

1994 Interim Meeting of the American Medical Association

Reports of the Council on Scientific Affairs

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EDITOR'S NOTE: *The Recommendations in these report summaries reflect AMA policy at the time the reports were adopted by the AMA House of Delegates. Consult the AMA PolicyFinder for the most recent AMA policy and directives.*

1994 AMA Interim Meeting

Summaries and Recommendations of Council on Scientific Affairs Reports

Endorsement as Guidelines of the "Standards for Pediatric Immunization Practices" (CSA Rep. 1, I-94)

SUMMARY

A set of standards for pediatric immunization practices was developed by the Centers for Disease Control and Prevention (CDC) in collaboration with a 35-member working group representing 24 public and private organizations with input from numerous state and local health departments, physician and nursing organizations, and public and private providers involved in clinical care and in prevention health services. The Standards represent a consensus of the National Vaccine Advisory Committee and the Ad Hoc Working Group for the Development of Standards for Pediatric Immunization Practices as to what are the most essential and desirable immunization policies and practices in an immunization service. The Standards were approved by the United States Public Health Service in 1992 and endorsed by the American Academy of Pediatrics. A number of other organizations subsequently endorsed the Standards, including the American Academy of Family Physicians. The American Medical Association was a participating member of the working group for the development of the Standards. However, the AMA made no formal move to endorse the Standards officially until the introduction of the resolution to which this report responds.

The Standards are recommended for use by all health professionals who administer vaccines to or manage immunization services for infants and children. They represent what is considered to be the most desirable immunization practices that health care providers should strive to achieve to the extent possible. The framers of the Standards recognized that not all providers would have the necessary resources or funds to fully implement the Standards immediately, but it was hoped that the Standards would provide a useful tool in better delineating immunization needs and in obtaining additional resources in the future in order to achieve the Healthy People 2000 objective of 90% immunization coverage levels of children by their second birthday.

The CSA believes that the word "standards" does not appear to capture the intent of the 1991 recommendation of the National Vaccine Advisory Committee which called for standards to guide immunization practices. The word "guidelines" appears to be a better choice in this connection. However, the Council feels that it is too late to effect this desirable change in wording of the official document.

This report also addresses concerns about the issue of cost recovery and the standard calling upon providers to operate a tracking system for vaccine administration.

The CSA encourages physicians who may be vaccine providers to read in its entirety the published Standards so that they are thoroughly familiar with the content. Finally, the CSA notes that the public media have often focused on the adverse effects occasionally associated with

vaccine administration without providing sufficient information on the seriousness of the diseases involved and the degree of protection that vaccines afford against these diseases. AMA members should work to dispel any unreasonable fear the public may have of recommended vaccinations.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1994 AMA Interim Meeting.
The AMA:

1. Encourages members who may be vaccine providers to become thoroughly familiar with the published Standards for Pediatric Immunization Practices in order that they are aware of the guidelines that have been established to assist the nation in achieving the Year 2000 national goal of 90% immunization coverage levels of children by the age of two;
2. Formally endorses as guidelines the Standards for Pediatric Immunization Practice recommended by the National Vaccine Advisory Committee, approved by the U.S. Public Health Service, and endorsed by the American Academy of Pediatrics and the American Academy of Family Physicians;
3. Encourages its members and state and local medical societies to work with their departments of public health, chapters of the American Academy of Pediatrics, and the American Academy of Family Physicians, and the AMA Alliance to implement the guidelines and goals included in the Standards; and
4. Advises its members as well as state and local medical societies to work with appropriate organizations to develop coordinated immunization and tracking systems in partnership with relevant local, state and federal government agencies.

Methadone Maintenance in Private Practice (CSA Rep. 2, I-94)

SUMMARY

This report addresses the use of "medical" methadone maintenance by qualified private practicing physicians as a public health measure in prevention of acquired immunodeficiency syndrome (AIDS).

Although still controversial, methadone maintenance is a widely used method of treating chronic relapsing addiction to heroin or other opioids. Methadone maintenance is considered an effective therapy for opioid dependence. A 1990 Institute of Medicine report concluded that there is strong evidence from clinical trials and other studies that heroin-dependent individuals have better outcomes on average when they are maintained on methadone than when they are not treated at all, acutely detoxified and released, expelled from treatment, or when the treatment program is closed. Methadone programs have higher rates of retention in treatment for opioid-dependent patients than do other treatment modalities applied to similar patient populations.

