AMA
AMERICAN MEDICAL ASSOCIATION

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INTEGRATED PHYSICIAN PRACTICE SECTION
Governing Council Report A
Interim 2026 Meeting

Access full text of resolutions/reports in the HOD meeting handbook.

Recommendations Key
Instructions for the delegate and alternate delegate are designated as follows:

- *Strongly support* – the delegate/alternate delegate shall support the resolution as written and actively speak in favor of the resolution
- *Support* – the delegate/alternate delegate shall support the resolution as written
- *Listen* – the delegate/alternate delegate is not instructed to take any action, however, may if they believe it is in the best interest of the Section
- *Refer* – the delegate/alternate delegate shall move to refer (the item goes to a Council) or refer for decision (item goes to the Board)
- *Amend* – the delegate/alternate delegate shall move to amend the resolution in the manner prescribed in Report A
- *Oppose* – the delegate/alternate delegate shall oppose the resolution as written
- *Strongly oppose* – the delegate/alternate delegate shall oppose the resolution as written and actively speak in opposition of the resolution

Some items may contain specific instructions not included among those listed above. In such cases, instructions to the delegate/alternate delegate are described in detail alongside the item of business.

Items highlighted in blue have been recommended for reaffirmation.

Item #	Ref Com	Title and sponsor(s)	Proposed policy	Governing Council recommendations
1	E&B	CEJA 03 – Guidelines on Chaperones for Sensitive Exams	The Council on Ethical and Judicial Affairs recommends the following be adopted and the remainder of the report be filed: 1. Opinion 1.2.4, "Use of Chaperones," be amended by deletion and addition as follows: Chaperones should be authorized members of the healthcare team. All chaperones should understand the responsibilities of the role and be aware of mechanisms for reporting unprofessional conduct in keeping with ethics guidance and without fear of retaliation. Physicians should establish clear expectations that chaperones will uphold professional and legal standards of privacy and confidentiality. Respecting patient boundaries and promoting patient dignity requires providing a safe and therapeutic clinical encounter during sensitive examinations and	Delegate instructed to support.

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			procedures while also empowering patients. ~~Efforts to provide a comfortable and considerate atmosphere for the patient and the physician are part of respecting patients' dignity.~~ Such ~~These~~ efforts ~~may~~ include measures that promote patient privacy, such as providing appropriate gowns, private facilities for undressing, sensitive use of draping, clear~~ly explaining~~ explanations of various components of the physical examination, and the use of ~~having~~ a chaperone ~~available~~. While a sensitive exam is typically understood as one involving any examination of, or procedure involving, the genitalia, breasts, perianal region, or the rectum, physicians should be aware that a patient's personal history, beliefs, or identity may broaden their definition of what constitutes a sensitive examination or procedure. Having a chaperone~~s~~ present ~~also~~ during a sensitive exam helps protect the integrity of the patient-physician relationship ~~prevent misunderstandings between patient and physician~~. Physicians should, as always, be mindful of any applicable legal or regulatory requirements regarding the use of chaperones. Additionally, ~~P~~physicians should: (a) Make every reasonable effort to provide a chaperone for all sensitive exams, regardless of patient capacity, unless a delay in obtaining a chaperone would result in significant harm to the patient. (b) Allow patients to decline the presence of a chaperone, unless the physician deems a chaperone necessary for the exam: i. if the patient and physician cannot come to an agreement, then the physician may defer non-emergent examinations or procedures and refer the patient to another clinician; ii. in emergency situations, the physician may proceed in providing care with the presence of a chaperone and document the rationale. ~~(c) Have an authorized member of the health care team serve as a chaperone. Physicians should establish clear expectations that chaperones will uphold~~	

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			~~professional standards of privacy and confidentiality.~~ ~~(d) In general, use a chaperone even when a patient's trusted companion is present.~~ ~~(e)~~(c) Minimize inquiries or history taking of a sensitive nature while a chaperone is present. (d) Make a reasonable effort to accommodate the expressed preferences of the patient regarding the characteristics of their chaperone, consistent with the interests of patients, physicians, and the maintenance of professional boundaries. (e) Allow a parent or guardian to act as the chaperone for young pediatric patients. If a parent or guardian is unavailable, or if their presence may interfere with the examination, another chaperone should be present. For adolescent patients, it is appropriate to use a chaperone either in addition to, or instead of, a family member or guardian as determined during shared decision-making between patient and physician. All outpatient practices and inpatient services should have a policy regarding sensitive examinations and procedures that includes the use of chaperones to protect patients and minimize risk. For nonsensitive examinations and procedures, patients may request a chaperone, and reasonable efforts should be made to make one available upon request. (Modify HOD/CEJA Policy) 2. Policy D-140.950 be rescinded, as it has been accomplished by this report. (Rescind HOD Policy)	
2	E&B	CEJA 04 - Supporting Efforts to	The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of the report be filed:	Delegate instructed to seek referral.

