Nos. 17-3508 and 18-2199

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MARK RICHARDSON,

Plaintiff-Appellant,

v.

CHICAGO TRANSIT AUTHORITY,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division

Case No. 16 CV 03027

The Honorable Judge John Robert Blakey

MOTION FOR LEAVE TO FILE BRIEF OF AMICI CURIAE

The Obesity Action Coalition, The Obesity Society, The Academy of Nutrition and Dietetics, The American Association of Clinical Endocrinologists, The American Society for Metabolic and Bariatric Surgery, The Black Women's Health Imperative, The Endocrine Society, The National Center for Weight and Wellness, The Obesity Medicine Association, and Equip for Equality

IN SUPPORT OF APPELLANT, MARK RICHARDSON, AND URGING REVERSAL

BARRY C. TAYLOR*
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MOTION FOR LEAVE TO FILE BRIEF OF AMICI CURIAE

Pursuant to Federal Rules of Appellate Procedure 27 and 29, The Obesity Action Coalition, The Obesity Society, The Academy of Nutrition and Dietetics, The American Association of Clinical Endocrinologists, The American Society for Metabolic and Bariatric Surgery, The Black Women's Health Imperative, The Endocrine Society, The National Center for Weight and Wellness, The Obesity Medicine Association, and Equip for Equality (collectively OAC Amici) respectfully request leave of this Court to file the attached brief as Amici Curiae in support of Plaintiff-Appellant. In support thereof, the OAC Amici state:

1. The OAC Amici are comprised of patient and scientific professional organizations with extensive expertise in the disease of obesity, and which have a great stake in ensuring that legal precedents about obesity are based on sound science.

2. The Obesity Action Coalition is a more than 60,000 member-strong national 501(c)(3) non-profit organization dedicated to improving the lives of individuals affected by the disease of obesity.

3. The Obesity Society is the leading professional society focused on obesity science, treatment, and prevention with a membership of 2,500 basic and clinical researchers, clinicians and care providers, educators, and public health and policy professionals.

4. The Academy of Nutrition and Dietetics is the world's largest organization of food and nutrition professionals, representing more than 104,000 credentialed practitioners, including registered dietitian nutritionists (RDNs), nutrition and dietetic technicians, registered (NDTRs) and advanced degree nutritionists committed to accelerating improvements in global health and well-being through food and nutrition.

5. The American Association of Clinical Endocrinologists represents over 5,000 endocrinologists in the United States, most of whom are Board-Certified in Endocrinology and Metabolism and concentrate their work on the treatment of patients with endocrine and metabolic disorders including diabetes, obesity, thyroid disorders and other endocrine diseases and disorders.

6. The American Society for Metabolic and Bariatric Surgery is the largest non-profit medical organization in the nation dedicated to metabolic and bariatric surgery.

7. The Black Women's Health Imperative is the only national organization dedicated solely to improving the health and wellness of our nation's 21 million Black women and girls—physically, emotionally and financially.

8. The Endocrine Society represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, infertility, obesity, osteoporosis, and thyroid disease.

9. The National Center for Weight and Wellness delivers patient-centered, science-based care to approximately 3,000 patients with obesity and severe obesity yearly.

10. The Obesity Medicine Association has over 2,100 members and is the largest organization of physicians, nurse practitioners, physician assistants, and other health care providers working every day to improve the lives of patients affected by obesity.

11. Equip for Equality (EFE) is a private nonprofit organization designated by the Governor to implement the federally mandated Protection and Advocacy System for the state of Illinois. Since Congress passed the Americans with Disabilities Act, 42 U.S.C. §12101, approximately 28 years ago, EFE has been committed to the Act's vigorous enforcement, including interpretation of the ADA consistent with current medical standards.[1]

12. The OAC Amici seek to file this amicus brief to inform the Court that medical knowledge and understanding of obesity has grown exponentially throughout the past two decades. Once understood as a simple matter of personal responsibility or willpower, we now know that obesity is a complex, chronic physiological condition.

[1] Additional information about each organization listed herein can be found in the Statements of Interest in the amicus brief.

13. The medical community recognizes obesity as a chronic disease that impacts one or more body systems, even without any secondary, underlying physical conditions.

14. Central to the resolution of this case is whether obesity, by itself and without any secondary, underlying physical conditions, can be an "impairment" as defined by the Americans with Disabilities Act.

15. Understanding the medical perspective regarding obesity as a chronic disease will assist the Court as it interprets the term "impairment."

16. The district court's conclusion that Mr. Richardson's obesity could not be a physiological condition in and of itself is contrary to the prevailing science about the causes of obesity, its biological origins and mechanisms, its clinical manifestations and impact, and the consensus view of the medical community.

17. The attached amicus brief is not duplicative of facts or legal analysis raised in the Plaintiff-Appellant's brief, but rather seeks to elucidate the medical consensus about the nature of obesity as a disease.

18. The OAC Amici have no financial interest in the outcome of this case. They have not received any money from any party to this suit or any other outside person intended to fund the preparation or submission of this amicus brief. This brief has not been authored, in whole or in part, by a party's counsel.

Wherefore, Amici Curiae The Obesity Action Coalition, The Obesity Society, The Academy of Nutrition and Dietetics, The American Association of Clinical Endocrinologists, The American Society for Metabolic and Bariatric Surgery, The Black Women's Health Imperative, The Endocrine Society, The National Center for Weight and Wellness, The Obesity Medicine Association, and Equip for Equality respectfully request leave to submit the attached brief in support of Plaintiff-Appellant and urging reversal of the district court's decision.

Respectfully submitted,
/s/ Barry C. Taylor

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CERTIFICATE OF COMPLIANCE

1. The foregoing motion complies with the type-volume limitation of Fed. R. App. P. 27(d)(2)(A) because this motion contains 864 words. In preparing this certificate, the undersigned relied on the word count of the word-processing system used to prepare the brief, Microsoft Word.

2. In accordance with Fed. R. App. P. 27(d)(1)(E), this motion complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this motion has been prepared in a proportionally spaced typeface using Microsoft Word Version 2007 in 12-point Palatino Linotype.

Respectfully submitted,
/s/ Barry C. Taylor

Counsel for Amici Curiae
Equip for Equality

CERTIFICATE OF SERVICE AND FILING

I hereby certify that on August 27, 2018, a copy of the foregoing motion was electronically filed with the Clerk of the Court for the United States Court of Appeals of the Seventh Circuit using the appellate CM/ECF system and served upon all counsel of record.

