AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY
Saturday, May 8, 2021

5. Council on Medical Education Report 3 – Status of Graduate Medical Education Capacity in Texas
6. Council on Medical Education Report 5 – Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs
7. Council on Medical Education Report 6 – Support for Acceptance of DACA Recipients to Texas Medical Schools
8. Council on Medical Education Report 7 – Update to TMA Policies on Advanced Practice Registered Nurses
9. Committee on Physician Distribution and Health Care Access Report 1 – Requiring All Texas Licensed Physicians to Pass Texas Medical Jurisprudence Exam
12. Committee on Physician Distribution and Health Care Access Report 4 – Renewed Effort to Increase Diversity Among the Texas Physician Workforce
13. Resolution 201 – Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools (Tabled Res 202 2020)
16. Resolution 204 – Defining What Constitutes Proper Use of the Terms “Residency” and “Fellowship” When Referring to Specialty Training
17. Resolution 205 – Skin of Color Representation in Medical Education and Research
19. Resolution 207 – Suicide Prevention Education in Medical School (Tabled Res 305 2020)

20. Resolution 208 – Facilitating Brain and Other Postmortem Tissue Donation for Research and Educational Purposes (Tabled Res 306 2020)

21. Resolution 209 – Promoting Careers in Geriatrics Among Medical Students (Tabled Res 204 2020)

22. Resolution 210 – Amending the Mental Health Question on the Physician Licensure Application to Reflect Current Impairment (Tabled Res 206 2020)

23. Resolution 211 – Medical School Compliance with the Americans With Disabilities Act

24. Resolution 212 – Support Addressing, Screening, and Providing Healthy Coping Mechanisms for Burnout
Subject: Sunset Policy Review

Presented by: Chelsea I. Clinton, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The council recommends amending the policy as follows:

30.019 195.032 Federal Physician Care Compare Website: Federal "Physician Care Compare Website": That the Texas Medical Association will monitor Centers for Medicare & Medicaid Services’ development of the Physician Care Compare Website to ensure that physicians currently in clinical practice are involved in the development of the standards to evaluate physician performance, that the measures and methodology used for the website are transparent and valid, and that physicians are provided with an opportunity to challenge a rating through a fair process (CSE Rep. 3-A-11).

Recommendation 1: Retain as amended.

The council recommends deletion of the following policy as they are no longer relevant:

115.011 Disease Management: Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions that supports the physician/patient relationship and plan of care; emphasizes prevention of complications utilizing cost-effective, evidence-based practice guidelines and patient empowerment strategies, such as self-management education; and continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

The decision to participate or not participate in a disease management program should be a coordinated decision between the patient and the patient’s physician based on discussion of the various elements of the disease management program (Amended CSA Rep. 5-A-01; amended CSPH Rep. 3-A-11).

Recommendation 2: Delete.
Subject: Initial Assessment and Treatment Recommendation by Specialists, Resolution 108-A-19

Introduced by: Chelsea I. Clinton., MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

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**Background**

The 2019 Texas Medical Association House of Delegates considered Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists, from the TMA Young Physician Section. The resolution expressed concern that nonphysician practitioners do not provide the level of expertise that primary care physicians seek when they refer patients to a physician specialist. The resolution sought to establish TMA policy recognizing “that the best practice of patient care dictates that it is the responsibility of the physician to develop the diagnosis and treatment in the evaluation of a patient, while it is recognized under limited circumstances that an initial evaluation may be conducted by a nurse practitioner or physician assistant.” The resolution was presented at the Reference Committee on Financial and Organizational Affairs, which recommended adoption with amendments. Further testimony at the House of Delegates, however, called for a thorough review of the resolution’s language for inclusivity of primary care physicians as well as physician specialists. Therefore, the House of Delegates recommended referral for study with report back at TexMed 2020, and the resolution was referred to the Council on Health Care Quality and Interspecialty Society Committee. Per the 2020 Joint Report of the Council on Health Care Quality and Interspecialty Society Committee, Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists, was referred again for further study to the Council on Health Care Quality and the Interspecialty Society Committee (ISC) with a report back at TexMed 2021.

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**Discussion**

As part of its due diligence on this controversial topic, the Council on Health Care Quality surveyed the members of the Council and the ISC, consulted with TMA’s Office of General Counsel, and held several Zoom meetings with the Council and ISC to thoroughly discuss Resolution 108. Included in these meetings were legal topics of antitrust, setting a precedent for standard of care and physician practice autonomy in delegating patient care. These conversations were rigorous, thoughtful, and impassioned, but consensus supporting adoption of Resolution 108 was not achieved. Instead, the Council and the ISC support reaffirmation of physician-led, team-based care in lieu of adopting Resolution 108.

**Recommendation:** Do not adopt Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists.
Subject: Sunset Policy Review

Presented by: Kevin W. Klein, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The council recommends retention of the following policy:

205.005 Funding Levels for Research and Medical Education:
The Texas Medical Association supports legislative initiatives and continued funding levels for mandated research and medical education at the state and national levels and legislative initiatives and funding requests for programs that encourage physicians to practice in underserved areas (CME, p 80, A-91; amended CME Rep. 2-A-01; reaffirmed CME Rep. 2-A-11).

185.015 Addressing Workforce Issues:
The Texas Medical Association (1) encourages the American Medical Association to actively support adequate federal funding of the National Health Service Corps Loan Repayment Program; (2) supports state funding for graduate medical education programs; (3) encourages Texas medical schools with rural missions to periodically evaluate their student admission criteria to ensure that the most appropriate criteria are utilized for identifying students most likely to select careers in rural medicine; (4) supports funding from the federal Health Resources and Services Administration of the U.S. Department of Health and Human Services for state-based health professions workforce planning activities; and (5) encourages the Texas Medical Board to conduct an ongoing survey of physicians seeking state licensure who are relocating from other states or countries to identify the primary reasons why physicians are moving to Texas for use in projecting future physician supply (CME Rep. 4-A-201; amended CME Rep. 2-A-11).

Policy 290.001 makes a direct reference to the TMA Knowledge Center and was reviewed by center staff and recommended for continuation, as written.

290.001 Academic Libraries:
The Texas Medical Association urges the American Medical Association to address and support federal funding of the Information Technology Research and Development Programs, including the National Research and Education Network, and similar computer networks that link universities, national libraries, non-profit institutions, government organizations, and private companies to consolidate and build upon existing interconnected telecommunications networks. TMA supports legislation establishing and funding statewide library networks that enhance the ability of physicians and students to access information in support of the delivery of quality health care. TMA agreed to participate in the planning of statewide information-sharing networks that benefit TMA membership.
TMA encourages medical libraries in Texas to promote the efforts of state and federal
government agencies, such as the Texas Department of State Health Services, the Centers for
Disease Control and Prevention, the National Library of Medicine, the National Institutes of
Health, and the National Cancer Institute that provide free access to authoritative medical
information on their Web sites and the Texas State Library and Archives Commission's
TexShare Consortium that provides remote access to online indexes and full-text materials to
participating libraries. TMA supports state laws that allow nonprofit libraries, including the
TMA Knowledge Center, to qualify for participation in the TexShare Consortium and
adequate state funding of this collaborative program (CME, pp 78-79, A-91; amended CME

**Recommendation:** Retain.
Resolution 202-A-18, Addressing Gender Bias in Undergraduate Medical Education and Implicit Bias Training

Some testimony asked that the scope of the policy be expanded beyond gender to also include training on bias related to race and ethnicity. The council also concurred with the testimony that supported the expansion of this policy to include training on racial and ethnic biases. Further, the council recognizes the potential benefit of mentorships for medical students, residents, and fellows in medical specialties with significant underrepresentation by gender and/or race/ethnicity. An example is women in surgical specialties.

The resolution proposed that TMA (1) support implementation of implicit bias training for Texas medical school faculty; and (2) advocate for the creation and implementation of formal mentorship programs at medical schools between residents, fellows, or attending physicians and female medical students for specialties in which women are underrepresented.

Results of Council’s Research

The council started by reviewing existing TMA policies. While several related policies were identified, none fully covered the topics in the resolution, such as the following policy:

**TMA Policy 60.008 Rejection of Discrimination**: TMA does not discriminate, and opposes discrimination, based on race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity. TMA supports physician efforts to encourage that the nondiscrimination policies in their practices, medical schools, hospitals, and clinics be broadened to include “race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity” in relation to patients, health care workers, and employees (CSPH Rep. 1-A-18).

**Policy 185.012** supports greater diversity in the state’s physician workforce, with the goals of improving the geographic maldistribution of physicians and reducing potential health disparities:

**TMA Policy 185.012 Physician Recruitment**: TMA supports expanded efforts by Texas medical schools to recruit and retain students and residents from underrepresented race/ethnic groups as well as underrepresented geographic areas of the state to enhance the diversity of the state’s physician workforce, affect geographic maldistribution, and reduce potential health disparities (Committee on Physician Distribution and Health Care Access, p 76, I-95; substitute CME Rep. 2-A-06; reaffirmed CME Rep. 2-A-16).
In addition, Resolution 112 Equal Pay for Equal Work (Dallas County Medical Society), adopted by the house in 2019, included a directive for TMA to create implicit bias training for male and female TMA members. TMA’s Women Physicians Section selected Unconscious Bias in Medicine, an online CME program offered by Stanford University School of Medicine, as the recommended training program in response to this resolution.

In the 24 years since the adoption of TMA Policy 185.012 on the recruitment of a diverse physician workforce, minimal change has occurred in the racial and ethnic diversity of the state’s physicians. Currently, far less diversity exists among Texas physicians than among the Texas population. The following statistics demonstrate the state’s far more diverse population than the state’s physician workforce:

**Race/Ethnicity**
- **Five times more** Hispanic Texans than Hispanic physicians,
- **Twice as many** Black/African American Texans than physicians, and
- **1.4 times more** white Texas physicians than white Texans.

*(Also, see Committee on Physician Distribution and Health Care Access Report 1 Renewed Efforts to Increase Diversity among the Texas Physician Workforce)*

**Gender**
- Women make up 50.3% of Texans, and only 35% of Texas physicians.
- In academic medicine in the U.S., women represent:
  - 16% of permanent deanship positions,
  - 15% of department chairs,
  - 21% of full professors,
  - 34% of associate professors, and
  - 38% of full-time medical school faculty.

*(Note: Data were not available at the state level.)*

In researching the potential for bias, the council found numerous prominent studies that showed:

- Although multiple federal laws such as the 1964 Civil Rights Act and the 1965 Medicare and Medicaid Act legislate against overt discrimination in health care, disparities in health care in the U.S. exist based on gender and racial/ethnic status.
- Unconscious bias can exist, and most individuals are unaware of their own biases and how they manifest.
- When individuals are made aware of unconscious biases, change is possible.
- Racial/ethnic concordance between patients and their physician is a positive association.
- Diversity of faculty, administration, and medical school enrollments is an important component of learning.
- Training programs about implicit bias at academic health centers have led to institutional changes that resulted in greater diversity in hiring and student admissions.

As proposed in Resolution 202, the council supports mentorship for women during medical school in the medical specialties that have an underrepresentation of women. The council also supports expanding this policy proposal to include underrepresented minorities with the goal of promoting greater diversity in medicine.
Recommendation: Adopt new Texas Medical Association policy as follows in lieu of Resolution 202-A-18:

Support Bias Training for All Texas Medical School Students, Resident Physicians, Staff, and Faculty of Academic Health Centers, and Promotion of Greater Diversity in Medicine. The Texas Medical Association supports bias training for all Texas medical school students and resident physicians, as well as staff and faculty at academic health centers.

TMA supports providing evidence-based educational programs at medical schools that help residents, fellows, and attending physicians mentor medical students in medical specialties for which medical schools recognize significant underrepresentation by gender and/or race/ethnicity within the physician workforce.
Medical education and residency training in the state suffered a series of interruptions and serious setbacks as a result of the COVID-19 pandemic. All forms of testing throughout the physician pipeline also were subject to interruptions, delays, and suspensions. This report provides an overview of the impact and offers recommendations for being better prepared for future catastrophic events of this nature.

Medical Education
On March 17, 2020, the Association of American Medical Colleges issued guidance that medical students should not be involved in direct patient care activities unless there was a critical health care workforce need in a particular area. Teaching hospitals, clinics, and community-based physician preceptors asked medical schools to withdraw medical students from in-person educational settings. Soon after, Texas Gov. Greg Abbott issued a series of executive orders that temporarily prohibited in-person educational programs, which shut down preclinical classes at the medical schools. Across the country, in-person testing was suspended for licensing board exams and medical specialty board certification.

In the early stages of the pandemic, medical students were treated in the same manner as visitors to teaching hospitals and facilities. In looking back, the question arises whether this was the best policy. In contrast, in some states such as New York, new medical school graduates were hired by hospitals as health care workers before starting their residency training. In retrospect, many academic leaders recognize medical students, with the proper precautions, can continue serving in their usual roles by taking patient histories and vital signs, organizing lab tests and data, issuing communications including some levels of interactions with family members of hospitalized patients, and engaging in many other organizational activities. Rather than being a hindrance or a liability, medical students can provide invaluable service as part of the medical team.

To be clear, no one questions the motivation for the action taken to remove medical students from training institutions in March 2020. It is not difficult to reconstruct the unknowns of those early days of the pandemic, such as the lack of knowledge about the epidemiology of the virus; the severe shortage and uncertainties about replenishment of personal protective equipment (PPE) and viral testing; and the need to focus all hospital staffing and other resources on saving lives.

Medical schools were nimble in responding to the changes. In-person preclinical courses were converted to online formats, and educational experts were consulted to guide this conversion. Students quickly became involved in virtual medicine in lieu of in-person clinical clerkships. Electives on the pandemic were quickly developed to enable students to earn academic credit for learning about current conditions. While some clinical training is conducive to virtual formats, other clerkships such as surgery are not a good fit at all. The Liaison Committee on Medical Education, the accrediting body for allopathic medical schools, made clear that the curriculum could not be 100% virtual; some education and training must be provided in person.
“Away” rotations were largely halted for fourth-year medical students. This hampered the ability of medical students to make in-person assessments of potential future training programs and facilities. Residency program and medical school interview processes were also converted to virtual formats.

The suspension of in-person U.S. Medical Licensing Exams and Comprehensive Osteopathic Medical Licensing Exams resulted in delays throughout the physician educational pipeline. Eventually, all Texas medical schools restarted in-person clinical training. The combined effects of all of these changes created significant pressures on medical education deans, administrators, faculty, their clinical partners, and learners. The full effects of the various disruptions and extensive amount of virtual learning on the educational and training experience of medical students and residents are not yet known.

**Interruptions to Graduate Medical Education**

Residents and fellows had the opposite experience of medical students, with great demands being placed on them in response to various surges in hospitalizations and spikes in demand for emergency and critical care services. In some cases, residents and fellows were temporarily reassigned from their training programs to fill gaps in staffing for areas in highest demand. Residents, fellows, and clinical faculty faced unprecedented levels of stress. These changes were disruptive to their training as well as their personal lives. Given their roles in delivering care, it is difficult to imagine how critical staffing needs could have been met without them.

Examples of disruptions to graduate medical education training:

- When patient clinics closed, clinical activities moved to telemedicine formats.
- Low patient volumes at times presented challenges to meeting clinical training requirements for some specialties, e.g., primary care, ophthalmology, and surgical specialties.
- Some hospitals temporarily limited operating room activities to essential residents to conserve PPE.
- Emergency medicine residents in San Antonio were temporarily removed from obstetrical rotations due to concerns about their potentially higher exposure rate as staff in emergency departments.
- Residents transitioned to elective research projects, as needed.
- Those participating in global health training programs were brought back to Texas.
- High-risk residents were reassigned from certain practice settings.
- Some residents in community-based preceptorships were reassigned to other clinical settings.

In the post-pandemic period, it is recommended that ALL involved in the teaching of medical students, residents, and fellows evaluate the policies in place for teaching and training during a pandemic or other extended catastrophic events. The emergency policies in place were primarily developed with a short-term and localized catastrophic event in mind, such as a hurricane. These policies were not designed to respond to an international pandemic of an extended and uncertain duration.

Questions to be addressed in a post-pandemic assessment:

- What have we learned?
- What were the best practices?
- What needs to be improved?
- What resources are needed?
- Should medical students be treated as if they are “visitors” to hospital and clinic facilities or included in the federal definitions of “essential workers” for their potential role in assisting in the delivery of medical care?
What are the policies for ensuring medical students and residents have access to PPE, viral testing, and vaccinations?

What are the policies for scheduling clinical learning activities for medical students or residents who are not candidates for vaccination or who are vaccine-hesitant?

This assessment may be an appropriate activity for the Texas Higher Education Coordinating Board to lead or contract out.

**Recommendation:** The council recommends the following be adopted as Texas Medical Association policy:

**Preserving Medical Education, and Residency and Fellowship Training During a Pandemic or Other Extended Catastrophic Event**

The Texas Medical Association supports a post-pandemic assessment of the policies that affect ALL involved in the teaching of medical students, residents, and fellows to evaluate policies in place for preserving education and training during a pandemic or other extended catastrophic event. The evaluation should consider what has been learned, identify best practices and needed improvements, and identify resources required for future improvements. TMA encourages the Texas Higher Education Coordinating Board to consider leading this post-pandemic assessment.

TMA encourages consideration of the following during the assessment:

1. Whether medical students should be treated in the same manner as visitors to teaching facilities – or treated differently, with recognition given to the role of learners in health care delivery at teaching facilities;
2. The need for a commitment to securing adequate supplies of personal protective equipment (PPE) and viral tests for all learners, within reason, recognizing frontline workers should receive the highest priority, and the need for appropriate training in the use of PPE;
3. Developing policies to preserve the ability of medical students to experience hands-on learning, including in-person clerkship experiences, with consideration given to alternative learning sites if needed to avoid high exposure to contagions;
4. Appropriate roles for medical students to contribute to a crisis response, with proper precautions and at a level appropriate for their education, experience, and training; and
5. More flexible policies, as needed, for unavoidable absences by students, residents, and fellows.

TMA should work with the American Medical Association to encourage federal authorities such as the U.S. Centers for Disease Control and Prevention and the U.S. Department of Homeland Security to reconsider how medical students are defined in official policies on “essential workers,” e.g., in publications such as the Cybersecurity and Infrastructure Security Agency’s Guidance on Essential Critical Infrastructure Workers.

TMA also supports an evaluation of the emergency policies enacted for residency training programs during the pandemic, including the impact on the length of training and qualifications for board certification for program completers.
REPORT OF COUNCIL ON MEDICAL EDUCATION

C-ME Report 5 2021

Subject: Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs

Presented by: Kevin W. Klein, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

A physician training in a residency program in Texas contacted the council to ask for assistance. Her residency program had designated a physician assistant to serve as the attending physician for her program, and she questioned whether this met national residency program accreditation standards. The resident physician also questioned whether the physician assistant’s education and training qualified that person to serve as the attending physician of a residency program. This concern is not limited to Texas. In fact, residents and fellows have formed various national groups to share common experiences and seek policy changes.

After reviewing the Accreditation Council for Graduate Medical Education (ACGME) Common Requirements for the accreditation of residency programs, council staff contacted ACGME to inquire about the eligibility of physician assistants to serve as “attending physicians.” The following common accreditation standard is applicable:

VI.A.2. Supervision and Accountability VI.A.2.a)(1)

Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care.

A physician staff member at ACGME provided the following comment:

There are a handful of specialty-specific requirements that allow individuals other than physicians to supervise residents in very specific circumstances. Clearly, though, there is a difference between being allowed to supervise a resident for a given process/procedure and being an attending physician.

The Council on Medical Education recommended that the resident report her concerns to ACGME. In addition, the council reached out to the dean of graduate medical education at the institution that sponsored the residency program to discuss the resident’s concern.

Role of Nonphysician Practitioners in Residency and Fellowship Training

The concern brought to the council was not about nonphysician practitioners, including physician assistants, serving as faculty at residency and fellowship programs. The concern was about their serving as the attending physician. The council recognizes many different types of health professionals are highly skilled and are excellent educators, and supports these successful staffing arrangements. In this case, the physician assistant was serving as the attending physician, which carries primary responsibility for the training of the residents in the program as well as the care they provide.

ACGME has 25 review committees that determine the standards for certain specialty areas. In combination with the ACGME Common Requirements, these form the guidelines for residency training. Each review
committee has discretion under Standard VI.A.2 (above) to specifically identify “licensed independent practitioners” who can have a role in supervising residents during certain phases of training. Council staff reviewed the program requirement FAQs for the 25 review committees and summarized the specific provisions for nonphysicians as supervisors by review committee (see attachment).

Of the 25 review committees, nine recognize independent practitioners (nonphysicians) in the role of supervisor of residents and fellows; 13 do not recognize independent practitioners in that role; and three are not known at this time – program requirement FAQs are under revision and temporarily unavailable.

Of the nine review committees that recognize the role of nonphysicians in teaching and supervising, most clarify that their level of supervisory responsibility is secondary to the attending physician. Emphasis is placed on physicians serving in the role as the attending physician, which means they retain the ultimate responsibility for the supervision of residents. An example is from the Review Committee on Ophthalmology:

While the attending physician may delegate an appropriately-qualified non-physician to assist or teach a resident in a specific aspect of an eye exam (e.g., refraction, low vision, contact lens, orthoptics, and optics), the ultimate responsibility for resident supervision remains the responsibility of the attending physician.