"Medical" methadone maintenance has been defined as the treatment by primary care physicians of rehabilitated methadone maintenance patients who are stable, employed, not abusing drugs, and not in need of supporting clinic services or, the treatment of socially rehabilitated methadone maintenance patients in physicians offices rather than in licensed clinics.

Injection drug use is the second most important risk factor in the transmission of human immunodeficiency virus (HIV) in this country and the primary source of heterosexual and perinatal transmission. There is evidence that methadone treatment is effective in reducing exposure to HIV infection by reducing intravenous drug use and by decreasing needle sharing.

The "medical" methadone maintenance model may be an appropriate approach for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment. Treatment that reduces street drug injection and needle-sharing will reduce the spread of HIV infection. Medical maintenance may be an efficient and cost effective approach to the related major problems of opioid dependence and an evolving HIV epidemic. Further investigation is needed to define the critical details of such programs.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1994 AMA Interim Meeting. The AMA

1. Reaffirms its position stated in the 1971 guideline on Oral Methadone Maintenance Techniques in the Management of Morphine-Type Dependence that, "the use of properly trained practicing physicians as an extension of organized methadone maintenance programs in the management of those patients whose needs for allied services are minimal" (called "medical" maintenance) should be evaluated further.
2. Supports the position that "medical" methadone maintenance may be an effective treatment for the subset of opioid dependent patients who have attained a degree of behavioral and social stability under standard treatment and thereby an effective measure in controlling the spread of infection with HIV and other blood-borne pathogens, but further research is needed.
3. Encourages additional research that includes consideration of the cost of "medical" methadone maintenance relative to the standard maintenance program (for example, the cost of additional office security and other requirements for the private office-based

management of methadone patients) and relative to other methods to prevent the spread of blood-borne pathogens among intravenous drug users.

CSA Rep. 3, I-94 *Deferred Report*

Educational and Informational Strategies for Reducing Pesticide Risks (CSA Rep. 4, I-94)

SUMMARY

Pesticides include a diverse group of chemicals that are widely used in agricultural and public health programs. Increasingly, pesticides are being used by commercial companies and homeowners for lawn care and indoor pest control. Educational and informational programs can be helpful for workers and the general public by improving their knowledge about the risks and benefits of pesticides. With such knowledge, individuals may be able to make more informed decisions about the potential hazards of pesticides used at home, in the community, and at work.

The widespread use of chemical pesticides is controversial because of their potential to adversely affect non-target species and the environment. Addressing such controversy can be difficult because of a lack of conclusive evidence for some pesticide hazards. For example, uncertainty exists regarding the long-term human health and ecological effects of multiple pesticide exposures in agricultural and nonagricultural settings. Particular uncertainty exists regarding the long-term health effects of low dose pesticide exposures. Current surveillance systems are inadequate to characterize potential exposure problems related either to pesticide usage or pesticide-related illnesses. Considering these data gaps, it is prudent for homeowners, farmers, and workers to limit pesticide exposures to themselves and others, and to consider the use of the least toxic chemical pesticides or nonchemical alternatives.

This report summarizes occupational and nonoccupational pesticide risks and discusses educational and informational approaches to reduce these risks. Recommendations include the need for continued research to determine the possible effects of existing pesticides and to develop effective and less toxic alternatives. Informed physicians and other health professionals can assist in educating workers and the general public about pesticide risks and measures to reduce exposures. Recent federal proposals may also be helpful by integrating educational and informational strategies to reduce or prevent occupational and nonoccupational pesticide risks.

RECOMMENDATIONS

The following actions, recommended by the Council on Scientific Affairs, were approved by the AMA House of Delegates at the 1994 AMA Interim meeting:

1. The AMA, professional medical specialty societies, and state medical societies should collaborate with government agencies, public health departments, farm organizations, and industry to develop educational and informational materials for physicians, pesticide workers, and the general public about the risks and benefits of pesticides.
2. The AMA urges Congress and the responsible government agencies to: (a) support improved educational and informational programs for pesticide applicators and the general public; (b) support research for the development of effective and less toxic chemical pesticides and nonchemical alternatives; (c) support improved reporting systems for pesticide usage and pesticide-related illnesses; (d) assess the effectiveness of pesticide applicator certification and training programs; (e) assess the effectiveness of posting and notification programs for lawn care and indoor structural pesticide applications; (f) provide financial and technical assistance to the states for the development and implementation of these programs; and (g) support all efforts to list both active and inert ingredients on pesticide container labels and material safety data sheets.
3. The AMA encourages physicians to: (a) educate themselves about the diagnostic and therapeutic aspects of pesticide-related illnesses; (b) consider and inquire about pesticide exposures when compiling patient histories; and (c) participate with state health departments to improve reporting systems for pesticide-related illnesses.

