

1999 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.*

1999 AMA Interim Meeting

Summaries and Recommendations of Council on Scientific Affairs Reports

Screening Nonimmigrant Visitors to the United States for Tuberculosis (CSA Rep. 1, I-99)

SUMMARY

Objective. To assess the feasibility of requiring proof of tuberculosis (TB) screening for certain populations of nonimmigrant visitors to the United States via a review of the scientific literature, current media reports, immigration regulations, and interviews with experts in the field.

Data Sources. Literature searches were conducted in the MEDLINE database from 1966 through 1998 using the search terms *tuberculosis* and *transmission*, combined with the individual qualifiers *foreign visitors*, *foreign students*, *foreign born*, and *policy*. Lexis/Nexis news databases were searched for developments in the last 2 years using the same terms. Additional information was obtained through direct consultation with leading experts in the field of TB control from the Centers for Disease Control and Prevention (CDC) and the Canadian government. The World Wide Web was searched for information using the search words *tuberculosis* and *transmission*.

Data Extraction. English-language articles were selected based on their ability to provide information directly related to control of TB transmission among foreign-born persons.

Results. The World Health Organization states that in order to control TB within countries, it must be cooperatively controlled at a global level. Strict border screening guidelines used as *exclusionary* measures can actually worsen the epidemic. The elimination of TB in the United States will depend significantly on the ability to control TB within the foreign-born population. The CDC issued a series of recommendations on September 16, 1998, to address preventing and controlling TB among the foreign-born immigrant population. The CDC states that the overseas TB screening of nonimmigrant visitors, who are unlikely to be sick with active TB and even less likely to transmit TB to persons in the United States, will be of extremely low yield. Additionally, requiring proof of TB screening of nonimmigrant visitors would be a significant deviation from the US "open door" policy for nonimmigrants and would have enormous logistical and political implications. Because data exist indicating that children appear to be at the lowest risk of TB following immigration, the CDC believes that screening for TB in entrants below the age of 15 years would not be cost effective at this time.

Conclusions. In general, the CDC has focused its TB-control efforts on eliminating TB in foreign-born persons ³ 15 years of age who intend to stay in the United States. This is a high-risk population that will most likely have an effect on the public health of the people already living in the United States and thus will provide the best yield for CDC and state and local public health department resources. The imposition of screening and monitoring requirements on the nonimmigrant foreign-born population would divert valuable resources from currently established and successful TB control programs for the foreign-born immigrant population. Thus, prior to imposing any TB screening requirements on the nonimmigrant foreign-born population, the CDC should study the epidemiology of TB within the nonimmigrant foreign-born population who reside

in the United States for significant periods of time, eg, longer than 6 months. If data from such studies indicate a need, the CDC should then consider the feasibility of TB screening for nonimmigrant visitors originating from high-risk TB countries who intend to reside in the United States for longer than 6 consecutive months. Finally, the CDC should consider decreasing the validity period of a TB screening for immigrants from 1 year to 6 months

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meetings.

1. The AMA recognizes that the control of TB in the foreign-born population is critical to the elimination of TB in the United States, and supports current Centers for Disease Control and Prevention (CDC) recommendations on the prevention and control of TB among foreign-born persons;
2. The AMA encourages the CDC to: (a) Study the epidemiology of TB within the nonimmigrant foreign-born population who reside in the United States for longer than 6 months; (b) consider the feasibility of TB screening for nonimmigrant visitors originating from high-risk TB countries who intend to reside in the United States for longer than 6 consecutive months, should data from the studies recommended in 2(a) indicate a need; and (c) consider decreasing the validity period of a TB screening for immigrants from 1 year to 6 months.
3. The AMA recognizes the need for global cooperative efforts to control TB and encourages the establishment of well-supported TB-control programs, especially in countries with a high incidence of TB, founded on the principles of the World Health Organization's Directly Observed Treatment - Short-course, or DOTS program.
4. The AMA will urge Congress to provide adequate funding for the CDC and other public health agencies in order to facilitate global cooperative efforts to control TB.

NOTE: The full text of this report has been published: Tan L, Altman RD, Nielsen NH, for the Council on Scientific Affairs. Screening nonimmigrant visitors to the United States for tuberculosis. *Arch Intern Med.* 2001;161:334-340. (February 12)

Labeling of Prescription Drug Containers for Generic-substituted Drugs (CSA Rep. 2, I-99)

SUMMARY

This report responds to Resolution 514, introduced at the 1998 Interim Meeting by the Michigan Delegation and referred to the Board of Trustees by the House of Delegates, which asked:

That the American Medical Association (AMA) reaffirm existing policy calling for complete explanatory information on prescription labels; and

That the AMA request the Food and Drug Administration (FDA) to require a pharmacy, when it changes between trademark drugs and generics or when it changes generic manufacturers for prescription refills, to note that fact on the prescription label so the patient can so inform the physician in case problems arise.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting.

1. AMA Policy H-115.974 is amended to read as follows: The AMA recommends: (a) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription. (b) That, except where the prescribing physician has indicated otherwise, the pharmacist include the following information on the label affixed to the container in which a prescription drug is dispensed: In the absence of product substitution, i) the brand or generic name of the drug dispensed; ii) the strength, if more than one strength of drug is marketed; iii) the quantity dispensed; and iv) the name of the manufacturer or distributor. When generic substitution occurs: i) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; ii) the strength, if more than one strength of drug is marketed; iii) the quantity dispensed; iv) the manufacturer or distributor; and v) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]." (c) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: i) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; ii) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug manufacturer or distributor and, show this to the patient; iii) affix to the primary label an auxiliary (sticker) label that states, "This medication contains the same active ingredient you have been getting. Color, size, or shape may appear different;" and iv) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed.
2. The AMA will send this report, as expeditiously as possible, to the National Association of Boards of Pharmacy

Inflight Medical Emergencies (CSA Rep. 3, I-99)

SUMMARY

Objective. To review the epidemiology of inflight medical emergencies, describe medical supplies and equipment that are available on commercial airlines to manage these emergencies, and identify medical guidelines for advising patients about medical problems that may occur during flight.

