INTRODUCTION

Resolution 115-A-12, “Obesity Should Be Considered a Chronic Medical Disease State,” introduced by the Illinois Delegation at the 2012 American Medical Association (AMA) Annual Meeting and referred by the House of Delegates, asks:

That our AMA: (1) recognize obesity and overweight as a chronic medical condition (de facto disease state) and urgent public health problem; (2) recommend that providers receive appropriate financial support and payment from third-party payers, thus ensuring that providers have an incentive to manage the complex diseases associated with obesity; (3) work with third-party payers and governmental agencies to recognize obesity intervention as an essential medical service; and (4) establish a comprehensive ICD code for medical services to manage and treat obese and overweight patients.

Reference Committee A recommended referral of Resolution 115-A-12 to clarify the first resolve. AMA Policy H-150.953, “Obesity as a Major Public Health Program,” already urges improved coding and payment mechanisms for the evaluation and management of obesity (Appendix). Additionally, both the ICD-9-CM and ICD-10-CM contain diagnosis codes for overweight and obesity, as well as body mass index (BMI). Therefore, this report addresses only the first resolve of Resolution 115-A-12.

The Council on Scientific Affairs (CSA) previously addressed this issue. Based on its interpretations of definitions of disease in common use, the Council argued that it was premature to classify obesity as a disease, citing the lack of characteristic signs or symptoms due to obesity, as well as evidence of any true causal relationships between obesity and morbidity and/or mortality. The resultant Policy D-440.971, “Recommendations for Physician and Community Collaboration on the Management of Obesity,” recommends that our AMA “work with the Centers for Disease Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a disease, using a systematic, evidence-based approach” (Appendix). No formal meeting with the Centers for Disease Control and Prevention (CDC) and other stakeholders was ever held.

This report examines the definitions of obesity and disease, the limitations of those definitions, and arguments both for and against the classification of obesity as a disease. The possible implications for provider reimbursement, public policy, and patient stigma also are considered. Of central
interest is the potential impact of classifying obesity as a disease on improving patient care and health outcomes. This report does not address food addiction, binge eating disorder, or other psychological disorders that may result in obesity, as the currently prevailing definitions of obesity do not specify its underlying causes.

CURRENT AMA POLICY RELATED TO OBESITY

The AMA has more than 20 policies that specifically refer to obesity. Most do not define or describe the term, but among those that do, obesity is referred to as a: “complex disorder” (Policy H-150.953), “urgent chronic condition” (Policy D-440.971), “epidemic” (Policy D-440.952), and “major health concern” and “major public health problem” (Policy H-440.902). AMA policy does not clearly define obesity as a disease, although policy D-440.980 directed our AMA to convene a task force to “recommend measures to better recognize and treat obesity as a chronic disease” (Appendix).

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases from 2004 to January 2013 using the search terms “obesity as a disease,” “obesity a disease,” “obesity should be considered a disease,” “what is disease,” and “definition of disease.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies and applicable professional and advocacy organizations also were consulted for relevant information.

BACKGROUND

Opinions within the medical profession have been divided for a number of years on whether or not obesity should be considered a disease, rather than a condition or disease risk factor. Those in favor of classifying obesity as a disease argue that excess body fat, which results from myriad genetic, behavioral, and other environmental factors, impairs a number of normal body functions. While the adverse health consequences and healthcare costs associated with obesity are generally well-recognized even in the absence of a disease label, proponents argue that neither provider reimbursement nor research into effective treatments will be adequate until obesity is considered a disease. Those opposed to classifying obesity as a disease argue that excess body weight increases risk of morbidity and mortality, but does not guarantee it. Concerns also exist about labeling 1/3 of Americans as “ill” and increasing stigmatization of obese individuals. However, others argue that classifying obesity as a disease will actually decrease stigma. These issues, and others, are discussed in more detail below.

WHAT IS OBESITY?

