psychological disorders that may result in obesity, as the currently prevailing definitions of obesity do not specify its underlying causes.

CURRENT AMA POLICY RELATED TO OBESITY

The AMA has more than 20 policies that specifically refer to obesity. Most do not define or describe the term, but among those that do, obesity is referred to as a: "complex disorder" (Policy H-150.953), "urgent chronic condition" (Policy D-440.971), "epidemic" (Policy D-440.952), and "major health concern" and "major public health problem" (Policy H-440.902). AMA policy does not clearly define obesity as a disease, although policy D-440.980 directed our AMA to convene a task force to "recommend measures to better recognize and treat obesity as a chronic disease" (Appendix).

METHODS

English language reports were selected from searches of the PubMed and Google Scholar databases from 2004 to January 2013 using the search terms "obesity as a disease," "obesity a disease," "obesity should be considered a disease," "what is disease," and "definition of disease." Additional articles were identified by manual review of the reference lists of pertinent publications. Websites managed by federal agencies and applicable professional and advocacy organizations also were consulted for relevant information.

BACKGROUND

Opinions within the medical profession have been divided for a number of years on whether or not obesity should be considered a disease, rather than a condition or disease risk factor. Those in favor of classifying obesity as a disease argue that excess body fat, which results from myriad genetic, behavioral, and other environmental factors, impairs a number of normal body functions. While the adverse health consequences and healthcare costs associated with obesity are generally well-recognized even in the absence of a disease label, proponents argue that neither provider reimbursement nor research into effective treatments will be adequate until obesity is considered a disease. Those opposed to classifying obesity as a disease argue that excess body weight increases risk of morbidity and mortality, but does not guarantee it. Concerns also exist about labeling 1/3 of Americans as "ill" and increasing stigmatization of obese individuals. However, others argue that classifying obesity as a disease will actually decrease stigma. These issues, and others, are discussed in more detail below.

WHAT IS OBESITY?

The World Health Organization (WHO) defines overweight and obesity as "abnormal or excessive fat accumulation that may impair health."[2] The WHO, as well as the Centers for Disease Control and Prevention (CDC)[3] and the National Heart, Lung, and Blood Institute (NHLBI),[4] describe overweight and obesity in adults using body mass index (BMI) categories (Table 1). The NHLBI additionally recommends measuring waist circumference in adults with BMIs below 35 kg/m^2, to further assess disease risk.[4]

While Simple and Inexpensive, BMI is a Limited Measure of Body Fatness

Both the WHO and NHLBI guidelines recognize that BMI is an indirect and imperfect measure of body fatness, although more accurate than body weight alone.[4] Originally designed as a rough population-level indicator of obesity, BMI has been widely recommended as an inexpensive

clinical screening tool to help assess disease risk, in addition to other indicators such as blood pressure and blood lipids.[5] Associations between BMI and adiposity (as well as disease risk, described below) vary by age, gender, ethnicity, socioeconomic status, stature, and athletic training. These variations generally reflect population-specific differences in body composition, fat distribution, causes of overweight, and genetic susceptibility.[5] As a screening tool for obesity, BMI demonstrates low sensitivity, particularly at BMIs below 30.[6] For example, some people with BMIs < 25 may have excess adipose tissue and proinflammatory cytokines, as well as metabolic disturbances associated with obesity, such as insulin resistance, hyperinsulinemia, dyslipidemia, hypertension, and cardiovascular disease (CVD).[5,6] On the other hand, some individuals with BMIs greater than 30 may not have excess body fat; however, even if they do, they may exhibit high insulin sensitivity and normal blood pressure and lipid levels.[5,6] Due to the limitations of BMI, some argue that BMI should be excluded from the definition of obesity when deciding whether or not obesity is a disease.[7-8]

NHLBI is currently developing new guidelines on overweight and obesity in adults as part of its development of cardiovascular risk reduction guidelines for adults.[9] These new guidelines will be based on rigorous and standardized systematic reviews of the scientific literature, which may clarify some of the uncertainties around the assessment and management of obesity in clinical practice. The release date of the new guidelines is currently unknown, but their availability for public comment is expected later in 2013.

Obesity as Measured by BMI is Associated with Increased Morbidity

Despite the limitations of BMI, a substantial body of literature has found increased BMI to be associated with myriad diseases and conditions, including: type 2 diabetes, coronary heart disease, stroke, hypertension, dyslipidemia, several cancers, gall bladder disease, osteoarthritis, asthma, chronic back pain, sleep apnea, pregnancy complications, stress incontinence, and depression.[5-6,10] The nature of the relationships between BMI and these conditions is generally similar across population groups, although the specific level of risk at a given BMI often differs by age, gender, ethnicity, and/or socioeconomic status.[5]

The Obesity Paradox

While co-morbidities generally increase as BMI increases, a number of research studies report no effect--or even slightly protective effects--of overweight and obesity on mortality risk (i.e., J- or U-shaped associations).[5-6,11] A number of factors beyond the inherent limitations of BMI may explain these seemingly paradoxical associations, including inadequate control (both under and over) for potential confounders and/or factors in the causal pathway (e.g., nutritional status, cardiorespiratory fitness, hypertension), and/or more aggressive screening and treatment efforts in individuals classified as overweight or obese.[5,11-13] In addition, the causes of death at low and high BMIs differ.[5,14] Nevertheless, most research indicates that individuals at the highest end of the adiposity spectrum are at increased risk of mortality.[5,13]

WHAT IS A DISEASE?

