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REPORT OF THE BOARD OF TRUSTEES

B of T Report 15-A-09

Subject: Tobacco Control Content in Electronic Health Records (Resolution 901, I-08)

Presented by: Joseph M. Heyman, MD, Chair

Referred to: Reference Committee D (James L. Milam, MD, Chair)

At the 2008 Interim Meeting of the House of Delegates, Resolution 901, "Tobacco Control Content in Electronic Health Records," was referred to the Board of Trustees. The resolution was introduced by the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP) as part of a Smokefree Clinical Practice and Policy Collaborative involving the American Medical Association (AMA), AAP, and AAFP.

Resolution 901 asks:

> That our American Medical Association advocate that all electronic health records should include templates that ask physicians and other clinicians and/or their practice teams to collect information about tobacco use, secondhand smoke exposure, cessation interest and past quit attempts; and
>
> That our AMA also advocate for inclusion of automatic prompts that remind physicians and other clinicians to act to encourage quitting, advise about maintaining smoke-free environments for children and adults, and connect patients and families to appropriate cessation resources and materials as part of the template.

DISCUSSION OF ISSUE

Tobacco use remains the number one preventable cause of death in the United States claiming the lives of 440,000 people annually. This includes the 53,000 who die from secondhand smoke exposure. An estimated 60 percent of U.S. children aged 3-11 years—or almost 22 million children—are exposed to secondhand smoke, primarily in the home. The 2006 report, *The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General*[1], recommended the complete elimination of smoking in indoor spaces and called on parents to create smokefree home and car environments. Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children. Children who are exposed to secondhand smoke are inhaling many of the same cancer-causing substances and poisons as smokers. Because their bodies are developing, infants and young children are especially vulnerable to the poisons in secondhand smoke. Secondhand smoke exposure can cause children who already have asthma to experience more frequent and severe attacks.

Physicians play a major role in changing patients' behaviors. Surveys of patients reveal that they expect physicians to address behavior issues and welcome the opportunity to work with their physician in changing an unhealthy behavior or adopting a healthier behavior or treatment. Physicians can influence patients to think about a behavior, plan for a change and eventually implement that change. This counseling might not result in an immediate beneficial outcome, but can make a tremendous impact over time.

Extensive evidence of the successful physician intervention in patient behaviors is seen for tobacco and alcohol use. The US Preventive Service Task Force[2] (USPSTF) found empirical evidence that brief smoking cessation interventions, including screening and brief counseling (less than 3 minutes) plus cessation aids, are effective in increasing the proportion of smokers who successfully quit smoking and remain abstinent after one year.

In May 2008, the US Public Health Service (USPHS) released *Treating Tobacco Use and Dependence: 2008 Update*[3]. Researchers for these clinical guidelines found that at least 70 percent of smokers see a physician each year. Moreover, 70 percent of smokers report wanting to quit, and almost two-thirds of smokers who relapse want to try quitting again within 30 days. Finally, smokers cite a physician's advice to quit as an important motivator for attempting to stop smoking.

Unfortunately, clinicians and health systems do not capitalize consistently on the opportunity to intervene. According to the National Committee for Quality Assurance's *State of Health Care Quality Report*[4], while there has been some improvement in tobacco dependence clinical intervention for the insured population, provision of specific help with quitting smoking is inconsistently provided. Recent Healthcare Effectiveness Data and Information Set (HEDIS) data showed that only 39 percent of smokers reported that their clinician discussed either medications or strategies to quit (www.web.ncqa.org/tabid/59/Default.aspx). As one step to improve the provision of preventive and early intervention services, the Physician Consortium for Performance Improvement's "Preventive Care & Screening Physician Performance Measurement Set[5]," approved in September 2008, includes measures for "Tobacco Use: Screening & Cessation Intervention."

The first step to treat tobacco use and dependence is to identify tobacco use. The effective identification of tobacco use by itself not only opens the door for successful interventions (e.g., clinician advice and treatment) but also guides clinicians to identify appropriate interventions based on patients' tobacco use status and willingness to quit. Based on these findings, the USPHS 2008 Update recommends that clinicians and health care systems use the office visit for universal assessment and intervention. It recommends that every patient who presents to a health care facility be asked if s/he uses tobacco, that all tobacco users be advised to quit, and the willingness of all tobacco users to make a quit attempt at this time be assessed.

The USPHS tobacco treatment guidelines also address children and secondhand smoke exposure. They recommend that clinicians ask parents about tobacco use and offer cessation advice and assistance. Assessing children's exposure to secondhand smoke and assisting parents in its elimination would have a short-term and long-term health benefit for the child. A review of the studies conducted by the USPHS expert panel showed that giving parents information on the harms of secondhand smoke reduces childhood exposure to such smoke and may reduce parental smoking rates.

Many Electronic Health Record (EHR) systems and paper intake/medical history forms include smoking as a health indicator and screen for current smoking behavior and number of cigarettes

smoked. Unfortunately, these forms stop short of including information on family exposure to secondhand smoke as well as information on quit attempts if the person is a smoker.

USE OF EHRs AND PROVIDER PROMPTS

Use of EHR systems allow physicians to capture data from a patient interaction in a structured way and can automatically prompt users to act on that information if needed. Data can be captured in a variety of ways, but templates are often used to efficiently, yet comprehensively organize medical history and risk factors. Automated prompts such as alerts and reminders are often used to prompt a specific action by the user.

Studies[6-10] have shown mixed results on the effectiveness of automated clinical reminders in EHRs for routine health maintenance services and preventive care tests in ambulatory settings. The authors of a research paper in the *Journal of the American Medical Informatics Association* (*JAMIA*)[11] found that the effectiveness of clinical reminders was impeded by lack of role-based reminders, using reminders while not with the patient, workload, lack of flexibility in the reminder, and poor interface usability. The study confirmed findings from previous research suggesting that clinician adherence to reminders is variable and declines over time. In order to increase the effectiveness of clinical reminders in EHR systems, the authors recommended that the number of reminders should be limited and that reminders must be embedded directly into the typical workflow.

Early users of EHR systems often found that the data capture process was time consuming and overwhelming in busy ambulatory environments. Alerts and reminders have also been criticized by users as being cumbersome and frustrating. In a study conducted by Kaiser Permanente (Center for Health Research Kaiser Permanente Northwest)[12], user acceptance of alerts and reminders was assessed by internal medicine, pediatrics, and family practice specialists. While endorsing electronic reminders and their utility, participants stated that reminders must be integrated into the workflow of the physician, simple to respond to, directed to the appropriate user for the necessary task, and clinically relevant.

The mere presence of EHR systems does not ensure that higher quality of care is being provided. EHR systems can be a powerful tool to organize large amounts of data, but often require a different documentation style than many physicians are accustomed to and can be cumbersome if not designed properly. Simply because EHR systems can capture, organize and query a large amount of patient data does not mean that users know how to most effectively use that information. There are enormous pressures on physicians to manage more health information within ever increasing time constraints, and research has shown that the effectiveness of automated prompts decrease when the user must respond to a large number of prompts. Therefore, it is critical that there be a balance between the amount of data captured at the point of care and the ability of clinicians to use that data in a meaningful way to impact health outcomes. EHR system design has improved, but there is still much to learn about how users interact with the EHR system, the attributes of a successful template, and how automated prompts can be integrated into the clinical practice to impact health outcomes.

CONCLUSION

There is no question that tobacco use and exposure to secondhand smoke are important health issues and that physicians need improved information systems that enable them to provide more timely and effective counseling to patients on the risks of tobacco use. These systems are also needed for an extensive number of medical conditions and behaviors that physicians regularly deal

with their patients. Once an automated prompt for one of these is included on an EHR system or paper form, however, there will be demands for more prompts, which will likely result in a diminished use of the prompts. For that reason, a balance must be found between the need for patient information and the manner in which it is collected.

One possible solution could be systems with a limited number of prompts in broader categories. These prompts could provide menus dealing with specific conditions or behaviors that a physician could select. For example, there could be a prompt on "Alcohol, Tobacco, and Drug Use" that contained menus for each area. In that way, a physician could drill down to a specific item without being presented with an overwhelming set of prompts for each condition or behavior.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 901 (I-08), and that the remainder of this report be filed.

1) That our American Medical Association encourage physicians to capture information from all their patients on tobacco use, secondhand smoke exposure, cessation interest, and past quit attempts. (New HOD Policy)

2) That our American Medical Association encourage the development of EHR systems that provide physicians with the ability to capture information on specific health behaviors deemed appropriate by the physician and that provide physicians the option to utilize automated reminders to benefit their patients. (New HOD Policy)

Fiscal note: Less than $500 to implement policy.

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RELEVANT AMA POLICY

H-30.958 Ethyl Alcohol and Nicotine as Addictive Drugs
The AMA (1) identifies alcohol and nicotine as drugs of addiction which are gateways to the use of other drugs by young people; (2) urges all physicians to intervene as early as possible with their patients who use tobacco products and have problems related to alcohol use, so as to prevent adverse health effects and reduce the probability of long-term addition; (3) encourages physicians who treat patients with alcohol problems to be alert to the high probability of co-existing nicotine problems; and (4) reaffirms that individuals who suffer from drug addiction in any of its manifestations are persons with a treatable disease. (Res. 28, A-91; Reaffirmed by CSA Rep. 14, A-97)

H-490.913 Smoke-Free Environments and Workplaces
On the issue of the health effects of environmental tobacco smoke (ETS) and passive smoke exposure in the workplace and other public facilities, our AMA: (1) (a) supports classification of ETS as a known human carcinogen; (b) concludes that passive smoke exposure is associated with increased risk of sudden infant death syndrome and of cardiovascular disease; (c) encourages physicians and medical societies to take a leadership role in defending the health of the public from ETS risks and from political assaults by the tobacco industry; and (d) encourages the concept of establishing smoke-free campuses for business, labor, education, and government; . . . . (3) . . . (e) urges eliminating cigarette, pipe, and cigar smoking in any indoor area where children live or play, or where another person's health could be adversely affected through passive smoking; . . .. . (CSA Rep. 3, A-04; Appended: Sub. Res. 426, A-04)

H-490.917 Physician Responsibilities for Tobacco Cessation
Cigarette smoking is a major health hazard and a preventable factor in physicians' actions to maintain the health of the public and reduce the high cost of health care. Our AMA takes a strong stand against smoking and favors aggressively pursuing all avenues of educating the general public on the hazards of using tobacco products and the continuing high costs of this serious but preventable problem. Additionally, our AMA supports and advocates for appropriate surveillance approaches to measure changes in tobacco consumption, changes in tobacco-related morbidity and mortality, youth uptake of tobacco use, and use of alternative nicotine delivery systems. In view of the continuing and urgent need to assist individuals in smoking cessation, physicians, through their professional associations, should assume a leadership role in establishing national policy on this topic and assume the primary task of educating the public and their patients about the danger of tobacco use (especially cigarette smoking). Accordingly, our AMA: . . . (2) supports (a) development of an anti-smoking package program for medical societies; (b) making patient educational and motivational materials and programs on smoking cessation available to physicians; and (c) development and promotion of a consumer health-awareness smoking cessation kit for all segments of society, but especially for youth; (3) encourages physicians to use practice guidelines for the treatment of patients with nicotine dependence and will cooperate with the Agency for Health Research and Quality (AHRQ) in disseminating and implementing evidence-based clinical practice guidelines on smoking cessation, and on other matters related to tobacco and health; (4) (a) encourages physicians to use smoking cessation activities in their practices including (i) quitting smoking and urging their colleagues to quit; (ii) inquiring of all patients at every visit about their smoking habits (and their use of smokeless tobacco as well); (iii) at every visit, counseling those who smoke to quit smoking and eliminate the use of tobacco in all forms; . . . (5) (a) supports efforts to identify gaps, if any, in existing materials and programs designed to train physicians and medical students in the behavior modification skills necessary to successfully counsel patients to stop smoking; (b) supports the production of materials and programs which would fill gaps, if any, in materials and programs to train physicians and medical students in the

behavior modification skills necessary to successfully counsel patients to stop smoking; (c) supports national, state, and local efforts to help physicians and medical students develop skills necessary to counsel patients to quit smoking; (d) encourages state and county medical societies to sponsor, support, and promote efforts that will help physicians and medical students more effectively counsel patients to stop smoking; (e) encourages physicians to participate in education programs to enhance their ability to help patients quit smoking; (f) encourages physicians to speak to community groups about tobacco use and its consequences; and (g) supports providing assistance in the promulgation of information on the effectiveness of smoking cessation programs; (6) (a) supports the concept that physician offices, clinics, hospitals, health departments, health plans, and voluntary health associations should become primary sites for education of the public about the harmful effects of tobacco and encourages physicians and other health care workers to introduce and support healthy lifestyle practices as the core of preventive programs in these sites; and (b) encourages the development of smoking cessation programs implemented jointly by the local medical society, health department, and pharmacists; and (7) (a) believes that collaborative approaches to tobacco treatment across all points of contact within the medical system will maximize opportunities to address tobacco use among all of our patients, and the likelihood for successful intervention; and (b) supports efforts by any appropriately licensed health care professional to identify and treat tobacco dependence in any individual, in the various clinical contexts in which they are encountered, recognizing that care provided in one context needs to take into account other potential sources of treatment for tobacco use and dependence.
(CSA Rep. 3, A-04; Appended: Res. 444, A-05; Reaffirmed: BOT Rep. 8, A-08)

D-478.996 Information Technology Standards and Costs
Our AMA will: (1) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (2) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (3) review the following issues when participating in or commenting on initiatives to create a NHII: (a) cost to physicians at the office-based level; (b) security of electronic records; and (c) the standardization of electronic systems; (4) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (5) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
(Res. 717, A-04; Reaffirmation, A-05; Appended: Sub. Res. 707, A-06; Reaffirmation A-07)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-09

Subject: Annual Update on Activities and Progress in Tobacco Control: February 2008 through February 2009

Presented by: Joseph M. Heyman, MD, Chair

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

INTRODUCTION

This report summarizes AMA activities and progress in tobacco control from February 2008 through February 2009 and is written in response to AMA Policy D-490.983 (AMA Policy Database), "Annual Tobacco Report."

DISCUSSION

Current Progress in Reducing Tobacco Use

According to the Centers for Disease Control and Prevention (CDC)[1], despite significant decreases since the 1960s, cigarette smoking and exposure to secondhand smoke remain the leading preventable causes of death in the United States, responsible for about 1 in 5 deaths annually. In 2008, the CDC reported that, for the period 2000-04, cigarette smoking and exposure to secondhand smoke resulted in an estimated 443,000 deaths and 5.1 million years of potential life lost (YPLL) each year[2]. The median mortality rate attributable to smoking declined by approximately 25 deaths per 100,000, from 288 deaths per 100,000 for the period 1996–99 to 263 deaths per 100,000 for the period 2000-04. This reflects progress made in lowering smoking prevalence in all states except Oklahoma. Annually, cigarette smoking costs more than $167 billion – $92 billion in lost productivity and $75.5 billion in health care expenditures.

In most respects, the tobacco use goals set forth in Healthy People 2010 will not be reached at current rates of change. According to the National Survey on Drug Use and Health (NSDUH)[3], in 2007, an estimated 70.9 million Americans aged 12 or older, 28.6 percent of the population in that age range, were current users of a tobacco product. This represents a small decrease in the rate of current use of any tobacco product among persons aged 12 or older, from 29.6 percent in 2006 to 28.6 percent in 2007; however, there were no significant decreases in the use of most types of tobacco products – cigarettes, smokeless tobacco, cigars, and pipe tobacco.

Among tobacco users, some of whom used more than one type of tobacco product, 60.1 million persons, 24.2 percent of the population, were current cigarette smokers; 13.3 million (5.4 percent) smoked cigars; 8.1 million (3.2 percent) used smokeless tobacco; and 2.0 million (0.8 percent) smoked tobacco in pipes. From 2002 to 2007, current use of any tobacco product decreased from 30.4 percent to 28.6 percent, and cigarette use declined from 26.0 percent to 24.2 percent; however, rates of use of cigars, smokeless tobacco, and pipe tobacco were similar in 2002 and 2007. As in prior years, young adults aged 18 to 25 years had the highest rate of current tobacco use at 41.8

percent but continuing a decline from the 2002 rate of 45.3 percent. The rate of young adult use of cigars remained higher in 2007 than in 2002, at 11.8 percent and 11.0 percent, respectively.

Among youths aged 12 to 17 in 2007, 3.1 million (12.4 percent) used a tobacco product in the past month, 2.5 million (9.8 percent) used cigarettes, and 1.1 million (4.2 percent) used cigars. These represent a continuing decline in the rate of cigarette use in this age group, from 13.0 percent in 2002 to 9.8 percent in 2007; however, use of smokeless tobacco in 2007 at 2.4 percent was higher than in 2002, 2.0 percent. Across age groups, cigarette use peaks among persons aged 21 to 25. Among those who smoke cigarettes, the percentage of daily smokers who smoke a pack or more of cigarettes per day rises from 18.5 percent among those aged 12 to 17, to 33.1 percent of 18 to 25 year old smokers, to 55.0 percent of smokers aged 26 or older.

In general, while the long-term but slow decline in tobacco use continued in 2007, patterns of use by product type differ greatly. Some troubling indicators include:

- An increase in the rate of cigar smoking among male young adults from 16.8 percent in 2002 to 18.4 percent in 2007;
- Despite an overall decrease of cigarette use among women aged 15 to 44 from 30.7 percent in 2002-2003 to 28.4 percent in 2006-2007, the decline among those who were pregnant was not statistically significant;
- Between 2006 and 2007, there were no statistically significant changes in use of a tobacco product for any racial/ethnic groups; and
- Large numbers of young people continue to start smoking.

In 2007, 59.7 percent of new smokers were under age 18. Approximately 6,100 new cigarette smokers began every day or a total of 2.2 million persons aged 12 or older. Although significantly lower than the 2006 estimate of 2.4 million, this was significantly higher than the estimates of 1.9 million for 2002 and 2.0 million for 2003.

Clean Indoor Air

According to the American Lung Association (ALA) *State of Tobacco Control 2008* report, only two states – Iowa and Nebraska – passed comprehensive laws that protect workers and the public from the dangers of secondhand smoke. Pennsylvania also passed legislation in 2008 that prohibits smoking in a number of public places, including restaurants; however, the law still permits smoking in taverns, casinos, private clubs and nursing homes and preempts localities from passing stronger laws that would protect everyone from exposure to deadly secondhand smoke. Comprehensive legislation was introduced in Michigan and Wisconsin, but neither state passed a bill into law. Overall, the ALA report gave 33 states and the District of Columbia passing grades; however, 16 states received an "F" for their weak or ineffective smoke-free laws.

Tobacco Excise Taxes

In early 2009, as part of the State Children's Health Insurance Program expansion legislation, the federal cigarette tax was raised from 39 cents per pack to $1.00. This legislation also increased the tax on cigars, smokeless tobacco, and loose tobacco.

Youth Tobacco Issues

The greatest hurdle to reducing tobacco use among youth is the tobacco industry's continued creation and promotion of products that have strong appeal to youth and the industry's use of deceptive marketing practices. The Campaign for Tobacco Free Kids, American Lung Association, American Heart Association, and the American Cancer Society released the *Big Tobacco's Guinea Pigs* report in February 2008 that clearly outlines the potential danger of these new products. According to this report, lack of government regulation has allowed the tobacco industry free rein to design and market their products. Among the points made in the report were:

- Tobacco manufacturers can introduce new products, secretly modify existing products with new designs and ingredients, and make unproven health claims without regard for the impact on public health;
- Flavor and product modifications not only make the product more appealing to kids, but often produce additional carcinogens; and
- Manipulation of nicotine and other chemicals increases addictiveness and harm; and misleading claims discourage smokers from quitting and thus cost countless lives.

The report concluded that, because of this lack of government oversight, the tobacco industry has been able to counter declining smoking rates and growing restrictions on smoking by unleashing a new generation of tobacco products.