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		Strengthen Medical Staffs Through Collective Actions and/or Unionization	1. That Opinion 1.2.10 be amended by addition and deletion with a change in title to read as follows: Advocacy and Collective Actions by Physicians ~~Political Action by Physicians~~ Like all Americans, physicians enjoy the right to advocate for change in law and policy, in the public arena, and within their institutions. Indeed, physicians have an ethical responsibility to seek change when they believe the requirements of law, ~~or~~ policy, or practice are contrary to the best interests of patients. However, advocacy actions should not put the well-being of patients in jeopardy. Collective action is one means by which physicians can advocate for patients, the health of communities, the profession, and their own health. Physicians have a responsibility to avoid disruption to patient care when engaging in any collective action. When considering collective actions that have the potential to be disruptive, whether aimed at changing the policies of government, the private sector, or their own institutions, there are additional considerations that should be addressed. These include avoiding harm to patients, minimizing the impact of actions on patient access to care, maintaining trust in the patient-physician relationship, fulfilling the responsibility to improve patient care, avoiding mental and physical harms to physicians, promoting physician well-being, upholding the values and integrity of the profession, and considering alternative measures that could reasonably be expected to achieve similar results with less potential effect on patient and physician well-being. When considering participation ~~Physicians who participate~~ in advocacy activities, including collective actions: (a) ~~Ensure that the health of patients is not jeopardized, and that patient care is not compromised.~~ Physicians should recognize that, in pursuing their primary commitment to patients, physicians can, and at times may have an obligation to, engage in collective political action to advocate for changes in law and institutional policy aimed at promoting patient care and well-being.	

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			(b) ~~Avoid using disruptive means to press for reform. Strikes and other collective actions may reduce access to care, eliminate or delay needed care, and interfere with continuity of care and should not be used as a bargaining tactic. In rare circumstances, briefly limiting personal availability may be appropriate as a means of calling attention to the need for changes in patient care. Physicians should be aware that some actions may put them or their organizations at risk of violating antitrust laws or laws pertaining to medical licensure or malpractice.~~ Physicians may also engage in collective action to advocate for changes within their institutions, including changes in patient care practices, physician work conditions, health and well-being, and/or institutional culture that negatively affect patient care: (i) physicians should refrain from collective action that would likely jeopardize the health of patients or compromise patient care; (ii) physicians may, if non-disruptive actions fail, consider engaging in disruptive forms of collective action that do not compromise patient care, with the primary objective to improve patient care and outcomes by calling attention to and/or making needed changes in practices, protocols, incentives, expectations, structures, and/or institutional culture; and (iii) physicians should avoid disruptive collective actions that would predictably and directly compromise patient care, including strikes, due to their potential to undermine physicians' primary duty to patient welfare, and should not use such actions primarily for physician self-interest. (c) Physicians should avoid forming workplace or other alliances, such as unions, with ~~workers~~ colleagues and others who do not share physicians' primary and overriding commitment to patients. (d) Physicians should refrain from using ~~undue influence or pressure colleagues~~ punitive or coercive means to force others to participate in advocacy activities or collective actions, or to penalize others ~~and should not punish colleagues, overtly or covertly,~~ for deciding not to participate in such activities. (Modify AMA Policy) 2. That Policy H-405.946(2) be rescinded as having been accomplished by this report. (Rescind AMA Policy)	