This seemingly straightforward question lacks a single, clear, authoritative, and widely-accepted definition.[8,15-17] CSA Report 4-A-05 identified some common precepts in the definitions of disease provided by several dictionaries and encyclopedias (Table 2).[1] Similar attempts have varied in their conclusions about what constitutes a disease, particularly in relation to obesity.[8] However, even the same definitions can yield varying conclusions. For example, the American Association of Clinical Endocrinologists (AACE) recently utilized the same disease criteria put forth in the previous

CSA report and concluded that obesity does, in fact, meet those criteria.[7] AACE's conclusion appears to be based less on new knowledge about obesity than on differences in their interpretation of the definition of disease.

In evaluating the variety of disease definitions currently in use (Table 2), some have noted that no one definition would encompass all diseases currently accepted as such (e.g., some definitions would exclude tuberculosis, stroke, alcoholism, some psychological disorders, or diabetes).[8] Indeed, the medical community's definitions of disease have been heavily influenced by contexts of time, place, and culture as much as scientific understanding of disease processes.[16] Given the often significant social and economic consequences of the dividing line between disease and "natural state" or "condition,"[8,16] it is imperative to consider the potential advantages, disadvantages, incentives, and obligations of the disease label for patients, clinicians, employers, third party payers, policy makers, and society as a whole.[8] Thus, rather than trying to determine if obesity meets arguably arbitrary disease criteria, the more relevant question is "would health outcomes be improved if obesity is considered a chronic, medical disease state?"[8]

WOULD CLASSIFYING OBESITY AS A DISEASE IMPROVE HEALTH OUTCOMES?

Various individuals and organizations have referred to obesity as a disease dating back to at least the 17th century, and possibly earlier--Hippocrates recognized the increased mortality risk of being overweight.[8] However, members of both the general public and the medical community remain divided on this issue.[8,15] While some arguments focus on whether obesity meets or does not meet the criteria for a specific definition of disease, other arguments directly address financial incentives for research and patient care, as well as the ability to offer treatment (Table 3). The financial and treatment arguments are particularly pertinent to the discussion of how classifying obesity as a disease might improve health outcomes; these arguments are considered in more detail below, along with arguments related to public policy, prevention programs, public perceptions and patient stigma.

Maybe Yes

More widespread recognition of obesity as a disease could result in greater investments by government and the private sector to develop and reimburse obesity treatments.[7,8] Some argue that the Food and Drug Administration (FDA) would face increased pressure to approve medications for obesity, and would therefore reframe their approval process to focus on the ability of pharmaceuticals to decrease adipose tissue rather than to improve other markers of metabolic health, such as blood pressure and lipid levels.[8] There is current interest in developing a "limited use" approval pathway that could facilitate the clinical review and FDA approval of prescription drugs. Antibiotics and drugs to treat obesity have been identified as appealing candidates for such a pathway. More effective medications on the market would likely spur physicians to prescribe, and patients to expect, pharmaceutical interventions for obesity.[8,18] In turn, third party payers would be harder pressed to deny coverage.[8]

Public policy and prevention programs related to obesity may benefit from the greater urgency a disease label confers. More funding for obesity-prevention programs, particularly for children and adolescents, could lead to improved health outcomes for years to come.[8] It is likely that a number of public policies related to healthy eating and physical activity, such as funding and regulations for K-12 meal programs and physical education, would receive greater attention and resources. Employers may be required to cover obesity treatments for their employees and may be less able to discriminate on the basis of body weight.[8]

Public perceptions may shift as a consequence of more extensive recognition of obesity as a disease, with greater appreciation of, and emphasis on, the complex etiology of obesity and the health benefits of achieving and maintaining a healthy weight.[8] Lack of self-control, laziness, and other detrimental character attributes might be less likely to be associated with obese individuals, and in turn reduce stigmatization.[8,19] The disease label also may provide greater motivation for some individuals to lose weight or maintain a healthy weight.[8] While increased emphasis on obesity may increase stigma (see below), some have argued that such consequences would oblige the medical community to take greater action to protect patients' rights.[8]

Maybe No

Concern exists that more widespread recognition of obesity as a disease would result in greater investments by government and the private sector to develop and reimburse pharmacological and surgical treatments for obesity, at the expense of clinical and public health interventions targeting healthy eating and regular physical activity.[18] "Medicalizing" obesity could intensify patient and provider reliance on (presumably costly) pharmacological and surgical treatments to achieve a specific body weight, and lead to prioritizing body size as a greater determinant of health than health behaviors.[18,20] Given the limitations of BMI (discussed above), this could also lead to the overtreatment of some people, such as those who meet the criteria for obesity, (i.e., BMI > 30) but are metabolically healthy. A similar concern is that obese individuals who improve their eating, physical activity, and sleeping habits, yet fail to lose enough weight to change their BMI classification, would still bear the "diseased" label and be pressured to receive medical treatment by clinicians, health insurers, and/or employers–even though their improved lifestyle behaviors are significant factors in preventing, delaying, and reducing the severity of obesity-associated outcomes. While some argue that BMI should be excluded from the definition of obesity in deciding whether or not obesity is a disease,[7,8] the fact remains that BMI is currently the prevailing clinical measure of obesity.