AMA ACTIVITIES

Professional Standards Activities

Reducing tobacco use and increasing physician cessation counseling for patients who smoke is a major component of the AMA's Healthy Lifestyles Initiative. The AMA released a physician's toolkit, *AMA Healthier Life Steps*[4], that enables physicians and patients to make positive, coordinated lifestyle changes in the four behaviors which lead to the leading causes of death and illness in the United States: smoking, excess or risky alcohol use, poor nutrition and eating behaviors, and physical inactivity. The toolkit provides a guide to physicians on how to assess patients' readiness to change and how to counsel them. The toolkit also includes brief patient screening forms, actions plans and tips on change, a health behavior tracking calendar and office reminder posters.

Additional linkages are provided on the AMA web site to federal smoking cessation and brief alcohol intervention resources for physicians and as part of the EPoCH (Educating Physicians on Challenges and Controversies in Health) series. Several new supportive videos and CME modules are available[5]:

- Motivating patients to change behavior;
- Connecting patients to community resources;
- Is obesity a disease?;
- Paying attention to preventing cardiovascular disease among racial and ethnic minorities;
- Binge drinking;
- Reducing excessive alcohol use: Engaging community action; and
- Self-management strategies for vulnerable populations.

As part of the our participation in the Building Healthier Chicago initiative, the AMA developed a PowerPoint presentation for the Chicago Medical Society to use for member education about how to utilize the smoking cessation Quitline.

The AMA also houses a project funded by the Environmental Protection Agency to reduce children's exposure to secondhand smoke. This project works with physicians and other clinicians to counsel parents about the health risks associated with exposure and provide assistance to help families adopt and enforce smoke-free home and car policies. As part of the project, staff developed and received approval for the first performance improvement CME on secondhand smoke in the country. This practice management project is being tested with five physicians representing a diverse range of patient population and geographic settings. In addition, 25 AMA medical student chapters have been recruited to make presentations to Head Start parents educating them about secondhand smoke exposure and offering advice and assistance in eliminating this health risks.

In May 2008, the AMA hosted a press conference led by Dr. Maves and Dr. Davis for the national release of the Public Health Service's *Treating Tobacco Use and Dependence Clinical Practice Guideline 2008 Update*[6] and released an updated version of a physician's pocket guide for helping patients to quit smoking. In addition, the AMA continued to participate in the National School Board Association/CDC National Consortium on Tobacco Use Prevention Through Schools and to support the AMA Alliance's "ScreenOut" program to remove cigarette use in movies targeted to children.

Advocacy

The AMA was engaged in numerous tobacco control activities. Highlights include:

- Actively supporting passage of the State Children's Health Insurance Program expansion legislation through which the federal cigarette tax was raised from 39 cents per pack of cigarettes to $1.00. This was a substantial victory due to the great impact that tax increases have on reducing tobacco use.

- Continuing to work with other advocacy organizations, including the Center for Tobacco Free Kids, the American Cancer Society, the American Heart Association, and the American Lung Association, to secure passage of legislation to allow the FDA to regulate tobacco product labeling, sales, distribution, advertising and promotion. This legislation would provide a major tool to reduce the appeal of cigarette products to youth by eliminating flavoring added to these products. Additional major features of the proposed legislation were that: a) all new tobacco products would require pre-market approval; b) standards would be set forth for the sale of modified risk tobacco products, and c) the Secretary of Health and Human Services would be required to: 1) establish tobacco product standards to protect the public health, reserving to Congress the power to ban any tobacco products or reduce the nicotine level to zero, and 2) to take specified actions, including public notification and recall, against unreasonably harmful products. For the first time this legislation was passed by the House of Representatives and passed out of the Senate HELP Committee, but it was not voted upon by the full Senate before the end of the Congressional Session. It is expected that it will be reintroduced during 2009.

- Signing on to a letter sent jointly with four other organizations, the Center for Tobacco Free Kids, the American Cancer Society, the American Heart Association, and the American Lung Association, to encourage the CVS Corporation to continue its internal discussions about stopping the sale of tobacco products in its pharmacies. The letter pointed to the examples of

the Wegman grocery chain and the Target Corporation, which have already stopped selling tobacco products.

- Joining an amicus brief filed by the Center for Tobacco Free Kids with the U.S. Supreme Court in *Altria v. Good*, a case brought by three smokers from Maine as a class action, alleging fraud under Maine's Unfair Trade Practices Act. This was based on false statements by Altria and its Philip Morris USA unit in deceptive advertisements that suggested "light" cigarettes were safer than regular ones. The Supreme Court ruled that federal tobacco labeling requirements do not preempt state law fraud statutes. This ruling will bolster dozens of other lawsuits claiming billions of dollars in damages.

- Issuing a press release commending Wal-Mart's efforts to establish an affordable smoking cessation program and urging Wal-Mart to take that program one step further by removing cigarettes and other tobacco products from its stores' shelves. The AMA remains concerned that selling cigarettes at the same time as offering a low-cost smoking cessation program is a mixed message that could keep many smokers from "kicking the habit."

- Supporting a New York State Department of Health petition to the Food and Drug Administration requesting that over-the-counter nicotine replacement therapies are safe and should be more widely available to smokers in order to increase their use, increase quit attempts and, eventually, increase quit attempt successes in order to reduce consumption and to advance public health.

- Supporting the Ohio State Medical Association's effort to maintain state funding for tobacco control activities through the Ohio Tobacco Prevention Foundation.

In addition, AMA membership in the Framework Convention Alliance for Tobacco Control was approved by that international organization, whose purpose is to promote ratification and implementation of the international Framework Convention on Tobacco Control. Although the U.S. has signed the Framework Convention, it has not yet been submitted to the U.S. Senate for ratification.

CONCLUSION

The AMA is engaged in a wide range of activities regarding tobacco control including promotion of member education, provision of cessation services, passage of local, state and federal policies, and education of the public regarding the dangers and impacts of tobacco usage. These activities involve staff at all levels of the organization and include frequent public statements and provision of member educational activities.

RECOMMENDATION

The Board of Trustees is taking steps to reduce the number of mandated, annual reports it prepares for the House of Delegates in order to reallocate staff to other activities. As a result, the Board of Trustees recommends that an informational report on tobacco be prepared to apprise the House of Delegates only when significant changes in tobacco use or policy occur. In order to achieve this, the Board of Trustees recommends that AMA Policy D-490.983 be rescinded, and that the remainder of this report be filed.

Fiscal note: Total staff savings of $2,100

REFERENCES

1. MMWR. 2007;56[44];1157-1161.

2. MMWR. 2009;58[2];29-33.

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4. Available at http://www.ama-assn.org/ama/pub/physician-resources/public-health/promoting-healthy-lifestyles/healthier-life-steps-program.shtml.

5. Available at www.ama-assn.org/go/epoch.

6. Fiore MD, Jaen CR, Baker TB, et.al. *Treating Tobacco Use and Dependence: 2008 Update*. Clinical Practice Guideline. Rockville, MD: US Department of Health and Human Services. Public Health Service. May 2008. 29: pp.411-28.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-09

Subject: CSAPH's Sunset Review of 1999 House Directives and Policies

Presented by: Carolyn B. Robinowitz, MD, Chair

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110, AMA Policy Database). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following steps:

- In the spring of each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Using the areas of expertise of the AMA Councils as a guide, the staffs of the AMA Councils determine which policies should be reviewed by which Councils.
- For the Annual Meeting of the House, each Council develops a separate policy sunset report that recommends how each policy assigned to it should be handled. For each policy it reviews, a Council may recommend one of the following actions: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy. A justification must be provided for the recommended action on each policy.
- The Speakers assign the policy sunset reports for consideration by the appropriate Reference Committees.

Although the policy sunset review mechanism may not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

In this report, the Council on Science and Public Health presents its recommendations on the disposition of the House directives and policies from 1999 that were assigned to it. The CSAPH's recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates directives and policies that are listed in the Appendix to this report be acted upon in the manner indicated in the Appendix and the remainder of this report be filed. (Directive to Take Action)

Fiscal Note: Less than $500 to update policy.

APPENDIX: Recommended Actions on 1999 House Policies and Directives

Policy Number	Title	Recommended Action and Rationale
D-10.996	Automatic Garage Door Safety and Education	Rescind. Accomplished.
D-10.997	Safety at Railroad Crossings	Rescind. Accomplished.
D-10.998	In-Line Skating	Retain. Still relevant.
D-30.999	Medicare Coverage for GGTP Assays as Part of Alcoholism Screening	Rescind. Covered by policy.
D-60.997	Neonatal Circumcision	Rescind. Accomplished.
D-60.998	Seclusion and Restraint of Children and Adolescents	Rescind. Accomplished.
D-75.998	Access to Emergency Contraception	Retain. Still relevant.
D-75.999	Emergency Contraception Pills	Rescind. Accomplished.
D-90.998	Establishing Disability in Various Stages of HIV Infection	Rescind. Accomplished.
D-95.996	Consensus Statement of the Physician Leadership on National Drug Policy	Retain. Still relevant.
D-95.997	Altered Illicit Substances	Retain. Still relevant.
D-95.998	Physicians as Patients: Their Right to Confidentiality	Rescind. No longer relevant. Currently covered by the Federation of State Physician Health Programs.
D-95.999	Reduction of Medical and Public Health Consequences of Drug Abuse: Update	Retain in part to read as follows: Our AMA encourages state medical societies to advocate for the expansion of and increased funding for needle and syringe-exchange programs and methadone maintenance and other opioid treatment services and programs.
D-110.999	Proprietary and Generic Drug Pricing	Rescind. Accomplished.
D-115.998	Labeling of Prescription Drug Containers for Generic-Substituted Drugs	Rescind. Accomplished.
D-115.999	Domestic Violence Prevention Information and Movie Theaters	Rescind. Accomplished.
D-120.999	Use of Opioids in Chronic Noncancer Pain	Rescind. Superseded by D120.976 and D95.984.
D-130.999	Organized Medicine's Role in the National Response to Terrorism	Rescind. Accomplished.

D-140.994	Use of DNA Testing	Rescind. Accomplished.
D-140.996	Review of Guidelines for Pre-test and Post-test Education and Genetic Counseling by the National Society of Genetic Counselors and Other Organizations	Rescind. Accomplished.
D-150.998	Genetically Modified Foods	Rescind. Accomplished.
D-160.996	Low Literacy as a Barrier to Healthcare	Rescind. Accomplished.
D-260.999	Laboratory Testing Panels	Rescind. Accomplished.
D-320.997	Clinical Practice Guidelines and Clinical Quality Improvement Activities	Rescind. Accomplished.
D-370.998	Organ Allocation	Rescind. Accomplished.
D-370.999	Xenotransplantation Clinical Trials	Rescind. Accomplished.
D-430.998	Health Care Standards in US Correctional Facilities	Rescind. Accomplished.
D-440.995	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Retain. Still relevant.
D-440.996	Sharps Disposal	Rescind. Accomplished.
D-450.996	American Medical Accreditation Program (AMAP)	Rescind. No longer relevant.
D-450.997	AMA Quality Care Alert	Rescind. Program no longer active.
D-460.990	Science, Policy Implications, and Current AMA Position Regarding Embryonic Pluripotent Stem Cell Research	Retain. Still relevant.
D-460.993	Support of Embryonic Stem Cell Research	Retain. Still relevant.
D-460.994	Decade of the Brain	Rescind. Accomplished.
D-460.995	Reports on a Single Web Site	Rescind. Accomplished.
D-460.996	Medical Genetics	Retain in part. Delete #3.
D-460.999	Support for Upgrading and Expanding Medical Research Facilities	Retain in part. Delete #2 since this is not a strategic priority.
D-470.999	Boxing Injuries	Rescind. Relevant content is covered by H-470.980 and H-470.984.
D-478.993	Criteria for Assessing the Quality of Health Information on the Internet	Rescind. No longer contemporary.
D-480.998	Minimal Standards for Medical Product Reuse	Retain. Still relevant.
D-490.996	Tobacco Control Summit Alliance	Rescind. Accomplished.

D-490.997	Urgent Action on States' Allocation of Tobacco Settlement Monies for Smoking Prevention, Cessation and Health Services	Retain in part with change in title: "~~Urgent~~ Continued Action on States' Allocation of Tobacco Settlement Monies for Smoking Prevention, Cessation and Health Services" Our AMA will: (1) translate that commitment into ~~immediate~~ action through aggressive lobbying activities ~~with the Administration and the Congress; (2)~~ to encourage and work with state and specialty societies to vigorously lobby state legislatures to: (a) assure that a significant percentage (depending on the objectively determined needs of the state) of the tobacco settlement monies be set aside first for tobacco control, nicotine addiction prevention, cessation and disease treatment for tobacco control and related public health purposes and medical services; (b) assemble an appointed state level task force, when needed, that includes experts in public health, smoking cessation and tobacco prevention programs ~~and program evaluation and consumer advocated,~~ to ensure that funds are spent on activities supported by the Centers for Disease Control and Prevention guidelines~~., determine the best utilization of those set aside monies through review of local needs and nationally established tobacco control guidelines and programs; and (3) report back to the House of Delegates at I-99 on the progress of these actions as well as the status of actions from Substitute Resolution 431 (I-98), as previously requested.~~ (Res. 428, A-99)
D-515.989	AMA Leadership in Dealing with Recent Mass Assaults	Rescind. Accomplished.
D-630.978	Implementing Mental Health Parity	Rescind. Accomplished.
H-5.991	RU-486 Availability	Rescind. Drug was approved for marketing in September 2000.
H-5.997	Violence Against Medical Facilities and Health Care Practitioners and Their Families	Retain. Still relevant.
H-10.968	Public Health Impact on Railroads	Retain. Still relevant.
H-10.969	In-Line Skating	Retain. Still relevant.
H-10.975	Promoting Protective Guards and Helmet Use in In-Line Skating	Retain. Still relevant.
H-15.958	Fatigue, Sleep Disorders, and Motor Vehicle Crashes	Retain. Still relevant.
H-45.978	Inflight Medical Emergencies	Retain. Still relevant.
H-45.979	Air Travel Safety	Retain. Still relevant.
H-45.981	Improvement in US Airlines Aircraft Emergency Kits	Retain. Still relevant.
H-45.983	Medical Oxygen Therapy on Scheduled Commercial Air Service	Retain. This problem has not yet been solved.
H-45.991	Safety Training which Includes Medical Training for Commercial Airline Crews	Rescind. Accomplished.

H-45.996	Emergency Equipment on Commercial Aircraft	Rescind. Covered by Policy H-45.981.
H-45.997	In-Flight Emergency Care	Retain. Still relevant.
H-50.979	Use of Blood Therapeutically Drawn from Hemochromatosis Patients	Retain. Still relevant.
H-60.945	Neonatal Circumcision	Retain. AAP Position statement still applicable.
H-60.946	Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for Their Treatment	Retain. Still relevant.
H-95.950	Consensus Statement of the Physician Leadership on National Drug Policy	Rescind. The current organization, although very similar in philosophy and stances, is Physicians and Lawyers for National Drug Policy with a somewhat different membership. Its Web site does not update its policies accordingly. In any case, this policy reads oddly since it does not actually state our support for that organization – only not to construe such support as support for legalization.
H-95.955	Substance Abuse Among Physicians	Retain with change in title. All still relevant. Recommend the following title change since the body of the language is broader than substance abuse. ~~Substance Abuse Among~~ Physician~~s~~ <u>Impairment</u>
H-95.962	Inhalant Abuse	Retain. Still relevant.

H-95.975	Substance Abuse as a Public Health Hazard	Retain in part. Change title as follows: Substance ~~Abuse~~ Use Disorders as a Public Health Hazard Our AMA: (1) recognizes that substance ~~abuse in the~~ use disorders are a major public health problem in the United States today and that their solution requires a multifaceted approach; (2) declares substance ~~abuse its number one~~ use disorders are a public health priority; (3) supports taking a positive stance as the leader in matters concerning substance ~~abuse~~ use disorders, ~~and~~ including addiction; (4) supports studying innovative approaches to the elimination of ~~abuse dependencies~~ use disorders and their resultant street crime, including approaches which have been used in other nations; and (5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances. (Res 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99)

H-95.984	Issues in Employee Drug Testing	Retain in part. The AMA (1) reaffirms its commitment to educate physicians and the public about the scientific issues of drug testing; (2) supports monitoring the evolving legal issues in drug testing of employee groups, especially the issues of positive drug tests as a measure of health status and potential employment discrimination resulting there from; (3) takes the position that urine ~~drug and~~ alcohol and other drug testing of employees should be limited to (a) preemployment examinations of those persons whose jobs affect the health and safety of others; (b) situations in which there is reasonable suspicion that an employee's (or physician's) job performance is impaired by alcohol and/or other drug ~~and/or alcohol~~ use; (c) monitoring as part of a comprehensive program of treatment and rehabilitation of substance use disorders; ~~alcohol and drug abuse or dependence;~~ and (d) urine, alcohol and other drug ~~and alcohol~~ testing of all physicians and appropriate employees of health care institutions may be appropriate under these same conditions; and (4) urges employers who choose to establish alcohol and other drug testing programs to use confirmed, positive test results in employees primarily to motivate those employees to seek appropriate assistance with their alcohol or other drug problems, preferably through employee assistance programs. (CSA Rep. A, A-87; Reaffirmed: Sub. Res. 39, A-90, CSA Rep. D, I-90; CSA Rep. 2, I-95; Reaffirmed: BOT Rep. 17, I-99)
H-110.995	Excessive Cost of Prescription Drugs	Rescind. This concern has been expressed and is covered by the intent of Policy H-110.998.
H-110.996	Cost of Prescription Drugs	Retain in part. Eliminate #1, which has been addressed in various ways by our AMA, and changes in FDA policies and procedures.
H-110.998	Cost of New Prescription Drugs	Retain. Still relevant
H-115.972	Over-the-Counter Inhalers in Asthma	Retain. Still relevant
H-150.952	Point-of-Sale Warning Signs Regarding Consumption of Raw Shellfish	Retain. Still relevant.
H-150.953	Obesity as a Major Health Program	Retain. Still relevant.

H-160.928	Drug Initiation or Modification by Pharmacists	Retain. Still relevant.
H-160.931	Health Literacy	Retain in part. Edit #6 to read as follows: (6) encourages the US Department of Education to include questions regarding health status, health behaviors, and difficulties communicating with health care professionals in ~~the National Adult Literacy Survey of 2002~~ all future National Assessment of Adult Literacy studies; and.
H-170.982	Education of Students on the Hazards of Ultraviolet Radiation (Tanning Rays)	Retain. Still relevant.
H-250.989	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Retain. Still relevant.
H-280.952	CMS Interim Final Rule on the Use of Seclusion and Restraints	Retain. Still relevant.
H-345.999	Statement of Principles on Mental Health	Retain. Still relevant.
H-420.960	Effects of Work on Pregnancy	Retain. Still relevant.
H-420.962	Perinatal Addiction – Issues in Care and Prevention	Retain in Part. Edit #2 as follows, and delete #6: (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education. ~~within the context of its "War on Drugs."~~ In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; ~~(6) will address the special needs of pregnant drug abusers within the context of its ongoing Health Access America programs.~~
H-420.971	Infant Victims of Substance Abuse	Retain in part. It is the policy of the AMA: (1) to develop educational programs for physicians to enable them to recognize, evaluate and counsel women of childbearing age about the impact of substance use disorders ~~substance abuse~~ on their children; and (2) to call for more funding for treatment and research of the long-term effects of maternal substance use disorders ~~substance abuse~~ on children. (Res. 101, A-90; Reaffirmation A-99)
H-420.974	Warnings Against Alcohol Use During Pregnancy	Retain. Still relevant.

