Your Reference Committee recommends the following consent calendar for acceptance:

**RECOMMENDED FOR ADOPTION**

1. Late Resolution 2—Developing Sustainable Solutions to Discharge of Chronically-Homeless Patients
2. Late Resolution 3—Affirming the Medical Spectrum of Gender

**RECOMMENDED FOR ADOPTION AS AMENDED**

3. Resolution 1—Support for Medicare Disability Coverage of Contraception For Non-Contraceptive Use
4. Resolution 6—Contraception for Incarcerated Women
5. Resolution 9—Medical Aid in Dying
6. Resolution 11—Delegation of Informed Consent

**RECOMMENDED REAFFIRMATION IN LIEU OF**

7. Resolution 2—Support for Medicare Disability Coverage of Contraception for Women of Reproductive Age
8. Resolution 3—Increasing Rural Rotations During Residency
10. Resolution 5—DACA in GME
11. Resolution 7—Decreasing Financial Burdens on Residents and Fellows
12. Resolution 8—Strategies to Reduce Burnout in Medical Trainees

**RECOMMENDED FOR NOT ADOPTION**

13. Late Resolution 1—Extending Pregnancy Medicaid To One Year Postpartum
14. Resolution 10—Improving Patient Care Through Patient Self-Awareness of Personal Health Information
(1) LATE RESOLUTION 2—DEVELOPING SUSTAINABLE
SOLUTIONS TO DISCHARGE OF CHRONICALLY-
HOMELESS PATIENTS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that
Late Resolution 2 be adopted.

Late Resolution 2 calls upon our AMA to work with relevant stakeholders in developing
sustainable plans for the appropriate discharge of chronically homeless patients from
hospitals. It further calls for the reaffirmation of AMA policies H-270.962 and H-130.940,
and that it be immediately forwarded to the HOD.

Your Reference Committee heard multiple individuals testify in support of this resolution.
They acknowledged the fact that the California Senate bill SB 1152, which requires
additional steps to be taken by hospitals before discharging homeless patients, including
offering a meal, weather-appropriate attire, vaccinations, screening for infectious
diseases, and transportation to the discharge destination, puts an increased strain on
already crowded hospital systems and overworked physicians and residents. Your
Reference Committee agrees with the authors that this is a timely issue related to the
passage of the CA Senate bill that could have overreaching effects throughout the
country, specifically with other states now looking at passing similar bills.

(2) LATE RESOLUTION 3—AFFIRMING THE MEDICAL SPECTRUM
OF GENDER

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends that
Late Resolution 3 be adopted.

Late Resolution 3 calls upon our AMA-RFS to: (1) support initiatives that educate state
and federal policymakers and legislators on and advocate for policies addressing the
medical spectrum of gender identity to ensure access to quality health care; and (2)
affirm that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and
gender identity are not always aligned or indicative of the other, and that gender for
many individuals may differ from the sex assigned at birth.

Your Reference Committee heard unanimously positive testimony in support of this
resolution, specifically noting RFS support of marginalized populations. It recommends
adoption since failure to do so would prevent AMA from responding in a timely fashion
when the newly altered HHS interpretation of Title IX is presented to the Department of
Justice at the end of 2018.
(3) RESOLUTION 1—SUPPORT FOR MEDICARE DISABILITY COVERAGE OF CONTRACEPTION FOR NON-CONTRACEPTIVE USE

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 1 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA-RFS encourage CMS prescription benefit plans to include coverage for all FDA-approved contraception, including the levonorgestrel intrauterine device, for non-contraceptive use in patients covered by Medicare disability insurance.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 1 be adopted as amended.

Resolution 1 calls upon our AMA-RFS to encourage CMS to include coverage for all FDA-approved contraception, including the levonorgestrel intrauterine device, for non-contraceptive use in patients covered by Medicare disability insurance. Your Reference Committee heard mixed testimony on this resolution. While it agrees with the spirit of it, Medicare disability enrolls patients in Part B which does not include a prescription benefit plan (actually falling under Part D).

There was concern from your Reference Committee regarding AMA encouraging off-label use of an FDA-approved contraception for non-contraceptive use, but acknowledges the following policy: Patient Access to Treatments Prescribed by Their Physicians H-120.988, which reads in part, “Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion.”

