AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 17, 2019
Tower Lobby, Governor's Lecture Hall - Hilton Anatole

5. Committee on Emergency Medical Services and Trauma Report 3 – Sunset Policy Review
6. Committee on Infectious Diseases Report 1 – Sunset Policy Review
7. Council on Practice Management Services Report 2 – Improving Health Technology Products to Address the Issues of Sex and Gender
13. Resolution 301 - Distribution and Display of Human Trafficking Aid Information in Public Places
14. Resolution 302 - Statement on Personhood Measures
15. Resolution 303 - Improving Medical Clearance Policies for Traumatic Brain Injury Patients
16. Resolution 304 - Requirement for Food Allergy Posters and Employee Training in Food Establishments
17. Resolution 305 - Allow the Possession and Administration of an Epinephrine Auto-injector in Certain Entities
18. Resolution 306 - Opposition to Limiting the Physician’s Role in the End-of-Life Process
19. Resolution 307 - Regulatory Recommendations for Bed Bugs
20. Resolution 308 - Regulation of Electric Scooters
21. Resolution 309 - Factoring Adolescent Sleep Patterns into Middle and High School Start Times
22. Resolution 310 - Amending TMA Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors

23. Resolution 311 - Identifying Trauma and Mental Health Susceptibilities in Schools

24. Resolution 312 - Opposition to Increasing Work Requirements for the Supplemental Nutrition Assistance Program (SNAP)

25. Resolution 313 - Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing

26. Resolution 314 - Support of Mandatory Paid Parental Leave

27. Resolution 315 - Notification of Generic Drug Manufacturing Changes

28. Resolution 316 – Determinants of Health
Subject: Sunset Policy Review

Presented by: Marian “Yvette” Williams-Brown, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Cancer recommends deletion of the following policy, as the Texas Department of State Health Services no longer regulates indoor tanning salons, thus rendering the policy irrelevant:

260.062 **Indoor Tanning Salon Regulation:** The Texas Medical Association supports the Texas Department of State Health Services in its regulatory and enforcement functions of indoor tanning salons (Amended CPH Rep. 5-I-99; amended CM-C Rep. 2-A-09).

**Recommendation:** Delete.
The Texas Medical Association Medical Student Section presented Resolution 306-A-18 to the House of Delegates and called for TMA to: (1) support legislation and other efforts to improve access to health care resources for children in the foster care system; (2) support legislation that protects the rights of foster care children to receive evidence-based care; and (3) oppose any legislation that allows for discrimination against adolescent patients seeking contraception.

The authors’ resolves and recommendations were developed in response to House Bill 3859 of the 85th Texas Legislature. Following testimony that clarified the bill did not apply to physicians and the practice of medicine, the author retracted the first and second resolves before the Reference Committee on Science and Public Health, but asked for consideration of the third resolve. The House of Delegates referred the third resolve to the Council on Legislation and the Committee on Child and Adolescent Health.

The committee reviewed the resolution and identified existing policy that affirms the association’s position on adolescent sexual activity and nondiscrimination policies:

- 55.004: Adolescent Sexual Activity
- 55.035: Right to Confidential Care
- 60.008: Rejection of Discrimination.
- 190.031: Texas Medicaid Reform Initiatives
- 190.033: Enhancing Children’s Health Insurance Program Coverage
- 265.018: Evidence-Based Medicine.
- 330.009: Preconception and Inter-gestational Health and Care

Because of existing policy, the committee recommends that the third resolve not be adopted. The resolution’s authors agree with the committee’s recommendation.

**Recommendation:** That Resolution 306-A-18 not be adopted.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Committee on Child and Adolescent Health recommends deletion of the following policy:

325.009 Child Abuse Prevention and Education: The Texas Medical Association supports: (1) working with legislators or congressmen to strengthen child abuse laws; (2) volunteering to teach community groups about prevention and identifying abuse; (3) providing parenting education opportunities to patients’ parents and other public audiences; (4) becoming involved in community child fatality review teams; and (5) fostering relationships with relevant government agencies and participate in community efforts and professional societies to coordinate activities that promote child abuse prevention, intervention and treatment (Council on Public Health, p 88, I-96; amended CPH Rep. 2-A-09).

Recommendation: Delete.

Presented by: Veer Vithalani, MD, Chair

Referred to: Reference Committee on Science and Public Health

At the May 2018 meeting, the House of Delegates considered Resolution 302-A-18 from the Travis County Medical Society. The resolution called on the Texas Medical Association to recommend Texas emergency medical services (EMS) systems adopt physician oversight ratios in order to support safe oversight of EMS medical practices. The resolution detailed ratios of full-time equivalent (FTE) physicians per life-support providers. The house referred the resolution to the Committee on Emergency Medical Services and Trauma for a report back in May 2019.

Last fall, the committee met with the resolution’s author as well as representatives from the Texas College of Emergency Physicians (TCEP) to discuss the resolution. While sympathetic to the author’s concerns, the committee and TCEP opposed adoption of the resolution. Many physicians were concerned that staffing requirement ratios would be costly to recreate in small EMS systems. Staffing ratios could create unfair burdens on small EMS systems in rural areas of the state. Further, the committee could not reach agreement on staffing ratios, as each EMS system is different throughout the state.

The Committee on Emergency Medical Services and Trauma recognizes the importance and challenges of physician oversight of EMS medical practices. There is evidence that errors in emergency settings such as emergency departments and emergency medical services can lead to poor outcomes for patients. One method of reducing these errors is to require physician staffing ratios per number of prehospital providers. Proponents of the resolution contend that staffing ratios would create greater oversight for EMS systems and decrease the likelihood of critical errors.

Recommendation: That the following new TMA policy be adopted in lieu of Resolution 302-A-18:

The Texas Medical Association will advocate for the Texas emergency medical service (EMS) systems to provide adequate funding for physicians to play an active role in the provision of Medical Direction and Oversight. This includes adequate support staff to accomplish this goal with the level of involvement necessary to perform the duties required by the Texas Medical Board (TMB) and Department of State Health Services (DSHS); thus facilitating safe oversight and management of EMS medical practices.
REPORT OF COMMITTEE ON EMERGENCY MEDICAL SERVICES AND TRAUMA

CM-EMST Report 3-A-19

Subject: Sunset Policy Review

Presented by: Veer Vithalani, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The committee recommends retaining Policy 100.013.

100.013 Trauma Funding: The Texas Medical Association supports the Texas Department of State Health Services’ efforts to secure a permanent funding source for state funding of emergency medical services and trauma (CM-EMS Rep. 1-I-98; reaffirmed CPH Rep. 2-A-09).

Recommendation 1: Retain.

The committee recommends deletion of the following policies:

205.029 Hurricane Ike and The University of Texas Medical Branch: The Texas Medical Association adopted the following set of principles relating to regional Hurricane Ike recovery issues and The University of Texas Medical Branch at Galveston:

Address a regional crisis regarding access to critical care, with the immediate establishment of a third Level 1 or 2 trauma center, or expansion of existing centers and supporting infrastructure (ICUs, inpatient beds, and the like) for adults and children in the Houston/Galveston/Beaumont area.

Use of emergency state appropriation to establish or expand the above-mentioned centers.

Apply existing trauma care funds, currently in the treasury, or regional tax for the sustainability of at least three Level 1 or 2 trauma centers in the region.

Adequately fund care for the uninsured patients who arrive from other counties. Use state and/or federal funding and/or mandatory uninsured compensation from the counties of residence.

The University of Texas Medical Branch (UTMB) can continue providing these services as part of its mission with state funding, or

Each county can contract with hospitals and physicians or establish hospital districts to obtain these services.

Provide adequate funding and resource capacity, either at UTMB or other facilities, for the care of:
Correctional patients (Texas Department of Criminal Justice)
Burn patients, both pediatric and adult
Mental health/substance abuse patients
Primary and preventive care patients
Chronic disease management patients

The Federal Emergency Management Agency provide 100-percent reimbursement for UTMB recovery costs, as was done for post-Katrina New Orleans.

Promote cost effective care of displaced patients and ensure reimbursement for medical schools/hospitals for costs incurred for medical students and residents transferred from UTMB (Res. 301-A-09).

Recommendation 2: Delete.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee of Infectious Disease recommends the following policy for deletion, because the Texas Department of State Health Services is no longer pursuing efforts for uniform bar coding on vaccines, thus rendering the policy irrelevant:

260.081 Bar Coding on Vaccines: Bar Coding on Vaccines: The Texas Medical Association will work with the Texas Department of State Health Services to encourage state and national efforts to promote the use of technology, such as bar coding of vaccines, to improve patient safety and standardized reporting of immunizations (CM-ID Rep. 2-A-09).

Recommendation: Delete.
Subject: Improving Health Technology Products to Address Issues of Sex and Gender

Presented by: D. Allen Schultz, MD, Chair

Referred to: Reference Committee on Science and Public Health

Background

The Council on Science and Public Health (SPH) and its LGBTQ Workgroup submitted Report 8-A-18 to the House of Delegates at its annual meeting in 2018. The report has four recommendations, two became TMA policy:

265.027 Costs to Update Health Information Technology Products to Address Issues of Sex and Gender: The Texas Medical Association believes that neither physicians nor patients should incur additional costs when electronic health records (EHRs) or health information technology (HIT) systems are updated to reflect the latest in regulatory requirements or evidence-based medical care in the area of lesbian, gay, bisexual, transgender, queer, or questioning health (CSPH Rep. 8-A-18).

265.028 Improving LGBTQ Health Care Access: The Texas Medical Association recognizes that lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals have unique health care needs and suffer significant barriers in access to care that result in health care disparities. TMA will provide educational opportunities for physicians on LGBTQ health issues to increase physician awareness of the importance of building trust so LGBTQ patients feel comfortable voluntarily providing information on their sexual orientation and gender identity, thus improving their quality of care. TMA also will continue to study how best to reduce barriers to care and increase access to physicians and public health services to improve the health of the LGBTQ population (CSPH Rep. 8-A-18).

The other two recommendations from Report 8-A-18 were referred to the Council on Practice Management Services (CPMS) and the Ad Hoc Committee on Health Information Technology (HIT):

(1) that TMA work with the American Medical Association and leaders in the field of lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) health such as the World Professional Association for Transgender Health and the Gay and Lesbian Medical Association to develop requirements for electronic health records (EHRs), health information exchanges (HIEs), and other health information technology (HIT) products reflecting best practices that include the ability to support, capture, and provide easy use by physicians of the following information: a. Current gender identity, b. Gender assigned at birth, c. Sexual orientation, d. Name (or names) and pronoun preference, e. Indicated health screenings, f. Appropriate clinical decision support tools, and g. History of gender-affirming surgery or treatment as part of past medical or surgical history, and h. Sex assigned at birth. These products also should incorporate effective privacy attributes, particularly for adolescents, and enable physician use of a longitudinal view of changes in demographics, gender identity, sexual preference, medical and surgical history, and past interventions;

(2) that TMA and AMA continue to advocate for the rapid incorporation of best practice requirements into EHRs, HIEs, and other HIT products;
Status

Representatives from the Ad Hoc Committee on HIT had an initial conference call with representatives from AMA to discuss related AMA policy and how TMA can work with AMA on the assigned issues. AMA has an LGBTQ Advisory Committee that addresses many of the same issues as TMA’s LGBTQ Workgroup. The following is AMA’s policy on the Medical Spectrum of Gender D-295.312:

- Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

On Jan. 7, 2019, TMA held a second call with representatives from the AMA LGBTQ Advisory Committee and the Gay and Lesbian Medical Association (GLMA) to discuss (1) sexual orientation and gender identity (SOGI) data management in HIT, and (2) how, working together, the three organizations and others can influence HIT companies to improve their products beyond the minimum required for designation as Certified Electronic Health Record Technology (CEHRT). Participants discussed the burdens physicians may encounter when collecting data on LGBTQ patients, such as local customization of EHRs to address SOGI issues, particularly with respect to clinical decision support, correct billing protocols, and appropriate privacy settings; ensuring such modifications are no extra cost to physicians; and more.

Recommendation: That the Texas Delegation to the AMA introduce a resolution to the American Medical Association House of Delegates asking the AMA to adopt the following:

1. Research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; and
2. Advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians, and investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query everyone regarding sexual orientation and gender identity at each encounter.
The 2018 House of Delegates considered Resolution 314 from the Texas Pediatric Society that called for TMA to advocate for legislation permitting extreme risk protection orders in Texas. Resolution 314 identified gun violence as a public health threat— noting that mental illness, domestic violence, and substance abuse often are factors in gun violence. Testimony at the hearing of the Reference Committee on Science and Public Health revealed both support for the proposal and concerns about the consequences of such legislation. Acknowledging the complexities and challenges of firearm safety legislation and the recent mass shootings in Texas, the reference committee recommended the resolution be referred for study. The recommendation was approved, and the Board of Trustees referred Resolution 314 to the Council on Science and Public Health and the Council on Legislation. As part of the councils’ review of Resolution 314, TMA President Doug Curran, MD, appointed a TMA Workgroup on Firearms and selected 13 physician experts to review, discuss, and advise both councils with recommendations for consideration. At Dr. Curran’s request, TMA Board of Trustees member Gary Floyd, MD, chaired this workgroup. Two meetings (during 2018 TMA Fall Conference and 2018 Advocacy Retreat) were held to work up recommendations on Resolution 314 as well as Resolution 313 (Raising the Minimum Purchase Age for All Guns to 21), which also was referred for study. Additionally, the workgroup evaluated gaps in TMA firearm policy to offer a set of additional principles for consideration by both councils for a report back at 2019 TMA Winter Conference.

John Carlo, MD, member of the American Medical Association Council on Science and Public Health and TMA Council on Legislation, brought to the discussion the newly adopted 2018 AMA report, “The Physician’s Role in Firearm Safety.” The AMA council report focused on the presupposition that 38,000 U.S. deaths from firearms in 2016 is unacceptable and that firearm violence is a public health threat. Racial and ethnic disparities make nonwhites 2.5 times more likely to die from firearms than whites. The report called on the need for more scientifically based research for effective measures to address the public health issues with firearm violence.

Gun Violence and Behavioral Health
The United States has the highest violent death rates among high-income countries; this includes the highest firearm homicide rates and firearm suicide rates — both at least twice that of other high-income countries. The Centers for Disease Control and Prevention (CDC) does not use the term “gun violence,” but in its role as national surveillant of violent deaths, CDC recently identified firearm-related deaths as a public health concern. Comparing data on firearm deaths in the 50 largest U.S. metropolitan statistical areas from 2012-13 and 2015-16, CDC reports that firearm-related death rates now have risen to the high rates of more than 10 years ago (2006-07).

CDC identifies suicides as “self-directed violence” and as a top 10 leading cause of death in the United States and one of only four causes of death with significant rate increases. There were more than 44,000 suicides in the United States in 2016, and 50 percent, or more than 22,000 deaths, were suicides by firearm. The rates of suicide by firearm vary by age group, but males consistently have the highest rates.
(more than 80 percent of all firearm suicides), with the rates rising among older age groups. The U.S. suicide rate by firearm increased 21 percent from 2006 to 2016 (for people more than 10 years old).

In 2016, Louisiana, Alabama, and Alaska had the highest rates of firearm mortality in the country (21.3 to 23.3 per 100,000). With 3,353 firearm-related deaths in this period, Texas had more deaths than any other state and a firearm-death rate of 12.1 (per 100,000). Like the rest of the country, Texas’ suicide rate increased from 2000 to 2016, and Texas’ suicide-by-firearm rate of 7.3 (per 100,000) is higher than the U.S. rate of 6.5.

Contrary to news reports that associate firearm violence and mass shootings with a mental illness, most of the people who carry out a mass shooting do not have a diagnosis of a mental illness. A very small proportion of those with a severe mental illness and a history of violence may be more likely to become violent when experiencing a high-risk event. The American Psychiatric Association notes that less than 1 percent of gun-related homicides in a mass shooting each year involved a person with a serious mental illness, and about 3 percent of individuals with a serious mental illness were involved in a violent crime. A report of the Federal Bureau of Investigation (FBI) also confirms that only 25 percent of 63 active shooters in the United States (2000-13) had been diagnosed with a mental illness, and three of these were diagnosed with a psychotic disorder. The FBI reports that most of those involved in a mass shooting were known to have demonstrated concerning behaviors or to have experienced one or more severe stressors before they engaged in firearm violence. Firearm violence has been more commonly associated with compulsive, angry behavior. A recent analysis of the National Comorbidity Study Replication found that about 10 percent of U.S. residents both report pathological anger and possess firearms and/or carry firearms outside the home. In many cases, these people already have a history of misdemeanor violence (e.g., controlled substance misuse, physical altercations). These traits and access to firearms appear to increase the risk for violent behaviors.

### Red Flag Laws and Protective Orders

Extreme risk protection orders, also known as “gun violence restraining orders” or “red flag” laws, are intended to remove firearms from individuals who are reported to be an extreme risk to themselves or to another person. While five states already have some type of red flag statute, an additional eight states recently have adopted red flag legislation. Legislation has been considered in many more states — including Texas — but has not been approved. Additionally, concerns have been raised about the complexity of these orders and their enforcement.

The United States has extensive statutory law that addresses firearm commerce, such as the Gun Control Act 1968, which limits the purchase of firearms by specific people such as those who are convicted of a felony or domestic violence, subject to a restraining order or involuntary commitment, or declared mentally incompetent. The 1968 legislation also raised the age for handgun purchase to 21 years. The Brady Handgun Violence Prevention Act established the National Instant Criminal Background Check System, and the National Crime Information Center was created for reporting required criminal justice information such as people identified under a protective restraining order.

Domestic protective orders and red flag laws are associated with federal laws on the purchase or possession of a firearm and the reporting of those not qualified to purchase or possess a firearm. While almost all states have protective orders, their scope varies by state. However, these orders generally are based on the type of risk presented — such as an association with family violence, a history of a felony conviction, or a diagnosed mental illness. The process for obtaining a protective order addresses who is at risk of harm and the mental status and history of firearm violence of the person identified as the offender. The petitioner for a protective order typically presents in court and must report direct threats or warning signs of a potential threat to family, household members, or law enforcement. The removal of firearms from the person identified as the offender is not automatic, but the petition can lead to removal if requested by the petitioner.
A protective order is not the same as a red flag law. Red flag laws do not focus on the domestic setting, nor do they relate to violence that already has occurred. Red flag laws are intended to prevent the future violent conduct of people who may have access to firearms and if there is evidence of direct threats to themselves, other individuals, or groups (e.g., in a home, school, or work setting), and/or there are other concerning behaviors. Red flag laws allow for the preemptive removal of a firearm based on potential risk.

Red Flag Law Effectiveness
Several states have had red flag laws for a few years, but red flag law requirements vary by state, and implementation of these laws still appears to be in an early stage in some states. Connecticut has the longest history, with its red flag law adopted in 1999, followed by Indiana’s red flag law authorized in 2005. No studies could be found on the impact of red flag laws in most of the states that already have implemented them. It may be that differences in these state laws and implementation status make them complex to assess.

A few studies have assessed the impact of these laws in Connecticut and Indiana. Key findings include:

- From 2005 to 2015, Indiana saw a 7.5-percent reduction in firearm-related suicides.
- Connecticut initially saw a 1.6-percent reduction in firearm-related suicides in the earliest years of implementation, but the rate of firearm-related suicides decreased most significantly after 2007. The study authors attribute this to more rigorous implementation of red flag laws following the 2007 mass shooting at the Virginia Polytechnic Institute and State University.
- Another study on Connecticut’s experience with its red flag law (1999-2012) found that while the number of suicides declined among those who had one or more firearms removed, suicides and suicide attempts that did not involve firearms increased. Suicidality was the key issue identified for almost two-thirds of the more than 760 people who were subject to a risk warrant petition. The study also found that some may seek and obtain mental health care, as 29 percent were in contact with the public mental health system in the year following their crisis. However, the removal of firearms from those at risk of suicide is viewed as a significant impact in Connecticut.

Several studies note significant inconsistencies in how red flag laws are implemented, and implementation can even vary by jurisdiction within a state. Interviews with legal counsel and judicial representatives associated with Connecticut’s red flag legislation revealed an interest in clarifying Connecticut’s process for approving risk-based warrants and also concern about the assurance of due process for people subject to firearm removal.

While there is a limited body of study on red flag laws, there is broader study on the effectiveness of domestic protective laws in reducing intimate partner violence, including reducing rates of homicide with firearms. Family and domestic protective orders are implemented in almost every state as a tool to prevent a personal assault or other violence.

Texas Statutes, Legislation, and Recent Action on Firearms
Unlike several other states, Texas does not require a permit to purchase a handgun, rifle, or shotgun, nor is registration or licensure required to possess these firearms. A permit is required to carry a handgun (open or concealed), although some facilities can restrict or prohibit the carry of a handgun. More than 1 million Texans have concealed handgun permits, and a recent national survey found that more than a third (35.7 percent) of Texas adults own a firearm. Texas’ safe storage law creates a misdemeanor if a firearm is accessible to a child, and the misdemeanor can be raised to a Class A misdemeanor if a child’s use of the firearm leads to death or serious injury to the child or another person. And while neither a municipality nor a county can adopt regulations on the possession, registration, or licensure of firearms or ammunition, municipalities can regulate the discharge of firearms within the city or the carry of a firearm at a public facility or certain events.
Texas does not have a red flag law, but like most states, Texas’ protective orders are for domestic or family violence and emergency protective orders. Texas’ protective orders statute is more expansive than most other states as it can refer not only to a spouse, family member, or other resident of the household but also to an intimate or “dating” partner and allows for a protective order against domestic or family violence or for a victim of sexual assault. Emergency protective orders also can be approved by a magistrate for a person who already has been arrested for family violence or assault — but may not allow for taking possession of a firearm. Texas’ statute also extends to the possession of ammunition. A Texas resident under a restraining order must be reported by courts to the Texas Department of Public Safety, which in turn reports to the federal National Crime Information Center.