H-440.927	Tuberculosis	Retain. Still relevant.
H-440.958	Universal Immunization for Hepatitis B Virus	Retain. Still relevant.
H-440.979	Control of Sexually Transmitted Diseases	Retain in part. Change title as follows: Control of Sexually Transmitted ~~Diseases~~ Infections Also change wording to read: "The AMA urges increased efforts at all levels of organized medicine to bring sexually transmitted ~~diseases~~ infections under control, through professional and public education, and support of the efforts of state Departments of Health, the Centers for Disease Control and Prevention, the National Institutes of Health, and other appropriate organizations."
H-440.980	Education on the Harmful Effects of UVA and UVB Light	Retain. Still relevant.
H-440.983	Update on Venereal Disease	Retain with the following change in title: Update on ~~Venereal Disease~~ Sexually Transmitted Infections Also change STD to STI: The AMA (1) urges medical students, primary care residents, and physicians in all specialties to familiarize themselves with sexually transmitted ~~diseases~~ infections (ST~~D~~ I), so that they will be better able to diagnose and treat them; (2) encourages instruction on ST~~D~~ I, both didactic and clinical, in all medical school and primary residency programs; (4) encourages the establishment of ST~~D~~ I fellowships by primary care specialties in order to develop a pool of clinical and research expertise in the area; (5) encourages state and local medical societies to promote ST~~D~~ I public service TV and radio announcements in their communities; and (6) supports continued communication of updated ST~~D~~ I information regularly through AMA publications. (CSA Rep E, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmation A-99)
H-450.952	Regional Input into the Accreditation Process	Retain in part. Retain #1. Delete #2.

H-470.962	Cardiovascular Preparticipation Screening of Student Athletes	Retain in part. The ~~role of the~~ AMA supports ~~includes working with appropriate medical specialty societies to~~ increas~~i~~ing awareness among physicians, state and local medical societies, parent-teacher organizations, state legislatures, athletic associations, school administrators, and school boards of the availability of consensus medical guidelines and recommendations for sports preparticipation evaluations.
H-470.970	Disclosure of Medical Information by Student Athletes	Rescind. No longer strategic issue.
H-470.971	Athletic Preparticipation Examinations for Adolescents	Retain. Still relevant.
H-470.973	Boxing as an Olympic Sport	Retain in part. The AMA supports ~~requests the United States Olympic Committee to transmit AMA's policy of opposition to boxing to the International Olympic Committee and ask that boxing be eliminated~~ the elimination of boxing as an Olympic sport.
H-470.980	Hazards of Boxing	Retain. Still relevant.
H-470.984	Brain Injury in Boxing	Retain in part. Delete #2.
H-480.972	Medical Device Safety and Physician Responsibility	Retain. Still relevant.
H-515.966	Violence and Abuse Prevention in the Healthcare Workplace	Retain. Still relevant.
H-515.982	Violent Acts Against Physicians	Retain. Still relevant.

REPORT 4 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-09)
Appropriate Supplementation of Vitamin D
(Resolution 425, A-08)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective: To highlight key information and considerations for physicians regarding vitamin D, including current recommendations for vitamin D intake and its potential for toxicity in the body. The report reviews the biochemistry and metabolism of vitamin D, as well as its association with various disease outcomes, with a focus on adults. Key limitations in the current literature are highlighted, as are areas requiring further research.

Methods: Literature searches for review articles were conducted in the PubMed database and the Cochrane Database of Systematic Reviews using the search term "vitamin D" in the article title and/or abstract. Web sites managed by federal agencies and applicable professional organizations were also reviewed for relevant information. Additional articles were identified by reviewing the reference lists of pertinent publications.

Results: Vitamins D2 (ergocalciferol) and D3 (cholecalciferol) are seco-steroid prohormones that are essential nutrients if sufficient levels of vitamin D3 cannot be produced in the skin. It is unclear how much sun or ultraviolet B radiation exposure, if any, allows for maximal cutaneous synthesis while minimizing the risk of skin cancer. Thus, fatty fish, fortified foods, and dietary supplements are recommended. 1,25-dihydroxyvitamin D is the active metabolite of vitamins D2 and D3, and is an important hormone, transcriptional activator, and immunomodulator. Since circulating levels of 1,25-dihydroxyvitamin D are tightly regulated by the body, serum 25-hydroxyvitamin D (25[OH]D) is the best indicator available of vitamin D status. A rapidly expanding literature has reported inverse associations between 25(OH)D and/or intakes of vitamin D and numerous outcomes related to bone health, several cancers, cognitive function, cardiovascular disease, diabetes, some infections, and several autoimmune diseases. However, clinical trials have yet to prove that vitamin D is causally related to most of these outcomes. It appears, nevertheless, that many people may have subclinically deficient or insufficient levels of vitamin D, prompting many to recommend intakes of 800 to 1,000 international units (IU) per day of vitamin D or even more, in the form of dietary supplements. However, there are significant limitations in the literature due to inadequate control of confounding variables, variability in serum 25(OH)D assays, and a lack of dose-response data on many skeletal and nonskeletal outcomes, including the potential for adverse outcomes. Caution is warranted given the surprising lack of effects, or sometimes even harmful effects, found in large, long-term trials of other previously promising nutrients and hormones, such as antioxidants and hormone replacement therapy. It is likely that greater vitamin D exposure will benefit at least some in the population, but more research is needed.

Conclusions: While the associations between vitamin D and various disease outcomes appear promising, clinical trials have yet to prove that vitamin D is causally related to most of these outcomes. More long-term, well-designed studies, including large intervention trials, are needed across all life stage and racial and ethnic groups to better understand vitamin D's role in disease prevention, to determine the optimal doses and serum 25(OH)D levels, and to fully elucidate the potential for adverse outcomes at various intakes. Nevertheless, physicians should consider measuring the serum concentration of 25(OH)D in patients at risk of vitamin D deficiency and counsel those with deficient or insufficient levels on ways to improve their vitamin D status.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-09

Subject: Appropriate Supplementation of Vitamin D
(Resolution 425, A-08)

Presented by: Carolyn B. Robinowitz, MD, Chair

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 425 (A-08) and the remainder of this report be filed:

1. That our American Medical Association (AMA) support continued research on vitamin D and its metabolites, particularly long-term studies that address adverse outcomes and potential confounders across all life stage groups. (Directive to Take Action)

2. That our AMA educate physicians about the evolving science of vitamin D and its impact on health and develop resources about vitamin D for patients. (Directive to Take Action)

3. That our AMA encourage physicians to consider measuring the serum concentration of 25-hydroxyvitamin D in patients at risk of vitamin D deficiency and counsel those with deficient or insufficient levels on ways to improve their vitamin D status. (New HOD Policy)

4. That our AMA monitor the development of new dietary references intakes for vitamin D in 2010 and respond as appropriate. (Directive to Take Action)

Fiscal Note: $ 3,500

REPORT 6 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-09)
Use of Tasers® by Law Enforcement Agencies
(Reference Committee D)

EXECUTIVE SUMMARY

Objective: To review the technology of conducted electrical devices (CEDs) such as Tasers®, the evidence on their direct physiological effects, and existing data on the morbidity and mortality associated with their use by law enforcement personnel. General guidelines on use-of-force policies and the role played by CEDs also are noted, and their relevance to public health and the health care system is discussed.

Methods: English-language reports on studies using human or animal subjects were selected from a PubMed search of the literature from 1985 to March 2009 using the text terms "taser," or "conducted electrical device" or the MeSH terms "law enforcement/methods" or "weapons," in combination with "electric injuries," and "diagnosis," "etiology," "physiopathology," "prevention and control," "mortality," or "forensic medicine." Additional articles were identified by manual review of the references cited in these publications. Web sites of Taser International, the U.S Department of Justice, the Canadian House of Commons, Amnesty International, and the International Association of Police Chiefs also were searched for relevant resources.

Results: The design of CEDs has evolved over the last 20 years. Tasers® are the primary CEDs used by law enforcement. Despite the designation of the Taser® as a less lethal or less-than-lethal weapon, Amnesty International has catalogued a temporal association between the use of CEDs and more than 330 in-custody sudden deaths in North America between June 2001 and August 2008, all involving M-26 or X-26 Tasers®. Swine models have demonstrated the ability of Tasers® to induce ventricular arrhythmias. Limited Taser® discharges applied to healthy human volunteers generally appear to be safe. Such studies cannot fully evaluate the responses of individuals who are confrontational, have taken drugs, or are desperate for escape, highly agitated, and combative.

Higher risk situations for restraint-related fatalities seem to be associated with pre-existing cardiovascular disease in individuals who have taken psychostimulants or other drugs and engage in a struggle against law enforcement personnel and then are subjected to restraint maneuvers (with or without Taser® use). The sudden in-custody deaths of individuals who are combative and in a highly agitated state have been attributed to the presence of "excited delirium." The latter is not a validated diagnostic entity in either the International Classification of Diseases or the *Diagnostic and Statistical Manual of Mental Disorders*, but is a more generally accepted entity in forensic pathology.

Conclusion: Concerns about the use of CEDs fall into three general areas: (1) they are used too frequently and at lower levels on the use-of-force continuum than indicated; (2) appropriate training and supervision of CED use is lacking in some jurisdictions; and (3) CEDs may contribute to the death of suspects, either directly or indirectly. Arrest-related deaths are not new and predate the deployment of CEDs. Most studies undertaken by law enforcement agencies (and others) indicate that deploying CEDs relative to other use-of-force options, such as pepper spray, physical force, police dogs, and batons, reduces injuries to officers and suspects and reduces the use of lethal force. If deployed according to an appropriate use-of-force policy, and used in conjunction with a medically driven quality assurance process, Taser® use by law enforcement officers appears to be a safe and effective tool to place uncooperative or combative subjects into custody.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 6-A-09

Subject: Use of Tasers® by Law Enforcement Agencies (Resolution 401, A-08)

Presented by: Carolyn B. Robinowitz, MD, Chair

Referred to: Reference Committee D (James L. Milam, MD, Chair)

Resolution 401, "Tasers," introduced by the American Academy of Child and Adolescent Psychiatry, American Psychiatric Association, American Academy of Psychiatry and the Law, and the American Academy of Pediatrics and referred at the 2008 Annual Meeting, asks:

> That our American Medical Association (AMA) Council on Science and Public Health prepare a report summarizing the scientific data on morbidity and mortality associated with the use of Tasers;
>
> That our AMA advocate for the development of appropriate guidelines to ensure that Tasers are only used in a manner which minimizes the risk of injury or death; and
>
> That our AMA encourage The Joint Commission and other appropriate accreditation and regulatory agencies to develop standards and guidelines regarding the use of Tasers in hospitals and other health care facilities.

Conducted electrical devices (CEDs) were designed as non-lethal weapons to assist law enforcement personnel in subduing subjects who actively resist arrest, or who present a serious threat to themselves or others. As these new tools have become more prominent in the law enforcement arsenal, their deployment has been temporally associated with more than 330 arrest-related or in-custody deaths since 2001.[1] The association of CEDs such as Tasers®[a] with fatalities, dramatized by video evidence, has led to further scrutiny of their use by human rights advocacy groups, government oversight bodies, law enforcement organizations themselves, and the media.

This report reviews the technology of CEDs, evidence of their direct physiological effects, and data on the morbidity and mortality associated with their use by law enforcement. The vast majority of published data concern the use of Tasers®. General guidelines on use-of-force policies and the role played by CEDs are noted, and their relevance to public health and the health care system is discussed.

METHODS

English-language reports on studies using human or animal subjects were selected from a PubMed search of the literature from 1985 to March 2009 using the text terms "taser," or "conducted electrical device" or the MeSH terms "law enforcement/methods" or "weapons," in combination

[a] TASER is an acronym for Thomas A. Swift Electronic Rifle

with "electric injuries," and "diagnosis," "etiology," "physiopathology," "prevention and control," "mortality," or "forensic medicine." Additional articles were identified by manual review of the references cited in these publications. Web sites of Taser International, the U.S. Department of Justice, the Canadian House of Commons, Amnesty International, and the International Association of Police Chiefs also were searched for relevant resources.

BACKGROUND

Conducted Electrical Weapons

The design of CEDs, especially Tasers®, has evolved over the last 20 years. Early versions of CEDs (e.g., stun guns) did not incapacitate subjects, and primarily attempted to achieve compliance through the infliction of pain. Current Taser® models are more efficient in incapacitating criminal suspects, and are the primary CEDs used by law enforcement. According to the manufacturer, Tasers® are currently used in more than12,750 law enforcement, military, and correctional agencies around the world, including more than two-thirds of law enforcement agencies in the United States.[2] Taser International produces various models for law enforcement personnel (M-26 and X-26), as well as civilian models (C2 and X-26C), which are less powerful.

The most recent evolution of the Taser® for law enforcement is the X-26 model. The X-26 is battery operated with a removable cartridge containing coiled electrical wires at the front, coupled with a data port that records the time and date of activation, and also incorporates an audio and video recording camera. Propelled by compressed nitrogen, the X-26 cartridge can launch the two tethered insulated wires with barbed probes up to 35 feet. When the trigger is depressed, a pulse wave with a high voltage leading edge (up to 50,000 V in open circuit) is delivered followed by a pulsed low amperage current delivered over 5 seconds. Both probes must attach to the skin or clothing. The initial short duration, high voltage signal allows a current path to be established through clothing via an "arc" of ionized air. The standard discharge cycle can be terminated early by the officer or can be extended, as long as the barbs remain in sufficient contact with the individual, by holding or repeatedly depressing the trigger. With the cartridge removed, the Taser® also can be used in push stun mode by directly applying a pair of electrical contact points (approximately 1.5 inches apart at the tip) to the subject. In comparison, the most recent civilian model (C2) can launch the probes up to 15 feet and can deliver a 30-second energy burst, thus enabling the subject to escape during that time period. The C2 also can be used in stun mode.

When used in the probe mode (i.e., barbed wires propelled by compressed nitrogen), the pulsed, low-amperage current activates α-motor neurons causing strong, repetitive contractions of skeletal muscles and temporary immobilization. The affected muscle mass area is determined by the probe's position and separation. In addition to temporary incapacitation, sensory nerves are stimulated causing substantial discomfort and pain.

Another company, Stinger Systems, also markets a projectile CED in the United States (the S-200).[3] The open circuit maximum voltage, pulse waveform, cycle duration, current characteristics, and peak amperage of the S-200 differ somewhat from the Taser X-26.

Federal, State, and Local Laws

Because they use compressed nitrogen rather than gunpowder to propel the probes, the federal Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF) does not classify the Taser® as a firearm; therefore, their sale to civilians is not subject to federal restrictions. The Transportation

Safety Administration prohibits airline passengers from possessing Tasers®, but can authorize their use by trained flight crew members.

Outside of the realm of law enforcement, at least 43 states allow civilians to purchase Tasers®, based on variable state statutes or local ordinances.[4] Some jurisdictions regulate CEDs as firearms or restrict where such devices can be carried. The issue of CED availability and potential use by civilians is not further examined in this report.

POLICIES AND PROCEDURES RELATED TO USE OF FORCE, INCLUDING TASERS®

Police officers are legally and morally required to use the lowest level of force necessary to control a situation and to deescalate at the earliest opportunity. Use-of-force policies are based on a continuum that provides various recommended options when encountering a subject based on the subject's actions and the officer's perception of the situation. Subject actions are classified as: (1) compliant; (2) passive resistance; (3) active resistance; (4) assault causing physical injury; or (5) assault that could cause serious physical injury or death. A model (continuum) for use-of-force options has been developed by the Federal Law Enforcement Training Center (FLETC), Department of Homeland Security.[5,6] When confronted with the potential for serious physical injury or death, police officers can respond with lethal force (i.e., firearms). The use of firearms under such circumstances is associated with a subject mortality of approximately 50%. Thus, alternatives to lethal force and better methods to subdue individuals that limit injuries and death are important tools.

Some semantic confusion exists regarding the classification of CEDs. The Department of Justice's National Institute of Justice (NIJ) classifies CEDs as a "less-lethal" technology. The NIJ defines a less-lethal weapon as "any apprehension or restraint device that, when used as designed and intended, has less potential for causing death or serious injury than conventional police weapons."[7] Such weapons (i.e., CEDS, chemical sprays, blunt force projectiles, directed energy devices) are designed to temporarily incapacitate or restrain an individual when lethal force is not appropriate. The ideal less-lethal weapon incapacitates a potentially dangerous person to facilitate his or her safe arrest, with only minimal risk of injury or death to the subject, law enforcement personnel, or bystanders. Others classify CEDs as a "less-than-lethal" weapon, which implies that use ordinarily will not result in lethality, but that a greater likelihood of serious bodily injury or death exists compared with "non-lethal" interventions.[8,9]

Although many law enforcement agencies rely on the FLETC continuum for training and decision-making in the field, a report issued by the General Accounting Office in 2005 found that the threshold at which Taser® use is deemed appropriate varied among police departments.[5] Some departments restricted its use to situations involving harmful assault or serious threats to oneself or others, while others permitted Taser® deployment at much lower thresholds; for example, on subjects who were "passively resisting" by not responding to lawful verbal commands of the officer. Training and recertification requirements for Taser® use also varied among police departments.

Guidelines for CED Use

Law enforcement agencies attempt to ensure proper deployment of CEDs by establishing and employing use-of-force policies, training requirements, operational protocols, and safety procedures. Because questions have been raised about the patterns of CED use and whether their use poses significant health risks, many related issues have emerged among law enforcement agencies. These include appropriate placement of CEDs on the use-of-force continuum; activation

parameters involving at-risk populations (see below); training questions, including mandatory exposure of officers to these devices; risks for injury and death in exposed subjects; and policies and procedures that are necessary to better ensure safe encounters between police officers and criminal suspects. Accordingly, detailed national guidelines, containing more than 50 provisions for CED use, have been developed by the U.S. Department of Justice and Police Executive Research Forum to inform officers on their appropriate deployment within the use-of-force continuum.[10]

The discussion below focuses on research that has been conducted on the physiologic effects of CEDs in animals and humans, their effects on subjects who have been targeted, and information relevant to their impact (after deployment) on police injuries and the use of lethal force.

PHYSIOLOGIC EFFECTS: ANIMAL MODELS AND HUMAN SUBJECTS

The occurrence of sudden deaths in close proximity to CED use immediately raised speculation about their potential direct effects on cardiac and respiratory function.

Cardiac Effects

Several studies on the cardiac effects of Tasers® have been conducted in anesthetized, ventilated swine models, both by industry-sponsored and independent investigators. Standard Taser® discharges are largely ineffective in generating ventricular fibrillation in the swine model,[11] and other studies support the view that a large safety factor, proportional to body mass, exists for inducing ventricular fibrillation.[12,13] Other studies have demonstrated the ability of Tasers® (or devices modified to generate Taser-like waveforms) to provoke ventricular tachycardia, and rarely, ventricular fibrillation. Ventricular arrhythmias typically are provoked only with prolonged discharges and electrode placements that bracket the heart, ensuring a transcardiac path.[14-17] Standard Taser® discharge can induce capture of implantable pacemakers and provoke discharge of implantable defibrillators in swine models, but sustained arrhythmias generally do not occur under such conditions.[18,19] These results have led some to hypothesize that thin stature and chest impalement may lower the safety margin for Taser® discharges in human subjects.[7]

Because they have a heart-body weight ratio and general cardiac anatomy similar to that of humans, swine have been used in the testing and development of pacemakers and implantable cardiac defibrillators. However, swine have a relatively low threshold for ventricular fibrillation, in part, because their Purkinje fibers cross the entire ventricular wall, in contrast to human hearts in which these fibers are largely confined to a thin layer in the endocardium. Additionally, the cardiac impulse proceeds from the epicardium to the endocardium in swine, potentially increasing their sensitivity to externally applied electrical currents compared with humans. These differences diminish the relevance of this model for evaluating the safety of CED exposure in humans.[20]

Theoretical modeling suggests that Tasers® are extremely unlikely to directly trigger cardiac arrhythmias in humans.[21] Experimental human studies have examined the cardiac and metabolic safety of Tasers®, largely using limited duration discharges applied to the dorsum of healthy, resting volunteers. In such subjects, a 2- to 10-second Taser® discharge provokes a modest increase in heart rate (generally already high due to anticipatory anxiety) and changes in the PR and QT interval that are not clinically significant.[22-26] Additionally, short-lived increases in minute ventilation and tidal volume occur, accompanied by small changes in serum lactate, bicarbonate and creatine kinase (at varying time points), but no clinically significant changes in systemic pH or electrolyte balance. Similarly, a 15-second discharge from a Taser X-26 does not increase the core body temperature of resting, non-environmentally stressed adult subjects.[27] Furthermore, no

evidence of dysrhythmia or myocardial ischemia is apparent, even when the barbs are positioned on the thorax and cardiac apex.[23] Case reports indicate that standard Taser® discharges induce ventricular capture in patients with pacemakers, and also can capture, but do not trigger the discharge of implantable cardiac defibrillators.[28,29] Whether the pacemaker is signaling that Tasers® induce ventricular capture, or whether the pacemaker is simply capturing the electrical train of the Taser® pulse is not established.

