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# STATE-BASED LICENSURE OF TELEMEDICINE: THE NEED FOR UNIFORMITY BUT NOT A NATIONAL SCHEME

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## INTRODUCTION

Over the last forty years, the practice of medicine in the United States has advanced from a predominantly isolated and local undertaking<sup>1</sup> to a national and even international concern,<sup>2</sup> involving integrated networks of hospitals, physicians, and other health care providers.<sup>3</sup> In the process, state-based regulatory schemes have struggled to adjust to the new corporate form. Just as railroads and other large business enterprises at the turn of the nineteenth century sought federal protection from myriad state laws and regulations,<sup>4</sup> so today's for-profit and nonprofit systems for delivering

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1. See Robert M. Wachter, *The "Dis-location" of U.S. Medicine—The Implications of Medical Outsourcing*, 354 NEW ENG. J. MED. 661, 661 (2006) ("Until recently, the need to take a patient's history and perform a physical examination, apply complex techniques or procedures, and share information quickly has made medicine a local affair."); see generally PAUL STARR, *THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE* 335 (1982) (detailing the "dramatic growth in the scale of American medicine" starting in the postwar decades).

2. See e.g., Wachter, *supra* note 1, at 661–63 (providing examples of the internationalization of U.S. medicine, including interpreters, radiologists, and intensive care providers, all of whom provide their services from overseas).

3. See Martin Gaynor & Deborah Haas-Wilson, *Change, Consolidation, and Competition in Health Care Markets*, 13 J. ECON. PERSP. 141, 142–43 (1999) (commenting on the trend toward integration and merger of managed care organizations, physician markets, and independent practice organizations).

4. Keith T. Poole & Howard Rosenthal, *The Enduring Nineteenth-Century Battle for Economic Regulation: The Interstate Commerce Act Revisited*, 36 J.L. & ECON. 837, 837–839 (1993) (noting the passage of the Interstate Commerce Act of 1887, its effect on the railroad industry, and the reasons for its passage).

health care seek uniform standards to operate more effectively and more efficiently across state lines.<sup>5</sup>

A prominent example is “telemedicine,” which, broadly stated, involves the practice of medicine “using electronic communication, information technology or other means.”<sup>6</sup> Employing internet technology, videoconferencing, and the like, physicians may diagnose and treat patients in distant locations, crossing state lines and international boundaries. Applications of telemedicine include clinical interviews, emergency evaluations, case management, and clinical supervision.<sup>7</sup> By way of example, psychiatrists and other mental health providers, using electronic means, can observe, assess, and treat secluded and disadvantaged populations, including prisoners, homebound individuals, and children in rural areas.<sup>8</sup>

Telemedicine’s potential for altering the course of health care delivery is transcendent, to say the least. According to a report of the American Psychiatric Association: “[O]riginally conceived to enhance access to health care for the geographically hard-to-reach and the underserved . . . telemedicine is much broader and will become the way we are all served—whether underserved or not—with greater efficiency, continuity, and timeliness.”<sup>9</sup> Congress’s recent passage of comprehensive health care legislation will place added stress on an already over-burdened delivery system and will accelerate the trend toward telemedicine and telehealth.<sup>10</sup>

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5. See Thomas R. McLean, *The Future of Telemedicine & Its Faustian Reliance on Regulatory Trade Barriers for Protection*, 16 HEALTH MATRIX 443, 461–63 (2006) (citing state medical licensure acts as a problematic trade barrier to the expansion and efficient operation of the practice of medicine).

6. Press Release, N.C. Med. Bd., Policy Committee Offers New Position Statement on Telemedicine (Nov. 24, 2009), available at [http://www.ncmedboard.org/notices/detail/policy\\_committee\\_offers\\_new\\_position\\_statement\\_on\\_telemedicine/](http://www.ncmedboard.org/notices/detail/policy_committee_offers_new_position_statement_on_telemedicine/).

7. See generally TELEMENTAL HEALTH STANDARDS AND GUIDELINES WORKING GROUP, AM. TELEMEDICINE ASS’N, EVIDENCE-BASED PRACTICE FOR TELEMENTAL HEALTH 9, 17–20 (2009), available at [http://www.americantelemed.org/files/public/standards/EvidenceBasedTelementalHealth\\_WithCover.pdf](http://www.americantelemed.org/files/public/standards/EvidenceBasedTelementalHealth_WithCover.pdf) (discussing the ways telemedicine is incorporated into diagnostic interviews, emergency assessments, and treatment).

8. AM. PSYCHIATRIC ASS’N, TELEPSYCHIATRY VIA VIDEOCONFERENCING I (1998), available at [http://archive.psych.org/edu/other\\_res/lib\\_archives/archives/199821.pdf](http://archive.psych.org/edu/other_res/lib_archives/archives/199821.pdf).

9. *Id.*

10. See John D. Goodson, *Patient Protection and Affordable Care Act: Promise and Peril for Primary Care*, 152 ANNALS INTERNAL MED. 742, 742 (2010) (discussing the “urgent need” to expand primary care capacity since “a projected 32 million people will gain access to health care” as a result of the Patient Protection and Affordable Care Act). California is an example of a state that is urging consideration of telemedicine as an alternate means of delivering health care services. MAC TAYLOR, LEGISLATIVE ANALYST’S OFFICE, THE PATIENT PROTECTION AND

Having earmarked funds for electronic medical records and related technology, the current administration and Congress look to telemedicine to improve access to care.<sup>11</sup> For example, in 2009, the Federal Communications Commission awarded millions of dollars to states for the construction of “medical networks” in the attempt to lessen the distance between urban specialists and their rural patients.<sup>12</sup>

But serious obstacles to the implementation of telemedicine exist.<sup>13</sup> Among the most significant of these are state-based licensure schemes. Before the advent of telemedicine, questions concerning the jurisdiction of state medical boards over practicing physicians rarely surfaced because the diagnosis, treatment, and care of patients almost always occurred face-to-face.<sup>14</sup> All state licensing boards required doctors to obtain a full, unrestricted license when practicing medicine in their state.<sup>15</sup> There were, of course, certain limited exceptions to the full licensure requirement.<sup>16</sup>

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AFFORDABLE CARE ACT: AN OVERVIEW OF ITS POTENTIAL IMPACT ON STATE HEALTH PROGRAMS 28 (2010).

11. See CTR. FOR TELEMEDICINE L., *TELEMEDICINE REIMBURSEMENT REPORT 4* (2003), available at <http://www.hrsa.gov/telehealth/pubs/reimbursement.htm> (explaining that “the push to improve rural access to telemedicine prevailed” when Congress passed an appropriations bill dealing with telemedicine reimbursement).

12. Christine Vestal, *States Get Help Expanding Telemedicine*, STATELINE.ORG, March 1, 2008, <http://www.stateline.org/live/details/story?contentId=287044>. The telemedicine grants have allowed states that have a great number of small towns and a relative lack of major roads—Maine, for example—to “transfer the specialist to the patient instead of physically sending the patient to the specialist.” *Id.* Further, telemedicine has allowed rural hospitals to retain patients they might otherwise lose to the larger, urban medical centers, thus also preserving the rural economy. *Id.*

13. See Jay H. Sanders & Rashid L. Bashshur, *Challenges to the Implementation of Telemedicine*, 1 *TELEMEDICINE J.* 115, 115–16 (1995) (explaining that there are a number of major problems that telemedicine must overcome if it is to become an “integral component of the health care system”). Dr. Sanders and Dr. Bashshur cite six problem areas in particular: (1) state licensing and accreditation; (2) legal liability and litigation; (3) patient privacy and autonomy; (4) reimbursement; (5) general knowledge of telemedicine; and (6) design and infrastructure. *Id.* at 115.

