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REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-18

Subject: Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States (Resolution 208-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

INTRODUCTION

Resolution 208-A-17, "Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States," introduced by the Medical Student Section (MSS) and referred by the House of Delegates (HOD) asked that our AMA amend Policy H-160.903, "Eradicating Homelessness," to read as follows:

> H-160.903 Eradicating Homelessness
> Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) will work with state medical societies to advocate for legislation implementing stable, affordable housing and appropriate voluntary social services as a first priority in the treatment of chronically-homeless individuals, without mandated therapy or services compliance and (3) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.

Policy H-160.903 originated as Resolution 401-A-15, which also was introduced by the MSS. As proposed, it asked that our AMA (1) support improving the health outcomes and decreasing health care costs of treating the chronically homeless through Housing First approaches; and (2) support the appropriate organizations in developing an effective national plan to eradicate homelessness. The Housing First language was removed by the reference committee due to concerns regarding the "program's effectiveness among a subset of the homeless who are dually-diagnosed with mental health or substance abuse issues." The intent of the reference committee was to extend support to many approaches to combat homelessness, including but not limited to Housing First. The House of Delegates concurred with this approach.

CURRENT AMA POLICY

As noted above, existing Policy H-160.903 supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services. Additionally, Policy H-160.978 describes the components that should be included in public policy initiatives addressing the homeless who have mental health problems.

These include access to care, clinical concerns, program development, and educational, housing, and research needs.

BACKGROUND

Based on the 2017 Annual Homeless Assessment Report to Congress, more than 553,000 people experience homelessness (defined as a person who lacks a fixed, regular, and adequate nighttime residence) in the United States on a single night.[1] Most (65 percent) were staying in emergency shelters or transitional housing programs, with the remaining (35 percent) staying in unsheltered locations.[1] Substance use disorders (SUD) and mental health problems are much more prevalent among people who are homeless than in the general population. According to the Office of National Drug Control Policy, approximately 30 percent of people experiencing chronic homelessness have a serious mental illness, and around two-thirds have a primary substance use disorder or other chronic health condition. Lack of stable housing leaves them vulnerable to substance use and/or relapse, exacerbation of mental health problems, and a return to homelessness.[2] Resolution 208-A-17 is specific to chronically-homeless individuals, which refers to those who are either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more; or (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years.[3]

DISCUSSION

There are two common approaches to addressing homelessness in the United States, the linear approach and Housing First. The linear approach assumes that individuals who are homeless need to graduate from a sequence of programs designed to address underlying conditions before they will become "housing ready."[4] This approach also emphasizes abstinence from substance use as an explicit goal. Housing First uses a harm reduction approach by connecting individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements.[5] Case management services are offered to residents, but it is a personal choice to address SUDs or mental health problems.[6]

Federal Strategic Plan to End Homelessness

The first comprehensive federal strategic plan to prevent and end homelessness, "Opening Doors," was presented to Congress in June 2010.[3] The strategic plan was updated in 2012 and 2015 and it is anticipated that it will be updated again in 2018. Since the adoption of the federal strategic plan, the federal government has emphasized Housing First, not only as a model plan, but as a community-wide approach and guiding principle.[3] Related goals include ensuring widespread adoption of a Housing First approach, thereby lowering barriers to housing entry.[3]

Approaches to End Homelessness: The Evidence

Evidence exists to support the effectiveness of the Housing First and linear models; each model exhibits different strengths and weaknesses.[7] Housing First interventions are effective in improving housing stability and quality of life among individuals who are homeless.[6] Studies have shown that Housing First programs significantly increase the time that people are stably housed.[8-11] However, evidence is mixed on the effectiveness of Housing First in improving outcomes related to SUDs suggesting that individuals experiencing SUDs may need additional support and services to reduce substance use.[8,12]

The linear model is more effective in achieving abstinence than non-abstinence dependent housing.[13] Studied for many years as part of the linear approach to homelessness, SUD treatment programs have demonstrated moderate effectiveness, but significant problems exist with retention.[6] Even when individuals in linear service models achieve abstinence, they are vulnerable to reoccurrence of homelessness if they are not able to find permanent housing and to relapse of their SUD.[7]

CONCLUSION

There are two common approaches to addressing homelessness in the United States. The federal government has adopted the Housing First approach as a part of its national strategic plan on addressing homelessness. Evidence supports the effectiveness of Housing First in improving housing stability and quality of life in individuals who are homeless. The linear approach is more effective in achieving abstinence from substance use among those who were homeless, but such individuals remain vulnerable to reoccurrence of homelessness and relapse in their SUD. Different individuals may benefit from one approach or the other. Current AMA policy is rooted in the support of clinically proven, high quality, and cost effective approaches to reducing homelessness. Adaptive strategies based on regional variations, community characteristics, and state and local resources are necessary to address this societal problem on a long-term basis.

RECOMMENDATION

The Board of Trustees recommends that the following recommendation be adopted in lieu of Resolution 208-A-17 and the remainder of the report be filed:

That Policy H-160.903, "Eradicating Homelessness," be amended to reads as follows:

> H-160.903 Eradicating Homelessness
> Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; (2) recognizes that stable, affordable housing as a first priority, without mandated therapy or services compliance, is effective in improving housing stability and quality of life among individuals who are chronically-homeless; (3) recognizes adaptive strategies based on regional variations, community characteristics and state and local resources are necessary to address this societal problem on a long-term basis; and(4~~2~~) ~~supports the appropriate organizations in~~ recognizes the need for an effective, evidence-based ~~developing an effective~~ national plan to eradicate homelessness.

Fiscal Note: less than $500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 27-A-18

Subject: Policy and Economic Support for Early Child Care (Resolution 416-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

INTRODUCTION

At the 2017 Annual Meeting of the House of Delegates (HOD), Resolution 416-A-17 was referred. Introduced by the New England Delegation and the Minority Affairs Section, Resolution 416-A-17 asked that our American Medical Association (AMA) advocate for: (1) improved social and economic support for paid family leave to care for newborns, infants, and young children; and (2) federal tax incentives to support early child care and unpaid child care by extended family members.

BACKGROUND

Increases in paid parental leave were associated with decreases in perinatal, neonatal, post-neonatal, infant, and child mortality in a sample of 18 Organization for Economic Co-operation and Development countries.[1]

Unpaid maternal leave provided through the Family and Medical Leave Act of 1993 (FMLA) in the US was associated with decreases in neonatal, post-neonatal, and infant mortality, but only among women who were married and had graduated from college, suggesting that women of lower socioeconomic position were unable to benefit from unpaid leave.

Although the FMLA requires larger employers to provide unpaid job-protected time off, there is no current federal law that requires employers to provide paid time off for the birth or care of children. About 38 percent of employers offer paid parental leave for employees who are new parents.[2] Paid parental leave is distinct from other paid-leave programs such as short-term disability, sick days, and government-funded disability or insurance payments.[3] Smaller employers in particular are less likely to provide meaningful paid time off beyond generic vacation or sick time. Further, much of the time off that is provided as it relates to children is oriented toward the period surrounding the birth of a child and typically does not extend to infants and young children as contemplated by Resolution 416-A-17. What success there has been in providing paid parental leave has been primarily at the state and local level and with a small number of high profile employers. For example, IBM offers 20 weeks of paid maternity leave to both salaried and hourly workers who are birth mothers and offers 12 weeks of paid paternity leave for all other parents.[4]A few states have enacted paid medical and family leave laws – California, New Jersey, New York, and Rhode Island. Additionally, a number of cities have enacted paid leave policies but most are oriented toward paid sick leave. While upwards of 20 other states have proposed their own paid leave laws, none have yet enacted a law. Regarding tax incentives to support early child care, tax law changes for 2018 raised child care tax credits up to a maximum of $2000 per child. The amount of the credit

is indexed by income level. The credits do not differentiate between medically related child care and general day care. This provision of the tax code already allows amounts paid to certain extended family members to be considered in the tax credit calculation under certain circumstances. For instance, if a child was sick at home and both parents had to work, a grandmother could provide care and if paid, the expense could be considered in the credit calculation, but the expenses are still subject to the maximums.

AMA POLICY

AMA policy supports voluntary employer policies that provide employees with reasonable job security and continued availability of health plan benefits in the event leave becomes necessary due to documented medical conditions (Policy H-420.979). The AMA recognizes the public health benefits of paid sick leave and other paid time off, although mandatory paid sick leave is not specifically endorsed by the AMA. Council on Medical Service (CMS) Report 3-A-16 provided a comprehensive review of sick leave and paid leave policies. The HOD adopted the recommendations in the report, which established policy supporting employer policies that provide employees with unpaid sick days to care for themselves or a family member (Policy H-440.823).

As it relates specifically to physician practices, AMA Policies for Parental, Family, and Medical Necessity Leave (Policy H-405.960) established guidelines that encourage medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.

Existing AMA policy also includes Policy H-405.954, "Parental Leave." BOT Report 9-I-17 was written and filed as an informational report, primarily to address possible expansion of the FMLA, but also made reference to paid parental leave. Policy H-405.954 states that the AMA will: "(1) encourage the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA) (a) a reduction in the number of employees from 50 employees; (b) an increase in the number of covered weeks from 12 weeks; (c) creating a new benefit of paid parental leave; and (2) study the effects of FMLA expansion on physicians in varied practice environments."

RESEARCH AND LEGISLATIVE ACTIVITIES

Currently, federal law does not require employers to provide paid family or parental leave. The FMLA requires employers of a certain size to provide medically-related unpaid time off.

The most recent effort at the federal level to provide a broad paid parental leave approach is currently stalled. The Family and Medical Insurance Leave Act ("FAMILY Act," H.R. 947/S. 337) was introduced in Congress in 2017. The bill would, among other things, provide paid family and medical leave to individuals who meet certain criteria. It would be financed through a tax on every individual and employer, and all self-employment income. Thus far, the bill has been supported by Democratic members of Congress and has seen little action since introduction. The bill as originally drafted would:

- Create a national program to provide all workers, regardless of company size, with up to 12 weeks of partially paid leave; and
- Enable workers to receive up to 66 percent of their monthly wages, up to a capped amount, during their time of leave.

The AMA has not taken a position on this bill. In 2016 the Society for Human Resources Management (SHRM) partnered with the Families and Work Institute to conduct a National Study of Employers (NSE) practices on workplace benefits, and paid parental leave was part of that study.[5] The study seems to be the most recent and relevant broad-based employer analysis of what policies are in place today for parental leave as well as trends for the future.

The NSE's surveys have been conducted five times since 2005, providing both snapshots in time and current trends in employer practices and attitudes. The 2016 study samples 920 employers with more than 50 employees, with a blend of for-profit and non-profit as well as single and multi-cite locations. Note that the findings cited below all relate to employers with more than 50 employees.

The NSE noted that despite announcements of expanded parental leave benefits from Netflix, Amazon, Microsoft, Johnson & Johnson, Ernst & Young and a few others, "The media blitz over the past few years regarding paid parental leave was not representative of the majority of U.S. employers with 50 or more employees in 2016."[5] It also noted that the average maximum number of weeks of parental and caregiving leaves did not change significantly between 2012 and 2016, and in fact the average number of weeks provided had slightly declined when looking back to pre-recession 2005. 2016 data showed that employers seemed to be more supportive of easing the transition of a parent back into the workforce upon the birth of child (81% of employers), and more supportive of work from home options (40 percent of employers), but the percentage of employers allowing at least some employees to take time off during the workday for family or personal needs without loss of pay had declined from 87 percent to 81 percent.

Another finding demonstrated that employer support for flexible work arrangements had dropped dramatically from 31 percent in 2005 to 14 percent in 2016. While definitive research was not available to explain this change, it may be that many employers had narrowed benefit offerings during the prolonged period of economic difficulty that began in 2008. While the study tended to focus more on whether employers provided time off, it did note that of those employers providing at least some pay to women during maternity leave, most (78 percent) did so by providing some type of short term disability pay. The survey also indicated that for those employers that do offer pay, 6 percent of employers offered full pay, 39 percent offered partial pay, and 11 percent said it depends on the situation. Forty-two percent of the employers responding offered no pay at all. However, in contrast to those findings, the same report indicated that 39 percent of employers allowed employees to take time off (at least 5 days) to care for *mildly ill* children without having to use vacation days or losing pay. The implication of this particular data is that employer policies on paid time off lack consistency.

As articulated in Board of Trustees Report 9-I-17, there is an abundance of literature about the benefits of employee access to medical leave provided under existing law, much of which was summarized in CMS Report 3-A-16.[6] Paid sick leave has been increasing throughout the United States whether by state or local law mandates or decisions by employers. However, paid leave to care for others outside of paid vacation, PTO (generic paid time off), or paid sick leave is still not prevalent in the US.

Given that only a handful of states have enacted paid parental leave programs, research on their effectiveness is limited. However, what little research there is has demonstrated generally neutral to positive feedback from employers. In particular, BOT Report 9-I-17 noted California's experience:

> In California, for example, the Paid Family Leave program provides employees with up to six weeks of paid leave to care for a new child or ill family member. The program is funded by employee payroll contributions, so while employers do not face financial

> burden as a result of the law, they are faced with ensuring the employees' workload is covered and that gaps in staffing are filled. The program in California, however, does not assure job protection during leave, provides wage replacement at only 55 percent, and does not cover care for grandparents, grandchildren, parents-in-law, or siblings. A 10-year review of California's expansion demonstrated that the Paid Family Leave benefit promoted family well-being, improved family economic security, equalized access to leave across occupations and income levels, and bolstered businesses by reducing workforce turnover. It was also noted that overall awareness of the program among those most likely to utilize it was low, implying that utilization rates could be higher if education and outreach were improved upon. Similar outcomes have been reported for other cities and states. [7-9]

An analysis published by IMPAQ International, Inc. and the Institute for Women's Policy Research summarizes a simulation of five paid family and medical leave model programs based on working programs in three states and a federal proposal, all applied to the national workforce. The findings suggest that expansion of FMLA laws, through covering more eligible workers, replacing a larger percentage of usual earnings, and offering more weeks of paid leave would increase costs. If based on any of the five models in the simulation, the cost for benefits would range from $31 billion to $43 billion. This report also projects that a national paid family and medical leave policy, depending on the type of expansion, would increase the amount of leave taken by 6 to 11 percent annually.[10]

Some employer groups claim paid leave policies or policies that provide coverage for more employees may burden and negatively impact employer operations.

When predicting employer reactions to programs, policies and benefits related to caregiving leaves and child and elder care, the NSE research articulated four primary factors: (1) the demographics of their workplace; (2) the demographics of the workforce; (3) financial health of the employer; and (4) human resources issues such as the difficulty or ease of attracting and retaining employees as well as the costs of employee benefits.

The attitude and approach of employers is fundamental to progress on a broad national approach to paid parental leave. It is not atypical for employers to consider all four of these factors when considering what benefits to offer their employees. As it relates to paid time off, some employers are specific about how that time can be used (vacation, sick time). Other employers are more flexible ("paid time off"), wherein the employer provides a bank of paid time off that employees can use for any purpose. Employers typically review benefits offerings every year, with time off being only one of a myriad of benefits being evaluated.

As noted above, recent changes in the federal tax code increased the child care tax credit up to $2000 per child. While it may be debatable whether the increase goes far enough, it is a positive step forward toward the intent of Resolution 416 and supporting the child care efforts of people with lower economic status.

While there has been recent publicity about proposals to have some type of child care financial assistance by allowing people to draw down future Social Security benefits, it does not seem at present that such proposals will receive meaningful consideration in Congress.

DISCUSSION

The Board's review of existing research has demonstrated that despite positive health outcomes for children being cared for by their parents, meaningful progress on national policy mandating paid parental leave is unlikely in the near term. The necessary broad-based support of employers to support such policy is simply not present at this point in time. Additionally, the anti-regulatory views of the current Administration and political climate in Washington DC may not be ripe for federal policy or action on paid family leave.

The first resolve of Resolution 416-A-17 asked the AMA to advocate for improved social and economic support for paid family leave to care for newborns, infants, and young children. The Board of Trustees believes that there would be considerable challenges to pursuing a public policy that would require employers to provide paid parental leave. Nevertheless, the Board believes that HOD policy supporting paid parental leave for the care of children is good public policy. Policy H-440.823 does support employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. As noted earlier in this report, approximately 38 percent of employers currently offer paid parental leave for employees who are new parents. Accordingly, the Board of Trustees also supports encouraging employers to offer and/or to expand these types of policies. The Board believes that state medical associations should also be encouraged to work with their state legislatures to establish and promote parental leave policies.

The second resolve of Resolution 416-A-17 asked the AMA to advocate for federal tax incentives to support early child care and unpaid child care by extended family members. As previously noted in this report, recent changes to Federal tax law have raised child care tax credits to a maximum of $2000 per child, beginning in 2018. The expense of paying extended family members to perform child care can be considered in the calculation of this credit under certain circumstances.

RECOMMENDATION

Therefore, the Board of Trustees recommends that the following be adopted in lieu of Resolution 416-A-17 and the remainder of this report be filed:

1. That our AMA reaffirm Policy H-440.823, "Paid Sick Leave," which recognizes the public health benefits of paid sick leave and other discretionary paid time off, and supports employer policies that allow employees to accrue paid time off and to use such time to care for themselves or a family member. (Reaffirm Current HOD Policy)

2. That our AMA encourage employers to offer and/or expand paid parental leave policies. (New HOD Policy)

3. That our AMA encourage state medical associations to work with their state legislatures to establish and promote paid parental leave policies. (New HOD Policy).

Fiscal Note: Less than $500.

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 28-A-18

Subject: Mandatory Public Health Reporting of Law Enforcement-Related Injuries and Deaths (Resolution 417-A-17)

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

INTRODUCTION

Resolution 417-A-17, "Mandatory Public Health Reporting of Law Enforcement-Related Injuries and Deaths," introduced by the New England Delegation and the Minority Affairs Section and referred by the House of Delegates asked:

> That our American Medical Association encourage the Centers for Disease Control and Prevention and state departments of health to collect data on serious law enforcement-related injuries and deaths and make law enforcement-related deaths a notifiable condition.

BACKGROUND

Legal intervention deaths represent a small portion of violent deaths (1%) and homicides (4%) in the United States each year.[1] However, data suggest that legal intervention deaths increased 45% between 1999 and 2013.[1] Males aged 10 or older represent 96 percent of these deaths.[2] From 2010 – 2014, the mortality rate for legal intervention deaths among non-Hispanic Black and Hispanic individuals was 2.8 and 1.7 times higher, respectively, than that of White individuals.[2] In the United States, there have been several recent, high-profile cases involving the use of lethal force by law enforcement, particularly in minority communities, which have led to protests and some incidents of civil unrest.[1,4] These events erode the relationship between law enforcement agencies and the populations they serve.[3]

Testimony at the reference committee hearing was mostly supportive of the intent of this resolution. However, confusion was evident regarding whether this data was already being collected, as well as around certain definitions.

Definitions

At the state level, jurisdictions can require the reporting of cases of specific infectious and noninfectious conditions to public health agencies, this is typically referred to as a "reportable condition."[5] A "nationally notifiable condition" refers to conditions that state health departments have agreed to voluntarily report to the Centers for Disease Control and Prevention (CDC).[5] The Council on State and Territorial Epidemiologists, with input from CDC, maintains and periodically revises the list of nationally notifiable diseases and conditions.

Surveillance case definitions enable public health officials to classify and count cases consistently across various reporting jurisdictions. A standard, agreed upon definition of "law enforcement-related deaths" is lacking.

In the literature, such deaths are typically referred to as "legal intervention deaths," based on the definition from the International Classification of Diseases 10th Revision (ICD-10). "Legal intervention deaths" are defined as "a death in which a person is killed by a law enforcement officer or other peace officer (i.e., a person with specified legal authority to use deadly force), including military police, while on duty."[6] This category excludes legal executions. It does not depend on whether the resulting injury was lawful or whether injuries were inflicted intentionally. Legal intervention death is the case definition used in reporting data on this issue to public health agencies.

Other case definitions include, "arrest-related deaths," which captures (1) "all deaths attributed to any use of force by law enforcement personnel acting in an official agency capacity;" (2) "any death that occurs while the decedent's freedom to leave is restricted by a state or local law enforcement agency prior to, during, or following an arrest;" and, (3) "any death that occurs while confined in lockups or booking centers."[7] Data on "use-of-force deaths" include "actions by a law enforcement officer as a response to resistance that results in the death or serious bodily injury of a person or when a law enforcement officer, in the absence of death or serious bodily injury, discharges a firearm at or in the direction of a person."[8]

Law enforcement-related deaths could also encompass law enforcement officer homicides, which are defined to capture deaths of law enforcement officers killed in the line of duty or those acting in an official capacity.[9]

DISCUSSION

Surveillance systems can help researchers and public health agencies examine data and identify patterns or associations that can inform preventive actions. Multiple systems currently exist that collect information regarding law enforcement-related deaths. These include both governmental and non-governmental reporting systems. Governmental reporting systems are either housed in law enforcement agencies or public health agencies. Data collected varies by system, with a number of different types of cases being reported from different sources. Most non-governmental systems were created by the media to try to develop a more accurate data set than what is available from governmental reporting systems.

Governmental Reporting Systems

There are four reporting systems that have been used by the government to collect data on law enforcement-related deaths, the Federal Bureau of Investigation's (FBI's) Uniform Crime Reporting (UCR) program, the Bureau of Justice Statistics (BJS) Arrest-Related Deaths (ARD) program, the CDC's National Vital Statistics System (NVSS), and National Violent Death Reporting System (NVDRS).

The BJS ARD program was designed as an annual, national census of persons who died during the process of arrest or while in the custody of state or local law enforcement.[10] In addition to deaths caused by the use of force by law enforcement personnel, it also captures those not directly related to law enforcement action, such as suicide, intoxication, accidental injury, illness, or natural causes. ARD was established as a state-based reporting system in which state reporting coordinators in all 50 states and the District of Columbia are responsible for identifying and reporting all eligible

cases.[10] In 2014, BJS determined that the ARD data did not meet BJS data quality standards, and therefore suspended data collection and publication.[10] In 2016, BJS announced a program redesign which relies on a mixed method, hybrid approach involving data collected from media sources and reporting from law enforcement agencies.[7]

The FBI's UCR program collects data from more than 18,000 law enforcement agencies nationwide and reports information on law enforcement officers killed and assaulted, justifiable homicide, and crime data statistics.[8] The FBI has agreed to work with other organizations, including the BJS and the law enforcement community, to gather and report data on officer-involved use-of-force incidents. Participation is open to all local, state, tribal, and federal law enforcement and investigative agencies.[8] Each law enforcement agency will be responsible for reporting information for its own officers connected to incidents that meet the criteria of the data collection. The goal is to provide an aggregate view of the incidents reported and the circumstances, subjects, and officers surrounding the incidents.[8]

The CDC's NVDRS is a state-based surveillance system that links information on violent deaths, including legal intervention deaths, from three required sources – death certificates, coroner/medical examiner reports, and law enforcement reports – into a single system to create a more complete picture of the circumstances that lead to violent death.[11] NVDRS also captures homicides of law enforcement officers. Currently 40 states, the District of Columbia, and Puerto Rico are funded under a cooperative agreement with CDC to operate NVDRS. The goal is to eventually have a national system, with all 50 states, U.S. territories and the District of Columbia funded to participate.

The CDC's NVSS has captured legal intervention deaths since 1949.[12] NVSS receives electronic mortality data from death certificates from all 50 states, the District of Columbia, New York City, and 5 territories.[13] The NVSS' reliance on death certificate data has resulted in the underreporting of legal intervention deaths due to coroners or medical examiners failing to mention police involvement in the death certificate's cause of death section or possibly due to coding errors at the CDC's National Center for Health Statistics.[12]

Non-governmental Reporting Systems

A number of non-governmental systems have begun to track legal intervention deaths in the United States because a comprehensive national database is lacking. The Counted, a project by the Guardian, seeks to count the number of people killed by police and other law enforcement agencies in the United States through verified, crowdsourced information.[14] The *Washington Post's* Fatal Force database tracks fatal shootings by U.S. police officers.[15] Fatal Encounters, has sought to create a comprehensive national database of people who are killed through interactions with law enforcement since January 1, 2000.[16] These systems utilize media reports, public records, and social media reports to help identify cases.

Existing State Public Health Reporting Requirements

In Tennessee, the state bureau of investigation is required to provide the commissioner of health and the general assembly a report on all law enforcement-related deaths that occurred in the prior calendar year. "Law enforcement-related deaths" is defined to include: (1) the death of an individual in custody, whether in a prison, in a jail or otherwise in the custody of law enforcement pursuant to an arrest or a transfer between institutions of any kind, or (2) the death of an individual potentially resulting from an interaction with law enforcement, while the law enforcement officer is on duty or while the law enforcement officer is off duty, but performing activities that are within

the scope of the officer's law enforcement duties, without regard to whether the individual was in custody or a weapon was involved.[17] While jurisdictions participating in NVDRS are required to report legal intervention deaths and law enforcement officer homicides, Tennessee appears to be the only state with a statute in place requiring the reporting of legal intervention deaths to the public health agency.

CONCLUSION

Various reporting systems exist to capture a range of different types of law enforcement-related deaths. However, no one system or case definition is perfect. Resolution 417-A-17 specifically relates to public health surveillance. NVDRS and NVSS are the existing public health reporting systems that capture legal intervention deaths and law enforcement officer homicides. Both systems have their strengths and weaknesses. NVDRS captures information from multiple sources and is therefore less likely to miss cases. However, it is not currently a national system. NVSS is a national system, but uses data from death certificates, which are often inaccurate or incomplete.[12] Since NVDRS is a more comprehensive public health surveillance system that collects information on both legal intervention deaths and law enforcement officer homicides, it makes sense to encourage its expansion to all states and territories. NVDRS is a state-based surveillance system; therefore it also seems reasonable to encourage the reporting of this information to state public health agencies. Increased public health surveillance will be useful for measuring the need for and effects of interventions to address such deaths.

CURRENT AMA POLICY

Existing AMA Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," encourages the National Academies of Sciences, Engineering, and Medicine to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities and encourages the CDC as well as state and local health departments to research the nature and public health implications of violence involving law enforcement. Policy H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," supports increasing funding for and the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories.

RECOMMENDATIONS

The Board of Trustees recommends that the following recommendations be adopted in lieu of Resolution 417-A-17 and the remainder of the report be filed.

1. That current AMA Policy H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes," be amended by addition and deletion to read as follows:

   H-515.955, "Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes"
   Our AMA: 1. ~~Our AMA~~ Eencourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities. 2. ~~Our AMA~~ A~~a~~ffirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social

determinant of health. 3. ~~Our AMA~~ Eencourages the Centers for Disease Control and Prevention as well as state and local public health ~~departments and~~ agencies to research the nature and public health implications of violence involving law enforcement. 4. Encourages states to require the reporting of legal intervention deaths and law enforcement officer homicides to public health agencies. (Modify Current HOD Policy)

2. That current AMA Policy, H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," which supports increased funding for and the expansion of the National Violent Death Reporting System to all 50 states and territories be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-18

Subject: CSAPH Sunset Review of 2008 House of Delegates Policies

Presented by: Robert A. Gilchick, MD, MPH Chair

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

At its 1984 Interim Meeting, the American Medical Association (AMA) House of Delegates (HOD) established a sunset mechanism for House policies (Policy G-600.110, "Sunset Mechanism for AMA Policy"). Under this mechanism, a policy established by the HOD ceases to be viable after 10 years unless action is taken by the HOD to retain it.

The objective of the sunset mechanism is to help ensure that the 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 HOD deliberations.