The World Health Organization (WHO) defines overweight and obesity as “abnormal or excessive fat accumulation that may impair health.” The WHO, as well as the Centers for Disease Control and Prevention (CDC) and the National Heart, Lung, and Blood Institute (NHLBI), describe overweight and obesity in adults using body mass index (BMI) categories (Table 1). The NHLBI additionally recommends measuring waist circumference in adults with BMIs below 35 kg/m², to further assess disease risk.
Both the WHO and NHLBI guidelines recognize that BMI is an indirect and imperfect measure of body fatness, although more accurate than body weight alone. Originally designed as a rough population-level indicator of obesity, BMI has been widely recommended as an inexpensive clinical screening tool to help assess disease risk, in addition to other indicators such as blood pressure and blood lipids. Associations between BMI and adiposity (as well as disease risk, described below) vary by age, gender, ethnicity, socioeconomic status, stature, and athletic training. These variations generally reflect population-specific differences in body composition, fat distribution, causes of overweight, and genetic susceptibility. As a screening tool for obesity, BMI demonstrates low sensitivity, particularly at BMIs below 30. For example, some people with BMIs < 25 may have excess adipose tissue and proinflammatory cytokines, as well as metabolic disturbances associated with obesity, such as insulin resistance, hyperinsulinemia, dyslipidemia, hypertension, and cardiovascular disease (CVD). On the other hand, some individuals with BMIs greater than 30 may not have excess body fat; however, even if they do, they may exhibit high insulin sensitivity and normal blood pressure and lipid levels. Due to the limitations of BMI, some argue that BMI should be excluded from the definition of obesity when deciding whether or not obesity is a disease.

NHLBI is currently developing new guidelines on overweight and obesity in adults as part of its development of cardiovascular risk reduction guidelines for adults. These new guidelines will be based on rigorous and standardized systematic reviews of the scientific literature, which may clarify some of the uncertainties around the assessment and management of obesity in clinical practice. The release date of the new guidelines is currently unknown, but their availability for public comment is expected later in 2013.

Obesity as Measured by BMI is Associated with Increased Morbidity

Despite the limitations of BMI, a substantial body of literature has found increased BMI to be associated with myriad diseases and conditions, including: type 2 diabetes, coronary heart disease, stroke, hypertension, dyslipidemia, several cancers, gall bladder disease, osteoarthritis, asthma, chronic back pain, sleep apnea, pregnancy complications, stress incontinence, and depression. The nature of the relationships between BMI and these conditions is generally similar across population groups, although the specific level of risk at a given BMI often differs by age, gender, ethnicity, and/or socioeconomic status.

The Obesity Paradox

While co-morbidities generally increase as BMI increases, a number of research studies report no effect—or even slightly protective effects—of overweight and obesity on mortality risk (i.e., J- or U-shaped associations). A number of factors beyond the inherent limitations of BMI may explain these seemingly paradoxical associations, including inadequate control (both under and over) for potential confounders and/or factors in the causal pathway (e.g., nutritional status, cardiorespiratory fitness, hypertension), and/or more aggressive screening and treatment efforts in individuals classified as overweight or obese. In addition, the causes of death at low and high BMIs differ. Nevertheless, most research indicates that individuals at the highest end of the adiposity spectrum are at increased risk of mortality.

WHAT IS A DISEASE?

This seemingly straightforward question lacks a single, clear, authoritative, and widely-accepted definition. CSA Report 4-A-05 identified some common precepts in the definitions of disease provided by several dictionaries and encyclopedias (Table 2). Similar attempts have varied in their
conclusions about what constitutes a disease, particularly in relation to obesity. However, even the same definitions can yield varying conclusions. For example, the American Association of Clinical Endocrinologists (AACE) recently utilized the same disease criteria put forth in the previous CSA report and concluded that obesity does, in fact, meet those criteria. AACE’s conclusion appears to be based less on new knowledge about obesity than on differences in their interpretation of the definition of disease.

