## Reference Committee E

### CSAPH Report(s)

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### Resolution(s)

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* Contained in Handbook Addendum
At its 1984 Interim Meeting, the House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to retain it.

The objective of the sunset mechanism is to help ensure that the American Medical Association (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House of Delegates deliberations.

At its 2012 Annual Meeting, the House modified Policy G-600.110 to change the process through which the policy sunset review is conducted. The process now includes the following:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.

2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA Councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset. (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) Retain the policy; (ii) Sunset the policy; (iii) Retain part of the policy; or (iv) Reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing Council shall provide a succinct, but cogent justification. (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports. (3) Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished. (4) The AMA Councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices. (5) The most recent policy shall be deemed to supersede contradictory past AMA policies. (6) Sunset policies will be retained in the AMA historical archives.
In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on the disposition of the House policies from 2007 that were assigned to it. The CSAPH’s recommendations on policies are presented in the Appendix to this report.

RECOMMENDATION

The Council on Science and Public Health recommends that the House of Delegates policies that are listed in the Appendix to this report be acted upon in the manner indicated and the remainder of the Report be filed. (Directive to Take Action)

Fiscal Note: Less than $500
### APPENDIX: Recommended Actions on 2007 House Policies and Directives

<table>
<thead>
<tr>
<th>Policy/Directive Number</th>
<th>Title</th>
<th>Recommended Action and Rationale</th>
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</thead>
<tbody>
<tr>
<td>D-10.993</td>
<td>Grade-Level Railroad Crossings</td>
<td>Sunset. Accomplished. Letters were sent to the Chair of the National Transportation Safety Board and the Administrator of Federal Railroad Administration informing them of AMA’s policy advocating study evaluating methods of limiting grade-level railroad crossing accidents and providing AMA staff contact information for further discussion if organizations willing.</td>
</tr>
<tr>
<td>D-30.993</td>
<td>A Call for Framework Convention on Alcohol Control</td>
<td>Sunset. Accomplished. Staff assisted APHA Alcohol, Tobacco and Other Drug Abuse Section in preparation of a resolution calling for framework convention which was submitted and approved by APHA. Staff also sent materials and made presentation to a European meeting of medical associations on alcohol policy and discussed resolution with organizations working with the WHO and they requested that the framework convention concept not be promoted until after a new WHO initiative on alcohol is formulated and passed (they indicated promoting the framework convention would result in no alcohol initiatives passing the WHO’s World Health Assembly).</td>
</tr>
<tr>
<td>D-60.974</td>
<td>Emotional and Behavioral Effects of Video Game and Internet Overuse</td>
<td>Sunset (1), (2), (4) and (5). Accomplished. Retain (3), and change to AMA Policy reading: “Our AMA supports increased awareness of the need for parents to monitor and restrict use of video games and the Internet and encourage increased vigilance in monitoring the content of games purchased and played for children 17 years old and younger.”</td>
</tr>
<tr>
<td>D-60.975</td>
<td>Early Literacy Programs</td>
<td>Retain and change to AMA Policy reading: “Our AMA encourages physicians to participate in early literacy programs to promote literacy development, educate parents on child development, and strengthen family interactions, so that these programs become a common part of child health care as a foundation for school readiness.”</td>
</tr>
<tr>
<td>D-95.985</td>
<td>Substance Use Disorder is a Disease</td>
<td>Sunset. CSAPH Report 8-A-08 was prepared on this subject.</td>
</tr>
<tr>
<td>D-95.986</td>
<td>Background on the Organization “Physicians and Lawyers for National Drug Policy” (PLNDP)</td>
<td>Sunset. Membership material and organizational information were sent out via Federation e-news. The PLNDP no longer exists.</td>
</tr>
<tr>
<td>D-120.963</td>
<td>Patient Access to Off-Label Use of Avastin</td>
<td>Sunset. Letter was sent to CEO of Genentech seeking policy reversal re: not to supply Avastin to compounding pharmacies. Genentech CEO responded that mutual accommodation had been agreed to</td>
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<tr>
<td>D-120.967</td>
<td>Accutane “I Pledge” Program</td>
<td>Sunset. Communications with staff at American Academy of Dermatology explored interest and feasibility of such a survey.</td>
</tr>
<tr>
<td>D-120.994</td>
<td>Isotretinoin</td>
<td>Sunset.Membership encouraged to participate in voluntary educational programs on isotretinoin.</td>
</tr>
<tr>
<td>D-150.982</td>
<td>Fresh Meat Color Preserving</td>
<td>Sunset. FDA Food Safety and Modernization Act was signed into law on January 4, 2011.</td>
</tr>
<tr>
<td>D-150.984</td>
<td>Eating Disorders and Promotion of Healthy Body Image</td>
<td>Sunset (1). Accomplished. Retain (2) and change to AMA Policy reading: “Our AMA supports increased funding for research on the epidemiology, etiology, diagnosis, prevention, and treatment of eating disorders, including research on the effectiveness of school-based primary prevention programs for pre-adolescent children and their parents, in order to prevent the onset of eating disorders and other behaviors associated with a negative body image.”</td>
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<tr>
<td>D-245.995</td>
<td>Support of Sudden Infant Death Syndrome (SIDS) Research</td>
<td>Sunset. Letter was sent to the National Association of Medical Examiners supporting the need for additional research on SIDS and encouraging coroners and medical examiners to collect tissue samples for research purposes from infants who have died unexpectedly to the extent permissible by law.</td>
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<tr>
<td>D-250.989</td>
<td>Support of the Nightingale Declaration for a Healthy World by 2020</td>
<td>Sunset. Letter of support was sent.</td>
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<tr>
<td>D-370.988</td>
<td>Hematopoietic Stem Cell Transplantation: Utilization of and Minority Representation on the National Bone Marrow Donor Registry</td>
<td>Sunset. A letter has been sent encouraging expansion of National Marrow Donor Program efforts to increase awareness by both physicians and patients of the Registry, reduce the time and cost of stem cell procurement and increase number of donated umbilical cord blood units, particularly from minorities. Also, Policy H-370.974 encourages efforts to increase the number of bone marrow donors, especially minorities.</td>
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<tr>
<td>D-385.969</td>
<td>FDA Regulation of Stereotactic Breast Biopsy</td>
<td>Retain. Ongoing issue. This item was referred for decision and the Board adopted the following: “Our AMA will monitor the activities and recommendations of the National Mammography Quality Assurance Advisory Committee and the Food and Drug Administration pertaining to interventional mammography procedures and respond as appropriate.”</td>
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<tr>
<td>D-420.995</td>
<td>Use of Serotonin Reuptake Inhibitors in Pregnancy</td>
<td>Sunset. Label has been changed to reflect new data.</td>
</tr>
<tr>
<td>D-440.949</td>
<td>Dysmetabolic Syndrome and Type 2 Diabetes in Children</td>
<td>Sunset. Contact was made with the American Academy of Pediatrics, sections on Endocrinology, Hematology/Oncology, Nephrology, Pulmonology, and Rheumatology. The AAP is updating clinical practice guidelines on type 2 diabetes in children and adolescents and is interested in including the AMA in the collaboration for the updating of these documents.</td>
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<tr>
<td>D-440.950</td>
<td>Support National Coalitions that Advocate for Increased Federal Funding for the Centers for Disease Control and Prevention</td>
<td>Sunset. The AMA became an official partner of The Campaign for Public Health and signed on to a letter to Congressional appropriations committees with 500 organizations to increase the CDC’s FY08 budget.</td>
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<tr>
<td>D-450.972</td>
<td>Empowering Patients, Improving Quality</td>
<td>Sunset. PCPI staff were informed of the request. As of 2017, PCPI is no longer part of the AMA.</td>
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<tr>
<td>D-490.977</td>
<td>Use of Tobacco Industry-Sponsored Cessation and Prevention Materials</td>
<td>Retain, and change to AMA Policy reading: “Our AMA urges (1) that when physicians and health organizations provide information or materials on tobacco to patients and consumers, such information and materials should come from credible and trustworthy sources with expertise in tobacco control; and (2) physicians and health organizations to avoid providing to patients and consumers information or materials on tobacco that come from tobacco companies or other groups aligned with the tobacco industry.”</td>
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<tr>
<td>D-515.998</td>
<td>Resources for Victims of Domestic Abuse in the Adolescent Population</td>
<td>Sunset. Many resources for adolescent victims of abuse are now available, including “Love is not Abuse,” a teen domestic violence and abuse prevention curriculum high school edition by Fifth and Pacific Companies, Inc. with periodic updates, including cyber abuse. Also, Policy H-515.965 addresses intimate partner violence in detail.</td>
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<tr>
<td>H-5.982</td>
<td>Late-Term Pregnancy Termination Techniques</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-10.990</td>
<td>Fluorescent Markings on Train Cars</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-15.957</td>
<td>Flooding</td>
<td>Retain with change in title to read: “Automobile Entrapment Flooding.” Automobile entrapment is still an issue.</td>
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<tr>
<td>H-30.943</td>
<td>Alcoholism and Alcohol Abuse Among Women</td>
<td>Retain in part with change in title to read as follows: “Alcohol Use Disorder and Unhealthy Alcohol Use Among Women.” “The AMA recognizes the prevalence of unhealthy use</td>
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of alcohol abuse, and dependence among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol use disorder abuse and dependence. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver and heart disease from alcohol and about the effect of alcohol on the developing fetus. The AMA encourages adequate funding for research to explore the nature and extent of alcohol use disorder and unhealthy alcohol use among women, effective treatment modalities for women with alcohol use disorder and unhealthy alcohol use, and variations in alcohol use and abuse among ethnic and other subpopulations. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women.”