At its 2012 Annual Meeting, the HOD 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 HOD policies from 2008 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 2008 House Policies and Directives

Policy/ Directive Number	Title	Recommended Action and Rationale
D-115.991	Manufacturer Labeling of Medical Supplies	Rescind. Accomplished by Unique Device Identifier regulations.
D-15.999	Options for Improving Motorcycle Safety	Retain in part. Part 1 was accomplished by NHTSA's publishing in November 2006 of national motorcycle guidelines. Retain part 2 and amend to H-policy. Our AMA~~: (1) encourages the National Highway Traffic Safety Administration to work with medical and public health organizations, national motorcycle rider organizations, state motor vehicle licensing agencies, law enforcement officials, and the motorcycle industry to develop a comprehensive national motorcycle safety plan that addresses rider education, training, and licensing; use of motorcycle helmets and other protective gear; public awareness of motorcycles; alcohol use among motorcyclists and other motor vehicle drivers; measures to increase the visibility of motorcyclists and motorcycles to other drivers; engineering and design of motorcycles and highway environments; and research to determine the effectiveness of current and proposed safety measures; and~~ ~~(2)~~ encourages physicians to (a) be aware of motorcycle risks and safety measures and (b) counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs.
D-155.999	Energy Efficiency and Medical Practice	Retain. Still relevant.
D-165.997	Physician Education of Their Patients About Prescription Medicines	Rescind. Accomplished by support and dissemination of Guidelines for Physicians for Counseling Patients about Prescription Medications in the Ambulatory Setting.
D-170.998	Alcohol and Youth	Retain. Still relevant.
D-20.989	HIV and Public Health Prevention Services	Rescind. Accomplished.
D-20.990	Global HIV/AIDS Prevention	Retain in part to read as follows and change to H-policy: Our AMA ~~extends its~~ supports ~~of~~ comprehensive family-life education to foreign aid programs to prevent the spread of HIV/AIDS and other sexually transmitted diseases.
D-20.998	Bloodborne Pathogen Transmission to and from	Rescind. The CDC published updated recommendations for the Hepatitis B Virus–infected health care providers

	Health Care Workers	and students in 2012. Updated guidance on HIV in the health care setting is also available. SHEA has also developed guidelines for the management of health care workers with HBV, HCV and/or HIV.
D-425.994	Early Recognition and Intervention in Chronic Kidney Disease	Rescind. Updated guidelines issued August 2012.
D-425.999	Public and Private Funding of Prevention Research	Retain in part to read as follows and change to H-policy: ~~(1)~~ Our AMA ~~will~~ seeks to work in partnership with the Centers for Disease Control and Prevention, the National Institutes of Health, and other Federal Agencies, the Public Health Community ~~(via the medicine/public health initiative)~~, and the managed care community to ~~develop~~ ensure that there is a national prevention research agenda~~and report back to the House of Delegates the current status of this agenda. (2) These groups work in partnership to develop a practical plan to implement recommendations which will allow such groups to support and participate more fully in prevention research.~~
D-470.992	Implementation of Automated External Defibrillators in High-School and College Sports Programs	Retain. Only 17 of 50 states have some type of legislation dealing with AEDs in schools, most commonly a requirement for AEDs in public grade schools or in both public grade schools and colleges.
D-490.998	Tobacco Control and Settlement	Retain. Still an important issue.
D-495.996	Opposition to Addition of Flavors to Cigarettes	Retain. Change to H-policy.
D-515.984	Health Care Costs of Violence and Abuse Across the Lifespan	Retain in part to read as follows and change to H-policy: 1. Our AMA urges ~~Congress~~ the National Academies of Sciences, Engineering, and Medicine to ~~commission the Institute of Medicine~~ continue to study ~~and issue a report on~~ the impact and health care costs of violence and abuse across the lifespan. 2. Our AMA~~: (a)~~ encourages the National Institutes of Health, the Agency for Healthcare Research and Quality, and the Centers for Disease Control and Prevention to conduct research on the cost savings resulting from health interventions on violence and abuse~~; and (b) will develop and implement a strategy to advocate for increased funding for such research.~~ 3. Our AMA encourages the appropriate federal agencies to increase funding for research on the impact and health care costs of elder mistreatment.
D-55.997	Cancer and Health Care Disparities Among Minority Women	Retain in part to read as follows and change to H-policy: Our AMA~~: (1)~~ encourages research and funding directed at addressing racial and ethnic disparities in

		minority women pertaining to cancer screening, diagnosis, and treatment. ~~; and (2) will work with the National Cancer Institute's Center to Reduce Cancer Health Disparities, the American Cancer Society, and other organizations to promote the use among minority women of educational materials that are culturally sensitive and at the appropriate literacy level.~~
D-60.971	Reduction of Underage Drinking	Retain. Change to H-policy.
D-60.972	Internet Marketing to Children on Health	Rescind. Online tools exist to educate children about health habits and lifestyles.
D-95.982	Drug Abuse ~~and Relapse Reduction Through Patient Identifiers~~ as a Chronic Disease	Retain in part to read as follows because a portion is no longer relevant and change to H-policy: Our AMA~~: (1)~~ strongly urges health care providers to take an active role in acknowledging ~~the diagnosis of~~ that addiction is a chronic disease.~~; and (2) will partner with organizations such as the American Society of Addiction Medicine, to explore the use of medication contracts to monitor the use of prescribed medications in patients with a known history of addiction.~~
D-95.984	Substance Use and Substance Use Disorders	Retain. Change to H-policy.
H-10.970	Use of Protective Eyewear by Athletes	Retain. AAP and AAO policies remain in place.
H-10.989	Better Fire Prevention in Public Buildings	Retain in part to read as follows: The AMA urges state public authorities to ~~consider~~ enact~~ment of~~ uniform fire protection codes in public buildings, for the risks such furnishings hold for the emission of toxic gases as well as intense heat, and at least in the case of new construction, the introduction of expanded sprinkler systems and fully automatic smoke detectors.
H-100.970	Informational Campaign on Diethylstilbesterol	Rescind. CDC program is no longer in place.
H-100.985	Need for Requirements of Ongoing Quality Assurance of the Bioavailability of Purity of Prescription Pharmaceuticals	Rescind. Appropriate regulations are in place.
H-100.987	Insufficient Testing of Pharmaceutical Agents in Children	Retain. Still relevant.
H-100.989	A Transitional Class for Drugs	Retain. Still relevant.
H-120.942	Personal Medication Supply in Times of Disaster	Retain. Still an issue.
H-125.981	Generic Medications	Retain in part to read as follows: Our AMA encourages the Food and Drug Administration to ~~reexamine the~~ maintain standards and criteria used for approving generic medications to

		ensure bioequivalence under various conditions and in relevant patient populations.
H-125.995	Therapeutic and Pharmaceutical Alternatives by Pharmacists	Retain in part to read as follows: The AMA opposes legislative attempts at any level of government that would permit pharmacists, when presented with a prescription for a drug product, to: (1) dispense instead a drug product that is administered by the same route and which contains the same pharmaceutical moiety and strength, but which differs in the salt or dosage form (pharmaceutical alternatives); and (2) dispense a drug product containing a different pharmaceutical moiety but which is of the same therapeutic and/or pharmacological class (therapeutic substitution). Our AMA will work with state medical associations to ensure that state pharmacy laws and medical practice acts are properly enforced so that a treating physician's ~~prescriptions~~ directions cannot be overruled or substituted without prior physician approval. ~~If this issue is not addressed in existing laws, our AMA will develop model legislation to assist state medical associations in this endeavor.~~
H-130.943	Physician Identification in Emergencies	The center is no longer operational. Retain in part to read as follows: Our AMA, ~~through the Center on Public Health Preparedness and Disaster Response,~~ will ~~continue to:~~ (1) monitor the development of volunteer registration systems, such as Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), as well as volunteer organizations, such as the Medical Reserve Corps (MRC), and report back as appropriate; and (2) support the development of laws and policies such as license reciprocity and civil liability protections that encourage physicians to volunteer services during disasters.
H-130.999	Health System Security for Disasters	Rescind. Covered by part 7 of "AMA Leadership in the Medical Response to Terrorism and Other Disasters," H-130.946.
H-135.940	Toxic Disposable Consumer Products	Retain. Still relevant.
H-135.952	Manganese in Gasoline	Retain. Still relevant.
H-135.981	Medical Perspective on Nuclear Power	Rescind. Relevant portions covered by "Low-Level Radioactive Wastes," H-135.966 and "Risks of Nuclear Energy and Low-Level Ionizing Radiation,"H-455.994.
H-135.982	Low Level Radioactive Wastes	Rescind. Covered by "Ionizing Radiation Exposure in the Medical Setting," D-455.998.
H-145.994	Control of Non-Detectable Firearms	Retain. Still relevant.
H-145.995	Ban Realistic Toy Guns	Retain. Still relevant.
H-15.998	Driver Education in Secondary Schools	Rescind. State departments of motor vehicles have the authority to approve driver education courses that are in

		line with current standards and many have approved several different delivery options, which are considered acceptable.
H-150.942	Rating System for Processed Foods	Rescind. Food label requirements have changed.
H-150.965	Eating Disorders	Retain. Still a societal issue.
H-150.975	Dangerous Health and Diet Books	Retain. Still relevant.
H-160.932	Asthma Control	Retain. Still relevant.
H-20.897	Prevalence of HIV in Minority Populations	Retain. Still important.
H-20.905	HIV/AIDS Research	Retain in part to read as follows: (1) Information on the HIV Epidemic Our AMA: a) Vigorously supports the need for adequate government funding for research, both basic and clinical, in relation to HIV/AIDS epidemic. Research on HIV should be prioritized, funded, and implemented in an expeditious manner consistent with appropriate scientific rigor, and the results of research should form the basis for future programs of prevention and treatment; b) Requests the Secretary of the Department of Health and Human Services to make available information on HIV expenditures, services, programs, projects, and research of agencies under his/her jurisdiction and, to the extent possible, of all other federal agencies for purposes of study, analysis, and comment. The compilation should be sufficiently detailed that the nature of the expenditures can be readily determined; c) Supports ongoing efforts of the Centers for Disease Control and Prevention to periodically monitor the incidence and prevalence of HIV infection in the U.S. population as a whole, as well as in groups of special interest such as adolescents and minorities; d) Encourages federal and state agencies, in cooperation with medical societies and other interested organizations, to study and report means to increase access to quality care for women and children who are HIV-infected; ~~e) Encourages further research to assess the risk of HIV transmission in specific surgical techniques and how any such risk may be decreased;~~ ~~f) Supports exploring ways to increase public awareness of the benefits of animal studies in HIV/AIDS research.~~ ~~(2) Lookback Studies~~ ~~Our AMA encourages the cooperation of the medical community and patients in scientifically sound look-back studies designed to further define the risk of HIV transmission from an infected physician to a patient and~~

		~~to determine if there is any scientific basis for the development of a list of exposure-prone procedures. A panel of experts should be assembled to translate available look-back information into a meaningful statement on the estimated true risk of transmission and the need, if any, for additional studies.~~ ~~(3)~~ (2) Community Research Initiatives Our AMA supports the objectives of community-based research to reduce HIV disease and encourages periodic review of progress toward these objectives.
H-275.939	Internet Gambling	Retain in part to read as follows: Our AMA: (1) informs physicians and patients of the dangers of addiction associated with Internet gambling; (2) ~~supports the prohibition of government-sponsored Internet gambling; and (3) in collaboration with appropriate specialty societies, pursues other avenues to~~ and supports prohibiting the availability of Internet gambling to children.
H-280.963	Drug Regimen Review in Long Term Care Settings	Retain. Still relevant.
H-30.940	AMA Policy Consolidation: Labeling Advertising, and Promotion of Alcoholic Beverages	Retain. Still relevant.
H-30.999	Admission of Alcoholics to General Hospitals	Rescind. Covered by "Recommendations for AMA Involvement in Alcoholism Activities," H-30.998.
H-345.990	Electroconvulsive Therapy	Retain. Still relevant.
H-420.977	Posting of Warnings Against Use of Alcohol During Pregnancy	Retain. Still valid.
H-425.974	Appropriate Aspirin Use for Prevention of Heart Disease and Stroke	Retain. Still relevant.
H-425.990	Prevention of Coronary Artery Disease	Retain. Physician oversight is encouraged.
H-440.862	Immunization Access to Parents of High-Risk Infants Younger than Six Months of Age	Retain. Still relevant.
H-440.900	Treatment of Chlamydia Trachomatis	Retain. Still an issue.
H-440.901	Achieving National Adolescent Immunization Goals	Retain. An important goal.
H-440.957	Reporting Potential for Hearing Loss Due to Personal Listening Devices	Retain in part to read as follows: It is the policy of the AMA that (1) physicians counsel patients about the potential loss of hearing associated with the misuse of personal listening devices; (2) research be directed at more specific definition of the relationship between acute and chronic use of personal

		listening devices and the occurrence of short-term and long-term noise-induced hearing loss~~; and (3) the AMA work with the National Institute on Deafness and Other Communication Disorders to enhance awareness, knowledge and remediation of causes of noise induced hearing loss.~~
H-440.965	The Future of Public Health	Retain. Relevant to AMA mission.
H-440.997	Research and Control of Gonorrhea	Retain. Still an issue.
H-440.998	US Public Health Service	Retain. Consistent with AMA's views.
H-440.999	Increase in Venereal Disease	Retain. Pending policy consolidation.
H-45.980	Airborne Infections on Commercial Flights	Retain in part to read as follows: (1) Under usual aircraft operation procedures, cabin air quality does not present a significant risk for transmission of airborne infections. (2) The AMA supports efforts of the Aerospace ~~Medicine~~ Medical Association and other groups to determine standards for cabin air quality and to educate physicians and the public about the public health risks associated with flying with airborne transmissible diseases. ~~(3) The AMA supports the ongoing research of organizations such as the American Society of Heating, Refrigeration and Air Conditioning Engineers and the National Institute of Occupational Safety and Health to determine standards for cabin air quality.~~
H-45.992	Airplane Safety	Retain. Still an issue.
H-455.991	Physician Training for Management of Injuries Encountered in ~~Nuclear Explosions~~ Radiological Incidents	Retain in part to read as follows: The AMA supports educating and training physicians in the management of injuries ~~that may be encountered in isolated~~ related to radiological ~~nuclear~~ incidents.
H-460.910	Systemic Lupus Erythematosus Research ~~and Its Impact on Minority Health~~	Retain in part to read as follows: Our AMA: (1) supports ~~increased~~ funding for biomedical research and educational programs that work toward finding the cause and a cure for lupus~~; and (2) will collaborate with medical specialty societies and federal organizations, including the Office of Research on Women's Health at the National Institutes of Health, involved with research and educational initiatives pertaining to lupus.~~
H-460.911	Increasing Minority Participation in Clinical Research	Retain. Still an issue.
H-460.923	Melanoma Registry	Rescind. A process is established. All states require physicians to report cases of melanoma to their central cancer registry.
H-460.930	~~Council on Scientific Affairs Conference: "~~Importance of Clinical Research~~:~~	Retain in part to read as follows: (1) Given the profound importance of clinical research as the transition between basic science discoveries and

	~~Assessing the Future in a Changing Environment"~~	standard medical practice of the future, the AMA will a) be ~~the principal~~ an advocate for clinical research; b) promote the importance of this science and of well-trained researchers to conduct it~~; and c) facilitate communication among different organizations and groups, including managed care organizations, that are essential for broad-based support of clinical research.~~ (2) Our AMA continues to advocate vigorously for a stable, continuing base of funding and support for all aspects of clinical research within the research programs of all relevant federal agencies, including the National Institutes of Health, the Agency for Healthcare Research and Quality ~~Health Care Policy and Research~~, the Centers for Medicare & Medicaid Services, the Department of Veterans Affairs and the Department of Defense. (3) ~~Traditional sources of financial support for clinical research and for academic health centers are diminishing significantly in the evolving health care environment of the 1990s. All endeavors that depend upon development of new knowledge and technologies for their continued success recognize the need to devote a proportion of revenue for research and development.~~ The AMA believes it is an inherent obligation of capitation programs and managed care organizations to invest in broad-based clinical research (as well as in health care delivery and outcomes research) to assure continued transition of new developments from the research bench to medical practice. The AMA strongly encourages these groups to make significant financial contributions to support such research. (4) Our AMA continues to encourage medical schools a) to support clinical research; b) to train and develop clinical researchers; c) to recognize the contribution of clinical researchers to academic medicine; d) to assure the highest quality of clinical research; and e) to explore innovative ways in which clinical researchers in academic health centers can actively involve practicing physicians in clinical research. ~~(5) Our AMA believes that one obligation of organized medicine and physicians is to support clinical research, as the basis of advances in medicine. To facilitate this, the AMA should explore ways physicians and physician organizations can encourage and assist in educating the public about the importance of clinical research such as through educational materials and programs for children and schools.~~ ~~(6)~~ (5) Our AMA encourages and supports development of community and practice-based clinical research networks.
H-460.973	Protection of Scientific	Retain. Still relevant.

	Freedom from Special Interest Groups	
H-460.974	Animal Research/Rights	Rescind. Covered by "Use of Animals in Research," H-460.979, "Increased Public Education Regarding Animal Research," H-460.932, and "Medical Research Involving Animals," H-460.957.
H-460.983	Availability of Funding for Research	Rescind. Covered by "Funding of Biomedical, Translational, and Clinical Research," H-460.926 and "Support of Biomedical Research," H-460.998.
H-460.993	Biopsychomedical Research Funding	Rescind. Covered by "Funding of Biomedical, Translational, and Clinical Research," H-460.926 and "Support of Biomedical Research," H-460.998.
H-470.976	Abuse of Anabolic Steroids	Retain. Still an issue.
H-470.983	Boxing as a Health Hazard	Retain. Still an issue.
H-470.993	Weight Loss in Amateur Wrestling	Retain. Still an issue.
H-470.998	Youth Physical Fitness	Retain. Still an issue.
H-480.962	Patient Access to Devices Pending Approval	Rescind. Processes are in place for expanded access to medical devices.
H-490.911	Smoke-Free America	Retain. Still relevant.
H-495.976	Opposition to Exempting the Addition of Menthol to Cigarettes	Retain in part to read as follows: Our AMA: (1) will continue to support ~~the Food and Drug Administration (FDA) legislation as amended by the House of Representatives and urge its passage and enactment as soon as possible as a major step forward in regulating tobacco products and the harm they create; (2) shall immediately petition the FDA to conduct inquiries and take steps to~~ a ban on the use and marketing of menthol in cigarettes as a harmful additive~~, if the current bill is passed without the menthol amendment, once enacted into law; and~~ (~~3~~2) encourages and will assist its members to seek state bans on the sale of menthol cigarettes ~~regardless of whether the current FDA legislation is enacted~~.
H-50.986	Blood Donations by Donors over 65 Years of Age	Rescind. No upper limit exists on the age for blood donation.
H-50.987	Autologous Transfusions for Elective Surgery	Retain. Still relevant.
H-50.998	Definition of Blood as a Medical Service	Retain. Still relevant.
H-50.999	Blood Banks	Rescind. Strict regulatory oversight in place.
H-515.961	Elder Mistreatment	Retain. Still an issue.
H-55.979	Genetic Susceptibility Testing for Hereditary Cancers	Retain. Still relevant.
H-55.988	Uniform Cancer Staging	Retain. Still relevant.
H-60.931	Toy Safety	Rescind. Toy safety standards in place.
H-60.932	Ensuring the Best In-School Care for Children with	Retain. Still important.

	Diabetes	
H-60.947	Guns in School Settings	Retain. Still relevant.
H-60.958	Rights of Minors to Consent for STD/HIV Prevention, Diagnosis and Treatment	Retain. Still relevant.
H-60.989	Sexually Oriented Advertising to Youth	Retain. Still relevant.
H-60.990	Child Pornography	Retain. Still an issue.
H-95.951	Role of Self-Help in Addiction Treatment	Retain in part to read as follows: The AMA: (1) recognizes that (a) patients in need of treatment for alcohol or other ~~drug-related~~ substance use disorders should be treated for these medical conditions by qualified professionals in a manner consonant with accepted practice guidelines and patient placement criteria; and (b) self-help groups are valuable resources for many patients and their families and should be utilized by physicians as adjuncts to a treatment plan; and (2) urges managed care organizations and insurers to consider self-help as a complement to, not a substitute for, treatment directed by professionals, and to refrain from using their patient's involvement in self-help activities as a basis for denying authorization for payment for professional treatment of patients and their families who need such care.
H-95.980	Increased Funding for Drug-Related Programs	Retain. Still relevant.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 4-A-18

Subject: The Physician's Role in Firearm Safety

Presented by: Robert A. Gilchick, MD, MPH, Chair

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

INTRODUCTION

In March 2017, the American Medical Association (AMA) and the American Bar Association co-sponsored a conference titled, "Preventing Gun Violence: Moving from Crisis to Action." The conference was attended by members of the Council on Science and Public Health (Council) and the findings of this conference served as the impetus for developing this report as a Council initiative.

The Council previously studied the issue of preventing violence against health care workers and issued recommendations (see Policy H-515.957, "Preventing Violent Acts Against Health Care Providers"). That topic is not further addressed in this report.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from January 2013 to January 2018 using the search terms "gun violence," "firearm safety," "firearm violence," "physician" and "firearm," "physician" and "gun," "suicide" and "gun" or "firearm", "children" and "firearm safety," "gun violence restraining order," and "domestic violence restraining order." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations also were reviewed for relevant information.

CURRENT AMA POLICY

As one of the main causes of intentional and unintentional injuries and deaths, the AMA recognizes that firearms are a serious public health problem in the United States. The AMA has extensive policy on firearm safety and prevention of gun violence. Relevant to this report is existing policy that affirms the rights of physicians to have free and open communication with their patients regarding firearm safety and that calls on physicians to educate and counsel patients about firearm safety. AMA policy also supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to inquire about the presence of household firearms as a part of childproofing the home and routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms. AMA policy also urges Congress to provide sufficient resources to enable the Centers for Disease Control and Prevention (CDC) to collect and analyze data on firearm-related injuries in order to help prevent injury, death and the other costs to society resulting from firearms.

EPIDEMIOLOGY OF FIREARM MORBIDITY AND MORTALITY

Firearm-related deaths are the third leading cause of injury-related deaths in the United States. In 2016, more than 38,000 persons died from injury by firearms in the United States.[1] While mass shootings are horrific, they represent a small percentage of firearm-related deaths (less than 1 percent). Firearm suicide deaths, on the other hand, constitute more than 60 percent of firearm deaths, with firearm homicides accounting for approximately 35 percent, and accidental firearm deaths accounting for approximately 1.5 percent.[1;2]

Males disproportionately bear the burden of firearm mortality, accounting for 86 percent of all victims of firearm death.[2] Young adults between the ages of 25 and 34 years have the highest rate of fatal firearm injury per 100,000 at 15.1, followed by those in the 15 to 24 year age group (14.4 per 100,000).[2] Rates of firearm homicide are highest among adolescents (8.9 per 100,000) and young adults (8.0 per 100,000) and tend to decrease with age.[2] Rates of firearm suicide tend to increase with age. The annual rate of firearm suicide was highest among persons aged 65 years and older (10.9 per 100,000) followed by those in the 55–64 year age group (9.4 per 100,000) and the 45–54 year old age group (9.2 per 100,000).[2]

Non-Hispanic blacks have the highest rates of firearm mortality overall (18.1 per 100,000), and this disparity is largely due to differences between racial/ethnic groups in firearm homicide.[2] Non-Hispanic whites (9.2 per 100,000) and non-Hispanic American Indian/Alaskan Native populations (7.8 per 100,000) have the highest rates of firearm suicide in the United States when compared to other groups.[2] Non-Hispanic white males account for the majority of firearm suicides.[2]

Although limited data are available to evaluate epidemiological trends for firearm-related injuries, it is estimated that more than 84,000 people suffered nonfatal firearm injuries in 2015.[3] A study utilizing data from the Nationwide Emergency Department Sample identified 150,930 people in the period 2006-14 who presented alive to the emergency department (ED) with a firearm-related injury, representing an estimated 25.3 ED visits per 100,000 people. The incidence of ED visits for firearm-related injuries varied by patient age. It was the lowest among patients younger than age 10 (less than 1.5 ED visits per 100,000) and the highest among patients ages 15–29 (66.4 ED visits per 100,000).[4] The incidence of firearm-related injuries was approximately nine-fold higher among male patients.[4]

The majority of patients who presented alive to the ED for a firearm-related injury were injured in an assault (49.5 percent) or unintentionally (35.3 percent). Attempted suicides and legal interventions accounted for 5.3 percent and 2.4 percent respectively.[4] Among all patients presenting to the ED with a firearm-related injury, 48.0 percent were discharged home and 7.7 percent were discharged to additional care facilities, while 37.2 percent were admitted to inpatient care and 5.2 percent died during their visit.[4] The financial burden associated with firearm-related injuries was estimated to be approximately $2.8 billion per year.[4]

PHYSICIAN COUNSELING

Households with firearms exhibit an increased risk of experiencing a homicide, suicide, or accidental firearm death of a household member.[5] While physicians counsel patients about a wide range of behaviors and conditions, a systematic review of the literature found that despite clinical acceptance of the need for firearm injury prevention among high-risk populations, screening and counseling to increase safety is performed by a minority of clinicians.[6] A number of barriers exist that may contribute to the lack of physician counseling on firearm safety. These include legal barriers, the lack of training and time, low expectancy that counseling is effective, uncertainty

regarding what to say to patients, and a desire to not offend patients.[6;7] As with many other behavioral interventions, clinicians who have high confidence in, and self-efficacy toward, counseling are more likely to screen.[6]

The Law Does Not Prohibit Counseling

While a number of states have considered laws limiting what physicians are allowed to ask their patients about firearms, Florida is the only state that enacted such a law, the Firearm Owners' Privacy Act (FOPA), which prohibited health care practitioners from inquiring about the ownership of a firearm.[8] An exception included in the law allowed practitioners who in good faith believed that the information was relevant to the patient's medical care or safety, or the safety of others, to inquire.[8] In 2017, the Eleventh Circuit Court of Appeals overturned the law, holding that FOPA's content-based restrictions violated the First Amendment as it applies to the states.[9]

Montana, Missouri, and Minnesota have laws around the collection of firearm information by health practitioners; none of these laws prohibit counseling. Minnesota's law prohibits the commissioner of health from collecting data on individuals regarding lawful firearm ownership or data related to an individual's right to carry a weapon.[10] Missouri's law prohibits health care professionals from disclosing information about the status of a patient as an owner of a firearm, unless medically indicated or necessitated.[11] Montana's law provides that health care providers may not refuse to provide health care to a person who declines to answer questions regarding firearm ownership, possession, or use.[12]

HIGH-RISK INDIVIDUALS

Little guidance is available regarding who should be screened for the risk of firearm injury.[6] The American Academy of Pediatrics (AAP) recommends that pediatricians incorporate questions about the presence and availability of firearms into patient histories and counsel parents about the dangers of allowing children to have access to firearms both inside and outside of the home.[13] Studies indicate that screening among high-risk populations may help identify patients at risk of firearm injury.[6] Risk factors for firearm injury include suicidal ideation or intent, homicidal ideation or intent, history of violence, alcohol or drug use disorder, mental illness, and conditions impairing cognition and judgment.[7]

Intimate Partner Violence (IPV)

Firearms in a violent home increase the likelihood that IPV incidents will result in death.[14;15] In 2013, approximately half of the 1,270 reported intimate partner homicides in the United States were committed with firearms.[15] Because of this risk, laws have been enacted to remove firearms from those who commit IPV. At the federal level, the Violent Crime Control and Law Enforcement Act of 1994 prohibits individuals subject to certain restraining orders from purchasing or possessing a firearm.[16] Furthermore, the Lautenberg Amendment makes it illegal for individuals convicted of misdemeanor domestic violence assault to purchase or possess firearms. However, there are a number of gaps in the federal law, including that it does not apply to non-spouse partners.

Mental Illness

According to the American Psychiatric Association, reasonable restrictions on gun access are appropriate, but should not be based solely on a diagnosis of mental disorder.[17] Diagnostic categories vary widely in the symptoms, impairments, and disabilities of affected individuals and a

considerable heterogeneity exists.[17] Furthermore, individuals with mental illness, when appropriately treated, do not pose an increased risk of violence over the general population.[18]

Suicidal Ideation

Suicide is a leading cause of preventable death in the United States and firearms are among the most lethal suicide attempt methods, with nearly 9 out of 10 attempts resulting in death. In 2015, firearms were the most common method used in suicide deaths in the United States, accounting for almost half of all suicide deaths.[19] Over the past 15 years, the total suicide rate has increased 24 percent from 10.5 to 13.0 per 100,000.[19] The suicide rate among males has remained approximately four times higher (20.7 per 100,000 in 2014) than among females (5.8 per 100,000 in 2014).[19]

Physicians and other health professionals should be trained to assess and respond to individuals who may be at heightened risk for violence or suicide.[17] In the context of suicide prevention, "lethal means counseling" refers to assessing whether a person at risk for suicide has access to a firearm or other lethal means and then working with them, their family, and support system to limit their access until they are no longer at elevated risk.[20] Counseling of suicidal patients or (for youth) their parents about restricting "lethal means" may increase rates of firearm removal from the home.[6]

Community Violence/Assault

High-risk youth presenting to an urban emergency department (ED) for assault have elevated rates of subsequent firearm violence.[21] Nearly 60 percent of assault-injured youth report violent firearm aggression, victimization, and/or firearm injury within 2 years of their index ED visit.[21] Among assault-injured youth seeking urban ED care, nearly 25% report having a firearm.[22] Retaliation may be a significant motivation for ensuing firearm violence. This underscores the need for ED screening of retaliation risk and interventions that focus on alternative means of conflict resolution.