14. See Mary Chaffee, *A Telehealth Odyssey*, 99 *AM. J. NURSING* 26, 30–32 (1999) (noting that there are several issues that might slow the pace of telehealth’s growth, including the need to implement multi-state licensure); see also Bruce H. Cohen, *Remote Consultation Offers a Valuable Alternative to Face-to-Face Medical Treatment*, *AAN NEWS*, May 7, 2008, [http://www.aan.com/news/?event=read&article\\_id=4744](http://www.aan.com/news/?event=read&article_id=4744) (describing face-to-face delivery of medical care as the “standard” method).

15. Peter D. Jacobson & Elizabeth Selvin, *Licensing Telemedicine: The Need for a National System*, 6 *TELEMEDICINE J. & E-HEALTH* 429, 431–32 (2000); Ross D. Silverman, *Current Legal and Ethical Concerns in Telemedicine and e-Medicine*, 9 *J. TELEMEDICINE & TELE CARE* 67 (2003); *AM. MED. ASS’N, PHYSICIAN LICENSURE: AN UPDATE OF TRENDS* (Sept. 11, 2010) <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/young-physicians-section/advocacy-resources/physician-licensure-an-update-trends.shtml>.

16. See, e.g., *MD. CODE ANN., HEALTH OCC. § 14-302* (LexisNexis 2009) (listing instances in which individuals need not have a Maryland medical license to practice in Maryland). The provision was added to the Maryland Annotated Code in 1957. *Id.*; see also Edward H. Forgotson & John L. Cook, *Innovations and Experiments In Uses of Health Manpower: The Effect of*

These included special dispensations for medical students,<sup>17</sup> physicians with academic appointments,<sup>18</sup> and physicians who were federal employees.<sup>19</sup> In addition, doctors in one state could provide advice to doctors in another state without violating most state laws.<sup>20</sup>

The proliferation of telemedicine required jurisdictionally-conscious state boards to determine precisely where the practice of medicine took place. A general consensus emerged that the practice of medicine occurred wherever the patient was located, notwithstanding the physician's location in another state.<sup>21</sup> Under the circumstances, state boundary lines were potential roadblocks to telemedicine unless an accommodation could be reached. Though the Federation of State Medical Boards (Federation) and other organizations sought a uniform approach,<sup>22</sup> many boards resisted.<sup>23</sup> By 2003, only eight states had adopted a "special purpose" license for

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*Licensure Laws*, 32 L. & CONTEMP. PROBS. 731, 735 (1967) (discussing licensure issues facing the medical profession in the late 1960s and noting that legislatures had carved out exceptions to medical practice acts).

17. See, e.g., HEALTH OCC. § 14-302(1) ("[T]he following individuals may practice medicine without a license: . . . [a] medical student or an individual in a postgraduate medical training program that is approved by the Board, while doing the assigned duties at any office of a licensed physician, hospital, clinic, or similar facility[.]").

18. See, e.g., ARIZ. REV. STAT. ANN. § 32-1432 (2010) ("A board approved school of medicine in this state . . . may invite a doctor of medicine to provide and promote professional education through lectures, clinics or demonstrations."). A physician practicing pursuant to Arizona's teaching license provision is not exempt from licensing requirements except as to the training and examination requirements. § 32-1432(C).

19. See, e.g., HEALTH OCC. § 14-302(3) ("[T]he following individuals may practice medicine without a license: . . . [a] physician employed in the service of the federal government while performing the duties incident to that employment[.]").

20. See, e.g., HEALTH OCC. § 14-302(2) ("[T]he following individuals may practice medicine without a license: . . . [a] physician licensed by and residing in another jurisdiction, while engaging in consultation with a physician licensed in this State[.]"). See also AM. MED. ASS'N, *supra* note 14 ("Until recently, a physician could provide an opinion or interpretation to a physician in another state who had primary patient care responsibility, and this practice was not regarded as practicing out of his/her state.").

21. P. Greg Gulick, *E-Health and the Future of Medicine: The Economic, Legal, Regulatory, Cultural, and Organizational Obstacles Facing Telemedicine and Cybermedicine Programs*, 12 ALB. L.J. SCI. & TECH. 351, 366 (2002) (comparing statutes in states that require a doctor treating a patient in the state via a telemedical consultation to be licensed to practice medicine in that state); AM. MED. ASS'N, *supra* note 15 ("In this day and age, a physician is considered to be practicing medicine in the state where the patient is located and is subject to that state's laws regarding medical practice, which typically means a license in that particular state is necessary.").

22. See Jacobson & Selvin, *supra* note 15, at 433 (noting the Federation of State Medical Board's approval of a Model Act for states to adopt).

23. See *id.* at 435 (noting that many parts of the Model Act rely on individual state boards to apply local standards to determine what the "practice of medicine across state lines" means, which might lead to incompatible telemedicine standards). See also CTR. FOR TELEMEDICINE L., *TELEMEDICINE LICENSURE REPORT 3* (2003), available at <ftp://ftp.hrsa.gov/telehealth/licensure.pdf> (stating that only eight states have adopted schemes similar to the FSMB's Model Act.).

telemedicine, which the Federation initially had proposed, while twenty-one states required a full-service license when providing direct care to patients across state lines by electronic means.<sup>24</sup> States that required a full-service license, while simultaneously defining the practice of telemedicine broadly to include phone calls, e-mails, and on-line discussions, circumscribed the use of the new technology.<sup>25</sup>

The application of restrictive state laws to telemedicine creates some perplexing situations. If a patient travels across state lines to see a specialist at the Mayo Clinic in Rochester, Minnesota, for example, then the Mayo physician does not need a license to practice medicine in the patient's state. But if the contact between the Mayo doctor and the patient occurs electronically, thus saving the patient the time and expense of travel, the Mayo doctor might need a full license in the patient's state.<sup>26</sup> Barring serious differences in the quality of care provided or improper use of distance technology, these discrepancies should not exist.

State medical boards that restrict out-of-state electronic transmissions to physicians with full-service licenses in their states arguably bolster the claims of critics that state licensing laws, ostensibly designed to protect the public, serve the economic interests of in-state physicians.<sup>27</sup> There are

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24. CTR. FOR TELEMEDICINE L., *supra* note 23, at 7.

25. See AM. MED. ASS'N, *supra* note 15 (noting that some states include all out-of-state practice—including phone calls and emails—in their definitions of “telemedicine,” and that this has led to the inability of some doctors to utilize technology such as videoconferencing). See also, e.g., OHIO REV. CODE ANN. § 4731.296(A) (LexisNexis 2010) (“For the purposes of this section, “the practice of telemedicine” means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication, by a physician located outside this state.”). But see LA. REV. STAT. ANN. § 37:1262(4) (Supp. 2010) (“Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient, or a true consultation as may be defined by rules promulgated by the board pursuant to the Administrative Procedure Act, constitutes telemedicine for the purposes of this Part.”).

26. See generally CTR. FOR TELEMEDICINE L., *supra* note 23, at 54–56 (showing that many states require a full license to be able to treat a patient via telemedicine in the state).

