

Reference Committee E

CSAPH Report(s)

01 CSAPH Sunset Review of 2009 House of Delegates Policies

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REPORT OF THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSAPH Report 1-A-19

Subject: CSAPH Sunset Review of 2009 House of Delegates Policies

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Referred to: Reference Committee E
(Leslie H. Secrest, 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.

1 In this report, the Council on Science and Public Health (CSAPH) presents its recommendations on
2 the disposition of the HOD policies from 2009 that were assigned to it. The CSAPH's
3 recommendations on policies are presented in the Appendix to this report.
4

5 RECOMMENDATION
6

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

Fiscal Note: Less than \$500

APPENDIX: Recommended Actions on 2009 House Policies and Directives

Number	Title	Recommended Action and Rationale
D-100.974	The Use of Hormones for Anti-Aging: A Review of Efficacy and Safety	Rescind. Accomplished.
D-130.968	Standards of Care During a Mass Casualty Event	<p>Retain in part to read as follows and change to an H-policy:</p> <ol style="list-style-type: none"> 1. Our American Medical Association acknowledges that, in a mass casualty event, adjustments in the current health and medical care standards may be necessary to ensure that the care provided results in saving as many lives as possible. 2. Our AMA will: (a) continue to participate with relevant stakeholders to develop and disseminate guidance on the issue of the appropriate standard of care in a mass casualty event; (b) encourage state and specialty medical societies to work with state departments of health and other stakeholders as they develop guidance on allocating scarce resources and establishing the standard of care; and (c) encourage the creation of an adequate legal framework at the local, state, and federal levels for providing health and medical care in a mass casualty situation. <p>Citation: (BOT Rep. 2, I-09)</p>
D-135.982	Regulation of Endocrine Disrupting Chemicals	Retain and change to H-policy.
D-135.983	Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)	Rescind. Include the specific standards outlined in this directive to H-135.946, "Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)".
D-150.979	Appropriate Supplementation of Vitamin D	<p>Retain in part to read as follows and change to an H-policy: Our AMA:</p> <ol style="list-style-type: none"> 1. supports continued research on vitamin D and its metabolites, particularly long-term studies that address the benefits, adverse outcomes, and potential confounders across all life stage groups; 2. will educate physicians about the evolving science of vitamin D and its impact on health and develop resources about vitamin D for patients; 3. encourages physicians to consider measuring the serum concentration of 25-hydroxyvitamin D in patients at risk of vitamin D deficiency and counsel those with deficient or insufficient levels on ways to improve their vitamin D status; and 4. will monitor the development of new dietary references intakes for vitamin D in 2010 and respond as appropriate.

Number	Title	Recommended Action and Rationale
D-350.990	Next Steps Following AMA Apology to African American Physicians	Retain in part to read as follows and change the title to more accurately represent the language in the policy: Next Steps Following AMA Apology to African American Physicians <u>Collaboration with the National Medical Association to Address Health Disparities</u> Our American Medical Association will continue to work with the National Medical Association on issues of common concern, that include opportunities to increase underrepresented minorities in the health care professional pipeline including leadership roles and will continue to support the Commission to End Health Care Disparities efforts to increase the cultural competence of clinicians, and reduce health disparities. Citation: (BOT Action in response to referred for decision Res. 606, A-09)
D-440.995	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Rescind. Accomplished.
D-450.968	Best Practices for Patients with Chronic Diseases	Rescind. Accomplished.
D-460.990	Science, Policy Implications, and Current AMA Position Regarding Embryonic/Pluripotent Stem Cell Research and Funding	Retain. Still relevant.
D-460.993	Support of Embryonic Stem Cell Research	Retain with change in title. Convert to an H policy. <u>Support of Embryonic/Pluripotent Stem Cell Research</u>
D-460.996	Medical Genetics	Retain. Still relevant.
D-460.999	Support for Upgrading and Expanding Medical Research Facilities	Rescind. Accomplished by 42 USC 283k(c)2.
D-480.979	Ultrasound Contrast Agents	Retain. Still relevant.
D-515.982	Promoting Physician Awareness of the Correlation Between Domestic Violence and Child Abuse	Retain. Still relevant.
D-60.973	Prevention of Underage Drinking: A Call to Stop Alcoholic Beverages with Special Appeal to Youths	Retain in part to read as follows: 1. Our AMA will advocate for a ban on the marketing of products such as <u>flavored malt liquor beverages</u> aleopops , gelatin-based alcohol products, food-based alcohol products, alcohol mists, and beverages that contain alcohol and caffeine and other additives to produce alcohol energy drinks that have special appeal to youths under the age of 21 years of age. 2. Our AMA supports state and federal regulations that would reclassify Aleopops <u>flavored malt liquor</u>

Number	Title	Recommended Action and Rationale
		<u>beverages</u> as a distilled spirit so that it can be taxed at a higher rate and cannot be advertised or sold in certain locations.
D-95.996	Consensus Statement of the Physician Leadership on National Drug Policy	Retain in part to read as follows and change to an H-policy: Our AMA endorses <u>supports</u> the 1997 Consensus Statement of the Physicians <u>and Lawyers for Leadership</u> on National Drug Policy as a rational approach to informing national drug policy on illegal drugs.
D-95.997	Altered Illicit Substances	Retain. Still relevant.
D-95.999	Reduction of Medical and Public Health Consequences of Drug Abuse: Update	Retain. Still relevant.
H-10.968	Public Health Impact on Railroads	Retain. Still relevant.
H-100.962	The Use of Hormones for Anti-Aging: A Review of Efficacy and Safety	Retain. Still relevant.
H-100.969	Assuring the Safety and Quality of Foreign-Produced Pharmaceuticals	Retain. Still relevant.
H-125.989	Opposition to Payment for Prescription-Switching	Retain. Still relevant.
H-135.941	Air Pollution and Public Health	Retain. Still relevant.
H-135.946	Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)	Retain with the addition of the specific standards included in D-135.983, "Protective NAAQS Standard for Fine Particulate Matter (PM 2.5)." Our AMA supports more stringent air quality standards for particulate matter than those proposed by the EPA Administrator. This position is supported by several medical specialty societies. <u>We specifically request a NAAQS that provides improved protection for our patients which includes:</u> - 12 µg/m3 for the average annual standard - 25 µg/m3 for the 24-hour standard - 99th percentile used for compliance determination
H-135.979	Clean Air	Retain. Still relevant.
H-145.979	Prevention of Unintentional Shooting Deaths Among Children	Retain. Still relevant.
H-15.958	Fatigue, Sleep Disorders, and Motor Vehicle Crashes	Retain in part to read as follows: Our AMA: (1) defines <u>recognizes</u> sleepiness behind the wheel as a major public health issue and <u>continues to</u> encourage a national public education campaign by appropriate federal agencies and relevant advocacy groups;

Number	Title	Recommended Action and Rationale
		<p>(2) recommends that the National Institutes of Health and other appropriate organizations support research projects to provide more accurate data on the prevalence of sleep-related disorders in the general population and in motor vehicle drivers, and provide information on the consequences and natural history of such conditions.</p> <p>(3) recommends that the U.S. Department of Transportation (DOT) and other responsible agencies continue studies on the occurrence of highway crashes and other adverse occurrences in transportation that involve reduced operator alertness and sleep.</p> <p>(4) encourages continued collaboration between the DOT and the transportation industry to support research projects for the devising and effectiveness-testing of appropriate countermeasures against driver fatigue, including technologies for motor vehicles and the highway environment.</p> <p>(5) urges responsible federal agencies to improve enforcement of existing regulations for truck driver work periods and consecutive working hours and increase awareness of the hazards of driving while fatigued. If changes to these regulations are proposed on a medical basis, they should be justified by the findings of rigorous studies and the judgments of persons who are knowledgeable in ergonomics, occupational medicine, and industrial psychology.</p> <p>(6) recommends that physicians: (a) become knowledgeable about the diagnosis and management of sleep-related disorders; (b) investigate patient symptoms of drowsiness, wakefulness, and fatigue by inquiring about sleep and work habits and other predisposing factors when compiling patient histories; (c) inform patients about the personal and societal hazards of driving or working while fatigued and advise patients about measures they can take to prevent fatigue-related and other unintended injuries; (d) advise patients about possible medication-related effects that may impair their ability to safely operate a motor vehicle or other machinery; (e) inquire whether sleepiness and fatigue could be contributing factors in motor vehicle-related and other unintended injuries; and (f) become familiar with the laws and regulations concerning drivers and highway safety in the state(s) where they practice.</p> <p>(7) encourages all state medical associations to promote the incorporation of an educational component on the dangers of driving while sleepy in all drivers education classes (for all age groups) in each state.</p> <p>(8) recommends that <u>states adopt regulations</u> guidelines be developed for the licensing of commercial and private drivers with sleep-related and other medical</p>

Number	Title	Recommended Action and Rationale
		<p>disorders according to the extent to which persons afflicted with such disorders experience crashes and injuries.</p> <p>(9) reiterates its support for physicians' use of E-codes in completing emergency department and hospital records, and urges collaboration among appropriate government agencies and medical and public health organizations to improve state and national injury surveillance systems and more accurately determine the relationship of fatigue and sleep disorders to motor vehicle crashes and other unintended injuries.</p> <p>Citation: (CSA Rep. 1, A-96; Appended: Res. 418, I-99; Reaffirmed: CSAPH Rep. 1, A-09)</p>
H-15.999	Automobile Safety Standards	Retain. Still relevant.
H-150.945	Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants	Retain. Still relevant.
H-150.952	Point-of-Sale Warning Signs Regarding Consumption of Raw Shellfish	Retain. Still relevant.
H-160.928	Drug Initiation or Modification by Pharmacists	Retain. Still relevant.
H-160.938	Disease-Specific Self-Management Programs	Retain. Still relevant.
H-170.962	An Updated Review of Sex Education Programs in the United States	Rescind. Covered by H-170.968, "Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools".
H-170.977	Comprehensive Health Education	<p>Retain in part to read as follows:</p> <p>(1) Educational testing to confirm understanding of health education information should be encouraged. (2) The AMA accepts the CDC guidelines on comprehensive health education. The CDC defines its concept of comprehensive school health education as follows: (a) a documented, planned, and sequential program of health education for students in grades <u>pre</u> - kindergarten through 12; (b) a curriculum that addresses and integrates education about a range of categorical health problems and issues (e.g., human immunodeficiency virus (HIV) infection, drug <u>misuse</u> abuse, drinking and driving, emotional health, environmental pollution) at developmentally appropriate ages; (c) activities to help young people develop the skills they will need to avoid: (i) behaviors that result in unintentional and intentional injuries; (ii) drug and alcohol <u>misuse</u> abuse; (iii) tobacco use; (iv) sexual behaviors that result in HIV infection, other sexually transmitted diseases, and unintended</p>