Childhood Injury Prevention

The most effective measure to prevent suicide, homicide, and unintentional firearm-related injuries to children and adolescents is the absence of firearms from homes and communities.[13] The AAP encourages firearm screening as a standard part of universal injury prevention screening.[6] Parents who possess firearms should be urged to prevent access by children because safer storage of firearms reduces injuries. Physician counseling linked with distribution of cable locks appears to increase safer storage.[13]

Cognitive Decline

Firearm access can pose a risk to cognitively-impaired individuals. It is estimated that as many as 60 percent of older people with dementia live in a home with a firearm, where there may be a greater likelihood that they are not locked or unloaded. The Alzheimer's Association suggests screening for firearm access along with other safety topics (i.e., driving) as well as keeping firearms locked, with ammunition stored separately.[23]

DISCUSSION

The federal Gun Control Act makes it unlawful for certain categories of persons to ship, transport, receive, or possess firearms or ammunition. Those categories include, but are not limited to individuals convicted of a felony; unlawful users or those with addiction involving any controlled

substance; individuals adjudicated as a "mental defective" or under an order of civil commitment; individuals subject to a court order restraining them from harassing, stalking, or threatening an intimate partner or child of the intimate partner; or persons who have been convicted of a misdemeanor crime of domestic violence.[24] However, inconsistencies in states' reporting of disqualifying records to the National Instant Criminal Background Check System, as well as loopholes in the requirements for background checks prior to a firearm purchase, contribute to the unsuccessful identification of people who should not have firearms. Furthermore, the background check system was designed to prevent someone from purchasing a new firearm; it does not grant the authority to remove firearms from a high-risk individual who already possesses them.[25] A number of policies have been developed to help address those gaps.

Temporary Firearm Transfer

Reducing access to lethal means is an effective, evidence-based method for suicide prevention. Most states allow the private transfer of firearms without a background check, but 19 states and Washington, DC, have universal background check (UBC) laws mandating a background check whenever a firearm is transferred. While these laws make it harder for high-risk persons to acquire firearms, they could make it more difficult for patients to temporarily transfer a firearm to reduce access to lethal means.[26] Some UBC states have mechanisms that facilitate temporary transfers without a background check to certain persons (i.e., family members) or for certain time periods (e.g., 72 hours), but others do not.[27] In states with rigid UBC laws, physicians should understand existing background check requirements and exceptions so they can offer tailored advice to lower the risks facing their patient.[26]

Gun Violence Restraining Orders (GVROs)

GVRO laws, also referred to as firearm restraining orders and extreme risk protection orders, give law enforcement, family members, or household members who observe an individual's dangerous behavior and believe it could be a precursor to violence (against themselves or others), the authority to petition a court to temporarily remove firearms from the individual's possession and prohibit them from purchasing a new firearm or ammunition.[28] The purpose is to target high-risk individuals on the basis of behavior, regardless of mental illness diagnosis, to reduce firearm violence.[29] Four states (Connecticut, Indiana, California, and Washington) have adopted this risk-based, preemptive approach to firearm removal.[30-33] Similar laws have been introduced in 22 other states and the District of Columbia.

In 1999, Connecticut was the first state to authorize law enforcement to petition for the removal of firearms from individuals due to "a risk of imminent personal injury to himself or herself or to other individuals."[30] Connecticut's law was challenged in the courts, but was upheld by the Connecticut Appellate Court as not restricting the rights of law-abiding citizens to use arms in defense of their homes and thus, not in violation of the Second Amendment.[34]

An evaluation of Connecticut's risk-warrant law shows that from 1999–2013, 762 risk-warrants were issued.[34] Almost all gun removal subjects were male (92 percent). Nearly half of the firearm removal cases were initiated by an acquaintance, with family members initiating 41 percent of cases, and employers or clinicians initiating eight percent of cases. Suicidality or self-injury threat was listed as a concern in sixty-one percent of cases, with the risk of harm to others a concern in thirty-two percent of cases.[34] Most risk-warrant subjects did not have contact with the public behavioral health system in the year before the risk-warrant was served. However, in the year following firearm removal, nearly one-third (29 percent) of risk-warrant subjects received treatment in the state system, suggesting the risk-warrant provided an entryway into needed mental

health and substance use related services.[34] In nearly all cases (99 percent), police found and removed firearms when they conducted a search, with an average of seven firearms removed per subject.[34] It is estimated that there was one averted suicide for every 10 to 11 firearm removals—saving 72 lives over a 14 year period.[34]

Firearm Safety Programs

Eighteen states have child access prevention (CAP) laws.[35] These laws mandate that a firearm be stored so that a child or teen (the specific age varies by state) is not able to gain easy access to the firearm. CAP laws do not typically mandate a specific storage method, although unloading the firearm and locking it up separately from the ammunition is recommended by some researchers. State CAP laws have been associated with lower rates of both accidental deaths of children and suicides among teens.[36]

RESOURCES AND RELATED ACTIVITIES

At A-17, the House of Delegates adopted policy calling on the AMA to work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death. In addition to this report, the Council is sponsoring an educational session at A-18 on "Preventing Gun Violence: What Physicians Can Do Now." The AMA is also in the process of developing an enduring continuing medical education (CME) module to help physicians navigate conversations with their patients on firearm safety. The CME module is expected to be available on the AMA's education center portal by the end of the year. The AMA is also working to provide physicians with state-specific guidance on firearm laws and how those laws interact with firearm safety counseling.

Other resources of interest include, "What You Can Do," a new initiative from University of California Davis' Violence Prevention Research Program designed to support health care providers in reducing firearm injury and death.[37] This initiative brings together a growing network of health care providers looking for ways to reduce firearm injury and death, with particular emphasis on addressing firearm injury for populations at elevated risk.[37]

CONCLUSION

Households with firearms are at increased risk of experiencing a homicide, suicide, or accidental firearm death of a household member. Despite clinical acceptance of the need for firearm injury prevention among high-risk populations, screening and counseling to increase safety is performed by only a minority of physicians. A need exists for physician training to increase physician confidence and self-efficacy toward counseling around firearm safety. While existing AMA policy encourages physicians to educate and counsel patients on firearm safety, it does not specifically address the issue of suicide. Given the prevalence of firearm suicides in the United States, physicians should be trained in lethal means safety counseling as a part of their suicide risk assessment and prevention efforts. Furthermore, laws in most jurisdictions do not provide the authority to remove firearms from a high-risk individual who already possesses them. The AMA should support common-sense laws allowing for the removal of firearms from individuals whose conduct indicates a heightened risk of violence to themselves or others.

RECOMMENDATIONS

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

1. That the following policy be adopted.

Firearms and High-Risk Individuals
Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders or convicted of misdemeanor domestic violence crimes, including dating partners, from possessing or purchasing firearms; (3) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (4) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (5) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals. (New HOD Policy)

2. That Policy H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," be amended by addition and deletion to read as follows:

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance ~~ab~~use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. 3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide. (Modify Current HOD Policy)

3. That Policies, H-145.976, “Firearm Safety Counseling in Physician-Led Health Care Teams,” H-145.990, “Prevention of Firearm Accidents in Children,” and H-145.997 “Firearms as a Public Health Problem in the United States - Injuries and Death” be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: Less than $1,000

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REPORT 5 OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH (A-18)
Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking (Resolution 403-A-17)
(Reference Committee D)

EXECUTIVE SUMMARY

Objective: This report examines the available evidence regarding harm reduction approaches to reducing tobacco-related mortality, with a focus on electronic cigarettes.

Methods: English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from March 2014 to January 2018 using the search terms "tobacco" and "harm reduction," "nicotine," "electronic cigarette," "e-cigarette," "ENDS,", "noncombustible tobacco product," "smokeless tobacco," and " tobacco cessation." Additional articles were identified by manual review of the reference lists of pertinent publications. Recognizing the dynamic nature of the research being published on this topic, the Council deemed it appropriate to summarize the findings and conclusions of the recent National Academies of Sciences, Engineering, and Medicine (National Academies) report on the "Public Health Consequences of E-Cigarettes" related to harm reduction. Articles published subsequent to the National Academies report are cited, as appropriate.

Results: Despite reductions in combustible tobacco use, it still represents the leading cause of preventable death in the United States. A growing number of non-combustible tobacco products are thought to be less hazardous than combustibles, but limited evidence is available on their long-term health risks. E-cigarettes are among the most widely used non-combustible tobacco product. Available evidence suggests that those who completely substitute e-cigarettes for combustible tobacco cigarettes have reduced exposure to numerous toxicants and carcinogens present in combustible tobacco cigarettes. However, the efficacy of e-cigarettes in reducing health risks has not been adequately evaluated in well-designed epidemiological studies and RCTs. Benefits are not realized in dual users, who in fact may be exposed to additional adverse health effects.

Conclusion: Currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless. Significant concerns exist that novel, non-combustible products may pose a significant threat to tobacco cessation and prevention efforts. Smokers concerned about their health who see the claims for novel tobacco products may think that a safer cigarette genuinely exists, making them less inclined to try to quit smoking. Likewise, those who never used tobacco products may initiate tobacco use assuming that a safe tobacco product exists. E-cigarette use among youth and young adults is a public health concern. Available data suggest that youth who use e-cigarettes are more likely to smoke combustible cigarettes. AMA policy should recognize that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction. Evidence-based methods for tobacco cessation exist. More needs to be done to promote evidence-based cessation methods to those who are trying to quit smoking.

REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 5-A-18

Subject: Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking (Resolution 403-A-17)

Presented by: Robert A. Gilchick, MD, MPH, Chair

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

INTRODUCTION

Resolution 403-A-17, "Tobacco Harm Reduction: A Comprehensive Nicotine Policy to Reduce Death and Disease Caused by Smoking," introduced by the Resident and Fellow Section and referred by the House of Delegates, asks:

> That our American Medical Association (AMA) advocate for tobacco harm reduction approaches to be added to existing tobacco treatment and control efforts (New HOD Policy);
>
> That our AMA educate physicians and patients on the myriad health effects of different nicotine products and emphasize the critical role of smoke and combustion in causing disease (Directive to Take Action);
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> That our AMA encourage physicians to adopt patient-specific, individualized approaches to smoking cessation, particularly for patients with disease secondary to smoking and for patients who have otherwise failed traditional methods for smoking cessation (New HOD Policy);
>
> That our AMA continue its focus on research to identify and expand options that may assist patients to transition away from smoking, including nicotine replacement therapies and noncombustible nicotine products (including e-cigarettes) (Directive to Take Action);
>
> That the AMA reaffirm its position on strong enforcement of US Food and Drug Administration and other agency regulations for the prevention of use of all electronic nicotine delivery systems and tobacco products by anyone under the legal minimum purchase age. This shall include marketing to children, direct use or purchasing by children and indirect diversion to children. Further, that our AMA reaffirm physician education of patients to limit these products for children in any and all capacity. (Reaffirm HOD Policy)

The Council on Science and Public Health (Council) has issued two previous reports on electronic cigarettes, in 2010 and 2014, which helped establish our AMA's existing policy around non-combustible tobacco products.

METHODS

English language reports were selected from searches of the PubMed, Google Scholar, and Cochrane Library databases from March 2014 to January 2018 using the search terms “tobacco” and “harm reduction,” “nicotine,” “electronic cigarette,” “e-cigarette,” “ENDS,”, “noncombustible tobacco product,” “smokeless tobacco,” and “ tobacco cessation.” Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal and state agencies and applicable regulatory and advocacy organizations also were reviewed for relevant information.

Recognizing the dynamic nature of the research being published on this topic, the Council deemed it appropriate to summarize the findings and conclusions of the recent National Academies of Sciences, Engineering, and Medicine (National Academies) report on the “Public Health Consequences of E-Cigarettes” related to harm reduction. Articles published subsequent to the National Academies report are cited, as appropriate, in this report.

CURRENT AMA POLICY

It is the AMA’s position that all tobacco products are harmful to health, and that there is no such thing as a safe cigarette. AMA policy urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA to have broad-based powers to regulate tobacco products. AMA policy also encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including the elimination of nicotine and elimination of additives that enhance addictiveness.

AMA policy encourages physicians to use evidence-based clinical practice guidelines on smoking cessation for the treatment of patients with nicotine dependence and urges physicians to promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers. Physicians should be prepared to counsel patients about the use of electronic nicotine delivery systems (ENDS), including electronic cigarettes (e-cigarettes), the potential for nicotine addiction, and the hazards of dual use of e-cigarettes with conventional cigarettes. Our AMA also encourages further clinical and epidemiological research on e-cigarettes as well as research and evaluation on promising smoking cessation protocols that promote abrupt cessation of smoking without reliance on pharmaceutical products.

HISTORY OF TOBACCO HARM REDUCTION

Tobacco products in any form are harmful and addictive and can cause disease and death.[1] Combustible cigarettes cause the majority of tobacco-related disease and are responsible for more than 480,000 deaths in the United States each year, and for millions more living with smoking-related diseases.[1,2] When used as intended, combustible cigarettes are addictive by design and are directly responsible for the deaths of at least half of all long-term users.[3]

Over the last decade, a new generation of tobacco products has entered the marketplace promising reduced exposure to toxicants in tobacco smoke and claiming to reduce the risk of cancer or other diseases.[4] This has resulted in a renewed discussion around harm reduction policies, which aim to reduce, but not eliminate tobacco-related health risks.[5]

Public health advocates have been hesitant to support harm reduction approaches for tobacco because of a lack of trust in tobacco companies and their ability or willingness to develop products that will actually reduce risks.[6] Several times in the last 50 years, the tobacco industry has

developed a new cigarette, which it has promoted as safer. Large proportions of the smoking population switched to these products, mistakenly believing they were reducing their health risk, only to realize these were false promises.[7] Specifically, experience with products promoted by the tobacco industry as safer in the past, such as "light" cigarettes, resulted in increased toxicant exposures with smokers compensating for reduced nicotine by smoking with greater frequency and intensity.[6]

In 2001, the Institute of Medicine (IOM, now the National Academies) assessed the science base for tobacco harm reduction. The IOM committee concluded that for many diseases attributable to tobacco use, reducing the risk of disease by reducing exposure to tobacco toxicants is feasible.[8] However, such products have not been evaluated adequately to conclude they are in fact associated with reduced risks.[8] Furthermore, according to the IOM, "the regulation of all tobacco products is a necessary precondition for assuring a scientific basis for determining the effects of potentially reduced-exposure products and assuring the public has current, reliable information on the risks and benefits."[8] Finally, the public health impact of potential reduced-exposure products is unknown because their effect on public health will depend on their biological harm and individual and community behaviors around their use.[8]

In 2005, with funding from the American Legacy Foundation and the Robert Wood Johnson Foundation, the Strategic Dialogue on Tobacco Harm Reduction (Dialogue) was formed to address critically important aspects of the harm reduction debate including research priorities, overarching strategic considerations, policy recommendations, and communication methods.[4] Members of the Dialogue agreed on the concept of the continuum of risk, which is determined by the delivery of toxicants and nicotine.[4,9] Nicotine replacement therapy (NRT) (i.e., "gum," patch, and lozenge) is on the safer end, with combustible cigarettes on the more hazardous end, of the spectrum.[4] When users of combustible cigarettes switch to smokeless tobacco products, "maximal potential reduction in harm could only occur with products that result in the lowest exposure to toxicants, are subject to government regulation, and that avoid adverse consequences such as increased initiation of tobacco use or decreased cessation."[4]

THE CONTINUUM OF RISK

There is a spectrum of tobacco and medicinal products that are designed to deliver nicotine to the user.[10] The toxicity associated with these products varies.[10]

FDA Approved Products for Treatment of Tobacco Use Disorder

FDA has approved several smoking cessation products designed to help users gradually withdraw from smoking by using specific amounts of nicotine that decrease over time. NRT products are safe and effective medications to help people stop smoking.[11] While NRT products contain nicotine in controlled amounts, they do not contain the other harmful chemicals found in tobacco products. NRT products are available over the counter and by prescription. Over-the-counter NRTs are approved for sale to people age 18 and older. They are available under various brand names (sometimes as generic products) and include transdermal nicotine patches, nicotine gum, and nicotine lozenges.[11] Prescription NRT is available under the brand name Nicotrol, and is available both as a nasal spray and an oral inhaler.[11] The FDA has approved two pharmacotherapy products for tobacco use disorder that do not contain nicotine. They are Chantix® (varenicline tartrate) and Zyban® (buproprion hydrochloride).[11] Both are available in tablet form and by prescription only.

Modified Risk Tobacco Product (MRTP)

MRTPs are tobacco products that are sold or distributed for use to reduce harm or the risk of tobacco-related disease associated with commercially marketed tobacco products.[12] FDA can issue an order authorizing the marketing of a MRTP if the evidence demonstrates that the product will or is expected to benefit the health of the population.[12]

The FDA has not approved any MRTPs. Applications from R.J. Reynolds Tobacco Company for their Camel Snus smokeless tobacco product and Philip Morris Products for their IQOS system with Marlboro Heatsticks (a heat not burn tobacco device) are currently under scientific review.[12] In January 2018, the FDA's Tobacco Products Scientific Advisory Committee (TPSAC) voted 8-0 with one abstention against Philip Morris' claim that the IQOS system can reduce the risks of tobacco-related diseases.[13] In considering whether switching completely to IQOS presents less risk of harm than continuing to smoke cigarettes, the committee voted narrowly against the claim.[13] TPSAC's recommendations and votes are not binding on the FDA.

Non-Combustible Tobacco Products

A number of non-combustible tobacco products are promoted as less harmful than combustible cigarettes. However, limited data are available on the long-term health effects of these products. E-cigarettes are among the most popular of these products. In 2014, more than 460 brands of e-cigarettes, available in >7,700 unique flavors, were being sold on the internet.[14] E-cigarette liquids can expose users to toxicants, including solvents (propylene glycol and glycerol), flavorings, and other additives. Furthermore, heating and aerosolizing e-liquids can generate additional harmful substances.[5] The FDA currently regulates smokeless tobacco and some dissolvable tobacco products. The agency has finalized a rule extending its regulatory authority to all tobacco products, including e-cigarettes, cigars, hookah, and pipe tobacco, but recently extended the deadline for agency review.

Combustible Cigarettes

There are approximately 600 known ingredients in combustible cigarettes.[15] When burned, more than 7,000 additional chemicals are created, at least 69 of which are known to cause cancer, and many others are poisonous.[15] Smoking leads to disease and disability and harms nearly every organ of the body. For every person who dies because of smoking, at least 30 people live with a serious smoking-related illness.[16] Smoking causes cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease, including emphysema and chronic bronchitis.[16] Secondhand smoke exposure contributes to approximately 41,000 deaths among non-smoking adults and 400 infant deaths annually.[16] Secondhand smoke causes stroke, lung cancer, and coronary heart disease in adults.[16] Infants and children who are exposed to secondhand smoke are at increased risk for sudden infant death syndrome, acute respiratory infections, middle ear disease, more severe asthma, respiratory symptoms, and slowed lung growth.[16]

FDA PLAN FOR TOBACCO AND NICOTINE REGULATION

In 2017, the FDA announced plans to reduce the devastating toll of tobacco use. The plan involves two primary parts: (1) reducing the addictiveness of combustible cigarettes and (2) recognizing and clarifying the role that potentially less harmful tobacco products could play in improving public health.[2] The FDA also has acknowledged the need for medicinal nicotine and other therapeutic products to play a greater role in helping smokers to quit and remain nonsmokers.[2]

The Family Smoking Prevention and Tobacco Control Act of 2009 gave the FDA the authority to establish tobacco product standards that are appropriate for the protection of the public's health.[17] Standards may require the reduction or elimination of an additive, constituent, or other component of a tobacco product because it is or may be harmful.[18] In March 2018, the FDA issued two advance notices of proposed rulemaking, one to explore a product standard to lower nicotine in cigarettes to minimally or non-addictive levels and the other calling on stakeholders to share data, research, and information to inform the role that flavors play in initiation, use, and cessation of tobacco products.

Reducing cigarettes' addictiveness could potentially help addicted users quit more easily and help keep those who are experimenting from becoming regular smokers.[2] While the FDA's current plan does not include lowering nicotine levels in non-combustible tobacco products, conceptually the availability of potentially less harmful tobacco products could reduce risk while delivering levels of nicotine for adults who still want it.[2]

E-CIGARETTES AND HARM REDUCTION

In January 2018, the National Academies issued a report on the "Public Health Consequences of E-cigarettes." The report committee undertook a comprehensive review of the scientific literature regarding key constituents in e-cigarettes, human health effects, initiation and cessation of combustible tobacco cigarette use, and harm reduction.

In addressing harm reduction, the National Academies noted the absence of randomized controlled trials and longitudinal observational studies on the effects of switching from combustible tobacco cigarettes to e-cigarettes to reduce harm.[5] Therefore, they relied on evidence regarding the exposure to toxicants present in e-cigarette aerosols compared with those in cigarette smoke, nicotine and toxicant exposures in e-cigarette users as an intermediate outcome, and comparisons of health effects on any health outcome from e-cigarette use compared with combustible tobacco cigarette smoking.[5]

Based on a limited number of laboratory studies comparing emissions of harmful and potentially harmful chemicals from e-cigarette devices with those from combustible tobacco cigarettes, aerosol emitted from e-cigarettes is substantially less complex than tobacco smoke.[5] Several potentially toxic substances have been identified in e-cigarette aerosol, but at significantly lower levels than in combustible tobacco smoke.[5] The National Academies found that "there is conclusive evidence that completely substituting e-cigarettes for combustible tobacco cigarettes reduces users' exposure to numerous toxicants and carcinogens present in combustible tobacco cigarettes."[5]

While the health effects of using e-cigarettes are not well understood, current evidence points to e-cigarettes being less harmful than combustible tobacco cigarettes.[5] All but one of the studies reviewed by the National Academies showed significant short-term improvements in health outcomes in smokers who switched from combustible tobacco cigarettes to e-cigarettes.[5] Thus, they concluded that "there is substantial evidence that completely switching from regular use of combustible tobacco cigarettes to e-cigarettes results in reduced short-term adverse health outcomes in several organ systems."[5]

Dual use of tobacco cigarettes and e-cigarettes is highly prevalent among adults and youth but little evidence exists about dual users' patterns of use. On dual use, the National Academies concluded that, "there is no available evidence whether or not long-term e-cigarette use among smokers (dual use) changes morbidity or mortality compared with those who only smoke combustible tobacco cigarettes" and "there is insufficient evidence that e-cigarette use changes short-term adverse health

outcomes in several organ systems in smokers who continue to smoke combustible tobacco cigarettes (dual users)."[5]

No long-term studies exist comparing the health effects resulting from passive exposure to secondhand aerosol from e-cigarettes with effects in non-smokers passively exposed to tobacco smoke.[5] A limited number of studies compared secondhand exposure to e-cigarette emissions to combustible tobacco cigarette smoke.[5] While e-cigarette use in indoor environments exposes non-users to nicotine and particulates, it is at lower levels compared to tobacco smoke from combustible cigarettes.[5] The National Academies concluded that, "there is moderate evidence that secondhand exposure to nicotine and particulates is lower from e-cigarettes compared with combustible tobacco cigarettes."[5]

CURRENT USE PATTERNS

In 2013 and 2014, more than a quarter (27.6 percent) of adults were current users of at least one type of tobacco product.[19] A total of 8.9 percent of youths had used a tobacco product in the previous 30 days and 1.6 percent of youths were daily users. Approximately 40 percent of tobacco users used multiple tobacco products, with cigarettes plus e-cigarettes as the most common combination.[19] Although consumption of combustible tobacco products has decreased, the consumption of non-cigarette combustible tobacco and smokeless tobacco has increased.[20]

In 2014, 12.6 percent of adults had ever tried an e-cigarette (at least one time) and 3.7 percent of adults currently used e-cigarettes.[16] In 2016, 20.2 percent of surveyed high school students and 7.2 percent of middle school students reported current tobacco product use.[21] E-cigarettes are the most commonly used tobacco product among high (11.3 percent) and middle (4.3 percent) school students.[21] In 2018, health officials raised concerns about Juul, a brand of e-cigarette that looks like a flash drive.[22] The devices are difficult to distinguish from a real flash drive and their vapor dissipates quickly making them easy to hide. Each Juul cartridge lasts about 200 puffs and has as much nicotine as an entire pack of cigarettes. "Juuling" has become widespread enough that school districts in several states have voiced concerns and, in some cases, have amended school policy to address the issue.[23]

Use of e-cigarettes, hookah, non-cigarette combustible tobacco, or smokeless tobacco by youth is associated with cigarette smoking one year later.[24] Furthermore, the risk of progressing to conventional cigarette smoking is increased with use of multiple forms of non-cigarette tobacco, suggesting that novel tobacco products have the potential to undermine public health gains in combatting the smoking epidemic.[24] Among adolescent cigarette experimenters, using e-cigarettes has been positively and independently associated with progression to current established smoking, suggesting that e-cigarettes may encourage cigarette smoking in this population.[25] E-cigarette use among youth and young adults is a public health concern, and coordinated efforts are needed to protect young people from a lifetime of nicotine addiction.[26]

SMOKING CESSATION

The United States Preventive Services Task Force (USPSTF) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, provide behavioral interventions and offer FDA-approved pharmacotherapy for cessation to adults who use tobacco.[27] In 2015, 68 percent of adults smokers wanted to quit smoking, 57 percent had been advised by a health professional to quit, and 31 percent had used cessation counseling and/or medications when trying to quit.[28] Fewer than one-third of persons used evidenced-based cessation methods when trying to

quit smoking.[28] To enhance cessation rates, health care providers should consistently identify smokers, advise them to quit, and promote the use of evidenced-based cessation treatments.[28]

The USPSTF also examined the evidence on the use of e-cigarettes or ENDS and concluded that the current evidence is insufficient to recommend ENDS for tobacco cessation in adults, including pregnant women.[27] Furthermore, a large prospective study of recently hospitalized smokers (n=1357) who planned to quit found a negative association between the use of e-cigarettes after discharge and subsequent tobacco abstinence.[29] Not only does the intermittent and concurrent use of e-cigarettes with other cessation aids not aid quitting, it may hamper it.[29] The USPSTF recommends that clinicians direct patients who smoke tobacco to cessation interventions with established effectiveness and safety.[27]

CONCLUSION

Despite reductions in combustible tobacco use, it still represents the leading cause of preventable death in the United States. A growing number of non-combustible tobacco products are thought to be less hazardous than combustibles, but limited evidence is available on their long-term health risks. The FDA has the authority to designate products as MRTP, but to date, no products have met the criteria and been approved through this pathway.

E-cigarettes are among the most widely used non-combustible tobacco products. Available evidence suggests that those who completely substitute e-cigarettes for combustible tobacco cigarettes have reduced exposure to numerous toxicants and carcinogens present in combustible tobacco cigarettes, resulting in reduced short-term adverse health outcomes in several organ systems. However, long-term studies on the health effects of e-cigarettes are lacking. Furthermore, the efficacy of e-cigarettes in reducing health risks has not been adequately evaluated in well-designed epidemiological studies and RCTs. Benefits are not realized in dual users, who in fact may be exposed to additional adverse health effects.

Significant concerns exist that novel, non-combustible products may pose a significant threat to tobacco cessation and prevention efforts. Smokers concerned about their health who see the claims for novel tobacco products may think that a safer cigarette genuinely exists, making them less inclined to try to quit smoking. Furthermore, ex-smokers may start smoking again, thinking they can now safely consume tobacco products. Likewise, those who never used tobacco products may initiate tobacco use assuming that a safe tobacco product exists. E-cigarette use among youth and young adults is a public health concern. Available data suggest that youth who use e-cigarettes are more likely to smoke combustible cigarettes.