(4) RESOLUTION 6—CONTRACEPTION FOR INCARCERATED WOMEN

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 6 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA supports access to contraceptive options for advocates for state and local health departments to work with
correctional facilities to provide contraception to incarcerated women prior to release; and be it further.

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 6 be amended by deletion to read as follows:

RESOLVED, That our AMA encourage partnerships between healthcare providers and correctional care communities, including state and local health departments, correctional facilities and community healthcare centers, so that access to contraception among women recently released from correctional facilities may be increased; and be it further.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 6 be amended by deletion to read as follows:

RESOLVED, That our AMA recognize that access to contraception is a serious healthcare concern among incarcerated women; and be it further.

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 6 be amended by deletion to read as follows:

RESOLVED, That our AMA petition the National Commission on Correctional Healthcare to recognize that access to contraception is a serious healthcare concern among incarcerated women.

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Resolution 6 be adopted as amended.

Resolution 6 calls upon our AMA to advocate for state and local health departments to work with correctional facilities in providing contraception to incarcerated women prior to release, that AMA encourage partnerships between healthcare providers and correctional care communities. Furthermore, it asks that our AMA recognize access to contraception is a serious issue among incarcerated women and petition the National Commission on Correctional Healthcare to do the same.
Your Reference Committee heard overwhelming support for the spirit of this resolution which addresses a vulnerable community. Individual testimony heard intended to ensure that contraception would be affordable, accessible, and offered options. Your Reference Committee believes the amended language accomplishes that objective without being overly prescriptive.

(5) RESOLUTION 9—MEDICAL AID IN DYING

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by deletion to read as follows:

RESOLVED, That our AMA-RFS support changes to AMA policy to support laws that allow for Medical Aid in Dying; and be it further

RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by deletion to read as follows:

RESOLVED, That our AMA-RFS support changes to AMA policy to move the AMA towards public support of Medical Aid in Dying; and be it further

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by deletion to read as follows:

RESOLVED, That our AMA-RFS support changes to AMA policy which codify that it is within the AMA’s Code of Medical Ethics for physicians to involve Medical Aid in Dying in their practice when allowed by law and agreed to by the patient and provider; and be it further

RECOMMENDATION D:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by deletion to read as follows:
RESOLVED, That our AMA-RFS work with appropriate external organizations to ensure that resident and fellow training includes training in Medical Aid in Dying as allowed by law and at the discretion of the trainee, and support policy changes within the AMA which seek to do the same; and be it further

RECOMMENDATION E:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by deletion to read as follows:

RESOLVED, That our AMA-RFS support the AMA in ending its practice of using the term “physician assisted suicide” and instead replace it with the term “Medical Aid in Dying.”

RECOMMENDATION F:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by addition to read as follows:

RESOLVED, That our AMA support protections for physicians and patients who participate in physician aid-in-dying in states where it is legal; and be it further

RECOMMENDATION G:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by addition to read as follows:

RESOLVED, That, where appropriate in AMA policy, the term “physician aid-in-dying” be substituted for “physician assisted suicide;” and be it further

RECOMMENDATION H:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by addition to read as follows:

RESOLVED, That our AMA-RFS adopt a position of neutrality towards physician aid-in-dying and continue to work with CEJA to move towards a neutral ethical position; and be it further
RECOMMENDATION I:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by addition to read as follows:

RESOLVED, That our AMA strike policy: H-140.966 – Decisions Near the End of Life section 4, H-140.952 – Physician Assisted Suicide section 1, and H-270.965 – Physician-Assisted Suicide in its entirety; and be it further

RECOMMENDATION J:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be amended by addition to read as follows:

RESOLVED, That our AMA adopt a neutral policy on the issue of physician aid-in-dying.

RECOMMENDATION K:

Mr. Speaker, your Reference Committee recommends that Resolution 9 be adopted as amended.

Resolution 9 calls upon the AMA-RFS to support changes to AMA policy to support laws that allow for Medical Aid in Dying and move the AMA towards public support of it. Furthermore, it asks that the AMA-RFS work with external organizations to educate residents and fellows on Medical Aid in Dying where permitted by law.

