

1998 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.*

1998 AMA Interim Meeting

Summaries and Recommendations of Council on Scientific Affairs Reports

Priorities in Clinical Preventive Services (CSA Rep. 1, I-98)

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

Resolution 509, introduced by the Colorado delegation at the 1997 Interim Meeting (I-97), was referred to the Board of Trustees. The House of Delegates adopted a related resolution, Substitute Resolution 509, "AMA Role in Prioritization of Preventive Services and Patient Education." Substitute Resolution 509 asked: "That the American Medical Association (AMA), with input from national specialty societies, become the body to determine the comparative value of preventive services, considering the following factors for each: the degree of benefit; likelihood of benefit; duration of benefit; cost; and whether the service will protect the public as well as the individual patient; that the AMA become the resource to provide education to the public and physicians on the value of different preventive services; that for those health plans which traditionally include preventive services, our AMA continue to work for inclusion of those services that rate highest in their evaluation; and that a progress report be presented within one year to the House of Delegates, and at least every other year thereafter on the progress of this program." The Board of Trustees referred the resolution to the Council on Scientific Affairs (CSA) for a report at the 1998 Interim Meeting.

The AMA has supported the idea of periodic health examinations, including preventive care, for decades. The AMA first called for annual physical examinations in 1947. Since that time, thinking about what should be included in a periodic health examination has changed, moving toward the evidence-based approach pioneered in 1979 by the Canadian Task Force on the Periodic Health Examination and subsequently adopted by the US Preventive Services Task Force (USPSTF), among others. The AMA supports the use of the latest guidelines from the USPSTF¹ as one resource for helping physicians tailor periodic health examinations for their patients. Physicians often use the opportunity presented by the periodic health visit to provide cancer screening and other preventive services.²

Conflicts may arise, however, when conflicting recommendations about the same service come from multiple sources that physicians trust, such as the National Cancer Institute, the American Cancer Society, and a medical specialty society. Taken with the fact that physicians feel busier than ever, and find it difficult to provide preventive services during a patient's visit for treatment of an illness or a problem seemingly unrelated to prevention, it is not surprising that preventive services are often omitted.

Recently, a nonprofit coalition of health groups, the "Partnership for Prevention," formed a Committee on Clinical Preventive Service Priorities to study the relative importance of clinical preventive services. Committee members represent clinicians, state and local public health agencies, health plans, purchasers of health care, consumer advocacy groups, and universities. With support from the Centers for Disease Control and Prevention and from the Health Care Financing Administration, the group investigated how best to set priorities for preventive care,

using the services recommended by the USPSTF for the general population of asymptomatic primary care patients.

Several criteria were identified by the committee for systematic application to the list of services:

- Burden of disease that could be prevented by the service or counseling
- Effectiveness of the service
- Cost effectiveness

For each service, the committee assembled evidence on each of the criteria based on an extensive literature search and expert opinion where data were not sufficient. This information was used to weigh the services on each of the three dimensions and obtain a cumulative priority score for each service. A draft of the findings, with a preliminary priority ranking, has been written. The Partnership anticipates completion of the project by the end of 1998.

The CSA recognizes that considerable effort, expertise, and resources have been expended on this project, and finds no reason to duplicate it. Further study on prioritization of preventive services should be considered, as new evidence becomes available about the utility of particular services. If possible, the priority list should be updated regularly. As the opportunity arises, the AMA should participate in this process.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting:

- (1) The AMA commends the Partnership for Prevention for its activity in studying clinical preventive services priorities and will review the report of the Committee on Clinical Preventive Service Priorities as soon as it is available.
- (2) The AMA will explore participating in further refinement and future versions of the Committee on Clinical Preventive Service Priorities report.
- (3) When the final report of the Partnership for Prevention becomes available, the Council on Scientific Affairs will evaluate and prepare a concise summary of the report for wide dissemination.

References

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2. Sox CH, Dietrich AJ, Tosteson TD, Winchell CW, Labaree CE. Periodic health examinations and the provision of cancer prevention services. *Arch Fam Med.* 1997;6:223-230.