Evidence-based methods for tobacco cessation exist. The FDA has approved several smoking cessation products designed to help users gradually withdraw from smoking by using specific amounts of nicotine that decrease over time. The USPSTF has reviewed the evidence and recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, provide behavioral interventions, and offer FDA approved pharmacotherapy for cessation to adults who use tobacco. More needs to be done to promote evidence-based cessation methods to those who are trying to quit smoking.

RECOMMENDATIONS

The Council recommends that the following statements be adopted in lieu of Resolution 403-A-17, and the remainder of the report be filed.

1. That Policy H-495.988, "FDA Regulation of Tobacco Products," be amended by addition and deletion to read as follows:

H-495.988 FDA Regulation of Tobacco Products
1. Our AMA: (A) ~~reaffirms its position~~ acknowledges that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (B) recognizes that currently available evidence from short-term studies points to electronic cigarettes as containing fewer toxicants than combustible cigarettes, but the use of electronic cigarettes is not harmless and is associated with the use of combustible tobacco cigarettes in youth; (C) encourages long-term studies of vaping (the use of electronic nicotine delivery systems) and recognizes that complete cessation of the use of tobacco and nicotine-related products is the goal; (D~~B~~) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (E~~C~~) reaffirms its position that the Food and Drug Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (F~~D~~) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (G~~E~~) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (H~~F~~) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; and (I~~G~~) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products… (Amend Current HOD Policy)

2. That Policy H-495.972, "Electronic Cigarettes, Vaping, and Health: 2014 Update," be amended by addition and deletion to read as follows, with a change in title:

Electronic Cigarettes, Vaping, and Health~~: 2014 Update~~
1. Our AMA urges physicians to: (a) educate themselves about electronic nicotine delivery systems (ENDS), including e-cigarettes, be prepared to counsel patients about the use of these products and the potential for nicotine addiction and the potential hazards of dual use with conventional cigarettes, and be sensitive to the possibility that when patients ask about e-cigarettes, they may be asking for help to quit smoking; (b) consider expanding clinical interviews to inquire about "vaping" or the use of e-cigarettes; (c) promote the use of FDA-approved smoking cessation tools and resources for their patients and caregivers; and (d) advise patients who use e-cigarettes to take measures to assure the safety of children in the home who could be exposed to risks of nicotine overdose via ingestion of replacement e-cigarette liquid that is capped or stored improperly. 2. Our AMA: (a) encourages further clinical and epidemiological research on e-cigarettes~~.~~ ;~~3. Our AMA~~ (b) supports education of the public on electronic nicotine delivery systems (ENDS) including e-cigarettes~~.~~; and (c) recognizes that the use of products containing nicotine in any form among youth, including e-cigarettes, is unsafe and can cause addiction. (Amend Current HOD Policy)

3. That Policy H-495.973, "FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products," be amended by addition and deletion to read as follows:

H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products

Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of ~~18~~21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth. (Amend Current HOD Policy)

4. That Policy, H-490.917, “Physician Responsibilities for Tobacco Cessation” be reaffirmed. (Reaffirm HOD Policy)

Fiscal Note: less than $500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-18)

Introduced by: Indiana

Subject: Danger from Bright Vehicle Headlights

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Advances in LED light emitting diode, xenon gas and incandescent illumination is producing brighter vehicular headlights; and

Whereas, The field of illumination can be altered in intensity of brightness, and shape and size; and

Whereas, Different tints and shades of light have also been used; and

Whereas, Better vehicular lights can enhance the safety of driving at night when no other vehicles are present; and

Whereas, The average age of the U.S. population is increasing with greater difficulty with vision at night consisting of glare and transient blindness when faced with a bright vehicular light at night; and

Whereas, The danger is increased for both drivers and their passengers if one or both have impaired vision due to glare or blindness from the bright lights of an approaching vehicle; and

Whereas, High beam lights can be especially bright and therefore dangerous when drivers fail to lower the beam for approaching vehicles; and

Whereas, Multiple state legislatures have been studying this issue and in some cases passing legislation to regulate the headlights; and

Whereas, The AMA has studied the health consequences of artificial light; and

Whereas, The Council on Science and Public Health might provide insight to our AMA by studying this issue; therefore be it

RESOLVED, That our American Medical Association study the danger of bright vehicle headlights and report back to the House of Delegates (Directive to Take Action); and be it further

RESOLVED, That our AMA study the safety risks to drivers and their passengers when they approach vehicles with incandescent, xenon gas or LED headlights, as well as the use of other technologies such as automated steering and automated windshield tinting to mitigate the risk (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for mandatory automated high-beam to low-beam headlight switching systems that would operate when an approaching vehicle headlight is detected. (Directive to Take Action)

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

Received: 02/12/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-18)

Introduced by: American Academy of Pediatrics

Subject: Schools as Gun-Free Zones

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Escalating violence and shootings are rampant such that as of the writing of this resolution, this is the eighteenth school shooting in 2018, the equivalent of one every two and a half days so far this year; and

Whereas, The President of the United States has proposed bonuses for teachers to undergo gun training for concealed weapons; and

Whereas, The job of a teacher is to educate their students, not to shoot potential armed assailants; and

Whereas, Randi Weingarten, head of the American Federation of Teachers, criticized the proposal in a statement on behalf of the teachers' union, "Teachers don't want to be armed," Weingarten said. "We want to teach. We don't want to be, and would never have the expertise needed to be, sharp shooters; no amount of training can prepare an armed teacher to go up against an AR-15."; and

Whereas, Arming teachers runs counter to existing AMA policy on guns in the school setting, school violence, training teachers to identify potentially dangerous children, increasing mental illness detection, and violence-reduction criteria that encourage states to ensure that schools are safe harbors, secure from weapons, and staffed with educators trained in violence mitigation (H-60.947, H-145.983, H-60.946, D-345.994, H-60.943); therefore be it

RESOLVED, That our American Medical Association advocate for schools to remain gun-free zones (New HOD Policy); and be it further

RESOLVED, That our AMA oppose requirements or incentives of teachers to carry weapons. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/19/18

RELEVANT AMA POLICY

Guns in School Settings H-60.947 - Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment. Res. 402, I-98 Reaffirmed: CSAPH Rep. 2, A-08

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997 - Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level. CSA Rep. A, I-87 Reaffirmed: BOT Rep. I-93-50 Appended: Res. 403, I-99 Reaffirmation A-07 Reaffirmation A-13 Appended: Res. 921, I-13

Gun Violence as a Public Health Crisis D-145.995 - Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban. Res. 1011, A-16

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975 - 1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. Sub. Res. 221, A-13 Appended: Res. 416, A-14 Reaffirmed: Res. 426, A-16

School Violence H-145.983 - The AMA encourages states to adopt legislation enabling schools to limit and control the possession and storage of weapons or potential weapons on school property. Sub. Res. 402, I-95 Reaffirmed: CSA Rep. 8, A-05 Reaffirmed: CSAPH Rep. 1, A-15

Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for their Treatment H-60.946 - Our AMA: (1) supports teacher education initiatives to better enable them to identify children at risk for psychiatric illnesses, substance abuse, and potentially dangerous behaviors; and (2) reaffirms its support for parity of coverage for mental illness.
Sub. Res. 118, A-99 Reaffirmed: CSAPH Rep. 1, A-09

See also: Increasing Detection of Mental Illness and Encouraging Education D-345.994; Bullying Behaviors Among Children and Adolescents H-60.943

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-18)

Introduced by: American Academy of Pediatrics

Subject: School Safety and Mental Health

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Many children, adolescents, and adults have died from firearm injury in schools; and

Whereas, The perpetrators of school-based firearm violence are usually students, former students, or young adults with mental illness; and

Whereas, Twenty percent of children, adolescents, and young adults have diagnosable mental health disorders; and

Whereas, Only 20% of children, adolescents, and young adults with mental health disorders receive mental health services; and

Whereas, There are community-based models through which students can undergo mental health screenings and receive mental health services as indicated on-site at school; and

Whereas, Schools can employ sufficient nurses and mental health clinical social workers to address the mental health problems of students; and

Whereas, Schools can contract with mental health professionals who partner with the schools to implement school-based comprehensive mental health programs for students; and

Whereas, The schools can develop telehealth mental health screening and therapy programs for students in partnership with primary care and mental health professionals; therefore be it

RESOLVED, That our American Medical Association promote the implementation of school-based mental health screening and therapy programs within its efforts to reduce school-based firearm violence. (New HOD Policy)

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

Received: 04/19/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-18)

Introduced by: Medical Student Section

Subject: Emphasizing the Human Papillomavirus Vaccines as Anti-Cancer Prophylaxis for a Gender-Neutral Demographic

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, About 14 million Americans are newly infected with human papillomavirus (HPV) each year;[1] and

Whereas, Subclinical HPV infection may be as high as 40%, which can further exacerbate the spread of HPV as these asymptomatic individuals may unknowingly infect others with the virus;[1,2,3,4,5,6,7] and

Whereas, Approximately 19,200 women and 11,600 men in the US are diagnosed with an HPV-caused cancer or dysplasia;[3,8,9,10] and

Whereas, From 2008-2012, HPV-related cancers climbed to 39,000 and of these cases, 28,500 were preventable with the currently available 9-valent HPV vaccine;[3,5] and

Whereas, Despite Centers for Disease Control and Prevention (CDC) supporting vaccination of boys and girls, US vaccination rates are still low at only 49.5% for girls and 37.5% for boys;[3,11] and

Whereas, Data demonstrates that a primary reason for poor vaccination rates despite health care coverage and CDC support has been the lack of a strong recommendation by providers;[6,10,12,13] and

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[1]Centers for Disease Control and Prevention. Genital HPV infection - fact sheet. https://www.cdc.gov/std/hpv/stdfact-hpv.htm. Updated July 17, 2017. Accessed September 20, 2017

[2]Jemal A1, Simard EP, Dorell C, et al. Annual report to the nation on the status of cancer, 1975-2009, featuring the burden and trends in human papillomavirus(HPV)-associated cancers and HPV vaccination coverage levels. *J Natl Cancer Inst*. February 6, 2013; 105(3): 175-201. doi: 10.1093/jnci/djs491

[3]Viens, LJ, Henley, SJ, Watson M, et al. Human papillomavirus-associated cancers - United States, 2008-2012. *MMWR Morb Mortal Wkly Rep*. July 8, 2016; 65(26): 661-666. doi: 10.15585/mmwr.mm6526a1

[4]Bednarczyk, RA, Davis, R, Ault K, Orenstein W, Omer, SB. Sexual activity-related outcomes after human papillomavirus vaccination of 11- to 12-year-olds. *J Pediatr*. November 2012; 130(5): 798-805. doi: 10.1542/peds.2012-1516

[5]Benard VB, Castle PE, Jenison SA, et al. Population-based incidence rates of cervical intraepithelial neoplasia in the human papillomavirus vaccine era. *JAMA Oncol*. June 1, 2017; 3(6): 833-837. doi: 10.1001/jamaoncol.2016.3609

[6]Goff SL, Mazor KM, Gagne SJ, Corey KC, Blake DR. Vaccine counseling: A content analysis of patient-physician discussions regarding human papilloma virus vaccine. *Vaccine*. October 6, 2011; 29(43): 7343-7349. doi: 10.1016/j.vaccine.2011.07.082

[7]Yanofsky VR, Patel RV, Goldenberg G. Genital warts: A comprehensive review. *J Clin Aesthet Dermatol*. June 2012; 5(6): 25-36.

[8] Centers for Disease Control and Prevention. HPV and cancer. https://www.cdc.gov/cancer/hpv/statistics/cases.htm. Updated March 3, 2017. Accessed September 20, 2017.

[9]Shah SS, Senapati S, Klacsmann F, et al. Current technologies and recent developments for screening of HPV-associated cervical and oropharyngeal cancers. *Cancers (Basel)*. September 9, 2016; 8(9): 85. doi: 10.3390/cancers8090085

[10]Daley, EM, Vamos, CA, Thompson, EL, et al. The feminization of HPV: How science, politics, economics and gender norms shaped U.S. HPV vaccine implementation. *Papillomavirus Res*, June 2017; 3: 142–148. doi: 10.1016/j.pvr.2017.04.004

[11]Walker TY, Elam-Evans LD, Singleton JA, et al. National, regional, state, and selected local area vaccination coverage among adolescents aged 13-17 years – United States, 2016. *MMWR Morb Mortal Wkly Rep*. August 25, 2017; 66(33): 874-882. doi: http://dx.doi.org/10.15585/mmwr.mm6633a2

[12]Reiter PL, Gilkey MB, Brewer NT. HPV vaccination among adolescent males: Results from the National Immunization Survey-Teen. *Vaccine*. June 10, 2013; 31(26): 2816-2821. doi: https://doi.org/10.1016/j.vaccine.2013.04.010

Whereas, The association of HPV vaccination as anti-STI instead of anti-cancer has created public misconceptions, leading to low vaccination rates despite a recent cohort study revealing no association between HPV vaccination and sexual-activity-related outcomes;[4] and

Whereas, Rates of HPV related cervical dysplasia have decreased in the age groups who had HPV vaccination available to them, while those in age groups beyond the recommended vaccination age have stayed stagnant;[5] and

Whereas, Research shows that health care provider (HCP) recommendation correlates strongly with HPV vaccination in females, whilst existing structural barriers as well as perceived low cost-effectiveness has prevented HCP recommendations for males;[14,15]and

Whereas, Head and neck cancer is the sixth most common cancer worldwide and its ever-increasing incidence is linked to HPV infection;[16] and

Whereas, Current oropharyngeal cancer screening is underdeveloped and uncommon, contributing to the need for increased emphasis of the HPV vaccine as a preventative measure;[9] and

Whereas, Oropharyngeal cancer is more common in males than females; men who received the HPV vaccine had increased levels of both circulating and oral HPV antibodies which may lead to a decrease in the incidence of oropharyngeal cancer;[17] therefore be it

RESOLVED, That our American Medical Association acknowledge HPV vaccines as beneficial to all genders as anti-cancer and anti-STI (New HOD Policy); and be it further

RESOLVED, That our AMA support appropriate stakeholders to increase public awareness of HPV vaccines effectiveness against both HPV-related cancers and STIs. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Date received: 04/26/18

RELEVANT AMA POLICY:
HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872
Human Papillomavirus (HPV) Inclusion in High School Education Curricula D-170.995
Insurance Coverage for HPV Vaccine D-440.955

[13]Brown B, Gabra MI, Pellman H. Reasons for acceptance or refusal of human papillomavirus vaccine in a California pediatric practice. *Papillomavirus Res*. June 2017; 3: 42–45. doi: https://doi.org/10.1016/j.pvr.2017.01.002

[14]Newman PA, Logie CH, Doukas N, Asakura K. HPV vaccine acceptability among men: A systematic review and meta-analysis. *Sex Transm Infect*. July 4, 2013; 89(7): 568-574. doi: 10.1136/sextrans-2012-050980

[15]Clark SJ, Cowan AE, Filipp SL, Fisher AM, Stokley S. Parent HPV vaccine perspectives and the likelihood of HPV vaccination of adolescent males. *Hum Vaccin Immunother*. 2016; 12(1): 47-51. doi: 10.1080/21645515.2015.1073426

[16]Okami K. Clinical features and treatment strategy for HPV-related oropharyngeal cancer. *Int J Clin Oncol*. October 2016; 21(5): 827-835. doi: https://doi-org.proxy.lib.wayne.edu/10.1007/s10147-016-1009-6

[17]Pinto LA, Kemp TJ, Torres BN, et al. Quadrivalent human papillomavirus (HPV) vaccine induces HPV-specific antibodies in the oral cavity: Results from the Mid-Adult Male Vaccine Trial. *J Infect Dis*. October 15, 2016; 214(8): 1276-1283. doi: 10.1093/infdis/jiw359

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-18)

Introduced by: Medical Student Section

Subject: Racial Housing Segregation as a Determinant of Health and Public Access to Geographic Information Systems (GIS) Data

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Health disparities persist among African American and other ethnic and racial minorities across and despite socioeconomic status (SES), and racial housing segregation is a structural source and amplifier of these racial health disparities;[1,2] and

Whereas, Numerous epidemiologic studies have demonstrated that segregated African American, Hispanic, and other ethnic and racial minority communities face increased rates of infant mortality, obesity, hypertension, asthma, lung cancer, mental health stressors, and psychiatric disorders, among other environmentally-associated adverse health outcomes;[3,4,5,6,7] and

Whereas, The Institute of Medicine, now known as the National Academy of Medicine, has acknowledged that communities of color are disproportionately exposed to environmental burdens and hazards affecting health, including but not limited to lead, air pollutants, and toxic waste due to where they live, and has advocated for the linking of data on environmental health outcomes to data on affected communities;[8] and

Whereas, Even when controlling for socio-economic status, racially-segregated minority neighborhoods have a disproportionate share of liquor stores and fast food outlets and a dearth of grocery stores and recreational facilities, leading to increased rates of diabetes, hypertension, and heart disease;[2,9,10]and

Whereas, The AMA has recognized that public education disparities, which fall along racial and economic lines, are a detriment to health (H-60.917), representing a public health and civil rights issue, and research establishes that such disparities are largely due to housing segregation;[1,2] and

Whereas, Despite the passage of the 1968 Fair Housing Act to end discriminatory housing practices that perpetuate race-based segregation, de facto racial housing segregation continues

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[1]Williams DR, Mohammed SA, Leavell J, Collins C. Race, Socioeconomic Status and Health: Complexities, Ongoing Challenges and Research Opportunities. *Annals of the New York Academy of Sciences*. 2010;1186:69-101.
[2]Landrine H, Corral I. Separate and Unequal: Residential Segregation and Black Health Disparities. *Ethnicity & Disease*. 2009;19:179-184.
[3]Jacobs DE. Environmental Health Disparities in Housing. *American Journal of Public Health*. 2011;101(Suppl 1):S115-S122.
[4]Kershaw KN, Robinson WR, Gordon-larsen P, et al. Association of Changes in Neighborhood-Level Racial Residential Segregation with Changes in Blood Pressure Among Black Adults: The CARDIA Study. JAMA Intern Med. 2017;177(7):996-1002.
[5]Hayanga AJ, Zeliadt SB, Backhus LM. Residential segregation and lung cancer mortality in the United States. JAMA Surg. 2013;148(1):37-42.
[6]Hanna-Attisha M, LaChance J, Sadler RC, Champney Schnepp A. Elevated Blood Lead Levels in Children Associated With the Flint Drinking Water Crisis: A Spatial Analysis of Risk and Public Health Response. *American Journal of Public Health*. 2016;106(2):283-290.
[7]Landrine H, Corral I et al. Residential Segregation and Racial Cancer Disparities: A Systemic Review. *J Racial Ethn Health Disparities*. 2016.
[8]Justice CO, Medicine IO. Toward Environmental Justice, Research, Education, and Health Policy Needs. National Academies Press; 1999.
[9]Bower KM, Thorpe RJ, Rohde C, Gaskin DJ. The Intersection of Neighborhood Racial Segregation, Poverty, and Urbanicity and its Impact on Food Store Availability in the United States. *Preventive medicine*. 2014;58:33-39.
[10]Kershaw KN, Pender AE. Racial/Ethnic Residential Segregation, Obesity, and Diabetes Mellitus. Curr Diab Rep. 2016;16(11):108.

in the form of restrictive zoning favoring low-density development and excluding multi-family housing, predatory loan practices, and the discouragement of people of color or low SES by real estate agents and landlords away from neighborhoods that are majority-white;[11,12,13] and

Whereas, As of 2010, a third of all metropolitan African Americans continued to live under conditions of housing hypersegregation and as of 2017, racial and ethnic gaps continue to exist in homeownership and housing wealth when comparing African Americans and Hispanics with whites;[14] and

Whereas, Geographic Information Systems (GIS) data, which can be used to co-locate demographic and mapping data, including housing segregation, with health outcomes has been a critical tool for public health researchers to elucidate and act on health disparities, most notably mapping the Flint water crisis and the disproportionate impact of lead exposure on African American neighborhoods;[6,15,16] and

Whereas, The Affirmatively Furthering Fair Housing (AFFH) GIS platform was created in 2015 by the Department of Housing and Urban Development (HUD) Office of Fair Housing and Equal Opportunity to monitor the progress of the 1968 Fair Housing Act, collect and make publicly accessible data on ongoing racial and economic segregation in communities, and examine the disparities in access to education and employment opportunities, and has been lauded by the American Public Health Association as a critical tool in advancing desegregation and improving health outcomes in minority communities;[17,18] and

Whereas, There is a proposed $8.8 billion (18.3%) cut to the HUD budget for the 2019 fiscal year;[19] and

Whereas, There is pending legislation to bar any federal funds to be used "to design, build maintain, utilize or provide access to a federal database of geospatial information on community racial disparities OR disparities in access to affordable housing";[20,21] therefore be it

RESOLVED, That our American Medical Association oppose policies that enable racial housing segregation (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for continued federal funding of publicly-accessible geospatial data on community racial and economic disparities and disparities in access to affordable housing, employment, education, and healthcare, including but not limited to the Department of Housing and Urban Development (HUD) Affirmatively Furthering Fair Housing (AFFH) tool. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/27/18

RELEVANT AMA POLICY: Disparities in Public Education as a Crisis in Public Health and Civil Rights H-60.917; Racial and Ethnic Disparities in Health Care H-350.974; Poverty Screening as a Clinical Tool for Improving Health Outcomes H-160.909; Improving the Health of Minority Populations H-350.961; Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984; Improving Healthcare of Hispanic Populations in the United States H-350.975; Improving the Health of Black and Minority Populations H-350.972; Strategies for Eliminating Minority Health Care Disparities D-350.996; Race and Ethnicity as Variables in Medical Research H-460.924

[11] Rugh JS, Massey DS. Racial Segregation and the American Foreclosure Crisis. *American sociological review*. 2010;75(5):629-651.
[12] Fair Housing Act of 1968. https://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/progdesc/title8
[13] U.S. Department of Housing and Urban Development. HOUSING DISCRIMINATION AGAINST RACIAL AND ETHNIC MINORITIES 2012 Executive Summary. 2013.
[14] Stanford Center on Poverty and Inequality, State of the Union 2017. 2017.
[15] Musa GJ, Chiang P-H, Sylk T, et al. Use of GIS Mapping as a Public Health Tool—From Cholera to Cancer. *Health Services Insights*. 2013;6:111-116.
[16] Fradelos EC, Papathanasiou IV, Mitsi D, Tsaras K, Kleisiaris CF, Kourkouta L. Health Based Geographic Information Systems (GIS) and their Applications. *Acta Informatica Medica*. 2014;22(6):402-405.
[17] Smedley BD, Tegeler P. "Affirmatively Furthering Fair Housing": A Platform for Public Health Advocates. *American Journal of Public Health*. 106, no. 6 (June 1, 2016): pp. 1013-1014.
[18] 28. AFFH Fact Sheet: The Duty to Affirmatively Further Fair Housing. HUD. https://www.huduser.gov/portal/sites/default/files/pdf/AFFH-Fact-Sheet.pdf
[19] Office of Management and Budget. Budget of the U.S. Government, Fiscal Year 2019. https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf
[20] H.R.482. Local Zoning Decisions Protection Act of 2017. 115th Congress.
[21] S.103. Local Zoning Decisions Protection Act of 2017. 115th Congress.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-18)

Introduced by: Medical Student Section

Subject: Support for Public Health Violence Prevention Programs

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, More than 60% of children and adolescents across different demographics have reported to being victim or witness to a form of violence;[1] and

Whereas, Childhood exposure to violence has been linked to negative long-term consequences, such as future commitment of violence, symptoms of trauma, feelings of helplessness, and negative school performance;[2,3,4,5,6] and

Whereas, As of 2010, the cost of violence in the United States was estimated to be at least $460 billion;[7] and

Whereas, WHO reports have shown that intervention programs based on public health models for early childhood, parenting, and family therapies correlate to a long-term decrease in violent behaviors;[5] and

Whereas, Cities that have implemented effective and evidence-based public health violence prevention models, such as the Cure Violence model, have seen a significant drop in violent acts, most notably showing an 80%-100% reduction in retaliation attacks;[8,9] and

Whereas, The CDC has endorsed an evidence-based, four-step public health approach to violence prevention;[10] and

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[1] Mohammad, E. *et al*. Impact of Child Exposure to Family and Community Violence on Adaptive Coping and Mental Health Symptoms Among Poor and Ethnic Minority Families. *Journal of Abnormal Child Psychology*. 2015;43(2):203-215.
[2]Roberts, A. *et al*. Witness of intimate partner violence in childhood and perpetration of intimate partner violence in adulthood. *Epidemiology*. 2010;6(21): 809–818.
[3]Kelly S. The psychological consequences to adolescents of exposure to gang violence in the community: An integrated review of the literature Journal of Child and Adolescent. *Psychiatric Nursing*. 2010;2(23): 61–73.
[4] Ma J. *et al*. Behavior Problems Among Adolescents Exposed to Family and Community Violence in Chile. *Fam Relat.* 2016;65: 502–516.
[5]Etienne G. *et al.* The world report on violence and health, *The Lancet.* 2002;360(9339): 1083-1088.
[6]Flannery, D. *et al*. Impact of exposure to violence in school on child and adolescent mental health and behavior. *Journal of Community Psychology*. 2004; 32(5): 559-573.
[7] Institute for Economics and Peace. 2012 United States Peace Index*. Institute for Economics and Peace.* 2012. http://visionofhumanity.org/app/uploads/2017/03/United-States-Peace-Index-Report-2012.pdf
[8] Dicker, R. Hospital-Based Violence Intervention: an Emerging Practice Based on Public Health Principles. Trauma Surgery & Acute Care Open. 2017;1(1).
[9] Cure Violence. Summary of Findings. *Cure Violence.* http://cureviolence.org/results/summary-of-findings/
[10] Corso, P. *et al.* Medical costs and productivity losses due to interpersonal and self-directed violence in the United States. *American Journal of Preventive Medicine.* 2007;32(6): 474-482.