Your Reference Committee received limited testimony on this resolution due to time constraints. Multiple people spoke in favor of the resolution with amendments. Overall, testimony favored the sentiment that AMA needs to update their policy with a more modern definition.

(6) RESOLUTION 11—DELEGATION OF INFORMED CONSENT

RECOMMENDATION A:

Mr. Speaker, your Reference Committee recommends that Resolution 11 be amended by deletion to read as follows:

RESOLVED, That our AMA in cooperation with other relevant stakeholders advocate that a qualified physician be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient’s condition, and the procedures to be performed on the patient.
RECOMMENDATION B:

Mr. Speaker, your Reference Committee recommends that Resolution 11 be amended by addition to read as follows:

RESOLVED, That our AMA study the implications of the Shinal v. Toms ruling and its potential effects on the informed consent process.

RECOMMENDATION C:

Mr. Speaker, your Reference Committee recommends that Resolution 11 be adopted as amended.

Resolution 11 asks our AMA, in cooperation with other relevant stakeholders, to advocate for a qualified physician to be able to delegate his or her duty to obtain informed consent to another provider that has knowledge of the patient, the patient’s condition, and the procedures to be performed on the patient.

Your Reference Committee heard testimony from the authors regarding the potential negative and far-reaching impact from the 2017 Pennsylvania Supreme Court Decision in Shinal v. Toms and the fact that the AMA submitted an amicus brief on behalf of the defendant in the lawsuit, Dr. Toms. The resolution was born out of a desire to create official AMA policy where our AMA has already asserted a public position on this matter. It was also pointed out that the level of complexity of a procedure should dictate who should be able to consent a patient for that procedure. For example, a resident or PA should be able to consent a patient for a blood transfusion, but a cardiothoracic surgeon should be the one to consent a patient for a complicated heart surgery. In addition, it was mentioned that physicians in training must learn how to consent patients, so the ability for residents and fellows to consent patients must be maintained. Finally, your Reference Committee also heard testimony in favor of referring this matter to CEJA.

Your Reference Committee believes this resolution is timely, important and that the overarching effects of the decision could be disastrous for residents and fellows. However, as framed, the Resolved clause seems to absolve the treating physician altogether of responsibility for ensuring that informed consent is appropriately obtained. Additionally, the Resolved clause does not mention any mechanism for determining what constitutes an appropriate level of knowledge for consenting. Your Reference Committee is concerned about unintended consequences of the proposed language and therefore recommends that this be studied. This will likely result in referral to CEJA, which your Reference Committee feels is appropriate to ensure that the policy is well developed.

(7) RESOLUTION 2—SUPPORT FOR MEDICARE DISABILITY COVERAGE OF CONTRACEPTION FOR WOMEN OF REPRODUCTIVE AGE

RECOMMENDATION:
Mr. Speaker, your Reference Committee recommends

AMA Policy H-180.958 be reaffirmed in lieu of Resolution 2.

Resolution 2 calls upon the AMA-RFS to encourage CMS to provide coverage for all FDA-approved contraception for reproductive aged women covered by Medicare disability insurance. Your Reference Committee heard mixed testimony on this resolution. Current AMA Policy H-180.958, which states that “(1) Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives; and (2) Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care” covers all prescription drug benefit plans to include coverage of prescription contraceptives.

Currently Medicare disability only includes enrollment in Medicare Part B, which does not include prescription coverage, but which is mandated by Medicare Part D. Your Reference Committee believes that policy H-180.958 sufficiently covers any prescription coverage for contraception.

(8) RESOLUTION 3—INCREASING RURAL ROTATIONS DURING RESIDENCY

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends

AMA Policy H-465.988 be reaffirmed in lieu of Resolution 3.

Resolution 3 calls upon our AMA to work with state and specialty societies, medical schools, teaching hospitals, governmental entities and other interested stakeholders to encourage and incentivize qualified physicians to serve in leadership roles on rural residency rotations. Furthermore, it asks AMA to work with accreditation and regulatory bodies to lessen or remove requirements on residency training and practice that preclude formal educational experiences and residency rotations in rural areas. Finally, it asks the AMA to work with interested stakeholders to identify strategies to increase rural residency training opportunities.