27. Heather L. Daly, *Telemedicine: The Invisible Legal Barriers to the Health Care of the Future*, 9 ANNALS HEALTH L. 73, 88 & n.93 (2000) (stating that not all licensing laws serve to protect the public, and noting that some argue that telemedicine regulation is particularly protectionist). For general arguments that licensure requirements tend to protect the profession more than the public, see STANLEY J. GROSS, OF FOXES AND HEN HOUSES: LICENSING AND THE HEALTH PROFESSIONS 147–51 (1984) (arguing that licensing is not an effective way to prevent incompetent practice); Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6, 16–17 (1976) (arguing that, by increasing competition and creating costly barriers to entry, professional licensing actually serves the interests of the profession, not the public); Daniel B. Hogan, *The Effectiveness of Licensing: History, Evidence, and Recommendations*, 7 L. & HUM. BEHAV. 117, 124–25 (1983) (arguing that licensing boards do not adequately discipline members of the professions they are supposed to regulate); Elton Rayack, *Medical Licensure: Social Costs and Social Benefits*, 7 L. & HUM. BEHAV. 147, 154–55 (1983) (providing empirical data on the lack of physician discipline by licensing boards). See also U.S. FED. TRADE COMM'N & DEPT. OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION 22 (2004) available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> (analyzing the role of licensing

many doctors today who might join these past critics. “Telemedicine,” a report from the American Medical Association (AMA) says, “has crystallized the tension between states’ role in protecting patients from incompetent physicians and protecting in-state physicians from out-of-state competition.”<sup>28</sup> Recognition on the part of the AMA, twice found guilty of anticompetitive practices in the past,<sup>29</sup> that state licensure requirements may be used to protect the economic interests of local physicians shows the extent to which regionalizing and nationalizing trends in the health care industry have changed physicians’ perspectives.<sup>30</sup> A large and increasing number of doctors now belong to regionally integrated systems that comprise, *inter alia*, academic medical centers, rural and suburban hospitals and clinics, imaging centers, and physician group practices.<sup>31</sup> Many of these systems are affiliated with physicians who reside in different states.<sup>32</sup>

Despite widespread agreement that something should be done to overcome barriers to interstate practice, no clear consensus has been reached about how to proceed. Some individuals and organizations advocate a national licensure scheme for telemedicine,<sup>33</sup> others support various forms of endorsement,<sup>34</sup> mutual recognition,<sup>35</sup> and reciprocity;<sup>36</sup>

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boards as it relates to competition in health care); *cf.* Reuben A. Kessel, *The A.M.A. and the Supply of Physicians*, 35 LAW & CONTEMP. PROBS. 267, 267 (1970) (arguing that the American Medical Association is able to control the number of physicians via licensure requirements).

28. AM. MED. ASS’N, *supra* note 15.

29. *Am. Med. Ass’n v. United States*, 317 U.S. 519, 526, 536 (1943); *In re Am. Med. Ass’n*, 94 F.T.C. 701, 974, 1036–38 (1979).

30. Roice D. Luke, *System Transformation: USA and International Strategies in Healthcare Organisation and Policy*, 5 INT’L J. PUB. POL’Y 190 (2010); *see also* MICHAEL E. PORTER & ELIZABETH O. TEISBURG, *REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS* 356 (2006) (explaining how the state-level licensing should be limited to facilitate a value-based competition model for health care).

31. Luke, *supra* note 30 at 190.

32. *See e.g.* PORTER & TEISBURG, *supra* note 30, at 172, 198–99 (discussing the benefits of regionally integrated health care services, such as those offered by the Cleveland Clinic and Mayo Clinic).

33. Jacobson & Selvin, *supra* note 15, at 433; Rashid Bashshur, *Telemedicine and State-Based Licensure in the United States, Revisited*, 14 TELEMEDICINE & E-HEALTH 310, 310–11 (2008); Joy E. Matak, Note, *Telemedicine: Medical Treatment Via Telecommunications Will Save Lives, But Can Congress Answer the Call?: Federal Preemption of State Licensure Requirements Under Congressional Commerce Clause Authority & Spending Power*, 22 VT. L. REV. 231, 233 (1997).

34. *See* Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 22 (1999) (noting that an endorsement licensure scheme better protects states’ goals for and integrity of medical licensing, and can be more efficient); *see also* AM. MED. ASS’N, *supra* note 15 (“State boards can grant licenses to health professionals licensed in other states that have equivalent standards.”).

35. *See* Sulentic, *supra* note 34, at 33–35 (using the Nursing Licensure Compact as an example of mutual recognition licensing, and concluding that the Compact is a “workable model” for telemedicine); *see also* AM. MED. ASS’N, *supra* note 15 (“Mutual recognition is a system in

still others, such as the Federation, have proposed a special or limited license and, more recently, a form of expedited endorsement.<sup>37</sup> The first proposal, national licensure for telemedicine, would alter the current state-based scheme; the remaining proposals, from mutual recognition to expedited endorsement, would retain the existing framework.

In this article, I examine two areas or sets of issues that underlie the current debate over the interstate licensing of doctors who engage in telemedicine. The first set of issues concerns the meaning of telemedicine and its relationship to medical licensing. My approach in this first section proceeds from commonly recognized definitions of telemedicine and their connection to professional licensing. Professional licensure, I note, is a legal process that allows physicians and other professionals (nurses, lawyers, accountants, etc.) to practice their profession in a particular state pursuant to certain limitations.<sup>38</sup> Such limitations typically concern a profession's scope of practice which, in the case of physicians, comprises most anything associated with the delivery of medical services.<sup>39</sup> Because telemedicine simply involves the electronic delivery of medical services when patient and physician are in different locations, there is no discernable basis for two separate licenses, one for the practice of medicine and the other for the so-called "practice of telemedicine."<sup>40</sup> A medical license presumably includes all forms of delivery associated with the type of medicine that a physician practices. If not, then arguably there should be a separate license for intrastate telemedicine. Rather than frame the issue

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which the licensing authorities voluntarily enter into an agreement to legally accept the policies and processes (licensure) of a licensee's home state.").

36. See Sulentic, *supra* note 34, at 28 (noting the many advantages of the reciprocity model, including facilitation of long-term relationships and clarification of the role of disciplinary boards); see also AM. MED. ASS'N., *supra* note 15 ("Reciprocity denotes the relationship between two states when each state gives the subjects of the other, certain privileges, on the condition that its own subjects shall enjoy similar privileges at the hands of the latter state.").

37. See FED'N OF STATE MED. BDS., REPORT OF THE SPECIAL COMMITTEE ON LICENSURE PORTABILITY (2002) [http://www.fsmb.org/pdf/2002\\_grpol\\_License\\_Portability.pdf](http://www.fsmb.org/pdf/2002_grpol_License_Portability.pdf) (proposing the development of an "expedited licensure by endorsement" for qualified physicians). For an explanation of what a special or limited licensure scheme entails, see AM. MED. ASS'N., *supra* note 15 ("Health professionals would be required to obtain a license from each state in which they practiced. However, the physician would have the option of obtaining a limited license that allows the delivery of a specific scope of health services under particular circumstances.").

38. See generally Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, in REGULATION OF THE HEALTHCARE PROFESSIONS (Timothy S. Jost ed., 1997); STARR, *supra* note 1.

39. See *infra* note 80 and accompanying text.

40. *Contra* Jacobson & Selvin, *supra* note 15 at 433 (explaining that, "similar to a special license, national licensure for telemedicine would require a single license for the practice of telemedicine" and delineating the two approaches to national licensure of either a complete federalization or a hybrid state-federal scheme).

around the particular means of delivery, regulators should address the jurisdictional problems related to the interstate practice of medicine.

The second set of issues concerns the practical aspects of board administration. In the second section, I argue that a national scheme for licensing telemedicine, notwithstanding the conceptual problems involved, would be unwieldy and difficult to implement.<sup>41</sup> I will show that the licensing and disciplinary functions of state medical boards substantially have changed since the 1970s; that current state board operations are multifaceted and complex; and that separate national and state licenses will hamper board administration, raise difficult choice-of-law questions, and likely lead to substantial delay and confusion.

Though I oppose national licensure for telemedicine, I strongly support the efforts of the Federation to advance a uniform scheme that limits state-based restrictions on the interstate practice of medicine. But if state medical boards fail to put aside their differences and create a uniform approach to regulating the practice of medicine across state lines, the federal government would have cause to intervene.<sup>42</sup> Telemedicine's potential for changing how medicine is practiced is too great to ignore, and its overall effect on costs and access to care will be substantial.