Although CED activation in normal volunteers appears to be very safe, these studies do not sufficiently reproduce the risks of Taser® exposure among criminal suspects, in whom coexisting medical and psychiatric conditions, alcohol and drug use, and other factors are often present. Human volunteers report that CED exposure is an extremely unpleasant experience, inducing both physiologic and psychological stress. Some experimental studies have begun to address these confounding factors. For example, preliminary reports of CED exposure in healthy volunteers designed to simulate (to a degree) the physiologic effects of fleeing from or struggling with police officers suggest that changes in systemic pH, lactate, and other markers are comparable to those associated with exercise of the same duration.[30-33] Such studies cannot fully evaluate the responses of individuals who are confrontational, have taken drugs, or are desperate for escape, highly agitated, and combative.

MORBIDITY AND MORTALITY

The emerging relevance of Taser® use for emergency room care was noted almost 25 years ago.[34] Despite the designation of the Taser® as a less lethal, or less-than-lethal weapon, Amnesty International has catalogued a temporal association between the use of CEDs and more than 330 in-custody sudden deaths in North America between June 2001 and August 2008, all involving M-26 or X-26 Tasers®.[1] Therefore, some debate still centers on whether to describe CEDs as non-lethal, less-than-lethal, or less lethal, and as impact or non-impact weapons. Because CEDs have been deployed at lower thresholds on the use-of-force continuum, deaths occurring in association with their use make the safety and deployment of CEDs a significant public health issue.

Most but not all studies undertaken by law enforcement agencies (and others) indicate that deploying CEDs relative to other use-of-force options such as pepper spray, physical force, police dogs, and batons reduces injuries to officers and suspects and reduces the use of lethal force.[8,35-40] CED activation also has recognized risks. For example, a potential exists for the probes to penetrate vulnerable parts of the body such as the eyes, mouth, head, or genitals, or large vessels in the neck and groin region. The strong muscle contractions induced by CEDs cause falls and impact-related injuries (e.g., fractures and head injuries), particularly in elderly individuals or pregnant women. Because experimental studies are inherently limited, epidemiologic and prospective investigations during actual weapon use are vitally important in conducting a realistic risk assessment of these weapons.

Mortality

Arrest-related deaths are not new and predate the deployment of CEDs. Initial studies on early CED weapons concluded that their association with in-custody deaths shared characteristics (to a large degree) with other in-custody deaths. Deceased subjects had a high prevalence of alcohol or other drug use, especially stimulants or phencyclidine (PCP), were agitated or exhibited otherwise bizarre behavior, engaged in intense physical struggle, and were subjected to various types of physical restraint.[41-43]

In 43% of autopsy reports reviewed by Amnesty International, the deceased had been shocked in the chest.[1] In more than half of the autopsy reports, the subjects (average age 36 years) had evident cardiovascular disease, an incidence that is significantly higher than that occurring in the general population of 36-year-old adult males. Some of those who died had no underlying disease or drugs in their system, but collapsed after being subjected to repeated or prolonged shocks and/or shocks to the chest, heightening concern that these factors may increase the risk of death or injury, even in relatively healthy individuals. These findings led Amnesty International to call for a suspension in the use of CEDs pending further (objective) study, or, at a minimum to "limit their use to situations where they are immediately necessary to avoid or reduce the likelihood of recourse to firearms."[1]

One case series based on a convenience sample of in-custody deaths between January 2001 and January 2005 identified 75 deaths that were associated with Tasers®.[44] Thirty-seven autopsy reports were made available for review. This study also revealed cardiovascular disease in more than half of the deceased subjects. Additionally, 78% had used substances, mostly stimulants, and 76% exhibited features typical of "excited delirium" (see below). Taser® use was considered a potential or contributory cause of death in 27% of these subjects. The generalizability of this study is limited because it was based on easily identifiable cases, was restricted to available autopsy reports, relied on (historical) information from police reports, and lacked access to official medical records. However, the overall findings are consistent with prior studies of restraint-related fatalities, with the authors noting:

> As has been stated elsewhere, it is likely that such pre-existing disease, when combined with stimulant use, struggle against law enforcement, and definitive restraint maneuvers (Taser® or otherwise), creates a high-risk situation for restraint-related fatalities.[7]

Similarly, the Police Executive Research Forum referred to a study it had commissioned of 118 deaths following Taser® activations, noting that "the results indicated that multiple and continuous activations of CEDs may increase the risk of death or serious injury, and that there may be a higher risk of death in people under the influence of drugs."[10]

Excited Delirium

Although not a validated diagnostic entity in either the International Classification of Diseases or the *Diagnostic and Statistical Manual of Mental Disorders*, "excited delirium" is a widely accepted entity in forensic pathology and is cited by medical examiners to explain the sudden in-custody deaths of individuals who are combative and in a highly agitated state.[45] Excited delirium is broadly defined as a state of agitation, excitability, paranoia, aggression, and apparent immunity to pain, often associated with stimulant use and certain psychiatric disorders. The signs and symptoms typically ascribed to "excited delirium" include bizarre or violent behavior, hyperactivity, hyperthermia, confusion, great strength, sweating and removal of clothing, and imperviousness to pain. Speculation about triggering factors include sudden and intense activation of the sympathetic nervous system, with hyperthermia, and/or acidosis, which could trigger life-threatening arrhythmias in susceptible individuals. Biochemical studies have shown alterations in the function of dopamine neurons and specific gene activation products in the central nervous system of such individuals.[45] The intense pain associated with Taser® exposure, the psychological distress of incapacitation, and hazards associated with various restraint methods also could contribute.

Of note, one study of emergency department cases over a six-year period evaluated 216 subjects who had been restrained in the "hobble" position; 20 of these subjects died suddenly and unexpectedly.[46] Almost all of these subjects had cardiovascular disease or were under the influence

of a stimulant. Four had been exposed to pepper spray, three to CEDs, and two had both exposures. The authors concluded that "such individuals are at a higher risk for sudden death, particularly those who are obese, under the influence of stimulant drugs, or have underlying (cardiovascular) disease." Ongoing debate exists on whether certain forms of physical restraint such as the "hobble" position and "hogtying" place some individuals at risk for positional asphyxia, even in the absence of the use of pepper spray or CEDs.

Governmental Review

Widespread media attention to some Taser®-associated deaths has triggered governmental review of their use in both Canada and the United States.[5,7,47] In June 2008, the National Institute of Justice published an interim report of its ongoing inquiry into deaths following police use of CEDs.[7] Although this interim report acknowledged the need for more research into the effects of CEDs, it concluded that medical evidence is lacking to support the view that CEDs pose a "significant risk" for inducing cardiac dysrhythmia when "deployed reasonably" and that law enforcement officials "need not refrain from deploying CEDs provided the devices are used in accordance with accepted national guidelines."[10,36] The report also urged "caution" in the use of "multiple activations." In its guidelines for CED use, the Police Executive Research Forum also recommends that, following the application of a CED, officers should "use a restraint technique that does not impair respiration."[10,36]

In response to the highly publicized death of a subject in the Vancouver airport, the Canadian House of Commons Standing Committee on Public Safety and National Security evaluated CED use and recommended that the Royal Canadian Mounted Police restrict the use of the Taser® by classifying it (effective no later than December 15, 2008) as an "impact weapon" rather than an intermediate weapon, so that its "use can be authorized only in situations where the subject is displaying assaultive behaviour or posing a threat of death or grievous bodily harm to the police, himself or the public."[47] The Committee further advised that this restriction should not be lifted "before independent research has indicated that use of the Taser® poses no unreasonable risk for the subject."

To more clearly establish the potential role of Tasers® in arrest-related deaths, the following information would be useful: (1) total in-custody deaths (or deaths proximate to restraint); (2) total Taser® deployments (or field applications); and (3) total in-custody deaths not involving Taser® use. Since 2003, all U.S. law enforcement agencies are required to not only report, but also categorize all in-custody deaths.[48] During the period from 2003 to 2005, 47 states and the District of Columbia reported 2,002 arrest-related deaths proximal to law enforcement's use of force, including 1,095 homicides by law enforcement personnel, 96% of which involved the use of a firearm by the arresting officer.[49] Approximately 4% of persons who died had been placed under physical restraints. CEDs were involved in 36 arrest-related deaths during this period. In 17 of these, the CED was causally linked to the death. This report acknowledges that the ability of CEDs to cause death is a subject of debate, and that due to reporting gaps, these 36 cases do not represent a complete count of all deaths in which the use of a CED was involved.

Prospective Field Evaluations

Two recent studies are instructive.[50,51] One prospective, multicenter, observational study tracked a consecutive case series of all CED weapon uses against criminal suspects at six U.S. law enforcement agencies for three years (2005-2008).[50] Physician site investigators reviewed police and medical records to identify and classify injuries sustained by subjects after CED use. To quality for consideration, law enforcement agencies had to use conducted electrical weapons, have

a physician already affiliated with the agency's tactical team with access to agency records, provide routine pre-incarceration medical screening to all arrestees (jail intake, paramedic evaluation at the scene, physician evaluation in hospital emergency departments), and perform mandatory use-of-force reviews after each CED use. CEDs were used against 1,201 subjects during a 36-month period; probe mode was used in 65% of subjects, stun mode in 27%, and both modes in the remainder. The mean number of discharges was 1.8 (median = 1).

Significant injuries (i.e., those requiring hospital admission, producing long-term disability, or that were life threatening) occurred in three subjects (0.25%), including two intracranial injuries from falls and one case of rhabdomyolysis. The remainder were classified as suffering minor or no injuries. The majority of mild injuries were superficial puncture wounds from the darts, and some blunt trauma or bruising attributable to falls. Two subjects died in police custody, but medical examiners eliminated CED use as a causal or contributory factor in both cases. Both subjects had struggled violently with police, and required additional restraint measures. One suffered from cardiomyopathy and had cocaine in his system; the other was being treated for mental illness (unspecified), and was subdued only after pepper spray application, two CED discharges, and restraint in the prone position. The subject collapsed 5 minutes after CED discharge, and was subsequently found to have an extremely high serum concentration of olanzapine. This outcome was judged to be "typical of other in-custody deaths."

The most carefully controlled prospective study involved an analysis of 426 consecutive CED activations in the Dallas police department from November 2004 through January 2006.[51] The study established on ongoing registry of CED application (Taser® X-26) after introduction of the device into the force continuum. All suspects who were subdued following CED activation were evaluated by paramedics, the jail intake nurse, or a police department tactical physician. In addition, the on-call tactical physician, if not already on the scene, was notified of the activation. Medical review of the registry entrants ultimately was conducted by the physician-led medical team.

One subject collapsed during transfer from the ground to the ambulance (after two standard discharges) and subsequently died. This individual had high serum concentrations of cocaine and metabolites and a core body temperature of > 107° F on arrival at the emergency room. No other suspect had an injury requiring treatment other than simple first aid. In 5.4% of the deployments the Taser® was deemed to have clearly prevented the use of lethal force. This study helps to corroborate the safety profile for CED use when a prescribed policy is followed. The use of a comprehensive training program likely contributed to the strong safety record in this study, as well as the fact that police personnel knew all Taser® applications would be strictly evaluated for compliance with established departmental use-of-force policies.

USE OF CONDUCTED ELECTRICAL DEVICES IN HEALTH CARE FACILITIES

In many hospitals security is provided by contract agencies or off-duty law enforcement personnel. The Joint Commission standard EC.2.10 addresses security, noting: "The hospital identifies and manages its security risks." The Element of Performance for EC.2.10.1 states: "The hospital develops and maintains a written management plan describing the process it implements to effectively manage the security of patients, staff, and other people coming to the hospital's facilities." Furthermore, the Joint Commission surveys hospitals to ensure that the hospital complies with the policies that it has established based on the risk assessment for that facility. Available personnel and security assessments vary greatly among hospitals, so a uniform Joint Commission-based guideline on the use of CEDs in hospitals is probably not warranted.

Concern has been expressed, as noted above, about the use of CEDs in individuals who are not compliant with law enforcement because of existing mental health problems. Although a few media reports of CED use in violent patients confined to mental health facilities have appeared, no systematic review or study of CED use for controlling violent patients or their use as negative reinforcement in uncooperative patients is available. Psychiatric facilities that accept Medicaid or Medicare payments are not permitted to use CEDs. Regardless, CEDs should not be used for the purpose of negative reinforcement in such patients.

SUMMARY AND CONCLUSION

Concerns about the use of CEDs fall into three general areas: (1) they are used too frequently and at lower levels on the use-of-force continuum than indicated; (2) appropriate training and supervision of CED use is lacking in some jurisdictions; and (3) CEDs may contribute to the death of suspects, either directly or indirectly.

CEDs have a role to play in law enforcement and prudent use can save lives during interventions that would otherwise involve the use of deadly force. If deployed according to an appropriate use-of-force policy, and used in conjunction with a medically driven quality assurance process, Taser® use by law enforcement officers appears to be a safe and effective tool to place uncooperative or combative subjects into custody. Treating CEDs as "only a substitute for deadly force, would endanger officers and negate the benefit that has been demonstrated."[8] Training protocols should emphasize that multiple activations and continuous cycling of CEDs appear to increase the risk of death or serious injury.[10]

The growing use of CEDs makes it virtually inevitable that more cases of in-custody death are occurring in proximity to CED activation. As noted by Link and Estes, important variables confounding Taser®-related deaths "cannot be fully investigated in retrospective reviews, registries, or reproduced in clinical investigations."[52] The "influence of confounding clinical factors such as excited delirium, physical restraint techniques, underlying cardiovascular disease, hyperadrenergic states, metabolic derangements, or the influence of alcohol, stimulants, or other drugs remains unknown in epidemiologic investigations, and uncontrollable in clinical investigations."

Ongoing issues include: (1) the need for clear usage guidelines, including restrictions on the application of multiple discharges; (2) an appreciation of the potential risks of injury and death associated with CED use and the gaps in knowledge about potential factors that affect the relative safety of deployment, and the risks of sudden death after exposure and physical restraint; (3) the need for independent peer-reviewed research into the safety (and usefulness) of CEDs in field applications; and (4) the need to establish a more comprehensive national database of in-custody deaths.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 401(A-08) and the remainder of the report be filed:

1. That our American Medical Association establish policy that law enforcement departments and agencies should have in place specific guidelines, rigorous training, and an accountability system for the use of conducted electrical devices (CEDs) that is modeled after available national guidelines. (New HOD Policy)

2. That our AMA encourage additional independent research involving actual field deployment of CEDs to better understand the risks and benefits under conditions of actual use. Federal, state, and local agencies should accurately report and analyze the parameters of CED use in field applications. (Directive to Take Action)

3. That our AMA establish policy that law enforcement departments and agencies have a standardized approach to the medical evaluation, management and post-exposure monitoring of subjects exposed to CEDs. (New HOD Policy)

Fiscal Note: Less than $500

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REPORT 7 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-09)
An Updated Review of Sex Education Programs in the United States
(Substitute Resolution 409, A-08)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective. To update previous Council analyses by reviewing published literature and sentinel reports that have appeared over the last 10 years on the effectiveness of both comprehensive and abstinence-only sexual education platforms.

Methods. English-language articles were identified by a Google Scholar and PubMed search for January 1999 to February 2009 using the key words "comprehensive sex education," "abstinence education," "abstinence only education," and "abstinence plus education." Articles were selected based on their evaluation of sexual education programs, with an emphasis on those that are federally funded. Additional articles were chosen to identify any gaps in knowledge, such as those addressing the evaluation of programmatic content. In addition, the Web sites of the Sexuality Information and Education Council of the United States (SIECUS), the Heritage Foundation, and Advocates for Youth were consulted for their specific content.

Results. Current estimates of reportable sexually transmitted disease (STD), teen pregnancy, and human immunodeficiency virus (HIV) transmission rates in the United States remain higher than those of other developed countries. Additionally, the teen birth rate has risen consistently for the past two years, a reversal from the previous 14-year decline. Measuring the comparative effectiveness of abstinence-only and comprehensive-based sexual education is difficult because of differences in the programs, the populations and ages of those served, and the various methods used for retrospective evaluation. Differing ideologies also lead to disparate views on what constitutes the most relevant outcome of interest. Although a few abstinence-only education programs have succeeded in temporarily altering teen attitudes toward abstinence, the overwhelming number of programs that have been reviewed fail to keep youth abstinent until marriage, or to significantly delay the onset of sexual activity. Funding for abstinence-only education programs has risen exponentially over the past 10 years, but there is scant evidence to support their effectiveness in changing adolescent behavior and permanently altering attitudes in regard to sexual activity. Such programs may have the minor effect of altering intent to engage in sexual activity, and do not adversely affect knowledge about contraceptives, condoms, and STDs.

Conclusions. The combination of the increases in STD, HIV transmission, and teen pregnancy rates underscores the need for sexual education methods for children, adolescents, and adults that result in behavior change; risk behavior reduction; or a measurable change in knowledge, attitudes, or beliefs. Although a few abstinence-only education programs have succeeded in changing and supporting teen attitudes toward abstinence, strong evidence is lacking that abstinence-based programs significantly delay the initiation of sex, keep youth abstinent until marriage, hasten return to abstinence, or reduce the number of sexual partners. Comprehensive-based sexuality education curricula that include accurate information about contraception and condom use, and that may also encourage abstinence (as the only fully effective way to prevent pregnancy and the transmission of disease), continue to be the most effective at increasing adolescents' knowledge about pregnancy and disease prevention.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 7–A-09

Subject: An Updated Review of Sex Education Programs in the United States (Substitute Resolution 409, A-08)

Presented by: Carolyn B. Robinowitz, MD, Chair

Referred to: Reference Committee D (James L. Milam, MD, Chair)

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Substitute Resolution 409 (A-08), and the remainder of the report be filed:

1. That our American Medical Association (AMA) recognize that increasing sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission rates among youth, as well as a recent increase in the national teen pregnancy rate, indicate a gap in public health education and should be addressed; and that comprehensive-based sex education is currently the most effective strategy to address these public health problems. (New HOD Policy)

2. That our AMA support the redirection of federal resources toward the development and dissemination of more comprehensive health and sex education programs that are shown to be efficacious by rigorous scientific methodology. This includes programs that include scientifically accurate education on abstinence in addition to contraception, condom use, and transmission of STDs and HIV. (New HOD Policy)

3. That our AMA reaffirm Policies H-170.968, “Sexuality Education, Abstinence, and Distribution of Condoms in Schools,” and H-170.977, “Comprehensive Health Education.”(Reaffirm HOD Policy)

Fiscal Note: < $500

REPORT 8 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-09)
Sustainable Food
(Resolution 405, A-08)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective: To address how medical schools, hospitals, and other health care facilities can model and encourage healthy eating in a manner that supports environmentally sustainable agricultural and food system practices. This report defines sustainability within the context of the overall food system and outlines areas requiring further attention.

Methods: Literature searches for articles published through February 2008 were conducted in the PubMed database using the search terms "sustainable food," "sustainable agriculture," and "organic food." Articles were selected that focused on human health and on the role health professionals and health care institutions could play in regard to these issues. Web sites managed by federal agencies and applicable professional and grassroots organizations were also reviewed for relevant information. Additional articles were identified by reviewing the reference lists of pertinent publications.