Recent legislation (2017) filed to expand protective orders in Texas includes House Bill 866 by Rep. Joe Moody and Senate Bill 434 by Sen. José Rodriguez to allow law enforcement to remove firearms with the issuance of a lethal violence protective order if family members or law enforcement can provide evidence that the individual or others are in immediate danger. HB 866 was left pending in committee. House Bill 131 by Rep. Joe Moody on extreme risk protection orders was the first bill to be filed on red flag legislation in the 2019 legislative session.

In response to the school shooting in Santa Fe High School and the November 2017 mass shooting in Sutherland Springs, Texas Gov. Greg Abbott convened three roundtables across the state on the safety of students and teachers in Texas schools. The Governor’s School and Firearm Safety Plan made recommendations on school safety and on the reduction of firearm-related threats. One recommendation calls on Texas legislative leadership to consider the merits of red flag legislation in Texas.

The Texas Senate appointed the Select Committee on Violence in Schools and School Security, whose charge includes a review of red flag orders. Testimony at the committee’s July 2018 hearing on red flag laws provided both support and opposition to the consideration of a red flag statute in Texas. Supporters suggested allowing family members and law enforcement to initiate an order to remove a firearm from someone they perceive as presenting harm to themselves or others, and in particular, someone who is recognized as being in a crisis situation. It was also noted that current statute could be broadened to address the person who has a history of violent behavior or reckless use of a firearm or other deadly weapons, or someone who has been released from a mental health hospital who also may present a risk. Others spoke on the ability to apply Health and Safety Code Chapter 573 in the Texas Mental Health Code that allows a peace officer to take into custody and restrain a person without a warrant if the officer believes the person has a mental illness and presents a substantial risk to himself or herself or to another person.

The Senate committee’s August 2018 report made several recommendations but none in support of legislation on red flag orders. The recommendations called for legislation to clarify current statute on whether and when an individual convicted of domestic violence may possess a firearm legally and on the return of firearms to individuals who have been detained and declared no longer to be a risk to themselves or others.

Discussion

Gun violence often is associated with mental illness, and both matters are of significant concern to physicians. Yet studies indicate physicians are not screening routinely or counseling even high-risk patients on firearm safety. And when screening is done, it is more likely done by primary care physicians, psychiatrists, or emergency medicine physicians. This suggests there may be a need to increase physician awareness of screening tools and interventions, especially for patients who may be at risk for violence to themselves or others.
Violence is indeed a concern, and domestic and family violence is a significant problem in Texas. Texas has broad protective order procedures intended to prevent domestic and family violence, but almost 200,000 incidents of family violence were reported in 2015, with 97 percent of these categorized as involving a physical assault. Physical force was used in 80 percent of assaults, and a firearm was involved in 1.7 percent of reported family violence cases. The Texas Council on Family Violence reports that male partners killed 146 women in 2016, and there were more than 170,000 hotline calls to Texas family violence programs in that period. Yet data on current violence in Texas and firearm violence in particular could not readily be found. Active surveillance of firearm-related injuries and deaths in Texas and access to these data would help physicians better understand the circumstances contributing to injuries and deaths associated with firearms. Texas remains one of the few states that does not participate in CDC’s National Violent Death Reporting System (NVDRS). CDC notes that the NVDRS helps communities understand the “who, when, where, and how” associated with violent deaths to enable communities to take action to save lives.

But physicians have important tools to support firearm violence prevention, and this begins with the patient-physician relationship that includes confidential communications on the care and personal safety of the patient. There is substantial evidence that patients depend on and trust the free exchange of information and personal guidance they receive from their physician. Patients are more likely to act upon direction from their physician than they are from other sources. This can and should include discussions on potential risks in the home such as firearm access by the patient or family members. Texas has clear statute on the duty to ensure firearm safety in the home, and physicians can inquire and readily share information on firearm risk in their communications with patients.

The public and physicians also can readily access state and volunteer resources on family and domestic violence. The Office of the Attorney General, the Texas Council on Family Violence, and many local community organizations offer information and assistance to those at risk of domestic violence. Patients also may be unaware of current protective order laws. In addition, Texas statute allows a physician and licensed or certified mental health professionals to disclose confidential patient information if a patient appears to be at imminent risk of self-harm or harm to another. Physicians do not have a duty to share information, but this presents an important option for physicians.

Conclusion

Background checks and age-based requirements for the possession and purchase of firearms have been the mainstay of federal and state management of firearms. Keeping firearms away from people who present a risk of harm or who are unable to make sound decisions provides a strong base for managing firearm safety. But with an estimated more than 400 million firearms in the United States, clearly purchase and possession laws are not providing adequate protection to prevent firearm access by those at high risk of harm to self or to others.

About 40 percent of U.S. adults own one or more firearms or live in a home where a firearm is present. Most of these firearms were purchased or otherwise obtained legally outside the federally regulated system for licensed firearm vendors. For a large proportion of U.S. adults, gun ownership is associated with an individual’s personal freedom, and protection is a key reason why many own one or more firearms.

With dozens of significant events involving firearm violence and mortality, the country remains divided on what actions are needed to prevent firearm-related violence. But firearm violence is not a new concern for medicine. The American Medical Association, the American Academy of Pediatrics, and the American College of Physicians have taken a firm stand on the physician role in addressing gun violence as a public health issue. Other medical associations also have agreed upon the urgency for identifying public health prevention strategies to reduce firearm mortality and morbidity.
CDC defines public health as the science of protecting and improving the health of people in their communities. Historically this has focused on preventing and responding to infectious disease outbreaks, but as public health science and medicine have evolved, it has become increasingly important to direct research to better understand the factors that contribute to preventable diseases and injuries such as firearm violence. State legislation to allow extreme risk protection laws may have an impact in reducing suicide rates, but such legislation alone may not fully address other factors associated with mass shootings and domestic violence. Thus physicians must continue to advocate for and seek evidence so they can be directly engaged in identifying how to reduce firearm morbidity and mortality.

Texas has a history and culture of independence, which for about a third of Texas adults includes the freedom to possess and use firearms as permitted by the U.S. Constitution. TMA does not take a position on firearm possession or purchase, but recognizes that physicians have a role in helping identify and support their patients at risk of harm, particularly if a patient has access to firearms or lives in an unsafe environment. Further, there is an urgent need to improve Texas’ understanding of firearm violence and of the outreach and public awareness that may be needed in some communities. Therefore, in lieu of adopting Resolution 314, the council makes the following recommendations:

Recommendation 1: Amend TMA Policy 260.015, Firearms, as follows:

The Texas Medical Association recognizes gun violence as a public health issue requiring the promotion of evidence-based strategies in Texas. Medical professional organizations should speak out about the prevention of firearm-related injuries and deaths, and TMA calls on physicians to support:

1. The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership, recognizing that physicians have an unencumbered right to inquire of and inform patients and their families about the risks of firearms and in particular the risk to children;
2. Promotion of the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife;
3. Physicians in the clinical setting providing anticipatory guidance in the clinical setting on the dangers of firearm ownership in an informational, nonjudgmental manner, encouraging firearm owners to adhere to best practices for reducing the risk of accidental or intentional injuries or deaths by ensuring firearms are not accessible to children; adolescents; or people with mental, behavioral, or substance use disorders;
4. Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession;
5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and
6. Unfettered study of issues involving firearms and public health and safety, and Texas’ participation in national surveillance studies on violence in the United States, ensuring the state has timely, accurate data on firearm-related mortality and morbidity to guide Texas’ public health prevention activities (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08; amended CSPH Rep. 5-A-18).

Recommendation 2: That the Task Force on Behavioral Health develop information for physicians on the prevention and assessment of suicide risk and promote awareness of mental health first-aid training for physicians and office staff, and of state statute on the sharing of information on patients at risk.

Recommendation 3: That TMA advocate for a protective order process to allow for the implementation of risk-based protective orders to support those reported to be at high risk of violence to others or self-harm.
Recommendation 4: Amend TMA Policy 325.002, Family Violence, as follows:

325.002 Family Violence: The Texas Medical Association believes that physicians should learn to be aware of the what resources are available in their community such as information provided by the Texas Family Violence Council and information on family protective orders developed by the Office of the Attorney General to inform and support to help victims of domestic violence. Physicians should make this information available in their waiting rooms or have their office staff provide it. The association should provide physicians with information on the symptoms of domestic violence and abuse, and that physicians should record information on domestic violence in the patient’s medical file (CPH, p 129, A-92; amended CPH Rep. 3-A-10).

Related TMA policy:

245.021 Patient-Doctor Privileged Communication: The Texas Medical Association (1) opposes efforts by the Texas Legislature to insert itself into the patient-physician relationship in any way that interferes with the free and full disclosure of health care information in the best interests of the patient, and (2) reaffirms its support of the free exchange of professional information in the patient-physician relationship as privileged and worthy of the highest professional protection (Amended Res. 108-A-13).

325.002 Family Violence: The Texas Medical Association believes that physicians should learn what resources are available in the community to help victims of domestic violence and make this information available in their waiting rooms or have their office staff provide it, that the association should provide physicians with information on the symptoms of domestic violence and abuse, and that physicians should record information on domestic violence in the patient's medical file (CPH, p 129, A-92; amended CPH Rep. 3-A-10).

Related AMA policy:

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

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

(1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns;
(5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
H-145.990 Prevention of Firearm Accidents in Children
Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care
1. Our AMA supports:
   a) federal and state research on firearm-related injuries and deaths;
   b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;
   c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;
   d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;
   e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
   f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and
   g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

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

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.972 Firearms and High-Risk Individuals
Our AMA supports:
(1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence;
(2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms;
(3) expanding domestic violence restraining orders to include dating partners;
(4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons;
(5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and
(6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

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

1. Our AMA supports:

a) federal and state research on firearm-related injuries and deaths;
b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;
c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;
d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;
e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and
g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

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

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.976 Firearm Safety Counseling in Physician-Led Health Care Teams

1. Our AMA:

(a) will oppose any restrictions on physicians' and other members of the physician-led health care team's ability to inquire and talk about firearm safety issues and risks with their patients;
(b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and
(c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.
H-145.996 Firearm Availability

1. Our AMA:

(a) advocates a waiting period and background check for all firearm purchasers;
(b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and
(c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Sources:

5. DSHS, Suicide Trends and Characteristics, Texas vs. United States.
13. Chapter 82 Subtitle B. Protective Orders, Chapter 82. Applying for Protective Order, Subchapter A. Application for Protective Order, Sec. 82.001.


20. Texas, Health and Safety Code 611.004 Authorized Disclosure of Confidential information other than in Judicial or Administrative Proceeding; Texas Medicine, The Texas Supreme Court Speaks: Mental Health Professionals Have No Duty to Warn or Protect Third Parties, Nov. 2002.

Support of Evidence-Based Medicine, Resolution 107-A-17

Presented by: Alice Gong, MD, Chair,

Referred to: Reference Committee on Science and Public Health

The 2017 House of Delegates considered Resolution 107-A-17 from the Resident and Fellow Section, Young Physician Section, and Medical Student Section. The House of Delegates recommended referral of the resolution. The resolution was referred to the Board of Councilors, which studied the issue and made a recommendation to the 2018 House of Delegates that Resolution 107-A-17 not be adopted. Testimony at the hearing of the Reference Committee on Financial and Organizational Affairs recommended referral to the LGBTQ Health workgroup with a report back in 2019.

Background

Resolution 107-A-17 called for Texas Medical Association to:

• Adopt policy opposing the criminalization of evidence-based medical care;
• Oppose the revocation of a medical license for the provision of evidence-based medical care; and
• Encourage TEXPAC to consider previous and planned actions to criminalize the practice of medicine when deciding endorsements and allocation of funds.

Testimony in 2017 on Resolution 107 expressed concerns with legislation proposed in the Texas Legislature associated with abortion. Testimony before the reference committee was largely supportive of the resolves although concern was expressed on the third resolve related to TEXPAC and the potential for unintended consequences. The resolution was referred to Board of Councilors, whose 2018 report to the House of Delegates did not support the resolves. Testimony at the 2018 reference committee focused on challenges to evidence-based medicine and specifically the creation of penalties for physicians for failure to comply with legislative requirements even though they were contrary to the practice of evidence-based medicine.

Penalties to the Practice of Evidence-Based Medicine

In 2011, the Florida legislature passed legislation that would restrict physician communications with their patients on firearm access. Penalties in the legislation imposed a “gag” that would include both a fine and the potential loss of the physician’s license for inquiring about firearms in the home. House Bill 155, Privacy of Firearm Owners, prohibited a licensed practitioner or a facility from recording the status of firearm ownership in a patient’s medical records or even inquiring about ownership or possession. Long a practice of pediatricians, inquiring about access to firearms and other potential hazards is a mainstay of pediatric screening and communications with children. HB 155 was finally struck down by a federal court of appeals.

Several proposals on abortion were filed during the 2017 Texas legislative session including House Bill 844 and Senate Bill 415, which called for a prohibition on the performance of “dismemberment” or partial-birth abortions. HB 844 provided penalties and created a criminal offense for physicians and others acting under the direction of a physician who performed this procedure, commonly known as dilation and evacuation (D&E), a procedure followed for abortions in the second-trimester. HB 844 was
not passed, but language from HB 844 was appended to Senate Bill 8 to prohibit D&E and other procedures. SB 8 addressed certain prohibited abortions and the treatment and disposition of a human fetus, human fetal tissue, and embryonic and fetal tissue remains. Currently, large components of the requirements in SB 8 remain under court review.

Discussion and Conclusion

A literature review of penalties on the practice of evidence-based medicine did not identify articles or studies but did turn up several reports regarding new challenges to the practice of evidence-based medicine. Public policy proposals on physician practices occasionally are developed in many states and certainly in Texas. Most recently in Texas, legislative activities have been proposed and sometimes approved, such as adding new requirements for women’s access to abortion services, for end-of-life care, for the use of marijuana as medicine, and making it easier to get an immunization exemption for a child to enroll in school.

Several recent articles note the challenges to the practice of evidence-based medicine. Among these are keeping abreast of the latest clinical research and changes in clinical guidelines necessary for effective patient care. But often the most significant challenge is managing developments and new guidelines while balancing the physician’s own judgment and expertise and the unique needs and characteristics of each patient. Patient literacy and individual preferences also will remain a challenge to the practice of evidence-based medicine.

There is little information on penalties or threats to physician licensure for the practice of evidence-based medicine. However, public policy decisions on social, clinical, and economic issues often are determined in the Texas Legislature, where stark ideological divisions are common. But the intervention of legislators and others in evidence-based medicine is not new to TMA; during legislative sessions, the association has consistently opposed obstacles to the practice of evidence-based medicine. This is why the Texas Medical Association focuses on developing effective relationships with local and state leadership to ensure physicians can serve as trusted resources for legislators on complex and divisive issues.

Resolution 107 referred to TMA Policy 265.018 on evidence-based medicine, which the Council on Science and Public Health updated significantly in 2018. Further, TMA’s policy related to abortion was updated in 2017. The council notes that while TMA has strong policy on evidence-based care, this policy does not directly address legislatively imposed penalties on physicians who are practicing evidence-based care. In lieu of Resolution 107-A-17, the council recommends amending TMA policy.

Recommendation: Amend TMA Policy 265.018 as follows:

**265.018 Evidence-Based Medicine and Practice:** The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of
evidence-based medicine to improve approval and payment for medical services where appropriate.

TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with professional standards, (2) whenever there is a significant change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the American Medical Association policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as “evidence-based medicine.”

TMA will oppose obstacles or penalties to the practice of evidence-based medicine including censure of licensure or criminal charges and calls for monitoring of local and state policy proposals that may allow for disruption to the patient-physician relationship and the practice of evidence-based care, especially in responding to vulnerable populations (CSA Rep. 3-A-08; amended CSPH Rep. 5-A-18).

Related TMA Policy:


10.003 Patient Autonomy and Accuracy of Information in Informed Consent for Abortion: The Texas Medical Association urges DSHS to distribute printed material to patients that accurately reflect current medical consensus of the potential health effects of abortion, updating the potential complications and risks of abortion so they are described in such a way that women understand the overall safety of the procedure. TMA supports the autonomy and dignity of the patient by respecting the patient’s right to decide what information she does and does not receive. TMA advocates for the Texas Legislature to relieve the penalties of refusal to admit to license exam or refusal of license issue or renewal if physicians are noncompliant with any state legislation that violates the physician's duty to act in the best interests of his or her patients (Amended Res. 306-A-12; amended CSPH Rep. 3-A-17).

60.008 Rejection of Discrimination: The Texas Medical Association 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)


265.018 Evidence-Based Medicine: The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of evidence-based medicine to improve approval and payment for medical services where appropriate.

TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with professional standards, (2) whenever there is a significant change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the American Medical Association policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as “evidence-based medicine” (CSA Rep. 3-A-08; amended CSPH Rep. 5-A-18).

Related AMA Policy:
H-65.964. Access to Basic Human Services for Transgender Individuals: Our AMA: (1) opposes policies preventing transgender individuals from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate for the creation of policies that promote social equality and safe access to basic human services and public facilities for transgender individuals according to one’s gender identity.

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations: 1. Our AMA: (a) believes that the physician’s nonjudgmental recognition of patients’ sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ) patients, this recognition is especially important to address the specific health care needs of people who
are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the
current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and
sexuality information from our patients; these efforts should start in medical school, but must also be a
part of continuing medical education; (ii) educating physicians to recognize the physical and
psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in
LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs
of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these
populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better
understand the medical needs of LGBTQ patients; and (c) opposes, the use of “reparative” or
“conversion” therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need
for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection
screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the
need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii)
appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that
individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender,
queer/questioning individuals) experience intimate partner violence, and how sexual and gender
minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may
have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase
physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on
issues of mutual concern in order to provide the most comprehensive and up-to-date education and
information to enable the provision of high quality and culturally competent care to LGBTQ people.

Sources:
1. Texas Department of State Health Services, Table 33 Induced Terminations of Pregnancy by Type of
Subject: Raising the Minimum Purchase Age for Guns, Resolution 313-A-18

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Science and Public Health

Background
The 2018 House of Delegates considered Resolution 313 submitted by the Texas Pediatric Society that called for TMA to support federal and state legislation to raise the age for the purchase of all firearms to 21 years. Testimony at the reference committee hearing was overwhelmingly in favor of the resolution, and the reference committee recommended adoption. However, there was extended discussion at the House of Delegates with members speaking in support of the resolution while others called for referral. Issues raised ranged from the association between mental illness and firearm violence, brain development and the decisionmaking capacity of adolescents, and a lack of information on the evidence that raising the age of purchase would reduce gun violence.

The House of Delegates supported the referral of the resolution, and the Board of Trustees referred Resolution 313 to the Council on Science and Public Health and the Council on Legislation. As part of the councils’ review of Resolution 313, TMA President Doug Curran, MD, appointed a TMA Workgroup on Firearms and selected 13 physician experts to review, discuss, and advise both councils with recommendations for consideration. At Dr. Curran’s request, TMA Board of Trustees member Gary Floyd, MD, chaired this workgroup. Additionally, the workgroup evaluated gaps in TMA firearm policy to offer a set of additional principles for considerations by both councils for a report back at 2019 TMA Winter Conference.

John Carlo, MD, member of the American Medical Association Council on Science and Public Health and of the TMA Council on Legislation, brought to the discussion the newly adopted 2018 AMA report, “The Physician’s Role in Firearm Safety.” The AMA council report focused on the presupposition that 38,000 U.S. deaths in 2016 from firearms is unacceptable and that firearm violence is a public health threat. Racial and ethnic disparities make nonwhites 2.5 times more likely to die from firearms than whites. The report called on the need for more scientifically based research for effective measures to address the public health issues of firearm violence.

Federal and State Laws on Firearm Purchase and Possession
Resolution 313 noted that gun violence is a threat to the health and safety of children, who are at high risk of firearm suicide, homicide, and unintentional injury, and that raising the age of purchase for long guns would align with federal and state law and would reduce child exposure to gun violence.

Federal law regulates firearm interstate commerce including purchase and possession. The 1968 federal Gun Control Act limits the purchase of firearms for certain people such as those who are convicted of a felony or domestic violence, subject to a restraining order or involuntary commitment, or declared mentally incompetent; however, federal law applies only to federally licensed firearm dealers. Federal law also sets the age of 18 years as the minimum legal age for possessing a handgun. While handguns can be purchased at the age of 21, the legal age for purchase of a rifle or a shotgun (long gun) is 18 years.

