

1997 Interim Meeting of the American Medical Association

Reports of the Council on Scientific Affairs

Title	Page
Helmets for Recreational Skiing and Other Winter Sports in Children and Adolescents	2
Recycling of Nursing Home Drugs	3
Bonding Programs for Women Prisoners and Their Newborn Children	4
Expense of Biohazardous Waste Removal	5
Alcoholism and Alcohol Abuse Among Women	6
Alzheimer's Disease	7
Awareness, Diagnosis, and Treatment of Depression	8
Norplant System Contraceptive Inserts	10
Medical Marijuana	11

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.*

1997 AMA Interim Meeting

Summaries and Recommendations of Council on Scientific Affairs Reports

Helmets for Recreational Skiing and Other Winter Sports in Children and Adolescents (CSA Rep. 1, I-97)

SUMMARY

With the goal of reducing traumatic brain injuries, this report assesses the potential benefits of the mandated use of protective headgear by children and adolescents engaged in recreational snow skiing and snowboarding

Although potentially serious head injury among skiers and snowboarders under 17 years of age is relatively rare, this population has about twice the risk of sustaining such an injury as older participants. Evidence presented in this report suggests that use of helmets by children and adolescents during skiing and snowboarding might have some benefit in preventing serious head injury. However, data are insufficient to support a policy of mandatory helmet use for children and adolescent skiers or snowboarders. Further research is needed on the epidemiology and outcomes of head injuries in this population and on the effectiveness of ski helmets or headgear in preventing brain trauma.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Interim Meeting.

1. The AMA supports the voluntary use of helmets and protective headgear for children and adolescents during recreational skiing and snowboarding. As of September 1997, there is insufficient scientific evidence to support a policy of mandatory helmet use.
2. The AMA encourages further research into the epidemiology and outcome of head injuries to children and adolescents from recreational skiing and snowboarding and research on the development of helmets to prevent or reduce the severity of these injuries.
3. The AMA encourages the American Society for Testing and Materials to finalize standards for ski helmets and study the effectiveness of ski helmets in preventing serious brain trauma.

Recycling of Nursing Home Drugs (CSA Rep. 2, I-97)

SUMMARY

The American Medical Association (AMA) was asked to study the feasibility of nursing homes (long-term care facilities, LTCFs) returning unused, sealed, and dated drugs to their vendor for credit and resale. This report briefly reviews the limited literature on medication waste in LTCFs, describes the policy statement of the American Society of Consultant Pharmacists (ASCP) and the views of the American Medical Directors Association (AMDA) on the return and reuse of medications in LTCFs, and provides the Council on Scientific Affairs' recommendations on the subject.

Based on limited studies, it appears that the cost associated with unused medications in LTCFs is between 4% and 10% of the total costs of the medications dispensed. More than 90% of the wasted medication is due to discontinuation or change in medication or death, transfer, or hospitalization of the resident. The ASCP has adopted a policy statement that supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in LTCFs and to offer substantial cost savings to the health care system, provided specific drug product safeguards and appropriate billing practices are in place. The AMDA supports the findings of ASCP and generally accepts the ASCP policy statement regarding the return of unused medications from LTCFs.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Interim Meeting.

1. The American Medical Association (AMA), consistent with the policy of the American Society of Consultant Pharmacists (ASCP), supports the return and reuse of medications to the dispensing pharmacy to reduce waste associated with unused medications in long-term care facilities (LTCFs) and to offer substantial savings to the health care system, provided the following conditions are satisfied:
 - (a) The returned medications are not controlled substances.
 - (b) The medications are dispensed in tamper-evident packaging and returned with packaging intact (eg, unit dose, unused injectable vials and ampules).
 - (c) In the professional judgment of the pharmacist, the medications meet all federal and state standards for product integrity.
 - (d) Policies and procedures are followed for the appropriate storage and handling of medications at the LTCF and for the transfer, receipt, and security of medications returned to the dispensing pharmacy.
 - (e) A system is in place to track re-stocking and reuse to allow medications to be recalled if required.
 - (f) A mechanism (reasonable for both the payer and the dispensing LTC pharmacy) is in place for billing only the number of doses used or crediting the number of doses returned, regardless of payer source.
2. The AMA will communicate this policy to the federal and state governments and other organizations, as appropriate.