Respectfully submitted,
/s/ Barry C. Taylor

Counsel for Amici Curiae
Equip for Equality

Nos. 17-3508 and 18-2199

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v.

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BRIEF OF AMICI CURIAE

The Obesity Action Coalition, The Obesity Society, The Academy of Nutrition and Dietetics, The American Association of Clinical Endocrinologists, The American Society for Metabolic and Bariatric Surgery, The Black Women's Health Imperative, The Endocrine Society, The National Center for Weight and Wellness, The Obesity Medicine Association, and Equip for Equality

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Appellate Court No: 17-3508 and 18-2199

Short Caption: Richardson v. CTA

To enable the judges to determine whether recusal is necessary or appropriate, an attorney for a non-governmental party or amicus curiae, or a private attorney representing a government party, must furnish a disclosure statement providing the following information in compliance with Circuit Rule 26.1 and Fed. R. App. P. 26.1.

The Court prefers that the disclosure statement be filed immediately following docketing; but, the disclosure statement must be filed within 21 days of docketing or upon the filing of a motion, response, petition, or answer in this court, whichever occurs first. Attorneys are required to file an amended statement to reflect any material changes in the required information. The text of the statement must also be included in front of the table of contents of the party's main brief. **Counsel is required to complete the entire statement and to use N/A for any information that is not applicable if this form is used.**

[ ] **PLEASE CHECK HERE IF ANY INFORMATION ON THIS FORM IS NEW OR REVISED AND INDICATE WHICH INFORMATION IS NEW OR REVISED.**

(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

The Obesity Action Coalition; NAASO, The Obesity Society, Inc.; The Academy of Nutrition and Dietetics; The American Society for Metabolic and Bariatric Surgery; The Black Women's Health Imperative.

Please see disclosure statement 2 for additional parties.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Equip for Equality, Inc.

(3) If the party or amicus is a corporation:

i) Identify all its parent corporations, if any; and

N/A

ii) list any publicly held company that owns 10% or more of the party's or amicus' stock:

N/A

Attorney's Signature: /s/ Barry C. Taylor Date: 8/27/18

Attorney's Printed Name: Barry C. Taylor

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** X **No** ____

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(1) The full name of every party that the attorney represents in the case (if the party is a corporation, you must provide the corporate disclosure information required by Fed. R. App. P 26.1 by completing item #3):

The Endocrine Society, Scott Kahan MD LLC d/b/a The National Center for Weight and Wellness,

The Obesity Medicine Association, Equip for Equality, The American Association of Clinical Endocrinologists

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

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N/A

Attorney's Signature: /s/ Barry C. Taylor Date: 8/27/18

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Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** X **No** ____

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STATEMENT OF INTEREST OF AMICI CURIAE

Patient and Scientific Professional Organizations

The Amici patient and scientific professional organizations have joined in this brief to inform the Court about the disease of obesity. Amici have a great stake in ensuring that legal precedents about obesity are based on sound science. Medical knowledge and understanding of obesity has grown exponentially throughout the past two decades. Once understood as a simple matter of personal responsibility or willpower, we now know that obesity is a complex, chronic physiological condition influenced by a variety of factors.

The district court's conclusion that Mr. Richardson's obesity could not be a physiological condition in and of itself is contrary to the prevailing science about the causes of obesity, its biological origins and mechanisms, its clinical manifestations and impact, and the consensus view of the medical community.

The Obesity Action Coalition (OAC) is a more than 60,000 member-strong national 501(c)(3) non-profit organization dedicated to improving the lives of individuals affected by the disease of obesity. OAC's core missions are to provide science-based education on obesity; raise awareness and improve access to the treatments for obesity; and advocate for the elimination of obesity bias and discrimination in the workplace and public accommodations. OAC works with the

medical and scientific communities; policymakers at local, state, federal and international levels; and other patient-advocacy organizations.

The Obesity Society (TOS) was founded in 1982 and is the leading professional society focused on obesity science, treatment and prevention. With a membership of 2,500, TOS members include basic and clinical researchers, clinicians and care providers, educators, and public health and policy professionals. TOS's mission is to promote innovative research, effective and accessible care, and public health initiatives that will reduce the personal and societal burden of obesity.

In 2008, TOS commissioned a panel of experts to review the evidence and arguments on the issue of approaching obesity as a disease. Following this review, the panel released *Obesity as a Disease -- A White Paper on Evidence and Arguments*, which concluded that obesity is a complex condition with many causal contributors, including some factors that are largely beyond an individual's control; that obesity causes much suffering; that obesity causally contributes to ill health, functional impairment, reduced quality of life, serious disease, and greater mortality; that successful treatment, although difficult to achieve, produces many benefits; and that individuals with obesity are subject to enormous societal stigma and discrimination. In the decade since the release of the White Paper, TOS has continued its advocacy efforts to educate healthcare professionals, patients, policymakers and the general public that obesity is a complex and chronic disease that must be treated seriously.

The Academy of Nutrition and Dietetics (the Academy) is the world's largest organization of food and nutrition professionals, representing more than 104,000 credentialed practitioners, including registered dietitian nutritionists (RDNs), nutrition and dietetic technicians, registered (NDTRs) and advanced degree nutritionists committed to accelerating improvements in global health and well-being through food and nutrition. As part of a multidisciplinary teams, the Academy's members effectively assist and lead successful treatment initiatives at individual, local, state and federal levels to combat the disease of obesity.

The Academy's Weight Management Dietetics Practice Group includes a subset of over 4,000 members with expertise in the research, prevention, and treatment of overweight and obesity throughout the lifecycle. These members focus exclusively on the science and application of weight management and treatment for all ages and work to connect the public, scientific organizations, and industry to dietetics professionals with an expertise in weight management. RDNs and NDTRs skilled in weight management understand the complex etiology of obesity, that there are contributors to obesity that are outside of personal control, and the difficulties around achieving significant, sustainable weight loss.

The American Association of Clinical Endocrinologists (AACE) represents over 5,000 endocrinologists in the United States. Most AACE members are Board-Certified in Endocrinology and Metabolism and concentrate their work on the treatment of

patients with endocrine and metabolic disorders including diabetes, obesity, thyroid disorders and other endocrine diseases and disorders. AACE has published evidence-based Comprehensive Clinical Practice Guidelines for Medical Care of Patients with Obesity and continues to provide resources and tools to assist physicians and other healthcare professionals on the latest treatment guidelines on caring for patients diagnosed with obesity. AACE believes patients with obesity should have access to the full spectrum of interventions available to treat their disease and opposes any policies that restrict access to medically necessary care and/or medications.

