

**DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS  
FOR DISEASE CONTROL AND PREVENTION (CDC)**

**Joint Meeting of the Ethics Subcommittee of the Advisory  
Committee to the Director (ACD) of CDC  
and the CDC Public Health Ethics Committee**



**Executive Summary  
February 17-18, 2011**

**Joint Meeting of the Ethics Subcommittee of the Advisory Committee to the Director,  
Centers for Disease Control and Prevention (CDC) and CDC's Public Health Ethics  
Committee**

**February 17-18, 2011**

**Thomas R. Harkin Global Communications Center, Distance Learning Auditorium  
Atlanta, Georgia**

**EXECUTIVE SUMMARY**

**February 17, 2011 – Day One**

**Introductory Remarks and Overview of Meeting Goals**

*Drue Barrett, PhD, Designated Federal Officer, Ethics Subcommittee*

*Ruth Gaare Bernheim, JD, MPH, Chair, Ethics Subcommittee*

At 1:12 PM on Thursday, February 17, 2011, after confirming that there was a quorum of Ethics Subcommittee members present, Drue Barrett, PhD, Designated Federal Officer (DFO) for the Ethics Subcommittee and Chair of the CDC Public Health Ethics Committee (PHEC), called the meeting to order. Ruth Gaare Bernheim, JD, MPH, Chair of the Ethics Subcommittee, welcomed the group and called upon the Ethics Subcommittee members to declare any conflicts of interest. No conflicts of interest were reported. After introduction of meeting participants, Ms. Bernheim reviewed the meeting agenda [see Appendix A].

**Review and Approve: Presentation for ACD on Ethical Considerations for Non-Communicable Disease Interventions**

*Ruth Gaare Bernheim, JD, MPH, Chair, Ethics Subcommittee*

A workgroup comprised of Ethics Subcommittee members and members of PHEC discussed a presentation for the Advisory Committee to the Director (ACD) of CDC in response to a charge from the ACD. Ms. Bernheim presented a draft version of the PowerPoint for the larger group's consideration. The presentation was framed in the context of specific questions from CDC leadership and focused on how to address the ethical tensions that arise when public health intends to implement restrictive, regressive policies and approaches that focus on chronic diseases and injury, rather than infectious, diseases. The presentation addresses the following main points:

- When is it appropriate and acceptable that public health limit individual choice, directly or indirectly?
- When should public health intervene in broader group efforts, such as intervening against the marketing of specific unhealthy foods?
- What ethical issues need to be considered for the successful implementation of noncommunicable disease interventions?

The public health roles of protection, prevention, and promotion can overlap. Each of the spheres may reflect a different responsibility, authority, and public acceptance of government responsibility. When considering tensions about competing social values, ethical tensions may become stronger along the spectrum from protection to prevention to promotion. In the area of infectious disease, public health's main focus lies in protection. In injury, public health works in both protection and prevention. Work in chronic disease conditions spans all three areas. Work in creating healthy conditions focuses on prevention and promotion. Creating healthy conditions may not be widely recognized as a public health responsibility.

Data on burden, impact, and evidence-based interventions are the framework of the "Winnable Battles." When there are knowledge and data, CDC has the responsibility and authority to act. Not acting creates harm, but the presence of data does not necessarily equal implementation. Within the gap between data and implementation, there exists a range of social values and moral claims by various stakeholders. The workgroup suggested using case examples to examine the range of ethical arguments and moral claims that might come from the affected stakeholders and to illustrate how CDC leadership might apply ethical considerations to noncommunicable disease interventions.