There are no age prohibitions for the possession of long guns, but federal law prohibits an unlicensed private owner or firearm dealer from selling or transferring a handgun to anyone under the age of 18.
Texas does not require a permit to purchase a handgun or a rifle or shotgun, nor is registration or licensure required to possess these firearms. A permit is required to carry a handgun (open or concealed), and Texas’ safe storage law makes it unlawful to have an unsecured firearm where a child is likely to be or where the child can obtain access. A recent national survey found that more than a third (35.7 percent) of Texas adults own a firearm.

Firearm Violence and Children

Firearms are second only to motor vehicle accidents as a cause of death among minors in the United States, and about 19 children are injured or die each day because of a firearm. More than half of the 1,300 child firearm deaths each year (2012-14) are a homicide, almost 40 percent are suicides, and about 6 percent are unintentional deaths. Older children aged 13 to 17 years are more than 12 times likely to die from a firearm than are younger children. The rate of firearm suicide is about 11 times higher for those 13 to 17 years than for 10- to 12-year-olds (suicide tracking starts at age 10). The highest rates of firearm mortality are among African-American children while annual firearm suicide rates are highest in American Indian children. More than 90 percent of child firearm deaths (in children aged 0 to 14 years) in high-income countries occur in the United States.

In 2015, 609 Texas children were injured or died because of a firearm. This includes 233 deaths from suicide, assault or homicide, or accidental firearm discharge or with an undetermined intent. More than half of these child deaths were homicides, and most deaths were in children aged 15 to 19 years.

<table>
<thead>
<tr>
<th>Texas Child Firearm-Related Deaths, Age 1 to 19 years, 2015</th>
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<tbody>
<tr>
<td>Firearm related deaths</td>
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<tr>
<td>------------------------------------------------------------</td>
</tr>
<tr>
<td>Self-harm/suicide</td>
</tr>
<tr>
<td>Assault/homicide</td>
</tr>
<tr>
<td>Discharge of firearm, undetermined intent</td>
</tr>
<tr>
<td>Accidental discharge</td>
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Source: DSHS

In a 2015 study that assessed data from 16 states participating in the Centers for Disease Control and Prevention’s (CDC’s) National Violent Death Reporting System (2005 to 2012), the authors estimate that more than 100 children aged 0 to 14 years die each year from an unintentional discharge of a firearm. For those children under the age of 10 years, almost 40 percent died from a self-inflicted discharge, while in most other cases a family member was the shooter. Hunting was a factor in some cases, but most unintentional firearm deaths took place in the child’s home or in the home of a friend. Of the children aged 11 to 14 years, 39 percent were killed in the home of a friend. And while some surveys indicate parents believe their children do not know how to access the firearms in the home, it appears that a lack of supervision for older children may be a factor in unintentional fatalities.
Age Restrictions in Texas

One of the issues raised during the House of Delegates’ discussion on raising the age for the purchase of firearms was on understanding the rationale for a specific age. A comprehensive study could not be found that described or explained the relevance of age for some federal and state laws. Both the federal and state governments have designated a minimum age for a range of activities of importance to government and as allowed under their constitutional powers. Setting an age in a statute establishes a minimum age when a person becomes legally responsible for a right or activity regulated by the government. Almost all states including Texas have designated 18 years as the age of majority. A minor in Texas is a person under the age of 18 years who has not been married and not sought emancipation. But there are many well-recognized laws in Texas with varying age limits. These either directly or generally address health and/or personal or public safety:

- Minors are directly prohibited from buying tobacco products, and it is illegal to sell tobacco products to a person under the age of 18, including e-cigarettes. A minor in violation of state law can be fined, and both the minor and his or her parents may be required to participate in community service or attend a tobacco awareness program. The City of San Antonio recently raised the age for legal purchase of tobacco to 21 years.
- Minors cannot consent to their own health care, but they have limited ability to consent for care in certain circumstances such as for a pregnancy, for treatment of a reportable infectious disease, or if seeking diagnosis or treatment for a mental health condition. Minor parents can consent to the health care of their child.
- Texas’ Alcoholic Beverage Code identifies a minor as someone who is under the age of 21 years. A person under the age of 21 is prohibited from buying, attempting to buy, or consuming alcohol, although a person aged 18 or older can serve alcohol. All state liquor age laws align with the federal minimum age as it appears that only states that observe the minimum age of 21 years can qualify for federal transportation funding.
- A minor can obtain a driver’s license at the age of 16 with graduated driving restrictions until the age of 18.
- A person under the age of 18 can be employed with the minimum age of work set at 14 years, although there are exceptions for even younger ages for certain types of work (e.g., working for a parent, agriculture). Employed minors aged 14 to 15 years are limited in the number of hours and the time of day they can work, and minors may not perform work hazardous to their safety or health.
- Minors cannot marry nor can they can enlist in the United States military without the consent of a parent.
- A minor cannot get a tattoo.

Finally, 18-year-olds can vote and hold almost any local public office (e.g., sheriff, constable, county commissioner, justice of the peace, tax assessor). They cannot be elected to serve as a U.S. senator or a member of Congress until the age of 25, although a Texas state senator must be at least 26 years and a Texas state representative must be at least 21 years of age.

While several states have adopted the age of 21 for the purchase of all firearms, the majority of states including Texas, have not done so.

Child Decisionmaking

TMA members offered testimony that some of those who are 18 years old still lack the executive function abilities needed to make reasoned, adult decisions such as the purchase of a firearm. There is a growing body of research on child brain development including the development of executive function.

Executive function of the brain refers to the brain’s organization of information from different parts of the brain needed for decisionmaking. The genes in our brains are continually expressed in the development of
millions of neural connections in different areas of the brain. Brain development starts while we are still in utero, and early neural development supports key sensory abilities such as vision and hearing, which allow an infant to build other abilities. The frontal lobe is where the integration of information occurs for executive function; the last stages of pruning or myelination in the brain occur in the frontal lobe, where these rapid developments will continue well into the mid- to late 20s for most.

By the time children are teenagers, many already have physically developed so that they appear to be an adult. But parents and educators may note that some – at the age of 18 or older – are not yet making informed adult decisions and often are receptive to activities that raise the risk of harm to themselves or others. Brain development and executive function capacity do not follow a regular schedule or pattern. There is evidence that adolescent and teenage brain development may be harmed or less developed based on a child’s experiences. For some, adverse experiences can hamper a child’s ability to access or process critical information from some parts of the brain. Unable to rapidly process memory or other information on a potentially harmful activity, a teenager may defer to his or her immediate emotional response. Poor decisionmaking can be exacerbated when a teen is regularly exposed to stress from school and peer pressure, financial concerns, family adversity, or even a lack of sleep or hormonal developments. Thus, while a teenager may be able to drive a car or understand the details of every new technology product, the brain of every 18-year-old is still in a process of maturation that will continue for several years. And while this process varies for every child, growing up in a stable, safe environment appears to contribute to improved ability to prioritize information and to manage emotions. This is particularly important for early brain development when daily, ongoing “serve and return” or back-and-forth interaction with parents and other adult caregivers supports neural development that connects different parts of a child’s brain.

Discussion and Conclusion

The United States and most states have an inconsistent method for determining the age at which a person can be held responsible for an activity that can have an impact on personal or public health, such as firearm purchase. In most cases, decisions on age-related public policy appear to be based on tradition rather than on evidence of an ability to manage a regulated activity.

In a November 2018 CDC, the nation’s public health agency identified firearm-related deaths as a public health concern and a leading cause of death in the United States. Firearm mortality is the second most common cause of death among U.S. children. Firearm homicide, suicide, and unintentional discharge are the major factors in both child injury and fatality. From 1994 to 2014, there were more than 180 million applications through the federal system for permits to purchase a firearm or to transfer firearms. The United States has a robust process for managing the sale of firearms by licensed vendors, but unlicensed firearm vendors can legally sell firearms at hundreds of gun show events held each year in Texas alone. Family members also can legally transfer firearms to other family members.

CDC has developed a framework for addressing child maltreatment and nurturing children that calls for bringing together those with shared interests in developing and supporting environments where children can grow healthy and be productive. This includes children being continually in an environment where they are secure and free of harm. As reported by the American Academy of Pediatrics, many parents believe their children will not touch a firearm or do not know where firearms are kept or can be accessed in the home. Most parents with firearms will talk to their children about firearm safety, but in homes where children are not taught, there is an increased risk, especially with children who are prone to make an impulsive decision. And the public health data tell us that children who are with untrained or otherwise careless adults or a friend that has access to a firearm are most likely to be injured or killed in an unintentional discharge.

There is extensive study on the development and role of executive function in teenagers, but it is not yet determined if brain imaging studies fully explain how we make decisions, particularly as we all are
continually exposed to different environments and experiences that can affect behavior and on the decisions an adult makes on a daily basis. Neuroscience and behavioral science are helping us better understand child maturation and development, but it does not appear the research is being applied for public policy development such as setting an age for the purchase of a firearm or other regulated activities. However, the rates of child injury and death from firearms indicate a need to reinforce and promote awareness of evidence-based harm reduction strategies for reducing firearm morbidity and mortality. Therefore, in recognition of the physician role in promoting evidence-based prevention, the council makes the following recommendations:


Recommendation 2: Adopt language from AMA policy H-145.990 as new TMA policy as follows:

Parental Education on Prevention of Firearm Accidents in Children: Texas Medical Association supports physician efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to: (1) inquire as to the presence of household firearms as a routine part of childproofing the home; and (2) share information materials to educate parents on the dangers of firearms to children; (3) encourage patients to educate their children and neighbors as to the dangers of child access to firearms; and (4) routinely remind patients to obtain firearm safety locks, store firearms under lock and key, and store ammunition separately from firearms.

Recommendation 3: Reaffirm TMA Policy 245.021, Patient-Doctor Privileged Communication:

245.021 Patient-Doctor Privileged Communication: The Texas Medical Association (1) opposes efforts by the Texas Legislature to insert itself into the patient-physician relationship in any way that interferes with the free and full disclosure of health care information in the best interests of the patient, and (2) reaffirms its support of the free exchange of professional information in the patient-physician relationship as privileged and worthy of the highest professional protection (Amended Res. 108-A-13).

Related TMA policy:

260.015 Firearms: The Texas Medical Association supports: 1. The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership; 2. The Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; 3. Physicians in the clinical setting providing anticipatory guidance on the dangers of firearm ownership in an informational, nonjudgmental manner; 4. Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; 5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and 6. Unfettered study of issues involving firearms and public health and safety (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08; amended CSPH Rep. 5-A-18).

55.033 Children’s Mental and Behavioral Health: Texas has a relatively young population, with about 28 percent of Texans under the age of 18. TMA recognizes that many mental health disorders of childhood are the basis of both physical and mental disease throughout an entire lifespan. Childhood and adolescence are critical times for brain development; consequently, many mental disorders develop during these periods.

Managing mental health disorders among children requires multiple strategies.
Physician Education. All physicians should have adequate information that enables them to recognize common mental disorders. Primary care physicians should be provided educational tools regarding the screening, diagnosis, and current available treatment modalities for mental disorders such as attention deficit disorder, mild depression, and mild anxiety. TMA can provide resources for physicians on national screening and treatment guidelines, and billing and coding information.

Practice. Access to care remains a critical issue for children and adolescents with mental health disorders, especially underserved children. A physician-led medical home, therefore, can play an important role in recognizing, consulting, and treating children with mental health disorders by following the United States Preventive Services Task Force (USPSTF) recommendations for screening children and adolescents for mental health disorders.

All physicians who see and treat children should be able to recognize and either treat or refer children with obvious mental illness including substance abuse disorder.

Because school is the “workplace of the child,” primary care physicians should have knowledge of the demands and resources of their local school districts.

Advocacy. TMA should facilitate and advocate for:

a. Continuing mental health education programs for physicians and mental health care providers regarding child and adolescent mental health and substance abuse,

b. Medical schools and graduate medical education programs that recognize the role of primary care physicians and provide effective training and research in all aspects of child and adolescent mental health and substance abuse,

c. Continuing dialogue and networking with the public mental health community on these issues,

d. Minimizing youth exposure to advertisements for legal addicting substances,

e. Positive mental health messages that counteract tobacco and alcohol advertisements,

f. Strong children’s mental health networks throughout the state,

g. Emphasizing pediatric mental health education for all physicians who see children,

h. Adequate numbers and quality of mental health professionals throughout the state,

i. Coordinating with the educational system for mentally healthy schools, and


Related AMA policy: (Partial)

H-145.990 Prevention of Firearm Accidents in Children: Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work
with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

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

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. 3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

**H-145.997** Firearms as a Public Health Problem in the United States – Injuries and Death: Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

(1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(5) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(6) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(7) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

**H-145.972** Firearms and High-Risk Individuals: Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor
domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic
violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in
place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence
restraining orders and gun violence restraining orders to be entered into the National Instant Criminal
Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that
allow for the removal of firearms from high-risk individuals.

**H-145.976 Firearm Safety Counseling in Physician-Led Health Care Teams:** 1. Our AMA: (a) will
oppose any restrictions on physicians’ and other members of the physician-led health care team’s ability
to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law
restricting physicians’ and other members of the physician-led health care team’s discussions with patients
and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination
of educational materials related to firearm safety to be used in undergraduate medical education. 2. Our
AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to
counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and
how to ask sensitive questions about firearm ownership, access, and use, and clarification on the
circumstances under which physicians are permitted or may be required to disclose the content of such
counseling conversations to family members, law enforcement, or other third parties.

**H-145.984 Data on Firearm Deaths and Injuries:** The AMA supports legislation or regulatory action
that: (1) requires questions in the National Health Interview Survey about firearm related injury as was
done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national
firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic
Injury Surveillance System.

**Sources:**
   140(1):e20163486 (firearm injuries treated in an emergency room).
3. Grinshteyn E, and Hemenway D, Violent death rates: the US compared with other high-income
4. DSHS, Deaths from Selected Causes,
   2:26.
6. The Giffords Law Center identifies 16 states (California, Connecticut, Delaware, Florida, Hawaii,
   Illinois, Iowa, Maryland, Massachusetts, Nebraska, New Jersey, New York, Ohio, Rhode Island,
   Vermont, Wyoming); accessed Nov. 2, 2018.
   Vol 7, Issue 6, June 2017.
The Task Force on Behavioral Health began its study on the relationship between childhood adversity, disease, and illness to address its charge from the Council on Science and Public Health to promote prevention and develop resources for physicians on behavioral health.

Significant recent advances in neuroscience and genomics have enhanced our understanding of the relationship between childhood adversity and health. Traumatic experiences in early childhood such as abuse, household dysfunction, or neglect can alter brain architecture and the functioning of the neurobiological systems that coordinate a person’s response to stress. For example, experiencing abuse in childhood has been associated with low baseline cortisol and increased stress-induced cortisol response. Smaller hippocampal volume has been observed among adults with a history of childhood abuse and with depression. In turn, adverse childhood experiences (ACEs) can predispose children to problems with development, behavior, and health throughout the lifespan. ACEs also have been linked to negative social and economic outcomes, including low educational attainment, financial stress, and incarceration. A parent’s experience of childhood adversity also can be associated with negative social, emotional, and physical health outcomes in their children, indicating there can be intergenerational transmission of ACEs.

Effect of ACEs on Health and Well-Being

The first major research on the health impact of childhood adversity occurred among Kaiser Permanente health system beneficiaries in southern California. In an effort to explain high dropout rates among patients in an obesity clinic who successfully lost weight, Vincent Felitti, MD, and Robert F. Anda, MD, surveyed more than 17,000 Kaiser Permanente patients on their general health and exposure to childhood abuse and household dysfunction. The results showed a strong, graded relationship between the number and intensity of adverse childhood experiences and the presence of health risk behaviors and chronic disease. Commonly known as the “ACE study,” Felitti and Anda’s work initiated further research on childhood adversity and health outcomes. The Centers for Disease Control and Prevention (CDC) continues to monitor the health of the original 17,000-plus ACE study participants. CDC’s longitudinal ACE surveys of the 17,000-plus participants (waves 1 and 2) identified physical abuse and household substance use as the most prevalent ACEs.
Measuring ACEs

While definitions vary in the literature, CDC and others generally recognize three categories of ACEs:

1. Abuse. Verbal, emotional, physical, or sexual abuse by or of a household member or other adult
2. Household dysfunction. Substance abuse, mental illness, or suicidality in the household; parental divorce or separation; a household member who is incarcerated; or physical violence in the family
3. Neglect. Physical or emotional neglect of a child

In research and clinical practice, a person’s ACE exposure typically is assessed via a questionnaire. The ACEs a person reports often are summed into an overall ACE “score,” with higher ACE scores reflecting more severe ACE exposure and risk. Studies have repeatedly shown a strong dose-response relationship between ACE scores and likelihood of subsequent negative health outcomes, including depression, anxiety, alcohol misuse, smoking, lung disease, heart disease, liver disease, and miscarriage. While the risk for health problems increases as ACEs accumulate, the research is clear that even one ACE is sufficient to predispose some people to poor health outcomes.

Several state and national public health surveillance systems measure ACEs in the general population, the most statistically powerful of which is CDC’s Behavioral Risk Factor Surveillance System (BRFSS). Each year, BRFSS is administered to adults aged 18 and over in all 50 states. In Texas, BRFSS is managed by the Texas Department of State Health Services (DSHS) and is the state’s largest ongoing population-based health survey, with a sample size of approximately 11,000 Texas adults per year. BRFSS collects standardized data on health risk factors and chronic conditions, and states may choose to collect optional data on health topics of interest, including ACEs. In 2015, DSHS included BRFSS’ optional ACE questionnaire and is scheduled to include the ACE questionnaire again in 2019.

Prevalence of ACEs in Texas

The 2015 Texas BRFSS measured the statewide prevalence of 11 different ACEs among Texas adults. Given the large and representative annual sample of Texas BRFSS, prevalence estimates are backed by considerable statistical power and can be presumed to represent the state population at large.

The most common ACE in Texas is parental separation or divorce, affecting 27 percent of Texas adults. Nearly one quarter of Texas adults were exposed to repeated verbal or emotional abuse by a parent or another adult in the household, and 20 percent lived with someone who was a problem drinker or an alcoholic. Roughly one in six Texas adults experienced physical abuse or family violence. Between 4 and 9 percent of Texans experienced various forms of sexual abuse.

Texas BRFSS did not report ACE scores, or an average cumulative number of ACEs per person. However, a large, multistate study of responses to BRFSS’ 2010 ACEs questionnaire – using identical questions to those asked in Texas in 2015 – found more than a third (36 percent) of adults in the sample experienced two or more ACEs.

More recent data indicates that childhood adversity and traumatic experiences remain prevalent among Texas youth today. According to the 2016-17 National Survey of Children’s Health (NSCH), approximately 20 percent of Texas children aged 0 to 17 years have experienced at least two ACEs. In 2017, the Texas Department of Family and Protective Services (TDFPS) confirmed 71,308 cases of child abuse statewide and removed 19,864 children from their homes, a 16-percent increase in removals since 2015. Neglectful supervision (which includes substance use in the home), physical abuse, and sexual abuse accounted for the majority of confirmed abuse reports. TDFPS’ Healthy Outcomes through Prevention and Early Support (HOPES) program provides support to caregivers in families identified as at risk for child maltreatment. In a 2018 evaluation of HOPES, 32 percent of caregivers surveyed had four or more ACEs.
Texans aged 18-plus who experienced the following events before age 18

<table>
<thead>
<tr>
<th>Adverse Childhood Experience</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents were separated or divorced</td>
<td>27.40%</td>
</tr>
<tr>
<td>Parent or adult in home swore at, insulted, or put you down more than once</td>
<td>23.50%</td>
</tr>
<tr>
<td>Lived with anyone who was a problem drinker or alcoholic</td>
<td>20.20%</td>
</tr>
<tr>
<td>Parent or adult in home ever hit, kick, or physically hurt you, not including spankings</td>
<td>17.50%</td>
</tr>
<tr>
<td>Parents or adults in home ever slapped, hit, kicked, punched, or beat each other up</td>
<td>16.50%</td>
</tr>
<tr>
<td>Lived with anyone who was depressed, mentally ill, or suicidal</td>
<td>13.90%</td>
</tr>
<tr>
<td>Lived with anyone who used illegal street drugs or abused prescription medications</td>
<td>9.20%</td>
</tr>
<tr>
<td>Anyone at least 5 years older or an adult touched you sexually</td>
<td>8.50%</td>
</tr>
<tr>
<td>Anyone at least 5 years older or an adult tried to make you touch them sexually</td>
<td>7.10%</td>
</tr>
<tr>
<td>Lived with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility</td>
<td>6.90%</td>
</tr>
<tr>
<td>Anyone at least 5 years older than you or an adult forced you to have sex</td>
<td>3.80%</td>
</tr>
</tbody>
</table>


Validation studies have confirmed BRFSS and NSCH ACE questionnaires as empirically sound measures of ACEs in a population, though some limitations must be considered. Data are based on self-report of sensitive events that some respondents may not wish to disclose or may not disclose accurately due to recall bias. ACE scoring is subject to limitations; it treats all trauma types as equally severe and does not convey trauma duration, frequency, or intensity.