Bonding Programs for Women Prisoners and Their Newborn Children (CSA Rep. 3, I-97)

SUMMARY

Given the growing female prison population, pregnancies during incarceration are becoming much more common. While the vast majority of children born to imprisoned women are then sent to live with family or in foster care, a small number each year are allowed to stay with their mothers in long-term prison nurseries. Long-term nursery programs operate only in the states of New York, Nebraska, and Massachusetts. In contrast, interim nurseries are available in many states and allow infants to stay with their mothers from age 2 days to 6 weeks. Nursery staff seek to assure that the child has sufficient and appropriate food, clothing, medical attention, social stimulation, and contact with the mother. In general, mother-child bonding and improved parenting skills are the goals.

However, it has not been proved that the skills provided to these mothers and the bonds created between the mother and infant are maintained after they leave the facility. In addition, these programs are expensive and currently reach only a small population. Therefore, it is unclear if the money invested in the mother and her child could have been better spent elsewhere.

In light of the available evidence, it is difficult to argue that implementation of additional nursery programs is the best way to ensure that children of incarcerated parents grow up in a supportive, safe, and nurturing environment. These resources could be redirected to provide parenting skills training and mental health and substance abuse services in order to ensure that all female inmates are better prepared to re-enter the nonprison environment as mothers.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Interim Meeting.

1. Because at this time there are insufficient data to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children.
2. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons.
3. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. Therefore, the AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children.
4. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children

Expense of Biohazardous Waste Removal (CSA Rep. 4, I-97)

SUMMARY

This report addresses the issues associated with biohazardous waste disposal from physicians' offices and methods to minimize or eliminate the expense to physicians of removal of biohazardous waste.

No federal mandate has been developed to define biohazardous waste. The Environmental Protection Agency, the Centers for Disease Control and Prevention, and the National Institutes of Health have definitions that address biohazardous waste handling. Since federal agencies' views differ, states and municipalities have developed their own criteria. Definitions also vary from state to state as to what qualifies as a small biohazardous waste generator.

The general public health risk posed by medical waste is exceedingly low; there is no evidence that a member of the public or waste industry worker has ever acquired infection from medical waste, although injuries have been reported. Physicians need to educate their patients and the public about the origins, attributable risks, and handling of biohazardous waste. Physicians can set an example by exemplary management of their own biohazardous waste.

The expense of biohazardous waste management can be reduced by ensuring that only regulated biohazardous waste is processed as such, and by forming alliances with other medical groups or health care facilities to negotiate group disposal rates with vendors.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Interim Meeting.

1. The AMA encourages the Environmental Protection Agency (EPA) to explore the feasibility of establishing a national definition of biohazardous waste, emphasizing the origins and relative importance of wastes that can plausibly transmit infection compared with wastes that cannot.
2. The AMA encourages the EPA to monitor the sources of medical waste in environmental settings and develop guidelines applicable to all waste generators, including home health care sites, to reduce these sources of environmental pollution.
3. The AMA will work with appropriate governmental agencies and medical societies to educate physicians about the management of biohazardous waste and advocate that these groups work collectively to attain cost savings in biohazardous waste management.
4. The AMA urges practicing physicians to develop a biohazardous waste management program that fulfills their county, state, and municipal regulations, and that considers the different health risks to employees and the general public.
5. The AMA Board of Trustees will refer to the appropriate Council the study of mechanisms that might decrease the expense of removal of biohazardous waste from physicians' offices.
6. The AMA will strive to repeal biohazardous waste laws that do not have any scientific validity.

<p>NOTE: A revised version of this report has been published: Cocchiarella L, Deitchman SD, Young DC, for the Council on Scientific Affairs. Biohazardous waste: What the physician needs to know. <i>Arch Fam Med.</i> 2000;9:26-29.(January)</p>
--

Alcoholism and Alcohol Abuse Among Women (CSA Rep. 5, I-97)

SUMMARY

The American Medical Association (AMA) has designated alcoholism and substance abuse as public health concerns of high priority and has adopted extensive policy on alcohol abuse. This report reviews issues related to women and alcoholism and alcohol treatment, including definitions and epidemiology, societal attitudes, barriers to treatment, physiology of women and alcohol, alcohol use during pregnancy, risk factors, interventions, and implications for physicians.