#### I. THE MEANING OF TELEMEDICINE AND ITS RELATIONSHIP TO THE PRACTICE OF MEDICINE

Any discussion of the regulation of telemedicine should begin with an understanding of what telemedicine involves. The definition of telemedicine that the North Carolina Medical Board has adopted is a good place to start. Telemedicine, the North Carolina Board says, "is the practice of medicine using electronic communication, information technology or other means between a physician in one location and a patient in another

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41. See *infra* Parts II.A–B.

42. See Ross D. Silverman, *Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards*, 26 AM. J.L. & MED. 255, 275–76 (2000) (describing the Comprehensive Telehealth Act of 1999 and noting the possibility that future federal laws might attempt to preempt state licensing requirements as they pertain to telemedicine). The federal government has tried, and was unsuccessful at the time, to impose uniform medical practice regulations. The Clinton Administration attempted to override state scope-of-practice laws in its failed Health Security Act. Section 1161 of the proposed Act provided that "no State may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." Health Security Act, H.R. 3600, 103d Cong. § 1161 (1994). In 1995, Representative Ron Wyden (OR) introduced a proposal that "would have prohibited restrictions on interstate commerce using advanced telecommunications services." AM. MED. ASS'N, *supra* note 14. One major piece of federal legislation concerning state licensing did get through Congress. The Health Care Quality Improvement Act of 1986 established the National Practitioners Data Bank, a central clearinghouse for disciplinary actions of hospitals, professional societies, malpractice insurers, and state medical boards. Pub. L. No. 99-660, 100 Stat. 3784, 3791 (1986) (codified as amended at 42 U.S.C. § 11137 (2006)).

location with or without an intervening health care provider.”<sup>43</sup> New York’s medical board stresses three features in its definition of telemedicine: (1) “the geographic separation between two or more participants and/or entities engaged in health care,” (2) “the use of telecommunication and related technology to gather, store and disseminate health-related information,” and (3) “the use of electronic interactive technologies to assess, diagnose and/or treat medical conditions.”<sup>44</sup> The American Telemedicine Association defines telemedicine as follows: “Telemedicine is the use of medical information exchanged from one site to another via electronic communications to improve patients’ health status.”<sup>45</sup>

What all three of these definitions and others have in common are the geographic separation of doctor and patient,<sup>46</sup> the exchange of medical information to improve a patient’s health, and the use of some form of electronic device or communication to facilitate the exchange. Two of these components—the geographic separation of doctor and patient and the use of an electronic device—do not call for a detailed and lengthy analysis. The other component of the definition—the exchange of medical information for health-related purposes—calls for closer scrutiny.

#### *A. Geographic Separation and Distance Technology*

The definition of telemedicine does not require that doctor and patient reside in different states. Physicians engage in telemedicine when they provide medical services through electronic means to a patient who lives in the same state. There should be little question that in such instances the state medical board in which both the doctor practices and the patient

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43. N.C. Med. Bd., *supra* note 6.

44. SPECIAL COMM. ON TELEMEDICINE, N.Y. BD. OF PROF’L MED. CONDUCT, STATEMENTS ON TELEMEDICINE BOARD FOR PROFESSIONAL MEDICAL CONDUCT (2009) <http://www.nyhealth.gov/professionals/doctors/conduct/telemedicine/htm>.

45. *Telemedicine Defined*, AM. TELEMEDICINE ASS’N, <http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333> (last visited Sept. 8, 2010).

46. Though the New York definition may appear more expansive in its reference to “participants and/or entities,” it does not alter the fact that doctor and patient are in different locations and that telemedicine, as distinguished from e-medicine or telehealth, constitutes the use of distance technology to provide medical care. The New York definition allows for the use of intermediaries (other physicians or nurse practitioners, for example) who may aid or assist in the delivery of medical services. However, most all state medical boards do not include consultations among health professionals in their definition of telemedicine. See AM. MED. ASS’N, PHYSICIAN LICENSURE: AN UPDATE OF TRENDS (Sept. 11, 2010) <http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/young-physicians-section/advocacy-resources/physician-licensure-an-update-trends.shtml>. This article adopts the most commonly recognized features of the definition, in particular, that telemedicine involves direct patient care. Ross D. Silverman, *Current Legal and Ethical Concerns in Telemedicine and e-Medicine*, 9 J. TELEMEDICINE & TELECare 67–9 (2003).

resides would have the power and the authority to regulate the exchange of medical services.<sup>47</sup>

Among the many problems with the concept of a national license for telemedicine is that such a license would purport to cover not just interstate, but also intrastate transactions. Presumably, this is not the intent of those who favor a national license. Unlike advocates of a national license for telemedicine, those who prefer state-based solutions (licensure by endorsement,<sup>48</sup> mutual recognition,<sup>49</sup> reciprocity,<sup>50</sup> or a special or limited license<sup>51</sup>) target interstate communications only. The Federation's proposal for a special or limited license set forth in its 1996 Model Act (1996 Act),<sup>52</sup> for example, concerns "the practice of medicine across state lines,"<sup>53</sup> not telemedicine. In addition, the Model Act covers more than interactive or electronic communications. Such communications, for instance, can include the delivery of "X-rays, EKGs, or laboratory tests" by courier<sup>54</sup> or involve "any contact that results in a written or documented medical opinion and that affects the diagnosis or treatment of a patient."<sup>55</sup>

#### *B. The Exchange of Medical Information for Patient Care Purposes*

The most important commonality among the definitions of telemedicine concerns the exchange of *medical* information for *patient care purposes*. The North Carolina Law refers to the "practice of medicine using electronic communication,"<sup>56</sup> the New York law to the use of electronically

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47. See *id.* (listing among telemedicine services "remote patient monitoring," which involves the use of telemedicine to monitor vital signs as a possible "supplement to the use of visiting nurses").

48. See *supra* note 34.

49. See *supra* note 35.

50. See *supra* note 36.

51. See FED'N OF STATE MED. BDS., REPORT OF THE SPECIAL COMMITTEE ON LICENSURE PORTABILITY (2002) [http://www.fsmb.org/pdf/2002\\_grpol\\_License\\_Portability.pdf](http://www.fsmb.org/pdf/2002_grpol_License_Portability.pdf) (proposing the development of an "expedited licensure by endorsement" for qualified physicians). For an explanation of what a special or limited licensure scheme entails, see AM. MED. ASS'N., *supra* note 14 ("Health professionals would be required to obtain a license from each state in which they practiced. However, the physician would have the option of obtaining a limited license that allows the delivery of a specific scope of health services under particular circumstances.").

52. See FED'N OF STATE MED. BDS., *supra* note 51 (indicating that the model act would regulate telemedicine only where it is practiced across state lines).

53. See *id.* § 1 (noting that the Federation's Ad Hoc Committee on Telemedicine drafted a model act requiring "the establishment of a special license limited to the practice of medicine across state lines.").

54. See *id.* (stating that the practice of medicine across state lines includes the use of courier services to transport patient data).

55. *Id.* § 3.

56. N.C. Med. Bd., *supra* note 6.

transmitted information to diagnose and treat “medical conditions,”<sup>57</sup> and the American Telemedicine Association to the exchange of “medical information. . .to improve patients’ health status”<sup>58</sup> These laws and definitions do not involve the more expansive term “telehealth”<sup>59</sup> which includes all health professionals and not just physicians. The concept of telehealth also encompasses e-health and distance education, two areas that might implicate distance technology but not necessarily the practice of medicine.<sup>60</sup>

There are at least three reasons why the particular means that physicians use to communicate with their patients should not be the basis for the issuance of a professional license. First, the medical licenses that state boards issue comprise the practice of medicine in whatever nature, manner, or form.<sup>61</sup> The most commonly professed purpose of state licensure is to protect the public from poor practitioners, the principal concern being the overall qualifications of physicians to practice medicine.<sup>62</sup> In assessing qualifications, licensing boards look to doctors’ education, training, and moral character. The examination that doctors take to qualify for state licensure is generic, not specialty-based.<sup>63</sup>

Presumably, physicians do not alter their diagnosis, assessment, and treatment of patients simply because the provision of medical services occurs electronically, rather than in person. The electronic device used, whether a television camera, the Internet, the telephone, or a dedicated high-speed line that is specially designed for telemedical purposes, expedites the delivery of medical care over wide distances.<sup>64</sup> If the problem which policy makers seek to resolve concerns the practice of medicine

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57. N.Y. BD. OF PROF’L MED. CONDUCT, *supra* note 44.