The council supports this degree of clarity in review committee policies for residency and fellowship training.

**Recommendation:** The council recommends the following be adopted as Texas Medical Association policy:

**Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs**

The Texas Medical Association encourages graduate medical education programs in Texas to designate physicians as supervisors in the clinical training environment for residents and fellows. TMA also continues to encourage interprofessional clinical training for residents and fellows.
## ATTACHMENT

### TMA SUMMARY OF ACGME PROGRAM REQUIREMENTS FOR GRADUATE MEDICAL EDUCATION, BY REVIEW COMMITTEE

**Question:** Can a nonphysician clinical staff member supervise a resident?

*ACGME Common Standard VI.A.2. Supervision and Accountability*

<table>
<thead>
<tr>
<th>REVIEW COMMITTEE</th>
<th>RESPONSE TO QUESTION:</th>
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<tbody>
<tr>
<td>Allergy and Immunology</td>
<td>Clinical psychologists, clinical social workers, nurse practitioners, physician assistants, and registered dieticians, for example, may supervise residents’ clinical activities when the program director determines that their special expertise will promote education and provide a level of supervision equivalent to that provided by an attending physician. During these situations, there must also be direct or indirect supervision by a physician faculty member.</td>
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<tr>
<td>Anesthesiology; Colon and Rectal Surgery; Dermatology</td>
<td>No reference to a role for non-physician clinical staff in supervising residents.</td>
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<tr>
<td>Emergency Medicine</td>
<td>The Review Committee will accept licensed or certified individuals on occasion to supervise residents in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, licensed clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Oversight by a faculty physician member during these situations is required.</td>
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<tr>
<td>Family Medicine</td>
<td>No reference.</td>
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<tr>
<td>Internal Medicine</td>
<td>Not known; FAQs are being revised and are not available at this time.</td>
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<tr>
<td>Neurological Surgery</td>
<td>No reference.</td>
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<tr>
<td>Neurology</td>
<td>Licensed practitioners [that may contribute to a residents’ education] include health care professionals who are licensed in the state and have appropriate credentials to provide patient care. These may include advanced practice providers or psychologists, for example.</td>
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<tr>
<td>Obstetrics/Gynecology</td>
<td>No reference.</td>
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<tr>
<td>Ophthalmology</td>
<td>Although the Review Committee believes that it is important for residents to acquire experience in leading and participating in health care teams, including those with nonphysicians (e.g., optometrists, orthoptists, or ophthalmic technicians), supervision of all clinical care rendered by residents is the responsibility of physician faculty members. Non-physicians are not permitted to independently supervise residents. While the attending physician may delegate an appropriately-qualified non-physician to assist or teach a resident in a specific aspect of an eye exam (e.g., refraction, low vision, contact lens, orthoptics, and optics), the ultimate responsibility for resident supervision remains the responsibility of the attending physician.</td>
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<td>Orthopedic Surgery</td>
<td>Each program is responsible for having clear policies for supervision. Direct supervision requires the supervising individual to be physically present. Appropriately credentialed and privileged nonorthopaedic attending physicians, as well as licensed independent practitioners (this may include non-physician faculty members working in conjunction with the orthopaedic surgery department) with whom the program has a clearly defined relationship outlined in the supervision policy, may directly supervise PGY-1 residents. The clinical care supervised by a...</td>
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<td>Specialty</td>
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<td>non-physician professional</td>
<td>A non-physician must be within the scope of practice of that non-physician professional.</td>
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<td>Otolaryngology</td>
<td>While other care providers are expected to be part of interprofessional teams that provide patient care, only appropriately-credentialed and privileged attending physicians may supervise residents.</td>
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<td>Pathology</td>
<td>Although pathologist’s assistants are not licensed independent practitioners, they may be authorized by a department to provide supervision or oversight of dissection of surgical specimens and autopsies.</td>
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<td>Pediatrics</td>
<td>Physician assistants, nurse practitioners, psychologists, physical and occupational therapists, speech and language pathologists, dieticians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e., school-based health centers, child development clinics) and inpatient (i.e., neonatal intensive care unit (NICU)) settings. Some states may have regulatory rules that won’t allow licensed independent practitioners to supervise residents.</td>
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<td>Physical Medicine and Rehab</td>
<td>Advanced nurse practitioners and psychologists may supervise residents, as appropriate.</td>
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<td>Preventive Medicine</td>
<td>PM-1 and PM-2 residents may be supervised by licensed allied health professionals who are identified as faculty members, provided that:</td>
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<td>• the clinical care is within their scope of practice expertise;</td>
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<td>• the level of clinical care is low risk;</td>
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<td>• physician faculty members are available by telephone; and,</td>
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<td>• the program director has approved the supervision with respect to the educational experience.</td>
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<td>Allied health professionals cannot substitute for physician faculty members to meet the 24-hour requirement for on-site supervision of resident care.</td>
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<td>Psychiatry</td>
<td>No reference.</td>
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<td>Radiation Oncology</td>
<td>No. The Review Committee’s opinion is that it is not relevant to our specialty to have other licensed independent practitioners supervise residents. Physician extenders may be present in some clinics, but the Review Committee does not view them as primarily responsible for patient care delivered by residents.</td>
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<tr>
<td>Radiology-Diagnostic</td>
<td>No reference.</td>
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<td>Sports Medicine – review committees for Emergency Medicine, Family Medicine, Pediatrics, and Physical Medicine and Rehabilitation</td>
<td>While there is an expectation that fellows and faculty members have ultimate responsibility for the overall care of each patient, there may be circumstances where a licensed independent practitioner or physician extender may also be involved in a supervisory role for the fellow. In such instances, the non-physician is expected to provide that supervision within the legal limits of his or her particular license.</td>
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<tr>
<td>Surgery and Thoracic Surgery</td>
<td>Not known; FAQs are under revision at this time.</td>
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<tr>
<td>Transitional and Urology</td>
<td>No reference.</td>
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Prepared by: TMA Medical Education Department.
TMA’s Medical Student Section submitted a resolution to the House of Delegates in 2020 for new TMA policy in support of the acceptance of DACA recipients to Texas medical schools. DACA refers to the Deferred Action for Childhood Arrivals program, a federal executive branch program created by President Barack Obama in 2012. This action was taken after the Development, Relief, and Education for Alien Minors Act of 2011 (DREAM Act of 2011) did not pass in Congress. The bill would have provided a pathway for citizenship for DACA eligibles. Similar bipartisan legislation, the Durbin-Graham Dream Act of 2021, is currently pending in Congress, but its passage is uncertain.

The DACA program was established to allow a narrow group of young individuals to gain temporary legal status if they entered the U.S. illegally before their 16th birthday, were less than 32 years of age in 2012, and have lived in the U.S. consistently since 2007. Individuals can receive a two-year, renewable authorization to remain and work in the U.S. through an Employment Authorization Document (or work permit) and can apply for a Social Security number. To be eligible, applicants must pass a background check, either be enrolled in school or have graduated or earned a GED, and be enrolled in the U.S. military or honorably discharged, and cannot have been convicted of a felony. An overwhelming majority of Americans (73%) support legalizing students who are undocumented. There are an estimated 230,000 DACA recipients in Texas.

The council researched current policies for DACA recipients at Texas medical schools and residency programs as well as Texas licensing laws. The council learned DACA recipients are eligible for:

- Admission to Texas undergraduate colleges and universities and in-state tuition,
- State financial aid for higher education but not federal financial aid,
- Participation in the National Resident Matching Program and acceptance to Texas residency programs,
- Clinical rotations through U.S. Department of Veterans Affairs health care facilities,
- Medicare graduate medical education payments to hospitals and facilities while in residency training,
- Physician-in-Training permits for residents and fellows in training from the Texas Medical Board,
- Board certification from member boards of the American Board of Medical Specialties and American Osteopathic Association Bureau of Osteopathic Specialists,
- Texas Medical Board medical licensing, and
- Employment on the basis of an Employment Authorization Documents or work permit and Social Security number.

While researching this topic, the council recognized there may be misunderstandings among medical school leadership about what a DACA recipient can and cannot do. Some expressed their understanding to TMA that DACA students are not eligible for a Texas residency training permit or a medical license. Others thought a work or education visa was required or certification from the Educational Commission for Foreign Medical Graduates. None of those restrictions are applicable, and the council recognized the need for educational programs within academic health centers to promote a greater understanding. Several medical schools noted
that TMA policy on the acceptance of DACA recipients to Texas medical schools would likely be useful in
the formulation of state admission policies.

Status of DACA Recipients at Texas Medical Schools
Currently, only one of the state’s 15 medical schools – Texas College of Osteopathic Medicine (TCOM) at
the University of North Texas Health Science Center in Fort Worth – accepts DACA recipients (see
attachment). Fewer than five DACA students are currently enrolled at TCOM. That school plans to stop
accepting applications from non-U.S. citizens, including DACA recipients, beginning in 2022. This change is
being made to align with the admission policies of other Texas medical schools.

Texas has a centralized medical school application program, the Texas Medical and Dental Schools
Application Service, that processes applications for 14 of the state’s 15 medical schools, including TCOM.
TCU and UNTHSC School of Medicine in Fort Worth is the only Texas medical school that does not
participate in the Texas application service. The advisory council for the application service held discussions
on DACA admissions policies in recent months and provided the following statement to TMA in January
2021 regarding these activities:

The Texas Health Education Service oversees administration of the Texas Medical and Dental
Schools Application Service (TMDSAS) and the service’s advisory council [has] been evaluating
policies related to DACA recipients. There has been interest among TMDSAS member institutions
to ensure policies and practices on DACA reflect the reality of the situation, particularly in regard
to recent legislation and other opportunities in the educational and state medical licensure
processes. TMDSAS would like to provide educational opportunities in 2021 to ensure all
participating institutions have accurate and shared understanding of the policies related to DACA.

Background for Current DACA Admission Policies
The council has long held the position that medical school admission policies are best determined by
admissions committees, not entities external to a medical school, with the exception of medical school
accrediting bodies. Certainly, medical schools are required to meet the standards defined by their national
accrediting bodies. However, neither the Liaison Committee on Medical Education nor the American
Osteopathic Association Commission on Osteopathic College Accreditation has standards that disqualify
DACA recipients from applying to an accredited medical school.

The council reached out to the admission deans at Texas medical schools to ask about the background for
their DACA policies. Two reasons were cited most often, as listed below, but there was not agreement on
these policies.

1. Ability of DACA recipients to afford medical school tuition.
   - Because DACA recipients are not eligible for federal student aid, some medical school leaders
     thought this could be an impediment to their success in medical school. Some admission deans
     strongly disagreed with this rationale: DACA students are eligible for state student aid and loans from
     banks and private sources.
   - Some questioned why a different admission criterion would be applied for medical schools than
     colleges and universities, recognizing DACA students are accepted to these schools and
     undergraduate degrees are required for application to medical school.
   - Other admission deans felt this policy excludes an applicant pool based on an assumption rather than
     a fact and expressed concerns about selective application of this criterion.
2. Concerns about the acceptance of DACA recipients by Texas residency programs.

In an outreach to graduate medical education programs, none reported formal policies prohibiting the acceptance of DACA physicians.

The institutions below sponsor the majority of the state’s residency programs, and each reported to TMA their general acceptance of residency position applications from DACA recipients.

- Baylor College of Medicine, Houston;
- Houston Methodist;
- Texas Tech University Health Sciences Center, Lubbock;
- UT Southwestern Medical Center, Dallas;
- UTHealth Houston;
- UT Health San Antonio and University Health System San Antonio; and
- UT Medical Branch, Galveston.

**Potential Benefits of DACA Medical Graduates**

In a research study reported in *Academic Medicine* in 2017, a high percentage (95%) of DACA recipients reported being bilingual, and the largest number spoke Spanish. DACA physicians could potentially help meet the medical needs of Hispanic, non-English-speaking patients in Texas.

Although an exceptionally small number of DACA recipients apply to medical schools (estimated to be less than 1%), research shows those who complete medical education and residency training are likely to have an interest in serving medically underserved populations as a result of life experiences and cultural interests. Studies have found that Hispanic physicians have a greater tendency to serve medically underserved patients, and patient-physician race/ethnic concordance has been shown to yield favorable patient outcomes and lower medical costs. Examples of these studies are listed on page 6 of the TMA Committee on Physician Distribution and Health Care Access’ Report 3 – Renewed Effort to Increase Diversity Among the Texas Physician Workforce.

**Other Considerations**

The DACA program is not open-ended to include every undocumented young person in the U.S. The program is narrowly defined; for example, the individual must have lived continuously in the U.S. since 2007. DACA status does not provide long-term legal protection to recipients and does not provide a pathway for citizenship. Some DACA recipients are able to qualify for citizenship status through other routes.

The council gave careful consideration to the state mandate for every public Texas medical school that limits the acceptance of non-Texas residents (as classified for the purposes of in-state tuition) to no more than 10% of their admissions each year. In other words, 90% of the schools’ admissions must be students classified as Texas residents. As noted, DACA recipients are eligible to be classified as Texas residents for the purposes of qualifying for in-state tuition. This results from a state law passed in 2001 and signed into law by Texas Gov. Rick Perry. This status is applicable to students who graduated from a high school in Texas or completed a GED in Texas and meet certain residency requirements. For this reason, DACA recipients from Texas would not be counted as part of the 10% nonresident admission cap. This status was considered by the council as it debated the issue of potentially accepting non-U.S. citizens into a Texas medical school.

**Related AMA Policy**

Recognizing that DACA is a national program, the council evaluated relevant American Medical Association policies and determined that AMA supports DACA recipients, as follows:
D-350.986 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages: Our AMA will issue a statement in support of current U.S. health care professionals, including those currently training as medical students or residents and fellows, who are DACA recipients. (Reaffirmation A-19)

Recent Court Rulings

To evaluate the status of the DACA program, the council looked at recent court actions. In September 2017, the Trump administration announced a halt to the acceptance of applications to the DACA program and a wind-down process for existing recipients. The U.S. Supreme Court ruled in June 2020 that justification had not been provided to end the DACA program and that the Trump administration’s termination of the program was unlawful. The DACA program was reactivated on Dec. 7, 2020.

The Association of American Medical Colleges, joined by 32 other organizations, in October 2019 filed an amicus brief in the U.S. Supreme Court case in support of the DACA program. The 19 organizations related to medicine that joined the amicus brief are listed below. About 200 corporations also filed amicus briefs.

- Academy of Child and Adolescent Psychiatry,
- American Academy of Family Physicians,
- American College of Obstetricians and Gynecologists,
- American College of Physicians,
- American College of Preventive Medicine,
- American Medical Association,
- American Medical Student Association,
- American Psychiatric Association,
- American Society of Hematology,
- American Society of Nephrology,
- American Thoracic Society,
- Association of Academic Health Centers,
- Association of American Indian Physicians,
- California Medical Association,
- Greater New York Hospital Association,
- National Council of Asian Pacific Islander Physicians,
- National Hispanic Medical Association,
- National Medical Association, and
- Society of General Internal Medicine.

U.S. District Court Hearing, Dec. 23, 2020

A hearing on the legality of the DACA program was held Dec. 23, 2020, in the U.S. District Court in Houston, and the case was left pending. President Joseph Biden has expressed support for continuation of the DACA program or congressional action on an immigration pathway.

Recommendation: The council recommends the following be adopted as Texas Medical Association policy:

Acceptance of Applications to Texas Medical Schools From Deferred Action for Childhood Arrivals (DACA) Recipients
The Texas Medical Association recognizes admissions policies are best determined by medical school admissions committees. TMA encourages Texas medical schools to evaluate their individual policies on the acceptance of applications from Deferred Action for Childhood Arrivals (DACA) recipients and supports schools that make the decision to accept them.

DACA recipients are eligible to apply to colleges and universities for undergraduate and graduate degrees, and TMA supports the same consideration for application to medical schools.

It is recognized that (1) DACA recipients are eligible for in-state tuition at higher education institutions and therefore would not be part of the state’s 10% cap on the acceptance of non-Texas residents to Texas public medical schools, and (2) DACA physicians are eligible to apply for Physician-in-Training permits, residency training, Texas medical licenses, employment in the state, and medical specialty board certification.

TMA supports communications by Texas medical schools to inform faculty, residency program directors, administrators, and other staff of the unique status of DACA recipients to promote better understanding.
Excerpt from Texas Medical and Dental Schools Application Service website:

“The following medical schools will only review and consider for admissions applicants who are U.S. citizens or legal Permanent Residents of the U.S.:

“University of Texas Southwestern Medical School
UT Medical Branch at Galveston
Long School of Medicine, UT Health San Antonio
McGovern Medical School (formerly The University of Texas HSC at Houston Medical School)
UT Austin Dell Medical School
UT Rio Grande Valley School of Medicine
Texas A&M Health Science Center, College of Medicine
Texas Tech University Health Sciences Center School of Medicine
Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine at El Paso

“The medical school listed below will review and consider for admissions international applicants, U.S. citizens and legal Permanent Residents of the U.S.:

“University of North Texas - Texas College of Osteopathic Medicine”

Source:
Texas Medical and Dental Schools Application Service
Accessed Jan. 17, 2021

References:
REPORT OF COUNCIL ON MEDICAL EDUCATION

C-ME Report 7 2021

Subject: Update to TMA Policies on Advanced Practice Registered Nurses

Presented by: Kevin W. Klein, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

Texas has 34,000 licensed advanced practice registered nurses (APRNs). These health care professionals are recognized as valuable members of the health care team, and many Texas physicians participate in delegation agreements with APRNs. Twenty-two states and the District of Columbia allow independent practice for APRNs. House Bill 2029 (Rep. Stephanie Klick, R-Fort Worth) was filed in late February 2021, seeking legislative approval of independent practice for APRNs in Texas. Similar legislation has been filed in the past several legislative sessions.

Full practice authority is defined by the American Association of Nurse Practitioners as “the authorization of nurse practitioners [NPs] to evaluate patients, diagnose, order and interpret diagnostic tests and initiate and manage treatments – including prescribe medications – under the exclusive licensure authority of the state board of nursing.” TMA has policy in opposition to independent practice for APRNs.

While physician assistants (PAs) function in similar roles as APRNs, the primary focus of this report is APRNs in response to physician concerns. It is less common for PAs to seek independent practice; however, many principles in this report are also applicable to PAs.

Physicians recognize the importance of nurses in advanced practice to our current health care system, as defined in TMA Policy 30.15. This policy documents TMA’s strong support for the state’s current laws that reflect the importance of team-based care based on clinical linkages with physicians through integrated practice, as follows:

**30.015 Nurses in Advanced Practice:** The Texas Medical Association acknowledges the importance of nurses in advanced practice to our current health care system. TMA strongly supports current Texas law that requires advanced practice nurses to maintain clinical linkages to physicians through integrated practice (Council on Medical Education, p 97, I-94; reaffirmed CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

The American Association of Family Physicians has policy similar to TMA’s, as follows:

The AAFP encourages health professionals to work together as multidisciplinary, integrated teams in the best interest of patients. Patients are best served when their care is provided by an integrated practice care team led by a physician.

This spring, proponents of APRN independent practice are saying APRNs are distinct from physicians in that they have a strong interest in practicing in rural medically underserved areas. Current physician delegation requirements do not prevent APRNs from practicing in these areas. Further, it is not a lack of interest that prevents from physicians from practicing in isolated, underserved areas but challenges to practice viability in sparsely populated, less resourced geographic areas.
Proponents of independent practice promote APRNs as being more cost efficient in practice, resulting in lower health care costs. Research studies show that APRNs prescribe more, order more tests, and make more referrals than physicians. All of these can be expected to result in greater health care costs, not less, as cited in research studies referenced later in this report.

It is critically important to fully understand the distinctions between the practice of medicine and the practice of nursing, including the considerable differences in educational preparation and training requirements between the two professions. Each brings important expertise and skills to health care. A physician’s extensive education and tens-of-thousands of hours of clinical training and experience prepare them for the critical thinking, informed by science, needed to diagnose, treat, manage, and supervise the medical care for all patient population groups. Advanced practice nursing places an emphasis on prevention and wellness, patient education, care coordination, and holistic evaluations.

