departments.
- Dr. Chandar reported that NACCHO has multiple surveys going out to its membership on a regular basis, and they have a profile of all the local health departments. This is done every couple of years. NACCHO has a research evaluation team that also would be interested in helping to ensure that the questions are appropriate and of high quality. Getting to the right person in each of 2,800 locations will be difficult to manage and is a challenge they must work through carefully.

Drue Barrett, PhD
Designated Federal Official, Ethics Subcommittee

Dr. Barrett reviewed comments made by ACD members and summarized plans to obtain public input on the ventilator guidance document. During their April meeting, ACD members expressed concerns about the complexity of the ventilator document and about how the document would be interpreted and used at the local level. ACD members suggested that a preamble be added to the document to make it clear how the document is supposed to be used. The Ventilator Workgroup is in the process of making those revisions. The ACD approved the document as a working draft, but they also wanted it made available for public comment. They suggested focusing on acquiring input from hospitals, public health departments, and other groups that would likely utilize this guidance. Dr. Barrett has been holding discussions with a variety of people to develop a strategy for obtaining public comment. This will include posting the document in the *Federal Register* and sharing it with groups who have been working on preparedness issues. This will include CDC funded grantees working on pandemic preparedness, and ASTHO and NACCHO sponsored workgroups on preparedness. Additionally, ASTHO is planning a meeting in September 2010 of public health preparedness directors. Jim Blumenstock at ASTHO indicated that he would be open to including a presentation at this meeting about this document. Dr. Barrett stressed that the first step is to finalize the document to address the comments that were made during the ACD meeting, which would hopefully be done within the next month.

Discussion Points

- Dr. Daniels pointed out that when the Ethics Subcommittee met a few months ago to consider the ventilator document, members of the public raised concerns about the fact that ventilators are a relatively scarce resource and that in a crisis, not everybody who needs one might have access to a ventilator. This called into question why the Ethics Subcommittee was talking about how to ration ventilators when instead they should be talking about producing many more. This is a version of what has been heard in the health reform debate about rationing. With that in mind, he wondered whether the ACD discussion and request for public input was in response to that public climate.
- Dr. Barrett replied that there was not a direct correlation. She clarified that Dr. Daniels was referring to the last Ethics Subcommittee meeting during which a couple of people on the phone offered public comments. Dr. Frieden said he thought a preamble would be helpful, with noted that they should be working to increase the supply of ventilators now. That has been added to the document. She thought the primary reason the ACD wanted public comment pertained to their concern about the complexity of the document and whether there would be variability in how the guidance was implemented.
- Dr. Hood added that the document addresses the issue of implementation of best practices in a more standardized manner versus allowing more local flexibility. That is an issue which public comment can address. In terms of transparency, it will be beneficial for jurisdictions

to specify who will make triage decisions. The overwhelming sense he got from the ACD was that they found this to be an important document, support this work, and want it to become a public document. They thought the public comment process would facilitate this.

- Dr. Barrett said the goal was to have a summary of the public comments before the ACD meets again, which will be at the end of October. A determination must be made about how to address the public comments and how to revise the document.
- Dr. Ortmann highlighted the importance of having standardized guidance, while recognizing that each health department is unique and that the guidance must be applied in that context.
- Reflecting on the original conception, Dr. Lo thought this document was a “points to consider” framework rather than guidance per se, and that this should be made clearer. Given limited resources in public health departments and hospitals, he did not feel comfortable advocating for purchasing ventilators. He thought this should be raised as an issue of the need to make allocation decisions and take into account opportunity costs. This should be part of the framework.
- Dr. Barrett noted that some additional work has been done on the number of ventilators that are available across the country, so the document will be updated to reflect this information. She added a statement in the preamble that addresses the need to increase the supply of ventilators, so she suggested that Dr. Lo review this to determine whether they needed to temper it with the comment he made about opportunity costs.
- Dr. Bayer pointed out that work began on this document when there was a sense of an impending crisis of pandemic influenza. The sense of crisis has past. Last year, there was not a global or domestic disaster. Taking 4 to 5 years to produce a document seemed to be a problem they should be thinking about.
- Dr. Barrett thought this would fit nicely with their discussion with Dr. Jaffe about the Ethics Subcommittee’s future work. Clearly, all of the guidance documents that the Ethics Subcommittee has developed (e.g., pandemic influenza, emergency preparedness, and ventilator) took several years to develop. Perhaps that is not the best use of this subcommittee’s time and there may be a different approach that they should be taking.
- Ms. Bernheim thought that offering “points to consider” versus guidance might take some pressure off of having a perfect document and would alleviate the time issue. They could frame this in the context of supporting state and local health departments, and could connect it with the public outreach and public engagement idea. They have heard repeatedly from state and local health departments that public engagement is often necessary for legitimacy.
- Dr. Barrett clarified that the introduction clearly states that this is a “points to consider” document. Despite that, when the ACD reviewed it, they remained concerned that the concepts were very complex.
- Dr. Daniels thought this point must be strengthened in the document. Pointing to the issue of local versus centralized decision making, provided there is transparency about the rationale behind it, perhaps more variation could be tolerated in terms of ventilators in the