Results: Sustainability refers to the capacity of being maintained indefinitely, in a manner that meets present needs without compromising the ability to meet future needs. It is a continual process of improvement that must constantly respond to the economic, ecological, and health inputs to the system. Food systems encompass food production, processing, packaging, labeling, distribution, access, and consumption. A sustainable food system includes sustainable agricultural practices (environmental stewardship, profitable farm incomes, and stable farm families and communities) as well as other practices within the entire food system that promote and preserve ecology (conservation of resources and genetic biodiversity), social values (just working conditions, humane treatment of animals, geographical and economic accessibility to food), health (nutritious food without potentially harmful contaminants), and economic viability (fair incomes for families and local economies). Organic, natural, and local foods are not necessarily healthy and/or sustainable, although healthy food should be both nutritious and sustainable. Using a "more/less" rather than "either/or" approach, local food is usually the most sustainable, being generally less resource intensive and less vulnerable to contamination, while providing fresher and less processed food and fostering healthier relationships between farmers and consumers. However, even eating more conventionally produced (i.e., nonorganic, nonlocal) fruits and vegetables in place of animal products improves the sustainability of the food system. Several organizations offer information, resources, and recommendations to help schools and health care facilities leverage their community and market leadership to adopt healthier, sustainable food policies and practices. Although more research is needed to clarify the best means of achieving a healthier food system, it is essential that it incorporate a systems approach.

Conclusions: Healthy diets are rich in fruits, vegetables, and whole grains, and low in unhealthy fats, sodium, and added sugars, but they also support environmental sustainability, economic viability, and human dignity and justice. Unhealthy food systems are not sustainable, and contribute to the very health problems the health care system is trying to solve – at extraordinary costs both economically and in terms of quality of life. It is essential that health care organizations become both models and advocates of healthy, sustainable food systems that promote wellness and that "first do no harm."

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 8-A-09

Subject: Sustainable Food
(Resolution 405, A-08)

Presented by: Carolyn B. Robinowitz, MD, Chair

Referred to: Reference Committee D
(James L. Milam, MD ,Chair)

Resolution 405 (A-08), "Sustainable Food," introduced by the American College of Preventive Medicine at the 2008 American Medical Association (AMA) Annual Meeting and referred to the Board of Trustees, asks:

> That our AMA Council on Science and Public Health (CSAPH) provide a report at the 2008 Interim or 2009 Annual Meeting to determine whether and how our AMA should encourage medical schools, hospitals, offices, and other health care facilities to adopt policies and implement practices that increase the purchasing and serving of food that promotes health and prevents disease, while minimizing the use of nontherapeutic antibiotics, greenhouse gas emissions, Concentrated Animal Feeding Operation (CAFO) and other industrial agricultural food sources; and
>
> That the same CSAPH report address whether and how our AMA should call on physicians and other health care professionals to serve as role models and educators by participating in and promoting a healthier and more sustainable food system that improves eating habits, increases patient and public health, and supports the long-term social, economic, and environmental well-being of communities in the US and throughout the world.

A recent CSAPH report on green initiatives and the health care community, presented at the 2008 Interim Meeting, addressed sustainable food practices in the context of hospital food purchasing practices. This report expands on the topic to address how medical schools, hospitals, and other health care facilities can model and encourage healthy eating in a manner that supports environmentally sustainable agricultural and food system practices, which in turn may provide additional social, economic, and health benefits to their surrounding communities and beyond.

CURRENT AMA POLICY RELATED TO SUSTAINABLE FOOD

The AMA currently has several policies that address environmentally friendly agricultural practices and encourage physicians to serve as educators and role models for healthy eating behaviors. These policies (AMA Policy Database):

- Encourage health care facilities to purchase and serve food that promotes health and prevents disease (H-150.949 and D-150.989);
- Oppose the nontherapeutic use of antimicrobials in agriculture (H-440.895);

- Support systematic safety assessments of genetically modified foods and continued research into the potential health and environmental impacts of genetically modified crops (H-480.958);
- Urge maximum feasible reductions of all forms of air pollution (H-135.998);
- Support alerting the public about the health hazards of environmental pollution and the need for expanded research and control measures (H-135.996);
- Encourage physicians to be spokespersons for environmental stewardship (H-135.973 and H-135.969); and
- Support the development and use of ecologically sustainable products, foods, and materials when possible, as well as community-wide adoption of "green" initiatives and activities by organizations, businesses, and health care entities (H-135.939).

METHODS

Literature searches for articles published through February 2008 were conducted in the PubMed database using the search terms "sustainable food," "sustainable agriculture," and "organic food." Articles were selected that focused on human health and on the role health professionals and health care institutions could play in regard to these issues. Web sites managed by federal agencies and applicable professional and grassroots organizations were also reviewed for relevant information. Additional articles were identified by reviewing the reference lists of pertinent publications.

BACKGROUND

Nutrition, public health, and sustainable agriculture have typically been separate, nonoverlapping fields, as exemplified by the stark inconsistencies between US farm policy and the Dietary Guidelines for Americans.[1] The current US food system is highly industrialized, focusing on the production of animal products and federally subsidized commodity crops, such as corn and soybeans. This has resulted in a highly processed, calorie-dense food supply, instead of one rich in a variety of fruits, vegetables, and whole grains, as recommended by the Dietary Guidelines for Americans.[2] The poor quality diets supported by this system contribute to four of the six leading causes of death in the United States: heart disease, stroke, diabetes, and some cancers. Individuals of lower socioeconomic standing are more likely to consume these subsidized, highly processed foods, and are likewise at increased risk of related adverse health outcomes.[3]

Beyond the issue of poor nutritional quality are methods of food production and distribution that have additional negative effects on human and environmental health.[4] These methods have contributed to the development of antibiotic resistance; air and water pollution; contamination of food and water with animal waste, pesticides, hormones, and other toxins; increased dependence on nonrenewable fossil fuels (including fertilizers)[2, 4]; and a food system that is increasingly vulnerable to accidental or intentional contamination.[3] These methods of food production and distribution are inherent parts of the prevailing agricultural system, which is may be referred to as "conventional farming, modern agriculture, or industrial farming."[5]

Clinical approaches to addressing diet-related health concerns are costly and not sustainable.[4] Additionally, it is difficult for individuals to change their eating behaviors when many forces in the social, cultural, and physical environment do not support such change.[4] The public looks to the health care community to provide leadership in the best practices to promote health. Medical schools, hospitals, and other health care facilities are key participants in the food system with potentially significant roles to play in fostering greater awareness, improving purchasing practices, and promoting consumption of healthy and sustainable food.

DEFINING SUSTAINABILITY

"Sustainability" has become a widely used term in social, economic, ecological, agricultural and food production sectors, although its precise definition remains relatively unclear and variable.[6] In a general sense, sustainability refers to the capacity of being maintained indefinitely, in a manner that meets present needs without compromising the ability to meet future needs.[6, 7] Sustainability refers to continual processes of improvement, as well as to the products of processes/practices.[1] As social, ecological, economic, and health inputs to a system continually change, so too must the system change in order to remain resilient and sustainable.[6]

Sustainable agriculture refers to methods of producing food (and fibers such as cotton) in a manner that:

- Provides profitable farm incomes;
- Promotes environmental stewardship (protection and promotion of high soil quality; reduced dependence on nonrenewable fuels, synthetic fertilizers, and pesticides; and limiting adverse impacts on safety, and on wildlife, water quality, and other natural resources); and
- Promotes stable and prosperous farm families and communities.[8]

No one method or set of methods works for every farm, ranch, or community. However, collectively, these efforts contribute to improved sustainability not just in agriculture, but also in food systems and the public health.

Sustainable food is defined within the context of the overall food system. Food systems encompass food production, processing, packaging, labeling, distribution (wholesaling, storage, transportation), access (grocers, restaurants, institutional food service, emergency food programs), and consumption (food purchasing, preparation, eating, and waste management).[7] A sustainable food system includes sustainable agricultural practices as well as other practices within the food system that promote and preserve the following:

- Ecology. Natural resources should be conserved, renewable, or enhanced in ways that limit and/or recycle wastes and preserve genetic biodiversity.
- Social values. Workers throughout the food system should be treated justly in terms of rights, pay, and work conditions. Animals should be treated humanely. Culturally acceptable foods should be accessible to all consumers in terms of location and affordability.
- Health. Food should be nutritious and contribute to a balanced diet, without potentially detrimental biological or chemical contaminants
- Economic viability. All food system activities should support livelihoods of families and contribute to local economic development, without concentrated economic control of large parts of the food system by any one entity.[4, 6]

Local, state, federal, and international policies are central influences on the food system. These policies impact what and how food is grown, processed, labeled, and made available for consumption.[6] Agricultural, food, and nutrition policies affect the choices people and organizations have, and in turn the health of individuals, communities, and the environment.

DEFINING ORGANIC, NATURAL, AND LOCAL FOODS

Organic, natural, and local foods are not necessarily one and the same. As described below, only organic food has a legal definition that distinguishes it, in at least some ways, from conventionally

produced food. "Conventional" food has no formal definition; usually, it refers to foods grown using modern agriculture or industrial farming methods. These methods generally involve large-scale farms; single/row crops grown on the same land over several consecutive seasons; uniform high-yield hybrid crops (with limited biodiversity); extensive use of pesticides, fertilizers, and nonrenewable energy sources; high labor efficiency; and confined, concentrated livestock systems.[5]

Foods that are labeled "organic" must be produced and processed in accordance with the US Department of Agriculture's (USDA) National Organic Program standards.[9] These standards require foods be produced without genetic engineering, ionizing radiation, and synthetic substances. Crops must be raised without most conventional pesticides or petroleum- or sewage sludge-based fertilizers. Organic meat, poultry, eggs, and dairy products must be produced from animals fed organic feed, given outdoor access, and not given antibiotics or growth hormones. Organic actually refers to the process of the food production, rather than the end product.

The term "natural" is not regulated by the USDA, except when used to describe meat and poultry. The USDA requires meat and poultry products labeled "natural" to be free from any artificial ingredient or added color, and be only minimally processed, such that the raw product is not fundamentally altered. In addition, the label must explain the use of the term natural (e.g., no added colorings, no artificial ingredients, minimally processed).[10] Natural food is not necessarily organic or local.

"Local" does not refer to any set distances between the food source and the consumer; rather, it is a relative term that encourages the consumption of foods produced nearest to the consumer. Locally produced food tends to be picked at peak ripeness (which generally improves the flavor and nutrient content), requires less fossil fuel to transport, and can foster healthier relationships between farmers, consumers, and the environment.[6] Locally grown foods are also usually less processed. Processed food products tend to be manufactured at a few key facilities that purchase their basic ingredients from around the country, or even around the globe, and in turn ship their products nationally and internationally. Not only does the production and distribution of such processed food use fossil fuels and generate emissions, but the plastic and paper packaging further depletes the environment of valuable natural resources.

Organic, natural, and local foods are not necessarily healthy, in that they may still be high in calories, saturated fat, sodium, and/or added sugars (e.g., whole milk, cheese, or cookies), or highly processed (e.g., organic white flour, chips, instant meals). Organic foods are not necessarily sustainable; in fact, many organic foods (like many conventionally grown foods) sold in the United States are from countries such as China or Argentina, and are therefore picked unripe (if fresh, not frozen), packaged, and transported over long distances. This can result in lower nutritional quality (compared to ripe fruit), further depletion of fossil fuels, and increased air pollution from emissions. Furthermore, organic, natural, and local foods are still at risk of contamination from microscopic organisms (e.g., due to contaminated water or unsanitary processing facilities).

HEALTHY FOOD IS NUTRITIOUS AND SUSTAINABLE

The Dietary Guidelines for Americans recommend 4 1/2 cups (9 servings) of fruits and vegetables daily for adults consuming the 2,000 calorie reference diet; they also recommend limiting consumption of saturated fats, sodium, and added sugars.[11] However, the United States would need to increase its fruit and vegetable production by approximately 13 million acres to produce sufficient quantities of fruits and vegetables for the entire population to meet these recommendations.[12] A recent report estimates that 86% of the land currently being used for fruit and vegetable production in the United States is threatened by development.[13] Clearly, US farm and zoning policies are not

sufficient to support the public health. Optimal public health requires a good, healthy food supply, but the United States cannot have a good, healthy food supply without a sustainable food system.[1]

Locally produced and organic foods are considered part of a healthy, sustainable food system for many reasons. They reduce the use of fuel, decrease the need for packaging and resultant waste disposal, preserve farmland, and/or support a greater diversity of crops. The related reduced fuel emissions contribute to cleaner air and in turn lower the incidence of asthma attacks and other respiratory problems. Organic meat production helps reduce the development of antibiotic resistance, as well as air and water pollution. Organic and local foods can have improved nutrient profiles: ripe produce, and some organic produce, contain peak amounts of micronutrients and phytochemicals, and pasture-raised, grass-fed animals produce leaner beef, and meat and milk with higher levels of beneficial essential fatty acids such as omega-3s.[6] Some people also believe local and organic foods taste better, which may encourage increased consumption of fruits, vegetables, and lean meat, while also decreasing exposure to pesticides and hormones. Shorter supply chains in local food systems also lessen their vulnerability to food contamination.[6]

It is important to note that conventionally produced fruits and vegetables are still strongly associated with reduction of chronic disease risks (most diet-disease studies do not differentiate between organic and conventional produce). Likewise, production of conventional fruits and vegetables uses far less fossil fuel and water than does the production of meat. Reducing the portion sizes of meat (pork and beef) and the frequency of meat consumption limits health risks and can also contribute to a sustainable food system. The Food and Agriculture Organization of the United Nations estimates that livestock alone contributes 18% of all greenhouse gas emissions.[14] Similarly, water use is greater for meat production: 6 gallons of water are needed to produce one serving of lettuce, 49 gallons to produce an 8-oz glass of milk, and 2,600 gallons to produce one serving of steak.[15]

The development of food systems that are sustainable involves continually improving strategies that emphasize “more/less” rather than “either/or.” For example, a sustainable food system is more localized rather than less, it is more environmentally sustainable rather than less, and there are more relationships among individual people in the food system rather than less.[1] In other words, members of a food system, such as health care institutions, can “triage” their food supply in the context of the food system: 1) Can the food be sourced locally? 2) If not, can a local substitute be used? 3) If not, can a more distant food source be obtained that includes the same environmental, social, and economic characteristics preferred in the local food?[1]

HOW HEALTH CARE INSTITUTIONS CAN TAKE A LEADERSHIP ROLE IN PROMOTING HEALTHY AND SUSTAINABLE FOOD SYSTEMS

Communities look to medical schools, hospitals, and other health care facilities as leaders in achieving and maintaining optimal health, which includes not just the absence of disease but also the promotion of physical, mental, and social well being.[16] While the connections between diet and health have long been recognized by the health care community,[4] it is imperative to lead by example. Health care organizations are substantial components of the food system, with the total health care market for food and beverages estimated at $12 billion annually.[4]

Several organizations offer information and resources to schools, universities, and health care facilities to help them leverage their community and market leadership to adopt healthier food purchasing policies and practices. These include the Green Guide for Health Care™ (GGHC), the Institute for Agriculture and Trade Policy (IATF), Yale’s Sustainable Food Project, the American Dietetic Association, and the Health Care Without Harm coalition. The GGHC is a voluntary, self-certifying metric toolkit of best practices that covers multiple facets of environmental sustainability,

not just food systems.[17] Health Care Without Harm likewise covers a range of issues involving the environment, and provides a more extensive array of resources and information that may be particularly helpful for organizations that are just beginning to explore their role in a sustainable food system.[18]

Health Care Without Harm is an international coalition of 473 organizations in more than 50 countries, whose mission is to "to transform the health care sector worldwide, without compromising patient safety or care, so that it is ecologically sustainable and no longer a source of harm to public health and the environment."[19] One of the coalition's key goals is to "encourage food purchasing systems that support sustainable food production and distribution, and provide healthy food on-site at health care facilities."[19] Central to this goal is the Healthy Food in Health Care Pledge,[20] which outlines key commitments that health care organizations should make to "first, do no harm" by realizing that wise use of food, and its responsible production and distribution, is actually preventive medicine that protects the health of patients, staff, and communities (Appendix). To date, at least 165 health care facilities in the United States have signed this pledge.[20]

Recognizing that a sustainable food system is a process, and that different organizations will have different capacities to change in different locales, Health Care Without Harm offers a full menu of options for organizations to choose from, with specific how-to suggestions, background information, policy statements, sample procurement policies, and examples of case-studies from organizations that have successfully implemented healthy food practices. Key recommendations include:

- Start a conversation within your organization about healthy food (e.g., form a "food team")
- Contract with a group purchasing organization, distributor, or food service provider that supports healthy food
- Implement purchasing policies for meat and poultry raised without nontherapeutic antibiotics
- Model local, nutritious, sustainable food at conferences, meetings, and workshops
- Buy milk produced without recombinant bovine growth hormone (rBGH or rBST)
- Buy organic and other certified food (e.g., Food Alliance Certified, Protected Harvest, Certified Humane, Fair Trade)
- Consider establishing an overarching food policy
- Buy food from local producers
- Become a fast food-free zone
- Limit use of vending machines and replace unhealthy snacks with healthy choices
- Host a farmers' market on hospital grounds
- Create hospital gardens to grow fresh produce and flowers
- Compost, divert, and reduce food waste
- Buy certified coffee[21]

AREAS REQUIRING FURTHER ATTENTION

Health care professionals tend to focus on health outcomes in individuals rather than in systems.[3] However, hospitals, medical schools, and other health care facilities are part of a food system that has the potential to both benefit and harm individual health directly and indirectly.[3] While support of sustainable food practices is not "high-tech" or procedure oriented, it promises significant improvements in health and economic costs to a health care system that is overburdened by diseases caused, at least in part, by an unhealthy food system. More research is needed to clarify the best means of achieving a healthier food system (e.g., whether subsidizing a variety of organically produced fruits and vegetables will increase their consumption and decrease consumption of highly refined food products),[3] but it is essential that the research and resultant policies and practices

incorporate a systems approach.[1, 4] For example, instead of asking whether genetically engineered food is good or bad, a better question may be: does genetic modification help grow enough food in a sustainable fashion?[4]

More attention also needs to be paid to the economic and regulatory policies that encourage the production of unhealthy, nonsustainable food at low immediate financial cost to consumers, at the expense of poorer health outcomes that cost far more to treat with medications and procedures than investments (at societal and personal levels) in healthy food. The US Farm Bill, which covers the bulk of federal agricultural and food policies (e.g., nutrition education, food assistance programs, conservation programs, agricultural trade), is one example of an issue with which members of the health care system should be more involved.

Educational efforts likewise should recognize that the development of healthy food systems involves continually improving strategies that emphasize "more/less" rather than "either/or." This may be particularly helpful when a lack of financial resources or geographic access is an issue. While healthier, more sustainable food is often more expensive than highly refined and processed foods, this tends to be more apparent when evaluating price per calorie[4] than price per serving of food. For example, a bowl of homemade oatmeal costs far less than a fast food breakfast sandwich, and a single apple or orange is often comparable in price, or even less expensive, than a bag of chips or a candy bar. Even on a per calorie basis, soft drinks are more expensive than tap water. A meal of pasta, jarred spaghetti sauce, steamed frozen broccoli, lettuce and carrot salad, and tap water is healthier, more ecologically sustainable, and cheaper than a carry-out pizza dinner with soft drinks. The first meal is "more" sustainable and healthy – not perfect, but better than the alternative meal. Convenience, taste, access, and cooking skill are also factors in people's food choices that deserve more attention in efforts to promote a more sustainable food system.

To foster determination and dissemination of best practices, and to clarify areas where challenges remain, efforts by health care organizations to improve food systems should be well-documented and shared with the health care community and the public, both in a quantitative and qualitative fashion. Research that outlines the costs, cost savings, and any changes in short- or long-term health outcomes is also essential. Again, these issues are best framed within a systems approach.