Members have expressed concerns to TMA regarding APRN education and training, including:

- Small amount of hands-on clinical training received by APRNs and the need for extensive “on-the-job” training.
- APRN programs that did not take responsibility for securing clinical training sites for their students, requiring students to hunt for their own. (More on page 10)
- Lack of direction to physician preceptors of intended outcomes for the preceptorship and lack of rigor in the process to be used by preceptors in evaluating APRNs in training. (Page 10)
- Proliferation of APRN education programs that are 100% online, with no requirement for in-person didactic education. (Page 9)

In researching the APRN profession in Texas, the council learned or confirmed the following:

- An APRN’s authority to provide medical aspects of patient care and to prescribe medications in Texas is only through delegation by a physician.
- Physicians receive a minimum of 30 times more clinical training than an APRN. (Page 10)
- A physician’s extensive training enables the physician “to generate broad differential diagnoses and provide comprehensive care to medically complex patients.” (Page 5)
- The number of APRNs grew more than six times faster than physicians during the past decade. (Page 8)
- It is not known how many APRNs want to practice independently in Texas. Anecdotally, many APRNs report no interest in changing their current delegation arrangements. This uncertainty raises questions about the impact of such legislation, particularly for rural underserved areas as is promoted by APRN advocacy groups. (Page 6)
- APRNs do not need independent practice to practice in rural underserved areas. (Page 7)
- Texas is projected to have an oversupply of nurse practitioners and certified registered nurse anesthetists (CRNAs) each year from 2018 to 2032. (Pages 9 and 14) Independent practice laws are not needed to recruit more of these types of APRNs to the state or to retain graduates for practice in the state.
- APRN curricula are not standardized. (Page 9).
- While APRNs have added qualifications and responsibilities over registered nurses, they remain part of the nursing profession, which is rooted in a highly compatible but distinct philosophy from medicine. (Page 3)
- A recent survey found most Texans do not support nurses, PAs, and other nonphysician health care professionals in the role of diagnosing and treating patients, or prescribing without the oversight of a licensed physician. (Page 6)
Updates to TMA policy

TMA has not adopted new policies on APRNs for many years, and the council offers this report with new policy proposals for consideration by the House of Delegates.

BACKGROUND

Differences in state definitions of physicians and APRNs

APRNs and physicians represent professions rooted in distinct philosophies of their unique roles in providing health care. While APRNs have added qualifications and responsibilities over registered nurses, they remain part of the nursing profession and are licensed and regulated by the Texas Board of Nursing not the Texas Medical Board (TMB).

Definition in the Texas Medical Practice Act:

“Practicing medicine” is defined as the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions.”

Definitions from the Texas Nursing Practice Act

“Professional nursing means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.”

Related definitions from Texas Board of Nursing rules, §221.1

“(3) The advanced practice nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings including but not limited to homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice nurse acts independently and/or in collaboration with other health care professionals in the delivery of health care services.

“(12) Protocols or other written authorization – Written authorization to provide medical aspects of patient care which are agreed upon and signed by the advanced practice nurse and the physician, reviewed and signed at least annually, and maintained in the practice setting of the advanced practice nurse. Protocols or other written authorization shall be defined to promote the exercise of professional judgment by the advanced practice nurse commensurate with his/her education and experience. Such protocols or other written authorization need not describe the exact steps that the advanced practice nurse must take with respect to each specific condition, disease, or symptom and may state types or categories of drugs which may be prescribed rather than just list specific drugs.”

Texas APRN scope of practice

An APRN’s authority to provide medical aspects of patient care and to prescribe medications in Texas is only through delegation by a physician. (See TMA’s white paper Delegation of Duties by a Physician to a Nonphysician, TMA Office of General Counsel, 2017.)

As noted by the Texas Board of Nursing, historically this delegation occurred through a protocol or other written authorization for medical acts and a separate written agreement for prescriptive authority. If agreeable to the delegating physician and the APRN, both can be reflected in the prescriptive authority agreement, as documented in this excerpt from the Texas Board of Nursing website:
APRNs and PAs are required to have delegated authority to provide medical aspects of patient care. Historically, this delegation has occurred through a protocol or other written authorization. Rather than have two documents, this delegation can now be included in a prescriptive authority agreement if both parties agree to do so. [See definition of “protocols or other written authorization” on page 3.]

**Physician supervision requirements**

TMB specifies that physicians who delegate to an APRN or PA must adequately supervise those individuals. Texas laws on physician supervision have changed over the years, which appears to have caused some confusion about the current requirements. In 2013, the Texas Legislature replaced the site-based requirements for the delegation and supervision of prescriptive authority with a framework of delegation and supervision that uses prescriptive authority agreements.

There is no limit to the number of APRNs or PAs a physician can supervise. In addition, there is no limit on the number of physicians an APRN or PA can have supervise him or her. There can be limits on the number of APRNs and/or PAs to whom a physician can delegate prescriptive authority, dependent on the practice setting. For facility-based hospital practices or practices that serve medically underserved populations there is not a maximum number to whom a physician can delegate, but there are other limitations. A physician can delegate prescriptive authority through a facility-based protocol at no more than one licensed hospital and two long-term care facilities. A prescriptive authority agreement can be used, if preferred, but a facility-based protocol is sufficient.

The maximum number to whom a physician can delegate prescriptive authority in practice settings other than facility-based hospital practices or practices serving medically underserved populations is a total of seven combined APRN and PA full-time-equivalents. A prescriptive authority agreement is required in these settings.

In response to the COVID-19 pandemic, Texas Gov. Greg Abbott issued an executive order on April 5, 2020, that allows increased flexibility in the physician delegation requirements for APRNs (and PAs): For the duration of the disaster declaration, the limit on the number of prescriptive delegates has been lifted, and supervisory relationships are not required to be in writing or registered with the Texas Medical Board. The order remains in effect at this writing.

TMB advises that a physician does not have to be physically present at all times to be considered to have adequate supervision, and there are no specific requirements for the geographic proximity of a supervising physician’s practice location and the practice site of an APRN or PA. This means an APRN or PA can practice at a different location from the supervising physician. TMB cautions “(i)n any given case, the distance between a physician’s primary practice and the practice site at which the physician’s delegates provide medical services may be an important factor in determining the quality of the physician’s supervision.”

Supervising physicians and the APRN or PA to whom they delegate are required to have regular meetings, and the supervising physicians is required to review a portion of the patient records. The location, method, and frequency of those meetings, and the number of medical records to be reviewed are to be determined by the physician, APRN or PA. TMB advises that “the number or percentage of charts reviewed may be an important factor in determining the quality of the physician’s supervision.”

There have been reports of APRNs paying exorbitant fees to physicians as a requirement for entering into a delegation agreement. No evidence has been provided, and it has not been possible to quantify or verify these reports.
Discord with Texas laws, staffing policies at Veterans Affairs clinics

In November 2020, the U.S. Department of Veterans Affairs adopted rules that permit APRNs and PAs to practice without the clinical supervision of physicians and without regard to Texas laws requiring physician delegation. In light of the complex health care needs of many veterans, including those with traumatic brain injuries and other serious medical and mental conditions, this new staffing rule is of particular concern. The council supports the state’s delegation laws and does not support different standards for veterans’ medical care.

Compilation of viewpoints: differences between medicine and advanced practice nursing

To promote a better awareness of the core differences between medicine and advanced practice nursing, the council reviewed numerous research studies, surveys, and other references and prepared the compilation below.

### Differences in Training, Particularly in Preparation for Formulating a Diagnosis

- “While nurse practitioners are trained to emphasize health promotion, patient education, and disease prevention, they lack the broader and deeper expertise needed to recognize cases in which multiple symptoms suggest more serious conditions. The primary care physician is trained to provide complex differential diagnosis, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of the patient’s overall health condition. This expertise is earned through the deep, rigorous study of medical science in the classroom and the thousands of hours of clinical study in the exam room that medical students and residents must complete before being allowed to practice medicine independently.”

- A physician’s extensive training enables the physician “to generate broad differential diagnoses and provide comprehensive care to medically complex patients.”

- “Nursing is knowing how to take care of patients’ needs, whether they are physical, social, psychological. Medicine is much more scientific; diagnosing the disease, not just the symptoms, weighing risks and benefits of treatment, understanding lab results and what they really mean. Nursing is not medicine. Medicine is not nursing. They overlap but should be separate entities to be best for patient care.”

- “Can a nurse practitioner gain the necessary knowledge to take on this role in an additional two years of training? Physicians who were previously nurse practitioners say no. The biggest reason: nurse practitioner schools did not adequately prepare them to be able to develop an adequate differential diagnosis, the essential list necessary to accurately diagnose disease.”

- “Nurse practitioners do not have the time or in-depth training during a two-year program to learn how to develop a comprehensive differential diagnosis.” “Nurse practitioners are taught pattern-based thinking, and physicians are taught more critical thinking.”

- Results from a 2013 survey published in the *New England Journal of Medicine* showed 66.1% of physicians reported physicians provide a higher-quality examination and consultation than do nurse practitioners during the same type of primary care visit.

- “The need for physician training occurs during those rare times when a medical situation is unusual or more complicated — and potentially life-threatening.” “Without additional training on how to perform a differential diagnosis and the fund of knowledge required to expand the potential diagnoses to include the most serious causes of a patient’s symptoms, non-physician practitioners may put patients at risk.”
Proponents of APRN independent practice commonly emphasize that APRNs have a strong interest in practicing in rural medically underserved areas. Further, APRN organizations promote greater cost savings by APRN practices.

What do the data show about preference for rural practice by APRNs? Table 1 provides a comparison of licensing data for APRNs and physicians in Texas for 2018. APRNs had a higher percentage (54%) located in the state’s five most-populous counties of Bexar, Dallas, Harris, Tarrant, and Travis than physicians (51.8%).

Table 1

<table>
<thead>
<tr>
<th>Percentage of Physicians and APRNs Practicing in Top Five Most-Populous Counties in Texas, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians: 51.8%</td>
</tr>
<tr>
<td>APRNs: 54%</td>
</tr>
</tbody>
</table>

Sources: Health Professions Resource Center, Texas Department of State Health Services; and Texas Board of Nursing. Prepared by: TMA.

About 7% of APRNs report a practice location in a rural area, as shown in Table 2. For context, 177 of Texas’ 254 counties are rural.
Table 2
APRN by Texas Urban and Rural County Location, 2018

<table>
<thead>
<tr>
<th>Location</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban County</td>
<td>93.1%</td>
</tr>
<tr>
<td>Rural County</td>
<td>6.9%</td>
</tr>
</tbody>
</table>

Source: Texas Board of Nursing. Prepared by: TMA

Challenges of rural practice for any health care practitioner

Of Texas’ 254 counties, 29 have been identified as not having a physician. These areas have a population density of three people per square mile, qualifying for what is often referred to as “frontier” areas (generally, defined as areas with fewer than seven people per square mile). The barriers that prevent physicians from practicing in these areas are typically the same barriers that prevent hospitals, pharmacies, grocers, and other retail businesses from locating to these areas. There is not a sufficient population base or infrastructure to support health care systems and businesses.

As an example, it has been estimated that a patient panel of about 2,500 may be needed to sustain a family physician’s practice. Of the 29 counties without a physician, 17 had a total population less than 2,500. Because geographic modifiers are used to determine the rates for Medicare payments, rural areas often have lower payment rates than larger population areas. These impediments to a successful physician practice can be expected for other types of health care professionals. Medicare payment policies are of particular significance to rural practices because of the relatively high percentage of Medicare beneficiaries living in rural Texas.

In addition, as noted on page 9, the study of APRN supply/demand commissioned by the Texas Center for Nursing Workforce Studies in 2017 determined the number of nurse practitioners and CRNAs exceeds demand and is projected to continue to do so each year through 2032. Texas has been successful in recruiting and retaining these professions and does not need to change delegation laws to achieve this goal.

Independent practice is also not needed to enable APRNs to practice in rural underserved areas. As an example, federally designated rural health clinics are required by federal law to have an APRN or PA on staff for 50% of the time the clinic is open. This evidences the potential availability of employment positions for APRNs in rural physician shortage areas of the state. Mapping research by the American Medical Association compares actual locations of primary care physicians with that of nurse practitioners who practice independently in other states. AMA found nurse practitioners did not move to rural areas in appreciable numbers but generally continued to practice in the same areas as physicians.

Lower cost for APRN care?

The following compilation provides a sampling of research findings published in a variety of professional journals, including nursing. In general, the studies showed APRNs prescribe more medications, including antibiotics and antimicrobials; order more tests and imaging services; and make a larger number of referrals. These practice patterns can be expected to result in greater health care costs. Further, APRNs working in collaborative practice arrangements with physicians can be expected to benefit from the efficiencies of an integrated practice.
Higher Rates of Prescribing by APRNs
Research published in the Open Forum on Infectious Diseases in 2016 looked at ambulatory visits between 2006 and 2011 involving nurse practitioners (NPs) and PAs. It was found that patient care visits by NPs and PAs more frequently resulted in an antibiotic prescription compared with physician-only visits (17% for visits involving NPs and PAs vs 12% for physician-only visits).vi

Study published in the Journal of Nursing Regulation in 2017 determined key differences were observed in the number and duration of prescriptions written by NPs and primary care physicians. There was a higher number of prescriptions issued by NPs for beneficiaries in moderate and high comorbidity groups.vi

More Frequent Referrals by APRNs
Referrals by physicians (vs APRNs or PAs) are of higher quality, better clarity, understanding of pathophysiology, and adequate prereferral evaluation and documentation. Less physician referrals were categorized as unnecessary in a study published in the Mayo Clinic Proceedings in 2013.

Quality of referrals to an academic medical center was higher for physicians than for NPs and PAs regarding the clarity of the referral question, understanding of pathophysiology, and adequate prereferral evaluation and documentation.vi

Higher Rates of Imaging Services Ordered by APRNs
Study published in JAMA Internal Medicine in 2015 found that advanced practice clinicians are associated with more imaging services than primary care physicians for similar patients during E&M office visits. While increased use of imaging appears modest for individual patients, this increase may have ramifications on care and overall costs at the population level.vii

Significantly More Resources Used by APRNs than PAs in Emergency Departments
In a comparison of resources used by APRNs and PAs in emergency rooms, a study published in the Journal of American Academy of Physicians Assistants found that regardless of experience level, NPs were reported to use significantly more resources than PAs.viii

APRN workforce in Texas, current and projected
APRNs are among the fastest growing health professions, growing more than 200% in Texas from 2011 to 2020, about seven times faster than physicians, as shown in Table 3. Nurse practitioners (NPs) grew at the fastest rate, by 311%. In comparison, physicians in direct patient care in Texas grew by only 32.9%. The four different types of APRNs are shown in the table.

<table>
<thead>
<tr>
<th>APRN Type</th>
<th>2011</th>
<th>2020</th>
<th>Difference</th>
<th>Rate of Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certified Nurse Midwife</td>
<td>268</td>
<td>538</td>
<td>270</td>
<td>100.7%</td>
</tr>
<tr>
<td>Certified RN Anesthetist</td>
<td>2,449</td>
<td>4,906</td>
<td>2,457</td>
<td>100.3%</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>1,602</td>
<td>1,242</td>
<td>-360</td>
<td>-22.5%</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>6,676</td>
<td>27,457</td>
<td>20,781</td>
<td>311.3%</td>
</tr>
<tr>
<td><strong>TOTAL APRNs</strong></td>
<td>10,995</td>
<td>34,143</td>
<td>23,148</td>
<td>210.5%</td>
</tr>
</tbody>
</table>

| Direct Patient Care Physicians | 42,716 | 56,765 | 14,049 | 32.9% |

Sources: Texas Board of Nursing, and Health Professions Resource Center, Texas Department of State Health Services Prepared by: Texas Medical Association, 2/21.
In Texas, nursing workforce planning activities are overseen by the Texas Center for Nursing Workforce Studies at the Texas Department of State Health Services. The center commissioned a study in 2017 of the projected supply and demand for APRNs (excluding clinical nurse specialists) for 2018 through 2032. This represents the most recent study of this type available in the state.

The study determined the supply of NPs and CRNAs currently EXCEEDS demand in Texas. This is not expected to change; Texas is projected to continue to have more NPs and CRNAs than projected demand each year through 2032. In contrast, the study found that Texas has a shortage of certified nurse midwives and demand is expected to exceed supply each year through 2032.

With a projected oversupply, independent practice laws are not needed in order to recruit more NPs and CRNAs to the state or to retain graduates for practice in the state. (See Appendix A for detailed projections. Note: This study was based on trends for supply and demand before the COVID-19 pandemic.)

APRN educational model

Two national groups accredit APRN educational programs, and there is not a standardized APRN curriculum. In Texas, 35 programs offer APRN education (see Appendix B). In comparison, there are 15 Texas medical schools. NPs are educated and certified in six population-focused areas of practice: family care, neonatal, pediatric acute care, pediatric primary care, psychiatric-mental health, and women’s health (see Appendix C for a detailed list, 2019).

During the pandemic, it is recognized that many educational programs have been converted to virtual formats to promote greater safety. Before the pandemic, however, TMA heard concerns about the proliferation of APRN programs that are 100% online. Unlike preclinical medical education and other types of health professional training during the pandemic, the 100% online format for a considerable number of APRN programs is not a temporary response to the pandemic.

Comparison, length of training for physician and APRNs

Some distinctions between medical education and APRN education are well known, such as the following:

Physician: Typically a four-year undergraduate degree, then four years of medical school. A medical school’s curriculum is at least 130 weeks and generally encompasses around 170 semester credit hours (source: Texas Higher Education Coordinating Board). Medical school and residency training requires a minimum of six to seven years, and with fellowship training, the total can extend to 12 years.

APRN: Typically a four-year undergraduate registered nurse degree, followed by an 18- to 24-month master’s or a post-master’s degree certificate program.

In 2018, the National Organization of NP Faculties issued a position statement that entry-level APRN programs should be elevated to the doctorate level by 2025. A previous proclamation for 2015 was not achieved. CRNAs are making this change, and all four CRNA educational programs in Texas are now at the doctorate of nursing practice (DPN) level. (See Appendix B.)
Comparison, clinical training requirements for physicians and APRNs

Table 4 demonstrates physicians are required to complete 30 times the amount of minimum clinical training as APRNs.

<table>
<thead>
<tr>
<th>Table 4</th>
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</thead>
<tbody>
<tr>
<td>Comparison of Minimum Clinical Training Requirements</td>
</tr>
<tr>
<td>Physicians: 15,000 hours</td>
</tr>
<tr>
<td>APRNs: 500 hours</td>
</tr>
</tbody>
</table>

APRN clinical training model

The APRN clinical training model has not changed in 50 years and is primarily dependent on a one-to-one preceptor-student model. Inconsistencies in clinical training requirements across APRN programs are summarized in the following excerpt from a white paper by the American Association of Colleges of Nursing:

APRN students enter clinical training experiences across the curriculum with varied skill levels. Variability among APRN programs, particularly for nurse practitioners and clinical nurse specialists, exists in the clinical competencies expected at various points throughout the curriculum, varied expectations for student performance across programs, and evaluation processes and tools. This variability may hamper efforts to expand the clinical training opportunities for students.

As noted, despite the heavy reliance on preceptors, including physicians, for clinical training, until recently some APRN educational programs did not take responsibility for securing clinical training sites for their students. Instead, students were required to find their own, and TMA heard concerns from physicians.

The Commission on Collegiate Nursing Education added an APRN accreditation standard in 2019 that makes reference to periodic reviews, but specific responsibility is not assigned to educational programs. Such a requirement was not found for the other accrediting body, the Accreditation Commission for Education in Nursing.

**Standard II-B:** Physical resources and clinical sites enable the program to fulfill its mission, goals, and expected outcomes. Adequacy of physical resources and clinical sites is reviewed periodically, and resources are modified as needed.

Both accrediting bodies have standards that require educational programs to clearly define and communicate the roles and performance expectations for preceptors. TMA has heard from physicians who served as APRN clinical preceptors regarding a lack of communication about the objectives of the preceptorship as well as the lack of an evaluation process.

Curricular differences between medicine, advanced practice nursing

In addition to striking differences in the length of training, there are vast differences in curricular content for the educational preparation of physicians and APRNs. To help demonstrate these differences, a comparison is presented in Appendix D of the curriculum for a family medicine physician, including medical school and a three-year residency, and a family nurse practitioner. This example is based on the curricula for these three different types of programs at The University of Texas Medical Branch (UTMB).

In considering the strength of the comments on page 5 of this report about the lack of training in diagnostic reasoning for APRNs, it is important to note that the curriculum for a family nurse practitioner at UTMB lists only two semester credit hours in nurse practitioner diagnostic reasoning.
Summary: Physician-led, team-based care is what is best for the patient

Texas physicians recognize the valuable role of APRNs as members of the health care team. They also recognize what is best for the patient is physician-led, team-based care. Physicians’ extensive education and tens-of-thousands of hours of clinical training and experience prepare them for the critical thinking, informed by science, needed to diagnose, treat, manage, and supervise the medical care for all patient population groups. Advanced practice nursing places an emphasis on prevention and wellness, patient education, care coordination, and holistic evaluations. The council strongly supports continuation of state requirements for physician supervision and delegation of authority for APRNs and PAs and consistent application of these laws within the state.

Recommendation: The Council on Medical Education recommends the following be adopted as Texas Medical Association policy:

Physician-Led Patient Care Teams
TMA will continue to advocate that physicians are uniquely qualified by their extensive and broad education, training, and credentialing to lead the patient care team. TMA opposes the independent practice of advanced practice registered nurses and physician assistants and strongly supports continuation of state requirements for physician supervision and delegation of authority for these health professions.

Physician Supervision and Delegation Responsibilities
TMA supports efforts to ensure physicians are well informed of their responsibility to supervise advanced practice registered nurses and physician assistants to whom they delegate practice and prescriptive authority, including through the required content and updating of practice agreements. Both the Texas Medical Board and TMA should periodically provide reminders to physicians of these responsibilities.