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3	E&B	CEJA 06 – Recording Clinical Encounters	The Council on Ethical and Judicial Affairs recommends that the following be adopted and the remainder of this report be filed: 1. Recording technologies can help improve the clinical experience but also present risks to privacy, safety, security, and trust. Any type of recording (audio, visual, or transcription) of the clinical encounter may provide some record of a patient's intimate details and, if made by or provided to a physician, constitutes a part of the medical record. The recording of a clinical encounter by either patient or physician necessitates that great care be taken not to cause undue harm to any party and requires transparency, communication, and trust. Covert recordings (by either physician or patient) endanger trust and harm the patient-physician relationship. Physicians should not record patients for non-medically relevant purposes, such as for a physician's personal use that is not medically related, even if patient consent might be obtained. Conversely, physicians should help patients understand that they should not record clinical encounters without disclosing their intent to do so, obtaining consent where legally required, and acting in compliance with all legal and clinical regulations and should generally only record medical encounters with the intention of supporting their own well-being. If a patient asks to record a clinical encounter, physicians may inquire about the patient's intent and, if appropriate, help to ensure that recordings do not capture other patients or staff without their express consent to uphold privacy and confidentiality. If the physician suspects that a patient wishes to record a clinical encounter due to distrust, the physician should strive to find ways to build trust in the patient-physician relationship. In general, physicians should remember to maintain professionalism in all patient interactions and that all interactions have the potential to be recorded. When recording clinical encounters, physicians should: (a) Inform the patient (or authorized decision maker) of the intent to record and: (i) the purpose of the recording;	Delegate instructed to seek referral.

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			(ii) that any uses of the recording will be limited to those related to healthcare; (iii) that they may withdraw consent to being recorded at any time, including during recording, and, if so, what will be done with the recording; (iv) their right to access and request that information recorded be amended for accuracy as part of their medical record; (v) assure the patient that their information will be treated as confidential health information and stored securely but acknowledge that no information can be perfectly secured. (b) Ensure that the patient has the opportunity to discuss any concerns about recording before, during, and after recording. (c) Obtain consent from the patient (or the authorized decision maker) prior to recording whenever possible. (d) In the case of minors, seek assent from the patient in addition to consent from the patient's parent or guardian. (e) Ensure recordings are securely stored and, when necessary, properly destroyed, in keeping with ethics guidance for managing medical records. (f) Engage openly with patients who wish to record their own clinical encounter. If the physician believes a patient recording compromises the patient-physician relationship, the physician may choose to terminate the relationship in keeping with ethics guidance.	
4	E&B	Res. 008 - Recognition of Moral Injury in the Physician Workforce (Resident and Fellow Section)	RESOLVED, that our American Medical Association defines moral injury as the harm that occurs when healthcare professionals are compelled by systemic constraints to act in ways that transgress their moral beliefs and professional obligations, including the inability to deliver evidence-based, equitable, and patient-centered care due to institutional, financial, or administrative barriers (New HOD Policy); and be it further RESOLVED, that our AMA recognizes moral injury as a distinct and significant threat to the wellbeing of medical students, residents, and physicians (New HOD Policy); and be it further RESOLVED, that our AMA study the prevalence, drivers, and impact of moral injury	Delegate instructed to refer for study—IPPS is concerned about ambiguity around the definitions of "distress" and "injury" and would like to see more thought put in place around implementing these concepts in physician practices.

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			across the continuum of medical training and practice, including medical students, residents, and practicing physicians, and report back with recommendations for systemic interventions. (Directive to Take Action)	
5	B	Res. 201 - Artificial Intelligence Having Prescriptive Authority (American Association of Clinical Urologists)	RESOLVED, that our American Medical Association oppose the use of Artificial Intelligence (AI) without a physician or other health care professional's direct supervision to prescribe either new or refill prescriptions (New HOD Policy); and be it further RESOLVED, that our AMA develops model state legislation regulating AI prescriptive authority so that both new and refill prescriptions are under the direct supervision and control of a physician or other licensed healthcare professional. (Directive to Take Action)	Delegate instructed to strongly support the proposed amendments listed in the Preliminary Reference Committee Report.
6	B	Res. 205 - Ensuring Accuracy and Physician Protections for Patient Attribution in Health Plan Quality Measurement and Value-Based Programs (Organized Medical Staff Section)	RESOLVED, that our AMA adopt as policy the following Universal Standards for Patient Attribution: 1. Clinical Relationship: Attribution must be based on a documented clinical relationship, defined by recent clinical encounter(s) within an appropriate timeframe or a verified patient designation of the physician as their primary care provider (PCP); 2. Prospective Notification: Payers must provide physicians with an option for retrospective or prospective attribution methodology and, if opting for prospective attribution, they should provide physicians with a list of attributed patients at least 30 days before the start of a measurement period; 3. Transparency: Payers must disclose the attribution algorithms, claims thresholds, and patient designation processes used to assign patients to physicians; 4. Mandatory Exclusion: Patients subject to an active attribution dispute must be excluded from all quality scoring and financial performance calculations until the dispute is resolved; 5. Dispute Resolution: Payers must provide a standardized, timely mechanism for physicians to correct or suppress inaccurate attributions, with a determination required within 30 days of submission; (New HOD Policy); and be it further RESOLVED, that our AMA Board of Trustees report back at the 2027 Annual Meeting	Delegate instructed to support recommendations offered in the Preliminary Reference Committee Report.