SUMMARY AND CONCLUSION

Healthy food is part of a sustainable food system, in which food is defined not only by its nutrient content, but also by how and where it is raised, grown, processed, and distributed. Public health dietary guidelines, as well as dietary recommendations targeting individuals for secondary and tertiary prevention, cannot be met without a greater emphasis on sustainable agriculture and food production as part of a larger food system. The health care community has a highly visible leadership role to play in the promotion of health and wellness policies, which should "first do no harm." Healthy diets are rich in fruits, vegetables, and whole grains, and low in unhealthy fats, sodium, and added sugars, but they also limit the depletion of nonrenewable resources; air, water, and soil pollution; the development of antibiotic-resistant bacteria; and the risk of food contamination. Unhealthy food systems are not sustainable, and contribute to the very health problems the health care system is trying to solve – at extraordinary costs both economically and in terms of quality of life. It is essential that health care organizations become both models and advocates of food systems that promote optimal health.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 405 (A-08) and that the remainder of this report be filed:

1. That our American Medical Association (AMA) support practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy food system, which provides food and beverages of naturally high nutritional quality, is environmentally sustainable and economically viable, and supports human dignity and justice. (New HOD Policy)

2. That our AMA encourage the development of a healthier food system through the US Farm Bill and other federal legislation. (Directive to Take Action)

3. That our AMA consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems. (Directive to Take Action)

Fiscal Note: $ 1000

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APPENDIX – The Healthy Food in Health Care Pledge, from Health Care Without Harm[20]

This Healthy Food in Health Care Pledge is a framework that outlines steps to be taken by the health care industry to improve the health of patients, communities and the environment.

As a responsible provider of health care services, we are committed to the health of our patients, our staff, and the local and global community. We are aware that food production and distribution methods can have adverse impacts on public environmental health. As a result, we recognize that for the consumers who eat it, the workers who produce it, and the ecosystems that sustain us, healthy food must be defined not only by nutritional quality, but equally by a food system that is economically viable, environmentally sustainable, and supportive of human dignity and justice. We are committed to the goal of providing local, nutritious and sustainable food.

Specifically, we are committed to the following healthy food in health care measures for our institution. We pledge to:

Increase our offering of fruit and vegetables, nutritionally dense and minimally processed, unrefined foods and reduce unhealthy (trans and saturated) fats and sweetened foods.

Implement a stepwise program to identify and adopt sustainable food procurement. Begin where fewer barriers exist and immediate steps can be taken, such as the adoption of rBGH free milk, fair trade coffee, or selections of organic and/or local fresh produce in the cafeteria.

Work with local farmers, community-based organizations and food suppliers to increase the availability of fresh, locally-produced food.

Encourage our vendors and/or food management companies to supply us with food that is produced in systems that, among other attributes, eliminate the use of toxic pesticides, prohibit the use of hormones and non-therapeutic antibiotics, support farmer and farm worker health and welfare, and use ecologically protective and restorative agriculture.

Communicate to our Group Purchasing Organizations our interest in foods whose source and production practices (i.e. protect biodiversity, antibiotic and hormone use, local, pesticide use, etc) are identified, so that we may have informed consent and choice about the foods we purchase.

Develop a program to promote and source from producers and processors which uphold the dignity of family, farmers, workers and their communities and support sustainable and humane agriculture systems.

Educate and communicate within our system and with our patients and community about our nutritious, socially just and ecologically sustainable healthy food practices and procedures.

Minimize and beneficially reuse food waste and support the use of food packaging and products that are ecologically protective.

Report annually on implementation of this Pledge.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-09)

Introduced by: American Academy of Child and Adolescent Psychiatry
American Psychiatric Association
American Academy of Psychiatry and the Law

Subject: Lead Levels in Children

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The Centers for Disease Control and Prevention currently utilizes 10 ug/dl as a lower limit of acceptable lead levels; and

Whereas, Research has demonstrated that even this level of lead exposure can have a significant impact on cognitive development; and

Whereas, The AMA Council on Science and Public Health last reviewed this issue in 1994; and

Whereas, There have been a number of key studies with significant implications published in the interim; and

Whereas, These studies may have significant implications from a public health perspective; therefore be it

RESOLVED, That our American Medical Association Council on Science and Public Health review and update its 1994 report on children and lead (Directive to Take Action); and be it further

RESOLVED, That our Council on Science and Public Health generate appropriate evidence-based recommendations regarding screening for lead (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for updated policies, procedures, and standards with respect to lead screening programs, consistent with current research and scientific knowledge. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $4,817.

Received: 05/06/09

RELEVANT AMA POLICY

H-60.956 Lead Poisoning Among Children
The AMA: (1) encourages physicians and public health departments to regularly screen all children under the age of six for lead exposure through history-taking and when appropriate by blood lead testing. The decision to employ blood testing should be made based on prevalence studies of blood lead levels in the local pediatric population. Findings from these studies will determine whether universal or targeted screening should be employed; and (2) encourages the reporting of all children with elevated blood levels to the appropriate health department in their state or community. In some cases this will be done by the physician, and in other communities by the laboratories. (CSA Rep. 6 - I-94; Reaffirmed: CSA Rep. 6, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-09)

Introduced by: American College of Emergency Physicians
American College of Radiology
American Society of Anesthesiologists
College of American Pathologists
Alabama, California and Pennsylvania Delegations

Subject: Model Physician Health Program Act

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Our AMA supports the concept of physician health programs and the right of privacy and confidentiality of medical information of physician patients; and

Whereas, Existing AMA policy and model legislation, "Model Impaired Physicians Treatment Act" of 1985, should be updated and re-titled in view of research and relevant policies developed over the intervening decades; and

Whereas, Many but not all states maintain some type of physician health program, but there is remarkable variability in the organization, administration, and funding mechanisms existing among these programs; and

Whereas, There is wide variability in relationships between physician health programs and licensing authorities, especially regarding mandatory reporting relationships and permissible confidentiality arrangements regarding physician licensee-clients; and

Whereas, Physicians are often unaware of the actual reporting relationships and confidentiality provisions regarding the physician health program in their state or territory; and

Whereas, Clear reporting relationships between physician health programs and corresponding licensing authorities protect the public by assuring that potentially impaired physicians may access the physician health program for diagnostic or therapeutic interventions, with guaranteed confidentiality unless there is actual impairment; and

Whereas, A guaranteed funding mechanism for physician health programs will assure their continued availability to licensees regardless of political influence or individual licensee physicians' financial considerations; therefore be it

RESOLVED, That our American Medical Association study the differences among physician health programs and their confidentiality safeguards and funding mechanisms, and report back at the 2010 Annual Meeting (Directive to Take Action); and be it further

RESOLVED, That our AMA review and update Policy H-275.964 "Impaired Physicians Practice Act" and model legislation regarding physician health programs to facilitate the enactment of legislative changes that would promote safe and effective utilization of physician health programs (Directive to Take Action); and be it further

RESOLVED, That our AMA educate members to help ensure they are fully knowledgeable about the purpose of physician health programs and the relationship that exists between the physician health program and the licensing authority in their state or territory. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $9,169 includes research and development of a CSAPH report.

Received: 05/01/09

RELEVANT AMA POLICY

H-275.964 Impaired Physicians Practice Act - Our AMA encourages state medical societies that do not have effectively functioning impaired physicians programs to improve their programs and to urge their states to adopt the AMA 1985 Model Impaired Physician Treatment Act, as necessary. (Sub. Res. 7, A-89; Reaffirmed: BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: BOT Rep. 17 and Sunset Report, A-00)

D-275.974 Depression and Physician Licensure - Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing. (Res. 319, A-05)

E-9.0305 Physician Health and Wellness - To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, construed broadly as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. When health or wellness is compromised, so may the safety and effectiveness of the medical care provided. When failing physical or mental health reaches the point of interfering with a physician's ability to engage safely in professional activities, the physician is said to be impaired. In addition to maintaining healthy lifestyle habits, every physician should have a personal physician whose objectivity is not compromised. Physicians whose health or wellness is compromised should take measures to mitigate the problem, seek appropriate help as necessary, and engage in an honest self-assessment of their ability to continue practicing. Those physicians caring for colleagues should not disclose without the physician-patient's consent any aspects of their medical care, except as required by law, by ethical and professional obligation (Opinion E-9.031), or when essential to protect patients from harm. Under such circumstances, only the minimum amount of information required by law or to preserve patient safety should be disclosed. The medical profession has an obligation to ensure that its members are able to provide safe and effective care. This obligation is discharged by: - promoting health and wellness among physicians; - supporting peers in identifying physicians in need of help; - intervening promptly when the health or wellness of a colleague appears to have become compromised, including the offer of encouragement, coverage or referral to a physician health program; - establishing physician health programs that provide a supportive environment to maintain and restore health and wellness; - establishing mechanisms to assure that impaired physicians promptly cease practice; - assisting recovered colleagues when they resume patient care; - reporting impaired physicians who continue to practice, despite reasonable offers of assistance, to appropriate bodies as required by law and/or ethical obligations. This may entail reporting to the licensing authority. (I, II) Issued June 2004 based on the report "Physician Health and Wellness," adopted December 2003.

See also: **E-8.21 Use of Chaperones During Physical Exams; E-9.031 Reporting Impaired, Incompetent, or Unethical Colleagues; H-95.955 Substance Abuse Among Physicians; H-275.940 Physician Impairment; H-275.952 Reporting Impaired, Incompetent or Unethical Colleagues; H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs; H-275.998 Physician Competence**

Council on Mental Health, "The Sick Physician" JAMA 1973;223(6):684-7

Model Impaired Physician Treatment Act June 1985

Virtual Mentor Physician Health and Well-Being Sept 2003

AMA BOT Statement on Physician Health Programs Feb 6, 2008

ACEP Model Physician Health Program Act 2009 Relevant and Supportive Materials

ACEP Policy on Physician Impairment Rev 2006 http://www.acep.org/practres.aspx?id=29630

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Hendin et al, "Licensing and Physician Mental Health: Problems and Possibilities" JMLD 93(2): 6-11 2007.

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-09)

Introduced by: California Delegation

Subject: Banning Tobacco Product Sales in Pharmacies

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, San Francisco recently approved a ban on sale of any tobacco products at pharmacies doing business in the city and county, a new policy slated to take effect in October 2008 and supported by a broad range of elected officials, medical and public health authorities and organizations; and

Whereas, Philip Morris tobacco corporation and Walgreens corporation in September filed suit to stop this ban, and hearings on the lawsuits are pending this fall; and

Whereas, Tobacco remains the leading preventable contributor to morbidity and mortality in the United States and beyond, with the most effective means of preventing this harm being preventing people from starting the use of tobacco and helping those who are users to quit, with social perception of smoking an important component of clinical and public health efforts to prevent and decrease tobacco use; and

Whereas, Pharmacies are rightly seen as vendors of health-promoting products, and it is contradictory and inconsistent with good health for them to also be marketing a lethal product with no positive use; and

Whereas, The Philip Morris suit challenging the San Francisco policy argues and admits that their contracts with some pharmacies include prominent placement of advertising for tobacco and that they have found this practice to be particularly valuable in marketing to smokers; and

Whereas, Many pharmacists have joined medical and public health officials and experts in opposing sales of tobacco in pharmacies, with the CMA, California Pharmacists Association, American Pharmacists Association, and others calling for voluntary removal of tobacco from pharmacies, which has been successful in reducing the number of independent pharmacies selling tobacco, but has not decreased the number of chain pharmacies doing so; and

Whereas, Contrary to some claims, there is no evidence to date that removing tobacco from pharmacies places an economic burden upon these businesses, will pose only an inconvenience for committed/addicted smokers, and San Francisco's new policy includes exemptions for some supermarkets and 'big box' chains which are not solely pharmacy retailers; and

Whereas, San Francisco's new policy has already attracted much attention and planned emulation with other municipalities around the nation expressing interest in similar health-promoting policies; therefore be it

RESOLVED, That our American Medical Association support prohibitions on the sale of tobacco products in any store that contains a pharmacy. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/01/09

RELEVANT AMA POLICY

H-495.986 Tobacco Product Sales and Distribution
Our AMA: (1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (2) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; (8) opposes the sale of tobacco at any facility where health services are provided; and (9) supports that the sale of tobacco products be restricted to tobacco specialty stores. (CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-09)

Introduced by: California Delegation

Subject: Head Protection in Soccer

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Independent peer-reviewed studies have shown that the frequency of concussion among youth and young-adult soccer players is as high as 40 to 60% per year; and

Whereas, The primary causes of concussions in soccer are head to head, head to ground and head to goalpost impacts, not the ball; and

Whereas, The head is used as an offensive tool in soccer to advance the ball, so changing this aspect of the game is unacceptable; and

Whereas, Independent studies have shown that head guards satisfying ASTM International (formerly American Society for Testing and Materials) standard number F2439 can reduce the occurrence of concussion by 50% in some typical soccer head impacts without affecting ball trajectory from heading; and

Whereas, An independent field study has concluded that players not wearing protective headgear were 2.65 times more likely to suffer a concussion than those wearing protective headgear; and

Whereas, This study also concluded that other forms of head injuries such as abrasions, contusions, and lacerations were also decreased, suggesting that players equipped with the protective headgear did not play more aggressively as some have feared; and

Whereas, Other organizations, including scientific organizations, who seek a preventative health care goal of reducing the risk of soccer-related concussions in a manner that does not change the nature of the game, have recommended protective head guards in soccer; therefore be it

RESOLVED, That our American Medical Association recognize the problem of concussion and head injury in soccer (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage additional studies into the incidence of head injury in soccer and methods to reduce these injuries. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/01/09

RELEVANT AMA POLICY

H-470.974 Athletic Helmets
The AMA urges the Consumer Product Safety Commission to establish standards that athletic and recreational helmets, including but not limited to football, baseball, hockey, horse back riding, bicycle and motorcycle riding, lacrosse, and skiing, produced or sold in the United States provide protection against head injury; and that the AMA advocate the use of appropriate and safe clear face guards as a permanent installation on the current bilateral ear protective batter's helmet to be worn by all baseball and softball players as required safety equipment in all organized baseball and softball for those children from 5 to 14 years of age. (Sub. Res. 16, I-88; Res. 419, A-93; Reaffirmed: CSA Rep. 8, A-03)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-09)

Introduced by: Guam Delegation

Subject: Raising the Age of Alcohol Consumption in the Territory of Guam

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, We as physicians encourage individual responsibility rather than statute as a general rule of conduct; and

Whereas, Underage alcohol use on Guam creates both negative health and social issues; therefore be it

RESOLVED, That our American Medical Association endorse raising the age of legal alcohol consumption to 21 years on Guam to mirror the local federal military standard and to help reduce any future adverse social impact of the impending military build up by 8,000 Marines and 22,000 support staff relocating to the small Island of Guam. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/06/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-09)

Introduced by: Guam Delegation

Subject: Reducing Tobacco Consumption in the Territory of Guam

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Guam has the highest tobacco use per capita of any US state or territory; and

Whereas, Guam has a corresponding highest cancer and cardiovascular rate attributed to tobacco use; and

Whereas, it is hoped that an increased tax would move to correct the health problem wrought by tobacco products and secondarily bring necessary increase in revenue to Government of Guam to address the health problems associated with tobacco use; therefore be it

RESOLVED, That our American Medical Association endorse the Guam Medical Society's efforts to have local legislation to sharply increase the Guam tobacco tax, which is the lowest in United States of America, in order to decrease the consumption of industrialized tobacco products. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/06/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-09)

Introduced by: Illinois Delegation

Subject: Health Food Pledge

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Industrial agriculture relies on application of high levels of synthetic fertilizers and toxic pesticides, herbicides, and fungicides, exposure to which can lead to elevated cancer risks and disruption of human reproductive, immune, endocrine and nervous systems[1]; and

Whereas, Non therapeutic antibiotics routinely fed to industrial livestock pass through the food chain to humans and contribute to human antibiotic resistance, and eliminating the use of non therapeutic antibiotics in livestock can help ensure that human antibiotic treatments remain effective;[2] and

Whereas, Manure from concentrated animal feeding operations (CAFOs) has resulted in severe air and water pollution; and nitrates from this manure are linked to blue baby syndrome, birth defects, thyroid disorders, and cancer;[3,4] and airborne particles and gases from CAFOs are linked to extremely elevated rates of respiratory and intestinal disorders in nearby residents;[5,6] and CAFOs are implicated in many outbreaks of food-borne illness such as E. coli and Salmonella;[7,8] leading the American Public Health Association to call for a moratorium on CAFOs[9]; and

Whereas, The food purchasing decisions made by health care institutions can affect the health of patients, staff, and visitors; and the massive purchasing power of the healthcare industry can influence the direction of U.S. agriculture by purchasing food that is produced in an environmentally and socially sustainable manner[10]; and

Whereas, The Illinois state legislature in 2007 expressed its interest in supporting the development of local food systems by adoption of the Illinois Food, Farms, and Jobs Act[11]; and

Whereas, The city of Chicago has adopted a plan to Improve Local Access to Locally Grown, Sustainable, Healthy Food and Value-Added Products and to Increase Public Awareness [12,13]; and

Whereas, Some Chicago-area hospitals have joined health systems across the country in signing the Healthy Food in Health Care Pledge[14], which commits the pledged institutions to:

- Work with local farmers, community-based organizations, and food suppliers to increase the availability of locally sourced food.
- Encourage vendors and/or food-management companies to supply food that is, among other attributes, produced without synthetic pesticides and hormones or antibiotics given to animals in the absence of diagnosed disease and which supports farmer health and welfare and ecologically protective and restorative agriculture.
- Implement a stepwise program to identify and adopt sustainable food procurement.

- Communicate an interest in foods that are identified as local and certified.
- Educate and communicate within the system and to patients and community about nutritious, socially just and ecological sustainable food, healthy food practices and procedures.
- Minimize or beneficially reuse food waste and support the use of food packaging and products that are ecologically protective;
- Develop a program to promote and source from producers and processors that uphold the dignity of family, farmers, workers, and their communities and support sustainable and humane agriculture systems; therefore, be it

RESOLVED, That our American Medical Association, encourage hospitals and other health care institutions to sign and support the Healthy Food in Health Care Pledge (Directive to Take Action); and be it further

RESOLVED, That our AMA, to the best of its ability, work to secure food for professional meetings consistent with this pledge, while taking into account food availability and economic feasibility. (Directive to Take Action)

This resolution relies heavily on materials written and developed by Jamie Harvie, PE from a paper presented by The Center for Health Design® and Health Care Without Harm at a conference sponsored by the Robert Wood Johnson Foundation, September 2006. www.healthdesign.