Your Reference Committee heard testimony that presented widespread support of the spirit of this resolution. There is clearly a need for more exposure to rural medicine during medical training. It was noted that even providers who do not end up practicing medicine in a rural setting could benefit from rural medicine education. However, your Reference Committee is concerned that existing policy already covers the essence of the resolution. It does not feel that enough evidence was provided to fully understand what the regulatory burdens are for rural preceptors. In addition, any regulations or requirements on residency training and physician practice that preclude formal educational experiences and rotations for residents in rural areas falls under the domain of ACGME and other regulatory bodies and AMA can only opine on its determinations.
Your Reference Committee believes that AMA Policy H-465.988, stating in part, “In light of the data available from the current literature as well as ongoing studies being conducted by staff, the AMA recommends that: (1) Our AMA encourage medical schools and residency programs to develop educationally sound rural clinical preceptorships and rotations consistent with educational and training requirements, and to provide early and continuing exposure to those programs for medical students and residents” adequately addresses the spirit of this resolution.

(9) RESOLUTION 4—PROMOTING NUTRITION EDUCATION AMONG HEALTHCARE PROVIDERS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends AMA Policies H-150.995 and H-150.953 be reaffirmed in lieu of Resolution 4.

Resolution 4 asks our AMA to advocate for greater recognition of the importance of an evidence-based approach to nutrition for the prevention and management of chronic diseases. Furthermore, it asks our AMA to work in collaboration with educational institutions to increase physician-in-training nutrition knowledge in order to build a strong foundation of nutrition concepts and subsequently promote patient education and lifestyle changes.

Your Reference Committee heard extensive testimony regarding the fact that residents don’t need extraneous educational burdens and that current AMA policy fully covers the intent of this resolution. In addition, this nutrition education is specialty-specific and should not be overly prescriptive mandating all healthcare providers undergo said training. Your Reference Committee believes that policy H-150.995, which states that, “Our AMA encourages effective education in nutrition at the undergraduate, graduate, and postgraduate levels,” and H-150.953, which states in part, “(4) encourage national efforts to educate the public about the health risks of being overweight and obese and provide information about how to achieve and maintain a preferred healthy weight; (7) encourage physicians to become knowledgeable of community resources and referral services that can assist with the management of overweight and obese patients” thoroughly cover the intent of this resolution.

(10) RESOLUTION 5—DACA IN GME

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends AMA Policies D-255.991 and D-350.986 be reaffirmed in lieu of Resolution 5.

Resolution 5 calls upon our AMA to advocate against the use of visa status, immigration status, or nationality for admission criteria when evaluating graduate medical education applicants, support DACA recipients such that they need not face potential legal
challenges, and urge policy makers to continue the program so that the candidates may complete their medical school, residency, and fellowship training.

Your Reference Committee heard testimony in favor of the spirit of the resolution but largely in opposition given concerns specific to each of the resolved clauses. Resolved 2 was felt to be problematic on the grounds that visa sponsorship is a highly nuanced issue with financial implications for training programs. For example, many programs are unable to sponsor trainees who lack visas and these concerns were not addressed in the resolution. There was individual support for Resolved 4.

AMA has adopted policy and continues to support legislation that will ensure international physicians, students and residents can practice medicine and obtain their medical training in the U.S. The AMA is actively involved in efforts to support U.S. healthcare professionals with DACA status, including but not limited to the following actions:

1. On June 5, 2018, the AMA sent a letter to the Director of the U.S. Citizenship and Immigration Services (USCIS) urging the agency to expedite review of pending H-1B visa applications by non-U.S. international medical graduates (IMGs) who have accepted positions in U.S. Graduate Medical Education programs which begin on or before July 1.

2. On Aug. 9 the AMA sent a letter to U.S. Citizenship and Immigration Services (USCIS) imploring them to clear the backlog for conversion from H-1B visas so that foreign-trained physicians already practicing in the U.S. can obtain permanent resident status. AMA has also been active regarding the travel ban. It joined the Association of American Medical Colleges (AAMC) in an amicus brief to the U.S. Supreme Court on the case.