<p>| H-30.944 | National Alcohol Screening Day | Retain. AMA supports this event and encourages our members to participate in this annual event taking place the first Thursday of the first full week in April. |
| H-30.958 | Ethyl Alcohol and Nicotine as Addictive Drugs | Retain. Still relevant. |
| H-30.995 | Alcoholism as a Disability | Retain in part as follows with change in title to read: “Alcohol Use Disorder as a Disability. Alcoholism as a Disability.” (1) The AMA believes it is important for professionals and laymen alike to recognize that alcoholism alcohol use disorder is in and of itself a disabling and handicapping condition. (2) The AMA encourages the availability of appropriate services to persons suffering from multiple disabilities or multiple handicaps, including alcoholism alcohol use disorder. (3) The AMA endorses the position that printed and audiovisual materials pertaining to the subject of people suffering from both alcoholism alcohol use disorder and other disabilities include the terminology “alcoholic person with alcohol use disorder and other multiple disabilities” or “alcoholic person with multiple handicaps.” Hopefully, this language clarification will be intended to reinforce the concept that alcoholism alcohol use disorder is in and of itself a disabling and handicapping condition. |
| H-30.997 | Dual Disease Classification of Alcoholism | Sunset. Accomplished. |</p>
<table>
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<th>H-45.982</th>
<th>Laser Lights</th>
<th>Sunset. In 2012, PL 112-95 was signed, “FAA Modernization and Reform Act of 2012” which makes it a federal crime to aim a laser pointer at an aircraft.</th>
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<tr>
<td>H-45.994</td>
<td>Continuation of Medical Research on Manned Space Flights</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-50.980</td>
<td>Increasing Bone Marrow Screening</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-60.950</td>
<td>Diagnosis and Treatment of Attention Deficit/Hyperactivity Disorder in School-Age Children</td>
<td>Retain in part. Modify policy to include mention of APA’s DSM-5, rather than DSM-IV, to read as follows: Our AMA (1) encourages physicians to utilize standardized diagnostic criteria in making diagnosis of ADHD, such as the American Psychiatric Association’s DSM-IV DSM-5™, as part of a comprehensive evaluation of children and adolescents presenting with attentional or hyperactivity complaints; (2) urges that attention be directed toward establishing developmentally appropriate criteria for the diagnosis and treatment of ADHD in adults; (3) encourages the creation and dissemination of practice guidelines for ADHD by appropriate specialty societies and their use by practicing physicians and assist in making physicians aware of their availability; (4) encourages efforts by medical schools, residency programs, medical societies, and continuing medical education programs to increase physician knowledge about ADHD and its treatment; (5) encourages the use of individualized therapeutic approaches for patients diagnosed with ADHD, which may include pharmacotherapy, psycho-education, behavioral therapy, school-based and other environmental interventions, and psychotherapy as indicated by clinical circumstances and family preferences; (6) encourages physicians and medical groups to work with schools to improve teachers’ abilities to recognize ADHD and appropriately recommend that parents seek medical evaluation of potentially affected children; and (7) encourages further research on the relative risks and benefits of medication used to treat ADHD, including evaluation of the impact of labeling changes on access to treatment and physician prescribing.</td>
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<tr>
<td>H-60.981</td>
<td>Adolescent Health</td>
<td>Retain. Still relevant.</td>
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<td>Description</td>
<td>Retention Status</td>
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<tr>
<td>H-60.988</td>
<td>The Dangers of Shaking a Child</td>
<td>Retain. Still an issue.</td>
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<td>H-75.995</td>
<td>Contraceptive Advertising</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>H-95.953</td>
<td>Informing Physicians About the Potential Misuses of Dextromethorphan</td>
<td>Sunset. Accomplished.</td>
</tr>
<tr>
<td>H-100.984</td>
<td>News Media Access to New Scientific Developments</td>
<td>Sunset. Accomplished.</td>
</tr>
<tr>
<td>H-115.970</td>
<td>Usage of Brand and Generic Name for Prescription Medications</td>
<td>Retain. Still an issue.</td>
</tr>
<tr>
<td>H-130.976</td>
<td>On-Site Emergency Care</td>
<td>Retain. Still valid.</td>
</tr>
<tr>
<td>H-130.977</td>
<td>Trauma Center Efficacy</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-150.962</td>
<td>Quality of School Lunch Program</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-150.988</td>
<td>Caffeine Labeling</td>
<td>Retain. Caffeine amounts are still not required on labels.</td>
</tr>
<tr>
<td>H-170.969</td>
<td>Teaching Preventive Self-Examinations to High School Students</td>
<td>Retain in part with change in title to read: “High School Health Curricula.” “The AMA supports the development of comprehensive high school health curricula in conjunction with local medical societies and health departments. This curriculum should include instruction in appropriate evidence-based physical self examination(s) of the skin, breasts, testes and other systems.”</td>
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<tr>
<td>H-170.984</td>
<td>Healthy Living Behaviors</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-245.972</td>
<td>Breast Milk Banking</td>
<td>Retain. According to the Human Milk Banking Association of North America, 26 milk banks currently exist, but that number is not enough to meet</td>
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<tr>
<td>Infant Mortality in the United States</td>
<td>Retain in part. Delete (1) and (2) as WHO now has the WHO Indicator and Measurement Registry (IMR), which promotes interoperability through the SDMX-HD indicator exchange format and allows incorporation of appropriate international standards such as SDMX MCV (Metadata Common Vocabulary), ISO 11179 (Metadata Registry), DDI (Data Documentation Initiative and DCMES (Dublin Core). The Core health indicators is a set of 100 indicators prioritized by the global community to provide concise information on the health situation and trends, including responses at national and global levels. Retain (3) and (4) as they are still applicable.</td>
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<tr>
<td>International Infant Mortality Data</td>
<td>Retain in part. (1) can be sunset based on modification of H-245.986 (above). (2) is still valid and should be retained. Policy to read as follows: The AMA (1) supports taking actions that would influence the World Health Organization to adopt a standard methodology for collecting infant mortality data. Such standardized data would permit more accurate comparison of the U.S. infant mortality rate with that of other countries; and (2) supports taking steps to make the public aware that baseline data differences exist in comparison studies, so that information presented for political purposes may be misleading.</td>
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<tr>
<td>Inclusion of Overseas Beneficiaries in WIC</td>
<td>Retain. Program has been expanded to include Germany, England, Belgium, Netherlands, Italy, Spain, Japan, Korea, Turkey, Portugal, Central America and Ireland, but not all countries.</td>
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<tr>
<td>AMA and Public Health in Developing Countries</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>Regulation of Tissue Banking</td>
<td>Retain. Still valid.</td>
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<tr>
<td>Reduction in Prenatal Care Visits</td>
<td>Sunset. Guidelines now exist for everyone at all risk levels, and the AMA generally avoids endorsing the guidelines of specific organizations.</td>
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<tr>
<td>Alcohol and Other Substance Abuse During Pregnancy</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>Fetal Alcohol Syndrome Warning Legislation</td>
<td>Retain. S.2060 was introduced in 114th Congress (2015-2016), but not passed.</td>
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<tr>
<td>Promoting Prevention Strategies in Waiting Rooms</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>Preconception Care</td>
<td>Retain. Still relevant.</td>
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<tr>
<td>Bonding Programs for Women Prisoners and their Newborn Children</td>
<td>Retain. Still relevant.</td>
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<td>Program</td>
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<tr>
<td>H-440.868 Expedited Partner Therapy</td>
<td>Retain. Although expedited partner therapy is permissible in 38 states, it is only potentially allowable in 8 states, and it is prohibited in 4 states.</td>
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<tr>
<td>H-440.871 Collaboration Between Human and Veterinary Medicine</td>
<td>Retain in part. Sunset (6). Retain (1), (2), (3), (4), and (5) with change in (1) to read as follows: “Our AMA (1) supports an initiative designed to promote collaboration between human and veterinary medicine;”</td>
<td></td>
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<tr>
<td>H-440.885 National Health Survey</td>
<td>Sunset. Starting in 2013, the NHIS surveys the population annually and includes questions on sexual orientation, gender identity, and sexual behavior.</td>
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<tr>
<td>H-440.886 State Tracking of HIV/AIDS and Other Serious Infectious Diseases</td>
<td>Retain in part as follows: Delete (1) in part and retain (2) to read as follows: (1) Our AMA encourages state medical associations to support state legislation to establish requirements for reporting and case follow-up for HIV/AIDS and other serious infectious diseases, nationwide. Specific statutes must be drafted that, while protecting to the greatest extent possible the confidentiality of patient information: (a) provide a method for warning unsuspecting sexual partners, needle-sharing partners, or other close contacts; (b) protect physicians from liability for failure to warn the unsuspecting third party; but (c) establish clear standards for when a physician should inform the public health authorities; (2) Our AMA will assist states in their efforts to take whatever actions are necessary to allow blood banks and health departments to share information for the purpose of locating and informing persons who have any transmissible bloodborne disease.</td>
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<tr>
<td>H-440.913 Cellular Phone Location of 911 Emergency Calls</td>
<td>Sunset. FCC Phase II E911 rules require wireless service providers to provide more precise location information to Public Safety Answering Points; specifically, the latitude and longitude of the caller. Wireless service providers are required to file with the FCC a list of counties, or portions of counties, that they seek to exclude from the location accuracy requirements only where wireless carriers determine that providing location accuracy is limited or technologically impossible because of either heavy</td>
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<tr>
<td>H-445.990</td>
<td>Hospital and Medical Facility Communications with Scientific Content</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-445.997</td>
<td>Interviews with News Media</td>
<td>Retain in part. Change “spokesmen for medicine” and “medical spokesmen” to “health professionals” to read as follows: Our AMA: (1) recommends that, when spokesmen for medicine health professionals cooperate with the media in the production of news stories and documentaries, every effort should be made to provide media personnel with additional information and medical authentication of materials being prepared for presentation to the public; and (2) urges media personnel to seek such assistance from medical spokesmen health professionals being interviewed for their program material.</td>
</tr>
<tr>
<td>H-450.958</td>
<td>Support for Development of Measures of Quality</td>
<td>Retain as still relevant with change in title to read: “Support for Ongoing Development of Measures of Quality”</td>
</tr>
<tr>
<td>H-455.978</td>
<td>Nuclear Regulatory Commission Medical Use Program</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-460.978</td>
<td>Communication Among the Research Community, the Media and the Public</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-460.979</td>
<td>Use of Animals in Research</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-470.999</td>
<td>Youth Fitness</td>
<td>Retain in Part. Name changed in June, 2010 to “President’s Council on Fitness, Sports, and Nutrition” to read as follows: The AMA (1) approves in principle the aims and objectives of the President’s Citizens Advisory Committee on the Fitness of American Youth President’s Council on Fitness, Sports, and Nutrition and urges its member physicians to cooperate in the promotion of properly developed and soundly conceived plans and programs for youth fitness, and (2) requests the constituent associations and their member local medical societies to work cooperatively with reputable professional and other ethical groups interested in the improvement of youth fitness.</td>
</tr>
<tr>
<td>Section</td>
<td>Topic</td>
<td>Status</td>
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<tr>
<td>H-480.963</td>
<td>Folk Remedies Among Ethnic Subgroups</td>
<td>Retain. Still relevant.</td>
</tr>
<tr>
<td>H-480.970</td>
<td>Latex Allergy Warning</td>
<td>Retain. Still an issue.</td>
</tr>
<tr>
<td>H-480.990</td>
<td>The Transfer of Technology</td>
<td>Sunset. Based on 30-year old Health Policy Agenda (HPA) long defunct. No longer necessary.</td>
</tr>
<tr>
<td>H-480.991</td>
<td>Allocation of Privileges to Use Health Care Technologies</td>
<td>Sunset. Based on 30-year old Health Policy Agenda (HPA) long defunct. No longer necessary.</td>
</tr>
<tr>
<td>H-515.962</td>
<td>Renewed Focus on Domestic Violence</td>
<td>Sunset. Domestic violence is addressed in detail in Policy H-515.965.</td>
</tr>
<tr>
<td>H-515.968</td>
<td>Informing the Public and Physicians About Health Risks of Sedative Hypnotics, Especially Rohypnol</td>
<td>Retain. Still an issue.</td>
</tr>
<tr>
<td>H-515.989</td>
<td>Evidence of Standards for Child Sexual Abuse</td>
<td>Sunset. As of April, 2016, there is “A National Protocol for Sexual Abuse Medical Forensic Examinations—Pediatric”</td>
</tr>
<tr>
<td>H-520.989</td>
<td>Elimination of Anti-Personnel Landmines</td>
<td>Retain in part. In September of 2014, the US announced a new policy. Retain 1(a), (2), and (4) to read as follows: Our AMA: (1) urges the US government to (a) renounce its claimed exceptions to a ban on anti-personnel landmines, b) effectuate through the United Nations an international ban on the product, stockpiling, sale, transfer, or export of these weapons, (c) establish a hemispheric landmine free zone in support of the Organization of American States position, and (d) sign the Ottawa Treaty banning all anti-personnel landmines by December 1997; (2) encourages the US government and all members of the United Nations, as well as other interested charitable and medical organizations to contribute funds for the care, treatment and rehabilitation of landmine trauma victims; (3) will work with the US Delegation to the United Nations to ban the manufacturing, trade, and use of landmines; and (4) (3) endorses a domestic and international ban on the manufacture, stockpiling, sale and use of anti-personnel landmines, and urges the President and the US Congress to work toward the achievement of this goal.</td>
</tr>
<tr>
<td>H-525.994</td>
<td>Quality of Pap Smear Analysis</td>
<td>Retain. Laboratory quality is still an issue.</td>
</tr>
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</table>
REPORT 2 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-17)
Emerging Drugs of Abuse are a Public Health Threat
(Reference Committee E)

EXECUTIVE SUMMARY

Objective. Emerging drugs of abuse are a public health threat that needs actionable solutions from multiple stakeholders. Drug poisoning is the leading cause of injury death in the United States and drug poisoning deaths are at the highest level ever recorded. The Council on Science and Public Health initiated this report to bring attention to this public health issue and offer recommendations to address it.

Methods. English-language articles were selected from a search of the PubMed database through January 2017 using the search term “emerging drugs of abuse,” coupled with “synthetic cannabinoid,” “synthetic cathinone,” “stimulant,” “novel synthetic opioid,” “fentanyl,” “empathogen,” “psychedelic,” “dissociative,” “depressant,” and “public health;” and the search term “public health approach” in combination with “addiction” (not “gambling”), “substance misuse,” and “drugs.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

Results. New psychoactive substances (NPS) are quickly emerging, transient, and difficult to track. Although some coordinated public health responses have been used to combat NPS outbreaks, most strategies and solutions to address illicit drug use remain compartmentalized and disconnected, and are lacking the necessary information and data sharing capability. A need for a multifaceted, collaborative multiagency approach to substance use exists. Increased NPS surveillance and early warning systems informed by laboratories and epidemiologic surveillance tools resulting in actionable information that can quickly reach law enforcement, public health officials, physicians, and vulnerable populations are solutions to mitigate the growing NPS problem.

Conclusion. The rate of NPS development and emergence is dramatically outpacing our ability to identify and regulate the compounds. Regulators agree that NPS will continue to pose a global threat to health and overdoses and deaths will continue to occur. Agreement also exists around the world that risks need to be highly publicized and education should be directed to correcting the perceptions that these substances are benign. Those who experiment with NPS have the ability to communicate and share experiences rapidly and globally using the Internet, which exacerbates the threat. Drug overdose deaths in the United States involving synthetic opioid drugs such as fentanyl and carfentanil have more than doubled between 2010 and 2015 and are expected to continue increasing. Continuing progress in eliminating the threat of NPS in the United States will require a comprehensive, multidisciplinary effort. Physicians, public health officials, law enforcement, first responders, and forensic laboratories all need to collaborate to decrease morbidity and mortality related to emerging drugs of abuse. Data systems need to be adaptable and utilized cooperatively by federal, state, and local agencies to derive actionable intelligence, and intelligence must be used in real-time to alert stakeholders of drug-related incidents. The frequent emergence of new NPS with unknown dangers and a potentially high death toll, especially NPS opioids, are a distinct challenge that will require a concerted and coordinated effort and response to mitigate risks to the public health and improve outcomes.
REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 2-A-17

Subject: Emerging Drugs of Abuse Are a Public Health Threat

Presented by: Bobby Mukkamala, MD, Chair

Referred to: Reference Committee E
   (Rebecca Hierholzer, MD, Chair)

INTRODUCTION

“New psychoactive substance(s)” (NPS) refers to emerging designer drugs of abuse. The term was standardized by the United Nations Office on Drugs and Crime (UNODC) and is used by the U.S. Drug Enforcement Administration (DEA) and the enforcement agencies of other countries who monitor the development of such drugs. A recent report from the UNODC confirms that NPS have become a phenomenon of transnational organized crime with a significant global impact; 102 countries have reported the emergence of NPS. The ease of global e-commerce allows for anonymity and circumvention of law enforcement and public health controls.

The term “new” in NPS does not necessarily refer to novel chemical entities that have been newly synthesized; it also includes substances in existing pharmacological classes that are subject to abuse, but are not currently scheduled under international drug control conventions or federal or state statutes. For example, many NPS were designed as research tools or as candidates for drug approval that subsequently failed; synthetic pathways are often published in journals or found in patent applications. These compounds are ingested with the intent to mimic the effects of a wide range of psychoactive substances, including prescription opioids, cannabinoids, stimulants, hallucinogens, and central nervous system (CNS) depressants. NPS are sold as “legal highs” and alternatives to established drugs of abuse or as ways to “beat drug tests.” NPS may be 100 times more potent (or more) than existing pharmaceuticals but few, if any, have undergone formal pharmacological or toxicological testing.

Various classes of NPS have been associated with occurrences of adverse public health events around the United States. Heroin adulterated with the synthetic opioid carfentanil was linked to 174 opioid overdoses in six days in Cincinnati, Ohio. Synthetic cannabinoids have been connected to the mass intoxication of individuals in a New York City neighborhood referred to as a “Zombie” outbreak. With the increasing availability of NPS not only via the Internet, but in gas stations, convenience stores, adult stores, and smoke shops, effective prevention and treatment interventions will require broad cross-disciplinary approaches and cooperation among many stakeholders. The Council on Science and Public Health initiated this report to bring attention to this public health threat and offer recommendations to address it.

CURRENT AMA POLICY

AMA Policy H-95.940, “Addressing Emerging Trends in Illicit Drug Use,” supports (1) assessing, monitoring, and disseminating information on emerging trends in illicit drug use; (2) developing continuing medical education on emerging drugs of abuse and; (3) expedited federal efforts to
deem emerging drugs illegal. AMA policy recognizes substance use disorders, including addiction, as diseases and a public health hazard and supports a federal drug policy that is weighted more toward demand reduction rather than a law enforcement approach to address this problem (Policies H-95.976, H-95.975, H-95.981, H-95.983).

METHODS

English-language articles were selected from a search of the PubMed database through January 2017 using the search term “emerging drugs of abuse,” coupled with “synthetic cannabinoid,” “synthetic cathinone,” “stimulant,” “novel synthetic opioid,” “fentanyl,” “empathogen,” “psychedelic,” “dissociative,” “depressant,” and “public health;” and the search term “public health approach” in combination with “addiction” (not “gambling”), “substance misuse,” and “drugs.” Additional articles were identified from a review of the references cited in retrieved publications. Searches of selected medical specialty society and international, national, and local government agency websites were conducted to identify clinical guidelines, position statements, and reports.

NEW PSYCHOACTIVE SUBSTANCES (NPS)

NPS Regulation

NPS exist in a gray area between legal and illegal, and constitute an international policy challenge. A control framework has been developed by the UNODC to identify chemical classes, structural analogues, and specific substances that are prohibited from manufacture, distribution, and sale.6-8 Establishing new controls in a timely manner is challenging because only a limited number of NPS have been reviewed and addressed by international drug convention members, each of which has their own national control regulations that may differ.

In early 2016, the European Union’s European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was monitoring more than 560 NPS, more than double the number of total drugs controlled under the UN conventions. In 2015, 100 of the compounds monitored by EMCDDA were detected for the first time, and more than 380 (70%) of those monitored were detected within the last 5 years.1,9 In October 2015, the Chinese government controlled 116 new substances; carfentanil also is now a controlled substance in China.10 The Japanese National Institutes of Health Sciences is a leader in surveying and identifying NPS; as of April 2015 Japan had scheduled 858 synthetic cannabinoids (SCs), making them illegal.11,12

In the United States, NPS are regulated using a rulemaking process under the Controlled Substances Act (CSA).13 This rulemaking process can be initiated by United States Attorney General, at the request of the Secretary of the Department of Health and Human Services (HHS) with the concurrence of the U.S. Food and Drug Administration (FDA) and the National Institute on Drug Abuse (NIDA), or on the petition of any interested party. Most NPS are temporarily placed onto schedule I of the CSA when they are first properly determined to be biologically active and a threshold of data is obtained by the DEA. Temporary scheduling is effective for two years, which can be extended for an additional year if proceedings to permanently control the substance are initiated. After scientific and medical evaluation and a period of public comment, a final rule regarding substance scheduling can be issued. State policy makers have added specific chemicals and their analogues to their controlled substance schedules, and have created civil and criminal penalties that target NPS manufacturers and sellers.

