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REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-A-14

Subject: Increasing Awareness of Nutrition Information in Schools
(Resolution 914-I-11)

Presented by: David O. Barbe, MD, MHA, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Resolution 914-I-11 “Increasing Awareness of Nutrition Information in Schools”, submitted by the
2 Medical Student Section, asked that our American Medical Association (AMA) support the
3 adoption of federal regulations requiring that all school and work cafeterias have nutritional
4 information for menu items available for public viewing.

5
6 Testimony on this resolution raised questions about the effectiveness of a federal mandate, as well
7 as concern for unintended consequences. The reference committee concluded that more
8 information was needed and therefore recommended referral, to which the House of Delegates
9 (HOD) agreed. This report reviews pertinent federal action which has been enacted since 2010 and
10 directly addresses this resolution, as well as related AMA policy and efforts.

11 INTRODUCTION

12
13
14 The consumption of healthy foods and beverages is influenced by multiple factors including
15 awareness, education, behavior, policy, and social determinants (such as access to grocery stores,
16 transportation, employment, income, language). For children, the ability to address these factors is
17 limited given that decisions about foods and beverages are often made for them by adults. Over 31
18 million children receive meals through the school lunch program; many students receive most of
19 their meals at school.¹ With one out of every three children in the U.S. considered overweight or
20 obese, schools are well positioned to improve children’s health.¹

21
22 In schools, the primary sources of foods and beverages include school meal programs, school
23 cafeterias, and vending machines. There is concern that those sources have not always provided
24 items of optimal nutritional value, and that when given a choice, children do not always pick the
25 healthiest items. The influence of industry to promote unhealthy items has complicated the issue of
26 foods and beverages in schools; however, federal policy in recent years has been enacted with the
27 intent of improving the health of all children in the U.S.

28 NATIONAL POLICY AND EFFORTS

29
30
31 In December 2010, Congress passed the Healthy, Hunger-Free Kids Act.² This comprehensive bill
32 addresses many aspects of school nutrition including:

- 33 • improvements in nutrition quality of preK-12 school food and beverages;
34 • enhancements to school-based meal programs to increase access;
35 • creation of demonstration projects to determine best practices;

- 1 • increase in farm-to-school programs to encourage the use of produce and whole foods; and
- 2 • expansion of access to drinking water.^{1,3}

3
4 Of particular relevance to Resolution 914, this Act:

- 5 • requires schools to make information about the nutritional quality of meals more readily
- 6 available^{1,3};
- 7 • gives the USDA the authority to set nutritional standards for all foods regularly sold in schools
- 8 and requires school districts to be audited every three years to see if they have met nutrition
- 9 standards; and
- 10 • strengthens local school wellness policies while requiring transparency and opportunities for
- 11 public input.

12
13 The Act does not specify how information about the nutritional quality of meals shall be made

14 available; such discretion will be determined at the local level. Many of the requirements of the Act

15 are set to start in the 2014-2015 school year.⁴

16
17 The 2010 Patient Protection and Affordable Care Act (ACA) established national labeling

18 requirements for chain restaurants, retail food establishments, and chain vending machine

19 operators;^{5,6} however, it does not address schools.

20
21 Organizations such as the School Nutrition Association; the Center for Science in the Public

22 Interest (CSPI); the Food, Research, and Action Center (FRAC); the Alliance for a Healthier

23 Generation; and the First Lady's "Let's Move" initiative are very active in the arena of school

24 nutrition and continue to monitor progress.

25 26 AMA POLICY AND EFFORTS

27
28 The AMA is committed to improving health outcomes, particularly those with cardiovascular

29 disease and/or type 2 diabetes, and continues to develop its population health agenda around

30 prevention of these chronic diseases. Proper nutrition can have a significant positive impact in the

31 prevention of these conditions. Furthermore, there is value in addressing nutrition at a young age so

32 as to cultivate healthy behaviors early in the life-span. Current AMA policy is supportive of both

33 nutrition education and labeling, especially regarding children and schools (see Appendix). Upon

34 review of relevant policies, it became apparent that Policies D-60.990 and D-150.988 have been

35 accomplished and are therefore recommended for rescission. In Policy D-60.990, the first clause is

36 addressed in the Healthy, Hunger-Free Kids Act of 2010, and the second clause was addressed by

37 the AMA's Weigh What Matters campaign (2011-2012). Regarding Policy D-150.988, it was

38 accomplished by a letter from the AMA to the FDA in 2005.

39 40 CONCLUSION

41
42 The Healthy, Hunger-Free Kids Act of 2010 contains a multi-factorial set of regulations to improve

43 nutrition in schools in order to benefit the health of all children. The Act requires schools to make

44 information about the nutritional quality of meals more readily available, therefore addressing the

45 main issue raised in Resolution 914-I-11 as well as reinforcing current AMA policy.

46
47 While the federal mandate is comprehensive, its full implementation remains to be seen. Study of

48 the implementation of the regulations in different school settings would be informative, particularly

49 as it relates to the availability of nutrition information to students, parents, caregivers, and decision-

50 makers. School districts should consider assessing student understanding of nutrition information,

1 particularly young children; advocating for improved nutrition education; and engaging adult
2 stakeholders such as parents, caregivers, educators, and the medical community. Further areas of
3 study include possible unintended consequences such as the impact on eating disorders, as well as
4 the potential burden put upon small school districts.

5
6 RECOMMENDATIONS

7
8 The Board of Trustees recommends that the following statements be adopted in lieu of Resolution
9 914-I-11 and the remainder of this report be filed:

- 10
11 1. That Policy H-150.948 be amended by addition and deletion to read as follows:

12
13 INCREASING ~~CUSTOMER~~ AWARENESS OF NUTRITION INFORMATION AND
14 INGREDIENTS LISTS ~~IN RESTAURANTS~~

15
16 Our AMA supports ~~and seeks~~ federal legislation or rules requiring (1) restaurants that have
17 menu items common to multiple locations to provide standard nutrition labels for all applicable
18 items, available for public viewing; and (2) all school and work cafeterias and restaurants to
19 have ingredient lists and nutritional information for all menu items, available for public
20 viewing. (Modify Current HOD Policy)

- 21
22 2. That Policies D-60.990 and D-150.988 be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than \$500

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APPENDIX

Relevant AMA Policies

H-150.948 Increasing Customer Awareness of Nutrition Information and Ingredient Lists in Restaurants

Our AMA supports and seeks federal legislation or rules requiring (1) restaurants that have menu items common to multiple locations to provide standard nutrition labels for all applicable items, available for public viewing; and (2) all school and work cafeterias and restaurants to have ingredient lists for all menu items, available for public viewing. (Sub. Res. 411, A-04; Reaffirmation A-07; Reaffirmed in lieu of Res. 413, A-09, Res. 416, A-09 and Res. 418, A-09)

D-60.990 Exercise and Healthy Eating for Children

Our AMA shall: (1) seek legislation that would require the development and implementation of evidence-based nutrition standards for all food served in K-12 schools irrespective of food vendor or provider; and (2) work with the US Public Health Service and other federal agencies, the Federation, and others in a coordinated campaign to educate the public on the epidemic of childhood obesity and enhance the K-12 curriculum by addressing the benefits of exercise, physical fitness, and healthful diets for children. (Res. 423, A-02; Reaffirmation A-04; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 408, A-11)

D-150.988 Revision of Nutrition Labels

Our AMA will ask the appropriate federal agency or body to require that the nutritional labels on all products sold in the United States have both the absolute amount (in appropriate units) and the percent daily values listed for the nutrients in the product. (Res. 428, A-05)

H-150.971 Food Labeling and Advertising

Our AMA believes that there is a need for clear, concise and uniform labeling on food products and supports the following aspects of food labeling: (1) Required nutrition labeling for all food products that includes a declaration of carbohydrates, protein, total fat, total saturated and polyunsaturated fatty acids, cholesterol, sodium and potassium content, and number of calories per serving. (2) Use of and/or ingredient labeling to declare the source of fats and oils. Knowledge of the degree of saturation is more important than knowing the source of oils in food products. It is not uncommon for manufacturers to use blends of different oils or to hydrogenate oils to achieve specific functional effects in foods. For example, vegetable oils that are primarily unsaturated may be modified by hydrogenation to more saturated forms that bring about desired taste, texture, or baking characteristics. This recommendation is therefore contingent upon nutrition labeling with saturated fat content. (3) The FDA's proposed rule on food labeling that requires quantitative information be provided on both fatty acid and cholesterol content if either one is declared on the label, as an interim step. (4) Warning statements on food labels are not appropriate for ingredients that have been established as safe for the general population. Moreover, the FDA has not defined descriptors for foods that are relatively higher in calories, sodium, fat, cholesterol, or sugar than other foods because there are no established scientific data indicating the level at which any of these substances or calories would become harmful in an individual food. (5) Our AMA commends the FTC for its past and current efforts and encourages the Commission to monitor misleading food advertising claims more closely, particularly those related to low sodium or cholesterol, and health claims. (6) Our AMA supports the timely approval of the Food and Drug Administration's proposed amendment of its regulations on nutrition labeling to require that the amount of trans fatty acids present in a food be included in the amount and percent daily value, and that definitions for "trans fat free" and "reduced trans fat" be set. (BOT Rep. C, A-90; Reaffirmed: Sunset Report, I-00; Appended: Res. 501, A-02; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04)

H-150.939 Accurate Reporting of Fats on Nutritional Labels

Our AMA urges the Food and Drug Administration to require the use of more precise processes to measure the fat content in foods, particularly trans fats and saturated fats, and to require that the most accurate fat content information based on these processes be included on food labels. (Res. 412, A-10)

See also:

H-150.945 Nutrition Labeling and Nutritionally Improved Menu Offerings in Fast-Food and Other Chain Restaurants

H-150.936 Support for Uniform, Evidence-Based Nutritional Rating System

H-150.942 Rating System for Processed Foods

H-150.935 Encouraging Healthy Eating Behaviors in Children Through Corporate Responsibility

H-170.961 Prevention of Obesity Through Instruction in Public Schools

H-150.953 Obesity as a Major Public Health Problem

H-150.944 Combating Obesity and Health Disparities

REPORT OF THE BOARD OF TRUSTEES

B of T Report 9-A-14

Subject: Cheerleading as a Sport
(Resolution 411-A-13)

Presented by: David O. Barbe, MD, MHA, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Resolution 411-A-13, “Cheerleading as a Sport,” introduced by the Illinois Delegation and referred
2 by the House of Delegates, asked:

3
4 That our American Medical Association support (1) the designation of cheerleading as a sport;
5 and (2) the requirement that cheerleading coaches undergo training on reducing risk associated
6 with potentially dangerous cheerleading activities.

7
8 The designation of cheerleading as “sport” would likely subject it to formal safety requirements
9 and injury reporting. Referral was based on the concern that school districts may face hardships
10 due to the burdens of implementing such requirements and reporting. Additionally, the designation
11 of cheerleading as a sport has implications under Title IX, which introduces complexity into the
12 decision. This report briefly reviews cheerleading participation and injuries, recommendations for
13 increased safety and the question of whether cheerleading should be designated as a sport.

14
15 **BACKGROUND ON CHEERLEADING**

16
17 Cheerleading became a common activity more than a century ago to support athletic teams from
18 the sidelines by leading spectators in cheers. Cheerleading routines consisted primarily of clapping,
19 with some minor physical stunts such as toe-touch jumps and the splits. In the 1980s, cheerleading
20 began to evolve into a more rigorous athletic activity, and today involves the incorporation of
21 individual gymnastics and tumbling stunts, and team stunts such as human pyramids, lifts, catches,
22 and tosses.^{1,2} Safely performing these technical stunts requires strength, stamina, balance, and
23 specialized training in dance, tumbling, and gymnastics.

24
25 More than three million individuals aged 6 years and older participate in cheerleading activities;
26 this number reflects an approximate 18% increase in participation over the last 25 years. The
27 majority of today’s cheerleaders are part of “sideline” squads, i.e., those whose primary function is
28 to support athletic teams at events. These squads are usually formed within a school setting such as
29 high school or college, but include professional cheerleaders as well. “Competitive” or “all-star”
30 squads are those that compete by performing a routine consisting of stunts. These competitions take
31 place apart from the traditional athletic support role played by sideline squads, but both sideline
32 and competitive squads perform stunts, and some sideline squads may participate in competitive
33 events. Likewise, individual cheerleaders may participate on both sideline and competitive squads.