Attitudes and social stereotypes about women and alcohol can create barriers to the detection and treatment of female alcohol abusers. Obstacles that can deter women from seeking treatment can be caused by both internal (self-perception) and external (environmental) factors. Physicians also can be influenced by these stereotypes about women and alcohol abuse. Other barriers to treatment include male-oriented treatment and intervention models and programs; opposition by family and friends; lack of insurance coverage; family responsibilities, such as care for dependent children; and threat of loss of custody of children, secondary to maternal alcohol abuse.

Physician interventions with patients can reduce alcohol use and decrease health care costs associated with alcohol problems. Physicians are in an excellent position to counsel patients who are abusing alcohol and to address the medical, psychological, and social sequelae of alcoholism and alcohol abuse. Evidence that intervention decreases alcohol intake should be a powerful motivator for physicians to conduct alcohol screening with their patients.

RECOMMENDATIONS

Physicians need to become more active in the prevention, diagnosis, and treatment of alcohol-related problems in women. The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Interim Meeting.

1. The AMA recognizes the prevalence of alcohol abuse, and dependence among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol abuse and dependence.
2. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver, and heart from alcohol and about the effect of alcohol on the developing fetus.
3. The AMA encourages adequate funding for research to explore the nature and extent of alcoholism among women, effective treatment modalities for women with alcoholism, and variations in alcohol use and abuse among ethnic and other subpopulations.
4. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women.

NOTE: The full text of this report has been published: Blum LN, Nielsen NH, Riggs JA, for the Council on Scientific Affairs. Alcoholism and alcohol abuse among women: report of the Council on Scientific Affairs. <i>Journal of Women's Health</i> . 1998;7:861-871. (September)
--

Alzheimer's Disease (CSA Rep. 6, I-97)

SUMMARY

Alzheimer's disease (AD) is a chronic, degenerative, dementing illness, the etiology of which is unknown. Irreversible dementia takes a heavy economic, social, physical, and psychological toll on patients and family members, who provide the majority of care for afflicted individuals. There is currently no cure for AD, only interventions that ameliorate to some extent the profound cognitive losses and difficult behavioral manifestations of the disorder. While community services exist to provide relief for the burden of care, they are underutilized. As traditional gatekeepers for services, physicians can encourage more families to use supportive services.

Several authoritative documents on the diagnosis and treatment of AD and related disorders are available. This report reviews the guidelines on the diagnosis and treatment of AD of the Agency for Health Care Policy and Research, the American Academy of Neurology, the Veterans Health Administration, and the American Psychiatric Association. These guidelines contain valuable information; however, there is need for increased and intensive medical education, seminars, and continuing medical education, whereby the information contained in these documents can be widely disseminated.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Interim Meeting.

1. The AMA encourages physicians to make appropriate use of guidelines for clinical decision-making in the diagnosis and treatment of Alzheimer's disease and other dementias.
2. The AMA encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services.
3. The AMA encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer's disease and related disorders.
4. The AMA encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer's disease and other dementing disorders.

NOTE: The full text of this report has been published: Guttman R, Altman RD, Nielsen NH, for the Council on Scientific Affairs. Alzheimer disease. <i>Arch Fam Med</i> . 1999;8:347-353. (July/Aug)

Awareness, Diagnosis, and Treatment of Depression (CSA Rep. 7, I-97)

SUMMARY

Depressive illnesses are a group of disorders that occur commonly in the general population, and they are seen even more frequently in medical settings. Depression is associated with considerable personal suffering, functional impairment, and a markedly elevated risk of suicide, and the health care and lost productivity costs are extremely high. Well-established diagnostic criteria and highly effective psychopharmacologic and psychotherapeutic treatments are available to treat depression.

Only about half of all cases of depression in primary care settings are recognized and diagnosed. Even when cases are recognized, the pharmacologic and psychotherapeutic treatments provided by both generalists and specialists often fall short of standard practice guidelines. When treatments of documented efficacy are used, short-term patient outcomes are generally quite good.