Physician Education of Their Patients About Prescription Medicines (CSA Rep. 2, I-98)

SUMMARY

Objectives. This Council on Scientific Affairs (CSA) report responds to referred Resolution 501 (I-97) and addresses the topic of physician education of their patients about prescription medicines. The report: 1) provides an overview of medication compliance; 2) reviews Food and Drug Administration (FDA) and AMA surveys of consumers on receipt of oral and written prescription medicine information from physicians; 3) describes past AMA efforts and current AMA policies regarding patient medication information; 4) discusses the development and AMA Board of Trustees' approval of Guidelines for Physicians for Counseling Patients About Prescription Medications in the Ambulatory Setting; 5) evaluates the role of patient medication cards in routine medication reviews; and 6) offers recommendations for physicians and the AMA.

Methods. Articles on medication compliance were obtained as follows: 1) search of MEDLINE database (1993-1998) for all English-language articles on patient compliance and drug therapy; 2) search of MEDLINE and HealthSTAR databases (1990-1998) on the topic of the effect of physician-patient oral and written communication on patient compliance with drug therapy; 3) from a Topical Bibliography on Prescription Medicine Compliance (published by the National Council on Patient Information and Education in 1995); and 4) from the bibliography in the FDA's 1995 Proposed Rule entitled, "Prescription Drug Product Labeling; Medication Guide Requirements." Articles on patient medication cards were obtained from a search of the MEDLINE database (1988-1998) using the phrase, medication card. The Guidelines for Physicians for Counseling Patients About Prescription Medications in the Ambulatory Setting were developed over a period of four months by a Working Group convened by the AMA, and that included physician representatives from the AMA and five medical specialty societies. The AMA's Board of Trustees approved the counseling guidelines in September 1996.

Results. The report documents that medication noncompliance is a serious problem for a wide range of diseases, resulting in adverse health and economic consequences. Despite a multitude of studies, there are few well-controlled trials that assess interventions to improve compliance and outcomes. However, most experts concur on a series of educational and behavioral strategies that physicians can use to improve patient compliance with therapy. Consumer survey data indicate that some patients receive no information from their physicians when prescribed a new medication, and often the information provided is incomplete. The Guidelines for Physicians for Counseling Patients About Prescription Medications in the Ambulatory Setting were prepared to help physicians provide useful oral counseling and, when appropriate, written information about prescription medications that are prescribed for their patients in the ambulatory setting. These guidelines provide concise and useful recommendations in five key areas: the medication record, the treatment plan, oral counseling about the medication, written information about the medication, and follow-up. Published data on the value of patient medication cards are limited.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting:

1. AMA Policy H-165.896 (7) is modified to read as follows: "The AMA encourages physicians to counsel their patients about their prescription medicines and, when appropriate, to supplement with written information; and supports the physician's role as the 'learned intermediary' about prescription drugs." AMA Policy H-115.991, regarding the discontinued Patient Medication Instruction (PMI) program, is rescinded.
2. The AMA supports and will widely disseminate the Guidelines for Physicians for Counseling Patients About Prescription Medications in the Ambulatory Setting.

3. The AMA encourages physicians to incorporate medication reviews, including discussions about drug interactions and side effects, as part of routine office-based practice, which may include the use of medication cards to facilitate this process. Medication cards should be regarded as a supplement, and not a replacement, for other information provided by the physician to the patient via oral counseling and, as appropriate, other written information.
4. The AMA will continue to participate on the National Council on Patient Information and Education (NCPIE) to foster better medication use through improved communication between physicians and their patients, and the AMA encourages state and specialty medical societies to become members of NCPIE.

Economic Impact of PASARR on Hospitals (CSA Rep. 3, I-98)

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

Resolution 802, introduced by the Indiana Delegation at the 1997 Interim Meeting and referred to the Board of Trustees, asked: "That the American Medical Association carefully scrutinize the whole Preadmission Screening and Annual Resident Review (PASARR) program at the national level to assess the actual impact of the program and cost effectiveness of the PASARR process as it applies to hospital-discharged nursing home admissions." Responsibility for the resolution was given to the Council on Scientific Affairs (CSA), and the Council has examined the available data on PASARR and its effectiveness to develop this report. Unfortunately, data on the aspects of PASARR of most concern in the resolution are severely limited. In fact, a review published earlier this year¹ reported only two published, peer-reviewed articles were available on preadmission screening of patients.