34
35 The vast majority (more than 96%) of cheerleading participants at the high school and lower levels
36 are female.² At the collegiate level, the percentage of male participation is higher, likely nearing

1 50%; the collegiate number is more difficult to estimate since squad composition is different at
2 each school.

3 4 INJURIES IN CHEERLEADING

5
6 The number of reported cheerleading-related injuries has steadily increased over the last several
7 decades. In 1980, nearly 5,000 cheerleading injuries were treated in emergency departments; by
8 2007, that number had climbed to nearly 27,000.³ The increase has been attributed to the growing
9 incorporation of technical stunts into cheerleading routines.² The most common injuries caused by
10 cheerleading are ankle sprains/strains, knee abrasions/contusions/hematomas, lower back
11 lacerations/punctures, concussions/closed head injuries, and in some cases neck fractures.⁴
12 However, the vast majority of injured cheerleaders (98%) are treated and released.³ Among
13 cheerleading injuries in participants aged 18 years or younger, 97% occur in females.¹

14
15 The rate of overall cheerleading injury is approximately 1 per 1,000 athletic exposures (AE;
16 “athletic exposures” is defined as one athlete participating in one practice or competition session).²
17 When compared with existing high school girls’ sports, the rate of overall cheerleading injuries is
18 lower than that for gymnastics (8.5 per 1,000 AE), soccer (5.3 per 1,000 AE), basketball (4.4 per
19 1,000 AE), field hockey (3.7 per 1,000 AE), and softball (3.5 per 1,000 AE).² However,
20 catastrophic injury rates are higher in cheerleading compared with these sports. Catastrophic
21 injuries are those that result in fatality, permanent severe functional disability, or severe
22 impairment (such as cervical spinal or skull fractures and closed-head injuries).⁵ Cheerleading’s
23 catastrophic injury rate is 0.50-1.62 per 100,000 AE, compared to 0.44, 0.03, 0.03, 0.02, and 0.0
24 per 100,000 AE for gymnastics, soccer, basketball, softball, and field hockey, respectively.⁶
25 College-level cheerleaders’ overall and catastrophic injury rates are higher than those of high
26 schoolers’ at 2.4 per 1,000 AE and 2.0 per 100,000 AE, respectively, presumably due to the more
27 technically difficult routines often performed at the collegiate level.^{5,6}

28 29 INCREASING THE SAFETY OF CHEERLEADING

30
31 Several groups have studied the issue of cheerleading safety and developed recommendations
32 aimed at reducing the risk of cheerleading injuries. These groups include the American Academy
33 of Pediatrics (AAP) and the American Academy of Orthopaedic Surgeons (AAOS); the National
34 Center for Catastrophic Sports Injury Research (NCCSIR), a research center focusing on sports
35 injury reporting and prevention; the American Association of Cheerleading Coaches and
36 Administrators (AACCA), an educational association for cheerleading coaches at all levels; the
37 National Federation of State High School Associations (NFHS), the body that writes the rules of
38 competition for most high school sports and activities in the United States; the National Cheer
39 Safety Foundation (NCSF), a cheerleading safety advocacy group; and the USA Federation for
40 Sport Cheering (USA Cheer), the national governing body for club and school-based cheer
41 programs.

42
43 Recommendations for improving the safety of cheerleading generally include training for coaches
44 and participants, implementation of rules for the execution of technical stunts, avoidance of hard
45 surfaces and preparedness for injury management. These are based on evidence suggesting that
46 injury risk is increased when coaches are inadequately trained and when stunts are performed
47 improperly and on surfaces that are hard or otherwise inappropriate.^{7,8} Proposed recommendations
48 that have broad-based support among the groups noted above include:

- 49
50 • Designate cheerleading as a sport under the National Collegiate Athletic Association (NCAA)
51 and the NFHS.^{5,6,9,11}

- 1 • Pre-participation physical examinations should be required and access to appropriate strength
2 and conditioning programs available.^{5,6,11}
- 3 • Cheerleading coaches should be trained and certified in proper cheerleading techniques, safety
4 measures and basic injury management.^{5,6,11-15}
- 5 • Cheerleaders should be trained in proper cheerleading techniques and should attempt stunts
6 only after demonstrating appropriate skills and proficiency.^{5,6,12-15}
- 7 • Coaches should be present during all practice and competition events.^{5,12-15}
- 8 • Technical stunts should not be performed on hard, wet, or uneven surfaces, or on surfaces with
9 obstructions; cheer events should not take place on surfaces composed of dirt, vinyl, concrete
10 or asphalt. Stunts should instead take place on a spring floor or on a traditional foam floor or
11 grass/turf with a landing mat.^{6,12,13,15}
- 12 • Coaches should follow rules for the execution of technical skills set forth in the most recent
13 version of the NFHS Spirit Rules Handbook.^{6,15}
- 14 • Coaches, parents and athletes should have access to a written emergency plan, designed in
15 conjunction with a physician and/or certified athletic trainer. When possible, a physician or
16 certified athletic trainer should be present at practices and competitions.^{5,6,11-14}
- 17 • Any cheerleader showing signs of a head injury should be removed from practice or
18 competition and not allowed to return until he or she has received written clearance from a
19 physician or qualified health care provider. All coaches and parents should be knowledgeable
20 on the cause, prevention, signs of and response to concussion.^{5,6,11,14,15}
- 21 • Surveillance of cheerleading injuries and research on safety should continue, with all
22 catastrophic injuries reported to the NCCSIR.^{5,6,11}

23 24 THE DESIGNATION OF CHEERLEADING AS A SPORT

25
26 Several groups, including the AAP, have promoted the idea that the designation of cheerleading as
27 a sport under the NCAA and the NFHS would make it safer. NCAA- and NFHS-designated sports
28 are subject to rules regarding practice length, practice facilities, coach training/certification,
29 availability of certified athletic trainers, access to medical care and injury surveillance/reporting.⁶
30 Despite the athleticism required of cheerleading participants and the competition-based atmosphere
31 of the activity, only a minority of states consider it a sport under NFHS, and the NCAA does not
32 consider it a sport. To be considered an NCAA-designated sport, several standards must be met,
33 including regularly scheduled team and/or individual head-to-head competitions (at least five)
34 within a defined competitive season and standardized rules with rating/scoring systems ratified by
35 official regulatory agencies and governing bodies.¹⁶ At present, cheerleading competitions are held
36 by several different organizations, each with different rules, meaning that it does not yet meet
37 NCAA-sport criteria.

38
39 In 2012, the U.S. Court of Appeals for the 2nd District upheld a lower court ruling that Quinnipiac
40 University could not consider cheerleading as a sport for Title IX purposes.¹⁷ Quinnipiac
41 University had discontinued its women's volleyball program and established a competitive
42 cheerleading team. Members of the volleyball team subsequently sued the university, alleging that
43 it was denying women equal athletic opportunities in violation of Title IX, which protects against
44 sex discrimination in federally funded educational programs. The court found that Quinnipiac's
45 competitive cheer program diverged from other sports for several reasons including the fact that
46 cheerleading has not been recognized as a sport by the NCAA.¹⁷ NCAA recognition is not a
47 requirement for Title IX eligibility, but it usually weighs heavily in eligibility decisions. NFHS has
48 stated that it believes competitive cheer should be counted as a Title IX-eligible sport.¹⁸

1 In response to the court decision, both USA Cheer and USA Gymnastics (the sole governing body
2 for the sport of gymnastics in the United States) submitted proposals to the NCAA Committee on
3 Women's Athletics requesting that forms of competitive cheerleading (called "STUNT" by USA
4 Cheer and "Acrobatics and Tumbling" by USA Gymnastics) be placed on the NCAA Emerging
5 Sports for Women list.¹⁹ Placement on the list is often a precursor to recognition as an NCAA
6 sport. The NCAA Committee on Women's Athletics has requested that USA Cheer and USA
7 Gymnastics jointly develop a single proposal, rather than proposals for two similar, competing
8 concepts.¹⁹

9
10 CONCLUSIONS

11
12 Cheerleading results in more catastrophic injuries than any other sport activity engaged in by
13 females. Medical specialty societies, research institutes, and cheerleading advocacy organizations
14 have developed recommendations aimed at reducing injury rates. Some of these recommendations
15 are supported by AMA policy: medical examinations prior to athletic participation (Policy H-
16 470.971) and authorization by a physician before returning to athletic activity after sustaining a
17 concussion (Policy H- 470.959).

18
19 The designation of cheerleading as a sport under NCAA and NFHS is supported by several groups,
20 both as a means for improving its safety and for improving its credibility as a sport on equal
21 footing with other NCAA-sanctioned sports. However, the NCAA does not believe that
22 cheerleading meets the requirements for such a designation at this time, and it has not yet been
23 placed on the Emerging Sports for Women list. Similarly, courts have recently ruled that it cannot
24 be considered a sport for Title IX purposes. Although the NFHS has stated that it supports the
25 designation of cheerleading as a sport, only a minority of states consider it as such. Given these
26 findings, it does not appear that cheerleading will be designated as a sport in the near future. Since
27 ensuring the health and safety of cheerleaders is immediately important, it seems most effective to
28 advocate for consistent adoption and implementation of recommendations aimed at improving
29 cheerleading safety now, rather than to advocate for a designation that may or may not ever occur.
30 Most of the suggested recommendations above enjoy broad support among medical professionals
31 and cheerleading groups alike.

32
33 RECOMMENDATIONS

34
35 The Board of Trustees recommends that the following statements be adopted in lieu of Resolution
36 411-A-13 and that the remainder of this report be filed.

- 37
38 1. That our American Medical Association recognizes the potential dangers inherent in
39 cheerleading, including the potential for concussion and catastrophic injury, and supports the
40 implementation of recommendations designed to improve its safety. These include proper
41 training of coaches, avoidance of inappropriate surfaces when performing stunts and adherence
42 to rules for the proper execution of stunts. (New HOD Policy)
- 43
44 2. That Policy H-470.959, which supports the requirement that athletes suspected of sustaining a
45 concussion be allowed to return to play only after approval by a physician, be reaffirmed.
46 (Reaffirm HOD Policy)
- 47
48 3. That Policy H-470.971, which supports medical examinations for youth before participation in
49 athletic activities, be reaffirmed. (Reaffirm HOD Policy)

Fiscal note: Less than \$500

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 10-A-14

Subject: Providing Physical Fitness Guidelines
(Resolution 427-A-12)

Presented by: David O. Barbe, MD, MHA, Chair

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Resolution 427-A-12 “Providing Physical Fitness Guidelines,” submitted by the Pennsylvania
2 Delegation, asked that our American Medical Association (AMA): (1) coordinate with the
3 appropriate national specialty societies to seek the development of a jointly endorsed checklist
4 designed to help identify underlying risk factors in patients interested in beginning or resuming
5 physical fitness activities; (2) offer non-legal guidance regarding the liability associated with
6 signing releases for patients’ participation in physical fitness activities; and (3) maintain a current
7 resource for its members as data becomes available regarding evidence-based recommendations
8 that would be appropriate for their patients.
9

10 The reference committee noted that physical activity is important, but there are challenges when
11 physicians are asked to sign releases, and further, that this work may be duplicative and out of the
12 scope of the AMA. Therefore, the reference committee recommended that Resolution 427-A-12 be
13 not adopted; however, due to mixed testimony on the floor of the House of Delegates (HOD), the
14 resolution was referred.
15

16 This report will review the initiatives of national organizations and specialty societies that are
17 involved in the establishment of physical activity guidelines for patients, as well as related
18 legislation and current policy efforts of the AMA.
19

20 INTRODUCTION

21
22 Scientific evidence has proven that regular physical activity is one of the most important steps a
23 person can take to improve and maintain his or her own health. It can reduce one’s risk of
24 cardiovascular disease, type 2 diabetes and some cancers, as well as help to maintain or lose
25 weight. Physical activity can also strengthen bones and muscles, improve mental health, mood and
26 capacity for daily activity, prevent falls, and increase longevity.¹ Despite the benefits, most adults
27 and youth in the United States do not meet current physical activity recommendations.² The
28 medical community plays an important role in promoting healthy lifestyles to their patients,
29 including encouraging participation in physical activity. Given the various ages, health conditions
30 and socioeconomic constraints of patients, physical activity counseling can be a challenge for
31 physicians.
32

33 NATIONAL GUIDELINES

34
35 In 2008, the U.S. Department of Health and Human Services (HHS) issued the *Physical Activity*
36 *Guidelines for Americans* (“Guidelines”), which provide guidance on the importance of being

1 physically active to promote good health and reduce the risk of chronic diseases.³ These
2 Guidelines, which target health care professionals and policymakers, are designed to provide
3 information and guidance on the significant health benefits of physical activity for people aged 6
4 and over. They also address women during pregnancy and postpartum, adults with disabilities and
5 people with chronic medical conditions.