The American Society for Metabolic and Bariatric Surgery (ASMBS), established in 1983, is the largest non-profit medical organization in the nation dedicated to metabolic and bariatric surgery. ASMBS is a multidisciplinary organization committed to educating medical professionals and encourages its members to investigate and discovery new advances as we continually strive to improve the quality and safety of care and treatment of people with obesity and related diseases.

ASMBS actively advocates for patients' access to high quality prevention and treatment of obesity and coordination of care with other medical disciplines whose patients are affected by obesity.

The Black Women's Health Imperative (BWHI) has, for more than 30 years, been the only national organization dedicated solely to improving the health and wellness of our nation's 21 million Black women and girls—physically, emotionally and

financially. BWHI advances and promotes Black women's health in three ways: evidence-based programs and initiatives; policy and advocacy; and research translation. As part of BWHI's advocacy for the health of Black women and their families, BWHI seeks to ensure Black women have access to quality and affordable healthcare that is culturally competent and patient-centered. Nearly 40% of Black women are considered to have obesity and benefit from policy and advocacy that recognizes their unique needs and lived experience, including advocacy for their freedom to live and work without discrimination based on their appearance and health conditions.

The Endocrine Society, founded in 1916, represents approximately 18,000 physicians and scientists engaged in the treatment and research of endocrine disorders, such as diabetes, hypertension, infertility, obesity, osteoporosis, and thyroid disease. The Society recognizes obesity as a disease and has published clinical practice guidelines, scientific statements, and other publications on obesity science and disease management.

The National Center for Weight and Wellness (NCWW) delivers patient-centered, science-based care to approximately 3,000 patients with obesity and severe obesity yearly. Founded in 2011, NCWW has a multidisciplinary team of physicians, behavioral psychologists, psychiatrists, dietitians, exercise counselors, and other specialists who dedicate their training and careers to the care of patients with obesity and the study of weight management. Via this clinical experience and extensive

participation in advocacy and research in obesity-related scientific areas, the NCWW team bridges the science of obesity medicine with compassionate, patient-centered care. NCWW's Director, Scott Kahan, M.D., M.P.H., is a recognized national leader in obesity science and practice and has faculty appointments at Johns Hopkins University and George Washington University.

The Obesity Medicine Association (OMA) is the largest organization of physicians, nurse practitioners, physician assistants, and other health care providers working every day to improve the lives of patients affected by obesity. OMA's more than 2,100 members are clinical experts in obesity medicine. They use a comprehensive, scientific, and individualized approach when treating obesity, which helps patients achieve their health and weight goals. OMA supports national and state-level advocacy efforts to increase access to and coverage of obesity treatment services to patients affected by obesity.

Equip for Equality

Equip for Equality (EFE) is a private nonprofit organization designated by the Governor in 1985 to implement the federally mandated Protection and Advocacy System for the state of Illinois. EFE's mission is to safeguard the rights of people with disabilities in Illinois through the provision of legal and advocacy services, public policy initiatives, prevention of abuse and neglect and self-advocacy training.

Among the most important of these rights are the protections provided by the

Americans with Disabilities Act (ADA or the Act), 42 U.S.C. § 12101. Since Congress passed the ADA approximately 28 years ago, EFE has been committed to the Act's vigorous enforcement, including interpretation of the ADA consistently with current medical standards.

Such standards now overwhelmingly recognize obesity as a disease and, in turn, a physiological disorder or condition that impacts one or more body systems. This means, in ADA terms, that obesity—on its own—can be a covered "impairment" under the Act. The district court's holding that obesity cannot be an ADA "impairment" absent an independent, underlying physical condition causing excess body weight disregards current medical science, and improperly limits the ADA's protections, in defiance of Congress's intent in enacting the ADA Amendment Act of 2008 (ADAAA), Pub. L. No. 110-325 (Sept. 25, 2008).

SUMMARY OF ARGUMENT

By overwhelming consensus, obesity is now recognized as a disease within the medical and public health communities. In 2013, the American Medical Association (AMA), with support from well-respected and established medical associations, passed a landmark policy that recognized "obesity as a disease state with multiple pathophysiological aspects requiring a range of interventions to advance obesity treatment and prevention." AMA House of Delegates, Policy H440.842, *Recognition of*

Obesity as a Disease (2013) (AMA Resolution). Appendix at 2.[1] The AMA policy is consistent with conclusions throughout the medical community regarding the nature and impact of obesity. *See infra pp. 15-21.* The AMA's declaration came on the heels of official statements to the same effect by dozens of other professional organizations, medical and public health entities, and governmental and nongovernmental agencies, including the World Health Organization and the National Institutes of Health.

This recognition is critical information for courts interpreting the definition of disability in the Americans with Disabilities Act. Under the ADA, an individual is entitled to protection if he or she is a person with a disability, defined as an individual who: (1) has an impairment that substantially limits one or more major life activities; (2) has a record of an impairment that substantially limits one or more major life activities; or (3) has been regarded as having an impairment. 42 U.S.C. § 12102(1).[2] Common to all three prongs of the definition of disability is the term "impairment," which is defined as a "physiological disorder or condition … affecting one or more body systems." 29 C.F.R. § 1630.2(h)(1).

Obesity falls squarely within the definition of impairment: it is a "disease" or physiological disorder/condition that impacts numerous body systems. *See infra pp. 22-*

[1] For the Court's convenience, we have included AMA Policy H440.842 and Resolution 420, which led to adoption of the Policy, in an Appendix to this brief. We refer to the Appendix pages when referencing these documents.

[2] The ADA also protects individuals from employment discrimination on the basis of their "association" with an individual with a disability. *See* 42 U.S.C. § 12112(b)(4).

26. Yet, the district court granted summary judgment to Defendant-Appellee after concluding that Plaintiff-Appellant *could not* show that obesity was an actual or perceived impairment without also showing a separate "underlying physiological disorder or condition." *Richardson v. Chicago Transit Auth.*, 292 F. Supp. 3d 810, 819 (N.D. Ill. 2017). Because this conclusion is at odds with the current medical consensus regarding obesity, it must be overturned.[3]

BACKGROUND

Obesity is an "abnormal or excessive fat accumulation that presents a risk to health."[4] Traditionally, obesity was viewed as simply a matter of personal responsibility or willpower. Evolving research in the field, especially throughout the past two decades, has shown that obesity is a chronic, relapsing, multifactorial condition consistent with a disease.