Whereas, The AMA supports "investment in primary prevention activities related to violence," as well as in research and services that encourage physicians to get involved in violence prevention (AMA Policy H-515.964); and

Whereas, H.R.2757 Public Health Violence Prevention Act aims to fund public health violence prevention models through a grant based system;[11] therefore be it

RESOLVED, That our American Medical Association support legislation in addition to other mechanisms that encourage the development and use of evidence-based public health models that prevent violence. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY:

Violence Activities H-515.964 - Our AMA: (1) endorses the Declaration of Washington, which urges national medical associations worldwide to promote an international ethos condemning the development, production, or use of toxins and biological agents that have no justification for peaceful purposes; (2) specifically endorses the WHO's World Report on Violence and Health and recognizes the value of its global perspective on all forms of violence; and (3) supports investment in primary prevention activities related to violence as well as in research and services that encourage physicians to get involved in violence prevention (e.g., detect violence among patients, advocate for legislation), and encourages the development of curricula for teaching of violence prevention in schools of medicine. Citation: (BOT Rep. 9, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

Research the Effects of Physical or Verbal Violence Between Law Enforcement Officers and Public Citizens on Public Health Outcomes H-515.955 - 1. Our AMA encourages the National Academies of Sciences, Engineering, and Medicine and other interested parties to study the public health effects of physical or verbal violence between law enforcement officers and public citizens, particularly within ethnic and racial minority communities. 2. Our AMA affirms that physical and verbal violence between law enforcement officers and public citizens, particularly within racial and ethnic minority populations, is a social determinant of health. 3. Our AMA encourages the Centers for Disease Control and Prevention as well as state and local health departments and agencies to research the nature and public health implications of violence involving law enforcement. Citation: Res. 406, A-16;

Violence and Abuse Prevention in the Health Care Workplace H-515.966 - Our AMA encourages all health care facilities to: adopt policies to reduce and prevent all forms of workplace violence and abuse; develop a reporting tool that is easy for workers to find and complete; develop policies to assess and manage reported occurrences of workplace violence and abuse; make training courses on workplace violence prevention available to employees and consultants; and include physicians in safety and health committees. Citation: Res. 424, I-98; Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified: BOT Rep. 2, I-12; Reaffirmed in lieu of Res. 423, A-13; Modified: CSAPH Rep. 07, A-16;

See also: **Family Violence-Adolescents as Victims and Perpetrators H-515.981; Health Care Costs of Violence and Abuse Across the Lifespan D-515.984; Public Health Policy Approach for Preventing Violence in America H-515.971**

[11] Public Health Violence Prevention Act. H.R.2757, 115th Congress. 2017.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-18)

Introduced by: Medical Student Section

Subject: Support for Research of Boxes for Babies' Sleeping Environment

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, The rate of Sudden Unexpected Infant Deaths (SUID) due to accidental strangulation or suffocation has been rising since 1997 to a peak of 23.1 deaths per 100,000 live births in 2015; totaling approximately 3,700, of which 25% were due to accidental strangulation or suffocation in bed;[1,2] and

Whereas, Infants younger than three months of age are significantly more likely to die of causes associated with bed-sharing than other sleep-associated suffocations such as lying prone on a blanket or stuffed animal;[3] and

Whereas, The rate of bed-sharing from 1993 to 2010 has doubled, and bed-sharing increases the risk of infant death through suffocation;[4] and

Whereas, Racial, socioeconomic, and geographic disparities exist in the rates of infant death, as black individuals display higher rates of bed-sharing and higher rates of infant death;[3,4] and

Whereas, The American Academy of Pediatrics (AAP) recommends focusing on a safe sleep environment as the primary way to reduce the risk of all sleep-related infant deaths, including SUID;[5] and

Whereas, The AAP recommends that infants sleep in the supine position and independently on an uncluttered flat surface and "in the parents' room, close to the parents' bed, but on a separate surface designed for infants, ideally for the first year of life, but at least for the first 6 months;"[6,7]and

Whereas, Baby boxes©, typically equipped with educational materials on newborn care and newborn supplies such as clothing and diapers, are cardboard boxes with a firm mattress that are designed to meet the AAP's description of a safe sleeping environment for infants;[8] and

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[1]National Center for Health Statistics. Compressed mortality file. https://www.cdc.gov/sids/data.htm. Accessed July 13, 2017.
[2]Trachtman Alroy, T. New Jersey gives out free baby boxes in move to lower infant mortality rates. *CNN.* January 26, 2017. http://www.cnn.com/2017/01/26/health/new-jersey- baby-boxes-safe-sleep/index.html. Accessed July 16, 2017.
[3]Colvin J, Collie-Akers V, Schunn C, Moon R. Sleep environment risks for younger and older infants. *Pediatrics.* 2014; 134(2): e406 - 412. DOI: 10.1542/peds.2014-0401
[4]Colson ER, Willinger M, Rybin D, *et al.* Trends and Factors Associated with Bed-Sharing: The National Infant Sleep Position Study (NISP) 1993–2010. *JAMA pediatrics.* 2013;167(11):1032-1037. doi:10.1001/jamapediatrics.2013.2560.
[5]Moon RY. Task Force on Sudden Infant Death Syndrome. SIDS and other sleep-related infant deaths: expansion of recommendations for a safe infant sleeping environment. *Pediatrics.* 2011;128:e1341-e1367. doi:10.1542/peds.2011-2285
[6]Moon R, Darnall R, Feldman-Winter L, *et al.* SIDS and Other Sleep-Related Infant Deaths: Updated 2016 Recommendations for a Safe Infant Sleeping Environment. *Pediatrics.* 2016; 138(5): e20162938. DOI: 10.1542/peds.2016-2938
[7]Woods NK. Safe Room, Safe Place. *Journal of Primary Care & Community Health*. 2016; 8(2): 94-96. DOI: 10.1177/2150131916670067
[8]Pao M. States Give New Parents Baby Boxes To Encourage Safe Sleep Habits. *National Public Radio.* March 26, 2017. http://www.npr.org/sections/health-shots/2017/03/26/521399385/states-give-new-parents-baby-boxes-to-encourge-safe-sleep-

Whereas, New Jersey, Alabama, Ohio, Colorado, Texas, and Virginia have developed statewide baby box programs which include a baby box and postpartum supplies, free of charge, upon completion of a 20-minute caretaker educational program;[8,9,10] and

Whereas, Unpublished data has shown that when provided the education, bed-sharing is decreased and mothers are more likely to use a baby box as a sleeping place for their infants;[11] and

Whereas, The AAP stated concerns over a lack of safety research and "insufficient data on the role cardboard boxes play in reducing infant mortality;"[12] therefore be it

RESOLVED, That our American Medical Association support the research of safe sleeping environment programs, which could include the study of the safety and efficacy of boxes for babies to sleep in as a potential initiative to decrease the incidence of Sudden Unexpected Infant Death in the United States. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY:

Infant Mortality in the United States H-245.986 - It is the policy of the AMA: (1) to continue to address the problems that contribute to infant mortality within its ongoing health of the public activities. In particular, the special needs of adolescents and the problem of teen pregnancy should continue to be addressed by the adolescent health initiative; and (2) to be particularly aware of the special health access needs of pregnant women and infants, especially racial and ethnic minority group populations, in its advocacy on behalf of its patients. Citation: BOT Rep. U, I-91; Modified by BOT Rep. 8, A-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmation A-07; Modified: CSAPH Rep. 01, A-17;

Infant Mortality D-245.994 - 1. Our AMA will work with appropriate agencies and organizations towards reducing infant mortality by providing information on safe sleep positions and preterm birth risk factors to physicians, other health professionals, parents, and child care givers. 2. Our AMA will work with Congress and the Department of Health and Human Services to improve maternal outcomes through: (a) maternal/infant health research at the NIH to reduce the prevelance of premature births and to focus on obesity research, treatment and prevention; (b) maternal/infant health research and surveillance at the CDC to assist states in setting up maternal mortality reviews; modernize state birth and death records systems to the 2003-recommended guidelines; and improve the Safe Motherhood Program; (c) maternal/infant health programs at HRSA to improve the Maternal Child Health Block grant; (d) comparitive effectiveness research into the interventions for preterm birth; (e) disparities research into maternal outcomes, preterm birth and pregnancy-related depression; and (f) the development, testing and implementation of quality improvement measures and initiatives.
Citation: (Res. 410, A-10)

See also: Sudden Infant Death Syndrome H-245.977; Infant Mortality Statistics H-245.998

habits?utm_source=facebook.com&utm_medium=social&utm_campaign=npr&utm_term=nprnews&utm_content=20170326. Accessed March 26, 2017.

[9] New Jersey Becomes First US State with Universal Baby Box Program to Provide a Safe and Supported Start in Life for Every Child. *Cooper Health*. January 26, 2017. http://blogs.cooperhealth.org/news/2017/01/new-jersey-becomes-first-us-state-with-universal-baby-box-program-to-provide-a-safe-and-supported-start-in-life-for-every-child/. Accessed March 26, 2017

[10] Chandler M. Virginia parents to receive free 'baby boxes,' part of campaign to promote safe sleep. *Washington Post.* August 2017. https://www.washingtonpost.com/local/social-issues/virginia-parents-to-receive-free-baby-boxes-part-of-a-campaign-to-promote-safe-sleep/2017/08/22/ebda3052-873c-11e7-a94f-3139abce39f5_story.html?utm_term=.5611aa3c4187. Accessed August 23, 2017.

[11] Baby Boxes, Combined with Personalized Sleep Education, Reduced Rates of a Key Unsafe Infant Sleep Practice during First Week of Infancy. May 22, 2017. http://www.templehealth.org/News/Default.aspx?showBack=true&id=3243&nid=3787. Accessed July 16, 2017.

[12] Section on Safe Sleep. *American Academy of Pediatrics.* https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Child-Death-Review/Pages/Safe-Sleep.aspx. Accessed July 16, 2017.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-18)

Introduced by: Medical Student Section

Subject: Ending Money Bail to Decrease Burden on Lower Income Communities

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, More than two thirds of the 630,000 people currently in local jails are pretrial detainees, the majority of which are charged with nonviolent crimes and cannot afford to pay bail;[1] and

Whereas, Detainment in jail confers an increased risk for self harm and suicide, accounting for 35.3% of all jail deaths at a rate of 50 deaths per 100,000 people in 2014, compared to the general US population rate of 13 deaths per 100,000 people;[2,3,4] and

Whereas, Infectious diseases such as tuberculosis, HIV/AIDS, hepatitis C, and common STDs are more prevalent in correctional facilities than the general US population, which increases the risk of transmission to both newly detained populations and the communities they re-enter upon release;[5] and

Whereas, Sexual victimization was reported by 3.2% of jail inmates from 2011 to 2012, disproportionately affecting women in both staff-on-inmate and inmate-on-inmate victimizations;[5,6] and

Whereas, Sixty-eight percent of people in jails have a substance use disorder, but less than 15% of those incarcerated receive appropriate treatment, increasing the likelihood of withdrawal while incarcerated as well as significantly increasing the likelihood of overdose upon release into the community;[5,7]and

Whereas, Thirty-eight states in 2014 had policies to terminate Medicaid coverage when incarceration lasted for more than 30 days, leading to interruptions in coverage and healthcare;[5] and

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[1] Rabuy, P. W. (n.d.). Mass Incarceration: The Whole Pie 2017. https://www.prisonpolicy.org/reports/pie2017.html
[2] Kaba, F., Lewis, A., Glowa-Kollisch, S., Hadler, J., Lee, D., Alper, H., Venters, H. (2014). Solitary Confinement and Risk of Self-Harm Among Jail Inmates. *American Journal of Public Health, 104*(3), 442-447. doi:10.2105/ajph.2013.301742
[3] Noonan, Margaret. "Mortality in Local Jails, 2000-2014 Statistical Tables." US Department of Justice, Bureau of Justice Statistics, Dec. 2016, www.bjs.gov/content/pub/pdf/mlj0014st.pdf.
[4] Curtin SC, Warner M, Hedegaard H. Increase in suicide in the United States, 1999–2014. NCHS data brief, no 241. Hyattsville, MD: National Center for Health Statistics. 2016. https://www.cdc.gov/nchs/products/databriefs/db241.htm
[5] David Cloud. On Life Support: Public Health in the Age of Mass Incarceration. New York, NY: Vera Institute of Justice, 2014. https://www.vera.org/publications/on-life-support-public-health-in-the-age-of-mass-incarceration
[6] Beck, Allen J, et al. "Sexual Victimization in Prisons and Jails Reported by Inmates, 2011 - 12." US Department of Justice, Bureau of Justice Statistics, May 2013, https://www.bjs.gov/content/pub/pdf/svpjri1112.pdf
[7] Binswanger IA, Stern MF, Deyo RA, et al. Release from prison—a high risk of death for former inmates. N Engl J Med. 2007;356(2):157–65.

Whereas, Incarceration separates families, leading to disruptions in education, employment, and housing, all of which can perpetuate cycles of poverty;[5,8] and

Whereas, Juvenile detention interrupts secondary education and has been shown to increase dropout rates after return to school;[9,10] and

Whereas, According to a study surveying formerly incarcerated people and their families in 14 different states, 49% of families were unable to meet basic food needs and 48% had trouble meeting basic housing needs while their loved one was incarcerated;[11] and

Whereas, Once detained, a defendant's time awaiting trial can exceed 3 years depending on where he or she lives;[10,12] and

Whereas, Members of lower income communities and minorities are disproportionately detained, incarcerated, and subjected to the significant health risks outlined above because of their inability to pay bail, as 80% of those who cannot afford bail are in the poorest half of society;[1] and

Whereas, Alternatives to money bail such as unsecured bonds, in which a defendant promises to pay a dollar amount only if he or she fails to appear at trial, have been shown to achieve equal levels of public safety and court appearance while shielding the individual from the aforementioned health risks of pretrial detention;[13] therefore be it

RESOLVED, That our American Medical Association support legislation that ends pretrial financial release options for individuals charged with nonviolent crimes. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/27/18

RELEVANT AMA POLICY:

AMA Support for Justice Reinvestment Initiatives H-95.931
Our AMA supports justice reinvestment initiatives aimed at improving risk assessment tools for screening and assessing individuals for substance use disorders and mental health issues, expanding jail diversion and jail alternative programs, and increasing access to reentry and treatment programs.
Citation: Res. 205, A-16;

See also: **Health Care While Incarcerated H-430.986**

[8] Pinto, Nick. "The Bail Trap." The New York Times, 13 Aug. 2015, www.nytimes.com/2015/08/16/magazine/the-bail-trap.html?mcubz=0.
[9] Holman, B., & Ziedenberg, J. (2006). The dangers of detention. A Justice Policy report. Washington, DC: Justice Policy Institute.
[10] Gonnerman, Jennifer. "Before the Law." The New Yorker, The New Yorker, 30 Aug. 2017, https://www.newyorker.com/magazine/2014/10/06/before-the-law
[11] Saneta deVuono-powell, Chris Schweidler, Alicia Walters, and Azadeh Zohrabi. Who Pays? The True Cost of Incarceration on Families. Oakland, CA: Ella Baker Center, Forward Together, Research Action Design, 2015. http://whopaysreport.org/wp-content/uploads/2015/09/Who-Pays-FINAL.pdf
[12] Faltering Courts, Mired in Delays. April 13 2013.
[13] Jones, Michael R.. Unsecured Bonds: The as effective and most efficient pretrial release option. *Pretrial Justice Institute.* 2013.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-18)

Introduced by: Medical Student Section

Subject: Food Advertising Targeted to Black and Latino Youth Contributes to Health Disparities

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Black and Latino youth exhibit disproportionately higher rates of overweight and obesity compared to their white counterparts;[1] and

Whereas, Black and Latino youth face higher risks for the severe, lifelong health consequences of poor diet and obesity, including cardiovascular disease, asthma, diabetes, and cancer;[2,3,4,5] and

Whereas, It has been shown that Blacks and Latinos consume fast food and sugary drinks more often than non-Hispanic white youth;[6,7] and

Whereas, Exposure to food advertising increases children's and teen's consumption of highly advertised fast food and sugary beverages, increases snacking, and increases total calories consumed;[6,8,9,10] and

Whereas, The Institute of Medicine found that food marketing to children results in increased preferences for nutrition poor foods and increased requests to parents for similarly unhealthy foods;[11] and

Whereas, Children are unable to recognize the persuasive intent of advertising and are therefore unable to modify their interpretations of advertising messages;[12] and

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[1]Ogden CL, Carroll MD, Kit BK, Flegal KM. Prevalence of childhood and adult obesity in the United States, 2011-2012. JAMA. 2014; 311(8):806-814.
[2]Basen-Engquist K, Chang M. Obesity and cancer risk: Recent review and evidence. Current Oncology Reports. 2011; 13 (1), 71-76.
[3]Franks PW, Hanson RL, Knowler WC, Sievers ML, Bennett PH, Looker HC. Childhood obesity, other cardiovascular risk factors, and premature death. New England Journal of Medicine. 2010; 362(6):485-493.
[4]Lau L, Lin H, Flores G (2012). Racial/ethnic disparities in health and health care among U.S. adolescents. Health Serv Res. 47(5):2031-59.
[5]Narayan KM, Boyle JP, Thompson TJ, Sorensen SW, Williamson DF. Lifetime risk for diabetes mellitus in the United States. JAMA. 2003; 290(14):1884-1890.
[6]Bowman SA, Gortmaker SL, Ebbeling CB, Pereira MA, Ludwig DS. Effects of fast-food consumption on energy intake and diet quality among children in a national household survey. Pediatrics. 2004; 113 (1):112- 118.
[7]Powell LM, Nguyen BT. Fast-food and full-service restaurant consumption among children and adolescents: Effect on energy, beverage, and nutrient intake. JAMA Pediatrics. 2013; 167(1):14-20.
[8]Giammattei J, Blix G, Marshak HH, Wollitzer AO, Pettitt DJ. Television watching and soft drink consumption: Associations with obesity in 11- to 13-year-old schoolchildren. Archives of Pediatrics and Adolescent Medicine. 2003; 157(9):882-886.
[9]Harris JL, Bargh JA, Brownell KD. Priming effects of television food advertising on eating behavior. Health psychology. 2009; 28(4):404- 413.
[10]Harris JL, Speers SE, Schwartz MB, Brownell KD. U.S. food company branded advergames on the internet: Children's exposure and effects on snack consumption. Journal of Children and Media. 2012; 6(1):51-68.
[11]McGinnis JM, Gootman J, Kraak VI. Institute of Medicine. Food marketing to children and youth: Threat or opportunity? Wash, DC: National Academies Press; 2006. National Academy of Sciences, Committee on Food Marketing and the Diets of Children and Youth.
[12] Campbell AJ. Rethinking Children's Advertising Policies for the Digital Age. Georgetown University Law Center. 2017:35-40

Whereas, Reports have shown that Black and Latino youth experience double the amount of unhealthy food marketing compared with white non-Hispanic youth;[13] and

Whereas, Companies market nutrition products to poor black and Latino youth at a rate that is disproportionately high when compared with white non-Hispanic youth;[14,15] and

Whereas, Current AMA policy states that "Our AMA … monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care." (D-440.978); and

Whereas, Current AMA policy states that "It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children." (H-60.972); therefore be it

RESOLVED, That our American Medical Association establish a formal position advocating against the use of targeted marketing of nutrient-poor food toward youth from vulnerable populations, including minority and low-income populations (Directive to Take Action); and be it further

RESOLVED, That our AMA amend Policy H-60.972 by addition to read as follows:

> (1) It is the policy of the AMA to join with appropriate organizations, including the American Academy of Pediatrics, in educating the public about the adverse effects of food advertising aimed at children.; and
>
> (2) The AMA will support legislation that limits targeted marketing of products that do not meet nutritional standards as defined by the USDA toward youth from vulnerable populations; (Modify Current HOD Policy) and be it further

RESOLVED, That our AMA work with the appropriate stakeholders to heighten awareness and regulation of targeted marketing of nutrient-poor food toward youth from vulnerable populations. (Directive to Take Action)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Banning Food Commercials Aimed at Children H-60.972
Culturally Responsive Dietary and Nutritional Guidelines D-440.978
Television Commercials Aimed at Children H-485.998
Alcohol and Youth D-170.998
Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths D-60.973

[13] Lappé A. Junk food industry's shameful targeting of black and Latino youth. Al Jazeera America.http://america.aljazeera.com/opinions/2014/5/junk-food-targetmarketingblacklatinoyouth.html. Published May 27, 2014. Accessed September 6, 2017.
[14]Harris JL, Shehan C, Gross R, et al. Food Advertising targeted to Hispanic and Black youth: Contributing to health disparities. UCONN Rudd Center.
[15]Harris JL, Schwartz MB, Brownell KD, Javadizadeh J, Weinberg M. Evaluating sugary drink nutrition and marketing to youth. New Haven, CT: Yale Rudd Center For Food Policy and Obesity. 2011.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-18)

Introduced by: Medical Student Section

Subject: Opposition to Measures that Criminalize Homelessness

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Homelessness results in decreased access to healthcare and higher hospitalization costs, and is an independent risk factor for increased mortality;[1,2,3,4,5,6] and

Whereas, There is a trend in U.S. cities over the past few decades to target homeless persons living in public spaces, using the justice system to criminalize activities necessary for sustaining life;[7,8] and

Whereas, The United Nations Human Rights Committee reports that "criminalization of people living on the street for everyday activities such as eating, sleeping, sitting in particular areas etc." within U.S. cities "raises concerns of discrimination and cruel, inhuman, or degrading treatment" and that "the State party should engage with state and local authorities to abolish criminalization of homelessness laws and policies at state and local levels";[9] and

Whereas, The Department of Justice has affirmed the constitutional rights of homeless individuals to sleep in public spaces, stating that it is "uncontroversial that punishing conduct that is a universal and unavoidable consequence of being human violates the Eighth Amendment";[10,11] and

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[1] Brown RT, Kiely DK, Bharel M, Grande LJ, Mitchell SL. Use of Acute Care Services Among Older Homeless Adults. *JAMA Internal Medicine*. 2013;173:1831-1834.
[2] Fazel S, Geddes JR, Kushel M. The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations. *The Lancet*. 2014;384(9953):1529-1540.
[3] Hwang SW, Weaver J, Aubry T, Hoch JS. Hospital Costs and Length of Stay Among Homeless Patients Admitted to Medical, Surgical, and Psychiatric Services. *Medical Care*. 2011;49:350-354.
[4] Montgomery, A. E., Szymkowiak, D., Marcus, J., Howard, P. Culhane, D. P. (2016). Homelessness, unsheltered status, and risk factors for mortality: Findings from the 100 000 homes campaign. *Public Health Reports*, 131(6):765-772.
[5] Baggett TP., Hwang SW., O'Connell JJ, et. al. Mortality among homeless adults in boston: Shifts in causes of death over a 15-year period. *JAMA Internal Medicine*. 2013;173(3), 189-195
[6] Morrison DS. Homelessness as an independent risk factor for mortality: results from a retrospective cohort study. *International Journal of Epidemiology*. 2009;38(3):877-883.
[7] The National Law Center on Homelessness and Poverty. Criminalizing Crisis: The Criminalization of Homelessness in U.S. Cities, November 2011.
[8] Homes Not Handcuffs: The Criminalization of Homelessness in U.S. Cities. Published by the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty, July 2009. United Nations Human Rights Committee, List of Issues to be Taken up in Connection
[9] United Nations Human Rights Committee, List of Issues to be Taken up in Connection with the Consideration of the Fourth Periodic Report of the United States of America (CCPR/C/USA/4), Adopted by the Committee at its 110th Session, 10-28 March 2014 (advance unedited version).
[10] The United States Department of Justice. Justice Department Files Brief to Address the Criminalization of Homelessness. http://www.justice.gov/opa/pr/justice-department-files-brief-address-criminalization-homelessness
[11] The United States Department of Justice. Bell v Boise Statement of Interest. (2015, August 6). http://www.justice.gov/opa/file/643766/download

Whereas, The ACLU has opposed several policies that target homeless individuals including regulations that prohibit sharing food outdoors with individuals in need, anti-panhandling ordinances, trespassing laws, and laws against encampment;[12,13] and

Whereas, According to the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty, types of criminalization measures against the homeless include, but are not limited to:

- Legislation that makes it illegal to sleep, sit, or store personal belongings in public spaces
- Selective enforcement of more neutral laws, such as loitering or open container laws, against homeless persons
- Sweeps of city areas where homeless persons are living to drive them out of the area, resulting in the destruction of those persons' personal property, including important personal documents and medications
- Laws punishing people for begging or panhandling in order to move poor or homeless persons out of a city or downtown area";[8] and

Whereas, Policies such as those listed by the National Coalition for the Homeless and the National Law Center on Homelessness & Poverty criminalize homelessness without addressing the underlying causes of homelessness and, through exacerbating the problem, lead to poorer health among homeless persons;[8,9] and

Whereas, Criminalization of homelessness leading to arrest for life-sustaining activities advances the development of criminal records among the homeless population, making it more difficult to obtain employment and housing;[8] and

Whereas, Criminalization of homelessness is not cost efficient; in a nine-city survey of supportive housing and jail costs, it was found that "jail costs were on average two to three times the cost of supportive housing";[14] and

Whereas, Homeless persons often suffer from poor nutrition, yet many U.S. cities have criminalized the feeding of homeless persons by both private individuals and nonprofit organizations;[8,12,15,16,17,18,19,20] and

Whereas, While homeless encampments reflect a temporary solution to the severe shortage of adequate affordable housing for the number of homeless persons in the U.S., forced evictions of people living in homeless encampments violates the human right to adequate housing;[21,22] and

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[12] American Civil Liberties Union of Pennsylvania. City of Philadelphia Sued over New Regulations that Prevent Religious Groups from Providing Food for the Homeless in City Parks.
[13] American Civil Liberties Union of Washington. Homelessness Advocacy Resource Center. https://www.aclu-wa.org/homelessness-advocacy-resource-center.
[14] The Partnership to End Long-Term Homelessness. Cost of Serving Homeless Individuals in Nine Cities. http://www.csh.org/resources/cost-of-serving-homeless-individuals-in-nine-cities/
[15] Hooper P. Putting the Public back in Public Parks. ACLU of Nevada. website. https://www.aclunv.org/en/news/putting-public-back-public-parks. Published September 1, 2010.
[16] Dallas, Tx., Ordinance No. 26023 (2005).
[17] Atlanta, Ga., Code of Ordinances ch. 43, § 1 2005.
[18] Cleveland, Oh., Code § 605.31 2005.
[19] Dayton, Oh., Rev. Code of Gen. Ordinances § 137.20. 2000.
[20] Cincinnati, Oh., Code § 910-12. 2004.
[21] Office of the United Nations High Commissioner for Human Rights. The Right to Adequate Housing. Fact Sheet No. 21 (Rev. 1). Signed by the United States of America.
[22] Thiele B. The human right to adequate housing: a tool for promoting and protecting individual and community health. *American Journal of Public Health*. 2002;92(5):712–715.

Whereas, A number of U.S states including Rhode Island, Connecticut, and Illinois have passed Homeless Bills of Rights enumerating that all homeless persons have equal rights, including access to emergency medical care and free movement in public spaces without harassment or intimidation, regardless of housing status;[23,24,25] therefore be it

RESOLVED, That our American Medical Association oppose measures that criminalize necessary means of living among homeless persons, including but not limited to, sitting or sleeping in public spaces (New HOD Policy); and be it further

RESOLVED, That our AMA advocate for legislation that requires non-discrimination against homeless persons, such as homeless bills of rights. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY:

Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; and (2) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.
Citation: (Res. 401, A-15)

The Mentally Ill Homeless H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.
Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16;

[23]Rhode Island, Bill § S 2052 SUBSTITUTE B. 2012
[24]Connecticut, Bill § S.B. No. 896. 2013
[25] Illinois, Bill § S.B. No. 1210. 2013

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-18)

Introduced by: Medical Student Section

Subject: Reporting Child Abuse in Military Families

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, In the last five years, the incidence of military child abuse and neglect has risen from 4.8 per 1,000 to 7.2 per 1,000;[1] and

Whereas, Military families typically relocate often, making it difficult to track instances of child abuse and neglect strictly through state child protective services (CPS);[2] and

Whereas, The Family Advocacy Program (FAP) within the Department of Defense (DoD) assists in reports of child abuse and neglect in the military when the alleged victim(s) are under age eighteen and/or have a physical or mental incapacity, in addition to being in the legal care of a military personnel, military family member, or DoD sanctioned child care provider;[3] and

Whereas, The FAP has over 2,000 counselors and specialized clinicians who work to prevent child abuse and neglect in military families through education and treatment of perpetrators and victims;[5] and

Whereas, HR 3894 was passed in December 2016, requiring individuals of the Armed Forces, DoD employees, or contracted military employees to promptly report known or suspected cases of child abuse and neglect within a military installation to the DoD and state CPS;[4] and

Whereas, There is currently no reciprocal requirement for state CPS to report known or suspected cases of child abuse and neglect to the FAP;[5] and

Whereas, The probability of linkage between a military child abuse and neglect case and a FAP report is lower if the treatment occurred in a civilian facility (9.8% of abuse occurs in civilian facilities versus 23.6% at military facilities), suggesting decreased communication of military child abuse and neglect from the state to the FAP;[6] and

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[1]Child abuse in the military: Failing those most in need. *Los Angeles Times*. http://www.latimes.com/nation/la-na-child-abuse-military-20161229-htmlstory.html. Accessed September 5, 2017.
[2]Clever M., Segal D.R. The Demographics of Military Children and Families. *The Future of Children*. 2013;23(2):13-39. doi:10.1353/foc.2013.0018.
[3]The Family Advocacy Program - - - Military OneSource. *Militaryonesourcemil*. 2017. Available at: http://www.militaryonesource.mil/-/the-family-advocacy-program. Accessed September 6, 2017.
[4]House Bill 3894. To amend title 10, United States Code, to require the prompt notification of State Child Protective Services by military and civilian personnel of the Department of Defense required by law to report suspected instances of child abuse and neglect. https://www.govtrack.us/congress/bills/114/hr3894.
[5]Fifield J. Why Child Abuse in Military Families May Be Going Unreported. *Pew Trusts*. http://www.pewtrusts.org/en/research-and analysis/blogs/stateline/2017/06/07/why-child-abuse-in-military-families-may-be-going-unreported. Published 2017. Accessed September 6, 2017.
[6]Wood J.N., Griffis H.M., Taylor C.M., Strane D., Harb G.C., Mi L., Song L., Lynch K.G., Rubin D.M. Under-ascertainment from healthcare settings of child abuse events among children of soldiers by the U.S. Army Family Advocacy Program. *Child Abuse & Neglect*. 2017;63:202-210. doi:10.1016/j.chiabu.2016.11.007.