6
7 The Guidelines are supported by the Community Preventive Services Task Force, which was
8 established by HHS in 1996 to identify population health interventions that are scientifically
9 proven to save lives, increase lifespans and improve quality of life.² Likewise, the Guidelines are
10 referenced by the U.S. Preventive Services Task Force (USPSTF), an independent panel of non-
11 Federal primary care provider experts in prevention and evidence-based medicine.⁴ Also, the
12 Institute of Medicine cited the Guidelines in its 2013 report, “Educating the Student Body: Taking
13 Physical Activity and Physical Education to School.”⁵

14
15 Various medical specialty societies also produce guidelines, recommendations and policy
16 statements for physicians pertaining to physical activity for specific subpopulations, including the
17 American Congress of Obstetricians and Gynecologists (ACOG), the American Academy of
18 Pediatrics (AAP), and the American College of Cardiology (ACC).⁶ Further, the American College
19 of Sports Medicine (ACSM) is particularly invested in this field given that its mission is to
20 “advance and integrate scientific research to provide educational and practical applications of
21 exercise science and sports medicine.”⁷ Web links to these guidelines and recommendations are
22 provided in the References.

23 24 PENDING NATIONAL LEGISLATION

25
26 House bill H.R. 2179, “The Physical Activity Guidelines for Americans Act,” was introduced in
27 May 2013 and would require the secretary of HHS to publish physical activity guidelines every ten
28 years based on the latest scientific evidence and include guidelines for identified population
29 subgroups.⁸ Every five years, the secretary would be required to issue a mid-course report that
30 summarizes best practices as well as emerging issues regarding physical activity. This bill was
31 endorsed by ACSM.

32 33 AMA POLICY AND EFFORTS

34
35 The AMA is committed to improving health outcomes, specifically by focusing on prevention and
36 treatment of cardiovascular disease and type 2 diabetes. Physical activity can have a significant,
37 positive impact on these conditions. The AMA is currently working to expand physician awareness
38 of and patient referral to the Diabetes Prevention Program (DPP) located at various YMCAs and
39 other community-based sites across the country. The DPP is an evidence-based lifestyle education
40 program which addresses the importance of physical activity. The AMA Healthier Life Steps®
41 program (2008-2012) provided a toolkit to physicians that addressed four areas of health behaviors:
42 healthy eating, physical activity, tobacco cessation and risky drinking. The toolkit provided
43 physicians with resources and tools to improve physical activity counseling within clinical practice.
44 The AMA is a member of the coordinating committee of the National Physical Activity Plan,
45 which makes recommendations for specific policies that promote physical activity in various
46 societal sectors; the AMA co-chairs the Health Care Sector Committee, which supports physician
47 counseling of patients based on the Guidelines.⁹ Existing AMA policy addresses physical activity
48 and fitness for all ages in various settings (see Appendix).

49
50 A review of AMA policy indicates that Policies D-470.991, D-90.993 and D-470.990 have been
51 accomplished and are therefore recommended for rescission. Policy D-470.991, “Adoption of a

1 Universal Exercise Database and Prescription protocols for Obesity Reduction,” has been
2 addressed by the Physical Guidelines for Americans, and Policy H-60.979. AMA Policy D-90.993,
3 “Fitness and Athletics Equity for Students with Disabilities,” was accomplished in 2008 by the
4 AMA’s Advocacy Resource Center, which communicated with all state and specialty societies.
5 Policy D-470.990, “Exercise Information on the American Medical Association Web Site,” was
6 accomplished by way of the AMA Healthier Life Steps® program webpage which provided
7 information and web links regarding physical activity from 2008-2012. This webpage was removed
8 in 2013 during the AMA website revision due to the strategic reorganization.
9

10 DISCUSSION

11
12 The first resolve of Resolution 427-A-12 asks for coordination of appropriate national specialties in
13 order to produce a single “jointly endorsed checklist designed to help identify underlying risk
14 factors in patients” who wish to begin/resume exercise. The identification of underlying risk factors
15 denotes a screening or more thorough examination. The HHS Guidelines advisory committee did
16 an extensive literature review through 2007 that did not locate any evidence supporting
17 examinations in healthy people or people with chronic illness as a mechanism to reduce exercise-
18 related adverse events.¹⁰ Additionally, the creation of the proposed checklist would require
19 significant effort and cost to the AMA. Existing Policy H-470.971, “Athletic Preparticipation
20 Examinations for Adolescents,” addresses this issue, recommending that the most current
21 guidelines established by the AAP, ACC, ACSM, and other appropriate medical specialty societies
22 be used to determine eligibility for sports participation.
23

24 The second resolve asks for non-legal guidance regarding liability pertaining to release forms for
25 patient participation in physical fitness activities. The interpretation and effect of release forms is a
26 matter of state law. Since there is likely to be variability among states, a comprehensive
27 examination of such relevant statutes and case law in all 50 states would require significant staff
28 and financial resources.
29

30 The third resolve asks for a database of “evidence-based recommendations that would be
31 appropriate for their patients,” although it does not specify what is meant by “recommendations.”
32 The USPSTF provides recommendations regarding screening and counseling to promote physical
33 activity and a healthful diet to prevent cardiovascular disease.¹¹ The Guidelines website provides a
34 wealth of resources for health care professionals, including the Guidelines Advisory Committee
35 Report describing the scientific background and rationale for the guidelines and Web links to other
36 resources that provide information for professionals and patients alike.¹² The specialty societies
37 listed earlier also provide recommendations and guidelines for subpopulations on their websites.
38

39 CONCLUSION

40
41 The federal government as well as several national organizations and specialty societies are active
42 in the field of physical activity. The actions requested in Resolution 427-A-12 are duplicative and
43 would require the AMA to involve itself in matters in which it does not have requisite expertise or
44 resources. Also, the request goes beyond the scope of the AMA’s current strategic focus.

1 RECOMMENDATIONS

2

3 The Board of Trustees recommends that the following statements be adopted in lieu of Resolution
4 427-A-12 and the remainder of this report be filed:

5

6 1. That Policy H-470.997, which encourages physicians to promote physical activity, be
7 reaffirmed. (Reaffirm HOD Policy)

8

9 2. That Policy H-60.979 be amended by addition and deletion to read as follows:

10

11 PHYSICAL ACTIVITY GUIDELINES

12 ~~PHYSICIAN-BASED PHYSICAL ACTIVITY AND EXERCISE COUNSELING~~

13 ~~PROTOCOLS FOR YOUTH AND ADOLESCENTS~~

14

15 The AMA supports the continued expert review and development of national guidelines
16 regarding physical activity for all ages and the dissemination of such guidelines to
17 physicians. ~~It is the policy of the AMA, in collaboration with appropriate agencies, to assist in~~
18 ~~the development of physician-based physical activity assessment and counseling protocols for~~
19 ~~youth and adolescents, including the development of training materials to instruct physicians in~~
20 ~~the use of these protocols.~~ (Modify Current HOD Policy)

21

22 3. That Policies D-470.991, D-90.993, and D-470.990 be rescinded. (Rescind HOD Policy)

Fiscal note: Less than \$500

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1. Centers for Disease Control and Prevention. Physical Activity and Health. <http://www.cdc.gov/physicalactivity/everyone/health/index.html> Accessed Feb 3, 2014.
2. Community Guide to Preventive Services Task Force. <http://www.thecommunityguide.org/about/aboutTF.html> Accessed Feb 3, 2014.
3. Physical Activity Guidelines for Americans. 2008 Physical Activity Guidelines for Americans Summary. <http://www.health.gov/paguidelines/guidelines/summary.aspx> Accessed Feb 3, 2014.
4. U.S. Preventive Services Task Force. <http://www.uspreventiveservicestaskforce.org/> Accessed Feb 3, 2014.
5. Institute of Medicine of the National Academies. Educating the Student Body: Taking Physical Activity and Physical Education to School. 2013.
6. American Congress of Obstetricians and Gynecologists. Resource Guide – Nutrition and Physical Activity to Address Overweight and Obesity. http://www.acog.org/About_ACOG/ACOG_Departments/Health_Care_for_Underreserved_Women/Resource_Guide_-_Nutrition_and_Physical_Activity Accessed Feb 3, 2014.
7. American College of Sports Medicine. <http://www.acsm.org/about-acsm/who-we-are> Accessed Feb 3, 2014.
8. H.R.2179: Physical Activity Guidelines for Americans Act. <https://www.govtrack.us/congress/bills/113/hr2179> Accessed Feb 3, 2014.
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10. Physical Activity Guidelines Advisory Committee Report, 2008. <http://www.health.gov/paguidelines/Report/pdf/CommitteeReport.pdf>. Accessed February 18, 2014.
11. USPSTF. Behavioral Counseling to Promote a Healthful Diet and Physical Activity for Cardiovascular Disease Prevention in Adults. <http://www.uspreventiveservicestaskforce.org/uspstf/uspophys.htm> Accessed February 18, 2014.
12. Physical Activity Guidelines for Americans. Appendix 3: Federal Web Sites That Promote Physical Activity. <http://www.health.gov/paguidelines/guidelines/appendix3.aspx> Accessed February 3, 2014.

APPENDIX

Relevant AMA Policies:

H-470.997 Exercise and Physical Fitness

The AMA encourages all physicians to utilize the health potentialities of exercise for their patients as a most important part of health promotion and rehabilitation, and urges state and local medical societies to emphasize through all available channels the need for physical activity for all age groups and both sexes. The AMA encourages other organizations and agencies to join with the Association in promoting physical fitness through all appropriate means. (BOT Rep. K, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

H-60.979 Physician-Based Physical Activity and Exercise Counseling Protocols for Youth and Adolescents

It is the policy of the AMA, in collaboration with appropriate agencies, to assist in the development of physician-based physical activity assessment and counseling protocols for youth and adolescents, including the development of training materials to instruct physicians in the use of these protocols. (Res. 186, I-90; Reaffirmed: Sunset Report, I-00; Reaffirmed: CSAPH Rep. 1, A-10)

D-470.991 Adoption of a Universal Exercise Database and Prescription protocols for Obesity Reduction

Our AMA: (1) will collaborate with appropriate federal agencies and professional health organizations to develop an independent meta-database of evidence-based exercise guidelines to assist physicians and other health professionals in making exercise prescriptions; and (2) supports longitudinal research on exercise prescription outcomes in order to further refine prescription-based exercise protocols. (Res. 415, A-10)

D-90.993 Fitness and Athletics Equity for Students with Disabilities

Our AMA will work with state medical associations and specialty societies to encourage individual state legislatures to enact laws which ensure that students with disabilities have an equal opportunity to participate in mainstream physical education programs and try out for and, if selected, participate in mainstream athletic programs, except when the inclusion of the student presents an objective safety risk to the student or to others, or fundamentally alters the nature of the school's mainstream physical education or mainstream athletic program. (Res. 202, A-08)

D-470.990 Exercise Information on the American Medical Association Web Site

Our AMA will work with appropriate agencies and organizations to improve means of disseminating information to patients and physicians regarding safe and effective options for healthy exercise on its public web site with the goal of increasing the number of patients who participate in regular physical activity. (Res. 425, A-10)

H-470.971 Athletic Preparticipation Examinations for Adolescents

To promote the health and safety of adolescents, our AMA recommends that state medical societies work with appropriate state and local agencies to promote the following: (1) The development of standards for preparticipation athletic examinations that are consistent with consensus recommendations of the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine. (2) Only licensed MDs, DOs, and licensed physician extenders practicing under the supervision of licensed MDs and