58. AM. TELEMEDICINE ASS’N, *supra* note 45.

59. *See* AM. TELEMEDICINE ASS’N, *supra* note 45 (“Closely associated with telemedicine is the term ‘telehealth,’ which is often used to encompass a broader definition of remote healthcare that does not always involve clinical services.”).

60. *Id.*

61. AM. MED. ASS’N, *supra* note 15.

62. *See* Dent v. West Virginia, 114 U.S. 114, 122–23 (1889) (stating “[r]eliance must be placed upon the assurance given by his license . . . that [one] possesses the requisite qualifications” because due consideration “for the protection of society may well induce the State to exclude from practise those who have no such a license . . .”).

63. *See, e.g.*, MD. CODE ANN., HEALTH OCC. § 14–307 (LexisNexis 2011)(requiring an applicant of a medical license to pass an examination as one of the many qualifications for licensure).

64. *See generally* Daly, *supra* note 27, at 75–77 (discussing the advantages of telemedicine over more traditional methods of health care delivery). *See also e.g.*, AM. TELEMEDICINE ASS’N, *supra* note 7, at 6 (stating that telemedicine is a “communication medium between provider and client/patient [that can] introduce additional layers of variables”); *see also* AM. PSYCHIATRIC ASS’N, *supra* note 8 (“Telemedicine is an enabling technology, originally conceived to enhance access to health care for the geographically hard-to-reach and the underserved.”).

across state lines, then the remedy or solution they choose should address interstate practice, not the particular method of communication between doctor and patient.

The second reason why telemedicine should not be the determining basis for licensure is because the type of communication that doctors use in caring for their patients is closely linked to their specialty area.<sup>65</sup> Approximately ninety percent of all practicing physicians are board-certified or seek board certification in a specialty or subspecialty area.<sup>66</sup> Board certification, not state licensure, has become the principal mechanism that hospitals, insurers, and other entities rely upon for assessing professional qualifications.<sup>67</sup> Hospitals use board certification for the granting of privileges,<sup>68</sup> HMOs and preferred provider organizations (PPOs) for choosing which doctors to include in their networks,<sup>69</sup> and insurers and government payers for deciding whether and how much to pay them.<sup>70</sup> Consumer groups and state agencies routinely measure health plan performance in terms of the percentage of board-certified physicians that are affiliated with a health plan.<sup>71</sup>

The crucial point is that telemedicine, for all practical purposes, concerns *the facilitation of specialty medical services*. Physicians may engage in distance communication with their patients for a wide variety of reasons, but most always in connection with their area of specialization.<sup>72</sup> Telemedicine, in other words, enhances the delivery of specialty services —

65. See John J. Smith, *Specialty Board Certification and the Federal Civil Rights Statutes*, 11 J. CONTEMP. HEALTH L. & POL'Y 111, 111 (1994) (noting that “[m]edical practice in the United States is structured around physician-specialists...”)

66. *Id.* at 111–12.

67. See William P. Gunnar, Note, *The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review, and the National Practitioner Data Bank?*, 14 ANNALS HEALTH L. 329, 340 (2005) (noting that state medical boards determine the scope of a medical license, as well as standards of conduct for practicing physicians).

68. Smith, *supra* note 65, at 116.

69. Paul B. Ginsburg & Ernest Moy, *Physician Licensure and the Quality of Care: The Role of New Information Technologies*, 15 REG. 32, 34 (1992).

70. See Smith, *supra* note 65, at 115, 117 (citing John A. Benson, Jr., *Certification and Recertification: One Approach to Professional Accountability*, 114 ANNALS INTERNAL MED. 238, 239 (1991)) (noting that some commentators believe that practical implications of board certification include higher salaries for certified physicians than for non-certified physicians).

71. See, e.g., N.Y. STATE, NEW YORK CONSUMER GUIDE TO HEALTH INSURERS 27 (2010), available at <http://www.ins.state.ny.us/hgintro.htm> (listing “[d]octors who are certified by a Medical Board” as a measure of HMO quality); UTAH DEP'T OF HEALTH, UTAH MEDICAID HMO PERFORMANCE REPORT 6 (2000), available at <http://health.utah.gov/hda/reports/99m.pdf> (stating that HMOs collect data on the percentage of board-certified doctors).

72. Teresa L. Thompson et al., *Handbook of Health Communications* 30 (2008) available at <http://mirror.lib.unair.ac.id/bahan/EFOLDER/Handbook%20of%20Health%20Communication.pdf#page=5> (explaining that managing specific diseases and classifying them according to the disease which it is used can generalize effectiveness of the system).

it is a means or tool within a doctor's larger arsenal of tools for providing health care, in this particular instance, at a distance. Standards or protocols for telemedicine might cover such things as patient confidentiality, documentation, training, and equipment,<sup>73</sup> but their application would depend on the context of the situation and the doctor's specialty or subspecialty area.<sup>74</sup>

A license to practice medicine does not differentiate among specialists or even between generalists and specialists.<sup>75</sup> Private specialty boards, not licensing boards, promulgate practice standards "across the whole of medicine."<sup>76</sup> Because most practitioners are specialists and the specialty boards govern specialty practice, specialty boards or, alternatively, specialty associations, are best-equipped to draft standards for telemedicine. The American Psychiatric Association already has guidelines in place.<sup>77</sup> A careful reading of these guidelines shows the close link between the practice of psychiatry and the application of the electronic medium.<sup>78</sup> The AMA has encouraged all specialty societies to follow the lead of the American Psychiatric Association.<sup>79</sup>

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73. See, e.g., TELEMENTAL HEALTH STANDARDS AND GUIDELINES WORKING GROUP, *supra* note 7, at 8 (providing privacy guidelines for physical surroundings and telecommunications equipment during remote mental health evaluations).

74. See, e.g., AM. PSYCHIATRIC ASS'N, *supra* note 8 (proposing standardized guidelines for psychiatrists' practice of telepsychiatry via videoconferencing). The American Psychiatric Association has issued detailed guidelines for videoconferencing, which establish the "clinical applications using videoconferencing" as to scope, clinical interview, emergency evaluations, case management, forensic psychiatry, procedures (such as "hypnosis, electroconvulsive therapy, and amyntal interviews"), and clinical supervisions. *Id.* at 2-3. The guidelines also include "other applications in telepsychiatry," such as distance learning, research, and administration. *Id.* at 3-4. See also, e.g., George H. Kamp, *Medical-Legal Issues in Teleradiology: A Commentary*, 166 AM. J. ROENTGENOLOGY 511, 511 (1996) (discussing teleradiology standards, including those for personnel, equipment specifications, and liability).

75. See generally FED'N OF STATE MED. BDS., STATE-SPECIFIC REQUIREMENTS FOR INITIAL MEDICAL LICENSURE (2010), available at [http://www.fsmb.org/usmle\\_eliinitial.html](http://www.fsmb.org/usmle_eliinitial.html) (listing licensing requirements for each state and establishing a single set of requirements without differentiating among specialists or between generalists and specialists).

76. See Rosemary A. Stevens, *Medical Specialization as American Health Policy: Interweaving Public and Private Roles*, in HISTORY AND HEALTH POLICY IN THE UNITED STATES: PUTTING THE PAST BACK IN 49, 66 (Rosemary A. Stevens et al. eds., 2006) (discussing the role of specialty boards' standards in American medical practice).