Statewide Efforts on ACEs and Trauma-Informed Care in Texas
Physicians and health care providers may have seen an increase in references to adverse childhood experiences and trauma-informed care models in health and human services systems in Texas. Some state agency programs directed by the Texas Legislature, along with nonprofit organizations, have taken steps to identify adverse childhood experiences and provide treatment because of their influence on health and wellness. Texas public agencies and private organizations have implemented a range of activities to improve and ensure supportive care for children.

Health Care System Efforts. The Texas Health and Human Services Commission (HHSC) promotes awareness and offers training to physicians and other health care professionals through the module Addressing Adverse Childhood Experiences through Trauma-Informed Care. The module aims to
promote ACE recognition, awareness of health effects of trauma and toxic stress, and culturally sensitive trauma-informed care. HHSC’s community mental health services for children incorporate an evaluation of the child and family’s trauma history using the Child and Adolescent Needs and Strengths (CANS) assessment.

With support from Episcopal Health Foundation and St. David’s Foundation, TDFPS, DSHS, and The University of Texas System Population Health recently convened a pediatric brain health summit to explore how current science on brain development in children from birth to age 3 can promote resilience to adverse childhood experiences. In greater Austin, the Trauma-Informed Care Consortium of Central Texas regularly brings together local health care and professional organizations and agencies to address community-specific needs. The St. David’s Foundation and Texas Pediatric Society have established a learning collaborative serving central Texas physicians interested in tools and practices that address social determinants of health, ACEs, and childhood trauma.

**Child Welfare, Juvenile Justice, and Education System Efforts.** Like HHSC, TDFPS also uses CANS to screen for trauma among all children placed in the state’s conservatorship as required by state law. TDFPS manages community-based programs, such as the evidence-based Nurse Family Partnership, to prevent juvenile delinquency and child abuse and neglect among at-risk pregnant women and caregivers of children from birth to age 5. TDFPS also requires staff, contractors, caregivers, and foster and adoptive parents to be trained on trauma-informed care and child traumatic stress.

TDFPS and DSHS are jointly reviewing data associated with maternal and child health and prevention and early intervention programs to assess statewide needs and develop effective plans to use federal funds allocated to Texas in the future. As now required by law, TDFPS, the Texas Juvenile Justice Department, the Texas Education Agency, and the Texas Military Department are coordinating services and progress reporting, and have identified a shared goal of ACE prevention. TDFPS also participates in the Texas Supreme Court’s Children’s Commission, an interagency, multidisciplinary group addressing trauma-informed care for children and families involved in the child welfare, mental health, and juvenile justice programs of the state.

**Discussion**

The council and the Task Force on Behavioral Health are working to promote awareness of ACEs and health. This includes a CME presentation at 2017 TMA Fall Conference, several CME offerings on ACEs in other settings, an article in *Texas Medicine*, and other TMA communications. Locally, physicians across Texas have come together to study and implement screening and support services for children and adults affected by adverse experiences. We recognize that evidence-based primary and secondary prevention activities can have an impact on child development. These activities include:

- **Primary Prevention.** Accurate identification of children and adults at risk of childhood adversity is the first step in providing intervention. Standardized tools that identify risk factors are available, and their use is funded by medical insurance. Patients may benefit from education on the purpose of ACE screening and the relationship between ACEs and their health.

- **Secondary Prevention.** Given the limited number of evidence-based interventions, primary care screeners need access to information on resources and strong referral networks for interventions and supports available in their communities. Early childhood intervention programs, community child and adolescent mental health services, and medicolegal partnerships to address social determinants all have a role in treatment but may not be known, available, or easily accessed by primary care physicians.
Texas data and assessment are critical for physicians to work with others to identify and implement initiatives for the prevention and treatment of ACEs in Texas. Such efforts should include consideration of the following strategies:

- Advocating for the use in primary care (including obstetrics) of routine screening for ACEs as part of the medical history, and especially advocacy for pediatricians screening parents;
- Improving education of physicians on the resources available for referral when risks are discovered;
- Advocating for education of people with a history of trauma, parents, child care providers, teachers, policymakers, civic leaders, and the general public about the long-term consequences of adverse childhood experiences, including physical, sexual, and verbal abuse; physical and emotional neglect; and family dysfunction. Tailored messaging to these populations should emphasize the widespread nature of ACEs, promote resilience, and convey availability of resources and supports; and
- Advocating at the national and state levels for adequate payment for the time needed for universal screening and for proportionate funding of evidence-based prevention through parenting classes, sexual abuse prevention training for teachers, respite care, home visits to new parents, and community capacity building.

**Conclusion and Recommendations**

Significant efforts to address ACEs are underway at both the state and local levels in Texas, but physicians must be more widely informed in order to support initiatives to prevent and respond to ACEs. Some types of early childhood trauma are not captured in the CDC’s definition of ACEs, such as fleeing war and armed conflict, surviving a natural disaster, or witnessing community violence. In Texas, these exclusions likely are not trivial given the state’s sizeable immigrant and refugee populations; our history of major natural disasters such as hurricanes Katrina, Rita, and Harvey; and non-negligible rates of violent crime. And while some degree of childhood adversity may be inevitable, promoting resilience and mitigating the severe effects of toxic stress are other important components of a public health approach. Strategies might include community collaborations to strengthen family social supports; encouraging positive parenting; and facilitating optimal childhood social, emotional, and academic development.

TMA will continue to promote the role of primary care physicians in screening and caring for patients exposed to ACEs, but TMA also can recognize early childhood adversity as a public health issue that must be widely recognized in order to improve the health and well-being of many of our individual patients. Because of the profound effects ACEs have on the health of children and adults, TMA must commit to leadership in addressing ACEs. Therefore, the council and the Task Force on Behavioral Health make the following recommendations:

**Recommendation 1:** Identify adverse childhood experiences (ACEs) as a public health issue and advance TMA activities to increase awareness and understanding of ACEs among TMA members and the public, and ensure physicians have information on resources for screening patients, payment for care, and local resources and services for their patients.

**Recommendation 2:** That TMA convene a summit with physicians and other health professionals, community leaders, and representatives of public health and high risk populations to identify priorities for addressing ACEs. This includes identifying barriers physicians face in screening and caring for children and adults, gaps in services and resources in public programs and communities, evidence-based programming, access to data for assessment, and understanding the unique needs of specific populations.

**Recommendation 3:** That TMA advocate for public health initiatives and activities that provide effective support and care for children and adults exposed to trauma.
Sources
Subject: Sunset Policy Review

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. Following are policies reviewed by the Council on Science and Public Health with recommendations for retention, amendment, and deletion.

The following policies are recommended for retention:

260.019 Protective Headgear for Equestrian Sports: The Texas Medical Association believes that educational programs should be given to parents, riding instructors, show organizers, and managers emphasizing the risks in horseback riding and methods to minimize them. A satisfactory, protective hat must be developed for each type of riding activity and worn when riding or preparing to ride. All riding schools, horse shows, rodeos, and other events at which young persons participate with horses should require that a protective hat be worn during the activity (Council on Public Health, p 98, A-93; reaffirmed CPH Rep. 2-A-09).


Recommendation 1: Retain.

Council review of the following policies revealed these are no longer relevant and are being recommended for deletion:

95.031 Controlled Substance Registrations: The Texas Medical Association will seek relief in the form of legislation or rule making that would allow for three-year renewal terms for Texas Department of Public Safety (DPS) controlled substance registrations (Amended Res. 204-A-09).

95.032 Minimum Pharmacy Disaster Standards: The Texas Medical Association will urge state and local officials to develop a plan to ensure a sufficient supply of medications that are critical to the population in times of disaster (Amended Res. 207-A-09).

100.017 Emergency Preparedness Re Chemical and Bio-Terrorism, Physician Education: Physician members should acknowledge the need for emergency preparedness to include chemical and biologic terrorism tactics. The Texas Medical Association will work with the Texas Department of State Health Services and others to make physicians aware of bioterrorist possibilities and provide education and information to those likely to provide front-
line treatment during a crisis situation (i.e., emergency medicine, internal medicine, pediatrics, family practice); explore the establishment of an informal network of experts willing to participate in emergency response studies; and work with the Texas Department of State Health Services to provide for coordination in the event of a bio-chemical attack in Texas (CM-ID Rep. 1-A-99; reaffirmed CPH Rep. 2-A-09).

260.051 Helmet Requirement for Motorcycle Riders: All who operate a motorcycle should be required to wear an approved helmet whenever they operate a motorcycle (Amended Committee on Rehabilitation, p 118, A-98; amended CPH Rep. 2-A-09).

260.041 Ephedrine: The Texas Medical Association, recognizing that many health care professionals may not be aware of the widespread availability and use of ephedrine and large number of adverse reactions which occur, supports including information on this drug in its communications on a regular basis (Amended Council on Public Health, p 150, A-96; reaffirmed by CPH Rep. 4-I-98; reaffirmed CPH Rep. 2-A-09).

260.059 Texas Poison Center Network: The Texas Medical Association supports the Texas Poison Center Network (TPCN) and encourages TPCN to seek system certification by the American Association of Poison Control Centers to assure that Texas physicians and the general public have access to comprehensive resources and information on emergency treatment, poison prevention, and other potential exposures (Amended Res. 303-A-99; amended CM-ID Rep. 1-A-09).

260.082 Reducing the Health Burden of Air Pollution in Texas: The Texas Medical Association will urge our local, state, and federal government leaders and legislators to act promptly and aggressively to reduce the health burden of pollution from vehicular, diesel, National Ambient Air Quality Standards criteria pollutants, and air toxics emissions (Amended Res. 205-A-09).

Recommendation 2: Delete.

Upon review of the following policies, council consensus was to update the language to read as follows:

95.023 Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices: The Texas Medical Association advocates that direct-to-consumer (DTC) prescription drug and medical device advertisements should contain the disclaimer, “Your physician may recommend other appropriate treatments.” TMA strongly supports AMA Policy H-105.988, which clearly disapproves of misleading advertising for prescription drugs to the general public and supports research into the effects of DTC marketing, including physician and patient behavior and the impact of DTC ads on the cost of medical services. TMA further opposes product-specific DTC advertisements and supports a ban on DTC advertising for prescription drugs and implantable medical devices, and until such a ban is in place, opposes product-claim DTC advertising that does not comply with the following AMA guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should
convey a clear, accurate, and responsible health education message by providing
objective information about the benefits and risks of the drug or implantable medical
device for a given indication. Information about benefits should reflect the true efficacy
of the drug or implantable medical device as determined by clinical trials that resulted in
the drug’s or device’s approval for marketing.
(c) The advertisement should clearly indicate that the product is a prescription drug or
implantable medical device to distinguish such advertising from other advertising for
non-prescription products.
(d) The advertisement should not encourage self-diagnosis and self-treatment, but should
refer patients to their physicians for more information. A statement, such as “Your
physician may recommend other appropriate treatments,” is recommended.
(e) The advertisement should exhibit fair balance between benefit and risk information when
discussing the use of the drug or implantable medical device product for the disease,
order, or condition. The amount of time or space devoted to benefit and risk
information, as well as its cognitive accessibility, should be comparable.
(f) The advertisement should present information about warnings, precautions, and potential
adverse reactions associated with the drug or implantable medical device product in a
manner (e.g., at a reading grade level) such that it will be understood by a majority of
consumers, without distraction of content, and will help facilitate communication
between physician and patient.
(g) The advertisement should not make comparative claims for the product versus other
prescription drug or implantable medical device products; however, the advertisement
should include information about the availability of alternative non-drug or non-operative
management options, such as diet and lifestyle changes, where appropriate, for the
disease, disorder, or condition.
(h) In general, product-specific DTC advertisements should not use an actor to portray a
health care professional who promotes the drug or implantable medical device product,
because this portrayal may be misleading and deceptive. If actors portray health care
professionals in DTC advertisements, a disclaimer should be prominently displayed.
(i) The use of actual health care professionals, either practicing or retired, in DTC to endorse
a specific drug or implantable medical device product is discouraged but, if utilized, the
advertisement must include a clearly visible disclaimer that the health care professional is
compensated for the endorsement.
(j) The advertisement should be targeted for placement in print, broadcast, or other
electronic media so as to avoid audiences that are not age appropriate for the messages
involved.
(k) In addition to the above, the advertisement must comply with all other applicable Food
and Drug Administration (FDA) regulations, policies, and guidelines. (CSA Rep. 2-I-01;

260.003 Poison Control Center Enhancements: The Texas Medical Association supports the
continued operation of the state’s six regional poison control centers, and their membership in
the American Association of Poison Control Centers, and supports ensuring sufficient
funding so that the centers can be able to timely respond to calls by physicians and the
public and collaborate with centers across the country (Res. 27BB, p 181-I, I-90; reaffirmed

260.080 Vaccine Delivery: The Texas Medical Association is dedicated to helping assure all
Texans are fully vaccinated. TMA recommends several actions to help remove barriers for
physicians and add accountability and transparency to all aspects of vaccine delivery.
1. That TMA work with the Texas Legislature to highlight the critical contribution of Texas physicians in reaching the state’s public health immunization goals by eliminating vaccine-preventable illnesses and also ensuring comprehensive services in the medical home setting. In addition, TMA supports legislation to:

(a) Eliminate the business tax on vaccines;
(b) Establish a purchase reference for acquisition of each vaccine recommended for children, based on a standard transparent source, such as the Centers for Disease Control and Prevention (CDC) Private Sector Price List;
(c) Mandate vaccine payment reporting by insurance companies in order to determine if they are covering the true costs of these preventive services; and
(d) Further universal reporting to the state’s immunization registry;
(e) Protect and preserve as the primary site of the receipt of immunizations a patient-centered medical home with a primary care physician; and,
(f) Mandate electronic reporting, by the vaccinating provider, of vaccines administered to children and adults outside their medical home (e.g., in pharmacies or through community-based delivery) to either (i) the public health agency immunization registry, or (ii) the local public health immunization exchange using the appropriate, current national health information standard (e.g., HL7 2.5.1 or C-CDA release 2.1 Common Clinical Data Set).

2. That TMA support increased federal funding of the Section 317 program and state funding to increase payment to physician payments for the administration of providing immunizations to patients in the Medicaid and Texas Vaccines for Children programs; encourage the Texas Department of State Health Services and CDC to work toward a significant decrease in the administrative burden for physicians participating in the federal Vaccines for Children program so more physicians can provide vaccines under the program at reasonable cost; and support federal and continued state funding to preserve the Adult Safety Net Program for access to vaccines, noting the health care savings and health benefits of this program greatly exceed the immediate cost.

3. That TMA work with the Texas Department of State Health Services and other recognized groups to expand and promote resources to assist physician members on how practices can best establish a business and public health case for providing immunizations and determine the tools necessary to negotiate best price (CPH Rep. 1-A-09).

260.083 Promotion of Healthy Lifestyles – Reducing the Population Burden of Cardiovascular Disease by Reducing the Intake of Sodium-Intake, Saturated Fats, and Added Sugars: The Texas Medical Association supports the AMA’s efforts to:

(1) Call for a stepwise, minimum 50-percent reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.
(2) Urge the Food and Drug Administration (FDA) to revoke the "generally recognized as safe" (GRAS) status of salt, and to develop regulatory measures to limit sodium in processed and restaurant foods. (3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.
TMA supports the AMA’s efforts to urge FDA regulation of sodium. TMA further supports recommendations of the Texas Public Health Coalition, including measures to label foods and post nutrition information.

To assist in achieving the Healthy People 2020 goals for sodium, saturated fat, and added sugar consumption, TMA will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers and members about the benefits of long-term, moderate reductions in the sodium intake of sodium, saturated fats, and added sugars. (4) Discuss with the FDA ways to improve labeling to assist consumers in understanding the amount of sodium contained in processed food products, and to develop label markings and warnings for foods high in sodium, and (5) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.

TMA supports the AMA’s efforts to urge FDA regulation of sodium. TMA further supports recommendations of the Texas Public Health Coalition, including measures to label foods and post nutrition information.

TMA will promote educational efforts for members and consumers about the risks of dietary sodium and ways to reduce consumption.

TMA supports educating and motivating consumers to adopt more healthful lifestyles (1) through targeted public communication, (2) by encouraging consumers in appropriate risk groups to use professional preventive health care services that would permit the early detection and treatment or the prevention of illness, and (3) by physicians demonstrating personal examples of healthy lifestyles (CSA Rep. 2-A-09).

280.035 ST-Elevation Acute Myocardial Infarction (STEMI): The Texas Medical Association supports AMA efforts to (1) work with relevant societies to conduct a thorough analysis of the geographic, economic, and political barriers to optimal care for the STEMI patient, e.g., the current environment, existing literature, the costs of ambulance ECG hardware, training and transmission, political issues of reimbursing one county for care provided to patients from another county or state, and the financial issues of shifting patients to centers that can perform preferred treatment algorithms, and (2) develop model legislation that would draw upon the successes of existing programs and the data garnered from a comprehensive environmental analysis, to identify workable solutions to breaking down the current geographic, economic, and political barriers to optimal care for the STEMI patient that currently exist.

Recognizing the importance of strengthening and standardizing STEMI protocol throughout Texas, TMA strongly supports the American Heart Association and American College of Cardiology STEMI-related statewide initiatives, including STEMI-related initiatives in Texas that reflect the most up-to-date guidelines and science.

TMA will promote ongoing educational initiatives for the general public, emergency medical personnel, physicians, and hospital administration on the benefits of early symptom recognition in ST wave myocardial infarction as well as development of an efficient and collaborative treatment algorithm (CSA Rep. 1-A-09).
Disaster Preparedness Planning and Response: The Texas Medical Association recognizes the challenges and issues in all-hazards disaster planning and the need to promote ongoing physician participation in state and local planning and response to ensure local readiness and protection of each community and our patients. To that end, TMA will:

1. Work with the Texas Department of State Health Services (DSHS) in statewide disaster planning and advocate for a strong role for county medical societies (CMSs) in local planning, drills, and other related activities;
2. Identify a member of the TMA’s Board of Trustees or the member’s designee to serve as a liaison to the commissioner of health and the state’s emergency coordinator to ensure consideration of medical needs during terrorism, public health emergencies, and natural disasters, and to identify specific needs and special services to support the medical needs of high-risk populations including bariatric patients and shelter evacuees during a disaster;
3. Work with DSHS state and regional officials to establish state-level communications and assist local health departments or other appropriate agencies in expanding the mechanism for apprising physicians of essential information on newly recognized outbreaks and potential emergencies;
4. Work with DSHS in the event of a pandemic or other infectious disease disaster to ensure that plans minimize the negative impact on the health care community and ensure a sufficient supply of medications critical to the population; and
5. Monitor state laws governing practice and liability under these various disaster declarations and advocate for any needed legislative changes to address these issues.

Recommendation 3: Retain as amended.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 301
A-19

Subject: Distribution and Display of Human Trafficking Aid Information in Public Places

Introduced by: Lone Star Caucus
Lubbock County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Human trafficking is slavery, including both labor and sex trafficking and involving people of any age, gender, race/ethnicity, nationality, immigration status, or sexual orientation; and

Whereas, Human trafficking represents one of the most insidious and seemingly invisible public health challenges; and

Whereas, The National Human Trafficking Hotline has reported more than 4,000 cases of human trafficking in Texas since 2007; and

Whereas, The National Human Trafficking Hotline recently reported 455 cases of human trafficking in Texas in 2018; and

Whereas, The reports presented by the National Human Trafficking Hotline are not a comprehensive report on the scale or scope of human trafficking within Texas, and the actual number of victims is likely much higher; and

Whereas, The reports from the National Human Trafficking Hotline indicate a persistent need for community response in order to serve victims and survivors, respond to human trafficking cases, and share information and resources; and

Whereas, Physicians have a unique and critical role to play in preventing human trafficking, and identifying and treating its victims; and

Whereas, Victims and survivors of human trafficking may be seen at local clinics, emergency departments, or other medical settings, and the health care team’s actions at that moment can make a lifesaving difference; therefore be it

RESOLVED, That the Texas Medical Association adopt as policy that readily visible signs, notices, posters, placards, or other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings; and be it further

RESOLVED, That the Texas Medical Association, through its website or internet presence, provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same; and be it further

RESOLVED, That the Texas Medical Association urge both state and federal governments to make changes in laws to advocate the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings; and be it further
RESOLVED, That our Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates for consideration.

Related TMA Policy:

260.101 Increasing Identification, Support, and Reporting of Human Trafficking Victims: Increasing Identification, Support, and Reporting of Human Trafficking Victims: The Texas Medical Association will work with (1) physician member experts on human trafficking and ensure continued participation in the activities of the Texas Human Trafficking Prevention Task Force to help: (a) identify and advocate public policy measures that strengthen infrastructure which will improve response to human trafficking victims; (b) aid physicians in promoting the use of effective screening tools so they can identify potential victims of human trafficking; (c) provide information to physicians on the availability of local resources in their communities, including information on treatment and recovery for victims of human trafficking, including trauma-informed interventions; and (d) with requirements related to reporting suspected abuse of children and of potential victims of violence and/or sexual abuse and exploitation; and (2) county medical societies to encourage training at local health facilities on identifying human trafficking victims or request training from nationally recognized human trafficking support entities (CSHP Rep. 3-A-16).

Related AMA Policy:

H-65.966 Physicians Response to Victims of Human Trafficking:

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise awareness about human trafficking and inform physicians about the resources available to aid them in identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or children.

