AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: (Assigned by HOD)
(I-26)

Introduced by: Organized Medical Staff Section

Subject: Strengthening Medicare and Accreditation Standards for Organized Medical Staff Independence

Referred to: Reference Committee (Assigned by HOD)

Whereas, the Medicare Conditions of Participation require hospitals to maintain an organized medical staff that operates under governing-body-approved bylaws, is responsible for the quality of medical care, and is well-organized and accountable to the governing body[1,2]; and

Whereas, the Centers for Medicare and Medicaid Services (CMS) interpretive guidance describes a collaborative system of checks and balances in which the medical staff exercised oversight through credentialing, privileging, peer review, policy approval, and quality improvement participation[2]; and

Whereas, the current Medicare Conditions of Participation address medical staff organization, accountability, composition, and bylaws but do not expressly prescribe the functional reporting relationship of medical staff office personnel or minimum protected budgetary, staffing, and independent-counsel resources for the organized medical staff[1,2]; and

Whereas, AMA Policies H-225.957 and H-235.980 recognize medical staff self-governance, control of medical staff funds, access to independent legal counsel, and the organized medical staff's role in determining the resources and financial support required to fulfill its responsibilities[3,4]; and

Whereas, AMA Policy H-375.962 recognizes the central role of confidentiality, privilege, good-faith participation, immunity, and protection from retaliation in effective peer review[5]; and

Whereas, because Medical Staff Office personnel administer credentialing, privileging, peer review, corrective action, quality improvement, and medical staff governance, exclusive administrative control over their medical-staff duties may create actual or perceived conflicts when the interests of hospital administration and the organized medical staff differ[2,3,5]; and

Whereas, CMS-approved accrediting organizations may survey hospitals for deemed compliance only through programs whose standards meet or exceed applicable Medicare requirements[6]; therefore be it

RESOLVED, that our American Medical Association advocate that the Centers for Medicare & Medicaid Services (CMS) establish standards requiring, as a Condition of Participation for hospitals participating in Medicare, that Medical Staff Office personnel performing functions on behalf of organized medical staff have clearly defined functional accountability to the organized medical staff, through the Medical Executive Committee or its designee for credentialing, privileging, peer review, corrective action, medical staff governance, quality oversight, and other organized medical staff functions; (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that CMS require hospital medical staff bylaws or related governing documents approved through the medical staff bylaw process to define the Medical Staff Office reporting structure, authority over medical-staff work assignments and performance evaluation, safeguards against administrative interference or retaliation, and standards governing access to, use of, and disclosure of confidential medical staff information (Directive to Take Action); and be it further

RESOLVED, that our AMA advocate that CMS-approved hospital accrediting organizations adopt uniform standards concerning Medical Staff Office functional accountability, protected medical staff resources, access to independent legal counsel when appropriate, and confidentiality of credentialing, privileging, peer review, quality-improvement, corrective-action, and disciplinary information (Directive to Take Action)

RESOLVED, that our AMA advocate that Joint Commission standards explicitly protect the organized medical staff's access to timely, transparent, and interpretable information, adequate resources, and independent authority necessary to meaningfully fulfill its self-governance responsibilities, regardless of how supporting personnel, technology, or administrative infrastructure are organized.

Fiscal Note: (Assigned by HOD)

REFERENCES

1. Electronic Code of Federal Regulations. 42 CFR § 482.22, Condition of Participation: Medical Staff. eCFR § 482.22 Accessed August 4, 2026.
2. Centers for Medicare & Medicaid Services. State Operations Manual, Appendix A: Survey Protocol, Regulations and Interpretive Guidelines for Hospitals, § 482.22. CMS State Operations Manual Appendix A Accessed August 4, 2026.
3. American Medical Association. Policy H-225.957, Principles for Strengthening the Physician-Hospital Relationship. AMA PolicyFinder Accessed August 4, 2026.
4. American Medical Association. Policy H-235.980, Hospital Medical Staff Self-Governance. AMA PolicyFinder Accessed August 4, 2026.
5. American Medical Association. Policy H-375.962, Legal Protections for Peer Review. AMA PolicyFinder Accessed August 4, 2026.
6. Centers for Medicare & Medicaid Services. Accrediting Organizations with CMS-approved programs and deeming authority. CMS Accrediting Organizations Accessed August 4, 2026.
7. American Medical Association. Code of Medical Ethics Opinion 9.5.1, Organized Medical Staff. AMA Code of Medical Ethics Accessed August 4, 2026.
8. American Medical Association. Policy H-235.976, Medical Staff Bylaws and Medical Staff Autonomy. AMA PolicyFinder Accessed August 4, 2026.
9. American Medical Association. Policy D-235.982, Model Hospital Medical Staff Bylaws; reproduced in Resolution 024 (A-24), Relevant AMA Policy section. AMA HOD source Accessed August 4, 2026.
10. American Medical Association. AMA Physician's Guide to Medical Staff Organization Bylaws, 7th ed. AMA guide landing page Accessed August 4, 2026.

