AMERICAN MEDICAL ASSOCIATION ORGANIZED MEDICAL STAFF SECTION

Resolution: 8
(A-25)

Introduced by: Oklahoma

Subject: Ensuring Patient Safety and Physician Oversight in the Integration of Hospital Inpatient Virtual Nursing

Referred to: OMSS Reference Committee
(xxxx, MD, Chair)

Whereas, inpatient hospital virtual nursing is a healthcare model that uses technology to provide nursing care remotely to patients admitted to a hospital; and

Whereas, virtual nursing in the inpatient setting involves experienced registered nurses working remotely—often from a centralized command center—to support bedside nurses and patients via video, audio, and digital tools; and

Whereas, virtual nursing can transform healthcare delivery by addressing long-standing challenges such as nursing shortages, burnout, and capacity issues in hospitals; virtual nursing has potential to alleviate the stress on direct-care staff but also can provide significant operational and financial benefits to healthcare organizations; and

Whereas, virtual nurses handle paperwork, patient education, and discharge planning to reduce the workload on bedside nurses as admission and discharge support; and

Whereas, virtual nursing can assist in ongoing patient monitoring, such as vital sign reviews and safety checks and provide information, answer questions, and check on patient well-being; and

Whereas, virtual nurses can be useful in patient and family education and communication; and

Whereas, there is currently no national policy or governance structure in place to guide the development and adoption of inpatient virtual nursing besides state nursing boards; and

Whereas, the Centers for Medicare & Medicaid Services does not yet have comprehensive guidelines just for inpatient virtual nursing, preferring to defer to state regulations and accrediting bodies; and

Whereas, current AMA policy H-225.957, “Positions for Strengthening the Physician-Hospital Relationship states, “the organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff, and visitors, and working continuously to improve patient care rendered and for patient safety vested with the organized medical staff; and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations;” and

Whereas, the deployment of virtual nursing models without adequate input from medical staff may lead to fragmentation of care, unclear clinical responsibilities, and diminished physician oversight; and

Whereas, the thoughtful integration of virtual nursing requires collaboration among physicians, nurses, hospital leadership, and technology developers to ensure that innovations support—not replace—physician-led high-quality, patient-centered care; therefore be it

RESOLVED, that our American Medical Association recognizes that organized medical staffs, as leaders in hospital medicine who have a duty to protect patient safety within their institutions, should work collaboratively to integrate inpatient virtual nursing in a way that supports physician-led, high-quality, patient-centered care (New HOD Policy); and be it further

RESOLVED, that our AMA undertake a comprehensive study of hospital inpatient virtual nursing, including an assessment of its benefits and risks for patient safety and an analysis of guidelines for credentialing, privileging, and documentation standards and any policy gaps related to oversight by the Centers for Medicare & Medicaid Services and The Joint Commission (Directive to Take Action); and be it further

RESOLVED, that our AMA engage relevant stakeholders—including nursing organizations, hospital systems, accrediting bodies, and federal agencies—to promote policies that ensure hospital inpatient virtual nursing models are implemented with clear roles, physician collaboration, and protections for patient safety and quality of care (Directive to Take Action).

Fiscal Note: (Assigned by HOD)

Received: 5/11/2025

REFERENCES

1. ‘More than just technology’: How virtual nursing models are shaping care delivery innovation. Beckers Hospital Review. Accessed: May 13, 2025. ‘More than just technology’: How virtual nursing models are shaping care delivery innovation - Becker's Hospital Review | Healthcare News & Analysis
2. TeledocHealth. Inpatient virtual nursing fundamentals, uses, and benefits: Mitigate the nursing shortage and enhance patient care with inpatient virtual nursing. Accessed: May 13, 2025. https://www.teladochealth.com/content/dam/tdh-www/us/en/documents/white-paper/Virtual_Nursing_White_Paper_Teladoc_Health.pdf

RELEVANT AMA POLICY

Principles for Strengthening the Physician-Hospital Relationship H-225.957

The following twelve principles are our American Medical Association policy:
PRINCIPLES FOR STRENGTHENING THE PHYSICIAN-HOSPITAL RELATIONSHIP

1. The organized medical staff and the hospital governing body are responsible for the provision of quality care, providing a safe environment for patients, staff and visitors, protection from interruption of delivery of care, and working continuously to improve patient care and health outcomes—including but not limited to the development, selection, and implementation of augmented intelligence—with the primary responsibility for the quality of care rendered and for patient safety vested with the organized medical staff. These activities depend on mutual accountability, interdependence, and responsibility of the organized medical staff and the hospital governing body for the proper performance of their respective obligations.
2. The organized medical staff, a self-governing organization of professionals, possessing special expertise, knowledge and training, discharges certain inherent professional responsibilities by virtue of its authority to regulate the professional practice and standards of its members, and assumes primary responsibility for many functions, including but not limited to: the determination of organized medical staff membership; performance of credentialing, privileging and other peer review; and timely oversight of clinical quality and patient safety.
3. The leaders of the organized medical staff, with input from the hospital governing body and senior hospital managers, develop goals to address the healthcare needs of the community and are involved in hospital strategic planning as described in the medical staff bylaws.
4. Ongoing, timely and effective communication, by and between the hospital governing body and the organized medical staff, is critical to a constructive working relationship between the organized medical staff and the hospital governing body.
5. The organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body. The organized medical staff and hospital bylaws, rules and regulations should be aligned, current with all applicable law and accreditation body requirements and not conflict with one another. The hospital bylaws, policies and other governing documents do not conflict with the organized medical staff bylaws, rules, regulations and policies, nor with the organized medical staff's autonomy and authority to self govern, as that authority is set forth in the governing documents of the organized medical staff. The organized medical staff, and the hospital governing body/administration, shall, respectively, comply with the bylaws, rules, regulations, policies and procedures of one another. Neither party is authorized to, nor shall unilaterally amend the bylaws, rules, regulations, policies or procedures of the other.
6. The organized medical staff has inherent rights of self governance, which include but are not limited to:
    a. Initiating, developing and adopting organized medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing body, which approval shall not be unreasonably withheld. The organized medical staff bylaws shall be adopted or amended only by a vote of the voting membership of the medical staff.
    b. Identifying in the medical staff bylaws those categories of medical staff members that have voting rights.
    c. Identifying the indications for automatic or summary suspension, or termination or reduction of privileges or membership in the organized medical staff bylaws,