Promoting Accurate Understanding of the APRN Profession, and Length and Content of APRN Training
TMA believes patients should be well informed of the distinct differences between the educational and clinical preparation of physicians and advanced practice registered nurses (APRNs). This will enable patients to make better informed decisions about their health care.

TMA determined it also critically important for state policymakers to be informed of these differences. In particular, they should be knowledgeable of the small amount of training APRNs receive in formulating a diagnosis. It should be made known that physicians are required to complete 30 times the amount of clinical training as APRNs, 15,000 hours vs. 500 hours. Further, it is critically important to understand the fundamental differences in the practice of medicine and the practice of nursing.

TMA supports clear and accurate representation of the role, education, and training of APRNs, including doctor of nursing practice (DNP) registered nurses, in the delivery of patient care, including the use of name tags and other labels. Further, APRNs have the obligation to represent themselves and their role in a clear and accurate manner in all communications with patients and other health care practitioners.

Promoting Quality Training for APRNs
TMA strongly supports assurances of high quality training for advanced practice registered nurses (APRNs). This includes consistent accreditation standards for all APRN education and training programs, and professional certification programs. TMA supports evidence-based studies of the degree of preparedness of APRNs for entry into practice. These studies should evaluate the amount of on-the-
job training by physicians required to prepare APRNs to function in their role on the health care team.  
TMA supports clear accreditation standards that place the responsibility for securing preceptorship  
opportunities on the APRN training programs not the APRN student.  

Physicians who elect to serve as preceptors to APRN students are strongly encouraged to see that the  
APRN educational programs provide the necessary guidance to enable them to serve in the role of a  
preceptor. Further, APRN educational programs that use physicians as preceptors for APRN clinical  
training should be required to adequately inform preceptors of their training role and the program’s  
expectations for the training experience.  

TMA supports evidence-based studies of the outcomes from APRN education programs that are  
provided 100% online.  

Different Standards for Veterans Clinics  
TMA opposes a different level of care for Texans who are veterans and receive their care at U.S.  
Department of Veterans Affairs facilities. TMA believes veterans should be treated equitably, not  
differentiated through federal policies that allow independent practice for nonphysician health care  
practitioners despite opposing state laws.  

Related TMA policies:  
30.001 CRNA Direct Reimbursement  
30.012 Nursing and Nurses with Advanced Training  
30.015 Nurses in Advanced Practice  
30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners  
170.006 Physician Liability for Acts of Assistants
APPENDIX A

Projections of Supply and Demand of APRNs for Texas, 2018 to 2032

The Texas Center for Nursing Workforce Studies at the Texas Department of State Health Services (DSHS) contracted with IHS, Inc. in 2017, to conduct a projection study of APRN supply and demand for Texas for the years 2018 and 2032. Below are the findings for three of the four types of APRNs; projections were not made for clinical nurse specialists.

This study projected an oversupply by 2032 for two of the three types of APRNs in the study: nurse practitioners (NPs) and certified registered nurse anesthetists (CRNAs). In contrast, a shortage was predicted for certified nurse midwives (CNMs).

NPs
The study projected there will be more NPs than demand in Texas, as shown in the graph below. The number of NPs is projected to grow by 117.3% from 20,922 NP full-time-equivalents (FTEs) in 2018 to 45,462 in 2032. During this period, demand is projected to grow by 35.6% from 19,317 FTEs in 2018 to 26,191 FTEs by 2032.

When you compare projections for NP supply and demand, a surplus of NPs is projected to grow from 1,605 in 2018 to 19,271 in 2032. Supply is expected to exceed demand for every year from 2018 to 2032.

Blue line (top trend line): Projected number of NPs in Texas
Gold line (bottom line): Projected demand for NPs in Texas
Charts showing projections for supply and demand for different types of NPs are available on the DSHS website.

CRNAs
The study also projected there will be more CRNAs than demand in Texas, as shown in the graph below.

The supply of CRNAs in Texas is projected to grow by 45.8% from 4,074 CRNA FTEs in 2018 to 5,938 in 2032. The demand for CRNAs in Texas is projected to increase 30.9% during this period from 2,075 CRNA FTEs to 2,717.

An oversupply of CRNAs is predicted for the entire projected period, growing from 1,999 in 2018 to 3,221 in 2032.

Blue line (top trend line): Projected number of CRNAs in Texas
Gold line (bottom line): Projected demand for CRNAs in Texas
CNMs
The projected supply of CNMs is expected to increase by 43.6% from 432 FTEs in 2018 to 621 in 2032. During this time, demand for CNMs is projected to exceed supply, increasing by 23% from 798 FTEs in 2018 to 981 in 2032.

A shortage of CNMs is projected for every year from 2018 to 2032. The shortage is predicted to gradually improve, starting with 45.9% in unmet need in 2018 and declining to 36.8% of unmet need by 2032.

Blue line (top trend line): Projected number of CNMs in Texas
Gold line (bottom line): Projected demand for CNMs in Texas

Source: Texas Center for Nursing Workforce Studies, Texas Department of State Health Services

Note: This study was based on trends for supply and demand before the COVID-19 pandemic. Workforce experts note that the effects of the pandemic on the supply and demand for health care professionals are not yet known. Post-pandemic projection studies may produce different outcomes based on changes in staffing, practice, and patient care demand.
APPENDIX B
Number of Educational Programs for APRNs in Texas, 2019, by Type of Program

Thirty-five educational programs in Texas offer different types of APRN programs:

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>42</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>6</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>4</td>
</tr>
<tr>
<td>Nurse-Midwife</td>
<td>2</td>
</tr>
</tbody>
</table>

Note: All four of the CRNA programs offered in Texas are at the doctorate of nursing practice (DNP) level.

Sources: Texas Center for Nursing Workforce, Texas Department of State Health Services; and Council on Accreditation of Nurse Anesthesia Programs.

Nurse practitioners (NPs) are required to be certified in a population-focused area of practice. The overwhelming majority licensed in Texas are certified as family nurse practitioners (69%); the next largest groups are 10% in pediatric fields and 9% in adult care, as shown below.

### Distribution of Licensed Nurse Practitioners in Texas by Area of Recognition, as Identified by Texas Board of Nursing

<table>
<thead>
<tr>
<th>Texas Board of Nursing Nurse Practitioner Area of Recognition</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>934</td>
<td>(4%)</td>
</tr>
<tr>
<td>Acute Care Adult</td>
<td>870</td>
<td>(4%)</td>
</tr>
<tr>
<td>Gerontological</td>
<td>287</td>
<td>(1%)</td>
</tr>
<tr>
<td>Emergency</td>
<td>99</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>15,867</td>
<td>(69%)</td>
</tr>
<tr>
<td>Neonatal</td>
<td>713</td>
<td>(3%)</td>
</tr>
<tr>
<td>Perinatal</td>
<td>12</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td><strong>Pediatrics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td>1,729</td>
<td>(8%)</td>
</tr>
<tr>
<td>Acute Care Pediatric</td>
<td>455</td>
<td>(2%)</td>
</tr>
<tr>
<td>Psychiatric/Mental Health</td>
<td>1,141</td>
<td>(5%)</td>
</tr>
<tr>
<td>School Nurse</td>
<td>9</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>984</td>
<td>(4%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>23,100</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Note: These statistics are for NPs only, excluding the other three types of advanced practice registered nurses: certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists.

Source: Texas Board of Nursing, September 2019 (most recent data available)
APPENDIX D
Comparison of Education and Training Pathways for Family Medicine Physicians
and Family Nurse Practitioners

To help demonstrate the differences between the education and training of physicians and nurse practitioners, the curriculum and training requirements at The University of Texas Medical Branch are used an example. Below is a summary of the educational and training requirements for medical school and the family medicine residency program, compared with registered nurses training in the family nurse practitioner program.

*Note: In addition, the registered nurse (RN) must have a Texas RN license and have completed at least one year of work experience as an RN.*

<table>
<thead>
<tr>
<th>Medical School/Residency Training</th>
<th>Family Physician</th>
<th>Family Nurse Practitioner (FNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical School Year 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Gross Anatomy and Radiology</td>
<td>Semester 1: (17 Semester Credit Hours [SCHs])</td>
<td>• Theoretical and Research Foundations for Advanced Nursing Practice (3 SCHs)</td>
</tr>
<tr>
<td>• Molecules, Cells, and Tissues</td>
<td>Semester 2:</td>
<td>• Pathophysiology (3 SCHs)</td>
</tr>
<tr>
<td>• Pathobiology and Host Defense</td>
<td>• Advanced Health Assessment (3 SCHs)</td>
<td>Semester 2:</td>
</tr>
<tr>
<td>• Neuroscience and Human Behavior</td>
<td>• Nurse Practitioner Diagnostic Reasoning (2 SCHs)</td>
<td>Semester 3:</td>
</tr>
<tr>
<td>• Practice of Medicine</td>
<td></td>
<td>• Pharmacology (3 SCHs)</td>
</tr>
<tr>
<td>• Cardiovascular and Pulmonary System</td>
<td>Semester 4: (26 SCHs)</td>
<td>• Public Policy (3 SCHs)</td>
</tr>
<tr>
<td>• Renal, Fluid, and Electrolytes</td>
<td>• Introduction to Primary Care of Adults (6 SCHs)</td>
<td></td>
</tr>
<tr>
<td>• Gastrointestinal/Nutrition</td>
<td>• Families and Health Promotion (2 SCHs)</td>
<td></td>
</tr>
<tr>
<td>• Endocrine/Reproduction</td>
<td>Semester 5:</td>
<td>• Primary Care: Children and Comprehensive Prenatal Care (6 SCHs)</td>
</tr>
<tr>
<td>• Dermatology/Hematology/Musculoskeletal</td>
<td>• Informatics/Quality Improvement (3 SCHs)</td>
<td>Semester 6:</td>
</tr>
<tr>
<td>• Great Syndromes</td>
<td>Semester 6:</td>
<td>• FNP Chronic Illness (6 SCHs)</td>
</tr>
<tr>
<td>• Practice of Medicine</td>
<td>• Nurse Practitioner Business and Roles (3 SCHs)</td>
<td>Semester 7: (6 SCHs)</td>
</tr>
<tr>
<td>Medical School Year 3</td>
<td>• Internal Medicine (12 weeks)</td>
<td>• Public Health Principles in Advanced Practice Nursing</td>
</tr>
<tr>
<td>• Pediatrics (8 weeks)</td>
<td>• Surgery (8 weeks)</td>
<td></td>
</tr>
</tbody>
</table>
| Medical School Year 3 Cont’d | Obstetrics/Gynecology (6 weeks)  
| Psychiatry (6 weeks)  
| Family Medicine (4 weeks)  
| Elective (4 weeks)  
| (3 SCHs)  
| FNP Clinical Practicum (3 SCHs) |
| Medical School Year 4 | Neurology Selective (4 weeks)  
| Emergency Medicine Selective (includes Advanced Cardiac Life Support) (4 weeks)  
| Acting Internship Selective (4 weeks)  
| Ambulatory Community Selective (4 weeks)  
| Basic Science/Humanities Selective (4 weeks)  
| Electives are 20 weeks with at least one required clinical |
| Family Medicine Residency Year 1 | Three years of post-medical school residency training (15,000 hours)  
| Continuity Clinic (1 half-day each week)  
| Ambulatory Pediatrics  
| Community Medicine  
| Emergency Medicine  
| Essential Skills in Family Medicine  
| Inpatient Medicine  
| Obstetrics 1  
| Medical Intensive Care Unit  
| Newborn Nursery  
| Pediatric Urgent Care  
| Principles of Family Medicine  
| Surgery  
| 780 semester credit hours for family nurse practitioner clinical training |
| Residency Year 2 | Continuity Clinic (4 half-days each week)  
| Behavioral Medicine  
| Cardiology  
| Electives  
| Geriatrics  
| Inpatient Medicine  
| Inpatient Pediatrics  
| Obstetrics 2  
| Procedures  
| Orthopedics  
| Women’s Health |
| Residency Year 3 | Continuity Clinic (4 half-days each week)  
| Ambulatory Family Medicine  
| Ambulatory Pediatrics  
| Electives  
| Family Medicine Board Review  
| Inpatient Medicine  
| Nephrology |
Residency Year 3  
*Cont’d*  
- Neurology  
- Orthopedics with Sports Medicine  
- Practice Management/Research  
- Surgical Subspecialties (Urology/ENT)  

Optional fellowship training.  
Family physicians have the option to continue training in added qualifications through fellowship programs.

Sources: The University of Texas Medical Branch website and Texas Board of Nursing website.

References:
1. Texas Board of Nursing Rules, Rule 221.1 Definitions  
2. TMA White Paper Delegation of Duties by a Physician to a Non-Physician, TMA Office of General Counsel  
3. Texas Board of Nursing Frequently Asked Questions, APRNs  
4. Texas Medical Board Frequently Asked Questions  
5. Texas Medical Board Coronavirus Resources  
6. Issue Briefing: Collaboration Between Physicians and Nurses Work, Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners, Primary Care Coalition, Texas.  
8. Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in HealthCare  
10. Perspectives of Physicians and Nurse Practitioners on Primary Care Practice.  
14. Texas Interested Citizens 32nd Annual Statewide Survey November 18-23 2020 1,200 Texas Registered Voters Interviewed Conducted by live Landline & Cell Phones plus Online Surveys + 2.9% Margin of Error at 95% Level of Confidence.  
16. Impact of Nurse Practitioner Practice Regulations on Rural Population Health Outcomes  
18. Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants  
20. Prescribing Practices by Nurse Practitioners and Primary Care Physicians: A Descriptive Analysis of Medicare Beneficiaries Ulrike Muench, RN, PhD; Jennifer Perloff, PhD; Cindy Parks Thomas, PhD; Peter I. Buerhaus, RN, PhD Journal of Nursing Regulation Volume 8, Issue 1, P21-30, April 01, 2017  
22. Comparison of the Quality of Patient Referrals From Physicians, Physician Assistants, and Nurse Practitioners Mayo Clinic Proceedings Robert H. Lohr, MD; Colin P. West, MD, PhD; Margaret Beliveau, MD; Jayawant N. Mandrekar, PhD James M. Naessens, ScD; Thomas J. Beckman, MD. Published: October 11, 2013
<p>| | | |</p>
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<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>22.</td>
<td>A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits Danny R. Hughes, PhD; Miao Jiang, PhD; Richard Duszak Jr, MD JAMA Intern Med. 2015;175(1):101-107.</td>
</tr>
<tr>
<td>3</td>
<td>24.</td>
<td>Nurse Practitioner COVID-19 Survey (aanp.org)</td>
</tr>
<tr>
<td>4</td>
<td>25.</td>
<td>WHITE PAPER Re-envisioning the Clinical Education of Advanced Practice Registered Nurses March 2015, American Association of Colleges of Nursing</td>
</tr>
</tbody>
</table>
Texas law requires a physician, with only few exceptions, to pass the Texas Medical Jurisprudence Exam to protect the citizens of Texas by establishing that newly licensed physicians have demonstrated competent knowledge of law and Texas Medical Board rules related to the practice of medicine. This requirement applies to the following types of medical licenses: full (with limited exceptions), telemedicine, administrative, conceded eminence, and faculty temporary permits.

A legislative bill was filed in the 2021 Texas legislative session that seeks to establish a new medical licensing pathway for certain physicians who are military veterans and commit to practice in a medically underserved area of the state. This licensing pathway would exempt the physician from the requirement to pass the Texas Medical Jurisprudence Exam. Recognizing that the exam was created to protect patient safety and to protect practicing physicians by informing them of state laws relevant to medical practice, the committee does not believe this is good public policy. The committee questions why it would not be beneficial to every physician practicing in the state to know applicable laws. Further, by varying the licensing standards, the implication is that underserved areas do not require or deserve the same licensing standards as other areas of the state. TMA already has policy opposing a lower standard for medically underserved areas, as follows:

175.019 Medical Licensing Exam Passage Attempts and Timeframe Limits: TMA does not endorse a lower medical licensing standard for medically underserved areas (CME Rep. 3-A-14).

TMA does not have policy that supports the requirement that all physicians licensed and engaged in the active practice of medicine in Texas must pass the Texas Medical Jurisprudence Exam. Such policy would facilitate TMA’s lobbying efforts in opposition to legislative bills that seek exemptions for certain licensed physicians.

Recommendation: The committee recommends the following be adopted as new Texas Medical Association policy:

Passage of Texas Medical Jurisprudence Exam by All Texas Licensed Physicians

TMA supports the requirement that all physicians licensed to practice medicine in Texas must successfully pass the Texas Medical Jurisprudence Exam in order to be aware of state laws and administrative rules of the Texas Medical Board related to the practice of medicine, for the protection of the public and the practicing physician.

TMA reaffirms its opposition to lower licensing standards for physicians and other health care professionals practicing in physician shortage and medically underserved areas of the state.
Subject: Sunset Policy Review

Presented by: Evan Pivalizza, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the committee with recommendations for retention, amendment, and deletion.

The committee recommends retention of the following policy:


Recommendation 1: Retain.

The committee recommends amending the following policy. These updates are based on recommendations provided by a number of rural practice experts, including members and staff of TMA’s Committee on Rural Health.

185.019 Rural Physician Workforce Policy: The Texas Medical Association (TMA) recognizes the following recommendations for improving physician supply in rural Texas:

Practice Incentive/Benefit and Other Recruitment Programs
1. Federal and state rural practice incentive/benefit programs such as loan repayment, rural training track grants, Family Medicine Residency Training Program, and the Statewide Primary Care Preceptorship Program should be sufficiently funded to be successful in recruiting and retaining physicians in rural, underserved communities.

2. Physicians, medical students, residents, and premed students should have easy access to information about rural practice incentive programs. Further, the programs should be widely publicized by state authorities, TMA, Texas Osteopathic Medical Association (TOMA), and application forms readily accessible and user-friendly.

3. Area health education centers need to be adequately funded through federal and state funding sources to: (a) provide recruitment and retention services in rural areas; (b) assist in locating reasonable housing for student and resident preceptorships; and (c) provide practice support services to physicians providers and communities, as referenced in other principles listed herein.
4. Incentives should be developed by state authorities to encourage physicians to add a secondary, part-time practice in rural, underserved communities located within a reasonable distance of their primary practice site. Physicians are encouraged to consider hiring and supervising mid-level practitioners, as appropriate, to augment their secondary practices.

5. Physicians are urged to adopt provide telemedicine services in their practices as outreach to patients in underserved to increase access to health care within their communities when applicable and purposeful in meeting health care needs suited to their practice and needs of their patients.

6. Efforts are needed to ensure adequate specialty referral networks are available for rural physicians with limited access to specialists in their immediate communities. This includes specialty services using telemedicine and specialty outreach programs offered by academic health centers such as Project ECHO and the Children’s Psychiatric Access Network.

7. Physicians should be informed of the potential impact of the employed-practice model on their scope of practice and should seek professional advice before signing hospital employment contracts, including resources provided by TMA, and TOMA professional medical specialty societies.

Promoting Rural Practice

8. Information on rural physician shortage areas should be readily available through coordinated websites of state agencies such as Texas Health and Human Services Commission, Texas Department of State Health Services, Texas Medical Board, area health education centers, and Texas State Office of Rural Health Department of Rural Affairs, to practicing physicians, medical students, and residents seeking rural practice opportunities, as well as to underserved communities.

To assist physicians in selecting practice opportunities, comprehensive community profiles should be compiled to identify characteristics and statistics such as: population demographics (percentage child-bearing [for obstetrical needs], aged [for adult medicine-needs], etc.); insurance status; supply of physicians and other health professionals; degree of physician shortage; socioeconomic status; as well as educational and recreational opportunities.

9. Physicians who locate to rural areas, as well as medical students and residents interested in locating to rural areas, should be informed by state and/or local authorities of benefits and incentives available to strengthen the financial viability of their practice, including Medicare bonus payments, recruitment assistance, publicly funded locum tenens programs, etc. Further, they should be informed of the health information technology and health care infrastructure in their area, including systems of care such as federally qualified health centers, indigent care clinics, rural health clinics, hospitals (including critical access hospitals), long-term care facilities, emergency medical services, and hospice. They also should be informed about the availability of other health providers professionals and services such as nursing, pharmacies, therapists, and medical equipment.
109. Physicians should be informed by state authorities, including Texas Medical Board, of the unique peer review services offered by Knowledge, Skills, Training, Assessment, and Research (KSTAR) Program at Texas A&M University Health Science Center for rural hospitals and physicians.

110. County medical societies, hospitals, and other health facilities (when available) should facilitate communication between new physicians and physicians with established practices in the community to help new physicians be better prepared for entering practice in an underserved community.

124. Physicians who receive benefits through state loan repayment programs also should be informed by state authorities of specialized practice support services, including practice start-up, billing, locum tenens, professional development and CME, staff recruitment and training, telemedicine, and so on.

132. Physician practice reentry programs should be widely publicized and monitored to assess their ability to meet demands by state authorities, TMA, and TOMA. Further, when licensed physicians allow their Texas medical license to lapse, they should be informed by Texas Medical Board (TMB) of the potential obstacles to relicensure should they decide to reenter practice following an extended absence from practice.

143. Outreach should be provided by state authorities to physicians without a full-time medical practice to promote volunteer work or part-time practice at clinics in underserved communities.