Data Sources. MEDLINE was searched for English-language articles published from 1980 to 1999. Additional information was derived from manual review of references cited in relevant journal articles, reports, and textbooks, and from communication with experts in aerospace and emergency medicine.

Data Synthesis. Inflight medical emergencies affect 1/10,000 to 1/40,000 passengers on domestic and foreign airlines. Neurological, syncopal, cardiac, psychiatric, and respiratory episodes are the most frequent categories of inflight medical problems. Fatalities during flight occur in <1/1,000,000 passengers. Myocardial disease is the most frequent cause of inflight death. To manage inflight emergencies, flight crews rely on their own training, the availability of passenger volunteers, communication with medical personnel on the ground, and the contents of onboard emergency medical kits and first aid kits. Variation exists among airlines in the contents and sophistication of inflight medical kits and in flight crew training requirements. Some US and foreign air carriers are upgrading inflight emergency medical kits and placing automated external defibrillators (AEDS) aboard aircraft. Little data are available regarding the effectiveness of such improvements in improving health or survival outcomes. Federal legislation was signed in 1998 requiring the Federal Aviation Administration to assess the extent of inflight medical emergencies, the adequacy of inflight emergency medical kits, and the need for AEDs on commercial aircraft.

Conclusions. Present data indicate that inflight morbidity and mortality are uncommon. Management of serious inflight medical events requires an integrated emergency response system that ensures rapid notification of medical personnel on the ground, assistance from appropriately trained flight crews and passenger volunteers (if available), and adequate medical supplies and equipment to stabilize the victim. Physicians have an important role in the preflight evaluation and counseling of patients who are at risk of inflight medical complications. Medical guidelines are available to assist physicians with determining a patient's fitness to fly. Recent federal legislation should alleviate liability concerns by providing immunity for physicians and others who render inflight medical assistance.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting.

1. Policy H-45.981 is amended to read: "The AMA urges federal action to require all US air carriers to report data on inflight medical emergencies, specific uses of inflight medical kits and emergency lifesaving devices, and unscheduled diversions due to inflight medical emergencies; this action should further require the Federal Aviation Administration to work with the airline industry and appropriate medical specialty societies to periodically review data on the incidence and outcomes of inflight medical emergencies and issue recommendations regarding the contents of inflight medical kits and the use of emergency lifesaving devices aboard commercial aircraft."

2. The AMA urges that decisions to expand the contents of inflight emergency medical kits and place emergency lifesaving devices onboard commercial passenger aircraft be based on empirical data and medical consensus; inflight medical supplies and equipment should be tailored to the size and mission of the aircraft, with careful consideration of flight crew training requirements.

3. The AMA urges the Federal Aviation Administration to work with appropriate medical specialty societies and the airline industry to develop and implement comprehensive inflight emergency medical systems that ensure: (a) rapid 24-hour access to qualified emergency medical personnel on the ground; (b) at a minimum, voice communication with qualified ground-based emergency personnel; (c) written protocols, guidelines, algorithms, and procedures for responding to inflight medical emergencies, (d) efficient mechanisms for data collection, reporting, and surveillance, including development of a standardized incident report form; (e) adequate medical supplies and equipment aboard aircraft; (f) routine flight crew safety training; (g) periodic assessment of system quality and effectiveness; and (h) direct supervision by physicians with appropriate training in emergency and aerospace medicine.

4. Policy H-45.996 is amended to read: "AMA policy is to pursue federal legislation mandating US commercial passenger aircraft to carry adequate medical supplies and equipment on each flight to allow onboard physicians and other healthcare professionals to administer reasonable emergency medical care to adult and pediatric passengers."

5. Policy H-45.997 be amended to read: "The AMA supports legislative provisions that grant any physician, other medical professional, or airline employee, acting in the role of a Good Samaritan during an inflight medical emergency, an umbrella of immunity against legal or personal redress by the airline, the passengers, or the persons involved in the medical emergency."

6. Policy H-45.991 is amended to read: "The AMA urges the Federal Aviation Administration to require safety training programs for commercial airline cabin crews which include, as a minimum, instruction in first aid; CPR; the Heimlich maneuver; and the location, function, operation, and maintenance of emergency medical kits and lifesaving medical equipment."

7. The AMA encourages physicians to inform themselves and their patients on the potential medical risks of air travel and how these risks can be prevented; and become knowledgeable of medical resources, supplies, and options that are available if asked to render assistance during an inflight medical emergency.

NOTE: The full text of this report has been published: Lyznicki JM, Williams MA, Deitchman SD, Howe JP III, for the Council on Scientific Affairs. Inflight medical emergencies. *Aviat Space Environ Med.* 2000;71;832-838. (August)

Medical Oxygen and Air Travel (CSA Rep. 4, I-99)

SUMMARY

Objective. To review physiological aspects of altitude-related hypoxemia, discuss medical indications for passengers who require supplemental oxygen during flight, and identify logistical and regulatory barriers for procuring medical oxygen for air travel.

Data Sources. MEDLINE was searched for English-language articles published from 1980 to 1999. Additional information was derived from manual review of references cited in relevant journal articles and textbooks, and from communication with experts in aerospace medicine and respiratory care.