Preadmission Screening: According to Snowden and Roy-Byrne,¹ a 1986 report from the Institute of Medicine indicated that many mentally ill people were being discharged from state mental hospitals to nursing homes that could not provide appropriate services, and many of those who were appropriately admitted were not receiving necessary care; a more recent report on these problems has not been forthcoming. Partly as a result of inappropriate nursing home admissions, the Omnibus Budget Reconciliation Act (OBRA) of 1987 (PL 100-203) "required preadmission screening and annual resident review to ensure that mentally ill persons were not inappropriately admitted to nursing homes and to increase mental health services to residents who were appropriately placed." (1, p. 229) In 1996, PL 104-319 (the Medicaid Nursing Homes Annual Resident Review Act of 1996) revised the requirements for PASARR, making annual reviews optional based on state requirements.

In addition to preadmission screening, OBRA-87 regulated several aspects of nursing home care, including the use of antipsychotic medications and physical restraints. States were given discretion to implement PASARR requirements in ways that met local needs. However, while both medication and restraint use have been the subject of considerable research (see Snowden and Roy-Byrne¹ for a summary), the value of screening has all but been ignored. Only one of the two published reports cited by Snowden and Roy-Byrne deals directly with the issue of screening, and it used 1985 data to project the demand for mental health treatment among nursing home admissions rather than measure the value of screening.² Interestingly, the projections appear not to have been evaluated.

A recent report (not available at the time the Snowden and Roy-Byrne report was prepared) evaluated the PASARR process in King County, Washington.³ Using data from the implementation year of PASARR (1989), Borson and colleagues report that Washington state's two-step evaluation process detected certain seriously mentally ill patients (i.e., those with schizophrenia and bipolar disorder) in need of nursing home care but was less effective for detecting patients with affective disorders and dementias with significant neuropsychiatric symptoms. These findings highlight PASARR's limitations as a means of estimating the true need for mental health services in nursing homes and the need for changes in approaches to screening in order to improve the detection of the diverse affective, psychotic, and behavioral disorders that are prevalent in nursing home patients. The authors recommended trials of alternative case finding mechanisms. An additional report from Snowden and colleagues⁴ studied PASARR evaluations of Medicaid patients in Washington State for 1992 and 1993 and found that 59% of residents screened in the PASARR evaluation receive a recommendation for a new mental health service. However, compliance with these recommendations occurred on average only 35% of the time and was significantly less for specialty mental health services such as psychiatric consultation, therapy, or day treatment than for use of psychiatric medications. Similarly,

PASARR recommendations for placement found that one-fourth of the sample was recommended to go to a less intensive alternate disposition setting, yet only 29% of those with alternate disposition recommendations were placed in other settings. The authors conclude that PASARR, however well intentioned, may not be achieving the desired goals of more appropriate placement and improved mental health care. With the exception of a study of the Resident Assessment Instrument (required for all nursing home residents) that suggested a favorable impact on rates of decline in cognition and social engagement after implementation of systematic assessment,⁵ the Council has been unable to locate other relevant published research.

AMA Policy: Council on Medical Service (CMS) Report 3 (A-94) previously examined aspects of long-term care financing and elements of OBRA-87 as it relates to the regulation of long term care. That report recognized the need for some regulation of nursing home admissions while also acknowledging the apparently arbitrary and burdensome nature of some regulations, including requirements for annual review. Policy H-280.969 (AMA Policy Compendium), which is a consolidation of several prior policy statements including policy from the CMS report, states, "The AMA will continue to work with HCFA and other appropriate federal agencies in an effort to simplify the requirements and to reduce the administrative burdens imposed on physicians, other health professionals and long-term care facilities in implementing the provisions of OBRA-87 related to nursing home reform, including the elimination of the unnecessary and expensive regulations mandated by the Preadmission Screening and Annual Record Review, and the simplification of the Minimum Data Set requirement for long-term care facilities." Since the adoption of this policy, the requirement for annual reviews has been, as noted above, relaxed and depends on state regulations. Moreover, states still have the ability to seek a Medicare/Medicaid waiver allowing them sole authority to regulate long-term care facilities, which would allow them to create alternatives to PASARR.