Whereas, Fifteen states have enacted laws or enforced policies already in place that require suspected cases of child abuse and neglect brought to CPS also be reported to the FAP;[7] therefore be it

RESOLVED, That our American Medical Association support state and federal-run child protective services in reporting child abuse and neglect in the military to the Family Advocacy Program within the Department of Defense. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY

Identifying and Reporting Suspected Child Abuse H-515.960
1. Our American Medical Association recognizes that suspected child abuse is being underreported by physicians.
2. Our AMA supports development of a comprehensive educational strategy across the continuum of professional development that is designed to improve the detection, reporting, and treatment of child maltreatment. Training should include specific knowledge about child protective services policies, services, impact on families, and outcomes of intervention.
3. Our AMA supports the concept that physicians act as advocates for children, and as such, have a responsibility legally and otherwise, to protect children when there is a suspicion of abuse.
4. Our AMA recognizes the need for ongoing studies to better understand physicians failure to recognize and report suspected child abuse.
5. Our AMA acknowledges that conflicts often exist between physicians and child protective services, and that physicians and child protective services should work more collaboratively, including the joint development of didactic programs designed to foster increased interaction and to minimize conflicts or distrust.
6. Our AMA supports efforts to develop multidisciplinary centers of excellence and adequately trained clinical response teams to foster the appropriate evaluation, reporting, management, and support of child abuse victims.
7. Our AMA encourages all state departments of protective services to have a medical director or other liaison who communicates with physicians and other health care providers.
Citation: (CSAPH Rep. 2, I-09)

See also: **H-515.965 Family and Intimate Partner Violence; H-515.981 Family Violence-Adolescents as Victims and Perpetrators**

[7]Child Abuse and Neglect Identification and Reporting. *Department of Defense*. 2017. http://www.usa4militaryfamilies.dod.mil/MOS/f?p=USA4:ISSUE:0:::P2_ISSUE,P2_STATE:1,TX. Accessed September 6, 2017.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-18)

Introduced by: Medical Student Section

Subject: Reducing the Use of Restrictive Housing in Prisoners with Mental Illness

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Restrictive housing, commonly practiced in the form of solitary confinement, is defined as "any type of detention that includes removal from the general inmate population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another inmate; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more;"[1] and

Whereas, Based on available data, there are between 80,000 and 100,000 prisoners in restrictive housing conditions on any given day in America's prisons and jails, including up to 25,000 in long-term isolation in supermax prisons;[2,3] and

Whereas, Restrictive housing can cause significant adverse effects on an inmate's mental health and can increase change of recidivation;[4,5,6] and

Whereas, It is the position of the National Commission on Correctional Healthcare that mentally ill individuals "should be excluded from solitary confinement of any duration;"[7] and

Whereas, In July 2017, a Department of Justice (DOJ) report examining the use of restrictive housing for inmates with mental illness by the Federal Bureau of Prisons (BOP) determined that current BOP policies do not adequately address the confinement of inmates with mental illness in restrictive housing units and that the BOP does not sufficiently track or monitor such inmates;[8] and

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[1]Department of Justice Office on the Inspector General. (January, 2018), Report and Recommendations concerning the Use of Restrictive Housing, 3.
[2] Browne, A., Cambier, A., & Agha, S. (2011). Prisons Within Prisons: The Use of Segregation in the United States. *Federal Sentencing Reporter, 24*(1), 46-49. doi:10.1525/fsr.2011.24.1.46
[3] Liman Program, Yale Law School & the Association of State Correctional Administrators. (2015). Time-in-cell: The ASCA-Liman 2014 National Survey of Administrative Segregation in Prison. New Haven, CT: Yale University. https://www.asca.net/system/assets/attachments/9195/*asca-liman_administrative_segregation_report_sep_2_2015.pdf?1450213204 or http://www.asca.net.
[4] Metzner, J. L., & Fellner, J. (2010). Solitary confinement and mental illness in U.S. Prisons: A challenge for medical ethics. Journal of American Academy of Psychiatry and the Law, 38(1), 104-108.
[5] Arrigo, B. A., & Bullock, J. L. (2008). The psychological effects of solitary confinement on prisoners in supermax units: Reviewing what we know and recommending what should
[6]Craig Haney, Professor of Psychology at the University of California, Santa Cruz, before the Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, U.S. Senate, concerning "Reassessing Solitary Confinement: The Human Rights, Fiscal, and Public Safety Consequences" (June 19, 2012), 10–11.
[7] National Commission on Correctional Healthcare. (April, 2016). NCCHC Position Statement: Solitary Confinement. Retrieved from www.corrections.com/system/assets/0000/1264/Solitary-Confinement-Isolation.pdf
[8] Department of Justice Office on the Inspector General. (July 2017). Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness,15-34. Retrieved from https://oig.justice.gov/reports/2017/e1705.pdf

Whereas, In order to mitigate the placement of inmates with mental illness in restrictive housing, the DOJ recommends that the BOP, "Assess the scalability of secure residential mental health treatment programs and develop alternatives to address their potential limitations;"[9] and

Whereas, The BOP has formally agreed with the DOJ recommendation cited above;[10] and

Whereas, Multiple state and local correctional departments, including but not limited to Nebraska, North Carolina, Oregon, New York City, and Middlesex County, New Jersey, are currently engaged in initiatives to significantly reduce the use of segregated housing through the advancement of safe and effective alternatives;[11] therefore be it

RESOLVED, That our American Medical Association encourage federal, state, local, and private correctional facilities to explore, develop, and implement alternatives to restrictive housing for inmates with mental illness in order to reduce and ultimately eliminate the use of restrictive housing in this population. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY

Solitary Confinement of Juveniles in Legal Custody H-60.922
Our AMA: (1) opposes the use of solitary confinement in juvenile correction facilities except for extraordinary circumstances when a juvenile is at acute risk of harm to self or others; (2) opposes the use of solitary confinement of juveniles for disciplinary purposes in correctional facilities; and (3) supports that isolation of juveniles for clinical or therapeutic purposes must be conducted under the supervision of a physician. Citation: Res. 3, I-14; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16

Bonding Programs for Women Prisoners and their Newborn Children H-430.990
Because there are insufficient data at this time to draw conclusions about the long-term effects of prison nursery programs on mothers and their children, the AMA supports and encourages further research on the impact of infant bonding programs on incarcerated women and their children. The AMA recognizes the prevalence of mental health and substance abuse problems among incarcerated women and continues to support access to appropriate services for women in prisons. The AMA recognizes that a large majority of female inmates who may not have developed appropriate parenting skills are mothers of children under the age of 18. The AMA encourages correctional facilities to provide parenting skills training to all female inmates in preparation for their release from prison and return to their children. The AMA supports and encourages further investigation into the long-term effects of prison nurseries on mothers and their children. Citation: CSA Rep. 3, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: CSAPH Rep. 01, A-17

Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

[9] Department of Justice Office on the Inspector General. (July 2017). Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness, 65-66. Retrieved from https://oig.justice.gov/reports/2017/e1705.pdf
[10] Department of Justice Office on the Inspector General. (July 2017). Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness,15-34. Retrieved from https://oig.justice.gov/reports/2017/e1705.pdf
[11] Department of Justice Office on the Inspector General. (July 2017). Review of the Federal Bureau of Prisons' Use of Restrictive Housing for Inmates with Mental Illness, 65-66. Retrieved from https://oig.justice.gov/reports/2017/e1705.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-18)

Introduced by: Medical Student Section

Subject: Improving Safety and Health Code Compliance in School Facilities

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Children are vulnerable to environmental exposures as a consequence of disproportionate food, water, and oxygen consumption relative to body size, and due to lower breathing zones, where certain air pollutants such as mercury tend to accumulate;[1,2] and

Whereas, In the United States, outstanding capital investment and deferred renovations of public school buildings are estimated at over $322 billion, thereby placing students at significant risk as identified facility shortcomings are left untreated;[3] and

Whereas, The Environmental Protection Agency (EPA) "does not routinely inspect and enforce...regulations in schools," with only some specific acts mandating direct EPA intervention in school settings;[4,5,6,7] and

Whereas, At least 39 states are known to have schools that supply drinking water with unsafe levels of lead, with "no scientific or practical reason" to assume that this characterization does not in fact apply to every state in America;[8,9] and

Whereas, Ninety percent of the schools in America receive water from a local utility rather than private wells, thereby exempting them from EPA guidelines and regulations;[10] and

Whereas, In 2006, only 51.4% of schools maintained a formal Indoor Air Quality management program, a number that has fallen in recent years;[11,12] and

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[1] Etzel, R., & Balk, S. (2012). Pediatric Environmental Health (3rd ed.). Elk Grove Village: American Academy of Pediatrics.
[2] Landrigan, P. J. (2016). Children's Environmental Health: A Brief History. Academic Pediatrics, 16(1), 1–9.
[3] Baker, L., & Bernstein, H. (2012). The Impact of School Buildings on Student Health and Performance: A Call for Research. McGraw-Hill Research Foundation.
[4] Clean Air Act Title VI: Stratospheric Ozone Protection (1990). United States Congress.
[5] TSCA Subchapter II: Asbestos Hazard Emergency Response Act (1986). United States Congress.
[6] Resource Conservation and Recovery Act (1976). United States Congress.
[7] Safety Checklist Program for Schools. (2003). Retrieved September 5, 2017, from https://www.cdc.gov/niosh/docs/2004-101/chap1.html
[8] Lambrinidou, Y., Triantafyllidou, S., & Edwards, M. (2010). Failing our children: lead in U.S. school drinking water. New Solutions : A Journal of Environmental and Occupational Health Policy : NS, 20(1), 25–47.
[9] Evens, Anne, Daniel Hyrhorczuk, Bruce P. Lanphear, Kristin M. Rankin, Dan A. Lewis, Linda Forst, and Deborah Rosenberg. "The Impact of Low-level Lead Toxicity on School Performance among Children in the Chicago Public Schools: A Population-based Retrospective Cohort Study." *Enviromental Health* (2015).
[10] Lambrinidou, Y., Triantafyllidou, S., & Edwards, M. (2010). Failing our children: lead in U.S. school drinking water. New Solutions : A Journal of Environmental and Occupational Health Policy : NS, 20(1), 25–47.
[11] Everett Jones, S., Amith, A., Wheeler, L., & McManus, T. (2010). School Policies and Practices That Improve Indoor Air Quality. Journal of School Health, 80(6), 280–286.
[12] Eitland, E., Klingensmith, L., MacNaughton, P., Cedeno Laurent, J., Spengler, J., Bernstein, A., & Allen, J. (2017). Schools for Health: Foundations for Student Success. http://schools.forhealth.org/

Whereas, In a landmark study examining Boston Public Schools, "approximately 85% of Boston Public Schools reported leaks or water stains, 36% reported visible mold growth, 63% reported overt pest signs, 83% reported repairs needed, and 61% reported improper chemical storage," a reality far from uncommon in both urban and rural settings;[13] and

Whereas, Children in "poor health" are far more likely to receive B's, C's, D's, and F's compared to children in "excellent/very good health;"[14] and

Whereas, Minority students and already vulnerable populations are more likely to attend underfunded schools with heightened risk of toxic exposures, along with heightened rates of neighborhood violence, both which negatively impact physical and mental health;[15,16,17,18] and

Whereas, The 2016 School Health Policies and Practices Study conducted by the CDC highlights current shortcomings in school safety inspections, including substandard assessment and remediation of lead, PCB, and mold exposures, indoor air quality, and chemical exposure through the use of unsafe cleaning products;[19] and

Whereas, As identified by the Committee to Review and Assess the Health and Productivity Benefits of Green Schools, schools that truly prioritize overall health and performance must establish specific criteria for dryness, indoor air quality, thermal comfort, frequent maintenance/repair, cleanliness, and quietness;[20] therefore be it

RESOLVED, That our American Medical Association support the development and implementation of standardized, comprehensive guidelines for school safety and health code compliance inspections (New HOD Policy); and be it further

RESOLVED, That our AMA support policies aiding schools in meeting said guidelines, including support for financial and personnel-based aid for schools based in vulnerable neighborhoods (New HOD Policy); and be it further

RESOLVED, That our AMA support creation of a streamlined reporting system for school facility health data potentially through application of current health infrastructure. (New HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY: Providing Medical Services through School-Based Health Programs H-60.991; Childhood Anaphylactic Reactions D-60.976; Adolescent Health H-60.981; Diagnosis and Treatment of Attention Deficit/Hyperactivity Disorder in School-Age Children H-60.950; School-Based and School-Linked Health Centers H-60.921; Quality of School Lunch Program H-150.962; Health Instruction and Physical Education in Schools H-170.999; Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools H-150.960; Improving the Health of Black and Minority Populations H-350.972; Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327; Combating Obesity and Health Disparities H-150.944; Safe Drinking Water H-135.928; Training in the Principles of Population-Based Medicine H-425.982; Green Initiatives and the Health Care Community H-135.939; Reducing Lead Poisoning H-60.924; Integration of Occupational Medicine, Environmental Health, and Injury Prevention Programs into Public Health Agencies H-365.988; Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327; Stewardship of the Environment H-135.973

[13] Graham, T., Zotter, J., & Camacho, M. (2006). Who's Sick at School?: Linking Poor School Conditions and Health Disparities for Boston's Children. Boston.
[14] School Health Issue Brief: Addressing Unmet Healthcare Needs of New York City Youth. (2016). New York.
[15] Pastor M, Jr, Sadd JL, Morello-Frosch R. Who's minding the kids? pollution, public schools, and environmental justice in Los Angeles. Soc Sci Quart 2002;83:263–80
[16] Simons, E., Hwang, S. A., Fitzgerald, E. F., Kielb, C., & Lin, S. (2010). The impact of school building conditions on student absenteeism in upstate New York. American Journal of Public Health, 100(9), 1679–1686.
[17] Intervention to Lessen the Effect of Violence Among Urban School Children. (2014) https://www.cdc.gov/prc/pdf/intervention-lessen-effects-violence-urban-school-children.pdf
[18] Whitaker, Damiya, Camelia Graham, Stevan Steverson, C. Deborah Furr-Holden, and William Latimer. "Neighborhood & Family Effects on Learning Motivation among Urban African American Middle School Youth." *Journal of Child and Family Studies* 21.1 (2012): 131-38.
[19] *Results from the School Health Policies and Practices Study 2016*. Centers for Disease Control and Prevention and the U.S. Department of Health and Human Services. https://www.cdc.gov/healthyyouth/data/shpps/pdf/shpps-results_2016.pdf
[20] National Research Council. 2006. Green Schools: Attributes for Health and Learning. Washington, DC: The National Academies Press. https://doi.org/10.17226/11756.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-18)

Introduced by: Medical Student Section

Subject: Sex Education Materials for Students with Limited English Proficiency

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Sexual education is important in informing adolescents about biological changes during puberty, sexual health, and sexual and romantic relationships and a strong foundation in sexual education promotes healthy sexual relationships, lower rates of teenage pregnancy, and encourages safe sexual practices later in life;[1,2] and

Whereas, As classified by the United States Census Bureau, if a person is a non-native speaker of the English language and has a limited ability to read, speak, write or understand English they are considered to have limited English proficiency (LEP); [3] and

Whereas, The LEP population in the United States has grown 80% from 1990 to 2013 and has increased from 6% of the total United States population in 1990 to 8.5% in 2013;[3] and

Whereas, The estimated percentage of students with LEP in United States public schools is 9.3%, of which 76.5% speak Spanish/Castilian; [4] and

Whereas, The highest rates of teenage pregnancy in the United States are in the Latino community; [5] and

Whereas, The STI rates for Latina adolescents is approximately two times higher than non-Latina White adolescents (8.93 and 4.3 per 1000, respectively), and 24% of newly diagnosed cases of HIV in persons aged 20 to 24 were Latino while 16% were caucasian;[6,7,8] and

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[1] Igras SM, Macieira M, Murphy E, Lundgren R. Investing in very young adolescents' sexual and reproductive health. *Glob Public Health*. 2014;9(5):555-569. doi:10.1080/17441692.2014.908230
[2] Morbidity and Mortality Weekly Report: Youth Risk Behavior Surveillance — United States, 2011. http://www.jstor.org/stable/24806047. Published June 8, 2012. Accessed April 17, 2017.
[3] Migration Policy Institute: The Limited English Proficient Population in the United States. http://www.migrationpolicy.org/article/limited-english-proficient-population-united-states Published July 8, 2015. Accessed April 17, 2017.
[4] U.S. Department of Education, National Center for Education Statistics: The Condition of Education 2016 (NCES 2016-144), https://nces.ed.gov/programs/coe/indicator_cgf.asp. Published March 2017. Accessed April 17, 2017.
[5] Hamilton BE, Ph D, Martin J a, Osterman MJK, Curtin SC, Statistics V. Births: Preliminary Data for 2014. *Natl Vital Stat Reports*. 2015;64(6):1-19.
[6] Cardoza, V. J., Documét, P. I., Fryer, C. S., Gold, M. A., Butler, J. Sexual health behavior interventions for US Latino adolescents: a systematic review of the literature. *Journal of pediatric and adolescent gynecology*. 2012; 25(2), 136-149.
[7] Lee, Y.-M., Dancy, B., Florez, E. and Holm, K. Factors Related to Sexual Practices and Successful Sexually Transmitted Infection/HIV Intervention Programs for Latino Adolescents. *Public Health Nurs*. 2013;30: 390–401.
[8] Centers for Disease Control and Prevention. HIV Surveillance Report, 2015. 27 http://www.cdc.gov/hiv/library/reports/hiv-surveillance.html. Published November 2016. Accessed September 18, 2017.

Whereas, Understanding aspects of Latino culture, such as social class, education, socioeconomic status, country of origin, religiosity, the changing role of women, the impact of the media, and view of family planning programs, are crucial for effective sex education efforts in the Latino community;[9] and

Whereas, There is evidence that language concordant and culturally competent sexual education taught both in English and Spanish results in reduced contraction of HIV in Latino populations, increased days of protected sex, and more frequent condom use;[10,11] and

Whereas, AMA Policy H-170.968 currently supports comprehensive sex education, but it does not encourage schools to use language concordant materials for LEP pupils; therefore be it

RESOLVED, That our American Medical Association amend policy H-170.968 by addition to read as follows:

Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968

(1) Recognizes that the primary responsibility for family life education is in the home, and additionally supports the concept of a complementary family life and sexuality education program in the schools at all levels, at local option and direction;

(2) Urges schools at all education levels to implement comprehensive, developmentally appropriate sexuality education programs that: (a) are based on rigorous, peer reviewed science; (b) incorporate sexual violence prevention; (c) show promise for delaying the onset of sexual activity and a reduction in sexual behavior that puts adolescents at risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases and for becoming pregnant; (d) include an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; (e) utilize classroom teachers and other professionals who have shown an aptitude for working with young people and who have received special training that includes addressing the needs of gay, lesbian, and bisexual youth; (f) include ample involvement of parents, health professionals, and other concerned members of the community in the development of the program; ~~and~~ (g) are part of an overall health education program; and (h) include culturally competent materials that are language concordant for Limited English Proficiency (LEP) pupils;

(3) Continues to monitor future research findings related to emerging initiatives that include abstinence-only, school-based sexuality education, and consent communication to prevent dating violence while promoting healthy relationships, and school-based condom availability programs that address sexually transmitted diseases and pregnancy prevention for young people and report back to the House of Delegates as appropriate;

(4) Will work with the United States Surgeon General to design programs that address communities of color and youth in high risk situations within the context of a comprehensive school health education program;

[9] Medina C. Latino culture and sex education. *SIECUS Rep*. 1987;15(3):1-4. http://www.ncbi.nlm.nih.gov/pubmed/12314913.
[10] Villarruel AM, Jemmott JB, Jemmott LS. A randomized controlled trial testing an HIV prevention intervention for Latino youth. *Arch Pediatr Adolesc Med*. 2006;160(8):772-777. doi:10.1001/archpedi.160.8.772.
[11] Advocates for Youth: ¡Cuidate! http://www.advocatesforyouth.org/publications/1142?task=view Published 2008. Accessed April 17, 2017.

(5) Opposes the sole use of abstinence-only education, as defined by the 1996 Temporary Assistance to Needy Families Act (P.L. 104-193), within school systems; (6) Endorses comprehensive family life education in lieu of abstinence-only education, unless research shows abstinence-only education to be superior in preventing negative health outcomes; (7) Supports federal funding of comprehensive sex education programs that stress the importance of abstinence in preventing unwanted teenage pregnancy and sexually transmitted infections, and also teach about contraceptive choices and safer sex, and opposes federal funding of community-based programs that do not show evidence-based benefits; and (8) Extends its support of comprehensive family-life education to community-based programs promoting abstinence as the best method to prevent teenage pregnancy and sexually-transmitted diseases while also discussing the roles of condoms and birth control, as endorsed for school systems in this policy; (9) Supports the development of sexual education curriculum that integrates dating violence prevention through lessons on healthy relationships, sexual health, and conversations about consent; and (10) Encourages physicians and all interested parties to develop best-practice, evidence-based, guidelines for sexual education curricula that are developmentally appropriate as well as medically, factually, and technically accurate. (Modify Current HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 04/26/18

RELEVANT AMA POLICY

An Updated Review of Sex Education Programs in the United States H-170.962
Our AMA: (1) recognizes that increasing sexually transmitted disease (STD) and human immunodeficiency virus (HIV) transmission rates among youth, as well as a recent increase in the national teen pregnancy rate, indicate a gap in public health education and should be addressed; and that comprehensive-based sex education is currently the most effective strategy to address these public health problems; and (2) supports the redirection of federal resources toward the development and dissemination of more comprehensive health and sex education programs that are shown to be efficacious by rigorous scientific methodology. This includes programs that include scientifically accurate education on abstinence in addition to contraception, condom use, and transmission of STDs and HIV, and teen pregnancy.
Citation: (CSAPH Rep. 7, A-09)

Human Sexuality Education H-170.966
Our AMA encourages physicians to assist parents in providing human sexuality education to children and adolescents.
Citation: (CSA Rep. 4, A-03; Reaffirmed: CSAPH Rep. 1, A-13)

See also: **Addressing Immigrant Health Disparities H-350.957; Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; Comprehensive Health Education H-170.977; Education on Condom Use H-170.965**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-18)

Introduced by: Colorado

Subject: Reducing Gun Violence in America

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Our AMA has formally recognized gun violence as a public health issue; and

Whereas, Public health research has led to interventions which save countless lives such as research on smoking and motor vehicle deaths; and

Whereas, US homicide rates were seven times higher than in other high-income countries, driven by a gun homicide rate that was 25.2 times higher. For 15- to 24-year-olds, the gun homicide rate in the United States was 49 times higher. Unintentional firearm deaths were 6.2 times higher in the United States. The overall firearm death rate in the United States from all causes was ten times higher. Ninety % of women, 91% of children aged <14 years, 92% of youth aged 15 to 24 years, and 82% of all people killed by firearms were from the United States[1]; and

Whereas, The Rand Corporation has recently produced a review of current literature regarding effectiveness of current state level gun laws[2]; and

Whereas, The Rand report identifies specific statutory interventions likely to reduce gun violence, gun related suicides and accidental shootings; and

Whereas, Policy dealing with public health issues should be based on evidence; and

Whereas, The Rand report cites the lack of funded research on the causes and potential remedies for gun violence as a barrier to addressing the problem; and

Whereas, Our AMA policy calls for the AMA to "actively lobby Congress to lift the gun violence research ban"; therefore be it

RESOLVED, That our American Medical Association reaffirm Policies D-145.995, "Gun Violence as a Public Health Crisis," H-145.975, "Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care," and H-145.997, "Firearms as a Public Health Problem in the United States - Injuries and Death" (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA work with other physician organizations to actively lobby for restoration of funding for gun violence research at the Centers for Disease Control and Prevention and elsewhere (Directive to Take Action); and be it further

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[1] Am J Med. 2016 Mar;129(3):266-73
[2] https://www.rand.org/pubs/research_reports/RR2088.html

RESOLVED, That our AMA review the Rand report on gun violence and other credible sources of research on causes and effective policy to reduce gun violence and report back at the 2018 Interim Meeting with findings and recommendations for further advocacy to reduce gun violence in the US. (Directive to Take Action)

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

Received: 05/01/18

RELEVANT AMA POLICY

Gun Violence as a Public Health Crisis D-145.995
Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and
(2) will actively lobby Congress to lift the gun violence research ban.
Citation: Res. 1011, A-16;

Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs
2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.
Citation: Sub. Res. 221, A-13; Appended: Res. 416, A-14; Reaffirmed: Res. 426, A-16;

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-18)

Introduced by: Medical Student Section

Subject: Medical Respite Care for Homeless Adults

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, The AMA recognizes that the growing crisis of poverty, homelessness, and decreased number of mental health facilities has led to increasingly more Medicaid patients visiting the Emergency Department for preventable and predictable conditions (AMA Policy H-160.903); and

Whereas, Current healthcare delivery to homeless patients contributes to poor health outcomes, increased healthcare spending, and increased medical provider frustration;[1,2,3,4] and

Whereas, Without a formalized post-hospitalization arrangement for homeless patients, a *de facto* process of care has emerged that leads to suboptimal discharge arrangements, provider burnout, poor patient outcomes, and an overall increase in cost of patient care;[1,5,6] and

Whereas**,** Medical Respite Care (MRC) is acute and post-acute medical care for homeless patients who are too sick to recover on the streets but not sick enough to be kept inpatient;[7] and

Whereas, MRC centers are third-party organizations that provide homeless patients MRC, including access to nursing care, behavioral health services, substance abuse services, case managers, and primary care providers;[7,8,9,10] and

Whereas, MRC is associated with fewer hospital readmissions, and a reduction in the total amount of time patients spend in the hospital across multiple parameters as compared to patients who were unable to access MRC care;[7,8] and

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[8] Doran, KM, Ragins KT, Gross CP, et. al. Medical respite programs for homeless patients: A systematic review. *J Health Care Poor Underserved.* 2013. 24, 499–524
[9] McMurray-Avila M, Ciambrone S, Edgington S. "Medical Respite Services for Homeless People: Practical Planning" *Health Care for the Homeless.* 2009 June.
[10] National Health Care for the Homeless Council, Inc. "2016 Medical Respite Program Directory" (2016).