DOs perform preparticipation examinations. (3) The decision of whether or not an adolescent is healthy and physically mature enough to participate in a particular sport is made by a qualified physician. (4) The decision of when an injured athlete resumes participation is made by a qualified physician. (5) The most current guidelines established by the American Academy of Pediatrics, American College of Cardiology, American College of Sports Medicine, and other appropriate medical specialty societies are used to determine eligibility for sports participation. (BOT Rep. R, A-90; Amended: CSA Rep. 5, I-99; Reaffirmed: CSAPH Rep. 1, A-09)

H-470.991 Promotion of Exercise

1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest. 2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible. (Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11)

H-470.990 Promotion of Exercise Within Medicine and Society

Our AMA supports (1) education of the profession on exercise, including instruction on the role of exercise prescription in medical practice in its continuing education courses and conferences, whenever feasible and appropriate; (2) medical student instruction on the prescription of exercise; (3) physical education instruction in the school system; and (4) education of the public on the benefits of exercise, through its public relations program. (Res. 56, I-78; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmation I-98; Reaffirmation A-07; Reaffirmed: BOT Rep. 21, A-12)

H-25.995 Exercise Programs for the Elderly

The AMA recommends that physicians: (1) stress the importance of exercise for older patients and explain its physiological and psychological benefits; (2) obtain a complete medical history and perform a physical examination that includes exercise testing for quantification of cardiovascular and physical fitness as appropriate, prior to the specific exercise prescription; (3) provide appropriate follow-up of patients' exercise programs; and (4) encourage all patients to establish a lifetime commitment to an exercise program. (CSA Rep. C, I-83; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)

H-440.917 Increased Physical Activity for Most US Adults

The AMA endorses, in principle, the movement calling for every adult to accumulate in the course of each day 30 or more minutes of physical activity of moderate intensity; and urges physicians to review the consensus statement of the Centers for Disease Control and Prevention and the American College of Sports Medicine which extends the traditional concept of physical fitness to include intermittent cumulative physical activity and the scientific evidence on which this advice rests. (Res. 408, A-95; Reaffirmed: CSA Rep. 8, A-05)

H-440.859 American's Health

Our AMA will: (1) make improving health through increased activity and proper diet a priority; (2) propose legislation calling on the federal government and state governments to develop new and innovative programs in partnership with the private sector that encourage personal responsibility for proper dietary habits and physical activity of individual Americans; and (3) continue to work in conjunction with the American College of Sports Medicine, American Heart Association, US Department of Health and Human Services and any other concerned organizations to provide educational materials that encourage a healthier America through increased physical activity and improved dietary habits. (Res. 201, A-09; Reaffirmation A-12)

H-425.972 Healthy Lifestyles

Our AMA: (1) recognizes the 15 competencies of lifestyle medicine as defined by a blue ribbon panel of experts convened in 2009 whose consensus statement was published in the Journal of the American Medical Association in 2010; (2) will urge physicians to acquire and apply the 15 clinical competencies of lifestyle medicine, and offer evidence-based lifestyle interventions as the first and primary mode of preventing and, when appropriate, treating chronic disease within clinical medicine; and (3) will work with appropriate federal agencies, medical specialty societies, and public health organizations to educate and assist physicians to routinely address physical activity and nutrition, tobacco cessation and other lifestyle factors with their patients as the primary strategy for chronic disease prevention and management. (Res. 423, A-12)

H-440.866 The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity

Our AMA supports: (1) greater emphasis in physician educational programs on the risk differences among ethnic and age groups at varying levels of BMI and the importance of monitoring waist circumference in individuals with BMIs below 35 kg/m²; (2) additional research on the efficacy of screening for overweight and obesity, using different indicators, in improving various clinical outcomes across populations, including morbidity, mortality, mental health, and prevention of further weight gain; and (3) more research on the efficacy of screening and interventions by physicians to promote healthy lifestyle behaviors, including healthy diets and regular physical activity, in all of their patients to improve health and minimize disease risks. (CSAPH Rep. 1, A-08; Reaffirmed: CSAPH Rep. 3, A-13)

H-425.993 Health Promotion and Disease Prevention

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. (Presidential Address, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03; Reaffirmed: BOT Rep. 8, I-06)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 401
(A-14)

Introduced by: Indiana
Subject: Public Health: "Heading in Soccer"
Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Chronic Traumatic Encephalopathy, described as a syndrome of progressive
2 neurodegeneration resulting from repetitive subconcussive brain injury that shares some
3 features of Alzheimer's dementia, has become a significant public health concern; and
4

5 Whereas, There is now radiological evidence consistent with chronic traumatic brain injury in
6 young, asymptomatic professional soccer players (with no known history of concussion) at a
7 mean age of 19 years and a mean duration of competition of 13 years; and
8

9 Whereas, There are some reports in the peer-reviewed literature of significant neurocognitive
10 deficits in current and retired professional soccer players, consistent with functions of the areas
11 noted to have the radiographic changes; and
12

13 Whereas, The younger the athlete the more susceptible to injury they may be due to less
14 physical development, less playing experience, higher risk at lower ball speeds, and longer
15 recovery time after brain trauma as compared to their older counterparts; and
16

17 Whereas, Formal training of heading technique usually does not begin before 15 years of age in
18 Europe; and
19

20 Whereas, The younger athletes tend to play in "unofficial" leagues with inexperienced players
21 and coaches; therefore be it
22

23 RESOLVED, That our American Medical Association discourage "heading" of the ball while
24 playing soccer until the athlete is playing in an organized league, once in high school, and has
25 been trained in the proper technique based upon contemporaneous standards (New HOD
26 Policy); and be it further
27

28 RESOLVED, That our AMA recommend that individuals trained in heading the ball similarly train
29 athletes when they are old enough (New HOD Policy); and be it further
30

31 RESOLVED, That our AMA encourage continued investigation by our local sports medicine,
32 pediatric and neurological colleagues, into the potential consequences of nonconcussive
33 heading involved with soccer participation. (New HOD Policy)

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

Received: 11/22/13

References:

- "Chronic Traumatic Brain Injury in Professional Soccer Players." Matser, J.T., et al. *Neurology*. 51: 371-376. (1998).
"Heading and Head Injuries in Soccer." Kirkendall, D.T., et al. *Sports Med*. 31: 369-386. (2001).
"Head Injuries, Heading, and the Use of Headgear in Soccer." Niedfeldt, M.W. *Curr Sports Med Rep*. 10: 324-329. (2011).
"Research Letter: White Matter Integrity in the Brains of Professional Soccer Players Without a Symptomatic Concussion." Koerte, I.K., et al. *JAMA*. 308: 1861. (2012).
"Heading in Soccer: Dangerous Play?" Spiotta, A.M., et al. *Neurosurg*. 70: 1-11. (2012).

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 402
(A-14)

Introduced by: American College of Cardiology
Subject: Limiting Access to Tobacco Products
Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Reduction in use of tobacco products is one of the most effective means of preventing
2 premature death and disability; and
3
4 Whereas, Limiting access to tobacco products has led to their reduced use; and
5
6 Whereas, All participants in health care should discourage use of tobacco products; and
7
8 Whereas, CVS/Caremark Pharmacies recently discontinued sale of tobacco products in its
9 stores; therefore be it
10
11 RESOLVED, That our American Medical Association congratulate CVS/Caremark Pharmacies
12 for its voluntary action to stop selling tobacco products (Directive to Take Action); and be it
13 further
14
15 RESOLVED, That our AMA call on all pharmacies and providers of health services and products
16 to similarly stop selling tobacco products. (Reaffirm HOD Policy)

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

Received: 03/03/14

RELEVANT AMA POLICY

H-495.986 Tobacco Product Sales and Distribution

Our AMA:

(1) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors;

(2) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to obtain proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age;

(3) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors;

(4) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products;

(5) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products;

(6) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail;

(7) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members;

(8) opposes the sale of tobacco at any facility where health services are provided; and

(9) supports that the sale of tobacco products be restricted to tobacco specialty stores.

(CSA Rep. 3, A-04; Appended: Res. 413, A-04; Reaffirmation A-07; Amended: Res. 817, I-07; Reaffirmation A-08; Reaffirmation I-08; Reaffirmation A-09; Reaffirmation I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 403
(A-14)

Introduced by: Medical Student Section

Subject: Sunscreen and Sun Protection Counseling by Physicians

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Skin cancer is the most common type of cancer in the US, and its incidence is on the
2 rise; and
3
4 Whereas, In 2010, the US spent an estimated \$2.36 billion in direct costs associated with the
5 treatment of Melanoma; and
6
7 Whereas, UV radiation exposure is the only known modifiable risk factor for the development of
8 Melanoma, so Melanoma and other skin cancers may be preventable by sunscreen use and
9 sun-protective behavior; and
10
11 Whereas, According to a 2014 *JAMA Dermatology* article, professional organizations, including
12 the American Academy of Dermatology, National Institutes of Health, American Cancer Society,
13 American Academy of Pediatrics, American College of Gynecologists, and American Academy
14 of Family Physicians, recommend that physicians provide patient counseling regarding sun
15 exposure and sun-protective behaviors; and
16
17 Whereas, AMA policy supports disseminating information to physicians and the public about the
18 dangers of ultraviolet light from sun exposure and the possible harmful effects of ultraviolet light
19 (AMA Policy H-440.980); therefore be it
20
21 RESOLVED, That our American Medical Association encourage physicians to counsel their
22 patients on sun-protective behavior. (New HOD Policy)

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

Received: 3/20/14

RELEVANT AMA POLICY

H-440.967 Public Information Program Addressing the Dangers of UVA Exposure

The AMA: (1) supports using its public education capabilities to warn the public of the risks of ultraviolet A radiation (UVA) exposure by skin tanning units; (2) endorses the findings released by the FDA warning Americans that the use of UVA tanning booths and sun beds pose potentially significant health risks to users and should be discouraged; (3) supports working with the FDA to ensure that state and local authorities implement legislation, rules, and regulations regarding UVA exposure, including posted warnings in commercial tanning salons and spas; (4) supports, in conjunction with various concerned national specialty societies, an educational campaign to secure appropriate state regulatory and oversight activities for tanning parlor facilities, to reduce improper and dangerous exposure to ultraviolet light by patients and general

public consumers; (5) supports intensified efforts to enforce current regulations; and (6) encourages the development of sunscreens that will protect the skin from a broad spectrum of ultraviolet radiation, including both UVA and UVB. (Sub. Res. 103, A-88; Res. 418, I-94; Appended: Res. 407, I-99; Reaffirmed: Res. 440, A-05)

H-440.980 Education on the Harmful Effects of UVA and UVB Light

Our AMA: (1) supports the dissemination of information to physicians and the public about the dangers of ultraviolet light from sun exposure and the possible harmful effects of the ultraviolet light used in commercial tanning centers; and (2) urges medical societies to work with all schools to include information in their health curricula on the hazards of exposure to tanning rays. (Res. 162, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Appended: Res. 407 and Reaffirmation I-99; Reaffirmed: CSAPH Rep. 1, A-09)

H-440.841 Permitting Sunscreen in Schools

Our AMA supports the exemption of sunscreen from over-the-counter medication possession bans in schools and encourages all schools to allow students to bring and possess sunscreen at school without restriction and without requiring physician authorization. (Res. 403, A-13)

D-440.969 Protect Children from Skin Cancer

Our AMA will: (1) support the enactment of federal legislation to: (a) prohibit access to the use of indoor tanning equipment (as defined in 21 CFR §1040.20 [a][9]) by anyone under the age of 18; and (b) require a United States Surgeon General warning be prominently posted, detailing the positive correlation between ultraviolet radiation, the use of indoor tanning equipment, and the incidence of skin cancer; and (2) urge the Food and Drug Administration's Center For Devices and Radiological Health to hold a fair hearing as soon as possible on the safety and efficacy of UVA bulbs, as used in indoor tanning facilities. (Res. 440, A-05; Reaffirmation A-11; Reaffirmation A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 404
(A-14)