United States. His sense was that the document should lay out issues, but not offer specific recommendations.

- Dr. Hood stressed that this was a difficult tension. His impression of the ACD meeting was that some members advocated for having a more consistent approach. When he talked to physicians groups in Florida, he definitely heard that they would prefer a standardized U.S. framework. However, the health officers he has spoken to want a great deal of local discretion. One reaction he had to this process was that the subcommittee was charged with an extraordinarily difficult topic about which there is not a lot of agreement.

Report from the Case Studies Development Workgroup

Robert Hood PhD, Ethics Subcommittee Chair
Norman Daniels PhD, Ethics Subcommittee Member
Jennifer Prah Ruger PhD MSc, Ethics Subcommittee Member
LaVera Marguerite Crawley MD MPH, Ethics Subcommittee Member
Ruth Gaare Bernheim JD MPH, Ethics Subcommittee Member

Dr. Daniels summarized the main features of the approach the Case Studies Development Workgroup has taken. All the cases focus in various ways on social determinants of health (e.g., transportation, housing, job security). A general point is that the cases address health impacts that arise as a result of decision making in non-health sectors. The case studies were partly an effort to bring out aspects of that concept. The group thought the case studies needed a layered approach. The layers would include, for example, examination of fact versus value statements, discussion of the ethical considerations, and examination of the factors that affect decision making. The outline for each case reflects this layering and includes background reading that might be relevant. What the work group did not resolve was the context in which these cases were to be used. Are these a component of a one-day workshop? Are these components in a series of one-hour lunchtime meetings? The basic idea behind all of the cases was that the group thought it would improve the ethical capabilities of different levels of public health workers.

Dr. Bernheim added that they wanted to develop cases that have dimensions that will engage people in the workforce at the state and local levels in order to build their capacity. How the decision making process occurs within health departments is key in terms of how these tools should be framed and will be used. Dr. Barrett pointed out that ideally the cases would be developed to allow as much flexibility in use as possible. There is a need to have a case book on public health ethics.

Discussion Points

- Dr. Ortmann said he has a lot of experience working with the Ethics Bowl, which is an undergraduate competition that involves cases on medical ethics and bioethics. He agreed that there was little in the way of public health ethics cases in comparison with what is available in bioethics and research ethics. It is very difficult to write cases for public health and social determinants, given that these function very differently from cases in bioethics and medical ethics. Bioethics and medical ethics tend to clearly point to one or two people as the decision makers. In public health, it is not always as clear who is responsible.
- It was suggested that a repository of cases be established, and that state and local entities be queried about what would be helpful to them.

Introduction to New CDC Associate Director for Science / Future PHEC Priorities

Harold Jaffe, MD, MA Associate Director for Science Centers for Disease Control and Prevention

Dr. Jaffe is the Associate Director for Science at CDC. He is returning to CDC from the University of Oxford where he recently served as Professor and the Head of the Department of Public Health, and also has been a Fellow at St. Cross College since 2004. He led the first national case-control study to determine risk factors for what is now known as HIV. Over the last two decades, he has served in leadership positions in CDC's expanding HIV / AIDS programs, including serving as the Director of the Division of HIV / AIDS.