3. The AMA sent letters to Congressional leaders strongly urging them to pass legislation, such as the Dream Act of 2017 (S. 1615/H.R. 3440), that would provide a solution to ensure DACA recipients are protected and do not face continuous threats and potential legal challenges. The AMA reminded Congressional Leadership that estimates have shown that the DACA initiative could help introduce 5,400 previously ineligible physicians into the U.S. healthcare system in the coming decades to help address potential physician shortages and ensure patient access to care, especially in rural and underserved areas. The AMA also noted that in addition, those protected by the DACA program also include medical students, residents, and fellows who are working to pass the lengthy and rigorous training and education needed to become a physician. In 2016, over 100 students with DACA status applied to U.S. allopathic medical schools.

4. During the AMA’s Interim meeting in November 2016, the AMA adopted policy, D-350.986 stating, “Our AMA will issue a statement in support of current US healthcare professionals, including those currently training as medical students or residents and fellows, who are Deferred Action for Childhood Arrival (DACA) recipients.”
5. On December 13, 2017, the AMA sent a letter to Congressional leaders, along with over 50 other healthcare stakeholders, re-affirming support for all members of the healthcare workforce with DACA status, further urging the need for immediate and permanent legislative solutions.

6. On February 6, 2017, the AMA also sent letters to Congressional leaders supporting S. 128/H.R. 496, the “Bar Removal of Individuals who Dream and Grow our Economy Act” (BRIDGE Act), which would provide employment authorization and temporary relief from deportation for undocumented young immigrants who have DACA status and DACA-eligible individuals. By providing legal status to such individuals for three years, this legislation would provide important protection and stability until a permanent solution on lawful immigration status for DACA recipients is implemented.

7. Informational report CME 4-A-17, Evaluation of DACA-Eligible Medical Students, Residents, and Physicians in Addressing Physician Shortages, contains a summary of AMA policies related to this topic.

Therefore, your Reference Committee recommends reaffirming AMA Policies D-255.991 and D-350.986 in lieu of Resolution 5.

(11) RESOLUTION 7—DECREASING FINANCIAL BURDENS ON RESIDENTS AND FELLOWS

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends AMA Policies H-310.922 and H-310.929 be reaffirmed in lieu of Resolution 7.

Resolution 7 calls upon our AMA to partner with the ACGME and other relevant stakeholders to encourage training programs to reduce financial burdens on residents and fellows by providing subsidized access to day care facilities and other basic necessities, such as on call meal allowances for residents taking in-house call and free parking on site.

Your Reference Committee heard testimony from numerous individuals in support of the spirit of the resolution. It was noted that due to the match process, residents often do not have an opportunity to agree to the benefits that they will receive. Lack of child care in particular is an issue that disproportionately affects female residents. However, it was also noted that the topic is adequately addressed by a previous AMA report and policy.

CME report 4-A-16 directly encourages teaching institutions to base residents’ salaries on a range of local economic factors, such as housing and transportation. AMA policy H-310.912 (5) and (6D) encourages teaching institutions to explore benefits to residents and fellows around housing, childcare, and transportation and calls for a safe workplace including “secure, clean, and comfortable on-call rooms and parking facilities.” There was concern that increasing mandates for specific benefits could be overly prescriptive, lead to decreased pay and less flexibility for residents to choose how to spend their
income, and leave a negative impression on more senior physicians in the HOD who may see residents and fellows as looking for a handout.

Your Reference Committee believes that these asks are very location and lifestyle specific and therefore recommends reaffirming H-310.922 which states, “Our AMA encourages teaching institutions to base residents’ salaries on the resident's level of training as well as local economic factors, such as housing, transportation, and energy costs, that affect the purchasing power of wages, with appropriate adjustments for changes in cost of living.” It also recommends reaffirming H-310.929 which states in part, “All residents should be compensated. Residents should receive fringe benefits, including, but not limited to, health, disability, and professional liability insurance and parental leave and should have access to other benefits offered by the institution. Residents must be informed of employment policies and fringe benefits, and their access to them. Restrictive covenants must not be required of residents or applicants for residency education.”

(12) RESOLUTION 8—STRATEGIES TO REDUCE BURNOUT IN MEDICAL TRAINEES

RECOMMENDATION:

Mr. Speaker, your Reference Committee recommends

AMA-RFS policy 291.015R be reaffirmed in lieu of
Resolution 8.