In evaluating the variety of disease definitions currently in use (Table 2), some have noted that no one definition would encompass all diseases currently accepted as such (e.g., some definitions would exclude tuberculosis, stroke, alcoholism, some psychological disorders, or diabetes). Indeed, the medical community’s definitions of disease have been heavily influenced by contexts of time, place, and culture as much as scientific understanding of disease processes. Given the often significant social and economic consequences of the dividing line between disease and “natural state” or “condition,” it is imperative to consider the potential advantages, disadvantages, incentives, and obligations of the disease label for patients, clinicians, employers, third party payers, policy makers, and society as a whole. Thus, rather than trying to determine if obesity meets arguably arbitrary disease criteria, the more relevant question is “would health outcomes be improved if obesity is considered a chronic, medical disease state?”

WOULD CLASSIFYING OBESITY AS A DISEASE IMPROVE HEALTH OUTCOMES?

Various individuals and organizations have referred to obesity as a disease dating back to at least the 17th century, and possibly earlier—Hippocrates recognized the increased mortality risk of being overweight. However, members of both the general public and the medical community remain divided on this issue. While some arguments focus on whether obesity meets or does not meet the criteria for a specific definition of disease, other arguments directly address financial incentives for research and patient care, as well as the ability to offer treatment (Table 3). The financial and treatment arguments are particularly pertinent to the discussion of how classifying obesity as a disease might improve health outcomes; these arguments are considered in more detail below, along with arguments related to public policy, prevention programs, public perceptions and patient stigma.

Maybe Yes

More widespread recognition of obesity as a disease could result in greater investments by government and the private sector to develop and reimburse obesity treatments. Some argue that the Food and Drug Administration (FDA) would face increased pressure to approve medications for obesity, and would therefore refocus their approval process to focus on the ability of pharmaceuticals to decrease adipose tissue rather than to improve other markers of metabolic health, such as blood pressure and lipid levels. There is current interest in developing a “limited use” approval pathway that could facilitate the clinical review and FDA approval of prescription drugs. Antibiotics and drugs to treat obesity have been identified as appealing candidates for such a pathway. More effective medications on the market would likely spur physicians to prescribe, and patients to expect, pharmaceutical interventions for obesity. In turn, third party payers would be harder pressed to deny coverage.

Public policy and prevention programs related to obesity may benefit from the greater urgency a disease label confers. More funding for obesity-prevention programs, particularly for children and adolescents, could lead to improved health outcomes for years to come. It is likely that a number of public policies related to healthy eating and physical activity, such as funding and regulations for K-12 meal programs and physical education, would receive greater attention and resources.
Employers may be required to cover obesity treatments for their employees and may be less able to
discriminate on the basis of body weight.8

Public perceptions may shift as a consequence of more extensive recognition of obesity as a
disease, with greater appreciation of, and emphasis on, the complex etiology of obesity and the
health benefits of achieving and maintaining a healthy weight.8 Lack of self-control, laziness, and
other detrimental character attributes might be less likely to be associated with obese individuals,
and in turn reduce stigmatization.8,19 The disease label also may provide greater motivation for
some individuals to lose weight or maintain a healthy weight.8 While increased emphasis on
obesity may increase stigma (see below), some have argued that such consequences would oblige
the medical community to take greater action to protect patients’ rights.8

Maybe No

Concern exists that more widespread recognition of obesity as a disease would result in greater
investments by government and the private sector to develop and reimburse pharmacological and
surgical treatments for obesity, at the expense of clinical and public health interventions targeting
healthy eating and regular physical activity.18 “Medicalizing” obesity could intensify patient and
provider reliance on (presumably costly) pharmacological and surgical treatments to achieve a
specific body weight, and lead to prioritizing body size as a greater determinant of health than
health behaviors.18,20 Given the limitations of BMI (discussed above), this could also lead to the
over-treatment of some people, such as those who meet the criteria for obesity, (i.e., BMI > 30) but
are metabolically healthy. A similar concern is that obese individuals who improve their eating,
physical activity, and sleeping habits, yet fail to lose enough weight to change their BMI
classification, would still bear the “diseased” label and be pressured to receive medical treatment
by clinicians, health insurers, and/or employers—even though their improved lifestyle behaviors are
significant factors in preventing, delaying, and reducing the severity of obesity-associated
outcomes. While some argue that BMI should be excluded from the definition of obesity in
deciding whether or not obesity is a disease,7,8 the fact remains that BMI is currently the prevailing
clinical measure of obesity.