RELEVANT AMA POLICY

Principles for Strengthening the Physician-Hospital Relationship H-225.957

Our American Medical Association adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:

1. Our AMA urges residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for physicians include:
    a. duration of leave allowed before and after delivery;
    b. category of leave credited;
    c. whether leave is paid or unpaid;
    d. whether provision is made for continuation of insurance benefits during leave, and who pays the premium;
    e. whether sick leave and vacation time may be accrued from year to year or used in advance;
    f. how much time must be made up in order to be considered board eligible;
    g. whether make-up time will be paid;
    h. whether schedule accommodations are allowed; and
    i. leave policy for adoption.
3. Our AMA policy is expanded to include physicians in practice, reading as follows:
    a. residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled;
    b. staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and
    c. physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA recommends that medical practices, departments and training programs strive to provide 12 weeks of paid parental, family and medical necessity leave in a 12-month period for their attending and trainee physicians as needed, with the understanding that no parent be required to take a minimum leave, and with eligibility beginning at the start of employment without a waiting period.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, abortion or stillbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.
7. Residency programs should develop written policies on leave for physicians. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. duration of leave allowed after abortion or stillbirth;
    d. category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability);

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

8. Medical schools should develop written policies on parental leave, family leave, and medical leave for medical students. Such written policies should include the following elements:
    a. leave policy for birth or adoption;
    b. duration of leave allowed before and after delivery;
    c. extended leave for medical students with extraordinary and long-term personal or family medical tragedies, without loss of previously accepted medical school seats, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life;
    d. how time can be made up in order for a medical students to be eligible for graduation with minimal or no delays;
    e. what period of leave would result in a medical student being required to complete an extra or delayed year of training; and
    f. whether schedule accommodations are allowed, such as modified rotation schedules, no night duties, and flexibility with academic testing schedules.
9. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.
10. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.
11. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.
12. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.
13. Our AMA encourages flexibility in residency programs and medical schools incorporating parental leave and alternative schedules for pregnant trainees.
14. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties (ABMS) to allow graduating residents to extend training after the traditional residency completion date while still maintaining board eligibility, in the event of leave beyond six weeks. Our AMA encourages specialty boards to develop flexible policies for board

certification for those physicians who take leave beyond the minimum of six weeks of family or medical leave (per ABMS policy) and whose residency programs are able to certify that residents meet appropriate competencies for program completion.

15. Our AMA will work with appropriate stakeholders to encourage that residency programs annually publish and share with FREIDA and other appropriate stakeholders, self-identified and other demographic data, including but not limited to the composition of their program over the last 5 years by age; historically marginalized, minoritized, or excluded status; sexual orientation and gender identity.
16. Our AMA will encourage the Accreditation Council for Graduate Medical Education and other relevant stakeholders to annually collect data on childbirth and parenthood from all accredited US residency programs and publish this data with disaggregation by gender identity and specialty.
17. These policies as above should be freely available online through FREIDA and in writing to all current trainees and applicants to medical school, residency or fellowship.
18. Medical schools are encouraged to develop clear, equitable parental leave policies and determine how a 12-week parental, family, or medical leave may be incorporated with alternative, timely means of completing missed curriculum while still meeting competency requirements necessary to complete a medical degree.
19. Our AMA opposes any discrimination related to physicians taking protected leave during training and/or medical practice for medical, religious, and/or family reasons.
20. Our AMA will encourage relevant stakeholders to survey physicians and medical students who have taken family leave, in an effort to learn about the experiences of various demographic groups and identify potential disparities in career progression trends.
21. Our AMA supports policies that provide physician employees with paid leave for routine prenatal care or any medical care related to pregnancy in addition to other existing forms of leave.