154. Federal and state policies that impact rural medicine, e.g., payment policies, and the economic viability of rural hospitals, should be monitored by Texas State Office of Rural Health, Department of Rural Affairs for their potential impact on the viability of rural practices. TMA, TOMA, and state medical specialty societies should continue to advocate for reimbursement parity between Medicaid and Medicare beyond the two-year period authorized by the Patient Protection and Affordable Care Act. In addition, TMA opposes reimbursement policies that discount professional services to be delivered in rural communities discourage rural practice and should be addressed.

165. Physicians in practice and those in training programs should be informed by TMB, TMA, TOMA, state medical specialty societies and other state authorities of special state medical licensing provisions applicable for practice in rural, underserved areas, including expedited licensing.

Preparing Physicians for Rural Practice

176. Medical schools and residency programs should be incentivized by state authorities to develop and adequately support rural education and training tracks. Examples include bonuses for medical students or residents who participate in rural training tracks, and additional state formula funding for medical students and residents in rural training tracks.

187. Appropriate screening criteria should be used by medical schools for identifying student-applicants and residents most likely to be successful in rural practice.
198. To measure outcomes, assessments should be conducted to identify whether students and residents who participate in rural educational or training tracks are retained in the state for practice after completion of training.

2049. Area health education centers should offer opportunities for community physicians who volunteer as preceptors to access information and knowledge of practices that contribute to a positive clinical learning experience. Further, educational institutions should provide adequate support and incentives to recruit and retain physician preceptors, including appropriate levels of recognition and benefits for their teaching efforts. This will become increasingly important as community physicians face continuing pressures to increase productivity.

210. Medicare GME policies should allow for residency program-specific support rather than institutional support for resident training to allow GME funding to follow the resident throughout their training.

221. Primary Care Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education, and Primary Care Residency Review Committees of the American Osteopathic Association, should consider allowing more flexibility for residents to travel away from their core programs to rural areas in order to achieve established training goals for minimum numbers of procedures or encounters.

232. The impact of changes in resident work duty-hour restrictions should be monitored for the impact on rural training programs and health care delivery in comparison to institution-based residency programs.

24. To help rural physicians successfully participate in value-based payment initiatives implemented by Medicaid, Medicare, or commercial payers, TMA, state medical specialty societies, and the Texas A&M University Rural and Community Health Institute should collaborate to address unique challenges faced by rural practices seeking to participate in these initiatives, including insufficient staffing, training, and health information infrastructure; quality and health performance measurement with small populations, and lack of local social and community resources.

Rural Access to Care

253. TMA and TOMA should continue to advocate for a single standard of care for all Texans in all areas of the state.

264. Discussions are needed to develop solutions, including promotion of the use of telemedicine for providing after-hours care for patients of federally funded health clinics requiring urgent or emergent care to prevent undue burdens on community physicians and rural hospital emergency departments.

275. Periodic research should be conducted by the Texas Health Professions Resource Center at Texas Department of State Health Services to monitor significant changes in rural physician workforce trends, including physician demographics and practice characteristics. (CM-PDHCA Rep. 1-A-11).

**Recommendation 2:** Retain as amended.
REPORT OF COMMITTEE ON PHYSICIAN DISTRIBUTION AND HEALTH CARE ACCESS

CM-PDHCA Report 3 2021

Subject: 2021 Texas Physician Workforce Update

Presented by: Evan Pivalizza, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

This report is submitted for 2021 by the committee in response to TMA Policy 185.001 Physician Workforce Texas, which calls for periodic updates on distribution trends for the state’s physician workforce. The committee is also offering policy recommendations related to the effects of the COVID-19 pandemic with the goal of being better prepared for the next catastrophic event.

Committee Findings on Physician Workforce Trends
The committee assembled the most recent information available on physicians practicing in the state along with the latest data available for the three pipelines into the profession: medical school enrollments, residents in training, and those obtaining their first Texas medical license. Most trends were exceedingly positive, however, Texas continues to run a general deficit of physicians, both at the state level and in many areas of the state.

Findings

Highest number in state’s history for:
- *State population.* (29 million. No. 1 in the U.S. for numerical growth from 2018 to 2019; gain of 370,000 persons. Percentage increase of 1.3% was more than 2x national growth rate of 0.5%)
- *Older Texans.* (3.7 million people aged 65+)
- *Physicians providing patient care.* (56,765)
- *Number of Texas medical license applications.* (6,288)
- *Residents in training.* (7,953) Also, see TMA Council on Medical Education’s Report 4 Status of Graduate Medical Education Capacity in Texas in Informational Reports of the Handbook.
- *Medical students.* (8,029)
- *Medical schools.* (15)

Highest proportion in the state’s history for:
- *Women in medicine.* (34.6%)
- *Women enrolled in Texas medical schools – more than 50% of total medical school enrollment, for the first time in the state’s history (50.3%). Enrollments by women grew 3x faster than male enrollments over past decade.*

Other Findings:
- Texas ranks 12th in a state listing by percentage of international medical graduates, with 26%. That percentage is higher than California’s.
- For newly licensed Texas physicians in 2020, the largest number of graduates from outside of Texas were graduates of Caribbean medical schools (294); more than the number from any state outside Texas.
- For physicians in direct patient care in Texas, there were more graduates from two Caribbean medical schools, Ross University in Barbados (561) and St. George’s University in Grenada (511), than from any state outside Texas.
• Women in medicine were 1.4x more likely to be Hispanic, Black/African American, or Asian than men (in terms of proportions for each race/ethnic group).
• Men in medicine are far more likely to practice in anesthesiology and more likely to practice in emergency medicine than women (in terms of proportions by specialty). Women are far more likely to practice in obstetrics/gynecology and more likely to practice in pediatrics.
• Men in medicine were 1.7x more likely to practice in rural areas and 1.6x more likely to practice in border areas of the state than women.
• For the five metropolitan areas with more than 1 million in population, Austin leads in both the ratio of physicians in direct patient care (all specialties) per 100,000 population and for primary care physicians per capita. The other four metro areas in order by ratio of direct patient care physicians per capita are: Dallas, Houston, San Antonio, and Fort Worth.

Positive Trends
• Texas has successfully recruited new physicians to the state at ever-increasing numbers.
• Number of physicians (all specialties) is growing at a faster rate than population (2.2x faster).
• Primary care physicians are also growing at a faster rate than population (1.7x faster).
• State’s ratio of physicians per capita consistently improved each year for the past decade.
• Exceptional record of retaining medical students and residents for practice (ranking 3rd in the nation).
• Set a new record for medical license applicants in 2020, breaking 6,000 for the first time.
• Licensed the second-largest number of new physicians in 2020. That is only seven – or 1% – less than the state’s historic peak in 2019.

Challenges: COVID-19
• National pandemic placed pressures on the Texas physician workforce at unprecedented levels.
• State policies in response to surges in COVID-19 hospitalizations had a destabilizing effect on some physician practices and physician employment.

Challenges: Physician Supply and Distribution
• Texas has 8.8% of the U.S. population but 7.1% of U.S. active physicians.
• State rankings of physicians per capita remain in the lowest national quintiles:
  o 41st in the U.S. for ratio of patient care physicians per 100,000 population.
  o 47th for ratio of primary care physicians in patient care per 100,000 population.
  o 48th for ratio of general surgeons in patient care per 100,000 population.
• Texas continues to have a geographic and specialty maldistribution of physicians.

Goals for Meeting Future Physician Workforce Needs:
• Increasing the number of physicians educated and/or trained in the state that are retained or recruited back to practice in the state.
• Continuing to recruit and retain large numbers of physicians from other states.
• Improving equity in access to care for Texans living in areas with physician shortages and other access barriers.
• Continuing to monitor the effects of the COVID-19 pandemic on the state’s physician workforce, and when the timing is right, conducting post-pandemic assessments of public policies and other market forces that strongly impacted physician practice. (See page 16.)
• Continuing to monitor the progress in meeting the state’s physician needs, including the pipelines for preparing physicians for practice.
• TMA will advocate during the 2021 Texas legislative session for state support of key programs that help to build and sustain the state’s physician workforce, including: Physician Education Loan Repayment Program, State Graduate Medical Education Expansion Grant Program, Medical
FINDING: Texas reached another historic peak in the number of physicians who applied for a Texas medical license. Annual number of applications exceeded 6,000 for the first time. The number has more than doubled since the passage of the 2003 state tort reform laws.

Newly Licensed Physicians in 2020
About 6,300 medical license applications were received by the Texas Medical Board in the state fiscal year that ended Aug. 31, 2020 (Figure 1). This marks the first time the number of applicants exceeded 6,000. Applications increased 2.5x since tort reform laws were passed in 2003. The number has exceeded 5,000 since 2014.

The Texas Medical Board issued 4,862 new licenses in fiscal year 2020, just shy (-7, -1%) of the highest number in the state’s history of 4,869, which was reached last year (Figure 2). For context, 14 U.S. states have fewer physicians than the number of newly licensed for Texas.
Texas has steadily attracted physicians to the state at a much higher rate since the adoption of state tort reform laws in 2003. In the 17 years preceding tort reform, Texas averaged 2,095 newly licensed physicians each year. In the 17 years post tort reform, the average was 1.8x greater, at 3,715 newly licensed physicians each year. A cumulative annual total of more than 63,000 new physician licenses have been issued in Texas since 2003.

Three out of 4 of the newly licensed physicians in the past year were graduates of medical schools outside of Texas, with 51% who graduated in other U.S. states or Canada and 25% in other countries (Figure 3).

FINDING: For newly licensed Texas physicians in 2020, the largest number of graduates from outside of Texas were graduates of Caribbean medical schools (294); more than the number from any state outside Texas.

When the committee looked at the medical school of graduation for newly licensed Texas physicians in fiscal year 2020, the highest number from schools outside of Texas were graduates of Caribbean medical schools (294) (Figure 4). The second-largest number were graduates of medical schools in India (232), followed by New York (222). Graduates from three The University of Texas medical schools ranked among the schools with the largest number: McGovern Medical School at UTHouston, The University of Texas Medical Branch School of Medicine at Galveston, and the UT Health San Antonio Long School of Medicine. Outside of Texas, the following states had large numbers of medical school graduates among the newly licensed: Illinois, Pennsylvania, Florida, and Missouri.

Medical schools in Pakistan also ranked among the top number of graduates. When graduates from India (232) are combined with those from Pakistan (130), the sum of 362 exceeds the sum of graduates from Caribbean schools (294) and ranks India and Pakistan together with having the highest number of graduates among newly licensed physicians from schools outside of Texas.
FINDING: For physicians in direct patient care in Texas, there were more graduates from two Caribbean medical schools, Ross University in Barbados (561) and St. George’s University in Grenada (511), than from any state outside Texas.

Medical School of Graduation for Total Texas Physician Workforce
When looking at the medical school of graduation for the total Texas physician workforce, it is surprising that two Caribbean medical schools – Ross and St. George’s – had more graduates in the Texas physician workforce than ANY state outside of Texas. In addition, two other foreign medical schools, Dow in Pakistan and Universidad Autónoma de Guadalajara in Mexico, ranked in the top 15 (Table 1).
The relatively large number of Texas physicians who graduated from the four non-U.S. medical schools listed in the table is a new trend. No non-U.S. medical schools were ranked in the top 15 for Texas physicians a decade ago.

**FINDING:** Even with Texas leading the nation in population growth for decades, the physician workforce is growing at a faster rate.

Texas has been leading in population growth in the U.S. for decades. The latest U.S. Census Bureau population estimates demonstrate the strength of recent growth in many metropolitan areas, from 2010 to 2019:

- Six of the 10 counties with the largest population gains this decade in the U.S. were in Texas: Harris, Tarrant, Bexar, Dallas, Collin, and Travis.
- Texas also had the most counties of any state in the top 10 fastest growing since 2010, including Hays, Comal, Kendall, and Williamson.

**Table 1: Top 15 Medical Schools for 2019 Texas Licensed Physicians**

<table>
<thead>
<tr>
<th>Medical School Ranking (By # Graduates Among 2019 Texas Physicians)</th>
<th>Medical School of Graduation</th>
<th># Graduates Among 2019 Texas Physicians</th>
<th>% Graduates Among 2019 Texas Physicians</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Univ. of Texas Medical Branch, Galveston</td>
<td>4,263</td>
<td>7.7%</td>
</tr>
<tr>
<td>2.</td>
<td>Univ. of Texas Southwestern Medical Center, Dallas</td>
<td>3,700</td>
<td>6.7%</td>
</tr>
<tr>
<td>3.</td>
<td>Univ. of Texas Medical School at San Antonio</td>
<td>3,528</td>
<td>6.4%</td>
</tr>
<tr>
<td>4.</td>
<td>Univ. of Texas Medical School at Houston</td>
<td>3,407</td>
<td>6.2%</td>
</tr>
<tr>
<td>5.</td>
<td>Baylor College of Medicine, Houston</td>
<td>2,423</td>
<td>4.4%</td>
</tr>
<tr>
<td>6.</td>
<td>University of North Texas Health Science Center, Texas College of Osteopathic Medicine, Fort Worth</td>
<td>2,178</td>
<td>3.9%</td>
</tr>
<tr>
<td>7.</td>
<td>Texas Tech University Health Sciences Center, Lubbock</td>
<td>2,050</td>
<td>3.7%</td>
</tr>
<tr>
<td>8.</td>
<td>Texas A&amp;M University Health Science Center, College Station</td>
<td>1,154</td>
<td>2.1%</td>
</tr>
<tr>
<td>9.</td>
<td>Ross Univ. School of Medicine, Barbados</td>
<td>561</td>
<td>1.0%</td>
</tr>
<tr>
<td>10.</td>
<td>St George's University School of Med, Grenada</td>
<td>511</td>
<td>0.9%</td>
</tr>
<tr>
<td>11.</td>
<td>University of Oklahoma College of Medicine, Oklahoma City, OK</td>
<td>494</td>
<td>0.9%</td>
</tr>
<tr>
<td>12.</td>
<td>Louisiana St. University School of Medicine, New Orleans, LA</td>
<td>491</td>
<td>0.9%</td>
</tr>
<tr>
<td>13.</td>
<td>Dow Med College, Dow University of Health Science, Karachi, Pakistan</td>
<td>487</td>
<td>0.9%</td>
</tr>
<tr>
<td>14.</td>
<td>Universidad Autonoma de Guadalajara, Mexico</td>
<td>444</td>
<td>0.8%</td>
</tr>
<tr>
<td>15.</td>
<td>Tulane University School of Medicine, New Orleans, LA</td>
<td>400</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

*Source: Texas Medical Board physician licensing file provided by Health Professionals Resource Center and analyzed by TMA. Prepared by: TMA.*
For metropolitan areas, Dallas-Fort Worth-Arlington had the largest numeric gain since 2010, with an increase of 1,206,599 (19%).

Three of the top 10 metro areas in the U.S. with the largest gains in population between 2010 and 2019 were in Texas: Dallas-Fort Worth-Arlington (noted on previous page); Houston-The Woodlands-Sugar Land (up 19.4%), and Austin-Round Rock-Georgetown (up 29.8%).

Texas was No. 1 in the U.S. for numerical growth from 2018 to 2019, with a gain of 370,000 in population. The percentage increase of 1.3% was more than 2x the national growth rate of 0.5%.

About 80,000 physicians have a current Texas medical license, and of this number, 56,765 report a practice in direct patient care in the state. Physician supply has been growing at a steady rate for decades, and over the past 10 years, the yearly growth ranged from 1% to 3%. As a positive indicator of the potential for improved access to care for Texans, the ratio of physicians per capita grew each year of the past decade (Figure 5), starting at 165 in 2011 and rising to 191.3 in 2020, for an increase of 15.9%.

Figure 5: Texas Ratio of Patient Care Physicians per 100,000 Population, 2011 to 2020

The committee wanted to measure the extent to which the gains in physician supply were exceeding population increases. Looking back over the past decade, physicians (all specialties) grew at 2.2x the rate as population and primary care physicians increased 1.7x faster than population (Figure 6).

Figure 6: Texas Physician Supply Growing Faster Than Population
Comparison of % Change for Population and Physician Supply
2011 to 2020

<table>
<thead>
<tr>
<th></th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Population</td>
<td>14.7%</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>25.6%</td>
</tr>
<tr>
<td>Patient Care Physician</td>
<td>32.9%</td>
</tr>
</tbody>
</table>

Source: Health Professions Resource Center; Texas Dept. State Health Services
Prepared by: TMA
To compare recent physician growth with previous years, the committee calculated the rate of change for the ratio of physicians per capita for the past three decades. The most recent decade, 2010 to 2019, had the fastest rate of growth (Table 2) over 30 years, with 13x more than 2000-2009, and 1.3x more than 1990-1999.

Table 2: Changes in Texas Ratio of Physicians per 100,000 People for Three Decades: 1990 to 1999; 2000 to 2009; and 2010 to 2019

<table>
<thead>
<tr>
<th>Decade</th>
<th>Ratio of Patient Care Physicians Per 100,000 People for Texas</th>
<th>Net Difference in Ratio</th>
<th>Rate of Change for Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990 to 1999</td>
<td>1990: 133.7, 1999: 151.8</td>
<td>18.1</td>
<td>13.5%</td>
</tr>
<tr>
<td>2000 to 2009</td>
<td>2000: 156.2, 2009: 158.3</td>
<td>2.1</td>
<td>1.3%</td>
</tr>
<tr>
<td>2010 to 2019</td>
<td>2010: 162, 2019: 189.6</td>
<td>27.6</td>
<td>17%</td>
</tr>
</tbody>
</table>

Although the committee identified numerous positive trends for the state’s physician workforce, it was also clear that serious challenges remain. Much of the state continues to experience geographic and specialty maldistribution, as demonstrated by the following examples:

- 28 (11%) of the state’s 254 counties do not have a physician;
- 138 (54%) do not have a pediatrician;
- 150 (59%) are without an obstetrician/gynecologist;
- 173 counties (68%) do not have a psychiatrist; and
- 131 (51.6%) counties do not have a general surgeon.

In addition to efforts to expand the state’s physician supply in shortage areas, the committee continues to search for innovative programs to increase access to care for physicians already practicing in medically underserved areas.

Impact of Pandemic on Texas Physicians

Beginning in March 2020, the COVID-19 pandemic impacted Texas physicians in myriad of ways. Nearly all physicians in active medical practice were affected, regardless of medical specialty, practice setting, or practice type. Texas has likely not seen this degree of disruption in physician medical practices since World War II.

The demand for physicians to treat COVID-19 varied between specialties (Table 3) with decreased primary care visits. Trends remained erratic with sporadic suspensions of elective surgeries and medical
procedures causing disruptions to practice and patient access to care. Some physicians lost their jobs, although the specific number is not known, while others saw pay cuts or furloughs. TMA’s COVID-19 Impact Survey in May 2020 found that 63% of physicians had salaries reduced by 50% or more. A little more than 2 out of 3 Texas physicians (68%) reported a reduction in work hours. There were anecdotal reports of older physicians who changed their practice setting or opted to retire rather than continue practicing in high-risk settings. Economic pressures may continue to challenge the viability of physician practices and health care facilities in the coming months. Also, the full effects of the pandemic on medical practices and the health care delivery system are not known. The committee supports a post-pandemic state study to assess how the state’s physician facility staffing needs were met during the peaks in demand during the pandemic.

<table>
<thead>
<tr>
<th>Geographic Distribution of Selected High-Demand Medical Specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>206 (81%) counties do not have a specialist in critical care medicine.</td>
</tr>
<tr>
<td>204 (80%) counties do not have a pulmonary disease specialist.</td>
</tr>
<tr>
<td>176 (69%) counties do not have an anesthesiologist.</td>
</tr>
<tr>
<td>110 (43%) counties do not have an emergency medicine physician.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 3: Numbers of Physicians in Medical Specialties in High Demand During COVID-19 Pandemic</th>
</tr>
</thead>
<tbody>
<tr>
<td>-Critical Care and Intensivist Medicine-</td>
</tr>
<tr>
<td>Critical Care Medicine TOTAL</td>
</tr>
<tr>
<td>Of which, 63 are pediatric specialists</td>
</tr>
<tr>
<td>539</td>
</tr>
<tr>
<td>-Other Specialties-</td>
</tr>
<tr>
<td>Anesthesiology</td>
</tr>
<tr>
<td>3,494</td>
</tr>
<tr>
<td>Blood Banking/Transfusion Med</td>
</tr>
<tr>
<td>7</td>
</tr>
<tr>
<td>Cardiovascular Diseases</td>
</tr>
<tr>
<td>1,854</td>
</tr>
<tr>
<td>Emergency Medicine</td>
</tr>
<tr>
<td>Of which, 118 are pediatric specialists</td>
</tr>
<tr>
<td>4,222</td>
</tr>
<tr>
<td>Hospitalists</td>
</tr>
<tr>
<td>486</td>
</tr>
<tr>
<td>Infectious Diseases</td>
</tr>
<tr>
<td>Of which, 23 are pediatric specialists</td>
</tr>
<tr>
<td>327</td>
</tr>
<tr>
<td>Palliative Medicine</td>
</tr>
<tr>
<td>89</td>
</tr>
<tr>
<td>Pathology</td>
</tr>
<tr>
<td>1,122</td>
</tr>
<tr>
<td>Pulmonary Diseases</td>
</tr>
<tr>
<td>Of which, 39 are pediatric specialists</td>
</tr>
<tr>
<td>367</td>
</tr>
<tr>
<td>Radiology</td>
</tr>
<tr>
<td>2,360</td>
</tr>
</tbody>
</table>

Source: Texas Medical Board physician licensing file provided by Health Professions Resource Center, DSFS, and analyzed by TMA. Prepared by: TMA
**Analysis of Physician Distribution by Gender**

**FINDING:** Women make up 50.3% of Texans, but only 34.6% of Texas physicians. The percentage of women in medicine in Texas tripled from 1987 to 2019.