### **Discussion Points**

- It is important to distinguish between what an ethical analysis can provide and the impact of existing social norms and political considerations. It is possible to claim an ethical justification for doing something even when the action is not supported by current social norms. For example, there is no ethical difference between a cigarette tax and a soda tax, especially in terms of who will bear the burden. However, a cigarette tax is much more acceptable than a soda tax today because the social norms around smoking have change.
- There was discussion regarding CDC's ethical obligations to use its available "tools," given that CDC is not a regulatory agency but one that generates recommendations, educates, and nudges. CDC prefers not to be regressive or restrictive. The agency can, however, attach requirements to grant programs.
- It was noted that the presentation for the ACD should be crisp and concise, with little detail about process. Separate work is needed regarding public engagement. It was also suggested that if the presentation does not focus solely on ethics, the value added of ethics will not be clear. Some ethical arguments also apply to social values, but social values and ethics are not the same thing.
- The presentation should assert that addressing ethical issues is critical. People in decision-making roles should engage issues beyond the notion that liberty always trumps public health. Ethics can acknowledge that some degree of liberty will be limited in the name of public good.
- CDC's role may vary with each winnable battle. In some cases, CDC may have no tools save persuasion and recommendations. In other cases, CDC may have more options, such as attaching conditions of participation to grants. Consideration of ethical issues can help CDC

think about implementation problems, what its tools are, and how to create a process for choosing which tools should be brought to bear on a problem.

- There was discussion of examples that the presentation might use. They could use examples to examine a particular intervention, such as a tax, or they could focus on a particular chronic disease (for example, obesity) and compare several interventions. The examples could also illustrate the ethical dimensions of using similar interventions for other issues. There was also a suggestion that the presentation include a discussion of different surveillance systems.
- The group discussed the similarities and differences between soda and cigarette taxes. Both taxes are regressive and could be considered coercive or liberty-restricting and choice-constraining. The differences include the evidence base, the direct relationship between a toxin and a consequence, social normative backgrounds, and confidence that a particular intervention will achieve the desired public health outcome.
- It was noted that for their purposes, it was important to accept that an intervention will work. With that agreement, they can consider the ethical and moral questions raised by an intervention that has the potential to be effective, but may nevertheless impinge upon other moral or ethical considerations. It was noted, that the agency requested help in understanding whether, if an intervention works, it might create another problem that had not been considered.
- The level of evidence is an important component of ethical analysis. There must be strong evidence of effectiveness in order to justify use of an intervention that limits individual liberties. Further, tensions between competing social values may not be strong when the intervention involves only sharing information. However, when the intervention is more liberty-limiting, these tensions may play a stronger role.
- In the last 40 years, a tremendous public health achievement has been reached, as overall smoking in the United States has been reduced by half. On the other hand, an unanticipated issue has emerged in that there is now a strong relationship between smoking and social class. This raises a moral challenge relating to equity in health outcomes and exposure to risk. Addressing these health equity issues would raise the level of public health ethical discussion.
- There was discussion regarding whether the presentation should outline different strategies and ethical issues associated with the winnable battles. For instance, they could present strategies for reducing smoking and then illustrate the ethical issues and problems created by each one of them. Analysis of all strategies across an area allows for cost-effectiveness analysis, given potential ethical objections.
- Time is limited for the presentation, so they hope to give a general sense of direction and a few examples to show the audience the value of ethics, in hopes that they would ask for additional analysis.

- The presentation should provide the audience with a systematic way to think through the ethical issues. In some ways, the approach is no different, whether the issue is a communicable or a noncommunicable disease.
- Public health may have few powers in some cases, and the ethical issues become academic. In cases in which public health has more power and authority to act on a problem, the ethical discussion is more significant. The benefit of using multiple examples is that they could show this dynamic. Tools vary by the problem.
- The issue of surveillance underlies many of the winnable battles. They can discuss how strongly CDC wants to act, giving examples of when CDC has intervened. They can focus on the tools that public health needs to utilize to address the winnable battles.
- Many suggested that tobacco would be a good example, as it shows the range of ethical issues at hand (e.g., equity, and autonomy). It also illustrates a range of interventions and effects (e.g., taxes, bans, prohibitions, education, social marketing, and unintended consequences).
- Others thought that by comparing the soda tax to another intervention, such as a surveillance approach to obesity with information-sharing, they could show where the tax was regressive and could have an impact on equity, where the population-wide approach with direct response would not be regressive.
- All agreed that the example should be important to CDC, illustrative of their methods, and focused on an area in which CDC has a stake in the remedy and a range of tools.
- CDC does not have much leverage in the area of motorcycle helmets, but there is still value in examining harms and in having an ethical rationale. CDC could also advance the issue for state and local health departments to use with their state legislatures, thereby contributing to policy formulation and public engagement support.
- There was mention of CDC's global impact and the ethical implications of its work in non-communicable diseases and global health.
- As there will not be another Ethics Subcommittee meeting before the ACD meeting, which is scheduled for April 28, 2011, the Ethics Subcommittee voted to approve the content of the presentation and empowered the Chair and the workgroup to finalize the presentation.