restricting the use of summary suspension strictly for patient safety and never for purposes of punishment, retaliation or strategic advantage in a peer review matter. No summary suspension, termination or reduction of privileges can be imposed without organized medical staff action as authorized in the medical staff bylaws and under the law.

d. Identifying a fair hearing and appeals process, including that hearing committees shall be composed of peers, and identifying the composition of an impartial appeals committee. These processes, contained within the organized medical staff bylaws, are adopted by the organized medical staff and approved by the hospital governing board, which approval cannot be unreasonably withheld nor unilaterally amended or altered by the hospital governing board or administration. The voting members of the organized medical staff decide any proposed changes.
e. Establishing within the medical staff bylaws:
    1. The qualifications for holding office.
    2. The procedures for electing and removing its organized medical staff officers and all organized medical staff members elected to serve as voting members of the Medical Executive Committee.
    3. The qualifications for election and/or appointment to committees, department and other leadership positions.
f. Assessing and maintaining sole control over the access and use of organized medical staff dues and assessments, and utilizing organized medical staff funds as appropriate for the purposes of the organized medical staff.
g. Retaining and being represented by legal counsel at the option and expense of the organized medical staff.
h. Establishing in the organized medical staff bylaws, the structure of the organized medical staff, the duties and prerogatives of organized medical staff categories, and criteria and standards for organized medical staff membership application, reapplication credentialing and criteria and processing for privileging. The standards and criteria for membership, credentialing and privileging shall be based only on quality of care criteria related to clinical qualifications and professional responsibilities, and not on economic credentialing, conflicts of interest or other non-clinical credentialing factors.
i. Establishing in the organized medical staff bylaws, rules and regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review and other organized medical staff activities, and engaging in all activities necessary and proper to implement those bylaw provisions including, but not limited to, periodic meetings of the organized medical staff and its committees and departments and review and analysis of patient medical records.
j. The right to define and delegate clearly specific authority to an elected Medical Executive Committee to act on behalf of the organized medical staff. In addition, the organized medical staff defines indications and mechanisms for delegation of authority to the Medical Executive Committee and the removal of this authority. These matters are specified in the organized medical staff bylaws.
k. Identifying within the organized medical staff bylaws a process for election and removal of elected Medical Executive Committee members.
l. Defining within the organized medical staff bylaws the election process and the qualifications, roles and responsibilities of clinical department chairs. The Medical Executive Committee must appoint any clinical chair that is not otherwise elected by the vote of the general medical staff.
m. Enforcing the organized medical staff bylaws, regulations and policies and procedures.

   n. Establishing in medical staff bylaws, medical staff involvement in contracting relationships, including exclusive contracting, medical directorships and all hospital-based physician contracts, that affect the functioning of the medical staff.
7. Organized medical staff bylaws are a binding, mutually enforceable agreement between the organized medical staff and the hospital governing body, as well as between those two entities and the individual members of the organized medical staff.
8. The self-governing organized medical staff determines the resources and financial support it requires to effectively discharge its responsibilities. The organized medical staff works with the hospital governing board to develop a budget to satisfy those requirements and related administrative activities, which the hospital shall fund, based upon the financial resources available to the hospital.
9. The organized medical staff has elected appropriate medical staff member representation to attend hospital governing board meetings, with rights of voice and vote, to ensure appropriate organized medical staff input into hospital governance. These members should be elected only after full disclosure to the medical staff of any personal and financial interests that may have a bearing on their representation of the medical staff at such meetings. The members of the organized medical staff define the process of election and removal of these representatives.
10. Individual members of the organized medical staff, if they meet the established criteria that are applicable to hospital governing body members, are eligible for full membership on the hospital governing body. Conflict of interest policies developed for members of the organized medical staff who serve on the hospital's governing body are to apply equally to all individuals serving on the hospital governing body.
11. Well-defined disclosure and conflict of interest policies are developed by the organized medical staff which relate exclusively to their functions as officers of the organized medical staff, as members and chairs of any medical staff committee, as chairs of departments and services, and as members who participate in conducting peer review or who serve in any other positions of leadership of the medical staff.
12. Areas of dispute and concern, arising between the organized medical staff and the hospital governing body, are addressed by well-defined processes in which the organized medical staff and hospital governing body are equally represented. These processes are determined by agreement between the organized medical staff and the hospital governing body.

Citation: Res. 828, I-07; Reaffiremd in lieu of Res. 730, A-09; Modified: Res. 820, I-09; Reaffirmed: Res. 725, A-10; Reaffirmed: A-12; Reaffirmed: CMS Rep. 6, I-13; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 024, A-24