Whereas, MRC report overall cost-savings, particularly when compared with the cost of hospitalization, with demonstrated cost avoidance for hospitals ranging from $3.5 to $5.5 million annually;[8,11] and

Whereas, As stated in the Standards for Medical Respite Care, MRC quality standards only require self-audits and do not promote standardization across facilities;[12] and

Whereas, Because the vast majority of MRC centers do not receive funding from Medicaid, MRC programs utilize an unreliable patchwork of funding mechanisms across the public and private sector, leading to challenges of incorporating and streamlining MRC;[11,13] therefore be it

RESOLVED, That our American Medical Association study funding, implementation, and standardized evaluation of Medical Respite Care for homeless persons. (Directive to Take Action)

Fiscal Note: not yet determined

Received: 04/26/18

RELEVANT AMA POLICY

Eradicating Homelessness H-160.903
Our American Medical Association: (1) supports improving the health outcomes and decreasing the health care costs of treating the chronically homeless through clinically proven, high quality, and cost effective approaches which recognize the positive impact of stable and affordable housing coupled with social services; and (2) supports the appropriate organizations in developing an effective national plan to eradicate homelessness.
Citation: (Res. 401, A-15)

The Mentally Ill Homeless H-160.978
(1) The AMA believes that public policy initiatives directed to the homeless, including the homeless mentally ill population, should include the following components: (a) access to care (e.g., integrated, comprehensive services that permit flexible, individualized treatment; more humane commitment laws that ensure active inpatient treatment; and revisions in government funding laws to ensure eligibility for homeless persons); (b) clinical concerns (e.g., promoting diagnostic and treatment programs that address common health problems of the homeless population and promoting care that is sensitive to the overriding needs of this population for food, clothing, and residential facilities); (c) program development (e.g., advocating emergency shelters for the homeless; supporting a full range of supervised residential placements; developing specific programs for multiproblem patients, women, children, and adolescents; supporting the development of a clearinghouse; and promoting coalition development); (d) educational needs; (e) housing needs; and (f) research needs. (2) The AMA encourages medical schools and residency training programs to develop model curricula and to incorporate in teaching programs content on health problems of the homeless population, including experiential community-based learning experiences. (3) The AMA urges specialty societies to design interdisciplinary continuing medical education training programs that include the special treatment needs of the homeless population.
Citation: BOT Rep. LL, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 01, A-16;

See also: **Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982**

[11] National Health Center for the Homeless Council, Inc. “Medical Respite Care: Reducing Costs and Improving Care” (2011)
[12] National Health Care for the Homeless Council, Inc. “Standards for Medical Respite Programs” (2016).
[13] Dobbins, Julia. Financing Medical Respite Care: A Practical Discussion to Ensure Sustainability. *National Healthcare for the Homeless.* 2017. Available at: https://www.youtube.com/watch?v=_tPvPuGbp64&feature=youtu.be. Accessed September 18, 2017.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-18)

Introduced by: Women Physicians Section

Subject: Reducing Disparities in Obstetric Outcomes, Maternal Morbidity, and Prenatal Care

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Thirty-eight percent (approximately 61 million) of women residing in the U.S. are members of a racial or ethnic minority populations and face disparities in obstetric outcomes[1]; and

Whereas, Studies have shown poor obstetric outcomes (e.g., preterm birth), maternal morbidity, and inadequate prenatal care is higher among racial/ethnic minority women in the U.S.[2-4]; and

Whereas, Poor obstetric outcomes that disproportionately affect racial/ethnic minorities include the higher incidences of congenital abnormalities (e.g., spina bifida and anencephaly); fetal demise (11.3 per 1,000 for Blacks compared to 5.0 per 1,000 for Non-Hispanic Whites); preterm birth (16.3% Blacks compared to 10.2% non-Hispanic Whites)[5]; and fetal growth restriction (15. 9 per 1,000 for Blacks compared 8.3 per 1,000 for non-Hispanic Whites)[6,7];and

Whereas, The birth prevalence of spina bifida is 4.18 per 10,000 births among Hispanic women, versus 3.37 per 10,000 for non-Hispanic white women[7,8]; and

Whereas, Among Asian women, Indian and Pakistani women have the highest risk of low birthweight newborns at term[9]; and

Whereas, Disparities in preterm births account for 80% of the Black-White disparity in infant mortality (in the U.S. in 2006, Blacks had an overall preterm birth rate of 18.4% compared to the general population's rate of 12.8%)[10]; and

Whereas, Polymorphisms in maternal and fetal genes for IL-1, IL-6 and other inflammatory factors may be associated with an increased risk of spontaneous preterm birth among Black women over other populations[11]; and

Whereas, These polymorphisms could also modify the risk of preterm birth associated with genital infections among certain female minority populations[12]; and

Whereas, In 2009, the prevalence of severe maternal morbidity in the U.S. was 129 per 10,000, representing a 75% increase since 1999[13]; and

Whereas, Non-Hispanic Black women are twice as likely to experience severe maternal morbidity than Caucasians[13-15]; and

Whereas, Among all women, pregnancy-related hypertension rates are the highest in Non-Hispanic Black women. Among Asian women, Filipina and Samoan women have higher risk than women from other subgroups[7]; and

Whereas, A report by the Centers for Disease Control and Prevention on Gestational Diabetes, found that Hispanic and Asian/Pacific Islander women at a greater risk for development of gestational diabetes (16.3% and 12.1% respectively) compared to Caucasian women (6.8%)[16]; and

Whereas, A report by the American Diabetes Association found that racial and ethnic minorities [Black (1.69), Hispanic (1.42), and Asian/Pacific Islander (1.25)] had higher rates of pregnant women with pre-existing diabetes compared to pregnant Caucasian women even after adjusting for maternal age[17]; and

Whereas, Studies have shown that Asian women are at an increased risk for gestational diabetes, prolonged second stage of labor, and perineal lacerations compared to Caucasian women[7,18-20]; and

Whereas, Research on Asian subgroups have shown that Filipina women had the highest risk of gestational hypertension/preeclampsia; Pacific Islander women had the highest risk of macrosomia; and Indian/Pakistani women had the highest risk of preterm delivery, gestational diabetes, and diabetes mellitus[7,18-22]; and

Whereas, The complex etiologies of these disparities include social constructs and variations in access to health care[23]; and

Whereas, Despite the 1998 FDA mandate to fortify cereal grains in the U.S., adequate intake of folic acid remains low in Hispanic groups[24,25]; and

Whereas, Black women are also more likely to experience higher rates of maternal morbidity (e.g., hypertensive disorders of pregnancy), some of which may be attributable to genetic factors as well[23]; and

Whereas, Studies have shown that maternal stress plays a role in preterm birth risk, in particular Black and Native Indian/Alaska Natives report undergoing chronic stressors during pregnancy[26-28]; and

Whereas, Racial and ethnic minorities have a higher incidence of being overweight and/or obese pre-pregnancy, which have been shown to contribute to pregnancy complications such as preterm birth, fetal death, macrosomia, gestational diabetes and cesarean delivery[29-31]; therefore be it

RESOLVED, That our American Medical Association work with stakeholders to encourage research on identifying barriers and developing strategies toward the implementation of evidence-based practices in ethnic minorities to prevent disease conditions that contribute to poor obstetric outcomes, maternal morbidity and maternal mortality. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/01/18

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RELEVANT AMA POLICY
H-350.974 Racial and Ethnic Disparities in Health Care
D-420.993 Disparities in Maternal Mortality
H-420.995 Medical Care for Indigent and Culturally Displaced Obstetrical Patients and Their Newborns

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-18)

Introduced by: Senior Physicians Section

Subject: A Guide for Best Health Practices for Seniors Living in Retirement Communities

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, The AMA-SPS mission is to engage physicians age 65 and above, both active and retired, to promote policies, products and services relevant to senior physicians; and

Whereas, The number of seniors in the United States is growing exponentially, with currently 46 million people age 65 or older with the number expected to grow to 73 million in the next 15 years[1]; and

Whereas, The "Baby Boomer" generation (generally accepted as birth dates between 1946 to 1964) is 74.9 million[2]; and

Whereas, Large numbers of these groups live independently in retirement communities not subject to any state or federal regulations as are required for assisted living, extended care and nursing homes; and

Whereas, The AARP has published its second edition of "Where We Live: Communities for All Ages" with a focus on communities in the forefront in addressing the needs of an aging population[3]; and

Whereas, Many senior physicians live in such communities and could be a resource for their communities in matters of health and wellness, enhancing the health of the community's residents, were there a template of suggestions to guide their efforts; and

Whereas, Although there are guidelines for immunizations from the CDC and publications touting the validity of exercise programs for the elderly, they are not cohesive and in "one place"; and

Whereas, There are no guidelines for independent living communities (on activities) that could prevent communicable diseases or even save lives (e.g. alcohol/soap hand dispensers in communal areas, maintenance suggestions for decorative fountains and cooling towers, placement of AEDs [AEDs — automated external defibrillators — can be found in almost every school building and airport but how many are in senior living facilities?]); and

Whereas, Senior citizens have special needs that may include safety features (e.g. wider doorways, absence of area rugs, leveling of doorsills), accommodations for disabilities, improved bathroom accessibility and enhanced lighting; and

Whereas, Norman Cohen, MD, a respected orthopedic surgeon at Highland Park Hospital in Illinois for 30 years, who, upon retirement, then practiced orthopedics at the Navajo Indian Reservation in Arizona and New Mexico over a five-year period, who lived in a senior retirement community and, as a member of the AMA Senior Physicians Section, wished to continue helping his fellow residents by submitting this resolution before he passed away in February 2018; therefore be it

RESOLVED, That our American Medical Association, in cooperation with other interested parties such as the public health community, geriatric specialties, and AARP, study the development of a document that could guide best health practices for the senior independent living community. (Directive to Take Action)

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

Received: 05/01/18

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http://www.aarp.org/livable-communities/tool-kits-resources/info-2016/where-we-live-communities-for-all-ages.html

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-18)

Introduced by: Washington

Subject: Violence Prevention

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Gun violence is a public health and medical issue of immediate importance and our responsibility as a medical community is to contribute to the solution of prevention; and

Whereas, In 2013 our AMA joined 51 other specialty societies in letters to our President and congress to highlight mental health issues involved in violence prevention, and in 2017 our AMA came together with the American Bar Association to discuss the crisis of gun violence in Chicago, we prioritized lifting the ban and restoring funding to the CDC and federal agencies to study gun violence and in the interim our statistics come from other sources; and

Whereas, Currently an average of 7 children and teens under 20 are killed by guns every day and more than 1 in 5 US teenagers (14-17 years old) report having witnessed a shooting, and an average of 34 Americans are murdered with guns every day and 151 are treated for gun assaults every day in an emergency room; [1] and

Whereas, 60% of gun sales occur with a background check, yet those states with weaker gun laws on average lead to more gun deaths; [1] and

Whereas, America is an outlier on gun violence because it has many more guns than other developed nations with 4.4% of the world's population but almost half of the civilian owned guns around the world;[2] and

Whereas, Change is imperative with rampant gun violence in both urban communities and mass shootings; with 1,600 mass shootings since Sandy Hook elementary school in 2012 with a total of 1,800 killed and 6,400 wounded; therefore be it

RESOLVED, That our American Medical Association advocate that a valid permit be required before the sale of all rapidly-firing semi-automatic firearms (New HOD Policy); and be it further

RESOLVED, That our AMA study options for removing access to firearms for those who may be a threat to themselves or others (Directive to Take Action); and be it further

RESOLVED, That our AMA study options for improving the mental health reporting systems and patient privacy laws at both the state and federal levels and how those can be modified to allow greater information sharing between state and federal government, law enforcement, schools and mental health professionals to identify, track and share information about mentally ill persons with high risk of violence and either report to law enforcement and/or the National Instant Criminal Background Check System, with appropriate protections. (Directive to Take Action)

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1. http://www.bradycampaign.org/gun-violence, Childhood Violence Exposure https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf
2. Harvard School of Public Health Injury Control Research Center, https://www.hsph.harvard.edu/hicrc/firearm-researcher-surveys/
3. http://www.gunviolencearchive.org/Gun Violence Archive compiled database since 2013 tracing reported shooting events (esp. Since CDC recent data is behind)

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

Received: 05/02/18

RELEVANT AMA POLICY

Firearm Availability H-145.996
Our AMA: (1) Advocates a waiting period and background check for all firearm purchasers;
(2) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and
(3) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.
Citation: Res. 140, I-87; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: BOT Rep. 12, A-16;

Increasing Toy Gun Safety H-145.974
Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.
Citation: (Res. 406, A-15)

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.
Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

Gun Safety H-145.978
Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and
(2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.
Citation: (Res. 425, I-98; Reaffirmed: Res. 409, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Reaffirmation A-13)

See also:
Prevention of Ocular Injuries from BB and Air Guns H-145.982; Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975; Gun Violence as a Public Health Crisis D-145.995; Ban Realistic Toy Guns H-145.995; Physicians and the Public Health Issues of Gun Safety D-145.997; Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989; Ocular Injuries from Air Guns H-10.961; Guns in School Settings H-60.947; Guns in Hospitals H-215.977; Gun Regulation H-145.999; AMA Campaign to Reduce Firearm Deaths H-145.988; Waiting Period Before Gun Purchase H-145.992; Waiting Periods for Firearm Purchases H-145.991

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-18)

Introduced by: Illinois

Subject: Mandatory Influenza Vaccination Policies for Healthcare Workers

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Policies requiring health care workers (HCW) to obtain influenza vaccinations as a condition of employment are gaining popularity; and

Whereas, Recent studies, such as the Cochrane review, have shown that policies requiring HCW influenza vaccinations do not reduce patient risk; and

Whereas, There has never been a study to investigate the cumulative toxicity of annual influenza vaccination administration; and

Whereas, The principle of herd immunity does not apply when ascribed to an occupational population or when the vaccine efficacy rate is low or unknown; and

Whereas, A recent CDC sponsored study concluded that spontaneous abortion “was associated with influenza vaccination in the previous 28 days” (adjusted odds ratio of 2:0); and

Whereas, Medical center vaccination consent forms for influenza vaccinations may contain the phrase (or something similar) that the employee will defend, indemnify, and hold harmless the medical center’s directors, officers, medical staff, employees, and agents from all claims, demands, and causes of action including court costs and attorney fees directly or indirectly arising from any action or proceedings arising from any adverse side effect; therefore be it

RESOLVED, That our American Medical Association enact as policy that no health care worker should be terminated from employment due solely to their refusal to be vaccinated for influenza. (Directive to Take Action)

Fiscal Note: Minimal - less than $1,000.

Received: 05/02/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-18)

Introduced by: Illinois

Subject: Product Date Labels

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, American consumers currently must contend with as many as a dozen different expiration date label designations on foods, medications and other perishable products, resulting in confusion and waste; and

Whereas, Consumers generally interpret date labels as an indication that food is no longer safe to eat, though the label may actually only represent the manufacturer's guess at its peak quality; and

Whereas, The largest grocery industry trade associations have introduced guidelines urging manufacturers to use only the standardized safety designation "use by" and the quality descriptor "best if used by" for product date labels; and

Whereas, Voluntary guidelines will not resolve the associated consumer confusion (whether accidental or intentional) and any qualitative date label will continue to promote the waste of safe food and products; therefore be it

RESOLVED, That our American Medical Association endorse federal standardization of date labels on foods and other products to ensure that they address safety concerns. (Directive to Take Action)

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

Received: 05/02/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 422
(A-18)

Introduced by: Michigan

Subject: School Drinking Water Quality Testing, Monitoring, and Maintenance

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Evidence-based research indicates that even a small amount of lead in a child's body can cause serious health problems; and

Whereas, Other studies have demonstrated lead's compromising effects on child health, the immune system, and association with impairments in neurobehavioral factors such as a child's learning skills, hearing, and self-regulatory ability resulting in delinquent behavior; and

Whereas, Children may be more susceptible to the adverse health effects of chemical, physical, and biological hazards than adults, while having reduced immunity, immaturity of organs and functions than adults; and

Whereas, Rapid growth and development can make children more vulnerable to the toxic effects of environmental hazards than adults; and

Whereas, During critical developmental stages, children spend much of their day within school environments; and

Whereas, The current action limit for lead in drinking water of 15 ppb is a regulatory measure, not a public health measure; and

Whereas, Research shows that there is no 100 percent "safe" level of lead in drinking water for school children; and

Whereas, It is imperative that standardized, sustainable protocols be developed to ensure school water safety; and

Whereas, Such protocol should include detailed water monitoring and maintenance standards and schedules, guidance on flushing of pipes and filter replacement/maintenance as deemed necessary given the condition of the water system, technical assistance, and both regulatory and independent oversight to ensure such protocols are sustained by state, local, and school system entities; and

Whereas, There are currently no national regulations requiring the testing of school water for lead, copper, and other metals as well as biological contaminants; and

Whereas, All children, regardless of the state or community in which they reside, require protection against metal, chemical and biological contamination in the water made available to them in schools; therefore be it

RESOLVED, That our American Medical Association amend policy H-60.918 by addition to read as follows:

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918
1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water.
5. Our AMA supports the creation and implementation of standardized protocols and regulations pertaining to water quality testing, reporting and remediation to ensure the safety of water in schools and child care centers (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA actively pursue changes to the federal lead and copper rules consistent with AMA policy H-135.928. (Directive to Take Action)

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

Received: 05/02/18

RELEVANT AMA POLICY

Safe Drinking Water H-135.928
Our AMA supports updates to the U.S. Environmental Protection AgencyÃ¢â‚¬â„¢s Lead and Copper Rule as well as other state and federal laws to eliminate exposure to lead through drinking water by:
(1) Removing, in a timely manner, lead service lines and other leaded plumbing materials that come into contact with drinking water; (2) Requiring public water systems to establish a mechanism for consumers to access information on lead service line locations; (3) Informing consumers about the health-risks of partial lead service line replacement; (4) Requiring the inclusion of schools, licensed daycare, and health care settings among the sites routinely tested by municipal water quality assurance systems;
(5) Improving public access to testing data on water lead levels by requiring testing results from public water systems to be posted on a publicly available website in a reasonable timeframe thereby allowing consumers to take precautions to protect their health; (6) Establishing more robust and frequent public education efforts and outreach to consumers that have lead service lines, including vulnerable populations; (7) Requiring public water systems to notify public health agencies and health care providers when local water samples test above the action level for lead; and
8) Seeking to shorten and streamline the compliance deadline requirements in the Safe Drinking Water Act. Citation: Res. 409, A-16;

Lead Contamination in Municipal Water Systems as Exemplified by Flint, Michigan H-60.918
1. Our AMA will advocate for biologic (including hematological) and neurodevelopmental monitoring at established intervals for children exposed to lead contaminated water with resulting elevated blood lead levels (EBLL) so that they do not suffer delay in diagnosis of adverse consequences of their lead exposure.
2. Our AMA will urge existing federal and state-funded programs to evaluate at-risk children to expand services to provide automatic entry into early-intervention screening programs to assist in the neurodevelopmental monitoring of exposed children with EBLL.
3. Our AMA will advocate for appropriate nutritional support for all people exposed to lead contaminated water with resulting elevated blood lead levels, but especially exposed pregnant women, lactating mothers and exposed children. Support should include Vitamin C, green leafy vegetables and other calcium resources so that their bodies will not be forced to substitute lead for missing calcium as the children grow.
4. Our AMA promotes screening, diagnosis and acceptable treatment of lead exposure and iron deficiency in all people exposed to lead contaminated water. Citation: Res. 428, A-16;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 423
(A-18)

Introduced by: Michigan

Subject: Grill Brush Warning

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, The dangers of wire-bristle grill brushes have been documented; and

Whereas, The study, "*Epidemiology of Wire-Bristle Grill Brush Injury in the United States, 2002-2014*" published in the SAGE Journals American Academy of Otolaryngology-Head and Neck Surgery on March 1, 2016, estimated that between 2002-2014, more than 1,600 emergency department visits occurred as a result of wire-bristle brush injuries; and

Whereas, Most people using wire-bristle grill brushes are likely not aware of the potential risk from bristles that break off and adhere to the grill; and

Whereas, These bristles can stick to the food being cooked and then accidentally ingested; and

Whereas, "Depending on the site of injury, multiple specialties--including emergency medicine, radiologists, otolaryngology-head and neck surgery, and general surgery--may be involved in the care of these patients"; and

Whereas, A lack of awareness can result in a delay in diagnosis and medical complications; and

Whereas, Ingested wire-bristles can become a surgical emergency; therefore be it

RESOLVED, That our American Medical Association request that the appropriate federal agency require the placement of a warning label on all wire-bristle grill brushes informing consumers about the possibility of wire bristles breaking off and being accidentally ingested. (Directive to Take Action)

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

Received: 05/02/18

Sources:

1. https://www.medicalnewstoday.com/articles/310615.php
2. https://www.consumerreports.org/food-safety/wire-grill-brush-danger/
3. https://www.cbsnews.com/news/grill-barbecue-metal-brush-dangers/
4. https://www.cnn.com/2016/04/05/health/grilling-injury-wire-bristle-brush/index.html

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 424
(A-18)

Introduced by: Michigan

Subject: Rape and Sexual Abuse on College Campuses

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, As physicians, parents, and grandparents we are concerned about the ongoing issues of rapes, sexual abuse, and physical abuse on college campuses; and

Whereas, The sequalae of rape, sexual abuse, and/or physical abuse can include physical and psychological problems; and

Whereas, Rape, sexual abuse, and/or physical abuse may be associated with the inappropriate use of alcoholic beverages; therefore be it

RESOLVED, That our American Medical Association evaluate the issues of rape, sexual abuse, and physical abuse on college campuses and the role state medical societies and our AMA can play in helping to address and resolve these issues (Directive to Take Action); and be it further

RESOLVED, That our AMA strongly express our concerns about the problems of rape, sexual abuse, and physical abuse on college campuses. (Directive to Take Action)

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

Received: 05/02/18

RELEVANT AMA POLICY

Addressing Sexual Assault on College Campuses H-515.956
Our AMA supports universities' implementation of evidence-driven sexual assault prevention programs that specifically address the needs of college students and the unique challenges of the collegiate setting.
Citation: Res. 402, A-16;

Sexual Assault Survivor Services H-80.998
Our AMA supports the function and efficacy of sexual assault survivor services, supports state adoption of the sexual assault survivor rights established in the Survivors' Bill of Rights Act of 2016, encourages sexual assault crisis centers to continue working with local police to help sexual assault survivors, and encourages physicians to support the option of having a counselor present while the sexual assault survivor is receiving medical care.
Citation: Res. 56, A-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmed: CSAPH Rep. 1, A-15; Modified: Res. 202, I-17;

Sexual Assault Survivors H-80.999
1. Our AMA supports the preparation and dissemination of information and best practices intended to maintain and improve the skills needed by all practicing physicians involved in providing care to sexual assault survivors.

2. Our AMA advocates for the legal protection of sexual assault survivorsrights and work with state medical societies to ensure that each state implements these rights, which include but are not limited to, the right to: (A) receive a medical forensic examination free of charge, which includes but is not limited to HIV/STD testing and treatment, pregnancy testing, treatment of injuries, and collection of forensic evidence; (B) preservation of a sexual assault evidence collection kit for at least the maximum applicable statute of limitation; (C) notification of any intended disposal of a sexual assault evidence kit with the opportunity to be granted further preservation; (D) be informed of these rights and the policies governing the sexual assault evidence kit; and (E) access to emergency contraception information and treatment for pregnancy prevention.
3. Our AMA will collaborate with relevant stakeholders to develop recommendations for implementing best practices in the treatment of sexual assault survivors, including through engagement with the joint working group established for this purpose under the Survivor's Bill of Rights Act of 2016.
Citation: Sub. Res. 101, A-80; Reaffirmed: CLRPD Rep. B, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10; Modified: Res. 202, I-17;

E-8.10 Preventing, Identifying and Treating Violence and Abuse
All patients may be at risk for interpersonal violence and abuse, which may adversely affect their health or ability to adhere to medical recommendations. In light of their obligation to promote the well-being of patients, physicians have an ethical obligation to take appropriate action to avert the harms caused by violence and abuse.
To protect patients well-being, physicians individually should:
(a) Become familiar with:
(i) how to detect violence or abuse, including cultural variations in response to abuse;
(ii) community and health resources available to abused or vulnerable persons;
(iii) public health measures that are effective in preventing violence and abuse;
(iv) legal requirements for reporting violence or abuse.
(b) Consider abuse as a possible factor in the presentation of medical complaints.
(c) Routinely inquire about physical, sexual, and psychological abuse as part of the medical history.
(d) Not allow diagnosis or treatment to be influenced by misconceptions about abuse, including beliefs that abuse is rare, does not occur in normal families, is a private matter best resolved without outside interference, or is caused by victims own actions.
(e) Treat the immediate symptoms and sequelae of violence and abuse and provide ongoing care for patients to address long-term consequences that may arise from being exposed to violence and abuse.
(f) Discuss any suspicion of abuse sensitively with the patient, whether or not reporting is legally mandated, and direct the patient to appropriate community resources.
(g) Report suspected violence and abuse in keeping with applicable requirements. Before doing so, physicians should:
(i) inform patients about requirements to report;
(ii) obtain the patients informed consent when reporting is not required by law. Exceptions can be made if a physician reasonably believes that a patients refusal to authorize reporting is coerced and therefore does not constitute a valid informed treatment decision.
(h) Protect patient privacy when reporting by disclosing only the minimum necessary information.
Collectively, physicians should:
(i) Advocate for comprehensive training in matters pertaining to violence and abuse across the continuum of professional education.
(j) Provide leadership in raising awareness about the need to assess and identify signs of abuse, including advocating for guidelines and policies to reduce the volume of unidentified cases and help ensure that all patients are appropriately assessed.
(k) Advocate for mechanisms to direct physicians to community or private resources that might be available to aid their patients.
(l) Support research in the prevention of violence and abuse and collaborate with public health and community organizations to reduce violence and abuse.
(m) Advocate for change in mandatory reporting laws if evidence indicates that such reporting is not in the best interests of patients.
AMA Principles of Medical Ethics: I,III
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Issued: 2016

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 425
(A-18)

Introduced by: Washington

Subject: Hospital Food Labeling

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, The U.S. Food and Drug Administration's (FDA's) new regulations require calorie information on restaurant menus for chains with 20 or more locations by May 7, 2018; and

Whereas, Restaurants are required to provide written nutrition information on their menu items (e.g. total fat, calories from fat, saturated fat, trans fat, cholesterol, sodium, total carbohydrates, dietary fiber, sugars and protein), but can have this information on posters, tray liners, signs, counter cards, handouts, booklets, computers, or kiosks; and

Whereas, Food in hospital cafeterias and inpatient meals will not have to list calorie or nutrition information; and

Whereas, Obesity is a serious concern in adults and children and is associated with poorer mental health outcomes, reduced quality of life and can lead to death or chronic illnesses such as diabetes, heart disease, stroke and some forms of cancer; and

Whereas, Our AMA has longstanding policy supporting providing consumers with nutrition information (AMA Policy H-150.945); therefore be it

RESOLVED, That our AMA modify Policy H-150.949 by addition to read as follows:

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthful food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthful beverages.
3. Our AMA hereby calls for hospital cafeterias and inpatient meal menus to publish nutrition information similar to what is being required for chain restaurants. (Modify Current HOD Policy)

REFERENCES
Food Facts from FDA https://www.fda.gov/Food/LabelingNutrition/ucm436722.htm

Fiscal Note: Minimal - less than $1,000.

Received: 05/02/18

RELEVANT AMA POLICY

Healthy Food Options in Hospitals H-150.949
1. Our AMA encourages healthy food options be available, at reasonable prices and easily accessible, on hospital premises.
2. Our AMA hereby calls on US hospitals to improve the health of patients, staff, and visitors by: (a) providing a variety of healthful food, including plant-based meals, and meals that are low in fat, sodium, and added sugars; (b) eliminating processed meats from menus; and (c) providing and promoting healthful beverages.
Citation: Res. 410, A-04; Reaffirmed: CSAPH Rep. 1, A-14; Appended: Res. 406, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 426
(A-18)

Introduced by: Maryland

Subject: Decrease Adolescent Mortality Through More Comprehensive Graduated Driver Licensing Programs

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Motor vehicle crashes are the leading causes of death for teenagers in the United States (16-19);[1] and

Whereas, Teen drivers ages 16-19 are three times more likely to be involved in a fatal accident than drivers over the age of 20;[2] and

Whereas, Teenagers (age 16-19) involved in fatal motor vehicle crashes are twice as likely to bear significant responsibility for their crash compared to similar fatal crashes of older counterparts;[3,4] and

Whereas, Newly licensed teenage drivers are twice as likely to crash in their first month of driving than they are after a year of experience, and most incidents tend to involve errors in judgement or lack of experience;[5] and

Whereas, Teenage drivers are more likely than their older counterparts to not recognize hazardous conditions or make critical decision errors while driving;[6,7] and

Whereas, The risk of fatal crashes amongst teenage drivers increases with the number of teen passengers, and said crashes are more likely to be in single vehicle-crashes;[8,9,10] and

Whereas, Graduated Driver Licensing (GDL) programs have been associated with a substantial reduction in fatal crash rates among teenage drivers;[11-12] and

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[1] WISQARS Fatal Injury Reports. Centers for Disease Control and Prevention. https://webappa.cdc.gov/sasweb/ncipc/mortrate.html. Published February 19, 2017. Accessed March 26, 2018.
[2] Insurance Institute for HIghway Safety. Fatality Facts: Teenagers. http://www.iihs.org/iihs/topics/t/teenagers/fatalityfacts/teenagers. Accessed March 27, 2018.
[3] Gonzales MM. Student Drivers: A Study of Fatal Motor Vehicle Crashes Involving Drivers 16 to 17 Years Old. *Academic Emergency Medicine*. 2004;11(5):443-443. doi:10.1197/j.aem.2004.02.033.
[4] Eustace D, Wei H. The Role of Driver Age and Gender in Motor Vehicle Fatal Crashes. *Journal of Transportation Safety & Security*. 2010;2(1):28-44. doi:10.1080/19439961003590811.
[5] Foss RD, Martell CA, Goodwin AH, Obrien NP. Measuring Changes in Teenage Driver Crash Characteristics During the Early Months of Driving. *PsycEXTRA Dataset*. doi:10.1037/e554022012-001.
[6] Jonah BA, Dawson NE. Youth and risk: age differences in risky driving, risk perception, and risk utility. *Alcohol, Drugs & Driving* 1987;3:13–29.
[7] McDonald CC, Curry AE, Kandadai V, et. al. Comparison of teen and adult driver crash scenarios in a nationally representative sample of serious crashes. *Accident Analysis & Prevention* 2014;72:302-308.
[8] Chen L-H. Carrying Passengers as a Risk Factor for Crashes Fatal to 16- and 17-Year-Old Drivers. *JAMA*. 2000;283(12):1578. doi:10.1001/jama.283.12.1578.
[9] Preusser DF, Ferguson SA, Williams AF. The effect of teenage passengers on the fatal crash risk of teenage drivers. *Accident Analysis & Prevention*. 1998;30(2):217-222. doi:10.1016/s0001-4575(97)00081-x.
[10] Ouimet MC, Pradhan AK, Brooks-Russell A, et. al. Young drivers and their passengers: a systematic review of epidemiological studies on crash risk. *Journal of Adolescent Health* 2015; 57 (1 Suppl):S24-35
[11] Ulmer RG, Preusser DF, Williams AF, Ferguson SA, Farmer CM. Effect of Florida's graduated licensing program on the crash rate of teenage drivers. *Accident Analysis & Prevention*. 2000;32(4):527-532. doi:10.1016/s0001-4575(99)00074-3.
[12] Shope JT, Molnar LJ. Graduated driver licensing in the United States: evaluation results from the early programs. *Journal of Safety Research*. 2003;34(1):63-69. doi:10.1016/s0022-4375(02)00080-4.