It is possible that public policy and prevention programs related to obesity may be diminished if
increased government financing of research into medical treatments reduces funds available for
public health prevention programs.18 Similarly, the medicalization of obesity could detract from
collective social solutions19 to environmental forces that shape people’s behaviors and impact a
number of conditions beyond just obesity.19 Thus, public efforts to enhance the built environment
to make healthy eating and physical activity choices easier may receive less attention, despite
providing substantial health benefits at every body weight;18,20 in turn, this could slow the
improvement of health outcomes for all Americans. In addition, employers may raise health
insurance premiums, limit hiring of obese individuals, and/or curtail employee wellness programs
that incentivize weight loss or maintaining a healthy weight.8

Public perceptions may shift as a consequence of more extensive recognition of obesity as a
disease, but not in a manner than improves health outcomes. For instance, some individuals may
conclude that health behaviors matter little in disease development and management, which may
decrease their motivation to eat healthfully and be physically active.8 In addition, an increased
clinical emphasis on obesity could potentially offend or otherwise alienate some obese individuals,
particularly if the emphasis is on achieving an ideal weight rather than healthy eating and physical
activity behaviors.19 Assuming the current BMI cut-points remain the primary clinical indicator of
obesity, such stigma would likely also impact people who are otherwise healthy, but who
nevertheless meet the criteria for obesity (BMI > 30).
AREAS REQUIRING FURTHER RESEARCH

If obesity is to be considered a disease, a better measure of obesity than BMI is needed to diagnose individuals in clinical practice. Further research is also warranted into the physiologic mechanisms behind why some obese individuals (e.g., the metabolically healthy obese) do not develop adverse health outcomes related to excess adipose tissue. This is particularly relevant given the difficulties most people have in achieving sustained weight loss. In addition, much more research is needed to develop effective and affordable obesity prevention and management strategies at both the clinical and community levels.

SUMMARY AND CONCLUSION

Without a single, clear, authoritative, and widely-accepted definition of disease, it is difficult to determine conclusively whether or not obesity is a medical disease state. Similarly, a sensitive and clinically practical diagnostic indicator of obesity remains elusive. Obesity, measured by BMI, is clearly associated with a number of adverse health outcomes, with greater consistency across populations at the highest BMI levels. However, given the existing limitations of BMI to diagnose obesity in clinical practice, it is unclear that recognizing obesity as a disease, as opposed to a “condition” or “disorder,” will result in improved health outcomes. The disease label is likely to improve health outcomes for some individuals, but may worsen outcomes for others.

What is clear is that a better measure of obesity than BMI alone is needed. NHLBI’s forthcoming guidelines on overweight and obesity in adults may help clarify clinical uncertainties regarding the best means of measuring obesity, at least in reference to cardiovascular risk. In the meantime, better clinical and public health strategies are warranted to assist individuals in improving their lifestyle behaviors and in reducing adverse outcomes associated with obesity.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 115-A-12 and the remainder of the report be filed.


2. That Policy H-150.953, “Obesity as a Major Public Health Program,” be re-titled “Obesity as a Major Public Health Problem.” (Modify Current HOD Policy)


Fiscal note: No significant fiscal impact
REFERENCES


TABLE 1. National Heart Lung and Blood Institute Classifications of Overweight and Obesity by BMI and Waist Circumference in Adults

<table>
<thead>
<tr>
<th>Classification</th>
<th>BMI (kg/m²)</th>
<th>Risk of type 2 diabetes, hypertension, and CVD relative to normal weight and waist circumference*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Men ≤ 40 in Women ≤ 35 in</td>
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<tr>
<td></td>
<td></td>
<td>Men ≥ 40 in Women ≥ 35 in</td>
</tr>
<tr>
<td>Underweight</td>
<td>&lt; 18.5</td>
<td>---</td>
</tr>
<tr>
<td>Normal weight</td>
<td>18.5–24.9</td>
<td>---</td>
</tr>
<tr>
<td>Overweight</td>
<td>25.0–29.9</td>
<td>Increased</td>
</tr>
<tr>
<td>Obesity (Class I)</td>
<td>30.0–34.9</td>
<td>High</td>
</tr>
<tr>
<td>Obesity (Class II)</td>
<td>35.0–39.9</td>
<td>Very High</td>
</tr>
<tr>
<td>Extreme obesity (Class III)</td>
<td>≥ 40</td>
<td>Extremely High</td>
</tr>
</tbody>
</table>