77. AM. PSYCHIATRIC ASS'N, *supra* note 8.

78. See *id.* (noting the many uses of electronic media in the practice of psychiatry and in medicine generally).

79. See SUSAN RUDD BAILEY, COUNCIL ON MED. EDUC., AM. MED. ASS'N, TELEMEDICINE AND MEDICAL LICENSURE (2010) (urging medical specialty societies to develop "appropriate practice parameters" for the practice of telemedicine within their specialties); cf. FED'N OF STATE MED. BDS., *supra* note 51 (arguing that medical boards have a responsibility to address concerns that arise out of the expanded use of telemedicine, and proposing that medical boards offer licensure by endorsement and require, *inter alia*, that physicians so licensed be certified by a specialty medical board); Silverman, *supra* note 42, at 269-70 (arguing that the Nurse Licensure

The third reason why policy makers should not pursue a separate license for telemedicine concerns state scope of practice laws which govern the workplace relationships among the various health professions. Just as state scope of practice laws would apply to the office, clinic, or hospital setting, so they would implicate medical services furnished electronically. A brief examination of the origins and evolution of scope of practice laws will show the connection.

Because state laws have defined the practice of medicine to include most any activity having to do with the diagnosis, treatment, and curing of any human disease or ailment,<sup>80</sup> nonphysician providers historically have had to “carve out” their own niche.<sup>81</sup> For some, this has comprised a subordinate position within an institutional setting (nurses, physician assistants); for others, a specific body part (podiatrists, optometrists, dentists) or a particular function (pharmacists).<sup>82</sup> The “carving out” of a niche or domain of practice has been painstaking and incremental, and largely the result of legal, political, social, cultural, and economic turf battles,<sup>83</sup> technological change, and fluctuations in professional status. In order to determine with some degree of specificity what nonphysician health professionals can and cannot do, legislatures and agencies in all fifty states and the District of Columbia have passed myriad scope of practice laws and regulations.<sup>84</sup> These laws vary greatly from state-to-state.<sup>85</sup>

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Compact, which provides national recognition of nursing licenses, is a promising model for a national telemedical licensing scheme).

80. Barbara J. Safriet, *Closing the Gap Between Can and May in Health-Care Providers' Scopes of Practice: A Primer for Policymakers*, 19 YALE J. ON REG. 301, 306 (2002); see also CARL F. AMERINGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION 26 (1999) (stating an early definition of the practice of medicine in Maryland encompassed “anyone ‘who shall operate on, profess to heal, prescribe for, or otherwise treat any physical or mental ailment.’”).

81. See Safreit, *supra* note 80, at 308 (discussing the extent to which non-physician health care practitioners have created their own scope of practice niches).

82. *Id.*

83. See *id.* at 308–09 (discussing the “inter-professional” conflicts that have arisen as a result of the need for scope of practice laws).

84. See, e.g., Mary D. Naylor & Ellen T. Kurtzman, *The Role of Nurse Practitioners in Reinventing Primary Care*, 29 HEALTH AFF. 893, 896 (2010) (citing Linda J. Pearson, *The Pearson Report*, 13 AM. J. FOR NURSE PRAC. 1, 1–82 (2009)) (discussing the consequences of state-by-state variation in non-physician scope of practice laws). Published annually, *The Pearson Report* details scope of practice laws regulating nurse practitioners in all fifty states and the District of Columbia. Pearson, *supra*, at 8. See also e.g., *For Your Information: Scope of Practice Issues*, MD. BD. OF PODIATRIC MED. EXAM'RS, <http://dhmh.maryland.gov/mbpme/scope.html> (last visited September 8, 2010) (establishing what medical procedures are within a licensed Maryland podiatrist's scope of practice).

85. See Safriet, *supra* note 80, at 313 (suggesting that the diversity of the scope of practice laws that govern non-physician health care providers is due in part to each professions' efforts to define its own scope of practice).

State scope of practice laws and restrictions have carried over into the telehealth and telemedicine setting, creating confusion and compliance issues for practitioners, hospitals, and related institutions. “Delivery of telehealth services,” an Institute of Medicine [IOM] report states, “has . . . been complicated by variability in state regulations, particularly whenever online communications cross state lines.”<sup>86</sup> Many in the health care community believe that state scope of practice laws limit the benefits of telehealth and telemedicine. According to legal scholar Barbara Safriet, “the crazy-quilt of [state scope of practice laws] has repeatedly been identified as the greatest legal impediment to ‘telepractice’ or ‘telehealth’ systems that would allow [nonphysicians providers] to monitor, diagnose, and treat patients at distant sites through telecommunications technology.”<sup>87</sup> A good example involves nurse practitioners who, the IOM report states, could “help bridge the gap between coverage and access” if allowed to practice to their full potential.<sup>88</sup>

None of the proposals to expedite the interstate practice of medicine would appear to address impediments that arise from scope of practice laws and regulations. Proposals such as licensure by endorsement or mutual recognition presumably would maintain the status quo; that is, physicians and other health care providers would have to satisfy the laws of the licensing state. A national license to practice telemedicine might complicate the situation even further.<sup>89</sup>

Which state’s scope of practice laws would apply to physicians who possess national licenses for telemedicine? Would there be any risk to doctors if they violate a particular state’s scope of practice requirements? Could doctors who violate such laws be charged by a state licensing board with “practicing with an unauthorized person or aiding an unauthorized person in the practice of medicine,”<sup>90</sup> a common ground for disciplinary action?<sup>91</sup> Federal preemption of state scope of practice laws should be considered in the context of a federal license for telemedicine, but preemption might not alleviate and might even exacerbate present

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86. INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH S-3–45 (2011).

87. Safriet, *supra* note 80, at 315.

88. INSTITUTE OF MEDICINE, *supra* note 86 at S-3

89. *See, e.g.*, U.S. DEP’T OF HEALTH & HUMAN SERVS., HEALTH RESOURCES & SERVS. ADMIN., TELEMEDICINE LICENSURE REPORT at 4-5 (2003) (describing potential impediments such as “traditional notions of federal-state responsibility and vested political interests”).

90. MD. CODE ANN., HEALTH OCC. § 14-404(a)(18) (LexisNexis 2010).

91. *See, e.g., id.*; D.C. CODE § 3-1205.14(a)(12) (2001); W. VA. CODE ANN § 30-3-14(c)(4) (2010). *See also* FEDERATION OF STATE MEDICAL BOARDS, A GUIDE TO THE ESSENTIALS OF A MODERN MEDICAL AND OSTEOPATHIC PRACTICE ACT, 25 (2010) available at [http://www.fsmb.org/pdf/GRPOL\\_essentials.pdf](http://www.fsmb.org/pdf/GRPOL_essentials.pdf).

conditions.<sup>92</sup> Under current proposals, preemption would only reach state regulation of telemedicine, not the underlying practice of medicine.<sup>93</sup>

## II. PRACTICAL ASPECTS OF STATE BOARD ADMINISTRATION: THE LICENSING AND THE DISCIPLINARY FUNCTIONS

There are numerous instances in which well-intentioned public policy fails or flounders, not because of opposition to the particular policy, but because lawmakers ignore its implementation and administration.<sup>94</sup> Those seeking to reduce jurisdictional impediments to telemedicine may hamper it further by overlooking features of state board administration and boards' significant role in consumer protection.

This section will examine how boards currently function—what it is that boards do and how they do it—in an effort to show the interconnected, multifaceted, and complex nature of the licensing and the disciplinary functions.<sup>95</sup> As previously noted, but for different reasons, the creation of a national license for the so-called “practice of telemedicine” would disrupt and impair traditional board functions.

