AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 524
(A-22)

Introduced by: Medical Student Section

Subject: Increasing Access to Traumatic Brain Injury Resources in Primary Care Settings

Referred to: Reference Committee E

Whereas, There has been a recent 43% increase in incidence of mild traumatic brain injuries (TBIs) in the United States in both non-athletic and athletic populations[1]; and

Whereas, The Centers for Disease Control and Prevention (CDC) acknowledges that non-athletic TBIs affect diverse patient populations[2,3]; and

Whereas, 64.4% of TBIs are non-sports related, caused by activities of daily living, traffic or work-related accidents, falls, motor vehicle crashes, recreation, acts of interpersonal violence, and blast injuries [4,5,6]; and

Whereas, Studies show that adult patients with non-athletic TBIs experience increased mortality rates and long-term consequences such as increased incidence of post-concussion symptoms[7]; and

Whereas, A study by the Center for Disease Control suggests that rates of pediatric hospitalization and death are higher in non-athletes compared to that of athletic brain injuries due to a lack of early intervention[7,8,9,10]; and

Whereas, Approximately 48% of patients are lost to follow-up three months after hospitalization for TBIs[11]; and

Whereas, Almost 88% victims of domestic violence survivors suffer TBIs, which can lead to devastating and permanent physical, behavioral, and cognitive consequences[12]; and

Whereas, Due to a lack of universally accepted diagnostic criteria, clinicians rely on likely mechanism of injury for diagnosis of TBI, which may delay care for victims of domestic violence who often do not report their injuries[12,13]; and

Whereas, Victims of domestic violence often face unstable social situations, homelessness, and impaired cognitive states as a result of years of repeated brain injury, thus when they do seek medical care for their injuries, they experience added barriers to follow-up care, such as transportation, communication, and education[12]; and

Whereas, 89% of women experiencing an intimate partner violence-related TBI reported post-concussion syndrome, and early intervention for victims of domestic violence with mild TBIs are correlated with a reduction in post-concussive and other residual symptoms[14,15]; and
Whereas, Due to longer time to admission for acute-injury admissions, ethnic minorities, including those with history of homelessness and incarceration, experience inequity in post-

injury rehabilitation, and are less likely to obtain post-injury hospital admission compared to Non-Hispanic White patients[16,17]; and

Whereas, When the severity of injury may not differ significantly between patients of color and white patients, there are non-medical factors including systemic and environmental barriers contributing to the delay in access to acute TBI-rehabilitation in patients of color[16]; and

Whereas, Patients with non-athletic TBI are more likely to seek treatment via primary care providers[13]; and

Whereas, Over the past year, only 12–23% of adult female victims report to seeking treatment from their primary care physician for their injuries and subsequent morbidity after experiencing intimate partner violence[18]; and

Whereas, Patients who access primary care physicians for post-TBI care may be less likely to receive equitable treatment compared to athletes who have access to athletic trainers, coaches, and specialty physicians with return-to-play models of treatment [19,20]; and

Whereas, Primary care providers who were trained by the CDC's Heads Up program on TBIs were able to improve their patients' rate of treatment success and symptom recovery[13,21]; and

Whereas, Providing patients with information emphasizing the importance of post-injury care, encouraging interdisciplinary collaboration, and equipping primary physicians with the tools needed for appropriate treatment and referral services improves patients' functional recovery and treatment success[22]; and

Whereas, The treatment tools provided to primary care physicians include screening for neurosurgical emergencies or cervical spine injury and targeted treatment for specific symptoms of post-injury headaches, sleep disturbance, and psychological distress through medication and environmental and behavioral changes[13,23]; and

Whereas, The AMA recognizes the need for TBI prevention and remediation of post-injury morbidities (H-470.954); and

Whereas, Current AMA policy does not emphasize ethnic minorities or victims of domestic violence in existing policy for TBIs, nor does it address post-injury rehabilitation in non-athletic injuries; therefore be it

RESOLVED, That our AMA recognize disparities in the care for traumatic brain injuries, and acknowledge non-athletic traumatic brain injuries as a significant cause of morbidity and mortality, particularly for ethnic minorities and victims of domestic violence; (New HOD Policy) and be it further

RESOLVED, That our AMA supports increased access to traumatic brain injury resources in primary care settings which advocate for early intervention, encourage follow-up retention of patients for post-injury rehabilitation, and improved patient quality of life. (New HOD Policy)

Fiscal Note: Not yet determined

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RELEVANT AMA POLICY

H-470.954 Reduction of Sports Related Injury and Concussion

1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.

3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.
5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).
CSAPH Rep. 3, A-15; Appended: Res. 905, I-16

H-470.984 Brain Injury in Boxing
The AMA supports the following series of steps designed to protect amateur and professional boxers from injuries:

(1) Encourage the establishment of a "National Registry of Boxers" for all amateur and professional boxers, including "sparring mates," in the country. The proposed functions of a computer-based central registry would be to record the results of all licensed bouts, including technical knockouts, knockouts, and other boxing injuries, and to compile injury and win/loss records for individual boxers.

(2) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in his opinion, result in serious injury for either contestant.

(3) Urge state and local commissions to conduct frequent medical training seminars for all ring personnel.

(4) Recommend to all boxing jurisdictions that no amateur or professional boxing bout should be permitted unless: (a) the contest is held in an area where adequate neurosurgical facilities are immediately available for skilled emergency treatment of an injured boxer; (b) a portable resuscitator with oxygen equipment and appropriate endotracheal tubes are available at ringside; and (c) a comprehensive evacuation plan for the removal of any seriously injured boxer to hospital facilities is ready.

(5) Inform state legislatures that unsupervised boxing competition between unlicensed boxers in "tough man" contests is a most dangerous practice that may result in serious injury or death to contestants, and should be condemned.

(6) Urge state and local boxing commissions to mandate the use of safety equipment, such as plastic safety mats and padded cornerposts, and to encourage continued development of safety equipment.

(7) Urge state and local boxing commissions to extend all safety measures to sparring partners.

(8) Urge state and local boxing commissions to upgrade, standardize and strictly enforce medical evaluations for boxers.

CSA Rep. F, A-82; Reaffirmed: A-83; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: Sub. Res. 408, I-93; Reaffirmed: CSA Rep. 3, A-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmed: CSAPH Rep. 3, A-15
H-515.965 Family and Intimate Partner Violence
(1) Our AMA believes that all forms of family and intimate partner violence (IPV) 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 survivors. 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.
(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. 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 survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.
(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors 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 to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (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; (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; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (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; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.
(4) Within the larger community, our AMA:
(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors 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 survivors and perpetrators of intimate violence.
(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.
(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 oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. 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 survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (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.
(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.
(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.
(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.
(d) Physicians should be informed about the possible 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. CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19