The Polaris Project -

In addition to offering services directly to victims of trafficking through offices in Washington, DC and New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  a. An assessment tool for health care professionals
  b. Online training in recognizing and responding to human trafficking in a health care context
  c. Speakers and materials for in-person training
  d. Links to local resources across the country

The Rescue & Restore Campaign -

The Department of Health and Human Services is designated under the Trafficking Victims Protection Act to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address the victim's medical, legal and social needs.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 302
A-19

Subject: Statement on Personhood Measures

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, In a growing number of states, vaguely worded and often misleading measures appear in legislation or as proposed constitutional amendments that define when life begins and grant legal "personhood" status to embryos at varying stages of development; and

Whereas, If approved, these measures would have profound consequences for women and their families; and

Whereas, If the goal of these measures is to make abortion illegal, that policy outcome should be addressed directly. Broadly worded or poorly worded measures could significantly affect medical treatments available to women of reproductive age, for example by:

- Making some common birth control measures illegal;
- Making illegal a physician’s ability to provide medically appropriate care to women experiencing life-threatening complications from a tubal pregnancy;
- Consigning infertility patients to less-effective, less-safe treatments for their disease; and
- Unduly restricting infertile patients’ right to make decisions about their medical treatments, including determining the fate of embryos created as part of in vitro fertilization; and

Whereas, A personhood measure would severely complicate the management of storage and disposition of human embryos; and

Whereas, An American Society of Reproductive Medicine position statement opposes ambiguously worded measures that would restrict the practice of reproductive medicine and the success of assisted reproductive technology; and

Whereas, The American Medical Association has a relevant policy, Code of Medical Ethics 4.2.5 Storage and Use of Human Embryos:

Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes.

While embryos usually are frozen with the expectation that they will be used for reproductive purposes by the prospective parents for whom they were created, frozen embryos also may offer hope to other prospective parents who otherwise would not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all these scenarios, ethical concerns arise regarding who has authority to
make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parents and individuals who provide gametes. At stake are the individuals’ interests in procreating.

When gametes are provided by the prospective rearing parents or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when and under what circumstances stored embryos may be: (a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor. (b) Made available to other patients for purposes of reproduction. (c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryos used for research will not be subsequently used for reproduction. (d) Allowed to thaw and deteriorate. (e) Otherwise disposed of; therefore be it

RESOLVED, That the Texas Medical Association oppose any personhood measure that is unclear, confusing, ambiguous, or not based on sound scientific or medical knowledge, which threatens the safety and effective treatment of patients, and which threatens access to assisted reproductive services.

Related TMA Policy:

265.018 Evidence-Based Medicine: The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of evidence-based medicine to improve approval and payment for medical services where appropriate.

TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with professional standards, (2) whenever there is a significant change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the American Medical Association policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as “evidence-based medicine” (CSA Rep. 3-A-08; amended CSPH Rep. 5-A-18).
10.002 Abortion: The Texas Medical Association recognizes abortion as a legal medical procedure, and
the performance of abortion must be based upon early and accurate diagnosis of pregnancy; informed and
nonjudgmental counseling; prompt referral to skillful and understanding personnel working in a good
facility; reasonable cost; and professional follow up (Remarks of Speaker, p 12, A-85; reaffirmed:
Council on Public Health, p 105, I-89; Res. 28WW, p 218-D, A-92; Res. 28J, p 168, A-94; and Council

Related AMA Policy:

H-5.990 Policy on Abortion: The issue of support of or opposition to abortion is a matter for members of
the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which
may be construed as an attempt to alter or influence the personal views of individual physicians regarding
abortion procedures.

H-5.995 Abortion: Our AMA reaffirms that: (1) abortion is a medical procedure and should be
performed only by a duly licensed physician and surgeon in conformance with standards of good medical
practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel
shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor
hospital personnel shall be required to perform any act violative of personally held moral principles. In
these circumstances, good medical practice requires only that the physician or other professional
withdraw from the case, so long as the withdrawal is consistent with good medical practice.

4.2.5 Storage & Use of Human Embryos (Stated in the sixth Whereas above.)
Subject: Improving Medical Clearance Policies for Traumatic Brain Injury Patients

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, About 6,000 people per day sustain a traumatic brain injury (TBI) in the United States; and

Whereas, People with TBI are twice as likely to commit suicide; veterans, a large population of whom have a TBI, are also twice as likely to commit suicide; a systematic review found that 18 percent of people affected by brain injury have attempted suicide and were successful three to four times more often than the general population; individuals with TBI are at significantly increased risk of committing violent crimes; and

Whereas, During the first year after moderate-to-severe TBI, psychiatric disorders were diagnosed in 61 percent of participants, which excludes the larger majority of mild TBI patients; and

Whereas, At-risk TBI patients obtain medical clearance before the Texas Department of Public Safety begins return-to-driving testing for individuals; and

Whereas, U.S. law prohibits anyone “who has been adjudicated as a mental defective or has been committed to any mental institution” from possessing or purchasing a firearm; and

Whereas, U.S. law 49 USC 31113(a)(8), 49 CFR 391.41-49 states that medical clearance is required for interstate commercial travel, and numerous states have laws promoting or requiring physicians to report to specific agencies (in Texas, the Medical Advisory Board [MAB]) patients with medical issues that would impair driving; and

Whereas, Texas Government Code, Title 4, Sec. 411.172, states that in order to carry a handgun, a person must be capable of exercising sound judgment with respect to the proper use and storage of the handgun; is not chemically dependent; does not suffer from a psychiatric disorder or condition that causes or is likely to cause substantial impairment in judgment, mood, perception, impulse control, or intellectual ability, or is in remission but reasonably likely to redevelop; cannot require continuous medical treatment for any of these issues; must not have been diagnosed by a licensed physician or declared by a court to be incompetent to manage his or her affairs; is not in default of a loan, or delinquent in tax payments or child support; and

Whereas, Pursuant to Health and Safety Code, Title 2, Sec. 12.095, the Texas Department of Public Safety (DPS) may request an opinion or recommendation from the Medical Advisory Board on the ability of an applicant or license holder to operate a motor vehicle safely or to exercise sound judgment on the proper use and storage of a handgun; in addition, DPS requests physicians to self-report, when they deem appropriate, a patient to the Texas MAB when he or she may pose a risk to self and others due to a medical condition or does not exercise sound judgment; and

Whereas, According to the Texas Health and Safety Code, Title 2, Sec. 12.092. MEDICAL ADVISORY BOARD; BOARD MEMBERS, The Texas MAB consists of “persons licensed to practice medicine in
Texas, including physicians who are board certified in medicine, psychiatry, neurology, physical medicine, or ophthalmology and who are jointly recommended by the department and the Texas Medical Association” as acutely attuned to conditions affecting sound judgment and impairment that could harm when related to driving and gun use; and

Whereas, the Texas Medical Association’s single gun policy is limited to supporting gun safety, advocating support of current gun laws, and supporting the study and education of gun safety, and this gun policy is directed at people with no cognitive or mental deficits; and

Whereas, TMA has policy for brain-injured patients only in regard to prevention and for student sports-related injuries and all-terrain-vehicle accidents; and

Whereas, Recently, TMA has supported and prioritized programs aimed at identifying abuse/violence and mental health disparities; and

Whereas, American Medical Association policies pertaining to TBI are boxing safety and sports-related injury/concussion safety; and

Whereas, AMA has policy focused on decreasing gun-related violence and deaths through public campaigning, generalized advocacy, and requests to the U.S. surgeon general; and

Whereas, AMA policy supports people with no cognitive deficits having to wait to purchase firearms and opposes people with no cognitive deficits who have committed domestic violence from purchasing or owning firearms; and

Whereas, AMA policy supports laws aimed at removing firearms from households that are at higher risk of violence and directs banning realistic toy guns due to safety concerns; and

Whereas, AMA supports physician reporting of impaired or possibly impaired patients to state agencies in regard to their driving abilities; therefore be it

RESOLVED, That Texas Medical Association reaffirm its policy stating that it strongly supports current national and Texas gun law and regulations relating to medical need and public safety, and advocates for legislation that more strongly implements these laws due to public health concerns; and be it further

RESOLVED, That TMA advocate for amending Texas law to clearly include prohibiting symptomatic TBI patients from obtaining or retaining a license to carry a firearm until medical clearance; and be it further

RESOLVED, That TMA create policy, advocates for, and supports legislation that expands to all people the medical clearance requirements and firearm purchasing restrictions in Texas’ license-to-carry law; and be it further

RESOLVED, That TMA advocate for legislation that would promote and emphasize the need and importance of physician reporting of all patients who have prohibitive conditions, including symptomatic TBI patients, to the Texas Medical Advisory Board; and be it further

RESOLVED, That TMA advocate for expansion of and investment into the Medical Advisory Board so it is better known by physicians, easier to use, and explicit regarding the medical conditions that may require reporting to it; and be it further
RESOLVED, That TMA advocate for legislation that expands the Medical Advisory Board’s oversight of possibly impaired individuals with gun licenses to all possibly impaired gun owners; and be it further
RESOLVED, That the Texas Delegation to the AMA carry any newly adopted policy related to TBI and access to firearms to AMA.

Related TMA Policy:

260.015 Firearms: The Texas Medical Association supports:

1. The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership;
2. The Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife;
3. Physicians in the clinical setting providing anticipatory guidance on the dangers of firearm ownership in an informational, nonjudgmental manner;
4. Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession;
5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and

Related AMA Policy:

H-470.963 Boxing Safety: While the AMA recognizes that boxing is a violent sport associated with brain and eye injuries, we recommend the following preventive strategies to reduce such injuries in boxers: (1) Relevant regulatory bodies are encouraged to: (a) require the use of objective brain injury risk assessment tools to exclude individual at-risk boxers from sparring or fighting. (b) develop and enforce standard criteria for referees, ringside officials, and ringside physicians to halt sparring or boxing bouts when a boxer has experienced concussive or subconcussive blows that place him or her at imminent risk of more serious injury. (c) encourage implementation of measures advocated by the World Medical Boxing Congress designed to reduce the incidence of brain and eye injuries. (d) require initial and repeat eye examinations for amateur and professional boxers and mandate suspensions from sparring or boxing for specific ocular pathology according to recommendations of the American Academy of Ophthalmology. (2) Our AMA promotes the concept that the professional responsibility of the physician who serves in a medical capacity at a boxing contest is to protect the health and safety of the contestants. The desire of spectators, promoters of the event, or even injured athletes that they not be removed from the contest should not be controlling. The physician's judgment should be governed only by medical considerations.

H-470.954 Reduction of Sports-Related Injury and Concussion: 1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.
2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.
3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.
4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of
concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and
other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified
by the number of and time interval between head impacts and concussions; (c) develop and evaluate
effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their
sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification,
management, and prognosis of athletes suffering from concussion to reduce the dependence on self-
reporting and inform evidence-based, age-specific guidelines for these patients.

5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum
from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).

H-470.984 Brain Injury in Boxing: The AMA supports the following series of steps designed to protect
amateur and professional boxers from injuries:

(1) Encourage the establishment of a “National Registry of Boxers” for all amateur and professional
boxers, including “sparring mates,” in the country. The proposed functions of a computer-based central
registry would be to record the results of all licensed bouts, including technical knockouts, knockouts, and
other boxing injuries, and to compile injury and win/loss records for individual boxers.

(2) Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in
progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in his
opinion, result in serious injury for either contestant.

(3) Urge state and local commissions to conduct frequent medical training seminars for all ring personnel.

(4) Recommend to all boxing jurisdictions that no amateur or professional boxing bout should be
permitted unless: (a) the contest is held in an area where adequate neurosurgical facilities are immediately
available for skilled emergency treatment of an injured boxer; (b) a portable resuscitator with oxygen
equipment and appropriate endotracheal tubes are available at ringside; and (c) a comprehensive
evacuation plan for the removal of any seriously injured boxer to hospital facilities is ready.

(5) Inform state legislatures that unsupervised boxing competition between unlicensed boxers in “tough
man” contests is a most dangerous practice that may result in serious injury or death to contestants, and
should be condemned.

(6) Urge state and local boxing commissions to mandate the use of safety equipment, such as plastic
safety mats and padded cornerposts, and to encourage continued development of safety equipment.

(7) Urge state and local boxing commissions to extend all safety measures to sparring partners.

(8) Urge state and local boxing commissions to upgrade, standardize and strictly enforce medical
evaluations for boxers.

H-145.974 Increasing Toy Gun Safety: Our American Medical Association (1) encourages toy gun
manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the
similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy
gun ownership risks.

H-145.979 Prevention of Unintentional Shooting Deaths Among Children: Our AMA supports
legislation at the federal and state levels making gun owners legally responsible for injury or death
caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable
measures to prevent child access to the gun were taken by the gun owner, and that the specifics,
including the nature of “reasonable measures,” be determined by the individual constituencies affected by the law.

H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death: Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms; (2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths; (3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns; (4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible; (6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms; (7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and (8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

H-145.978 Gun Safety: Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care: 1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs. 2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior. 3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
D-145.995 **Gun Violence as a Public Health Crisis:** Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

H-145.996 **Firearm Availability:** 1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms. 3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

D-145.997 **Physicians and the Public Health Issues of Gun Safety:** Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

H-145.985 **Ban on Handguns and Automatic Repeating Weapons:** It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to: (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers; (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21; (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel); (d) the imposition of significant licensing fees for firearms dealers; (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and (f) mandatory destruction of any weapons obtained in local buy-back programs.

(2) Support legislation outlawing the Black Talon and other similarly constructed bullets.

(3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls.

(4) Oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws.

(5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
H-145.989 Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns: It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.

H-60.947 Guns in School Settings: Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

H-215.977 Guns in Hospitals: 1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present.

H-145.999 Gun Regulation: Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

H-145.988 AMA Campaign to Reduce Firearm Deaths: The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.
H-145.972 Firearms and High-Risk Individuals: Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

H-145.992 Waiting Period Before Gun Purchase: The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Sources:
5. Texas Department of State Health Services. *Medical Advisory Board.*

A person is eligible for a license to carry a handgun if the person: is not a chemically dependent person; and is not incapable of exercising sound judgment with respect to the proper use and storage of a handgun. A person is incapable of exercising sound judgment with respect to the proper use and storage of a handgun if the person: has been diagnosed by a licensed physician as suffering from a psychiatric disorder or condition that causes or is likely to cause substantial impairment in judgment, mood, perception, impulse control, or intellectual ability; suffers from a psychiatric disorder or condition that is in remission but is reasonably likely to redevelop at a future time or requires continuous medical treatment to avoid redevelopment; has been diagnosed by a licensed physician, determined by a review board or similar authority, or declared by a court to be incompetent to manage the person’s affairs; or has entered in a criminal proceeding a plea of not guilty by reason of insanity.
Subject: Requirement for Food Allergy Posters and Employee Training in Food Establishments

Introduced by: Harris County Medical Society
Louise H. Bethea, MD, Texas Allergy, Asthma & Immunology Society

Referred to: Reference Committee on Science and Public Health

Whereas, Anaphylaxis is a potentially fatal systemic allergic reaction, and foods are a common cause; and

Whereas, Many food service employees are unaware of the frequency and severity of food allergies in their clientele; and

Whereas, Many food service employees are unaware of the top eight food allergies: milk, eggs, wheat, soy, shellfish, fish, peanuts, and tree nuts; and

Whereas, Many food service employees are unaware of the ingredients in the foods they serve; and

Whereas, Every three minutes, a food allergy reaction sends someone to the emergency department. These reactions result in approximately 200,000 emergency department visits per year. The reaction is often so severe that a potentially life-threatening reaction (anaphylaxis) occurs roughly every six minutes; and

Whereas, Even a tiny amount of an allergen can cause a severe and potentially life-threatening allergic reaction; and

Whereas, Proper cooking does not reduce or eliminate the chances of a food allergy reaction; and

Whereas, Proper food allergy cooking and handling procedures are available for use by food establishments; and

Whereas, The Food Allergy Research and Education Organization and the Food Allergy Awareness Organization have free downloadable posters with the needed information available to post on the food establishment’s employee information board; and

RESOLVED, That the Texas Medical Association provide advocacy support to the Texas Allergy, Asthma & Immunology Society’s efforts as the society seeks the passage of legislation mandating, not just recommending, that all food service establishments display a poster related to food allergen awareness in an area of the establishment accessible primarily to its employees. This poster must include the risk of an allergic reaction, a list of the major food allergens, methods to prevent cross-contamination in food preparation, and signs and symptoms associated with anaphylaxis with instructions to call 911; and be it further

RESOLVED, That TMA advocate for a mandate that food service employees be required, on a biennial basis, to be trained in food allergy awareness with information on which foods – milk, eggs, wheat, soy, shellfish, fish, peanuts, and tree nuts – cause the most reactions; trained in the prevention of cross-contamination in food preparation; and trained in the signs and symptoms associated with anaphylaxis with instructions to call 911. The training programs can be completed online or in class form and should
be certified by a nationally recognized organization and approved by the Texas Department of Health and Human Services.

Related TMA Policy:

55.053 Childhood Medical Emergencies and Anaphylactic Reactions in Schools: The Texas Medical Association urges all schools, from preschool through 12th grade, to:

Develop Medical Emergency Response Plans (MERPs);

Practice these plans to identify potential barriers and strategies for improvement;

Ensure that school campuses have a direct communication link with an emergency medical service (EMS);

Identify students at risk for life-threatening emergencies, and ensure these children have an individual emergency care plan that is formulated with input from a physician;

Designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families;

Train school personnel in cardiopulmonary resuscitation in addition to information on district emergency policies, signs and symptoms of anaphylaxis, and strategies to reduce the risk of exposure;

Adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy Research and Education; and

Ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff know how to use this equipment.

TMA will work to expand to all state laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis.

TMA supports increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis.

TMA urges the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies.

TMA urges physicians to work with schools to ensure that all their patients with a food allergy have an individualized emergency plan.

TMA urges physicians to work with school health advisory councils to ensure districts have comprehensive emergency management plans that address prevention and recognition of anaphylaxis, and medication administration. Plans should include procedures for students without a previously diagnosed allergy.

TMA will work to allow all appropriately trained clinical first responders to carry and administer epinephrine in suspected cases of anaphylaxis (CM-CAH Rep. 4-A-08; amended CM-CAH Rep. 1-A-13).

100.008 Statewide Emergency Communication Network System: Texas should maintain a robust and adequately funded statewide 911 communications system and, as part of that effort, county medical societies should assist in advocating needed resources to support their local 9-1-1 emergency systems and
local expansion of the emergency service infrastructure to include next generation 9-1-1 features (CPH, p 91, A-95, amended CPH Rep. 3-A-10; amended Res. 308-A-17).

100.016 Texas Department of State Health Services Emergency Medical Services Local Projects Grant Program: The Texas Medical Association supports the DSHS EMS Local Projects Grant program which provides emergency medical services education, training and equipment to rural and frontier areas of Texas (CM-EMS Rep. 2-A-99; reaffirmed CPH Rep. 2-A-09).

100.018 Emergency Medical Resources: The Texas Medical Association will work to pass legislation that removes limits of emergency medical resources to the acutely sick and injured and provides resources necessary to meet the needs of patient trauma care (Amended Res. 17-I-02; reaffirmed CSPH Rep. 1-A-13).

100.025 Access to Emergency Care in Texas: The Texas Medical Association will seek to establish a Texas bipartisan commission to examine, address, and support issues related to access to emergency care in Texas, or a coalition of organizations to address the current crisis (Res. 205-A-08; reaffirmed CM-EMST Rep. 2-A-18).

100.029 Requirement for Epinephrine Auto-Injectors in Texas Schools: The Texas Medical Association supports legislation that (1) requires all Texas schools, pre-Kindergarten through 12th grade, to have epinephrine auto-injectors available on their campuses and at school activities to treat acute life-threatening allergic emergencies; (2) includes a mandate for school personnel to be trained to recognize and treat allergic emergencies; and (3) would amend Section 74.151(a) of the Civil Practice and Remedies Code to state that physicians prescribing unassigned epinephrine auto-injectors for use in schools and athletic settings, and nurses and trained school personnel administering epinephrine auto-injectors during medical emergencies, not be liable for civil damages unless the act was willfully or wantonly negligent (Res. 301-A-14).

170.001 Good Samaritan and Charitable Immunity Laws: The Texas Medical Association continues to support the Good Samaritan Law, that allows persons including physicians, to render aid in an emergency free from liability when it is not provided for or in expectation of compensation. The Texas Medical Association continues to support the Charitable Immunity Law which allows any health care provider who voluntarily provides medical or health care to the needy free of charge to be free of liability risks. These laws allow semi-retired and retired health care professionals to participate in providing health care to those in need without having to purchase professional liability insurance. TMA continues to support legislative efforts to dissolve road blocks to access to medical care by the needy (Res. 27DD, p 181K, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

170.002 Charitable Immunity: The Texas Medical Association favors extending liability protections of the Texas Charitable Immunity and Liability Act of 1987 to physicians acting as direct-service volunteers on behalf of city, county, and state health departments, as well as those who volunteer services in local, state, or federally owned health care facilities, and voted to seek amendment of that law (Res. 28HH, p 207, A-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

260.037 Essential Public Health Services: The Texas Medical Association adopted the Essential Public Health Services Work Group's definition of public health and essential public health services: (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7); link people to needed personal health services and assure the provision of health care when otherwise unavailable; (8) assure a competent public health and personal health care
workforce; (9) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and (10) research for new insights and innovative solutions to health problems. In addition, in accordance with stated principles, TMA affirms that public health departments should be adequately funded in order to provide these essential services in every Texas community deliberately and apart from indigent care. TMA supports efforts to arrive at agreeable solutions to ensuring a stable public health system capable of adapting to health systems reform and the challenges of addressing emerging public health issues (CPH, p 80, I-95; reaffirmed CPH Rep. 2-A-05; amended CSPH Rep. 3-A-13).

