

Items in Supplement are in italics.

AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 3, 2024

1. [Council on Science and Public Health Report 1 – Sunset Policy Review](#)
2. [Council on Science and Public Health Report 2 – Resolution 301 2023 – Labeling of Sugar-Sweetened Beverages](#)
3. [Council on Science and Public Health Report 3 – Resolution 306 2023 – Over the Counter Continuous Glucose Monitors](#)
4. [Council on Science and Public Health Report 4 – Resolution 318 2022 – Supporting Transgender Youth Participation in Sports](#)
5. [Committee on Behavioral Health Report 1 – Sunset Policy Review](#)
6. [Committee on Cancer Report 1 – Sunset Policy Review](#)
7. [Committee on Child and Adolescent Health Report 1 – Sunset Policy Review](#)
8. [Committee on Infectious Diseases Report 1 – Sunset Policy Review](#)
9. [Committee on Infectious Diseases Report 2 – TMA Policy on Wastewater Surveillance](#)
10. [Committee on Reproductive, Women’s, and Perinatal Health Report 1 – Sunset Policy Review](#)
11. [Committee on Reproductive, Women’s, and Perinatal Health Report 2 – Updates to Midwifery and Home or Outpatient Obstetrical Delivery Policies](#)
12. [Joint Report 3 – Resolution 304 2023 – Social Media and Smart Phone Use](#)
13. [Joint Report 5 – Resolution 317 2023 – Incorporating Emergency Hemorrhage Control into School Curriculum](#)
14. [Resolution 301 – Amateur Radio: Reliable Medical Communication When All Else Fails](#)
15. [Resolution 302 – Disposal of E-cigarettes and E-cigarette-related Products](#)
16. [Resolution 303 – Dedicated On-Site Physician Requirement for Emergency Departments](#)
17. [Resolution 304 – Preparing for Future Policy Exigencies](#)
18. [Resolution 305 – Intentionally Promoting Trusting Relationships between Patients and Medical Community](#)
19. [Resolution 306 – Medication Supply Chain Transparency and Pricing](#)
20. [Resolution 307 – Reducing Disparities in Women’s Health Research](#)
21. [Resolution 308 – Naloxone Administration Training in Schools](#)

22. [Resolution 309 – School-Located Vaccination](#)
23. [Resolution 310 – Addressing Food Insecurity in Undergraduate and Graduate Schools](#)
24. [Resolution 311 – Language Access Plans](#)
25. [Resolution 312 – Public Transportation](#)
26. [Resolution 313 – Balancing Motherhood and Medicine: Advocating for Support for Working Women Physicians Against Added Barriers They Face](#)
27. [Resolution 314 – Fighting Period Poverty in the Health Care Field: Improving Access to Menstrual Hygiene Products for Health Care Workers](#)
28. [Resolution 315 – Promoting Mobile Mammography Units in Medically Underserved Regions](#)
29. [Resolution 316 – Reversing Rising Rates in Syphilis and Congenital Syphilis](#)
30. [Resolution 317 – Safety with Devices Producing Carbon Monoxide](#)
31. [Resolution 318 – Sustain Funding for HIV Treatment to End the Epidemic](#)
32. [Resolution 319 – Administration of Vaccines on School Grounds](#)
33. [Resolution 320 – Individual Personal Autonomy for Medical Intervention and Vaccinations](#)
34. [Resolution 321 – Physician Personal Autonomy for Medical Intervention and Vaccinations](#)
35. [Resolution 322 – Opposing Mandates for Medical Interventions](#)
36. [Resolution 323 – Proper and Adequate Sports Physicals](#)
37. [Resolution 324 – TMA Response to Emergency Use Authorizations \(EUA\)](#)
38. [Resolution 325 – Vaccine Administration in Medical Facilities](#)
39. [Resolution 326 – Adapting TMA Gender Policy](#)
40. [Resolution 327 – Uphold the Integrity and Accessibility of In Vitro Fertilization Services in Texas](#)

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

C-SPH Report 1 2024

Subject: Policy Review

Presented by: Benjamin C. Lee, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 House of Delegates policies in the Texas Medical Association's Policy Compendium are reviewed
 2 periodically for relevance and appropriateness. Following are policies reviewed by the council with
 3 recommendations for retention, amendment, and deletion.

4
 5 The council recommends retaining these policies:

6
 7 **60.002 Televised Executions:** The Texas Medical Association opposes public televised executions
 8 (Council on Public Health, p 109, A-94; reaffirmed CPH Rep. 3-A-04; reaffirmed CSPH Rep.
 9 2-A-14).

10
 11 **260.087 Natural Gas Fracking in Texas:** The Texas Medical Association believes that the Texas
 12 Legislature, while encouraging natural gas production, should protect our water from the risk
 13 of fracking by requiring disclosure of fracking fluid components. This would include the
 14 removal of exemption from the Emergency Planning and Community Right-to-Know Act and
 15 the removal of a special exemption from the Safe Drinking Water Act; Clean Water Act;
 16 Clean Air Act; Resource Conservation and Recovery Act; Comprehensive Environmental
 17 Response, Compensation, and Liability Act; and National Environmental Policy Act for all
 18 companies engaged in this process (Res. 203-A-11; amended Res. 306-A-14).

19
 20 **280.011 Scientific Evaluation Guidelines:** The Texas Medical Association adopted the following
 21 guidelines for consideration of new scientific procedures and other topics concerning the
 22 scientific aspects of medical practice:

23
 24 (1) The Council on Science and Public Health or a subgroup will review and make
 25 recommendations.

26
 27 (2) An opinion from the council could be rendered under the following headings: (a)
 28 established treatment method; (b) investigational; (c) unacceptable for further review
 29 (explain); and (d) indeterminate – no consensus to date.

30
 31 (3) The council or subgroup will solicit information and expert advice from many sources –
 32 other councils and committees, TMA Library search, AMA, other state medical societies
 33 – and from known experts in the field in question.

34
 35 (4) The council will make a statement: (a) for general information (to the source asking in
 36 question); (b) for TMA information or action and, when deemed advisable, in the public
 37 interest, disseminate this information and opinion (Council on Scientific Affairs, pp 132-
 38 133, A-93; reaffirmed CSA Rep. 6-A-04; amended CSPH Rep. 2-A-14).

39

1 **280.013 Animal Research:** The Texas Medical Association supports the humane and responsible use
 2 of animals in education and biomedical and veterinary research in accordance with federal
 3 and state guidelines and recommends that biomedical scientists be encouraged to replace,
 4 reduce and refine research methods that require the use of animals as rapidly as science and
 5 technology permit. In addition, TMA supports legislation at all levels that impose criminal
 6 sanctions against those who break the law in their opposition to the use of animals in
 7 biomedical and veterinary research (Council on Scientific Affairs, p 129, A-94; reaffirmed
 8 CSA Rep. 6-A-04; amended CSPH Rep. 2-A-14).
 9

10 **280.029 Stem Cell Research:** The Texas Medical Association (1) supports biomedical research on
 11 multipotent stem cells (including embryonic, adult, and cord blood stem cells); (2) supports
 12 the use of somatic cell nuclear transfer technology in biomedical research (therapeutic
 13 cloning); (3) opposes the use of somatic cell nuclear transfer technology for the specific
 14 purpose of producing a human child (reproductive cloning); (4) encourages strong public
 15 support of federal funding for research involving human pluripotent stem cells; and (5) will
 16 continue to monitor developments in stem cell research and the use of somatic cell nuclear
 17 transfer technology (CSA Rep. 3-A-04; reaffirmed CSPH Rep. 2-A-14).
 18

19 **Recommendation 1:** Retain.

20
 21 The council recommends amending these policies as follows:
 22

23 **260.029 Preventive Medicine:** Preventive medicine is the practice of promoting preventive health
 24 care to improve patient well-being. The goal is to ultimately prevent disease, disability, and
 25 premature death. The primary reason to invest in prevention is to promote health, extend life,
 26 improve functioning, and prevent suffering. Preventive interventions should be used
 27 whenever they produce more health benefit than alternative services. This includes assisting
 28 physicians in incorporating disease prevention and health promotion in individual patient and
 29 community care.
 30

31 The Texas Medical Association supports universal access to clinical preventive services for
 32 all Americans and believes that clinical preventive services of proven effectiveness, delivered
 33 in a cost-efficient manner, should be included in insurance benefits.
 34

35 TMA encourages (1) physicians to become familiar with and increase their utilization of
 36 clinical preventive services protocols; (2) individual physicians as well as organized medicine
 37 at all levels to increase communication and cooperation with and support of public health
 38 agencies; (3) physicians to promote and to serve on local and state advisory boards; and (4)
 39 physicians to be leaders in studying local community needs, defining appropriate public
 40 health objectives, and working toward achieving public health goals for the community.
 41

42 TMA acknowledges that a significant portion of morbidity and mortality in this country is
 43 related to unhealthy lifestyle ~~choices~~ behaviors and endorses efforts to educate, motivate, ~~and~~
 44 encourage, and assist patients in overcoming barriers to adopting healthier
 45 behaviors ~~individuals to choose behaviors conducive to good health.~~ TMA also acknowledges
 46 that the environment in which people live (homes and neighborhoods), go to school, work,
 47 play, and recreate, as well as other social determinants of health adversely impact health
 48 behaviors. Therefore, TMA supports evidence-based community and public health efforts to
 49 promote healthier behaviors and environments of individuals, including work place, home,
 50 community, and socioeconomic status, influence conditions for taking responsibility for

1 health (Council on Public Health, p 107, and Council on Scientific Affairs, p 128, A-94;
2 reaffirmed CSA Rep. 6-A-04; amended CSPH Rep. 2-A-14).

3
4 **Recommendation 2:** Retain as amended.

5
6 The council recommends deletion of the following policies as they are no longer relevant or the policy
7 was consolidated with other similar policy:

8
9 **95.025 Hydrocodone Classification:** TMA supports the classification of hydrocodone as a Schedule
10 III, not a Schedule II, drug (Res. 304-A-04; amended CSPH Rep. 2-A-14 and reaffirmed Res.
11 310-A-14).

12
13 **95.039 United States Pharmacopeia and The National Formulary One-Hour-Rule:** The Texas
14 Medical Association opposes the “immediate use” exception to the United States
15 Pharmacopeial (USP) Chapter 797 guidelines as currently written. TMA supports adopting
16 policy when the issue comes before the USP convention in 2015 (Res. 311-A-14).

17
18 **260.098 Reduce Ozone Causing Emissions From Three Antiquated Coal-Fired Power Plants:**
19 The Texas Medical Association (1) will urge the Texas Commission on Environmental
20 Quality to modify the rules of the 2014 State Implementation Plan (SIP) on complying with
21 EPA's present and future ozone standards to allow consideration and tighter regulation of
22 sources of ozone-causing air pollution originating outside the non-attainment
23 counties, specifically the three antiquated coal-fired power plants in Martin Lake, Big Brown,
24 and Monticello; and (2) that if the 2014 SIP does not result in action that reduces ozone levels
25 in the 10 non-attainment counties to levels below present and future EPA standards, TMA will
26 support legislative action or rulemaking that will ensure that by 2018, air-pollution emissions
27 from the three antiquated coal-fired power plants will be reduced to levels allowed from
28 newly built power plants (Res. 304-A-14).

29
30 **280.030 Licensure of Genetic Counselors:** The Texas Medical Association does not support
31 licensure of genetic counseling in Texas as it may erode patient access to genetic counseling
32 as well as physician oversight of the genetic counseling process (CM-MPH Rep. 6-A-04;
33 reaffirmed CSPH Rep. 2-A-14).

34
35 **Recommendation 3:** Delete.

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

C-SPH Report 2 2024

Subject: Resolution 301 2023 - Labeling of Sugar-Sweetened Beverages

Presented by: Benjamin C. Lee, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 Resolution 301 was presented at TexMed 2023 by the Bexar County Medical Society and calls for the
2 Texas Medical Association to work on legislation labeling all sugar-sweetened beverages with COVID-19
3 and other disease warning labels, as well as educating Texans on the medical dangers of excessive sugar-
4 sweetened beverage consumption. The specific language of the resolution resolves is as follows:
5

6 RESOLVED, That the Texas Medical Association work toward legislation to label all sugar-
7 sweetened beverages with warnings of the beverage’s high caloric content and subsequent
8 deleterious medical effects on the human body such as obesity, diabetes, and increased risk of
9 serious complications and death from COVID infections; and be it further

10
11 RESOLVED, That TMA, through all its resources, embark on an educational campaign to
12 educate all the residents of our state on the medical dangers of the consumption of excessive
13 calories from sugar-sweetened beverages, such as obesity, diabetes, and increased risk of serious
14 complications and death from COVID infections.
15

16 The resolution was referred to the Council on Science and Public Health for further study and a report
17 back to the House of Delegates in 2024.
18

19 **Background**

20 Sugar-sweetened beverages (SSBs) are any liquids with added sweeteners, including various types of
21 sugar, high-fructose corn syrup and other syrups, honey, molasses, dextrose, fructose, glucose, lactose,
22 maltose, and sucrose. Common SSBs include sweetened waters, soda (not sugar-free), fruit drinks, sports
23 and energy drinks, and coffee and tea with added sugar. The harms of frequent SSB consumption have
24 been well documented in research: increased risk of tooth decay; weight gain; obesity; gout; type 2
25 diabetes; and cardiovascular, liver, and kidney disease. An estimated 63% of youth and 49% of adults
26 drink at least one SSB on a given day, and, though SSB consumption varies across demographics,
27 individuals who are non-Hispanic Black, Mexican American, male, and/or with lower socioeconomic
28 status tend to have the highest SSB intake.
29

30 Severe outcomes of COVID-19 include hospitalization, admission to the intensive care unit (ICU),
31 intubation or mechanical ventilation, or death. COVID-19 does not affect all demographic groups equally.
32 Age is the strongest risk factor for severe COVID-19 outcomes, with the risk of severe outcomes
33 increasing with increasing age. Racial, ethnic, and sociodemographic disparities were also evident during
34 the COVID-19 pandemic, with individuals from racial and ethnic minority groups more likely to contract,
35 be hospitalized for, be admitted to the ICU for, and die from COVID-19. Further, patients with one or
36 more of the following underlying medical conditions are at higher risk for severe COVID-19 outcomes:
37

- 38 • Cancer;
- 39 • Chronic kidney disease;

- 1 • Chronic liver disease;
- 2 • Chronic lung diseases;
- 3 • Cystic fibrosis;
- 4 • Dementia or other neurological conditions;
- 5 • Diabetes (type 1 or type 2);
- 6 • Disabilities;
- 7 • Heart conditions;
- 8 • HIV infection;
- 9 • Immunocompromised condition or weakened immune system;
- 10 • Mental health conditions;
- 11 • Overweight and obesity;
- 12 • Physical inactivity;
- 13 • Pregnancy;
- 14 • Sickle cell disease or thalassemia;
- 15 • Smoking, current or former;
- 16 • Solid organ or blood stem cell transplant;
- 17 • Stroke or cerebrovascular disease;
- 18 • Substance use disorders; and
- 19 • Tuberculosis.

20
21 Though peer-reviewed research has not specifically looked at the association between consumption of
22 SSBs and severe COVID-19 disease, given the increased risk of obesity, diabetes, and other diseases from
23 SSB intake, as well as the increased risk of severe COVID-19 complications for those who are obese,
24 diabetic, or have other underlying conditions and diseases, Resolution 301 leans on the presumed
25 association between SSB intake and severe COVID-19 disease.

26
27 **State, Federal, and International SSB Warning Label Regulations**

28 Currently Texas has no state laws mandating warning labels on SSBs. Other state-level legislation
29 requiring SSB warning labels has been introduced in California, Hawaii, New York, Vermont, and
30 Washington but was unsuccessful. The city of San Francisco passed a local ordinance that required the
31 beverage industry to post this health warning on advertisements for SSBs:

32
33 WARNING: Drinking beverages with added sugar(s) contributes to obesity, diabetes, and tooth
34 decay. This is a message from the City and County of San Francisco.

35
36 However, the ordinance was later blocked by the U.S. Court of Appeals for the Ninth Circuit, which
37 found that the city's law violated the First Amendment by limiting the beverage industry's right to free
38 speech.

39
40 There are also no federal requirements for warning labels on SSBs. The extent of required federal labeling
41 by the Food and Drug Administration (FDA) is added sugars on the nutrition facts label for packaged
42 foods. In 2020, FDA finalized new nutrition facts label to help consumers make informed food choices
43 that support a healthy diet. The updated label reflects current scientific information, including the link
44 between diet and chronic diseases, with a design that emphasizes serving size and calories in a bolded and
45 larger font. The nutrition label also lists added sugars in grams and as a percent daily value, which reflects
46 scientific data indicating it is difficult for individuals to meet nutrient needs while staying within calorie
47 limits if more than 10% of their total daily calorie consumption is from added sugar.

1 Internationally, a number of other countries have implemented labeling regulations on SSBs and other
2 unhealthy foods. Chile was the first country in the world to mandate front-of-package labeling and enact
3 marketing restrictions and school sales/marketing policies. Beverages containing added sugars exceeding
4 set thresholds for content of total sugar or overall calories are considered “high in” products, subject to a
5 black “stop sign” octagonal warning label on the front of the product. Further, Chile’s marketing policies
6 restrict any child-directed marketing; marketing during children’s programming; marketing from 6 am to
7 10 pm on television; or marketing, sale, or free giveaways at kiosks, cafeterias, and feeding programs at
8 schools and nurseries. The black “stop sign” front-of-package warning label on SSBs and other unhealthy
9 foods is required in the countries of Colombia, Mexico, and Peru and also is being nascently tested for
10 potential implementation in South Africa. In Brazil, front-of-package warning labels are required on
11 packaged foods and beverages that exceed set levels of sugar, saturated fat, or sodium content per 100g
12 (foods) or 100mL (beverages). Other countries with mandatory warning labels on SSBs include
13 Argentina, Israel, Uruguay, and Venezuela. A comprehensive world map indicating countries with
14 mandatory or voluntary interpretive and warning labels on packaged foods and drinks is published by the
15 Global Food Research Program at the University of North Carolina at Chapel Hill.

16 17 **Effectiveness of SSB Warning Labels and Other Strategies to Influence SSB Consumption**

18 Overall, the effectiveness of warning labels on influencing consumer choices regarding various products,
19 including tobacco products and SSBs, has been well documented in the research. Most familiar in the
20 U.S. are the FDA requirements for warning labels on tobacco products. As an example, Appendix A
21 provides a list of all required warning labels on all tobacco products derived from the tobacco plant,
22 including cigarettes, smokeless tobacco, electronic nicotine delivery products, cigars, pipe tobacco, and
23 others. Regarding SSBs, specifically, Chile saw significant decreases in sugary drink consumption after
24 implementation of its SSB warning label requirements. However, the SSB warning labels in Chile were
25 also implemented simultaneously with the stringent marketing policies to prevent marketing exposure to
26 children.

27
28 The American Heart Association supports a more multi-faceted approach to address SSB consumption,
29 which includes warning labels but also taxes on SSBs:

30
31 The American Heart Association supports clinical guidance, programming, education, media
32 campaigns, and policies that help lower the intake of sugar-sweetened beverages (SSBs) by the
33 American public. We welcome new and innovative public policy approaches that may help to curb
34 sugar-sweetened beverage consumption. Warning labels on sugary drinks are one such intervention
35 and this includes warning labels on advertisements and on restaurant menus. We view a sugary drink
36 warning label approach as one strategy in the broad policy portfolio to combat diabetes, heart disease
37 and other chronic illness, which includes taxes on sugar-sweetened beverages.

38
39 Besides warning labels, other strategies associated with decreased SSB consumption indicated by the
40 science are increasing the price of the product, such as implementing taxes; limiting physical access of the
41 product, such as not allowing SSBs to be served in early education programs and schools; marketing and
42 advertising restrictions; education, for example, through public awareness campaigns and contests; and
43 improving the capacity of settings to promote healthy beverages, such as conducting water testing and
44 remediation to improve water quality and increase water consumption. The World Health Organization, in
45 its manual on SSB taxation policies, also supports a multi-strategy approach to reduce SSB consumption,
46 stating:

47
48 Taxation is made more effective when implemented as part of a comprehensive policy package
49 that also includes other demand reduction measures such as the restriction of marketing of SSBs;
50 regulation of their labels, for example to include warnings; banning the use of health and nutrition

1 claims, as well as other persuasive elements such as images of fresh and natural foods, cartoon
 2 characters; banning SSBs from schools and other settings; as well as providing education about
 3 nutrition and healthy dietary practices.

4
 5 The effectiveness of warning labels also may depend on factors such as the size of the label, its
 6 placement, whether or not there are graphic images, and if they can be easily interpreted by individuals
 7 with limited education and/or literacy, among others. Also of note: Some researchers have found the
 8 effectiveness of SSB warning labels to wane over time, while others express concern that use of any
 9 graphic warning labels on SSBs could promote obesity stigma.

10 **Discussion and Recommendations**

11 During the 2023 Reference Committee on Science and Public Health testimony, the Council on Science
 12 and Public Health opposed the resolution and recommended against its adoption, though not because of
 13 any fundamental disagreement with the idea that SSBs are harmful to health. Instead, the council
 14 recommended a referral for study because COVID-19 is such a politically charged topic, and further
 15 investigation into the science may help TMA find more effective ways to address SSB consumption. The
 16 council expressed concerns that the large segment of the population that is skeptical of all medical advice
 17 regarding COVID-19 may be prone to disregard recommendations to limit/avoid sugar-sweetened
 18 beverages for health reasons, when they might otherwise have considered it if it were not linked to
 19 COVID-19.

20
 21 After the resolution was assigned to the Council on Science and Public Health for study, a workgroup of
 22 the council was assigned to work on the resolution. The members discussed how the SARS-CoV-2 virus
 23 that causes COVID-19 is not the only virus that causes higher morbidity and mortality in individuals who
 24 are obese and/or diabetic – influenza is also a culprit. One member had issue with labeling “all” sugar-
 25 sweetened beverages because almost all beverages have some amount of sugar, whether natural or added
 26 in processing. A small amount of sugar may be necessary for palatability, so it does not necessarily mean
 27 all beverages that have some sugars are unhealthy. This member recommended limiting the warning
 28 labels to SSBs that exceed 12 grams of sugar per 12 ounces, based on guidelines from the Harvard T.H.
 29 Chan School of Public Health. There was also discussion on how highlighting COVID-19 on an SSB
 30 warning label would certainly garner attention, but, given the political charge around COVID-19, would
 31 be a “nail in the coffin” for the label, as one member expressed it. Overall, the workgroup generally
 32 supported the idea of spreading awareness about how SSB consumption is associated with adverse health
 33 outcomes and labeling accordingly. However, the workgroup suggested taking out COVID-19
 34 specifically from the label and replacing it with warnings of “obesity, diabetes, and other disease
 35 complications,” especially given that peer-reviewed research has not looked at the specific association
 36 between consumption of SSBs and severe COVID-19 disease.