TMA has multiple policies in support of greater diversity within the physician workforce. The representation of women in Texas medicine has grown every year, in a stair-step pattern since TMA began collecting these data in 1987 (data are not available for some years, as noted in Figure 7). The percentage of women in medicine has **tripled** since then. Women now represent 1 out of 3 Texas physicians.

**Figure 7: Growth of Women in Texas Medicine, 1987 to 2019**

![Graph showing the percentage of women in medicine from 1987 to 2019.]

*Source: Health Professions Resource Center, Texas Dept. of State Health Services Prepared by: TMA.*

**FINDING:** For the first time in the state’s history, there are now more women enrolled in Texas medical schools than men.

The steady uptick of women in medicine is expected to continue based on the percentage of women enrolled in Texas medical schools (52.8%) and the percentage of women among the state’s newly licensed physicians (45%). Women make up a little more than half of the **first-year medical students** (52.8%) in 2019—the highest percentage ever for Texas (Figure 8).

**Figure 8: Texas % Female First-Year Medical School Enrollments, 2000 to 2019**

![Graph showing the percentage of female first-year medical school enrollments from 2000 to 2019.]

*Sources: Texas Higher Education Coordinating Bd., Univ. of the Incarnate Word, and TCU and UNTHSC Medical School. Prepared by: TMA.*
For the first time ever, the majority of total enrollments at Texas medical schools are women (50.8%) (Figure 9). More women applied to Texas medical schools (51%) in 2019 than men and more women enrolled.

Figure 9: % Women Among Total Texas Medical School Enrollments, 2010-2019

Proportion of women among the total Texas medical school enrollments increased 3x times faster than for men over the past decade. The percentage of men declined from 54.5% in 2010 to 49.2% in 2019.

Three Texas schools had the highest percentages of women among the 2019 entering class, including two of the newest schools. The University of Texas at Austin Dell Medical School had the highest percentage in the state, at 64.7% (33 women; 18 men). University of the Incarnate Word School of Osteopathic Medicine in San Antonio followed at 61.4% (102 women; 64 men). And Texas Tech University Health Sciences Center School of Medicine in Lubbock had 57.9% (103 women; 75 men).

Profiles of Texas Physicians

Demographic and practice characteristics for Texas physicians are shown in Tables 4 and 5 below.

Table 4: Demographic and Practice Profile of Texas Physicians, 2019

| Gender: Male: 36,145 (65.4%) Female: 19,166 (34.6%) |
| Average Age: 51 |
| Race/Ethnicity: White 32,086 (58%) Hispanic 4,207 (7.6%) Black/African American 3,380 (6.1%) Other (Including Asian) 15,658 (28.3%) |
| Number and percentage with DO Degree: 4,803 (8.7%) |
| % International Medical Graduates (IMGs): 27% |
| Countries with Highest Number of Graduates for IMGs: India and Pakistan Combined: 5,273 (9.5%) |
| % Who Practice in Metro Area: 95% |
Top 10 Medical Specialties:

1. Family Medicine/General Practice (8,116, 14.7%)
2. Internal Medicine (6,968, 12.6%)
3. Pediatrics (4,303, 7.8%)
4. Emergency Medicine (3,966, 7.2%)
5. Anesthesiology (3,401, 6.1%)
6. Obstetrics/Gynecology (2,697, 4.9%)
7. Psychiatry (2,187, 4%)
8. Radiology (2,063, 3.7%)
9. Orthopedic Surgery (1,452, 2.6%)
10. General Surgery (1,383, 2.5%)

Table 5: Comparison of Demographic and Practice Characteristics for Texas Physicians, by Gender

<table>
<thead>
<tr>
<th></th>
<th>MEN</th>
<th>WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>53.3</td>
<td>46.6</td>
</tr>
<tr>
<td>Years of age</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>1.3x more likely to be Anglo</td>
<td>1.4x more likely to be Hispanic, Black/African American, or Asian</td>
</tr>
<tr>
<td>Practice Location</td>
<td>1.7x more likely to practice in a rural area and 1.6x more likely to practice in a border area</td>
<td>Less likely to practice in rural or border areas</td>
</tr>
</tbody>
</table>

MEN                       WOMEN
1. Family Medicine          1. Family Medicine
2. Internal Medicine        2. Pediatrics
3. Emergency Medicine       3. Internal Medicine
4. Anesthesiology           4. Obstetrics/Gynecology
5. Pediatrics               5. Emergency Medicine

Men are FAR more likely to specialize in anesthesiology than women, and more likely to practice in emergency medicine. Women are FAR more likely to practice in obstetrics/gynecology than men, and more likely to practice in pediatrics.

FINDING: Austin continues to have the best ratio of physicians per capita of the state’s five largest metropolitan areas.

In a comparison of physician distribution for the state’s five largest metropolitan areas (with population above 1 million), the Austin Metro Area has the smallest population but the best ratio of physicians per capita, both for total specialties as well as for primary care specialties. The Dallas Metro Area follows Austin in the rankings, then Houston, San Antonio, and Fort Worth, as shown in Table 6 and Figure 10. There was one exception: The Fort Worth Metro Area had a slightly better ratio of primary care physicians per capita than San Antonio.
Table 6: Ratios of Patient Care and Primary Care Physicians per 100,000 Population for Texas Counties With Population Above One Million, 2019

<table>
<thead>
<tr>
<th>Metro Area with Population Above One Million</th>
<th>Population</th>
<th>No. Patient Care Phys. (All Specialties)</th>
<th>Ratio Patient Care Physicians per 100,000 Pop. (Texas County Ranking)</th>
<th>No. Primary Care Patient Care Physicians</th>
<th>Ratio Primary Care Physicians per 100,000 Pop. (Texas County Ranking)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin Metro Area (5 Counties) Bastrop, Caldwell, Hays, Travis, and Williamson Counties</td>
<td>2.2M</td>
<td>4,954</td>
<td>226.2 (#21)</td>
<td>1,942</td>
<td>88.7 (#30)</td>
</tr>
<tr>
<td>Dallas Metro Area (7 Counties) Collin, Dallas, Denton, Ellis, Hunt, Kaufman, and Rockwall Counties</td>
<td>5.1M</td>
<td>11,048</td>
<td>217.9 (#25)</td>
<td>4,182</td>
<td>82.5 (#44)</td>
</tr>
<tr>
<td>Houston Metro Area (9 Counties) Austin, Brazoria, Chambers, Ft. Bend, Galveston, Harris, Liberty, Montgomery, and Waller Counties</td>
<td>7.2M</td>
<td>15,188</td>
<td>210.4 (#28)</td>
<td>5,863</td>
<td>81.2 (#45)</td>
</tr>
<tr>
<td>San Antonio Metro Area (8 Counties) Atascosa, Bandera, Bexar Comal, Guadalupe, Kendall, Medina, and Wilson Counties</td>
<td>2.6M</td>
<td>5,190</td>
<td>201.2 (#30)</td>
<td>1,982</td>
<td>76.8 (#52)</td>
</tr>
<tr>
<td>Fort Worth Metro Area (6 Counties) Hood, Johnson, Parker, Somervell, Tarrant, and Wise Counties</td>
<td>2.5M</td>
<td>4,850</td>
<td>191 (#32)</td>
<td>1,980</td>
<td>77.8 (#50)</td>
</tr>
</tbody>
</table>

Sources: Texas Health Professions Resource Center, Texas Dept. of State Health Services, and U.S. Census Bureau. Prepared by: TMA.

Figure 10: Geographic Comparison of Physician Distribution for Most Populous Texas Counties, >1 Million

Sources: Texas Health Professions Resource Center, Texas Dept. of State Health Services, and U.S. Census Bureau. Prepared by: TMA.
To monitor how Texas compares with other states, the committee monitors the state rankings produced by the Association of American Medical Colleges (AAMC) on a biennial basis. Texas rankings for several key indicators on medical education and the physician workforce for 2019 are shown in **Table 7**. Texas continued to rank among the highest in the U.S. for the retention of physicians following medical school and residency training. Texas ranked **No. 2** in retention of physicians from medical school, **No. 3** in retention of physicians from both medical school and residency training, and **No. 4** in retention from residency training.

### Table 7: Texas State Rankings for Medical Education and Physician Workforce Indicators, 2019

<table>
<thead>
<tr>
<th>Retention* of Physicians in Texas</th>
<th>State Ranking for Texas</th>
<th>Texas Physician Retention* Rate</th>
<th>U.S. Physician Retention Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>From:</strong> Medical School</td>
<td>Texas ranks <strong>No. 2</strong></td>
<td>Texas Rate: 59.7%</td>
<td>U.S. Rate: 38.2%</td>
</tr>
<tr>
<td></td>
<td>(California ranked #1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>From:</strong> Residency Training</td>
<td><strong>No. 4</strong></td>
<td>Texas Rate: 58.5%</td>
<td>U.S. Rate: 47.1%</td>
</tr>
<tr>
<td></td>
<td>(California, Alaska, and Montana rank above Texas)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>From:</strong> Both Medical School and Residency Training</td>
<td><strong>No. 3</strong></td>
<td>Texas Rate: 81%</td>
<td>U.S. Rate: 67.3%</td>
</tr>
<tr>
<td></td>
<td>(Hawaii and California rank above Texas)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Ratios of Active Patient Care Physicians by Specialty Groupings per 100,000 Population

<table>
<thead>
<tr>
<th>Doctors (All Specialties)</th>
<th>State Ranking for Texas</th>
<th>Texas Ratio per 100,000 Population</th>
<th>U.S. Ratio per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physicians</strong></td>
<td>No. 41**</td>
<td>199.9</td>
<td>242.1</td>
</tr>
<tr>
<td><strong>Primary Care Physicians</strong></td>
<td>No. 47</td>
<td>66.5</td>
<td>83.2</td>
</tr>
<tr>
<td><strong>General Surgeons</strong></td>
<td>No. 48</td>
<td>5.4</td>
<td>6.6</td>
</tr>
</tbody>
</table>

### Ratios per 100,000 Population

<table>
<thead>
<tr>
<th>Doctors</th>
<th>State Ranking for Texas</th>
<th>Texas Ratio per 100,000 Population</th>
<th>U.S. Ratio per 100,000 Population</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical Students</strong></td>
<td>No. 37</td>
<td>28.3</td>
<td>36.8</td>
</tr>
<tr>
<td><strong>Residents and Fellows</strong></td>
<td>No. 25</td>
<td>29.9</td>
<td>41.0</td>
</tr>
</tbody>
</table>

### Percentage

<table>
<thead>
<tr>
<th>Percentage</th>
<th>State Ranking for Texas</th>
<th>Texas %</th>
<th>U.S. %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Active Female Physicians</strong></td>
<td>No. 24</td>
<td>35.2%</td>
<td>35.8%</td>
</tr>
<tr>
<td><strong>Active IMG Physicians</strong></td>
<td>No. 12</td>
<td>25.9%</td>
<td>24.6%</td>
</tr>
</tbody>
</table>

*Rankings are based on an assessment by Association of American Medical Colleges of medical school and residency history for physicians who were practicing in Texas at one point in time – Dec. 31, 2018. These physicians may have relocated to Texas from other states before that date.

**Only a slight improvement from the ranking of #42 a decade ago.


Prepared by: Texas Medical Association.

Comparisons from 2017 to 2019:

There was no change in the state ranking for Texas between 2017 and 2019 for the majority of indicators. Other changes are highlighted below.

### Ratios of Physicians per 100,000 Population

Texas continued to rank **41st** for patient care physicians (all specialties); **47th** for patient care primary care physicians; and **48th** for patient care general surgeons. The ratios per capita increased for Texas and at the national level for patient care physicians and patient care primary care physicians. There was a slight decline in the ratio for patient care general surgeons for Texas and the U.S. as a whole.
Active Female Physicians

The percentage of active female physicians in the Texas workforce increased slightly between 2017 and 2019, from 33.9% to 35.2%. Despite the increase, Texas dropped in the state rankings from No. 23 to No. 24. This happened because the percentage for the state of Hawaii increased more rapidly than in Texas.

Active International Medical Graduates

Texas continued to rank No. 12 for the percentage of international medical graduates (IMGs) and to exceed the national total. The percentage for Texas increased from 25.7% in 2017 to 25.9% in 2019. Texas also has a higher percentage of IMGs than California’s.

Ratio of Medical Students and Residents per 100,000 Population

Texas moved down in the state ranking for ratio of medical students per 100,000 population, from No. 36 in 2017 to No. 37 in 2019. Georgia moved into the No. 36 slot. The ratio for Texas actually increased from 27.4 to 28.3 between the two years.

The biggest change for Texas among the state rankings included in this analysis was for residents per 100,000 population, with Texas dropping three spots from No. 22 to No. 25. The ratio actually increased for Texas from 28.7 to 29.9 between the two years. But the ratio increased more rapidly in Iowa, Kentucky, and Hawaii than Texas during this time period.

Texas ranked No. 2 in the percentage of physicians retained from medical school, the same ranking as in 2017. The Texas percentage actually declined slightly from 59.9% in 2017 to 59.7% in 2019. California remained No. 1 with 62.8%, the same ranking and percentage as 2017. Like Texas, the percentage for the U.S. as a whole saw a slight decline, from 38.5% to 38.2%.

Texas moved up a slot for the percentage of physicians retained from graduate medical education, from No. 5 to No. 4, by having a better percentage than Florida in 2019. California, Alaska, and Montana had better retention rates than Texas in both 2017 and 2019.

Texas also moved up a slot in the percentage of physicians retained from both medical school and residency training, from No. 4 to No. 3, by having a better percentage than Arkansas in 2019. Hawaii and California had a better retention rate than Texas in both 2017 and 2019.

TMA Action During 2021 Texas Legislative Session

During the 2021 Texas legislative session, TMA is advocating for state support of key programs that help to build and sustain the state’s physician workforce, including:

- State Physician Education Loan Repayment Program
- State Graduate Medical Education Expansion Grant Program
- State Medical Student and Graduate Medical Education Formula Funding
- Family Medicine Residency Program
- Statewide Primary Care Preceptorship Program
- Joint Admission Medical Program

A legislative one-pager has been prepared for this advocacy work and is accessible through this link: TMA 2021 Texas Legislative Session One-Pager on Physician Workforce Needs

Summary

TMA recognizes that good health is dependent on access to medical care. Many positive trends were identified in the committee’s analysis of the state’s physician workforce, as presented in this report that could be signs of improved access to medical care for Texans.

Many milestones were achieved and all pipelines into the physician workforce are at the highest levels in the state’s history. Record-high numbers of physicians are seeking medical licensure in the state and are
being educated and trained in the state. Physician shortages remain, however, as a result of geographic and specialty maldistributions.

The pandemic has had a deleterious impact on many physicians’ practices. Some physicians have worked abnormally long days – and under extremely high levels of stress – for extended periods of time during peak demands for hospital staffing. Physicians in other specialties had diminished patient numbers, and in some cases were periodically idled. Some lost their jobs or were furloughed. The full effects on physicians’ practices and the health care delivery system are not fully known.

**Policy Proposals**

The committee is offering two policy recommendations for the post-pandemic period. Both recommendations are related to the pandemic and are intended to help Texas be better prepared for future events. The following background information may be helpful to the House of Delegates in considering these policy proposals.

The committee is offering a recommendation that would involve the Texas Statewide Health Coordinating Council (SHCC). This body is a 17-member council staffed by the Texas Department of State Health Services and 13 of the 17 members are appointed by the governor. Two physicians are currently appointed to the council. In addition to the governor’s appointments, four members represent specific state agencies on the council, as defined in state law.

The SHCC makes recommendations on state health planning activities to the governor and the legislature through biennial updates to the Texas State Health Plan. The plan is due to the governor by Nov. 1 of even-numbered years. The committee’s first recommendation also suggests collaboration with schools of public health. Texas has several at various university systems that could potentially be invited to participate in this research activity.

**Recommendation:** The Committee on Physician Distribution and Health Care Access recommends the following be adopted as Texas Medical Association policy:

1) Recognizing that the COVID-19 pandemic resulted in unprecedented demands for physician staffing at Texas hospitals, TMA supports a post-pandemic research study by the Texas Statewide Health Coordinating Council at the Texas Department of State Health Services, in conjunction with the state’s schools of public health on the success of methods used to meet staffing needs. It is recommended that the study include identification of the most effective methods employed by individual hospital systems in the state and that the study be used to inform state emergency preparedness agencies in amending state emergency preparedness plans to better enable the state to respond to surges in hospital physician staffing needs during future extended catastrophic events.

2) TMA recommends an assessment by the Texas Medical Board of the emergency medical licensing provisions and their effectiveness in meeting the state’s emergency hospital physician staffing needs during the COVID-19 pandemic. The goal would be to determine if changes are needed in preparation for future extended catastrophic events.
Supplement

REPORT OF COMMITTEE ON PHYSICIAN DISTRIBUTION AND HEALTH CARE ACCESS
CM-PDHCA Report 4 2021

Subject: Renewed Effort to Increase Diversity Among the Texas Physician Workforce

Presented by: Evan Pivalizza, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

The Texas Medical Association has longstanding policy in support of increased diversity among the Texas physician workforce, including Policy 185.012, which originated with the committee in 1995 and was reaffirmed by the TMA House of Delegates in 2006 and 2016.

TMA Policy 185.012 Physician Recruitment: TMA supports expanded efforts by Texas medical schools to recruit and retain students and residents from underrepresented race/ethnic groups as well as underrepresented geographic areas of the state to enhance the diversity of the state’s physician workforce, affect geographic maldistribution, and reduce potential health disparities (Committee on Physician Distribution and Health Care Access, p 76, I-95; substitute CME Rep. 2-A-06; reaffirmed CME Rep. 2-A-16).

Despite this policy, there continues to be less diversity among Texas physicians than among the state’s population, as shown in Figure 1.

Figure 1: Comparison of Racial/Ethnic Diversity for Texas Physicians and Texas Population, 2019

To quantify the differences:

Proportion of Hispanic Texans is five times greater than the proportion of Hispanic physicians. And, for Black/African Americans, the proportion is two times greater among the Texas population than among Texas physicians.
Population Projections
The Texas Demographic Center projects Hispanic populations in Texas will have the highest growth rate from 2010 to 2030 as shown in the graph in the Attachment. Population projections for individual race/ethnic groups in 2030 are summarized in Table 1:

<table>
<thead>
<tr>
<th>Race/Ethnic Group</th>
<th>Projected Population in 2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>14.5 million</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>12.8 million</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>4.3 million</td>
</tr>
<tr>
<td>Non-Hispanic Asian</td>
<td>2.4 million</td>
</tr>
<tr>
<td>Non-Hispanic Other</td>
<td>0.9 million</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34.9 million</strong></td>
</tr>
</tbody>
</table>

Source: Texas Demographic Center. Prepared by: TMA.

Comparisons of Diversity Among Texas Population, Physicians, Medical Students, and Resident Physicians
When additional comparisons are made between physicians in training, including medical students and residents, and the state’s population, there continues to be less diversity among medical learners than among the Texas population.

As shown in Figure 1, among Hispanic Texans, there is a considerably lower proportion among physicians (7.6%) than among medical students (16.4%) and residents (13.8%). Representation of Hispanic Texans among medical students and among resident physicians is about twice that of Hispanic physicians. All these groups have a much lower percentage than that of Hispanics in the Texas population as a whole, at 39.8%.

There is little difference in the proportion of Black/African Americans among physicians, medical students, and resident physicians. Percentages range from 5.3% for medical students to 6.1% for physicians, and all three groups represent about half the proportion for the Texas population, at 12%.

Figure 1: Comparison of Racial/Ethnic Diversity for Texas Population, Physicians, Medical Students, and Residents in Training, 2019

Sources: Health Professions Resource Center, Texas Dept. of State Health Services, Texas Higher Education Coordinating Board, individual Texas medical schools, American Medical Association, and U.S. Census Bureau. Prepared by: TMA.
The low proportion of underrepresented minorities among medical students and residents in Texas means there are limited opportunities for recruitment within the state. Recruitment of underrepresented minority physicians to the Texas physician workforce must be focused primarily on physicians in other states.

Diversity Among Texas Medical School Enrollments

For the proportion of underrepresented minority students, The University of Texas Rio Grande Valley Medical School (UTRGV) leads the state for both Hispanic/Latino origin and Black/African-American students, as shown in Table 2.

- **Hispanic/Latino origin**
  UTRGV’s percentage of Hispanic/Latino origin students, at 37.3%, is close to equaling the percentage of Hispanic/Latino origin population for Texas (39.8%).

