

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-26)

Preliminary Report of the Organized Medical Staff Section Reference Committee

Theodore Christopher, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:
2

3 **RECOMMENDED FOR ADOPTION AS AMENDED**
4

- 5 1. Resolution 1 – Federal Legislation to Prohibit Social Media Use by Minors Under Age 16
6 2. Resolution 2 – Supporting Regulations for More Stringent Safety Measures for
7 Micromobility
8 3. Resolution 3 – Ensuring Accuracy and Physician Protections for Patient Attribution in
9 Health Plan Quality Measurement and Value-Based Programs
10 4. Resolution 5 – Medical Staff Oversight of Hospital Augmented Intelligence
11 5. Resolution 6 – Protecting Children from Potential Harms of Caffeinated Products
12 6. Resolution 7 – Survey of Medical Staffs
13

14 **RECOMMENDED FOR REFERRAL**
15

- 16 7. Resolution 4 – Medical Bylaws Update Needs to be a Mandated Joint Commission
17 Standard

RECOMMENDED FOR ADOPTION AS AMENDED

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2
3 (1) RESOLUTION 1 – FEDERAL LEGISLATION TO PROHIBIT
4 SOCIAL MEDIA USE BY MINORS UNDER AGE 16
5

6 **RECOMMENDATION A:**
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8 **The first resolve in Resolution 1 be amended by addition and**
9 **deletion to read as follows:**
10

11 RESOLVED, that our American Medical Association will ~~formally~~
12 ~~call upon the United States Congress and the President of the~~
13 ~~United States~~ to enact federal legislation establishing a minimum
14 age of 16 for ~~the~~ independent social media account creation and
15 use of social media accounts on platforms accessible in the United
16 States with limited supervised access permitted for younger minors
17 only through verifiable parental consent and platform-implemented
18 safeguards (Directive to Take Action); and be it further
19

20 **RECOMMENDATION B:**
21

22 **The second resolve in Resolution 1 be amended by addition**
23 **and deletion to read as follows:**
24

25 RESOLVED, that our AMA advocate for legislation ~~to requireing~~
26 social media platforms to ~~implement robust, technologically reliable~~
27 ~~age verification systems to prevent access by users under 16 with~~
28 deploy privacy-preserving, minimally intrusive age assurance
29 technologies consistent with constitutional protections, subject to
30 Federal Trade Commission oversight and meaningful civil and
31 criminal penalties for platforms that fail to comply non-compliance
32 (Directive to Take Action); and be it further
33

34 **RECOMMENDATION C:**
35

36 **The third resolve in Resolution 1 be amended by addition and**
37 **deletion to read as follows:**
38

39 RESOLVED, that our AMA ~~advocate for legislation to provide for~~
40 ~~independent auditing of social media platform compliance with~~
41 ~~regulatory oversight by the Federal Trade Commission and/or a~~
42 ~~designated federal agency with authority to enforce penalties~~
43 support platforms to (a) disable addictive design features (infinite
44 scroll, autoplay) by default for minors, (b) limit daily usage, and (c)
45 conduct transparent health impact assessments prior to algorithmic
46 changes affecting youth (Directive to Take Action); and be it further
47

48 **RECOMMENDATION D:**
49

50 **The fourth resolve in Resolution 1 be deleted.**
51

1 ~~RESOLVED, that our AMA advocate for robust federal funding for~~
2 ~~longitudinal research into the effects of social media on child and~~
3 ~~adolescent mental health, neurodevelopment, and academic~~
4 ~~performance, to be administered through the National Institutes of~~
5 ~~Health and the Centers for Diseases Control and Prevention~~
6 ~~(Directive to Take Action); and be it further~~
7

8 **RECOMMENDATION E:**

9
10 **The fifth resolve in Resolution 1 be amended by addition and**
11 **deletion to read as follows:**

12
13 RESOLVED, that our AMA advocate for robust federal funding for
14 longitudinal research into the effects of social media, including
15 equity impacts on rural and underserved youth ~~on child and~~
16 ~~adolescent mental health, neurodevelopment, and academic~~
17 ~~performance, to be administered through the National Institutes of~~
18 ~~Health and the Centers for Diseases Control and Prevention~~
19 ~~(Directive to Take Action); and be it further~~
20