It is possible that public policy and prevention programs related to obesity may be diminished if increased government financing of research into medical treatments reduces funds available for public health prevention programs.[18] Similarly, the medicalization of obesity could detract from collective social solutions[20] to environmental forces that shape people's behaviors and impact a number of conditions beyond just obesity.[19] Thus, public efforts to enhance the built environment to make healthy eating and physical activity choices easier may receive less attention, despite providing substantial health benefits at every body weight;[18,20] in turn, this could slow the improvement of health outcomes for all Americans. In addition, employers may raise health insurance premiums, limit hiring of obese individuals, and/or curtail employee wellness programs that incentivize weight loss or maintaining a healthy weight.[8]

Public perceptions may shift as a consequence of more extensive recognition of obesity as a disease, but not in a manner than improves health outcomes. For instance, some individuals may conclude that health behaviors matter little in disease development and management, which may decrease their motivation to eat healthfully and be physically active.[8] In addition, an increased clinical emphasis on obesity could potentially offend or otherwise alienate some obese individuals, particularly if the emphasis is on achieving an ideal weight rather than healthy eating and physical activity behaviors.[19] Assuming the current BMI cut-points remain the primary clinical indicator of obesity, such stigma would likely also impact people who are otherwise healthy, but who nevertheless meet the criteria for obesity (BMI > 30).

AREAS REQUIRING FURTHER RESEARCH

If obesity is to be considered a disease, a better measure of obesity than BMI is needed to diagnose individuals in clinical practice. Further research is also warranted into the physiologic mechanisms behind why some obese individuals (e.g., the metabolically healthy obese) do not develop adverse health outcomes related to excess adipose tissue.[21] This is particularly relevant given the difficulties most people have in achieving sustained weight loss. In addition, much more research is needed to develop effective and affordable obesity prevention and management strategies at both the clinical and community levels.

SUMMARY AND CONCLUSION

Without a single, clear, authoritative, and widely-accepted definition of disease, it is difficult to determine conclusively whether or not obesity is a medical disease state. Similarly, a sensitive and clinically practical diagnostic indicator of obesity remains elusive. Obesity, measured by BMI, is clearly associated with a number of adverse health outcomes, with greater consistency across populations at the highest BMI levels. However, given the existing limitations of BMI to diagnose obesity in clinical practice, it is unclear that recognizing obesity as a disease, as opposed to a "condition" or "disorder," will result in improved health outcomes. The disease label is likely to improve health outcomes for some individuals, but may worsen outcomes for others.

What is clear is that a better measure of obesity than BMI alone is needed. NHLBI's forthcoming guidelines on overweight and obesity in adults may help clarify clinical uncertainties regarding the best means of measuring obesity, at least in reference to cardiovascular risk. In the meantime, better clinical and public health strategies are warranted to assist individuals in improving their lifestyle behaviors and in reducing adverse outcomes associated with obesity.

RECOMMENDATIONS

The Council on Science and Public Health recommends that the following statements be adopted in lieu of Resolution 115-A-12 and the remainder of the report be filed.

1. That Policies H-150.953, "Obesity as a Major Public Health Program," and H-440.866, "The Clinical Utility of Measuring Body Mass Index and Waist Circumference in the Diagnosis and Management of Adult Overweight and Obesity," be reaffirmed. (Reaffirm HOD Policy)

2. That Policy H-150.953, "Obesity as a Major Public Health Program," be re-titled "Obesity as a Major Public Health Problem." (Modify Current HOD Policy)

3. That Policy D-440.971, "Recommendations for Physician and Community Collaboration on the Management of Obesity," be rescinded. (Rescind HOD Policy)

Fiscal note: No significant fiscal impact

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TABLE 1. National Heart Lung and Blood Institute Classifications of Overweight and Obesity by BMI and Waist Circumference in Adults[4]

Classification	**BMI (kg/m^2)**	**Risk of type 2 diabetes, hypertension, and CVD *relative* to normal weight and waist circumference***	
		Men ≤ 40 in Women ≤ 35 in	**Men ≥40 in Women ≥ 35 in**
Underweight	< 18.5	---	---
Normal weight	18.5 – 24.9	---	---
Overweight	25.0 – 29.9	Increased	High
Obesity (Class I)	30.0 – 34.9	High	Very High
Obesity (Class II)	35.0 – 39.9	Very High	Very High
Extreme obesity (Class III)	≥ 40	Extremely High	Extremely High

*NHLBI guidelines note that increased waist circumference can indicate increased disease risk even in individuals considered normal weight.