  In numbers of Hispanic/Latino students, UT Medical Branch led the state with 187 (19.7%), followed by the UT Health San Antonio Long School of Medicine with 171 (19.9%).

- **Black/African American**
  UTRGV’s percentage of Black or African American students is 10.8% (22 students). UTHealth McGovern Medical School in Houston had the highest number of students at 73 (7.5%), followed closely by UT Medical Branch at 67 (7.1%). In comparison, the proportion of Black Texans in the state overall is 12%. Once again, the percentage at UTRGV closely approximates the state’s population.

### Table 2: Proportion of Underrepresented Minorities Among Texas Medical School Enrollments, 2019, by Medical School

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Hispanic or Latino Origin</th>
<th>Black or African American</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>%</td>
</tr>
<tr>
<td>BAYLOR COLLEGE OF MEDICINE</td>
<td>91</td>
<td>11.9%</td>
</tr>
<tr>
<td>TAMUHSC-COLLEGE OF MEDICINE</td>
<td>67</td>
<td>11.2%</td>
</tr>
<tr>
<td>TEXAS COLLEGE OSTEOPATHIC MEDICINE</td>
<td>89</td>
<td>9.7%</td>
</tr>
<tr>
<td>TTHSC FOSTER SCHOOL OF MED EL PASO</td>
<td>120</td>
<td>29.8%</td>
</tr>
<tr>
<td>TTHSC SCHOOL OF MEDICINE LUBBOCK</td>
<td>97</td>
<td>13.3%</td>
</tr>
<tr>
<td>UNIVERSITY OF THE INCARNATE WORD</td>
<td>35</td>
<td>7.5%</td>
</tr>
<tr>
<td>UT AUSTIN DELL MEDICAL SCHOOL</td>
<td>22</td>
<td>11.2%</td>
</tr>
<tr>
<td>UT MEDICAL SCHOOL-GALVESTON</td>
<td>187</td>
<td>19.7%</td>
</tr>
<tr>
<td>UT MEDICAL SCHOOL- HOUSTON</td>
<td>146</td>
<td>15.0%</td>
</tr>
<tr>
<td>UT MEDICAL SCHOOL- SAN ANTONIO</td>
<td>171</td>
<td>19.9%</td>
</tr>
<tr>
<td>UT SOUTHWESTERN MEDICAL SCHOOL</td>
<td>132</td>
<td>14.5%</td>
</tr>
<tr>
<td>UTRGV - MEDICAL SCHOOL</td>
<td>76</td>
<td>37.3%</td>
</tr>
<tr>
<td><strong>Total for Texas (Excluding TCU and UNTHSC)</strong></td>
<td><strong>1,233</strong></td>
<td><strong>15.5%</strong></td>
</tr>
</tbody>
</table>

Note: TMA was unable to obtain data for the TCU and UNTHSC Medical School.
Sources: Texas Higher Education Coordinating Board and individual medical schools reported to TMA.
Prepared by: TMA.
To gauge whether minority percentages have increased at Texas medical schools in recent years, the committee compared statistics for 1999 and 2019 as presented in Table 3.

Texas had eight medical schools in 1999. Five schools saw improvements for both underrepresented minority groups, one school saw declines for both, another saw an improvement in one but no real change for the other, and one saw an improvement in one and a sharp decline in the other. Some medical schools more than doubled the percentage of underrepresented minority students during this period. At the state level, a greater increase occurred for Hispanic/Latino origin percentages, but the increases for both groups were modest.

- **Hispanic/Latino origin**
  More progress was made in the proportion of Hispanic/Latino origin medical students for individual medical schools than of Black/African American students over the two decades, with seven of the eight schools showing increases. Only one school, UT Medical Branch, saw a decline.

- **Black/African American**
  A majority of medical schools saw improved numbers, with increased percentages of Black/African American students at five of the eight Texas medical schools. Two schools had a decline in percentages, and one had no change.

### Table 3: Proportion of Underrepresented Minorities Among Texas Medical School Enrollments, 1999 and 2019

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Hispanic or Latino Origin</th>
<th>Black or African American</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999 %</td>
<td>2019 %</td>
</tr>
<tr>
<td>BAYLOR COLLEGE OF MEDICINE</td>
<td>10.2%</td>
<td>11.9%</td>
</tr>
<tr>
<td>TAMU HSC-COLLEGE OF MEDICINE</td>
<td>8.9%</td>
<td>11.2%</td>
</tr>
<tr>
<td>TEX COLLEGE OSTEOPATHIC MEDICINE</td>
<td>8.4%</td>
<td>9.7%</td>
</tr>
<tr>
<td>TUTHSC FOSTER SCHOOL OF MED EL PASO</td>
<td>8.4%</td>
<td>120%</td>
</tr>
<tr>
<td>TUTHSC SCHOOL OF MEDICINE LUBBOCK</td>
<td>8.4%</td>
<td>13%</td>
</tr>
<tr>
<td>UNIVERSITY OF THE INCARNATE WORD</td>
<td>35%</td>
<td>7.5%</td>
</tr>
<tr>
<td>UT AUSTIN DELL MEDICAL SCHOOL</td>
<td>22%</td>
<td>11.2%</td>
</tr>
<tr>
<td>UT MEDICAL SCHOOL-GALVESTON</td>
<td>24.8%</td>
<td>187%</td>
</tr>
<tr>
<td>UT MEDICAL SCHOOL- HOUSTON</td>
<td>14.6%</td>
<td>146%</td>
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</tr>
<tr>
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<td><strong>13.2%</strong></td>
<td><strong>1,233</strong></td>
</tr>
</tbody>
</table>

**Note:** Council staff was unable to obtain data for the TCU and UNTHSC Medical School.
**Sources:** Texas Higher Education Coordinating Board and individual medical schools.
**Prepared by:** TMA.
Accreditation Requirements for Diverse Medical Student Body and Faculty
The national accrediting body for allopathic medical schools, the Liaison Committee for Medical Education, has specific standards for diversity among medical school students, faculty, other staff, and partners, as noted below:

Standard 3.3 Diversity/Pipeline Programs and Partnerships
A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes. (Emphasis added.)

TMA Actions
TMA has written about the lack of progress in diversifying the Texas physician workforce in TMA periodicals, such as Texas Medicine. The TMA Foundation also provides a $10,000 scholarship to an underrepresented minority matriculant (first-year student) every year at each Texas medical school through the TMA Minority Scholarship Program. This program was approved by the TMA House of Delegates in 1998 at the urging of the committee’s parent council, the Council on Medical Education, and has awarded a total of 148 scholarships totaling $967,500 during the program’s history. Texas medical schools have recognized this program as particularly important in recruiting underrepresented minority students as Texas public medical schools are restricted in providing scholarships of this type.

Joint Admission Medical Program
In 2003, the Texas Legislature established the Joint Admission Medical Program (JAMP) to assist economically disadvantaged students to pursue careers in medicine. The program provides mentoring and support to students who likely otherwise would not have attended medical school. This program has been successful and has been described as being the envy of other states.

A total of 1,838 Texas undergraduate students participated in the program, 963 students matriculated into a Texas medical school, and 586 JAMP students completed a medical degree.

The JAMP program receives $5.1 million in state funding per year, and the budget has not increased since the program was started in 2003. Since then, seven medical schools have opened in the state and another is in development. With more students but no additional funding, resources are not available to fully grow the program’s services to meet the need.

In its legislative appropriations request for the 2022-23 state budget, the Texas Higher Education Coordinating Board proposed a budget cut of 5%, from $10.2 million to $9.7 million, a loss of $510,000 for JAMP. This program cannot afford a funding loss in the next state budget.

TMA has policy, adopted in 2004, in support of the JAMP program:

200.040 Joint Admission Medical Program: TMA supports the Joint Admission Medical Program (JAMP) and the goal of increasing the number of economically disadvantaged students enrolled in Texas medical schools, including underrepresented minorities. Ongoing monitoring should be implemented to measure the success of program participants in completing medical school and establishing practice in Texas (CME Rep. 3-A-04; reaffirmed CME Rep. 2-A-14).
Prairie View A&M University Premedical Academy

To promote an increase in the number of Black students who pursue medical careers, the state provides funding to the undergraduate premedical academy at Prairie View A&M University. This school has a higher than average percentage of Black students. The academy offers a mentor cooperative network to foster interest in medicine, dentistry, and veterinary medicine among Black students. TMA has the following policy in support of the academy:


Little information on outcomes from the premedical academy was readily available. Knowing about outcomes from the program would be helpful in assessing existing state resources for Black students.

Underrepresented Minority Student Pipeline Programs

Several medical schools in Texas have partnerships with high schools for the health professions in various parts of the state that are designed to provide pathways for underrepresented minority students to ultimately pursue medical degrees. These programs have yielded positive results.

Racial/Ethnic Health Disparities

Statistics on deaths due to COVID-19 among underrepresented minorities have drawn attention to racial/ethnic health disparities. The Centers for Disease Control and Prevention reports that Black and Hispanic Americans are 2.8 times more likely to die of COVID-19 than white, non-Hispanic Americans. Additional studies point to racial/ethnic disparities in accessing health care. Less access to care and poor health status have been contributing factors to health disparities.

For decades, research studies have consistently shown a positive correlation between patient-physician race/ethnicity concordance and health outcomes. Studies have also found that underrepresented minority physicians have a greater tendency to practice in medically underserved areas or to serve medically underserved populations.

Examples of relevant research with links to journal articles:

- Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations
  Major finding: Racial concordance contributes to a more effective therapeutic relationship, improved health care, and lower health care costs.

- The Racial and Ethnic Composition and Distribution of Primary Care Physicians
  Major finding: “Racial and ethnic minority physicians are more likely to practice primary care and serve in underserved communities.”

- Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review
  Major finding from review of 72 studies: “Studies found significant relationships between physician race/ethnicity and language and practice in underserved areas.”

There is a greater societal focus at this time on public policies for expanding inclusiveness and equity. TMA’s Council on Medical Education submitted a handbook report to the TMA House of Delegates (C-ME Report 1) that recommends the adoption of new TMA policy in support of bias training for all Texas medical school students and resident physicians, as well as staff and faculty at academic health centers.

In 2016, the Association of American Medical Colleges (AAMC) issued an update on the low numbers of Black men in medical school. A startling finding was that the number of Black men applying to U.S. medical schools had actually declined over 40 years. In 1978, 1,410 applied, while in 2014, the number was 1,337. Black men represent 4% of U.S. physicians. In comparison, 13% of the U.S. population is black.

Quote from AAMC President and CEO David J. Skorton, MD, August 2020:

The academic medicine community must take even more aggressive steps to attract and engage talent from all segments of our society to address public health needs. We are dealing with historically entrenched systems of exclusion and oppression for racial and ethnic minorities in the United States. Systemic changes are necessary to make a lasting change in the representation of Black men in medicine, and this will require us to build a coalition of voices and collaborators across multiple communities.

Excerpt from AAMC report Diversity in Medicine: Facts and Figures 2019:

Focusing solely on increasing compositional diversity along the academic medicine continuum is insufficient. To effectively enact institutional change at academic medical centers and leverage the promise of diversity, leaders must focus their efforts on developing inclusive, equity-minded environments. A shared desire for change, aided by a growing number of resources, will enable medical schools and academic health centers to assess their institutional culture and climate and improve their capacity for diversity and inclusion.

Recommendation: The Committee on Physician Distribution and Health Care Access recommends the following be adopted as Texas Medical Association policy:

Renewed Efforts to Increase Racial/Ethnic Diversity Among the Texas Physician Workforce

The Texas Medical Association recognizes the Texas physician workforce is not sufficiently diverse to reflect the racial/ethnic diversity of the Texas population.

1. Working for Greater Diversity Among Texas Physicians. TMA urges Texas medical schools, as well as residency and fellowship programs, to continue their efforts to increase racial and ethnic diversity among medical students, resident physicians, and fellows training in Texas. This includes continued support for pipeline programs that help foster an interest in careers in medicine among underrepresented minority students such as the high schools for the health professions that are often located in high minority areas of the state. TMA encourages support services that facilitate success for underrepresented minority students through college, medical school, and residency programs. Further, TMA recognizes the benefits of role models among academy leadership and faculty for mentorship of minority students and residents.

Health care institutions and health plans are encouraged to strive for diversity in the physician workforce.
2. Role of Physicians. Every physician, in every type of practice or practice setting, can have a valuable role in mentoring the next generation of physicians. Students of underrepresented minorities often have a greater need for mentoring and support to counter challenges in pursuing the pathway to become a physician. TMA encourages Texas physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine. Students can be exposed to the physician’s practice, pursue shadowing opportunities, and progress to active roles in the office or as scribes. Each physician can make an impact in building the future workforce that is prepared to meet the needs of Texas’ diverse patient population.

3. Protection of Joint Admission Medical Program From Budget Cuts in 2022-23. TMA supports adequate funding for the state’s Joint Admission Medical Program (JAMP), which reserves medical student positions for qualified students who are economically disadvantaged, recognizing that this includes a high proportion of underrepresented minority students. TMA strongly opposes the proposed budget cut of $510,000 for the JAMP program in the 2022-23 state budget and advocates for consideration of the need to increase resources to accommodate students from the new Texas medical schools.

Attachment
Population Projections by Race/Ethnicity, Texas, 2010-2030

Source: Texas Demographic Center, 2018 Vintage Population Projections, 2010-2015 Migration Scenario
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 201
2021

Subject: Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools (Tabled Res 202 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, In 2012, the U.S. Department of Homeland Security established the Deferred Action for Childhood Arrivals (DACA) program, which provides temporary legal status to young, undocumented immigrants brought to the U.S. as children by their guardians; and

Whereas, The DACA program allows this population to receive work permits; and

Whereas, The DACA program currently has 700,000 recipients nationwide and 115,290 (16% of all recipients) in Texas alone; and

Whereas, Despite political debate over this policy, the DACA program is currently active, and recipients can renew their status for the foreseeable future; and

Whereas, Seventy-three percent of Americans, including majorities of both Democrats and Republicans, support permanent U.S. legal status for DACA recipients; and

Whereas, Since 2001, undocumented students in Texas are considered Texas residents for purposes of admission to Texas public institutions of higher education and are eligible for in-state tuition and state financial aid; and

Whereas, The Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine support protections for DACA medical students due to their role in diversifying the physician workforce, treating underserved communities, and reducing physician shortages; and

Whereas, Of the 141 medical schools granting MD degrees in the U.S., 73 report willingness to admit DACA students; and

Whereas, Of the 34 medical schools granting DO degrees in the U.S., seven report willingness to admit DACA students; and

Whereas, Almost none of the 15 Texas medical schools report willingness to admit DACA students; and
Whereas, Anecdotal evidence indicates at least one case of multiple Texas medical schools rescinding acceptances from a Texas DACA student after discovering his immigration status; therefore be it

RESOLVED, That the Texas Medical Association encourage Texas medical schools to implement admissions policies that allow admission of Deferred Action for Childhood Arrivals (DACA) students, for as long as the DACA program is intact.

Relevant TMA Policy:
200.022 Medical Education Admissions
200.031 Medical School Admissions
200.040 Joint Admission Medical Program
205.018 Hopwood v Texas
185.012 Physician Recruitment

Relevant AMA Policy:
D-350.986 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages
D-200.982 Diversity in the Physician Workforce and Access to Care
H-350.960 Underrepresented Student Access to US Medical School
WHEREAS, The World Health Organization defines maternal mortality as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”; and

WHEREAS, Although maternal mortality in most of the world has been declining, in the United States it has more than doubled since 1987, from 7.2 deaths per 100,000 live births to 16.7 deaths per 100,000 live births in 2016; and

WHEREAS, Maternal mortality and morbidity rates in Texas are even higher than the national average, at 18.5 per 100,000 births; and

WHEREAS, A study by the Centers for Disease Control and Prevention found that approximately three in five pregnancy-related deaths were preventable; and

WHEREAS, A disproportionate number of pregnancy-related deaths are among women of color, as African American and Native American/Alaska Native women are three to four times more likely to die from pregnancy-related complications than Hispanic and white non-Hispanic women; and

WHEREAS, Implicit bias refers to the “attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner”; and

WHEREAS, Implicit bias can affect the quality of care given by physicians providing perinatal care; and

WHEREAS, Implicit bias training brings unconscious biases to one’s conscious attention; and

WHEREAS, In a longitudinal case study with physicians and nurses, it was shown that implicit bias recognition provoked critical questioning and awareness, allowing for reflection on biases and leading to explicit behavioral changes; and

WHEREAS, Precedent for implicit bias training legislation has been established, such as in California Senate Bill No. 464, California Dignity in Pregnancy and Childbirth Act; and

WHEREAS, Implicit bias training for perinatal physicians will allow for improved health outcomes for women and their newborns through access to more informed, sensitive, and empathic care; therefore be it

RESOLVED, That the Texas Medical Associate advocate for and support the use of implicit bias training for perinatal physicians to improve maternal health outcomes.
Related TMA Policy:
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Related AMA Policy:
Racial and Ethnic Disparities in Health Care H-350.974

References:
1. World Health Organization. Maternal mortality ratio (per 100,000 live births).
Subject: Service Animal Assisted Therapy in Health Care (Tabled Res 205 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

RESOLVED, That the Texas Medical Association encourage physicians to use the Americans With Disabilities Act material concerning service animals as part of their patients’ therapeutic plans in inpatient and outpatient settings; and be it further

RESOLVED, That TMA support the provision of community resources for individuals with service animals that explain how service animals can be part of a therapeutic treatment plan.

Related TMA Policy:
None.

Related AMA Policy:
H-90.966 Service Animals, Animal-Assisted Therapy, and Animals in Healthcare

References:


Subject: Defining What Constitutes Proper Use of the Terms “Residency” and “Fellowship” When Referring to Specialty Training

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Medical Education and Healthcare Quality

Whereas, All physicians pursuing specialty board certification are required to complete standardized and accredited training referred to as “residency,” with the possibility for further subspecialized training referred to as “fellowship”; and

Whereas, The term “resident” historically refers to physician training in the early 20th century, when medical trainees resided in hospitals during their formative years; and

Whereas, Some postgraduate training programs for nonphysician clinicians have started using the same nomenclature and labeling their programs as “residencies” and “fellowships”; and

Whereas, The public has been surveyed and has expressed confusion over which clinicians have medical degrees or degrees of osteopathic medicine and favor transparency of training; and

Whereas, The American Academy of Dermatology has stated that labeling nonphysician training programs as residencies or fellowships is misleading, and that this terminology should only apply to physician training programs; and

Whereas, The American Academy of Emergency Medicine has stated that training programs for physician assistants and nurse practitioners should avoid use of the terms “resident” and “fellow”; therefore be it

RESOLVED, That the Texas Medical Association develop a position statement that highlights the historical value and current nature of the terminology “residency” and “fellowship” to describe physician postgraduate training and addresses the ramifications of nonphysician clinician groups using similar nomenclature.

Related TMA Policy:
245.013 Appropriate Title Nomenclature in Medical Settings

Related AMA Policy:
D-275.979 Non-Physician “Fellowship” Programs

References:
2. AMA. Truth in Advertising Survey results.
Subject: Skin of Color Representation in Medical Education and Research

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Half of all skin-related medical visits are not to dermatologists, yet fewer than 40% of primary care residents feel adequately prepared to manage common skin conditions; and

Whereas, Nearly 50% of dermatologists and dermatology residents in a landmark 2011 study reported that their medical school and/or their residency program provided inadequate training in recognizing dermatological conditions on Black skin; and

Whereas, Only 25.4% of chief residents and 19.5% of program directors report having lectures from a knowledgeable expert on Skin of Color (SoC), representing Fitzpatrick's skin phototypes IV through VI as defined as light brown skin to dark skin; and

Whereas, Dermatological health disparities disproportionately affect patients with SoC, resulting in delayed treatment courses and increased morbidity and mortality; and

Whereas, By 2044, people of color will make up more than half the U.S. population; and

Whereas, According to the 2019 U.S. Census, 58.8% of the population of Texas does not identify as solely white, and that number is expected to grow; and

Whereas, Many systemic diseases have dermatological manifestations, which makes it vital for all specialties to be able to recognize cutaneous changes on all skin tones; and

Whereas, Frequent misdiagnosis of “COVID toes” and other cutaneous manifestations of SARS-CoV-2 on darker skin tones has shed light on longstanding health inequalities in the field of dermatology, particularly in the way physicians are taught to recognize dermatological conditions, with words and pictures that typically describe manifestations on lighter skin; and

Whereas, A systematic literature review of publications describing cutaneous manifestations of COVID-19 included no clinical images representing Fitzpatrick type V or VI skin, which may be a contributing factor to higher rates of mortality and morbidity in people of color; and

Whereas, Knowing the cutaneous manifestations of COVID-19 and being able to identify them has been proven to be invaluable in evaluating otherwise asymptomatic patients in the health care setting, yet current literature fails to provide the tools needed for physicians to evaluate these dermatological manifestations on darker skin tones; and

Whereas, Analysis of medical textbook imagery found that only 4.5% of images represent dark skin tones, and dermatology sections of common United States Medical Licensing Examination (USMLE) preparatory resources showed only 24% of dermatological presentations were on SoC; and
Whereas, Medical students in a 2020 study were shown to be less likely to visually diagnose squamous cell carcinoma, atopic dermatitis, and urticaria correctly when presented on SoC, demonstrating the need for cutaneous manifestations of disease to be presented on both light and dark skin tones in medical education; and

Whereas, Lack of SoC representation in clinical research could exacerbate existing health disparities, with only 60% of dermatologic clinical trials in the U.S. reporting their participants’ race/ethnicity and less than 25% recruiting patients who do not identify as white; and

Whereas, An ongoing study suggests that exposure to dermatological pathology on SoC increases physician and student confidence in diagnosing pathology in patients of color; and

Whereas, A cross-sectional study published in JAMA Dermatology revealed that dermatologists with specialized training in SoC reported higher rates of patient satisfaction among Black patients due to their increased knowledge of SoC, cultural competency, cost-conscious care, and empathetic communication skills; and

Whereas, Current American Medical Association policy H-350.974 recognizes racial and ethnic health disparities as a major public health issue and supports the education of residents of all specialties on addressing these disparities in their fields; and

Whereas, Current Texas Medical Association policy 200.020, says medical schools should incorporate a broad range of educational opportunities and perspectives in their curricula, not exclusively related to the basic sciences; therefore be it

RESOLVED, That the Texas Medical Association advocate for dermatological conditions to be presented on varied skin tones in both pre-clinical curricula and clinical didactic sessions; and be it further

RESOLVED, That the Texas Medical Association supports recruiting more patients with skin of color for dermatologic medical research to better represent the diversity of the patient population.