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		pregnancies; (v) imprudent dietary patterns; and (vi) inadequate physical activity; (d) instruction provided for a prescribed amount of time at each grade level; (e) management and coordination in each school by an education professional trained to implement the program; (f) instruction from teachers who have been trained to teach the subject; (g) involvement of parents, health professionals, and other concerned community members; and (h) periodic evaluations, updating, and improvement.
H-20.896	Support of a National HIV/AIDS Strategy	Retain in part to read as follows: Our AMA supports the creation of a National HIV/AIDS strategy, and will work with the White House Office of National AIDS Policy, the Coalition for a National HIV/AIDS Strategy, and other relevant stakeholders <u>bodies to develop a update and implement the National HIV/AIDS strategy.</u>
H-245.973	Standardization of Newborn Screening Programs	Retain. Still relevant.
H-250.989	Screening Nonimmigrant Visitors to the United States for Tuberculosis	Retain with a change in title. Screening Nonimmigrant Visitors to the United States for <u>Global Tuberculosis Control</u>
H-280.952	CMS Interim Final Rule on the Use of Seclusion and Restraints	Retain. Still relevant.
H-280.959	Recycling of Nursing Home Drugs	Retain. Still relevant.
H-345.999	Statement of Principles on Mental Health	Retain in part to read as follows: (1) Tremendous strides have already been made in improving the care and treatment of the emotionally disturbed patients with psychiatric illness , but much remains to be done. The mental health field is vast and includes a network of factors involving the life of the individual, the community and the nation. Any program designed to combat mental <u>psychiatric</u> illness and promote mental health must, by the nature of the problems to be solved, be both ambitious and comprehensive. (2) The AMA recognizes the important stake every physician, regardless of type of practice, has in improving our mental health knowledge and resources. The physician participates in the mental health field on two levels, as an individual of science and as a citizen. The physician has much to gain from a knowledge of

Number	Title	Recommended Action and Rationale
		<p>modern psychiatric principles and techniques, and much to contribute to the prevention, handling and management of emotional disturbances. Furthermore, as a natural community leader, the physician is in an excellent position to work for and guide effective mental health programs.</p> <p>(3) The AMA will be more active in encouraging physicians to become leaders in community planning for mental health.</p> <p>(4) The AMA has a deep interest in fostering a general attitude within the profession and among the lay public more conducive to solving the many problems existing in the mental health field.</p>
H-350.958	Hispanic Population and Access to the US Healthcare System	Rescind. Policy H-160.931 Part 2 covers this topic.
H-350.959	Guiding Principles for Eliminating Racial and Ethnic Health Care Disparities	Rescind. This policy adopted the guiding principles of the Commission to End Health Care Disparities. Since the Commission no longer exists, it does not make sense to keep a policy that references their guiding principles.
H-420.971	Infant Victims of Substance Abuse	Retain. Still relevant.
H-420.974	Warnings Against Alcohol Use During Pregnancy	Retain. Still relevant.
H-440.857	Placement of Alcohol-Based Hand Sanitizer Dispensers in Highly Trafficked Areas	Retain. Still relevant.
H-440.858	Disease Transmission Via Foods: Public Health Disaster in Waiting	Retain. Still relevant.
H-440.927	Tuberculosis	<p>Retain in part to read as follows with a change in title:</p> <p><u>Tuberculosis Control Measures</u></p> <p>Public Health Policy, Compliance and Coercion: The AMA: (1) supports <u>state and local health authorities'</u> the initiative of public health authorities to modernize the health codes of their states on tuberculosis (TB) control programs, including specific authorization for implementation of control orders a Commissioner-ordered program of directly observed therapy for tuberculosis when patient compliance poses a risk to the public;</p> <p>(2) supports the view that directly observed therapy for tuberculosis TB <u>TB</u> for newly discharged patients from hospitals is seen as desirable routine policy for community control against the evolution of multi-drug resistant strains;</p> <p>(3) supports the view that, <u>recognizes in cases where</u></p>

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		<p>when coercive examination, evaluation, treatment or detention are deemed seen as necessary by public health authorities, each decision should be individualized and subject to due process; and</p> <p>(4) recognizes that the control of tuberculosis (TB) in the foreign-born population is critical to the elimination of TB in the United States, and supports current Centers for Disease Control and Prevention (CDC) recommendations on the prevention and control of TB among foreign-born persons.</p>
H-440.958	Universal Immunization for Hepatitis B Virus	<p>Retain in part to read as follows:</p> <p>For enhanced effectiveness in decreasing the incidence of hepatitis B in the United States, it appears to be necessary to broaden current immunization strategies. Safe and effective vaccines are available for prevention of the disease but this use is limited by cost. Eradication of the disease on a national and international basis is a definite hope, but may not be possible without the development of antiviral treatments to control or eliminate the virus in the carrier state and in infected vaccine nonresponders. Education about the disease and its transmission is an essential element for any effective program to reduce the incidence of hepatitis B. Therefore,</p> <p>(1) The AMA supports endorses the principle of the universal immunization with hepatitis B vaccine of all infants, adolescents, military recruits, and students entering colleges and technical schools. While the ultimate goal is the complete immunization of all these groups, the process will need to be a gradual one beginning with the immunization of high risk groups and then the phasing in of infants, adolescents, and the other groups. the recommendations of Advisory Committee on Immunization Practice for the prevention of Hepatitis B.</p> <p>(2) The AMA encourages the immunization of all students entering medical school. The costs for the immunizations should be included in the school tuition.</p> <p>(3) The Association supports the immunization of all other risk groups with special emphasis on patients attending sexually transmitted disease clinics and drug rehabilitation centers.</p> <p>(4) (3) The AMA Association supports the proposed regulation of OSHA requiring the vaccination of all healthcare workers at risk of hepatitis B virus infection.</p> <p>(5) (4) The AMA Association encourages further professional and public education on hepatitis B disease, its transmission, and prevention. Such education should include state and federal legislators</p>

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		and emphasize the need for funding for immunization programs. In addition, education concerning hepatitis B should be a part of every sex and AIDS education course in the nation. (6) The Association encourages the scientific community to intensify its efforts to find effective therapies for patients infected with hepatitis B virus. (7) (5) The AMA Association encourages the U.S. Public Health Service and the World Health Organization to develop strategies for the elimination of hepatitis B both nationally and globally.
H-440.983	Update on Sexually Transmitted Infections	Retain. Still relevant.
H-45.977	Flu Protection Guidelines for Air Travel	Retain. Still relevant.
H-45.983	Medical Oxygen Therapy on Scheduled Commercial Air Service	Retain. Still relevant.
H-45.997	In-Flight Emergency Care	Retain. Still relevant.
H-450.952	Regional Input Into the Accreditation Process	Retain. Still relevant.
H-460.920	Public Access to Unpublished Research Data	Retain. Still relevant.
H-460.971	Support for Training of Biomedical Scientists and Health Care Researchers	Retain. Still relevant.
H-460.976	Congressional Earmarking of Federal Research Funds	Retain. Still relevant.
H-460.977	Proposed Moratorium on New Animal Patents	Retain. Still relevant.
H-460.994	Support for Careers in Research	Retain. Still relevant.
H-460.995	Support for Careers in Research	Retain. Still relevant.
H-470.962	Cardiovascular Preparticipation Screening of Student Athletes	Retain. Still relevant.
H-470.973	Boxing as an Olympic Sport	Retain. Still relevant.
H-470.980	Hazards of Boxing	Rescind. Covered by H-470.983, "Boxing as a Health Hazard," and H-470.984, "Brain Injury in Boxing".
H-478.990	Tobacco Control Content in Electronic Health Records	Retain. Still relevant.
H-480.972	Medical Device Safety and Physician Responsibility	Retain. Still relevant.
H-495.975	Reducing Tobacco Consumption in the Territory of Guam	Rescind. AMA policy supporting tobacco taxes applies to all jurisdictions.
H-5.997	Violence Against Medical Facilities and Health Care	Retain. Still relevant.