Data Synthesis. Passengers who are unable to compensate for the hypoxemia and gas expansion that occur during air travel may experience significant symptoms and medical complications. Although passengers with chronic cardiac and pulmonary conditions seem to be at greatest risk, limited data are available to assess the incidence and clinical significance of hypoxemia and hypoxemia-induced symptoms and complications in cardiopulmonary patients traveling on commercial airlines. With appropriate preflight screening and preparation, most patients with cardiopulmonary problems can safely tolerate effects of flight-related hypoxia. Preflight evaluation of at-risk patients includes estimation of partial oxygen pressure in arterial blood (PaO₂) during flight and prescription for supplemental oxygen if required. Supplemental oxygen should be considered for passengers whose PaO₂ drops below 55 mm Hg at any airborne altitude. If the preflight PaO₂ is <70 mm Hg at or near sea level, provision also should be made for supplemental oxygen. For safety and security reasons, federal regulations prohibit travelers from using their own portable oxygen system onboard commercial aircraft. Many US airlines supply medical oxygen for use during flight but policies and procedures vary. Oxygen-dependent passengers must make additional arrangements for the use of supplemental oxygen in airports.

Conclusions. Commercial air travel exposes passengers to altitude-related hypoxia, which can have serious consequences for passengers with cardiopulmonary disease. Patients at risk of potential hypoxemia during flight should be evaluated before flight to determine their ability to travel safely by air. Supplemental oxygen may be needed to maintain adequate tissue oxygenation and prevent hypoxemic complications. Medical guidelines are available to help physicians evaluate and counsel cardiopulmonary patients who wish to travel by commercial airlines. Uniform standards are needed to specify procedures and equipment for the use of medical oxygen in airports and aboard commercial aircraft. Revision of federal regulations should be considered to accommodate oxygen-dependent passengers and permit them to have an uninterrupted source of oxygen from departure to destination.

RECOMMENDATION

The following statement, recommended by the Council of Scientific Affairs, was adopted by the AMA House of Delegates as AMA policy at the AMA 1999 Interim Meeting.

The AMA (1) supports the accommodation of passengers requiring medical oxygen therapy on scheduled commercial aircraft and in airports; (2) recommends that regulatory agencies, medical specialty societies, commercial air carriers, airport authorities, and other interested parties develop a coordinated system, with uniform guidelines specifying acceptable procedures and equipment for the use of medical oxygen in airports and aboard commercial aircraft, that will permit passengers to schedule oxygen with the least possible administrative and financial difficulty and to have available to them an

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uninterrupted source of oxygen from departure to destination; and (3) urges that any revised system to improve the accommodation of passengers requiring medical oxygen ensure the safety and security of other airline passengers and airport personnel."

NOTE: The full text of this report has been published: Lyznicki JM, Williams MA, Deitchman SD, Howe JP III, for the Council on Scientific Affairs. Medical oxygen and air travel. *Aviat Space Environ Med.* 2000;71:827-831. (August)

Cardiovascular Preparticipation Screening of Student Athletes (CSA Rep. 5, I-99)

SUMMARY

Objective. To review recommendations of the American Heart Association for cardiovascular preparticipation screening of competitive athletes and consensus physician guidelines for performing athletic preparticipation evaluations (PPEs).

Data Sources. MEDLINE was searched for English-language articles published from 1980 to 1999. Additional information was derived from manual review of references cited in relevant journal articles and textbooks and from communication with experts in sports medicine and cardiology.

Data Synthesis. About 10 high school or college athletes die suddenly each year of cardiac-related problems. The risk of sudden death in high school athletes is estimated at 1/200,000 per academic year. Most sudden deaths in young athletes are due to underlying congenital cardiac abnormalities. To prevent the occurrence of sudden death or cardiovascular disease progression in young athletes, the American Academy of Family Physicians, American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, American Heart Association, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine have developed or endorsed recommendations for cardiovascular preparticipation screening of high school and college athletes. Recent national surveys indicate that 17% to 40% of states have PPE questionnaires that are consistent with current medical recommendations.

Conclusions. Sudden cardiac death is a rare event in young athletes. Although scientific evidence is lacking to support cardiovascular preparticipation screening, such screening is recommended based on cost, medical, and legal concerns. Physicians who care for young athletes should be knowledgeable of recent medical guidelines for performing PPEs and for determining eligibility for participation. Current knowledge and understanding of the PPE needs to be applied to encourage uniform nationwide standards.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 Interim AMA Meeting.

1. AMA Policy H-470.971 is amended to read: "To promote the health and safety of adolescents, the AMA recommends that state medical societies work with appropriate state and local agencies to promote the following: (a) The development of standards for preparticipation athletic examinations that are consistent with consensus recommendations of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine. (b) Only MDs, DOs, and licensed physician extenders practicing under the supervision of licensed MDs and DOs perform preparticipation examinations. (c) The decision of whether or not an adolescent is healthy and physically mature enough to participate in a particular sport is made by a qualified physician. (d) The decision of when an injured athlete resumes participation is made by a qualified physician. (e) The most current guidelines established by the American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, and other appropriate specialty societies are used to determine eligibility for sports participation."

2. The AMA will work with appropriate medical specialty societies to increase 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.
3. The AMA will submit this report to the Preparticipation Physical Evaluation Task Force (comprised of representatives of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine) requesting that American Heart Association recommendations for (a) family history of heart disease; (b) a specific item for recognition of a heart murmur in the physical examination; and (c) a specific item for recognition of the physical stigmata of Marfan syndrome be considered in future iterations of the Preparticipation Physical Evaluation form.

NOTE: The full text of this report has been published: Lyznicki JM, Nielsen NH, Schneider JF, for the Council on Scientific Affairs. Cardiovascular screening of student athletes. *Am Fam Physician*. 2000;62:765-781. (August 15)

Prevention Research (CSA Rep. 6, I-99)

NOTE: Because of the brevity of this report, the full text is given here.