Resolution 8 calls upon our AMA-RFS to support taking quantitative, definitive steps towards studying and implementing organizational level strategies to decrease medical trainee burnout, including amending AMA-RFS policy 291.015R which states, “That our AMA-RFS work with the ACGME to study resident burnout and determine if (1) recommendations can be made on how to recognize burnout, how to treat it, and, if possible, how to prevent it; (2) it relates to the professionalism core competency for residents; and (3) recognizing, treating and possibly preventing burnout could be included in the program requirements for residency program directors.” It also asks to amend AMA policy H-295.858 “Access to Confidential Health Services for Medical Students and Physicians” by expanding the asks of accreditation bodies and Medical Education Committees to provide additional support for trainee burnout.

Your Reference Committee heard limited testimony in support of this resolution, specifically noting that biannual monitoring would not be overly burdensome and that the surveys do not appear to be too time intensive. However, your Reference Committee also received strong testimony in opposition to the resolution including how such tools could add undue burden and actually be a contributing factor in burnout. It was also stated that this resolution does not specifically address ways to alleviate burnout but only further study what is already widely known in the undergraduate and graduate medical education community.

A CME report on this topic is set to be released at A-19 that will look at specific methods of studying burnout and therefore your Reference Committee finds this resolution to be premature. It recommends waiting to see what the extensive work of the Council reveals
prior to putting forth amendments to existing policy. Therefore, your Reference Committee recommends reaffirming 291.015R in lieu of Resolution 8.

(13) LATE RESOLUTION 1—EXTENDING PREGNANCY MEDICAID TO ONE YEAR POSTPARTUM

Mr. Speaker, your Reference Committee recommends that Late Resolution 1 not be adopted.

Late Resolution 1 calls upon our AMA to petition CMS to extend pregnancy Medicaid to a minimum of one year postpartum. Your Reference Committee heard testimony from multiple individuals in support of this resolution and the effect that this policy would have on maternal mortality. However, it also received testimony in opposition, specifically noting that Medicaid is a state-run program and therefore CMS would not be able to singlehandedly and adequately address this issue.

While your Reference Committee is in support of the spirit of this resolution, Medicaid is a federally assisted state-run program and therefore it would be outside of the purview of the AMA to dictate that CMS mandate this coverage. Your Reference Committee urges the authors to consider working with state societies or the AMA Advocacy Resource Center to create model state legislation in order to support this ask.

(14) RESOLUTION 10—IMPROVING PATIENT CARE THROUGH PATIENT SELF-AWARENESS OF PERSONAL HEALTH INFORMATION

Mr. Speaker, your Reference Committee recommends that Resolution 10 not be adopted.

Resolution 10 calls upon our AMA-RFS to ask our AMA to evaluate methods that would help garner patient responsibility with the ultimate goal of having patients provide their own Protected Health Information (PHI) to their healthcare providers. It also asks the AMA to study the impact that such methods may have on health outcomes.

Your Reference Committee heard favorable testimony supporting the spirit of the resolution in terms of making patients more autonomous and knowledgeable about their health. However, there was concern raised that the ask places an undue responsibility/burden on patients to maintain their own PHI, much of which patients may not fully understand nor have the technical equipment or savvy to effectively manage. In addition, there was testimony that pointed out the local and national efforts already taking place to improve and optimize EHR interoperability, which would lessen or eliminate the benefit of patients taking on the responsibility of maintaining their own PHI.

While your Reference Committee agrees with the spirit of this resolution, it feels that the current culture of healthcare in the United States makes this difficult to implement. Patients in the US do not have the culture of owning their own health records like patients in other countries such as China. Your Reference Committee agrees with testimony that focusing efforts on the optimization of EHR interoperability and patient accessibility is a more feasible method of providing patient control over their PHI.
Mr. Speaker, this concludes the Resident and Fellow Section Reference Committee Report. I would like to thank Helene Nepomuceno, MD, David Harris, MD, M.Phil, Anupriya Dayal, MD, Valerie Lockhart, MD, MBA, Brett Youngerman, MD and all those who testified before the Committee.

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