Two standard approaches to identifying NPS for regulation exist in the United States. A neurochemical approach is used by the DEA, certain states (Iowa, Maryland, Texas), and other
jurisdictions (District of Columbia). To assign a substance to schedule I using this approach, the
substance must demonstrate receptor binding characteristics and be active in functional assays
similar to an existing member of designated chemical classes. This approach theoretically
eliminates the need to continually update schedules each time a new compound is discovered; it is
limited to the binding site(s) recognized by the statute in each jurisdiction and by uncertainty about
the level of proof necessary to satisfy the statutory requirement. The alternative method for
regulation is the analogue approach, which requires that a substance be both substantially similar
structurally to an existing Schedule I or II controlled substance, and that it has, or is intended to
have, a substantially similar effect on the body as the scheduled substance. This approach covers
every molecule as long as it is structurally similar to at least one schedule I or II substance. No
clear guidance exists on what constitutes “substantially similar,” and some substances have failed
this test because of “lack of structural similarity,” despite otherwise having the pharmacologic
attributes of an NPS.14 The legal and scientific communities recognize the need to clarify and
simplify language around scheduling and also have identified a “language barrier” surrounding this
issue as a challenge to overcome.

NPS Epidemiology

NPS usage is difficult to capture and is likely underreported because these drugs emerge quickly,
may have a transient period of use, and are difficult to individually track and identify. Experts warn
that because of the dynamic nature of the NPS market, many of the existing epidemiological
indicators of drug use are poorly suited to measure or monitor the use of emerging substances. For
example, including specific questions about the use of NPS in national surveys is difficult because
these surveys often take years to plan and poison center data is often limited by the absence of
analytical confirmation and reliance on secondary reporting of clinical features.15

NPS Pharmacology

Up to thirteen categories of NPS have been described by global authorities based on chemical
structure.¹ Not all drugs in a chemical class produce the same pharmacological effects; for
example, the phenethylamine category includes central nervous stimulants, d-lysergic acid
diethylamide (LSD)-like hallucinogens, and 3,4-methylenedioxy-methamphetamine (MDMA)-like
stimulant empathogen-entactogens (drugs that produce feelings of empathy, openness, and being
touched). Furthermore, the same pharmacological effect can be produced by drugs from different
categories; for example, many synthetic cathinones, substituted phenethylamines, and piperazines
are central nervous system stimulants.

This report will focus on six broad categories based on pharmacological and clinical effects:
synthetic opioids, synthetic cannabinoids, stimulants, hallucinogens (psychedelics and
dissociatives), CNS depressants, and others (Table 1).

Synthetic Opioids. Serious adverse events, overdoses and deaths have been increasingly attributed
to NPS opioids in recent years, the vast majority of which are fentanyl analogues (Table 1).¹⁶-­³³
From 2014 to 2015, the death rate from synthetic opioids other than methadone increased by 72%
in the United States, most likely illicitly manufactured fentanyl, and potentially other NPS
opioids.³⁴ Fentanyl, its analogues, and other synthetic opioids are particularly concerning because
they have recently been linked to numerous clusters of deaths around the United States. Carfentanil
was linked to 174 opioid overdoses in six days in Cincinnati;⁴ a cluster of deaths has been
attributed to acetylfentanyl in Rhode Island;⁵ illicit fentanyl has been marketed as cocaine and
resulted in an overdose cluster in Connecticut;⁶ counterfeit Norco® (hydrocodone/acetaminophen)
contaminated with fentanyl in Sacramento led to over 50 overdoses and 12 deaths;³⁷,³⁸ and
counterfeit Norco® in San Francisco (that was actually fentanyl and promethazine, which
potentiates the CNS depressant effects of opioids) resulted in another public health threat.39

NPS synthetic opioids are generally selective mu-opioid receptor (MOR) agonists and former
candidates for regulatory approval as therapeutic agents. The potency of these compounds varies
greatly with some analogues having only slightly higher potency than morphine and others having
significantly greater potency. For example U-47,700 is 7.5 times more potent, while carfentanil is
10,000 times more potent than morphine.40-42 Knowledge about the majority of fentanyl analogues
and other recent opioid-like NPS is limited because they have not been studied in humans. Even
studying them in model systems is difficult because of their extraordinary potency which places
researchers who handle them at high risk for harm from accidental exposure.40

China and Mexico are the primary source countries for many NPS opioids.3,43-46 These compounds
are being substituted for heroin and other opioids (such as hydrocodone), are being used to
adulterate heroin and other non-opioid drugs of abuse, and are being sold on the street. Not only are
they desired by those seeking relief from opioid withdrawal, they are gaining popularity as drugs of
choice among recreational opioid users.32,36 The DEA expects the designer NPS market,
particularly designer fentanyls, to continue to expand as novel products attract new users.3 In its
2016 annual Emerging Threat Report, 60% of the NPS opioids were identified for the first time.37
Public warnings have been issued cautioning the public and law enforcement officials about the
danger of the potency of NPS opioids and the fact that high or multiple doses of naloxone may be
needed to reverse their effects in the event of an overdose.36,44 A recent review details the structure-
activity relationships of fentanyl-related compounds and derivatives,48 which unregulated
laboratories in China continue to develop.49

Synthetic Cannabinoids. SCs are the largest category among NPS and have become colloquially
known by the names of previously “branded” products K2 and Spice (Table 1). SC products
typically contain one or more compounds dissolved in a solvent and sprayed on a plant material,
sometimes with flavorings such as bubblegum or strawberry, which is then smoked. The laced
plant material is often placed in branded packets, labeled as “not for human consumption” in order
to circumvent drug laws, and sold as “herbal incense.”3 These products also are being increasingly
sold in liquid forms for e-cigarette cartridges.3,50 The chemical structures of SCs vary greatly and
new derivatives are emerging constantly. SCs have been associated with clusters of outbreaks of
adverse events including severe delirium and “zombielike” altered mental status.5,51,52
A wide variety of SC chemical compounds exist that likely activate multiple pharmacological
pathways causing diverse and unexpected adverse effects.53,54 SCs are mainly cannabinoid receptor
1 (CB1) agonists intended to mimic the effects of Δ^9-tetrahydrocannabinol (THC), however, some
also have affinity for the peripheral cannabinoid receptor 2, CB2.54-56 Most SCs are full agonists, as
opposed to the partial agonist activity of THC. They have higher affinity for cannabinoid receptors
and act more rapidly at these receptors than does THC. Cannabis or cannabis plant extracts contain
other cannabinoids including cannabidiol (CBD), which appears to possess anxiolytic or
antipsychotic properties that can attenuate the psychotomimetic properties of THC. Because SCs
exist in pure form, they generally result in more intense psychotomimetic effects than does use of
herbal cannabis.57 It is noteworthy that SCs are associated with severe psychosis, agitation, and
intense sympathomimetic effects.58 Additionally, many SCs have potent active metabolites which
can cause prolonged adverse effects.58 Considering the potency of the compounds, the risks of
misuse and addiction are a concern.54 Recent reviews summarize structure-activity, epidemiology,
pharmacodynamics, metabolism, clinical implications, and adverse effects of SCs.12,55,58-63
Stimulants. The category of NPS stimulants contains many classes of chemical structures with varying pharmacological effects and varying potency (Table 1). Convention has been to compare them to relatively well-studied stimulants. Some compounds mimic amphetamine (classic psychostimulants) to produce arousal and stimulation. Others mimic MDMA (“Molly”), are empathogen-entactogens, and are used mainly to enhance sociability. Still other NPS stimulants are intended to mimic cocaine or methylphenidate.

A number of agents among the NPS stimulants commonly known as “bath salts” (usually synthetic cathinones) or “plant food” are sold as “research chemicals,” and are labeled as “not for human consumption” in attempts to circumvent drug laws. These chemicals are usually powders, crystalline mixtures, or pressed into tablets. Often NPS stimulants are mixed with cocaine or methamphetamine and many have become substitutes for MDMA, unbeknownst to users. Some common NPS stimulants in the news recently have been the different “bath salts,” methylenedioxypyrovalerone (MDPV), methedrone, and alpha-PVP (“Flakka”). It is not uncommon for users to be consuming multiple NPS stimulants in a product and to be unaware of the identity of the compound(s) they are using.

NPS stimulants alter synaptic concentrations of the neurotransmitters dopamine, norepinephrine, and 5-hydroxytryptamine (5-HT, otherwise known as serotonin) by inhibiting and/or inducing transport (reuptake) proteins to varying degrees. The pharmacologic properties of NPS stimulants account for their potential to trigger patterns of misuse and addiction. Adverse effects of NPS stimulants are reported to be similar to those of other stimulants. However, their use may lead to serotonin syndrome, violence, homicidal combative behavior, self-mutilation, coma, and death. Recent reviews summarize the neuropharmacology and adverse effects of NPS stimulants.

Hallucinogens. Two distinct subcategories of NPS hallucinogens have emerged: psychedelics which are designed to have LSD-like activity, and dissociative agents which are purported to have phencyclidine (PCP) or ketamine-like pharmacologic effects (Table 1).

In addition to being LSD analogues, many NPS psychedelics are also members of the phenethylamine or tryptamine chemical classes and have multiple pharmacologic profiles. For example, some phenethylamines such as the NBOMe-series of drugs are stimulants as well as psychedelics. This pharmacologic effect has been described as MDMA and LSD fusing together, thus producing new psychedelic substances. NPS psychedelics generally affect extracellular serotonin concentrations. As a result, serotonin syndrome and sympathomimetic toxicity are concerns.

Full pharmacologic profiles of many NPS psychedelics have not yet been elucidated; however, some analytical and animal model behavioral characterizations are beginning to emerge for individual compounds. Receptor studies performed on individual NPS psychedelics reveal varied pharmacodynamic properties with respect to receptor affinity and activation of signaling pathways; drug users anecdotally recognize, respond to, and report on these differences. A litany of over 230 psychedelic compounds, including synthesis instructions, bioassays, and dosages exists in two books, PiHKAL and TiHKAL, published by psychopharmacologist Alexander Shulgin (Shulgin is credited with discovering most of the cataloged psychedelic compounds). Because the effects of these drugs vary dramatically, users can theoretically choose the experience they desire based on onset, duration, and relative potency to a compound such as LSD. Some of these inherent properties lead to dangers; for example, in the case of Bromo-DragonFLY, very high potency coupled with delayed onset has resulted in re-dosing and subsequent toxicity. Note that Shulgin has attained cult-hero status among users of these compounds; his books frequently glorify...
use of these products for recreational purposes – the neologism PiHKAL stands for “phenylethylamines I have known and loved,” and TiHKAL stands for “tryptamines I have known and loved.”

NPS dissociative drugs are primarily analogues of PCP and ketamine (“Special K”) and as such are principally uncompetitive N-methyl-D-aspartate (NMDA) receptor antagonists. Many of the known PCP and ketamine analogues were developed through legitimate research and their structures exist in peer-reviewed and patent literature. However, re-emergence of NPS dissociative agents has occurred through online forums – with forum members collaboratively planning, synthesizing, and characterizing rationally designed compounds, including methoxetamine, with online “research chemical” vendors subsequently selling the compounds. Little data on behavioral and psychological effects exist; however, anecdotal reports note effects comparable to PCP and ketamine although with varying degrees of intensity and duration. Inconsistent data on withdrawal symptoms have been recorded; anecdotal reports of “cravings” have emerged. Little toxicological data exist, although some case studies have been presented. A recent publication reviews the non-medical use of dissociative drugs.

CNS Depressants. NPS CNS depressants consist mainly of benzodiazepine analogues (Table 1). The first compounds to emerge as NPS benzodiazepines were phenazepam (“Bonsai”) and etizolam. Because these drugs are controlled substances in a few European countries, entrepreneurs derived subsequent NPS from failed therapeutic drug candidates in old pharmaceutical research to circumvent drug laws in many countries. Similar to marketed benzodiazepines, NPS benzodiazepines have active metabolites that are also marketed as NPS (for example, the active metabolite of flunitrazepam, norflunitrazepam, is marketed on drug forums as fonazepam). A diverse range of possible modifications and the potential for development of families of novel NPS benzodiazepines has public health officials concerned about this emerging class. Benzodiazepines have been offered as research chemicals on the Internet; investigators and public health officials speculate these are consumed not only to induce a state of intoxication, but also for self-medication of anxiety disorders.

Similar to classic benzodiazepines, NPS benzodiazepines bind to the ionotropic gamma-aminobutyric acid (GABA$_A$) receptor. NPS benzodiazepines remain one of the least-well-characterized categories of NPS. Similarity to established agents is unclear; drug disposition and elimination rates are largely unknown, which takes on increasing importance in the context of multiple dosing, use by naïve patients, and/or use in combination with alcohol and other drugs. One study evaluated pharmacokinetic properties of a single dose of flubromazepam and noted a very long half-life of more than 100 hours and detectable urinary metabolites for more than 28 days post-ingestion, the activity of metabolites was not assessed in this study. Also of note is that many of these compounds have a high potency compared to traditional benzodiazepines, which could lead to unintentional overdoses; there is also concern about their use in drug-facilitated crimes, including sexual assault and robbery. Additionally, complex metabolic pathways and shared metabolites could complicate clinical investigation and analytical findings.

Others. Other emerging drugs (including botanicals and other classes of psychoactive drugs that do not fit neatly into the aforementioned categories) are being sold on the gray market and cataloged on online drug forums. Etaqualone, first synthesized in 1963, has become a popular “research chemical” for sale over the Internet and is watched by the DEA. It is an analogue of methaqualone (brand name Quaalude) and is a GABA$_A$ receptor agonist resulting in sedative and hypnotic effects. Several other methaqualone analogues cited in literature could emerge as NPS.
Mitragyna speciosa is a deciduous tree indigenous to Thailand and other Southeast Asian countries. Over 25 alkaloids have been isolated from *M. speciosa* including mitragynine and 7-hydroxymitragynine, which are believed to be the primary pharmacologic constituents. Kratom is the colloquial name of the dried plant material of *M. speciosa*. Its active components are not classified as opioids but have been identified as partial MOR agonists and competitive kappa- and delta-opioid receptor antagonists. Traditionall *M. speciosa* has been used by Southeast Asian laborers to alleviate fatigue or as a mood enhancer and/or analgesic. More recently, in addition to recreational use, kratom has been touted as an antidepressant, anxiolytic, anti-inflammatory, analgesic, and alternative to methadone or buprenorphine for medication-assisted treatment of opioid use disorder. Pharmacological studies evaluating kratom are limited, but are beginning to emerge. The DEA recommended kratom for inclusion on schedule I of the CSA in early 2016, but public opposition led to reconsideration. The 8-factor analysis used in the decision not to add kratom to schedule I of the CSA concluded that kratom has substantially lower harmfulness and abuse potential than opioids and that its consumption is primarily motivated by its perceived benefits as a natural “home remedy” and alternative to conventional medicines for a variety of ailments.