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4. The AMA reaffirms Policies 55.990, 135.974, and 135.988 to determine the human health and environmental effects of pesticides and encourages Congress and the responsible government agencies to support continued research in these areas.
5. The AMA will continue to monitor developments and issues regarding the environmental and public health impact of pesticides.

NOTE: The complete text of this report has been published. Educational and informational strategies to reduce pesticide risk. *Preventive Medicine*. 1997;26:191-200.

Female Genital Mutilation (CSA Rep. 5, I-94)

SUMMARY

Female genital mutilation is the medically unnecessary modification of female genitalia. Although most girls undergo female genital mutilation around the age of 7, mutilated women suffer severe medical complications throughout their adults lives. Female genital mutilation most frequently occurs in Africa, the Middle East, and in Muslim parts of Indonesia and Malaysia, and it is generally part of a ceremonial induction into adult society. Recent political and economic problems in these regions, however, have increased the numbers of students and refugees to the United States. Consequently, US physicians are treating a growing number of mutilated patients.

The Council on Scientific Affairs recommends that American physicians join the World Health Organization, the World Medical Association, and other major health care organizations in opposing all forms of medically unnecessary surgical modification of the female genitalia.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1994 AMA Interim Meeting. The AMA:

1. Condemns the practice of female genital mutilation (FGM);
2. Considers FGM a form of child abuse;
3. Supports legislation to eliminate the performance of FGM in the United States and to protect young girls and women at risk of undergoing the procedure; and
4. Supports that physicians who are requested to perform FGM on a patient provide culturally sensitive counseling to educate the patient and her family members about the negative health consequences of the procedure, and discourage them from having the procedure performed. Where possible, physicians should refer the patient to social support groups that can help them cope with changing societal mores.

NOTE: The complete text of this report has been published. Female genital mutilation. <i>JAMA</i> . 1995;274:1714-1716. (December 6)
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Lead Poisoning Among Children (CSA Rep. 6, I-94)

SUMMARY

Lead poisoning continues to be a common and significant environmental threat to young children. In the United States today, 1.7 million children from all geographic areas and socioeconomic strata are estimated to have lead levels high enough to cause adverse health effects. Poor, minority children in the inner cities are at particular risk.

In 1991 the federal government released a strategic plan that outlined the first five years of a 20-year effort to eliminate childhood lead poisoning as a public health problem. The plan encompasses both a research and a programmatic agenda. Cooperative efforts between the Department of Health and Human Services, the Environmental Protection Agency, and the Department of Housing and Urban Development, and state and local programs are essential to the success of this plan.

Childhood lead exposure costs the United States billions of dollars in medical and special education costs and decreased future earnings. Most exposures occur in the home, with lead-based paint continuing to be the principal high-dose source.

While progress has been made, continued need exists for efforts to prevent lead poisoning among children. Doing so will require effort by many groups, including public health officials, environmental agencies, housing agencies, and health care professionals. Appropriate screening programs will be essential to the effort.

Physicians can play a critical role in preventing lead poisoning, both in their practices and by governmental advocacy. It is important that the tradition of public involvement continue and that physicians continue to act publicly as advocates for the health of children.

RECOMMENDATIONS

The following statements, recommended by the Council of Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1994 AMA Interim Meeting:

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 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.

Effects of Electric and Magnetic Fields (CSA Rep. 7, I-94)

SUMMARY

This report considers basic principles related to electric and magnetic fields, summarizes their known effects, and provides recommendations about reducing exposures. Electric and magnetic fields are ubiquitous and are related to the electromagnetic spectrum and its many uses and to electric charges, their movements, and the associated forces. Electric and magnetic fields from power lines are of low energy and are not mutagenic. Interactions of the fields with the body and their physiologic effects are not fully understood. Electric appliances, power lines, and grounding systems are the main exposure sources for most persons. Known human effects include changes in heart function, decrements in performance, suppression of melatonin secretion, and enhancement of wound and fracture healing.