At 4:07 pm, Ms. Bernheim called for any public comment, either in person or on the phone. Hearing none, they resumed discussion of the presentation to the ACD. The meeting adjourned for the day at 4:33 PM.

## **February 18, 2011 – Day Two**

After a quorum of Ethics Subcommittee members was reached, the meeting was called to order on the second day at 8:43 AM. Ms. Bernheim welcomed the group and as he was not able to attend the first day of the meeting, she invited Ken Goodman, a new member of the Ethics Subcommittee, to introduce himself. Dr. Goodman is founder and director of the University of Miami Bioethics Program and its Pan American Bioethics Initiative and co-director of the university's Ethics Programs, including its Business Ethics Program. He chairs the Ethics Committee of the American Medical Informatics Association and he directs the Florida Bioethics Network. Dr. Goodman's research has emphasized issues in health information technology, including bioinformatics or the use of computers in genetics, and in epidemiology and public health. Dr. Goodman indicated that he had no conflicts of interest. After reviewing the day's agenda, Ms. Bernheim summarized the discussion from the previous day.

### **Summary of Discussions from Day One**

*Ruth Gaare Bernheim, JD, MPH, Chair, Ethics Subcommittee*

The presentation will be 15 minutes long. It will look at particular cases and present ethical dimensions of particular topics such as obesity, or particular interventions such as the soda tax. It will address lessons learned regarding intended and unintended consequences in tobacco initiatives and the comparison of cigarette tax and soda tax, as well as motorcycle helmets. They would also consider the ethical dimensions of surveillance, a traditional tool of public health. The workgroup will obtain additional guidance from CDC regarding other cases that might be relevant. Several ethics frameworks available in the literature will help them build the presentation.

### **Discussion Points**

- Caution was expressed regarding CDC leadership's desire for an assessment of potential positive and negative outcomes associated with noncommunicable disease interventions. It was pointed out that providing an ethical frame for thinking about interventions will not predict outcomes.
- The presentation will assess historical cases to provide insight and offer suggestions about ethical dimensions. The example of blind sero-surveillance was suggested.

### **Discussion: Support of State, Tribal, Local and Territorial Health Departments**

*Leslie Wolf, JD, MPH, Ethics Subcommittee Member*

Ms. Wolf provided an update on the webinars with state, tribal, local, and territorial health departments. The webinars included information about public health ethics activities at CDC and then focused on learning from the participants about their most pressing public health ethics challenges. Three cases on topics relating to tuberculosis, emergency preparedness, and surveillance were presented as "triggers" for discussion. The discussion also focused on how CDC could be most helpful to health departments in assisting them in their efforts to address

ethical issues. To date, three webinars have been hosted with state health officials, one with local health officials, one with a tribal group, and one more is scheduled with state health officials. Overall, the participants indicated that they still face the issues posed in the “trigger cases,” and they still need help with them. Other issues emerged, including the following:

- ❑ Resource allocation - Specific examples of issues that health officers had faced included:
  - How to deal with budget cuts – prioritization
  - Emergency-related resource allocation
    - Use of resources from the Strategic National Stockpile – during H1N1 pandemic they had to set aside assets to share with private sector
    - Guidance for ventilator distribution
    - Distribution of antivirals during H1N1 outbreaks/epidemic
  - Prioritizing waiting list for people requiring assistance with AIDS drugs
  - Use of state resources for treatment of undocumented residents including providing prenatal care for undocumented women; Cost of screening for citizen status will cost more than just providing treatment
  - Conflict about use of resources for populations who reject public health recommendations (e.g., resources used to urge vaccination among non-compliant communities)
  - Evaluating possible cancer clusters vs. using resources for issues that affect more people
  