37
 38
 39 After careful discussion and deliberation, the Council on Science and Public Health recommends the
 40 following regarding 2023 Resolution 301 – Labeling of Sugar-Sweetened Beverages:

41
 42 **Recommendation:** That the Texas Medical Association adopt Resolution 301 2023 – Labeling of Sugar
 43 Sweetened Beverages with the following amendments:

44
 45 RESOLVED, That the Texas Medical Association work toward legislation to label all sugar-
 46 sweetened beverages that exceed 12 grams of sugar per 12 ounces with warnings of the
 47 beverage’s high caloric content and subsequent deleterious medical effects on the human body
 48 such as obesity, diabetes, and other disease complications ~~increased risk of serious~~
 49 ~~complications and death from COVID infections~~; and be it further
 50

1 RESOLVED, That TMA, through all its available resources, embark on an educational
 2 campaign to educate all the Texas residents of our state on the medical dangers of the
 3 consumption of excessive calories from sugar-sweetened beverages, such as obesity, diabetes,
 4 and other disease complications increased risk of serious complications and death from COVID
 5 infections.
 6

7 **Related TMA Policy:**

8 [260.083 Promotion of Healthy Lifestyles, Reducing the Population Burden of Cardiovascular Disease by](#)
 9 [Reducing the Intake of Sodium, Saturated Fats, and Added Sugars](#)
 10 [260.095 Eligibility of Sugar-Sweetened Beverages for SNAP and Counseling](#)

11
 12 **Related AMA Policy:**

13 [Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974](#)
 14 [Strategies to Reduce the Consumption of Food and Beverages with Added Sweeteners H-150.927](#)
 15 [Eligibility of Sugar-Sweetened Beverages for SNAP D-150.975](#)

16
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Appendix A. Chart of Required Warning Statements on Tobacco Product Packaging and Advertising

Tobacco Products	Warning Statements
<p>Cigarettes</p>	<ul style="list-style-type: none"> • SURGEON GENERAL'S WARNING: Smoking Causes Lung Cancer, Heart Disease, Emphysema, And May Complicate Pregnancy. • SURGEON GENERAL'S WARNING: Quitting Smoking Now Greatly Reduces Serious Risks to Your Health. • SURGEON GENERAL'S WARNING: Smoking By Pregnant Women May Result in Fetal Injury, Premature Birth, And Low Birth Weight. • SURGEON GENERAL'S WARNING: Cigarette Smoke Contains Carbon Monoxide.
<p>Smokeless Tobacco (must display one of the warnings on the two principal display panels)</p>	<ul style="list-style-type: none"> • WARNING: This product can cause mouth cancer. • WARNING: This product can cause gum disease and tooth loss. • WARNING: This product is not a safe alternative to cigarettes. • WARNING: Smokeless tobacco is addictive.
<p>Cigarette Tobacco (must display the warning on the two principal display panels)</p>	<ul style="list-style-type: none"> • WARNING: This product contains nicotine. Nicotine is an addictive chemical.
<p>Roll-Your-Own Tobacco (RYO) (must display the warning on the two principal display panels)</p>	<ul style="list-style-type: none"> • WARNING: This product contains nicotine. Nicotine is an addictive chemical.
<p>Covered Tobacco Products* (except cigars) (must display the warning on the two principal display panels)</p>	<ul style="list-style-type: none"> • WARNING: This product contains nicotine. Nicotine is an addictive chemical. <p><i>*Note: The United States District Court for the District of Columbia recently issued an order vacating the health warning requirements for cigars and pipe tobacco set forth in 21 CFR §§ 1143.3 and 1143.5 and remanding the Final Deeming Rule's warning requirements for cigars and pipe tobacco back to the Agency. See Order, Cigar Ass'n of Am. v. U.S. Food & Drug Admin., No. 1:16-cv-01460 (D.D.C. September 11, 2020). Although the requirement has been vacated, cigar and pipe tobacco firms may choose to voluntarily comply with these health warning provisions. FDA will continue to enforce the other requirements it was already enforcing for cigars and pipe tobacco under the FD&C Act and its implementing regulations, such as not selling these products to individuals under 21 years of age or marketing them as modified risk tobacco products without an FDA order.</i></p>

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<p>Cigarette Tobacco, RYO, and Covered Tobacco Products* in Small Packaging</p>	<p>Must display applicable warning statements. For more information, see 21 CFR § 1143.3(d), 81 Fed. Reg. 29060, and FDA’s Guidance: Compliance Policy for Required Warning Statements on Small-Packaged Cigars</p> <p><i>*Note: The United States District Court for the District of Columbia recently issued an order vacating the health warning requirements for cigars and pipe tobacco set forth in 21 CFR §§ 1143.3 and 1143.5 and remanding the Final Deeming Rule’s warning requirements for cigars and pipe tobacco back to the Agency. See Order, Cigar Ass’n of Am. v. U.S. Food & Drug Admin., No. 1:16-cv-01460 (D.D.C. September 11, 2020). Although the requirement has been vacated, cigar and pipe tobacco firms may choose to voluntarily comply with these health warning provisions. FDA will continue to enforce the other requirements it was already enforcing for cigars and pipe tobacco under the FD&C Act and its implementing regulations, such as not selling these products to individuals under 21 years of age or marketing them as modified risk tobacco products without an FDA order.</i></p>
<p>Cigars* (must display one of the warnings on the two principal display panels)</p>	<ul style="list-style-type: none"> • WARNING: Cigar smoking can cause cancers of the mouth and throat, even if you do not inhale. • WARNING: Cigar smoking can cause lung cancer and heart disease. • WARNING: Cigars are not a safe alternative to cigarettes. • WARNING: Tobacco smoke increases the risk of lung cancer and heart disease, even in nonsmokers. • WARNING: Cigar use while pregnant can harm you and your baby.; or SURGEON GENERAL WARNING: Tobacco Use Increases the Risk of Infertility, Stillbirth and Low Birth Weight. • WARNING: This product contains nicotine. Nicotine is an addictive chemical. <p><i>*Note: The United States District Court for the District of Columbia recently issued an order vacating the health warning requirements for cigars and pipe tobacco set forth in 21 CFR §§ 1143.3 and 1143.5 and remanding the Final Deeming Rule’s warning requirements for cigars and pipe tobacco back to the Agency. See Order, Cigar Ass’n of Am. v. U.S. Food & Drug Admin., No. 1:16-cv-01460 (D.D.C. September 11, 2020). Although the requirement has been vacated, cigar and pipe tobacco firms may choose to voluntarily comply with these health warning provisions. FDA will continue to enforce the other requirements it was already enforcing for cigars and pipe tobacco under the FD&C Act and its implementing regulations, such as not selling these products to individuals under 21 years of age or marketing them as modified risk tobacco products without an FDA order.</i></p>

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<p>Cigars Sold Individually without Packaging*</p>	<p>Retailers must display all six of the required warning statements on a sign posted at the point-of-sale that complies with 21 CFR 1143.5(a)(3). See “Cigars” row above for text of the warning statements.</p> <p><i>*Note: The United States District Court for the District of Columbia recently issued an order vacating the health warning requirements for cigars and pipe tobacco set forth in 21 CFR §§ 1143.3 and 1143.5 and remanding the Final Deeming Rule’s warning requirements for cigars and pipe tobacco back to the Agency. See Order, Cigar Ass’n of Am. v. U.S. Food & Drug Admin., No. 1:16-cv-01460 (D.D.C. September 11, 2020). Although the requirement has been vacated, cigar and pipe tobacco firms may choose to voluntarily comply with these health warning provisions. FDA will continue to enforce the other requirements it was already enforcing for cigars and pipe tobacco under the FD&C Act and its implementing regulations, such as not selling these products to individuals under 21 years of age or marketing them as modified risk tobacco products without an FDA order.</i></p>
<p>Tobacco products that do not contain tobacco or nicotine and are not made or derived from tobacco</p>	<p>Required warning statements under the FD&C Act and its implementing regulations are <i>not applicable</i>.</p>

REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

C-SPH Report 3 2024

Subject: Resolution 306 2023 – Over the Counter Continuous Glucose Monitors

Presented by: Benjamin C. Lee, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 Resolution 306 was presented at TexMed 2023 by Harris County Medical Society and calls for the Texas
2 Medical Association to work with appropriate federal and national-level entities to remove the
3 prescription requirement for continuous glucose monitors. The specific language of the resolution
4 resolves is as follows:

5
6 RESOLVED, That the Texas Medical Association urge the Food and Drug Administration to
7 drop the requirement for a health professional’s prescription for continuous glucose monitors; and
8 be it further
9

10 RESOLVED, That the Texas Delegation to the American Medical Association (AMA) carry this
11 resolution to the AMA House of Delegates for further advocacy.
12

13 The resolution was referred to the Council on Science and Public Health for further study and a report
14 back to the House of Delegates at TexMed 2024.
15

16 Background

17 Diabetes is a chronic disease resulting from the body’s inability to produce or use insulin to regulate
18 blood glucose levels. In turn, unregulated glucose levels in the bloodstream, either hypo- or
19 hyperglycemia, can harm blood vessels and various parts of the body over time, leading to serious health
20 problems. Common health complications with diabetes include heart disease; chronic kidney disease;
21 nerve damage; and problems with vision, hearing, oral health, and mental health. Diabetes is the eighth
22 leading cause of death in the U.S. and the No. 1 cause of kidney failure, lower-limb amputations, and
23 adult blindness. The 2021 National Diabetes Statistics Report estimates 38.4 million people in the U.S.
24 have diabetes (11.6% of the population), and 97.6 million people aged 18 years or older have prediabetes
25 (38% of the adult population). Though there are three types of diabetes (type 1, type 2, and gestational),
26 type 2 diabetes affects about 90% to 95% of people with diabetes and can be prevented or delayed with a
27 healthy diet, physical activity, and weight loss.
28

29 Glucose monitoring for individuals with diabetes provides a means to assess the glucose levels in the
30 body; a physician can then treat the patient and patients can modify behavior accordingly. The technology
31 has evolved since the first iteration in the mid-1800s, which was a urine test. The most commonly known
32 glucose monitors today are devices that require finger pricks for small samples of blood to assess blood
33 glucose levels, often referred to as self-monitoring blood glucose systems (SMBGs). Rather than relying
34 on repeated finger sticks for blood samples, continuous glucose monitors (CGMs), first developed in
35 1999, are attached to the body via subcutaneous insertion or implantation of a sensor that continuously
36 measures the level of glucose in interstitial fluid.
37

38 In the U.S., the Food and Drug Administration (FDA) has only approved CGMs for use by people with
39 diabetes. Initially, FDA classified CGMs as Class III devices, which is the highest-risk class, requiring the

1 highest level of premarket oversight via a premarket approval. In 2018, after the technology of CGMs
2 evolved with better designs and a known risk profile, FDA reclassified CGMs as Class II devices. CGMs
3 still require a medical prescription in the U.S., whereas SMBGs are available over the counter. In Europe,
4 availability of CGMs over the counter varies, depending on the country and on the specific make and
5 model of the device.

7 **Research on Continuous Glucose Monitors**

8 Over the years, CGM technology has become less painful and more convenient, accurate, and timely.
9 Some of the latest real-time CGMs have accompanying smartphone applications for easy access to an
10 individual's continuous glucose level data taken every five minutes. These data are helpful in adjusting
11 insulin therapy for patients with type 1 diabetes and in modifying lifestyle for patients with type 2
12 diabetes. Individuals with type 1 and type 2 diabetes who use a CGM have fewer instances of
13 hypoglycemia and lower blood glucose levels. Patients can see in real time if they are at risk for either
14 hypo- or hyperglycemia and take preventive measures, as necessary. Overall, research has found CGMs
15 to be effective in helping patients maintain better glycemic control.

16
17 The American Diabetes Association (ADA) supports greater access to CGM technology, especially for
18 populations most afflicted by diabetes, which include individuals who are Black, Hispanic or Latino,
19 American Indian, Alaska Native, or Pacific Islander and Asian American. Diabetes is also inversely
20 proportional to household income level, with the lowest socioeconomic status communities seeing the
21 highest diabetes rates. Access to health insurance has been found to be one of the strongest predictors of
22 whether people with diabetes receive high-quality diabetes care and can get a CGM. ADA commissioned
23 a study of the relationship between insurance coverage, age, geography, and race to identify the greatest
24 barriers to CGM access. The study found that individuals least likely to get a CGM are people of color
25 who are low-income, on Medicaid, and live in states with some of the highest rates of diabetes.

27 **Other Considerations**

28 Depending on cost and availability, having CGMs available over the counter may potentially help give
29 people with diabetes the ability to self-monitor and improve their health, the use of CGMs has gained
30 popularity among people without diabetes who are not medically indicated to use the devices as approved
31 by FDA. At least one CGM available in Europe has been specifically designed to be a glucose sport
32 biosensor for athletes who do not have diabetes. The concept behind CGMs for athletes is that
33 understanding real-time glucose levels can help them know what foods to consume and when, to
34 potentially optimize muscle recovery and athletic performance. CGMs are also advertised to people who
35 do not have diabetes as a device to help lose weight, improve metabolism, maintain consistent energy
36 levels, and observe how the body responds to sleep and stress.

37
38 Physicians – endocrinologists, especially – have concerns regarding CGM use among individuals who do
39 not have diabetes or prediabetes. One is that the CGMs approved by FDA were specifically developed,
40 designed, and tested for people who have diabetes. Because people who have diabetes are more prone to
41 blood level spikes, glucose level thresholds of concern for people who have diabetes are not necessarily
42 the same or applicable to people who do not have diabetes. Another concern is the limited medical
43 guidance for the use of CGMs among healthy individuals. CGMs for people with diabetes are tied to the
44 prescription from a physician, who would provide professional medical guidance to patients throughout
45 their CGM use. Alternatively, individuals who do not have diabetes and do not have a physician's
46 oversight may not have the professional knowledge and guidance to use the device appropriately. For
47 example, the potential exists for an individual who does not have diabetes to take an unhealthy action
48 such as quickly eating easily accessible simple carbohydrates (e.g., a bag of potato chips or some donuts)
49 in response to an "alarming" low blood sugar reading that may be, in fact, normal for someone who does
50 not have diabetes. A CGM might even create unwarranted anxiety or "data/information overload" around

1 the numbers and readings, and subsequently diet and physical activity, for someone who does not have
2 diabetes. Rather than relying on a CGM, some physicians would prefer that healthy individuals adhere to
3 known healthy living choices both to prevent diabetes and to improve health overall (eating whole,
4 natural foods; being physically active every day; avoiding processed foods; and limiting consumption of
5 added sugars).

6
7 The American Medical Association supports coverage of CGMs for patients when it is evidence-based
8 and determined appropriate by physicians. Also, as CGMs are classified as durable medical equipment
9 (DME), AMA's policy on DME requirements highlights the physician-led role in recommending and
10 prescribing DMEs and reaffirms the concept that physicians are ultimately responsible for the medical
11 needs of their patients.

12 13 **Discussion and Recommendations**

14 A workgroup of the Council on Science and Public Health was assigned to study the research on over-the-
15 counter (OTC) continuous glucose monitors and deliberate on recommendations. Members compared
16 both sides of the argument, both of which have legitimate concerns. Regarding the advantages of having
17 OTC CGMs, patients with diabetes could readily monitor their blood glucose levels to improve their
18 health. Individuals from historically marginalized populations, especially, who are less likely to seek
19 medical care or may not have a medical home (because of lack of insurance or funding, distrust or
20 skepticism of medicine, and the like) may be willing to use easily accessible OTC CGMs, which could
21 help guide them towards healthier behaviors. Any tool that can help motivate people to improve their diet,
22 exercise, and overall lifestyle would be of great benefit. The devices pose fairly minimal risk; standard
23 glucose monitors that require blood have been available without prescription for years. Further, other
24 parts of the world have made OTC CGMs readily accessible without significant reported problems.

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26 Regarding the disadvantages, diabetes is a complex, multifaceted disease that should be under the care of
27 a professional. Enabling self-management may keep individuals with diabetes from benefiting from other
28 opportunities for screening and secondary prevention of the common consequences of diabetes. Also,
29 CGMs becoming available OTC does not necessarily mean people with limited financial means could
30 afford to buy them. Endocrinology medical societies have concerns about individuals for whom CGMs
31 are not medically indicated – those without diabetes – using the devices under the guise of fitness and
32 health promotion.

33
34 The workgroup discussed how there may not be dramatic shifts in self-management patterns among
35 individuals who do not have a medical home. For example, one member's experience is that, typically,
36 individuals who use a conventional self-monitoring blood glucose system and do not regularly access the
37 health care system will seek out physician care after noticing significant uncontrolled glucose elevations
38 on a regular basis. The workgroup also observed that the issue is not black and white (only people with
39 diabetes with a prescription from their physician can access CGMs versus complete liberation from any
40 medical oversight as to who can purchase CGMs). "The CGM ship will sail, regardless of what we in the
41 physician community do," one member said. Because CGMs are monitoring – not therapeutic – devices,
42 athletes and others will likely consider them fairly harmless and find a way to acquire and use them.
43 Workgroup members discussed how, likely, the best course of action is to retain physician oversight for
44 prescribing CGM devices but to leave it up to the physician as to the best indication for use, beyond only
45 patients with diabetes, as applicable.

46
47 However, as mentioned, research on CGM use by people without diabetes is limited, and thus CGMs are
48 not medically indicated for them. For this reason, after careful discussion and deliberation, the Council on
49 Science and Public Health determined there is not enough evidence to support CGMs being readily
50 available to the general population over the counter.

1 **Recommendation:** Not adopt Resolution 306 2023 – Over the Counter Continuous Glucose Monitors

2
3 **Related TMA Policy:**

4 None

5
6 **Related AMA Policy:**

7 [Coverage of Continuous Glucose Monitoring Devices H-330.885](#)

8 [Coverage for Continuous or Flash Glucose Monitoring Devices D-480.959](#)

9 [Durable Medical Equipment Requirements H-330.945](#)

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REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

C-SPH Report 4 2024

Subject: Resolution 318 2022 – Supporting Transgender Youth Participation in Sports

Presented by: Benjamin C. Lee, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 Resolution 318 was presented at TexMed 2022 by the Medical Student Section and calls for the Texas
2 Medical Association to support transgender youth participation in sports. The specific language of the
3 resolution resolves is as follows:

4
5 RESOLVED, That the Texas Medical Association supports the right of transgender youth in
6 Texas to participate in athletic teams that correspond to these transgender individuals' gender
7 identity and expression, and opposes any effort that would prohibit, restrict, or otherwise impinge
8 on this right; and be it further

9
10 RESOLVED, That our TMA supports the right of transgender youth in Texas to use amended
11 birth certificates to access programs and accommodations related to their gender identity and
12 expression.

13
14 The resolution was referred to the Committee on Child and Adolescent Health in 2022 for study and a
15 report back to the House of Delegates in 2023. After study, the committee recommended the house adopt
16 the resolution because of the importance of physical activity and inclusive team participation to support
17 both physical health and mental health of vulnerable transgender students. The committee also cited
18 robust TMA policy in support of educational systems ensuring a school environment that supports mental
19 health and is free of stigma related to mental or behavioral health issues (55.033 Children's Mental and
20 Behavioral Health). During the 2023 Reference Committee on Science and Public Health, significant
21 testimony, both online and in person, called for re-referral of the resolution because of concerns regarding
22 the physiological differences between biological males and females, potential safety risks, competitive
23 inequity, and the topic being outside the scope of organized medicine. Therefore, the 2023 House of
24 Delegates referred the resolution again, this time to the Council on Science and Public Health.

25
26 **Background**

27 The U.S. Department of Labor (DOL) defines gender identity as:

28
29 A person's internal sense of being male, female, or something else such as agender, binary,
30 gender fluid, gender nonconforming, genderqueer, or nonbinary. Since gender identity is
31 internal, one's gender identity is not necessarily visible to others. All people have a gender
32 identity.

33
34 DOL defines transgender as:

35
36 A broad term for people whose gender identity or expression is different from those typically
37 associated with their sex assigned at birth.

38
39 For further clarification on the key terminology surrounding gender identity used by DOL and as
40 compiled by the National LGBTQ Task Force, see Appendix A.

1 Several states including Texas and governing sports organizations have passed legislation or policy
 2 restricting transgender athletes' ability to participate in sports in accordance with their gender identity,
 3 which, according to the original resolution authors, was the impetus for the resolution.
 4

5 **Texas State Law**

6 Gov. Greg Abbot in 2021 signed House Bill 25 into law, which took effect in 2022, requiring
 7 interscholastic athletes to play on sports teams that match the sex listed on an athlete's birth certificate.
 8 This effectively banned transgender students from participating in publicly funded school sports
 9 according to their identified gender, as the law disallows students from participating in a sport that is
 10 "designated for the biological sex opposite to the student's biological sex as correctly stated on the
 11 student's official birth certificate or another government record." HB 25 further does not allow
 12 transgender youth to use an amended birth certificate (unless only amended for "clerical errors") as
 13 documentation when signing up for school sports. Texas has no strict laws on gender markers or name
 14 changes to identifying documents. In Texas, one needs a court order to change one's name or gender
 15 marker, which means it is up to an individual judge's ruling to change information on a birth certificate.
 16 Minors can apply for a change to their birth certificate if both guardians/caregivers agree. This requires
 17 payment of a \$300 fee and a physician's and/or therapist's note describing the minor's gender identity.
 18 However, as mentioned, HB 25 prohibits the use of amended birth certificates for participating in sports.
 19

20 Proponents of HB 25 claim that while this law does not completely prohibit transgender children from
 21 participating in school sports, it does require them to play on teams that correspond to their sex assigned
 22 at birth. They argue that it protects cisgender girls under Title IX; they believe cisgender girls might be
 23 excluded from participating in sports because of the potential physiological advantage that transgender
 24 girls may have. Texas lawmakers have cited Title IX as the reason for HB 25 and to uphold equality in
 25 girls' sports; however, opponents argue that Title IX is meant to protect a larger population.
 26 Outside of Texas University Interscholastic League (UIL) policy referencing gender determination of
 27 athletes based on students' birth certificates as outlined in Section 33.0834 of the Texas Education Code,
 28 it is unclear how HB 25 is being enforced.
 29

30 **Federal and Other State Laws**

31 Federally, Title IX of the Education Amendments of 1972 protects people from discrimination based on
 32 sex in education programs or activities that receive federal financial assistance. Title IX states:
 33

34 No person in the United States shall, on the basis of sex, be excluded from participation in, be
 35 denied the benefits of, or be subjected to discrimination under any education program or activity
 36 receiving Federal financial assistance.
 37

38 In March 2021, the U.S. Department of Education (ED) launched a comprehensive review of its Title IX
 39 regulations and received public feedback from a broad range of stakeholders. In June 2021, the ED Office
 40 for Civil Rights (OCR) issued a Notice of Interpretation explaining that it will enforce Title IX's
 41 prohibition on discrimination on the basis of sex to include (1) discrimination based on sexual orientation
 42 and (2) discrimination based on gender identity. Also in June 2021, OCR held a nationwide virtual public
 43 hearing on Title IX, and feedback over the following year from several meetings and listening sessions
 44 was incorporated into ED's 2022 proposed amendments to its Title IX regulations. The proposed
 45 regulations would protect students who are lesbian, gay, bisexual, transgender, queer, questioning,
 46 asexual, intersex, or nonbinary, or who identify their sexual orientation or gender identity in other ways
 47 from gender inequality and discrimination based on sexual orientation, gender identity, and sex
 48 characteristics in all educational programs and activities receiving federal funding. Of note, all public
 49 school districts and most institutions of higher education (through participation in federal student aid
 50 programs) receive some federal financial assistance, which requires them to comply to Title IX. Though

1 the proposal would prohibit categorical bans on transgender students participating in sports consistent
2 with their gender identity, it would still allow some restrictions according to grade level, sport, and level
3 of competition that are substantially related to an important educational objective and are aimed to
4 minimize harm. However, ED in May 2023 announced a delay Title IX rulemaking, citing the need for
5 more time to carefully consider and review the more than 240,000 public comments received. The notice
6 mentioned updating ED's spring unified agenda to reflect an anticipated date of October 2023 for the final
7 Title IX rule. As of December 2023, it is still unclear when schools will see final Title IX rules from the
8 U.S. Department of Education.

9
10 Regarding other state laws, as of November 2023, 24 states have laws or regulations that ban transgender
11 students from participating in sports consistent with their gender identity. However, temporary
12 injunctions have blocked enforcement of the bans in some states, with cases still active in the court
13 system pending further judicial review.

14 15 **Sports Institutions Policies**

16 The National Collegiate Athletic Association (NCAA) does not receive federal financial assistance and
17 therefore is not regulated under Title IX. However, institutions such as public universities who participate
18 in NCAA do receive federal funds; therefore, NCAA may still be affected by Title IX regulations. In
19 2022, NCAA updated its transgender sport participation policy in support of a sport-by-sport approach
20 "that preserves opportunity for transgender student-athletes while balancing fairness, inclusion and safety
21 for all who compete," i.e., transgender participation for each sport would be determined by the national
22 governing body of that sport. The updated NCAA policy took a stance similar to that of the International
23 Olympic Committee (IOC) and the U.S. Olympic and Paralympic Committee.

24 25 **Scientific Research and Medical Considerations**

26 Social and psychological development often occur in school settings, where adolescents spend most of
27 their time interacting with those outside of the home, including peers and teachers. Participation in
28 organized sports is beneficial in child and adolescent social and psychological development. However,
29 many transgender students experience harassment, stigma, transphobia, prejudice, discrimination, and
30 violence because of their gender identity. This can result in negative mental health outcomes, such as
31 depression, suicidal ideation, and post-traumatic stress disorder. A nationwide study found that 68% of
32 high school seniors play at least one sport, however, only 24% of LGBTQ youth currently play on a
33 sports team for their school, with 13% of these youth reporting they avoided playing sports altogether
34 because they "do not feel [they] will be accepted on the team because [they are] LGBTQ." The lack of
35 inclusive environments is the primary barrier to participation in organized sports for transgender people.
36 Given the benefits of physical activity and sports for mental and physical health, research supports
37 fostering an inclusive environment, particularly for transgender students, who have a high prevalence of
38 depression and anxiety, both of which can be mitigated with exercise. Further, when a school team openly
39 accepts a transgender student as a player, the student may feel a sense of belonging, which can help
40 validate the student's identity. Research shows that transgender-inclusive policies can substantially
41 benefit transgender youth by promoting safety, academic performance, attendance, and positive mental
42 health.

43
44 Transgender athletes pose a dilemma to the sex-segregated approach of traditional interscholastic
45 athletics, as it is predicated upon the assertion that males and females are biologically incongruent. The
46 American College of Sports Medicine (ACSM) published an expert consensus statement in September
47 2023 on the biological basis of sex differences in athletic performance. Some of the key findings of the
48 statement pointed to biological sex being a determinant of athletic performance, as adult males are often
49 faster, stronger, and more powerful than females because of fundamental sex differences in anatomy and
50 physiology dictated by sex chromosomes. ACSM also said that before puberty, sex differences in athletic

1 performance are minimal, but significant differences emerge at puberty because of anabolic effects of
 2 testosterone in males. The direct and indirect effects of testosterone during male puberty include
 3 increased skeletal muscle mass due to a larger muscle fiber cross-sectional area, especially fast, type II
 4 fibers; lower percentage of body fat; higher hemoglobin concentration and mass; larger ventricular mass
 5 (heart) and cardiac volumes; larger airways and lungs; greater body height; and longer limbs. However,
 6 ACSM did point out the limited studies of females versus males in athletic performance, acute exercise,
 7 and exercise training, and that the rate of improvement in athletic performance of women has exceeded
 8 that of men in the past 100 years. Further, depending on the specific sport, skill and talent may provide
 9 more competitive advantage than size, speed, and strength, e.g., skills-based sports such as archery or
 10 bowling. Another consideration regarding transgender athletes may be the timing of hormone therapy.
 11 Data demonstrate some significant changes in lean body mass, hemoglobin concentration, grip strength,
 12 and running times in transgender men who have been treated with testosterone. However, performance
 13 improvement is multifactorial and could be greatly impacted by time of hormone administration in regard
 14 to puberty timing and pre-hormonal athleticism.

16 Discussion and Recommendations

17 A workgroup of the council was assigned to study the resolution. Following are points from their robust
 18 discussions:

- 20 • Exercise and physical activity are integral in promoting physical health and mental well-being for
 21 everyone, including youth.
- 22 • Team sports help foster camaraderie and the basics of teamwork: collaboration, responsibility, and
 23 respect. Healthy competition provides the opportunity to both excel and learn resiliency.
- 24 • There are anatomic and physiological differences between males and females that become more
 25 apparent during and after puberty. Science has shown that on average, males are taller and heavier
 26 and have higher muscle mass, lung capacity, bone density, and hemoglobin concentration than
 27 females. Gender identity (one's self-identified gender) alone does not alter one's biology.
- 28 • Fair competition is one important issue. Physical attributes produce significant differences in same-
 29 sport results in high school state championships such as track and field, swimming, and even bowling.
 30 In many events, several athletes in the boys' division outperformed the winner of the girls' division.
 31 Conversely, the winner of the girls' division would not even place in the top three in the boys'
 32 division (some would have finished last). This is one of the reasons boys and girls have separate
 33 divisions currently.
- 34 • Player safety is another concern, particularly in contact sports via inter-player contact or through
 35 sporting equipment (e.g., hockey puck, soccer ball, lacrosse ball). Physics states that force = mass x
 36 acceleration. Those with a larger mass and/or who can generate higher acceleration will create a
 37 larger force that will be received by something or someone. While injuries can occur in any scenario,
 38 given the physical differences between males and females, particularly during and after puberty, these
 39 increased force differentials could lead to increased injuries in both trans and cisgender children.
- 40 • While there are less noticeable differences in height and weight in mixed teams of pre-pubertal
 41 children, those differences are more apparent as they age (3- to 5-year-olds versus 6- to 8-year-olds);
 42 however, the benefits of social interaction and physical activity likely outweigh issues of safety and
 43 competitive advantage.
- 44 • Physiological advantages may be less of an issue in skills-based versus contact-based sports but may
 45 not eliminate it. Some sports have safety measures in place that provide some leveling of the playing
 46 field, e.g., wrestling and boxing having different divisions by weight. There continues to be
 47 differences in how each sport addresses transgender athletes.
- 48 • At this time, there is insufficient scientific evidence that universally addresses transgender children on
 49 sports teams, as the issues are multifaceted: social and physical science, age of the child, pubertal

1 status, specific sport, fair competition, player safety, and player mental health. Rather than a universal
 2 approach, individualization by sport may be needed.