Whereas, All 50 states and DC have adopted some form of GDL program, but they vary quite drastically with respect to their specific requirements;[13] and

Whereas, The NIH and United States Department of Transportation have found that the most effective legislation includes at least 5 of the following 7 elements, "A minimum age of 16 for a learner's permit, a mandatory waiting period of at least six months before a driver can apply for an intermediate license, a requirement for 50 to 100 hours of supervised driving before testing for an intermediate license, a minimum age of 17 for an intermediate license, restrictions on nighttime driving, a limit on the number of teenaged passengers allowed in the car, and a minimum age of 18 for a full license;"[14] and

Whereas, As of March 2018 no states have adopted all of the best practices for state GDL laws proposed by the Insurance Institute for Highway Safety who estimate such measures could save over 500 lives a year;[15] and

Whereas, Research has shown that the most influential components of varying Graduated Driving Licensing programs in lowering the risk of fatal teen crashes are a delayed permit and licensing age, more required practice hours, nighttime restrictions, and teenage passenger restrictions;[16-17] therefore be it

RESOLVED, That our American Medical Association support the standardization and implementation of more comprehensive Graduated Driver Licensing programs including but not limited to increasing permit and licensing age requirements, mandatory minimum training hours, and nighttime and teenage passenger restrictions. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/08/18

RELEVANT AMA POLICY

Licensing People to Drive H-15.972
Older Driver Safety H-15.954
Medical Advisory Boards in Driver Licensing H-15.995
Automobile-Related Injuries H-15.990
Fatigue, Sleep Disorders, and Motor Vehicle Crashes H-15.958
Options for Improving Motorcycle Safety D-15.999
Automatic (i.e., Passive) Restraints to Prevent Injuries and Deaths from Motor Vehicle Accidents H-15.986
Motor Vehicle Accidents H-15.992

[13] Teen and Novice Drivers. Governor's Highway Safety Association. https://www.ghsa.org/state-laws/issues/teen and novice drivers. Accessed March 26, 2018.
[14] Graduated drivers licensing programs reduce fatal teen crashes. National Institutes of Health. https://www.nih.gov/news-events/news-releases/graduated-drivers-licensing-programs-reduce-fatal-teen-crashes. Published September 18, 2015. Accessed March 26, 2018.
[15] Teenagers: Driving Carries Extra Risk for Them. Insurance Institute for Highway Safety. http://www.iihs.org/iihs/topics/laws/gdl_calculator?topicName=teenagers. Accessed March 26, 2018.
[16] Lyon JD, Pan R, Li J. National evaluation of the effect of graduated driver licensing laws on teenager fatality and injury crashes. *Journal of Safety Research*. 2012;43(1):29-37. doi:10.1016/j.jsr.2011.10.007.
[17] Chen L-H, Baker SP, Li G. Graduated Driver Licensing Programs and Fatal Crashes of 16-Year-Old Drivers: A National Evaluation. *Pediatrics*. 2006;118(1):56-62. doi:10.1542/peds.2005-2281.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 427
(A-18)

Introduced by: Maryland

Subject: Support Gun Buyback Programs in Order to Reduce the Number of Circulating Unwanted Firearms

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Existing AMA-policy states "gun violence represents a public health crisis which requires a comprehensive public health response and solution" (D-145.995); and

Whereas, A survey of 186 people in Massachusetts who turned in 339 weapons (and received between $25-75 for doing so) for which 109 (59%) responded found that 54% turned in guns for safety reasons, 47% for no longer needing or wanting their guns, and 13% for concern that the gun(s) were accessible to children[1]; and

Whereas, 87% of respondents in the survey felt that the buyback program helped encourage neighborhood awareness of firearm safety[1]; and

Whereas, Gun buyback programs have also been utilized in Maryland, with motivating factors including recent school shootings and a desire for guns to be removed from circulation so they do not end up in the wrong hands and cause harm to others;[2,3,4] and

Whereas, Following the massacre of 35 people in Australia in 1996 by a lone gunman using a semi-automatic weapon, Australia instituted several measures among which were compulsory buybacks of the banned guns[5]; and

Whereas, Australia's national firearm stockpile decreased by ⅓ following the passing of this legislation, rates of total gun deaths have declined, public mass shootings stopped, and it was estimated that at least 200 deaths and $500 million was being saved annually[2]; and

Whereas, The UK has used a few approaches to stemming gun violence, among which is a gun buyback program[6]; and

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[1] Green J, et al. Are "goods for guns" good for the community? An update of a community gun buyback program. J Trauma Acute Care Surg. 2017;83:284-288.
[2] Duncan I. Baltimore buyback takes in 461 guns in wake of Conn. shooting. http://www.baltimoresun.com/news/maryland/crime/bs-md-ci-gun-buyback-20121215-story.html Accessed 26 March 2018.
[3] Duncan I. Gun buyback event draws hundreds in Howard County. http://www.baltimoresun.com/news/maryland/howard/columbia/bs-md-howard-gun-buyback-20130316-story.html Accessed 26 March 2018.
[4] Baltimore Holds City-Wide Gun Buyback Program. http://baltimore.cbslocal.com/2014/07/26/baltimore-holds-city-wide-gun-buy-back-program/ Accessed 26 March 2018.
[5] Dudley MJ, et al. The Port Arthur massacre and the National Firearms Agreement: 20 years on, what are the lessons? Med J Aust. 2016;204:381-383
[6] Weller C. These four countries have nearly eliminated gun deaths - here's what the US can learn. http://www.independent.co.uk/news/world/americas/gun-deaths-eliminated-america-learn-japan-australia-uk-norway-florida-shooting-latest-news-a8216301.html Accessed 14 March 2018

Whereas, It was estimated in 2010 that there were 3.78 guns per 100 people in the UK while the US had 101 guns per 100 people, and that there have been 50-60 gun-related deaths per year in the UK while the US, with about 6 times more people, has more than 160 times as many gun-related homicides[3]; therefore be it

RESOLVED, That our American Medical Association support the institution of gun buyback programs. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/08/18

References:
http://lawcenter.giffords.org/gun-laws/policy-areas/who-can-have-a-gun/minimum-age/#federal

RELEVANT AMA POLICY

Prevention of Unintentional Shooting Deaths Among Children H-145.979
Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics, including the nature of "reasonable measures," be determined by the individual constituencies affected by the law.
Citation: (Res. 204, I-98; Reaffirmed: BOT Rep. 23, A-09)

Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
Citation: (CSA Rep. A, I-87; Reaffirmed: BOT Rep. I-93-50; Appended: Res. 403, I-99; Reaffirmation A-07; Reaffirmation A-13; Appended: Res. 921, I-13)

See also:
Gun Safety H-145.978
Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Gun Violence as a Public Health Crisis D-145.995
Physicians and the Public Health Issues of Gun Safety D-145.997
Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns H-145.989
Guns in School Settings H-60.947
Guns in Hospitals H-215.977
Gun Regulation H-145.999
AMA Campaign to Reduce Firearm Deaths H-145.988
Firearm Availability H-145.996
Waiting Periods for Firearm Purchases H-145.991

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 428
(A-18)

Introduced by: Maryland

Subject: LGBTQIA+ Inclusive Sex Education Alongside Heterosexual Sex Education

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Many LGBTQIA students do not receive formal sex or sexuality education in schools and must seek information elsewhere;[1] and

Whereas, Only about 5 percent of students reported being taught positive information about L.G.B.T. people or issues in their health classes;[2] and

Whereas, L.G.B.T. youth are five times more likely than their non-L.G.B.T. peers to search for sexuality information online;[2] and

Whereas, Inclusive sex education should give all students the opportunity to increase awareness, dispel myths and break down stereotypes;[3] and

Whereas, Truly L.G.B.T.-inclusive sex ed weaves the issues of L.G.B.T. people throughout the curriculum without judgment or stigma and creates space for honest discussions of sexual orientation and gender identity; [3] therefore be it

RESOLVED, That our American Medical Association update the policy on Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools to mandate inclusive sexuality education in all schools. (Modify Current HOD Policy)

[1] Pingel, E.S., Thomas, L., Harmell, C. et al. Creating Comprehensive, Youth Centered, Culturally Appropriate Sex Education: What Do Young Gay, Bisexual, and Questioning Men Want? *Sex Res Soc Policy.* 2013;10: 293. https://doi.org/10.1007/s13178-013-0134-5
[2] 2015 National School Climate Survey: LGBTQ students experience discrimination but school systems can make a difference. *GLSEN.* 2015.
[3] Betz, J. Sex Ed Needs to Better Include the Needs of L.G.B.T Students. *New York Times.* 2015. https://www.nytimes.com/roomfordebate/2015/04/28/whats-the-best-way-to-teach-sex-ed-today/sex-ed-needs-to-better-include-the-issues-of-lgbt-students

Fiscal Note: Minimal - less than $1,000.

Received: 05/08/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 429
(A-18)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: E-Cigarette Ingredients

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Cigarettes remain a major health threat to Americans; and

Whereas, Research into the dangers of cigarette smoking was hampered due to the proprietary nature of the ingredients used in cigarettes; and

Whereas, Electronic cigarettes are increasingly marketed toward youth[1]; and

Whereas, Youth who smoke e-cigarettes may be more likely to start smoking standard cigarettes[2]; and

Whereas, Some believe that e-cigarettes may play a role as a smoking-cessation aid[3]; and

Whereas, E-cigarette cartridge makers have refused to reveal the ingredients of their products; and

Whereas, Current e-cigarette labels may not accurately reflect the amount of nicotine inhaled during vaping[2]; and

Whereas, There is evidence that, in addition to nicotine, e-cigarettes release formaldehyde (a probable carcinogen), ethylene glycol, diacetyl and acetyl propionyl (associated with respiratory disease), and other substances not commonly considered to be part of the electronic cigarette liquid[4]; and

Whereas, It is in the interest of public health to avoid repeating the policies of the past in which research into smoking products was hampered to the detriment of our society, both in terms of the health of our society and the considerable economic costs incurred; and

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[1] Murthy, VH. E-Cigarette Use Among Youth and Young Adults: A Major Public Health Concern. JAMA Pediatr 2017;171(3)209-210. doi:10.1001/jamapediatrics.2016.4662.
[2] Soneji S, Barrington-Trimis JL, Wills TA, et al. Association Between Initial Use of e-Cigarettes and Subsequent Cigarette Smoking Among Adolescents and Young Adults: A Systematic Review and Meta-analysis. JAMA Pediatr 2017; 171(8):788-797. doi 10.1001/jamapediatrics.2017.1488.
[3] Yeh, JS, Bullen C, Glantz SA. E-Cigarettes and Smoking Cessation. N Engl J Med 2016; 374:2172-2174. DOI: 10.1056/NEJMclde1602420
[4] Dinakar C and O'Connor GT. The Health Effects of Electronic Cigarettes. N Engl J Med 2016; 375:1372-1381. DOI: 10.1056/NEJMra1502466

Whereas, That research, which depends upon understanding the ingredients in e-cigarette cartridges, is necessary to determine the risks and benefits of the use of e-cigarettes by the public[3], particularly comparing those risks and benefits in current tobacco smokers as opposed to current non-smokers[5]; and

Whereas, Jurisdiction over electronic cigarettes is at the federal, rather than state level; and

Whereas, The Food and Drug Administration has previously indicated its plans to regulate nicotine delivery devices such as e-cigarettes[6]; therefore be it

RESOLVED, That our American Medical Association urge federal officials, including but not limited to the U.S. Food and Drug Administration (FDA), to prohibit the sale of any e-cigarette cartridge that does not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling) (New HOD Policy); and be it further

RESOLVED, That our AMA urge federal officials, including but not limited to the FDA, to require that an accurate nicotine content of e-cigarettes be prominently displayed on the product alongside a warning of the addictive quality of nicotine. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/08/18

[5] Fairchild AL, Lee JS, Bayer R, Curran J. E-Cigarettes and the Harm-Reduction Continuum. N Engl J Med 2018; 378:216-219. DOI 10.1056/NEJMp1711991

[6] Gottlieb S, Woodcock J, Zeller M. Advancing medicinal nicotine replacement therapies as new drugs — a new step in FDA's comprehensive approach to tobacco and nicotine. Silver Spring, MD: Food and Drug Administration, November 29, 2017 (https://blogs.fda.gov/fdavoice/index.php/2017/11/advancing-medicinal-nicotine-replacement-therapies-as-new-drugs-a-new-step-in-fdas-comprehensive-approach-to-tobacco-and-nicotine).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 430
(A-18)

Introduced by: American Academy of Dermatology, Florida, American Society for Dermatologic Surgery Association, Society for Investigative Dermatology, American Society of Dermatopathology, California, Arizona, Mississippi, New Jersey, Maryland, South Carolina, Tennessee, Virginia, District of Columbia, New York, Michigan, Delaware, American Academy of Neurology, Georgia, Alabama, North Carolina, Massachusetts, Wisconsin, West Virginia, American College of Mohs Surgery, Puerto Rico, Kentucky

Subject: Vector-Borne Diseases

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Current AMA policy supports US and global efforts to fight epidemics and pandemics (H-440.835) and

Whereas, The Centers for Disease Control and Prevention (CDC) reported in May 2018 that during the 13-year period from 2004 to 2016, illnesses from mosquito, tick and flea bites have tripled in the United States, and nine new vector-borne human diseases were discovered or introduced; and

Whereas, According to the CDC, “To effectively reduce transmission and respond to outbreaks (of vector-borne diseases) will require major national improvement of surveillance, diagnostics, reporting and vector control, as well as new tools, including vaccines”; and

Whereas, According to the CDC, “The data show that we’re seeing a steady increase and spread of tick-borne diseases, and an accelerating trend of mosquito-borne diseases introduced from other parts of the world. We need to support state and local health agencies responsible for detecting and responding to these diseases and controlling mosquitoes, ticks, and fleas that spread them”; and

Whereas, According to the CDC, “Zika, West Nile, Lyme, and chikungunya—a growing list of diseases caused by the bite of an infected mosquito, tick, or flea—have confronted the US in recent years, making a lot of people sick. And we don’t know what will threaten Americans next. Our Nation’s first lines of defense are state and local health departments and vector control organizations, and we must continue to enhance our investment in their ability to fight against these diseases”; and

Whereas, According to the CDC, “Preventing and responding to vector-borne disease outbreaks are high priorities for CDC and will require additional capacity at state and local levels for tracking, diagnosing, and reporting cases; controlling vectors; and preventing transmission;” and

Whereas, In the United States, the number of tick-borne diseases, including Lyme disease, spotted fever rickettsioses, babesiosis, and anaplasmosis/ehrlichiosis, more than doubled from 2004-2016; and

Whereas, In the United States, the number of mosquito-borne diseases, including West Nile, dengue, Zika and Plague, increased nearly ten-fold from 2004-2016; and

Whereas, Our AMA currently has no policy regarding the emerging healthcare concern of vector-borne diseases; therefore be it

RESOLVED, That our American Medical Association study the emerging epidemic of vector-borne diseases including an analysis of currently available testing and treatment standards and their effectiveness (Directive to Take Action); and be it further

RESOLVED, That our AMA issue a white paper on vector-borne diseases for the purpose of increasing awareness of the epidemic of vector-borne diseases (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for local, state and national research, education, reporting and tracking on vector-borne diseases. (Directive to Take Action)

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

Received: 05/10/18

RELEVANT AMA POLICY

AMA Role in Addressing Epidemics and Pandemics H-440.835
1. Our AMA strongly supports U.S. and global efforts to fight epidemics and pandemics, including Ebola, and the need for improved public health infrastructure and surveillance in affected countries.
2. Our AMA strongly supports those responding to the Ebola epidemic and other epidemics and pandemics in affected countries, including all health care workers and volunteers, U.S. Public Health Service and U.S. military members.
3. Our AMA reaffirms Ethics Policy E-2.25, The Use of Quarantine and Isolation as Public Health Interventions, which states that the medical profession should collaborate with public health colleagues to take an active role in ensuring that quarantine and isolation interventions are based on science.
4. Our AMA will collaborate in the development of recommendations and guidelines for medical professionals on appropriate treatment of patients infected with or potentially infected with Ebola, and widely disseminate such guidelines through its communication channels.
5. Our AMA will continue to be a trusted source of information and education for physicians, health professionals and the public on urgent epidemics or pandemics affecting the U.S. population, such as Ebola.
6. Our AMA encourages relevant specialty societies to educate their members on specialty-specific issues relevant to new and emerging epidemics and pandemics.
Citation: Sub. Res. 925, I-14; Reaffirmed: Res. 418, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 431
(A-18)

Introduced by: American Thoracic Society, American College of Chest Physicians

Subject: Low Nicotine Cigarette Product Standard

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, Regardless of the route of administration, nicotine is a highly addictive substance that has adverse health effects on neurological development and the cardiovascular system; and

Whereas, The 2009 Family Smoking Prevention and Tobacco Control Act gave the Food and Drug Administration authority to regulate all tobacco products, including developing a nicotine product standard for cigarettes; and

Whereas, FDA Commission Scott Gottlieb, MD, has expressed support for developing a cigarette nicotine product standard that would reduce the addictive potential of cigarettes; and

Whereas, Effective regulation will require the development of a nicotine product standard in all tobacco products; and

Whereas, The Food and Drug Administration has issued an advanced notice of proposed rule-making seeking public input on the creation of a nicotine product standard for cigarettes; and

Whereas, A nicotine product standard on cigarettes, without parallel action on other nicotine products – like cigars and e-cigarettes – will not truly address the significant adverse health effects of nicotine addiction; therefore be it

RESOLVED, That our American Medical Association develop a report on the individual health and public health implications of a low nicotine standard for cigarettes. Such a report should consider and make recommendations on scientific criteria for selection of a nicotine standard that is non-addictive, regulatory strategies to ensure compliance with an established standard, and how a low-nicotine standard should work with other nicotine products in a well-regulated nicotine market. (Directive to Take Action)

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

Received: 05/10/18

RELEVANT AMA POLICY

Light and Low-Tar Cigarettes H-495.981

Our AMA concurs with the key scientific findings of National Cancer Institute Monograph 13, Risks Associated with Smoking Cigarettes with Low Machine-Measured Yields of Tar and Nicotine:
(a) Epidemiological and other scientific evidence, including patterns of mortality from smoking-caused diseases, does not indicate a benefit to public health from changes in cigarette design and manufacturing over the last 50 years.
(b) For spontaneous brand switchers, there appears to be complete compensation for nicotine delivery, reflecting more intensive smoking of lower-yield cigarettes. (c) Cigarettes with low machine-measured yields by Federal Trade Commission (FTC) methods are designed to allow compensatory smoking behaviors that enable a smoker to derive a wide range of tar and nicotine yields from the same brand.
(d) Widespread adoption of lower yield cigarettes in the United States has not prevented the sustained increase in lung cancer among older smokers.
(e) Many smokers switch to lower yield cigarettes out of concern for their health, believing these cigarettes to be less risky or to be a step toward quitting; many smokers switch to these products as an alternative to quitting.
(f) Advertising and promotion of low tar cigarettes were intended to reassure smokers who were worried about the health risks of smoking, were meant to prevent smokers from quitting based on those same concerns; such advertising was successful in getting smokers to use low-yield brands.
(g) Existing disease risk data do not support making a recommendation that smokers switch cigarette brands. The recommendation that individuals who cannot stop smoking should switch to low yield cigarettes can cause harm if it misleads smokers to postpone serious attempts at cessation.
(h) Measurements of tar and nicotine yields using the FTC method do not offer smokers meaningful information on the amount of tar and nicotine they will receive from a cigarette.

Our AMA seeks legislation or regulation to prohibit cigarette manufacturers from using deceptive terms such as "light," "ultra-light," "mild," and "low-tar" to describe their products.

CSA Rep. 3, A-04 Reaffirmed in lieu of Res. 421, A-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 432
(A-18)

Introduced by: American Thoracic Society, American College of Chest Physicians

Subject: Legal Action to Compel FDA to Regulate E-Cigarettes

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, The Family Smoking Prevention and Tobacco Control Act of 2009 passed by Congress and signed by the president gave the Food and Drug Administration (FDA) authority to regulate all tobacco products; and

Whereas, The Family Smoking Prevention and Tobacco Control Act established that all products that were introduced in the U.S. market after February 15, 2007 would be considered new products and would need to be reviewed by the FDA under its premarket approval process; and

Whereas, In 2016 the FDA issued a final rule that expressed authority to regulate all tobacco products including e-cigarettes and cigars; and

Whereas, The 2016 FDA deeming rule established a series of time lines for manufacturers to submit product information on cigars and e-cigarettes to begin the FDA pre-market review of these products; and

Whereas, Since its introduction in the U.S., e-cigarettes market has grown into a multi-billion dollar industry; and

Whereas, E-cigarettes are produced in a variety of flavors, including “cotton candy”, “gummy bear”, “peanut butter cup”, “cookies ‘n cream”, “pop rocks” and “unicorn vomit” intended to appeal to youth; and

Whereas, E-cigarettes are now the most commonly used nicotine product by middle school and high school children; and

Whereas, Since the banning of flavored cigarettes, tobacco companies have introduced a new generation of candy flavored cigars, including flavors like “chocolate”, “wild berry”, “watermelon”, “lemonade” and “cherry dynamite”, that are targeted to appeal to youth; and

Whereas, Cigar use has now surpassed cigarette use in middle school and high school children; and

Whereas, The FDA recently issued a multi-year delay in the timeline for tobacco manufacturers to submit product information on cigars and e-cigarettes under the premarket review authority; and

Whereas, The FDA recently issued an advanced notice of proposed rule-making on regulation of cigars and a separate advance notice of proposed rule-making on flavoring agents in tobacco products; and

Whereas, The two advance notice of proposed rule makings appear to ignore the public comments and final determination made by FDA on cigars and tobacco flavoring agents under the 2016 FDA deeming rule; and

Whereas, The American Academy of Pediatrics, the American Lung Association and other public health groups has filed suit in federal court to compel the FDA to take swift action to regulate cigars and e-cigarettes; and

Whereas, The American Thoracic Society will file an amicus brief in support of the petitioner's case to seek court action to compel FDA to take swift action to regulate cigars and e-cigarettes products; therefore be it

RESOLVED, That our American Medical Association consider joining other medical organizations in an amicus brief supporting the American Academy of Pediatrics legal action to compel the U.S. Food and Drug Administration to take timely action to establish effective regulation of e-cigarettes, cigars and other nicotine tobacco products. (Directive to Take Action)

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

Received: 05/10/18

RELEVANT AMA POLICY

FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products H-495.973
Our AMA: (1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act; and (2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 18; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth.
Res. 206, I-13 Modified in lieu of Res. 511, A-14 Modified in lieu of Res. 518, A-14 Modified in lieu of Res. 519, A-14 Modified in lieu of Res. 521, A-14 Modified: CSAPH Rep. 2, I-14 Reaffirmation A-15 Reaffirmed in lieu of Res. 412, A-15 Reaffirmed in lieu of Res. 419, A-15 Reaffirmed: Res. 421, A-15 Reaffirmation A-16

See also: Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes H-495.986

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 433
(A-18)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont

Subject: Firearm Safety

Referred to: Reference Committee D
(Shannon Kilgore, MD, Chair)

Whereas, The United States has about 25 times the incidence of gun homicides than other high income countries and on an average day 96 Americans are killed with guns including 7 children and teens;[i] and

Whereas, United States citizens are 51 times more likely to be killed by firearms than people in Great Britain;[ii] and

Whereas, In Australia there were four mass shootings between 1987 and 1996, and Australia then passed restrictive gun laws including banning assault rifles and there have been no mass shootings in Australia since;[iii] and

Whereas, In the United States we have been plagued by mass shootings with assault weapons with high capacity magazines and high velocity bullets including 17 killed in Parkland, FL in February 2018; 26 killed in Sutherland Springs, TX in November 2017; 58 killed in Las Vegas, NV in October 2017 with bump stock addition to assault weapons; 49 killed in Orlando, FL in June 2016; 14 killed in San Bernardino, CA in December 2015; 27 killed in Newtown, CT in December 2012; and 12 killed in Aurora, CO in July 2012; and

Whereas, States with shall-issue laws permitting concealed carry (in contrast to may-issue laws) have 10.6 % higher handgun homicide rates;[iv] and

Whereas, In an average month 50 women in the United States are shot to death by intimate partners;[v] and

Whereas, There are often warning signs that individuals are harboring violent intentions to harm themselves or others, and five states (CA, CO, IN, WA and OR) have enacted “red flag” laws that empower relatives and close friends as well as law enforcement officers to ask judges to issue “gun violence restraining orders;” therefore be it

RESOLVED, That our American Medical Association adopt the following firearm safety policies:

1. Amend Policy H-145.993, "Restriction of Assault Weapons," by addition to read as follows:

> Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon and ban the sale and ownership to the American public of all assault-type weapons, bump stocks and related devices, high capacity magazines of more than 10 bullets, and high-velocity and armor piercing bullets.

2. Require the licensing of owners of firearms including completion of a required safety course and registration of all firearms.

3. Support local law enforcement in the permitting process in such that local police chiefs are empowered to make permitting decisions regarding "concealed carry", by supporting "gun violence restraining orders" for individuals arrested or convicted of domestic violence or stalking, and by supporting "red-flag" laws for individuals who have demonstrated significant signs of potential violence. In supporting local law enforcement, we support as well as the importance of "due process" so that decisions could be reversible by individuals petitioning in court for their rights to be restored. (New HOD Policy)

Fiscal Note: Minimal - less than $1,000.

Received: 05/08/18

RELEVANT AMA POLICY

Restriction of Assault Weapons H-145.993
Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as "Saturday night specials," and large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon.
Citation: Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17

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[i] Grinshteyn E., Hemenway D. *Violent Death Rates: The US Compared with Other High-income OECD Countries*, 2010. Am J Med. 2016 Mar;129(3):266-73.

[ii] Richardson, Erin G., and David Hemenway, *Homicide, Suicide, and Unintentional Firearm Fatality: Comparing the United States With Other High-Income Countries*; 2003. Journal of Trauma, Injury, Infection, and Critical Care. June 2010.

[iii] Rebecca Peters & Charles Watson, *A Breakthrough in Gun Control in Australia After the Port Arthur Massacre*, 2 Inj. Prev. 253 (1996), http://injuryprevention.bmj.com/content/2/4/253.full.pdf. For a recent discussion of the processes and impacts associated with these changes, see John Howard, *I Went After Guns. Obama Can Too*, NY Times (Jan. 16, 2013), http://www.nytimes.com/2013/01/17/opinion/australia-banned-assault-weapons-america-can-too.html?smid=fb-nytimes.

[iv] Siegel M, Xuan Z, Ross CS, Galea S, Kalesan B, Fleegler E, Goss K. *Easiness of Legal Access to Concealed Firearm Permits and Homicide Rates in the United States*. American Journal of Public Health. 2017:107:61-67.

[v] Everytown for Gun Safety Support Fund. https://everytownresearch.org/gun-violence-by-the-numbers/ 3-13-18.