First, boards' primary role in medical discipline is to assure that physicians are fit to practice medicine—that they are generally competent and do not engage in fraud, substance abuse, or any other type of unprofessional conduct that might harm their patients.<sup>96</sup> Establishing a separate national licensing scheme for the “practice of telemedicine” would fragment the disciplinary process, obscure state boards' traditionally generalist orientation, and potentially call for the enforcement of national technical standards, a burden that state boards are poorly equipped to undertake. Second, separate national and state jurisdictions, one for the practice of telemedicine and one for the practice of medicine, would give rise to choice of law issues that would delay and potentially impair

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92. See, e.g., Daniel J. Gilman, *Physician Licensure and Telemedicine: Some Competitive Issues Raised by the Prospect of Practicing Globally While Regulated Locally*, 14 J. HEALTH POL., POL'Y & L 85 (2011) (describing problematic aspects of federal preemption of state licensure, including a lack of adequate institutional oversight and potential political complications).

93. See, e.g. Matak, *supra* note 33, at 247 (explaining that federal telemedicine legislation would be constitutional under the Supreme Court's commerce clause jurisprudence only if such legislation regulated the interstate transactional aspects of telemedicine and not those areas of health care administration which are traditionally regulated by the states).

94. JEFFERY L. PRESSMAN & AARON WILDAVSKY, *IMPLEMENTATION: HOW GREAT EXPECTATIONS IN WASHINGTON ARE DASHED IN OAKLAND* xii (1973) (describing how an experimental economic development project failed due to lack of implementation, despite adequate funding, political support and public popularity).

95. See *infra* Parts II.A–B.

96. See *infra* Parts II.A–B.

disciplinary action.<sup>97</sup> Third, a national licensing scheme for the practice of telemedicine would invite conflicts between national and state authorities over the collection and sharing of information, the formulation and timing of charges, and the resolution or sanctioning of offenders.<sup>98</sup> Fourth, a national licensing scheme for telemedicine could impair or even sever the current link between licensing and discipline in areas such as initial licensure, licensure renewal, and post-sanction monitoring.<sup>99</sup>

#### *A. The Evolution of Board Functions*

Established in the late 1800s,<sup>100</sup> boards' initial role was to support the private medical establishment.<sup>101</sup> Their principal activities were to restrict the supply of physicians to graduates of "approved" medical schools and to protect the wide boundaries of medical practice from chiropractors, nurse midwives, and other potential competitors.<sup>102</sup> Until about the 1980s, the link between state medical societies and state medical boards was tight.<sup>103</sup> State societies dominated the selection of board members, thus ensuring that board actions met with the approval of the medical establishment.<sup>104</sup> Board discipline of wayward physicians was minimal.<sup>105</sup> While boards supported efforts of state and local medical societies to prevent doctors from acting "unethically," they did little to police physician

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97. See *infra* Part II.B.

98. See *infra* Parts II.B–C.

99. See *infra* Parts II.C–E.

100. JEFFREY L. BERLANT, *PROFESSION AND MONOPOLY: A STUDY OF MEDICINE IN THE UNITED STATES AND GREAT BRITAIN* 234 (1975).

101. See *id.* (noting that the first state medicals were essentially "inoperative" and did not do much more than serve as registration boards where doctors could register their medical society licenses).

102. See, e.g., Ronald C. Lippincott & James W. Begun, *Competition in the Health Sector: A Historical Perspective*, 7 J. HEALTH POL., POL'Y & L. 460, 466–67 (1982) (tracing the history of medical board involvement in Ohio medical licensing, and noting that boards required licensed physicians to graduate from "legally chartered" medical schools and largely admitted only "regular physicians" to the practice of medicine).

103. See AMERINGER, *supra* note 80, at 12 (attributing the growing tension between "former allies," medical boards and state medical societies, to the increasing focus in the 1970s and 80s on consumer interests).

104. *Id.* at 33–34; see also BERLANT, *supra* note 100, at 234 (suggesting that the state societies' dominance over the selection of state licensing board members in the late 1800s resulted in the monopolization of American organized medicine, which ensured that board actions tracked those of the medical profession); N.C. MED. SOC'Y, *150 YEARS OF LEADERSHIP: THE HISTORY OF THE NORTH CAROLINA MEDICAL SOCIETY'S PIONEERING PHYSICIAN LEADERS* 2, 4 (2004), available at [http://www.ncmedsoc.org/media/pdf/NCMS\\_history\\_brochure1.pdf](http://www.ncmedsoc.org/media/pdf/NCMS_history_brochure1.pdf) (discussing how the leadership of the North Carolina Medical Society helped develop the state Board of Medical Examiners and elected seven members to the first Board).

105. See BERLANT, *supra* note 100, at 78–79 (noting that in 1965 only seven medical societies had ever disciplined physicians because of incompetence).

incompetence.<sup>106</sup> Most of the cases that boards received originated in the state courts and in the local medical associations where, in many instances, the seriousness of the violations already had been determined.<sup>107</sup>

The decline of the organized medical profession (consisting of the American Medical Association and its component state and local societies) (hereafter, “organized medicine”) in the latter half of the twentieth century was a defining moment in the evolution of the medical licensing boards. So too was the simultaneous rise of medical specialization.<sup>108</sup> The former freed state medical boards from the profession’s grip; the latter diminished the significance of a state license. Organized medicine’s decline began with the passage of Medicare and Medicaid in 1965,<sup>109</sup> the increase in physician supply as federal dollars flowed to medical schools,<sup>110</sup> and the introduction of cost-cutting measures in the 1970s.<sup>111</sup> Cost-cutting efforts of HMOs and other managed care organizations (utilization review, gatekeeping, and capitation, for example), when combined with the new contractual and employment relationships that such organizations brought about, disrupted the medical establishment. A series of antitrust actions in the late 1970s and early 1980s that targeted national, state, and local associations across all professions did much to undermine organized medicine as well.<sup>112</sup>

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106. See Frank P. Grad, *The Antitrust Laws and Professional Discipline in Medicine*, 1978 DUKE L.J. 443, 458–59 & n.72 (1978) (describing as sanctionable under “unprofessional conduct” offenses including advertising and fee-sharing, and noting that in several states this was one of the most often cited categories for physician discipline); see also AMERINGER, *supra* note 80, at 34–35 (noting that most physician disciplinary action involved violations of narcotics laws and “unethical conduct,” even though “professional incompetence” was one of the most pressing problems).

107. See AMERINGER, *supra* note 80, at 30–31 (detailing the large role that Med Chi, Maryland’s medical society, played in bringing disciplinary actions against physicians).

108. For the classic account of the rise of medical specialization during the twentieth century, see generally ROSEMARY A. STEVENS, *AMERICAN MEDICINE AND THE PUBLIC INTEREST* 3 (1971).

109. See *id.* at 442–43 (explaining that the passage of Medicare and Medicaid in 1965 “marked the beginning of a new era” in organized medicine by replacing organized medicine with the public as the “dominant decision maker” of the nation’s medical needs based on social and political factors).

110. See STARR, *supra* note 1, at 352 (noting a “national investment” in research and hospitals resulted in a sharp increase in the flow of funds to medical schools).

111. See generally Carl F. Ameringer, *Devolution and Distrust: Managed Care and the Resurgence of Physician Power and Autonomy*, 5 DEPAUL J. HEALTH CARE L. 187, 187–191 (2002) (discussing the general decline of organized medicine in the 1970s and noting in particular the contribution that efforts to cut health care costs made to that decline).