Numerous barriers exist to diagnosing and treating depression in general medical settings, including those related to stigma; patient somatization and denial; physician knowledge and skill deficits; limited physician time for assessment or treatment; lack of availability of providers and specific treatments; limitations of third-party coverage; and restrictions on specialist, drug, and psychotherapeutic care. A number of programs are underway to increase public and employer awareness and to educate physicians about these barriers, but the undertreatment of depression remains a serious public health problem. Concerted public and professional education efforts, destigmatization, and improvements in access to mental health care are all needed to reduce the magnitude of this problem.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1997 AMA Interim Meeting.

1. The AMA encourages medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression, both when it occurs by itself and when it occurs with another general medical condition.
2. The AMA encourages all physicians providing clinical care to acquire the same knowledge and skills.
3. The AMA encourages additional research into the course and outcomes of patients with depression who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
4. The AMA reaffirms Policies H-345.992, H-345.984, and H-345.986 in that it fully supports equivalent third-party coverage for all psychiatric disorders, including depression, with that for other medical disorders, and that it strongly oppose any arbitrary restrictions or limitations on the provision of mental health services.
5. The AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression, to reduce the stigma associated with depression, and to increase patient access to quality care for depression.

NOTE: The full text of this report has been published: Goldman LS, Nielsen NH, Champion HC, for the Council on Scientific Affairs. Awareness, diagnosis, and treatment of depression. *Journal of General Internal Medicine (JGIM)*. 1999;14:569-580. (September 1999)

CSA Rep. 8, I-97 *Deferred Report*

Norplant System Contraceptive Inserts (CSA Rep. 9, I-97)

SUMMARY

The NORPLANT SYSTEM (levonorgestrel implants, or Norplant) is a long-term reversible method that provides continuous contraception for as long as 5 years. Through 1996, at least 1 million women in the United States had received Norplant; however, its use has declined precipitously in the last 3 years because of widespread litigation and negative news media publicity. In light of the controversy surrounding Norplant, the Council on Scientific Affairs has examined the development of Norplant and compiled this informational report on its safety, efficacy, and current role as a contraceptive option.

Currently, Norplant retains a small niche in the array of contraceptive choices available to women in the United States. It is of potential value in motivated women making an informed decision who have been dissatisfied with other methods or experienced method failure, particularly those at high risk of unintended pregnancy, including adolescents. Norplant also is an option for most women who cannot take estrogens, and for those seeking long-term contraception as an alternative to sterilization.

RECOMMENDATIONS

Because this is an informational report, there are no Recommendations

Medical Marijuana (CSA Rep. 10, I-97)

SUMMARY

This report summarizes federal and AMA responses to recent state initiatives designed to facilitate the medical use of marijuana. Additionally, the past and current status of marijuana, especially as related to federal regulations governing its medical use and the conduct of clinical research, are explained. Finally the pharmacology of marijuana and its major psychoactive ingredient, delta-9-tetrahydrocannabinol (THC) are reviewed, and the evidence for claims of therapeutic benefits is evaluated.

The debate on marijuana as medicine covers four main issues: (1) its role as a significant drug of abuse and the reluctance of policy makers to dissociate the potential harmful effects of recreational marijuana use from its potential therapeutic effects; (2) the wisdom of burning and inhaling the combustion products of a dried plant product as a valid therapeutic agent; (3) the failure to view smoked marijuana as a unique therapeutic substance rather than as simply an alternate, but more toxic delivery vehicle for delta-9-tetrahydrocannabinol (THC; Dronabinol[®]); and (4) the value of analyzing smoked marijuana's potential medical use in the traditional manner of risk-versus-benefit in individual patients.

Depending on the condition, research on the medical utility of smoked marijuana may involve determination of efficacy, comparisons with oral THC, evaluation of its use in combination with standard therapies or in patients refractory to standard medications, and determination of its relative value in marijuana-experienced versus inexperienced smokers. Additional concerns in conducting research on smoked marijuana are the lack of data on its safety in older patients and in those with serious diseases, especially involving the cardiovascular system.

Areas in which preclinical, anecdotal, or controlled evidence suggests that further clinical research on marijuana may be warranted include acquired immunodeficiency syndrome wasting syndrome and cancer cachexia, acute and delayed nausea and vomiting induced by cancer chemotherapy, spasticity, and neuropathic pain.

RECOMMENDATIONS

See CSA Report 6, 2001 Annual Meeting, for updated AMA policy on this subject.