Introduced by: Medical Student Section
Subject: Prevention of Mosquito Transmitted Diseases
Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Mosquito infection predicts increasing rates of human infection, and, for many
2 aboviral diseases, like West Nile Virus (WNV), vector control remains the primary, and often
3 only, tool for reducing disease incidence; and
4
5 Whereas, Symptomatic persons infected with West Nile Virus may develop WNV neuroinvasive
6 disease, which has a fatality rate of 10% and does not have a vaccine; and
7
8 Whereas, West Nile Virus likely will remain a serious threat and could affect any city; therefore,
9 required preparedness and early decisive action should be supported; and
10
11 Whereas, The Centers for Disease Control and Prevention recommends active surveillance to
12 detect and monitor infection rates and disease prevention done by local health departments
13 supported by state health departments; and
14
15 Whereas, Community protective practices, such as eliminating stagnant water sources around
16 the home, ensuring well-fitting screens on doors and windows, and personal protective
17 practices, such as wearing long pants, wearing long sleeves, and utilizing insect repellent have
18 been shown to reduce infection rates; and
19
20 Whereas, In 2012, the AMA offered a free resource from the *Journal of the American Medical*
21 *Association (JAMA)* to help the public and physicians obtain more information about WNV; and
22
23 Whereas, Current AMA policy supports educating the medical community on the potential
24 adverse public health effects of global climate change, including infectious and vector-borne
25 diseases (AMA Policy H-135.938); therefore be it
26
27 RESOLVED, That our American Medical Association encourage physicians to discuss and
28 promote protective practices specific for mosquitos, such as those developed by the Centers for
29 Disease Control and Prevention, with patients when clinically appropriate. (New HOD Policy)

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

Received: 3/20/14

RELEVANT AMA POLICY**H-135.938 Global Climate Change and Human Health**

Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (CSAPH Rep. 3, I-08)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 405
(A-14)

Introduced by: Minority Affairs Section

Subject: Elimination of Tobacco Products Sold by National Retailers

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, 18.1% of all US adults aged 18 years or older were current cigarette smokers (in
2 2012); and
3
4 Whereas, Cancer, stroke, heart disease and lung diseases are among the results of smoking,
5 according to the CDC. More than 5 million deaths per year are caused by tobacco use. Smokers
6 also tend to die 10 years before nonsmokers, according to the CDC; and
7
8 Whereas, Cigarette smoking increases the risk for many types of cancer, including cancers of
9 the lip, oral cavity, pharynx, esophagus, pancreas, larynx, lung, uterine cervix, urinary bladder,
10 and kidney; and
11
12 Whereas, The risk of developing lung cancer is about 23 times higher among men who smoke
13 cigarettes and about 13 times higher among women who smoke cigarettes compared with never
14 smokers; and
15
16 Whereas, If sales of cigarettes at pharmacies continue rising at the current rate, by 2020 almost
17 15% of all US cigarette sales will occur at pharmacies; and
18
19 Whereas, More than 32% of pharmacies sold cigarettes, and traditional chain pharmacies were
20 far more likely to sell cigarettes than independently owned pharmacies; and
21
22 Whereas, There are 21.8% of non-Hispanic/Alaska Natives, 18.1% of non-Hispanic Blacks,
23 12.5% of Hispanics, and 26.1% of multiple race individuals 18 or older who are current smokers
24 compared to 19.1% of non-Hispanic Whites; and
25
26 Whereas, Racial disparities in smoking-related morbidity and mortality may be associated with
27 socioeconomic status, cigarette smoking patterns, difference in nicotine metabolism, and
28 tobacco industry marketing strategies all of which disproportionately impacts minorities;
29 therefore be it
30
31 RESOLVED, That our American Medical Association publicly support all pharmacies or retailers
32 that discontinue the sale of tobacco products. (New HOD Policy)

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

Received: 04/07/14

RELEVANT AMA POLICY

H-500.975 AMA Corporate Policies on Tobacco - (1) Our AMA: (a) continues to urge the federal government to reduce and control the use of tobacco and tobacco products; (b) supports developing an appropriate body for coordinating and centralizing the Association's efforts toward a tobacco-free society; and (c) will defend vigorously all attacks by the tobacco industry on the scientific integrity of AMA publications. (2) It is the policy of our AMA to continue to use appropriate lobbying resources to support programs of anti-tobacco health promotion and advertising. (3) Our AMA's House of Delegates endorses the April 24, 1996, statement by the AMA Secretary-Treasurer that all physicians, health professionals, medical schools, hospitals, public health advocates, and citizens interested in the health and welfare of our children should review their personal and institutional investments and divest of any tobacco holdings (including mutual funds that include tobacco holdings); and specifically calls on all life and health insurance companies and HMOs to divest of any tobacco holdings. (4) Our AMA defines the Tobacco Industry as companies or corporate divisions that directly produce or purchase tobacco for production or market tobacco products, along with their research and lobbying groups, including the Council for Tobacco Research and the Smokeless Tobacco Research Council. A company or corporate division that does not produce or market tobacco products but that has a tobacco producing company as or among its owners will not be considered a prohibited part of the tobacco industry as long as it does not promote or contribute to the promotion, sale and/or use of tobacco products. If such promotional practices begin, the company will be placed on an "unacceptable for support" list. (5) Accordingly, it is the policy of our AMA (a) not to invest in tobacco stocks or accept financial support from the tobacco industry; (b) to urge medical schools and their parent universities to eliminate their investments in corporations that produce or promote the use of tobacco and discourage them from accepting research funding from the tobacco industry; (c) to likewise urge all scientific publications to decline such funded research for publication; and (d) to encourage state and county medical societies and members to divest of any and all tobacco stocks. (6) Our AMA (a) encourages state and local medical societies to determine whether candidates for federal, state and local offices accept gifts or contributions of any kind from the tobacco industry, and publicize their findings to both their members and the public; and (b) urges state and county medical societies and local health professionals along with their allies to support efforts to strengthen state and local laws that require public disclosure of direct and indirect expenditures to influence legislation or ordinances, given recent allegations about tobacco industry strategies. (CSA Rep. 3, A-04)

H-495.977 Banning the Sale of Tobacco Products and/or Tobacco By-Products in Retail Outlets Housing Store-Based Health Clinics - Our AMA supports efforts to ban the sale of tobacco products and/or tobacco by-products in retail outlets housing store-based health clinics. (Res. 422, A-08; Reaffirmation I-13)

D-495.994 Oppose Sale of Tobacco Products in Pharmacies - Our AMA: (1) specifically and publicly opposes the sale and marketing of tobacco products, including cigarettes, in pharmacies; (2) will communicate with appropriate federal agencies, including the bureau of alcohol, tobacco and firearms, many public health groups, various pharmacy trade groups, and media outlets, in seeking their help in removing tobacco products, including cigarettes, from pharmacy shelves; (3) will work to pass legislation at the local, state and federal levels to accomplish the goal of banning tobacco sales in pharmacies nationwide; (4) will work with Federation members and national organizations concerned about tobacco use to develop a recognition program for pharmacies that voluntarily agree to eliminate the sale of tobacco; (5) will work with state and local medical societies to disseminate information on these recognized pharmacies to their membership; and 6) will work through its Advocacy Resource Center to provide that list to organizations interested in preventive healthcare. (Sub. Res. 419, A-09; Reaffirmed in lieu of Res. 422, A-10; Reaffirmed in lieu of Res. 426, A-10; Modified in lieu of Res. 405, A-12 and Res. 420, A-12; Reaffirmation I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 406
(A-14)

Introduced by: International College of Surgeons - US Section

Subject: Air Pollution

Referred to: Reference Committee D
(Diana Ramos, Chair)

1 Whereas, Air pollution due to multiple causes has been shown to increase the incidence of
2 disease--especially pulmonary disease including childhood asthma; and
3

4 Whereas, Such pollution may originate from various sources; and
5

6 Whereas, Demolition of residential and commercial structures have been shown to increase
7 pollution and associated health risks; and
8

9 Whereas, Older equipment and diesel engines have all been shown to add to this problem;
10 therefore be it
11

12 RESOLVED, That our American Medical Association support:
13

14 (1) anti-idling technology should be installed and maintained to modern standards for all
15 diesel trucks and engines,
16

17 (2) all new vehicles and equipment meet federal air pollution guidelines,
18

19 (3) appropriate air testing be conducted on a regular basis for (a) fine particle content (soot);
20 (b) lead; (c) N₂O and; (d) other noxious contaminants, and
21

22 (4) appropriate laws are developed and enforced to maintain legally accepted clean air
23 standards. (New HOD Policy)

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

Received: 04/16/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 407
(A-14)

Introduced by: International College of Surgeons - US Section

Subject: Toxic Mercury in the Water Supply

Referred to: Reference Committee D
(Diana Ramos, Chair)

- 1 Whereas, Mercury at low levels may be toxic and harmful to an individual's health; and
2
3 Whereas, As much as 2,000 pounds of Mercury from all sources may be deposited in Lake
4 Michigan alone; and
5
6 Whereas, Such Mercury may enter the food chain; therefore be it
7
8 RESOLVED, That our American Medical Association support minimal standards for pollutant
9 discharge into lakes and other bodies of water by industry (New HOD Policy); and be it further
10
11 RESOLVED, That our AMA encourage the US Environmental Protection Agency to set
12 deadlines and enforce such established standards. (Directive to Take Action)

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

Received: 04/16/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 408
(A-14)

Introduced by: International College of Surgeons - US Section

Subject: Global Warming

Referred to: Reference Committee D
(Diana Ramos, Chair)

- 1 Whereas, Global warming continues as demonstrated by various measurements including
2 glacier / ice melt; and
3
4 Whereas, The release of billions of tons of CO₂ into the atmosphere is not a healthy practice;
5 therefore be it
6
7 RESOLVED, That our American Medical Association support that all fuels as well as their
8 utilization should be evaluated to determine their relative impact on CO₂ increase and global
9 warming (New HOD Policy); and be it further
10
11 RESOLVED, That our AMA support higher pricing and taxation on environmentally harmful fuels
12 such as gasoline and coal. (New HOD Policy)

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

Received: 04/16/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 409
(A-14)

Introduced by: American Association of Public Health Physicians

Subject: Federal Resources to Protect the Public and the Medical Profession From
and During a Communicable Disease Outbreak

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Communicable disease outbreaks can be minimized or prevented by quarantine,
2 isolation, vaccination, specific treatment, or medication to protect individuals and the public; and
3
4 Whereas, The state public health police powers created to prevent disease and protect the
5 public are ineffective without appropriate and sufficient resources applied in a timely manner;
6 and
7
8 Whereas, Communicable diseases and other public health threats do not respect political
9 boundaries, nor those created under private Accountable Care Organizations. All public health
10 jurisdictions must be able to quarantine, isolate, vaccinate, treat, or provide prophylaxis to all
11 individuals who pose a risk to others, regardless of citizenship, national origin, insurance status,
12 or willingness or ability to pay for care; and
13
14 Whereas, Some individuals who pose a risk to the community will not have access to a “medical
15 home,” with appropriate infection control capacity, able to handle necessary public health
16 services, nor the resources to cover necessary costs; and
17
18 Whereas, The absence of an affordable, accessible and appropriate facility(s) in which the
19 public health professionals are able to perform the necessary interventions to protect the
20 community while meeting the needs of the individual can result in a dangerous and public health
21 crisis; and
22
23 Whereas, Examples of cost saving services include vaccination to prevent further spread of
24 measles, medication to prevent further spread of TB and STD’s, and appropriate isolation of the
25 first cases of novel and emerging infectious diseases; therefore be it
26
27 RESOLVED, That our American Medical Association study the nature, magnitude and
28 frequency of the problem of citizens being unable to receive established clinical preventive
29 services in instances of public health threats and emergencies because of a lack of an
30 established source of emergency resources to assure the capacity of an individual and/or
31 community to provide such services (Directive to Take Action); and be it further
32
33 RESOLVED, That our AMA, no later than the 2015 Annual Meeting, present a report,
34 recommendations and an action plan (including legislative proposals), to the House of
35 Delegates whereby our AMA will advocate action to address this serious resource deficiency.
36 (Directive to Take Action)

Fiscal Note: Estimated cost of \$13,000 to implement.