Ayahuasca is a brew of two plants, *Psychotria viridis*, which contains *N*,*N*-dimethyltryptamine (DMT), primarily a serotonin modulator, and *Banisteriopsis caapi*, which has monoamine oxidase inhibiting (MAOI) properties and is orally active. Ayahuasca administration is characterized by a modified state of awareness where users experience deep introspection and increased insight, dream-like imagery, enhanced emotions, and recollection of personal memories. Ayahuasca use originated as an Amazonian medicinal, spiritual, and cultural practice, but the experience has since spread into non-indigenous syncretistic and recreational practices worldwide. The globalization of ayahuasca has raised both public health and legal concerns. Although DMT is on the UNODC international conventions scheduled list, no plants containing the drug are currently included on the list. Some reports suggest that ayahuasca may have therapeutic effects for the treatment of substance use disorders and psychotherapeutic interventions. Recent reviews discuss the pharmacology and therapeutic potentials of ayahuasca.

Dietary supplements (DS) sold for weight-loss purposes are among the most adulterated DS on the market and are the third most prevalent group of supplements that require recalls of products containing unapproved pharmaceutical ingredients. Several synthetic NPS stimulants have appeared in DS over the last several years, perhaps in an effort to replace Ephedra after it was banned. Many are added to DS in the guise of a plant ingredient on the label. Some of the more noteworthy stimulants include the structurally similar 1,3-dimethylamylamine (DMAA) and 1,3-dimethylbutylamine (DMBA), which are labeled as geranium and Pouchong Tea, respectively, and have been associated with adverse health effects; β-methylphenethylamine (BMPEA), often labeled *Acacia rigidula*, is the subject of an FDA study; and *N*,*α*-diethyl-phenylethylamine (*N*,*α*-DEPEA), a methamphetamine analogue isomer which was labeled as dendrobium, has been the subject of several news stories. A recent review discusses several NPS sympathomimetic stimulants that have been detected in DS.

NPS MARKET

A UN World Drug Report on the world drug problem, published before a special session of the General Assembly, includes a detailed market analysis for each class of NPS; noteworthy are the
numerous ways and forms in which they are marketed and the many different user groups engaged with NPS. The UNODC and the DEA agree that the market for NPS will continue to expand and that the Internet is transforming the drug trade and allowing for global access to these emerging compounds.

Trafficking and selling NPS has a high profit margin. They are sold mostly on the surface Internet by major online marketplaces that advertise their products and accept payment by major credit and debit cards and online payment services or direct bank transfers through product websites. The anonymity, low-cost, scope, and apparent reliability of these websites makes it a challenge for law enforcement to seize the thousands of unmarked small packages being shipped to individuals all over the world. Research has been conducted detailing online cryptomarkets, the anonymous global Amazon-like marketplaces that seem to be a primary wholesale source of NPS on the deep web, and suggests likely growth in the coming years in sales and continued resilience to law enforcement.

NPS TREATMENT CHALLENGES

NPS have been increasingly associated with hospital emergencies, acute adverse health consequences, and drug-induced deaths. Individuals rarely know the dose and identity of the drug they are taking. Furthermore, other considerations include variable purity and potency of the active ingredient and the potential presence of adulterants or contaminants.

Treating NPS intoxication is limited by the lack of inexpensive and rapid screening tests to confirm the presence of most NPS. Very few, if any, NPS are detected by standard immunoassay urine drug screens, and with limited availability of reference standards, developing laboratory-validated analytical methods is a challenge. Even when analytical methods are developed, the rapid appearance of NPS on the market limits test reliability and the ability of laboratories to keep up. For individuals with histories suggestive of drug misuse, particularly opioids and benzodiazepines, physicians should be aware of this limitation and carefully assess “false-positive” urine drug testing results, much like medical review officer protocols advise.

To add to these clinical challenges, some NPS (synthetic cannabinoids for example) have a short detection window in biological fluids, doses are low, the compounds are extensively metabolized, and little to no parent compound is excreted in urine. Fentanyl and fentanyl analogues pose a threat not only to users, but also to health care professionals, law enforcement personnel, and postal service employees since minuscule amounts of the drug are lethal and can be inadvertently inhaled or absorbed through the skin.

NPS AND PUBLIC HEALTH

Public health approaches have been used to successfully address outbreaks of NPS overdoses. When such approaches have been successful, pre-existing coordinated relationships among multiple groups (law enforcement, emergency medical services personnel, forensic laboratories, public health officials, social service providers, and hospital emergency department physicians and personnel) have allowed for a rapid and comprehensive response to a given outbreak and its sequelae.

For example, an extended pattern of SC use in Anchorage, Alaska was eventually contained through the use of multiple collaborative interventions. In New York, New York, a “Zombie” outbreak caused by a new NPS was identified and characterized within 17 days, including the successful development of reference standards for the laboratory detection of emerging substances.
and their metabolites. This was made possible because of close collaboration among medical professionals who documented clinical histories, additional background and drug paraphernalia provided by law enforcement, and reliable analysis performed by laboratories. Finally, a rapid and controlled public health response involving multiple health care providers reduced the impact of an outbreak of fentanyl laced cocaine in New Haven, Connecticut and mitigated more severe public health consequences.

Although coordinated responses like the ones mentioned do exist, most strategies and solutions for illicit drugs remain compartmentalized and disconnected; examples of such surveillance programs are detailed below. A need for a multifaceted, collaborative multiagency approach to combat NPS use exists. This approach, as well as increased NPS surveillance and early warning systems informed by laboratories, and epidemiologic surveillance tools resulting in actionable information that can quickly reach law enforcement, public health officials, emergency physicians, and vulnerable populations will aid in mitigating the growing NPS problem.

### Surveillance

Public health and law enforcement agencies are both tasked with protecting individuals, but have different philosophies and use different methods. For example, the term “surveillance” in a public health context refers to systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event; in law enforcement surveillance generally means the observation of people or premises during the course of an investigation. Recently, law enforcement entities have started to align their efforts more closely with public health objectives in an effort to combat the public health threat posed by emerging drugs of abuse.

The Council of State and Territorial Epidemiologists (CSTE) released a position statement in 2008 stating that the “identification and quantification of the determinants and human health consequences of use and abuse of substances is an essential first step in prevention.” At that time, substance abuse had no devoted categorization under the CSTE organizational structure and was not addressed in previous capacity assessments. The position statement called for the development of performance measures for addressing substance abuse within five years. In its 2013 National Assessment of Epidemiology Capacity, CSTE reported that less than 12 percent of states had substantial capacity for substance abuse epidemiology (by this time, a formal CSTE category), 43 percent of states had no capacity, and most states had no plans to develop capacity despite the fact that substance abuse problems contribute directly to the leading causes of death in the U.S. CSTE noted part of the reason for states’ unwillingness to develop capacity in the area of substance abuse was “turf issues” with other agencies and a perception among politicians that treatment-based efforts are sufficient to combat the problem. CSTE recommends the development of a strategy to increase the epidemiologic capacity to address substance abuse at the local, state, and national levels and to encourage more effort to publicize successes and to expand the role of epidemiology in the program area. Accordingly, in 2015, the SAMHSA Center for Behavioral Health Statistics and Quality (CBHSQ) incorporated a Community Epidemiology Team with deployment capacity to respond to local outbreaks related to drug use. In 2016, CBHSQ/SAMHSA began phase two of this project in partnership with CSTE to identify and promote a core set of behavioral health indicators intended to contribute to a national behavioral health surveillance system capable of responding to community-level needs. CSTE has a capacity assessment underway.

The National Drug Early Warning System (NDEWS) is funded by NIDA and administered by the Center for Substance Abuse Research (CESAR) at the University of Maryland. CESAR monitors emerging substance use trends. Its activities help enable health experts, researchers, and citizens to
better respond to potential outbreaks of illicit drug use and to identify increased use of NPS.\textsuperscript{123} NDEWS builds on what was formerly the NIDA Community Epidemiology Work Group (CEWG), monitoring not only local data from the CEWG program, but also incorporating a national perspective to monitor emerging issues.

**Role of the DEA.** In the United States, the DEA is tasked with identifying new drugs of abuse and determining the need to appropriately schedule and classify them in collaboration with the FDA and NIDA. Temporarily scheduling a new NPS by the DEA requires a threshold of data regarding that drug. In the current landscape of constantly emerging NPS, obtaining the relevant and appropriate amount of data from users who have experienced adverse events and overdoses can be challenging. Emergency department physicians are limited by drug testing capabilities at their facilities and may not collect appropriate specimens for testing and positive identification of NPS. Outbreaks may not be recognized, and medical examiner and coroner offices strained by increasing cases may not perform comprehensive toxicology screens on all cases and may miss NPS identifications. Additionally, reference materials may not be available in laboratories to identify new emerging compounds.

As new NPS emerge, the DEA collaborates with the Chemistry and Drug Metabolism Section (CDM) at NIDA. When data for regulation via the neurochemical approach are needed, CDM obtains purified drug samples from the DEA and performs the appropriate assays. The data obtained are quickly published to provide laboratories and regulating bodies around the world with needed information. The CDM also collaborates with universities worldwide and governmental forensic institutes, with the goal of circulating information to hospitals and laboratories as rapidly as possible and to share information about chemical structures with commercial reference standard manufacturers.\textsuperscript{12}

The DEA Special Testing and Research Laboratory (STRL) has an Emerging Trends Program to analyze NPS for enforcement and intelligence purposes. However, a formal identification is made only when authenticated reference material is available for comparison. This is a limitation because many NPS may go undetected. When reference material is not available, the drug is identified as “substance unconfirmed.” Throughout periods in the same calendar year, the landscape of drugs detected can change dramatically.\textsuperscript{124,125} STRL also has a Reference Materials Program through which reference standards are synthesized and characterized. Information about NPS chemical structures are subsequently shared with law enforcement, forensic, and public health communities.

The DEA National Forensic Laboratory Information System (NFLIS) systematically collects results from federal, state, and local forensic laboratories to evaluate how substance use varies geographically. More than 300 state and local forensic laboratories in the United States exist, performing nearly two million drug analyses each year. The data in the most current yearly report include 50 state systems and 101 local or municipal laboratories/laboratory systems (representing a total of 277 individual laboratories) and federal data from DEA and U.S. Customs and Border Protection laboratories.\textsuperscript{126} An NFLIS special publication on 2C-phenethylamines (mostly NPS stimulants and hallucinogens) reported a 295 percent increase in their identification from 2011 to 2015.\textsuperscript{127} An NFLIS Brief reported a 15-fold increase in fentanyl reports submitted to laboratories between 2013 and 2015 and that the majority of fentanyl drug reports resulted from clandestinely produced and trafficked fentanyl, not fentanyl diverted from traditional pharmaceutical sources.\textsuperscript{128}

Complications from emerging drugs of abuse, such as acetylfentanyl, frequently surface initially in emergency departments. Prompt recognition and treatment can help reduce morbidity and mortality. The American College of Emergency Physicians published an information paper highlighting the complexity of the NPS problem and providing a listing of surveillance sources for
healthcare providers. The National Drug Control Strategy recommends the pursuit of innovations in data collection that reach beyond traditional methods in an effort to keep up with the rapidly evolving drug culture. For example, scanning social media and using Internet search tools to understand local trends can augment local emergency department data, and technologies that estimate drug use within communities in real-time can complement traditional epidemiological survey studies.

**Fusion Centers**

Data fusion involves the exchange and analysis of information, previously siloed, from multiple sources such as law enforcement, public safety, public health/health care, and the private sector, with the end goal of developing meaningful and actionable intelligence and information. Additionally, updates can be provided based on re-evaluation of data in the context of new information. Across the nation, fusion centers have been established to facilitate the sharing of information among multiple agencies and to build intelligence capabilities. It should be noted that fusion centers operate in accordance with existing state and federal privacy laws and requirements. Both the Centers for Disease Control and Prevention (CDC) and the Association of State and Territorial Health Officials agree that reliable data are critical in order for public health and law enforcement agencies to effectively carry out their mission. Because these organizations share a responsibility to protect the public, the CDC lists “information sharing” as one of the 15 capabilities for national public health preparedness standards that are used to assist public health departments in strategic planning.

Generally, fusion centers have focused on bioterrorism, but their applications also include intelligence gathering and risk assessment for other hazards, including NPS, in order to protect the security of the country. Drug-specific fusion centers are being developed to better understand the scope of the drug problem in local communities and to enhance prevention, treatment, and enforcement efforts.

In New Jersey, the Drug Monitoring Initiative (DMI) is a successful example of a drug-specific fusion center. The DMI was initiated by the NJ State Police in response to an exponential rise in drug overdoses. The goal is to better understand the scope of the problem through continuous statewide monitoring of drug activities. Continuous statewide monitoring of drug activities and creation of an “information sharing environment” enables law enforcement, community services, and public health experts to better understand trends, patterns, implications, and threats from illicit drug activity on both the supply and demand side. This process allows for intelligence-led policing, investigative support for law enforcement, and intelligence-led outreach for treatment and prevention efforts. DMI also has established a list of best practices, including a monthly conference call involving representatives from 48 states in order to provide information to other law enforcement, public health, and fusion centers across the country. Additionally, a basic drug recognition course is offered for law enforcement first responders and health partners so they are informed about emerging drug trends and able to share the information. Four additional sites in the United States are currently being modeled after DMI. See Appendix 1 for a summary sheet outlining the DMI program.

**Interventions Directed at Preventing or Reducing Harm**

Educational campaigns are effective at reducing harms from NPS. Drug checking is another harm reduction strategy utilized by drug users to evaluate the contents of pills or powders after obtaining them. Some users will seek illicit drugs despite the known risks of substitution and adulteration, for example as with MDMA. The availability of commercially available kits allows
users to distinguish MDMA from other compounds, such as bath salts, before use. Commercially available drug checking kits, although limited by the methods used to check the drugs, are an effective strategy to test contents of pills and powders for validity and/or the addition of contaminants or adulterants. The rationale is that if prevention campaigns have failed, this harm reduction strategy could result in more informed user decisions.\textsuperscript{119,137}

**CONCLUSIONS**

The rate of NPS development and emergence is dramatically outpacing our ability to identify and regulate such substances. The UNODC and the DEA agree that NPS will continue to pose a global threat to health, and overdoses, other serious adverse events, and deaths will continue to occur. Agreement also exists around the world that risks need to be highly publicized and education should be directed to correcting the perceptions that these substances are benign. Those who experiment with NPS have the ability to communicate and share experiences rapidly and globally using the Internet. As an example, the chemistry and subjective effects of the SCs contained in “Spice” products were being discussed by users in online forums at least 2 years before they were officially identified and characterized by a laboratory.\textsuperscript{138} Drug overdose deaths in the United States involving synthetic opioid drugs such as fentanyl and carfentanil have more than doubled between 2010 and 2015 and are expected to continue increasing.\textsuperscript{139} Continuing progress in eliminating the threat of NPS in the United States will require a comprehensive, multidisciplinary effort. Physicians, public health officials, law enforcement, first responders, and forensic laboratories all need to collaborate to decrease morbidity and mortality related to emerging drugs of abuse. Data systems need to be adaptable and utilized cooperatively by federal, state, and local agencies to derive actionable intelligence, and intelligence must be used in real-time to alert stakeholders of drug-related incidents. The frequent emergence of new NPS with unknown dangers and high death tolls, especially NPS opioids, are a distinct challenge that will require a concerted and coordinated effort and response to improve outcomes.