260.042 Core Public Health Functions: The Texas Medical Association affirms the need for the practice of the core public health functions of assessment, assurance, and policy development as distinct, inherently governmental, complementary, and necessary to support population health in each Texas community. TMA recognizes the need for objectivity and the potential for conflict of interest in community health and opposes the delegation of responsibility entirely to non-governmental entities. In addition, TMA supports legislation that would more clearly assign responsibility for performing core public health functions which would ensure necessary resources to maintain and further improve the public health infrastructure in Texas. TMA supports efforts to educate the public, legislators, and other elected and appointed officials about the mission and role of public health in order to ensure continued and adequate funding. TMA supports efforts to amend the Local Public Health Reorganization Act as a means to simplify and improve the efficiency of local public health by facilitating and removing barriers to city and county collaborations for the provision of public health services (CPH, p 125A, I-96; amended CPH Rep. 2-A-09; amended CSPH Rep. 3-A-13).

260.049 Local Public Health Authorities and Training: The Texas Medical Association recognizes that there is an interdependence between medicine and public health and supports the preservation of the local health authority role as the bridge between both. TMA supports increased public health training in medical schools, residencies, and continuing medical education to improve physician understanding of public health and to help bridge the gap between private medicine and public health. TMA also urges the Department of State Health Services to encourage the local public health entities that they fund to collaborate with county medical societies to strengthen the bond between medicine and public health (Council on Public Health, p 76, A-97; amended CPH Rep. 2-A-07; amended CSPH Rep. 3-A-13).

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 305
A-19

Subject: Allow the Possession and Administration of an Epinephrine Auto-Injector in Certain Entities

Introduced by: Harris County Medical Society
Louise H. Bethea, MD, Texas Allergy, Asthma & Immunology Society

Referred to: Reference Committee on Science and Public Health

RESOLVED, That epinephrine auto-injectors be allowed to be placed in public places in areas accessible as determined by the entity. Those entities include amusement parks, camps, institutions of higher education, food service establishments, sports venues, concerts, state government entities, retail facilities, churches, synagogues, youth centers, and any other entity the Texas Executive Commissioner, by rule, designates as an entity that would benefit from the possession and administration of epinephrine auto-injectors; and be it further

Whereas, Anaphylaxis is a potentially fatal systemic allergic reaction. Primary treatment consists of administration of epinephrine as soon as the reaction is identified. Prompt administration (e.g., within minutes of symptoms of anaphylaxis) of epinephrine (adrenaline) is crucial to treating anaphylactic reactions successfully. Any delay in administration of epinephrine has been shown to be the major risk factor for death from anaphylaxis; and

Whereas, Food allergies affect approximately 15 million Americans, including one in 13 children in the United States; and

Whereas, Every three minutes, a food allergy reaction sends someone to the emergency department. These reactions result in approximately 200,000 emergency department visits per year. The reaction is often so severe that a potentially life-threatening reaction (anaphylaxis) occurs roughly every six minutes; and

Whereas, Symptoms of anaphylaxis can develop rapidly after exposure to an allergen, often within minutes and usually within 30 minutes. However, symptoms can take up to two hours after exposure to a food allergen to become apparent; and

Whereas, Teenagers and young adults with food allergies are at the highest risk of fatal food-induced anaphylaxis; and

Whereas, Food is the most common cause of anaphylaxis, and eight foods cause 90 percent of the reactions. These foods are milk, egg, wheat, soy, shellfish, fish, peanuts, and tree nuts; and

Whereas, Past reactions to a food allergy do not predict future reactions. A person can have a life-threatening reaction to a food to which they are allergic even if they have never had a prior serious reaction; and

Whereas, Other causes of anaphylaxis are latex, medications, and bites from insects, such as fire ants; and

Whereas, Anaphylaxis must be treated immediately with epinephrine (adrenaline), which is crucial for the individual to survive a potentially life-threatening reaction; therefore be it
RESOLVED, That an employee or volunteer with these entities be trained on an annual basis by an
approved source to administer an epinephrine auto-injector to a person reasonably believed to be
experiencing anaphylaxis on the premises of the entity; and be it further

RESOLVED, That policies relating to epinephrine auto-injectors be established by the Texas Executive
Commission; and be it further

RESOLVED, That a trained person who in good faith initiates treatment using an epinephrine auto-
injector under the rules established by the state be immune from civil or criminal liability, as will the
entity or business and those associated with the prescribing, dispensing, and administration of the
epinephrine auto-injectors.

Related TMA Policy:

55.002 Comprehensive School Health Education in All School Districts: The Texas Medical
Association believes the Texas Education Agency should have statutory authority to require
comprehensive school health education in all school districts of the state, and that the process should
begin with implementation of the TEA-developed modules on physical education, nutrition, substance
reaffirmed CM-CAH Rep. 4-A-10).

55.019 School Health Education: The Texas Medical Association encourages physicians to become
involved with school health education planning committees in their communities and to promote
comprehensive school health education (Committee on School Health and Children with Disabilities, p

55.053 Childhood Medical Emergencies and Anaphylactic Reactions in Schools: The Texas Medical
Association urges all schools, from preschool through 12th grade, to:

Develop Medical Emergency Response Plans (MERPs);

Practice these plans to identify potential barriers and strategies for improvement;

Ensure that school campuses have a direct communication link with an emergency medical service
(EMS);

Identify students at risk for life-threatening emergencies, and ensure these children have an individual
emergency care plan that is formulated with input from a physician;

Designate roles and responsibilities among school staff for handling potential life-threatening
emergencies, including administering medications, working with EMS and local emergency departments,
and contacting families;

Train school personnel in cardiopulmonary resuscitation in addition to information on district emergency
policies, signs and symptoms of anaphylaxis, and strategies to reduce the risk of exposure;

Adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy
Research and Education; and

Ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is
available and that assigned staff know how to use this equipment.
TMA will work to expand to all state laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis.

TMA supports increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis.

TMA urges the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies.

TMA urges physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan.

TMA urges physicians to work with school health advisory councils to ensure districts have comprehensive emergency management plans that address prevention and recognition of anaphylaxis, and medication administration. Plans should include procedures for students without a previously diagnosed allergy.

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100.008 Statewide Emergency Communication Network System: Texas should maintain a robust and adequately funded statewide 911 communications system and, as part of that effort, county medical societies should assist in advocating needed resources to support their local 9-1-1 emergency systems and local expansion of the emergency service infrastructure to include next generation 9-1-1 features (CPH, p 91, A-95, amended CPH Rep. 3-A-10; amended Res. 308-A-17).

100.016 Texas Department of State Health Services Emergency Medical Services Local Projects Grant Program: The Texas Medical Association supports the DSHS EMS Local Projects Grant program which provides emergency medical services education, training and equipment to rural and frontier areas of Texas (CM-EMS Rep. 2-A-99; reaffirmed CPH Rep. 2-A-09).

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115.004 Indemnification of Physicians: The Texas Medical Association supports state and federal legislative mechanisms whereby the state and/or federal governments will indemnify physicians who provide medical services for Medicaid, Medicare, and indigent patients (Res. 28JJ, p 209, A-92; reaffirmed CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

170.001 Good Samaritan and Charitable Immunity Laws: The Texas Medical Association continues to support the Good Samaritan Law, that allows persons including physicians, to render aid in an emergency free from liability when it is not provided for or in expectation of compensation. The Texas Medical Association continues to support the Charitable Immunity Law which allows any health care provider who voluntarily provides medical or health care to the needy free of charge to be free of liability risks. These laws allow semi-retired and retired health care professionals to participate in providing health care to those in need without having to purchase professional liability insurance. TMA continues to support legislative efforts to dissolve road blocks to access to medical care by the needy (Res. 27DD, p 181K, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

170.002 Charitable Immunity: The Texas Medical Association favors extending liability protections of the Texas Charitable Immunity and Liability Act of 1987 to physicians acting as direct-service volunteers on behalf of city, county, and state health departments, as well as those who volunteer services in local, state, or federally owned health care facilities, and voted to seek amendment of that law (Res. 28HH, p 207, A-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

260.037 Essential Public Health Services: The Texas Medical Association adopted the Essential Public Health Services Work Group's definition of public health and essential public health services: (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and assure the provision of health care when otherwise unavailable; (8) assure a competent public health and personal health care workforce; (9) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and (10) research for new insights and innovative solutions to health problems. In addition, in accordance with stated principles, TMA affirms that public health departments should be adequately funded in order to provide these essential services in every Texas community deliberately and apart from indigent care. TMA supports efforts to arrive at agreeable solutions to ensuring a stable public health system capable of adapting to health systems reform and the challenges of addressing emerging public health issues (CPH, p 80, I-95; reaffirmed CHP Rep. 2-A-05; amended CSPH Rep. 3-A-13).

260.042 Core Public Health Functions: The Texas Medical Association affirms the need for the practice of the core public health functions of assessment, assurance, and policy development as distinct, inherently governmental, complementary, and necessary to support population health in each Texas community. TMA recognizes the need for objectivity and the potential for conflict of interest in community health and opposes the delegation of responsibility entirely to non-governmental entities. In addition, TMA supports legislation that would more clearly assign responsibility for performing core public health functions which would ensure necessary resources to maintain and further improve the public health infrastructure in Texas. TMA supports efforts to educate the public, legislators, and other elected and appointed officials about the mission and role of public health in order to ensure continued and adequate funding. TMA supports efforts to amend the Local Public Health Reorganization Act as a means to simplify and improve the efficiency of local public health by facilitating and removing barriers to city and county collaborations for the provision of public health services (CPH, p 125A, I-96; amended CPH Rep. 2-A-09; amended CSPH Rep. 3-A-13).
260.049 Local Public Health Authorities and Training: The Texas Medical Association recognizes that there is an interdependence between medicine and public health and supports the preservation of the local health authority role as the bridge between both. TMA supports increased public health training in medical schools, residencies, and continuing medical education to improve physician understanding of public health and to help bridge the gap between private medicine and public health. TMA also urges the Department of State Health Services to encourage the local public health entities that they fund to collaborate with county medical societies to strengthen the bond between medicine and public health (Council on Public Health, p 76, A-97; amended CPH Rep. 2-A-07; amended CSPH Rep. 3-A-13).

WHEREAS, The role of a physician in providing health care to a patient should include honest discussions about important end-of-life decisions; and

WHEREAS, Recent efforts in the Texas Legislature by right-to-life organizations have centered on limiting physicians’ ability to participate in executing the wishes of a patient at the end of life; and

WHEREAS, Legislation passed by the 2017 Texas Legislature has the effect of allowing a surrogate to override the wishes of a patient; and

WHEREAS, The physician may be the last person to hear a patient’s end-of-life wishes; and

WHEREAS, The physician may be in the best position to help patients and family make these very difficult decisions; therefore be it

RESOLVED, That the Texas Medical Association oppose any efforts to limit the physician’s appropriate and ethical role in the end-of-life process.

Related TMA Policy:

**20.006 Alzheimer’s Disease and Other Dementia:** The Texas Medical Association:

1. Encourages physicians to make appropriate use of guidelines for clinical decisionmaking in the diagnosis and treatment of Alzheimer’s disease and other dementias;
2. Encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
3. Encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer’s disease and related disorders;
4. Encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer’s disease and other dementing disorders;
5. Supports the use of evidence-based, cost-effective technologies with prior consent of patients or designated health care power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer’s disease and other related dementias with the help of appropriate allied specialty organizations;
6. Supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer’s disease and related dementias;
7. Encourages increased enrollment in clinical trials of appropriate patients with Alzheimer’s disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer’s disease and related dementias;
8. Encourages physicians to promote regular physical activity, healthy eating, and management of cardiovascular risk factors (diabetes, obesity, smoking, and hypertension) to reduce the risk of cognitive decline and of dementia; and
9. Encourages physicians to discuss living wills, medical power of attorney, directive to physicians, and other end-of-life planning decisions with all appropriate patients (Extracted CSA Rep. 4-I-98; reaffirmed CSA Rep. 4-A-08; amended CSPH Rep. 5-A-18).

85.003 Education of Advance Directives: The Texas Medical Association encourages its members to educate patients, families, caregivers, and significant others in the necessity to have an appropriate, properly executed advance directive to protect the patient’s wishes in a pre-hospital environment and in the appropriate use of emergency medical services in terminal situations (Amended Res. 28BB, p 201, A-92; reaffirmed by Sub. MSS 3-I98; reaffirmed CM-EMS Rep. 1-A-03; reaffirmed BOC Rep. 6-A-13).


85.006 Life-Prolonging Measures: Medical staffs should develop general guidelines for the care of critically ill and/or terminally ill patients and should refer to the Current Opinions of the Board of Councilors and other Texas Medical Association policy for guidance and implementation of these guidelines (Board of Councilors, p 59, A-94; amended CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

85.007 Treatment of Terminally Ill: Treatment of the terminally ill patient should be handled on an individual basis. The physician, in consultation with the family and the patient, should determine in what setting the treatment can be most appropriately delivered (Council on Health Facilities, p 83, A-94; reaffirmed CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

85.008 Physician Assisted Suicide: The Texas Medical Association strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician's role as healer (Res. 29J, p 198, I-96; amended BOC Rep. 5-A-07; amended BOC Rep. 6-A-17).

85.009 Do Not Resuscitate Orders: The Texas Medical Association supports the right of terminally and chronically ill patients to utilize DNR orders in non-hospital settings (Medical Student Section, p 139, A-97; reaffirmed BOC Rep. 5-A-07; reaffirmed BOC Rep. 6-A-17).

85.010 Terminally Ill: Only one physician should be required to certify that a patient is terminally ill under the Texas Advance Directives Act rather than certification by two physicians (BOC Rep. 8-I-98; amended BOC Rep. 7-A-08; reaffirmed BOC Rep. 7-A-18).

85.011 Palliative Care: The Texas Medical Association (1) urges Texas medical schools to periodically assess the adequacy of their curricular content in preparing medical students and residents to respond to the special needs of patients requiring palliative care with the goals of maintaining the highest quality of life possible during the final stages of life and preparing physicians for clinical and ethical issues related to end-of-life care; and (2) encourages availability of continuing medical education courses on the clinical and ethical issues related to end-of-life care (Amended CME Rep. 2-I-98 and Sub. Res. 201-I-98; amended CME Rep. 1-A-08; reaffirmed CME Rep. 2-A-18).

85.012 Advance Directives: The Texas Medical Association encourages physicians who staff hospitals to attempt to obtain appropriate advance directives before discharging a patient (CM-EMS Rep. 4-A-00; reaffirmed CHSO Rep. 1-A-10).
85.013 *Absence of Advance Directives*: When patients have not executed advance directives, facility staff should be permitted to follow physician orders for patient care (CHSO Rep. 3-A-02; reaffirmed CHSO Rep. 2-A-12).

85.014 *Physician Responsibility with End-of-Life Care*: Physicians should educate themselves on the opportunities and responsibilities provided by state law governing advance directives and medical power of attorney and use all appropriate opportunities to educate their patients on the subject (Amended CHSO Rep. 1-A-05; reaffirmed CHSO Rep. 1-A-15).

85.015 *Advance Care Planning*: All payers, including the Medicare and Medicaid systems, should add advance care planning as a quality measure and a reimbursable physician service (CHSO Rep. 2-A-08; amended CHSO Rep. 1-A-18).

85.016 *Medical Orders for Scope of Treatment in Texas*: The Texas Medical Association will work with other health care and community organizations to promote adoption of a statewide medical orders for scope of treatment (MOST) document, thus better promoting patient-centered care and enhancing communication about patient wishes between sites of care. TMA will encourage the development of education programs for physicians and patients about the appropriate use of MOST (Amended Res. 419-A-12; reaffirmed Res. 411-A-14; originally numbered 200.049; amended CHSO Rep. 2-A-15).

85.017 *Medical Orders for Scope of Treatment Coalition Recommendations*: The Texas Medical Association supports the use of a Medical Orders for Scope of Treatment (MOST) document that is: (a) a written expression of the unique values and goals of a patient in relation to medical care, expressed by a patient or a surrogate decisionmaker; (b) produced as a product of a conversation with a physician, a midlevel provider under appropriate supervision and delegation, or another person who is properly trained to conduct the conversation; (c) signed by the patient or, if the patient lacks capacity, by the patient’s surrogate decisionmaker(s); (d) verified and signed by a physician (or midlevel provider under proper delegation) who has established that the patient or surrogate understands and agrees with the form contents; (e) reevaluated periodically AND when there is a change in the patient’s status; (f) a guide concerning patient wishes for medical care to be used by any medical caregiver, but does not override any physician’s independent clinical decisionmaking; and (g) not legislatively mandated or modified in any way. TMA will work with the MOST Coalition to develop an education program for Texas physicians regarding the Medicare advance planning payments and the use of the MOST document (CHSO Rep. 2-A-16).

105.001 *Consent for Medical and Surgical Treatment*: The Texas Medical Association supports provision for consent for medical and surgical treatment by appropriate surrogate decision makers on behalf of incompetent or comatose patients (Res. 28M, p 148, l-91; reaffirmed BOC Rep. 3-A-03; reaffirmed BOC Rep. 6-A-13).

105.009 *Informed Consent*: An informed patient is the best patient, ethically and legally. Disclosure techniques and information recommended by the Texas Medical Disclosure Panel, in addition to other information which physicians may provide, enable patients to give an informed consent for proposed procedures (Board of Councilors, p 58, A-94; reaffirmed BOC Rep.3-A-04; reaffirmed BOC Rep. 6-A-14).

195.029 *Registry for Advance Directives*: The Texas Medical Association supports a Centers for Medicare & Medicaid Services requirement for all Medicare patients to register the advance directive of their choice to facilitate their end-of-life preferences being respected (Res. 307-A-09).
**Related AMA Policy:**

**H-140.949 Physician-Assisted Suicide:** The AMA will (1) initiate an educational campaign to make palliative treatment and care directions based on values-based advance care planning the standard of care for meeting the needs of patients at the end of life; and (2) will work with local, state, and specialty medical societies to develop programs to: facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life; and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life.

**5.7 Physician-Assisted Suicide:** Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

*AMA Principles of Medical Ethics: I, IV*

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

**5.8 Euthanasia:** Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life.
Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that a cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

*AMA Principles of Medical Ethics: I,IV*

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 307
A-19

Subject: Regulatory Recommendations for Bed Bugs

Presented by: Wendell H. Williams III, MD

Referred to: Reference Committee on Science and Public Health

Whereas, The incidence of bed bug (Cimex lectularius) infestations in Texas has been increasing at an alarming rate, with several cities routinely considered among the worst according to private industry; and

Whereas, Bed bugs are an important public health issue according to the Centers for Disease Control and Prevention, able to cause potentially serious physical, mental, and financial harm to individuals; and

Whereas, Bed bug infestations are insidious and refractory to treatment, often requiring multiple visits, and associated with significant material loss to individuals; and

Whereas, Children, the elderly, and those disabled by physical or psychiatric comorbidities are particularly vulnerable to bed bug infestations; and

Whereas, Multifamily dwelling units can function as a central location of dissemination to the overall population as infestations become even more refractory and insidious, spreading to adjacent units often without the knowledge of the building community; and

Whereas, The lack of a mechanism for the collection, analysis, and dissemination of data regarding bed bug infestations in Texas makes it difficult to evaluate its effect on public health; and

Whereas, Outside of Texas, many state and local municipalities have taken proactive legislative and regulatory steps to improve public awareness, and encourage the prompt reporting and complete treatment of bed bug infestations; and

Whereas, Despite the existing mandates in sections 341.011 and 341.012 of the Texas Health and Safety Code, the Texas Association of City and County Health Officials recognizes that current enforcement is difficult and that laws should be strengthened to further promote pest-free environments; and

Whereas, Bed bugs (Cimex lectularius) can cause potentially serious physical and mental harm to individuals and therefore are to be considered a public health issue; therefore be it

RESOLVED, That the Texas Medical Association consider bed bugs as a public health issue; and be it further

RESOLVED, That this resolution be referred to the appropriate Texas Medical Association council, committee, or body to seek a mechanism for the collection, study, and public reporting of data on the impact of bed bugs on the public health of Texans; and be it further

RESOLVED, That this resolution be referred to the appropriate TMA council, committee, or body to collaborate with the Texas Association of City and County Health Officials to develop guidelines for local health authorities using an Integrated Pest Management approach to bed bugs; and be it further
RESOLVED, That TMA in collaboration with the Texas Department of State Health Services support regulatory changes that encourage the reporting, treatment, and study of bed bugs in state-supported living centers; and be it further

RESOLVED, That TMA seek legislation to address the public health issue of bed bugs in Texas, most especially when affecting vulnerable populations or inhabitants of multifamily dwelling units (MDUs); and be it further

RESOLVED, That the Texas Delegation carry this resolution, or a similar one, to the American Medical Association to develop public health recommendations and seek regulatory or legislative action for this growing national public health issue, especially in regard to the collection, study, and public reporting of data on the impact of bed bugs; the effect of bed bug infestations on MDUs; and the U.S. Department of Housing and Urban Development’s role in bed bug management.