Conclusion: While evidence suggests that some regulatory elements stemming from OBRA-87 have proven beneficial, particularly those regulations dealing with the use of psychoactive medications and physical restraints, there is a serious and unfortunate lack of data on the preadmission screening and annual resident review program. Despite serious concerns about and considerable criticism of the PASARR requirements, published material evaluating PASARR is practically nonexistent. Under these circumstances, the CSA is unable to assess the program as called for in the referred resolution. More importantly, the Council believes adequate data are not likely to become available in the absence of a review by HCFA or other appropriate federal agencies. The available data do suggest that some PASARR requirements may be useful, although procedures need refinement and improvement,^{3,5} but the evidence is merely suggestive. In addition, the issue is complicated by variation across states in policies and procedures for conducting PASARR evaluations. These are further reasons to seek an evaluation of the program by federal authorities.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting:

1. The AMA will work with HCFA to commission a study to examine: a) the efficacy of the Preadmission Screening and Resident Review (PASARR) program in meeting the original intent of identifying patients with active psychiatric disorders requiring treatment; b) the extent of variation among states in applying the PASARR program; c) the costs and benefits of PASARR screening; d) procedures to improve the sensitivity of the screening process; e) the identification of more appropriate care settings for patients who were considered by the process not to be appropriate for nursing home care (i.e., how many patients are screened out); and f) the extent to which recommended interventions and treatments are actually implemented.

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2. The AMA reaffirms AMA Policy H-280.969, which advocates for working with HCFA to simplify nursing home regulations and reduce related administrative burdens.

References

1. Snowden M, Roy-Byrne P. Mental illness and nursing home reform: OBRA-87 ten years later. *Psychiatr Serv.* 1998;49:229-233.
2. Eichmann MA, Griffin BP, Lyons JS, Larson DB, Finkel S. An estimation of the impact of OBRA-87 on nursing home care in the United States. *Hosp Commun Psychiatry.* 1992;43:781-789.
3. Borson S, Loebel JP, Kitchell M, Domoto S, Hyde T. Psychiatric assessments of nursing home residents under OBRA-87: should PASARR be reformed? *J Am Geriatr Soc.* 1997; 45:1173-1181.
4. Snowden M, Piacitelli J, Koepsell T. Compliance with PASARR recommendations for Medicaid recipients in nursing homes. *J Am Geriatr Soc.* 1998; 46:1132-1136.
5. Phillips CD, Morris JN, Hawes C, Fries BE, Mor V, Nennstiel M, Iannocchione V. Association of the Resident Assessment Instrument (RAI) with changes in function, cognition, and psychosocial status. *J Am Geriatr Soc* 1997;45:986-993.

Importation of Foreign Blood and Blood Products Into the United States (CSA Rep. 4, I-98)

SUMMARY

Objective. To address the safety of blood and blood products imported from foreign countries via an examination of the current scientific literature, media, and governmental regulations and legislation.

Data Sources. Literature searches were conducted in the MEDLINE and PREMEDLINE databases from 1980 through 1998 on the terms blood banking, blood safety, and blood regulations. Lexis/Nexis news databases were searched for current developments using the same terms. The World Wide Web was searched using the key terms blood safety and blood regulations and was used to access the Code of Federal Regulations, the United States Code, and the Food and Drug Administration (FDA) to determine legislative and regulatory actions and health surveillance. Another informational source was the FDA Office of Compliance memorandum entitled "AMA opposition to the importation of blood and blood products from foreign countries."

Data Extraction. English-language articles were selected based on their ability to provide information pertinent to the assessment of the mechanisms in place in the United States to protect the blood supply and the legislation and regulations present that govern the safety of imported blood and blood products.

Results. Current FDA standards for biological products and good manufacturing practices for drugs and devices apply to the production of blood and blood products in the United States. In addition, there are further standards and good manufacturing practices that are specifically applicable to blood and its components. Foreign blood and blood products are classified as biologics by the Public Health Act and require licensure prior to importation into the United States. As part of the licensure provision in the Public Health Act, these foreign biologics are subject to the same standards and good manufacturing practices as domestic biologics. Thus, the standards that are applied to imported blood and blood products are identical to those applied to domestic blood and blood products.