- ❑ Policy/legislation/politics - Health officers also commonly raised issues about how policy, legislation, or politics can impact public health efforts. Decisions made outside the public health department could affect how their work could be accomplished, their priorities, or whether they could even work on the issue at all. Some specific examples raised included:
  - Immunization issues (new rules that require disclosure about vaccine side effects making it easier for parents to refuse childhood vaccinations)
  - End of life issue
  - Budget cuts – states are in survival mode
    - Constantly having to redefine priorities and decide what programs to cut
    - Decision of what to tell public about how cuts affect capability
  - Prioritization of issues and enforcement of issues
    - Potential conflicts between laws (and enforcement) and underlying public health goals
  
- ❑ Data use and management, including privacy and confidentiality protection - Health officers indicated that data use and management, and obligations to protect confidentiality, frequently arise. Specific examples raised included:
  - Review of requests for use of state surveillance data
  - Use of information for purposes other than why the data originally collected (example – Newborn Registries/blood spot data)

- IT security and data access; State laws that require reporting of sexual activity of minors who seek treatment for STD
- Release of data from small jurisdictions (how to protect confidentiality of the data)
- Distinguishing between surveillance/public health practice and research
  
- Control of infectious diseases - With respect to control of infectious diseases, health officers raised a number of different, specific concerns:
  - Border security and working across federal agencies –challenges of detaining people at the border who have TB, providing partial treatment and then returning them back to their home country (without full treatment)
  - Notification of passengers about possible exposure to infectious diseases
  - Treatment of TB cases among transient populations
  - Low vaccination rates
  
- Immigration - Issues related to immigration were also common raised. While some of these issues were raised in the context of resource allocation, other issues were identified as important:
  - Targeting foreign students for health screenings on college campuses
  - Use of resources for treatment of undocumented residents
  - Requests to collect data about immigration status
  
- Community engagement - Health officers also discussed issues relating to community engagement, including:
  - How best to engage the community on controversial issues, like allocation of scarce resources
  - Building trust in the community, especially concerning vaccination
  - Deciding how much information to share with the public about various health department decisions
  
- Balancing individual choice with protecting the public good - In some of the webinars, health officers discussed the dilemma of balancing individual choice against protecting the public good and raised the following examples of this dilemma.
  - Rights of parents to refuse vaccines for their children versus rights of day care centers to refuse admission to unvaccinated children
  - Consumption of raw milk
  - Mandatory vaccination of health care workers
  
- Relationship between hospitals/physicians and public health - In one webinar, health officers raised the issue of the relationship between hospitals/physicians and public health, identifying the following issues of concern:
  - Difficulty of physicians in transferring ethics from individual framework to population framework – working to educate them
  - Providing an appropriate amount of guidance and regulations to hospitals and physicians – assisting without intruding

- ❑ Addressing ethics issues - Health officers also raised issues about how to incorporate ethics into decision-making both within and outside the department, as follows:
  - How to address ethical issues that cross state lines (several environmental health issues raised)
  - How best to implement the Public Health Code of Ethics
  - Consideration of ethics as part of the accreditation process
  - How best to interact with local health departments on public health ethics issues

Of the listed issues, resource allocation and politics were the most talked-about in the webinars. There was a wide range in what the groups were actively doing in ethics. Some have active collaborations with academic ethicists, some have formal ethics groups, and others have no public health ethics resources. The webinar participants hoped that CDC would create tools for dealing with public health ethics issues, including:

- ❑ Having case studies that extend beyond “classic cases” to other issues, such as immunization, cross-jurisdiction, general use of public health powers and balancing individual rights and the public good, immigration, and social determinants of health
- ❑ A reference guide or website resources
- ❑ On-line public health ethics training

Many participants appreciated the webinar as a chance to talk to others about ethical issues. The idea of convening additional opportunities for group discussion was welcomed. The Regional Health Administrators may help facilitate these conversations across states, and CDC could offer more opportunities. The idea of a Public Health Ethics Consortium was well-received.