Dr. Jaffe indicated that his department at the University of Oxford had a medical ethics unit called Ethox Centre, which was headed by Professor Tony Hope and then Professor Mike Parker, who are both well-known medical ethicists in the United Kingdom. For this meeting, he was asked to address the future priorities for the Ethics Subcommittee, which has already been engaged in a considerable amount of helpful work for CDC over the last few years. He indicated that while he did not yet know Dr. Frieden's exact expectations for the Ethics he thought that Dr. Frieden would be supportive of the Ethics Subcommittee efforts to support state and local health departments, particularly given that one of the director's priorities is to work with and support CDC's state and local partners.

Dr. Jaffe also raised the possibility of having the Ethics Subcommittee explore issues relating to international research ethics. He pointed out that a new Center for Global Health has been established at CDC, which is headed by Dr. Jaffe's former colleague, Kevin DeCock, who was most recently the Division Director for HIV / AIDS at World Health Organization (WHO). The Center for Global Health includes programs in global AIDS, malaria, global disease detection, influenza, polio, and measles. At some point, Dr. Jaffe will have the opportunity to discuss the Center for Global Health's interest in ethical issues and what guidance they may need from the Ethics Subcommittee.

Discussion Points

- Dr. Bayer expressed concern about shifting the Ethics Subcommittee's focus from public health ethics to research ethics. Dr. Daniels was also skeptical of focusing on research ethics unless the focus was on public health interventions. He stated that the Ethics Subcommittee should not duplicate what has already been done in this area by groups such as the Fogarty International Center at the National Institutes of Health (NIH).
- Dr. Bernheim suggested focusing on capacity-building case development in the international realm versus venturing into a new area.
- Dr. Lo agreed that they probably should not engage in any efforts that did not align with Dr. Frieden's priorities, and that consideration also should be given to the added value of having Ethics Subcommittee input. Some efforts could be carried out by individuals or subcontractors to build upon what is already being done. Consideration should also be given to whether a more rapid ethics consultation process is needed versus the years it has taken to work on something that was originally thought to be a fairly urgent piece of work (e.g., ventilators).
- Dr. Barrett responded that the internal CDC Public Health Ethics Committee (PHEC) has developed a public health ethics consultation service in order to rapidly respond to ethics issues. This mechanism has not involved the entire Ethics Subcommittee membership. The problem is that PHEC members typically have no formal ethics training. They have benefited from the input of Dr. Leonard Ortmann, the CDC-Tuskegee Public Health Ethics Fellow, who has been very helpful in providing input on consults. They have also relied upon input from individual members of the Ethics Subcommittee. Perhaps it would be useful to explore other mechanisms for having more in-house staff who are actually ethicists. She agreed that they must think about the value added in having a standing ethics subcommittee that can be turned to for input. Perhaps writing guidance documents is not the best value. Perhaps instead a consultation team can be established if an urgent issue arises. One complicating factor is that the Ethics Subcommittee must follow Federal Advisory Committee Act (FACA) rules. This requires that meetings be announced in the *Federal Register* and that products of the Ethics Subcommittee be approved by the ACD.
- Dr. Bayer said he detected a sense of institutional anxiety in the last few minutes of discussion. The truth is that the world of public health ethics and its role in dealing with institutions around public health is relatively new compared to the role of bioethics and advising governments and agencies. It seemed to him to be crucially important to have an institutional identity of a subcommittee that has as its focus, mission, and charge providing a forum within which ethical issues that emerge in public health, especially at CDC, can be aired. He asked Dr. Jaffe, as he thinks about the Ethics Subcommittee's role and talks to Dr. Frieden about this, to try to structure and focus the Ethics Subcommittee's efforts in a way that takes advantage of what the subcommittee has to offer.
- Dr. Hood acknowledged the excellent work that CDC has done in creating an internal and external public health ethics structure and in being a strong advocate for public health ethics. It seemed that they were all struggling with identifying the best mechanism for addressing public health ethics. Perhaps they should frame their discussion about what this subcommittee could do in terms of developing resources, setting expectations, and linking public health agencies with existing resources as one way to move forward.

- Dr. Bernheim noted that this was an interesting opportunity to look at the domains in the public health accreditation standards that are now being beta tested to determine how to overlay ethics to measure the ethical dimensions of the accreditation domains.
- Dr. Hood noted that some CDC funding requires states to address the ethical dimensions of public health emergencies and has supported public health ethics work in a number of jurisdictions. Grant requirements such as this are small efforts that can have structural consequences in terms of implementing public health ethics. Perhaps the Ethics Subcommittee's role could be one of thinking about how CDC might implement such a practice.
- Dr. Jaffe committed to learning more about Dr. Frieden's priorities before the next Ethics Subcommittee meeting.