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 02/26/09

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1 Blair, A., and SH Zahm. 1995. "Agricultural exposures and cancer." Environmental Health Perspectives
2 Smith D.L., J. Dushoff , and J.G. Morris. "Agricultural Antibiotics and Human Health." PLoS Med. 2005
3 Mensinga, T., G. Speijers, and J. Meulenbelt. 2003. "Health Implications of Exposure to Environmental Nitrogenous Compounds." Toxicological Reviews. 22(1):41-51.
4 Mirvish, S.S. 1991. The significance for human health of nitrate, nitrite, and n-nitroso compounds in Nitrate Contamination: Exposure, Consequence, and Control. NATO ASI Series, Vol. G30.
5 Thu K, K. Donham, R. Ziegenhorn, S. Reynolds S., et al. 1997. A control study of the physical and mental health of residents living near a large-scale swine operation. J Agric Saf Health 3:13–26.
6 Southwest Utah Board of Health and Southwest Utah Public Health Department. 2001. "An Evaluation of Health Concerns in Milford, Utah and the Possible Relationship of Circle Four Farms to Those Concerns."
7 USDA. (n.d.) Prevalence of *Salmonella spp*. and *Escherichia coli* On U.S. Livestock Operations. Emerging Animal Health Issues.
8 Centers for Disease Control and Prevention. 1998. Surveys of waterborne disease outbreaks compiled by the Center for Disease Control and Prevention from 1986 to 1998, published in Morbidity and Mortality Weekly Reports. CDC, Atlanta.
9 American Public Health Association (APHA). 2003. Policy Statement 2003 -7 Precautionary Moratorium on New Concentrated Animal Feed Operations. Retrieved on August 23, 2007. http://www.apha.org/advocacy/policy/policysearch/default.htm?id=1243
[10] California Medical Association, Resolution, "Health Through Sustainable Food Purchasing,"705-07, 2007.
[11] Illinois Food, Farms, and Jobs Act 095-0145 8/14/2007
[12]http://egov.cityofchicago.org/city/webportal/portalContentItemAction.do?BV_SessionID=@@@@0678339903.1201558368@@@@&BV_EngineID=cccdadedeihmllecefecelldffhdfgn.0&contentOID=536957067&contenTypeName=COC_EDITORIAL&topChannelName=HomePage
[13] http://egov.cityofchicago.org/webportal/COCWebPortal/COC_EDITORIAL/Eat_Local_Live_Healthy.pdf
[14] http://www.noharm.org/us/food/pledge

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-09)

Introduced by: Illinois Delegation

Subject: The Physician's Obligation to Identify and Treat Prenatal and Perinatal Addiction

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Prenatal alcohol exposure is associated with significant maternal and fetal health risks including spontaneous abortion, prenatal and postnatal growth restriction, birth defects, and neurodevelopment deficits, including fetal alcohol syndrome--the most common cause of mental retardation[1]; and

Whereas, Smoking during pregnancy increases the likelihood of placenta previa, abruption, premature rupture of membranes, preterm delivery, fetal growth restriction, low birth weight, as well as increasing the incidence of orofacial cleft defects and sudden infant death syndrome after birth[2]; and

Whereas, Illicit drug use during pregnancy, especially cocaine use, has been linked to increased risk of low birth weight, prematurity, perinatal death, abruptio placenta, and small- for-gestational-age births[3]; and

Whereas, The 2006 National Survey on Drug Use and Health found that 11.8 percent of women reported current alcohol use and 2.9 percent reported binge drinking (greater than five drinks on the same occasion) during pregnancy, 16.5 percent of women reported tobacco use during pregnancy, and four percent of women reported using illicit drugs during pregnancy[4]; and

Whereas, A variety of screening tools have been introduced to properly screen and identify pregnant women using alcohol, tobacco, and illicit drugs, including the five A's of tobacco, TACE for alcohol, and FRAMES for other drug use[5]; and

Whereas, The American College of Obstetricians and Gynecologists endorses universal screening as an ethical obligation[6]; and

Whereas, One study shows that by merely identifying the pregnant substance user and the particular substance(s) used, 54% of women cleaned up after brief physician advice and a urine drug screen at each prenatal visit[7]; and

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[1] R.L. Floyd, *et al.* **The clinical content of preconception care: alcohol, tobacco, and illicit drug exposures** *American Journal of Obstetrics & Gynecology* December 2008 (Vol. 199, Issue 6, Pages S333-S339)
[2] Id.
[3] Id.
[4] 2006 *National Survey on Drug Use and Health* , http://www.oas.samhsa.gov/nsduh/2k6nsduh/2k6results.pdf (Last accessed 03/04/2009)
[5] *American Journal of Obstetrics & Gynecology* December 2008 (Vol. 199, Issue 6, Pages S333-S339)
[6] American College of Obstetricians and Gynecologists. **At-risk drinking and illicit drug use: ethical issues in obstetric and gynecologic practice.** ACOG Committee Opinion No. 422, December 2008.
[7] I.J. Chasnoff, *et al.* **The 4P's Plus Screen for Substance Use in Pregnancy: Clinical Application and Outcomes.** Journal of Perinatology (2005) 25, 368–374.

Whereas, In one treatment facility from 2002-2008, detection and simple intervention resulted in 274/323 (84.8%) substance-free births, with a pre-term rate of 22.2% (pre-term delivery rate for all patients in this hospital is 19.6%)[8]; and

Whereas, In that same facility, of the patients who were identified as positive with a urine drug screen who did not return for prenatal care but who did show up for delivery, 26/49 (53%) were substance-free births, indicating that the process of detection is, in fact, an intervention in and of itself[9]; and

Whereas, The medical profession has historically expressed concern for a healthy intrauterine environment for the prenatal period; and

Whereas, The medical profession has historically supported initiatives to help those who are addicted to drugs and ask for help, and supports government initiatives to implement substance abuse programs that are appropriately designed and monitored for quality, cost effectiveness, and reduced recidivism; therefore be it

RESOLVED, That our American Medical Association, through its communication vehicles, encourage all physicians to increase their knowledge regarding the effects of drug and alcohol abuse during pregnancy and to communicate that information to women of reproductive age pre-conception (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage physicians to routinely inquire about alcohol, tobacco and drug use during the course of providing prenatal care (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage physicians to identify alcohol, tobacco, and drug use in their pregnant patients and provide them with treatment options best suited to their needs (Directive to Take Action); and be it further

RESOLVED, That our AMA collaborate with health partners across the country to study the prevalence and benefits of implementing a simple screening process. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated cost of $10,721 which includes staff time and costs for approximately 2 meetings of appropriate stakeholders to survey current screening procedures, evaluate the benefits of implementing standard screening, and make recommendations.

Received: 05/05/09

RELEVANT AMA POLICY

H-420.962 Perinatal Addiction - Issues in Care and Prevention - The AMA: (1) adopts the following statement: Transplacental drug transfer should not be subject to criminal sanctions or civil liability; (2) encourages the federal government to expand the proportion of funds allocated to drug treatment, prevention, and education within the context of its "War on Drugs." In particular, support is crucial for establishing and making broadly available specialized treatment programs for drug-addicted pregnant women wherever possible; (3) urges the federal government to fund additional research to further knowledge about and effective treatment programs for drug-addicted pregnant women, encourages also the support of research that provides long-term follow-up data on the developmental consequences of perinatal drug exposure, and identifies appropriate methodologies for early intervention with perinatally exposed children; (4) reaffirms the following statement: Pregnant substance abusers should be provided with rehabilitative treatment appropriate to their specific physiological and psychological needs; (5) through its communication vehicles, encourages all physicians to increase their knowledge regarding the effects of drug and alcohol abuse during pregnancy and to routinely inquire about alcohol and drug use in the course of providing prenatal care; and (6) will address the special needs of pregnant drug abusers within the context of its ongoing Health Access America programs. (CSA Rep. G, A-92; Reaffirmation A-99)

[8] James. J. Nocon, M.D., J.D., Director Prenatal Substance Use Clinic, Wishard Memorial Hospital, 1001 West 10th Street, F5102, Indianapolis, IN 46202

[9] Id.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-09)

Introduced by: Minority Affairs Consortium
International Medical Graduates Section
National Medical Association

Subject: Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The 2003 Institute of Medicine's (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* found that health care disparities persist across a number of disease states, independent of access-related factors, and subsequent national disparities reports from the Agency for Health Care Research and Quality document many ongoing disparities; and.

Whereas, The American Medical Association, the National Medical Association (NMA), the National Hispanic Medical Association (NHMA) and other professional associations formed the Commission to End Health Care Disparities (Commission) in response to the IOM report and to spearhead and coordinate the efforts of organized medicine to eliminate health care disparities; and

Whereas, The Commission now represents more than 70 medical and health professional organizations who meet to develop consensus on strategies and solutions that organized medicine can implement to effectively address health care disparities; and

Whereas, The Commission has developed a set of principles and recommendations to guide the analysis, development and implementation of policies to address health care disparities; therefore be it

RESOLVED, That our American Medical Association adopt the Guiding Principles document of the Commission to End Health Care Disparities as AMA policy (New HOD Policy); and be it further

RESOLVED, That our AMA, in collaboration with the National Medical Association and the National Hispanic Medical Association, distribute these guiding principles to all members of the federation and encourage them to adopt and use these principles when addressing policies focused on racial and ethnic health care disparities (Directive to Take Action); and be it further

RESOLVED, That our AMA shall work with the Commission to End Health Care Disparities to develop a national repository of state and specialty society policies, programs and other actions focused on studying, reducing and eliminating racial and ethnic health care disparities. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.
Received: 05/01/09

RELEVANT AMA POLICY

D-350.995 Reducing Racial and Ethnic Disparities in Health Care
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations: (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care. (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03)

D-350.996 Strategies for Eliminating Minority Health Care Disparities
Our American Medical Association: (1) commend the Institute of Medicine (IOM) on its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," and that all applicable AMA Councils be requested to formally review the IOM report and its recommendations and submit reports back to the AMA House of Delegates at the 2003 Interim Meeting from their areas of expertise with specific strategies to move towards the elimination of racial and ethnic health care disparities; and (2) identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. (Res. 731, I-02)

H-350.974 Racial and Ethnic Disparities in Health Care
Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association. The AMA emphasizes three approaches that it believes should be given high priority: (1) Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform. (2) Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities. (3) Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. (CLRPD Rep. 3, I-98; Appended and Reaffirmed:: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-09)

Introduced by: Minority Affairs Consortium

Subject: Hispanic Population and Access to the US Healthcare System

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The Hispanic population now is estimated to be 45.5 million or 15% of the estimated total US population of 301.6 million; and

Whereas, According to US Census Bureau reports, the Hispanic population is estimated to triple by 2050, comprising 50.1% of the U.S. population; and

Whereas, Language and health care views associated with culture are barriers to care and consequently impact seeking care; and

Whereas, Access to care is associated with a lack of a medical home, which represents a usual source of care, and a lack health insurance; and

Whereas, An estimated 25 percent of Hispanics in the United States don't have a regular health care provider to treat their medical needs; and

Whereas, Last year 83% of Hispanic patients received health care information from the media, which includes radio, newspapers, television and the Internet, as compared to 71% receiving information from a health professional; and

Whereas, Media-based health information appears to reach a receptive audience and leads many individuals to take action, according to the Pew study; and

Whereas, Most physicians trying to get health care information to Hispanic patients who do not have regular physicians have some other means of getting information to such populations through some Spanish media outlets but not all communities have such media outlets available; and

Whereas, Socioeconomic barriers exist such as working poor Hispanic patients have difficulty deciding to take time off from work to find care, and do not have the financial means to pay for health care; and

Whereas, Many Hispanic patients are shown to have chronic diseases such as diabetes and are not educated regarding the disease and treatment mostly due to cultural and language barriers; therefore be it

RESOLVED, That our American Medical Association encourage promotion of educational information in Spanish and assistance in listing media resources to help care for this growing population with regards to preventative medicine and disease management (Directive to Take Action); and be it further

RESOLVED, That our AMA continue to encourage and promote physicians to go to federally designated health shortage areas to increase the pool of physicians to care for the Hispanic population and encourage physicians to become more involved in the Hispanic community in their areas. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/01/09

RELEVANT AMA POLICY

H-350.975 Improving Healthcare of Hispanic Populations in the United States
It is the policy of our AMA to: (1) Encourage health promotion and disease prevention through educational efforts and health publications specifically tailored to the Hispanic community. (2) Promote the development of substance abuse treatment centers and HIV/AIDS education and prevention programs that reach out to the Hispanic community. (3) Encourage the standardized collection of consistent vital statistics on Hispanics by appropriate state and federal agencies. (4) Urge federal and local governments, as well as private institutions, to consider including Hispanic representation on their health policy development organization. (5) Support organizations concerned with Hispanic health through research and public acknowledgment of the importance of national efforts to decrease the disproportionately high rates of mortality and morbidity among Hispanics. (6) Promote research into effectiveness of Hispanic health education methods. (7) Continue to study the health issues unique to Hispanics, including the health problems associated with the United States/Mexican border. (CLRPD Rep. 3, I-98; Reaffirmed: CLRPD Rep. 1, A-08)

D-350.996 Strategies for Eliminating Minority Health Care Disparities
Our American Medical Association: (1) commend the Institute of Medicine (IOM) on its report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," and that all applicable AMA Councils be requested to formally review the IOM report and its recommendations and submit reports back to the AMA House of Delegates at the 2003 Interim Meeting from their areas of expertise with specific strategies to move towards the elimination of racial and ethnic health care disparities; and (2) identify and incorporate strategies specific to the elimination of minority health care disparities in its ongoing advocacy and public health efforts, as appropriate. (Res. 731, I-02)

D-350.995 Reducing Racial and Ethnic Disparities in Health Care
Our AMA's initiative on reducing racial and ethnic disparities in health care will include the following recommendations: (1) Studying health system opportunities and barriers to eliminating racial and ethnic disparities in health care. (2) Working with public health and other appropriate agencies to increase medical student, resident physician, and practicing physician awareness of racial and ethnic disparities in health care and the role of professionalism and professional obligations in efforts to reduce health care disparities. (3) Promoting diversity within the profession by encouraging publication of successful outreach programs that increase minority applicants to medical schools, and take appropriate action to support such programs, for example, by expanding the "Doctors Back to School" program into secondary schools in minority communities. (BOT Rep. 4, A-03)

See also:
E-9.121 Racial and Ethnic Health Care Disparities
H-295.897 Enhancing the Cultural Competence of Physicians

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-09)

Introduced by: Maryland Delegation

Subject: Reduction or Elimination of Gun Violence in the Mass Media

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Our AMA has conducted a very successful media campaign for several years to minimize, or eliminate, tobacco use in films because tobacco has been recognized as a public health problem; and

Whereas, Gratuitous gun violence is a public health problem and has become a staple of certain film genres, e.g., Die Hard, Terminator, Indiana Jones, and James Bond films among others; and

Whereas, These films are often pitched to teenage and young adult male audiences and have the power to influence their behavior; and

Whereas, As an example, on 4/16/2007 a senior at Virginia Tech University shot and killed 32 people and wounded 17 others and took video images of himself before the assault brandishing guns in both hands in a manner similar to many scenes from such movies and video games; and

Whereas, Gun violence among members of this specific group has increased in recent years with devastating effect on their peers and society at large; and

Whereas, A recent study[1] shows 39% of US households have a firearm on the premises, 20% of households that include adolescents have at least one firearm in the home, nearly a third of those firearms are stored unlocked, a fifth are stored loaded and a twelfth are stored unlocked and loaded; and

Whereas, "Typically in households where there are both firearms and children, parents are not aware of the extent to which their children are knowledgeable about the location of the guns and ammunition…(and) fully one-third of children and adolescents reported handling a firearm within the household (and) 5% of adolescents who have handled guns report unsupervised use and …half have actually fired the gun without supervision";[2] and

Whereas, Guns are the weapons used in most homicides in the US as well as in the majority of completed suicides; and

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[1] Johnson RM et al.: Are household firearms stored less safely in homes with adolescents? Analysis of a national random sample of parents. Arch Pediatr. Adolesc. Med. 2006; 160: 788-792

[2] McNamara NK Findling RL: Guns adolescents and mental illness. Am. J. Psychiat. 165:2 2008 190-194

Whereas, A sixteen year old Maryland boy on 2/2/2008 left a party where he was playing video games with his friends, went home and took one of the many guns lying around his house unsecured, and shot and killed his father (an attorney), his mother (a former PTA President), and two young brothers as they slept, and then returned to the party and continued to play the games as though nothing had happened, eventually confessing to the crime; and

Whereas, There is very little in the media that shows responsible gun ownership and use; therefore be it

RESOLVED, That our American Medical Association ask the Council on Science and Public Health to evaluate the feasibility and value of pursuing a multi-media campaign with the AMA Alliance and AMA Foundation to promote the reduction, and/or elimination, of gratuitous gun violence in the media as well as portraying the devastating consequences of gratuitous gun violence in films, and undertake an initiative calling for the popular media to portray responsible gun ownership and advertise this initiative in theaters, and portray leading characters demonstrating this behavior. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $2,718.

Received: 05/06/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-09)

Introduced by: Michigan Delegation

Subject: Obesity as a Disability

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Obesity is a well known natural epidemic; and

Whereas, Obesity is a major risk factor for many disease processes and complications; and

Whereas, It is imperative that physicians not only be allowed, but should be required, to discuss obesity and its complications; and

Whereas, There are organizations lobbying to make obesity declared a disability; and

Whereas, If obesity is designated as a disability, physicians could be sued or reprimanded for discrimination under the Americans with Disability Act if a patient takes offense at the physician discussing obesity; therefore be it

RESOLVED, That our American Medical Association not support the effort to make obesity a disability. (New HOD Policy)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/06/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-09)

Introduced by: Missouri Delegation

Subject: Support of Nutrition Labeling in Restaurants

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The obesity epidemic is growing to the point that three states are now above the 30th percentile in prevalence of obesity; and

Whereas, The obesity epidemic spans to children where approximately 17 percent of children are overweight and an additional 17 percent are at risk of being overweight; and

Whereas, The AMA Resident and Fellow Section recognizes obesity as a complex disorder and is working to educate the population on the prevention and management of obese children and adults, including nutrition counseling; and

Whereas, New York City recently passed a law requiring restaurants with over 15 outlets to post the number of calories for each item on their menus and menu boards; and

Whereas, The United States Court of Appeals for the Second Circuit has upheld the authority of state government and local municipalities to require mandatory nutrition labeling by restaurants; therefore be it

RESOLVED, That our American Medical Association work with medical societies, the restaurant industry, and other interested parties to create a method for displaying nutritional information on restaurant menus and menu boards for all food and beverage items. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 04/22/09

RELEVANT AMA POLICY

H-150.945 Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants
Our AMA: 1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards; 2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum, calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible; 3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and 4. urges restaurants to improve the nutritional quality of their menu offerings--for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners. (Res. 419, A-07)

H-150.948 Increasing Customer Awareness of Nutrition Information and Ingredient Lists in Restaurants
Our AMA supports and seeks federal legislation or rules requiring (1) restaurants that have menu items common to multiple locations to provide standard nutrition labels for all applicable items, available for public viewing; and (2) all school and work cafeterias and restaurants to have ingredient lists for all menu items, available for public viewing. (Sub. Res. 411, A-04; Reaffirmation A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-09)

Introduced by: Medical Student Section

Subject: Physician-Assisted Regulation of Firearm Access by Suicidal Patients

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Suicide is the second leading cause of death in the US among individuals under the age of forty; and

Whereas, A firearm is used in more than half of all completed suicides; and

Whereas, It has been suggested that to create safer environments for potentially suicidal patients, physicians should address not only a patient's mental state, but also a patient's access to firearms and other lethal means of committing suicide; and

Whereas, The legally prescribed role of physicians in regulating their suicidal patients' access to firearms varies from state to state; and

Whereas, In California and Connecticut, physicians treating inpatient patients for mental illness are required by law to report the patients' firearm possession to law enforcement authorities; and

Whereas, In Massachusetts, Rhode Island, and Oklahoma, an individual who has been previously confined to an institution or a hospital for mental illness may not acquire a firearm without physician certification that the patient is "mentally stable" or is no longer disabled by any mental or psychiatric illness; and

Whereas, It remains unclear whether and how current physician involvement in firearm regulation affects suicide rates; and

Whereas, Physician involvement in firearm regulation raises numerous ethical and professional questions, including concerns about patient privacy; therefore be it

RESOLVED, That our American Medical Association complete a comprehensive study of the following issues with report back at the 2009 Interim Meeting:

1. The current role of physician-assisted regulation of firearm access by suicidal patients in all 50 states;
2. The variation among states in communication between physicians and local authorities in relation to the regulation of firearm access for patients who pose harm to themselves and to others;
3. The impact of physician-assisted regulation of firearm access in states where there is already a legally prescribed role for physicians in regulating their suicidal patients' access to firearms;
4. Patient privacy concerns surrounding physician-assisted regulation of firearms; and
5. The best way to increase the physician's role in minimizing the potential harm of firearms to at-risk patients. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $4,804 to research and generate CSAPH report.

Received: 04/30/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-09)

Introduced by: Medical Student Section

Subject: Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The occurrence of domestic violence in the home is strongly associated with the occurrence of child abuse; and

Whereas, A *Journal of Family Psychology* meta-analysis estimates that among American households experiencing either domestic violence or child abuse, 40 percent experience *both* domestic violence *and* child abuse; and

Whereas, According to the US Advisory Board on Child Abuse and Neglect, domestic violence is the single major precursor to child abuse and child neglect fatalities in the United States; and

Whereas, While our AMA directs physicians to routinely inquire about physical, sexual, and psychological abuse as part of the medical history and provides guidance to physicians on how to report evidence of violence or abuse (E-2.02), current AMA policy does not recognize the link between domestic violence and child abuse or outline the role of the physician in situations where both are suspected; and

Whereas, Recognition of the frequent co-occurrence of domestic violence and child abuse has prompted the creation of domestic violence/child abuse educational programs tailored to domestic violence advocates and child protective services officials; and

Whereas, There currently exist no such educational programs targeted to physicians; therefore be it

RESOLVED, That our American Medical Association work with members of the Federation of Medicine and other appropriate organizations to educate physicians on (1) the relationship between domestic violence and child abuse and (2) the appropriate role of the physician in treating patients when domestic violence and/or child abuse are suspected. (Directive to Take Action)

Fiscal note: Implement accordingly at estimated staff cost of $4,592 to format and post existing educational materials on the AMA Web site and complete CSAPH Report for the 2009 Interim Meeting.