21 **RECOMMENDATION F:**

22
23 **The sixth resolve in Resolution 1 be amended by addition and**
24 **deletion to read as follows:**

25
26 RESOLVED, that our AMA support the development of clinical
27 screening guidelines for ~~pediatricians and family physicians to~~
28 ~~screen for harmful social media use as part of routine well-child and~~
29 ~~adolescent health visits~~ and public education campaigns (Directive
30 to Take Action); and be it further
31

32 **RECOMMENDATION G:**

33
34 **The seventh resolve in Resolution 1 be deleted.**

35
36 ~~RESOLVED, that our AMA engage in sustained public education~~
37 ~~efforts to inform parents, educators, and policymakers about the~~
38 ~~documented risks of social media use by minors under 16,~~
39 ~~leveraging the organization's standing as a trusted public health~~
40 ~~authority (Directive To Take Action); and be it further~~
41

42 **RECOMMENDATION H:**

43
44 **The eighth resolve in Resolution 1 be amended by addition and**
45 **deletion to read as follows:**

46
47 RESOLVED, that our AMA communicate ~~its positions~~ these harmful
48 social media use positions to the U.S. Congress, the White House
49 ~~Office of Science and Technology Policy, the Federal Trade~~
50 ~~Commission, the Federal Communications Commission, and all~~
51 ~~relevant state medical associations~~ with policy reassessment

1 required after five years based on outcomes data (Directive to Take
2 Action).

3
4 **RECOMMENDATION I:**

5
6 **Resolution 1 be adopted as amended with a change in title to**
7 **read:**

8
9 **FEDERAL FRAMEWORK FOR SOCIAL MEDIA ACCESS BY**
10 **MINORS UNDER AGE 16**

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12 **RECOMMENDATION J:**

13
14 **Resolution 1 be held back and forwarded for consideration at**
15 **the 2026 Interim Meeting of the AMA House of Delegates.**
16

17 **FEDERAL LEGISLATION TO PROHIBIT SOCIAL MEDIA USE BY MINORS UNDER AGE 16**

18
19 RESOLVED, that our American Medical Association will formally call upon the United States
20 Congress and the President of the United States to enact federal legislation establishing a
21 minimum age of 16 for the creation and use of social media accounts on platforms accessible in
22 the United States (Directive to Take Action); and be it further

23
24 RESOLVED, that our AMA advocates advocate for legislation to require social media platforms to
25 implement robust, technologically reliable age verification systems to prevent access by users
26 under 16 with meaningful civil and criminal penalties for platforms that fail to comply (Directive to
27 Take Action); and be it further

28
29 RESOLVED, that our AMA advocate for legislation to provide for independent auditing of social
30 media platform compliance with regulatory oversight by the Federal Trade Commission and/or a
31 designated federal agency with authority to enforce penalties (Directive to Take Action); and be it
32 further

33
34 RESOLVED, that our AMA urge Congress to require social media platforms to conduct and
35 publicly disclose independent health impact assessments examining the effects of their products
36 on users under 18 before launching new features or algorithmic changes (Directive to Take
37 Action); and be it further

38
39 RESOLVED, that our AMA advocate for robust federal funding for longitudinal research into the
40 effects of social media on child and adolescent mental health, neurodevelopment, and academic
41 performance, to be administered through the National Institutes of Health and the Centers for
42 Diseases Control and Prevention (Directive to Take Action); and be it further

43
44 RESOLVED, that our AMA support the development of clinical guidelines for pediatricians and
45 family physicians to screen for harmful social media use as part of routine well-child and
46 adolescent health visits (Directive to Take Action); and be it further

47
48 RESOLVED, that our AMA engage in sustained public education efforts to inform parents,
49 educators, and policymakers about the documented risks of social media use by minors under
50 16, leveraging the organization's standing as a trusted public health authority (Directive To Take
51 Action); and be it further
52

1 RESOLVED, that our AMA communicate its positions to the U.S. Congress, the White House
2 Office of Science and Technology Policy, the Federal Trade Commission, the Federal
3 Communications Commission, and all relevant state medical associations (Directive to Take
4 Action).