Public Comments

No public comments were offered.

Procedural Issues and Meeting Wrap-up

Robert Hood, PhD Ethics Subcommittee Chair

In conclusion of the meeting, Dr. Hood led the participants in summarizing the next action steps, which included the following:

- Further discuss the development of ethics content for the package for new state health officials. Dr. Hood will speak further with Dr. Barrett about how they might work on this. Perhaps the State and Local Support Workgroup could take on this task.
- Explore the option of holding a "Think Tank" on ethics as part of the accreditation process.
- Complete the draft of the survey. A survey should be prepared within the next couple of months in order to get it into the OMB process. The group agreed to review the current draft and submit their comments and questions to Dr. Barrett.
- Further discuss the case studies and how they should be used. Perhaps a facilitator's guide should be developed so that whomever teaches these cases will have guidance in terms of focusing their discussion. Perhaps additional case studies could be developed and a case book published.

- ❑ With respect to the public health ethics consortium discussion, one of the functions of PHEC is to offer training to CDC staff on public health ethics. While they have been focusing on a CDC audience, perhaps they should explore opening these training events up more broadly. CDC puts on a Grand Rounds series which is held once a month, which has been opened up so that people can access the event through the internet. Something similar could be explored for public health ethics training.
- ❑ The next meeting is scheduled for October 7-8, 2010 and it is preferred that this be a face-to-face meeting.

Dr. Hood thanked everyone for their time, recognizing that meetings via telephone are much more difficult than in person.

With no further business posed or questions raised, the meeting was officially adjourned at 3:06 pm.

Certification

I hereby certify that to the best of my knowledge, the foregoing Minutes of the June 17, 2010 PHEC Meeting are accurate and complete.

Date

Robert Hood, PhD
Ethics Subcommittee Chair

**List of Attendees
June 17, 2010
1:00 – 3:30 pm Eastern Time**

Ethics Subcommittee, Advisory Committee to the Director

Ronald Bayer, Columbia University
Ruth Gaare Bernheim, University of Virginia
Vivian Berryhill, ACD Representative, National Coalition of Pastors' Spouses
LaVera Marguerite Crawley, Stanford University Center for Biomedical Ethics
Norman Daniels, Harvard University
Robert Hood, Ethics Subcommittee Chair, Florida Department of Health
Bernard Lo, University of California, San Francisco
Jennifer Prah Ruger, Yale University
Pamela Sankar, University of Pennsylvania Department of Medical Ethics
Leslie Wolf, Georgia State University

Centers for Disease Control and Prevention

Drue Barrett (Designated Federal Officer, Ethics Subcommittee)
Elise Beltrami, NCEZID
Scott Campbell, NCDDD
Catina Conner, OADS
Laurie Dieterich, NCEZID
Barbara Ellis, OPHPR
Lindsay Feldman, OADS
Karen Gavin, NCEH/ATSDR
Neelam D. Ghiya, OADS
Sara Giordano, OPHG
Sean David Griffiths, OADS
Sonja Hutchins, OCPHP
Christopher Jackson, OADS
Harold Jaffe, OADS
Mim Kelly, OADS
Kimberly Lane, OADS
Lisa M. Lee, OSELS
Eileen Malatino, OPHPR
Daniel McDonald, OCOO
Marilyn Metzler, NCIPC
Judith Monroe, OSTLTS
Mary Neumann, NCHHSTP
Julie Orta, OADS
Leonard Ortmann, OADS
Ron Otten, OADS
Lauretta Pinckney, NCHHSTP
Tanja Popovic, OADS
Joan Redmond Leonard, NCCDPPH
Cheri Rice, MASO
Tom Simon, NCIPC
Antonia Spadaro, NCCDPPH

Members of the Public

Brenda Robertson, Emory Clinic

Subha Chandar, NACCHO
Amy Johnson, Cambridge Communications and Training Institute
Kathy Kinlaw, Emory University Center for Ethics
Janice McCoy, Sedgwick County Health Department
Katie Sellers, ASTHO