Related TMA Policy: None found.

Related AMA Policy: None found.

Sources:
Texas State Law
1. Sec. 341.011. NUISANCE. Each of the following is a public health nuisance:
   (1) a condition or place that is a breeding place for flies and that is in a populous area;
   (2) spoiled or diseased meats intended for human consumption;
   (3) a restaurant, food market, bakery, other place of business, or vehicle in which food is prepared, packed, stored, transported, sold, or served to the public and that is not constantly maintained in a sanitary condition;
   (4) a place, condition, or building controlled or operated by a state or local government agency that is not maintained in a sanitary condition;
   (5) sewage, human excreta, wastewater, garbage, or other organic wastes deposited, stored, discharged, or exposed in such a way as to be a potential instrument or medium in disease transmission to a person or between persons;
   (6) a vehicle or container that is used to transport garbage, human excreta, or other organic material and that is defective and allows leakage or spilling of contents;
   (7) a collection of water in which mosquitoes are breeding in the limits of a municipality or a collection of water that is a breeding area for mosquitoes that can transmit diseases regardless of the collection's location other than a location or property where activities meeting the definition of Section 11.002(12)(A), Water Code, occur;
   (8) a condition that may be proven to injuriously affect the public health and that may directly or indirectly result from the operations of a bone boiling or fat rendering plant, tallow or soap works, or other similar establishment;
   (9) a place or condition harboring rats in a populous area;
   (10) the presence of ectoparasites, including bedbugs, lice, and mites, suspected to be disease carriers in a place in which sleeping accommodations are offered to the public;
   (11) the maintenance of an open surface privy or an overflowing septic tank so that the contents may be accessible to flies; and
   (12) an object, place, or condition that is a possible and probable medium of disease transmission to or between humans.

2. Sec. 341.012. ABATEMENT OF NUISANCE.
   (a) A person shall abate a public health nuisance existing in or on a place the person possesses as soon as the person knows that the nuisance exists.
(b) A local health authority who receives information and proof that a public health nuisance exists in the local health authority's jurisdiction shall issue a written notice ordering the abatement of the nuisance to any person responsible for the nuisance. The local health authority shall at the same time send a copy of the notice to the local municipal, county, or district attorney.

c) The notice must specify the nature of the public health nuisance and designate a reasonable time within which the nuisance must be abated.

d) If the public health nuisance is not abated within the time specified by the notice, the local health authority shall notify the prosecuting attorney who received the copy of the original notice. The prosecuting attorney:

   (1) shall immediately institute proceedings to abate the public health nuisance; or
   (2) request the attorney general to institute the proceedings or provide assistance in the prosecution of the proceedings, including participation as an assistant prosecutor when appointed by the prosecuting attorney.

Subject: Regulation of Electric Scooters

Presented by: Bexar County Medical Society

Referred to: Reference Committee on Science and Public Health

RESOLVED, That the Texas Medical Association work with the Texas Department of Public Safety (DPS) to have electric scooters regulated as bicycles and require operators to follow traffic laws as bicycle operators; and be it further

RESOLVED, That TMA work with DPS to place an age restriction on electric scooter operators to limit the use of these scooters by children too young to understand traffic laws and to allow only one operator per scooter; and be it further

RESOLVED, That TMA work with DPS to require the use of helmets when operating electric scooters and to add safety features so that car drivers can see them.

Related TMA Policy:

55.021 Bicycle Helmets: The Texas Medical Association supports the use of bicycle helmets certified by the U.S. Consumer Products Safety Commission, by Texans of all ages and passage of a law mandating approved helmet use for all cyclists (Substitute Committee on Emergency Medical Services and Trauma and Medical Student Section, p 155, A-96; reaffirmed CPH Rep. 3-A-10; amended CM-CAH Rep. 1-A-14).

Related AMA Policy:

H-10.964 Helmets for Riders of Motorized and Non-motorized Cycles: General Helmet Use: Our AMA: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use; (6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs.
(i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.

Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) encourages the availability of helmets at the point of bicycle purchase.

Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.

Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.
Texas Medical Association House of Delegates

Resolution 309
A-19

Subject: Factoring Adolescent Sleep Patterns into Middle and High School Start Times

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, 72.7 percent of high school students sleep less than the consensus recommendation by the American Academy of Sleep Medicine (AASM) of eight to 10 hours; and

Whereas, 57.8 percent of middle school students sleep less than the consensus recommendation by AASM of nine to 12 hours; and

Whereas, Adolescents who get less than the recommended amount of sleep have double the risk of being overweight or obese, which is associated with an increased risk for metabolic syndrome; and

Whereas, Partial sleep restriction for even one week in healthy individuals increases risk of atherosclerosis and cardiovascular disease; and

Whereas, Sleep deprivation decreases memory consolidation, recall, cognitive function, and learning outcomes in adolescents; and

Whereas, Sleep deprivation in adolescents has negative impacts on mental health, including increased depression, anxiety, and suicidal ideation; and

Whereas, Chronic sleep loss increases impulsivity and risky behaviors such as substance use; and

Whereas, Adolescents experience a natural delay in sleep onset, with teenagers struggling to fall asleep before 11 pm, leading to late-morning awakening; and

Whereas, Only 12 percent of school districts in Texas and fewer than 20 percent of middle and high schools in the United States have a start time of 8:30 am or later as recommended by the American Academy of Pediatrics (AAP) and the American Medical Association; and

Whereas, Opening schools later substantially increases the amount of sleep adolescents receive; and

Whereas, Starting school later improves student well-being, mood, and depressive symptoms; and

Whereas, Delaying high school start times leads to increased attendance, graduation rates, and academic performance outcomes in core subjects on state and national exams; and

Whereas, The majority of parents and principals in Texas’ largest school district, Houston Independent School District, voted for start times of 8:30 am or later for middle and high school students; and

Whereas, AAP and AMA support middle and high school start times of 8:30 am or later; therefore be it
RESOLVED, That the Texas Medical Association encourage physicians to be informed on the biologic sleep needs of adolescents, promote awareness of this need to the community, and communicate with local school health advisory committees to share evidence-based, best practices regarding health promotion, including the benefits of later school start times for adolescents.

Related TMA Policy:


55.027 Public School Education: With the goal of improving the public school system through active participation, TMA members are encouraged to become involved with the public school system in their areas to the degree possible, including mentoring students and joining in community/school partnership programs, where available. In addition, TMA encourages its members to work with local school systems to establish advanced placement and enrichment programs in Science, Technology, Engineering, and Math (STEM) with special emphasis on encouraging participation of disadvantaged students in these programs (Council on Medical Education, p 92, A-98; reaffirmed CM-PDHCA Rep. 2-A-08; amended CM-PDHCA Rep. 2-A-18).

Related AMA Policy:

H-60.930 Insufficient Sleep in Adolescents:

1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.

2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Sources:


Resolution 310
A-19

Subject: Amending TMA Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, People between 18 and 21 years of age have the highest rate of JUUL use, the most common electronic cigarette, occupying 70 percent of the electronic cigarette market in 2019; and

Whereas, Electronic cigarettes can deliver the addictive substance nicotine to the body, including some electronic cigarettes that deliver nicotine at levels higher than combustible cigarettes; and

Whereas, Adolescents who use electronic cigarettes are 6.17 times more likely to smoke cigarettes as they transition to adulthood; and

Whereas, Texans pay $8.85 billion annually in smoking-caused health bills, while 28,000 Texans die each year from smoking-related illness; and

Whereas, The aerosol that users inhale and exhale from e-cigarettes potentially exposes both themselves and bystanders to harmful substances, including heavy metals, volatile organic compounds, and ultrafine particles that can be inhaled deeply into the lung; and

Whereas, The cytotoxic profile of electronic cigarettes adversely impacts the pulmonary, cardiovascular, immune, and central nervous systems; and

Whereas, Nicotine exposure to people under 21 years of age can cause damage to the brain, which continues to develop until 25 years of age; and

Whereas, Nicotine use in people under 21 years of age can adversely impact memory, attention, and learning; and

Whereas, Electronic cigarette usage grew by 78 percent (approximately 1.3 million people) from December 2017 to December 2018 among high school students nationwide; and

Whereas, The most common reason cited for using JUUL is seeing a person in a social circle using it; and

Whereas, More than half the people aged 18 years or younger who use JUUL receive it from a social source; and

Whereas, Increasing the purchase age of electronic cigarettes to 21 years or older will make electronic cigarettes less likely to be in the same social networks as high school students; therefore be it

RESOLVED, That the Texas Medical Association amend Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors as follows:
The Texas Medical Association supports (1) limiting the sale of electronic cigarettes (e-cigarettes) and associated products only to those people who are at least 21 years of age or older; (2) regulation of e-cigarettes in Texas in a similar manner as tobacco products; (3) increased clinical research on the effects of e-cigarettes; and (4) education in schools for children and adolescents about the effects of e-cigarettes, nicotine, tobacco, and other addictive substances (Res. 305-A-14).

Related TMA Policy:

315.030 Physicians and Regulation of Electronic Cigarettes: The Texas Medical Association will (1) work with the Texas Department of State Health Services to develop communications for physicians to share with patients on e-cigarettes and associated products and to encourage the Texas Quit line to identify the use of e-cigarettes by callers; (2) encourage physicians to work with their county medical societies and local public officials to ensure that current smoke-free ordinances include e-cigarettes and associated products; and (3) work with the Texas Legislature to restrict the purchase of e-cigarettes and associated products by minors (CSPH Rep. 4-A-14).

Related AMA Policy:

H-495.986 Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes: Our AMA: (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21; (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to prove of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and (10) supports that
the sale of tobacco products be restricted to tobacco specialty stores.

**H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and
Tobacco Products: Our AMA:**

(1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its
deeding authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars,
hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by
the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco
Control Act;

(2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical
tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in
all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health
care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco
cigarettes, including prohibitions on television advertising, product placement in television and films, and
the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco
cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA;
(e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on
containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product
(include e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and
contraindications for use; (g) requires transparency and disclosure concerning product design, contents,
and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such
products to youth; and

(3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a)
prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of
ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an
accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently
displayed on the product alongside a warning of the addictive quality of nicotine.

**Sources:**


Subject: Identifying Trauma and Mental Health Susceptibilities in Schools

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Student mental health concerns have been brought to the forefront by recent traumatic events such as the Santa Fe shooting and Hurricane Harvey; and

Whereas, Environmental sources of mental stress can induce depression, post-traumatic stress disorder, substance use, other mental disorders, learning difficulties, behavioral issues, and poor developmental and health outcomes that persist long into adulthood; and

Whereas, Community epidemiological studies have found that approximately 20 percent of American children and adolescents are currently experiencing symptoms that would qualify them for a psychiatric diagnosis, yet only a very small percentage of these youth are typically identified; and

Whereas, Key environmental protective factors, which include attachment to nurturing caregivers, a sense of belonging, and a protective community, have been associated with the development of “resilience” in a child that can buffer him or her from the negative health outcomes associated with adverse childhood events; and

Whereas, Because children spend a significant portion of their time in school, educators can play a key role in fostering protective environments for children and identifying children who may need additional support; and

Whereas, It has been shown that school-based mental health identification efforts, including teacher identification efforts, have been successful in promoting the identification of those in need of mental health services, and the improvement of academic and mental health functioning; and

Whereas, The National Alliance on Mental Illness and Mental Health of America, nationally recognized advocacy groups for the advancement of mental illness treatment, as well as the American Academy of Pediatrics support mental health services being provided in a school-based format; and

Whereas, Although Texas law mandates that teachers be trained in recognizing trauma, it requires only one training for new teachers when they are hired, with no requirement for refresher trainings; and

Whereas, Texas Medical Association Policy 215.019, Public Mental Health Care already supports: (1) state efforts to provide the public mental health system with funding sufficient to address common severe mental illness across the lifespan for all in need; (2) state efforts to ensure that appropriated funds are used to provide best practices for patients in a cost-efficient manner for taxpayers; (3) equity of reimbursement for primary care providers offering behavioral health care in a primary care setting as a way of improving access to mental health care; and (4) innovative and evidence-based approaches for the early detection and prevention of mental illness (Res. 201-A-07; amended CSPH Rep. 3-A-17); therefore be it

RESOLVED, That the Texas Medical Association advocate for school-based systems of mental health care that provide an integrated system of educator training, referral to treatment, and clear access to providers.
Related TMA Policy:

55.033 Children's Mental and Behavioral Health: Because school is the "workplace of the child," primary care physicians should have knowledge of the demands and resources of their local school districts.

Advocacy. TMA should facilitate and advocate for:

h. Adequate numbers and quality of mental health professionals throughout the state,

i. Coordinating with the educational system for mentally healthy schools, and


Related AMA Policy:

H-345.977 Improving Pediatric Mental Health Screening: Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

D-345.994 Increasing Detection of Mental Illness and Encouraging Education:

1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

H-60.929 National Child Traumatic Stress Network: Our AMA: 1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and 2) will work with mental health organizations and relevant healthcare organizations to support full funding of the National Child Traumatic Stress Initiative at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network.

H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters: Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.

(2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

(3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate
federal agencies; state, local, and medical specialty societies; other health care associations; and private
foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health
response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to
address mass casualty care; (c) implement communications strategies to inform health care professionals and
the public about a terrorist attack or other major disaster, including local information on available medical and
mental health services; (d) convene local and regional workshops to share "best practices" and "lessons
learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific
knowledge and information for enhancing the medical and public health response to terrorism and other
disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician
knowledge of the diagnosis and treatment of depression, anxiety, and post-traumatic stress disorders
associated with exposure to disaster, tragedy, and trauma.

(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the
community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual
clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient
information for surveillance as well as the rationale and procedures for reporting patients and patient
information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions,
decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents
likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and
others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g)
understand the essentials of risk communication so that they can communicate clearly and nonthreateningly
with patients, their families, and the media about issues such as exposure risks and potential preventive
measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical
services, emergency management, and incident management systems in disaster response and the individual
health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty
event should be knowledgeable of public health interventions that must be considered following the onset of a
disaster including: (a) quarantine and other movement restriction options; (b) mass
immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing
exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal
resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal
issues and disaster response. These include: (a) their professional responsibility to treat victims (including
those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from
harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local, and national public
health, law enforcement, and emergency management authorities in developing and implementing disaster
preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism
and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of
the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the
immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes
against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines,
pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection
and defense capabilities.
Sources:
Whereas, The Supplemental Nutrition Assistance Program (SNAP), commonly known as “food stamps,” provides financial assistance to low-income individuals and families to address domestic hunger; and

Whereas, SNAP is a federal-state partnership, with the federal government funding 100 percent of recipients’ food expenditures and up to 50 percent of administrative costs for the program, with states funding the remaining administrative costs; and

Whereas, SNAP serves 38 million people in the United States and 3.5 million individuals in Texas alone; and

Whereas, In Texas, SNAP prevents more than 900,000 recipients, including 479,000 children, from falling below the poverty line annually due to family expenditures on food; and

Whereas, SNAP usage is associated with improved nutrition, better health outcomes, and lower cost of health care among recipients; and

Whereas, In order for individuals to qualify for SNAP, federal law requires work or participation in employment and training programs for certain adults aged 18 to 59; and

Whereas, Efforts to increase work requirements for recipients of welfare programs can have negative effects on recipients’ health outcomes and limit their ability to find stable employment; and

Whereas, Many recipients register for SNAP only after losing employment, and more than 80 percent report securing employment within a year after starting to receive SNAP benefits; and

Whereas, Many able-bodied SNAP recipients who are unemployed are forced to report health issues as their reason for not working enough to qualify for benefits; and

Whereas, Increased work requirements to qualify for SNAP have the potential to create administrative barriers that prevent even working recipients from receiving benefits; and

Whereas, Both federal and state governments share authority over SNAP work requirements, and states can exempt recipients from federal work requirements at their discretion to allow more individuals to benefit from SNAP; and

Whereas, The Agriculture Improvement Act of 2018, commonly known as the “farm bill,” continues funding for SNAP through September 2023; and
Whereas, The U.S. House of Representatives’ original version of the 2018 farm bill would have extended work requirements to all adults capable of work and increased states’ administrative duties to implement these requirements, leading to opposition in Congress and the removal of this provision; and

Whereas, In a recent letter to the U.S. Senate, the American Medical Association expressed its support for the preservation of SNAP and opposed increasing work requirements that would reduce benefits for recipients, as proposed by the U.S. House of Representatives; and

Whereas, The Food and Nutrition Service proposed a new rule on Feb. 1, 2019, that would limit states’ authority to exempt recipients from work requirements; therefore be it

RESOLVED, That the Texas Medical Association oppose any governmental efforts to increase work requirements for the Supplemental Nutrition Assistance Program (SNAP) beyond the level detailed in the Agriculture Improvement Act of 2018; and be it further

RESOLVED, That TMA oppose any governmental efforts to limit the Texas government’s ability to exempt SNAP recipients from work requirements.

Related TMA Policy:

190.037 Medicaid Work Requirements: The Texas Medical Association opposes: (1) any federal Medicaid waiver seeking to impose mandatory work requirements, but instead collaborate with lawmakers, the Texas Health and Human Services Commission, and the Centers for Medicare & Medicaid Services to support constructive measures to help Medicaid enrolled and eligible patients overcome barriers that prevent them from working or engaging in other meaningful community activities; (2) efforts to impose lifetime limits on adult Medicaid enrollees; and (3) any policy or regulation that punitively limits access to affordable health care for Medicaid-eligible patients (CSE Rep. 6-A-18).

190.038 Opposition to Medicaid Work Requirements: The Texas Medical Association will apply all appropriate resources to oppose Medicaid work requirements to ensure that vulnerable, low-income adults with children and other covered populations continue to receive necessary medical services and that Texas does not increase uncompensated care for physicians (Res. 402-A-18).

260.095 Eligibility of Sugar-Sweetened Beverages for SNAP and Counseling: The Texas Medical Association 1) will develop educational materials for physicians to support their efforts to inform and counsel parents and their children about the effects of sugar-sweetened beverages (SSBs) and high-fat, -salt, or -carbohydrate foods on obesity and overall health; and 2) encourages the Texas Health and Human Services Commission (HHSC) to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines and to extend local programs that multiply value for the purchase of fresh fruits and vegetables under SNAP; and 3) will work with both the Texas Legislature and the HHSC to remove SSBs from SNAP (Amended Res. 302-A-13; amended CSPH Rep. 4-A-18).

Related AMA Policy:

H-150.937 Improvements to Supplemental Nutrition Programs: Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Sources:


WHEREAS, Direct-to-consumer genetic tests are genetic tests marketed directly to consumers and can be bought online or in stores; and

WHEREAS, Personal genome services (PGSs) such as 23andMe and Ancestry.com sell direct-to-consumer genetic tests to the public; and

WHEREAS, Texas Medical Association Policy 155.008 addresses the issue that genetic testing and interpretation should be done by a physician, and “appropriate informed consent should occur prior to testing”; and

WHEREAS, Direct-to-consumer genetic tests may be unreliable because they rely on invalidated algorithms, single nucleotide polymorphisms that may underpredict or overpredict the risk of disease, and they fail to take into consideration the multi-factorial nature of health; and

WHEREAS, The Federal Drug Administration recognizes direct-to-consumer genetic tests can be unreliable and may persuade patients to undergo unnecessary health procedures; and

WHEREAS, Patients use the information from direct-to-consumer genetic tests to make their health decisions; and

WHEREAS, Collection of genetic information creates the risk of privacy violation because genetic information cannot be de-identified, and large-scale data breaches are common; and

WHEREAS, Unauthorized access to personal genetic information can result in unintended consequences, including but not limited to employers discriminating against employees, genetic information being used for state surveillance, and genetic information being used to influence decisions; and

WHEREAS, Genetic information can be used to target advertising; and

WHEREAS, Collected genetic information has been and can be distributed to pharmaceutical companies; and

WHEREAS, Pharmaceutical companies do not have to obtain informed consent before using genetic information for research; and

WHEREAS, PGSs that do obtain informed consent may not obtain it for all uses of genetic material or may change their policies; and

WHEREAS, Failure to gain informed consent is a violation of biomedical research ethics; therefore be it
RESOLVED, That the Texas Medical Association support establishing policies that promote educating the public about potential risks created by direct-to-consumer genetic testing; and be it further RESOLVED, That TMA support encouraging physicians to caution patients on risks that direct-to-consumer genetic testing can pose, including but not limited to unreliable test results and privacy violations.

Related TMA Policy:
105.009 Informed Consent: An informed patient is the best patient, ethically and legally. Disclosure techniques and information recommended by the Texas Medical Disclosure Panel, in addition to other information which physicians may provide, enable patients to give an informed consent for proposed procedures (Board of Councilors, p 58, A-94; reaffirmed BOC Rep.3-A-04; reaffirmed BOC Rep. 6-A-14).