Number	Title	Recommended Action and Rationale
	Practitioners and Their Families	
H-50.979	Use of Blood Therapeutically Drawn from Hemochromatosis Patients	Retain. Still relevant.
H-515.965	Family and Intimate Partner Violence	<p>Retain in part to read as follows:</p> <p>(1) Our AMA believes that all forms of family and intimate partner violence (<u>IPV</u>) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of victims <u>survivors</u>. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against family violence and remains open to working with all interested parties to address violence in US society. Our AMA's efforts will be guided, in part, by its Advisory Council on Family Violence.</p> <p>(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula when developed. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist victims <u>survivors</u>. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.</p> <p>(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter victims <u>survivors</u> on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians</p>

Number	Title	Recommended Action and Rationale
		<p>to:</p> <p>(a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care;</p> <p>(b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course;</p> <p>(c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible;</p> <p>(d) Have written lists of resources available for victims <u>survivors</u> of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid;</p> <p>(e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence;</p> <p>(f) Become aware of local resources and referral sources that have expertise in dealing with trauma from victimization <u>IPV</u>;</p> <p>(g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either victims <u>survivors</u> or abusers themselves;</p> <p>(h) Give due validation to the experience of <u>IPV</u> victimization and of observed symptomatology as possible sequelae;</p> <p>(i) Record a patient's <u>IPV</u> victimization history, observed traumata potentially linked to the IPV <u>victimization</u>, and referrals made;</p> <p>(j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level;</p> <p>(4) Within the larger community, our AMA: (a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all victims <u>survivors</u> of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters. (b) Believes it is critically important that programs be available for victims <u>survivors</u> and perpetrators of intimate violence. (c) Believes that state and county medical societies should convene or join state and local health</p>

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		<p>departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.</p> <p>(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA opposes the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult victims <u>survivors</u> of intimate partner violence if the required reports identify victims <u>survivors</u>. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the laws must incorporate provisions that: (a) do not require the inclusion of victims' <u>survivors'</u> identities;</p> <p>(b) allow competent adult victims <u>survivors</u> to opt out of the reporting system if identifiers are required;</p> <p>(c) provide that reports be made to public health agencies for surveillance purposes only;</p> <p>(d) contain a sunset mechanism; and</p> <p>(e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states.</p> <p>(6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that: (a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.</p> <p>(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.</p> <p>(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.</p> <p>(d) Physicians should be informed about the possible</p>

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		pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior. (e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.
H-55.977	Male Breast Cancer	Retain. Still relevant.
H-60.946	Need for Adequate Training of Teachers to Identify Potentially Dangerous Children and the Provision of Adequate Insurance Coverage to Provide for their Treatment	Retain. Still relevant.
H-90.974	Opposition to Obesity as a Disability	Retain. Still relevant.
H-95.955	Physician Impairment	Retain in part to read as follows: (1) The AMA defines physician impairment as any physical, mental or behavioral disorder that interferes with ability to engage safely in professional activities and will address all such conditions in its Physician Health Program. (2) The AMA encourages state medical society-sponsored physician health and assistance programs to take appropriate steps to address the entire range of <u>illnesses with the potential to cause impairment</u> problems that affect physicians, to develop case finding mechanisms for all types of physician impairments, and to collect data on the prevalence of conditions affecting physician health. (3) The AMA encourages additional research in the area of physician <u>illness with the potential to cause impairment</u> , particularly in the type and impact of external factors adversely affecting physicians, including workplace stress, litigation issues, and restructuring of the health care delivery systems.
H-95.962	Inhalant Abuse	Retain. Still relevant.
H-95.975	Substance Use Disorders as a Public Health Hazard	Retain. Still relevant.
H-95.976	Drug Abuse in the United States – the Next Generation	Retain in part with a change in title to read as follows: Drug Abuse in the United States – the Next Generation <u>Addiction and Unhealthy Substance Use</u> Our AMA is committed to efforts that can help <u>the</u>

Number	Title	Recommended Action and Rationale
		<p>this national problem of <u>addiction and unhealthy substance use</u> from becoming a chronic burden. The AMA pledges its continuing involvement in programs to alert physicians and the public to the dimensions of the problem and the most promising solutions. The AMA, therefore:</p> <p>(1) supports cooperation in activities of organizations such as the National Association for Perinatal Addiction Research and Education (NAPARE) in fostering education, research, prevention, and treatment of <u>substance abuse addiction</u>;</p> <p>(2) encourages the development of model substance abuse addiction treatment programs, complete with an evaluation component that is designed to meet the special needs of pregnant women and women with infant children through a comprehensive array of essential services;</p> <p>(3) urges physicians to routinely provide, at a minimum, a historical screen for all pregnant women, and those of childbearing age for substance abuse and to follow up positive screens with appropriate counseling, interventions and referrals;</p> <p>(4) supports pursuing the development of educational materials for physicians, physicians in training, other health care providers, and the public on prevention, diagnosis, and treatment of perinatal addiction. In this regard, the AMA encourages further collaboration with the Partnership for a Drug-Free America in delivering appropriate messages to health professionals and the public on the risks and ramifications of perinatal drug and alcohol use;</p> <p>(5) urges the National Institute on Drug Abuse, the National Institute on Alcohol Abuse and Alcoholism, and the <u>Substance Abuse and Mental Health Services Administration</u> Federal Office for Substance Abuse Prevention to continue to support research and demonstration projects around effective prevention and intervention strategies;</p> <p>(6) urges that public policy be predicated on the understanding that alcoholism and drug dependence, including tobacco dependence <u>use disorder</u> as indicated by the Surgeon General's report, are diseases characterized by compulsive use in the face of adverse consequences;</p> <p>(7) affirms the concept that <u>substance abuse addiction</u> is a disease and supports developing model legislation to appropriately address perinatal addiction as a disease, bearing in mind physicians' concern for the health of the mother, the fetus and resultant offspring; and</p>

Number	Title	Recommended Action and Rationale
		(8) calls for better coordination of research, prevention, and intervention services for women and infants at risk for both HIV infection and perinatal addiction.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 501
(A-19)

Introduced by: Virginia; American Association of Clinical Urologists; American College of Allergy, Asthma and Immunology; Kansas; South Carolina; Louisiana; Maryland

Subject: USP 800

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, USP <800> becomes effective December 1, 2019 and describes hazardous drug handling related to the receipt, storage, compounding, dispensing, administration, and disposal of both sterile and nonsterile products and preparations in all locations including physician offices; and

Whereas, USP <800> is mainly applicable to large pharmacies and hospitals which employ pharmacists, pharmacy technicians, etc.; and

Whereas, United States Pharmacopeia (USP) standards such as USP <800> are enforced by local, state and federal regulatory agencies such as The Joint Commission, the US Food and Drug Administration, the Centers for Medicare and Medicaid Services, and some state licensing boards; and

Whereas, The National Institute for Occupational Safety and Health (NIOSH) develops risk assessment levels for antineoplastic and other hazardous drugs in healthcare settings; and

Whereas, There is some debate about the NIOSH categorization of some medications previously given safely in the office setting; and

Whereas, USP expressly defined administration as the mixing or reconstituting of a drug according to manufacturers' recommendations for a single patient for immediate use in USP Chapter 797 update to be published on June 1, 2019 in the USP-NF, a combination of two compendia, the United States Pharmacopeia (USP) and the National Formulary (NF); and

Whereas, USP defines compounding as the mixing of two or more FDA-approved drugs or ingredients, with exceptions; and

Whereas, National specialty societies can develop white papers/best practices for the safe and appropriate handling of medications utilized in physician offices and systems for ongoing monitoring of potential complications; and

Whereas, If all of the new USP <800> requirements for preparation of medications in the office setting are implemented December 1, 2019, patient access to proven therapies will decrease, costs will increase, and patient harm may result from not receiving needed treatment in a timely manner; therefore be it

1 RESOLVED, That our American Medical Association adopt as policy that physicians and other
2 health care providers administering medications (defined as the mixing or reconstituting of a
3 drug according to manufacturers' recommendations for a single patient for immediate use) not
4 be subject to the USP 800 compounding guidance (New HOD Policy); and be it further
5

6 RESOLVED, That our AMA support development of specialty specific white papers/best
7 practices and systems for both safe medication administration practices and ongoing monitoring
8 of potential complications from the administration of medications deemed suitable for
9 exemptions from the National Institute for Occupational Safety and Health, United States
10 Pharmacopeia, and other regulatory bodies when used in an office setting under the direction of
11 a licensed physician (New HOD Policy); and be it further
12

13 RESOLVED, That our AMA continue its working group, consisting of national specialty
14 organizations, state medical societies and other stakeholders to advocate for such exemptions.
15 (Directive to Take Action)

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

Received: 03/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 502
(A-19)

Introduced by: Young Physicians Section

Subject: Destigmatizing the Language of Addiction

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Addiction is a chronic brain disease¹ and is the most severe form of substance use disorder, a chronic medical illness with potential for both relapse and recovery²; and

Whereas, Substance use disorder has been recognized by our AMA as a treatable disease³; and

Whereas, 20.1 million Americans have a substance use disorder and only 6.9% receive treatment⁴ and 1 in 7 people in the United States will develop a substance use disorder over the course of their lifetime²; and

Whereas, Substance use disorder has historically been viewed as a moral failing and social problem rather than a chronic medical illness; and

Whereas, Treatment of substance use disorders has been siloed from mainstream healthcare and patients with substance use disorders have been subjected to discrimination and stigma by the healthcare system and healthcare providers; and

Whereas, Language related to substance use disorders shapes attitudes among healthcare professionals towards patients with addiction and commonly used terms like substance abuse and drug abuser explicitly and implicitly convey that patients are at fault for their disease⁵ and influence perceptions and judgments even among highly trained, experienced healthcare professionals⁶; and

Whereas, Negative attitudes among healthcare professionals regarding patients with substance use disorders are linked with reduced empathy and engagement with patients, reduced delivery of evidence-based treatment services and poorer patient outcomes⁷; and

Whereas, Existing AMA policy calls for our AMA to take a positive stance as the leader in matters concerning substance use disorders, including addiction⁸ and to assist in reducing the stigma associated with substance use^{3,9}; and

¹ Volkow ND, Koob GF, McLellan AT. Neurobiologic Advances from the Brain Disease Model of Addiction. N Engl J Med 2016; 374:363-371.

² U.S. Department of Health and Human Services (HHS), Office of the Surgeon General, Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health. Washington, DC: HHS, November 2016.

³ AMA Policy, Substance Use and Substance Use Disorders D-95.922

⁴ Substance Abuse and Mental Health Services Administration. (2017). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from <https://www.samhsa.gov/data/>.

⁵ Botticelli MP, Koh HK. Changing the Language of Addiction. JAMA 2016;316(13):1361-1362.