5
6 Your Reference Committee heard significant support for the intent behind Resolution 1 with
7 members agreeing that social media use and content present a real health concern for minors.
8 Testimony reflected that the resolution could likely be consolidated without damaging the intent
9 but thereby improving its likelihood for success at the House of Delegates. The Committee
10 agrees with this assessment and proposes the amendments offered here mostly as a method
11 for achieving a more streamlined resolution.

12
13 The Committee did give considerable discussion to the minimum age offered by Resolution 1,
14 considering that opinions are likely to vary about what age, be it 16 or 18, should be adopted as
15 a threshold and, regardless, what empirical evidence could be presented in making the
16 argument for either. The Committee also wondered how enforcement of these policies would
17 reasonably be enacted, appreciating that humans in general and children in particular have
18 historically proven to be adept at getting around internet-based verification methods, be they for
19 age or geographic location or any other characteristic. The Committee ultimately agreed,
20 however, that any attempt to address the issues is better than holding out for a perfect one.
21 Recognizing the issue of minor use of social media is neither new nor emergent, the Committee
22 recommends holding back Resolution 1 until the 2026 Interim meeting when its focus on
23 advocacy will likely lend to its success.

24
25 Your Reference Committee thus recommends that Resolution 1 be adopted as amended and
26 held back for consideration by the House of Delegates at the 2026 Interim Meeting.

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30 (2) RESOLUTION 2 – SUPPORTING REGULATIONS FOR MORE
31 STRINGENT SAFETY MEASURES FOR MICROMOBILITY

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33 **RECOMMENDATION A:**

34
35 **The resolve in Resolution 2 be amended by addition and**
36 **deletion to read as follows:**

37
38 RESOLVED, that our American Medical Association ~~endorse~~
39 ~~the following policies~~ better define and expand AMA policy to
40 help improve safety for micromobility (e-bikes and e-
41 scooters) usage:

- 42 1. Helmets, certified by the US Consumer Safety Product
43 Commission and rated for speed, should be worn for all
44 and be mandatory for Class 3 e-bikes and all scooters;
- 45 2. Additional gear should include elbow pads, knee pads,
46 wrist guards, closed-toe footwear and high-visibility or
47 reflective gear for use at nighttime;
- 48 3. Headphones should be avoided during use;
- 49 4. E-scooters and Class 3 e-bikes should have a minimum
50 age of 16 to operate;
- 51 5. Require education and training for Class 3 e-bikes;

6. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths and no operation allowed on sidewalks;
7. No distractions while operating;
8. No passengers while operating;
9. Regulate out-of-class products and anti-tampering;
10. Training required to operate devices, including smooth and consistent braking at high speeds and basic traffic rules;

(Directive to Take Action); and be it further

RECOMMENDATION B:

Resolution 2 be amended by addition of a second resolve to read as follows:

RESOLVED, that our AMA advocate for standardized injury surveillance and reporting of micromobility-related injuries at the state and national level, including integration into existing trauma registries and public health reporting systems (Directive to Take Action); and be it further

RECOMMENDATION C:

Resolution 2 be amended by addition of a third resolve to read as follows:

RESOLVED, that our AMA encourage and advocate for accelerated research into the root causes of e-bike and e-scooter injuries in the United States, with the goal of defining actionable best practices to prevent and/or minimize serious injury associated with operation of various classes of such vehicles, as well as the relevant demographics of the operators thereof (Directive to Take Action).

RECOMMENDATION D:

Resolution 2 be adopted as amended.

RECOMMENDATION E:

Resolution 2 be held back and forwarded for consideration at the 2026 Interim Meeting of the AMA House of Delegates.

RESOLVED, that our American Medical Association endorse the following policies to help improve safety for micromobility (e-bikes and e-scooters) usage:

1. Helmets, certified by the US Consumer Safety Product Commission and rated for speed, should be worn for all and be mandatory for Class 3 e-bikes and all scooters;
2. Additional gear should include elbow pads, knee pads, wrist guards, closed-toe footwear and high-visibility or reflective gear for use at nighttime;
3. Headphones should be avoided during use;
4. E-scooters and Class 3 e-bikes should have a minimum age of 16 to operate;

- 1 5. Require education and training for Class 3 e-bikes;
- 2 6. Define where e-bikes can be ridden both on and off-road, including speed limits on shared paths
- 3 and no operation allowed on sidewalks;
- 4 7. No distractions while operating;
- 5 8. No passengers while operating;
- 6 9. Regulate out-of-class products and anti-tampering;
- 7 10. Training required to operate devices, including smooth and consistent braking at high speeds
- 8 and basic traffic rules;
- 9 (Directive to Take Action).