The Disease of Obesity

Obesity involves numerous pathophysiologic processes, including changes at cellular, hormonal, neurochemical and organ levels. For example, at a cellular level, adipose (fat) cells secrete a range of inflammatory mediators that have wide-ranging

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[3] This Amicus Brief offers no opinion as to whether the Plaintiff-Appellant has an ADA-qualifying *disability*; instead, it seeks to educate the Court about the medical community's understanding of obesity and to demonstrate that obesity in and of itself can be an *impairment* under the ADA. The terms impairment and disability have different definitions and meanings under the ADA.

[4] World Health Organization (WHO), http://www.who.int/topics/obesity/en/ (last viewed Aug. 26, 2018).

biological effects, such as increasing blood vessel reactivity and decreasing insulin sensitivity.[5] Obesity causes or contributes to altered production of numerous hormones, such as stress hormones and estrogenic hormones, which have pathologic effects across bodily systems and cause further adverse health effects, including estrogen-dependent cancers.[6]

Numerous organs are affected by obesity, often bi-directionally, such that obesity causes organ dysfunction and the same organ dysfunction further exacerbates the individual's obesity. For instance, obesity is a central cause of non-alcoholic fatty liver disease, and liver disease in turn contributes to insulin resistance, which further drives weight gain and contributes to many obesity-related health conditions such as diabetes and cardiovascular disease.[7] Fat deposition in areas within and surrounding the neck, along with structural weakening of airways, causes obstructive sleep apnea; sleep

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[5] Margaret F. Gregor & Gökhan S. Hotamisligil, *Inflammatory Mechanisms in Obesity*, 29 Annual Rev. Immunology, 415-445 (2011).

[6] Celine Gerard & Kristy A Brown, *Obesity and Breast Cancer - Role of Estrogens and the Molecular Underpinnings of Aromatase Regulation in Breast Adipose Tissue*, 46 Molecular and Cellular Endocrinology, 15-30 (2018).

[7] Norbert Stefan, Konstantinos Kantartzis & Hans-Ulrich Haring, *Causes and Metabolic Consequences of Fatty Liver*, 7 Endocrine Rev. 939-960 (2008).

apnea, in turn, contributes to appetite dysregulation, altered metabolism, and weight gain.[8]

Genetic factors cause or contribute to obesity and the severity of obesity. For example, persons with genetic defects in leptin (a hormone secreted by adipose cells that has wide-ranging effects throughout the body, including a central regulating role in appetite, metabolism and body weight) production develop extreme obesity within the first few years of life.[9] Moreover, acquired leptin deficiency contributes to weight gain – and especially to weight regain following weight loss.[10]

At a neurochemical level, obesity leads to inflammation within appetite control centers in the hypothalamus, which decreases response to hunger and satiety signaling from other parts of the body.[11] This appetite dysregulation, which leads to elevated hunger and diminished satiety, makes behavioral changes to decrease food intake progressively more challenging. This and other biochemical changes are believed to

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[8] Mark A Brown et al., *The Impact of Sleep-Disordered Breathing on Body Mass Index (BMI): The Sleep Heart Health Study (SHHS)*, 3 Southwest J Pulmonary Critical Care, 159-168 (2011).

[9] I. Sadaf Farooqi & Stephen O'Rahilly, *New Advances in the Genetics of Early Onset Obesity*, 29 Int'l J. of Obesity, 1149-1152 (2005).

[10] Pryia Sumithran et al., *Long-Term Persistence of Hormonal Adaptations to Weight Loss*, 365 N. En. J. Med., 1597-1604 (2011).

[11] Joshua P. Thaler & Michael W. Schwartz, *Inflammation and Obesity Pathogenesis: The Hypothalamus Heats Up*, 151 Endocrinology 4109-4115 (2010).

underlie the commonly discussed "set point" of body weight that helps to explain why sustained weight loss is so difficult to achieve and maintain.[12]

Diagnosing Obesity

Initial screening for obesity is usually done via calculation of body mass index (BMI; weight in kilograms divided by the square of height in meters), a ratio of weight and height that has been shown in actuarial studies and public health studies to correlate with risk for premature mortality.

BMI is standard because it is quick and cheap, even though misclassification is somewhat common: a person who is very muscular may be misclassified as having obesity, despite having very low fat mass; similarly, a frail person with decreased lean mass (muscle, bone) but elevated fat mass may be misclassified as healthy weight. In cases where misclassification is presumed or a more accurate assessment of body composition is warranted for diagnostic purposes, additional assessment may include computerized tomography (CT) scan, DEXA scan, magnetic resonance imaging (MRI), densitometry (water displacement measurement), plethysmography (air displacement measurement), or other modalities.

Following evaluation of body composition, the clinical effects of obesity on health, feeling and functioning are considered. This evaluation includes medical history

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[12] Michael W. Schwartz et al., *Obesity Pathogenesis: An Endocrine Society Scientific Statement*, 38 Endocrine Rev. 267-296 (2017).

and physical examination; risk-factor evaluation; history of weight trajectory; and impact of the person's weight on their health status. Based on these results, some patients will be eligible for science-based obesity treatments, which may include behavioral counseling, Food and Drug Administration-approved medications or medical device placement, and bariatric/metabolic surgery.

ARGUMENT

I. Obesity Falls Squarely Within the ADA's Definition of Impairment

The ADA defines impairment as "[a]*ny physiological disorder or condition*, cosmetic disfigurement, or anatomical loss *affecting one or more body systems*, such as neurological, musculoskeletal, special sense organs, respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine." 29 C.F.R. § 1630.2(h)(1) (emphasis supplied). This definition is found in the ADA's regulations, promulgated by the Equal Employment Opportunity Commission (EEOC), as authorized by Congress.

Because the medical community recognizes obesity to be a "physiological disorder or condition" that "affect[s] one or more body systems," 29 C.F.R. § 1630.2(h)(1), and because it would be illogical to disregard current medical understanding of disease when determining which conditions meet the ADA's definition of impairment, the Court should hold that the disease of obesity satisfies the ADA's definition of impairment.

Recognizing obesity as a condition that, in general, can be an ADA impairment does not mean that *all* individuals with obesity will be afforded protection by the ADA. The ADA's protections against disability discrimination extend only to those individuals who: (1) have an impairment that substantially limits one or more major life activities; (2) have a record of an impairment that substantially limits one or more major life activities; or (3) are regarded as having an impairment. *See* 42 U.S.C. § 12102(1).