**RECOMMENDATIONS**

The Council on Science and Public Health recommends that the following be adopted and the remainder of the report be filed:

1. That Policy H-95.940, “Addressing Emerging Trends in Illicit Drug Use,” be amended by addition and deletion as follows:

   Addressing Emerging Trends in Illicit Drug Use
   Our AMA: (1) recognizes that emerging drugs of abuse, especially new psychoactive substances (NPS), are a public health threat;
   (2) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, the Centers for Disease Control and Prevention, the Department of Justice, the Department of Homeland Security, state departments of health, and poison control centers to assess and monitor emerging trends in illicit drug use, and to develop and disseminate fact sheets, and other educational materials, and public awareness campaigns;
   (3) supports a collaborative, multiagency approach to addressing emerging drugs of abuse, including information and data sharing, increased epidemiological surveillance, early warning systems informed by laboratories and epidemiologic surveillance tools, and population driven real-time social media resulting in actionable information to reach stakeholders;
(4) encourages adequate federal and state funding of agencies tasked with addressing the emerging drug of abuse health threat;

(2) (5) encourages the development of continuing medical education on emerging trends in illicit drug use; and (3)

(6) supports efforts by the federal, state, and local government agencies to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. (Modify Current HOD policy)

2. That our AMA participate as a stakeholder in a CDC/DEA taskforce for the development of a national forum for discussion of NPS-related issues. (Directive to Take Action)

Fiscal Note: $1,000
REFERENCES


13. 21 U.S.C. ch. 13 § 801 et seq.


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**Notes:**
- MDMA, 3,4-methylenedioxy-methamphetamine; LSD, d-lysergic acid diethylamide; PCP, phencyclidine; MOR, mu-opioid receptor; CB<sub>1</sub>, cannabinoid receptor 1; CB<sub>2</sub>, cannabinoid receptor 2; NET, norepinephrine transporter; DAT, dopamine transporter; SERT, serotonin transporter; MOA, monoamine; NT, neurotransmitter; 5-HT, serotonin; GPCR, G-Protein coupled receptor; NMDA, N-methyl-D-aspartate; GABA<sub>A</sub>, gamma-aminobutyric acid
Appendix 1: Overview of the New Jersey Drug Monitoring Initiative (DMI).

An Intelligence Capability to Understand New Jersey’s Drug Environment

Drug Monitoring Initiative (DMI) Overview
Heroin and opiate use in New Jersey has increased exponentially in recent years. The high rate of addiction drives the increased demand for both heroin and prescription painkillers, and recent statistics identify an increase in illicit heroin and opiate use, seizures, and deaths. During 2013, the State Medical Examiner’s Office recorded 1,336 fatal drug overdoses. This common scenario has indiscriminately played out in New Jersey and across the country, affecting all races, genders, age groups, and social classes.

The New Jersey State Police developed DMI in response to this situation and to understand the scope of the problem through continuous monitoring of drug activity statewide. The DMI intelligence capability establishes a drug information sharing environment that enables law enforcement, human services, and public health experts to better understand trends, patterns, implications, and threats from illicit drug activity having an impact on specific locations statewide. DMI gathers investigative and administrative data, both on the supply side and the demand side, to develop a 360-degree view of the State’s drug environment. The analysis is used to produce intelligence products for partners across state and local agencies and non-profit organizations. This process enables intelligence-led policing and investigative support for law enforcement and intelligence-led outreach for treatment and prevention efforts.

Collection Process
Various agencies collect drug data needed to interpret New Jersey’s illicit drug environment. DMI leverages the existing people, processes, and platforms through an information sharing network which directs essential drug data sets to DMI for storage, analysis, production, and sharing. DMI leverages the following entities, which provide the respective data elements through data-sharing agreements and in a de-identified fashion, where appropriate:

- State Police and county forensics laboratories – all analyzed drug data
- NJ Department of Health (DOH) – EMS Narcan deployments
- County Prosecutor’s Offices – Narcan deployments by law enforcement
- State Medical Examiner’s Office – Drug involved death data
- NJ Mental Health and Addiction Services – Patient admissions and drug use data
- Automated Fingerprint Information System – Daily drug arrest data
- Prescription Drug Monitoring Program – Collected transactional data

Production
All of the information allowed to be shared is normalized and uploaded to the Project Safe Neighborhood Mapping Program, where it is stored, geo-coded, mapped, and made available to law enforcement, human services, and health partners via MAGCLEN’s RissNet portal. DMI analysts use this information to provide:

1) Investigative support for strict liability cases and other drug investigations.
2) Situational awareness through the following products:
   - Daily Drug Environment Report – Heroin stamps seized and involved in overdoses are included in this report along with opiate pills seized in NJ.
   - Ad hoc Alerts – The NJ ROIIC provides heroin overdose alerts, new and emerging drug notifications, and drug environment products from New Jersey and other regional DMI partners.

Training and Outreach
To increase drug awareness and information sharing, DMI developed the:

1) Monthly Conference Call – Brings together law enforcement, health partners, fusion centers and other entities to share information pertaining to drug trends in different areas of the country.
2) Basic Drug Recognition Course – Law enforcement, fire service, EMS, and health partners learn about drugs, trends, identifiers, and how to collect and share drug-related information.
DMI Established Best Practices

- Facilitates collaboration among diverse multidisciplinary entities to address the drug problem
- Uses automated drug data collection processes to ensure a timely exchange of information
- Desensitizes information to ensure seamless and transparent information sharing
- Derives intelligence from all investigative and administrative drug data
- Incorporates subject matter experts from various disciplines into the drug intelligence production process
- Supports narcotic investigations and overdose strict liability cases
- Employs the Journey-to-Drugs methodology to understand a drug’s impact on local areas
- Coordinates collection, analysis, and mapping of drug-incident data statewide
- Facilitates expedited analysis of drugs seized through forensic labs
- Uses empirical data as opposed to survey data to understand the drug environment
- Provides drug training for law enforcement, fire service, and EMS personnel
- Provides drug situational awareness for all constituents
- Tracks Naloxone administrations by law enforcement and EMS statewide to identify potential spikes in drug overdoses
- Provides real-time alerts to the public, law enforcement, and healthcare partners of spikes in drug overdoses occurring in specific areas
- Creates & leverages a network of existing people, platforms, and processes

For more information on the Drug Monitoring Initiative, contact Sgt. Adam Polhemus at lpp6422@gw.nsip.org or call 609-414-3356.
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-17)

Introduced by: Illinois

Subject: Airplane Emissions

Referred to: Reference Committee E
(Rebecca S. Hierholzer, MD, Chair)

Whereas, While the relationship between automobiles and carbon emissions is part of regular
discourse, the connection between air travel and carbon emissions is largely ignored; and

Whereas, Compared with the auto industry, aviation emission standards are virtually
nonexistent; and

Whereas, Air travel is incredibly carbon-inefficient; therefore be it

RESOLVED, That our American Medical Association urge the President and the Environmental
Protection Agency to expeditiously publish regulations, including binding limits on carbon
dioxide emissions and other hazardous byproducts, that will stimulate development of clean
aviation technology. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 02/21/17
Whereas, Ingredients such as acrylates are often inactive ingredients in many products including cosmetics, skincare products, nail polish, and sunscreens; and

Whereas, Acrylates and their copolymers are often used as film-forming agents, stabilizing agents, and waterproofing agents in hair styling products, cosmetics products, and sunscreens; and

Whereas, Acrylates have long been known to have the potential to induce cutaneous hypersensitization; and

Whereas, Acrylates were named the Contact Allergen of the Year in 2012 by the American Contact Dermatitis Society; and

Whereas, Patients may be exposed to acrylates in occupational settings (painters, printers, dental personnel, orthopedic surgeons, beauticians) and in non-occupational settings (i.e. artificial nails, dental prostheses, hearing aids, cosmetics and skin products); and

Whereas, Acrylates can penetrate most gloves (latex, nitrile, and vinyl), therefore gloves offer minimal protection for affected individuals; and

Whereas, Skin patch testing is available that can help determine sensitivity to acrylates and other ingredients; and

Whereas, Treatment of confirmed acrylate allergy requires removal of exposure to the causative agent; and

Whereas, Some products including cosmetics, skincare products, and nail polish do not always make their ingredient list available on the bottle; and

Whereas, Inactive ingredients in these products are not easily accessible by consumers; therefore be it

RESOLVED, That our American Medical Association encourage the US Food and Drug Administration to mandate that all manufacturers of cosmetics, skincare products, nail polish, and sunscreens make their full ingredient lists available on the package and online to consumers (Directive to Take Action); and be it further
RESOLVED, That our AMA prepare a report to increase awareness of acrylate allergy, update potential sources of occupational and non-occupational exposure, and provide an update as to the best ways and barrier methods to avoid acrylate exposure by susceptible individuals, with a report back to the AMA HOD at the 2017 Interim Meeting. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/24/17
Whereas, The increasing burden of mental illness demonstrates a mounting public health problem that impacts 32.4% of adults in the U.S. within a 12-month period\(^1\); and

Whereas, Among these adults, research has demonstrated a striking difference in patterns of mental illness among men and women\(^2\), despite identical overall rates among the groups\(^3\); and

Whereas, Gender is a critical determinant of health, one that is reflected in the patterns in which mental illnesses are diagnosed; and

Whereas, Women are twice as likely to be diagnosed with depression and are 3 to 4 times more likely to suffer from depression if exposed to violence (sexual or physical)\(^2\); and

Whereas, Women are also more likely to suffer from anxiety compared to men\(^2\); and

Whereas, The higher rates of depression and anxiety and high rates of comorbidity are, in part, related to interconnected and concurrent risk factors such as gender-based roles, stressors, and negative life experiences and events\(^3\); and

Whereas, Gender-specific risk factors for mental health disorders that disproportionately affect women include gender-based violence, poverty, discrimination, and socioeconomic disadvantages\(^2\); and

Whereas, Exposure to these risk factors also complicates the type and range of adverse outcomes associated with severe mental disorders, including higher rates of suicide attempts\(^2\); and

Whereas, The prevalence of depression and anxiety are more pronounced in women who are of child-bearing age\(^2\); and

Whereas, Some women experience symptoms of mental disorders, such as perinatal depression, premenstrual dysphoric disorder, and perimenopause-related depression, at times of significant hormonal change; and

Whereas, The overrepresentation of women diagnosed with certain mental illness and the severity of illness urgently needs to be addressed in order to lessen the burden of disability, to effectively utilize mental health care resources, and to address the looming economic burden on an already strained health care system; therefore be it
RESOLVED, That our American Medical Association encourage key organizations to identify barriers in access to mental health services and improve treatment models in order to address gender disparities in mental health (Directive to Take Action); and be it further

RESOLVED, That our AMA publicize the impact of violence and social determinants on women’s mental health (Directive to Take Action); and be it further

RESOLVED, That our AMA encourage the development of gender-specific risk factor reduction strategies, including gender sensitive services that focus on psychosocial resources and reproductive health, in order to improve women’s mental health (Directive to Take Action); and be it further

RESOLVED, That AMA Policy H-420.953 “Improving Mental Health Services for Pregnant and Postpartum Mothers,” be amended by addition to read as follows:

H-420.953, Improving Mental Health Services for Pregnant and Postpartum Mothers

Our AMA: 1. supports improvements in current mental health services for women during pregnancy and postpartum; 2. supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; 3. supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and 4. will continue to advocate for funding programs that address perinatal and postpartum depression, anxiety and psychosis through research, public awareness, and support programs. (Modify Current HOD Policy)

Fiscal note: Modest – between $1,000 - $5,000

Received: 04/27/17

Relevant AMA Policy:
Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Our AMA: 1. supports improvements in current mental health services for women during pregnancy and postpartum; 2. supports advocacy for inclusive insurance coverage of mental health services during gestation, and extension of postpartum mental health services coverage to one year postpartum; 3. supports appropriate organizations working to improve awareness and education among patients, families, and providers of the risks of mental illness during gestation and postpartum; and 4. will continue to advocate for funding programs that address perinatal and postpartum depression through research, public awareness, and support programs. (Res. 102, A-12)

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984
1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.
2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses. 3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings. (Policy Timeline: Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16)

References:
Whereas, According to the Centers for Disease Control and Prevention, in 2015, nearly one in 10 infants delivered in the United States was preterm (occurs before 37 weeks gestation); and

Whereas, At 13%, the prevalence rate of preterm birth (PTB) among African-American women is nearly 50% higher than the prevalence rate among white women; and

Whereas, Recent research indicates that PTB may serve as a harbinger of cardiovascular (CV) or cerebrovascular (CVD) disease in women; and

Whereas, Compared to women who had full-term pregnancies, women with PTB had a 42% increased risk of stroke or myocardial infarction later in life; and

Whereas, PTB is independently predictive of CV disease, even after accounting for development of postpartum chronic hypertension, hyperlipidemia, type 2 diabetes, and changes in body mass index following index birth; and

Whereas, There is an inverse relationship between delivering gestational age and risk of CVD in the mother; and

Whereas, Common genetic factors in mothers of preterm infants may predispose them to CV or CVD; and

Whereas, Underlying predisposition for CVD morbidity is most pronounced for women with early or recurrent PTB; and

Whereas, PTB may serve as a useful target in reducing CV or CVD prevention in women; and

Whereas, Research suggests that occult CV or CVD dysfunction in young women may be manifested in pregnancy by predisposing them to PTB, and CV or CVD later in life may be a manifestation of that underlying defect; therefore be it

RESOLVED, That our American Medical Association work with partner organizations to provide education on the potential risks of cardiovascular or cerebrovascular disease in pregnant women, particularly among vulnerable populations (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for more research on ways to identify modifiable risk factors for preterm birth (PTB) and its association with cardiovascular or cerebrovascular disease in pregnant women. (Directive to Take Action)
RELEVANT AMA POLICY:
Heart Disease in Women H-525.975
1. Our AMA supports increased awareness and education on preventive measures for heart disease in women and encourages comprehensive care of heart disease in women.
2. Our AMA urges research to address the gaps in knowledge related to coronary pathophysiology and diagnostic, treatment, and interventional strategies for heart disease in women; and to better understand the role of demographic, socioeconomic, and psychological factors in the onset of heart disease in women. (Res. 506, A-16)

References
Whereas, Sepsis occurs as a result of infections acquired both in the community and in hospitals and other health care facilities; and

Whereas, Sepsis is a life-threatening condition that affects over one million people yearly in the United States; and

Whereas, Sepsis occurs most often in people 65 years or older or younger than one year, with weakened immune systems, or with chronic medical conditions (e.g., diabetes); and

Whereas, Sepsis is a leading cause of morbidity, mortality and expense, accounting for nearly $24 billion in hospital costs in 2013; and

Whereas, Sepsis contributes to approximately one-third to one-half of all deaths in hospitalized patients; and

Whereas, Despite its national importance, public awareness of sepsis is poor; and

Whereas, Early recognition of sepsis and institution of antimicrobial therapy leads to a significant improvement in mortality of patients with sepsis; and

Whereas, Education of patients and family members, as well as continued education of health care professionals, may lead to early identification and treatment of sepsis, therefore improving sepsis-related mortality; therefore be it

RESOLVED, That our American Medical Association encourage educational and public awareness programs to assure that physicians actively educate their patients and/or caregivers on the signs and symptoms of sepsis (New HOD Policy); and be it further