⁶ Wakeman SE, Pham-Kanter G, Donelan K. Attitudes, practices, and preparedness to care for patients with substance use disorder: Results from a survey of general internists. Substance Abuse 2016;37(4):635-641.

⁷ van Boekel LC, Brouwers EPM, van Weeghel J, Garretsen HFL. Stigma among health professionals towards patients with substance use disorders and its consequences for healthcare delivery: Systematic review. Drug and Alcohol Dependence 2013;131:23– 35.

⁸ AMA Policy, Substance Use Disorders as a Public Health Hazard H-95.975

⁹ AMA Policy, Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

Whereas, According to the U.S. Surgeon General², clinically accurate, preferred terms include “substance use,” “substance misuse,” “substance use disorder,” “recovery,”³ while non-preferred, stigmatizing terms include “substance abuse,” “drug abuser,” “addict,” “alcoholic,” and “clean” or “dirty”; and

Whereas, AMA PolicyFinder includes a topic heading called “drug abuse” and contains over 70 active policy statements that use non-clinically accurate, stigmatizing terminology, because it has not been recognized by our AMA that such terminology can negatively impact physician attitudes and compromise patient care^{6,7}; therefore be it

RESOLVED, That our American Medical Association use clinically accurate, non-stigmatizing terminology (substance use disorder, substance misuse, recovery, negative/positive urine screen) in all future resolutions, reports, and educational materials regarding substance use and addiction and discourage the use of stigmatizing terms including substance abuse, alcoholism, clean and dirty (New HOD Policy); and be it further

RESOLVED, That our AMA and relevant stakeholders create educational materials on the importance of appropriate use of clinically accurate, non-stigmatizing terminology and encourage use among all physicians and U.S. healthcare facilities. (Directive to Take Action)

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

Received: 04/04/19

RELEVANT AMA POLICY

Substance Use and Substance Use Disorders H-95.922

Our AMA:

- (1) will continue to seek and participate in partnerships designed to foster awareness and to promote screening, diagnosis, and appropriate treatment of substance misuse and substance use disorders;
- (2) will renew efforts to: (a) have substance use disorders addressed across the continuum of medical education; (b) provide tools to assist physicians in screening, diagnosing, intervening, and/or referring patients with substance use disorders so that they have access to treatment; (c) develop partnerships with other organizations to promote national policies to prevent and treat these illnesses, particularly in adolescents and young adults; and (d) assist physicians in becoming valuable resources for the general public, in order to reduce the stigma and enhance knowledge about substance use disorders and to communicate the fact that substance use disorder is a treatable disease; and
- (3) will support appropriate federal and state legislation that would enhance the prevention, diagnosis, and treatment of substance use disorders.

Citation: CSAPH Rep. 01, A-18

Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction D-95.981

1. Our AMA:

- a. will collaborate with relevant medical specialty societies to develop continuing medical education curricula aimed at reducing the epidemic of misuse of and addiction to prescription controlled substances, especially by youth;
- b. encourages medical specialty societies to develop practice guidelines and performance measures that would increase the likelihood of safe and effective clinical use of prescription controlled substances, especially psychostimulants, benzodiazepines and benzodiazepines receptor agonists, and opioid analgesics;
- c. encourages physicians to become aware of resources on the nonmedical use of prescription controlled substances that can assist in actively engaging patients, and especially parents, on the benefits and risks of such treatment, and the need to safeguard and monitor prescriptions for controlled substances, with the intent of reducing access and diversion by family members and friends;

d. will consult with relevant agencies on potential strategies to actively involve physicians in being a part of the solution to the epidemic of unauthorized/nonmedical use of prescription controlled substances; and
e. supports research on: (i) firmly identifying sources of diverted prescription controlled substances so that solutions can be advanced; and (ii) issues relevant to the long-term use of prescription controlled substances.

2. Our AMA, in conjunction with other Federation members, key public and private stakeholders, and pharmaceutical manufacturers, will pursue and intensify collaborative efforts involving a public health approach in order to:

a. reduce harm from the inappropriate use, misuse and diversion of controlled substances, including opioid analgesics and other potentially addictive medications;

b. increase awareness that substance use disorders are chronic diseases and must be treated accordingly; and

c. reduce the stigma associated with patients suffering from persistent pain and/or substance use disorders, including addiction.

Citation: (CSAPH Rep. 2, I-08; Appended: Res. 517, A-15; Reaffirmed: BOT Rep. 5, I-15

Substance Use Disorders as a Public Health Hazard H-95.975

Our AMA: (1) recognizes that substance use disorders are a major public health problem in the United States today and that its solution requires a multifaceted approach;

(2) declares substance use disorders are a public health priority;

(3) supports taking a positive stance as the leader in matters concerning substance use disorders, including addiction;

(4) supports studying innovative approaches to the elimination of substance use disorders and their resultant street crime, including approaches which have been used in other nations; and

(5) opposes the manufacture, distribution, and sale of substances created by chemical alteration of illicit substances, herbal remedies, and over-the-counter drugs with the intent of circumventing laws prohibiting possession or use of such substances.

Citation: (Res. 7, I-89; Appended: Sub. Res. 401, Reaffirmed: Sunset Rep., I-99; Reaffirmed: CSAPH Rep. 1, A-09; Modified and Reaffirmed: CSAPH Rep. 1, A-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 503
(A-19)

Introduced by: Missouri

Subject: Addressing Healthcare Needs of Children of Incarcerated Parents

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, The U.S. is the most heavily incarcerated country in the developed world, and five million, or approximately 7% of American children, have an incarcerated parent^{1,2}; and

Whereas, Parental imprisonment is recognized as one of several known Adverse Childhood Experiences (ACE), with 64% of children with incarcerated parents experiencing two or more additional adverse events including substance abuse, mental illness, and sexual abuse^{1,3}; and

Whereas, Poor health outcomes in children associated with the exposure to parental incarceration include forgone health care, prescription drug abuse, ten or more lifetime sexual partners, higher likelihood of emergency department use, illicit injection drug use, HIV/AIDS, obesity, and behavioral or conduct problems^{1,2,4}; and

Whereas, Although efforts have been made to mitigate the harm associated with having an incarcerated parent, few are focused on meeting the direct health needs of children through preventative health care⁵; and

Whereas, Children with incarcerated parents may benefit from initial ACE screening to identify those who require further assessment, health behavioral counseling, or the establishment of a medical home to help them gain access to care^{2,6}; therefore be it

RESOLVED, That our American Medical Association support comprehensive and evidence-based care that addresses the specific healthcare needs of children with incarcerated parents and promote earlier intervention for those children who are at risk. (New HOD Policy)

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

Received: 04/16/19

References

- ¹ Lee RD, Fang XM, Luo F. The impact of parental incarceration on the physical and mental health of young adults. *Pediatrics*. 2013; 131(4): 1188-1195. <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3608482/>
- ² Heard-Garris N, et al. Health care use and health behaviors among young adults with history of parental incarceration. *Pediatrics*. 2018; 142(2). <http://pediatrics.aappublications.org/content/142/3/e20174314>
- ³ Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. The Adverse Childhood Experiences (ACE) Study. *Am J Prev Med*. 1998;14(4):245-258.
- ⁴ Turney, K. Stress proliferation across generations? Examining the relationship between parental Incarceration and childhood health. 2014. <https://journals.sagepub.com/doi/10.1177/0022146514544173#>
- ⁵ Christian S. Children of Incarcerated Parents. National Conference of State Legislatures. 2009. <https://www.ncsl.org/documents/cyf/childrenofincarceratedparents.pdf>
- ⁶ Barnert E, Chung PJ. Responding to parental incarceration as a priority pediatric health issue. *Pediatrics*. 2018; 142(3). <http://pediatrics.aappublications.org/content/142/3/e20181923>

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 504
(A-19)

Introduced by: California

Subject: Screening, Intervention, and Treatment for Adverse Childhood Experiences

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, The Centers for Disease Control and Prevention, the Substance Abuse and Mental
2 Services Health Administration, and the American Academy of Pediatrics have all attributed
3 ACEs (Adverse Childhood Experiences) as a contributing factor for mental health and disease
4 states. ACEs can include physical, mental or sexual abuse or neglect. It also includes children
5 who experience divorce, who have a parent with a substance abuse problem or mental illness,
6 or a relative who is incarcerated; and
7

8 Whereas, ACEs has been associated with myocardial infarction, COPD, mental distress,
9 depression, smoking, disability, substance abuse, coronary artery disease, Alzheimer's disease,
10 stroke and diabetes. ACEs has also been associated with decreased income, unemployment,
11 lack of health insurance, further victimization as adults of abuse and lower education attainment;
12 and
13

14 Whereas, Per the California BRFSS (Behavioral Risk Factor Surveillance System) study, more
15 than 61% of Californians have exposure to at least one ACEs. Identifying and intervening on
16 children early with adequate community, behavioral or mental health resources may benefit
17 children. Adults can be referred for post-trauma treatment or support groups; therefore be it
18

19 RESOLVED, That our American Medical Association support efforts for data collection,
20 research and evaluation of Adverse Childhood Experiences (ACEs), cost-effective ACE
21 screening tools without additional burden for physicians, and effective interventions, treatments
22 and support services necessary for a positive screening practice in pediatric and adult
23 populations (New HOD Policy); and be it further
24

25 RESOLVED, That our AMA support efforts to educate physicians about the facilitators, barriers
26 and best practices for providers implementing ACE screening and trauma-informed care
27 approaches into a clinical setting (New HOD Policy); and be it further
28

29 RESOLVED, That our AMA support additional funding sources for schools, behavioral and
30 mental health services, professional groups, community and government agencies to support
31 children and adults with ACEs. (New HOD Policy)

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

Received: 04/29/19

RELEVANT AMA POLICY**National Child Traumatic Stress Network H-60.929**

Our AMA: 1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and 2) will work with mental health organizations and relevant health care organizations to support full funding of the National Child Traumatic Stress Initiative at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network.