At the American Medical Association (AMA) 1998 Interim Meeting, the House of Delegates adopted Resolution 418, introduced by the American College of Preventive Medicine. In accordance with the resolution, the Council on Scientific Affairs is to submit an informational report to the House of Delegates that summarizes progress toward a national prevention research agenda and support for that agenda. The resolution asked:

That the American Medical Association work in partnership with the Centers for Disease Control and Prevention (CDC), the National Institutes of Health, and other Federal Agencies, the Public Health Community (via the medicine/public health initiative), and the managed care community to develop a national prevention research agenda and report back to the House of Delegates the current status of this agenda; and that these groups work in partnership to develop a practical plan to implement recommendations which will allow such groups to support and participate more fully in prevention research.

This report identifies AMA policies that support cooperative medicine and public health efforts, research funding, and prevention activities. The report then examines the Medicine and Public Health Initiative (M&PHI) and its Research Subcommittee as a mechanism to respond to the activities requested in Resolution 418.

Methods

The policies of the AMA were reviewed as well as the work of the M&PHI and its Research Subcommittee in light of actions requested in Resolution 418.

AMA Policy

Current AMA Policies H-440.911 and H-440.912 (*AMA Policy Compendium*) support joint medicine and public health efforts through the M&PHI. Recommendation 3 of Policy H-440.911 calls for the creation of joint research efforts and a common research agenda for public health and medicine. The AMA is co-chair of the M&PHI along with the American Public Health Association. Others on the M&PHI are the CDC, National Institutes of Health, other federal health agencies and the public health community, the groups that Resolution 418 wishes to unite in action on prevention research.

The AMA has substantial policy that encourages prevention research, including funding, and prevention for specific diseases and circumstances: health promotion and disease prevention

(H-425.993); clinical preventive services (H-425.984, H-425.987, H-425.988); population-based practice (H-285.971); health information and education (H-170.986); Healthy People 2000 (H-425.986); biomedical research (H-460.926); research funding (H-460.983); health care reform (H-460.943); injury (H-10.982, H-15.990); HIV (H-20.936); suicide (H-60.980); drug abuse (H-95.976, H-95.978); perinatal addiction (H-420.962); alcohol (H-420.976); environment (H-135.973, H-135.999); sickle cell anemia (H-350.999); folic acid (H-440.915); immunization (H-440.991); technology assessment (H-480.984); smokeless tobacco (H-490.974); and violence (H-515.979).

Prevention Research and the M&PHI

Joint medicine and public health research efforts constitute one of the seven fundamental goals established at the founding of the M&PHI. The focus is not only on cooperative research efforts of medicine and public health but also on a shared vision of necessary research and encouragement for public and private agencies to provide funding for these research efforts.

Prevention Research and the M&PHI Research Subcommittee

The recently formed Research Subcommittee of the M&PHI is chaired by Roger Bulger, MD, president of the Association of Academic Health Centers, and co-chaired by William Roper, MD, dean of the School of Public Health, University of North Carolina and former director of the CDC. Members of the Research Subcommittee are David Atkins, MD, MPH, dean, School of Public Health, University of Texas-Houston; Ruth Berkelman, MD, senior advisor to the director of the CDC; William Harlan, MD, associate director for disease prevention, National Institutes of Health; Patricia Mullen, DrPH, professor, Center for Health Promotion, University of Texas-Houston; F. Douglas Scutchfield, MD, MPH, director, Center for Health Science Management and Development, College of Allied Health Professions, University of Kentucky; Edward Sondik, PhD, director, National Center for Health Statistics; Stephen Thacker, MD, MSc, director, Epidemiology Program Office, CDC; and Steve Wolffe, MD, family practice, Medical College of Virginia.

The focus of this newly formed subcommittee is to convene a conference on prevention research, with special attention to community prevention concerns, and to develop and disseminate the research agenda that is formulated at this meeting of experts. The Research Subcommittee is still in the planning stage for a conference, and therefore there is no progress to report on a national prevention research agenda at this time.

The Council on Scientific Affairs will make a subsequent report, as appropriate, on the progress of the Research Subcommittee of the M&PHI, the national prevention research agenda, and support for implementation of a national prevention research agenda.

RECOMMENDATIONS

Because this is an informational report, it does not contain Recommendations.

**Sexuality Education, Abstinence, and Distribution of Condoms in Schools
(CSA Rep. 7, I-99)**

SUMMARY

Objective. To identify appropriate actions regarding approaches to sexuality education including abstinence-only, safer sex, and the free distribution of condoms in schools based on a review of the recent medical literature, and to consolidate existing American Medical Association (AMA) policy on these issues.

Methods. Databases searched included MEDLINE, HealthSTAR, and the Combined Health Index Database that is maintained by the Centers for Disease Control and Prevention. This cross-disciplinary search spanned the years 1990 - 1999. Interviews were conducted with leading authorities on adolescent pregnancy and abstinence education. Relevant AMA policies were reviewed.

Findings. Abstinence-only, safer sex, and condom distribution programs vary with respect to outcomes. Abstinence-only programs are characterized by limited evaluations, and there are no published studies that measure behavioral effects of the curricula. Evaluations of safer-sex sexuality education show inconsistent but promising results. School-based condom availability programs do not hasten the initiation of sexual intercourse, are viewed favorably by students, and usually demonstrate increased condom use.

Conclusions. Comprehensive approaches to sexuality education can be included in a health education program that is designed to meet the informational and skills needs of both those students who have not yet made their sexual debut and those who may already have initiated sexual activity. Condom availability can be a service component of a comprehensive sexuality education program. Monitoring the research findings related to evaluations of comprehensive sexuality education curricular approaches and condom availability programs should precede decisions to support one approach exclusively.

Current AMA policies are adequate to address sexuality education, abstinence education, and condom distribution. This report recommends consolidation of these policies to enhance their accessibility.