Related TMA Policy:
200.020 Medical Education Curriculum
60.008 Rejection of Discrimination

Related AMA Policy:
Racial and Ethnic Disparities in Health Care H-350.974
Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
Increasing Minority Participation in Clinical Research H-460.911

References:


Subject: Develop Guidelines for Proper Oversight of and Collaboration With Midlevel Practitioners by Physicians (Tabled Res 422 2020)

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Patients deserve care led by physicians, as four of five patients prefer having physicians lead their health care team; and

Whereas, Like Texas, many states require physician supervision of midlevel practitioners, and Texas Medical Association has published a resource guide on midlevel supervision; and

Whereas, Physician supervision of midlevel practitioners is enforced by the Texas Medical Board; therefore be it

RESOLVED, That the Texas Medical Association educate physicians about the basic tenets of proper physician oversight and supervision of midlevel practitioners, and encourage physicians to notify the Texas Medical Board of physicians who are not providing proper supervision per the delegation of duties; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates, urging it to develop national guidelines for proper physician oversight of and collaboration with midlevel practitioners.

Related TMA Policy:
100.032 Appropriate Physician Oversight of Emergency Medical Service Medical Practices
30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners
30.025 Allied Health Care Professionals
30.029 Physician Extenders in Rural Health Clinics
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 207
2021

Subject: Suicide Prevention Education in Medical School (Tabled Res 305 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Suicide is a national public health concern and the 10th leading cause of death in the U.S.; and

Whereas, The suicide rate in Texas has risen by more than 18% since 1999; and

Whereas, Many individuals who died by suicide did not have a mental health diagnosis and were not regularly visiting specialized mental health professionals at the time of their death; and

Whereas, Stigma surrounding persons with mental illness remains prevalent and can deter health care professionals from effectively treating these individuals; and

Whereas, Emergency department visits for suicidal ideation and/or self-directed violence increased by 25.5% in 2018 compared with 2017; and

Whereas, Universal screening tools for depression and suicidality such as the PHQ-9, while useful predictors, are not used consistently in primary care settings and do not identify all individuals who may be suicidal; and

Whereas, The Joint Commission has supported work demonstrating that current health care protocols miss signs of suicidal ideation and that more proactive measures can help health care professionals identify suicide risk; and

Whereas, Several administrations, the U.S. Congress, and the U.S. Department of Health and Human Services have financially supported efforts to expand suicide prevention education, such as through the Mental Health First Aid program, to health care professionals, educators, and other professionals who encounter individuals with suicidal ideation; and

Whereas, The Texas Suicide Prevention Council’s Suicide Prevention Plan supports implementing programs about suicide prevention and intervention based on recommendations from the Substance Use and Mental Health Services Administration, and the Suicide Prevention Resource Center; and

Whereas, The rate of suicide among U.S. veterans exceeded 6,000 each year from 2008 to 2017; and while the Association of American Medical Colleges reported in 2014-15 that 14 medical schools participated in veteran care curricula by case-based instructional method, fewer than four medical schools participated in clinical experience (e.g., ambulatory and inpatient) instructional methods; and

Whereas, Medical students may not receive adequate or effective education about suicide prevention and intervention, impairing their ability to treat individuals with suicidal ideation; and
Whereas, Only 15% of U.S. medical schools formally include suicide prevention in their medical curriculum; and

Whereas, Studies demonstrate that medical students who receive education about risk factors for suicide are more prepared to recognize and emergently respond to individuals who are experiencing suicidal ideation; and

Whereas, Early patient interaction, possibly including some patients with suicidal ideation, during the preclinical curriculum is becoming more common and has been found to improve preparedness for clerkships; therefore be it

RESOLVED, That the Texas Medical Association support integrating validated suicide prevention training programs into the curriculum of preclinical students in Texas medical schools in accordance with Association of American Medical Colleges interpersonal, intrapersonal, and science competencies for medical students, and Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation standards; and be it further

RESOLVED, That TMA recognize the importance of studying suicide identification and prevention training programs to develop the most efficacious method to prepare Texas students.

Related TMA Policy:
200.030 Preventive Medicine Education

Related AMA Policy:
Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

References:
3. Durkin M. Preventing Suicide in Primary Care. ACP Internist. October 2018.


16. Allexan S. Suicide Curriculum in Medical Education (undated).


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 208
2021

Subject: Facilitating Brain and Other Postmortem Tissue Donation for Research and Educational Purposes (Tabled Res 306 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Postmortem tissue contains information that can be invaluable in medical research and education to improve our understanding of human physiology and pathophysiology and thus enhance patient care; and

Whereas, Recent research using postmortem brain tissue has been critical to our understanding of the pathogenesis of neurological and psychiatric illnesses such as Parkinson’s disease, dementia, post-traumatic stress disorder, autism, and major depression and builds upon advances from neuroimaging, genetic, biomarker, and animal studies; and

Whereas, States have undertaken efforts to raise awareness of and increase donations for organ transplant, including asking individuals if they would like to join transplant donor registries when applying for or renewing their driver’s license; and

Whereas, In Texas alone, nearly 7 million people have joined the Texas Donor Registry since a question regarding organ donation for transplantation was added to driver’s license applications; and

Whereas, Ninety-eight percent of organ donation registration occurs at motor vehicles departments, where promotional materials and clerk training have been shown to increase organ donation registration by up to 7.8%; and

Whereas, Although Texas offers an option for organ and tissue donation on driver’s licenses and identification cards, brain tissue donation requires a separate consenting process that often occurs after death through the next of kin; and

Whereas, Recruitment for brain banks and willed body programs is not standardized across institutions and can create a large financial and logistic burden on institutions that potentially could be alleviated by standardized premortem consenting; and

Whereas, Widespread efforts to inform individuals of the importance of tissue donation for research and health professions education and to provide interested individuals with the opportunity to easily give informed consent have potential to increase donation rates, decrease costs, and eliminate the need for families to make decisions for their loved ones postmortem; and

Whereas, A study of public perceptions surrounding whole body donation found that 58.8% of participants reported insufficient understanding of the body and tissue donation process for research and educational purposes, 77.4% reported they did not know how to register to become a whole body donor, and 23.9% reported they did not know they could be registered as both a transplant organ donor and whole body donor or tissue donor; and
Whereas, Several studies have found that after receiving information about tissue donation, the majority of participants would be likely or somewhat likely to donate their brain tissue (>60%) for research; and

Whereas, While current TMA Policy 280.010 addresses increasing organ and tissue donation education and improving procurement for transplantation, TMA does not address education or procurement improvement for postmortem tissue donation for research or educational purposes; therefore be it

RESOLVED, That the Texas Medical Association support the production and distribution of educational materials regarding the importance of postmortem brain tissue donation for the purposes of medical research and education; and be it further

RESOLVED, That our TMA encourage the inclusion of additional information and consent options for brain tissue donation for research purposes on appropriate donor documents; and be it further

RESOLVED, That our TMA encourage all persons to consider consenting to brain and other tissue donation for research purposes; and be it further

RESOLVED, That our TMA encourage efforts to develop and improve logistical frameworks for the procurement and transit of postmortem tissue for research and educational purposes.

Related TMA Policy:
- 280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation
- 280.016 Human Subject Research – A Patients Bill of Rights
- 280.020 Science Coalition
- 205.005 Funding Levels for Research and Medical Education

Related AMA Policy:
- H-460.930 Importance of Clinical Research
- E-7.1.1 Physician Involvement in Research
- D-370.985 Organ Donation
- H-370.998 Organ Donation and Honoring Organ Donor Wishes
- H-370.982 Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients
- H-370.983 Tissue and Organ Donation
- H-370.995 Organ Donor Recruitment
- H-370.996 Organ Donor Recruitment
- H-85.954 Importance of Autopsies
- H-370.984 Organ Donation Education
- H-460.890 Improving Body Donation Regulation
- E-6.1.2 Organ Donation After Cardiac Death
- E-6.1.3 Studying Financial Incentives for Cadaveric Organ Donation
- E-6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors

References:


Subject: Promoting Careers in Geriatrics Among Medical Students (Tabled Res 204 2020)

Introduced by: Medical Student Association

Referred to: Reference Committee on Medical Education and Healthcare Quality

Whereas, The United States has 49 million people over the age of 65, and 12.6% of Texas’ population is made up of people over age 65; and

Whereas, The number and percentage of individuals over age 65 in Texas is expected to more than double by 2050, thereby requiring more physicians and resources for this population; and

Whereas, As many as 30% of these individuals will need the expertise of a geriatrician to manage their care; and

Whereas, Texas had only 405 board-certified geriatricians in 2018 to care for nearly 3.5 million individuals; and

Whereas, The Texas Medical Association and the American Medical Association provide support for primary care specialties, TMA does not have policy to support including geriatric medicine in medical student education; and

Whereas, TMA supports preceptorship programs for some primary care specialties to encourage medical student involvement in these specialties and has not expanded these efforts to include geriatrics; therefore be it

RESOLVED, That the Texas Medical Association recognize and support the need for more geriatricians in Texas by providing medical students with information and opportunities that encourage them to specialize in geriatrics; and it be further

RESOLVED, That TMA support the efforts of medical schools to foster interest in geriatrics through interest groups, shadowing opportunities, and other activities.

Related TMA Policy:
185.002 Physician Workforce – Primary Care and Specialty Training
185.022 Promoting Careers in Psychiatry Among Medical Students
255.002 Primary Care
255.003 Undergraduate Medical Education

Related AMA Policy:
H-295.981 Geriatric Medicine
D-295.969 Geriatric and Palliative Care Training For Physicians
H-200.949 Principles of and Actions to Address Primary Care Workforce
H-200.969 Definition of Primary Care
References:
4. Geriatrics Workforce By the Numbers at www.americangeriatrics.org/geriatrics-profession/about-4
   geriatrics/geriatrics-workforce-numbers. (n.d.).
5. American Geriatrics Society. Current Number of Board Certified Geriatricians by State at
   www.americangeriatrics.org/sites/default/files/inline-files/Current Number of Board Certified
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 210
2021

Subject: Amending the Mental Health Question on the Physician Licensure Application to Reflect Current Impairment (Tabled Res 206 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, previously, any person applying for a medical license in the state of Texas was required to report all mental health diagnoses and treatment in the past five years without regard to current impairment; and

Whereas, previous Texas medical licensure applications included questions related to mental illness in likely violation of Title II of the Americans with Disabilities Act (ADA), which states it is unlawful to subject individuals with disabilities to greater requirements or burdens than a nondisabled person; and

Whereas, the ADA defines as a disability the diagnosis of major depressive disorder, bipolar disorder, substance abuse disorders, and other mental health conditions; and

Whereas, substantial prevalence of mental illness exists among physicians and medical students, with 11.3% of physicians reporting moderate to severe depression in one study and another study estimating the rate of depression in medical students at 27.2%; and

Whereas, medical students with depression cited lack of confidentiality (37%), stigma associated with using mental health services (30%), and fear of documentation on academic record (24%) as barriers to receiving treatment; and

Whereas, 75% of surgeons who had experienced suicidal thoughts within the previous year of being surveyed reported they had not sought help due to concerns that doing so would affect their ability to renew their license; and

Whereas, physicians working in a state where the mental health question(s) violate ADA standards were 20% more likely to be reluctant to seek help than physicians working in states that met ADA standards; and

Whereas, 40% of all surveyed physicians in states that did not meet ADA standards reported reluctance to seek formal medical care for their mental health conditions; and

Whereas, in 2018 the American Medical Association House of Delegates adopted a widely supported Council on Medical Education report calling on medical licensing boards to not ask questions about history of mental illness; therefore be it

RESOLVED, That the Texas Medical Association support as policy that the Texas Medical Board licensure application require disclosure of only current or active mental health conditions; and
RESOLVED, That TMA support policy and judicial decisions in line with the American Medical Association, that physicians not be required to disclose previous treatment for mental health conditions and instead be evaluated solely on performance and current impairment.

Fiscal Note: TBD

Relevant TMA Policy:
None

Relevant AMA Policy:
- H-275.970 Licensure Confidentiality
- D-275.974 Depression and Physician Licensure
- H-275.945 Self-Incriminating Questions on Applications for Licensure and Specialty Boards

References:
8. Dyrbye, L. N. Medical licensure questions and physician reluctance to seek care for mental health conditions.
Subject: Medical School Compliance With the Americans with Disabilities Act

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Disability is included in the definition of diversity put forth by the Association of American Medical Colleges (AAMC) Group on Diversity and Inclusion; and

Whereas, Physician diversity has been shown to improve care in underserved populations; and

Whereas, Studies have indicated patients from various backgrounds feel more comfortable with physicians who share similar backgrounds; and

Whereas, Patients with a disability are more likely to experience ineffective patient-physician communication that detrimentally affects their care; and

Whereas, A disparity in individuals reporting a disability exists among the general American population (20%), medical students (4.6%), and practicing physicians (2%), demonstrating underrepresentation of people with disabilities; and

Whereas, Diversity within medical school student bodies, which AAMC supports, will create a diverse physician workforce in the future; and

Whereas, Many universities have created initiatives to promote inclusion of physicians with disabilities, such as the University of Michigan’s #docswithdisabilities campaign to normalize disability in medicine; and

Whereas, To eliminate discrimination and bias against those with disabilities, medical schools must provide reasonable accommodations, made known to students who are considering applying; and

Whereas, Reasonable accommodation for people with disabilities may include magnifying devices for students with visual disabilities, auxiliary aids for students with communication disabilities, extended test times for students with learning disabilities, or a convertible wheelchair for students with paraplegia to stand at a surgical table; and

Whereas, Improving accommodations for medical students with hearing disabilities has been found to increase patient quality of care by increasing the number of physicians providing culturally and psychologically compatible care to deaf and hard of hearing populations; and

Whereas, In spite of the passage of the Americans with Disabilities Act (ADA) of 1990, many medical schools have made few to no changes in accommodations in line with their legal obligations for people with disabilities; and
Whereas, Research shows that two-thirds of medical schools do not provide information on their websites about accommodations and do not have reasonable accommodations in compliance with the ADA for students with vision, hearing, and mobility disabilities; and

Whereas, AAMC recommended in 2019 that all medical schools provide on their websites information about accommodations and their university’s policies because not providing this information could discourage applicants; and

Whereas, AAMC suggests medical schools also employ a disability services provider, who is an administrator knowledgeable about the accommodations the university and the medical facilities provide; and

Whereas, Our Texas Medical Association and American Medical Association supports the Joint Medical Admission Program, which works to recruit, enroll, and retain qualified applicants from racially diverse backgrounds to increase diversity in health professions, but this does not include students with disabilities; and

Whereas, Our TMA supports a diverse, qualified medical student body for Texas medical schools, and diversity includes those with disabilities; therefore be it

RESOLVED, That our Texas Medical Association encourage medical schools to provide reasonable accommodations for students with disabilities in accordance with the Americans with Disabilities Act and to describe these accommodations on their websites; and be it further

RESOLVED, That TMA support medical schools’ efforts to recruit, enroll, and retain qualified students with disabilities; and be it further

RESOLVED, That TMA encourage medical schools to employ a disability services provider, a staff member who is knowledgeable about accommodations for students at that university and can provide support to students with disabilities; and be it further

RESOLVED, That TMA amend Policy 200.031 Medical School Admissions as follows:

Medical School Admissions: The Texas Medical Association reaffirms its current policy supporting medical schools’ efforts to recruit, enroll, and retain qualified underrepresented minorities and strongly supports a diverse, qualified medical student body for Texas medical schools. In addition, TMA strongly supports the State of Texas partnership with Texas medical schools in efforts to increase the representation of underrepresented minorities including but not limited to Hispanic and African American students, and students with disabilities medical students among those attending Texas medical schools toward the goal of reaching their proportion in the Texas population (Council on Medical Education, p 73, I-96; reaffirmed BOT Rep. 11-I-99; reaffirmed CME Rep. 2-A-09; reaffirmed CME Rep. 1-A-19).

Related TMA Policy:

60.008 Rejection of Discrimination
200.040 Joint Admission Medical Program
200.031 Medical School Admissions
200.007 Medical Student and Resident Abuse
1 Related AMA Policy:
2 Minorities in the Health Professions H-350.978
3 Strategies for Enhancing Diversity in the Physician Workforce H-200.951
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 212
2021

Subject: Support Addressing, Screening, and Providing Healthy Coping Mechanisms for Burnout

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Burnout is defined as a work-related mental health impairment comprising three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment; and

Whereas, During the past 30 years, 182 studies involving 109,628 physicians in 45 countries reported overall burnout at 67%, emotional exhaustion at 72%, depersonalization at 68.1%, and low personal accomplishment at 63.2%; and

Whereas, As of 2018, approximately 300-400 physicians commit suicide each year nationwide, at a rate of 28-40 per 100,000, which is more than double the suicide rate of the general population; and

Whereas, Burnout is detrimental to physicians experiencing it, and can increase medical errors and impact patient satisfaction; and

Whereas, Medical personnel involved in treating and diagnosing patients with COVID-19 should undergo regular screening by multidisciplinary psychiatry teams to evaluate stress, depression, and anxiety; and

Whereas, Screening measures estimated that between 61.9% and 80.5% of physicians experience burnout or other mental health issues, indicating screening may be beneficial in settings with high prevalence of mental illness; and

Whereas, Interventions, such as training on coping mechanisms and communication skills; yoga, and other spiritual programs based on meditation; teamwork; computer programs; and staff appreciation can help reduce burnout among physicians and nurses, such that 50% of interventions positively impacted physicians and 67% positively impacted nurses; and

Whereas, Interventions that emphasize relationships, such as those in a health-care team, and balanced performance measures that recognize positive and negative aspects of a medical career are more likely to promote well-being and improve workplace cultures, reducing burnout among physicians; and

Whereas, The Centers for Disease Control and Prevention recognizes these coping mechanisms for stress: healthy diet, regular exercise, scheduled breaks, proper sleep, conversation with others, drug and alcohol avoidance, acknowledgement of personal limits, and counseling; and

Whereas, Previous studies have shown motivational programs, communication training skills, electronic methods, and/or psychiatric programs can reduce burnout in physicians; and

Whereas, American Medical Association policy supports existing programs to assist physicians in early identification and management of stress, and affirms the importance of physician health and education about physician health and wellness; therefore be it
RESOLVED, That the Texas Medical Association recognize burnout – defined as emotional exhaustion, depersonalization, and reduced sense of personal accomplishment – as a critical issue among healthcare workers and medical students; and be it further

RESOLVED, That TMA support training for medical practitioners to recognize burnout, and help prevent burnout by encouraging healthy coping mechanisms and the use of support services such as physician health and wellness programs; and be it further

RESOLVED, That TMA amend Policy 215.020 Improved Funding for Mental Illness and Substance Use Disorder(s) as follows:

The Texas Medical Association advocates for: (1) improved prevention, identification, and treatment of mental illness, burnout, and substance use disorder(s); (2) increased funding for mental illness and substance use disorders in areas of the state to be proportional to the service requirements of the area; and (3) no psychiatric hospital beds to be closed based solely on budgetary concerns in Texas (Res. 402-A-10, amended C-SPH Rep. 2 2020).

Related TMA Policy:
100.022 Emergency Psychiatric Services
105.010 Physician Health and Wellness
215.020 Improved Funding for Mental Illness and Substance Use Disorder(s)

Related AMA Policy:
D-310.968 Physician and Medical Student Burnout
D-345.983 Study of Medical Student, Resident, and Physician Suicide
H-295.858 Access to Confidential Health Services for Medical Students and Physicians
H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs
H-310.907 Resident/Fellow Clinical and Educational Work Hours
H-405.961 Physician Health Programs
H-405.957 Programs on Managing Physician Stress and Burnout

References: