NO. 96335-5
(Ninth Circuit No. 16-35205)

IN THE SUPREME COURT
FOR THE STATE OF WASHINGTON

CERTIFICATION FROM THE COURT OF APPEALS
FOR THE NINTH CIRCUIT

CASEY TAYLOR and ANGELINA TAYLOR, husband and wife and the marital community composed thereof,

Appellants,

v.

BURLINGTON NORTHERN RAILROAD HOLDINGS, INC., a Delaware corporation licensed to do business in the State of Washington; and BNSF RAILWAY COMPANY, a Delaware corporation licensed to do business in the State of Washington,

Respondents.

AMICI CURIAE BRIEF OF OBESITY ACTION COALITION AND DISABILITY RIGHTS WASHINGTON IN SUPPORT OF APPELLANTS

Brendan W. Donckers, WSBA #39406
BRESKIN JOHNSON & TOWNSEND, PLLC
1000 Second Avenue, Suite 3670
Seattle, WA 98104
Telephone (206) 652-8660
Counsel for *Amici Curiae* OAC and DRW

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I. IDENTITY AND INTEREST OF *AMICI* PARTIES

The Obesity Action Coalition ("OAC") is a national 501(c)(3) non-profit organization with more than 60,000 members. Approximately 1,400 of these members are in Washington. OAC is dedicated to improving the lives of individuals affected by the disease of obesity. OAC's core focus includes providing evidence-based education on obesity, advocacy for eliminating weight bias and discrimination, and elevating the conversation about weight and its impact on public health.

Disability Rights Washington ("DRW") is a private non-profit organization that is designated to serve as the protection and advocacy system for the State of Washington. *See* Motion for Leave to File Amici Curiae. DRW seeks to assist the Court in interpreting the Washington Law Against Discrimination, RCW 49.60.010, as invited by letter on December 26, 2018.

II. STATEMENT OF THE CASE

OAC and DRW adopt the statement of the case set forth in the Brief of Appellants on Certified Question (October 22, 2018) at 2-8.

III. ARGUMENT

A. Summary of argument

As this Court has long held, the Washington legislature passed the Washington Law Against Discrimination (WLAD) with the

"express purpose" of eliminating discrimination, and directed "liberal construction of the provisions of RCW 49.60 in order to accomplish its purpose." *Holland v. Boeing Co.*, 90 Wn.2d 384, 387–88, (1978) (*citing* RCW 49.60.010; RCW 49.60.020). As such, the WLAD prohibits employment discrimination on the basis of disability.

A "disability" under the WLAD requires establishing, in pertinent part, the presence of "sensory, mental, or physical impairment." RCW 40.60.040(7)(a). An "impairment," in turn, includes, "but is not limited to: any physiological disorder, *or* condition…affecting one or more of the following body systems," including the musculoskeletal, lymphatic, endocrine and cardiovascular systems. RCW 49.60.040(7)(c)(i) (emphasis added).

Over the last two decades, the medical and scientific communities have reached consensus that obesity is a condition that involves numerous physiological processes that make it consistent with a disease or disorder. As demonstrated below, these communities have concluded that obesity is both a physiological disorder and a condition that affects one or more of the body systems enumerated in the WLAD, including the musculoskeletal, lymphatic, endocrine, and cardiovascular systems. It thus fits squarely within the WLAD's definition of "impairment." OAC and DRW respectfully request that this Court reach the same conclusion as the

medical and scientific communities and hold that obesity is an impairment under the WLAD.

B. Obesity is a physiological disorder or a condition that affects one or more body systems

1. Obesity is a disease

Obesity has traditionally been viewed as a matter of personal responsibility and willpower, but medical and scientific research over the last two decades have shown that obesity is a chronic, relapsing, multifactorial condition consistent with a disease. 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 biological effects, such as increasing blood vessel reactivity and decreasing insulin sensitivity.[1] 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.[2]

[1] Margaret F. Gregor & Gökhan S. Hotamisligil, *Inflammatory Mechanisms in Obesity*, 29 Annual Rev. Immunology, 415-445 (2011).
[2] 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).