### **Discussion Points:**

- The Subcommittee needs to respond to the needs expressed in the webinars in ways that are useful for state and local entities. A tangible product should be generated. One tangible product would be the development of a public health ethics consortium. Such a consortium may be a way to match universities with local public health departments to build synergy.
- The Public Health Accreditation Board (PHAB) is entertaining suggestions and recommendations regarding the accreditation process. It was suggested that there needs to be a stronger emphasis on ethics as part of the accreditation process. Meeting participants were encouraged to provide their individual input to PHAB.
- There was a discussion about public engagement and the varying forms it takes. This includes the public making decisions through a democratic process, either directly or through representatives and the public providing input to decision-making. Hearing and committees are elements of this input. A third area of public engagement centers on the issue of knowledge and public engagement around ethical issues. Another purpose of public

engagement is to have dialogue regarding the nuances behind complicated issues. There was also a discussion of the national public consultation frameworks in the United Kingdom and Canada. Webinar participants asked for help in conducting discussions around difficult issues such as ventilator allocation and other issues of scarce resources and “life and death.”

- PHEC and the Ethics Subcommittee have worked on case studies. The public health ethics consortium is another initiative that they would like to pursue. Discussion has also focused on use of the Public Health Code of Ethics. They will work closely with the CDC Office of State, Tribal, Local and Territorial Support (OSTLTS), which leads coordination efforts with state health departments.
- The Subcommittee expressed support for creating case studies and sharing them in a forum such as a webinar, which would provide opportunity for discussion. The Subcommittee agreed to prioritize its efforts, offering immediate help via case studies. Then they would address the more difficult issues around public engagement. The workgroup would discuss ways to move forward with the public health ethics consortium.

### **Review and Approve: Revision of Ventilator Document to Address Public Comments**

*Bernard Lo, MD, Ethics Subcommittee Member*

Dr. Lo explained the background behind the ventilator document. Dr. Barrett summarized the comments collected on the document, which were categorized as follows:

- Requests for additional implementation detail
- Requests for more attention to the needs of infants and children
- Comments on the triage process and triage team
- Comments on uniformity of decision-making versus local flexibility
- Discussion of withdrawal of patients from ventilators
- Comments on the importance of public engagement

Dr. Lo turned the group's attention to a summary of revisions that were made to the document in response to the comments [see Appendix B].

### **Discussion Points**

- The document advocates for central control of the process of allocating ventilators under pandemic circumstances. Central control is essential so that neighboring locales do not establish different standards.
- The document is designed to provide ethical considerations, not specific algorithms for action. Additional language was added to the preamble to specify that the document is a conceptual framework, and difficult decisions need to be made at the state and local level with input from a variety of different partners.
- The document will go forward to the ACD for approval. Once approved it will be posted on CDC's website, where previous Ethics Subcommittee documents are posted.

- There was discussion of the length of the approval process and what that timeframe means for the Subcommittee's ability to produce useful documents. The Subcommittee is moving away from developing documents that take too much time to create.

There was a motion to approve the ventilator document and to forward it to ACD. The motion was seconded and approved unanimously, with one abstention.

No public comments were offered during the second day of the meeting.

### **Procedural Issues and Meeting Wrap-Up**

There was discussion of potential new Ethics Subcommittee members. Members of the Subcommittee and of PHEC were asked to forward suggestions to Dr. Barrett. The following suggestions were made during the meeting:

- Jeffrey Kahn, University of Minnesota Medical School
- Eric Meslin, Indiana University Center for Bioethics
- Dorothy Vawter, Minnesota Center for Healthcare Ethics
- John Stone, Creighton University
- Include someone with expertise at the local or state level

Ms. Bernheim summarized the meeting, and Dr. Barrett reminded them of their next meeting dates: June 16-17, 2011 and October 5-5, 2011. She also reminded everyone to complete their evaluation forms. The meeting was officially adjourned at 11:20 AM.

### **Certification**

I hereby certify that to the best of my knowledge, the foregoing minutes of the February 17-18, 2011 Ethics Subcommittee meeting are accurate and complete.