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			with recommendations to align and consolidate existing AMA policies related to patient attribution to ensure a streamlined advocacy strategy. (Directive to take Action)	
7	B	Res. 208 - Facilitating Short-Term Supervised Clinical Training for International Physicians (American College of Surgeons)	RESOLVED, that our American Medical Association amend Policy H-255.989, Exchange Programs for Visitor Physicians, by adding the following new directive: “3. Our AMA supports modifications to the federal Exchange Visitor Program regulations governing J-1 physicians to establish a short-term supervised clinical training category that would permit qualified international physicians to participate in structured educational clinical experiences at accredited U.S. teaching hospitals and medical schools without enrollment in an ACGME-accredited residency or fellowship program or completion of USMLEs, provided that such training: (a) is limited in duration and has an educational purpose; (b) occurs pursuant to a structured curriculum established in advance that includes defined educational objectives, appropriate instruction and supervision, and a mechanism for evaluating whether those objectives have been achieved; (c) is conducted under the direct supervision of appropriately licensed and certified U.S. physicians; (d) complies with all applicable federal and state laws and institutional policies; (e) does not authorize independent clinical practice or unrestricted patient care; (f) is intended to facilitate the transfer of medical knowledge and procedural skills to improve health care delivery in participants' home countries; (g) does not interfere with or diminish the clinical learning opportunities of residents, fellows, medical students, or other trainees at the hosting institution; (h) does not substitute for physicians, residents, fellows, advanced practice professionals, or other health care professionals or personnel who would otherwise be employed or engaged to provide patient care, and is not used to address staffing shortages or increase the clinical or procedural capacity of the hosting institution or supervising physician; (i) includes appropriate institutional oversight and safeguards to protect participating international physicians from exploitation and ensure that clinical activities are undertaken solely to advance the program’s defined educational objectives”	Delegate instructed to seek referral.

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			(Modify Current HOD Policy); and be it further RESOLVED, that our AMA advocate before the U.S. Department of State, Department of Homeland Security, Educational Commission for Foreign Medical Graduates, and other appropriate federal agencies for modifications to the Exchange Visitor Program regulations consistent with this policy (Directive to Take Action); and be it further RESOLVED, that our AMA collaborates with specialty societies, academic medical centers, the ACGME, ECFMG, and other stakeholders to develop recommendations regarding appropriate program eligibility, supervision, duration, institutional sponsorship, patient safety safeguards, and educational standards for such a short-term clinical training category. (Directive to Take Action)	
8	B	Res. 210 - Requiring Physician Oversight for Artificial Intelligence Tools (Indiana)	RESOLVED, that our American Medical Association support federal and state policies requiring that any artificial intelligence-generated diagnostic or treatment recommendations be reviewed, interpreted, and communicated by a licensed physician. (New HOD Policy)	Delegate instructed to support.
9	B	Res. 215 – Establishing Product Liability for Clinical Augmented Intelligence Failures (Washington)	RESOLVED, that our American Medical Association advocate for federal and state legislation establishing that when a clinical AI product produces an erroneous output and a physician has used the product as intended while exercising appropriate clinical judgment, the liability for resulting patient harm constitutes a product liability claim against the AI vendor, manufacturer, or distributor, not a medical malpractice claim against the physician (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that AI vendors and manufacturers be held to the same product liability standards as manufacturers of other medical devices under the Restatement (Third) of Torts: Products Liability, including strict liability for manufacturing defects, and liability for design defects and failure to provide adequate instructions or warnings (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for legislation requiring that AI vendors and	Delegate instructed to seek referral.