*NHLBI guidelines note that increased waist circumference can indicate increased disease risk even in individuals considered normal weight.
### TABLE 2. Examples of disease definitions

<table>
<thead>
<tr>
<th>Definition of disease</th>
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<tbody>
<tr>
<td>All 3 of the following criteria must be met:</td>
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<tr>
<td>a) “An impairment of the normal functioning of some aspect of the body</td>
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<tr>
<td>b) Characteristic signs or symptoms; and</td>
</tr>
<tr>
<td>c) Resultant harm or morbidity to the entity affected”1</td>
</tr>
<tr>
<td>1) Based on biostatistical theory: “Deviation from species-typical functioning; disease is deviation from the average.” -or-</td>
</tr>
<tr>
<td>2) Based on evolutionary functions: “Disease occurs when an organ is not performing the job that allowed it to evolve via natural selection.”(quoted in 8)</td>
</tr>
<tr>
<td>All 4 of the following criteria must be met:</td>
</tr>
<tr>
<td>a) “A condition of the body, its parts, organs, or systems, or an alteration thereof;</td>
</tr>
<tr>
<td>b) Resulting from infection, parasites, nutritional, dietary, environmental, genetic, or other causes;</td>
</tr>
<tr>
<td>c) Having a characteristic, identifiable, marked, group of symptoms or signs;</td>
</tr>
<tr>
<td>d) Deviation from normal structure or function (variously described as abnormal structure or function; incorrect function; impairment of normal state; interruption, disturbance, cessation, disorder, derangement of bodily or organ functions).”22</td>
</tr>
<tr>
<td>“Damage to an organ, part, structure, or system of the body such that it does not function properly (e.g., cardiovascular disease), or a state of health leading to such dysfunctioning (e.g., hypertension); except that diseases resulting from essential nutrient deficiencies (e.g., scurvy, pellagra) are not included in this definition.”23</td>
</tr>
<tr>
<td>“An impairment of the normal state of the living animal or plant body or one of its parts that interrupts or modifies the performance of the vital functions, is typically manifested by distinguishing signs and symptoms, and is a response to environmental factors (as malnutrition, industrial hazards, or climate), to specific infective agents (as worms, bacteria, or viruses), to inherent defects of the organism (as genetic anomalies), or to combinations of these factors.”24</td>
</tr>
<tr>
<td>1. “An interruption, cessation, or disorder of a body, system, or organ structure or function.</td>
</tr>
<tr>
<td>2. A morbid entity ordinarily characterized by two or more of the following criteria: recognized etiologic agent(s), identifiable group of signs and symptoms, or consistent anatomic alterations.”25</td>
</tr>
<tr>
<td>Yes, Obesity is a Disease</td>
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<tr>
<td>--------------------------</td>
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<tr>
<td>Obesity meets disease criteria (e.g., outlined in CSA Report 4-A-05):</td>
</tr>
<tr>
<td>a) <strong>Impairment of normal functioning of the body:</strong> “Appetite dysregulation, abnormal energy balance, endocrine dysfunction including elevated leptin levels and insulin resistance, infertility, dysregulated adipokine signaling, abnormal endothelial function and blood pressure elevation, nonalcoholic fatty liver disease, dyslipidemia, and systemic and adipose tissue inflammation.”</td>
</tr>
<tr>
<td>b) <strong>Characteristic signs and symptoms:</strong> Increase in body fat has both anatomic sequelae (e.g., joint pain, immobility, sleep apnea) and metabolic sequelae (progression to type II diabetes and cardiovascular disease).</td>
</tr>
<tr>
<td>c) <strong>Results in harm or morbidity to the entity affected:</strong> Obesity is directly associated with increased mortality and morbidity due to a number of factors, and weight loss improves obesity-related morbidity and mortality (e.g., improved glycemic control in diabetes and reduced risk of type II diabetes, CVD, some cancers, and alleviation of symptoms of osteoarthritis, sleep apnea, etc).</td>
</tr>
<tr>
<td>Obesity is similar to other diseases (e.g., hypertension, diabetes, lung cancer) that result from a combination of genetics and environmental factors (including behaviors).</td>
</tr>
<tr>
<td>All diseases work through pathways and mechanisms; simply because obesity’s anatomic and metabolic sequelae include already recognized diseases does not mean obesity is not also a disease.</td>
</tr>
<tr>
<td>The disease label (i.e., “medicalization”) would help improve attitudes and financial support to expand: a) research into prevention and treatment, and b) resources for patient care.</td>
</tr>
<tr>
<td>“Medicalization” of obesity is intended to drive financial gains of certain providers/interests.</td>
</tr>
<tr>
<td>Most experts agree obesity is a disease.</td>
</tr>
<tr>
<td>Just because most experts agree (if true) does not mean obesity meets the criteria for disease, and some experts disagree.</td>
</tr>
<tr>
<td>Obesity is treatable in at least some individuals but a lack of treatment should not be a criterion for considering obesity a disease.</td>
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<tr>
<td>There is no effective, well-established treatment for obesity.</td>
</tr>
</tbody>
</table>