- 3 • The birth certificate is a legal document that reports the sex assigned at birth. Provisions of amending
 4 legal documents are outside the scope of organized medicine and TMA.

5
 6 Overall, the council feels this is an important issue and deserves further evaluation after more scientific
 7 research emerges. Though the council agrees with the perceived spirit of the resolution, based on the
 8 nascence of the topic and the need for a nuanced approach, the council is unable to support the resolution
 9 as written:

10
 11 **Recommendation:** Not adopt Resolution 318 2022 – Supporting Transgender Youth Participation in
 12 Sports.

13
 14 **Related TMA Policy:**

15 [55.033 Children’s Mental and Behavioral Health](#)

16 [55.058 Sexual Orientation Change Efforts and Gender-Affirmation Therapies for Minors](#)

17 [55.066 Opposition to Criminalization of Gender-Affirming Care for Transgender Youth](#)

18 [60.008 Rejection of Discrimination](#)

19 [60.009 Gender Identity and Public Facility Use](#)

20 [60.011 Reference to Sex and Gender in TMA Policy](#)

21 [260.139 Gender-Affirming Care](#)

22 [265.028 Improving LGBTQ Health Care Access](#)

23 [265.031 Promoting Education of Sexual Orientation and Gender Identity Health Issues in Academic
 24 Health Centers](#)

25
 26 **Related AMA Policy:**

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1 Appendix A. Gender Identity: Key Terminology

2
3 **What is the difference between sex and gender?** *Sex* (i.e., male, female, or intersex) is assigned at
4 birth based on a combination of a baby's biological characteristics, including chromosomes,
5 hormones, and reproductive organs, and is originally documented on a person's birth certificate.
6 The [World Health Organization](#) defines *gender* as the "socially constructed roles, behaviors,
7 activities, and attributes that a given society considers appropriate" based on sex.

8
9 **Agender:** An identity under the nonbinary and transgender umbrellas. Some agender individuals
10 have no gender identity, although some define agender as having a gender identity that is neutral.

11
12 **Bigender:** An identity under the nonbinary and transgender umbrellas. Bigender individuals
13 identify with more than one gender.

14
15 **Cisgender:** A person whose gender identity matches with the sex they were assigned at birth.

16
17 **Gender expression:** How a person represents or expresses one's gender identity to others, often
18 through behavior, clothing, hairstyles, voice, or body characteristics. All people have a gender
19 expression.

20
21 **Genderfluid:** Refers to an identity under the nonbinary and transgender umbrellas. Genderfluid
22 individuals have different gender identities at different times. A genderfluid individual's gender
23 identity could be multiple genders at once, and then switch to none at all, or move between
24 single gender identities. For some genderfluid people, these changes happen as often as several
25 times a day, and for others, monthly, or less often.

26
27 **Gender identity:** A person's internal sense of being male, female, or something else such as
28 agender, binary, gender fluid, gender nonconforming, genderqueer, or nonbinary. Since gender
29 identity is internal, one's gender identity is not necessarily visible to others. All people have a
30 gender identity.

31
32 **Gender nonconforming (GNC) or Genderqueer:** Terms for people whose gender identity and/or
33 expression is different from societal expectations related to gender.

34
35 **Gender-affirming care:** An inclusive term for treatments and procedures that help an individual
36 align their physical and/or other characteristics with their gender identity, often called transition-
37 related care.

38
39 **Intersex:** Refers to a person who is born with sexual or reproductive anatomy that does not fit
40 within the sex binary of male or female, encompassing a variety of sex expressions.

41
42 **LGBT or LGBTQ:** Shorthand for lesbian, gay, bisexual, transgender, and queer people.

43
44 **Nonbinary:** A term used by people who identify as neither entirely male nor entirely female. This
45 can include people who are agender, bigender, genderfluid, gender nonconforming, and
46 genderqueer, among others. Some nonbinary people identify as transgender, while others do not.

1 **Pronouns:** Terms used to substitute a person's name when they are being referred to in the third-
2 person. Some common pronouns include he/him/his, she/her/hers, and they/them/their(s). A
3 person's gender should not be assumed based on their pronouns.
4

5 **Queer:** An umbrella term which embraces a variety of sexual preferences, orientations, and
6 habits of those who are not among the exclusively heterosexual and monogamous majority.
7 Although the term was once considered derogatory and offensive, the community has reclaimed
8 the word and now uses it widely as a form of empowerment. Younger generations tend to use the
9 term "queer" for reasons such as the fact that it does not assume the gender of the queer person or
10 the gender of any potential romantic partners, and/or in order to make a political statement about
11 the fluidity of gender.
12

13 **Sexual Orientation:** A person's identity in relation to whom they are attracted to. All people have
14 a sexual orientation. Sexual orientation, gender identity, and gender expression are distinct
15 components of a person's identity. Sexual orientation should not be confused with a person's
16 gender identity or gender expression.
17

18 **Transgender:** A broad term for people whose gender identity or expression is different from
19 those typically associated with their sex assigned at birth. "Trans" is shorthand for "transgender."
20 Note: Transgender is correctly used as an adjective, for example: "transgender people," "people
21 who are transgender," "a woman who is transgender," etc. However, "transgenders" or
22 "transgendered" are incorrect and disrespectful.
23

24 **Transition:** A broad term commonly used to refer to the ongoing process by which a person
25 alters components of their gender expression and/or other personal characteristics to better align
26 with their gender identity. A person's transition may or may not include a combination of social
27 changes (e.g., name, pronouns, appearance and/or clothing), legal changes (e.g., legal name
28 and/or legal gender markers), and medical changes (e.g., gender-affirming hormone therapy
29 and/or surgeries). Note: Not all transgender and/or non-binary people want to transition or are
30 able to access the resources necessary to do so. However, regardless of whether, how, or when a
31 person takes any, some, or all of these actions, their gender identity is valid and should be
32 respected and affirmed.
33

34 **Transphobia:** The hatred or fear of transgender, nonbinary, and gender nonconforming people.
35 This sometimes leads to acts of violence and expressions of hostility. Transphobia is not
36 confined to any one segment of society and can be found in people from all walks of life.
37

38 **Two-Spirit:** Contemporary umbrella term that refers to the historical and current First Nations
39 people whose individual spirits were a blend of female and male spirits. This term has been
40 reclaimed by Native American LGBTQ+ communities in order to honor their heritage and
41 provide an alternative to the Western labels of gay, lesbian, or transgender.

REPORT OF COMMITTEE ON BEHAVIORAL HEALTH

CM-BH Report 1 2024

Subject: Sunset Policy Review

Introduced by: Celia B. Neavel, MD, and Leslie H. Secrest, MD, Co-Chairs

Referred to: Reference Committee on Science and Public Health

1 House of Delegates policies in the Texas Medical Association's Policy Compendium are reviewed
 2 periodically for relevance and appropriateness. The following are policies reviewed by the committee
 3 with recommendations for retention, amendment, and deletion.

4
 5 The committee recommends deletion of the following policy, as it is outdated and redundant to more
 6 robust mental health policy:

7
 8 **215.012 Quality Care for Mentally Ill:** The Texas Medical Association supports efforts of the
 9 Texas Health and Human Services Commission and its appropriate agency councils to
 10 maintain physicians' ability to provide good quality medical care to the mentally ill
 11 patient, including appropriate use of psychotropic medication, while under court-ordered
 12 mental treatment (Council on Socioeconomics, p 181, I-94; amended CSA Rep. 6-A-04;
 13 reaffirmed CSPH Rep. 2-A-14).

14
 15 **Recommendation 1:** Delete Texas Medical Association Policy 215.012 Quality Care for Mentally Ill.

16
 17 The committee recommends amending these policies as follows, to update language to match current
 18 diagnostic and health care terminology:

19
 20 **215.009 ~~Mental Health Institutions~~ Community Mental Health Care Centers ~~Centers~~ Facilities:**
 21 Community mental health and intellectual and developmental disability centers,
 22 ~~community mental retardation centers~~, are providing diagnostic, therapeutic,
 23 rehabilitative, preventive, and/or educational services to a large number of persons with
 24 mental, behavioral, emotional, and/or adjustment problems, or with intellectual
 25 disabilities and/or with related disorders. Such centers are and should be classified as
 26 mental health care facilities, and the clinical director of all such centers should be
 27 required to be a licensed physician, preferably a psychiatrist, experienced in mental
 28 health care. (Committee on Mental Health and Mental Retardation, p 135, A-94;
 29 reaffirmed CSA Rep. 6-A-04; amended CSPH Rep. 2-A-14).

30
 31 **215.021 ~~Alternative to Incarceration for Individuals With Nonviolent Behavioral Issues~~:**
 32 The Texas Medical Association will work with the Texas Association of Counties, the
 33 Department of State Health Services, and local mental health authorities to identify
 34 resource information on Texas jail diversion programs and will develop information for
 35 physicians and county medical societies on Texas jail diversion programs and encourage
 36 physician engagement in support of best practice programs that result in enhanced
 37 community health outcomes (Res. 305-A-13; amended CSPH Rep. 3-A-14).

38
 39 **Recommendation 2:** Retain as amended Texas Medical Association Policies 215.009 Mental Health
 40 Institutions Community Mental Health Care Centers and 215.021 Alternative to Incarceration for
 41 Individuals With Nonviolent Behavioral Issues.

REPORT OF COMMITTEE ON CANCER

CM-C Report 1 2024

Subject: Sunset Policy Review

Presented by: Mammen A. Sam, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 The Texas Medical Association periodically reviews House of Delegates policies in the association's Policy
2 Compendium for relevance and appropriateness. The following policy was reviewed by the committee with
3 recommendation for retention, amendment, or deletion.
4

5 The committee recommends amending the policy as follows:
6

7 **55.010 Lung Cancer Screening:** The Texas Medical Association supports the ~~U.S. Preventive Services~~
8 ~~Task Force December 2013~~ American Cancer Society 2023 Guidelines for lung cancer screening
9 recommendations regarding the annual screening of appropriately selected high-risk patients for
10 lung cancer with low-dose computed tomography. TMA also supports dissemination of lung
11 cancer screening recommendations to improve screening rates and decrease lung cancer morbidity
12 and mortality in Texas (CM-C Rep. 1-A-14).
13

14 **Recommendation:** Retain as amended.

REPORT OF COMMITTEE ON CHILD AND ADOLESCENT HEALTH

CM-CAH Report 1 2024

Subject: Sunset Policy Review

Introduced by: Lauren K. Gambill, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 House of Delegates policies in the Texas Medical Association's Policy Compendium are reviewed
 2 periodically for relevance and appropriateness. The following are policies reviewed by the committee
 3 with recommendations for retention, amendment, and deletion.

4
 5 The committee recommends deletion of the following policy, as it is no longer relevant:

6
 7 **55.038 Acanthosis Nigricans Screening:** The Texas Medical Association will work toward
 8 repealing the current legislative mandate for acanthosis nigricans screening to adhere to
 9 basic scientific principles of screening and urges a moratorium of additional expansion of
 10 the current program until more scientific principles of screening are utilized (CM-CAH
 11 Rep. 3-A-04 and Res. 303-A-04; reaffirmed CM-CAH Rep. 1-A-14).

12
 13 **Recommendation 1:** Delete Texas Medical Association Policy 55.038 Acanthosis Nigricans Screening.

14
 15 The committee recommends amending these policies as follows:

16
 17 **55.015 ~~Day Care and After School Care Programs:~~** The Texas Medical Association
 18 recognizes the importance and strongly supports the provision of concept of school
 19 districts voluntarily providing affordable and accessible after school care and programs
 20 by school districts in order to reduce the extremely high prevalence of afternoon risky
 21 behaviors among children who are unsupervised from the time school is out until parents
 22 or guardians arrive home ~~from work~~ (Committee on School Health and Children with
 23 Disabilities, p 123, A-94; reaffirmed CM-CAH Rep. 4-A-04; amended CM-CAH Rep. 1-
 24 A-14).

25
 26 **260.074 All-Terrain Vehicles:** It is the policy of the Texas Medical Association that: ~~(1)~~
 27 ~~operators of all terrain vehicles in Texas be required to wear a helmet and to show proof~~
 28 ~~of successful completion of a state sponsored ATV operator and certification program;~~
 29 ~~(2)~~
 30 (1) There be an increase in the minimum age from 14 to 16 years be established for
 31 operators; (3) no passengers be allowed on single seat ATVs; (4)
 32 (2) Owners of ATVs be required to hold the state's current minimum requirement for
 33 bodily injury liability coverage at least \$30,000 of health care benefits. The level of
 34 required benefits should be adjusted every four years for inflation; and ~~(5)~~
 35 (3) The Texas Department of State Health Services (DSHS) continue to be urged to
 36 strengthen injury data collection, analysis, and reporting in Texas and implement Centers
 37 for Disease Control and Prevention guidance when it comes to injury prevention and
 38 surveillance in Texas. TMA encourages more vigorous enforcement of laws pertaining to
 39 ATV operations (CM-R Rep. 2-A-04; amended CM-CAH Rep. 1-A-14).

- 40
- 41 **325.004** **Child Abuse and Neglect and Family Violence:** The Texas Medical Association has a
- 42 continuing commitment to the identification, treatment, and prevention of child abuse,
- 43 neglect, and family violence, and recognizes the need to assert its medical leadership in
- 44 these areas. To attain these goals, the association supports the following initiatives:
- 45 (1) Legislation to strengthen Texas child protection laws.
- 46 (2) Provision for adequate funding for protective, health, and social services for
- 47 ~~maltreated~~ children who have been maltreated and their families.
- 48 (3) Recommendation for all medical schools and primary care residency programs in
- 49 the state to provide education and to encourage research at the undergraduate,
- 50 graduate, and postgraduate levels in the diagnosis, treatment, and prevention of
- 51 child abuse and neglect.
- 52 (4) Encouragement of continuing medical education for physicians who provide
- 53 evaluations and care to ~~abused~~ minors in child abuse referral centers and
- 54 emergency ~~rooms~~ departments.
- 55 (5) Promotion of the use of diagnostic and treatment guidelines for cases of
- 56 suspected child abuse and neglect and examination and treatment by a physician
- 57 of victims of maltreatment whenever possible or by a qualified physician
- 58 extender (e.g., child health associate, nurse practitioner, or physician assistant) in
- 59 areas or situations when a physician is unavailable.
- 60 (6) Compliance with reporting provisions of state child abuse laws by health care
- 61 personnel and others.
- 62 (7) Recognition of the importance of encouraging members to become more aware
- 63 of the following aspects of child abuse and family violence: (a) need to publicize
- 64 the dangers of shaking a child; (b) existence of child pornography and ritual
- 65 abuse; (c) importance of screening for risk factors, such as the role of substance
- 66 use and neglect abuse in the etiology of child maltreatment; (d) adverse
- 67 consequences of corporal punishment in the schools; and (e) importance of
- 68 regional child death review teams to determine and address preventable causes of
- 69 child death, including abuse and family violence.
- 70 (8) Dedication to child abuse prevention through improvement of availability,
- 71 accessibility, and quality of health and social services to all abused children and
- 72 ~~their~~ families.
- 73 (9) Support of home visitation programs and establishment of physician supervision
- 74 to evaluate and recommend treatment for survivors of childhood abuse-abused
- 75 ~~children~~ (Committee on Maternal and Child Health, p 142, I-94; reaffirmed CM-
- 76 CAH Rep. 4-A-04; amended CM-CAH Rep. 1-A-14).

77

78 **Recommendation 2:** Retain as amended Texas Medical Association policies 55.015 Day Care and After

79 School Care; 260.074 All-Terrain Vehicles; 325.004 Child Abuse and Neglect and Family Violence.

80

81 The committee recommends retention of the following policies:

- 82
- 83 **55.008** **Early Childhood Intervention Program:** Believing early medical intervention in
- 84 childhood disabilities is often essential for children who have the potential to lead
- 85 normal, productive lives and that it may significantly improve the quality of life for
- 86 disabled children, the Texas Medical Association endorses the continuation of the Early
- 87 Childhood Intervention program (Committee on Rehabilitation, p 140, A-93; reaffirmed
- 88 Council on Scientific Affairs, p 129, A-94; reaffirmed CM-R Rep. 3-A-04; reaffirmed
- 89 CM-CAH Rep. 1-A-14).

90 **100.029** **Requirement for Epinephrine Auto-Injectors in Texas Schools:** The Texas Medical
91 Association supports legislation that (1) requires all Texas schools, pre-Kindergarten
92 through 12th grade, to have epinephrine auto-injectors available on their campuses and at
93 school activities to treat acute life-threatening allergic emergencies; (2) includes a
94 mandate for school personnel to be trained to recognize and treat allergic emergencies;
95 and (3) would amend Section 74.151(a) of the Civil Practice and Remedies Code to state
96 that physicians prescribing unassigned epinephrine auto-injectors for use in schools and
97 athletic settings, and nurses and trained school personnel administering epinephrine auto-
98 injectors during medical emergencies, not be liable for civil damages unless the act was
99 willfully or wantonly negligent (Res. 301-A-14).

100
101 **Recommendation 3:** Retain Texas Medical Association Policies 55.008 Early Childhood Intervention
102 Program and 100.029 Requirement for Epinephrine Auto-Injectors in Texas Schools.

REPORT OF COMMITTEE ON INFECTIOUS DISEASES

CM-ID Report 1 2024

Subject: Sunset Policy Review

Presented by: Trish M. Perl, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 House of Delegates policies in the Texas Medical Association’s Policy Compendium are reviewed
2 periodically for relevance and appropriateness. Following are policies reviewed by the council with
3 recommendations for retention, amendment, and deletion.

4
5 The committee recommends retaining the following policy as amended:

6
7 **260.097 Post-Exposure Prophylaxis for Management of Communicable Diseases:**
8 The Texas Medical Association will (1) work with the Texas Medical Board to
9 enassure appropriate rule changes are developed to inform physicians about and
10 allow them to implement ~~recommendations for~~ post-exposure prophylaxis (PEP)
11 that ~~is~~ are approved ~~recommended~~ by the Centers for Disease Control and
12 Prevention and (2) work with the Department of State Health Services to
13 enassure physicians are informed on the PEP recommendations; and the services
14 available from state and local health authorities; and provided ~~with that~~ timely
15 information on outbreaks of preventable diseases ~~be provided to physicians~~ (CID
16 Rep. 2-A-14).

17
18 **Recommendation 1:** Retain as amended.

REPORT OF THE COMMITTEE ON INFECTIOUS DISEASES

CM-ID Report 2 2024

Subject: TMA Policy on Wastewater Surveillance

Presented by: Trish M. Perl, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 Background

2 Wastewater surveillance or wastewater-based epidemiology is a method of identifying the presence and
3 changes in levels of pathogens, chemicals, and contaminants in a community by testing samples of
4 wastewater from municipal systems. Such testing in communal wastewater sources serves as a passive
5 way to monitor markers of health and illness in a population and complements active monitoring
6 strategies such as health care visits with symptom- and test-based case reporting. Early applications of
7 testing wastewater for pathogens in a population occurred in the 1940s as part of polio eradication efforts.
8 The practice of testing wastewater continued to be adapted and applied in the 1990s through the 2010s for
9 pathogenic outbreaks, the flu, and antimicrobial resistance. Most recently, its use exponentially increased
10 in monitoring SARS-CoV-2, beginning in 2020. During the COVID-19 pandemic, 55 countries
11 contributed wastewater surveillance data to a global dashboard, with 43 countries continuing as of the end
12 of 2023. The monitoring of SARS-CoV-2 demonstrated that the change (increase/decrease) in level of
13 virus found in wastewater samples preceded the same change in human cases by two weeks.

14
15 Individuals with infections, bacterial or viral, or exposed to chemicals such as opioids, can shed pieces of
16 the pathogenic agent or chemical material through bodily fluids that are transported from sanitation
17 facilities into the sewage system as wastewater. Before the wastewater is treated, samples can be taken at
18 various points on its path from the sanitation facility to final processing, from the building level (such as
19 schools, prisons, hospitals) to various communities and geographic regions, depending on the size and
20 characteristics of the population to be included. Individuals who may be the source of pathogens or
21 chemicals cannot be identified on the basis of wastewater monitoring. The samples are sent to public
22 health laboratories that identify and quantify levels of pathogens and other substances of interest such as
23 chemicals, pharmaceuticals, and contaminants in a community's wastewater. Detection and quantified
24 results can be available as soon as five to seven days from when the biomaterial entered the sewage
25 system. The data produced from sample analysis are then used by health officials at the local, territorial,
26 tribal, state, and/or national level in conjunction with other sources of health information to determine risk
27 to the population and subsequent actions to be taken. Monitoring trends over time would allow for
28 formulation of policy for mitigation strategies, treatment options, and evaluation of implemented policies.

29 Value for Physicians

30 *Value:* Wastewater surveillance is a passive, population-based, inclusive tool health care professionals can
31 use to prepare and protect a community. It expands routine surveillance to situations where there may be
32 limited human testing data for individuals or to communities with limited public health resources. Using
33 the two-week-early indication from wastewater samples could allow for additional time for preparation in
34 health care facilities, the mobilization of resources, and the facilitation of testing and mitigation strategies.
35 Physicians would have an evidence-based, unbiased look at levels of pathogens and chemicals in their
36 patient population, both symptomatic and asymptomatic, without dependence on patients' health-seeking
37 behavior or timely accessibility to health care visits. Multiple pathogens and markers of interest can be
38 monitored, including new variants of SARS-CoV-2, influenza, and other respiratory viruses; norovirus;
39 sexually transmitted diseases; emerging threats such as mpox, antimicrobial resistance, and dengue;
40

1 toxins and contaminants that may take time to build up and cause illness; and monitored drugs such as
2 opiates.

3
4 Through collection at different points, wastewater surveillance assists in the identification of outbreaks,
5 like polio, and/or populations at risk, such as schools or nursing homes, allowing for situational
6 awareness for the community. Having robust, serialized data on populations at risk could assist in earlier
7 preventive measures before wider spread into the community and earlier detection where routine
8 screening and diagnosis is limited. Using the geographic- and threshold-level aspects of the surveillance
9 information could help minimize implementation of more extreme countermeasures, thus minimizing
10 disruption. When an intervention is introduced, like a vaccine or treatment strategy, wastewater
11 surveillance can contribute to the observational assessment of the intervention's effect on population
12 health without infringing on individual rights and liberties and supports transparency in decision-making
13 with the provision of data. Wastewater surveillance initiatives are strengthened by the network
14 contribution and engagement, with the ability to observe local/regional-level trends alongside that of
15 larger population trends further assisting physicians and other health professionals in the protection of
16 their communities.

17
18 *Limitations:* Wastewater surveillance is limited to households or institutions on a centralized municipal
19 sewage system and therefore will not include households that use decentralized waste management
20 systems, like septic systems, largely found in rural and remote areas. Infrastructure is limited by the
21 public health laboratory's capacity to safely and effectively collect, process, and analyze samples and by
22 the extent of the wastewater surveillance network. Because of the multidisciplinary nature of wastewater
23 surveillance activities by various entities – utilities, public health laboratories, universities or companies
24 conducting the data analysis, and medical institutions – there is currently not a standardized procedure
25 connecting the data generated to physicians to aid in their decision-making. Additionally, different
26 jurisdiction partners may have different thresholds and methodologies for the analysis and reporting of
27 data, potentially causing discrepancies in how the information is interpreted and used.

28
29 Wastewater sample data are not sufficient on their own to support public health decisions and are best
30 used as an early warning and initiator to supplement information from other sources. There is variability
31 in viral and chemical shedding from person to person and with different conditions, leading to variability
32 in sample concentrations. Similarly, low concentrations of substances may not be detectable. Sample
33 sources can be diluted and contaminated by environmental events that may flood the system and can be
34 contaminated by animal sources. Serial collection and analysis are needed to generate useful information
35 rather than to be used as a point source. The quantification of wastewater components is a relatively new
36 strategy, and so the interpretation of the data and understanding of the variability are still evolving.
37 Further understanding of pathogen concentrations in wastewater and the correlation to health events will
38 lead to better-established thresholds for more effective guidance.

39
40 **National/State/Local Efforts**
41 *National:* The Centers for Disease Control and Prevention (CDC) established the National Wastewater
42 Surveillance System (NWSS) in September 2020 to coordinate health department efforts and develop an
43 enhanced network of ongoing COVID-19 case tracking in 53 jurisdictions, including Texas, covering
44 more than 200 million people in the United States. Sites contributing to the NWSS follow equitable
45 sample collection and testing procedures to ensure standardized, readily comparable data. Health
46 departments that submit testing data to the NWSS portal, DECIPHER, receive trend reports and access to
47 the data to aid in public health decision-making. A public-facing dashboard is available on the CDC
48 COVID Data Tracker page, so anyone can look up virus level information for their area of interest.