TABLE 2. Examples of disease definitions

Definition of disease
All 3 of the following criteria must be met: a) "An impairment of the normal functioning of some aspect of the body b) Characteristic signs or symptoms; and c) Resultant harm or morbidity to the entity affected"[1]
1) Based on biostatistical theory: "Deviation from species-typical functioning; disease is deviation from the average." -or- 2) Based on evolutionary functions: "Disease occurs when an organ is not performing the job that allowed it to evolve via natural selection."(quoted in [8])
All 4 of the following criteria must be met: a) "A condition of the body, its parts, organs, or systems, or an alteration thereof; b) Resulting from infection, parasites, nutritional, dietary, environmental, genetic, or other causes; c) Having a characteristic, identifiable, marked, group of symptoms or signs; d) Deviation from normal structure or function (variously described as abnormal structure or function; incorrect function; impairment of normal state; interruption, disturbance, cessation, disorder, derangement of bodily or organ functions)."[22]
"Damage to an organ, part, structure, or system of the body such that it does not function properly (e.g., cardiovascular disease), or a state of health leading to such dysfunctioning (e.g., hypertension); except that diseases resulting from essential nutrient deficiencies (e.g., scurvy, pellagra) are not included in this definition."[23]
"An impairment of the normal state of the living animal or plant body or one of its parts that interrupts or modifies the performance of the vital functions, is typically manifested by distinguishing signs and symptoms, and is a response to environmental factors (as malnutrition, industrial hazards, or climate), to specific infective agents (as worms, bacteria, or viruses), to inherent defects of the organism (as genetic anomalies), or to combinations of these factors:"[24]
1. "An interruption, cessation, or disorder of a body, system, or organ structure or function. 2. A morbid entity ordinarily characterized by two or more of the following criteria: recognized etiologic agent(s), identifiable group of signs and symptoms, or consistent anatomic alterations."[25]

TABLE 3. Arguments For and Against Classifying Obesity as a Medical Disease State*

Yes, Obesity is a Disease	No, Obesity is *Not* a Disease
Obesity meets disease criteria (e.g., outlined in CSA Report 4-A-05[1]): a)*Impairment of normal functioning of the body*: "Appetite dysregulation, abnormal energy balance, endocrine dysfunction including elevated leptin levels and insulin resistance, infertility, dysregulated adipokine signaling, abnormal endothelial function and blood pressure elevation, nonalcoholic fatty liver disease, dyslipidemia, and systemic and adipose tissue inflammation."[7] b) *Characteristic signs and symptoms*: Increase in body fat has both anatomic sequelae (e.g., joint pain, immobility, sleep apnea) and metabolic sequelae (progression to type II diabetes and cardiovascular disease).[7] c) *Results in harm or morbidity to the entity affected*: Obesity is directly associated with increased mortality and morbidity due to a number of factors, and weight loss improves obesity-related morbidity and mortality (e.g., improved glycemic control in diabetes and reduced risk of type II diabetes, CVD, some cancers, and alleviation of symptoms of osteoarthritis, sleep apnea, etc.).[7]	Obesity does NOT meet disease criteria (e.g., outlined in CSA Report 4-A-05[1]): a)*Impairment of normal functioning of the body:* Excess adipose tissue is not necessarily an impairment; rather, it is a biological adaptation that can have beneficial effects. In fact, it is normal for the obese body to resist weight loss efforts.[1] b) *Characteristic signs and symptoms*: There are no specific symptoms of obesity and the only sign is increased weight and body fat, which is the definition of obesity.[1] c) *Results in harm or morbidity to the entity affected*: True causality has not been established in the literature, as obesity has only been associated with morbidity and mortality.[1]
Obesity is similar to other diseases (e.g., hypertension, diabetes, lung cancer) that result from a combination of genetics and environmental factors (including behaviors).[7]	Simply because other diseases share similarities with obesity does not mean obesity is a disease.[8] Obesity results from personal choices to overeat or live a sedentary lifestyle, not an illness.[7]
All diseases work through pathways and mechanisms; simply because obesity's anatomic and metabolic sequelae include already recognized diseases does not mean obesity is not also a disease.[8]	Obesity is a modifiable risk factor - it increases risk of morbidity and/or mortality only by causing other diseases.[8]
The disease label (i.e., "medicalization") would help improve attitudes and financial support to expand: a) research into prevention and treatment, and b) resources for patient care.[7]	"Medicalization" of obesity is intended to drive financial gains of certain providers/interests.[8]
Most experts agree obesity is a disease.[8]	Just because most experts agree (if true) does not mean obesity meets the criteria for disease, and some experts disagree.[8]
Obesity is treatable in at least some individuals but a lack of treatment should not be a criteria for considering obesity a disease.[8]	There is no effective, well-established treatment for obesity.[8]

*Arguments listed were discussed in the cited references, but do not necessarily reflect those authors' views.

APPENDIX.
Current AMA policies relevant to the issue of obesity as a chronic medical disease state

H-150.953 Obesity as a Major Public Health Program
Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6, A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12)

H-440.902 Obesity as a Major Health Concern
The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12)

D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis
Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-

establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) provide a progress report on the above efforts to the House of Delegates by the 2004 Annual Meeting. (Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07)