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			manufacturers maintain product liability insurance adequate to cover claims arising from AI product failures in clinical settings, and that such insurance obligations be a condition of FDA marketing authorization (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for legislation prohibiting contractual provisions, including end-user license agreements and vendor contracts, that attempt to shift product liability for AI tool failures from the manufacturer to the physician or health system end user (Directive to Take Action); and be it further RESOLVED, that our AMA advocate for federal legislation requiring AI vendors and manufacturers to disclose known failure rates, limitations, and performance data for their clinical AI products, including performance across different patient populations, so that physicians can make informed decisions about the clinical appropriateness of AI tool outputs (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that when a health system, hospital, payer, or other entity mandates the use of a specific AI tool and that tool produces an error resulting in patient harm, the mandating entity and the AI vendor bear the liability, and the physician who was required to use the tool and exercised appropriate clinical judgment is not liable for errors originating in the mandated product. (Directive to Take Action)	
10	B	Res. 221 - Preserving Duration of Status for J-1 Physicians in Graduate Medical Education (International Medical Graduates Section)	RESOLVED, that our American Medical Association advocate that the Department of Homeland Security maintain or restore the Duration of Status for J-1 physicians in graduate medical education, or, if not restored, allow a fixed admission period equal to the full training program plus six months (Directive to Take Action); and be it further RESOLVED, that our AMA advocate that the U. S. Citizenship and Immigration Service provide premium processing, deference to Intealth's multi-year DS-2019 sponsorship, automatic J-2 work-authorization extensions, and VSRE/SEVIS integration for J-1 extension-of-stay applications (Directive to Take Action); and be it further	Delegate instructed to support recommendations in the Preliminary Reference Committee Report.

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			RESOLVED, that our AMA work with the Department of Homeland Security, the U. S. Citizenship and Immigration Service, Intealth, and other stakeholders to confirm J-1 physicians may change training programs or employers during a pending extension of stay, minimizing administrative burdens on physician training and patient care. (Directive to Take Action)	
11	F	CLRPD 01 - Evaluation of the Size and Structure of the AMA House of Delegates	The Council on Long Range Planning and Development recommends that the following recommendations be adopted and the remainder of the report be filed: 1. That delegate apportionment will be capped at its current level (793 delegates) for 2027 apportionment. Constituent association allocation will remain 351 with a corresponding number of 351 specialty society delegates to be apportioned according to established procedures. All other delegations will continue at their A-26 apportionment. 2028 apportionment will be based on year-end 2027 membership figures and so forth moving forward. 2. That, for 2027 apportionment and onward, the bylaws be amended to delete all apportionment language which includes "or fraction thereof" when apportioning any additional delegates beyond the first, so that additional delegates will not be added for a fraction of the recommended apportionment ratio. 3. That specialty society membership numbers will be obtained every three years as opposed to every five years for increased accuracy. 4. That there is a review of current apportionment rules and procedures with a report back to the HOD at the 2027 Interim Meeting, including assessing the ability to and costs associated with obtaining specialty society membership figures on an annual basis.	Delegate instructed to Listen.
12	F	CLRPD 02 - Underrepresented in Medicine Advocacy Section Five-Year Review	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Underrepresented in Medicine Advocacy Section through 2031 with the next review no later than the 2031 Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	Delegate instructed to support.
13	F	CLRPD 03 - Integrated Physician	The Council on Long Range Planning and Development recommends that our American Medical Association renew delineated section status for the Integrated Physician Practice Section through 2031 with the next review no later than the 2031	Delegate instructed to strongly support.

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		Practice Section Five-Year Review	Interim Meeting and that the remainder of this report be filed. (Directive to Take Action)	
14	J	Res. 803 - Coverage of Embryonic Monogenic Disorder Screening as a Medically Necessary Benefit (American Society for Reproductive Medicine)	RESOLVED, that our American Medical Association support public and private health insurance coverage for clinically indicated monogenic disorder screening, including carrier and preimplantation embryo testing, when supported by evidence-based clinical guidelines and physician judgment (New HOD Policy); and be it further RESOLVED, that our AMA advocate for embryonic monogenic disorder screening to be recognized as a medically necessary covered benefit by public and private payers when such testing is recommended according to established professional society guidelines or based on individualized clinical assessment (Directive to Take Action); and be it further RESOLVED, that our AMA encourage insurers to develop transparent and standardized coverage policies for embryonic monogenic disorder screening that minimize administrative barriers, including burdensome prior authorization requirements, that may delay medically appropriate care (New HOD Policy); and be it further RESOLVED, that our AMA advocate for equitable access to medically indicated embryonic monogenic disorder screening to reduce disparities in reproductive healthcare decision-making among historically underserved populations (Directive to Take Action); and be it further RESOLVED, that our AMA work with relevant medical specialty societies, patient advocacy organizations, and policymakers to promote education regarding the clinical utility and cost-effectiveness of embryonic monogenic disorder screening of embryos in improving patient outcomes and informing patient-centered care. (Directive to Take Action)	Delegate instructed to support recommendations in the Preliminary Reference Committee Report.
15	J	Res. 815 - Improving Technology to Combat Automated	RESOLVED, that our American Medical Association advocate with urgency, including through EHR certification criteria and standard billing and clearinghouse functionality, for electronic health record, billing, and practice management systems to	Delegate instructed to support Alternate