49

1 *State and Regional:* Approximately 80% of Texas households are part of the centralized public sewer
2 system, similar to national coverage, and thus available to be part of a wastewater surveillance system.
3 Texas Department of State Health Services (DSHS) coordination of wastewater surveillance for COVID-
4 19, influenza, and mpox in 16 municipalities is supported by CDC and in partnership with the Texas
5 Epidemic Public Health Institute. These counties, covering more than 12.5 million people, contribute
6 wastewater sample data to NWSS, with the Houston Health Department being a Texas pioneer in the field
7 and recognized by CDC as a National Wastewater Surveillance System Center of Excellence. The role of
8 the state health departments is to set case and outbreak thresholds and specify public health actions in
9 response to notifiable conditions and to share the information with other state and national agencies to
10 determine risk. State and regional efforts provide physicians and other health care partners the flexibility
11 and agility to monitor pathogens of interest, coordinate preparation and mitigation strategies, and
12 strengthen interdisciplinary networks to improve future responses.

14 **Ethics**

15 Discussions on the ethics of wastewater surveillance are concerned with defining clear public health
16 purposes and the benefit to the population; data security and privacy; population size/scope to avoid
17 stigmatization or harm; and effective communication strategies to appropriate target audiences. Previous
18 committees that reviewed the ethics of wastewater surveillance concluded the surveillance to be low risk,
19 while other opportunities for review have been declined on the basis that there are no ethical issues to be
20 considered. The current uses led by national, state, or regional institutions are not research, and therefore
21 informed consent is not collected. The smallest catchment areas that could be included and isolated are
22 schools, hospitals, or prisons on a municipal system, if wastewater is not treated before leaving the
23 facility. While pinpointing geographic areas is important for identifying sources and relatedly intervening
24 rapidly, how this information is shared could potentially lead to blame, stigma, and harm for the singled-
25 out population. This scenario supports an adequately sized population, determined by where the sample is
26 collected, in wastewater surveillance, with the possibility that small catchment sampling be reviewed by
27 an ethics committee.

28
29 Data security and privacy concerns are centered around ownership of the data generated from individuals'
30 biological material, how to keep the data anonymous, and what protections there are for the data once
31 generated and reported. With the addition of genomic sequencing for the identification of new COVID-19
32 variants, concerns arose around the fact that human information could be sequenced and released without
33 consent. Those involved in the analysis and provision of the data have the opportunity to assure users and
34 the public that the data are anonymous, from the sampling from a communal source to the sequencing that
35 is focused on viral and bacterial genetic material and toxic substances to the reporting of strictly necessary
36 information. The timeliness of the release of information and communication is another way in which
37 health professionals can ensure the information is of benefit to the population.

39 **Conclusion and Recommendations**

40 After discussion and deliberation, the Committee on Infectious Diseases offers the following
41 recommendations:

42
43 **Recommendation 1:** That the Texas Medical Association adopt a new policy on wastewater surveillance
44 as follows:

45
46 **Wastewater Surveillance for Physician Preparedness:** The Texas Medical Association
47 supports the importance of wastewater surveillance as a supplemental method for the detection,
48 identification, and quantification of pathogens and potentially toxic chemicals in a community.
49 TMA supports physician awareness and education initiatives on how to effectively utilize

1 wastewater surveillance data in conjunction with notifiable conditions or event reporting to aid in
 2 preparedness and protection of patient, physician, and health care professional populations.
 3

4 **Recommendation 2:** That the Texas Medical Association facilitate continuing medical education on the
 5 following:
 6

- 7 1. What wastewater surveillance is and what information it provides;
- 8 2. How is it being used in Texas;
- 9 3. How it can be expanded/applied for emerging threats; and
- 10 4. How Texas physicians can utilize the data.

11
 12 **Related TMA Policy:**

13 None.

14
 15 **Relevant AMA Policy:**

16 None.

17
 18 **References:**

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REPORT OF COMMITTEE ON REPRODUCTIVE, WOMEN'S, AND PERINATAL HEALTH

CM-RWPH Report 1 2024

Subject: Sunset Policy Review

Presented by: Rakhi C. Dimino, MD, Chair

Referred to: Reference Committee on Science and Public Health

1 The Texas Medical Association periodically reviews House of Delegates policies in the association's Policy
2 Compendium for relevance and appropriateness. The Committee on Reproductive, Women's, and Perinatal
3 Health recommendations for retention or amendment are as follows:
4

5 The following policy is recommended for retention:
6

7 **25.007 Fetal Alcohol Syndrome:** Physicians should continue to support the Texas Department of State
8 Health Services in efforts to develop appropriate evidence-based policies to prevent fetal alcohol
9 syndrome including prioritizing pregnant women for drug and alcohol treatment. TMA also should
10 support funding to increase the availability of drug and treatment centers, as well as, mental health
11 resources to be available to this vulnerable population (Committee on Addictive Diseases, p 116,
12 A-94; reaffirmed CM-MPH Rep. 4-A-04; amended CSPH Rep. 2-A-14).
13

14 **Recommendation 1:** Retain.
15

16 The committee recommends amending these policies as follows:
17

18 **280.031 Methylmercury and Public Health:** Women who might become pregnant, are pregnant, or who
19 are breastfeeding should follow state and federal advisories on fish consumption. Because some
20 types of fish are known to have much lower than average levels of methylmercury and can be
21 safely consumed more often and in larger amounts, women should also seek specific consumption
22 recommendations from those authorities regarding locally caught or sold fish. Physicians should
23 assist in educating patients about the relative mercury content of fish and shellfish products and
24 increase awareness of national, regional, and local fish consumption advisories. (CM-MPH Rep.
25 7-A-04; amended CSPH Rep. 2-A-14).
26

27 **330.009 Preconception and Inter-gestational Health and Care:** The Texas Medical Association
28 recognizes that preconception and inter-gestational care are components of a larger health care
29 goal of optimizing the health of every person who can become pregnant woman. Reproductive
30 capacity spans almost four decades for most women. Optimizing women's people's health before
31 and between pregnancies is an ongoing process that requires access to and the full participation of
32 all segments of the health care system.
33

34 TMA believes that all women people in Texas should have the opportunity to benefit from
35 preconception and inter-gestational care. TMA supports efforts to asensure that every pregnancy is
36 a planned pregnancy and that all women people in Texas have access to contraception counseling
37 and affordable options when pregnancy is not desired. This includes counseling and assistance
38 with pregnancy spacing to achieve the best possible health outcomes for mother birthing people
39 and baby.
40

41 Further, TMA supports improving access to care for women people of reproductive age in order to
42 be able to: (1) screen for and optimize management of chronic medical conditions prior to
43 pregnancy; (2) screen for and treat sexually transmitted infections (STIs); (3) reduce perinatal
44 morbidity from vaccine-preventable infections; (4) use medications that are safe in pregnancy;
45 (5) assess family history and genetic risk; (6) address tobacco and substance use; (7) address

1 nutritional issues and weight management; (~~86~~) assess occupational and environmental exposures;
2 and; (~~97~~) screen for and address mental health issues.

3

4 All annual exams for ~~women~~ people of reproductive age should address pregnancy intention,
5 status, and planning. In addition, clinicians providing reproductive care ~~to women~~ should
6 encourage their patients to formulate a reproductive health plan and should discuss it in a
7 culturally sensitive, nondirective way at each visit. TMA will work to provide and promote
8 resources that can help physicians discuss these plans with their patients.

9

10 TMA encourages all physicians who treat ~~women~~ people of reproductive age to consider
11 pregnancy status, contraceptive use status, STI status, and pregnancy intentions when prescribing
12 treatments and recommending care (Amended CM-MPH Rep. 1-A-0; amended CM-MPH Rep. 1-
13 A-14.

14

15 **Recommendation 2:** Retain as amended.

REPORT OF COMMITTEE ON REPRODUCTIVE, WOMEN’S, AND PERINATAL HEALTH

CM-RWPH Report 2 2024

Subject: Updates to Midwifery and Home or Outpatient Obstetrical Delivery Policies

Presented by: Rakhi C. Dimino, Chair

Referred to: Reference Committee on Science and Public Health

1 The Committee on Reproductive, Women’s, and Perinatal Health (CRWPH) reviewed Texas Medical
2 Association policies related to midwifery, 33.005 Midwifery and 330.012 Obstetrical Delivery in the
3 Home or Outpatient Facility, to update the language and recommendations.

4 **Background**

5
6 Resolution 336 2021 – Results and Regulation of Freestanding Birthing Centers and at Home Birthing
7 Services (Tabled Res 426 2020) was presented by the Harris County Medical Society at TexMed 2021.
8 This resolution was adopted and called for TMA to (1) work with state agencies to study the results,
9 regulation, and quality review mechanisms of freestanding birthing centers and at-home birthing services,
10 and (2) determine if additional regulations and public education are needed. In 2022, the Committee on
11 Reproductive, Women’s, and Perinatal Health was assigned related TMA policies (330.011 Home
12 Deliveries and 330.012 Obstetrical Delivery in the Home or Outpatient Facility) as part of the sunset
13 review process. The committee recommended combining the two policies, and the House of Delegates
14 adopted this recommendation. These policies now exist in TMA’s Policy Compendium as 330.012
15 Obstetrical Delivery in the Home or Outpatient Facility. In continuing the efforts assigned to it by the
16 2021 House of Delegates to study birthing centers and to determine if there is a need to better regulate or
17 educate the public, the committee convened a subset of its specialized and interested membership into a
18 Birthing Center Workgroup in 2023 to further study birthing center regulations and the overall practice of
19 midwifery in Texas.

20 **Discussion and Recommendation**

21
22 The Birthing Center Workgroup assessed existing TMA policy on birthing centers and midwifery and
23 discussed the need for further education and clarity on the different types of midwives and their scope of
24 practice in Texas, as well as the overall regulations and data-reporting requirements for midwives and
25 licensed birthing centers.

26
27 To provide more information on birthing centers and midwifery, the Birthing Center Workgroup invited
28 Carla Morrow, CNM, DNP, founder and midwifery services director at Midwife+Co. in the Dallas/Fort
29 Worth area, to present at a meeting. Ms. Morrow presented on the differences between licensed and
30 accredited birthing centers; the differences between certified nurse midwives (CNMs), certified midwives
31 (CMs), and certified professional midwives (CPMs); the types of providers who practice in birthing
32 centers; and birth data for midwives and birthing centers. See Attachment 1 for a comparison of the three
33 types of midwife credentials. Her presentation also included outcomes and transfer data from the National
34 Birth Center Study II published by the American Association of Birth Centers (AABC) in 2013. Texas
35 does not require midwives or licensed birthing centers to report data on birth outcomes. Birthing centers
36 accredited by the Commission for the Accreditation of Birth Centers are required to report data to AABC.
37 As of January 2024, only four of the 91 licensed birthing centers in Texas are accredited by AABC.

38
39 When reviewing existing TMA policy, the workgroup identified a need for further clarification on the
40 types of midwives licensed to practice in Texas. The American College of Nurse-Midwives (ACNM)
41 recognizes three types of midwifery credentials in the United States: certified nurse midwife, certified
42 midwife, and certified professional midwife. Policy 33.005 Midwifery refers to CPMs as “licensed
43 professional midwives,” “direct entry midwives,” and “lay midwives.” For clarity and accuracy, the
44 proposed amendments below to Policy 33.005 remove these terms and only use credential titles

1 recognized by ACNM. The reference to certified midwives in Policy 330.012 012 Obstetrical Delivery in
 2 the Home or Outpatient Facility also was removed because they are not licensed in Texas. Currently,
 3 Policy 33.005 only includes recommendations for CPMs. The proposed amendment extends the
 4 recommendations to CNMs, where applicable.

5
 6 After robust discussion and deliberation, the Committee on Reproductive, Women's, and Perinatal Health
 7 recommends the following:

8
 9 **Recommendation:** Amend policies 33.005 Midwifery and 330.012 Obstetrical Delivery in the Home or
 10 Outpatient Facility as follows:

11
 12 **33.005 Midwifery**

13 Texas offers licensure for two types of midwives to deliver newborns. Certified nurse midwives
 14 (CNMs), ~~also known as who are~~ advanced practice nurses, are licensed by the Texas Board of
 15 Nursing (TBON) and are required to have at least a masters-level degree in nursing. ~~TMA-The~~
 16 Texas Medical Association supports current training standards for ~~certified nurse midwives~~
 17 CNMs and encourages the use of CNMs within a medical team setting. ~~Direct entry midwives,~~
 18 ~~also known as lay midwives or licensed~~ Certified professional midwives (CPMs); are not required
 19 to have a nursing or bachelor's degree. CPMs are licensed by the Texas Department of Licensing
 20 and Regulation (TDLR). Direct entry midwives may choose to be licensed by the Texas
 21 Midwifery Board. Lay midwives or birth attendants have no accredited training and are not
 22 licensed in the state of Texas. The Texas Medical Association supports the following measures to
 23 promote the safety and health of mothers and newborns who receive care by a ~~direct entry~~
 24 midwife CNM or CPM:

25
 26 Supervision and Training: The practice of ~~direct entry midwives~~ CNMs and CPMs should only
 27 take place in consultation with regular record review by a licensed physician practicing obstetrics.
 28 TMA recommends regular record review of newborns delivered by CNMs and CPMs to ensure
 29 appropriateness of care.

30
 31 Patient Safety Guidelines and Informed Consent: The American College of Nurse-Midwives
 32 Standards for the Practice of Midwifery and Texas ~~midwifery rules~~ administrative rules for
 33 midwives (16 Texas Administrative Code, Chapter 115) should specify protocols and standards to
 34 be used by practicing ~~direct entry midwives,~~ CNMs and CPMs, respectively. These should
 35 include ~~ing~~ clear standards for the delineation of findings that preclude a woman's or newborn's
 36 condition as being classified as normal. The definition of a normal pregnancy should be based on
 37 national medical guidelines, and any indication of a high-risk pregnancy should require
 38 immediate consultation or transfer to the care of a physician. Any care provided to the infant
 39 following birth must adhere to the perinatal care guidelines set forth by the American College of
 40 Obstetricians and Gynecologists and the American Academy of Pediatrics.

41
 42 ~~Direct entry midwives~~ CPMs must maintain a signed, at a minimum, a patient safety transfer
 43 agreement plan with a physician and ensure that each patient pre-registers at a hospital where the
 44 patient and/or infant can be transferred in case of an emergency receiving facility and, where
 45 applicable, a signed transfer agreement with a receiving facility. Any transfer agreement plan
 46 between a midwife and a physician or hospital should stipulate a verbal handoff by the midwife
 47 as well as a transfer of all relevant medical records. TMA supports rules to require a standard
 48 informed consent form for clients to sign that follows the Informed Disclosure for Midwifery
 49 Care standards set by the North American Registry of Midwives.

1 Accountability and Oversight: TMA supports legislative action to require that ~~direct-entry~~
 2 ~~midwives~~ CNMs and CPMs maintain liability insurance. All ~~direct-entry midwife~~ CPM-assisted
 3 pregnancies that are either transferred or referred for emergency care or have adverse outcomes
 4 should be reported by the midwife to a midwifery advisory body and the case reviewed by a
 5 committee that includes at least one physician. TMA calls for the ~~Texas Midwifery Board~~ TBON
 6 and TDLR to require CNMs and CPMs, respectively, to monitor-report data on pregnancy and
 7 delivery-birth outcomes, including intended versus actual delivery location. TMA supports data-
 8 reporting requirements for emergency departments and hospitals that receive birthing patients
 9 with an intended initial delivery site outside the facility, attended by direct-entry midwives and to
 10 report this information to the state. TMA supports new requirements to ensure that ~~Texas~~
 11 ~~Midwifery Board~~ TBON and TDLR take all necessary steps to facilitate transparency and the
 12 participation of members and the public, including allowing participation via telephone
 13 conference. TMA also supports designating at least one ~~Certified Nurse Midwife~~ CNM, one
 14 licensed pediatrician or neonatologist, one licensed obstetrician-gynecologist, and one licensed
 15 maternal and fetal medicine physician to serve as members of the ~~Texas Midwifery Board~~
 16 Midwife Advisory Board facilitated by TDLR.

17
 18 Public Education: TMA supports education on the differences between CNMs, CPMs, and lay
 19 midwives for patients, the Texas Legislature, and the public (Committee on Maternal and Child
 20 Health, p 125, A-93; CM-MPH Rep. 4-I-01; amended CM-MPH Rep. 3-A-03; substituted
 21 policies 30.005, 30.006, 30.009 for this comprehensive policy CM-MPH Rep. 4-A-04; Res. 305-
 22 A-04; amended CM-MPH Rep. 1-A-15).

23 24 **330.012 Obstetrical Delivery in the Home or Outpatient Facility**

25 The Texas Medical Association (1) supports the American College of Obstetricians and
 26 Gynecologists' (ACOG's) statement that hospitals and accredited birth centers are the safest
 27 settings for labor, delivery, and the immediate postpartum period. Further, TMA recognizes that
 28 each woman has the right to make a medically informed decision about delivery. Importantly,
 29 women should be informed that several factors are critical to reducing perinatal mortality rates
 30 and achieving favorable home birth outcomes. These factors include the appropriate selection of
 31 candidates for home birth; the availability of a certified nurse midwife, certified professional
 32 midwife, or midwife whose education and licensure meet International Confederation of
 33 Midwives Global Standards for Midwifery Education, or physician practicing obstetrics within an
 34 integrated and regulated health system; ready access to consultation; and access to and a clear
 35 plan for safe and timely transport to a nearby hospital; (2) supports state legislation that helps
 36 ensure safe deliveries and healthy babies by acknowledging that the safest setting for labor,
 37 delivery, and the immediate post-partum period is in the hospital, or a birthing center within a
 38 hospital complex, that meets standards jointly outlined by the American Academy of Pediatrics
 39 and ACOG, or in a freestanding birthing center that meets the accepted standards of the
 40 Accreditation Association for Ambulatory Health Care, The Joint Commission, or the American
 41 Association of Birth Centers, including but not limited to proper licensing, accreditation,
 42 equipment, and staffing; (3) supports that obstetrical care should be provided by qualified and
 43 licensed personnel who function in an environment conducive to peer review; (4) supports that
 44 obstetrical facilities and their staff should recognize the wishes of women and their families
 45 within the bounds of sound obstetrical practice; and (5) encourages public education concerning
 46 the risks and benefits of various birth alternatives (Res. 307-A-12; amended CM-RWPH Rep. 1
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22 &ch=115&rl=Y](https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=16&pt=4&ch=115&rl=Y)

Attachment 1: Types of Midwife Certifications in the United States

	Certified Nurse Midwife (CNM)	Certified Midwife (CM)	Certified Professional Midwife (CPM)
EDUCATION			
Minimum Degree Required for Certification	Graduate Degree	Graduate Degree	Certification does not require an academic degree.
Minimum Education Requirements for Admission to Midwifery Education Program	Bachelor's Degree	Bachelor's Degree	High School Diploma or equivalent.
	Earn RN license prior to or within midwifery education program.	AND Successful completion of required science & health courses and related health skills training prior to or within midwifery education program.	Prerequisites for accredited programs vary, but typically include specific courses such as statistics, microbiology, anatomy and physiology, and experience such as childbirth education or doula certification.
LICENSING AND REGULATION			
Legal Status	Licensed in all 50 states, the District of Columbia, and U.S. territories	Licensed in Arkansas, Colorado, Delaware, Hawaii, Maine, Maryland, New Jersey, New York, Oklahoma, Rhode Island, Virginia, and the District of Columbia	Licensed in 37 states (including Texas) and the District of Columbia
Licensure and Regulatory Agency in Texas	Texas Board of Nursing (TBON)	NA – Not licensed in Texas	Texas Department of Licensing and Regulations (TDLR)
Certifying Organization	American Midwifery Certification Board (AMCB)		North American Registry of Midwives (NARM)
SCOPE OF PRACTICE			
Care Provided	Midwifery as practiced by CNMs and CMs encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. CNMs and CMs also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life.	Midwifery as practiced by CNMs and CMs encompasses the independent provision of care during pregnancy, childbirth, and the postpartum period; sexual and reproductive health; gynecologic health; and family planning services, including preconception care. CNMs and CMs also provide primary care for individuals from adolescence throughout the lifespan as well as care for the healthy newborn during the first 28 days of life.	Midwifery as practiced by CPMs offers care, education, counseling and support to women and their families throughout the caregiving partnership, including pregnancy, birth and the postpartum period. CPMs provide on-going care throughout pregnancy and continuous, hands-on care during labor, birth and the immediate postpartum period, as well as maternal and well-baby care through the 6-8 week postpartum period. In Texas, CPMs provide care up to 6 weeks after birth.

	<p>expedited partner therapy; admit, manage, and discharge patients; order and interpret laboratory and diagnostic tests; and order medical devices, durable medical equipment, and home health services.</p> <p>Midwifery care as practiced by CNMs and CMs includes health promotion, disease prevention, risk assessment and management, and individualized wellness education and counseling. These services are provided in partnership with individuals and families in diverse settings such as ambulatory care clinics, private offices, telehealth and other methods of remote care delivery, community and public health systems, homes, hospitals, and birth centers.</p>	<p>CPMs provide initial and ongoing comprehensive assessment, diagnosis, and treatment. CPMs are trained to recognize abnormal or dangerous conditions requiring consultation with and/or referral to other healthcare professionals. They conduct physical examinations, administer medications, and use devices as allowed by state law, order and interpret laboratory and diagnostic tests.</p>
Practice Settings	<p>All settings – hospitals, homes, birth centers, and offices. The majority of CNMs and CMs attend births in hospitals.</p>	<p>Homes, birth centers, and offices. The majority of CPMs attend births in homes and/or birth centers.</p>
Standards of Practice in Texas	<p>TBON requires CNMs to follow Standards for the Practice of Midwifery set by the American College of Nurse-Midwives (ACNM).</p>	<p>TDLR requires CPMs to follow the Standards of Practice set by the Midwives Administrative Rules (TAC, Chapter 115). These standards include adhering to Core Competencies set by the Midwives Alliance of North America (MANA).</p>
Prescriptive Authority	<p>All US jurisdictions</p>	<p>Nationally, CPMs do not maintain prescriptive authority. In Texas, CPMs may administer eye prophylaxis and oxygen. All other medications can only be administered under the supervision of a licensed physician.</p>
PROFESSIONAL ASSOCIATION		
National	<p>American College of Nurse-Midwives (ACNM)</p>	<p>National Association of Certified Professional Midwives (NACPM)</p>
Texas	<p>Consortium of Texas Certified Nurse Midwives</p>	<p>Association of Texas Midwives</p>
<p><i>Note: This table does not address individuals who are not certified and may attend births with or without legal recognition, such as lay midwives and birth attendants.</i></p>		

Sources: American College of Nurse-Midwives, Association of Texas Midwives, Texas Administrative Code, Texas Department of Licensing and Regulation

JOINT REPORT OF COUNCIL ON HEALTH PROMOTION
AND COMMITTEE ON CHILD AND ADOLESCENT HEALTH

Joint Report 3 2024

Subject: Resolution 304 2023 – Social Media and Smart Phone Use
Presented by: Li-Yu Mitchell, MD, Chair, Council on Health Promotion
Lauren K. Gambill, MD, Chair, Committee on Child and Adolescent Health
Referred to: Reference Committee on Science and Public Health

Resolution 304 – Social Media and Smart Phone Use was considered and presented at TexMed 2023. It was introduced by the Lone Star Caucus. The resolution 304 states:

- (1) That the Texas Medical Association develop a social media policy that guides parents and caregivers regarding the healthy use of social media and “smart phone” use;
- (2) That TMA advocate for state legislation compelling social media companies (over a certain size) to allow academic researchers access to their data;
- (3) That TMA advocate for state legislation to set restrictions on the data mining of minors;
- (4) That TMA advocate for state legislation to establish an “internet” age of majority for unsupervised use of social media consistent with accordant risks; and
- (5) That the Texas Delegation to the American Medical Association take a resolution to the AMA House of Delegates advocating for federal legislation to establish an “internet” age of majority for unsupervised use of social media consistent with accordant risks.

The resolution highlighted the following:

- Childhood and adolescent social media use has been associated with worsened mood, diet, sleep deprivation, addiction, anxiety, behavioral problems, body image, physical activity, online grooming, sight, and headaches.
- Risks of digital and social media include negative health effects on sleep, attention, and learning; a higher incidence of obesity and depression; exposure to inaccurate, inappropriate, or unsafe content and contacts; and compromised privacy and confidentiality.
- Internal corporate documents have revealed that Facebook was aware of the detrimental impact of Instagram on teenage girls, yet the company has continued to defend the platform.

The 2023 Science and Public Health Reference Committee received mixed testimony on this resolution, but all testifiers recognized the emerging challenges posed by social media use on emotional, mental, and behavioral health. This resolution was referred to the Committee on Child and Adolescent Health and the Council on Health Promotion for further study and report back to the House of Delegates at TexMed 2024.

Background: Social Media Use Is Universal

This report calls attention to the growing concerns about the effects of social media on youth mental health while acknowledging that social media use is universal and can be challenging to regulate at the individual level. According to the U.S. surgeon general’s advisory on social media and youth mental health, up to 95% of youth aged 13-17 report using a social media platform, nearly 67% of teenagers report using social media every day, and about 33% report using social media “almost constantly.”

1 **Impact of Social Media on Mental Health**

2 Recent research has explored the frequent use of social media among adolescents and its associated
3 mental health concerns, leading to mixed findings. There is still a lot to learn, since social media
4 comprises of a vast array of digital tools, making it hard to characterize its overall effect on youth.

5 6 *Mental Health Risks*

7 Data from the Cyberbullying Research Center suggest about one in every four teens has experienced
8 cyberbullying. Cyberbullying is also associated with higher rates of self-harm and suicidal behavior.
9 Victimization from cyberbullying occurs to teens around 14 years of age, when children spend more time
10 on their mobile phones and social media platforms. A few studies have shown evidence that
11 cyberbullying was one of the most significant negative aspects of the internet's influence on self-harm,
12 but that this was an area of research still in its preliminary stages.

13
14 Youth may be at greater risk of engaging in risky behaviors if they are exposed to content
15 displaying suicide and self-harm. In a recent study of more than 400 youth who were psychiatrically
16 hospitalized because of risk of harm to self or others, a meaningful proportion reported viewing online
17 content that promoted suicide (14.8%) or self-injury (16.6%) during the two weeks preceding their
18 admission.