RECOMMENDATIONS

As recommended by the Council on Scientific Affairs, AMA policy on this subject was consolidated by the AMA House of Delegates at the 1999 AMA Interim Meeting, as follows:

1. The AMA recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction.
2. The AMA urges schools to implement comprehensive, developmentally appropriate sexuality education programs that (a) are based on rigorous, peer reviewed science; (b) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (c) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (d) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (e) include ample involvement of parents, health

- professionals, and other concerned members of the community in the development of the program; and (f) are part of an overall health education program.
3. The AMA will continue to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate.
 4. The following AMA policies are rescinded: H-420.983; H-170.994; H-170.978; H-170.974; H-170.973; and H-75.997.
 5. The AMA will work with the US Surgeon General to design programs that address communities of color and youth in high-risk situations within the context of a comprehensive school health education program.

Establishing Disability in Various Stages of HIV Infection (CSA Rep. 8, I-99)

SUMMARY

Objective: To clarify the different interpretations of the terms "impairment" and "disability" and to identify the role of physicians in assessing impairment and disability, especially in patients with human immunodeficiency virus (HIV) infection.

Methods: Legal statutes and policies from leading national and international associations, including the American Medical Association, World Health Organization, Social Security Administration, and the Institute of Medicine were reviewed to assess their positions on impairment and disability assessment. Further information was obtained from a MEDLINE search of English-language articles published from 1986-1999, using the key words *impairment*, *disability*, *HIV*, and *workers compensation*. Additional information was obtained from consultation with experts in this field.

Results: Although impairment has similar definitions and applications, criteria for disability determination are situation-specific, primarily applied to the ability to perform activities of daily living or work. Therefore, leading organizations have different views on how disability is determined. There is a trend towards de-emphasizing disability and emphasizing abilities and activity limitations. Asymptomatic HIV infection is considered a medical impairment. According to the Americans with Disabilities Act, individuals with asymptomatic HIV infection have a disability in reproduction and are regarded as being medically impaired, therefore qualifying them for protection against discrimination. According to the Social Security Administration and most workers compensation statutes, an asymptomatic individual with HIV infection is not disabled from working and, therefore, would not qualify for Social Security or workers compensation benefits.

Conclusions: The role of the physician is to determine medical impairment, and assess function and any limitations of activity due to the medical impairment. The physician can provide information on how the impairment affects the individual's ability to perform specific activities of daily living. State and federal jurisdictions determine disability awards, although the determination of disability requires collaboration between physicians and the requesting parties.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 Interim AMA Meeting.

1. In settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines.
2. The AMA advocates further study to define the residual function and limitations associated with impairments.
3. The AMA encourages physicians to contribute their medical expertise to disability determinations.

**Consensus Statement of the Physician Leadership on National Drug Policy
(CSA Rep. 9, I-99)**

SUMMARY

The Physician Leadership on National Drug Policy is an ad hoc group of physicians with experience in health, medical care, and policy development. In June 1997, this group developed and adopted a Consensus Statement on national drug policy toward illegal drugs. In the belief that elements of their Consensus Statement are aligned with current American Medical Association (AMA) policy, this group has asked for AMA endorsement of the Consensus Statement. The Council on Scientific Affairs (CSA) has reviewed the document.

Conclusion

The main elements of the Physician Leadership on National Drug Policy Consensus Statement are consistent with AMA policy. Because of the large public health impact, programmatic and advocacy activities of the AMA appropriately emphasize tobacco and alcohol issues. These are not the focus of the Consensus Statement.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting.

1. The AMA endorses the 1997 Consensus Statement of the Physician Leadership on National Drug Policy as a rational approach to informing national drug policy on illegal drugs.
2. The AMA will promote medical approaches to substance use disorders by continuing to encourage physician involvement in case identification, diagnostic assessment, clinical therapeutic interventions, medical evaluation and management, and ongoing chronic disease management, as appropriate, for cases of alcohol and other drug addiction.
3. The AMA continues to believe that the legalization of illegal drugs would be contrary to the best interests of the public health and support for the positions of the Physician Leadership on National Drug Policy ought not be construed as support for such legalization.

Neonatal Circumcision (CSA Rep. 10, I-99)

SUMMARY

Objective. To review the epidemiology of routine neonatal circumcision, its potential medical risks and benefits, and the effectiveness of available pain control techniques in order to inform parental decision-making.

Data Sources. Published studies from the years 1966 to July 1999 were identified through MEDLINE and Lexis/Nexis Medical Library searches of English-language articles using the key words *circumcision*, *male*, *adverse effects*, and *pain control*. Related articles in the MEDLINE database using the additional MeSH term *pain prevention & control*, also were identified. A total of 338 articles were retrieved. Additional articles were identified by manual review of the references cited in these publications.

Data Synthesis. A majority of boys born in the United States continue to receive nonritual circumcisions. Circumcision decreases the incidence of urinary tract infections in the first year of life, and also protects against the development of penile cancer later in life. However, the low incidence of these conditions minimizes the potential medical benefits compared to risks of circumcision. The circumcised male also may be somewhat less susceptible to human immunodeficiency virus (HIV) infection and certain sexually transmissible diseases, but behavioral factors are far more important in preventing these infections than the presence or absence of a foreskin.

Neonates experience pain during the circumcision procedure, which can be blocked or minimized through the use of several local anesthetic techniques. Ring block or dorsal penile blocks using lidocaine are most effective. EMLA cream has more limited utility but has not been sufficiently investigated with regard to dose-response effects.

Conclusions. Although potential medical benefits are associated with newborn male circumcision, these data are not sufficient to recommend routine performance of this procedure on medical grounds. However, in the United States, parental decision-making appears to be based on social and cultural rather than medical concerns. When the decision is made to proceed with circumcision, local anesthesia should be provided for the procedure.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting.