155.008 Direct Access Laboratory Testing: Patients are best served when laboratory tests are ordered by qualified physicians, a physician directs the course of a patient’s diagnostic and therapeutic care, and a physician determines which clinical and anatomic laboratory services are appropriate. Individual pathologists, pathology groups, or laboratories should decide for themselves whether to accept requests for diagnostic laboratory studies directly from patients and should retain the right to refuse direct access laboratory testing requests. More information about risks and benefits of direct access laboratory testing is needed, such as data on whether direct access laboratory testing improves health and wellness or reduces morbidity or mortality rates. To ensure maximum safety and quality, direct access laboratory testing should occur with the following stipulations: (a) It should be confidential (not anonymous) with contact information provided by the patient. Anonymous testing should occur only with built-in assurances of patient follow up for counseling; (b) It must be performed by a laboratory certified by the Clinical Laboratory Improvement Amendments. The results should be provided to the patient, and the laboratory physician should review the results with the patient. The responsibility for subsequent actions are solely that of the patient; (c) Appropriate informed consent should occur prior to testing; (d) Only tests licensed in the United States for diagnostic testing should be performed (e.g., no research tests); and (e) Appropriate reflex/confirmatory testing should be performed. Repeat testing should be done if appropriate, with the patient contacted if additional blood specimens are needed (Amended BOT Rep. 15-A-06; amended CHCQ Rep. 2-A-16).

Related AMA Policy:
4.1.1 Genetic Testing & Counseling: Genetic testing can provide valuable information to support informed decision making about personal health risks and care options as well as reproductive choices. The fact that genetic information carries implications for others to whom the individual is biologically related raises ethical challenges of balancing confidentiality against the well-being of others. Because genetic contribution to disease can be complex and highly variable, interpreting findings and helping patients understand the implications for their health and health care requires special skill and attention. Genetic testing is most appropriate when the results of testing will have meaningful impact on the patient’s care. Physicians should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, or to predict future health risks, or to provide information for managing a disease, it is important that the patient receives appropriate counseling. Physicians who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should: (a) Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other health care professionals who can provide these services, such as licensed genetic counselors. (b) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (c) Discuss with the patient: (i) what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Physicians should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing; (ii) medical and psychological
implications for the individual’s biological relatives; (iii) circumstances under which the physician will expect the patient to notify biological relatives of test findings; and (iv) that the physician will be available to assist in communicating with relatives. (d) Obtain the individual’s informed consent for the specific test or tests to be performed. (e) Ensure that appropriate measures are taken to protect the confidentiality of the patient’s and their biological relatives’ genetic information.

4.1.2 Genetic Testing for Reproductive Decision Making: Genetic testing can provide information to help prospective parents make informed decisions about childbearing. Genetic testing to inform reproductive decisions was once recommended only for women/couples whose family history or medical record indicated elevated risk for a limited set of genetically mediated conditions. As procreation among individuals of diverse ancestries becomes more common and tests for more conditions become more accurate and less costly, the relevance of broad preconception, pre-implantation, or prenatal genetic screening grows stronger. Physicians may ethically provide genetic testing to inform reproductive decision making when the patient requests, but may also wish to offer broad screening to all persons who are considering having a child. Physicians who provide reproductive health care that includes genetic testing should: (a) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (b) Discuss reasons for and against genetic testing and ethically inappropriate uses of genetic testing, such as to identify non-disease-related characteristics or traits. (c) Obtain the individual’s informed consent to the specific test or tests to be performed. Physicians should ascertain whether the person wishes to be informed about incidental findings. (d) Inform the individual about any abnormal findings for the tests ordered and discuss the severity of the associated health condition, likelihood of clinical manifestation (penetrance), age at onset, and other factors relevant to a decision about childbearing. (e) Respect an individual’s decision to terminate or continue a pregnancy when testing reveals a genetic abnormality in the fetus, in accordance with applicable law. (f) Refer the individual to another qualified physician when personal moral values prohibit the physician from providing lawful abortion services when this is a service that the person desires, in keeping with ethics guidance.

H480.944 Improving Genetic Testing and Counseling Services: Our AMA supports: (1) appropriate utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services, and impact of genetic testing and counseling on patient care and outcomes.

D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing: (1) recommends that genetic testing be carried out under the personal supervision of a qualified health care professional; (2) encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for further information; (3) will work with relevant organizations to develop criteria on what constitutes an acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not misleading; such advertisements should include all relevant information regarding capabilities and limitations of the tests, and contain a statement referring patients to physicians to obtain further information; (5) will work to educate and inform physicians regarding the types of genetic tests that are available directly to consumers, including information about the lack of scientific validity associated with some direct-to-consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

4.1.3 Third-Party Access to Genetic Information: The rapid pace of development and dissemination of genetic testing has made it possible to generate information about individuals across a wide and growing
spectrum of genetic variations associated with disease risk. The prospect of access to and use of such information by third parties who have a stake in an individual’s health raises ethical concerns about confidentiality and potentially inappropriate use of genetic information. Patients who undergo genetic testing have a right to have their information kept in confidence, and a variety of state and federal laws prohibit discrimination by employers, insurers, and other third parties based on genetic information they obtain about an individual. Physicians who provide and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to: (a) Maintain the confidentiality of the patient’s health information, including genetic information. (b) Release a patient’s genetic information to third parties only with the patient’s informed consent. (c) Decline to participate in genetic testing at the request of third parties (for example, for purposes of establishing health care or other benefits or coverage for the individual) except when at the patient’s request and with their informed consent.

H-55.979 Genetic Susceptibility Testing for Hereditary Cancers: (1) That physicians who feel unprepared to provide comprehensive genetic test counseling should refer candidates for genetic susceptibility testing to specialized care centers with experience and expertise in hereditary cancers or to investigators for relevant research, where family history can be confirmed and they can be tested if they so choose. (2) That genetic susceptibility testing, including that marketed directly to consumers, should be provided only in the context of fully informed consent and comprehensive pre- and post-test counseling by a qualified health care professional.

H-460.908 Genomic-Based Personalized Medicine: (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians' voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.

H-460.931 Genetics Testing Legislation: The AMA opposes legislative initiatives on genetic testing that would unduly restrict the ability to use stored tissue for medical research; and will continue to support existing federal and private accreditation and quality assurance programs designed to ensure the accuracy and reliability of tests, but oppose legislation that could establish redundant or duplicative federal programs of quality assurance in genetic testing.

H-315.983 Patient Privacy and Confidentiality: 1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. 2. Our AMA affirms: (a) that physicians and
medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be granted access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures. 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is
appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. 21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

D-460.976 Genomic and Molecular-based Personalized Health Care: (1) continue to recognize the need for possible adaptation of the US health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans; (2) support studies aimed at determining the viability of prospective care models and measures that will assist in creating a stronger focus on prospective care in the US health care system; (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing; (4) maintain a visible presence in genetics and molecular medicine, including web-based resources and the development of educational materials, to assist in educating physicians about relevant clinical practice issues related to genomics as they develop; and (5) promote the appropriate use of pharmacogenomics in drug development and clinical trials.

9.6.7 Direct-to-Consumer Advertisement of Prescription Drugs: Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patients’ health and safety, and compromising patient physician relationships. In the context of direct-to-consumer advertising of prescription drugs, physicians individually should: (a) Remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products. (b) Engage in dialogue with patients who request tests, drugs, treatments, or devices they have seen advertised to: (i) assess and enhance the patient’s understanding of the test, drug or device; (ii) educate patients about why an advertised test, drug, or device may not be suitable for them, including providing cost-effectiveness information about different options. (c) Resist commercially induced pressure to prescribe tests, drugs, or devices that may not be indicated. (d) Obtain informed consent before prescribing an advertised test, drug, or device, in keeping with professional standards. (e) Deny requests for an inappropriate test, drug, or device. (f) Consider reporting to the sponsoring manufacturer or appropriate authorities direct-to-consumer advertising that: (i) promotes false expectations; (ii) does not enhance consumer education; (iii) conveys unclear, inaccurate, or misleading health education messages; (iv) fails to refer patients to their physicians for additional information; (v) does not identify the target population at risk; (vi) encourages consumer self-diagnosis and treatment. Collectively, physicians should: (g) Encourage and engage in studies that examine the impact of direct-to-consumer advertising on patient health and medical care. (h) Whenever possible, assist authorities to enforce existing law by reporting advertisements that do not: (i) provide a fair and balanced discussion of the use of the drug
product for the disease, disorder, or condition; (ii) clearly explain warnings, precautions, and potential adverse reactions associated with the drug product; (iii) present summary information in language that can be understood by the consumer (iv) comply with applicable regulations; (v) provide collateral materials to educate both physicians and consumers.

H-480.941 Direct-to-Consumer Laboratory Testing: Our AMA will: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.

7.1.2 Informed Consent in Research: Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will. Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual’s consent must also be voluntary.

A valid consent process includes: (a) Ascertaining that the individual has decision-making capacity. (b) Reviewing the process and any materials to ensure that it is understandable to the study population. (c) Disclosing: (i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research; (ii) any conflicts of interest relating to the research, in keeping with ethics guidance; (iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience; (iv) the likelihood of therapeutic or other direct benefit for the participant; (v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study; (vi) the nature of the research plan and implications for the participant; (vii) the differences between the physician’s responsibilities as a researcher and as the patient’s treating physician. (d) Answering questions the prospective participant has. (e) Refraining from persuading the individual to enroll. (f) Avoiding encouraging unrealistic expectations. (g) Documenting the individual’s voluntary consent to participate. Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when: (h) Consent is given by the individual’s legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research. (i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity. (j) There is potential for the individual to benefit from the study. In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

Sources:


Subject: Support of Mandatory Paid Parental Leave

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, While 193 countries offer paid parental leave, the United States is the only developed country to not mandate paid parental leave; and

Whereas, The 1993 Family and Medical Leave Act was pivotal in providing job-protected access to leave for parents, but this law does not require the leave to be paid and does not apply to employers that have fewer than 50 employees; and

Whereas, As of 2019, Rhode Island, California, and New Jersey, followed by other states in 2020, have state-financed programs that allow for partial compensation when on leave; and

Whereas, The Texas Workforce Commission does not stipulate parental leave unless it would be under reasonable disability- or pregnancy-related accommodations, and, even if granted, such leave can be paid or unpaid; and

Whereas, A study from McGill University delineates that little evidence exists correlating paid leave with negative employment or economic consequences; and

Whereas, A longitudinal study conducted by Rutgers University found that women who took paid parental leave reported to work within nine to 12 months compared to those who did not take parental leave, and women who returned to work after paid leave have a 39-percent lower likelihood of utilizing federal aid and a 40-percent lower likelihood of needing food stamps; and

Whereas, Medical checkups; diphtheria, pertussis, and tetanus/oral polio immunizations; and breastfeeding in the first year of life are likely to be less frequent for children whose mothers return to work early; specifically, there is a stronger concern for children whose mothers return to work full-time within the first three months of delivery; and

Whereas, The maternal mortality rate in Texas has risen exponentially from 18.6 per 100,000 live births in 2010 to 38.7 in 2013, in comparison to national rates rising from 19.3 in 2011 to 21.5 in 2014; and

Whereas, Studies from the Texas Department of State Health Services’ Maternal Mortality and Morbidity Task Force reveal that most deaths occur between 42 and 365 days after delivery, and most causes of maternal deaths are stress-related, including preeclampsia, cardiac complications, and overdoses; and

Whereas, The American College of Obstetricians and Gynecologists supports providing at least six weeks of paid parental leave, noting benefits such as decreased infant mortality, improved health of child and mother, and improved worker morale and retention; and
Whereas, A Pew Research Center poll from March 2018 shows that 82 percent of Americans believed mothers should get paid time off for the birth or adoption of a child, and 69 percent believed fathers should as well; therefore be it

RESOLVED, That the Texas Medical Association support the expansion of existing legislation regarding job-secured parental leave of at least 12 weeks, to include monetary compensation; and be it further

RESOLVED, That TMA advocate for mandatory paid parental leave.

Related TMA Policy:

260.104 Parental Leave: The Texas Medical Association will promote awareness and education for physicians, legislators, and the public on the importance of paid parental leave in ensuring good maternal and infant health outcomes and promoting the health and well-being of the family. TMA will work with the Department of State Health Services, Health and Human Services Commission, and state higher education institutions to support study on the barriers to expanding paid parental leave in Texas, particularly for the Texas workforce who does not have access to paid leave (CSPH Rep. 2-A-17).

Related AMA Policy:

H-405.954 Parental Leave: 1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

H-405.960 Policies for Parental, Family and Medical Necessity Leave: AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed, and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Sources:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 315
A-19

Subject: Notification of Generic Drug Manufacturing Changes

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Generic drug use is prevalent across the medical spectrum, with multiple manufacturers producing the same base drug; and

Whereas, Pharmacies and pharmacy benefit managers may change a generic manufacturer from one prescription to another; and

Whereas, Generic drugs are not required to replicate the extensive clinical trials used in the development of brand drugs; and

Whereas, Bioequivalence only needs 24 to 36 healthy, normal volunteers to demonstrate the time it takes a generic to reach the bloodstream and its concentration in the bloodstream; and

Whereas, Two versions of a drug are said to be bioequivalent if the 90-percent confidence intervals for the ratios of the geometric means of the area under the curve and chemical makeup fall within 80 percent and 125 percent; and

Whereas, Generic drugs are not required to contain the same non-medicinal ingredients as the brand or another manufacturer’s generic drug; and

Whereas, Most patients are unaware of a change from one manufacturer to another of their generic drug prescription; and

Whereas, The unknown change in generic manufacturers has caused harm to patients; therefore be it

RESOLVED, That the Texas Medical Association work with Texas legislators to ensure that each patient is expressly notified by the pharmacy or pharmacy benefit manager of a change in the manufacturer of his or her generic medication; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association present a similar resolution to the AMA House of Delegates for congressional approval and implementation.

Related TMA Policy:

95.004 Drugs Labeling of Generic Substitutions: Drugs Labeling of Generic Substitutions: When generic substitutions are made, the prescription label on the container should show the brand name of the generic substitution, the generic chemical and the generic name. Texas Medical Association voted to ask the pharmaceutical community to cooperate in this endeavor (Resolution 28C, p 138, I-91; reaffirmed CSA Rep. 2-A-02; reaffirmed CSPH Rep. 3-A-12).

95.012 Drug Antisubstitution Laws and Generic Prescriptions: Compulsory generic prescribing should be opposed because generic equivalency in drugs does not necessarily mean therapeutic equivalence. The patient’s right to receive the drugs and medications best suited for his or her individual
needs should be protected by preserving the current system of brand name prescribing. Legislation and regulations which prohibit generic drug substitution without prior agreement between the pharmacist and the physician should be supported (Council on Socioeconomics, p 177, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

180.031 Pharmacy Benefit Managers: The Texas Medical Association will (1) gather evidence of the administrative burden placed on physicians and patients by the policies and operating practices of Pharmacy Benefit Managers (PBMs) in order to document the impact on medical practices and determine whether the business practices of PBMs comply with state laws and regulations; (2) explore the possibility of legislative action should no state laws or regulations apply to the preauthorization process required by PBMs; and (3) promote cooperation by Texas pharmacists to provide physicians with up-to-date information about prescriptive drugs covered by pharmacy benefit managers and appropriate alternative medications in pharmacy benefit managers' formularies (Amended Res. 401-A-06; reaffirmed CSE Rep. 6-A-16).

Related AMA Policy:

H-115.974 Prescription Labeling: Our AMA recommends (1) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription.

(2) That, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.

(3) When generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]".

(4) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed.

H-115.988 Qualitative Labeling of All Drugs: The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over-the-counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert.

D-120.933 Pharmacy Benefit Managers Impact on Patients: Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy
benefit manager (PBM) tactics may have on patient’s timely access to medications, patient outcomes, and the physician-patient relationship; (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and compile, data on the top twenty-five medication precertification requests and the percent of such requests approved after physician challenge.

**H-125.986 Pharmaceutical Benefits Management Companies:** Our AMA:

(1) encourages physicians to report to the Food and Drug Administration’s (FDA) MedWatch reporting program any instances of adverse consequences (including therapeutic failures and adverse drug reactions) that have resulted from the switching of therapeutics alternates;

(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers’ influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate;

(3) pursues congressional action to end the inappropriate and unethical use of confidential patient information by pharmacy benefits management companies;

(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients;

(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to ensure that they are based on sound science and represent safe and cost-effective medical care;

(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and

(7) encourages the FTC and FDA to monitor PBMs’ policies for potential conflicts of interests and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest.
TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 316
A-19

Subject: Determinants of Health

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Determinants of health are conditions in the environment that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples include stress and burnout, economic conditions, housing, food insecurity, public safety, culture, levels of education including health education, access to health care services, access to job/economic opportunities, among many others; and

Whereas, Determinants of health are an important component of overall health care quality and a driver in health care costs; and

Whereas, The phrase “social determinants of health” has garnered renewed attention in academia and in the discussion of the move from fee-for-service to value-based care; and

Whereas, Physician performance is now being judged by governmental and commercial payors using a set of quality standards and cost metrics that do not account for determinants of health that are outside of a physician’s control, such as patient noncompliance and lifestyle choices; and

Whereas, Physicians can be financially disadvantaged and/or rated inaccurately due to poor health outcomes and lack of adequate risk adjustment methodology by governmental and commercial payors; and

Whereas, Physicians are not systematically given both adequate and accurate clinical and financial information on their performance in real time including quality and cost data, cost of care options, emergency department utilization, and risk attribution; therefore be it

RESOLVED, That the Texas Medical Association study the social determinants of health for the purpose of better understanding its impact on medicine; and be it further

RESOLVED, That TMA advocate to governmental and commercial payors the power of determinants of health on overall health care quality and health care costs; and be it further

RESOLVED, That TMA advocate that governmental and commercial payors modify existing performance and quality programs to include determinants of health in the total compensation for the provision of medical services.

Related TMA Policy:

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).


180.029 Economic Profiling: The Texas Medical Association opposes all forms of economic profiling schemes that do not accurately assess quality cost effective health care. TMA will work with insurers, health plans, and HMOs to advise on the development of credible, reliable, and understandable clinical measurements of medical practice that contribute to improving quality of care in a cost effective manner (Res. 409-A-04; reaffirmed CSE Rep. 2-A-14).

195.033 Medicare Payment Incentives and Penalties: The Texas Medical Association advocates that any Medicare penalty or incentive program including the Value-Based Payment Modifier program and the Merit-Based Incentive Payment System be designed so that: (1) the measures and standards used do not result in financial penalties for physicians when their patients do not comply with orders or recommendations for testing and treatment; (2) physicians are not penalized for providing services to disadvantaged patients; (3) physicians are not penalized for noncompliance with obsolete or superseded guidelines and standards; and (4) both cost and quality measures are adequately risk adjusted to eliminate the effects of poverty, poor educational attainment, and cultural differences from the measures used to adjust payment. Until all of the above are implemented, Medicare payments should not be adjusted using these measures (CSE Rep. 2-A-12; amended CSE Rep. 6-A-17).

265.017 Pay-for-Performance Principles and Guidelines. Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the American Medical Association Guidelines for Pay-for-Performance Programs and the following five American Medical Association Principles for Pay-for-Performance Programs:

1. **Ensure quality of care.** Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. **Foster the patient-physician relationship.** Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. **Offer voluntary physician participation.** Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. **Use accurate data and fair reporting.** Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. **Provide fair and equitable program incentives.** Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.
Guidelines for Pay-for-Performance Programs

Safe, effective, and affordable health care for all Americans is the American Medical Association’s goal for our health care delivery system. AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment AMA’s Principles for Pay-for-Performance Programs and provide AMA leaders, staff, and members operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality-of-care measures must be the primary measures used in any program.
  1. All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
  5. Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.
  6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
  7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care, quality, and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the program must be phased in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must explain these programs prospectively to the patients and communities covered by them.

Patient-Physician Relationship

- Programs must be designed to support the patient-physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not cause conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
  2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient deselection.
Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

**Physician Participation**

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties wishing to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
  1. Programs should provide physicians tools to facilitate participation.
  2. Programs should be designed to minimize financial and technological barriers to physician participation.
- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

**Physician Data and Reporting**

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act.
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not cause financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a nonpunitive manner.
  1. Programs should use accurate administrative data and data abstracted from medical records.
  2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
  3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
  1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
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2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Programs must offer financial support to physician practices that implement IT systems or software that interacts with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve prespecified absolute program goals or demonstrate prespecified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not penalize physicians financially based on factors outside of the physician’s control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not penalize physicians financially when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.


265.018 Evidence-Based Medicine. The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of evidence-based medicine to improve approval and payment for medical services where appropriate.
TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with professional standards, (2) whenever there is a significant change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the American Medical Association policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as “evidence-based medicine” (CSA Rep. 3-A-08; amended CSPH Rep. 5-A-18).

265.024 Bridges to Excellence as Best Practice Model: The Texas Medical Association supports Bridges to Excellence (BTE) modules for asthma, cardiac care, and diabetes as best practice models, and will investigate risk stratification models and patient compliance assessment tools as modifiers in measuring quality of care (Amended CHCQ Rep. 2-A-13).