Citation: (Res. 419, A-11)

Family Violence-Adolescents as Victims and Perpetrators H-515.981

The AMA (1) (a) encourages physicians to screen adolescents about a current or prior history of maltreatment. Special attention should be paid to screening adolescents with a history of alcohol and drug misuse, irresponsible sexual behavior, eating disorders, running away, suicidal behaviors, conduct disorders, or psychiatric disorders for prior occurrences of maltreatment; and (b) urges physicians to consider issues unique to adolescents when screening youths for abuse or neglect. (2) encourages state medical society violence prevention committees to work with child protective service agencies to develop specialized services for maltreated adolescents, including better access to health services, improved foster care, expanded shelter and independent living facilities, and treatment programs. (3) will investigate research and resources on effective parenting of adolescents to identify ways in which physicians can promote parenting styles that reduce stress and promote optimal development. (4) will alert the national school organizations to the increasing incidence of adolescent maltreatment and the need for training of school staff to identify and refer victims of maltreatment. (5) urges youth correctional facilities to screen incarcerated youth for a current or prior history of abuse or neglect and to refer maltreated youth to appropriate medical or mental health treatment programs. (6) encourages the National Institutes of Health and other organizations to expand continued research on adolescent initiation of violence and abuse to promote understanding of how to prevent future maltreatment and family violence.

Citation: (CSA Rep. I, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 505
(A-19)

Introduced by: California

Subject: Glyphosate Studies

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, Glyphosate is the most commonly produced herbicide and used on multiple
2 agricultural crops, including corn, soy, canola and wheat, and is found in significant amounts in
3 popular household food products; and
4

5 Whereas, The International Agency for Research on Cancer (IARC) under the World Health
6 Organization classified glyphosate as a Group 2A chemical or likely carcinogen in 2015
7 because emerging research indicates it could potentially cause cell damage; and
8

9 Whereas, Research has shown an association between non-Hodkin's lymphoma and
10 glyphosate in human studies and other carcinogenic effects of glyphosate in animal studies; and
11

12 Whereas, Research has also shown that glyphosate can damage DNA in the peripheral blood of
13 exposed humans through oxidative stress; and
14

15 Whereas, Data shows a significant increase in the use of glyphosate on crops in the past 20
16 years especially in the United States; and
17

18 Whereas, The State of California's Office of Environment Health Hazard Assessment (OEHHA)
19 listed glyphosate (the primary chemical in the herbicide branded Roundup) on the list of
20 chemicals known to cause cancer for the purposes of Proposition 65 which now must carry
21 warnings; therefore be it
22

23 RESOLVED, That our American Medical Association advocate for a reduction in the use of
24 glyphosate-based pesticides (the primary chemical in the herbicide branded Roundup),
25 encourage the evaluation of alternatives, and support additional research to determine the long-
26 term effects and association between glyphosate and disease. (Directive to Take Action)

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

Received: 04/29/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 506
(A-19)

Introduced by: Illinois

Subject: Clarify Advertising and Contents of Herbal Remedies and Dietary Supplements

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Much misleading information is contained in advertising of herbal remedies and dietary supplements; and

Whereas, Herbal remedies and dietary supplements are sold as food but advertised in such a way as to imply some therapeutic effect of their contents; and

Whereas, Americans spend billions of dollars each year on herbal remedies and dietary supplements in the hope that doing so will enhance their own good health in some way; and

Whereas, Herbal remedies and dietary supplements are not regulated by the US Food and Drug Administration and consequently the identities of their ingredients, active or inactive, and their concentrations are mostly unknown; and

Whereas, Herbal remedies and dietary supplements are not subject to strict regulation, therefore they may or may not have the ingredients listed on the label; and

Whereas, Some herbal remedies and dietary supplements have been documented to have active medications not indicated on the label and some have been documented to contain toxic drugs; and

Whereas, Patients seeking relief of symptoms may turn to herbal remedies and dietary supplements before consulting a medical professional and thus delay the proper diagnosis and therapy for their condition; and

Whereas, Any merchandise that claims to have health benefits is not food; therefore be it

RESOLVED, That our American Medical Association work with the National Center for Complementary and Integrative Health (NCCIH), the federal agency responsible for oversight of herbal remedies and dietary supplements, to institute stricter guidelines for advertising and labeling of these products so that consumers will be informed of what they are purchasing (Directive to Take Action); and be it further

RESOLVED, that our AMA support a licensing body through legislation for manufacturers of dietary supplements and herbal remedies, with the requirement that those manufacturers must supply proof that their products have health benefits (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA urge that the increased cost of a stricter NCCIH program on dietary
- 2 supplements and herbal remedies be paid for by the manufacturers who produce them.
- 3 (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 507
(A-19)

Introduced by: Illinois

Subject: Removing Ethylene Oxide as a Medical Sterilant from Healthcare

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Ethylene oxide (EtO) is a known human carcinogen as identified by the International Agency for Research on Cancer (IARC) and USEPA. It is used for sterilization of medical equipment that cannot be sterilized by steam. This process is open to the workplace environment at various points allowing the escape of EtO into the area and community. Safer substitution, therefore, should be considered, as alternatives exist that are equally efficacious with respect to sterilization of non-metal products. [6] While many hospitals have switched away from ethylene oxide due to the toxicities, an estimated 80% of non-metallic medical equipment is still being sterilized with EtO at industrial facilities before delivery [6]; and

Whereas, Only 0.05% of the annual production is used for sterilization, sterilization and fumigation is where the highest exposure levels to workers and communities have been measured. [6] Inhaling contaminated air exposes surrounding communities to ethylene oxide when the gas is released from a sterilant facility; and

Whereas, Ethylene oxide exposure is associated with irritation of the respiratory tract, eyes, and skin. [6] With direct contact it can cause burns, blistering, and desquamation of the skin. It can also cause conjunctivitis and contact dermatitis. [6, 4] Acute high-level exposure can cause asthma, and sensitization. [6, 4] It can lead to peripheral neuropathy and central neurotoxicity including neuropsychological abnormalities, and seizures. [4] In animals, exposure has been shown to cause spontaneous abortion, preterm births, and reproductive toxicity in both males and females [4][6]; and

Whereas, In 1984, the International Agency for Research on Cancer (IARC) included ethylene oxide in its list as a probable carcinogen by 2008 with adequate information available only in animals, microorganisms, and invitro. It has been shown to induce sensitive, persistent dose-related frequency of chromosomal aberrations, sister chromatid exchange in peripheral lymphocytes and micronuclei in bone-marrow cells of exposed workers [4][14]; and

Whereas, Epidemiologic studies of humans in 2004, since reviewed by IARC and USEPA, have documented EtO as a Class 1 known human carcinogen. EtO's carcinogenic impact is due to its action as an alkylating agent and specifically has been associated with malignancies of the breast, lymphatic and hematopoietic systems in humans [6][18][19]; and

Whereas, Based on this new information, USEPA changed EtO's adult-based inhalation unit risk from 0.0001 per microgram per cubic meter ($\mu\text{g}/\text{m}^3$) to 0.003 per $\mu\text{g}/\text{m}^3$, a 30-fold increase in cancer potency. In Willowbrook, Illinois, this elevated the additional lifetime risk of 6.4 cancers in a population of 1,000 residents who could be exposed to EtO emissions from a local industrial sterilizing facility. This cancer risk exceeds U.S. EPA's decision-making cancer risk range of 1.0

x 10⁻⁶ to 1.0 x 10⁻⁴, and adds to the lifetime background cancer risk of an average American of 1 in 3 people [24] [25]; and

Whereas, For community exposures no regulations exist save the USEPA's advice with respect to carcinogenic risk and the need for action when the risk exceeds the U.S. EPA's decision-making cancer risk range of 1.0 x 10⁻⁶ to 1.0 x 10⁻⁴; and

Whereas, Due to the impossibility of sterilizing these materials in an enclosed system, safer substitution is the most effective means to address this problem of EtO community exposures. As described by the industry consensus standards Association for the Advancement of Medical Instrumentation, these include radiation sterilization, hydrogen peroxide, nitrogen dioxide and hydrogen peroxide-ozone. The Federal Drug Administration noted in 2016 that hydrogen peroxide was an alternative that they were familiar with and invited applications for sterilization process reviews using this chemical [23]; therefore be it

RESOLVED, That our American Medical Association adopt as policy and urge, as appropriate, the prevention of ethylene oxide emissions and substitution of ethylene oxide with less toxic sterilization alternatives that are currently available, including hydrogen peroxide, steam, and other safer alternatives, which do not release carcinogens into the workplace or community air and allow no residual exposures to the patient (New HOD Policy); and be it further

RESOLVED, That our AMA adopt as policy and urge that when health care facilities are evaluating surgical and medical devices that require sterilization, in addition to effectiveness of the device for best patient outcomes, that facilities also be required to prioritize the modes of sterilization for the highest degree of worker and environmental safety. (New HOD Policy)

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

Received: 04/25/19

References:

1. Hazardous Substance Data Bank. (2008). Ethylene Oxide. Last Reviewed Sep 18, 2008. Retrieved Jan 14, 2019 from <https://toxnet.nlm.nih.gov/cgi-bin/sis/search2/f?/.temp/~IRj2LK:3>
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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 508
(A-19)

Introduced by: New York

Subject: Benzodiazepine and Opioid Warning

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, During 1999–2017, the rate of drug overdose deaths approximately tripled with
2 approximately 70,000 overdose deaths occurring nationally in 2017, nearly 68 percent involving
3 an opioid; and
4

5 Whereas, By 2017, fentanyl was involved in 57 percent of all drug overdose deaths in New York
6 City; and
7

8 Whereas, Illicitly manufactured fentanyl (a synthetic, short-acting opioid with 50 – 100 times the
9 potency of morphine) has been mixed into heroin, cocaine, and counterfeit pills with or without
10 the users' knowledge, and has increased the risk of fatal overdose; and
11