1. The AMA encourages training programs for pediatricians, obstetricians, and family physicians to incorporate information on the use of local pain control techniques for neonatal circumcision.
2. The AMA supports the general principles of the 1999 Circumcision Policy Statement of the American Academy of Pediatrics, which reads as follows: Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision. In circumstances in which there are potential benefits and risks, yet the procedure is not essential to the child's current well-being, parents should determine what is in the best interest of the child. To make an informed choice, parents of all male infants should be given accurate and unbiased information and be provided the opportunity to discuss this decision. If a decision for circumcision is made, procedural analgesia should be provided.
3. The AMA urges that as part of the informed consent discussion, the risks and benefits of pain control techniques for circumcision be thoroughly discussed to aid parents in making their decisions.

School Violence (CSA Rep. 11, I-99)

SUMMARY

Objective: A number of school shootings over the last few years have raised awareness of violence in the nation's schools. Responding to a resolution, this report surveys the literature on three specific issues: the incidence of school violence, the effects of media coverage of events, and the efficacy of school-based violence prevention programs. The report is only an initial component of the AMA's pending project on youth violence.

Data Sources: The literature reviewed for this report came from computer searches using *violence* and *schools* as the search term. Searches were conducted via MEDLINE as well as the Online Computer Library Center, which permitted searches of the education literature. In addition, recent books on the topic were surveyed.

Findings: School violence is a serious issue, with several hundred thousand incidents each year. Although schools in this country are relatively safe, recent instances of multiple homicides in schools have raised public concerns that schools may be becoming less safe. The dramatic nature of these episodes requires investigation into the causes of such events as well as into programs that might prevent further tragedies. At the same time, school-aged youths are much more likely to be victimized away from school than in school (or at school-related functions), and unintentional injuries at school are far more common than violence-related injuries. As such, efforts to address violence in the schools should not detract from efforts to address these other sources of injury morbidity among youths. The effect of media coverage of violent events in school is unknown. School-based violence prevention programs show some promise, particularly those that involve parents or engage whole communities, but few programs have been adequately evaluated.

RECOMMENDATION

The following statement, recommended by the Council on Scientific Affairs, was adopted by the AMA House of Delegates as an AMA directive at the 1999 AMA Interim Meeting:

The American Medical Association will collaborate with the US Surgeon General on the development of a comprehensive report on youth violence prevention, which should include such issues as bullying, racial prejudice, discrimination based on sexual orientation, and similar behaviors and attitudes.

Organ Allocation (CSA Rep. 12, I-99)

SUMMARY

Substitute Resolution 505 (A-98) on organ transplants, referred to the Board of Trustees for decision, asked that the: "American Medical Association (AMA) commend the United Network of Organ Sharing (UNOS) for the tremendous progress it has made in organ transplantation; and urge the US Department of Health and Human Services (DHHS) and UNOS to work together in order to correct the disparities in the present system of organ distribution and allocation; and support the original intent of National Organ Transplant Act (NOTA) which gave DHHS oversight responsibility and gave the primary responsibility to the transplant community including the organ transplant professionals for developing policy; and promote greater professional and public awareness of the urgent need for increased organ donation."

Resolution 522, introduced by the Organized Medical Staff Section at the 1998 Interim Meeting and referred to the Board of Trustees, asked:

That our AMA Policy H-370.990 (*AMA Policy Compendium*), "Transplantable Organs as a National Resource," be amended to state that organs and tissues retrieved for transplantation be treated as a resource for local, then regional and finally, national distribution.

Conclusion

The AMA recognizes that the just allocation of organs is an exquisitely complex process and that disparities continue to exist in organ availability across geographic regions. The requirement in the proposed final rule for elimination of geographical boundaries is consistent with AMA policy. Some of the controversy in the proposed final rule relates to the need for clarification of the DHHS intent concerning the extent of Organ Procurement and Transportation Network (OPTN) oversight. The AMA supports an oversight role of the DHHS that is intended to foster equitable access to organs. The AMA further believes that ethical consensus in concert with proper medical practice, as established by the professional transplant community, should underpin any changes in allocation policy. To this end, it is reasonable that a rigorous evaluation of the current technologies used in organ procurement and transplantation be used to support any significant change in the current organ transplantation policy. The Council believes that the AMA should endorse the creation of an "independent, multidisciplinary, scientific review board responsible for assisting the DHHS Secretary in ensuring that the allocation system of the OPTN is grounded on the best available medical science and is as effective and as equitable as possible" as recommended by the Institute of Medicine. Finally, it can not be over emphasized that increased organ donation is the most critical component in achieving an equitable allocation strategy. Physicians can be effective advocates for encouraging their families, staff, and patients to become organ donors.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting.

1. The AMA supports the United Network of Organ Sharing (UNOS) policy calling for regional allocation of livers to status 1 (most urgent medical need) patients as an effort to more equitably distribute a scarce resource;
2. The AMA supports the findings and recommendations of the Institute of Medicine Committee on Organ Procurement and Transplantation Policy; and

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3. The AMA will monitor the outcome of the proposed final rule: "Organ Procurement and Transplantation" issued by the Department of Health and Human Services and respond as appropriate.
4. Policies H-370.990, H-370.982, and H-370.983 are reaffirmed.

Update on Clinical Research (CSA Rep. 13, I-99)

SUMMARY

This report responds to the first resolve of Resolution 309 (I-98), which asked "That our American Medical Association (AMA) report as part of its Clinical Research Summit activities on the need for a national clinical research agenda to establish resource allocation priorities." Resolution 309 (I-98) was introduced by the Illinois Delegation and referred to the Board of Trustees.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting.

1. The AMA supports the findings of the National Clinical Research Summit as developed at the Graylyn Consensus Development Conference, November 20-22, 1998;
2. The AMA actively supports the establishment of the Clinical Research Roundtable as a component of the National Academy of Sciences/Institute of Medicine and Commission on Life Science; and
3. The AMA reaffirms policies H-55.987, H-315.983, H-460.926, H-460.930, H-460.933, H-460.965, H-460.982, H-460.986, H-460.998, H-460.999, and H-460.990.