RESOLVED, That our AMA encourage increased enrollment in clinical studies with all appropriate sepsis and septic shock patients, to better identify predictors of short and long-term adverse outcomes, and to advance the treatment of sepsis and sepsis-related complications. (New HOD Policy)

Fiscal note: Minimal – less than $1,000

Received: 04/27/2017
References:
Whereas, Drug overdoses now claim more lives annually in the United States than motor vehicle accidents,\(^1\,^2\) and fatalities from opioid overdoses have sharply increased since 2000, with more than 28,000 people dying from overdoses involving opioids in 2014,\(^3\) and

Whereas, Despite nearly 2 million Americans having a substance abuse disorder related to their nonmedical use of prescription pain relievers within the past year in 2014, only 772,000 received treatment for their use of pain relievers in that year;\(^4\,^5\) and

Whereas, Buprenorphine/naloxone combination drug formulations have been shown to be effective as a component of outpatient treatment of opioid use disorder, and the use of buprenorphine/naloxone is associated with a lower risk of fatal overdosing;\(^6\) and

Whereas, Non-medical use of methadone is associated with higher hospitalization rates, greater ICU utilization rates, and worse medical outcomes relative to non-medical use of buprenorphine, suggesting that buprenorphine is safer;\(^7\) and

Whereas, Physicians are required to complete special training on the treatment and management of patients with opioid use disorders to obtain a federal waiver to prescribe buprenorphine products;\(^8\) and

\(^1\) 2015 National Drug Threat Assessment Summary. Drug Enforcement Administration. Published October 2015.
\(^5\) Center for Behavioral Health Statistics and Quality. Receipt of Services for Behavioral Health Problems: Results from the 2014 National Survey on Drug Use and Health. Published September 2015.
Whereas, Physicians who have obtained this waiver can treat a maximum of 275 patients, which has recently been increased from 100;¹⁹ and

Whereas, Only 3.0% of family physicians and general internists have obtained a federal waiver to prescribe buprenorphine products;¹⁰ and

Whereas, In a study of 3,234 physicians who prescribed buprenorphine, the median monthly patient census was 13 patients, more than 20% of physicians treated 3 or fewer patients, and less than 10% treated more than 75 patients;¹¹ and

Whereas, Barriers that prevent physicians with the necessary federal waiver from prescribing buprenorphine include insufficient access to more experienced prescribers for new prescribers, inadequate access to substance abuse counseling services, a dearth of institutional support, time constraints, and a lack of mental health and psychosocial support;¹¹,¹²,¹³,¹⁴ therefore be it

RESOLVED, That our American Medical Association study solutions to overcome the barriers preventing appropriately trained physicians from prescribing buprenorphine for treatment of Opioid Use Disorder. (Directive to Take Action)

Fiscal note: Modest – between $1,000 - $5,000

Received: 04/28/17

RELEVANT AMA POLICY:
Reduction of Medical and Public Health Consequences of Drug Abuse D-95.999
Third-Party Payer Policies on Opioid Use Disorder Pharmacotherapy H-95.944
Treatment of Opioid Dependence D-120.953
The Reduction of Medical and Public Health Consequences of Drug Abuse H-95.954
Substance Use Disorders as a Public Health Hazard H-95.975
Drug Abuse and Relapse Reduction Through Patient Identifiers D-95.982
Harm Reduction Through Addiction Treatment H-95.956
Treatment Versus Criminalization - Physician Role in Drug Addiction During Pregnancy H-420.970
A More Uniform Approach to Assessing and Treating Patients for Controlled Substances for Pain Relief D-120.947
Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

Whereas, Synthetic drugs are manmade chemicals designed and produced to mimic the effects of traditional illicit drugs of abuse, which include synthetic cannabinoids and synthetic cathinones (commonly known as “bath salts”), and

Whereas, The incidence of synthetic drug use is largely unknown, as modification of chemical structures has allowed for rapid evolution to evade detection by standard drug testing and legal regulation; and

Whereas, Synthetic drugs are labeled “not for human consumption” to avoid regulation of their production by the Food and Drug Administration (FDA); and

Whereas, The effects of synthetic drugs are unpredictable due to the dearth of regulatory oversight over the manufacturing process and the rapidly-changing collection of chemicals used; and

Whereas, Variations in chemical structure can generate enhanced toxicity and addictive potential, and use can lead to effects such as tachycardia, myocardial infarction, seizures, psychosis, violent behavior, suicidal thoughts, and death, and

Whereas, The number of synthetic drugs available has increased dramatically, and 158 new synthetic substances were identified in 2012 alone;¹ and

Whereas, In June 2013, the Drug Enforcement Agency launched Project Synergy in 35 states to target “the upper echelon of dangerous designer synthetic drug trafficking organizations,” and as of November 2014, 9,445 kilograms of individually-packaged synthetic drugs, 299 kilograms of cathinone drugs, and 1,252 kilograms of cannabinoid drugs had been seized;⁶ and

Whereas, Young adults are the primary users of synthetic drugs, and as of 2013, 8% of high school seniors had used synthetic cannabinoids within the past year, making it more widely used than any illicit drug except cannabis;¹³ and

Whereas, Synthetic drugs are sold without age restrictions and are easily obtainable through the internet and small retail outlets, further increasing availability to younger individuals;³ and

Whereas, Only 34% of emergency physicians had heard of Spice and 49% had heard of K2, 80% did not feel prepared to treat patients with acute intoxication with Spice or K2, and 92% felt they needed more education on emerging drugs of abuse;⁷ and

Whereas, The AMA supports efforts to educate physicians on the emerging trends of illicit drug use (H-95.940); therefore be it

RESOLVED, That our American Medical Association amend existing AMA Policy H-95.940 by addition to read as follows:

H-95.940, Addressing Emerging Trends in Illicit Drug Use

Our AMA: (1) supports ongoing efforts of the National Institute on Drug Abuse, the Drug Enforcement Administration, and poison control centers to assess and monitor energy trends in illicit and legal synthetic drug use, and to develop and disseminate fact sheets and other educational materials; (2) encourages the development of continuing medical education on emerging trends in illicit and legal synthetic drug use; and (3) supports efforts by the federal government to identify new drugs of abuse and to institute the necessary administrative or legislative actions to deem such drugs illegal in an expedited manner. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/28/17

RELEVANT AMA POLICY:
Banning Synthetic Drugs Referred to as "Bath Salts" D-95.979
Addressing Emerging Trends in Illicit Drug Use H-95.940
Whereas, Animal-assisted therapy (AAT) is a therapeutic modality involving a highly-trained animal, a therapist, and a patient with a specific therapeutic goal;¹ and

Whereas, Service animals must be "individually trained" to "do work or perform tasks for the benefit of an individual with a disability," and the tasks must be directly related to the individual’s disability;² and

Whereas, Emotional support animals (ESAs) may be “animals of any species that provide support, well-being, comfort, aid, or a calming influence through companionship, non-judgmental positive regard, affection, and a focus in life simply by being close to their handler”³; and

Whereas, The use of therapy dogs was associated with lower reported levels of pain and higher levels of hospital stay satisfaction in total hip arthroplasty and total knee arthroplasty patients;⁴ and

Whereas, AAT significantly decreased internalizing symptoms, increased total competence, and improved global functioning in children and adolescents hospitalized for severe psychiatric disorders;⁵ and

Whereas, Research suggests that children who are socially unresponsive or experience heightened anxiety benefit from AAT due to therapy dogs’ perceived non-judgmental nature;⁶ and

⁵ Berget B, Ekeberg Ø, Braastad BO. Animal-assisted therapy with farm animals for persons with psychiatric disorders: effects on self-efficacy, coping ability and quality of life, a randomized controlled trial. Clinical Practice and Epidemiology in Mental Health. 2008;4(9).
Whereas, AAT facilitated rapid recovery in vigilance and activity after anesthesia in pediatric surgery patients, who also perceived less post-operative pain relative to patients receiving standard care; therefore be it

RESOLVED, That our American Medical Association (1) recognize the potential medical benefits of animal-assisted therapy and animals as companions; and (2) encourage research into the use and implementation of service animals, emotional support animals and animal-assisted therapy as both a therapeutic and management technique of disorders and handicaps when expert opinion and the scientific literature show a potential benefit. (New HOD Policy)

Fiscal Note: Minimal – less than $1,000

Received: 04/28/17

Relevant AMA Policy:

Alternative Medicine H-480.964 – Policy of the AMA on alternative medicine is: (1) Well-designed, controlled research should be done to evaluate the efficacy of alternative therapies. (2) Physicians should routinely inquire about the use of alternative or unconventional therapy by their patients, and educate themselves and their patients about the state of scientific knowledge with regard to alternative therapy that may be used or contemplated. (3) Patients who choose alternative therapies should be educated as to the hazards that might result from postponing or stopping conventional medical treatment. CSA Rep. 12, A-97 Reaffirmed: BOT Rep. 36, A-02 Modified: CSAPH Rep. 1, A-12

Alternative Medicine H-295.902 – (1) AMA policy states that courses offered by medical schools on alternative medicine should present the scientific view of unconventional theories, treatments, and practice as well as the potential therapeutic utility, safety, and efficacy of these modalities. (2) Our AMA will work with members of the Federation to convey physicians' and patients' concerns and questions about alternative care to the NIH Office of Alternative Medicine and work with them and other appropriate bodies to address those concerns and questions. CSA Rep. 12, A-97 Appended by Res. 525, A-98 Reaffirmed: CSAPH Rep. 2, A-08

Strategies to Address Rising Health Care Costs H-155.960 – Our AMA: (1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government; (2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease; (b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and (d) promote "value-based decision-making" at all levels; (3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training; (4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers; (5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors; (6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings; (7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and (8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care. (9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system. (CMS Rep. 8, A-07 Reaffirmed: CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 828, I-08 Reaffirmation A-09 Reaffirmation I-09 Reaffirmation A-11 Reaffirmation I-11 Reaffirmed in lieu of: Res. 239, A-12 Reaffirmed in lieu of: Res. 706, A-13 Reaffirmed: CMS Rep. 1, I-12 Modified: CMS Rep. 2, A-13 Reaffirmed in lieu of: Res. 122, A-15 Reaffirmed in lieu of: Res. 121, A-16)
AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-17)

Introduced by: Medical Student Section

Subject: Exploring Applications of Wearable Technology in Clinical Medicine and Medical Research

Referred to: Reference Committee E
(Rebecca S. Hierholzer, MD, Chair)

Whereas, Wearable technology encompasses clothing and accessories that incorporate computing technology and electronics, such as smart watches, smart clothing, smart jewelry, fitness trackers/wristbands, and other body-mountable personal devices;¹ and

Whereas, Wearable devices intended for consumer use can monitor an ever-increasing spectrum of wearers' health data on a continuous basis;² and

Whereas, An estimated 39.5 million adults 18 years old and over used wearable devices in 2015, and this number is expected to double to 81.7 million users by 2018;³ and

Whereas, Data collected through wearable devices regarding medical risk factors could be integrated into disease management strategies and used to encourage preventive health measures;⁴ and

Whereas, The applications of wearable devices are being explored for research, particularly involving clinical trials, as well as for clinical interventions for obesity, asthma, and other chronic conditions;⁵,⁶ and

Whereas, Smart watch applications to detect seizures, differentiate Parkinson’s disease postural tremor from essential tremor, allow speech pathologists to monitor their patients’ at-home speech exercises, and train people to perform CPR are under study;⁷ and

⁹ Mertz, L. (2016). Are Wearables Safe?: We Carry Our Smart Devices with Us Everywhere - Even to Bed - But Have We Been Sleeping with the Enemy, or are Cautionary Tales Overinflated? IEEE Pulse, 7(1), 39-43. doi:10.1109/mpul.2015.2498477
Whereas, The FDA does not regulate low risk general wellness products, including some devices, to determine whether they comply with the Federal Food, Drug & Cosmetics Act; and

Whereas, Concerns about accuracy of data from wearable devices, integrating this data into the healthcare system, the distracting nature of some devices (raising driver safety issues), and data security and privacy have not been adequately addressed; and

Whereas, A recent randomized clinical trial revealed that overweight and obese adults who received a standard behavioral weight loss intervention and were provided and encouraged to use a wearable technology that offered information on energy expenditure and physical activity lost less weight than a comparison group receiving just the standard behavioral intervention; therefore be it

RESOLVED, That our American Medical Association study the safety, efficacy, and potential uses of wearable devices within clinical medicine and clinical research. (Directive to Take Action)

Fiscal note: Estimated cost of $200,000 to implement resolution.

Received: 04/28/17

RELEVANT AMA POLICY:

Guidelines for Mobile Medical Applications and Devices D-480.972 – 1. Our AMA will monitor market developments in mobile health (mHealth), including the development and uptake of mHealth apps, in order to identify developing consensus that provides opportunities for AMA involvement. 2. Our AMA will continue to engage with stakeholders to identify relevant guiding principles to promote a vibrant, useful and trustworthy mHealth market. 3. Our AMA will make an effort to educate physicians on mHealth apps that can be used to facilitate patient communication, advice, and clinical decision support, as well as resources that can assist physicians in becoming familiar with mHealth apps that are clinically useful and evidence-based. 4. Our AMA will develop and publicly disseminate a list of best practices guiding the development and use of mobile medical applications. (CSAPH Rep. 5, A-14 Appended: Res. 201, A-15)

Medical Innovations H-480.978 – Where "the policy of the AMA to continue to publicly support adequate funding for the development and implementation of medical innovations, and that the reasoning behind this position be communicated to physicians, the public, and appropriate policymakers." (Sub. Res. 508, I-92) (Reaffirmed: CSA Rep. 8, A-03) (Modified: CSAPH Rep. 1, A-13)

See also:
Medical Device Safety and Physician Responsibility H-480.972
Medical Device Amendments of the FDA H-480.996
Interoperability of Medical Devices H-480.953
Use of Remote Sensing & Monitoring Devices E-1.2.9

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-17)

Introduced by: New York

Subject: Ban on the Use of Paraquat

Referred to: Reference Committee E
(Rebecca S. Hierholzer, MD, Chair)

Whereas, Paraquat is a herbicide used to control a very broad range of weeds and other unwanted plants in more than 100 crops; and

Whereas, The US Environmental Protection Agency classifies Paraquat as a “restricted use,” pesticide meaning that it can be used only by people who are licensed applicators; and

Whereas, Paraquat is highly toxic to animals and has serious and irreversible delayed effects if absorbed and as little as one teaspoonful of the active ingredient is fatal, with death occurring up to 30 days after ingestion; and

Whereas, While banned in 32 countries worldwide, it continues to be manufactured internationally for sale in the United States, where its use is actually on the rise; and

Whereas, In 2011, a US National Institutes of Health study showed a link between Paraquat use and Parkinson's disease in farm workers; a co-author of the paper said that…‘people who used paraquat, or other pesticides with a similar mechanism of action, were more likely to develop Parkinson’s’; Paraquat-induced toxicity in rats has also been linked to Parkinson’s-like neurological degenerative mechanisms; a study by the Buck Institute for Research on Aging showed a connection between exposure to Paraquat and iron in infancy and mid-life Parkinson's in laboratory mice; a 2013 meta-analysis published in Neurology found that exposure to paraquat ... was associated with about a 2-fold increase in risk' of Parkinson's disease; therefore be it