10
11 Your Reference Committee heard testimony supporting Resolution 2 but questioning if it
12 couldn't be improved to have more real-world impact instead of staying limited to AMA policy.
13 Testimony also reflected the concern for rising head injuries, fractures and orthopedic trauma
14 seemingly directly related to use and misuse of e-scooters and e-bikes. At the same time,
15 testaments noted that micromobility devices such as these have become critical for populations
16 that cannot afford independent transportation, thus they have value.

17
18 The Committee recommends adopting two additional resolve clauses offered in testimony to
19 deepen the impact of Resolution 2 and to provide a novel enough addition to AMA policy as to
20 avoid reaffirmation by the House of Delegates. Additionally, the Committee believes recasting
21 the existing resolve clause slightly to reflect the desire to expand existing AMA policy will
22 improve the resolution's chances for success. Because the issue of micromobility access is
23 neither new nor emergent, the committee believes Resolution 2 should be heard at the 2026
24 Interim Meeting instead of being advanced immediately.

25
26 Your Reference Committee ultimately recommends that Resolution 2 be adopted as amended
27 and held back for consideration by the House of Delegates at the 2026 Interim Meeting.
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31 (3) RESOLUTION 3 – ENSURING ACCURACY AND PHYSICIAN
32 PROTECTIONS FOR PATIENT ATTRIBUTION IN HEALTH PLAN
33 QUALITY MEASUREMENT AND VALUE-BASED PROGRAMS
34

35 **RECOMMENDATION A:**

36
37 **The first resolve in Resolution 3 be amended by addition and**
38 **deletion to read as follows:**

39
40 RESOLVED, that our American Medical Association adopt as policy
41 the following Universal Standards for Patient Attribution:

- 42 1. Clinical Relationship: Attribution must be based on a
- 43 documented clinical relationship, defined by recent clinical
- 44 encounter(s) within an appropriate timeframe or a verified
- 45 patient designation of the physician as their primary care
- 46 provider (PCP);
- 47 2. Prospective Notification: Payers must provide physicians with
- 48 prospective lists an option for retrospective or prospective
- 49 attribution methodology and, if opting for prospective attribution,
- 50 they should provide physicians with a list of attributed patients
- 51 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

RECOMMENDATION B:

Resolution 3 be adopted as amended.

RECOMMENDATION C:

Resolution 3 be held back and forwarded for consideration at the 2026 Interim Meeting of the AMA House of Delegates.

RESOLVED, that our American Medical Association 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 prospective lists 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;
- (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate for federal and state legislation and regulation that ensures accurate patient attribution and prevent physicians from being evaluated on patients with whom they have no established care relationship, including enforcement mechanisms for payers who fail to maintain accurate attribution lists (Directive to Take Action); and be it further

RESOLVED, that our AMA develop model state legislation and regulatory policy addressing accurate patient attribution in health plan quality measurement and value-based payment programs, based on the Universal Standards for Patient Attribution, with modular components adaptable to varying state legislative and regulatory environments (Directive to Take Action); and be it further

RESOLVED, that our AMA Board of Trustees report back at the 2026 Interim Meeting with recommendations to align and consolidate existing AMA policies related to patient attribution to ensure a streamlined advocacy strategy (Directive to Take Action).

1 Your Reference Committee heard generally strong support for Resolution 3 with several
2 members specifically calling out examples of attribution in their own facilities that were
3 improperly assigned or otherwise inappropriate to treatment and care. Testaments reflected
4 growing concern that problems with attribution will only continue to grow under value-based
5 care arrangements. The Committee agreed with these sentiments, only diverging slightly with
6 the resolution's recommendation around prospective attribution; The Committee considered that
7 some physicians may prefer retrospective attribution rather than prospective and suggests
8 amending that clause to allow for flexibility based on physician preference. The Committee
9 considered whether the resolution should be immediately advanced, however ultimately
10 believed holding until the Interim 2026 meeting will benefit the resolution by allowing it to be
11 included in the HOD Handbook and the HOD online reference committees, thus giving more
12 members the opportunity to consider and discuss the issue.