D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity

Our AMA will: (1) work with the Centers for Disease Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a disease, using a systematic, evidence-based approach; (2) continue to actively pursue measures to treat obesity as an urgent chronic condition, raise the public's awareness of the significance of obesity and its related disorders, and encourage health industries to make appropriate care available for the prevention and treatment of obese patients, as well as those who have co-morbid disorders; (3) encourage physicians to incorporate body mass index (BMI) and waist circumference as a component measurement in the routine adult physical examination, and BMI percentiles in children recognizing ethnic sensitivities and its relationship to stature, and the need to implement appropriate treatment or preventive measures; (4) promote use of our Roadmaps for Clinical Practice: Assessment and Management of Adult Obesity primer in physician education and the clinical management of adult obesity; (5) develop a school health advocacy agenda that includes funding for school health programs, physical education and physical activity with limits on declining participation, alternative policies for vending machines that promote healthier diets, and standards for healthy a la carte meal offerings. Our AMA will work with a broad partnership to implement this agenda; and (6) collaborate with the CDC, the Department of Education, and other appropriate agencies and organizations to consider the feasibility of convening school health education, nutrition, and exercise representatives, parents, teachers and education organizations, as well as other national experts to review existing frameworks for school health, identify basic tenets for promoting school nutrition and physical activity (using a coordinated school health model), and create recommendations for a certificate program to recognize schools that meet a minimum of the tenants. (CSA Rep. 4, A-05; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 1, A-08; Reaffirmation I-10; Reaffirmed: BOT Rep. 21, A-12)

H-425.994 Medical Evaluations of Healthy Persons

The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) *Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs.* (6) Continued investigation is required to determine the usefulness of

test procedures that may be of value in detecting disease among asymptomatic populations. CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-90.974 Opposition to Obesity as a Disability
Our AMA opposes the effort to make obesity a disability. (Res. 412, A-09)

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)

D-440.952 Fighting the Obesity Epidemic
1. Our AMA Council on Science and Public Health (CSAPH) will critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting. 2. Our AMA will consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles. 3. Our AMA Council on Medical Service and CSAPH will collaborate to evaluate the relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35. (BOT Rep. 9, A-07)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 420
(A-13)

Introduced by: American Association of Clinical Endocrinologists
American College of Cardiology
The Endocrine Society
American Society for Reproductive Medicine
The Society for Cardiovascular Angiography and Interventions
American Urological Association
American College of Surgeons

Subject: Recognition of Obesity as a Disease

Referred to: Reference Committee D
(Douglas W. Martin, MD, Chair)

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

Whereas, Congruent with this criteria there is now an overabundance of clinical evidence to identify obesity as a multi-metabolic and hormonal disease state including impaired functioning of appetite dysregulation, abnormal energy balanced, endocrine dysfunction including elevated leptin levels and insulin resistance, infertility, dysregulated adipokine signaling, abnormal endothelial function and blood pressure elevation, nonalcoholic fatty liver disease, dyslipidemia, and systemic and adipose tissue inflammation; and

Whereas, Obesity has characteristic signs and symptoms including the increase in body fat and symptoms pertaining to the accumulation of body fat, such as joint pain, immobility, sleep apnea, and low self-esteem; and

Whereas, The physical increase in fat mass associated with obesity is directly related to comorbidities including type 2 diabetes, cardiovascular disease, some cancers, osteoporosis, polycystic ovary syndrome; and

Whereas, Weight loss from lifestyle, medical therapies, and bariatric surgery can dramatically reduce early mortality, progression of type 2 diabetes, cardiovascular disease risk, stroke risk, incidence of cancer in women, and constitute effective treatment options for type 2 diabetes and hypertension; and

Whereas, Recent studies have shown that even after weight loss in obese patients there are hormonal and metabolic abnormalities not reversible by lifestyle interventions that will likely require multiple different risk stratified interventions for patients; and

Whereas, Obesity rates have doubled among adults in the last twenty years and tripled among children in a single generation and a recent report by the Robert Wood Johnson Foundation states evidence suggests that by 2040 roughly half the adult population may be obese; and

Whereas, The World Health Organization, Food and Drug Administration (FDA), National Institutes of Health (NIH), the American Association of Clinical Endocrinologists, and Internal Revenue Service recognize obesity as a disease; and

Whereas, Obesity is recognized as a complex disease by CIGNA, one of the nation's largest health insurance companies; and

Whereas, Progress in the development of lifestyle modification therapy, pharmacotherapy, and bariatric surgery options has now enabled a more robust medical model for the management of obesity as a chronic disease utilizing data-driven evidenced-based algorithms that optimize the benefit/risk ratio and patient outcomes; and

Whereas, The suggestion that obesity is not a disease but rather a consequence of a chosen lifestyle exemplified by overeating and/or inactivity is equivalent to suggesting that lung cancer is not a disease because it was brought about by individual choice to smoke cigarettes; and

Whereas, The Council on Science and Public Health has prepared a report that provides a thorough examination of the major factors that impact this issue, the Council's report would receive much more of the recognition and dissemination it deserves by identifying the enormous humanitarian and economic impact of obesity as requiring the medical care, research and education attention of other major global medical diseases; therefore be it

RESOLVED, That our American Medical Association recognize obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention. (New HOD Policy)