Under the first two prongs of the ADA's definition of disability, an individual with obesity must still show that, as a result of such impairment, he has a substantial limitation in a major life activity. 42 U.S.C. § 12102(1); *See, e.g., Mann v. Louisiana High Sch. Athletic Ass'n*, 535 F. App'x 405, 411–12 (5th Cir. 2013) (unpublished) (concluding that the plaintiff's diagnosis of anxiety disorder by itself was insufficient to support a finding that he had a substantially limiting impairment and, thus, a disability under the ADA); *Hataway v. Bd. of Trustees of Univ. of Illinois*, 2013 WL 160442, at *3 (C.D. Ill. Jan. 15, 2013) (unpublished) ("[T]he mere medical diagnosis of an impairment is insufficient to qualify as a 'disability'" under prong one, requiring proof of an impairment that "substantially limits" major life activities.).

And under the third prong, an individual must show that he or she was "regarded as having a physical or mental impairment." *Mercado v. Puerto Rico*, 814 F.3d 581, 588 (1st Cir. 2016); 42 U.S.C. § 12102(3)(A) (stating that an individual is "regarded as" having a disability if "he or she has been subjected to an action prohibited under

this chapter because of an actual or perceived physical . . . impairment whether or not the impairment limits or is perceived to limit a major life activity"). Further, an individual with obesity proceeding under the third prong would be unable to maintain a "reasonable accommodation" claim. *See* 42 U.S.C. § 12201(h).

A. Leading Medical Authorities Recognize Obesity as a Disease

The overwhelming consensus in the medical community is that obesity is a disease. Obesity is not merely a physical descriptor, a lifestyle choice, or a risk factor for other diseases—it is a disease in and of itself.[13]

The American Medical Association declared obesity to be a disease in 2013. *See* Appendix at 2. One argument the AMA considered in favor of the resolution was that "there is now an overabundance of clinical evidence to identify obesity as a *multi-metabolic and hormonal disease*." *Id*. at 3 (emphasis supplied). The policy adopted also recognized obesity as "a *disease state* with multiple *pathophysiological* aspects." *Id*. at 2 (emphasis supplied).

The AMA Resolution was introduced and supported by a large number of well-respected mainstream medical associations, including the American Association of Clinical Endocrinologists (AACE), the American College of Cardiology, the Endocrine Society, the American Society for Reproductive Medicine, the Society for

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[13] Jeffrey I. Mechanick et al., *American Association of Clinical Endocrinologists' Position Statement on Obesity and Obesity Medicine*, 18 Endocrine Prac. 642, 644 (2012) (AACE Position Statement).

Cardiovascular Angiography and Interventions, the American Urological Association, and the American College of Surgeons.[14]

In 2012, the AACE had published its own position statement explaining that "obesity is a disease with multiple pathophysiological aspects, including genetic, environmental, physiological, and psychological factors."[15] It "strongly" asserted, based on "biomedical knowledge that has accumulated… and… a better understanding of

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[14] The resolution compelling the AMA's policy lists twenty-seven prior policy statements relevant to obesity and weight. Appendix at 4-9. The first policy, adopted in 1999 and reaffirmed as recently as 2013, resolved to "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[.]"AMA House of Delegates, Policy H-150-953, *Obesity as a Major Public Health Program*. A 2009 policy, however, stated that the AMA "opposes the effort to make obesity a disability." AMA House of Delegates, Policy H-90.974, *Opposition to Obesity as a Disability*. The underlying resolution indicates that this policy was aimed at protecting physicians from potential lawsuits. AMA House of Delegates Resolution 93-90A ("[I]f obesity is designated as a disability, physicians could be sued or reprimanded for discrimination under the Americans with Disability Act if a patient takes offense at the physician discussing obesity"). Although this policy remains in effect until 2019, the AMA House of Delegates was fully aware of it when they subsequently adopted the 2013 policy declaring obesity a disease. *See* Scott Kahan & Tracy Zvenyach, *Obesity as a Disease: Current Policies and Implications for the Future*, 5 Current Obesity Rep. 292-297, 295 (2016) (by passing the 2013 resolution, the "AMA formally updated prior statements that obesity should neither be considered a disability nor a disease.")

[15] AACE Position Statement at 644.

pathophysiology of obesity and its impact on the health of individuals," that "obesity is a primary disease."[16]

Official recognition of obesity as a disorder or disease by the AMA and other organizations like AACE was not surprising given the advancing science and earlier conclusions reached by a wide range of medical organizations. In 1998, the National Institutes of Health's (NIH's) expert panel who drafted *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults—The Evidence Report*, described obesity as "a complex multifactorial chronic disease that develops from an interaction of genotype and the environment."[17] Acknowledging that "[o]ur understanding of how and why obesity develops is incomplete," the panel concluded that the disease "involves the integration of social, behavioral, cultural, physiological, metabolic and genetic factors."[18] In 2001, the American Academy of Family Physicians published an article titled *Obesity: Assessment and Management in Primary Care*, stating that "[i]ncreasing evidence suggests that obesity is not a simple problem of will power or self-control but a complex disorder involving appetite regulation and energy metabolism. . . although its etiology is not firmly established, genetic, metabolic,

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[16] *Id.*

[17] National Institutes of Health, National Heart, Lung, and Blood Institute, *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults—The Evidence Report* at xi (1998), https://www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf.

[18] *Id.*

biochemical, cultural and psychosocial factors contribute to obesity."[19] In 2003, the World Health Organization similarly concluded, "obesity should be considered a disease in its own right."[20] Obesity was becoming widely recognized as a "disease state."[21]

Within months of the AMA's resolution, the American Heart Association, the American College of Cardiology and The Obesity Society (TOS) joined to issue treatment guidelines for obesity in adults.[22] The guidelines adopted a "Chronic Disease Management Model" for treatment of obesity.[23] Other medical organizations, like the Endocrine Society, explicitly concurred "that current scientific evidence supports the

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[19] James M. Lyznicki et al., *Obesity: Assessment and Management in Primary Care*, 63 American Family Physician 2185-2197, 2185 (2001).

[20] World Health Organization Fact Sheet (2003), http://www.who.int/dietphysicalactivity/media/en/gsfs_obesity.pdf.

[21] Louise J. Aronne, Donald S. Nelinson & Joseph L. Lillo, *Obesity as a Disease State: A New Paradigm for Diagnosis and Treatment.* 9 Clinical Cornerstone 9-25 (2009) ("Cornerstone").

[22] Michael D. Jensen et al., *2013 AHA/ACC/TOS Guideline for the Management of Overweight and Obesity in Adults*, 129 Circulation S102-S138 (2013). These guidelines were based on a comprehensive review of the scientific evidence and designed to update NIH's 1998 guidelines. National Institutes of Health, National Heart, Lung, and Blood Institute, *Managing Overweight and Obesity in Adults—Systematic Evidence Review From the Obesity Expert Panel* (2013), https://www.nhlbi.nih.gov/sites/default/files/media/docs/obesity-evidence-review.pdf.