Citation: CCB/CLRPS Rep. 4, A-13; Modified: Res. 305, A-14; Modified: Res. 904, I-14; Modified: Res. 307, A-22; Modified: Res. 302, I-22; Modified: Res. 312, I-22; Modified: CME Rep. 01 and Res. 306, I-23; Modified: Res. 302, I-24; Appended: Res. 306, I-25

Hospital Medical Staff Self-Governance H-235.980

1. Our AMA: supports essentials of self-governance for hospital medical staffs which, at a minimum include the right to: (a) initiation, development and adoption of medical staff bylaws, rules and regulations; (b) approval or disapproval of amendments to the medical staff bylaws, rules and regulations; (c) selection and removal of medical staff officers; (d) establishment and enforcement of criteria and standards for medical staff membership; (e) establishment and maintenance of patient care standards; (f) accessibility to and use of independent legal counsel; (g) credentialing and delineation of clinical privileges; (h) medical staff control of its funds; and (i) successor-in-interest rights.
2. Our AMA opposes any attempts to reengineer or otherwise amend medical staff bylaws or split the bylaws into a variety of separate and unincorporated manuals or policies, thereby eliminating the control and approval rights of the medical staff as required by the principles of medical staff self-governance.
3. Our AMA will ask its Commissioners to the Joint Commission on Accreditation of Healthcare Organizations to require that JCAHO medical staff standards require the

following components to be an integral part of the medical staff bylaws, and not separate "governance documents," requiring approval by the entire medical staff. The medical staff is responsible for the following:
(a) Application, reapplication, credentialing and privileging standards;
(b) Fair hearing and appeal process;
(c) Selection, election and removal of medical staff officers;
(d) Clinical criteria and standards which manage quality assurance, utilization review;
(e) Structure of the medical staff organization;
(f) Rules and regulations that affect the entire medical staff.

4. Our AMA recognizes that hospital non-compliance with JCAHO Standard MS 1.20 will be treated in the same way as hospital non-compliance with any other standard.

Citation: Sub. Res. 201, A-89; Reaffirmed: Sub. Res. 808, A-94; Reaffirmed, Amended, and Appended: Sub. Res. 817, I-01; Reaffirmed: A-05; Appended: Res. 730, A-05; Reaffirmed: CMS Rep. 1, A-15; Reaffirmed: CMS Rep. 01, A-25

Medical Staff Bylaws and Medical Staff Autonomy H-235.976

Our AMA reaffirms that (1) medical staff bylaws are a contract between the organized medical staff and the hospital; and (2) application for medical staff appointment and clinical privileges should provide that each member of the medical staff, as well as the hospital, is bound by the terms of the medical staff bylaws, and the terms of the medical staff bylaws should be incorporated by reference into the application.

Citation: Res. 8, A-91; Modified: Sunset Report, I-01; Reaffirmed: BOT Rep. 9, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: CMS Rep. 01, A-24

Model Hospital Medical Staff Bylaws D-235.982

1. Our AMA will continue to update the Physician’s Guide to Medical Staff Organization Bylaws to address emerging issues in medical staff affairs, including relevant changes to medical staff regulatory and accreditation requirements, such as those outlined in the Medicare Hospital Conditions of Participation and in the accreditation standards of The Joint Commission and other hospital accrediting organizations.
2. Our AMA will develop guidance for physicians on key state-by-state differences in medical staff bylaws requirements and best practices, and work with state medical societies to catalog state-specific medical staff resources available to physicians.
3. Our AMA will pursue opportunities to improve the accessibility and usability of the content contained in the Physician’s Guide to Medical Staff Organization Bylaws, including but not limited to development of supplemental materials such as education modules, checklists, and so forth.