12 Whereas, Benzodiazepines, often used to aid in relieving symptoms like anxiety, are schedule
13 IV substances available through a physician with a high risk for illicit use; and
14

15 Whereas, Illicit use of benzodiazepines is becoming more common--especially in teens and
16 young adults; and
17

18 Whereas, Benzodiazepines used in excess, can lead to memory loss, dulled emotions,
19 compulsive actions, personality changes and can lead to fatal overdose; and
20

21 Whereas, More than 30 percent of overdoses involving opioids also involve benzodiazepines
22 which include diazepam (Valium), alprazolam (Xanax), and clonazepam (Klonopin), and others;
23 and
24

25 Whereas, The dangers of co-prescribing opioids and benzodiazepines has been well known for
26 many years; and
27

28 Whereas, The illegal drug market has been producing illicit alprazolam laced with illicit fentanyl
29 leading to addiction and overdose death; therefore be it
30

31 RESOLVED, That our American Medical Association raise the awareness of its members of the
32 increased use of illicit sedative/opioid combinations leading to addiction and overdose death
33 (Directive to Take Action); and be it further
34

35 RESOLVED, That our AMA warn members and patients about this public health problem.
36 (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 509
(A-19)

Introduced by: International Medical Graduates Section

Subject: Addressing Depression to Prevent Suicide Epidemic

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Major depressive disorder affects approximately 14.8 million American adults in a given year, approximately 6.7 percent of the U.S. population age 18 and older and is the leading cause of disability in the U.S. for ages 15-44; and

Whereas, Roughly 40 million American adults ages 18 and older in a given year, or about 18.1 percent of people in this age group, have an anxiety disorder which is frequently coincident with depressive disorders; and

Whereas, Suicide is the 10th leading cause of death each year in the U.S., claiming the lives of nearly 45,000 people and accounting for \$50.8 billion in cost; and

Whereas, Suicide is the 2nd leading cause of death for people aged 10–34 and more than 90% of people who die by suicide show symptoms of mental illness especially major depressive or bipolar disorder, and substance use disorders; and

Whereas, One doctor per day or 300-400 U.S. physicians die by suicide each year, according to the American Foundation for Suicide Prevention; therefore be it

RESOLVED, That our American Medical Association collaborate with the Centers for Disease Control and Prevention (CDC), the National Institute of Health (NIH) and other stakeholders to increase public awareness about symptoms, early signs, preventive and readily available therapeutic measures including antidepressants to address depression and suicide; (Directive to Take Action) and be it further

RESOLVED, That our AMA work with the CDC, the NIH and encourage other specialty and state medical societies to work with their members to address the epidemic of depression and anxiety disorder and help to prevent death by suicide by promoting services to screen, diagnose and treat depression. (Directive to Take Action)

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

Received: 05/01/19

References:

1 U. S. Department of Health and Human Services, <https://www.hhs.gov/answers/mental-health-and-substance-abuse/does-depression-increase-risk-of-suicide/index.html>, "Does depression increase the risk for suicide?"

2 The National Institute of Mental Health, <http://www.nimh.nih.gov>, "Major Depression" and "Suicide."

3 Data on behavioral health in the United States <https://www.apa.org/helpcenter/data-behavioral-health>

4 Mental health by the numbers <https://www.nami.org/learn-more/mental-health-by-the-numbers>

RELEVANT AMA POLICY

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

1. Our AMA encourages: (a) medical schools, primary care residencies, and other training programs as appropriate to include the appropriate knowledge and skills to enable graduates to recognize, diagnose, and treat depression and other mental illnesses, either as the chief complaint or with another general medical condition; (b) all physicians providing clinical care to acquire the same knowledge and skills; and (c) additional research into the course and outcomes of patients with depression and other mental illnesses who are seen in general medical settings and into the development of clinical and systems approaches designed to improve patient outcomes. Furthermore, any approaches designed to manage care by reduction in the demand for services should be based on scientifically sound outcomes research findings.

2. Our AMA will work with the National Institute on Mental Health and appropriate medical specialty and mental health advocacy groups to increase public awareness about depression and other mental illnesses, to reduce the stigma associated with depression and other mental illnesses, and to increase patient access to quality care for depression and other mental illnesses.

3. Our AMA: (a) will advocate for the incorporation of integrated services for general medical care, mental health care, and substance use disorder care into existing psychiatry, addiction medicine and primary care training programs' clinical settings; (b) encourages graduate medical education programs in primary care, psychiatry, and addiction medicine to create and expand opportunities for residents and fellows to obtain clinical experience working in an integrated behavioral health and primary care model, such as the collaborative care model; and (c) will advocate for appropriate reimbursement to support the practice of integrated physical and mental health care in clinical care settings.

4. Our AMA recognizes the impact of violence and social determinants on women's mental health.

Citation: Res. 502, I-96; Reaffirm & Appended: CSA Rep. 7, I-97; Reaffirmation A-00; Modified: CSAPH Rep. 1, A-10; Modified: Res. 301, A-12; Appended: Res. 303, I-16; Appended: Res. 503, A-17

Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination D-420.991

Our AMA: (1) will work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women presenting alone or with their child during prenatal, postnatal, pediatric, or emergency room visits; (2) encourages the development of training materials related to maternal depression to advise providers on appropriate treatment and referral pathways; and (3) encourages the development of state-based care coordination programs (e.g., staffing a psychiatrist and care coordinator) to assure appropriate referral, treatment and access to follow-up maternal mental health care.

Citation: Res. 910, I-17

Depression and Physician Licensure D-275.974

Our AMA will (1) recommend that physicians who have major depression and seek treatment not have their medical licenses and credentials routinely challenged but instead have decisions about their licensure and credentialing and recredentialing be based on professional performance; and (2) make this resolution known to the various state medical licensing boards and to hospitals and health plans involved in physician credentialing and recredentialing.

Citation: (Res. 319, A-05; Reaffirmed: BOT action in response to referred for decision Res. 403, A-12

Senior Suicide H-25.992

It is the policy of the AMA to (1) educate physicians to be aware of the increased rates of suicide among the elderly and to encourage seniors to consult their physicians regarding depression and loneliness; and (2) to encourage local, regional, state, and national cooperation between physicians and advocacy agencies for these endangered seniors.

Citation: (Res. 107, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 510
(A-19)

Introduced by: Resident and Fellow Section

Subject: The Intracranial Hemorrhage Anticoagulation Reversal (ICHAR) Initiative

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Cerebrovascular disease is the fifth most common cause of mortality in the United States, responsible for 5.2% of deaths nationwide or 140,000 per year¹; and

Whereas, Intraparenchymal hemorrhages are the most common nontraumatic hemorrhagic stroke and have the highest risk of mortality²; and

Whereas, The largest reversible risk factor for poor outcomes in intraparenchymal hemorrhages is use of anticoagulants, such as warfarin³; and

Whereas, The effects of anticoagulants can be mitigated with rapid use of newer reversal agents, such as prothrombin complex concentrate, which have replaced transfusion as a standard of care⁴; and

Whereas, Many emergency rooms do not know about new anticoagulation reversal medications or do not know how to use them, resulting in worse outcomes for patients prior to transfer to tertiary centers; and

Whereas, Savings in healthcare expenditures and worker productivity are expected with better patient outcomes, while reversal medications are relatively inexpensive; therefore be it

RESOLVED, That our American Medical Association support initiatives to improve and reduce the barriers to the use of anticoagulation reversal agents in emergency settings to reduce the occurrence, disability, and death associated with hemorrhagic stroke and other life-threatening clinical indications. (New HOD Policy)

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

Received: 05/01/19

References:

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3 Esfahani DR, Radnis CA, Hussein AE, Amin-Hanjani S, Charbel FT, Alaraj A. Thresholds for Volume and Expansion in Intraparenchymal Hemorrhage: Predictors of Neurologic Deterioration and Mortality. World neurosurgery. 2017.

4 Hemphill JC, 3rd, Greenberg SM, Anderson CS, et al. Guidelines for the Management of Spontaneous Intracerebral Hemorrhage: A Guideline for Healthcare Professionals from the American Heart Association/American Stroke Association. Stroke. 2015;46(7):2032-2060.

RELEVANT AMA POLICY

Home Anti-Coagulation Monitoring H-185.951

1. Our AMA encourages all third party payers to extend coverage and reimbursement for home monitors and supplies for home self-monitoring of anti-coagulation for all medically appropriate conditions.
 2. Our AMA (a) supports the appropriate use of home self-monitoring of oral anticoagulation therapy and (b) will continue to monitor safety and effectiveness data, in particular cost-effectiveness data, specific to the United States on home management of oral anticoagulation therapy.
 3. Our AMA will request a change in Centers for Medicare & Medicaid Services' regulations to allow a nurse, under physician supervision, to visit a patient who cannot travel, has no family who can reliably test, or is unable to test on his/her own to obtain and perform a protime/INR without restrictions.
- Citation: (Res. 825, I-05; Modified and Reaffirmed: CSAPH Rep. 9, A-07; Appended: Res. 709, A-14)

Stroke Prevention and Care Legislation H-425.978

Our AMA supports comprehensive stroke legislation such as S.1274, the Stroke Treatment and Ongoing Prevention Act (STOP Stroke Act) as introduced, and work with Congress to enact legislation that will help improve our nation's system of stroke prevention and care.

Citation: (Res. 215, I-01; Reaffirmed: BOT Rep. 22, A-11)

The Next Transformative Project: In Support of the BRAIN Initiative H-460.904

Our AMA: (1) supports the scientific and medical objectives of the Brain Research through Advancing Innovative Neurotechnologies (BRAIN) Initiative of mapping the human brain to better understand normal and disease process; (2) encourages appropriate scientific, medical and governmental organizations to participate in and support advancement in understanding the human brain in conjunction with the BRAIN Initiative; and (3) supports the continued Congressional allocation of funds for the BRAIN Initiative, thus providing for research and innovation in technologies that will advance knowledge of neurologic function and disease.