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		and Artificial Intelligence-Directed Downcoding of Evaluation and Management Services by Health Insurance Companies (Florida)	automatically detect from the electronic remittance advice when a payer has adjudicated or reimbursed a claim at an E/M service level lower than the level submitted — whether by code reassignment or payment reduction — and to alert physicians or their billing staff, with the original and adjudicated codes, the payer's stated reason, and the applicable appeal deadline, within the time needed to appeal (Directive to Take Action); and be it further RESOLVED, that our AMA increase awareness of automated, algorithmic, and artificial intelligence-directed E/M downcoding among physicians, medical societies, policymakers, regulators, and other stakeholders; develop, provide, and update resources — including downcoding-specific appeal templates, model contract language, and documentation guidance — to help physicians identify, document, and appeal inappropriate downcoding; and collect and periodically report data on the prevalence and payer-level patterns of such downcoding. (New HOD Policy)	Resolution 815 in lieu of Res. 815.
16	J	Res. 816 - Enhancing Advocacy to Combat Automated Insurance Downcoding of EM Services (Florida)	RESOLVED, that our American Medical Association uses its legal and advocacy resources, when appropriate, to support litigation, including class action suits, challenging automated, algorithmic, or artificial intelligence-directed downcoding of properly documented E/M services without appropriate medical record review (New HOD Policy); and be it further RESOLVED, that our AMA advocates and requests CMS to enforce and strengthen its 2024 Final Rule requirements applicable to Medicare Advantage plans regarding automated coverage and coding criteria, restricts downcoding without clear separate notification of each incident with the explanation of benefits, and establishes minimum transparency standards for all algorithmic claims adjudication policies including public disclosure of the criteria and methodologies used. (Directive to Take Action)	Delegate instructed to support Alternate Resolution 815 in lieu of Res. 816.
17	K	Res. 907 – Affirming Support for the National Institutes of	RESOLVED, that our American Medical Association supports initiatives to ensure continuity and stability in scientific advisory councils, including the timely and appropriate replacement of members on NIH Advisory Councils and review panels, as well as other HHS agencies, with equally qualified members to prevent the delay,	Delegate instructed to support.

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		Health Advisory Councils (Medical Student Section)	interruption, or cessation of HHS-funded research initiatives (New HOD Policy); and be it further RESOLVED, that our AMA opposes the active removal of qualified scientists from NIH advisory councils and review panels, as well as qualified leaders in other HHS agencies, without documented proof of wrongdoing or misconduct in accordance with established federal or state legal statutes. (New HOD Policy)	
18	K	Res. 920 – Improving Protection for Patient Medical Records and Health Care (LGBTQ+ Section)	RESOLVED, that our American Medical Association oppose governmental efforts to compel the disclosure of identifiable patient medical records from physicians or health care institutions when such efforts are primarily directed at investigating or deterring the provision of otherwise ethical, evidence-based medical care and lack a compelling patient safety or public health justification (New HOD Policy); and be it further RESOLVED, that our AMA advocate that governmental requests for identifiable patient medical records in connection with investigations of clinical care be narrowly tailored, supported by an individualized legal basis, and implemented in a manner that minimizes unnecessary intrusion into patient privacy and the patient-physician relationship (New HOD Policy); and be it further RESOLVED, that our American Medical Association amend Policy D-315.966, "Improving Protection for Reproductive Health Information," by addition to read as follows: 1. Our American Medical Association supports legislation and regulations prohibiting the use or disclosure of protected health information (PHI) to conduct a criminal, civil, or administrative investigation into or to impose criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health and gender-affirming care. 2. Our AMA advocates to ensure that the release of protected health information of a decedent to forensic pathologists be unimpeded by unnecessary administrative burdens. (Modify Current HOD Policy)	Delegate instructed to support.

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