Citation: BOT Rep. 35, A-18

Legal Protections for Peer Review H-375.962

Definition and Purpose of Peer Review

Peer review is the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice. It is the mechanism by which the medical profession fulfills its obligation to ensure that its members are able to provide safe and effective care. The responsibility assigned to and scope of peer review is the practice of medicine; ie, professional services administered by a physician and the portion of care under a physician's direction. Therefore, elements of medical care, which describe the knowledge, skills, attitudes, and educational experiences of physicians and provide the foundation of physician activities, are subject to peer review and its protections. Those elements include, but are not limited to the following: patient care, medical knowledge, interpersonal and communication skills, practice-based learning and improvement, and systems-based practice. Activities that comprise medical care are subject to the scope and rigor of peer review and entitled to the protections and privileges afforded by peer review law.

Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care. Accountability to patients and their care, to the medical profession and colleagues, and to the institution granting privileges is inherent to the peer review process.

Composition of the Peer Review Committee

Peer review is conducted in good faith by physicians who are within the same geographic area or jurisdiction and medical specialty of the physician subject to review to ensure that all physicians consistently maintain optimal standards of competency to practice medicine. Physicians outside of the organization that is convening peer review may participate in that organization's peer review of a physician if the reviewing physician is within the same geographic area or jurisdiction and medical specialty as the physician who is the subject of peer review.

Definitions

Good Faith Peer Review. Peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains, or due to personal vendetta is not considered a good faith peer review.

Medical Peer Review Organizations. Any panel, committee, or organization that is composed of physicians or formed from a medical staff or formed by statute, such as physician wellness peer review boards, which engages in or utilizes peer reviews concerning the care and treatment of patients for the purposes of self-monitoring and maintaining the administration of patient safety and quality of care consistent with optimal standards of practice is a medical peer review

organization. The responsibility of a medical peer review organization is to ensure: (1) that all physicians consistently maintain optimal standards of competency to practice medicine; and (2) the quality, safety, and appropriateness of patient care services. The medical peer review committee's obligations include review of allegations of infirmity (e.g., fitness to practice medicine), negligent treatment, and intentional misconduct. Peer review protections and privilege should extend to investigation and subsequent correction of negligent treatment and intentional misconduct.

Proceedings. Proceedings include all of the activities and information and records of a peer review committee. Proceedings are not subject to discovery and no person who was in attendance at a meeting of a peer review organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions, or other actions of such organization or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of a peer review organization, nor should any person who testifies before a peer review organization or who is a member of a peer review organization be prevented from testifying as to matters within their knowledge; but such witness cannot be asked about their testimony before a peer review organization or about opinions formed by them as a result of the peer review organization hearings.

Peer Review Activity. Peer review activity means the procedure by which peer review committees or quality assessment and assurance committees monitor, evaluate, and recommend actions to improve and ensure the delivery and quality of services within the committees' respective facilities, agencies, and professions, including recommendations, consideration of recommendations, actions with regard to recommendations, and implementation of actions.

Peer Review Records. Peer review records mean all complaint files, investigation files, reports, and other investigative information relating to the monitoring, evaluation, and recommendation of actions to improve the delivery and quality of health care services, licensee discipline, or professional competence in the possession of a peer review committee or an employee of a peer review committee.

Privilege. The proceedings, records, findings, and recommendations of a peer review organization are not subject to discovery. Information gathered by a committee is protected. Purely factual information, such as the time and dates of meetings and identities of any peer review committee attendees is protected. Peer review information otherwise discoverable from "original sources" cannot be obtained from the peer review committee itself. In medical liability actions, the privilege protects reviews of the defendant physician's specific treatment of the plaintiff and extends to reviews of treatment the physician has provided to patients other than the plaintiff.

Confidentiality. Peer review records and deliberations are confidential and may not be disclosed outside of the judicial process.

Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in good faith peer review

activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities.

Citation: BOT Rep. 10, A-09; Reaffirmed: BOT Rep. 13, I-11; Modified: BOT Rep. 05, I-17; Reaffirmed: BOT Rep. 29, A-24; Modified: Speakers Rep. 02, I-24

9.5.1 Organized Medical Staff

The organized medical staff performs essential hospital functions even though it may often consist primarily of independent practicing physicians who are not hospital employees. The core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.

Members of the organized medical staff may choose to act as a group for the purpose of communicating and dealing with the governing board and others with respect to matters that concerns the interest of the organized medical staff and its members. This is ethical so long as there is no adverse effect on patient safety and the quality of care.

AMA Principles of Medical Ethics: IV,VI
The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

Citation: Issued: 2016