Received: 04/20/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 410
(A-14)

Introduced by: American Academy of Child and Adolescent Psychiatry
American Psychiatric Association
American Academy of Psychiatry and the Law
American Academy of Family Physicians
American Academy of Neurology
American College of Preventive Medicine

Subject: Evaluating and Reducing the Risk of Youth Sports Concussions

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, It is estimated that over 3.8 million children, adolescents and adults experience at
2 least one concussion in any given year as a result of participation in youth sports and
3 recreation; and
4

5 Whereas, Football, soccer, basketball, ice hockey, lacrosse and equestrian activities carry the
6 highest risk of concussion; and
7

8 Whereas, The risk of concussion from girls soccer approaches that of boys football; and
9

10 Whereas, Research suggests that multiple episodes of minor head trauma may have a
11 cumulative effect; and
12

13 Whereas, While many young people recover fully from a concussion, a significant number
14 experience serious and lasting consequences including headache, difficulty concentrating,
15 impaired memory, irritability, photophobia, sleep disturbance and depression; and
16

17 Whereas, Such consequences can interfere with the ability to function at school, at work, at
18 home or with friends; and
19

20 Whereas, Research suggests that most parents, teachers and coaches underestimate the risk
21 and potential consequences of concussion as a result of participation in youth sports; therefore
22 be it
23

24 RESOLVED, That our American Medical Association ask our Council on Science and Public
25 Health to prepare a report summarizing the existing data on the risk of concussion in youth
26 sports (Directive to Take Action); and be it further
27

28 RESOLVED, that our AMA ask the Council on Science and Public Health to develop specific
29 recommendations to aid physicians in efforts aimed at reducing the risk of concussion as a
30 result of participation in youth sports (Directive to Take Action); and be it further

1 RESOLVED, That our AMA work with all appropriate state and specialty societies to enhance
2 access to appropriate continuing education for physicians emphasizing evolving literature on the
3 diagnosis and management of concussion resulting from participation in youth sports (Directive
4 to Take Action); and be it further

5

6 RESOLVED, That our AMA work with all appropriate state and specialty societies to help
7 educate the general public about the established risks of concussion associated with
8 participation in youth sports, as well as theoretical risks under study. (Directive to Take Action)

Fiscal Note: Estimated cost of \$33,000 to implement.

Received: 04/29/14

RELEVANT AMA POLICY

H-470.957 Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention - Our AMA: (1) supports the adoption of evidence-based guidelines for the evaluation and management of concussions by all athletic organizations; and (2) encourages further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy. (Res. 905, I-13)

H-470.959 Return to Play After Suspected Concussion - Our AMA: (1) promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion, should not return to play or practice without the written approval of an MD or DO; and (2) encourages educational efforts designed to improve the understanding of concussion by athletes, their parents, coaches, and trainers. (Res. 910, I-10)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 411
(A-14)

Introduced by: American Medical Group Association

Subject: Ban on Super Magnetic Toys as a Choking and Gastrointestinal Hazard to Children

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Magnetic desk toys usually contain more than 200 tiny round or cube-shaped
2 neodymium magnets whose flux strength (adhesion property) is 15 times more powerful than
3 standard magnets; and
4
5 Whereas, The neodymium magnets adhere to each other with such force that, if swallowed by a
6 child, they can draw together parts of the gastrointestinal tract, causing pressure necrosis
7 leading to bowel ulcerations and lacerations along the tract; and
8
9 Whereas, Typically, 80%-90% of ingested foreign bodies pass spontaneously, 10%-20% will
10 require endoscopic removal and 1% require surgical intervention; and
11
12 Whereas, In one report of 123 cases of patients who ingested magnets between 2008 and 2012
13 (102 cases between 2010 and 2012 alone), 80% required endoscopy, surgery or both; 26%
14 underwent either laparotomy, laparoscopy and/or thoracotomy; 31% underwent surgery for
15 magnet removal alone; 43% required additional procedures including fistula repair (60%) and
16 bowel resection (15%); and 9% of patients required long-term care including bowel
17 rehabilitation; and
18
19 Whereas, In 2013 alone, there were at least seven published reports of high-powered magnet
20 ingestions affecting children in the US; and
21
22 Whereas, Since 2002, reports indicate that the incidence of ED visits for children with possible
23 magnet ingestion increased 8.5 fold with a 75% average annual increase; and
24
25 Whereas, A recent study of US emergency-room admissions from the National Electronic Injury
26 Surveillance System estimated that 7,159 pediatric emergency-room admissions from 2002
27 through 2011 were a sequelae of swallowing of high-powered magnet sets; therefore be it
28
29 RESOLVED, That our American Medical Association work with the Consumer Product Safety
30 Commission (CPSC) and other relevant governmental agencies to prohibit the sale of
31 neodymium magnetic balls whose flux, or magnetic, strength index is greater than 50 and also
32 who fail the CPSC's cylinder tests for choking hazards. (Directive to Take Action)

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

Received: 04/30/14

RELEVANT AMA POLICY

H-60.963 Preventable Airway Obstructions in Children

The AMA supports educational programs to apprise the public of the dangers of airway obstruction hazards in children and on methods to prevent these hazards. (Res. 412, A-92; Reaffirmed: CSA Rep. 8, A-03; Modified: CSAPH Rep. 1, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 412
(A-14)

Introduced by: California
Subject: Management of Concussion Guidelines
Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Concussion in school aged children is increasing in awareness but still
2 underdiagnosed and misunderstood; and
3
4 Whereas, Concussion can occur in varied sports from football to cheerleading; and
5
6 Whereas, School aged children have a better prognosis for recovery than adults due to neural
7 plasticity; and
8
9 Whereas, Every effort be made to use the latest evidence based guidelines for the treatment
10 of concussion to insure the best possible prognosis and to prevent permanent disability; and
11
12 Whereas, The American Academy of Neurology has developed the most comprehensive
13 evidence-based guidelines with a committee of specialists involved in the treatment of
14 concussion; therefore be it
15
16 RESOLVED, That our American Medical Association promote awareness of the “Evaluation and
17 Management of Concussion in Sports: Report of the Guideline Development Subcommittee of
18 the American Academy of Neurology.” (Directive to Take Action)

Fiscal Note: Minimal - Less than \$1,000

Received: 05/08/14

RELEVANT AMA POLICY

H-470.959 Return to Play After Suspected Concussion

Our AMA: (1) promotes the adoption of requirements that athletes participating in school or other organized youth sports and who are suspected by a coach, trainer, administrator, or other individual responsible for the health and well-being of athletes of having sustained a concussion, should not return to play or practice without the written approval of an MD or DO; and (2) encourages educational efforts designed to improve the understanding of concussion by athletes, their parents, coaches, and trainers. (Res. 910, I-10)

H-470.957 Athlete Concussion Management and Chronic Traumatic Encephalopathy Prevention

Our AMA: (1) supports the adoption of evidence-based guidelines for the evaluation and management of concussions by all athletic organizations; and (2) encourages further research in the diagnosis, treatment, and prevention of chronic traumatic encephalopathy. (Res. 905, I-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 413
(A-14)

Introduced by: Illinois

Subject: National Nutritional Guidelines for Food Banks and Pantries

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Overweight and obesity are now responsible for a higher global mortality than
2 underweight, and 68% of American adults and 32% of children are overweight or obese; and
3
4 Whereas, Overweight and obesity rates are significantly higher in lower socioeconomic groups
5 that are the primary users of the Supplemental Nutrition Assistance Program (SNAP) and food
6 pantries/food banks; and
7
8 Whereas, Food banks (which usually serve as large repositories that supply local food pantries)
9 and food pantries are not-for-profit charitable organizations that depend on donations of
10 produce and funds, as well as federal surplus food via the United States Department of
11 Agriculture (USDA), and they do not have national or state standards or certification for the
12 nutritional quality of the food they dispense; and
13
14 Whereas, Food banks and food pantries are inspected and regulated by the USDA Food Safety
15 Division and state and county health departments to ensure that food dispensed is safe, but not
16 that it is nutritious or represents a healthy diet; and
17
18 Whereas, Consumption of fresh fruits and vegetables as a major component of the diet rather
19 than the high-caloric, high-fat, high-sugar, high-salt foods that are a prime component of the
20 foods dispensed by food banks/food pantries would aid in combating the obesity epidemic that
21 unduly affects the populations that use these services; and
22
23 Whereas, Some food banks, notably the Food Bank of Central New York and several food
24 banks in California, are making strides in establishing nutritional expectations in their programs
25 and improving access to fresh fruits and vegetables by partnering with local farmers and grocery
26 stores as well as increasing the emphasis on nutritional education and healthy cooking; and
27
28 Whereas, In Chicago, the use of a “fresh produce dispensing bus” to increase access to fresh
29 fruit and vegetables to food deserts/underserved areas has been undertaken, and similar trucks
30 might serve as a mobile source of produce to the food pantries from which patrons could select
31 a certain amount of fresh produce; and
32
33 Whereas, Numerous organizations throughout the US are utilizing a voucher program that may
34 include physicians prescribing the vouchers (such as the Fruit and Vegetable Prescription
35 Program, or “FVRx,” now in Chicago) for fresh fruits and vegetables to be used at farmers
36 markets or grocery stores; therefore be it

- 1 RESOLVED, That our American Medical Association adopt policy in support of the use of
- 2 existing national nutritional guidelines for food banks and food pantries. (New HOD Policy)

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

Received: 04/30/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 414
(A-14)

Introduced by: California

Subject: Meningococcal Vaccination for School Children

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Infectious diseases are on the rise in the United States, jeopardizing the public health
2 of our communities and unnecessarily endangering the lives of our children; and
3
4 Whereas, Recent incidences of meningococcal meningitis in the United States have sparked
5 fears of a potential outbreak, and have served as a reminder of the critical role of vaccinations in
6 helping to prevent this potentially lethal disease; and
7
8 Whereas, While rare, meningococcal disease can have devastating effects where 10 to 14
9 percent of cases are fatal and 11 to 19 percent of survivors have permanent hearing loss, brain
10 injury, loss of limbs or other serious effects; and
11
12 Whereas, Meningococcal disease is spread by close contact with respiratory or throat
13 secretions, such as saliva; and
14
15 Whereas, Once contracted, the bacteria can kill an individual within hours; and
16
17 Whereas, Infants, adolescents and young adults are at highest risk of contacting meningococcal
18 disease; and
19
20 Whereas, Meningococcal disease may be treatable if caught early, however, they are often
21 ineffective given the spread of the disease; and
22
23 Whereas, According to the Centers for Disease Control and Prevention's (CDC) National
24 Immunization Survey, just 70 percent of adolescents received their first dose of meningococcal
25 vaccine in 2011; and
26
27 Whereas, It is best to prevent the disease through vaccination; therefore be it
28
29 RESOLVED, That our American Medical Association support efforts to require that school
30 children receive meningococcal vaccine per the Advisory Committee on Immunization Practices
31 guidelines. (New HOD Policy)

Fiscal Note: Minimal - Less than \$1,000

Received: 05/08/14

RELEVANT AMA POLICY

D-440.975 Support Efforts to Educate Health Care Providers and the Public about Meningococcal Disease and Vaccine

Our AMA will continue to work with the CDC in educating physicians and other health care providers on the importance of informing parents and the public about the meningococcal disease and the availability of a vaccine. (Res. 515, A-04)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 415
(A-14)

Introduced by: Illinois
Subject: Safer Chemical Policies
Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, The US chemical industry designs, produces, and imports 42 billion pounds of
2 chemical substances per day, with global production growing a projected four-fold by 2050;^{1 2}
3 and
4
5 Whereas, Many of the substances useful to society are also hazardous to human and
6 ecosystem health; and
7
8 Whereas, Hazardous chemical exposure poses the greatest threat to children and to women
9 before and throughout reproductive age, impacting children's health, development, behavior,
10 and learning, with exposure to neurotoxic chemicals during critical child development periods
11 linked to lifelong deficits in brain function;³ and
12
13 Whereas, The National Academies of Sciences (NAS) released three reports between 2007 and
14 2009 that recommended modernizing chemical health evaluations in the United States,
15 concluding that significant improvements in both chemical testing and risk assessment are
16 needed to protect people from toxic chemicals; and
17
18 Whereas, Most of these landmark recommendations are not widely known and have not been
19 implemented, even though they would significantly improve current practices; and
20
21 Whereas, The Toxic Substances Control Act (TSCA), the 1976 federal statute intended to
22 regulate chemicals before and during their use in commerce, has, according to numerous
23 independent analyses,^{4 5 6 7 8 9 10 11} fallen short of its objectives by failing to serve as a vehicle

¹ American Chemistry Council. 2003. Guide to the Business of Chemistry, p 37. American Chemistry Council: Arlington, Virginia

² Organization for Economic Cooperation and Development (OECD). 2001. Environmental Outlook for the Chemicals Industry, pp. 34-36 (<http://www.oecd.org/dataoecd/7/45/2375538.pdf>).