19
20 Incidences of cyberbullying and adolescent suicide are rising in the U.S., with recent Centers for Disease
21 Control and Prevention data showing that 14.9% of adolescents have been cyberbullied and 13.6% have
22 made a serious suicide attempt. Antibullying legislation and the requirement that schools prohibit any
23 bullying that interferes with learning in the classroom or through technology has given rise to
24 cyberbullying regulations.

25
26 Social media use also can be associated with a risk of sexual solicitation/exploitation. Online sexual
27 exploitation and abuse (OSEA) includes online grooming, live-streaming of sexual abuse, child sexual
28 abuse material, online sexual coercion and extortion, online sex trafficking, and image-based sexual
29 abuse. Because of the large number of unreported instances, the real scope of the problem is generally
30 unclear. Equality Now's analysis of OSEA laws and policies, as well as in-depth discussions
31 with activists and lawyers working with OSEA survivors, discovered that international and national laws
32 are not up to date with the evolving landscape of technological advances and social media. There is no
33 single internationally binding tool that defines and addresses OSEA, as there is a lack of defined
34 legislation and internationally approved OSEA laws. There is also friction between digital rights and
35 freedoms and the right to protection and safety from OSEA. Rules governing digital service providers and
36 platforms vary and do not offer protection from OSEA.

37
38 Body image is defined as a person's perceptions, thoughts, and feelings about their own body, and it
39 reflects societal constructs produced by the adoption of body ideals that are widely spread through media,
40 family, and peers. Higher levels of online social comparison have been associated with adolescent
41 depression symptoms, and appearance-specific comparisons on social media may increase the incidence
42 of eating disorders (EDs) and body image concerns. Over the past 30 years, the media have exposed
43 young people to "thinness ideals," resulting in the development of new beauty standards. Young women
44 are particularly prone to the idea of thinness; as a result, they frequently compare themselves with online
45 beauty standards, negatively influencing their sense of self. There is social pressure to maintain a
46 particular physical appearance, which may contribute to the onset of EDs.

47
48 One study investigates the impact of Instagram use on body dissatisfaction among female adolescents and
49 young women, with a focus on different activities (browsing, commenting, posting) and targets of social
50 comparison (close peers, distant peers, social media influencers). The findings reveal that browsing has
51 the most negative impact on a young person's self-image. Idealized body images shared on Instagram,

1 particularly by social media influencers, contribute to lower levels of body satisfaction. Content displayed
2 on this social media platform is influenced by its built-in algorithm, which is designed to curate and
3 prioritize content based on user interactions, preferences, and engagement patterns.
4

5 Another article, published by Stanford University Human-Centered Artificial Intelligence, states that the
6 addictive nature of social media, driven by variable rewards like “likes,” triggers dopamine pathways
7 associated with motivation and addiction. Endless scrolling can lead to harmful social comparison,
8 eroding self-esteem, and cyberbullying. To moderate cyberbullying, some companies have employed
9 artificial intelligence to filter negative comments and ban communities from posting harmful content. As
10 for next steps, the article notes that while psychiatrists acknowledge the positive aspects of social media,
11 they advocate for more research, emphasizing the need to balance harm reduction with promoting well-
12 being. They propose a shift toward ethical app design that prioritizes mental health over addictive
13 features.
14

15 Increased screen time is another detrimental effect of social media on health. In 2019, an infographic
16 titled “The New Normal: How Devices Affect Daily Life” outlined how screen time before bed has an
17 adverse effect on sleep, resulting in reduced sleep duration, decreased quality, and increased daytime
18 sleepiness. Thirty-six percent of teenagers report they have woken up at least once during the night to
19 check their mobile device, and 29% of teens sleep with a mobile device in bed. National survey data
20 showed that the percentage of teenagers who don’t get enough sleep has increased significantly, with
21 more than 40% reporting that they sleep for less than seven hours on most nights. The study also found a
22 connection between inadequate sleep and everyday use of electronic media for two or more hours.
23

24 **Benefits to Mental Health**

25 While there are many emerging risks of social media and smartphone use, as outlined above, it is
26 important to note that there also are a range of positive impacts, such as social connection, support of
27 activism, humor, entertainment, identity exploration, and creative expression. The American
28 Psychological Association (APA) acknowledges the positive impacts of social media on youth,
29 emphasizing that social media, at its best, facilitates connection and positive engagements. APA
30 specifically highlights the role of social media in providing support for marginalized communities, such
31 as lesbian, gay, bisexual, transgender, queer, or questioning youth, who may find valuable connections
32 online that they might be reluctant or unable to seek elsewhere. Overall, APA recognizes social media’s
33 role in experiencing social support and fostering a sense of community/positive connections, especially
34 for youth facing isolation and seeking support.
35

36 Children and adolescents gain self-awareness through online experiences. Social media can be a source of
37 new information and news on current events and a platform to engage in societal issues. The Pew
38 Research Center published findings that eight in 10 Americans say social media platforms are effective
39 for raising public awareness about political or social issues. Seventy-seven percent of Americans believe
40 these platforms are at least somewhat effective for creating sustained social movements.
41

42 One study explores young people’s engagement in social activism through social media, focusing on
43 preferences, language usage, and perceived impact. Results of this study indicate a high prevalence of
44 youth participation in social causes, leveraging social media for expression and communication.
45 Motivation for participation is linked to concerns in their educational, family, and peer environments. The
46 study emphasizes the transformative potential of youth engagement through social media, advocating for
47 civic education and equitable digital access. It also underscores the importance of youth social
48 participation in a hyperconnected world. Participating in community-building and activism online can
49 influence and reinforce positive social identities. Additionally, this strengthened shared identity has the
50 potential to result in positive psychological effects, including a heightened sense of empowerment.

1 **Social Media Use Advisories**

2 APA advocates for a comprehensive approach to managing adolescents' social media use during early
3 adolescence (ages 10-14 years). While emphasizing adult monitoring, which involves ongoing review,
4 discussion, and coaching about social media content, the association recommends minimizing exposure to
5 content portraying illegal or maladaptive behaviors. Prompt reporting and removal of such content are
6 crucial to mitigate the risk of psychological harm. Additionally, APA advises against using technology
7 and algorithms that drive users toward harmful content.

8
9 Recognizing the need for substantial research funding, APA calls for long-term longitudinal studies
10 involving younger children and marginalized populations. Access to data, including information from
11 technology companies, is deemed crucial for independent scientists to conduct thorough examinations of
12 the associations between social media use and adolescent development.

13
14 The American Academy of Pediatrics (AAP) has outlined comprehensive "Guidelines for Health
15 Supervision of Infants, Children, and Adolescents," offering recommendations for social media use across
16 different developmental stages. Stressing the importance of health care professionals understanding the
17 benefits and risks associated with social media, AAP highlights the significance of parents becoming
18 media literate. Specific recommendations include establishing media-free zones, promoting critical
19 thinking about online information, and encouraging positive role modeling by parents. The document
20 addresses age-specific considerations, such as managing screen time for young children and guiding them
21 on building positive social networks.

22 **Guidelines on an "Internet Age"**

23 Aligned with AAP's recommendations, the U.S. surgeon general issues advisory guidelines directing
24 policymakers to collaborate with various stakeholders in enhancing protections for children on social
25 media platforms. The surgeon general's advisory emphasizes the development of flexible, age-appropriate
26 health and safety standards for technology platforms, advocating for features that promote safe content
27 and protect against harmful material. Recommendations include safeguards against issues like eating
28 disorders, violence, substance abuse, sexual exploitation, and suicide, alongside limitations on
29 engagement-maximizing features and tools preserving activities essential for healthy development, such
30 as sleep.

31
32
33 Additionally, the surgeon general recommends a higher standard of data privacy for children to address
34 concerns about potential exploitation and abuse. The advisory advocates for policies restricting access to
35 social media for children, enforcing age minimums to minimize harm. It also underscores the importance
36 of technology companies sharing relevant health impact data with independent researchers and the public
37 while ensuring privacy protection. Notably, the advisory refrains from establishing a specific "internet
38 age" for unsupervised social media use, recognizing the need for ongoing research and emphasizing the
39 importance of aligning standards with individual developmental needs.

40
41 APA's health advisory on social media use in adolescence emphasizes that adolescent development is a
42 gradual process, encompassing biological, neurological, and social changes from around 10 years of age
43 until approximately 25 years of age. The recommendation for age-appropriate social media use is based
44 on individual maturity levels, considering factors such as self-regulation skills, intellectual development,
45 and comprehension of risks within the home environment. Acknowledging the variability in adolescents'
46 maturation rates, APA emphasizes ongoing research to determine a specific age or time point for social
47 media recommendations.

48
49 Furthermore, the surgeon general supports the implementation of digital and media literacy curricula in
50 schools, promoting digital skills to enhance resilience against online risks like cyberbullying and
51 excessive social media use. The advisory calls for increased funding for future research on both the

1 benefits and harms of social media use for children, adolescents, and families. Lastly, it encourages
2 policymakers to engage with international partners to collectively address online harm to the health and
3 safety of children and adolescents.

4
5 Parents, as key stakeholders in their children’s well-being, are advised to adopt specific measures. This
6 involves the development of a family media plan and the establishment of tech-free zones within the
7 household. Furthermore, parents are encouraged to model responsible social media use for their children
8 and actively promote in-person relationships as an integral aspect of healthy development.

9 10 **Other Guidelines and Initiatives**

11 In the landscape of digital parenting resources, AT&T provides valuable tools and insights for navigating
12 the challenges presented by raising children in the digital age. Its comprehensive approach includes expert
13 tips, a collaborative questionnaire co-created with AAP, and a range of resources covering smartphones,
14 TV, internet, and gaming. AT&T’s digital parenting toolkit also emphasizes proactive management
15 through features like parental controls, allowing families to regulate online experiences. In addition to its
16 own resources, AT&T directs users to external sources like the Common Sense Media Parents’ Ultimate
17 Guides, acknowledging the dynamic nature of media and technology trends.

18
19 Common Sense, a nonprofit organization, serves as a trusted guide in the ever-evolving landscape of
20 media and technology with the goal of fostering a digital world where children can thrive. Recognizing
21 the pivotal role of technology in children’s lives, Common Sense offers valuable resources for families
22 and educators, providing reviews, advice, and age-based ratings across various media platforms. With a
23 focus on media choice, digital equity, digital literacy and citizenship, tech accountability, and healthy
24 childhood, the organization is dedicated to creating a safe, healthy, and equitable digital environment.
25 Through a combination of original research and advocacy, Common Sense works to enhance the digital
26 experience for children, offering insights and guidance on entertainment choices, including movies, TV
27 shows, books, and more.

28
29 Common Sense’s Parents’ Ultimate Guides offer a valuable resource for parents navigating the ever-
30 evolving landscape of apps, games, and websites their children engage with. These guides provide
31 comprehensive information on popular platforms and trends, addressing common concerns such as safety,
32 functionality, and content appropriateness. From exploring the intricacies of TikTok and Snapchat to
33 delving into the immersive worlds of Minecraft, Roblox, Fortnite, Discord, and Instagram, these guides
34 serve as informative tools for parents seeking a deeper understanding of the digital spaces their children
35 inhabit. Covering everything from safety considerations to practical insights, these guides empower
36 parents to make informed decisions and actively participate in their children’s online experiences.

37
38 Via HealthyChildren.org, AAP has released an online resource, the Family Media Plan, designed as a
39 structured framework to assist families in navigating social media. It provides a mechanism for
40 formulating and prioritizing media-related guidelines aligned with household values and preferences. The
41 iterative nature of the plan allows for periodic revisions, adapting to evolving circumstances such as the
42 beginning of each academic year or during breaks.

43
44 Families should tailor the Family Media Plan to the media consumption habits in their households. They
45 can choose to create a comprehensive plan or selectively incorporate elements most relevant to their
46 circumstances.

47
48 The Family Media Plan includes:

- 49
50
- A list of media priorities to choose from;

- 1 • Practical tips to facilitate plan implementation;
- 2 • Insight into the plan's significance;
- 3 • The ability to print or share the finished plan; and
- 4 • An option to save the plan for future modifications.

5
6 The article "Social Media: Anticipatory Guidance" emphasizes how social media has become a big part
7 of the lives of kids, teens, and their parents, impacting their health, development, and well-being. The
8 article suggests that pediatricians should talk to parents about social media use at every stage of a child's
9 growth. It highlights the need for pediatricians and parents to work together to guide kids in using social
10 media positively. The article gives practical tips to parents, like keeping an eye on what kids do on social
11 media, sharing media experiences, setting reasonable limits, being good examples of media use and
12 online behavior, and making kids aware of potential risks online.

13 14 **Existing Age Restrictions and International Guidelines**

15 Many social media companies do not allow individuals under the age of 13 to use their platforms. This
16 restriction aligns with the Children's Online Privacy Protection Rule (COPPA), which imposes specific
17 requirements on websites or online services targeting children under 13 as well as sites with knowledge of
18 collecting personal information from children under 13. COPPA serves to safeguard the privacy and
19 online data of young users.

20
21 Facebook requires users to be at least 13 years old; Instagram similarly enforces a minimum age of 13.
22 On Instagram, users below 18 years with a birth date indicating youth will automatically have a private
23 account. TikTok also sets a minimum age of 13 for basic feature use. For users younger than 13, a curated
24 version allows them to view clean content without the ability to comment, search, or post their own
25 videos. Additionally, TikTok imposes restrictions on users below 18, limiting them to 60 minutes of app
26 usage per day, after which a password is required for further access. These age-specific measures aim to
27 create age-appropriate and safer online environments for users on these platforms.

28
29 International guidelines, as exemplified by Australia's eSafety Commissioner, underscore the pivotal role
30 parents play in guiding children through their online journeys. Addressing concerns about when children
31 are ready to explore the digital realm, the guidelines provide insights into managing screen time, choosing
32 age-appropriate content, introducing smartphones, and determining social media readiness. The emphasis
33 is on individualized approaches, considering a child's age, maturity, and family dynamics. Additionally,
34 the UK Safer Internet Centre focuses on age restrictions across popular platforms. Notably, WhatsApp
35 recently raised its age limit to 16 in Europe, aligning with the General Data Protection Regulation
36 (GDPR).

37
38 Internetmatters.org contributes to this landscape by offering a toolkit that emphasizes the need to be
39 aware of age limits on social media platforms. The toolkit provides a guide to common social networks,
40 directing users to age reference pages for each platform. It stresses that some platforms may not be
41 suitable for certain age groups or may involve interactions with older communities.

42
43 In conclusion, despite international efforts to establish guidelines, standardizing an internet age remains
44 challenging, particularly at the state legislative level. Australia, the United Kingdom, and the U.S. employ
45 different legal frameworks such as COPPA and GDPR, influencing age restrictions on social media
46 platforms. The dynamic nature of technology, coupled with diverse cultural norms, underscores the
47 complexity of creating a universal standard for children's online engagement.

1 **Legislative Influences on Social Media Use**

2 Amid growing concerns about the impact of social media on children’s mental health, state legislators
3 across the U.S. are introducing measures to safeguard minors online. Proposed legislation includes the
4 creation of study commissions, requirements for age verification or parental consent for social media
5 accounts, and the integration of digital and media literacy courses for K-12 students. Illinois has adopted a
6 resolution urging federal regulation to protect minors from negative social media algorithms, while
7 Louisiana enacted the Secure Online Child Interaction and Age Limitation Act. Mississippi and Utah
8 have introduced laws regulating pornographic content exposure to children and social media usage,
9 respectively. Montana has taken the drastic step of banning TikTok within the state. These initiatives
10 reflect a nationwide effort to address the challenges associated with children’s online interactions. In
11 response to the impact of social media on society, numerous states have introduced legislation to regulate
12 its use, recognizing the implications for privacy, cybersecurity, and the spread of misinformation. The
13 National Conference of State Legislatures lists various states legislation on social media and children
14 from 2023.

15
16 Arkansas created Act 689, known as the Social Media Safety Act, which introduces regulations aimed at
17 enhancing the safety of social media use, particularly for minors. The act defines key terms and outlines
18 provisions related to the regulation of social media. Among the key points, the act requires social media
19 companies to implement reasonable age verification methods, using third-party vendors to confirm the
20 age of account holders. Minors are only allowed to be account holders with the express consent of a
21 parent or legal guardian. The act establishes liability for social media companies that knowingly violate
22 these provisions, imposing penalties and damages for noncompliance. The act leaves the determination of
23 “reasonable age verification” to the discretion of the social media companies, focusing on the overall
24 process and responsibilities rather than prescribing a specific age limit for users. The act also addresses
25 the liability of commercial entities and third-party vendors, prohibiting the retention of identifying
26 information after access to the social media platform is granted and outlining penalties for
27 noncompliance.

28
29 Three pending California bills aim to comprehensively regulate social media platforms. Assembly Bill
30 1282 prioritizes mental health, directing the formulation of a statewide strategy to mitigate associated
31 risks, especially for children and youth. Senate Bill 287 focuses on harmful features impacting child
32 users, introducing audits and civil penalties for violations. Senate Bill 764 addresses the prioritization of
33 user engagement over the safety of minors, proposing civil penalties for violations. This bill also includes
34 provisions prohibiting social media platforms from using targeted algorithms for youth users.

35
36 Following the recent Texas 88th legislative session, two bills came into effect, namely House Bill 18 and
37 House Bill 1181. HB 18, known as the Securing Children Online through Parental Empowerment
38 (SCOPE) Act, is a comprehensive measure aimed at safeguarding minors from harmful digital practices.
39 It establishes regulations for digital service providers, outlining duties and prohibitions such as age
40 verification, limitations on personal information collection, and prevention of exposure to harmful
41 material. The legislation introduces the concept of “verified parents,” granting them authority over their
42 minor’s digital interactions, and addresses the use and transfer of electronic devices in schools, mandating
43 standards and internet filters. Additionally, the bill requires a study on the effects of various media on
44 minors. Enforced by the attorney general, with a private cause of action for parents, the SCOPE Act seeks
45 to create a safer online environment for children, with specific effective dates outlined for
46 implementation. Simultaneously, HB 1181 focuses on regulating the publication or distribution of sexual
47 material that can be harmful to minors on the internet, instituting age verification methods and health
48 warnings, and imposing civil penalties for noncompliance.

49

1 Beslow is a list of bills from the 2023 Texas Legislature regarding social media and children that failed to
2 pass.

3	Bill	Title	Bill Summary
4	HB 99	Digital Citizenship Instruction in Public Schools	Relates to digital citizenship instruction in public schools.
5	HB 896	Use of Social Media Platforms by Children	Relates to prohibiting use of social media platforms by children.
6	HB 1594	Duties of Social Media Companies Regarding Prostitution	Relates to the duties of social media companies regarding prostitution and trafficking of persons; creates a criminal offense.
7	HB 2155	Social Media Algorithm Prohibitions	Relates to prohibiting social media platforms from using certain social media algorithms to target minors.
8	HB 2206	Prohibition of Certain Social Media Platforms	Relates to a prohibition of certain social media platforms developed or provided by certain foreign entities.
9	HB 2690	Liability for Distribution of Abortion Inducing Drugs	Relates to abortion, including civil liability for distribution of abortion-inducing drugs and duties of internet service providers; creates a criminal offense; authorizes a private civil right of action.
10	HB 2790	School Access to Social Media and Social Networking	Relates to access to social media and social networking websites on public school campuses.
11	HB 3134	Notification of Social Media Posted Threats	Relates to requiring social media platform operators to identify and notify law enforcement of credible threats of violence published on their platforms; creates a criminal offense.
12	HB 3357	Civil Liability for Obscenity	Relates to civil liability for obscenity.
13	HB 3570	Restricting Access to Sexual Material Harmful to Minors	Relates to restricting access to sexual material harmful to minors on an internet website.
14	HB 3585	Restricting Access to Sexual Material Harmful to Minors	Relates to restricting access to sexual material harmful to minors on an internet website.
15	HB 4412	Minors and Digital Service Provider Agreements	Relates to online agreements between certain minors and certain digital service providers.
16	HCR 46	Pass Legislation to Protect Children	Urges Congress to pass legislation to protect children from the harms of social media.
17	SB 2021	Websites Containing Sexual Material Harmful to Minors	Relates to requirements for certain internet websites containing sexual material harmful to minors.
18	SB 2164	Restricting Access to Sexual Material Harmful to Minors	Relates to restricting access to sexual material harmful to minors on an internet website.
19	SB 2255	Social Media Companies and Law Enforcement Cooperation	Relates to cooperation between social media companies and law enforcement agencies; imposes a civil penalty.

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41 Meanwhile, in Florida, the House of Representatives unanimously approved House Bill 379, which
42 requires public school districts to block social media access on school-provided Wi-Fi and implement a
43 safety policy for minors' internet use. While students can still use personal devices to access social media,
44 the bill restricts device use during class to educational purposes directed by teachers. The legislation
45 mandates the Department of Education to develop social media safety curricula for grades 6-12,
46 addressing its social, emotional, and physical effects. The bill explicitly prohibits TikTok and successor
47 applications on school devices and for school-related communication. The measure aims to create a
48 focused learning environment and improve academic performance by disconnecting students from
49 devices in classrooms. The move responds to concerns about cyberbullying, emotional overwhelm, and
50 the link between social media use and human trafficking. Despite its unanimous approval, the bill faces a

1 final vote in the House after Senate amendments. The related measure, Senate Bill 258, codifies and
2 expands an executive order banning TikTok on government devices.

3
4 The Protecting Kids on Social Media Act, a federal initiative sponsored by a bipartisan group of senators,
5 aims to address the mental health crisis among America’s youth linked to social media use. The proposed
6 legislation sets the minimum age for social media users at 13, mandates parental consent for users aged 13
7 to 18, and prohibits platforms from using algorithms to recommend content to these young users. The bill
8 also requires adults to create accounts for their teens, providing valid ID for platform access. While the
9 federal act has garnered support for its intention, concerns have been raised by advocacy groups regarding
10 potential negative impacts on privacy and access to resources for vulnerable minors.

11 **Keeping Social Media and Technology Companies Accountable**

12 Once again, as mentioned in the U.S. surgeon general’s advisory on social media and youth mental health,
13 it is difficult to conclude that social media is sufficiently safe for children and adolescents. The advisory
14 recommends that policymakers can act by holding technology companies accountable, ensuring these
15 companies “share data relevant to the health and impact of their platforms with independent researchers
16 and the public in a manner that is timely, sufficiently detailed, and protects privacy.” As social media
17 becomes a growing form of communication, researchers are encouraged to:

- 18 1. Establish the impact of social media on youth mental health as a research priority and develop a
19 shared research agenda;
- 20 2. Develop and establish standardized definitions and measures for social media and mental health
21 outcomes that are regularly evaluated and applied across research contexts;
- 22 3. Evaluate best practices for healthy social media use in collaboration with experts including physicians
23 and health care providers, parents, and youth; and
- 24 4. Enhance research coordination and collaboration.

25
26
27
28 Lastly, the advisory calls on technology companies to do the following:

- 29 1. Conduct and facilitate transparent and independent assessments of the impact of social media
30 products and services on children and adolescents;
- 31 2. Prioritize user health and safety in the design and development of social media products and services;
- 32 3. Design, develop, and evaluate platforms, products, and tools that foster safe and healthy online
33 environments for youth;
- 34 4. Share data relevant to the health impact of platforms and strategies employed to ensure safety and
35 well-being with independent researchers and the public in a manner that is timely and protects
36 privacy;
- 37 5. Create effective and timely systems and processes to adjudicate requests and complaints from young
38 people, families, educators, and others and address online abuse, harmful content and interactions,
39 and other threats to children’s and adolescents’ health and safety.

40 **Discussion and Recommendations**

41
42 Physician member volunteers from the Committee on Child and Adolescent Health and the Council on
43 Health Promotion convened multiple times to discuss this resolution, assess the research, share relevant
44 perspectives and expertise, and determine their proposed recommendations. Key discussion points from
45 the workgroup meetings are:

- 46 • There is a need for ongoing education about social media use and how we can comment on media
47 consumption.

- 1 • There can be some guidance for social media regulations when looking at the parallels between
2 distracted driving and cyberbullying. Both issues required intervention.
3
- 4 • The intersection of technology and daily life has given rise to pressing concerns regarding its
5 impact on safety and well-being. Legislative measures addressing cell phone use while driving
6 can serve as a guide and precedent for using policy to address social media usage. In 2021, 12%
7 of all Texas car crash fatalities were caused by drivers distracted by cellphone use. Texas
8 intervened by enacting strict policies against cellphone use while driving, to prevent further
9 accidents and deaths. Similarly, with a link between social media use/cyberbullying and self-
10 harm and suicide, a policy intervention could help prevent further adverse mental health
11 outcomes.
- 12 • As lawmakers grapple with the challenges of regulating technology in the physical realm, a
13 similar imperative arises in the virtual space, where the influence of tech companies on social
14 media platforms necessitates accountability. By juxtaposing these two spheres, we illuminate the
15 significance of simultaneously addressing imminent safety concerns and cultivating a digital
16 environment that promotes the well-being of users.
17
- 18 • We need more awareness and research regarding mental health impacts of social media and cannot
19 dismiss the positive impacts it has for encouraging a sense of social connectedness.
20

21 Here is the workgroup's breakdown of the original Resolution 304 and why the group believes it is
22 important to strengthen existing TMA Policy 55.065 Impact of Social Networking Services on the Health
23 of Adolescents instead:
24

- 25 • Point 1 of the resolution asks TMA to develop a social media policy that guides parents and
26 caregivers regarding the healthy use of social media and smartphone use. In lieu of creating a new
27 policy, it is important for TMA to direct attention to existing guidelines on healthy social media and
28 smartphone use, as discussed in the report. It is also important to note that TMA has Policy 55.065.
29 The joint workgroup feels it is best to strengthen this existing TMA policy.
- 30 • The workgroup believes points 2, 4, and 5 are out of TMA's scope. Establishing an internet age
31 requires more research. It is difficult to recommend an internet age of majority given the difficulties
32 with regulating social media use among youth. The onus and accountability should be on social media
33 and technology companies to ensure they are promoting a safe online environment.
- 34 • The workgroup would like to add Point 3 of the resolution to existing TMA Policy 55.065.
35

36 After thorough discussion, the committee and the council recommend the following.
37

38 **Recommendation:** Amend Texas Medical Association Policy 55.065 Impact of Social Networking
39 Services on the Health of Adolescents as follows in lieu of adopting Resolution 304 – Social Media and
40 Smart Phone Use:
41

42 **55.065 Impact of Social Networking Services-Media Platforms on the Health of Adolescents:**

43 The Texas Medical Association affirms that use of electronic social networking services media
44 platforms has the potential to negatively impact the physical and mental health of individuals,
45 especially adolescents and those with preexisting psychosocial conditions, and therefore these
46 services should have established, evidence-based, reliable safeguards to protect vulnerable
47 populations from harm.
48

- 49 1. To help prevent adverse mental health outcomes, TMA urges the development of state
50 legislation to set restrictions on the data mining of minors.