Most studies of magnetic field effects in children, workers, and other populations do not meet accepted scientific criteria in terms of accurately measuring past exposures, identifying comparable test and control groups, and accounting for potentially confounding factors. Findings of studies are inconsistent in terms of whether a risk exists, what conditions might be related to exposures, and risk magnitude. Positive studies indicate, for the most part, that the associated relative risks are low.

Strengths of electric and magnetic fields diminish as distances from their sources increase; also, technical methods exist whereby the fields can be decreased. This report encourages continued investigation of basic effects and physiologic mechanisms, studies of people's average exposures, and the developing of national exposure standards, if such are recommended by an authoritative advisory panel.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1994 AMA Interim Meeting. The AMA:

1. Will continue to monitor developments and issues related to the effects of electric and magnetic fields even though no scientifically documented health risk has been associated with the usually occurring levels of electromagnetic fields.
2. Encourages research efforts sponsored by agencies such as the National Institutes of Health, U.S. Department of Energy, and the National Science Foundation to continue on exposures to electromagnetic fields and their effects, average public exposures, occupational exposures, and the effects of field surges and harmonics.
3. Supports convening an authoritative, multidisciplinary committee under the auspices of the National Academy of Sciences or the National Council on Radiation Protection and Measurements to make recommendations about exposure levels of the public and workers to electromagnetic fields and radiation.

Health Care Needs of Gay Men and Lesbians In the United States (CSA Rep. 8, I-94)

SUMMARY

This report updates the 1981 Council on Scientific Affairs report concerning the health care needs of gay men and lesbians. It reviews the prevalence of male and female homosexuality, significance of the sexual history in medical practice, diagnostic and therapeutic considerations of gay men and lesbians (including HIV and other sexually transmissible diseases, cancer, hepatitis and other diseases), mental health issues (including emotional and substance abuse concerns), adolescents and homosexuality, access to health care by gay men and lesbians, and recommendations on how best to meet the health needs of gay men and lesbians.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1994 AMA Interim Meeting.

1. The AMA believes that the physician's nonjudgmental recognition of sexual orientation and behavior enhances the ability to render optimal patient care in health as well as in illness. In the case of the homosexual patient this is especially true, since unrecognized homosexuality by the physician or the patient's reluctance to report his or her sexual orientation and behavior can lead to failure to screen, diagnose, or treat important medical problems. With the help of the gay and lesbian community and through a cooperative effort between the physician and the homosexual patient, effective progress can be made in treating the medical needs of this particular segment of the population.
2. The AMA is committed to taking a leadership role in: (a) educating physicians on the current state of research in and knowledge of homosexuality and the need to take an adequate sexual history; these efforts should start in medical school, but must also be a part of continuing medical education; (b) educating physicians to recognize the physical and psychological needs of their homosexual patients; (c) encouraging the development of educational programs for homosexuals to acquaint them with the diseases for which they are at risk; (d) encouraging physicians to seek out local or national experts in the health care needs of gay men and lesbians so that all physicians will achieve a better understanding of the medical needs of this population; and (e) working with the gay and lesbian community to offer physicians the opportunity to better understand the medical needs of homosexual and bisexual patients.

NOTE: A revised version of this report has been published. Health care needs of gay men and lesbians in the United States. <i>JAMA</i> . 1996;275:1354-1359. (May 9)
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Violence Toward Men: Fact or Fiction? (CSA Rep. 9, I-94)

SUMMARY

As a result of the AMA's Campaign Against Family Violence, there have been repeated calls for the AMA to address the issue of intimate violence against men by their spouses. This report examines the extant data on the subject and concludes that regardless of the competing claims about "battered men," the injuries suffered by men in intimate violence present regularly before physicians and require treatment.

The report recommends that the AMA include male victims of family violence in materials prepared as part of the Campaign Against Family Violence and encourage physicians to be alert in their practices to the presence of male victims of abuse.

RECOMMENDATIONS

See CSA Report 7 (2000 Interim AMA Meeting), "AMA Data on Violence Between Intimates," for updated AMA policy on domestic violence issues.