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

Received: 05/16/13

RELEVANT AMA POLICY

H-150.953 Obesity as a Major Public Health Program - Our AMA will: (1) urge physicians as well as managed care organizations and other third party payers to recognize obesity as a complex disorder involving appetite regulation and energy metabolism that is associated with a variety of comorbid conditions; (2) work with appropriate federal agencies, medical specialty societies, and public health organizations to educate physicians about the prevention and management of overweight and obesity in children and adults, including education in basic principles and practices of physical activity and nutrition counseling; such training should be included in undergraduate and graduate medical education and through accredited continuing medical education programs; (3) urge federal support of research to determine: (a) the causes and mechanisms of overweight and obesity, including biological, social, and epidemiological influences on weight gain, weight loss, and weight maintenance; (b) the long-term safety and efficacy of voluntary weight maintenance and weight loss practices and therapies, including surgery; (c) effective interventions to prevent obesity in children and adults; and (d) the effectiveness of weight loss counseling by physicians; (4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (5) urge physicians to assess their patients for overweight and obesity during routine medical examinations and discuss with at-risk patients the health consequences of further weight gain; if treatment is indicated, physicians should encourage and facilitate weight maintenance or reduction efforts in their patients or refer them to a physician with special interest and expertise in the clinical management of obesity; (6) urge all physicians and patients to maintain a desired weight and prevent inappropriate weight gain; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients; and (8) urge the appropriate federal agencies to work with organized medicine and the health insurance industry to develop coding and payment mechanisms for the evaluation and management of obesity. (CSA Rep. 6,

A-99; Reaffirmation A-09; Reaffirmed: CSAPH Rep. 1, A-09; Reaffirmation A-10; Reaffirmation I-10; Reaffirmation A-12; Reaffirmed in lieu of Res. 434, A-12)

H-440.902 Obesity as a Major Health Concern - The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients. (Res. 423, A-98; Reaffirmed and Appended: BOT Rep. 6, A-04; Reaffirmation A-10; Reaffirmed in lieu of Res. 434, A-12)

D-440.980 Recognizing and Taking Action in Response to the Obesity Crisis - Our AMA will: (1) collaborate with appropriate agencies and organizations to commission a multidisciplinary task force to review the public health impact of obesity and recommend measures to better recognize and treat obesity as a chronic disease; (2) actively pursue, in collaboration and coordination with programs and activities of appropriate agencies and organizations, the creation of a "National Obesity Awareness Month"; (3) strongly encourage through a media campaign the re-establishment of meaningful physical education programs in primary and secondary education as well as family-oriented education programs on obesity prevention; (4) promote the inclusion of education on obesity prevention and the medical complications of obesity in medical school and appropriate residency curricula; and (5) provide a progress report on the above efforts to the House of Delegates by the 2004 Annual Meeting. (Res. 405, A-03; Reaffirmation A-04; Reaffirmation A-07)

D-440.971 Recommendations for Physician and Community Collaboration on the Management of Obesity - Our AMA will: (1) work with the Centers for Disease Control and Prevention to convene relevant stakeholders to evaluate the issue of obesity as a disease, using a systematic, evidence-based approach; (2) continue to actively pursue measures to treat obesity as an urgent chronic condition, raise the public's awareness of the significance of obesity and its related disorders, and encourage health industries to make appropriate care available for the prevention and treatment of obese patients, as well as those who have co-morbid disorders; (3) encourage physicians to incorporate body mass index (BMI) and waist circumference as a component measurement in the routine adult physical examination, and BMI percentiles in children recognizing ethnic sensitivities and its relationship to stature, and the need to implement appropriate treatment or preventive measures; (4) promote use of our Roadmaps for Clinical Practice: Assessment and Management of Adult Obesity primer in physician education and the clinical management of adult obesity; (5) develop a school health advocacy agenda that includes funding for school health programs, physical education and physical activity with limits on declining participation, alternative policies for vending machines that promote healthier diets, and standards for healthy a la carte meal offerings. Our AMA will work with a broad partnership to implement this agenda; and (6) collaborate with the CDC, the Department of Education, and other appropriate agencies and organizations to consider the feasibility of convening school health education, nutrition, and exercise representatives, parents, teachers and education organizations, as well as other national experts to review existing frameworks for school health, identify basic tenets for promoting school nutrition and physical activity (using a coordinated school health model), and create recommendations for a certificate program to recognize schools that meet a minimum of the tenants. (CSA Rep. 4, A-05; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: CSAPH Rep. 1, A-08; Reaffirmation I-10; Reaffirmed: BOT Rep. 21, A-12)

D-440.954 Addressing Obesity - Our AMA will: (1) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (2) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and

medical programs that serve vulnerable populations; and (3) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention. (BOT Rep. 11, I-06)

H-90.974 Opposition to Obesity as a Disability - Our AMA opposes the effort to make obesity a disability. (Res. 412, A-09)

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)

H-170.961 Prevention of Obesity Through Instruction in Public Schools - Our AMA will urge appropriate agencies to support legislation that would require meaningful yearly instruction in nutrition, including instruction in the causes, consequences, and prevention of obesity, in grades 1 through 12 in public schools and will encourage physicians to volunteer their time to assist with such an effort. (Res. 426, A-12)

D-440.952 Fighting the Obesity Epidemic - 1. Our AMA Council on Science and Public Health (CSAPH) will critically evaluate the clinical utility of measuring body mass index (BMI) and/or waist circumference in the diagnosis and management of overweight and obesity, with input from leading researchers and key stakeholder organizations, with a report back at the 2007 AMA Interim Meeting. 2. Our AMA will consider convening relevant stakeholders to further examine the issue of incentives for healthy lifestyles. 3. Our AMA Council on Medical Service and CSAPH will collaborate to evaluate the relative merits of bariatric surgery and the issue of reimbursement for improving health outcomes in individuals with a BMI greater than 35. (BOT Rep. 9, A-07)