Screening and Brief Interventions for Alcohol Problems (CSA Rep. 14, I-99)

SUMMARY

Background: Alcohol use disorders are common and important. Prevalence studies suggest that in the United States, 20% of men and 10% of women drink above recommended limits of alcohol use (for men > 2 drinks/day or >4 drinks/occasion; for women >1 drink/day or >3 drinks/occasion) and are at risk for a variety of health and social problems. Alcohol use is implicated in many health and social problems including hypertension, glucose intolerance, cardiovascular disease, depression, suicide, trauma, cancer, violence, child abuse, family health problems, tobacco use, illicit drug use, and prescription drug abuse.

Methods: A comprehensive review of the literature was performed to assess the current scientific evidence that supports the prevention and treatment of alcohol use disorders in medical care settings.

Conclusions: The medical care community has a major role in this area of clinical medicine. There are a number of screening tests that identify persons at-risk and a variety of effective treatment methods are available, including pharmacotherapy. Implementation of systematic screening and treatment protocols can reduce alcohol use, health resources utilization, and health care problems in patients seen in medical care settings.

Recommendations: Physicians should establish routine alcohol screening procedures for all patients over the age of 14 years. Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing, and such training should become a regular part of medical school curricula. Medical care settings should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine. It is further recommended that the American Medical Association urge the National Committee on Quality Assurance to consider developing a Health Plan Employer Data and Information Set (HEDIS) measure on screening patients over the age of 14 years for alcohol use disorders.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting.

1. The AMA in conjunction with medical schools and appropriate specialty societies will advocate curricula, actions and policies that will result in the following steps to assure the health of patients who use alcohol: (a) Primary care physicians should establish routine alcohol screening procedures (e.g., CAGE) for all patients, including children and adolescents as appropriate, and medical and surgical subspecialists should be encouraged to screen patients where undetected alcohol use could affect care. (b) Primary care physicians should learn how to conduct brief intervention counseling and motivational interviewing. Such training should be incorporated into medical school curricula and be subject to academic evaluation. Physicians are also encouraged to receive additional education on the pharmacological treatment of alcohol use disorders and co-morbid problems such as depression, anxiety, and post-traumatic stress disorder. (c) Primary care clinics should establish close working relationships with alcohol treatment specialists, counselors, and self-help groups in their communities, and, whenever feasible, specialized alcohol and drug treatment programs should be integrated into the routine clinical practice of medicine.

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2. The AMA will urge the National Committee on Quality Assurance to consider developing a HEDIS (Health Plan Employer Data and Information Set) measure for problem drinking or alcohol use disorders.

Embryonic/Pluripotent Stem Cell Research and Funding (CSA Rep. 15, I-99)

SUMMARY

Objective. To examine the science, policy implications, and American Medical Association (AMA) initiatives and activities with regard to the current debate about pluripotent stem cell (PSC) research and funding.

Methods. English-language articles were identified from a MEDLINE search for the years 1980 through October 1999. The Internet was searched for governmental and medical/bioethics/private sector sites that provided information on the positions of those supporting and those opposing PSC research and funding. AMA policy and activities related to PSC research and funding issues were identified.

Findings. PSC research offers the possibility for numerous clinical applications; potentially treatable diseases include juvenile-onset diabetes mellitus, myocardial infarction, neurodegenerative diseases (i.e., Parkinson's disease), spinal cord injury, and hematopoietic regeneration following marrow ablation for malignancy. However, stem cell research continues to generate controversy, with federal funding as a central question. To date, PSC research has been funded by the private sector. Support for PSC research and federal funding has come from a broad spectrum of the scientific community, as well as from patient advocacy groups (eg, the Patient's Coalition for Urgent Research). Opponents argue that PSC research--by using cells derived from embryos and aborted fetuses--destroys human life and will lead to increased demand for fetal tissues; they oppose federal funding for PSC research and advocate further legal restrictions, including stringent informed consent requirements. The AMA has supported research utilizing human PSCs and endorsed the National Institutes of Health plan to develop clear guidelines to address the specifics of funding, as well as scientific, legal, and ethical issues. In September 1999, the National Bioethics Advisory Committee recommended that federal funding be allowed to permit scientists to both experiment with and derive stem cells from human embryos that were originally created for infertility treatments, as well as to conduct research on stem cells that are derived by groups funded by the private sector.

Conclusions. There appears to be a consensus that federal funds should not be used to create embryos for stem cell research (as opposed to the use of PSC derived from embryos remaining after infertility treatment). Controversy will continue on the issue of public scrutiny of this research, which holds great potential for advancing medical care and understanding basic mechanisms of developmental biology. How to apply public scrutiny and the use of federal funds to effect public oversight will require continued vigilance to this area of biomedical research. The Council on Scientific Affairs recommends that the AMA encourage strong public support of federal funding for PSC research; support the recommendations of the National Bioethics Advisory Committee; and continue to monitor PSC research and update AMA policy as required.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1999 AMA Interim Meeting:

1. The AMA encourages strong public support of federal funding for research involving human pluripotent stem cells (PSC);
2. The AMA supports the recommendations of the National Bioethics Advisory Commission (NBAC) report, "Ethical Issues in Human Stem Cell Research, September 1999", which include: (a) research involving the derivation and use of human embryonic germ cells (EGC) from fetal tissue cadavers should continue to be eligible for federal funding; (b) research involving the derivation and use of human embryonic stem cells (ESC) [ie, PSC]