- 1 2. [TMA encourages families and physicians to refer to established guidelines from the](#)
2 [American Psychological Association and the American Academy of Pediatrics on promoting](#)
3 [healthy technology use.](#)
- 4 3. [TMA strongly supports ongoing research and education regarding the growing impacts of](#)
5 [social media, smartphone use, and overall technological advancements on mental health.](#)
6 (Res. 320 2021).

8 **Related TMA Policies**

9 [55.065 Impact of Social Networking Services on the Health of Adolescents](#)

11 **Related AMA Policies**

12 [D-478.965 Addressing Social Media and Social Networking Usage and its Impacts on Mental Health](#)

13 [D-105.995 Protecting Social Media Users by Updating FDA Guidelines](#)

14 [H-478.976 Teens and Social Media](#)

15 [H-478.977 Minimizing the Influence of Social Media on Gun Violence](#)

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JOINT REPORT OF COMMITTEE ON CHILD AND ADOLESCENT HEALTH
AND COMMITTEE ON EMERGENCY SERVICES AND TRAUMA

Joint Report 5 2024

Subject: Resolution 317 2023 – Incorporating Emergency Hemorrhage Control into School Curriculum

Presented by: Lauren K. Gambill, MD, Chair, Committee on Child and Adolescent Health
Hilary E. Fairbrother, MD, Chair, Committee on Emergency Services and Trauma

Referred to: Reference Committee on Science and Public Health

1 Resolution 317 2023, Incorporating Emergency Hemorrhage Control into School Curriculum, was
2 considered and presented at TexMed 2023. It was introduced by the Bexar County Medical Society and the
3 Texas Medical Association Medical Student Section. The resolves of Resolution 317 2023 state:

- 4
- 5 (1) That TMA encourage the inclusion of emergency hemorrhage control into school curriculum
6 beginning no earlier than grade 7;
 - 7 (2) That TMA support legislation regarding the inclusion of emergency hemorrhage control into school
8 curriculum beginning no earlier than grade 7;
 - 9 (3) That TMA encourage the allocation of state and/or private funds toward the establishment of a
10 school curriculum for the instruction of emergency hemorrhage control;
 - 11 (4) That TMA encourage the development of emergency hemorrhage control education materials such
12 as web resources, training guides, and/or tools, potentially adapted from Stop the Bleed training
13 classes, to be provided to schools for the instruction of emergency hemorrhage control; and
 - 14 (5) That TMA will act as a resource and offer recommendations to the state legislature, local
15 government agencies, or other interested organizations regarding emergency hemorrhage control
16 education in schools.

17
18 The 2023 Reference Committee on Science and Public Health debated Resolution 317 and received mixed
19 testimony. Testifiers raised concerns about the appropriateness of training in grade 7, along with a
20 suggestion that emergency hemorrhage control training be integrated into the staff training program instead
21 of the school curriculum. The reference committee discussed concerns regarding the trauma of the training
22 to young adolescents and the potential benefits of such training, given the increase in firearm violence in
23 schools. Additionally, witnesses noted Stop the Bleed (STB) training as a useful tool in treating injuries
24 resulting in significant blood loss.

25
26 Because of the lack of consensus on the appropriateness of STB training among students in middle school,
27 the reference committee recommended that the House of Delegates refer the resolution for further study,
28 and the house concurred. Subsequently, the Committee on Child and Adolescent Health and the Committee
29 on Emergency Services and Trauma were tasked with studying and developing recommendations for
30 consideration by the house at TexMed 2024.

31
32 **Background: Firearm Violence Nationally and Within the State**

33 According to the American Public Health Association (APHA), firearm violence is a leading cause of
34 premature death in the U.S., and APHA has deemed firearm violence a public health issue. Each year, more
35 than 39,000 people in the U.S. die as a result of gun violence. Firearm injuries and deaths have increased,

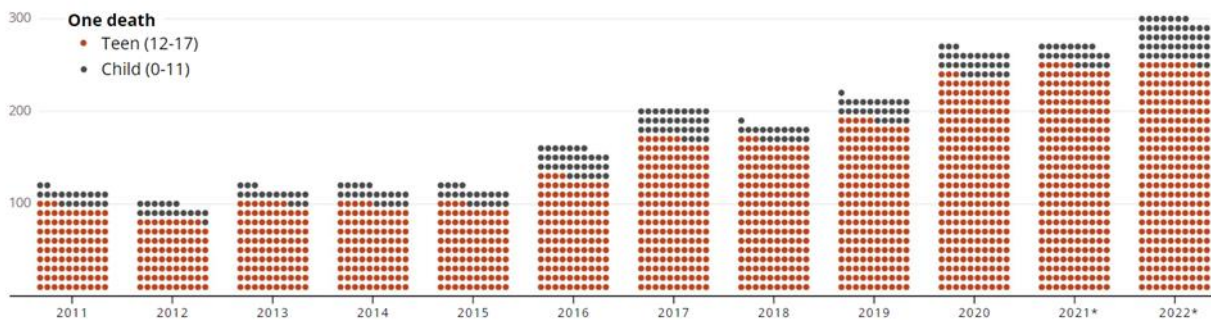
1 especially among children and adolescents. For example, among the 300 mass shootings reported in the
 2 U.S. during the first half of 2022 was the devastating school shooting in Uvalde, Texas.

3
 4 In an average year, 3,996 people in Texas die and 5,556 are wounded by firearms. Texas has the 28th
 5 highest rate of gun violence in the nation. In 2020 and 2021, firearms were the leading cause of death for
 6 children under age 19 in the U.S., and they are the leading cause of death among children and adolescents
 7 in Texas.

8
 9 As of Nov. 10, 2023, in the U.S., 5,507 children and teens (aged 0-17) were killed and injured as a result
 10 of gun violence. In Texas, an annual average of 430 children and adolescents lose their lives from firearms
 11 – suicide accounts for 36% of these deaths, and homicides account for 58%. A recent report citing Texas
 12 Department of State Health Services’ data shows that 295 Texans younger than age 18 died from gunshots
 13 in 2022. From February 2022 to October 2023, 28 victims were killed in a school shooting in Texas, and
 14 25 victims were injured. The shooting at Robb Elementary School in Uvalde accounts for most of these
 15 deaths. The graph below illustrates the rise in deaths attributable to gunshots in Texas.

16
 17 **Guns are killing Texas youths**

18 A total of 295 Texans younger than 18 died from gunshots last year. Each of the dots below represents one of those Texans who lost their life to guns.



*Data for 2021 and 2022 is not final.

Note: Numbers in this chart include homicides, suicides, accidental shootings and all other undetermined firearm-related causes of death.

Source: Texas Department of State Health Services

Credit: Susie Webb

30
 31
 32
 33 **Emergency Medicine Education in Schools**

34 A coalition of physician, military, law enforcement, and first responders developed Stop the Bleed kits and
 35 training, a hemorrhage control program, after a 20-year-old gunman murdered 20 children and six adults at
 36 Sandy Hook Elementary School in Newtown, Conn., in 2012. At the time of STB’s development,
 37 community leaders and advocates supported STB as an intervention for victims of mass shootings who do
 38 not make it to the hospital in time for life-saving treatment. Because of the hospital-grade level of items
 39 offered within STB, participants must be trained to understand how to use the products for hemostasis. The
 40 training encourages laypeople to apply pressure to wounds, pack them, and apply tourniquets above the
 41 wounds to reduce blood loss. These kits contain tourniquets, compression bandages, and blood-clotting
 42 hemostatic gauze to aid in stopping excessive blood loss – hence the name. Kits range from \$50 to more
 43 than \$1,000 and have been deployed nationwide to many schools and other sites, particularly those far from
 44 hospitals, e.g., in rural towns. To date, STB has trained more than 3 million people in emergency
 45 hemorrhage control techniques across the U.S.

46
 47 Importantly, while STB began as an initiative to help laypeople respond to traumatic wounds following a
 48 mass shooting, the training extends to other types of accidents or injuries where excessive blood loss can
 49 occur. Emergency response trauma kits, such as STB, function as an extension of first aid. Many states,
 50 including California, enacted legislation to promote the distribution of these kits statewide to schools and
 51 train personnel in their use. However, survey data collected from adult training participants (average age

1 48 years old) from 2017 to 2018 show less than 4% of respondents used the techniques. Few studies have
2 looked at the effectiveness or safety of this training in children in public schools, as most of the safety
3 education has been aimed at teachers, nurses, and other school staff. One study in Seattle looked at pre- and
4 post-STB training surveys of 31 public high school students in grades 9-12. They reported increased
5 comfort with emergency hemorrhage control protocols and no concerns about the training being harmful.
6 However, the authors of this research recommended more training be done to confirm their results.
7

8 Most states require teachers and other school staff to train in cardiopulmonary resuscitation (CPR) and first
9 aid, commonly used life-saving techniques. CPR, invented in the 1960s, involves mouth-to-mouth
10 breathing and chest compressions. In 2013, Texas passed a law requiring all students in grades 7-12 to take
11 at least one CPR course before graduating from high school. In the Fort Worth area, children as young as
12 fifth graders have been taught CPR in schools, although most programming across U.S. public school
13 settings focuses on high schoolers. A systematic review of 14 studies outlined the effectiveness of school-
14 based training, which showed that these programs enhance knowledge and skills in adolescents in how to
15 deliver CPR. The review calls for a randomized controlled trial to prove the effectiveness of these trainings
16 in preventing morbidity and mortality. CPR training can be provided easily because of the low cost of
17 training and no need for external medical/first-aid tools or kits.
18

19 In contrast, STB has been around for only a decade and requires equipment typically reserved for first
20 responders and military medics. Medical schools are still in the process of adding these training courses to
21 their curriculum. In a survey of STB course participants, first responders are twice as likely as other groups
22 to use these skills. Because of the high cost of the training in addition to the low utility for laypeople, some
23 surgeons have called for training focused only on high-yield groups such as first responders rather than
24 mass education.
25

26 **Texas Legislature and Hemorrhage Control Training**

27 In 2019, the Texas Legislature passed House Bill 496 requiring Texas schools to have a plan called the
28 “traumatic injury response protocol.” TMA and several other state specialty societies, including the Texas
29 Pediatric Society, supported the bill. This plan calls for schools to have kits called “bleeding control
30 stations” that contain tourniquets, chest seals, compression bandages, bleeding control bandages,
31 emergency space blankets, gloves, markers, scissors, and instructional documents detailing methods to
32 prevent blood loss following a traumatic event. These kits should be in easy-to-reach places chosen by the
33 school safety committee. The law also requires that certain school staff, like security personnel and school
34 resource officers, be trained to use these kits. The traumatic injury response protocol also must require each
35 school district and open-enrollment charter school to annually offer instruction on the use of a bleeding
36 control station to students enrolled at the campus in grade 7 or higher. The instruction must be provided by
37 a school resource officer or other appropriate district or school personnel who have received the state-
38 approved training.
39

40 Texas Education Agency (TEA) approved bleeding control trainings are Stop the Bleed; Bleeding Control
41 Basics; the University of Texas Southwestern Medical Center at Dallas Department of Emergency
42 Medicine’s Campus Emergency Preparedness and Survival Training; and Williamson County Emergency
43 Medical Services Hemorrhage Control.
44

45 **Note that while traumatic injury response protocols and bleeding control stations are offered,**
46 **bleeding control trainings are not part of the Texas public school curriculum.** The State Board of
47 Education sets the public school curriculum in Texas. (Health education and curriculum standards are
48 outlined within the Texas Administrative Code, Title 19 Education, Part 2 Texas Education Agency,
49 Chapter 115 Texas Essential Knowledge and Skills for Health Education.)
50

1 In the aftermath of Texas' deadliest school shooting in Uvalde, House Bill 1147, which did not pass during
2 the 2023 legislative session, proposed to lower the training threshold to include elementary school children
3 (starting training from third grade). The Texas Elementary Principals and Supervisors Association opposed
4 this bill, with a representative noting that it doesn't make sense for a child to be involved with this type of
5 training.

6
7 State lawmakers did pass House Bill 3, effective September 2023, which expands and strengthens existing
8 school safety initiatives, including the mandate for more school staff to undergo mental health training. It
9 also provides schools with additional options for allocating safety funds and establishes a new safety and
10 security department within TEA, overseen by Gov. Greg Abbott's appointed chief of school safety and
11 security. This bill requires school district boards to determine the appropriate number of armed security
12 officers for each campus, ensuring at least one security officer is at each school campus, with certain
13 exceptions.

14
15 Testimonies from parents of the Uvalde victims called for stricter gun regulations during the 2023 regular
16 legislative session. While there was a heightened emphasis on school safety, the concerns from these
17 parents' testimonies were not addressed. Uvalde victims' families advocated for a bill that would raise the
18 minimum age for purchasing assault rifle-style weapons from 18 to 21, which failed to pass, along with
19 various other proposed firearm safety measures.

20 21 **Impact of Active Shooter Drills on Mental Health**

22 Concurrently with other efforts to prevent firearm injuries and deaths in schools, rising concerns over school
23 violence have led educational institutions to conduct active shooter drills. These drills, designed to
24 familiarize students and teachers with potential threats and equip them with crisis response skills, can carry
25 profound psychological repercussions. Children are the first generation to undergo regular and structured
26 active shooter drills as a routine part of their schooling experience, and the normalization of such drills
27 raises critical questions about the long-term impact on students' mental health and well-being.

28
29 A study of 815 participants aged 14-24 illustrates the impact of gun violence and active shooter drills on
30 students' emotional state. The findings reveal that more than 60% of the surveyed youth reported feeling
31 unsafe, scared, helpless, or sad as a result of these drills. Conflicting perspectives among students regarding
32 the effectiveness of the drills highlight the need for alternative approaches that prioritize psychological
33 well-being. As active shooter drills become increasingly commonplace, educators, administrators, and
34 policymakers must acknowledge the potential mental health implications and explore strategies to bolster
35 behavioral health care in school settings.

36
37 While 95% of American public schools conduct lockdown active shooter drills, there is limited evidence
38 of their effectiveness in preventing school shootings. Given that only 0.2% of gun deaths occur on school
39 grounds annually, the widespread adoption of drills prompts careful examination of their potential, yet
40 unproven benefits against the detrimental impact on mental health and well-being.

41
42 The Everytown for Gun Safety Support Fund conducted research in collaboration with the Georgia Institute
43 of Technology's Social Dynamics and Wellbeing Lab to investigate the immediate and long-term impacts
44 of active shooter drills. The study analyzed social media conversations surrounding 114 K-12 schools
45 before and after drills. Active shooter drills were associated with increases in stress and anxiety (42%),
46 depression (39%), and physiological health problems (23%), affecting individuals of all ages, including 5-
47 year-olds, high schoolers, parents, and teachers. The results urge for a shift toward more mindful and
48 proactive approaches to address school violence.

49
50 The American Academy of Pediatrics (AAP) announced its opposition to high-intensity active shooter
51 simulations in 2020. The AAP suggested making accommodations for school students who may have had

1 previous traumatic experiences or who are otherwise at a higher risk of negative reactions. In 2021, the
2 National Association of School Psychologists, the National Association of School Resource Officers, and
3 Safe and Sound Schools released guidance on school lockdown drills, recommending getting parental
4 permission and training staff to recognize trauma signs. In 2022, motivated by Georgia Tech’s research,
5 lawmakers in Washington state passed a bill prohibiting school lockdown drills from involving lifelike
6 simulations or reenactments that are not “trauma-informed and age and developmentally appropriate.”
7 Researchers agree that further study is needed to understand the long-term impacts of lockdown drills.

8
9 In the same vein, countermeasures that schools use to mitigate the risk of gun violence, such as the use of
10 metal detectors and armed guards, often yield unintended consequences, contributing to students feeling
11 less safe than students in schools without such interventions. The anticipation of violence in educational
12 settings contributes to heightened anxiety, fear, and depression among students and their families. Placing
13 armed officers in schools does not prevent gun-related incidents, and it may potentially contribute to
14 increased mortality rates.

15
16 In parallel, **the efficacy of emergency hemorrhage control education remains unverified without a**
17 **comprehensive evaluation of its impact on mental health in children.** Despite the prevailing assumption
18 that such drills and trainings enhance safety, negative emotions reported by a significant number of children
19 and adolescents suggest the imperative to prioritize discussion-based exercises addressing emotional well-
20 being. Recommendations include involving school psychologists in drill planning, providing advance
21 notice to stakeholders, tailoring content appropriate to age, integrating support systems to address student
22 mental health, and conducting ongoing assessments of school safety interventions. Addressing the complex
23 interplay between school shootings and mental health requires a nuanced approach to alleviate these
24 alarming trends.

25 26 **Need for Increased Mental/Behavioral Health Research**

27 In 2019, children accounted for approximately 25% of victims in all mass shootings and were more likely
28 to be victims of gun violence within their homes. This highlights the multifaceted challenges and impacts
29 associated with pediatric firearm injuries and the need for comprehensive and preventive strategies to
30 address them.

31
32 The associated financial burden of childhood firearm injuries is substantial, exceeding \$700 million in costs
33 to U.S. taxpayers. This financial strain extends to families because of the cost of life-saving interventions,
34 such as high-quantity blood transfusions, surgery, and interventional radiology procedures. The aftermath
35 involves close follow-ups and complications, with 43% of cases requiring hospital readmission.
36 Additionally, the long-term mental health consequences are significant, with almost half of firearm victims
37 at risk for post-traumatic stress disorder.

38
39 Unfortunately, for more than two decades, Congress has hindered federal funding for certain gun violence
40 research through the Dickey Amendment, which prohibits the use of funds for advocating for or promoting
41 gun control. The amendment originated in response to efforts treating gun violence as a public health issue
42 in the early 1990s. In 2018, a compromise was introduced through an omnibus spending bill, clarifying that
43 while the amendment still existed, it did not prevent federal funding for research on the *causes* of gun
44 violence.

45 46 **Need for Increased Mental/Behavioral Health Services**

47 The mental health crisis among youth is alarming. There has been a 47% increase in suicide rates among
48 U.S. youth between 2007 and 2018, making suicide the third leading cause of death among 10-19-year-
49 olds. The COVID-19 pandemic exacerbated this crisis between 2019 and 2022. Nearly 20% of children and
50 adolescents are diagnosed with a mental health disorder, with many more experiencing symptoms that
51 impact their well-being and physical health. Mental health conditions, when left untreated, can lead to

1 negative outcomes, underscoring the importance of early diagnosis and treatment. Recognizing the
2 correlation between mental health and potential violence, it is crucial to increase access to comprehensive
3 mental health services.
4

5 Most people diagnosed with a mental health condition, even a severe one, rarely commit mass violent
6 crimes. This is important to note, so that people who need mental health services feel safe seeking care
7 without fear of stigma. More often, people diagnosed with a mental health condition are victims of violence,
8 including self-inflicted harm. Increased state funding for accessible mental health services to youth can
9 address immediate concerns and prevent future negative health outcomes.
10

11 **Discussion and Recommendations**

12 Physician member volunteers from the Committee on Child and Adolescent Health and the Committee on
13 Emergency Services and Trauma convened to discuss this resolution, assess the research, share relevant
14 perspectives and expertise, and determine their proposed recommendation. Key discussion points from the
15 workgroup meetings regarding emergency hemorrhage control training in educational settings are as
16 follows:
17

- 18 • *Voluntary training among adults:* The workgroup recommends interested adults, such as school staff,
19 voluntarily undergo emergency hemorrhage control training rather than mandating emergency
20 hemorrhage control training within students' curriculum. It is important to note that the average age of
21 individuals undergoing emergency hemorrhage control training is about 37 years old.
- 22 • *Texas' Stop the Bleed Campaign:* The 2019 Texas Legislature supported the STB campaign through
23 House Bill 496, which Governor Abbott signed into law. The bill requires the TEA to approve training
24 for the use of a bleeding control station in the event of an injury to another person. Once again, the
25 workgroup notes the importance for interested adults to undergo training while not putting the onus on
26 schoolchildren.
- 27 • *Emergency hemorrhage control training might not be age-appropriate:* The workgroup notes that it is
28 not practical to assign responsibility for emergency hemorrhage control training to middle and high
29 school students. Further evaluation is required to determine the appropriateness of such training for
30 youth, including more research regarding potential mental and behavioral health impacts. The
31 possibility of trauma resulting from these training courses warrants careful consideration.
- 32 • *Cost implications:* Mandates for emergency hemorrhage control training and associated equipment may
33 impose significant costs on school districts. The workgroup also notes the uncertainties surrounding
34 the implementation of such programs in schools. With a use rate of 4% in a targeted audience of first
35 responders from a small study, we can infer that the skills will be used less frequently by children,
36 although more study is needed.
- 37 • *Behavioral health support:* The workgroup notes that funding given to promote emergency hemorrhage
38 control training and kits could instead be allocated to bolstering behavioral health services within
39 educational institutions. Both committees support increased access to mental and behavioral health
40 services and support within schools.
- 41 • *Efficacy of training:* The efficacy of emergency hemorrhage control education (such as STB), as well
42 as active shooter drills, remains uncertain. While there is an assumption that such trainings enhance
43 safety, a significant number of children and adolescents report negative emotional consequences. This
44 underscores the need to prioritize alternative exercises addressing emotional well-being.
45

46 These considerations reflect the challenges and opportunities associated with implementing emergency
47 hemorrhage control training within public school curriculums. Following an extensive discussion, both
48 committees concluded that despite the good intent behind this resolution, the existing research does not
49 lend support to implementing emergency hemorrhage control training programs for children and
50 adolescents within school settings.

1
2 **Recommendation:** Not adopt Resolution 317 2023 – Incorporating Emergency Hemorrhage Control Into
3 School Curriculum.

4
5 **Related TMA Policies:**

6 [100.031 Hemorrhage Control Supplies in First Aid Kits](#)

7 [260.015 Firearms](#)

8 [260.130 Reducing Intimate Partner Homicide](#)

9 [55.019 Comprehensive School Health Education](#)

10
11 **Related AMA Policies:**

12 [H-130.935 Support for Hemorrhage Control Training](#)

13 [H-130.934 The Intracranial Hemorrhage Anticoagulation Reversal Initiative](#)

14 [H-145.983 School Violence](#)

15 [D-145.992 Further Action to Respond to the Gun Violence Public Health Crisis](#)

16 [D-145.995 Gun Violence as a Public Health Crisis](#)

17 [H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death](#)

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 301
2024

Subject: Amateur Radio: Reliable Medical Communication When All Else Fails

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

1 Whereas, Health care systems and processes are increasingly dependent on technology such as electricity,
2 cell phones, cable/wireless internet, satellites, and the like; and
3

4 Whereas, All these technologies have limitations and are vulnerable in various ways, e.g., a cyberattack
5 taking down the internet, hurricanes destroying cable facilities, wildfire smoke blocking satellites, solar
6 flares disrupting/destroying satellites and/or the power grid; and
7

8 Whereas, In an event when conventional communication is not possible, volunteer amateur radio
9 operators (including those in Amateur Radio Emergency Services and Radio Amateur Civil Emergency
10 Services) are available to provide local and regional communication capability for the American Red
11 Cross, hospitals, geriatric care facilities, health care coalitions, first responders, law enforcement, local
12 government entities, and others; and
13

14 Whereas, Volunteer amateur radio operators can provide both analog voice and digital communications
15 (emails, text messages, more than 100 pre-made forms, and digital pictures) to transmit and receive local,
16 regional, statewide, countrywide, and global information; and
17

18 Whereas, The disaster availability of amateur radio is underappreciated and underfunded; and
19

20 Whereas, Amateur radio has more than 100 years of history as a proven and reliable alternative
21 communication system when all else fails; and
22

23 Whereas, When electricity is not available and all forms of conventional communication devices are
24 affected, amateur radio's simple infrastructure allows uninterrupted operation using batteries, gas/solar
25 generators, solar panels, and the like; therefore be it
26

27 RESOLVED, That the Texas Medical Association support the continued development of a reliable and
28 robust emergency communication infrastructure, such as amateur radio, that is not dependent on the grid
29 system or the internet at the local, regional, and statewide levels to meet the needs of the medical
30 community, served agencies, first responders, government entities, and the community at large.
31

32 **Related TMA Policy:**

33 [100.008 Statewide Emergency Communication Network System](#)
34

35 **Related AMA Policy:**

36 [H-130.998 Special Amateur Radio Bands for Medical Emergencies](#)
37

38 Our AMA supports the allocation of a special band of radio frequencies for emergency health services.
39

39 **Reference:**

Res 301 2024

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 302
2024

Subject: Disposal of E-cigarettes and E-cigarette-related Products

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

1 Whereas, U.S. teens and adults are buying roughly 12 million disposable vapes per month; and
2
3 Whereas, Health issues are known to be associated with the use of e-cigarettes and e-cigarette-related
4 products; and
5
6 Whereas, Nonrefillable e-cigarettes contain nicotine, lithium, and other metals that cannot be reused; and
7
8 Whereas, Under current federal regulations, these products can be disposed of in a typical garbage
9 container; and
10
11 Whereas, Rechargeable batteries have been linked to explosions; and
12
13 Whereas, Liquid nicotine can be absorbed through the skin and cause accidental poisoning; and
14
15 Whereas, The Food and Drug Administration has tips for safe disposal of e-cigarettes and nicotine waste;
16 and
17
18 Whereas, The Texas Medical Association and American Medical Association have policies addressing e-
19 cigarette use and regulations; and
20
21 Whereas, TMA has policies on the disposal of unused medications and polystyrene foam medication
22 case(s) with or without ice packs; therefore be it
23
24 RESOLVED, That the Texas Medical Association educate its members and encourage the education of the
25 public on the importance of the proper disposal of e-cigarettes and their accessories; and be it further
26
27 RESOLVED, That the Texas Medical Association support legislation that would require (1) an additional
28 fee/tax (e.g., \$2) to be collected at the point of retail sale to be used for public education in Texas focused
29 on the proper disposal of e-cigarettes and e-cigarette-related accessories; and (2) a return deposit fee
30 collected at retail that is sufficient to encourage returns of e-cigarettes and e-cigarette-related accessories.
31
32 **Related TMA Policy:**
33 [315.030 Physicians and Regulation of Electronic Cigarettes](#)
34 [315.031 Restricting the Sale of Electronic Cigarettes to Minors](#)
35 [95.042 Promoting Safe and Effective Disposal of Unused Medications](#)
36 [95.047 Promoting Safe and Effective Disposal of Polystyrene Foam Medication Case\(s\) With or Without](#)
37 [Ice Packs](#)

1 **Related AMA Policy:**

2 [D-495.992 Legal Action to Compel FDA to Regulate E-Cigarettes](#)

3 [H-495.986 Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems \(ENDS\)](#)
4 [and E-cigarettes](#)

5

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 303
2024

Subject: Dedicated On-Site Physician Requirement for Emergency Departments

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

1 Whereas, Facility designations using the term “emergency” within their title are reasonably presumed to
2 offer full-service emergency duties and services; and
3

4 Whereas, Patients seeking emergency medical care search for facilities prepared to offer full-service
5 evaluation and medical diagnosis for undifferentiated acute symptoms, recognition and stabilization of
6 emergency conditions, and appropriate emergency treatment with transfer to a higher level of care for
7 emergency conditions when appropriate; and
8

9 Whereas, In the state of Texas, physicians are the only health professionals authorized to practice
10 medicine without limitation; and
11

12 Whereas, Having nonphysician medical providers with off-site physician collaboration implies a lower
13 degree of physician involvement in patient care than direct physician supervision, inasmuch as
14 collaboration may imply mere consultation with the physician only when deemed necessary by the
15 nonphysician practitioner, which is often inadequate for emergency medical care; and
16

17 Whereas, The American College of Emergency Physicians, in a policy statement released June 2023, said
18 the standard for physician supervision of nonphysician practitioners (such as nurse practitioners and
19 physician assistants) in the emergency department is for the licensed physician to have real-time
20 opportunity to be involved in the contemporaneous care of any patient presenting to the emergency
21 department and seen by a physician assistant or nurse practitioner; and
22

23 Whereas, Every patient presenting to a facility in Texas that represents itself as a place where patients can
24 seek full-service emergency medical care should be under the direct real-time care of a licensed physician
25 including the on-site and real-time supervision of nonphysician practitioners; and
26

27 Whereas, The Texas Medical Association acknowledges current workforce limitations in specific Centers
28 for Medicare & Medicaid Services-designated facilities, including critical access hospitals and rural
29 emergency hospitals, in which supervision of a nurse practitioner or physician assistant by an emergency
30 physician may be provided “off-site” by telehealth; therefore be it
31

32 RESOLVED, That the Texas Medical Association support legislation requiring that all facilities in Texas
33 that bear the designation of emergency department, emergency room, or other like title, facility logo, or
34 design implying provision of full-service emergency medical care – with the exception of facilities
35 designated by the Centers for Medicare & Medicaid Services as critical access hospitals or rural
36 emergency hospitals – must have the real-time, on-site presence of and supervision of nonphysician
37 practitioners by a licensed physician with training and experience in emergency medical care when such
38 facilities are open; off-site physician collaboration with a nonphysician practitioner will not fulfill this
39 requirement.