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.[3] Fat deposition in areas within and surrounding the neck, along with structural weakening of airways, causes obstructive sleep apnea; sleep apnea, in turn, contributes to appetite dysregulation, altered metabolism, and weight gain.[4]

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

[3] Norbert Stefan, Konstantinos Kantartzis & Hans-Ulrich Haring, *Causes and Metabolic Consequences of Fatty Liver*, 7 Endocrine Rev. 939-960 (2008).
[4] 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).

life.[5] Moreover, acquired leptin deficiency contributes to weight gain – and especially to weight regain following weight loss.[6]

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.[7] 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 underlie the commonly discussed "set point" of body weight that helps to explain why sustained weight loss is so difficult to achieve and maintain.[8]

2. Diagnosing obesity

Obesity is a condition that is medically diagnosed. Calculating an individual's body mass index ("BMI") is only the first step in diagnosing obesity. A BMI calculation (weight in kilograms divided by the square height in meters) has been shown in actuarial 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

[5] I. Sadaf Farooqi & Stephen O'Rahilly, *New Advances in the Genetics of Early Onset Obesity*, 29 Int'l J. of Obesity, 1149-1152 (2005).
[6] Pryia Sumithran et al., *Long-Term Persistence of Hormonal Adaptations to Weight Loss*, 365 N. En. J. Med., 1597-1604 (2011).
[7] Joshua P. Thaler & Michael W. Schwartz, *Inflammation and Obesity Pathogenesis: The Hypothalamus Heats Up*, 151 Endocrinology 4109-4115 (2010).
[8] Michael W. Schwartz et al., *Obesity Pathogenesis: An Endocrine Society Scientific Statement*, 38 Endocrine Rev. 267-296 (2017).

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 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.

3. The medical community recognizes obesity as a disease affecting several body systems

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.[9]

The American Medical Association declared obesity to be a disease in 2013.[10] 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 multimetabolic and hormonal *disease*."[11] The policy adopted also recognized obesity as "a *disease* state with multiple pathophysiological aspects."[12]

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 Cardiovascular Angiography and

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[9] 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).

[10] *See* AMA House of Delegates, Policy H440.842, *Recognition of Obesity as a Disease* (2013) (AMA Resolution). For the Court's convenience, AMA Policy H440.842 and Resolution 420, which led to adoption of the Policy, is included in an Appendix to this brief. The Appendix and specific page number is cited below when referencing these documents.

[11] Appendix at 3 (emphasis added).

[12] *Id*. at 2 (emphasis added).

Interventions, the American Urological Association, and the American College of Surgeons.[13]

In 2012, the AACE published its own position statement explaining that "obesity is a disease with multiple pathophysiological aspects, including genetic, environmental, physiological, and psychological factors."[14] It "strongly" asserted, based on "biomedical knowledge that has accumulated…and…a better understanding of pathophysiology of obesity and its impact on the health of individuals," that "obesity is a primary disease."[15]

Official recognition of obesity as a disorder or disease by the AMA and other organizations like AACE was not surprising given the advancing

[13] The resolution compelling the AMA's policy lists 27 prior policy statements relevant to obesity and weight. *See* 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").

[14] AACE Position Statement at 644.

[15] *Id.*

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."[16] 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."[17] 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, biochemical, cultural and psychosocial factors contribute to obesity.[18]

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[16] 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.
[17] *Id.*
[18] James M. Lyznicki et al., *Obesity: Assessment and Management in Primary Care*, 63 American Family Physician 2185-2197, 2185 (2001).

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

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.[21] The guidelines adopted a "Chronic Disease Management Model" for treatment of obesity.[22] Other medical organizations, like the Endocrine Society, explicitly concurred "that current scientific evidence supports the view that obesity is a disease."[23] And the evidence has continued to mount that obesity has its own independent pathogenesis.[24]

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

[20] 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").

[21] 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.

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

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

[24] 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).