13
14 Your Committee thus recommends that Resolution 3 be adopted as amended and held back for
15 consideration by the House of Delegates at the 2026 Interim Meeting.

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19 (4) RESOLUTION 5 – MEDICAL STAFF OVERSIGHT OF HOSPITAL
20 AUGMENTED INTELLIGENCE

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22 **RECOMMENDATION A:**

23
24 **The resolve in Resolution 5 be amended by addition and**
25 **deletion to read as follows:**

26
27 RESOLVED, that our American Medical Association recommends
28 medical staffs of hospitals and other medical treatment
29 establishments include physician reviews of all augmented
30 intelligence recommendations that impact patient care schedule
31 and hold regular, timely physician-led meetings (e.g. weekly,
32 biweekly or monthly) to review management outcomes of all
33 patients whose care involved augmented/artificial intelligence
34 recommendations in the interval between meetings, and also
35 review proposed treatment as well as any delayed consequences
36 of prior care that may have arisen (Directive to Take Action).

37
38 **RECOMMENDATION B:**

39
40 **Resolution 5 be adopted as amended.**

41
42 **RECOMMENDATION C:**

43
44 **Resolution 5 be immediately forwarded for consideration at the**
45 **2026 Annual Meeting of the AMA House of Delegates.**

46
47 RESOLVED, that our American Medical Association recommends medical staffs of hospitals and
48 other medical treatment establishments schedule and hold regular, timely physician-led meetings
49 (e.g. weekly, biweekly or monthly) to review management outcomes of all patients whose care
50 involved augmented/artificial intelligence recommendations in the interval between meetings, and
51 also review proposed treatment as well as any delayed consequences of prior care that may have
52 arisen (Directive to Take Action).

1
2 Your Reference Committee heard universally strong support for Resolution 5 with several
3 members applauding the resolution for building on existing AMA policy surrounding physician
4 involvement in creation and deployment of augmented intelligence in the hospital setting.
5 Testaments reflected that Resolution 5 would help to ensure that augmented devices and
6 protocols are evaluated by physicians in addition to being initially approved of by them. The
7 Committee only found itself in disagreement with establishing an exactly prescribed method of
8 evaluation (i.e., monthly/weekly/annually) and worry about requiring medical staffs participate in
9 yet another meeting, particularly given that many healthcare facilities have already begun to
10 establish AI committees or subcommittees that are presumably beginning to engage in the kind
11 of work Resolution 5 recommends. The Committee believes that letting each facility figure out
12 the logistics of such procedures on their own is the wisest course of action.

13
14 Given that augmented intelligence is not only an emergent issue but a rapidly changing one,
15 your Reference Committee recommends that Resolution 5 be adopted as amended and
16 immediately forwarded for consideration by the House of Delegates at the 2026 Annual
17 Meeting.

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21 (5) RESOLUTION 6 – PROTECTING CHILDREN FROM POTENTIAL
22 HARMS OF CAFFEINATED PRODUCTS

23
24 **RECOMMENDATION A:**

25
26 **The resolves in Resolution 6 be amended by substitution to**
27 **read as follows:**

28
29 ~~RESOLVED, that our American Medical Association will advocate~~
30 ~~for more public education and awareness about the potential side-~~
31 ~~effects of caffeinated product consumption (Directive to Take~~
32 ~~Action); and be it further~~

33
34 ~~RESOLVED, that our AMA will advocate for more limits on~~
35 ~~commercial advertising of caffeinated products targeting children~~
36 ~~and youth (Directive to Take Action); and be it further~~

37
38 ~~RESOLVED, that our AMA will advocate for children under the age~~
39 ~~of 12 years old to avoid caffeinated products entirely and teenagers~~
40 ~~to limit intake to <100mg per day (Directive to Take Action).~~

41
42 RESOLVED, that our American Medical Association amend
43 existing policy H-150.988 by addition of an addendum to point 3 to
44 read:

45 “; also, that children under the age of 12 years old should
46 avoid caffeinated products entirely and those under the age
47 of 18 should limit intake to <100mg per day as supported by
48 evidence-based research and guidelines.”