Res 303 2024

1 **Related TMA Policy:**
2 [130.024 Physician Coverage of Hospital Emergency Departments](#)

3
4 **Related AMA Policy:**
5 [D-35.976 Promoting Supervision of Emergency Care Services in Emergency Departments by Physicians](#)

6
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 304
2024

Subject: Preparing for Future Policy Exigencies

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

1 Whereas, Public health emergencies are likely to continue into the future; and

2

3 Whereas, When those emergencies arise, the Texas Medical Association will be called upon to share its
4 position and provide insight and advice; therefore be it

5

6 RESOLVED, That the Texas Medical Association develop a set of guidelines to follow for future public
7 health emergencies on how facts can be identified quickly, how best to disseminate this knowledge and its
8 limitations, and how to offer suggestions regarding the most appropriate role for TMA.

9

10 **Related TMA Policy:**

11 None.

12

13 **Related AMA Policy:**

14 None.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 305
2024

Subject: Intentionally Promoting Trusting Relationships Between Patients and Medical Community

Introduced by: Young Physician Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, Medical literature demonstrates medical mistrust (across many areas of health care, such as in
2 vaccination, racial disparity, and cancer diagnosis and treatment) leads to poorer outcomes for patients;
3 and
4

5 Whereas, Increased trust “between patients and physicians as well as doctors and their organizations” can
6 reduce burnout and physician turnover; and
7

8 Whereas, The medical community (and American Medical Association policy) currently recognizes trust
9 as paramount in the patient-physician relationship; therefore be it
10

11 RESOLVED, That the Texas Medical Association acknowledge that a trusting patient-physician
12 relationship is a guiding principle in all activities and legislative efforts of the organization and express an
13 intention to support future efforts and policies that promote trust in patient-physician relationships and
14 within the medical community.
15

16 **Related TMA Policy:**

17 [245.021 Patient-Doctor Privileged Communication](#)

18 [245.003 Protections Against Interference in the Practice of Medicine and the Patient-Physician
19 Relationship](#)
20

21 **Related AMA Policy:**

22 [Code of Medical Ethics: 8.6 Promoting Patient Safety](#)

23 [Licensure and Discipline: Patient/Physician Relationship and Medical Licensing Boards H-275.937](#)
24 [Public Health: Digital Vaccine Credential Systems and Vaccine Mandates in COVID-19 H-440.808](#)
25

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 306
2024

Subject: Medication Supply Chain Transparency and Pricing

Introduced by: Women Physicians Section

Referred to: Reference Committee on Science and Public

1 Whereas, Almost all, if not all, practicing physicians have been unable to prescribe at least one
2 medication because of shortages, patient care is negatively affected; and
3

4 Whereas, Drug shortages existed pre-COVID, with articles being written for at least two decades prior
5 regarding the U.S. Food and Drug Administration’s role in responding to drug shortages. Such drug
6 shortages in the U.S. often involve generic medications because manufacturers have little financial
7 incentive to produce off-patent medications. This leaves only a few if not just one manufacturer to
8 produce a particular drug; and
9

10 Whereas, As of early 2023, supply chain gaps, manufacturing delays, and spikes in demand have resulted
11 in 309 ongoing drug shortages in the U.S. – the highest in nearly a decade. COVID further worsened the
12 supply chain disruptions; and
13

14 Whereas, Although the American Society of Health-System Pharmacists’ website has a list of current
15 drug shortages, it does not provide information on where the shortage is occurring or when or if the
16 medication will be put in production; and
17

18 Whereas, Some commercial payers penalize physicians through their contracts for not writing for generic
19 medications even when the generic equivalent is not available; and
20

21 Whereas, Such shortages delay appropriate care and can negatively affect patient outcome; therefore be it
22

23 RESOLVED, That the Texas Medical Association advocate for supply transparency by drug
24 manufacturers, wholesalers, and pharmacies to both physicians and health care providers when supply
25 shortfalls occur within their respective domains; and be it further
26

27 RESOLVED, That TMA advocate for legislation that would require payers to honor brand name
28 medications at the equivalent generic medication pricing when the equivalent generic is not available
29 because of a drug shortage; and be it further
30

31 RESOLVED, That our Texas Delegation to the American Medical Association take this resolution to the
32 AMA House of Delegates for consideration.
33

34 **Relevant TMA Policy**

35 None.
36

37 **Relevant AMA Policy**

38 [National Drug Shortage H-100.956](#)

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 307
2024

Subject: Reducing Disparities in Women’s Health Research

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, Females make up less than 50% of the population in the United States; and
2
3 Whereas, Females experience significant inequities in medicine, including longer wait times for
4 diagnosis and pain relief, or are more likely to be misdiagnosed or discharged during serious medical
5 events; and
6
7 Whereas, Sex and gender bias persists against female participants in clinical studies; and
8
9 Whereas, In nearly three-quarters of the cases where a disease afflicts primarily one gender, the funding
10 pattern favors males, in that either the disease affects more women and is underfunded (with respect to
11 burden) or the disease affects more men and is overfunded; and
12
13 Whereas, Women, specifically women of color, are underrepresented in clinical trials, limiting biological
14 understanding and contributing to health inequities and social injustice; and
15
16 Whereas, Women make up only 29% to 34% of participants in early-phase drug development trials,
17 limiting understanding of dosage safety and efficacy in females; and
18
19 Whereas, There remains a paucity of research trials directly targeting pregnant and lactating women; and
20
21 Whereas, There are significant gender disparities among National Institutes of Health (NIH) grant
22 recipients, with female principal investigators less likely to receive funding; and
23
24 Whereas, The h-index quantifies the amount and quality of research output and serves as a metric in
25 academic productivity; h-indices increase with higher academic rank, and men have overall higher scores
26 than their female colleagues; and
27
28 Whereas, To address gender and sex-related disparities in research, NIH has made the consideration of
29 sex as a biological variable a requirement for NIH-funded research; and
30
31 Whereas, The American College of Obstetrics and Gynecology recognizes the critical nature of women’s
32 health research, advocating for increased funding for and representation of women in research and a
33 reduction of barriers for pregnant and lactating women’s participation in research trials; therefore be it
34
35 RESOLVED, That our Texas Medical Association support legislation and measures that increase federal
36 and state funding for women’s health research, increase the representation of women and
37 underrepresented minorities in clinical research, and promote the safe inclusion of pregnant and lactating
38 women in research trials; and be it further
39
40 RESOLVED, That our TMA support legislation and measures that increase the representation of women
41 conducting research and promote the evaluation of disparities in women’s health research.

Related TMA Policy:[265.018 Evidence-Based Medicine and Practice](#)**Related AMA Policy:**[H-460.911 Increasing Minority, Female, and other Underrepresented Group Participation in Clinical Research](#)[H-525.988 Sex and Gender Differences in Medical Research](#)[8.5 Disparities in Health Care](#)[H-460.891 Mitigating Gender Bias in Medical Research](#)**References:**

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 308
2024

Subject: Naloxone Administration Training in Schools

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, Median monthly overdose deaths among U.S. adolescents more than doubled from 2019 to
2 2021, with 90% of increased deaths due to opioids and 85% due to illicit fentanyl; and

3
4 Whereas, the U.S. Food and Drug Administration in March 2023 approved Narcan for over-the-counter
5 sales, and officials have said it is safe for children of all ages; and

6
7 Whereas, Naloxone is now available over the counter and is safe for all ages, and children as young as 6
8 have demonstrated the ability to effectively administer naloxone; and

9
10 Whereas, Multiple Texas bills propose naloxone availability in middle and high schools and in
11 institutions of higher education, as well as overdose education for students and employees; and

12
13 Whereas, A study on the cost-effectiveness of school-based Narcan programs indicates that such
14 interventions are likely to cost less than \$50,000 per quality-adjusted life-year gained, demonstrating their
15 potential value in settings where overdose risks are significant; therefore be it

16
17 RESOLVED, That the Texas Medical Association support legislation for providing opioid overdose
18 reversal medications, education, and other resources to age-appropriate students and staff in elementary,
19 middle, and high schools and in institutions of higher education; and be it further

20
21 RESOLVED, That TMA forward this resolution to the American Medical Association House of
22 Delegates at its 2024 Annual Meeting.

Related TMA Policy:

23
24 [95.049 Encourage Equitable Access to Medication for Opioid Use Disorder](#)

25 [235.041 Buprenorphine Access for Opioid Substance Use Disorder Treatment](#)

26 [95.040 Addressing Prescription Drug Abuse and Overdose](#)

27 [260.092 Responsible Opioid Prescribing for Pain Management](#)

Related AMA Policy:

28
29 [D-95.987 Prevention of Drug-Related Overdose](#)

30 [H-95.908 Increase Access to Safe and Effective Overdose Reversal Medications in Educational Settings](#)

31 [H-95.932 Increasing Availability of Naloxone and Other Safe and Effective Overdose Reversal
32 Medications](#)

33 [D-95.981 Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of
34 Nonmedical Prescription Drug Use and Addiction](#)

35 [D-525.993 Education on Sex-Based Response to Opioids](#)

36 [D-95.972 Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder](#)

37 [D-95.965 Dispelling Myths of Bystander Opioid Overdose](#)

38 [H-95.905 Development and Implementation of Recommendations for Responsible Media Coverage of
39 Opioid Overdoses](#)

40
41

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 309
2024

Subject: School-Located Vaccination

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, School-located vaccination (SLV) clinics have expanded access to vaccination for students,
2 families, and school employees; and
3

4 Whereas, Schools play a vital role in educating caregivers and students about vaccination; and
5

6 Whereas, Children and adolescents living in disadvantaged communities may not have the means and
7 access to receive annual care and vaccinations at health care clinics; thus, they would benefit from having
8 the option to obtain vaccinations at school; and
9

10 Whereas, SLVs can lead to increased vaccination rates among students and employees, increase access to
11 and equity in vaccination for disadvantaged communities, and improve overall community health
12 outcomes; and
13

14 Whereas, SLVs have been shown to decrease morbidity and mortality related to vaccine-preventable
15 illnesses; and
16

17 Whereas, School-located influenza vaccination programs have been shown to significantly decrease
18 school absenteeism and influenza-related hospitalizations; and
19

20 Whereas, Some barriers to maintaining SLVs are inadequate staffing, inadequate payment for providers,
21 caregiver disagreement, and misinformation; and
22

23 Whereas, Vaccination rates among children in Texas public and accredited private schools have not risen
24 to prepandemic levels as of the 2022-23 school year; and
25

26 Whereas, Clinicians and parents identify transportation, difficulty taking time off work, and lack of child
27 care as reasons for missed well-child visits; and
28

29 Whereas, Existing Texas Medical Association Policy 135.012 Immunizations in Texas supports
30 vaccinations, with the exception of influenza vaccinations, for children and adolescents under the
31 direction of a Texas-licensed physician in the context of a preventive care exam; therefore be it
32

33 RESOLVED, That the Texas Medical Association support legislation which serves to invest in the
34 resources, training, physician reimbursement, and infrastructure for school-located influenza vaccinations;
35 and be it further
36

37 RESOLVED, That TMA support legislation to educate students, caregivers, and employees about
38 influenza vaccination at schools.
39

40 **Related TMA Policy:**
41 [260.080 Vaccine Delivery](#)

- 1 [135.030 Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic](#)
 2 [260.021 Sexually Transmitted Infections Prevention, Screening, and Education](#)
 3 [135.012 Immunizations in Texas](#)
 4 [50.008 HPV Vaccination](#)

5
 6 **Related AMA Policy:**

- 7 [H-60.923 Meningococcal Vaccination for School Children](#)
 8 [D-170.995 Human Papillomavirus \(HPV\) Inclusion in School Education Curricula](#)
 9 [H-60.969 Childhood Immunizations](#)
 10 [D-440.956 Expanding the Vaccines for Children Program](#)
 11 [H-440.992 National Immunization Program](#)
 12 [H-440.830 Education and Public Awareness on Vaccine Safety and Efficacy](#)
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 310
2024

Subject: Addressing Food Insecurity in Undergraduate and Graduate Schools

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, Several studies have demonstrated that more than 20% of undergraduate students are food
2 insecure; and

3

4 Whereas, One study with approximately 100,000 students, discovered that 23% of undergraduate students
5 and 12% of graduate students experience food insecurity, which are higher than those of the general
6 public; and

7

8 Whereas, Since the COVID-19 pandemic, about 33% of students have experienced food insecurity; and

9

10 Whereas, Students experiencing food insecurity are also about half as likely (43%) to graduate from
11 college, a situation that is particularly acute for first-generation students, of whom less than half are likely
12 to complete their education when experiencing food insecurity; and

13

14 Whereas, Recent reviews have found regular consumption of a minimum of two meals per day is linked
15 to elevated grade point average, and a diet of higher nutritional quality is consistently correlated with
16 improved academic outcomes in the youth demographic; and

17

18 Whereas, Food insecurity affects 47% of Black, 42% of Hispanic, and 46% of Pell Grant recipient
19 students at four-year institutions, contributing to disparities in educational attainment; and

20

21 Whereas, Public health experts and researchers have suggested increasing awareness of food insecurity on
22 campuses is vital, as is providing anonymous food sources (campus fridges or food pantries); and

23

24 Whereas, Awareness of campus food resources among first-generation college students is associated with
25 a 49% reduction in the likelihood of food insecurity compared with those without such knowledge;
26 therefore be it

27

28 RESOLVED, That the Texas Medical Association supports state and federal advocacy for policies and
29 funding to address food insecurity in higher education and educate students about resources available to
30 them.

31

32 **Related TMA Policy:**

33 [165.006 Supplemental Nutrition Assistance Program Reform](#)

34 [55.046 Recommendations for Ensuring the Health of the Adolescent Athlete](#)

35

36 **Related AMA Policy:**

37 [D-150.978 Sustainable Food](#)

38 [H-150.937 Improvements to Supplemental Nutrition Programs](#)

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 311
2024

Subject: Language Access Plans

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, More than one in three Texas households speak a language other than English; and
2
3 Whereas, Thirteen percent of Texans have limited English proficiency (LEP); and
4
5 Whereas, Nearly 3 million Texans with LEP speak Spanish at home, and more than 500,000 Texans with
6 LEP speak languages other than Spanish at home; and
7
8 Whereas, Vietnamese, Chinese (including Mandarin and Cantonese), and Arabic are among the top non-
9 Spanish languages spoken in Texas; and
10
11 Whereas, People with LEP are less likely to have routine health visits and more likely to defer needed
12 health care, which result in worse health care outcomes; and
13
14 Whereas, People with LEP are at higher risk of being uninsured than those who are English proficient;
15 and
16
17 Whereas, People with LEP experience difficulties because of language barriers throughout the enrollment
18 and renewal process for benefit programs, including lack of enrollment assistance and of forms or
19 interpreter services available in their preferred language; and
20
21 Whereas, Language access plans (LAPs) are formal documents that guide the provision of services to
22 individuals who are non-English speaking or have LEP; and
23
24 Whereas, LAPs prepare organizations and their staff to provide high-quality, equitable care to individuals
25 with LEP by establishing formal and clear protocols; and
26
27 Whereas, LAPs are currently in use by several Texas state agencies, including the Commission on
28 Environmental Quality, Department of Transportation, and Supreme Court; and
29
30 Whereas, Title VI of the Civil Rights Act of 1964 requires recipients of federal financial assistance to take
31 reasonable steps to provide meaningful access to people whose primary language is not English; and
32
33 Whereas, Under Section 1557 of the Affordable Care Act, entities receiving federal financial assistance
34 must undertake reasonable measures to ensure meaningful access to health programs and activities for
35 individuals with LEP; and
36
37 Whereas, The Texas Medical Association acknowledges the requirement that covered entities
38 accommodate people with LEP in accordance with Title VI and Section 1557; and
39
40 Whereas, The Texas Health and Human Services Commission does not currently have a LAP; therefore
41 be it

1 RESOLVED, That the Texas Medical Association support the development of language access plans
2 (LAPs) in the Texas Health and Human Services Commission; and be it further

3
4 RESOLVED, That TMA support the implementation of LAPs at institutions including but not limited to
5 hospitals, health care centers, and state agencies; and it be further

6
7 RESOLVED, That TMA support the creation of LAPs that encompass commonly spoken languages,
8 including but not limited to Spanish, Vietnamese, Chinese, Arabic, and other common non-English
9 languages spoken in Texas to address the diverse linguistic needs of residents.

10
11 **Related TMA Policy:**

12 [265.022 Improving Patient Care Quality by Decreasing Comm Errors from Language Barriers](#)

13
14 **Related AMA Policy:**

15 [H-315.963 Accurate Collection of Preferred Language and Disaggregated Race and Ethnicity to](#)
16 [Characterize Health Disparities](#)

17 [H-350.956 Increasing Access to Healthcare Insurance for Refugee Populations](#)

18 [D-385.978 Language Interpreters](#)

19 [H-160.924 Recently Modified Use of Language Interpreters in the Context of the Patient-Physician](#)
20 [Relationship](#)

21 [H-160.914 Recently Modified Support of Multilingual Assessment Tools for Medical Professionals](#)

22 [H-160.931 Recently Modified Health Literacy](#)

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 312
2024

Subject: Public Transportation

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

- 1 Whereas, According to the American Hospital Association, each year around 3.6 million Americans are
2 unable to obtain the medical care they need because of transportation limitations; and
3
4 Whereas, Limited access to transportation options can disproportionately affect underserved communities,
5 contributing to health disparities and reduced access to medical care, employment opportunities,
6 nutritious food, and other essential services; and
7
8 Whereas, Patients frequently identify transportation barriers as a major reason for missing health care
9 appointments; and
10
11 Whereas, In Texas, particularly, some estimates have indicated that nearly 90% of Medicaid recipients
12 receiving welfare benefits do not own a private automobile, yet Texas Medicaid transportation programs
13 for non-emergency medical transportation provide services for just 7% of Medicaid recipients; and
14
15 Whereas, The Texas Sunset Advisory Commission issued the following statement in a 1998 report:
16 “Transportation is among the most frequently cited barriers to service delivery for health and human
17 services clients in Texas”; and
18
19 Whereas, Missed appointments are associated with increased medical care costs for the patient, disruption
20 of patient care, delayed care, and increased emergency department visits, ultimately costing the health
21 system \$150 billion each year; and
22
23 Whereas, Expanding access to public transportation can lead to improved health outcomes by enabling
24 individuals to access medical appointments, ultimately reducing health care costs; and
25
26 Whereas, The U.S. transportation sector is responsible for more greenhouse gas emissions than any other
27 sector of the economy, with transportation accounting for a third of emissions; and
28
29 Whereas, Public transportation initiatives can reduce traffic congestion, air pollution, and greenhouse gas
30 emissions, mitigating the impact of climate change, which is closely linked to various health-related
31 issues; and
32
33 Whereas, Access to reliable and affordable transportation is an essential determinant of an individual’s
34 health and well-being, influencing health care access, social participation, and overall quality of life; and
35
36 Whereas, Existing Texas Medical Association policy does not cover public transportation; therefore be it
37
38 RESOLVED, That the Texas Medical Association support policies that prioritize the maintenance,
39 accessibility, expansion, and improvement of public transportation systems.
40
41 **Related TMA Policy:**

1 None.

2

3 **Related AMA Policy:**

4 [H-130.954 Non-Emergency Patient Transportation Systems](#)

5 [H-135.939 Green Initiatives and the Health Care Community](#)

6 [H-425.993 Health Promotion and Disease Prevention](#)

7 [H-15.992 Motor Vehicle Accidents](#)

8 [H-15.990 Automobile-Related Injuries](#)

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 313
2024

Subject: Balancing Motherhood and Medicine: Advocating for Support for Working Women
Physicians Against Added Barriers They Face

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, The number of active, practicing women physicians in the United State has risen from 28% in
2 2008 to 37% in 2022; and
3
4 Whereas, Physician mothers face unique challenges related to family leave policies that their male or
5 paternal counterparts do not; and
6
7 Whereas, Physician mothers face stress and guilt related to burdening colleagues during family leave; and
8
9 Whereas, Physician mothers face long work hours and lack of part-time opportunities, particularly during
10 residency; and
11
12 Whereas, Physicians mothers lack adequate childcare services and encounter breastfeeding challenges
13 while working; and
14
15 Whereas, Physician mothers face the risk of complications during pregnancy; and
16
17 Whereas, Women physicians delay pregnancy, leading to increased risk of miscarriage, infertility and
18 pregnancy complications compared with nonphysician mothers; and
19
20 Whereas, Physician mothers experience maternal discrimination, which in turn can limit or even prevent
21 them from achieving academic advancements; and
22
23 Whereas, The Texas Medical Association already advocates equal opportunities for women and opposes
24 gender discrimination in the medical field; therefore be it
25
26 RESOLVED, That the Texas Medical Association encourage increased resources and assistance for
27 working physician mothers in balancing their dual identities, such as childcare, to prevent the
28 development of gender discrimination and unequal opportunity.
29

30 **Related TMA Policy:**

31 [245.023 Equal Pay for Equal Work](#)

32 [245.010 Physician Discrimination](#)

33 [245.005 Age Discrimination](#)

34 [245.016 Physician Reentry Into Practice](#)

35 [245.024 Support Addressing, Screening, and Providing Healthy Coping Mechanisms for Burnout](#)

36 [245.025 Workplace Bullying in the Practice of Medicine](#)

37

38 **Related AMA Policy:**

39 [H-525.998 Women in Organized Medicine](#)

40 [D-65.989 Advancing Gender Equity in Medicine](#)

- 1 [H-65.961 Principles for Advancing Gender Equity in Medicine](#)
- 2 [H-245.982 AMA Support for Breastfeeding](#)
- 3 [H-525.973 Increasing Access to Hygiene and Menstrual Products](#)
- 4 [D-345.997 Access to Mental Health Services](#)
- 5 [H-200.954 US Physician Shortage](#)
- 6

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 314
2024

Subject: Fighting Period Poverty in the Health Care Field: Improving Access to Menstrual Hygiene Products for Health Care Workers

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, In 2021, 16.4 million women were employed in a health care setting, equating to 77.6% of the
2 total 21.2 million workers in the industry; and
3

4 Whereas, Period poverty is the public health issue described as the lack of access to period or menstrual
5 hygiene products; and
6

7 Whereas, Many health care workers often experience period poverty in their health care workplace, as
8 these workplaces and health care spaces typically do not provide easy access to free menstrual products;
9 and
10

11 Whereas, The topic of menstruation remains taboo, and women in the workplace often feel stigmatized
12 when bringing it up in their professional settings; and
13

14 Whereas, As a result of menstruation stigma and period poverty in the workplace, women are left with
15 increased stress, social isolation, and in some cases depression and anxiety; and
16