³ Goldman, L.R. and Koduru, S.H. 2000. Chemicals in the environment and developmental toxicity in children: A public health and policy perspective. Environmental Health Perspectives, 108(3): S443-S448 (<http://ehp.niehs.nih.gov/members/2003/6115/6115.html>).

ⁱ Janssen, S, Sass, J, Schettler, T, Solomon, G. AI Strengthening Toxic Chemical Risk Assessments to Protect Human Health NRDC Monograph, February 2012

⁴ National Academy of Sciences Commission on Life Sciences. 1984. Toxicology Testing: Strategies to Determine Needs and Priorities. National Academy of Sciences Press: Washington, DC.

⁵ US General Accounting Office. 1994. Toxic Substances Control Act: Legislative Changes Could Make the Act More Effective. GAO/RCED-94-103. US Government Printing Office: Washington, DC.

⁶ Congress of the United States Office of Technology Assessment. 1995. Screening and Testing of Chemicals in Commerce: Background Paper. US Government Printing Office: Washington, DC.

⁷ Roe D, Pease W, Florini K, Silbergeld E. 1997. Toxic Ignorance: The Continuing Absence of Basic Health Testing for Top-Selling Chemicals in the United States. Environmental Defense: Washington, DC (http://www.edf.org/documents/243_toxicignorance.pdf).

⁸ US Environmental Protection Agency. 1998. Chemical Hazard Data Availability Study. US Government Printing Office: Washington, DC: (www.epa.gov/oppt/chemrtk/pubs/general/hazchem.pdf).

⁹ Goldman L. 2002. Preventing pollution?: U.S. Toxic Chemicals and Pesticides Policies and Sustainable Development. Environmental Law Review, 32:11018-11041.

1 for effective public, industrial, and governmental assessment of the hazards of chemicals in
2 commerce and control of those of greatest health concern; and
3

4 Whereas, Among TSCA's failings are that it does not require chemical producers to generate or
5 disclose chemical hazard information on the more than 80,000 chemicals registered for use in
6 commerce, nor the 2000 new chemicals introduced each year; it requires government to meet
7 an excessively high standard of proof before acting to protect public or environmental health,
8 primarily allowing protective action only after chemicals have caused harm; and it does not
9 encourage prevention through the development and use of safer alternatives;^{11 12 13} and
10

11 Whereas, Under TSCA, current market conditions fail to safeguard public health, creating
12 problems including the appearance of hundreds of industrial chemicals in human tissues and
13 fluids, including the cord blood of infants;^{14 15} the development of chronic diseases and
14 premature death related to chemical exposures in the workplace; disproportionate risks due to
15 chemical exposures among members of minority, immigrant, and low-income communities;¹¹
16 and accidental releases of chemicals of unknown human toxicity into the water supply and
17 ecosystem such as the recent contamination of the West Virginia public water system; and
18

19 Whereas, Sweeping changes in public and environmental health policy in the European Union
20 are driving global interest in cleaner technologies, including safer chemicals;¹⁶ and
21

22 Whereas, The United States is becoming a market for hazardous substances no longer
23 permitted for sale in the European Union and other regions that are taking steps to implement
24 modern chemicals policies;¹⁷ and
25

26 Whereas, Delegates from over 100 governments together with representatives of civil society
27 (including the World Medical Association) and the private sector adopted the Strategic Approach
28 to International Chemicals Management (SAICM), a global plan of action to achieve the sound
29 management of chemicals so that, by 2020, chemicals are used and produced in ways that lead
30 to the minimization of significant adverse effects on human health and the environment; and
31

32 Whereas, In 2008, our AMA in Policy H-135.942, declared its support for the Strategic Approach
33 to International Chemicals Management (SAICM) process; and
34

35 Whereas, In 2012, in policy D-135.976, our AMA declared that it will: (1) collaborate with
36 relevant stakeholders to advocate for modernizing the Toxic Substances Control Act (TSCA) to
37 require chemical manufacturers to provide adequate safety information on all chemicals and
38 give federal regulatory agencies reasonable authority to regulate hazardous chemicals in order

¹⁰ US Government Accountability Office. 2005. Chemical Regulation: Options Exist to Improve EPA's Ability to Assess Health Risks and Manage Its Chemicals Review Program. US Government Printing Office: Washington, DC.¹⁰

¹¹ Wilson M, Chia D, Ehlers B. 2006. Green Chemistry in California: A framework for leadership in chemicals policy and innovation. Special Report to the California Legislature. University of California Policy Research Center: Berkley, CA (http://coeh.berkeley.edu/news/06_wilson_policy.htm).

¹² Anastas P, Warner J. 1998. Green Chemistry: Theory and Practice. Oxford University Press: New York.

¹³ National Academy of Sciences, National Research Council, Board on Chemical Sciences and Technology. 2005. Sustainability in the Chemical Industry: Grand Challenges and Research Needs—A Workshop Report. National Academy Press: Washington, DC (<http://www.nap.edu/books/0309095719/html>).

¹⁴ Centers for Disease Control and Prevention. 2005. The Third National Report on Human Exposure to Environmental Chemicals (<http://www.cdc.gov/exposurereport/>).

¹⁵ Houlihan J et al. 2005. Body Burden: The Pollution in Newborns. Environmental Working Group: Washington, DC (<http://archive.ewg.org/reports/bodyburden2/execsumm.php>).

¹⁶ Ambachtsheer J, Kron J, Lirioff RA, Little T, Massey R. 2007. Fiduciary Guide to Toxic Chemical Risk. The Investor Environmental Health Network, The Rose Foundation for Communities and the Environment: Oakland, CA (<http://www.rosefdn.org/toxicrisk.pdf>).

¹⁷ Dension R. 2007. Not That Innocent: a Comparative Analysis of Canadian, European Union, and United States Policies on Industrial Chemicals. Environmental Defense: Washington, DC (http://www.environmentaldefense.org/documents/6149_NotThatInnocent_Fullreport.pdf).

1 to protect the health of all individuals, especially vulnerable populations; (2) support the public
2 disclosure of chemical use, exposure and hazard data in forms that are appropriate for use by
3 medical practitioners, workers, and the public; and (3) work with members of the Federation to
4 promote a reformed TSCA that is consistent with goals of Registration, Evaluation,
5 Authorization, and Restriction of Chemicals (REACH) (Res. 515, A-12); and

6
7 Whereas, Our AMA adopted H-135.942 in November 2013, renewing this call on Congress to
8 amend the Toxic Substances Control Act (TSCA) of 1976; therefore be it

9
10 RESOLVED, That our American Medical Association review the recommendations of the
11 National Academies of Sciences with respect to Chemical Policy reform. (Directive to Take
12 Action)

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

Received: 04/30/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 416
(A-14)

Introduced by: Michigan

Subject: Gun Violence Prevention as a Continuing Medical Education Topic

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Every year in America there are 30,000 gun related deaths, two-thirds of which are
2 suicides; and
3

4 Whereas, Eight children die each day from gun-inflicted injuries, while 42 are shot and if there
5 is a gun in the home a child is three times more likely to be shot; and
6

7 Whereas, Women who live with a gun in the household are much more likely to be threatened,
8 shot, or killed than those of any other industrialized country; and
9

10 Whereas, Given the above, and in the context of the multiple events of gun violence in public
11 venues over the last decade, gun violence in the United States has clearly become a serious
12 public health crisis¹; and
13

14 Whereas, Informed physicians, through counseling about gun safety, can help to prevent death
15 and injury due to gun violence; therefore be it
16

17 RESOLVED, That our American Medical Association encourage inclusion of presentations
18 about the prevention of gun violence in national, state, and local continuing medical education
19 programs. (Directive to Take Action)

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

Received: 04/30/14

RELEVANT AMA POLICY

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care

1. Our AMA supports: 1) federal and state research on firearm-related injuries and deaths; 2) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; 3) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; 4) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; 5) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; and 6) encouraging physicians to become involved

¹ Source of statistics from David Hemenway's authoritative book. Hemenway, D. 2004. Private Guns, Public Health. Ann Arbor, MI: The University of Michigan Press.

in local firearm safety classes as a means of promoting injury prevention and the public health.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance abuse disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. (Sub. Res. 221, A-13)

H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 417
(A-14)

Introduced by: Michigan
Subject: Nutrition Literacy and Improving Outcomes
Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, More than one-third of U.S. adults or about 35.7 percent are obese and the estimated
2 annual medical cost of obesity in the U.S. was \$147 billion in 2008 U.S. dollars; and
3
4 Whereas, The medical costs for people who are obese were \$1,429 higher than those of normal
5 weight¹; and
6
7 Whereas, It is known that obesity and the health problems associated with it are inversely
8 related to complete diet including fruits, vegetables, and whole grains²; and
9
10 Whereas, It has been shown that there is a correlation between poverty dense areas in America
11 and obesity, “with poverty rates of >35 percent have obesity rates 145 percent greater than
12 wealthy counties”³; and
13
14 Whereas, The Supplemental Nutrition Assistance Program (SNAP), Electronic Benefit Transfer
15 (EBT), and Women, Infants, and Children (WIC) programs currently aid more than 45 million
16 Americans, many still do not obtain the proper variety of calories in their respective diets
17 including fruits, vegetables, and whole grains⁴; and
18
19 Whereas, Increasing access to a healthy diet has not displayed a direct relation with attaining
20 said diet; and
21
22 Whereas, Pricing incentives, enhancing nutrition education, and improving the SNAP retailer
23 environment can increase fruit and vegetable purchasing⁴, benefitting consumers’ health⁵; and
24
25 Whereas, The Agricultural Act of 2014, recently signed into law on February 7, 2014, has
26 created the Food Insecurity Nutrition Incentive Grants (Sec. 4208) providing \$100 million in
27 grants through 2018 for governmental agencies, authorized retailers, non-profits, and other
28 entities that seek to increase the purchase of fruits and vegetables by SNAP participants by
29 providing incentives at the point of purchase⁶; and

¹ CDC (no date). Adult Obesity Facts Retrieved February 15, 2014 from <http://www.cdc.gov/obesity/data/adult.html>

² Harvard School of Public Health (no date). Obesity Prevention Source. Retrieved February 15, 2014 from <http://www.hsph.harvard.edu/obesity-prevention-source/obesity-causes/diet-and-weight/>

³ Levine JA. Poverty and Obesity in the US. *Diabetes*. 60 (11): 2667-2668, 2011. doi: 10.2337/db11-1118

⁴ Leung CW, Hoffnagle EE, Lindsay AC, Lofink HE, Hoffman VA, Turrell S, Willett WC and Bluementhal SJ. A qualitative study of diverse experts’ views about barriers and strategies to improve the diets and health of Supplemental Nutrition Assistance Program (SNAP) beneficiaries. *J. Acad. Nut. & Diet*. 113 (1): 70-76, 2013. doi: 10.1016/j.jand.2012.09.018

⁵ Boone-Heinonen J, Gordon-Larsen P, Kiefe CI, Shikany J M, Lewis CE and Popkin BM. Fast food restaurants and food stores: longitudinal associations with diet in young to middle-aged adults: the CARDIA study. *Arch. Int. Med*. 171 (13): 1162-1170, 2011. doi:10.1001/archinternmed.2011.283.