49 (Amend HOD Policy); and be it further

50
51 RESOLVED, that our AMA amend existing policy D-150.976
52 by addition of an addendum to #1 to read:

1 “with special attention to scientific evidence of harm
2 to children below ages 12 and 18.”
3 and #2 to read:
4 “with specific warning of harm to children below the
5 age of 18.”
6 (Amend HOD Policy).

7
8 **RECOMMENDATION B:**

9
10 **Resolution 6 be adopted as amended.**

11
12 **RECOMMENDATION C:**

13
14 **Resolution 6 be immediately forwarded for**
15 **consideration at the 2026 Annual Meeting of the AMA**
16 **House of Delegates.**

17
18 RESOLVED, that our American Medical Association will advocate for more public
19 education and awareness about the potential side-effects of caffeinated product
20 consumption (Directive to Take Action); and be it further

21
22 RESOLVED, advocate for more limits on commercial advertising of caffeinated products
23 targeting children and youth (Directive to Take Action); and be it further

24
25 RESOLVED will advocate for children under the age of 12 years old to avoid caffeinated
26 products entirely and teenagers to limit intake to <100mg per day (Directive to Take Action)

27
28 Your Reference Committee heard strong support for Resolution 6 with some
29 suggestions for amendments around strengthening definitions of terms and precisely
30 articulating the kinds of awareness in advertising and promotion the AMA should engage
31 in. While the Committee did not inherently disagree with any of these suggestions, it was
32 concerned that Resolution 6 could still be placed on reaffirmation without a novel
33 approach that clearly delineated it from already established AMA policy. The Committee
34 was thus persuaded by suggestions that the resolves be substituted with language that
35 specifically updates policy, reducing the changes for reaffirmation. The Committee also
36 pondered what the evidentiary basis for ages 12 and 18 were in terms of potential harm,
37 as well as the rationale for limiting caffeine intake to specific doses, however ultimately
38 the Committee believes these are secondary concerns and could be debated
39 independently without risking the fate of the entire resolution.

40
41 While caffeine intake in youth is neither a new nor emergent issue and thus there is little
42 to justify immediate consideration by the house, The committee believes grounding the
43 amended resolution in updates to AMA policy makes it applicable for consideration at an
44 Annual Meeting. Your Reference Committee thus recommends that Resolution 6 be
45 adopted as amended and immediately forwarded for consideration by the House of
46 Delegates at the 2026 Annual Meeting.

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1 (6) RESOLUTION 7 – SURVEY OF MEDICAL STAFFS

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3 **RECOMMENDATION A:**

4
5 **The resolve in Resolution 7 be amended by addition to**
6 **read as follows:**

7
8 RESOLVED, that our American Medical Association work
9 with the Organized Medical Staff Section to sponsor a
10 survey of sufficient statistical power to determine the
11 spectrum of composition and influence of the contemporary
12 medical staff across the United States, including but not
13 limited to information such as:

- 14 • Is your hospital owned by a system, is it independent,
15 or is it affiliated with a system?
- 16 • Do you have your own medical staff with officers? If part
17 of a system, is there one medical staff for the system or
18 does each facility have its own?
- 19 • What are the categories of medical staff membership?
20 Please define these.
- 21 • Are the officers appointed by the hospital or are they
22 elected by the medical staff?
- 23 • Is there a medical staff executive committee (MEC) that
24 meets regularly? How often? Does it meet with hospital
25 leadership? Do non-medical staff members have a vote
26 on the MEC?
- 27 • To what degree are independent physicians (solo,
28 members of group organizations, etc) versus employed
29 physicians active in the administration of medical staff,
30 i.e. involvement in committees or ad hoc initiatives?

31 (Directive to Take Action).

32
33 **RECOMMENDATION B:**

34
35 **Resolution 7 be adopted as amended.**

36
37 **RECOMMENDATION C:**

38
39 **Resolution 7 be immediately forwarded for**
40 **consideration at the 2026 Annual Meeting of the AMA**
41 **House of Delegates.**

42
43 RESOLVED, that our American Medical Association sponsor a survey of sufficient
44 statistical power to determine the spectrum of composition and influence of the
45 contemporary medical staff across the United States, including but not limited to
46 information such as:

- 47 • Is your hospital owned by a system, is it independent, or is it affiliated with a system?
- 48 • Do you have your own medical staff with officers? If part of a system, is there one
49 medical staff for the system or does each facility have its own?