RESOLVED, That our American Medical Association seek appropriate legislation to permanently ban the use of Paraquat in all forms in the United States. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 04/28/17

References:


Pezzoli, Gianni; Cereda, Emanuele (2013). "Exposure to pesticides or solvents and risk of Parkinson disease". Neurology. 80 (22): 2035–2041.
Whereas, The National Pain Strategy, released by the Interagency Pain Research Coordinating Committee in March 2016, clearly documents the tremendous burden that pain--particularly chronic pain--places on the American public; and

Whereas, The Institute of Medicine released a report, "Relieving Pain in America..." in 2011 highlighting the public burden of approximately 100 million Americans who suffer with chronic pain; and

Whereas, There is an imbalance regarding the attention paid by governmental and regulatory agencies toward the appropriate treatment of chronic pain versus the risks of opioid addiction; and

Whereas, There is ample evidence-based research showing the success of Multidisciplinary Pain Management programs in treating chronic pain; and

Whereas, Multidisciplinary and Integrative Pain Care typically do not rely heavily on opioids; and

Whereas, The new concept of the Anesthesiology Perioperative Surgical Home has demonstrated excellent reduction in the burden of post-operative pain and thus results in less chronic pain and less need for opioids; and

Whereas, Many mental health techniques for the treatment of pain, such as Cognitive Behavioral Training, Meditation, Relaxation techniques, Biofeedback, Self-Hypnosis among others, have been shown to be successful in decreasing pain symptoms and reducing the need for opioids; and

Whereas, While the Centers for Disease Control and Prevention drafted the Guideline for Prescribing Opioids for Chronic Pain to address the dramatic rise in opioid-related deaths, the document has, in some cases, had the unintended consequence of encouraging undertreatment, marginalization and stigmatization of the many patients with chronic pain; and

Whereas, The AMA Task Force to Reduce Opioid Abuse was created to reduce the inappropriate prescribing of opioids and address the growing crisis of heroin overdose and death but does not address all of the alternatives to using opioids in clinical practice; and

Whereas, A gap exists in educating physicians about alternative treatment options (alternative medications for treating pain, alternative treatment modalities and the importance of behavioral health support, Physical Therapy, etc., along with proper prescribing of opioids); and

Whereas, This gap can be reduced by a concerted effort on the part of organized medicine; therefore be it
RESOLVED, That our American Medical Association convene a task force from organized medicine to discuss medicine’s response to the public health crisis of undertreated and mistreated pain (Directive to Take Action); and be it further

RESOLVED, That this task force explore and make recommendations for augmenting medical education designed to educate healthcare providers on how to help patients suffering from pain with evidence-based treatment options (Directive to Take Action); and be it further

RESOLVED, That this task force discuss strategies that may prevent or mitigate acute pain, educate physicians about these strategies, and suggest research to study if these strategies prevent the development of chronic pain (Directive to Take Action); and be it further

RESOLVED, That this task force involve many primary care, medical and surgical specialties that are involved in providing pain care. (Directive to Take Action)

Fiscal Note: Estimated cost of $74,000 to implement resolution.

Received: 05/01/17

References:
Buckenmaier CC. Advanced Regional Anesthesia Morbidity and Mortality Grading System: Regional Anesthesia Outcomes Reporting (ROAR) Pain Medicine 10(6) 2009
Sustained improvements in pain, mood, function and opioid use post interdisciplinary pain rehabilitation in patients weaned from high and low dose chronic opioid therapy.
The Effectiveness of an Intensive Interdisciplinary Pain Rehabilitation Program in the Treatment of Post-Laminectomy Syndrome in Patients Who Have Failed Spinal Cord Stimulation.
Bailey JC1, Kurklinsky S1, Sletten CD1, Osborne MD1.
Short-Term Functional, Emotional, and Pain Outcomes of Patients with Complex Regional Pain Syndrome Treated in a Comprehensive Interdisciplinary Pain Management Program.
McCormick ZL1, Gagnon CM2, Caldwell M1, Patel J1, Kornfeld S3, Atchison J2, Stanos S4, Harden RN2, Calisoff R2.
A longitudinal study of the efficacy of a comprehensive pain rehabilitation program with opioid withdrawal: comparison of treatment outcomes based on opioid use status at admission.
Townsend CO1, Kerkvliet JL, Bruce BK, Rome JD, Hooten WM, Luedtke CA, Hodgson JE
Treatment outcomes for workers compensation patients in a U.S.-based interdisciplinary pain management program. Gagnon CM1, Stanos SP, van der Ende G, Rader LR, Harden RN.
Treatment of menstrual migraine; multidisciplinary or mono-disciplinary approach. Witteveen H1, van den Berg P2, Vermeulen G3. 
WHEREAS, a recent National Health and Nutrition Examination Survey (NHANES) review showed that more than half of American adults use some form of medical or nutritional supplement; and

WHEREAS, of that population less than one quarter do so at the recommendation of a physician; and

WHEREAS, randomized clinical trials often fail to confirm the advertised benefit of many of these products and in fact sometimes demonstrate severe adverse effects; and

WHEREAS, The *Dietary Supplement Health and Education Act of 1994* (DSHEA) gives supplement manufacturers and products the benefit of the product being safe until the U.S. Food and Drug Administration finds otherwise; and

WHEREAS, these products are advertised through “Direct to Consumer” advertising and are available without prescription or consultation with a physician; and

WHEREAS, many of these products contain inactive ingredients which may counteract prescription medications; therefore be it

RESOLVED, that our American Medical Association study the need for U.S. Food and Drug Administration regulation of dietary supplements. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/01/17
Whereas, Supervised Injection Facilities (SIF) are places where people who inject drugs can self-administer pre-obtained drugs under the supervision of healthcare professionals or other staff; and

Whereas, Facility staff members do not directly assist in injection but are present to provide sterile injection supplies, answer questions on safer injection practices, monitor for potential overdose, administer first aid if needed, and link people to healthcare and social services, such as housing, addiction treatment, and mental health support; and

Whereas, SIFs were first initiated in Switzerland in 1986; and

Whereas, SIFs are now found in 11 countries with at least 100 sites functioning; and

Whereas, France opened a SIF in 2016, and Vancouver, BC is rapidly expanding sites in response to a fentanyl crisis; and

Whereas, There is a growing coalition representing public health, academic, criminal justice reform, and other groups to establish a supervised injection facility in New York City; and

Whereas, In September 2016, the New York City Council agreed to fund a $100,000 study on the pros and cons of SIFs; and

Whereas, The mayor of Ithaca, NY last year recommended a harm reduction program that included SIFs as a means of combatting the opioid and heroin crisis; and

Whereas, There is an extensive body of research on SIFs which finds a strong association with reductions in overdose fatalities as well as potential reductions in HIV, HCV and other medical harms of injection drug use; and

Whereas, A study using this research found that opening SIFs in San Francisco found that this intervention would be cost effective and potentially cost saving; and

Whereas, There has been discussion within the New York State Legislature about state funded SIFs; therefore be it

RESOLVED, That our American Medical Association conduct a comprehensive study of Supervised Injection Facilities in the United States. (Directive to Take Action)
Whereas, Retinoblastoma is the most common primary intraocular malignancy in children; and

Whereas, Up to 90% of US households use pesticides in their house, garden, or yard and more than half of the products applied were insecticides; and

Whereas, Environmental toxins may act as risk factors during pregnancy for the development of unilateral retinoblastoma; and

Whereas, The underlying mechanism for development of unilateral retinoblastoma is likely associated with somatic mutations during fetal development; and

Whereas, There has been an observed increase in unilateral retinoblastoma associated with prenatal pesticide use around the home during pregnancy; and

Whereas, There has also been an observed association between using professional lawn or landscaping services and unilateral retinoblastomas during the prenatal period; therefore be it

RESOLVED, That our American Medical Association encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma (New HOD Policy); and

RESOLVED, That our AMA encourage physicians to discuss with patients the potential risks of using pesticides at home for pregnant women, including unilateral retinoblastoma. (New HOD Policy)

REFERENCES

Fiscal Note: Minimal – less than $1,000

Received: 05/03/17
RELEVANT AMA POLICY

Transgenerational Effects of Environmental Toxins on Reproductive Health H-135.926
Our AMA encourages study of the transgenerational effects of environmental toxins on reproductive health and development.
Res. 521, A-16

Effects of Work on Pregnancy H-420.960
Our AMA: (1) supports the right of employees to work in safe workplaces that do not endanger their reproductive health or that of their unborn children; (2) supports workplace policies that minimize the risk of excessive exposure to toxins with known reproductive hazards irrespective of gender or age; (3) encourages physicians to consider the potential benefits and risks of occupational activities and exposures on an individual basis and work with patients and employers to define a healthy working environment for pregnant women; (4) encourages employers to accommodate women's increased physical requirements during pregnancy; recommended accommodations include varied work positions, adequate rest and meal breaks, access to regular hydration, and minimizing heavy lifting; and (5) acknowledges that future research done by interdisciplinary study groups composed of obstetricians/gynecologists, occupational medicine specialists, pediatricians, and representatives from industry can best identify adverse reproductive exposures and appropriate accommodations.

Use of Non-Toxic Aversive Additives H-10.986
The AMA (1) in conjunction with other professional organizations, encourages individual manufacturers to consider adding non-toxic aversive products to either existent or newly introduced formulations when such have been deemed as having significant toxic potentials in order to provide safety in poison prevention; (2) believes that such actions should be publicized as intended to augment, but in no way replace, other poison prevention programs such as child-resistant containers, appropriate packaging and labeling, parental education, etc; and (3) supports continuing efforts by the household products and drug industries to identify methods of reducing the incidence of accidental poisonings.

Emerging Toxic Challenge H-130.971
Our AMA proclaims its continued endorsement of poison information programs as essential components of the nation's health care emergency response system.
Whereas, Opioids are necessary to treat many acute pain conditions related to injury or surgery, they are often being prescribed to patients in larger quantities than are needed or used, leaving families with unused medications and little guidance on safe storage or disposal. All prescribers of opioids and other controlled substances including dentists, oral surgeons, nurse practitioners, advance practice nurses and physician’s assistants, have been implicated in this over-prescription of opioids and other controlled substances; and

Whereas, Leftover opioids and other controlled substances have contributed to the abuse epidemic in our country, they are the leading cause of non-medical opioid use in children and adolescents; and

Whereas, The DEA and FDA have information on National Medication Take Back Days and “Drop Boxes” for Medication take backs, these can vary widely from community to community and are often not discussed by prescribers or pharmacists with patients. Websites that include specific information regarding locations and dates for “Take Back”, exist and can be extremely useful; and

Whereas, The FDA and DEA have resources on safe storage and disposal of unused medications, these do not emphasize the addictive nature of, and abuse potential of opioids and other controlled substances, and are not widely disseminated to families. Prescribers rarely discuss the importance of keeping these medications away from other family members, in particular toddlers and teenagers; and

Whereas, Many local resources (police stations, fire-stations, pharmacies etc.) already exist to take back medications, more need to be certified and made available for return of medications, to decrease pollution of our water supplies; therefore be it

RESOLVED, That our American Medical Association and its Task Force to Reduce Opioid Abuse continue to adapt current educational materials to distribute to prescribers and patients, emphasizing the importance of safe storage and disposal of opioids, and encouraging prescribers and patients to investigate and advocate for more local drug take back programs (Directive to Take Action); and

RESOLVED, That our AMA and its Task Force to Reduce Opioid Abuse encourage all prescribers to work with local organizations and pharmacists to develop and disseminate information on local Take Back resources and the most up to date information (New HOD Policy); and be it further
RESOLVED, The our AMA and its Task Force to Reduce Opioid Abuse continue to educate all
prescribers on the importance of optimal use of opioids, including appropriately limiting the
quantities of opioid prescriptions and advocating for e-prescription capabilities for controlled
substances. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/03/17

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Background

Opioids are needed to treat a variety of acute conditions and when prescribed and used appropriately are safe and
effective. However, the growing opioid addiction crisis threatens every community, and often starts in adolescents. Prescribers
frequently prescribe more analgesic than is required by the patient. Families are not counseled on either safe storage or disposal of
these medications, making them available for anyone who visits their home. One study from Johns Hopkins (Yaster ASA) revealed
that 87% of pediatric patients getting discharged from a University hospital received a prescription for narcotic pain medication. Over
90% of these prescriptions were filled, but only 60 % were used. Ninety percent of families had NOT been counselled on safe
disposal, 5 % actually did dispose of these medications and 50% had teenagers in the house. At the end of 2 weeks families had on
average 36 tablets (range 0-95) or 67 ml (range 0-567 ml) of prescription opioids left over. Another study by Abou-Karam et.al.
showed a similar pattern in children receiving morphine after surgery in Montreal. They noted that 1431 doses were ordered and
only 131 doses (9.2%) were administered. Sixty five percent of respondents stored the morphine in the kitchen, and 86% received
some information from their healthcare provider on safe disposal. As a result 55% of families returned the left over morphine to the
pharmacy and 27% threw it away. A brand new study (Opioid Poisoning Hospitalization in Children reveals an increase in
hospitalization over the past 16 years due to opioid poisoning in children by 2 fold. While the increase occurred in all age group it
increased more in children younger than 4 and older adolescents.

Data from Monitoring the Future (monitoringthefuture.org) a group that studies ongoing attitudes and behaviors in youth, revealed
that most of the drugs being misused in teens are non-medical use of prescription “narcotic drugs other than heroin”. Questions
about past-year use OxyContin and Vicodin without a doctor’s orders, showed annual prevalence levels in 2015 of approximately
4% by 12th grade. There is very little difference between family socioeconomic status and drug use. These teenagers often
reporting trying these drugs in 9th or 10th grade, obtaining it from their own or others’ leftover prescriptions. According to Monitoring
the future approximately 40% of 12 graders find “narcotics other than heroin” easy or moderately easy to obtain and their sources
are quoted as “from a prescription I had” (35%), “bought from a friend” (32%) or “given for free from a friend or relative” (50%).
Many do not believe these medications are risky or harmful.

The FDA and other organizations recommend storing narcotics and opiates in a locked storage unit that cannot be easily accessed
by children on teenagers. Most physicians and pharmacists do not counsel families and surveys show that the majority of families
do not store them in a locked area.

Many states, cities, pharmacies and communities have “Take Back” programs, where excess medication (including opiates) can be
returned for safe disposal.

Most prescribing health care professionals and dispensing pharmacies are unaware of these resources and/or do not counsel
patients regarding these resources. The FDA lists many opioids as safe for flushing, although local communities are actively working
to prevent opioids from getting into the water supply, creating confusions for patients and their families. FDA: Safe Disposal of
Medication

The DEA has a list of authorized public collection sites that can be searched using zip codes or addresses DEA: Controlled
Substance Public Disposal Locations, as well as information on periodic National Take Back Days, where medication can be safely
and securely returned

Many local communities have their own websites that are more up to date and accurate than the DEA website and includes Police
and/or Fire Stations are able to take opioids. An example is Don’t Rush to Flush in the Bay Area, California. There are a multitude of
other on-line resources to help physicians and other prescribers determine local authorized medication take back centers. However,
it is critical that prescribers and pharmacist discuss the importance of this with families. Many adults will save their left over opioids
for possible future use; a practice that should be discouraged. However, if they persist, they need to understand the importance of
locking these medications up and keeping them away from other family members.