4-18-11

Date

\_\_\_\_\_  
Ruth Gaare Bernheim, JD, MPH  
Ethics Subcommittee Chair

February 17, 2011  
1:00 – 5:00 pm Eastern Daylight Savings Time

**Meeting Participants**

Ethics Subcommittee, Advisory Committee to the Director

Ronald Bayer, Columbia University  
Ruth Gaare Bernheim, University of Virginia  
Norman Daniels, Harvard University (phone)  
Nancy Kass, Johns Hopkins University (phone)  
Sara Rosenbaum, George Washington University  
Jennifer Prah Ruger, Yale University  
Pamela Sankar, University of Pennsylvania  
Marion C. Wheeler, ACD Member, Strategic Consultant  
Leslie Wolf, Georgia State University

Centers for Disease Control and Prevention

Drue Barrett (Designated Federal Officer, Ethics Subcommittee)  
Michael Arenson  
Mary Ari  
Elise Beltrami  
Fred Bloom (phone)  
Scott Campbell  
Xiaohong Davis  
Zhuohui Deng  
Barbara Ellis  
Lindsay Feldman  
Natalie Gonzalez  
Sean D. Griffiths (phone)  
Norman Hayes  
Gail Horlick  
Sonja Hutchins (phone)  
Harold Jaffe  
Dolly Katz (phone)  
Mim Kelly (phone)  
Lisa M. Lee  
Aun Lor  
Hugh Mainzer  
Kathleen McDuffie (phone)  
Mary Neumann (phone)  
Leonard Ortmann  
Tanja Popovic  
Joan Redmond Leonard  
Joseph Rush  
Salaam Semaan  
Laurence Slutzker  
Dixie Snider  
Beth Stevenson  
Ranni Tewfik

Members of the Public

Brenda Robertson, Emory University (phone)

February 18, 2011  
8:30 am – 12:30 pm Eastern Daylight Savings Time

**Meeting Participants**

Ethics Subcommittee, Advisory Committee to the Director

Ronald Bayer, Columbia University  
Ruth Gaare Bernheim, University of Virginia  
Norman Daniels, Harvard University (phone)  
Kenneth Goodman, University of Miami  
Nancy Kass, Johns Hopkins University (phone)  
Bernard Lo, University of California, San Francisco (phone)  
Jennifer Prah Ruger, Yale University  
Pamela Sankar, University of Pennsylvania  
Marion C. Wheeler, ACD Member, Strategic Consultant  
Leslie Wolf, Georgia State University

Centers for Disease Control and Prevention

Drue Barrett (Designated Federal Officer, Ethics Subcommittee)  
Michael Arenson  
Scott Campbell  
Catina Conner  
Lindsay Feldman  
Neelam D. Ghiya  
Natalie Gonzalez  
Gail Horlick  
Sonja Hutchins (phone)  
Mim Kelly (phone)  
Kathleen McDuffie (phone)  
Mary Neumann (phone)  
Leonard Ortmann  
Ron Otten  
Tanja Popovic  
Joan Redmond Leonard (phone)  
Joseph Rush  
Dixie Snider

Members of the Public

Robert Levine, Yale University (phone)

## **Appendix A**

### **Joint Meeting of the Ethics Subcommittee of the Advisory Committee to the Director, Centers for Disease Control and Prevention (CDC) and CDC's Public Health Ethics Committee**