Conclusions. Blood and blood products that are imported into the United States are subject to the same standards and good manufacturing practices as blood and blood products derived in this country. This is a requirement of the licensure process that provides licenses to any facility or product that will be engaged in interstate or international movement of products. Foreign blood facilities must provide an unsuspended and unrevoked license; otherwise their products will be denied entry. Consequently, foreign blood and blood products should be as safe as domestic blood and blood products.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting.

1. The AMA supports current federal regulations and legislation governing the safety of imported blood and blood products.
2. The AMA will encourage the Food and Drug Administration to continue aggressive surveillance and inspection of foreign establishments seeking or possessing United States licensure for the importation of blood and blood products into the United States.
3. The AMA will request periodic reports from the Food and Drug Administration on the safety of imported blood and blood products.

Air Travel Safety (CSA Rep. 5, I-98)

SUMMARY

A resolution at the 1997 AMA Interim Meeting asked that the AMA endorse the White House Commission Report on Aviation Safety and Security, and that the AMA work toward the implementation of these goals and standards for air travel safety

In 1996, the crash of Trans World Airlines Flight 800 off New York raised national concern about the safety and security of civil aviation. In response, President Clinton created the White House Commission on Aviation Safety and Security. The Commission issued its Final Report in February 1997 with 57 recommendations pertaining to aviation safety, security, air traffic control, and disaster response. Overall, these recommendations provide a framework for government officials and airline personnel as they develop strategies to ensure greater passenger safety and security, promote modernization and progress in aviation, and maintain global leadership of the United States in the aviation industry.

While the Council on Scientific Affairs appreciates the effort of the White House Commission to address the complex issue of aviation safety and security, the CSA found that most of the recommendations in the Commission report are not clinically relevant. This finding was supported by representatives of the Aerospace Medical Association and the American College of Emergency Physicians, who were asked by the CSA to examine the Commission report who indicated that while the Commission report thoroughly addresses current problems and concerns in aviation safety, security, and air traffic control, the focus of the report is beyond the purview of most physicians.

Because most of the Commission's recommendations deal with nonmedical issues, reviewers limited their comments to two aspects of the report that have medical implications for consideration by the AMA. The first is the need to reduce the occurrence of human error in aviation crashes. Reviewers further recommended that the AMA support a Commission recommendation that all passengers be appropriately restrained, regardless of age, during takeoff, landing, and turbulent conditions. This is particularly a concern for children under the age of 2 years and requires that standard certified child safety seats be developed and used on commercial flights.

The Commission report does not address passenger health issues, particularly the medical care and treatment of passengers during in-flight emergencies. The state of medical care of passengers aboard commercial aircraft is an issue of national interest and is currently being studied by the FAA, the airline industry, and medical specialty societies.

In lieu of full or partial endorsement of the Commission report and its 57 recommendations, the CSA recommends that the AMA support the general concept of improving aviation safety and security.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting.

1. The AMA encourages the appropriate federal agencies to work with the aviation industry to develop and implement a comprehensive plan to ensure greater public safety and security in airports and aboard aircraft.
2. The AMA urges the appropriate federal agencies and the aviation industry to expand efforts to reduce the incidence and effects of human error in aviation.

3. The AMA encourages the ongoing efforts of the Federal Aviation Administration, the airline industry, the Aerospace Medical Association, the American College of Emergency Physicians, and other appropriate organizations to study and implement regulations and practices to meet the health needs of airline passengers and crews, with particular focus on the medical care and treatment of passengers during in-flight emergencies.

Options for Motorcycle Safety (CSA Rep. 6, I-98)

SUMMARY

Objective. To review options for improving motorcycle safety and identify opportunities for physician intervention and collaboration.

Methods. Twenty-five national organizations involved with traffic safety issues were contacted regarding their motorcycle safety policies and programs. Epidemiological and clinical information on motorcycle crash injuries was derived from a MEDLINE search of English-language articles, published from 1980 to 1998, using the key words *motorcycle crashes*, *motorcycle injuries*, and *motorcycle safety*. Additional articles were derived by manual review of references listed in pertinent publications and from consultation with experts in this field.

Results. Improving motorcycle safety requires a comprehensive approach that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; alcohol use; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current and proposed safety measures. While many national health and safety organizations have policy supporting motorcycle helmet laws, and some may advocate for such laws, few have dedicated programs in motorcycle safety.