The FDA had a special meeting September 2016 to review opioid use and research in children. Of note almost 3 million
prescriptions for opioids were dispensed to children under 16 in 2015. Pediatricians were the top prescriber specialty for both
immediate release (IR) and ER/LA (extended release/long acting) opioid analgesics in patients’ ages 0-1 years and for ER/LA opioid
analgesics in patients ages 2-6 years and 7-16 years. Dentists were the top prescriber specialty for IR opioid analgesics in patients’
ages 2-16 years. Hospitalists, Otolaryngologist, Emergency Physicians, Orthopedic Surgeons, Nurse Practitioners and Physician’s
Assistants made up the remainder of the top prescribers of opioids for children under age 16. More details can be found at: FDA
Anesthetic and Analgesic Drug Products Advisory Committee

Groenewald CB, Rabbitts JA, Gebert JT, Palermo TM. Pain. 2016 May;157(5):1021-7 Unused opioid analgesics and drug disposal
following outpatient dental surgery: A randomized controlled trial. Maughan BC, Hersh EV, Shofer FS, Wanner KJ, Archer E,
Whereas, In-flight conditions such as changes in humidity and cabin pressure may exacerbate medical conditions leading to a risk of exacerbating underlying medical conditions; and

Whereas, Approximately 646 million people traveled on commercial US flights in 2014, with one in every 646 flights or 44,212 passengers involve a reported in-flight medical emergency worldwide every year; and

Whereas, 85% of flights with an emergency have a physician on board; and

Whereas, Physician passengers provided medical assistance in 48.1% of reported in-flight medical emergencies (2013 study); and

Whereas, The Aviation Medical Assistance Act of 1998 was passed to give limited protection to medical personnel who act as “Good Samaritans” and respond to in-flight medical emergencies on domestic flights; and

Whereas, Most in-flight medical emergencies can be successfully managed with timely and appropriate care such that only 7% of in-flight medical emergencies require flight diversion; and

Whereas, FAA regulations require all US commercial airlines weighing 7,500 pounds or more and serviced by a least one attendant to carry a defibrillator and an enhanced emergency medical kit; and

Where's, There are no international regulations requiring the complete enhanced medical kit to be available on commercial airlines; and

Whereas, Basic equipment on board commercial flights must contain a defibrillator, saline solution, aspirin, antihistamines, epinephrine, and nitroglycerin tablets and other commonly used medications; however the kits vary widely in quality; and

Whereas, When the heart fails, the lack of oxygenated blood can cause brain damage in only a few minutes. A person may die within 8 to 10 minutes & may experience cognitive deficits if deprived of oxygen for greater than 4 minutes; therefore a prolonged period of time to verify credentials can lead to a negative patient outcome; and

Whereas, Lufthansa and partner airlines have successfully initiated a Doctor on Board program that allows physicians to add their name to a list of those willing to be called should there be an in-flight emergency; and
Whereas, Medical assistance at 36,000 feet requires managing atypical environmental conditions such as lower air pressure, cramped quarters, and the roar of an engine; and

Whereas, Many countries in Europe and Australia require physicians to respond during an inflight emergency; and

Whereas, Physicians in training and in practice do not receive routine instructions on handling an in-flight medical emergency; therefore be it

RESOLVED, That our American Medical Association support and advocate for a requirement that all U.S. based commercial carriers consult with the Air Transport Medicine Committee Aerospace Medical Association every six months to determine the minimal medical equipment that should be available on domestics and international commercial flights and provide easy access to that information to passengers in order to aid in responding to likely emergencies such as adding naloxone to target potential opioid overdoses and a glucometer given the increase prevalence of diabetes (New HOD Policy); and be it further

RESOLVED, That our American Medical Association support and advocate for a requirement that medical supplies, equipment, and medications available for an inflight medical emergency are standardized based upon the size and mission of the aircraft across all domestic and international commercial US based airlines with careful consideration of flight crew training requirements (New HOD Policy); and be it further

RESOLVED, That our American Medical Association support and advocate for a requirement that flight crews will no longer be required to verify a medical professional's credentials before allowing that person to assist with an inflight medical emergency (New HOD Policy); and be it further

RESOLVED, That our American Medical Association support and advocate for a requirement that US based commercial carriers develop an online process for health providers to become credentialed in advance of a flight in order to respond to an inflight emergency (New HOD Policy); and be it further

RESOLVED, That our American Medical Association offer medical trainees and physicians medical education courses to prepare for addressing in-flight emergencies during its meetings and/or by strongly encouraging its affiliated state and local branches to offer similar education courses. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/03/17

References:
Whereas, The effects of neurobehavioral disorder-prenatal exposure to alcohol (fetal alcohol syndrome) begins during the first trimester of pregnancy; and

Whereas, More than over 50% of pregnancies are unplanned; and

Whereas, Adequate levels of choline are necessary to maintain a normal pregnancy including neural development of the fetus and reducing the incidence of birth defects; and

Whereas, The prevalence of neurobehavioral disorder-prenatal exposure (nd-pae) to alcohol is disproportionately high in African-Americans due to the prevalence of liquor stores in low income African-American communities and a mechanism of choline depletion during pregnancy is alcohol consumption; and

Whereas, The effects of nd-pae include learning and behavioral disorders, explosive behavior, and hyperactivity disorders; and

Whereas, The recommended amount of choline intake for pregnant women is 450 mg/day and current vitamins only contain 0-55 mg and 90% of women do not have enough dietary choline; therefore be it

RESOLVED, That our American Medical Association support and advocate for an increase of choline in all prenatal vitamins to 450 mg/day. (New HOD Policy)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/03/17

References:
RELEVANT AMA POLICY

Fetal Effects of Maternal Alcohol Use H-420.991
The AMA believes that (1) The evidence is clear that a woman who drinks heavily during pregnancy places her unborn child at substantial risk for fetal damage and physical and mental deficiencies in infancy. Physicians should be alert to signs of possible alcohol abuse and alcoholism in their female patients of child-bearing age, not only those who are pregnant, and institute appropriate diagnostic and therapeutic measures as early as possible. Prompt intervention may prevent adverse fetal consequences from occurring in this high-risk group. (2) The fetal risks involved in moderate or minimal alcohol consumption have not been established through research to date, nor has a safe level of maternal alcohol use been established. One of the objectives of future research should be to determine whether there is a level of maternal alcohol consumption below which embryotoxic and teratogenic effects attributable to alcohol are virtually non-existent. (3) Until such a determination is made, physicians should inform their patients as to what the research to date does and does not show and should encourage them to decide about drinking in light of the evidence and their own situations. Physicians should be explicit in reinforcing the concept that, with several aspects of the issue still in doubt, the safest course is abstinence. (4) Long-term longitudinal studies should be undertaken to give a clearer perception of the nature and duration of alcohol-related birth defects. Cooperative projects should be designed with uniform means of assessing the quantity and extent of alcohol intake. (5) To enhance public education efforts, schools, hospitals, and community organizations should become involved in programs conducted by governmental agencies and professional associations. (6) Physicians should take an active part in education campaigns. In so doing, they should emphasize the often overlooked consequences of maternal drinking that are less dramatic and pronounced than are features of the fetal alcohol syndrome, consequences that are at least indicated, if not sharply delineated, by some of the research that has been conducted in several parts of the world with diverse populations.


Fetal Alcohol Syndrome Educational Program H-420.964
Our AMA supports informing physicians about Fetal Alcohol Syndrome and the referral and treatment of alcohol abuse by pregnant women or women at risk of becoming pregnant.

Fetal Alcohol Syndrome Warning Legislation H-420.981
The AMA supports appropriate mechanisms, including legislation, intended to increase public awareness of Fetal Alcohol Syndrome.

Alcohol and Other Substance Abuse During Pregnancy H-420.976
Our AMA: (1) supports ongoing efforts to educate the public, especially adolescents, about the effects of alcohol abuse on prenatal and postnatal development; (2) favors expanding these efforts to target abuse of other substances; and (3) encourages intensified research into the physical and psychosocial aspects of maternal substance abuse as well as the development of efficacious prevention and treatment modalities.
Res. 244, A-89 Reaffirmation A-99 Reaffirmation A-07
Whereas, The World Health Organization (WHO) and the American Society for Reproductive Medicine (ASRM) have recognized infertility as a disease of the reproductive system defined by the failure to achieve a clinical pregnancy after 12 months or more of regular unprotected sexual intercourse with earlier evaluation being warranted after 6 months for women over age 35 years; and

Whereas, Infertility affects 15% of couples and is recognized as a complex disease with multiple etiologies by many of the largest health insurance companies in the United States including Cigna, Optum Health and Aetna; and

Whereas, Our American Medical Association’s Council on Scientific Affairs Report 4-A-05 has identified the following common criteria in defining a disease: 1) an impairment of the normal functioning of some aspect of the body; 2) characteristic signs or symptoms; and 3) harm or morbidity; and

Whereas, Congruent with these criteria there is now an overabundance of clinical evidence to identify infertility as a multi- etiology and hormonal disease state inclusive of ovulatory dysfunction (present in about 20% of couples), utero-tubal peritoneal factor (present in ~30% of couples), semen migration factor (10% of cases) and male factor (30% of couples); and

Whereas, Causes of infertility exhibit both male and female factors with approximately 40% of all infertile couples demonstrating a combination of factors and about 15% of couples lack any objective alteration making a definite diagnosis difficult; and

Whereas, Infertility leads to a decline in many quality of life metrics, including poor marital adjustment, less intercourse satisfaction and depression; early treatment of infertility improves these metrics and the overall prospects of pregnancy; and

Whereas, Significant socioeconomic and ethnic disparities exist in the utilization and success of fertility treatments due to lack of infertility coverage; and

Whereas, There is now evidence that broader insurance coverage for infertility treatment reduces these disparities; and
Whereas, Up to two times greater utilization of fertility services and improved outcomes including lower multiple births, decline in multi-fetal gestation rates, and improved live birth outcomes were demonstrated in states with the greatest infertility coverage; therefore be it

RESOLVED, That our American Medical Association recognize infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention (New HOD Policy); and be it further

RESOLVED, That our AMA strongly advocate for greater access to established fertility treatments inclusive of broader insurance coverage. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000

Received: 05/03/17

References:

Ref 2: Definitions of infertility and recurrent pregnancy loss: a committee opinion
Ref 3: (ASRM committee opinion–Diagnostic evaluation of the infertile female: a committee opinion)

Brugo-Olmedo S1, Chillik C, Kopelman S.


REF 7: SOCIOECONOMIC DISPARITIES IN THE UTILIZATION AND SUCCESS OF FERTILITY TREATMENTS: ANALYSIS OF DATA FROM A PROSPECTIVE COHORT IN THE UNITED STATES

James F. Smith, MD MS,1,4,10 Michael L. Eisenberg, MD,7 David Glidden, PhD,2 Susan G. Millstein, PhD,6 Marcelle Cedars, MD,4 Thomas J. Walsh, MD MS,4 Jonathan Showstack, PhD, MPH,10 Laura A. Pasch, PhD,* Nancy Adler, PhD,* and Patricia P. Katz, PhD.*

Fertile steril, 2011 PMCID: PMC3129357, NIHMSID: NIHMS290879


Sunderam S, Kissin DM, Crawford SB, Folger SG, Jamieson DJ, Warner L, Barfield WD; Centers for Disease Control and Prevention (CDC).

Whereas, There is a significant risk of dosing error with pediatric medications; and

Whereas, Dosing cups, which are commonly supplied with pediatric medications, can increase the risk of dosing errors; and

Whereas, Listing dosing instructions on labels in both milliliter and teaspoon volumes may increase the risk of dosing error; and

Whereas, The American Academy of Pediatrics in a 2015 policy statement supported expressing dosing only in metric measurements; therefore be it

RESOLVED, That our American Medical Association seek rules from the US Food and Drug Administration requiring that all orally administered liquid over-the-counter medications list dosing only in metric measurements and that appropriate dosing syringes be provided with all orally administered liquid medications. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17

RELEVANT AMA POLICY

Promotion of Milliliter-Only for Liquid Medication Dosing D-120.939
1. Our AMA will advocate to relevant federal and state entities for the exclusive use of metric-based dosing with milliliters (mL) and milligrams (mg) for orally administered liquid medications. 
2. Our AMA will advocate that dispensing pharmacies be required to provide a device calibrated in milliliters for medication administration.

Res. 518, A-16
Whereas, Clotrimazole/betamethasone dipropionate cream is a combination of an anti-fungal
cream and a high-potency steroid that has been shown to be less effective, less safe and more
expensive than single anti-fungal creams, as well as being commonly misused by physicians;
and

Whereas, Clotrimazole/betamethasone dipropionate is less effective than single agent
antifungal creams; and

Whereas, Clotrimazole/betamethasone dipropionate cream carries a risk of causing persistent
and recurrent fungal infections in children\(^1\); and

Whereas, Clotrimazole/betamethasone dipropionate is indicated for patients 12 years and over,
but is often prescribed in younger patients with over half the prescriptions written for patients
under 4 years old\(^2\); and

Whereas, Dermatologists, who are experts in skin disease, prescribed single anti-fungal
creams, as opposed to the combination cream, 96 percent of the time since they are more
effective, safer and less expensive\(^3\); and

Whereas, Prescribers are often not aware that the combination cream contains a high-potency
steroid, increasing the risk of side effects including stretch marks, growth retardation, excess
hair growth and treatment failure\(^4\); and

Whereas, The combination cream is more expensive than single anti-fungal topicalcs, but is less
effective and the treatment failures cause further treatment and additional expense\(^5\); and

Whereas, The American Academy of Dermatology treatment guidelines for superficial fungal
infections recommend single agent anti-fungals as the first line therapy and caution regarding
the use of the combination cream; therefore be it

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\(^1\) Alston SJ, Cohen BA, Braun, BA. Persistent and recurrent tinea corporis in children treated with combination antifungal/
\(^2\) Fleischer AB, Feldman SR. Prescription of high-potency corticosteroid agents and clotrimazole-betamethasone dipropionate by
\(^3\) Smith ES, Fleischer AB Jr, Feldman SR. Nondermatologists are more likely than dermatologists to prescribe
1998;39:43–47
\(^4\) Greenberg HL, Shwayder TA, Bieszcz N, Fivenson DP Clotrimazole/betamethasone dipropionate: a review of costs and
\(^5\) Ibid
RESOLVED, That our American Medical Association work with the US Food and Drug Administration to review the safety and indications of the combination clotrimazole/betamethasone dipropionate cream and lotion. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17
Whereas, Pharmacy generated retail prescription bottle labels contain patient specific information and when discarded, can unintentionally expose private identity and health information; and

Whereas, A discarded prescription bottle with an intact label for a scheduled medication could attract unwelcomed interest from someone with criminal intent; and

Whereas, Prescription labels are glued to prescription bottles so securely that they are not easily removed or destroyed when the prescription medicine is finished, and those on multiple prescriptions are especially affected; therefore be it

RESOLVED, That our American Medical Association petition the American Pharmacist Association, the US Food and Drug Administration and other relevant agencies, to recommend that labels used for retail prescription bottles be affixed in a manner that allows easy removal or destruction to protect patient privacy. (Directive to Take Action)

Fiscal Note: Modest – between $1,000 - $5,000

Received: 05/11/17