17 Whereas, Women are often forced to practice unsafe and unhealthy menstrual practices, such as
18 prolonged use of a tampon or even paper towels, which put them at risk for infections; and
19

20 Whereas, Research has shown that women with poor menstrual hygiene habits – usually due to a lack of
21 access to disposable menstrual hygiene products – have a higher prevalence of urogenital infections, with
22 30.1% of these women developing bacterial vaginosis; and
23

24 Whereas, These negative effects have implications for patient care because health care workers caring for
25 patients in a state of distress may not perform at their best, and the health and safety of patients may be at
26 risk; therefore be it
27

28 RESOLVED, That the Texas Medical Association support the easy access to free menstrual products in
29 clinics, hospitals, and other health care spaces to aid in the support of their health care workers; and be it
30 further
31

32 RESOLVED, That TMA advocate for legislation and encourage public and private health care spaces to
33 increase access to menstrual hygiene products especially to ensure equitable access to health care
34 workers.
35

36 **Related TMA Policy:**

37 [330.016 Tax Exemption for Feminine Hygiene Products](#)

38 [260.075 Preventive Health Care for Texas Women](#)

39 [200.006 Inclusion of Medical Students in Protections for Health Care Workers](#)

40

Related AMA Policy:

- 2 [H-525.973 Increasing Access to Hygiene and Menstrual Products](#)
- 3 [H-525.974 Considering Feminine Hygiene Products as Medical Necessities](#)
- 4 [H-525.981 Discrimination of Women Physicians in Hospital Locker Facilities](#)
- 5 [H-525.998 Women in Organized Medicine](#)
- 6 [D-525.994 Gender Equity in Hospital Medical Staff Bylaws](#)

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 315
2024

Subject: Promoting Mobile Mammography Units in Medically Underserved Regions

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

- 1 Whereas, Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer
- 2 deaths in women in the United States; and
- 3
- 4 Whereas, Regular mammography screenings can detect breast cancers at early stages, when interventions
- 5 are more effective and prognoses are better; and
- 6
- 7 Whereas, Mammography screening results in a 41% reduction in mortality and a 25% reduction in the
- 8 incidence of advanced-stage breast cancers; and
- 9
- 10 Whereas, Lack of participation in screening mammography is linked to social determinants of health,
- 11 such as lower education and income levels, lack of transportation, less access to care, and less expensive
- 12 housing; and
- 13
- 14 Whereas, Low-income individuals from racial or ethnic minority groups are 30% more likely to be
- 15 diagnosed with late-stage breast cancer than higher-income individuals from racial or ethnic minority
- 16 groups, due in part to low rates of screening mammography and poor access to care; and
- 17
- 18 Whereas, Mobile mammography units (MMUs) are vehicles that contain mammography equipment that
- 19 can be driven to various locations, and they have been widely successful in increasing breast cancer
- 20 screening adherence; and
- 21
- 22 Whereas, MMUs are equipped with high-quality technology and staffed by board-certified technologists
- 23 and interpreting physicians in accordance with American College of Radiology accreditation guidelines;
- 24 and
- 25
- 26 Whereas, MMUs had a recall rate of 7% and a cancer detection rate of 4.5 per 1,000 mammograms,
- 27 which align with optimal recall and early breast cancer detection rate recommendations; and
- 28
- 29 Whereas, The patient population of MMUs primarily consists of individuals from low-income and/or
- 30 racial or ethnic minority backgrounds, with more than 55% of patients being uninsured and 71% of
- 31 patients identifying as a racial or ethnic minority, compared with 15% at traditional breast cancer
- 32 screening facilities; and
- 33
- 34 Whereas, One MMU intervention helped avoid nearly \$1.2 million in health care costs by decreasing
- 35 emergency department visits from breast cancer complications by more than 1,100 visits over the span of
- 36 four years; and
- 37
- 38 Whereas, MMUs reduce geographic and socioeconomic disparities and increase cost-effectiveness in
- 39 breast cancer screening with a gain in participation among women living in areas more than nine miles
- 40 (15 kilometers) from a breast cancer screening facility; and

1 Whereas, Despite low accessibility to mammographic facilities in rural and medically underserved
2 regions, MMUs were sub-optimally dispatched to these locations, considering that MMUs were only
3 dispatched 23% of days within the study window; therefore be it

4
5 RESOLVED, That the Texas Medical Association recognize the role of mobile mammography units in
6 breast cancer screening for individuals in medically under-resourced regions; and be it further

7
8 RESOLVED, That TMA support the appropriate stakeholders in identifying optimal locations for mobile
9 mammography units.

10
11 **Related TMA Policy:**

12 [330.002 Mammography](#)

13 [50.009 Cancer Screening](#)

14 [50.012 Addressing Cancer Health Disparities](#)

15
16 **Related AMA Policy:**

17 [H-525.986 Guidelines and Medicare Coverage for Screening Mammography](#)

18 [H-525.993 Screening Mammography](#)

19 [H-525.998 Mammography Screening for Breast Cancer](#)

20
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 316
2024

Subject: Reversing Rising Rates in Syphilis and Congenital Syphilis

Introduced by: LGBTQ Health Section and Women Physicians Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, The Texas Department of State Health Services (DSHS) reports that Texas congenital syphilis
2 rates have risen 300% since 2017; and
3

4 Whereas, Existing Texas Medical Association policy supports increased local, state, and national efforts
5 to reduce sexually transmitted infections, including syphilis, gonorrhea, human papillomavirus, and
6 chlamydia, through professional and public education and through DSHS, Centers for Disease Control
7 and Prevention, and National Institutes of Health mitigation activities; and
8

9 Whereas, Existing TMA policy strongly recommends that all individuals with syphilis, HIV infection,
10 and AIDS be reported to the local health authority or DSHS by name, city, age, sex, race, treating
11 physician, disease, type of diagnosis, and date of onset in accordance with state law; and further, TMA
12 approves seeking legislative action to authorize contact tracing by DSHS for all individuals diagnosed
13 with syphilis and HIV infection, with adequate funding for such tracing; and
14

15 Whereas, The rise in incidence and prevalence of syphilis is multifactorial, including but not limited to
16 changes in measurement (transition to the reverse algorithm); lack of understanding by patients and
17 physicians and health care professionals of the infection transmission and treatment options; challenges in
18 communication between public health systems and clinicians; public health funding constraints for
19 contact tracing; and drug shortages of intramuscular penicillin G; and
20

21 Whereas, The rise of syphilis and congenital syphilis in Texas disproportionately affects disadvantaged
22 communities. In 2020, rates were highest among people who identify as Black (466.5 cases per 100,000
23 live births), followed by Hispanic people (147.9 cases per 100,000 live births), White people (69.5 cases
24 per 100,000 live births), and others (24.6 per 100,000 live births); and
25

26 Whereas, The rise of syphilis and congenital syphilis in Texas demonstrates a greater need to support the
27 public health infrastructure and is a surrogate indicator of the preparedness level for infectious diseases
28 threats; therefore be it
29

30 RESOLVED, That the Texas Medical Association reaffirm previous policy on sexually transmitted
31 infection prevention, screening, reporting, and education and recognize that the significant rise of syphilis
32 rates and congenital transmission in Texas are serious public health threats; and be it further
33

34 RESOLVED, That TMA support further educational efforts for all physicians, health practitioners,
35 patients, and public health systems about syphilis testing and treatment guidelines, transmission, and
36 disease presentation; and be it further
37

38 RESOLVED, That TMA support improving public health funding and infrastructure in addressing
39 increased syphilis and other sexual infection rates; and be it further

40 RESOLVED, That TMA support efforts to address the drug shortage and cost prohibition of
41 intramuscular penicillin G, as this is the standard of care for syphilis outpatient treatment in most patients;
42 and be it further

43
44 RESOLVED, That TMA support the Texas Department of State Health Services (DSHS) and public
45 health system in studying causes contributing to the increased incidence and prevalence of syphilis and
46 congenital syphilis; and be it further

47
48 RESOLVED, That TMA support DSHS and public health in reversing the causes leading to increased
49 incidence and prevalence of syphilis and congenital syphilis.

50

51 **Relevant TMA Policy**

52 [15.001 Recommendations for HIV and STI Screening, Reporting, and Education](#)

53 [260.021 Sexually Transmitted Infections Prevention, Screening, and Education](#)

54

55 **Relevant AMA Policy**

56 None.

57

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 317
2024

Subject: Safety With Devices Producing Carbon Monoxide

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Science and Public Health

1 Whereas, Unintentional carbon monoxide deaths in the United States rose from 393 in 2015 to 543 in
2 2021; and

3
4 Whereas, Between 2017 and 2019, an average of 216 deaths per year in the U.S. were attributed to
5 unintentional non-fire, carbon monoxide-producing consumer products; and

6
7 Whereas, Between 2003 and 2013, roughly 1,400 people were hospitalized each year in the U.S. because
8 of non-fire-related carbon monoxide poisonings; and

9
10 Whereas, Nineteen of the 246 deaths during the February 2021 winter storm in Texas were attributed to
11 carbon monoxide poisoning; and

12
13 Whereas, Half of the carbon monoxide-related deaths following the Texas winter storm were caused by
14 unsafe usage of generators; and

15
16 Whereas, Mortality related to unsafe use of carbon monoxide-producing devices increases following
17 natural disasters; and

18
19 Whereas, The U.S. Consumer Product Safety Commission has the authority to develop uniform safety
20 standards for consumer products; and

21
22 Whereas, Generator manufacturers have shown resistance to adopting voluntary standards to reduce harm
23 caused by carbon monoxide; therefore be it

24
25 RESOLVED, That the Texas Medical Association support the U.S. Consumer Product Safety
26 Commission in implementing higher safety standards for consumer products that produce carbon
27 monoxide; and be it further

28
29 RESOLVED, That TMA support public education efforts to minimize harm caused by carbon monoxide
30 poisoning produced in enclosed spaces or too close to exterior openings; and be it further

31
32 RESOLVED, That our TMA forward this resolution to the American Medical Association House of
33 Delegates at its 2024 Annual Meeting.

34
35 **Related TMA Policy:**

36 [260.077 Clean Air in Texas](#)

37
38 **Related AMA Policy:**

39 [H-135.991 Clean Air](#)

1 [H-135.945 Encouraging Alternatives to PVC/Phthalate Products in Health](#)
2 [H-470.974 Athletic Helmets](#)

3
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 318
2024

Subject: Sustain Funding for HIV Treatment to End the Epidemic

Introduced by: John T. Carlo, MD; Dallas County Medical Society; LGBTQ Health Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, The successful model of care for HIV treatment has used an integrated funding approach,
2 leveraging both government and private-sector funding; and
3

4 Whereas, Effective interventions have driven the number of new HIV infections in the United States to
5 less than 35,000 per year; however, not everyone has benefited from these interventions; and
6

7 Whereas, Community-based clinics that use Ryan White HIV/AIDS Program funds achieve higher viral
8 suppression rates despite focusing on low-income, uninsured, and medically underserved communities;
9 and
10

11 Whereas, Novel HIV treatment strategies, including long-acting injectable treatments, have the potential
12 to further drive lower infection rates and improve viral suppression in highly marginalized communities;
13 and
14

15 Whereas, Without continued diligence towards funding, progress made towards ending the HIV epidemic
16 will stop and quickly reverse; therefore be it
17

18 RESOLVED, That our Texas Medical Association support and will strongly advocate for the funding of
19 state-level plans to end the HIV epidemic that focus on (a) diagnosing individuals with HIV infection as
20 early as possible; (b) treating HIV infection to achieve sustained viral suppression; (c) preventing at-risk
21 individuals from acquiring HIV infection, including through the use of pre-exposure prophylaxis; and (d)
22 rapidly detecting and responding to emerging clusters of HIV infection to prevent transmission; and be it
23 further
24

25 RESOLVED, That our TMA advocate for inclusion of long-acting injectable HIV treatment into the
26 Texas HIV Medication Program formulary; and be it further
27

28 RESOLVED, That our Texas Delegation to the American Medical Association take a resolution to the
29 American Medical Association House of Delegates that amends 340B Drug Discount Program H-110.985
30 as follows:
31

32 Our AMA: (1) will advocate for 340B Drug Discount Program (340B program) transparency,
33 including an accounting of covered entities' 340B savings and the percentage of 340B savings
34 used directly to care for underinsured patients and patients living on low-incomes; (2) will
35 support recommendations to equip the Health Resources and Services Administration (HRSA)
36 with more authority, resources and staff to conduct needed 340B program oversight; (3)
37 recognizes the 340B program does not support the extent of care provided by ineligible physician
38 practices to the medically indigent or underserved, and work with HRSA to establish 340B
39 eligibility for all practices demonstrating a commitment to serving low-income and underserved

1 patients; (4) will support a revised 340B drug discount program covered entity eligibility formula,
2 which appropriately captures the level of outpatient charity care provided by hospitals, as well as
3 standalone community practices; ~~and~~ (5) will confer with national medical specialty societies on
4 providing policymakers with specific recommended covered entity criteria for the 340B drug
5 discount program; and (6) supports Ryan White HIV/AIDS Program-funded and other
6 community health centers' utilization of the 340B program as legislatively intended.
7

8 **Related TMA Policy:**

9 None.

10
11 **Related AMA Policy:**

12 [Support of National HIV/AIDS Strategy H-20.896](#)

13 [HIV/AIDS as a Global Public Health Priority H-20.922](#)

14 [340B Drug Discount Program H-110.985](#)

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 319
2024

Subject: Administration of Vaccines on School Grounds

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Science and Public Health

- 1 Whereas, Most public school facilities do not employ a physician or medical provider; and
2
3 Whereas, Children participating in school have a recommendation to have Advisory Committee on
4 Immunization Practices- or state-recommended childhood vaccines; and
5
6 Whereas, The administration of vaccines requires proper informed consent; and
7
8 Whereas, The parent(s)/guardian(s) are responsible for the child’s health and well-being; and
9
10 Whereas, The administration of a vaccine can cause a severe reaction, anaphylaxis, or need for
11 resuscitation; and
12
13 Whereas, The administration of vaccines by school personnel would generally not fall within the scope of
14 medical practice; therefore be it
15
16 RESOLVED, That the Texas Medical Association oppose the administration of vaccines on school
17 grounds.
18
19 **Related TMA Policy:**
20 [135.012 Immunizations in Texas](#)
21 [135.030 Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic](#)
22
23 **Related AMA Policy:**
24 [H-440.877 Distribution and Administration of Vaccines](#)

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 320
2024

Subject: Individual Personal Autonomy for Medical Intervention and Vaccination

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Science and Public Health

1 Whereas, Personal health care decisions should be decided by the individual person; therefore be it
2
3 RESOLVED, That the Texas Medical Association affirm that the decision of whether an individual
4 submits to a medical intervention, including vaccination, should rest only with that individual in
5 consultation with their personal physician.
6

7 **Related TMA Policy:**

8 [105.009 Informed Consent](#)

9 [135.012 Immunizations in Texas](#)

10 [135.013 Universal Influenza Vaccination](#)

11 [135.029 Restricting School Immunization Exemptions to Exemptions for Medical Reasons](#)

12 [135.030 Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic](#)

13 [135.031 Disease and Setting-Specific Immunization Policies](#)
14

15 **Related AMA Policy:**

16 [2.1.1 Informed Consent](#)

TEXAS MEDICAL ASSOCIATION HOUSE OF DELGATES

Resolution 321
2024

Subject: Physician Personal Autonomy for Medical Intervention and Vaccinations

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Science and Public Health

1 Whereas, Personal health care decisions should be decided by the individual person; therefore be it
2
3 RESOLVED, That the Texas Medical Association affirm that the decision of whether an individual
4 physician submits to a medical intervention, including vaccination, should rest only with that individual
5 physician in consultation with their personal physician.
6

7 **Related TMA Policy:**

8 [245.019 Physician Immunizations Against Communicable Diseases](#)

9 [105.009 Informed Consent](#)

10 [135.012 Immunizations in Texas](#)

11 [135.013 Universal Influenza Vaccination](#)

12 [135.029 Restricting School Immunization Exemptions to Exemptions for Medical Reasons](#)

13 [135.030 Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic](#)

14 [135.031 Disease and Setting-Specific Immunization Policies](#)
15

16 **Related AMA Policy:**

17 [8.11 Health Promotion and Preventive Care](#)

18 [H-440.877 Distribution and Administration of Vaccines](#)

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 322
2024

Subject: Opposing Mandates for Medical Interventions

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Science and Public Health

1 Whereas, Physicians are trained to establish best recommendations for their individual patients; and

2
3 Whereas, There is not a "cookie cutter" approach to any disease process where EVERY person responds
4 the same to a treatment modality; and

5
6 Whereas, The surveillance and safeguards for patients post emergency use authorization (EUA) vaccine
7 rollout may not have been properly utilized; and

8
9 Whereas, Observational science and hypotheses are studied for correlation and proof; therefore be it

10
11 RESOLVED, That the Texas Medical Association opposes mandates for medical interventions.

- 12
13 **Related TMA Policy:**
14 [105.009 Informed Consent](#)
15 [135.012 Immunizations in Texas](#)
16 [135.013 Universal Influenza Vaccination](#)
17 [135.029 Restricting School Immunization Exemptions to Exemptions for Medical Reasons](#)
18 [135.030 Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic](#)
19 [135.031 Disease and Setting-Specific Immunization Policies](#)

- 20
21 **Related AMA Policy:**
22 [2.1.1 Informed Consent](#)

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 323
2024

Subject: Proper and Adequate Sports Physicals

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Science and Public Health

1 Whereas, Most public school facilities do not employ a physician or medical provider; and

2

3 Whereas, Some children participating in sports are required to have a sports physical; and

4

5 Whereas, Sports physicals are recommended to be done by a licensed physician as per Texas Medical
6 Association policy; and

7

8 Whereas, Sports physicals may be being performed outside the scope of medical practice; therefore, it be

9

10 RESOLVED, That the Texas Medical Association support that any schools in Texas should maintain
11 proof that students participating in sports programs had sports physicals performed by medical
12 professionals within their scope of medical practice.

13

14 **Related TMA Policy:**

15 [55.056 Physician Examinations for Young Athletes](#)

16 [55.046 Recommendations for Ensuring the Health of the Adolescent Athlete](#)

17

18 **References:**

19 1. [Education Code, Title 2. Public Education, Subtitle F. Curriculum, Programs, and Services, Chapter](#)
20 [33. Service Programs and Extracurricular Activities](#)

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 324
2024

Subject: TMA Response to Emergency Use Authorizations (EUA)

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Science and Public Health

1 Whereas, The Emergency Use Authorizations (EUA) of vaccines and medications associated with the
2 COVID-19 pandemic were approved without proper trials establishing safety and efficacy; and
3

4 Whereas, There was inadequate surveillance of efficacy and safety of the general public of the
5 aforementioned vaccines and medications; and
6

7 Whereas, Now there is some evidence of severe adverse reactions, including but not exclusive of
8 peri/myocarditis, neurological disorders, blood dyscrasias including bleeding and thrombotic events,
9 increases in spontaneous abortions, stillbirths and birth defects, Postural Orthostatic Tachycardia
10 Syndrome (POTS), and autoimmune disorders; and
11

12 Whereas, These injuries are difficult to treat and may permanently disable patients; and
13

14 Whereas, The vaccine industry has some protections from liability occurring from vaccines; and
15

16 Whereas, Informed consent is part of a physician's oath and obligation in recommending any intervention,
17 including vaccination; therefore be it
18

19 RESOLVED, That the Texas Medical Association respond to Emergency Use Authorizations (EUA) by
20 ensuring that physicians licensed in Texas have the most accurate information available so they can
21 comply with their duty to provide proper informed consent for any medical intervention to the citizens of
22 Texas.
23

24 **Related TMA Policy:**
25 [105.009 Informed Consent](#)
26

27 **Related AMA Policy:**
28 [2.1.1 Informed Consent](#)

TEXS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 325
2024

Subject: Vaccine Administration in Medical Facilities

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Science and Public Health

1 Whereas, The possibility of medical errors exists when dispensing vaccines in pharmacies and has a
2 potential for patient harm; and
3

4 Whereas, Pharmacy employees may not be trained to handle medical emergencies such as anaphylaxis;
5 and
6

7 Whereas, Pharmacy employees may not be trained in resuscitation to the same degree as other health care
8 professionals; therefore be it
9

10 RESOLVED, That the Texas Medical Association assert that vaccines should be administered in a
11 medical facility where the providers and employees are trained and equipped to handle medical
12 emergencies that are within the scope of their license.
13

14 **Related TMA Policy:**

15 [135.012 Immunizations in Texas](#)

16 [135.030 Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic](#)

17

18 **Related AMA Policy:**

19 [H-440.877 Distribution and Administration of Vaccines](#)

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 326
2024

Subject: Adapting TMA Gender Policy

Introduced by: Duren Michael Ready, MD

Referred to: Reference Committee on Science and Public Health

1 Whereas, Medical conditions where there is only one treatment are exceedingly rare; and

2
3 Whereas, Medical conditions where there will only be one treatment for all time are nonexistent; and

4
5 Whereas, When adopting policy it is optimal to articulate a proposed policy in a manner that can garner
6 the greatest support from the greatest number of members; and

7
8 Whereas, The American Academy of Pediatrics has recently been sued by a detransitioner for its policy
9 supporting gender affirming care; and

10
11 Whereas, The American Pain Society ceased operation in the face of numerous lawsuits alleging its role
12 in expanding opiate prescribing for nonmalignant pain; therefore be it

13
14 RESOLVED, That the Texas Medical Association amend policy 260.139 by deletion and substitution as
15 follows:

16
17 260.139

18 ~~Gender Affirming Care:~~

19 ~~Gender affirming care encompasses a range of social, psychological, behavioral, and medical~~
20 ~~interventions designed to support and affirm an individual's gender identity when it conflicts with~~
21 ~~the gender that person was assigned at birth.~~

22
23 1. ~~TMA supports physician efforts to provide medically appropriate gender affirming care~~
24 ~~and therapies relating to gender identity and strongly opposes the criminalization of these~~
25 ~~practices.~~

26 2. ~~TMA supports the practice of evidence based, patient centered, gender affirming care~~
27 ~~and will aggressively oppose the use of potentially harmful, unproven therapies for~~
28 ~~children.~~

29 3. ~~TMA encourages physicians to stay informed of the harms of criminalization of gender-~~
30 ~~affirming therapies. (CM-CAH Rep. 3 2023).~~

31
32 Gender dysphoria / incongruence (transgenderism) care:

33 Gender dysphoria / incongruence is a condition where a person experiences discomfort or distress
34 because there's a mismatch between their biological sex and gender identity.

35
36 1. TMA supports physician efforts to provide evidence-based care for gender dysphoria and
37 as in other aspects of Evidence Based medical practice, we reaffirm our opposition to any
38 criminalization of appropriate medical practices.

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- 1 2. TMA supports physician efforts to provide evidence-based care for gender dysphoria and
- 2 will aggressively oppose the use of potentially harmful, unproven therapies for children.
- 3 3. TMA encourages physicians to stay informed of the complexities regarding all aspects of
- 4 gender dysphoria.
- 5

6 **Relater TMA Policy:**

7 [60.011 References to Sex and Gender in TMA Policy](#)

8 [160.013 Medical Expert Witness Standards](#)

9

10 **Related AMA Policy:**

11 None.

12

13 **References:**

- 14 1. <https://thehill.com/opinion/4284777-matthews-here-come-the-gender-detransitioner-lawsuits/>
- 15 2. [US medical group that pushed doctors to prescribe painkillers forced to close | Opioids crisis | The Guardian](#)
- 16

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 327
2024

Subject: Uphold the Integrity and Accessibility of In Vitro Fertilization Services in Texas

Introduced by: LGBTQ Health Section

Referred to: Reference Committee on Science and Public Health

1 Whereas, The practice of in vitro fertilization (IVF) has offered countless families the invaluable
2 opportunity to conceive and bear children, overcoming various infertility challenges; and
3

4 Whereas, IVF and assisted reproductive technologies are recognized by the global medical community as
5 essential health care services significantly contributing to the physical and emotional well-being of
6 individuals and couples; and
7

8 Whereas, the state of Texas is committed to fostering a health care environment that supports innovation,
9 respects medical science, and promotes access to comprehensive reproductive health services; and
10

11 Whereas, it is imperative to differentiate the medical and scientific processes involved in IVF treatments
12 from broader ethical and legal debates, ensuring that the regulation of IVF remains grounded in medical
13 best practices and patient care standards; therefore be it
14

15 RESOLVED, That the Texas Medical Association advocate for policies and legislative measures that:
16

- 17 1. Clearly recognize and protect in vitro fertilization (IVF) and related assisted reproductive technology
18 (ART) procedures as distinct medical practices focused on facilitating the creation of life and
19 supporting family building, without encroaching upon or being hindered by unrelated legal definitions
20 and statuses;
- 21 2. Ensure that the regulation of IVF and ART services remains within the purview of medical and
22 scientific oversight, guided by the principles of patient safety, ethical medical practice, and evidence-
23 based care;
- 24 3. Promote the development of clear guidelines and standards for the practice of IVF and ART, in
25 collaboration with reproductive health specialists, ethicists, and legal experts, to safeguard these
26 services against potential legislative challenges that may not consider the specialized nature of
27 fertility treatments;
- 28 4. Encourage the continuation and expansion of access to IVF and ART services for all Texans,
29 recognizing these technologies as crucial options for those facing infertility and ensuring that such
30 services are provided with compassion, dignity, and respect for individual choices and needs; and
31 5. Support ongoing education and dialogue among physicians and health care providers, lawmakers, and
32 the public about the medical, ethical, and social dimensions of IVF and ART, aiming to foster
33 understanding and respect for the complexities involved in assisted reproduction; and be it further
34

35 RESOLVED, That TMA work proactively with state lawmakers, physicians and health care providers,
36 and community stakeholders to ensure that any future legislation related to reproductive health, including
37 IVF and ART, is informed by medical expertise, respects the autonomy of individuals and families, and
38 upholds the highest standards of care and compassion.
39

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1 **Related TMA Policy:**

2 None.

3

4 **Related AMA Policy:**

5 [4.2.1 Assisted Reproductive Technology](#)