D-150.993 Obesity and Culturally Competent Dietary and Nutritional Guidelines - Our AMA and its Minority Affairs Consortium will study and recommend improvements to the US Department of Agriculture's Dietary Guidelines for Americans and Food Guide Pyramid so these resources fully incorporate cultural and socioeconomic considerations as well as racial and ethnic health disparity information in order to reduce obesity rates in the minority community, and report its findings and recommendations to the AMA House of Delegates by the 2004 Annual Meeting. (Res. 428, A-03)

H-150.933 Taxes on Beverages with Added Sweeteners - 1. Our AMA recognizes the complexity of factors contributing to the obesity epidemic and the need for a multifaceted approach to reduce the prevalence of obesity and improve public health. A key component of such a multifaceted approach is improved consumer education on the adverse health effects of excessive consumption of beverages containing added sweeteners. Taxes on beverages with added sweeteners are one means by which consumer education campaigns and other obesity-related programs could be financed in a stepwise approach to addressing the obesity epidemic. 2. Where taxes on beverages with added sweeteners are implemented, the revenue should be used primarily for programs to prevent and/or treat obesity and related conditions, such as educational ad campaigns and improved access to potable drinking water, particularly in schools and communities disproportionately effected by obesity and related conditions, as well as on research into population health outcomes that may be affected by such taxes. 3. Our AMA will advocate for continued research into the potentially adverse effects of long-term consumption of non-caloric sweeteners in beverages, particularly in children and adolescents. (CSAPH Rep. 5, A-12)

H-150.944 Combating Obesity and Health Disparities - Our AMA supports efforts to: (1) reduce health disparities by basing food assistance programs on the health needs of their constituents; (2) provide vegetables, fruits, legumes, grains, vegetarian foods, and healthful nondairy beverages in school lunches

and food assistance programs; and (3) ensure that federal subsidies encourage the consumption of products low in fat and cholesterol. (Res. 413, A-07; Reaffirmation A-12)

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)

H-425.994 Medical Evaluations of Healthy Persons - The AMA supports the following principles of healthful living and proper medical care: (1) The periodic evaluation of healthy individuals is important for the early detection of disease and for the recognition and correction of certain risk factors that may presage disease. (2) The optimal frequency of the periodic evaluation and the procedures to be performed vary with the patient's age, socioeconomic status, heredity, and other individual factors. Nevertheless, the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors. (3) These recommendations should be modified as appropriate in terms of each person's age, sex, occupation and other characteristics. All recommendations are subject to modification, depending upon factors such as the sensitivity and specificity of available tests and the prevalence of the diseases being sought in the particular population group from which the person comes. (4) The testing of individuals and of population groups should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors that are identified. (5) Physicians need to improve their skills in fostering patients' good health, and in dealing with long recognized problems such as hypertension, obesity, anxiety and depression, to which could be added the excessive use of alcohol, tobacco and drugs. (6) Continued investigation is required to determine the usefulness of test procedures that may be of value in detecting disease among asymptomatic populations. (CSA Rep. D, A-82; Reaffirmed: CLRPD Rep. A, I-92; Reaffirmed: CSA Rep. 8, A-03)

H-30.937 Setting Domestic and International Public Health Prevention Targets for Per Capita Alcohol Consumption as a Means of Reducing the Burden on Non-Communicable Diseases on Health Status - Our AMA will: (1) continue to address the role of alcohol use on health status and the impact of behaviorally-associated chronic illnesses (including obesity, diabetes, heart disease, chronic respiratory diseases, and many cancers) on the overall burden of disease and the costs of health care services in America; (2) encourage federal health services planning agencies and public health authorities to address the role of alcohol and tobacco consumption on health and to promote environmental interventions including evidence based tobacco control and alcohol control policies to improve the health status of Americans; and (3) encourage the World Health Organization to continue its work on the impact of Non Communicable Diseases (NCDs) on health status and to include targets for reduced per capita alcohol consumption among its major proposed interventions in developed and developing nations to reduce the incidence of, prevalence of, and rates of disability and premature deaths attributable to chronic non-communicable diseases. (Res. 413, A-12)

H-150.937 Reducing the Price Disparity Between Calorie-Dense, Nutrition-Poor Foods and Nutrition-Dense Foods - Our AMA supports: (1) 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 (2) 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)

H-150.965 Eating Disorders - The AMA (1) adopts the position that overemphasis of bodily thinness is as deleterious to one's physical and mental health as is obesity; (2) asks its members to help their patients avoid obsessions with dieting and to develop balanced, individualized approaches to finding the body weight that is best for each of them; (3) encourages training of all school-based physicians,

counselors, coaches, trainers, teachers and nurses to recognize unhealthy eating, dieting, and weight restrictive behaviors in adolescents and to offer education and appropriate referral of adolescents and their families for interventional counseling; and (4) participates in this effort by consulting with appropriate specialty societies and by assisting in the dissemination of appropriate educational and counseling materials pertaining to unhealthy eating, dieting, and weight restrictive behaviors. (Res. 417, A-92; Appended by Res. 503, A-98; Modified and Reaffirmed: CSAPH Rep. 2, A-08)