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."[25] And just last month, TOS updated this statement, concluding that:

> [o]besity is a multi-causal chronic disease recognized across the life-span resulting from long-term positive energy balance with development of excess adiposity that over time leads to structural abnormalities, physiological derangements, and functional impairments. The disease of obesity increases the risk of developing other chronic diseases and is associated with premature mortality. As with other chronic diseases, obesity is distinguished by multiple phenotypes, clinical presentations, and treatment responses.[26]

Similarly, 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

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[25] Council of The Obesity Society, *Obesity as a Disease: The Obesity Society Council Resolution*, 16 Obesity 1151 (2008) (first published 2012).
[26] The Obesity Society, *Obesity as a Disease: The Obesity Society 2018 Position Statement*, 27 Obesity 1, 8 (2019). *See* https://onlinelibrary.wiley.com/doi/epdf/10.1002/oby.22378.
[27] Obesity Medicine Association, https://obesitymedicine.org/definition-of-obesity.

"hormonal, metabolic, psychological, cultural and behavioral factors" operate to "promote fat accumulation and weight gain."[28] ASMBS also recognizes that obesity is progressive and requires lifelong 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."[30] 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

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[28] American Society for Metabolic and Bariatric Surgery, https://asmbs.org/patients/disease-of-obesity.
[29] *Id.*
[30] Appendix at 4; *see also* AACE Position Statement at 645

for the Prevention and Management of Obesity in 2017.[31] The first fundamental competency for treating patients with obesity is "a working knowledge of obesity as a disease."[32] 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.[33]

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[31] 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/library/provider-competencies-for-the-prevention-and-management-of-obesity/. 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.

[32] *Id.* at 4.

[33] 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 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-milandeclaration-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*

4. Policymakers 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. For instance, in 1977, the Health Care Financing Administrations' (HCFA) Coverage Issues Manual stated that "obesity is not an illness."[34] But that view has shifted dramatically.

In 2004, the Centers for Medicaid and Medicare Services (CMS) (HCFA's successor) removed the 1977 statement that "obesity is not an illness" and now provides coverage for bariatric surgery through the Medicare program.[35] The Social Security Administration now recognizes obesity as "a complex, chronic disease characterized by excessive accumulation of body fat"[36] and directs disability evaluators that "[w]e

Federation, 18 Obesity Rev. 715-723, 720 (2017) ("obesity is a chronic, relapsing, progressive disease process").

[34] 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.

[35] 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.

[36] 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.

may also find that obesity, by itself, is medically equivalent to a listed impairment."[37]

Other federal agencies have followed suit. NIH has determined that "[o]besity is a complex multifactorial chronic disease."[38] 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). In the past six years, the Food and Drug Administration has approved four new medications and five new devices for the treatment of obesity. Even the Internal Revenue Service views obesity as an independent disease, allowing individuals to deduct treatment costs as a medical expense.[39]

In 2017, the United States Senate 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

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[37] *Id*. at Question 7.
[38] 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.
[39] I.R.S. Rev. Rul. 2002-19, https://www.irs.gov/pub/irs-drop/rr-02-19.pdf.

barriers of misunderstanding and stigma regarding obesity and to improve the lives of all individuals affected by obesity and their families.[40]

Also 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."[41] 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[.]"[42]

C. As a physiological disorder *and* condition that affects one or more body systems, obesity is an "impairment" under the WLAD

The WLAD defines "disability" as the "presence of a sensory, mental, or physical impairment that: (i) Is medically cognizable or diagnosable; or (ii) Exists as a record or history; or (iii) Is perceived to exist whether or not it exists in fact." RCW 49.60.040(7)(a)(i)-(iii). An "impairment" includes,

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[40] S. Res. 325, 115th Cong. (as passed by Senate Nov. 8, 2017).
[41] National Lieutenant Governors Association Resolution, *Resolution in Support of the Treatment and Prevention of Obesity*, (adopted June 29, 2018), http://www.nlga.us/wp-content/uploads/2018-Resolution-in-Support-of-the-Preventionand-Treatment-of-Obesity-2.pdf.
[42] *Id.*

> but is not limited to: any physiological disorder, or condition, cosmetic disfigurement, or anatomical loss affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genitor-urinary, hemic and lymphatic, skin, and endocrine[.]