- 1 • What are the categories of medical staff membership? Please define these.
- 2 • Are the officers appointed by the hospital or are they elected by the medical staff?
- 3 • Is there a medical staff executive committee (MEC) that meets regularly? How often?
- 4 Does it meet with hospital leadership? Do non-medical staff members have a vote on
- 5 the MEC?
- 6 • To what degree are independent physicians (solo, members of group organizations,
- 7 etc) versus employed physicians active in the administration of medical staff, i.e.
- 8 involvement in committees or ad hoc initiatives?
- 9 (Directive to Take Action).

10
11 Your Reference Committee heard universally support for Resolution 7. Testaments
12 reflected that in order for the OMSS to continue to be effective in its mission it needs a
13 solid understanding of the current landscape of medical staffs in the United States,
14 including a deep understanding of the trends in ownership and organizational structure
15 of healthcare facilities. The Committee was made aware that a similar survey is currently
16 ongoing in Massachusetts, potentially giving the AMA/OMSS a template that could easily
17 be used to achieve the same strategic insights at a national level. The Committee
18 believes it also worth noting that such efforts could have advantageous secondary
19 effects for the Section by way of improved awareness of the OMSS and greater
20 opportunities for targeting new membership. Because there are logistical realities to
21 mounting a nation-wide survey with enough participants to generate statistically
22 significant and generalizable results, the Committee believes the best likelihood for
23 success is to utilize appropriate AMA business units that have expertise and resources
24 for this type of information gathering and asking that they work with the OMSS to
25 achieve a rich, final result.

26
27 Because the need for this type of understanding is so central to the OMSS's mission,
28 your Reference Committee recommends that Resolution 7 be adopted as amended and
29 immediately forwarded for consideration by the House of Delegates at the 2026 Annual
30 Meeting.

RECOMMENDED FOR REFERRAL

(7) RESOLUTION 4 – MEDICAL BYLAWS UPDATE NEEDS
TO BE A MANDATED JOINT COMMISSION STANDARD

RECOMMENDATION:

Resolution 4 be referred.

RESOLVED, that our American Medical Association will ask The Joint Commission to make AMA policies H-235.991 and H-220.976 mandatory for hospital medical staff (Directive to Take Action); and be it further

RESOLVED, that our AMA will ask The Joint Commission to make it illegal for hospitals or hospital systems to make selective bylaw changes instead of going through a proper process of bylaw development that adequately safeguards a self-governing medical staff (Directive to Take Action); and be it further

RESOLVED, that our AMA will ask The Joint Commission to make it mandatory for hospital medical staffs to have a comprehensive bylaws document review at least every three years (Directive to Take Action).

Your Reference Committee heard mixed testimony on Resolution 4 with some testaments offering support for the resolution while others opposed the approach even if they supported the intent; still others suggested that the mandate created by the resolution could have unforeseen consequences, particularly for smaller healthcare facilities with fewer resources at their disposal. The Committee found itself in agreement with these sentiments and expressed a particular reluctance to create more mandated conditions, particularly ones that would ultimately be outside the control of the AMA as The Joint Commission would be expected to come to its own conclusions. The Committee also considered that medical staffs have recourse already established for situations where they feel they are not being treated appropriately and doubt that establishing another standard would provide relief. The Committee did consider, however, that this issue will become more significant as hospital consolidation continues to grow and more physicians find themselves in practice settings that are perhaps far different from the ones they initially agreed to work in.

Given the complexity of the issue and the potentially far-reaching implications, your Reference Committee thus recommends that Resolution 4 be referred to the OMSS Governing Council for study in the hopes that time to research the implications will provide greater clarity on the best path forward.

1 Doctor Chair, this concludes the report of the Organized Medical Staff Section Reference
2 Committee. We would like to thank Drs. Mona Alqualali, Art Snow, and Barbara Spivak as
3 well as all those who testified before the Committee.

Theodore Christopher, MD
Chair, OMSS Reference Committee

Mona Alqualali, MD

Art Snow, MD

Barbara Spivak, MD