[23] *Id*. at S109-S116.

view that obesity is a disease."[24] And the evidence has continued to mount that obesity has its own independent pathogenesis.[25]

Significantly, since 2008, those experts most familiar with the science and treatment of obesity from the research, clinical, and surgical perspectives have recognized obesity as an independent physiological process. In 2008, TOS issued an official statement recognizing "that obesity is a complex condition with numerous causes, many of which are largely beyond an individual's control."[26] The Obesity Medicine Association (OMA) defines obesity as a "chronic, relapsing, multi-factorial, neurobehavioral disease…"[27] And the American Society of Metabolic and Bariatric Surgery (ASMBS) characterizes obesity as "a multifactorial disease with a strong genetic component;" against this genetic background, a number of "hormonal, metabolic, psychological, cultural and behavioral factors" operate to "promote fat accumulation

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[24] Caroline M. Apovian et al., *Pharmacological Management of Obesity: An Endocrine Society Clinical Practice Guideline*, 100 J Clinical Endocrinology & Metabolism 342–362, 345 (2015).

[25] Two statements from the Endocrine Society illustrate the continuing developments in this area. *See* George A. Bray et al., *The Science of Obesity Management: An Endocrine Society Scientific Statement*, 39 Endocrine Rev. 79-132 (2018); Michael W. Schwartz et al., *Obesity Pathogenesis: An Endocrine Society Scientific Statement*, 38 Endocrine Rev. 267-296 (2017).

[26] Council of The Obesity Society, *Obesity as a Disease: The Obesity Society Council Resolution*, 16 Obesity 1151 (2008) (first published 2012).

[27] Obesity Medicine Association, https://obesitymedicine.org/definition-of-obesity (last visited Aug. 26, 2018).

and weight gain."[28] ASMBS also recognizes that obesity is progressive and requires life-long treatment.[29]

The fact that lifestyle choices contribute to obesity does not require a different conclusion. As the AMA Resolution explains: "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 an individual choice to smoke cigarettes." Appendix at 4; *see also* AACE Position Statement at 645. Nor does the fact that obesity is associated with other conditions (often referred to as comorbidities) detract from obesity's separate state as a disease. Obesity is like many other diseases in this regard. For example, an individual whose diabetes leads to chronic kidney disease has two co-existing diseases, not one. Diabetes is a disease in itself as well as a risk factor for other diseases. The same is true for obesity.

The understanding that obesity is an independent disease is now mainstream. Recently, twenty leading health organizations representing a dozen health professions designed and published *Provider Competencies for the Prevention and Management of*

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[28] American Society for Metabolic and Bariatric Surgery, https://asmbs.org/patients/disease-of-obesity (last visited Aug. 26, 2018).

[29] *Id.*

Obesity in 2017.[30] The first fundamental competency for treating patients with obesity is "a working knowledge of obesity as a disease."[31] Within this competency, the working group recognized the importance of health professionals understanding "[t]he "potential role of genetics/epigenetics, critical periods (e.g., prenatal development), and natural history to obesity and its complications;" and "[t]he physiology/pathophysiology of obesity and weight regulation (e.g., neurohormonal control of predisposing conditions)."

The conclusion that obesity is a disease or disorder, not solely due to its link to other conditions, but in and of itself, is inescapable given the well-established medical evidence directly on point.[32]

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[30] Donald W. Bradley, William H. Dietz & Provider Training and Education Workgroup, *Provider Competencies for the Prevention and Management of Obesity*, Washington, D.C. Bipartisan Policy Center (June 2017), https://bipartisanpolicy.org/wp-content/uploads/2017/07/Provider-Competencies-for-the-Prevention-and-Management-of-Obesity.pdf. Participating organizations included the Academy of Nutrition and Dietetics, American Academy of Family Physicians, American Academy of Pediatrics, American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Board of Obesity Medicine, American Psychological Association, Association of American Medical Colleges, National Organization of Nurse Practitioner Faculties, Physician Assistant Education Association, The Obesity Society and the Centers for Medicare and Medicaid Services.

[31] *Id.* at 4.

[32] Scientific and obesity-related organizations in other countries have reached the same conclusion. *See, e.g.*, Canadian Medical Association Policy (2015) ("The Canadian Medical Association (CMA) has declared obesity to be a chronic medical disease requiring enhanced research, treatment and prevention efforts"), https://www.cma.ca/En/Pages/cma-recognizes-obesity-as-a-disease.aspx; European

B. As a Disease, Obesity is a Physiological Disorder or Condition that Impacts One or More Body Systems

Given the extensive literature and support among the medical community that obesity is a disease, it logically follows that obesity is a "physiological disorder or condition," the first part of the definition of an "impairment" under the ADA. *See* 29 C.F.R. § 1630.2(h)(1) (defining impairment as "[a]*ny physiological disorder or condition*, cosmetic disfigurement, or anatomical loss…") (emphasis supplied)). Indeed, references to physiological disorders or conditions are found throughout the medical literature discussed above.[33]

Obesity also satisfies the remaining requirements in the ADA's definition of "impairment," as obesity has a number of harmful effects on "body systems," including the musculoskeletal, lymphatic, endocrine and cardiovascular systems. *See* 29 C.F.R. § 1630.2(h)(1) (defining impairment as a physiological disorder or condition "affecting one or more body systems, such as neurological, musculoskeletal, special sense organs,

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Association for the Study of Obesity Declaration (2015) (obesity is a chronic, progressive disease and a "gateway to many other disease areas"), http://easo.org/2015-milan-declaration-a-call-to-action-on-obesity/; George A. Bray et al., *Obesity: a Chronic Relapsing Progressive Disease Process. A Position Statement of the World Obesity Federation*, 18 Obesity Rev. 715-723, 720 (2017) ("obesity is a chronic, relapsing, progressive disease process").

[33] *See, e.g.*, AACE Position Statement at 644 ("obesity is an altered physiological and metabolic state); Appendix at 2 ("obesity [i]s a disease state with multiple pathophysiological aspects"); WHO at 1 ("obesity is a complex condition"); Cornerstone at 15 ("Obesity has a recognized pathophysiology").

respiratory (including speech organs), cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin, and endocrine").

Modern medical science refutes the outdated notion that there are merely correlations between obesity and an increased risk of other conditions. Rather, studies repeatedly demonstrate that obesity *itself* inherently involves physical and chemical processes that affect the operation of individuals' bodily systems.[34] Obesity may even cause significant dysfunction, long before related diseases are clinically diagnosed.