Conclusions. The prevention of motorcycle-related trauma requires a multifaceted approach that includes education, legislation, law enforcement, and research, and requires the active participation of physicians at local, state, and national levels. Increased efforts are needed to increase the use of motorcycle helmets, reduce the number of alcohol-impaired riders, and ensure that all motorcyclists are properly trained and licensed. Physicians and organized medicine have a responsibility to protect public safety by supporting the enactment and enforcement of universal helmet laws in all states and opposing attempts to weaken or repeal existing laws. Physicians also have a role in counseling their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting.

1. Existing AMA Policies H-10.977, H-15.971, H-15.980, and H-15.994 are reaffirmed.
2. The AMA will encourage the National Highway Traffic Safety Administration to work with medical and public health organizations, national motorcycle rider organizations, state motor vehicle licensing agencies, law enforcement officials, and the motorcycle industry to develop a comprehensive national motorcycle safety plan that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; alcohol use among motorcyclists and other motor vehicle drivers; measures to increase the visibility of motorcyclists and motorcycles to other drivers; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current and proposed safety measures.
3. The AMA will seek opportunities to work with the NHTSA to educate and inform physicians and patients about motorcycle safety issues.
4. The AMA encourages physicians to (a) be aware of motorcycle risks and safety measures and (b) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate

- training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.
5. The AMA will report on conclusions and recommendations of the motorcycle safety strategic planning effort that is being coordinated by the National Highway Traffic Safety Administration and the Motorcycle Safety Foundation.

Recommendations for Colorectal Cancer Screening and Surveillance in People At Average and Increased Risk (CSA Rep. 7, I-98)

SUMMARY

This report reviews the evidence both for and against the screening of sporadic colorectal cancer (CRC) in people at average or normal risk as well as in those at high risk (ie, with familial genetic syndromes). It describes various screening procedures for detection of CRC and recommends a set of guidelines for the screening of various populations. Recommended screening methods for the detection of CRC in people aged 50 years or older include fecal occult blood testing (FOBT) and sigmoidoscopy.

It is unclear which of these procedures is preferable for initial screening, or whether a combination of the two is more beneficial than either test alone. The results of three randomized controlled trials indicate that FOBT combined with subsequent diagnostic work-up reduces mortality from CRC. The evidence for the effectiveness of sigmoidoscopy in detecting CRC is less strong; it is derived from case-control epidemiologic studies. An annual FOBT (with or without hydration) is recommended by most authorities, who also suggest screening every 3 to 5 years with sigmoidoscopy. Based on estimates from case-control studies, people who are not at high risk may be protected for at least 10 years after flexible sigmoidoscopy. The adoption of widespread FOBT or sigmoidoscopy screening requires considerable direct and indirect cost. The scientific evidence for clinical benefit may be outweighed by economic, political, and other considerations. Low patient compliance and inadequate workforce and financial resources may render the practice of widespread screening impractical. For individuals who have a single first-degree relative with colon cancer, the small increase in the absolute risk of cancer may not justify the routine use of colonoscopy rather than other screening methods. For those with an increased risk of developing cancer before the age of 50, colonoscopy may be warranted, particularly if the affected relatives had CRC at earlier ages. It is not known whether screening younger persons who are at average risk for CRC provides any mortality benefit. Patients at very high risk of CRC, who should receive regular endoscopic screening as part of routine diagnosis and management, include those with a family history of hereditary syndromes (ie, familial adenomatous polyposis or hereditary nonpolyposis colon cancer, those with a history of long-standing ulcerative colitis, and those with a prior diagnosis of high-risk adenomatous polyps or colon cancer).

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting.

1. The AMA supports the general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which screen the entire colon, should be considered as appropriate alternatives.
2. Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receive more intensive screening efforts.
3. Physicians should become aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that may become available in this area.
4. The AMA will continue to monitor clinical research and new guidelines regarding the effectiveness and appropriateness of screening and surveillance tests for CRC.