- from embryos remaining after infertility treatments should be eligible for federal funding; (c) federal agencies should not fund research involving the derivation or use of human ESC from embryos made either solely for research purposes using IVF, or made using somatic cell nuclear transfer into oocytes; (d) prospective donors of embryos remaining after infertility treatments should receive timely, relevant, and appropriate information to make informed and voluntary choices; (e) in federally funded research involving embryos remaining after infertility treatments, researchers may not promise donors that ESC derived from their embryos will be used to treat patient-subjects specified by the donors; (f).embryos and cadaveric fetal tissue should not be bought or sold;(g) DHHS should establish a National Stem Cell Oversight and Review Panel to ensure that all federally funded research involving the derivation and/or use of human ESC/EGC is conducted in conformance with the ethical principles and recommendations contained in the NBAC report; (h) protocols involving the derivation of human ESC and EGC should be reviewed and approved by an institutional review board (IRB) or by another appropriately constituted and convened institutional review body prior to consideration by the Oversight and Review Panel; (i) for privately funded research projects that involve ESC or EGC that would be eligible for federal funding, private sponsors and researchers are encouraged to adopt voluntarily the applicable recommendations of the report; and (j) the National Stem Cell Oversight and Review Panel should be chartered for a fixed period of time, not to exceed five years.
3. The AMA will continue to monitor PSC research and update AMA policies as required with reference to advances in this field.

CSA Rep. 16, I-99 *Report Not Available*

**Organized Medicine's Role in the National Response to Terrorism: Update 1
(CSA Rep. 17, I-99)**

NOTE: Because of the brevity of this report, the full text is given here.

At the 1999 Annual Meeting, the American Medical Association (AMA) House of Delegates adopted the recommendations, as amended, in Council on Scientific Affairs (CSA) Report 4, "Organized Medicine's Role in the National Response to Terrorism." These recommendations, which were adopted in lieu of Resolutions 426 and 432 (A-99), are:

1. That the AMA and the Federation of Medicine work with appropriate public health, law enforcement, hospital, and emergency response agencies and associations, as well as the pharmaceutical industry and media to develop coordinated plans and strategies that identify the specific needs, roles, contributions, and participation of organized medicine and individual physicians in disaster planning and emergency response to terrorist attacks and identify procedures for the rapid detection, early reporting, and medical management of affected individuals.
2. That the AMA and the Federation of Medicine sponsor a planning conference on this topic immediately preceding the Interim 1999 AMA Meeting and invite all interested parties to help develop such plans and strategies, and that the plans developed from these efforts be reported back to the House of Delegates at the Annual 2000 AMA Meeting.
3. That the AMA urge medical schools and residency programs to develop curricula and training programs for medical students and residents regarding medical and public health aspects of biological and chemical terrorism, as well as community disaster planning and emergency response procedures in the event of such terrorism.

In implementing recommendations 1 and 2, the CSA confirms the need for an AMA-sponsored conference. This need stems from the premise that although the nation is investing major resources to prepare for, and respond to, acts of terrorism, organized medicine has not been involved in the planning process. This omission must be remedied because in an actual terrorist event physicians will care for victims and ultimately will implement many of the responses being proposed. A vehicle is needed that can bridge this gap between practicing physicians and national planners. The Federation of Medicine, which includes county, state, and specialty medical societies and represents the great majority of American physicians, is that ideal vehicle. As the largest and most diverse component of the Federation, the AMA can serve to convene and facilitate the needed interactions between medical societies and other stakeholders in this area.

Shortly after the 1999 Annual Meeting, the CSA began planning for a conference to be conducted in San Diego, California, immediately preceding the 1999 Interim House of Delegates Meeting. It became apparent that such a conference would need to include educational content on the threat of terrorism and on medical issues in counterterrorism preparation. This background would help the participants develop model plans and recommendations for organized medicine. As the CSA was discussing ways to provide this educational content, it became aware of another conference focusing on educational issues to be held in San Diego in February 2000, sponsored by the University of San Diego College of Medicine, San Diego County, and the Johns Hopkins Center for Civilian Biodefense Studies. Because of the close proximity of this meeting to the 1999 Interim Meeting, the logistical problems of conducting another meeting in conjunction with the 1999 Interim Meeting, and because many important stakeholders will be attending the February conference in San Diego, the AMA agreed to serve as a co-sponsor for this conference to help

inform stakeholders on the educational issues and to foster a cooperative relationship with the Johns Hopkins Center.

Subsequently, the CSA was contacted by military physicians in the House of Delegates and invited to participate in a Department of Defense conference being planned for April 3-6, 2000. Called "Medic WMD 2000," the conference will present information on the weapons of mass destruction that might be used by terrorists and highlight the military and other federal medical and public health resources that will be available if an act of terrorism occurs. The intended audience of this conference is the civilian medical and public health communities.

The CSA has concluded that the will of the House of Delegates can be better served by joining "Medic WMD 2000" than by convening a separate AMA-sponsored meeting. Any disadvantage caused by delaying a planning conference for four months will be offset by the rich educational content that will be provided by military and federal representatives at "Medic WMD 2000." A joint conference also will take advantage of efficiencies of scale and avoid duplications. For these reasons the Council has agreed to participate in "Medic WMD 2000," and a member of the Council will speak at the opening plenary session. During the conference, Council members will lead planning discussions at AMA breakout sessions to achieve the goals set forth in CSA Report 4 (A-99). The Council wishes to thank the Department of Defense and in particular the Office of the Surgeon General of the United States Army, which is organizing "Medic WMD 2000" and has generously invited the AMA to participate.

The CSA encourages state, county, and specialty medical societies to send representatives to "Medic WMD 2000." The Council will also contact societies directly to encourage participation, and will assist in publicizing the conference. The Council will report back to the House at the 2000 Annual Meeting to describe the outcome of the conference. In the interim, interested members of the House of Delegates and their medical societies are invited to contact the CSA office at AMA headquarters for more information on "Medic WMD 2000."

RECOMMENDATIONS

Because this is an informational report, it does not contain Recommendations