RCW 49.60.040(7)(c)(i).

Obesity is an "impairment" under the WLAD definition for at least two reasons: it is a physiological disorder *and* a condition affecting one or more of the statutorily enumerated body systems, *viz.*, the musculoskeletal, lymphatic, endocrine and cardiovascular systems.

First, given the extensive literature and support among the medical community that obesity is a disease, it logically follows that obesity is a "physiological disorder" under RCW 49.60.040(7)(c)(i). Indeed, references to physiological disorders are found throughout the medical literature discussed above.[43]

Second, obesity is a condition that affects "one or more" of the statutorily enumerated body systems. Indeed, it affects not simply one, but several: the musculoskeletal, lymphatic, endocrine and cardiovascular systems. *See* RCW 49.60.040(7)(c)(i) (defining "impairment" as a

[43] *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").

condition "affecting one or more of the following body systems: Neurological, musculoskeletal, special sense organs, respiratory, including speech organs, cardiovascular, reproductive, digestive, genito-urinary, hemic and 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 inherently involves physical and chemical processes that affect the operation of individuals' bodily systems.[44] Obesity may even cause significant dysfunction, long before related diseases are clinically diagnosed.

Looking at several of the "body systems" enumerated in RCW 49.60.070(c)(i) illustrates this point:

1. Obesity affects 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.[45]

[44] *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.").
[45] *See, 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

2. Obesity also impacts 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.[46]
3. 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.[47]
4. Obesity also affects the "endocrine" system because adipose tissue secretes hormones that regulate metabolism, contributing to insulin resistance and ultimately diabetes.[48]

(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 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.").

[46] 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).

[47] 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).

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[.]"[49] Applying this definition, the AMA concluded that obesity is a disease, a conclusion that necessarily includes a finding that obesity affects normal body functioning.[50] This is consistent with the Obesity Medicine Association, which defined 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."[51]

Obesity readily satisfies the WLAD's definition of impairment. This conclusion is fully consistent with the medical community's understanding of the nature and impact of obesity and the broad protections provided by the WLAD.

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[48] 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.
[49] Appendix at 3 (emphasis added).
[50] 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").
[51] Obesity Medicine Association, https://obesitymedicine.org/definition-of-obesity.

IV. CONCLUSION

OAC and DRW respectfully request that the Court conclude that obesity is an "impairment" under the WLAD.

DATED: January 14, 2019.

BRESKIN JOHNSON & TOWNSEND, PLLC

By: *s/Brendan W. Donckers*

Brendan W. Donckers, WSBA #39406
1000 Second Avenue, Suite 3670
Seattle, WA 98104
(206) 652-8660 Fax (206) 652-8290
bdonckers@bjtlegal.com

Attorneys for Amici Curiae OAC and DRW

CERTIFICATE OF SERVICE

I certify under penalty of perjury under the laws of the State of Washington that on this date I electronically filed the attached document with the Clerk of the Court and caused service on the following counsel of record, via the efiling portal and email:

Kenneth W. Masters
ken@appeal-law.com
Shelby R. Fost Lemmel
shelby@appeal-law.com
MASTERS LAW GROUP PLLC

Jay R. Stephens
rod@stephenslawfirm.com
THE STEPHENS LAW FIRM

Attorneys for Appellant

Richard P. Lentini
lentini@ryanlaw.com
Britenae M. Pierce
pierce@ryanlaw.com
RYAN SWANSON & CLEVELAND PLLC

Bryan P. Neal
bryan.neal@tklaw.com
THOMPSON & KNIGHT LLP

Attorneys for Respondents

DATED January 14, 2019, at Seattle, Washington.

s/ Leslie Boston
Leslie Boston, Paralegal

APPENDIX

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)

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