**February 17-18, 2011**

**Thomas R. Harkin Global Communications Center, Distance Learning Auditorium  
Atlanta, Georgia**

**Call-in Information: 1-877-928-1204, Pass Code 4305992#**

### **Meeting Agenda**

#### **Day 1 – Thursday, February 17, 2011**

- 1:00 – 1:30     **Introductory Remarks and Overview of Meeting Goals** – Ruth Gaare Bernheim, JD, MPH, Chair, Ethics Subcommittee
- Welcome and introductions
  - Ethics Subcommittee members declaration regarding conflicts of interest
  - Overview of Meeting Goals
    - Review and approve presentation for the Advisory Committee to the Director (ACD) on ethical considerations for noncommunicable disease interventions
    - Review revisions to the ventilator document made in response to public comments and approve document
    - Provide update on webinars with state, tribal, local, and territorial health departments and discuss next steps
- 1:30 – 3:40     **Review and Approve: Presentation for ACD on Ethical Considerations for Noncommunicable Disease Interventions** – Ruth Gaare Bernheim, JD, MPH
- 3:40 – 4:00     **BREAK**
- 4:00 – 4:15     **Public Comment**
- 4:15 – 4:45     **Continued Discussion of Presentation for ACD on Ethical Considerations for Noncommunicable Disease Interventions**
- 4:45 – 5:00     **Concluding Comments** – Ruth Gaare Bernheim, JD, MPH
- 5:00             **Adjourn**

**Note: Any individuals needing special accommodations in order to participate in the Ethics Subcommittee meeting should notify the Ethics Subcommittee Chair (Ruth Gaare Bernheim) or the Designated Federal Official (Drue Barrett) prior to the start of the meeting on February 17, 2011 for further assistance.**

**Joint Meeting of the Ethics Subcommittee of the Advisory Committee to the Director, Centers for Disease Control and Prevention (CDC) and CDC's Public Health Ethics Committee**

**February 17-18, 2011**

**Day 2 – Friday, February 18, 2011**

- 8:30 – 9:00     **Summary of Decisions from Day 1** – Ruth Gaare Bernheim, JD, MPH
- 9:00 – 10:30    **Discussion: Support of State, Tribal, Local, and Territorial Health Departments** – Leslie Wolf, JD, MPH, Ethics Subcommittee Member
- Update on webinars
  - Next steps
- 10:30 – 10:45   **BREAK**
- 10:45 – 12:00   **Review and Approve: Revision of Ventilator Document to Address Public Comments** – Bernard Lo, MD, Ethics Subcommittee Member
- Review of public comments
  - Discussion of revisions
- 12:00 – 12:15   **Public Comment**
- 12:15 – 12:30   **Procedural Issues and Meeting Wrap up** – Ruth Gaare Bernheim, JD, MPH
- Review action items
  - Recommendations for new Ethics Subcommittee members
  - Complete evaluation forms
- 12:30            **Adjourn**

## **Appendix B**

# **Summary of Revisions to the Ventilator Document**

**Prepared for the Joint Ethics Subcommittee/CDC Public Health Ethics Committee Meeting  
February 17-18, 2011**

- 1) Page 1: Added additional language to the preamble to further reiterate that the intent of the document is to serve as a conceptual framework to assist the planning process. Planning still needs to occur at the state, local, and institutional level to develop specific operational details and implementation steps.
- 2) Page 5: Added information on number of pediatric ventilators and updates section with published reference.
- 3) Page 8: Added language regarding need for training on implementation of crisis standards of care.
- 4) Page 8: Added footnote about VA and DoD facilities as possible resources.
- 5) Page 9: Added sentence about stewardship of scarce resources.
- 6) Page 10-11: Added language on nonmaleficence.
- 7) Page 13: Added additional examples of efforts to develop a modified SOFA score.
- 8) Page 13: Added language about use of expert opinion if valid scoring systems not available.
- 9) Page 14: Deleted sentence about allowing the availability of ventilators to determine how many eligible patients receive one due to concern that this sentence could be misinterpreted to suggest a first-come, first serve distribution.
- 10) Page 14: Added a sentence about the potential of QALYs and DALYs to create invidious distinctions based on arbitrary judgments regarding quality of life.
- 11) Page 17: Added mention of including an ethicist on the triage team and using the hospital ethics team as a resource.
- 12) Page 19: Moved Community Engagement section so that all clinically-related considerations listed together. Added paragraph about the challenges of conducting public engagement.
- 13) Page 22: Added paragraph on special considerations relating to children.
- 14) Throughout Document: Made changes to improve sentence flow or grammar.
- 15) Revised references.

Note: Between November 2010 and January 2011, comments on the ventilator document were solicited from a variety of public health, healthcare, and emergency management professionals. We received 32 comments. While all comments were carefully reviewed, considered, and ultimately have directly or indirectly enriched this revision, those best aligned with the original intent and scope of the document were most valuable in shaping this revision.