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-440.978 Culturally Responsive Dietary and Nutritional Guidelines - Our AMA and its Minority Affairs Consortium will: (1) encourage the United States Department of Agriculture (USDA) Food Guide Pyramid Reassessment Team to include culturally effective guidelines that include listing an array of ethnic staples and use multicultural symbols to depict serving size in their revised Dietary Guidelines for Americans and Food Guide Pyramid; (2) seek ways to assist physicians with applying the final USDA Dietary Guidelines for Americans and Food Guide Pyramid in their practices as appropriate; and (3) monitor existing research and identify opportunities where organized medicine can impact issues related to obesity, nutritional and dietary guidelines, racial and ethnic health disparities as well as assist physicians with delivering culturally effective care. (BOT Rep. 6, A-04)

D-150.989 Healthy Food in Hospitals - Our AMA will urge (1) component medical societies, member physicians and other appropriate local groups to encourage palatable, health-promoting foods in hospitals and other health care facilities and oppose the sale of unhealthy food with inadequate nutritional value or excessive caloric content as part of a comprehensive effort to reduce obesity; and (2) health care facilities that contract with outside food vendors to select vendors that share their commitment to the health of their patients and community. (Res. 420, A-05)

H-150.954 Dietary Supplements and Herbal Remedies- (1) Our AMA will work with the FDA to educate physicians and the public about FDA's MedWatch program and to strongly encourage physicians and the public to report potential adverse events associated with dietary supplements and herbal remedies to help support FDA's efforts to create a database of adverse event information on these forms of alternative/complementary therapies. (2) Our AMA continues to urge Congress to modify the Dietary Supplement Health and Education Act to require that (a) dietary supplements and herbal remedies including the products already in the marketplace undergo FDA approval for evidence of safety and efficacy; (b) meet standards established by the United States Pharmacopeia for identity, strength, quality, purity, packaging, and labeling; (c) meet FDA postmarketing requirements to report adverse events, including drug interactions; and (d) pursue the development and enactment of legislation that declares metabolites and precursors of anabolic steroids to be drug substances that may not be used in a dietary supplement. (3) Our AMA work with the Federal Trade Commission (FTC) to support enforcement efforts based on the FTC Act and current FTC policy on expert endorsements. (4) That the product labeling of dietary supplements and herbal remedies contain the following disclaimer as a minimum requirement: "This product has not been evaluated by the Food and Drug Administration and is not intended to diagnose, mitigate, treat, cure, or prevent disease." This product may have significant adverse side effects and/or interactions with medications and other dietary supplements; therefore it is important that you inform your doctor that you are using this product. (5) That in order to protect the public, manufacturers be required to investigate and obtain data under conditions of normal use on adverse effects, contraindications, and possible drug interactions, and that such information be included on the label. (6) Our AMA continue its efforts to educate patients and physicians about the possible ramifications associated with the use of dietary supplements and herbal remedies. (Res. 513, I-98; Reaffirmed: Res. 515, A-99; Amended: Res. 501 & Reaffirmation I-99; Reaffirmation A-00; Reaffirmed: Sub. Res. 516, I-00; Modified: Sub. Res. 516, I-00; Reaffirmed: Sub. Res. 518, A-04; Reaffirmed: Sub. Res. 504, A-05; Reaffirmation A-05; Reaffirmed in lieu of Res. 520, A-05; Reaffirmation I-09; Reaffirmed in lieu of Res. 501, A-10; Reaffirmation A-11)

H-150.960 Improving Nutritional Value of Snack Foods Available in Primary and Secondary Schools - The AMA supports the position that primary and secondary schools should replace foods in vending machines and snack bars, which are of low nutritional value and are high in fat, salt and/or sugar, with healthier food choices which contribute to the nutritional needs of the students. (Res. 405, A-94; Reaffirmation A-04; Reaffirmed in lieu of Res. 407, A-04; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)

H-150.962 Quality of School Lunch Program - The AMA recommends to the National School Lunch Program that school meals be congruent with current U.S. Department of Agriculture/Department of HHS Dietary Guidelines. (Sub. Res. 507, A-93; Reaffirmed: CSA Rep. 8, A-03; Reaffirmation A-07)

H-150.964 Availability of Heart-Healthy and Health-Promoting Foods at AMA Functions - The AMA and its constituent medical societies strive to make heart-healthy and other health-promoting foods available as options at all functions. (Res. 406, I-92; Reaffirmed: CLRPD Rep. 5, A-03)

H-150.969 Commercial Weight-Loss Systems and Programs - It is the policy of the AMA to (1) continue to cooperate with appropriate state and/or federal agencies in their investigation and regulation of weight-loss systems and programs that are engaged in the illegal practice of medicine and/or that pose a health hazard to persons to whom they sell their services; (2) continue to provide scientific information to physicians and the public to assist them in evaluating weight-reduction practices and/or programs; and (3) encourage review of hospital-based weight-loss programs by medical staff. (CSA Rep. A, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CSAPH Rep. 1, A-11)

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-150.989 Weight Loss Clinics - The AMA encourages any person considering participation in a weight loss program to first consult his or her regular attending physician, or any other independent physician, for a physical examination and an objective professional evaluation of the proposed weight loss program as it relates to the individual's physical condition. (Res. 59, A-83; CLRPD Rep. 1, I-93; Reaffirmed: CSA Rep. 8, A-05)