Received: 04/30/09

RELEVANT AMA POLICY

E-2.02 Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse
Interpersonal violence and abuse were once thought to primarily affect specific high-risk patient populations, but it is now understood that all patients may be at risk. The complexity of the issues arising in this area requires three distinct sets of guidelines for physicians. The following guidelines address assessment, prevention, and reporting of interpersonal violence and abuse.
1. When seeking to identify and diagnose past or current experiences with violence and abuse, physicians should adhere to the following guidelines:
A. Physicians should routinely inquire about physical, sexual, and psychological abuse as part of the medical history. Physicians should also consider abuse as a factor in the presentation of medical complaints because patients' experiences with interpersonal violence or abuse may adversely affect their health status or ability to adhere to medical recommendations.
B. Physicians should familiarize themselves with the detection of violence or abuse, the community and health care resources available to abused or vulnerable persons, and the legal requirements for reporting violence or abuse.
C. Physicians should not be influenced in the diagnosis and management of abuse by such misconceptions as the beliefs that abuse is a rare occurrence, does not occur in "normal" families, is a private problem best resolved without outside interference, or is caused by the victims own actions.
2. The following guidelines are intended to guide physicians' efforts to address acts of violence and abuse:
A. Physicians must treat the immediate symptoms and sequelae of violence and abuse, while also providing ongoing care for patients so as to address any long-term health consequences that may arise as the result of exposure.
B. Physicians should be familiar with current information about cultural variations in response to abuse, public health measures that are effective in preventing violence and abuse, and how to work cooperatively with relevant community services. Physicians should help in developing educational resources for identifying and caring for victims. Comprehensive training in matters pertaining to violence and abuse should be required in medical school curricula and in post graduate training programs.
C. Physicians should also provide leadership in raising awareness regarding the need to assess and identify signs of abuse. By establishing guidelines and institutional policies it may be possible to reduce the volume of abuse cases that go unidentified, and consequently, help to ensure that all patients receive the benefit of appropriate assessment regardless of their age, gender, ethnicity, or social circumstances. The establishment of appropriate mechanisms should also direct physicians to external community or private resources that might be available to aid patients.
D. Physicians should support research in the prevention of violence and abuse and seek collaboration with relevant public health authorities and community organizations.
3. Physicians should comply with the following guidelines when reporting evidence of violence or abuse:
A. Physicians should familiarize themselves with any relevant reporting requirements within the jurisdiction in which they practice.
B. When a jurisdiction mandates reporting suspicion of violence and abuse, physicians should comply. However, physicians should only disclose minimal information in order to safeguard patients' privacy. Moreover, if available evidence suggests that mandatory reporting requirements are not in the best interests of patients, physicians should advocate for changes in such laws.
C. In jurisdictions where reporting suspected violence and abuse is not legally mandated, physicians should discuss the issue sensitively with the patient by first suggesting the possibility of abuse, followed by describing available safety mechanisms. Reporting when not required by law requires the informed consent of the patient. However, exceptions can be made if a physician reasonably believes that a patient's refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision. (I, III) Issued December 1982; Updated June 1994 based on the report "Physicians and Family Violence: Ethical Considerations," adopted December 1991 (JAMA. 1992; 267: 3190-93); updated June 1996; updated June 2000 based on the report "Domestic Violence Intervention," adopted June 1998, and updated in November 2007 based on the report "Physicians' Obligations in Preventing, Identifying, and Treating Violence and Abuse."

See also H-515.962 and H-515.983.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-09)

Introduced by: Nebraska, Minnesota and South Dakota Delegations

Subject: Support of Calorie Labeling in Restaurants

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The obesity epidemic is growing to the point that three states now have a prevalence of obese adults greater than 30%[1]; and

Whereas, The obesity epidemic spans to children where approximately 17 percent of children (K-12) are overweight and an additional 17% are obese[2]; and

Whereas, The AMA recognizes obesity as a complex disorder and is working to educate the population on the prevention and management of obese children and adults, including nutrition counseling; and

Whereas, New York City recently passed a law requiring restaurants with over 15 outlets to post the number of calories for each item on their menus and menu boards[3]; and

Whereas, The United States Court of Appeals for the Second Circuit supported this law by stating that state and local municipalities have the preserved authority to impose mandatory nutrition labeling on restaurants[4]; therefore be it

RESOLVED, That our American Medical Association work with all state medical associations, state restaurant associations, state departments of health, and other interested parties, to create a method for displaying calories on restaurant menus and menu boards for all food and beverage items. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/06/09

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[1] http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm

[2] National Health and Nutrition Examination Surveys (NHANES) 2003-2006

[3] New York City Regulation 81.50

[4] New York State Restaurant Association v. New York City Board of Health, New York City Department of Health and Mental Hygiene, Thomas R. Frieden. 08-1892-cv (2d Cir. 2008)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-09)

Introduced by: Oklahoma Delegation

Subject: Secondhand Smoke

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Secondhand smoke has an immediate detrimental effect on the cardiovascular system, and causes respiratory diseases, lung cancer and heart disease; and

Whereas, The health consequences of secondhand smoke kills 53,000 Americans each year; and

Whereas, The US Surgeon General's 2006 report, The Health Consequences of Involuntary Exposure to Tobacco Smoke, concluded that scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke; and

Whereas, Completely eliminating exposure to indoor smoke is the only way to protect workers; and

Whereas, In 1997, President Clinton issued Executive Order 13058 which prohibited smoking in most federal buildings but contained provisions for allowing smoking to continue in certain designated areas; and

Whereas, Twenty-three states, the District of Columbia and Puerto Rico have passed comprehensive laws protecting workers from secondhand smoke; and

Whereas, The Federal government should lead by example in protecting workers; and

Whereas, On December 22, 2008, the General Services Administration (GSA) issued a directive requiring all federal buildings under GSA management to become totally smoke free; and

Whereas, Only about thirty percent of the federal workforce are covered by the GSA ban; and

Whereas, Twelve members of Congress, in a letter dated March 3, 2009, have asked the President to issue a new Executive Order closing the loopholes in the earlier Executive Order and thus protecting all federal workers; therefore be it

RESOLVED, That our American Medical Association urge the President of the United States to issue an Executive Order making all federal workplaces, including buildings and campuses, entirely smoke free and urge its federation members to do the same. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $1,859.

Received: 05/01/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-09)

Introduced by: Resident and Fellow Section

Subject: Support of Calorie Labeling in Restaurants

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The obesity epidemic is growing to the point that three states are now above the 30th percentile in prevalence of obesity[1]; and

Whereas, The obesity epidemic spans to children where approximately 17 percent of children are overweight and an additional 17 percent are at risk of being overweight; and

Whereas, The AMA-RFS recognizes obesity as a complex disorder and is working to educate the population on the prevention and management of obese children and adults, including nutrition counseling; and

Whereas, New York City recently passed a law requiring restaurants with over 15 outlets to post the number of calories for each item on their menus and menu boards[2]; and

Whereas: The United States Court of Appeals for the Second Circuit has upheld this law by stating that state government and local municipalities have the authority to impose mandatory nutrition labeling on restaurants[3]; therefore be it

RESOLVED, That our American Medical Association work with state medical associations, state restaurant associations, state departments of health, and other interested parties to create a method for displaying nutritional information on restaurant menus and menu boards for all food and beverage items. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 04/20/09

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[1] http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/index.htm
[2] New York City Regulation 81.50
[3] New York State Restaurant Association v. New York City Board of Health, New York City Department of Health and Mental Hygiene, Thomas R. Frieden. 08-1892-cv (2d Cir. 2008)

RELEVANT AMA POLICY

H-150.945 Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants
Our AMA: 1. supports federal, state, and local policies to require fast-food and other chain restaurants with 10 or more units (smaller, neighborhood restaurants could be exempt) to provide consumers with nutrition information on menus and menu boards; 2. recommends that nutrition information in fast-food and other chain restaurants include calorie, fat, saturated fat and trans fat, and sodium labeling on printed menus, and, at a minimum, calories on menu boards, since they have limited space, and that all nutrition information be conspicuous and easily legible; 3. urges federal, state, and local health agencies, health organizations, and physicians and other health professionals to educate people how to use the nutrition information provided in restaurants to make healthier food choices for themselves and their families; and 4. urges restaurants to improve the nutritional quality of their menu offerings--for example, by reducing caloric content; offering smaller portions; offering more fruits, vegetables, and whole-grain items; using less sodium; using cooking fats lower in saturated and trans fats; and using less added sugars/sweeteners. (Res. 419, A-07)

H-150.953 Obesity as a Major Public Health Program
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-09)

Introduced by: American Association of Public Health Physicians

Subject: Oppose Sale of Tobacco Products in Pharmacies

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The health hazards associated with use of tobacco products are well known, and direct tobacco use remains our number one and a preventable public health challenge, while second hand smoke exposure ranks number three on the list of public health enemies; and

Whereas, Many pharmacies are marketing themselves as comprehensive healthcare facilities and have more patients including children walk in their premises to be seen in their in-store clinics; and

Whereas, Those pharmacies that sell cigarettes and other tobacco products, do so to generate additional profits, while making it convenient, and sometimes subtly enticing their customers to use a product which can only harm the health of the user and those around him/her; and

Whereas, Current AMA Policy opposes the sale of tobacco at any facility where health services are provided and further supports the restriction of sale of tobacco products to tobacco specialty stores only, that policy does not go far enough to have any effect on the practice of the pharmacies selling cigarettes; be it therefore

RESOLVED, That our American Medical Association specifically and publicly oppose the sale and marketing of tobacco products including cigarettes in a pharmacy (Directive to Take Action); and be it further

RESOLVED, That our AMA communicate with appropriate federal agencies including the Bureau of Alcohol, Tobacco and Firearms, many public health groups, various pharmacy trade groups and media outlets seeking their help in removing tobacco products including cigarettes from the pharmacy shelves (Directive to Take Action); and be it further

RESOLVED, That our AMA study the feasibility of introduction and support of such federal legislation as would ban sale of tobacco products including cigarettes in pharmacies across the country and report back to the AMA HOD at the 2010 Annual Meeting. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $4,365.

Received: 05/14/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-09)

Introduced by: American Association of Public Health Physicians

Subject: Study of Appropriate Use of Electronic Cigarettes in Smoking Cessation Programs

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, There are over 40 million smokers in the US; and

Whereas, Tobacco use kills 500,000 Americans each year; and

Whereas, The medical community employs numerous protocols, techniques and tools to help smokers quit tobacco with limited success; and

Whereas, The Electronic Cigarettes provide nicotine only with water vapors, but, do not contain the approximately 4,000 other chemicals including several proven carcinogens isolated from a burning cigarette; and

Whereas, The producers and supporters publicize the efficacy and safety of electronic cigarettes, and are hard at work to convince the FDA and the congressional sponsors of the FDA/Tobacco bill which is currently pending, to prevent a ban on the marketing and sale of their product in the US; and

Whereas, Nicotine is addictive and has been implicated in the causation of vascular disease, oral and gingival disease; and

Whereas, Helping patients quit tobacco use altogether is an ideal strategy that saves lives, disease and money, it is not always easily accomplished, and harm reduction with smokeless tobacco products (such as SNUS) and electronic cigarettes is being increasingly promoted, causing some confusion among physicians who want to do what is best for their patients; and

Whereas, Our AMA has a unique opportunity to look at the available evidence and issue appropriate guidance to the physicians and this endeavor would be consistent with the AMA's mission and priorities previously articulated; be it therefore,

RESOLVED, That our American Medical Association Council on Science and Public Health study the available evidence and develop recommendations for our profession on appropriate use of electronic cigarettes in smoking cessation programs, with a report back at the 2010 Annual Meeting. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $3,813.

Received: 05/14/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-09)

Introduced by: American Association of Public Health Physicians

Subject: Strengthen State and Local Health Department Pandemic Response Capacity

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The public health infrastructure nationally has been in a disarray for a number of years, first cited by the Institute of Medicine in 1988 and again in 1994; and

Whereas, The last time significant public health infrastructure was established in the US dates back nearly 40 years; and

Whereas, The only new public health funding received in the last decade for bioterrorism is now in a phase of radical reduction; and

Whereas, The federal, state and local governments continue to de-fund the public health infrastructure and current economic circumstances make it exceedingly difficult for essential public health needs to be met; and

Whereas, The resources of the public health infrastructure were severely strained in the last few weeks while responding to the H1N1 North American outbreak and WHO level 5 declaration of imminent pandemic flu; and

Whereas, It is projected that H1N1 Influenza will return this fall, possibly in a more virulent form; therefore be it

RESOLVED, That our American Medical Association urge the Centers for Disease Control and Prevention to urgently assess, in collaboration with the leadership of state and local health departments and the national organizations representing them, the funding, staffing, vaccine, drug and data management capacity to prepare for and respond to a potential influenza pandemic as early as this coming fall of 2009 (Directive to Take Action); and be it further

RESOLVED, That our AMA urge President Obama and the Congress to take rapid action to provide dollars and other resources necessary to bolster the capacity of various state and local health departments to prepare and respond effectively and timely to protect the population we serve from expected disease and deaths due to a potential influenza pandemic this year and in future years. (Directive to Take Action)

Fiscal Note: Staff cost estimated at less than $500 to implement.

Received: 05/14/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-09)

Introduced by: American Psychiatric Association
American Academy of Child and Adolescent Psychiatry
American Academy of Psychiatry and the Law

Subject: Preventing Suicide in Physicians

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Existing medical and epidemiological literature suggest that both male and female physicians may constitute a high risk demographic group for suicide; and

Whereas, Every year three to four hundred physicians take their own lives--the equivalent of two to three medical school classes; and

Whereas, Available studies show that 3% to 15% of medical students have suicidal ideation during medical school training; and

Whereas, Available studies show that the suicide rate among medical students is higher than in the age-matched population and is reportedly the second leading cause of death in medical students; and

Whereas, Major depressive disorder is not the only health condition associated with high rates of physician suicide (with alcohol and other drug addiction being risk factors for suicide independent of the presence of co-occurring mood disorders); and

Whereas, Targeted educational campaigns to physicians can be successful, as evidenced by decreases of from 40 to 60 percent in physician deaths from smoking-related illnesses after targeted educational campaigns to reduce smoking among physicians; and

Whereas, Extensive data shows that good medical student and physician health increases the likelihood that they will counsel their patients to be healthy on related issues; therefore be it

RESOLVED, That our American Medical Association collaborate with appropriate state and specialty societies to prepare an updated review of the literature on the incidence and risk factors of suicide by physicians and medical students (Directive to Take Action); and be it further

RESOLVED, That such a study of suicide by physicians and medical trainees include specific recommendations designed to reduce the incidence of suicide by physicians at all stages of training and practice. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $4,938.

Received: 05/14/09

RELEVANT AMA POLICY

D-345.993 Physician Suicide
Our AMA will: (1) work with the American Foundation for Suicide Prevention and the Federation of State Physician Health Programs to study, to educate physicians, and to increase awareness through medical schools, state physician health committees, the AMA Alliance, and internal publications to anticipate, mitigate and eliminate, as far as possible, the preventable endemic catastrophe of physician suicide; and (2) contact the director of the Substance Abuse and Mental Health Services Administration and the American Psychiatric Association to join with the initiative to explore ways to act now to reduce the high prevalence of suicide in the United States particularly among physicians. (Res. 429, A-06)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-09)

Introduced by: New Jersey Delegation

Subject: Ban Tobacco Sales in Pharmacies

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, Smoking has proven to be detrimental to health; and

Whereas, Pharmacies represent agencies for the promotion of healthcare; and

Whereas, Pharmacies that sell tobacco products convey a message that is inconsistent with good health; and

Whereas, Communities that have banned smoking in public establishments are perceived as contributing to the public health good; and

Whereas, Eight Canadian provinces have successfully banned the sale of tobacco products in pharmacies since 1993; and

Whereas, The city of San Francisco has legislated a ban on the sale of tobacco in pharmacies, effective in October 2008; therefore be it

RESOLVED, That our American Medical Association lobby Congress to pass legislation to accomplish the goal of banning tobacco sales in pharmacies nationwide. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated staff cost of $5,000.

Received: 05/19/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-09)

Introduced by: New Jersey Delegation

Subject: Instructional Resources on Epidemic and Pandemic Flu for Medical Office Staffs

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, There is no instructional video available for medical office staffs on procedures to follow during a flu epidemic or pandemic; and

Whereas, Visual aids easily walk office staffs through problems that they are likely to face while taking care of patients during a flu epidemic or pandemic; therefore be it

RESOLVED, That our American Medical Association provide or obtain instructional resources on procedures to follow and solutions to foreseeable problems during a flu epidemic or pandemic for medical office staffs in ambulatory care settings. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated cost of $87,258 which includes professional fees and printing and production.

Received: 05/19/09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-09)

Introduced by: New York Delegation

Subject: Support of a National HIV/AIDS Strategy

Referred to: Reference Committee D
(James L. Milam, MD, Chair)

Whereas, The Centers for Disease Control and Prevention (CDC) estimates that approximately 1.1 million people in the United States are living with HIV[1]; and

Whereas, The CDC reported a 15% increase in HIV infections in 34 states between 2004 and 2007[2]; and

Whereas, Recent incidence data estimates that 56,300 new HIV infections occurred in the United States in 2006[3]; and

Whereas, In fiscal year 2008, $17 billion were spent on the domestic HIV/AIDS epidemic[4]; and

Whereas, The United States federal government requires individual states to develop plans for distributing funds[4]; and

Whereas, The President's Emergency Plan for AIDS Relief (PEPFAR) recommends that countries receiving aid abide by the "Three Ones" -- one national plan, one national coordinating authority, and one national monitoring and evaluation system[5]; and

Whereas, The United States government does not have a national strategy coordinating efforts, resources, and funds; therefore be it

RESOLVED, That our American Medical Association support the creation of a National HIV/AIDS strategy (New HOD Policy); and be it further

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[1] CDC. HIV Prevalence Estimates—United States, 2006. *MMWR* 2008; 57: 1073-1076.
[2] CDC. HIV/AIDS Surveillance Report, 2007. Vol. 19. Atlanta: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention; 2009
[3] Hall HI, Ruiguang S, Rhodes P, et al. Estimation of HIV incidence in the United States. JAMA. 2008;300:520-529.
[4] Coalition for a National AIDS Strategy. *Framework for Developing an Effective National AIDS Strategy for the United States*. October 2008.
[5] The U.S. President's Emergency Plan for AIDS Relief. http://www.pepfar.gov

RESOLVED, That our AMA to support the following guiding principles as outlined by the Coalition for a National AIDS Strategy:

- Improve prevention, care, and treatment outcomes through reliance on evidence-based programming;
- Set ambitious and credible prevention, care, and treatment targets and require annual reporting on progress toward goals;
- Identify clear priorities for action across federal agencies and assign responsibilities, timelines, and follow-through;
- Include, as a primary focus, the prevention and treatment needs of African Americans and other communities of color, women of color, men who have sex with men of all races and ethnicities, and other groups at elevated risk for HIV;
- Address social, economic, and structural factors that increase vulnerability to HIV infection;
- Promote a strengthened and more highly coordinated HIV prevention and treatment research effort; and
- Involve many sectors in developing the Strategy, including government, business, community, civil rights organizations, faith-based groups, researchers, and people living with HIV/AIDS (New HOD Policy); and be it further

RESOLVED, That our AMA to work with the White House Office of National AIDS Policy and other relevant bodies to develop a National HIV/AIDS strategy. (Directive to Take Action)

Fiscal Note: Implement accordingly at estimated cost of $8,950 for travel, meetings, and staff time.

Received: 05/14/09