Looking at several of the "body systems" enumerated in 29 C.F.R. § 1630.2(h)(1) illustrates this point.

- Obesity harms the "cardiovascular" or "circulatory" system. Increased adipose tissue has a direct impact on heart structure and function because it releases proteins that cause heart inflammation; increases total blood volume and enlarges portions of the heart; and deposits fat directly onto the heart, causing it increased strain.[35]

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[34] *See, e.g.*, Cornerstone at 15 ("Over the last 2 decades, it has become clear that adipose tissue is not only a passive storage depot for energy in the form of triglycerides—it is also an active endocrine organ that affects metabolism, energy balance, and cardiovascular function.").

[35] S*ee, e.g.*, Jennifer Logue et al., *Obesity is Associated with Fatal Coronary Heart Disease Independently of Traditional Risk Factors and Deprivation*, 9 Heart 564-568 (2011); Obesity and Heart Disease, *supra*, at 849 ("Until recently the relation between obesity and coronary heart disease was viewed as indirect, *i.e.*, through covariates related to both obesity and coronary heart disease risk . . . Long-term longitudinal studies, however, indicate that obesity as such not only relates to but independently predicts coronary

- Obesity also causes harmful effects on the "musculoskeletal" system as the mass inherently associated with increased body fat places increased stress on the joints – in particular, the weight born by the knees – which causes cartilage degradation and leads to osteoarthritis.[36]
- Obesity affects the "lymphatic" system. Studies show that increased adipose tissue impairs the flow of lymphatic fluid by compressing and damaging lymphatic vessels and thus leading to lymphedema.[37]
- Obesity also affects the "endocrine" system because adipose tissue secretes hormones that regulate metabolism, contributing to insulin resistance and

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atherosclerosis."); Paul Poirier et al., *Obesity and Cardiovascular Disease: Pathophysiology, Evaluation, and Effect of Weight Loss: An Update of the 1997 American Heart Association Scientific Statement on Obesity and Heart Disease from the Obesity Committee of the Council on Nutrition, Physical Activity, and Metabolism*, 113 Circulation 898 at 900-901, 905 (2005) ("[O]besity is listed as a potential modifiable risk factor for stroke, but the independence of this relationship from cholesterol, hypertension, and diabetes was only recently identified" and "obesity in adolescents and young adults accelerates the progression of atherosclerosis decades before the appearance of clinical manifestations.").

[36] George A. Bray, et al., *The Science of Obesity Management: An Endocrine Society Scientific Statement*, 39 Endocrine Rev. 79-132, 90 (2018) (trauma from weight may contribute directly to osteoarthritis in knees and ankles, "the increased osteoarthritis in non–weight-bearing joints suggests that some components of the excess weight may alter cartilage and bone metabolism independent of weight bearing."); Peter W. Lementowski & Stephen B. Zelicof, *Obesity and Osteoarthritis*, 37 Am. J. Orthopedics 148-51 (2008).

[37] Arin K. Greene, Frederick D. Grant & Sumner A. Slavin, Letter to the Editor, *Lower Extremity Lymphedema and Elevated Body-Mass Index*, 366 N. En. J. Med. 2136, 2136-37 (2012).

ultimately diabetes.[38]

Moreover, when defining obesity as a disease, the AMA used a definition of disease that requires a condition to negatively impact normal body functioning: 1) "*an impairment of the normal functioning of some aspect of the body*; 2) characteristic signs or symptoms; and 3) harm or morbidity[.]" Appendix at 3 (emphasis supplied). Applying this definition, the AMA concluded that obesity is a disease, a conclusion that necessarily includes a finding that obesity affects normal body functioning. *See also* Appendix at 3 (concluding that obesity causes "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"); *see also* Obesity Medicine Association (defining obesity as a disease "wherein an increase in body fat promotes adipose tissue dysfunction and abnormal fat mass physical forces, resulting in adverse metabolic, biomechanical, and psychosocial health consequences").[39]

Accordingly, obesity can readily satisfy the ADA's definition of impairment. To

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[38] Mitchell A. Lazar et al., *Not a Tall Tale*, 307 Science 373, 374 (2005) ("obesity causes stress in a system of cellular membranes called endoplasmic reticulum (ER), which in turn causes the endoplasmic reticulum to suppress the signals of insulin receptors"); see also AACE Position Statement at 645.

[39] Obesity Medicine Association, https://obesitymedicine.org/definition-of-obesity/ (last visited Aug. 26, 2018).

find otherwise would require a disregard of current medical understanding of the nature and impact of obesity.

The district court erred when it declined to consider evidence of obesity in the record and instead only considered evidence of Plaintiff-Appellant's weight. Weight is not synonymous with obesity. Obesity, as described *supra at pp. 9-12*, relates to pathophysiology and harms resulting from excess adipose tissue while weight—standing alone—is merely a measure of appearance. Not everyone who appears to have excess weight has the disease of obesity.

II. Policymakers at Federal and State Levels Recognize Obesity As An Independent Disease

Federal and state policies reflect the established medical consensus that obesity without any co-existing conditions is a disease. Like medical knowledge and understanding of obesity, policymakers' views have been evolving throughout the past two decades. In 1977, the federal view espoused in the Health Care Financing Administrations' *Coverage Issues Manual* was that "obesity is not an illness."[40] But by

[40] Theodore K. Kyle, Emily J. Dhurandhar & David B. Allison, *Regarding Obesity as a Disease: Evolving Policies and Their Implications*, 45 Endocrinol Metab Clin North Am. 511–520 (2016). The Health Care Financing Administration was the predecessor agency to the current Centers for Medicare and Medicaid Services.

1998 that view shifted when NIH, as noted above, determined that "[o]besity is a complex multifactorial chronic disease."[41]

Other agencies began following suit. In 2002, the Internal Revenue Service (IRS) considered whether an individual who was diagnosed with obesity—but no other conditions—could deduct the cost of a weight-loss program. After reviewing the medical consensus on the issue and noting a Food and Drug Administration 2000 statement that "obesity is a disease," the IRS concluded that the individual could deduct the costs as a medical-care expense because he had "a disease, obesity."[42]

Later that same year, the Social Security Administration (SSA) published a policy–which remains in effect today–recognizing obesity as "a complex, chronic disease characterized by excessive accumulation of body fat."[43] In this policy, the SSA directs disability evaluators that "[w]e may also find that obesity, by itself, is medically equivalent to a listed impairment."[44]

In 2004, the Centers for Medicaid and Medicare Services (CMS) revised its

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[41] National Institutes of Health, National Heart, Lung, and Blood Institute, *Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults—The Evidence Report* at xi (1998), https://www.nhlbi.nih.gov/files/docs/guidelines/ob_gdlns.pdf.