⁶ Center on Budget and Policy Priorities’ assessment of the Agriculture Act of 2014. Retrieved February 23, 2014 from http://www.cbpp.org/cms/?fa=view&id=4082#_ftn1

1 Whereas, The 2002 World Health Report and 2003 WHO Fruit and Vegetable Promotion
2 Initiative states that low fruit and vegetable consumption is among the top 10 risk factors
3 contributing to attributable mortality, specifically three million deaths a year from cardiovascular
4 diseases, cancer, and strokes^{7 8}; therefore be it
5

6 RESOLVED, That our American Medical Association support incentives for Supplemental
7 Nutrition Assistance Program (SNAP), Electronic Benefit Transfer (EBT), and Women, Infants,
8 and Children (WIC) program participants to purchase fruits, vegetables, and whole grains in
9 grocery markets (New HOD Policy); and be it further
10

11 RESOLVED, That our AMA advocate for the participation of authorized retailers in programs
12 that qualify for grants and other initiatives that aim to increase the purchase of fruits and
13 vegetables by Supplemental Nutrition Assistance Program (SNAP) participants by providing
14 incentives at the point of purchase to promote healthy food choices in their businesses (New
15 HOD Policy); and be it further
16

17 RESOLVED, That our AMA support the inclusion of literature about nutrition education, healthy
18 affordable recipes, and the knowledge of healthier meal choices targeted to Supplemental
19 Nutrition Assistance Program (SNAP), Electronic Benefit Transfer (EBT), and Women, Infants,
20 and Children (WIC) program participants. (New HOD Policy)

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

Received: 04/30/14

RELEVANT AMA POLICY

H-150.937 Improvements to Supplemental Nutrition Programs

Our AMA supports: (1) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (2) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (3) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program. (Res. 414, A-10; Reaffirmation A-12; Reaffirmation A-13; Appended: CSAPH Rep. 1, I-13)

D-150.975 Eligibility of Sugar-Sweetened Beverages for SNAP

Our AMA will: (1) publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines, and (3) work to remove SSBs from SNAP. (Res. 238, A-13)

⁷ World Health Report 2002. World Health Organization. Retrieved February 23, 2014 from http://www.who.int/whr/2002/en/whr02_en.pdf?ua=1

⁸ World Health Organization Fruit and Vegetable Promotion Initiative. A Meeting Report. August 25-27, 2003. http://www.who.int/dietphysicalactivity/publications/f&v_promotion_initiative_report.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 418
(A-14)

Introduced by: Nevada

Subject: Condom use in Films

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, Condoms are an effective barrier against STDs; and
2
3 Whereas, STD epidemics have occurred among actors in sexually explicit films; and
4
5 Whereas, Condom use in films sets a good example; therefore be it
6
7 RESOLVED, That our American Medical Association recommend that for films made in the US,
8 actors in sexually explicit scenes be required to wear condoms. (New HOD Policy)

Fiscal Note: Minimal - Less than \$1,000

Received: 05/08/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 419
(A-14)

Introduced by: New York

Subject: Raising the Purchase Age of All Tobacco Products

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

1 Whereas, Ninety percent of chronic smokers began their addiction to nicotine in their teens or
2 younger, when the brain is more susceptible to addiction; and
3

4 Whereas, The e-cigarette and other nicotine delivery devices can initiate or perpetuate that
5 addiction; and
6

7 Whereas, Companies manufacturing e-cigarettes are marketing their products to youth, by
8 using special flavors and devices that mimic smoking; and
9

10 Whereas, Many states and municipalities have enacted legislation which restricts the sale of
11 tobacco, nicotine products and electronic cigarettes to persons over the age of 21; therefore
12 be it
13

14 RESOLVED, That our American Medical Association support legislation which would:
15

16 a) limit the promotion of tobacco and cigar products, smokeless tobacco products,
17 electronic cigarettes or other unregulated nicotine delivery devices in any state;
18

19 (b) prohibit the sale of tobacco and cigar products, smokeless tobacco products,
20 electronic cigarettes or other unregulated nicotine delivery devices to anyone
21 under 21 years of age; and
22

23 (c) increase the penalties for the sale of any of these products to persons under
24 21 years of age. (Directive to Take Action)

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

Received: 05/08/14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-14)

Introduced by: American Thoracic Society
American College of Preventive Medicine
American College of Chest Physicians

Subject: Support FDA Regulation of All Tobacco Products

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, On June 22, 2009, the President signed into law the Family Smoking Prevention and
2 Tobacco Control Act. This historic legislation passed by Congress with broad bipartisan support
3 granted the US Food and Drug Administration (FDA) the authority to regulate all tobacco
4 products; and
5
6 Whereas, The Family Smoking Prevention and Tobacco Control Act specifically directs the FDA
7 to regulate cigarettes, cigarette tobacco, roll-your-own tobacco and smokeless tobacco, it also
8 authorizes the agency to extend its authority to other categories of tobacco products, including
9 cigars and e-cigarettes; and
10
11 Whereas, The FDA recently released proposed rules to extend regulatory authority over all
12 tobacco products including cigars, e-cigarettes, pipe tobacco and dissolvable nicotine products;
13 and
14
15 Whereas, No tobacco product is safe; and
16
17 Whereas, Nicotine is addictive; and
18
19 Whereas, The FDA has issued proposed rules to establish basic regulations over all tobacco
20 products; and
21
22 Whereas, The proposed FDA rules would:
23 - Prohibit the sales of tobacco products to anyone under the age of 18
24 - Prohibit vending machine sales (except in places where only adults can access)
25 - Require registration by all manufactures with FDA, including a list of all tobacco products
26 they sell
27 - Require disclosure of ingredients by manufacturers to FDA
28 - Eliminate free sampling of newly deemed tobacco products
29 - Require good manufacturing practice standards
30 - Require Premarket review for any “new” tobacco product
31 - Mandate premarket review of any product wishing to make a “modified risk or harm”
32 claim
33 - Collect User fees for most types of newly deemed products; and
34
35 Whereas, The FDA is seeking comment on whether “premium cigars”--defined as large hand
36 rolled cigars that are priced at or above \$10/cigar--should be exempt from FDA regulation; and

1 Whereas, The National Cancer Institute has established the health harms associated with
2 cigars; and
3

4 Whereas, Our AMA recognizes all forms of tobacco have adverse health effects and are
5 potential addictive; therefore be it
6

7 RESOLVED, That our American Medical Association support the US Food and Drug
8 Administration (FDA) as it takes an important first step in establishing basic regulations of all
9 tobacco products (New HOD Policy); and be if further
10

11 RESOLVED, That our AMA strongly oppose any FDA rule that exempts any tobacco product,
12 including certain cigars, from FDA regulation (New HOD Policy); and be if further
13

14 RESOLVED, That our AMA join with physician and public health organizations in submitting
15 comments on FDA proposed rule to regulate all tobacco products. (Directive to Take Action)

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

Received: 05/08/14

RELEVANT AMA POLICY

H-495.988 FDA Regulation of Tobacco Products

Our AMA: (1) reaffirms its position that all tobacco products (including but not limited to, cigarettes, smokeless tobacco, chewing tobacco, and hookah/water pipe tobacco) are harmful to health, and that there is no such thing as a safe cigarette; (2) asserts that tobacco is a raw form of the drug nicotine and that tobacco products are delivery devices for an addictive substance; (3) reaffirms its position that the Food and Drug Administration (FDA) does have, and should continue to have, authority to regulate tobacco products, including their manufacture, sale, distribution, and marketing; (4) strongly supports the substance of the August 1996 FDA regulations intended to reduce use of tobacco by children and adolescents as sound public health policy and opposes any federal legislative proposal that would weaken the proposed FDA regulations; (5) urges Congress to pass legislation to phase in the production of less hazardous and less toxic tobacco, and to authorize the FDA have broad-based powers to regulate tobacco products; (6) encourages the FDA and other appropriate agencies to conduct or fund research on how tobacco products might be modified to facilitate cessation of use, including elimination of nicotine and elimination of additives (e.g., ammonia) that enhance addictiveness; (7) encourages the FDA to assert its authority over the manufacture of tobacco products to reduce their addictive potential at the earliest practical time, with a goal for implementation within 5-10 years; and (8) strongly opposes legislation which would undermine the FDA's authority to regulate tobacco products and encourages state medical associations to contact their state delegations to oppose legislation which would undermine the FDA's authority to regulate tobacco products. (CSA Rep. 3, A-04; Reaffirmed: BOT Rep. 8, A-08; Appended: Res. 234, A-12; Reaffirmation A-13; Modified: Res. 402, A-13)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 421
(A-14)

Introduced by: American Thoracic Society
American College of Preventive Medicine
American College of Chest Physicians

Subject: Support EPA Regulation of Carbon Pollution

Referred to: Reference Committee D
(Diana Ramos, MD, Chair)

- 1 Whereas, The International Panel on Climate Change (IPCC) has issued several reports
2 documenting global climate change; and
3
4 Whereas, The most recent IPCC reports states with high confidence that climate change is
5 being driven by anthropogenic emissions; and
6
7 Whereas, The IPCC notes climate change will have direct impact on human health including
8 - increased deaths from heat-related stress
9 - increased length, duration and intensity of the allergy season
10 - increased ozone air pollution caused by increased temperature
11 - increased range for vector-borne diseases
12 - increased morbidity and mortality from intensified weather events; and
13
14 Whereas, The third US National Climate Assessment (2014) finds:
15
16 - Climate change is “unambiguous” and “driven primarily by human activity.”
17 - “Climate change is already affecting the American people in far-reaching ways.”
18 - Widespread climate-related impacts are occurring now and are expected to increase.
19 - “Climate change will, absent other changes, amplify some of the existing health threats the
20 nation now faces.
21 - “Children, the elderly, the sick, the poor and some communities of color” are “especially
22 vulnerable” to the impacts of this changing climate.
23 - “Responding to climate change provides opportunities to improve human health and well-
24 being across many sectors”.
25 - “The amount of future climate change will still largely be determined by choices society
26 makes about emissions.”; and
27
28 Whereas, The third US National Climate Assessment further notes that, “Climate change
29 threatens human health and well-being in many ways, including impacts from increased
30 extreme weather events, wildfire, decreased air quality, threats to mental health, and illnesses
31 transmitted by food, water, and disease-carriers such as mosquitoes and ticks. Some of these
32 health impacts are already underway in the United States”; and
33
34 Whereas, The US Supreme Court has affirmed the authority of the US Environmental Protection
35 Agency to regulate greenhouse gases; and

1 Whereas, The US Environmental Protection Agency has proposed standards to regulation
2 carbon pollution emissions from new and existing power plants; and
3

4 Whereas, Power plants in the US account for nearly 1/3 of all US greenhouse gas emissions;
5 and
6

7 Whereas our AMA policy states, the AMA:
8

9 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth
10 assessment report and concurs with the scientific consensus that the Earth is undergoing
11 adverse global climate change and that anthropogenic contributions are significant. These
12 climate changes will create conditions that affect public health, with disproportionate impacts
13 on vulnerable populations, including children, the elderly, and the poor.
14

15 2. Supports educating the medical community on the potential adverse public health effects
16 of global climate change and incorporating the health implications of climate change into the
17 spectrum of medical education, including topics such as population displacement, heat
18 waves and drought, flooding, infectious and vector-borne diseases, and potable water
19 supplies.
20

21 3. (a) Recognizes the importance of physician involvement in policymaking at the state,
22 national, and global level and supports efforts to search for novel, comprehensive, and
23 economically sensitive approaches to mitigating climate change to protect the health of the
24 public; and (b) recognizes that whatever the etiology of global climate change, policymakers
25 should work to reduce human contributions to such changes.
26

27 4. Encourages physicians to assist in educating patients and the public on environmentally
28 sustainable practices, and to serve as role models for promoting environmental
29 sustainability.
30

31 5. Encourages physicians to work with local and state health departments to strengthen the
32 public health infrastructure to ensure that the global health effects of climate change can be
33 anticipated and responded to more efficiently, and that the AMA's Center for Public Health
34 Preparedness and Disaster Response assist in this effort.
35

36 6. Supports epidemiological, translational, clinical and basic science research necessary for
37 evidence-based global climate change policy decisions related to health care and treatment;
38 therefore be it
39

40 RESOLVED, That our American Medical Association support US Environmental Protection
41 Agency in setting strong carbon pollution limits for existing power plants (New HOD Policy); and
42 be it further
43

44 RESOLVED, That our AMA submit comments with medical physician organizations during
45 public comment period on the proposed rule to underscore the need to keep the standards
46 strong and protective of public health. (Directive to Take Action)

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

Received: 05/08/14

RELEVANT AMA POLICY

H-135.938 Global Climate Change and Human Health

Our AMA: 1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor. 2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies. 3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes. 4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability. 5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort. 6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment. (CSAPH Rep. 3, I-08)