*Arguments listed were discussed in the cited references, but do not necessarily reflect those authors’views.*


APPENDIX.
Current AMA policies relevant to the issue of obesity as a chronic medical disease state

H-150.953 Obesity as a Major Public Health Program
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12)

H-440.902 Obesity as a Major Health Concern
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12)

D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-
establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) provide a progress report on the above efforts to the House of Delegates by the 2004 Annual Meeting. (Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07)

D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity

Our AMA will: (1) work with the Centers for Disease Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a disease, using a systematic, evidence-based approach; (2) continue to actively pursue measures to treat obesity as an urgent chronic condition, raise the public’s awareness of the significance of obesity and its related disorders, and encourage health industries to make appropriate care available for the prevention and treatment of obese patients, as well as those who have co-morbid disorders; (3) encourage physicians to incorporate body mass index (BMI) and waist circumference as a component measurement in the routine adult physical examination, and BMI percentiles in children recognizing ethnic sensitivities and its relationship to stature, and the need to implement appropriate treatment or preventive measures; (4) promote use of our Roadmaps for Clinical Practice: Assessment and Management of Adult Obesity primer in physician education and the clinical management of adult obesity; (5) develop a school health advocacy agenda that includes funding for school health programs, physical education and physical activity with limits on declining participation, alternative policies for vending machines that promote healthier diets, and standards for healthy a la carte meal offerings. Our AMA will work with a broad partnership to implement this agenda; and (6) collaborate with the CDC, the Department of Education, and other appropriate agencies and organizations to consider the feasibility of convening school health education, nutrition, and exercise representatives, parents, teachers and education organizations, as well as other national experts to review existing frameworks for school health, identify basic tenets for promoting school nutrition and physical activity (using a coordinated school health model), and create recommendations for a certificate program to recognize schools that meet a minimum of the tenants. (CSA Rep. 4, A-05; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 1, A-08; Reaffirmation I-10; Reaffirmed: BOT Rep. 21, A-12)

H-425.994 Medical Evaluations of Healthy Persons

The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of

**H-90.974 Opposition to Obesity as a Disability**
Our AMA opposes the effort to make obesity a disability. (Res. 412, A-09)

**H-440.866 The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity**
Our AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m2; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (CSAPH Rep. 1, A-08)

**D-440.952 Fighting the Obesity Epidemic**
1. Our AMA Council on Science and Public Health (CSAPH) will critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting. 2. Our AMA will consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles. 3. Our AMA Council on Medical Service and CSAPH will collaborate to evaluate the relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35. (BOT Rep. 9, A-07)