Citation: (Res. 522, A-13; Modified: Res. 514, A-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 511
(A-19)

Introduced by: Resident and Fellow Section

Subject: Mandating Critical Congenital Heart Defect Screening in Newborns

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

Whereas, Approximately 18 out of every 10,000 infants are born with a critical congenital heart defect (CCHD)¹; and

Whereas, CCHDs are life-threatening and often require intervention during infancy¹; and

Whereas, Many CCHDs are not detected prenatally or in the immediate post-natal period¹; and

Whereas, The pulse oximetry screening protocol is a low-cost and sensitive screen that can be used to detect CCHD; and

Whereas, A 2013 study in *Pediatrics* estimated screening could potentially identify 1,189 more newborns with CCHD at birth hospitals in the United States annually and screening may cost approximately \$40,000 per life-year saved, which is considered cost-effective²; and

Whereas, Our AMA has policy in support of standardized newborn screening (H-245.973) and newborn hearing screening (H-245.970); and

Whereas, 43 states have taken steps toward newborn screening through legislation, regulations, and hospital guidelines, 35 of which have legislation mandating screening for congenital heart defects³; therefore be it

RESOLVED, That our American Medical Association support screening for critical congenital heart defects for newborns following delivery prior to hospital discharge. (New HOD Policy)

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

Received: 05/01/19

¹ American Academy of Pediatrics. (2018) "Newborn Screening for CCHD." Available at <https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/PEHDIC/Pages/Newborn-Screening-for-CCHD.aspx>

² Peterson C, Grosse S, Oster M, Olney R, and Cassell C. Cost-effectiveness of routine screening for critical congenital heart disease in US newborns. *Pediatrics* 2013; 132(3).

³ Glidewell J, Olney RS, Hinton C, Pawelski J, Sontag M, Wood T, Kucik J; Daskalov R, Hudson J. State Legislation, Regulations, and Hospital Guidelines for Newborn Screening for Critical Congenital Heart Defects — United States, 2011–2014. *CDC Weekly Morbidity and Mortality Report*. 19 June 2015: 64(23):625-630.

RELEVANT AMA POLICY

Standardization of Newborn Screening Programs H-245.973

Our AMA: (1) recognizes the need for uniform minimum **newborn screening** (NBS) recommendations; and (2) encourages continued research and discussions on the potential benefits and harms of NBS for certain diseases. (CSAPH Rep. 9, A-06; Reaffirmed in lieu of Res. 502, A-09)

Early Hearing Detection and Intervention H-245.970

Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing **screening**, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing **screening** of newborns and infants, prompt evaluation and diagnosis of children referred from **screening** programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss. (Res. 514, A-11; Reaffirmed: CMS Rep. 6, I-15)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 512
(A-19)

Introduced by: Resident and Fellow Section

Subject: Fertility Preservation in Pediatric and Reproductive Aged Cancer Patients

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, Cancer treatments in younger patients can lead to reduced fertility¹; and

2
3 Whereas, Studies have demonstrated that oncology patients are interested in the option of
4 fertility preservation²; and

5
6 Whereas, There are several methods to help preserve fertility in pediatric and reproductive aged
7 patients including cryopreserving embryos, oocytes, sperm, or gonadal tissue¹; and

8
9 Whereas, Fertility preservation has not been associated with delayed cancer treatment or
10 decreased survival; and

11
12 Whereas, There are significant geographic and clinic variations in the support for fertility
13 preservation amongst oncologists and fertility specialists; and

14
15 Whereas, There is a lack of adequate provision of information on fertility preservation and lack
16 of referral to fertility clinics for pediatric and reproductive aged oncology patients often resulting
17 from oncologist discomfort in providing adequate counseling to such patients¹; and

18
19 Whereas, There is a significant disparity in access to fertility preservation for pediatric and
20 reproductive aged oncology patients; therefore be it

21
22 RESOLVED, That our American Medical Association encourage disclosure to cancer patients
23 on risks to fertility when gonadotoxicity due to cancer treatment is a possibility (New HOD
24 Policy); and be it further

25
26 RESOLVED, That our AMA support education for providers who counsel patients that may
27 benefit from fertility preservation. (New HOD Policy)

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

Received: 05/01/19

¹ The Ethics Committee of the American Society for Reproductive Medicine. "Fertility Preservation and Reproduction in Cancer Patients." *Ethics Committee Report*, Elsevier, Inc, 11 Mar. 2005, oncofertility.northwestern.edu/sites/oncofertility/files/legacy_files/uploadedfilecontent/ASRM_FP_in_Cancer_2005.pdf

² National Comprehensive Cancer Network. *NCCN Guidelines Version 2.2018 Adolescent and Young Adult Oncology*. 11 Oct. 2017.

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14

[Code of Medical Ethics: Opinion 2.1.1 Informed Consent](#)

[Code of Medical Ethics: Opinion 2.1.3 Withholding Information from Patients](#)

[Code of Medical Ethics: Opinion 2.2.1 Pediatric Decision Making](#)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 513
(A-19)

Introduced by: Women Physicians Section

Subject: Determining Why Infertility Rates Differ Between Military and Civilian Women

Referred to: Reference Committee E
(Leslie H. Secrest, MD, Chair)

1 Whereas, According to the Service Women's Action Network (SWAN) December 2018 report,
2 there are more than 369,000 service women (more than 17% of the military) and two million
3 women veterans (10% of veterans population). Further, women comprise 18.5% of all veterans
4 under age 45;¹ and

5
6 Whereas, Infertility rates in military women are significantly higher than the general population;
7 and

8
9 Whereas, A 2018 SWAN survey found that over 37% of active service women reported having
10 difficulty getting pregnant when actively trying after one year (or longer), which is much higher
11 than the reported rate of the general population;² and

12
13 Whereas, The Centers for Disease Control and Prevention reports that approximately 12.1%³ of
14 the general U.S. female population have impaired fecundity, which is a condition related to
15 infertility and refers to women who have difficulty getting pregnant or experience recurrent
16 pregnancy loss;⁴ and

17
18 Whereas, Twenty percent of active service women and 32% of female veterans reported that
19 they did not seek medical services for infertility and cited location, accessibility, and cost as
20 factors;² and

21
22 Whereas, Only six military treatment facilities in the U.S. offer a full range of infertility
23 treatments, and there are often long wait times to access these services;⁵ and

24
25 Whereas, Tricare benefits exclude assisted reproductive technology for veterans, unless it can
26 be demonstrated that a related injury occurred while on active duty;⁶ and

27
28 Whereas, Some women reported being denied care "unless they can demonstrate their infertility
29 is service connected";² and

30
31 Whereas, Without insurance, one round of In Vitro Fertilization treatment can cost \$15,000 or
32 more, with multiple cycles sometimes required for success ;² and

33
34 Whereas, Women in the military are exposed to reproductive health hazards that can increase
35 their risk of infertility;⁷ and

36
37 Whereas, Infertility among service women is often associated with sexual assault and/or
38 combat-related trauma;⁸ and

1 Whereas, In 2018, the U.S. Department of Defense noted that 79 percent of the reports of
2 sexual assault were from women;⁹ and

3
4 Whereas, Survivors of sexual assault are at risk for acquiring sexually transmitted infections
5 such as chlamydia and gonorrhea, which can lead to pelvic inflammatory disease and infertility;
6 and

7
8 Whereas, It is unknown whether the etiology of higher infertility rates among service women is
9 related to unique occupational exposures within the military;⁸ therefore be it

10
11 RESOLVED, That our American Medical Association advocate for additional research to better
12 understand whether higher rates of infertility in service women may be linked to military service
13 and which approaches might reduce the burden of infertility among service women. (Directive to
14 Take Action)

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

Received: 05/01/19

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9. DoD Releases Annual Report on Sexual Assault in Military. Available at dod.defense.gov/News/Article/Article/1508127/dod-releases-annual-report-on-sexual-assault-in-military/. Accessed March 2019.

RELEVANT AMA POLICY

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

Citation: CMS Rep. 01, I-16

Support for Access to Preventive and Reproductive Health Services H-425.969

Our AMA supports access to preventive and reproductive health services for all patients and opposes legislative and regulatory actions that utilize federal or state health care funding mechanisms to deny established and accepted medical care to any segment of the population.

Citation: Sub. Res. 224, I-15; Reaffirmation: I-17

Recognition of Infertility as a Disease H-420.952

Our AMA supports the World Health Organizations designation of infertility as a disease state with multiple etiologies requiring a range of interventions to advance fertility treatment and prevention.

Citation: Res. 518, A-17

Preconception Care H-425.976

1. Our AMA supports the 10 recommendations developed by the Centers for Disease Control and Prevention for improving preconception health care that state:

- (1) Individual responsibility across the lifespan--each woman, man, and couple should be encouraged to have a reproductive life plan;
- (2) Consumer awareness--increase public awareness of the importance of preconception health behaviors and preconception care services by using information and tools appropriate across various ages; literacy, including health literacy; and cultural/linguistic contexts;
- (3) Preventive visits--as a part of primary care visits, provide risk assessment and educational and health promotion counseling to all women of childbearing age to reduce reproductive risks and improve pregnancy outcomes;
- (4) Interventions for identified risks--increase the proportion of women who receive interventions as follow-up to preconception risk screening, focusing on high priority interventions (i.e., those with evidence of effectiveness and greatest potential impact);
- (5) Inter-conception care--use the inter-conception period to provide additional intensive interventions to women who have had a previous pregnancy that ended in an adverse outcome (i.e., infant death, fetal loss, birth defects, low birth weight, or preterm birth);
- (6) Pre-pregnancy checkup--offer, as a component of maternity care, one pre-pregnancy visit for couples and persons planning pregnancy;
- (7) Health insurance coverage for women with low incomes--increase public and private health insurance coverage for women with low incomes to improve access to preventive women's health and pre-conception and inter-conception care;
- (8) Public health programs and strategies--integrate components of pre-conception health into existing local public health and related programs, including emphasis on inter-conception interventions for women with previous adverse outcomes;
- (9) Research--increase the evidence base and promote the use of the evidence to improve preconception health; and
- (10) Monitoring improvements--maximize public health surveillance and related research mechanisms to monitor preconception health.