[42] I.R.S. Rev. Rul. 2002-19, https://www.irs.gov/pub/irs-drop/rr-02-19.pdf.

[43] Evaluation of Obesity, Social Security Administration, Program Operations Manual System (POMS), Effective Dates: 03/24/2017, DI 24570.001, https://secure.ssa.gov/poms.nsf/lnx/0424570001.

[44] *Id*. at Question 7.

Coverage Issues Manual and removed the 1977 statement that "obesity is not an illness." Two years later, CMS issued a National Coverage Determination providing coverage for bariatric surgery through the Medicare program.[45] This change in approach can only be explained by a reassessment of obesity as a medical condition. Even the Department of Defense has now acknowledged that treatment for obesity is warranted "even if it is the sole or major condition treated." 82 Fed. Reg. 45438, 45441 (Sept. 29, 2017) (interim final rule updating coverage under the Tricare program, which provides healthcare to service members, retired military, and their families).

Similar paradigm shifts have occurred in the Food and Drug Administration's (FDA's) approval process. For 13 years, the FDA approved no new medications or devices designed to treat obesity and in fact rejected two new offerings in 2011, likely due in part to a general misunderstanding of obesity as a lifestyle choice rather than a physiologic condition.[46] After discussions with the obesity community (including several Amici here), the FDA has approved four new medications and five new devices for obesity since 2012.

Legislators at the federal and state levels are also now recognizing obesity as a chronic, complex disease in its own right. For example, in 2017, the United States Senate

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[45] CMS Manual System, Medicare National Coverage Determinations, Pub. 100-03 (April 28, 2006), https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R54NCD.pdf.

[46] Scott Kahan et al. *Obesity Drug Outcome Measures: Results of a Multi-Stakeholder Critical Dialogue*, 2 Current Obesity Rep. 128-133 (2013).

passed by unanimous consent a resolution in support of "National Obesity Care Week." The resolution recognized "the disease of obesity" and encouraged "all people in the United States to create a foundation of open communication to break barriers of misunderstanding and stigma regarding obesity and to improve the lives of all individuals affected by obesity and their families." S. Res. 325, 115th Cong. (as passed by Senate Nov. 8, 2017). Most recently, the National Lieutenant Governors Association (NLGA) adopted a resolution encouraging states to "eliminate the stigma of obesity that impedes treatment" and provide "comprehensive care to manage this chronic disease."[47] In the resolution's preamble, the NLGA noted that obesity "is recognized as a chronic disease by many leading medical professional and patient organizations" and that "experts and researchers agree obesity is a complex disease influenced by various psychological, environmental, and genetic factors[.]"[48]

CONCLUSION

Modern medical science confirms that obesity is a condition or disorder that causes an ongoing negative impact on multiple body systems. Thus, obesity satisfies the ADA's definition of impairment, and the district court's conclusion to the contrary does

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[47] Resolution in Support of the Treatment and Prevention of Obesity, National Lieutenant Governors Association Resolution (adopted June 29, 2018), http://www.nlga.us/wp-content/uploads/2018-Resolution-in-Support-of-the-Prevention-and-Treatment-of-Obesity-2.pdf.

[48] *Id.*

not comport with the current understanding of obesity. *See* 29 C.F.R. § 1630.2(h)(1) (impairment is a condition "affecting one or more body systems").

This is not the first time—nor will it be the last—where courts must look to current medical science when assessing whether a condition meets the ADA's definition of impairment. In 1998, the U.S. Supreme Court, in *Bragdon v. Abbott*, 524 U.S. 624 (1998), concluded that asymptomatic HIV was an impairment under the ADA. The Court acknowledged, and quickly dismissed, the fact that commentary to regulations promulgated under the Rehabilitation Act, the predecessor to the ADA with the same definition of disability, did not include HIV in its list of physical impairments, explaining in part that "HIV was not identified as the cause of AIDS until 1983." *Id*. at 633. The Court's decision invalidated a circuit court opinion that concluded asymptomatic HIV was not an impairment, based on a flawed understanding of the condition. *See Runnebaum v. NationsBank of Maryland, N.A.*, 123 F.3d 156, 168 (4th Cir. 1997) (holding that asymptomatic HIV infection is not an impairment under the ADA because it had no "diminishing effects"). In short, the Supreme Court ensured that legal jurisprudence about asymptomatic HIV evolved with the medical understanding of the disease. The same must be done for obesity.

Respectfully submitted,
/s/ Barry C. Taylor

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 6,863 words, excluding the parts exempted by Fed. R. App. P. 32(f). In preparing this certificate, the undersigned relied on the word count of the word-processing system used to prepare the brief, Microsoft Word Version 2007.

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word Version 2007 in 12-point Palatino Linotype.

Respectfully submitted,
/s/ Barry C. Taylor

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CERTIFICATE OF SERVICE

I hereby certify that on August 27, 2018, the foregoing was electronically filed with the Clerk of the Court for the United States Court of Appeals of the Seventh Circuit using the appellate CM/ECF system filed electronically, and served upon all counsel of record.

Respectfully submitted,
/s/ Barry C. Taylor

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Equip for Equality

Nos. 17-3508 and 18-2199

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MARK RICHARDSON,

Plaintiff-Appellant,

v.

CHICAGO TRANSIT AUTHORITY,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division

Case No. 16 CV 03027

The Honorable Judge John Robert Blakey

APPENDIX TO BRIEF OF AMICI CURIAE

The Obesity Action Coalition, The Obesity Society, The Academy of Nutrition and Dietetics, The American Association of Clinical Endocrinologists, The American Society for Metabolic and Bariatric Surgery, The Black Women's Health Imperative, The Endocrine Society, The National Center for Weight and Wellness, The Obesity Medicine Association and Equip for Equality

IN SUPPORT OF APPELLANT, MARK RICHARDSON, AND URGING REVERSAL

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Recognition of Obesity as a Disease H-440.842

Topic: Public Health	Policy Subtopic: NA
Meeting Type: Annual	Year Last Modified: 2013
Action: NA	Type: Health Policies
Council & Committees:	undefined

Our AMA recognizes **obesity as a disease** state with multiple pathophysiological aspects requiring **a** range **of** interventions to advance **obesity** treatment and prevention.

Policy Timeline

Res. 420, **A**-13

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)