Preservation of Medical Records (CSA Rep. 8, I-98)

SUMMARY

This report responds to Resolution 507, introduced at the 1996 Interim Meeting by the American Academy of Ophthalmology and referred to the Board of Trustees by the House of Delegates, which asked: "That the American Medical Association (AMA) support the retention of medical records documenting permanent structural alteration to the patient." This report reviews current regulatory and legal standards regarding retention of medical records, notes current related AMA policy and activities, and offers recommendations for amplifying the policy.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting.

1. Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes, chemotherapy records, and records documenting permanent structural alteration to the patients should always be part of the patient's chart.
2. The AMA will work with other appropriate organizations to further study and develop principles and criteria for the retention of medical records.
3. The AMA will monitor progress in information technology leading to development of a practical and secure personal electronic medical record.

Truth in Nutrition Labeling Related to *Trans* Fatty Acids (CSA Rep. 9, I-98)

SUMMARY

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

Resolution 509, introduced at the 1997 Annual Meeting by the Resident Physicians Section and referred to the Board of Trustees by the House of Delegates, asks:

That the American Medical Association (AMA) support and advocate for changing Food and Drug Administration (FDA) policy to require manufacturers to include levels of *trans* fatty acids on the nutrition facts portion of food labels; and

That the AMA support and advocate for the development of guidelines for labeling foods as "low fat" and "low cholesterol" which include levels of *trans* fatty acids.

This resolution was introduced because the FDA has no requirement for separately listing amounts of *trans* fatty acids in foods and no guidelines for allowed amounts of *trans* fatty acids in foods labeled as "low fat" or "low cholesterol." *Trans* fatty acids contain one or more double bonds in the *trans* configuration and are produced commercially by hydrogenation of vegetable oils or fish oils. They also occur naturally in meat and dairy products through anaerobic bacterial fermentation in ruminant animals. Additional information on *trans* fatty acids in food labeling is intended to augment consumer information to help reduce harmful dietary fat.

After reviewing published data on the impact of *trans* fatty acids on plasma lipid concentrations and epidemiological data on *trans* fatty acid intake and the risk of cardiovascular disease, and after considering the health implications of changing the food label versus the cost of doing so, the Council on Scientific Affairs believes that a fundamental change in food labeling to include specific information on *trans* fatty acids is not warranted at this time.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting.

1. Based on its current analysis, the Council on Scientific Affairs recommends that Resolution 509 (A-97) not be adopted.
2. The AMA's Council on Scientific Affairs will monitor the progress of the Food and Drug Administration's November 9, 1998, proposal to amend its regulations to provide for the declaration of *trans* fatty acids in nutrition labeling and report as necessary.

Bloodborne Pathogen Transmission From and To Health Care Workers (CSA Rep. 10, I-98)

SUMMARY

This report reviews the rates of transmission of hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) from infected health care workers to their patients. There is one dentist and one surgeon who have occupationally transmitted HIV to patients. HBV has been occupationally transmitted at a much higher rate, with many published reports of clusters of patients infected from the health care worker providing their care. There are two reported occupational HCV transmissions, but HCV has only been studied since its identification in 1989.

The report recommends that terminology of "significant risk" be adopted for guidelines that determine restrictions on infected health care workers and that guidelines for HIV-infected health care workers be separate from HBV-infected health care worker guidelines.

RECOMMENDATIONS

The following statements, recommended by the Council on Scientific Affairs, were adopted by the AMA House of Delegates as AMA policy at the 1998 AMA Interim Meeting..

1. The AMA will use the terminology "significant risk" in AMA policies, correspondence, and official actions when indicating the threshold of risk that is appropriate for restrictions on medical practice of physicians infected with bloodborne pathogens that can be transmitted to patients; and the will AMA recommend that other medical associations, federal agencies, and courts also use the terminology "significant risk" consistently.
2. AMA Policy 20.969(5) is modified to read: "As a general rule or until there is scientific information to the contrary, the health care worker should be permitted to provide health care services as long as there is no significant risk of patient infection and no compromise in physical or mental ability of the health care worker to perform the health care procedures.
3. The AMA recommends separate guidelines for HIV-infected and HBV-infected health care workers because of substantial differences in rates, risks, modes and consequences of transmission
4. The AMA requests that the Centers for Disease Control and Prevention review its guidelines for HIV/HBV-infected health care workers with specific consideration of adopting a significant risk standard and consideration of separate guidance for HIV-infected health care workers and HBV-infected health care workers.