2. Our AMA supports the education of physicians and the public about the importance of preconception care as a vital component of a woman's reproductive health.

Citation: Res. 414, A-06; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 514
(A-19)

Introduced by: American Medical Women's Association

Subject: Opioid Addiction

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

Whereas, Sex-based differences in response to opioids can result in women developing opioid addiction more readily than men, even when using lower doses for shorter periods of time; and

Whereas, An increasing number of women are addicted to opioids; and

Whereas, Women of child-bearing age who are using opioids inappropriately may be reluctant to seek health care because of the stigma attached to substance use disorder; and

Whereas, Women who used opioids prior to caesarian section are more likely to require opioids for longer periods of time after the procedure; and

Whereas, Enhanced recovery after surgery (ERAS) protocols for caesarian section have been shown to decrease opioid use during hospitalization and after discharge, while improving mobilization and other outcomes; therefore be it

RESOLVED, That our American Medical Association work with constituent organizations to assure that women of child-bearing age who are using opioids and are accessing the health care system undergo evaluation for pregnancy and, if pregnancy, be offered prenatal care (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that women who use opioids prior to caesarian section are offered multi-modalities to control pain and improve function after the procedure with the goal of transitioning to other methods of pain control for long term (Directive to Take Action); and be it further

RESOLVED, That our AMA work with hospitals and relevant constituent organizations to assure that the enhanced recovery after surgery protocol for caesarian section is widely adopted to optimize recovery and improve function while decreasing use of opioid medications for pain, especially given the impact of such use in breast-feeding mothers and their infants. (Directive to Take Action)

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

Received: 05/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 515
(A-19)

Introduced by: American Medical Women's Association

Subject: Reversing Opioid Epidemic

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

1 Whereas, Deaths from overdose of opiates are increasing more rapidly in women than men,
2 with an increase of 5-fold in women compared to 3.6-fold in men between 1999 and 2010; and
3

4 Whereas, These data may be explained by sex-based differences in chronic pain, response to
5 opioids, and risk of opioid addiction; and
6

7 Whereas, Women are more likely to have conditions that lead to chronic pain such as
8 osteoarthritis, inflammatory arthritis, temporal mandibular syndrome, or injuries resulting from
9 intimate partner violence; and
10

11 Whereas, Because of sex-based differences in brain signaling pathways and higher prevalence
12 of untreated co-existing depression and PTSD, women may perceive pain more intensely than
13 men; and
14

15 Whereas, Sex-based differences in response to opioids can result in women developing opioid
16 addiction more rapidly than men, even when using lower doses for shorter time periods, and
17 having greater issues with addiction treatment; therefore be it
18

19 RESOLVED, That our American Medical Association include in their program, Reversing the
20 Opioid Epidemic, education materials for physicians regarding sex-based differences in
21 perception of pain, including the impact of co-morbid conditions, sex-based differences in
22 response to opioids and risks for opioid addiction, and issues with accessing and outcomes of
23 addiction programs among women. (Directive to Take Action)

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

Received: 05/01/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 516
(A-19)

Introduced by: American Society of Clinical Oncology

Subject: Alcohol Consumption and Health

Referred to: Reference Committee E
(Leslie Secrest, MD, Chair)

Whereas, The Global Burden of Diseases, Injuries, and Risk Factors Study 2016¹ found that, despite a protective effect for ischemic heart disease and diabetes, no level of alcohol consumption minimizes the health loss due all-cause mortality and cancer; and

Whereas, Previous studies suggesting a health benefit for moderate alcohol consumption may have been poorly designed to estimate the full extent of health effects from alcohol due to survival biases, including “sick quitter” hypothesis, and poor study design²; and

Whereas, the Global Burden of Diseases, Injuries and Risk Factors Study 2016 found alcohol to be the 7th leading global risk factor for deaths and disability-adjusted life-years; and

Whereas, Alcohol consumption is a recognized modifiable risk factor for several common types of cancer, including liver, esophageal, oropharyngeal, laryngeal, breast and colon³; and

Whereas, Between 2006 and 2010, the Centers for Disease Control and Prevention reported that 88,000 deaths⁴ were attributed to excessive alcohol consumption in the United States; and

Whereas, Although the greatest risk of cancer is associated with high levels of consumption even light alcohol consumption is associated with a higher risk of esophageal, oral cavity and pharyngeal, and breast cancers with relative risks of 1.26, 1.13, and 1.04 respectively⁵; and

Whereas, The World Cancer Research Fund/American Institute for Cancer Research estimates a 5% increase in premenopausal breast cancer and a 9% increase in postmenopausal breast cancer per 10 grams of ethanol consumed per day⁶; and

Whereas, Consumption of alcohol, without the development of alcoholism or alcohol dependence, is an underappreciated cause of cancer; and

Whereas, Many people engage in excessive drinking without recognition of the risk factors it poses to health, including increased risk of developing cancer; and

¹ GBD 2016 Alcohol Collaborators. Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet*. 392(10152);22-28: 2018.

² Burton R, Sheron N. No level of alcohol consumption improves health. *Lancet*. 392(10152);22-28: 2018.

³ LoConte, Noelle et al. Alcohol and Cancer: A Statement of the American Society of Clinical Oncology. *J Clin Onc* 2018 36:1, 83-93.

⁴ Centers for Disease Control and Prevention: Alcohol use and health. <http://www.cdc.gov/alcohol/fact-sheets/alcohol-use.htm>

⁵ Bagnardi V, Rota M, Botteri E, et al: Alcohol consumption and site-specific cancer risk: A comprehensive dose-response meta-analysis. *Br J Cancer* 112:580-593, 2015.

⁶ World Cancer Research Fund: Diet, nutrition, physical activity and breast cancer. http://www.wcrf.org/sites/default/files/CUP_BREAST_REPORT_2017_WEB.pdf

Whereas, The International Agency for Research on Cancer classified alcohol as a group 1 carcinogen⁷; therefore be it

RESOLVED, That our American Medical Association recognize alcohol consumption as well as alcohol abuse as a modifiable risk factor for cancer (New HOD Policy); and be it further

RESOLVED, That our AMA support research and educational efforts about the connection between alcohol consumption and several types of cancer (New HOD Policy); and be it further

RESOLVED, That our AMA amend policy H-425.993, "Health Promotion and Disease Prevention," by addition and deletion to read as follows:

"...(4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol consumption, abuse, particularly that which leads to illness, cancer, and accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits..." (Modify Current HOD Policy)

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

Received: 05/01/19

RELEVANT AMA POLICY

Health Promotion and Disease Prevention H-425.993

The AMA (1) reaffirms its current policy pertaining to the health hazards of tobacco, alcohol, accidental injuries, unhealthy lifestyles, and all forms of preventable illness; (2) advocates intensified leadership to promote better health through prevention; (3) believes that preventable illness is a major deterrent to good health and accounts for a major portion of our country's total health care expenditures; (4) actively supports appropriate scientific, educational and legislative activities that have as their goals: (a) prevention of smoking and its associated health hazards; (b) avoidance of alcohol abuse, particularly that which leads to accidental injury and death; (c) reduction of death and injury from vehicular and other accidents; and (d) encouragement of healthful lifestyles and personal living habits; and (5) strongly emphasizes the important opportunity for savings in health care expenditures through prevention.

Citation: Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06; Reaffirmed: CSAPH Rep. 01, A-16

Alcohol Abuse and the War on Drugs H-30.972

Our AMA (1) supports documenting the strong correlation between alcohol abuse and other substance abuse; (2) reaffirms the concept that alcohol is an addictive drug and its abuse is one of the nation's leading drug problems; and (3) encourages state medical societies to work actively with drug task forces and study committees in their respective states to assure that their scope of study includes recognition of the strong correlation between alcohol abuse and other substance abuse and recommendations to decrease the immense number of health, safety, and social problems associated with alcohol abuse.

Citation: (Sub. Res. 97, I-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10

Alcohol Use Disorder and Unhealthy Alcohol Use Among Women H-30.943

The AMA recognizes the prevalence of unhealthy use of alcohol among women, as well as current barriers to diagnosis and treatment. The AMA urges physicians to be alert to the presence of alcohol-related problems among women and to screen all patients for alcohol use disorder and dependence. The AMA encourages physicians to educate women of all ages about their increased risk of damage to the nervous system, liver and heart disease from alcohol and about the effect of alcohol on the developing

⁷ World Cancer Research Fund/American Institute for Cancer Research: Food, Nutrition, Physical Activity, and the Prevention of Cancer: A Global Perspective. Washington, DC, American Institute for Cancer Research, 2007.

fetus. The AMA encourages adequate funding for research to explore the nature and extent of alcohol use disorder and unhealthy alcohol use among women, effective treatment modalities for women with alcohol use disorder and unhealthy alcohol use, and variations in alcohol use among ethnic and other subpopulations. The AMA encourages all medical education programs to provide greater coverage on alcohol as a significant source of morbidity and mortality in women.

Citation: CSA Rep. 5, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Modified: CSAPH Rep. 01, A-17

Screening and Brief Interventions For Alcohol Problems H-30.942

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

Citation: CSA Rep. 14, I-99; Reaffirmation I-01; Modified: CSAPH Rep. 1, A-11; Reaffirmation: A-18