112. See, e.g., *Fed. Trade Comm’n v. Ind. Fed’n of Dentists*, 476 U.S. 447, 465–66 (1986) (holding that a federation of Indiana dentists engaged in unfair competition when they promulgated a rule prohibiting members from submitting x-rays to dental insurers considering claims); *Arizona v. Maricopa Cnty. Med. Soc’y*, 457 U.S. 332 335–36 (1982) (holding that an agreement among competing physicians that fixed a maximum fee physicians could collect violated the Sherman Antitrust Act); *Nat’l Soc’y of Prof’l Eng’rs v. United States*, 435 U.S. 679,

Physicians who once joined the AMA and its umbrella state and local medical societies to secure hospital privileges, referrals, medical malpractice coverage, and protection from outside competition, now looked to HMOs and hospital systems for such benefits.<sup>113</sup>

Public and private efforts to control health care costs, the diminished authority of organized medicine, a medical malpractice “crisis” in the 1970s, the rise of consumerism, and a more active media, helped to focus attention on physician performance. Seeking to satisfy enhanced expectations of consumer groups, lawmakers, and federal oversight bodies, boards increased the number and variety of cases they investigated, prosecuted, reported, and monitored.<sup>114</sup> To accomplish this, they reorganized and modernized their operations and gained the resources and the infrastructure needed to collect and to process large amounts of data.<sup>115</sup> In the process, the connection between the medical boards and the organized profession was attenuated.

Today’s health care landscape is fundamentally different from the one that existed in the 1970s, before the advent of market competition and industry consolidation.<sup>116</sup> Doctors now face intense scrutiny for several reasons, including: (1) enhanced government regulation; (2) institutional liability for medical malpractice; (3) increased emphasis on risk management and quality assurance; (4) the development of clinical standards and protocols; and (5) technological advances in the collection, assessment, and dissemination of performance-based information.<sup>117</sup>

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681 (1978) (holding that the National Society of Professional Engineers’ code of professional ethics prohibiting competitive bidding violated the Sherman Antitrust Act); *In re Am. Med. Ass’n*, 94 F.T.C. 701, 974 (1979) (finding that American Medical Association, The Connecticut State Medical Society, and The New Haven County Medical Association violated the Federal Trade Commission Act by obstructing competition between doctors); *cf.* *Goldfarb v. Va. State Bar*, 421 U.S. 773, 775, 793 (1975) (holding that a minimum fee schedule for lawyers in the Virginia State Bar violated the Sherman Antitrust Act).

113. See STARR, *supra* note 1, at 396–98 (discussing the initial creation of Health Maintenance Organizations (HMOs), and noting that the membership of the American Medical Association dropped by half after the advent of the HMO).

114. See generally AMERINGER, *supra* note 80, at 51–56 (tracing the gradual development of state medical boards’ abilities to handle larger caseloads and to deal with more complex issues in physician discipline).

115. *Id.* at 4–7, 57–58.

116. See generally JAMES C. ROBINSON, *THE CORPORATE PRACTICE OF MEDICINE: COMPETITION AND INNOVATION IN HEALTH CARE* (1999); See also STARR, *supra* note 1, at 420–21 (noting that, while physicians have maintained autonomy from corporations, that autonomy is increasingly threatened by the rise of corporate enterprise in health services).

117. See generally AMERINGER, *supra* note 80, at 122–27 (discussing the “new regime” of medicine and noting that physicians are now accountable to third-parties outside the profession and to the government, and that external scrutiny has become the norm). See also STARR, *supra* note 1, at 447 (noting that the corporatization of health services leads to closer scrutiny of physicians and higher quality assurance in order to avoid liability for malpractice, which is

As before, boards remain uniquely responsible for protecting the public from incompetent, impaired, or corrupt physicians — those physicians who represent a clear danger to the health and safety of their patients, their colleagues, and the integrity of the medical profession.<sup>118</sup> But in performing their duties, medical boards now interact with several entities (hospital committees, managed care organizations, government agencies, other medical boards) in the licensing, re-licensing, and disciplining of physicians.<sup>119</sup> In addition, medical boards now issue guidelines to instruct doctors in proper pain management,<sup>120</sup> the use of controlled substances,<sup>121</sup> sexual misconduct,<sup>122</sup> Internet prescribing,<sup>123</sup> the practice of alternative medicine,<sup>124</sup> physician impairment,<sup>125</sup> and outpatient surgery.<sup>126</sup> Finally, boards now oversee and monitor allied health providers, which may include

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facilitated by gathering information about physician performance). Professor Starr also suggests that the increase in federal involvement with health care has contributed to the public's perception that a huge bureaucracy is largely standing in the way of the formation of "well-integrated health service scheme[s]." *Id.* at 506. For a critical view on the role that specialization has played in developing "chronic stresses and strains" within the medical profession, see STEVENS, *supra* note 108, at 3.

118. *The Role of the State Medical Board*, FED'N OF STATE MED. BDS., [http://www.fsmb.org/grpol\\_talkingpoints1.html](http://www.fsmb.org/grpol_talkingpoints1.html) (last visited Sept. 14, 2010). According to the Federation of State Medical Boards, "the state medical board investigates any evidence that appears to indicate that a physician is or may be incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine or that the Medical Practice Act or the rules and regulations of the Board have been violated." *Id.*

119. HUMAYUN CHAUDHRY ET AL., FED'N OF STATE MED. BDS., MAINTENANCE OF LICENSURE: PROTECTING THE PUBLIC, PROMOTING QUALITY HEALTH CARE 5 (2010) <http://www.fsmb.org/pdf/mol-bg.pdf>.

120. *See, e.g.*, FED'N OF STATE MED. BDS., MODEL POLICY FOR THE USE OF CONTROLLED SUBSTANCES IN THE TREATMENT OF PAIN (2004)

[http://www.fsmb.org/pdf/2004\\_grpol\\_Controlled\\_Substances.pdf](http://www.fsmb.org/pdf/2004_grpol_Controlled_Substances.pdf) (recognizing that treatment of pain is integral to medical practice and establishing a model policy for physicians to provide "appropriate and effective pain relief").

121. *Id.* (delineating model policies for the medical use of controlled substances in pain management).

122. FED'N OF STATE MED. BDS., ADDRESSING SEXUAL BOUNDARIES: GUIDELINES FOR STATE MEDICAL BOARDS (2006) [http://www.fsmb.org/pdf/GRPOL\\_Sexual%20Boundaries.pdf](http://www.fsmb.org/pdf/GRPOL_Sexual%20Boundaries.pdf) (providing investigative and disciplinary guidelines so that state medical boards can police physician sexual misconduct).

123. SPECIAL COMM. ON PROF'L CONDUCT & ETHICS, FED'N OF STATE MED. BDS., MODEL GUIDELINES FOR THE APPROPRIATE USE OF THE INTERNET IN MEDICAL PRACTICE 2 (2002), [http://www.fsmb.org/pdf/2002\\_grpol\\_Use\\_of\\_Internet.pdf](http://www.fsmb.org/pdf/2002_grpol_Use_of_Internet.pdf).

124. FED'N OF STATE MED. BDS., MODEL GUIDELINES FOR THE USE OF COMPLEMENTARY AND ALTERNATIVE THERAPIES IN MEDICAL PRACTICE 1 (2002) [http://www.fsmb.org/pdf/2002\\_grpol\\_Complementary\\_Alternative\\_Therapies.pdf](http://www.fsmb.org/pdf/2002_grpol_Complementary_Alternative_Therapies.pdf).

125. FED'N OF STATE MED. BDS., REPORT OF THE AD HOC COMMITTEE ON PHYSICIAN IMPAIRMENT (1995) [http://www.fsmb.org/pdf/1995\\_grpol\\_Physician\\_Impairment.pdf](http://www.fsmb.org/pdf/1995_grpol_Physician_Impairment.pdf).

126. FED'N OF STATE MED. BDS., REPORT OF THE SPECIAL COMMITTEE ON OUTPATIENT (OFFICE-BASED) SURGERY (2002) [http://www.fsmb.org/pdf/2002\\_grpol\\_Outpatient\\_Surgery.pdf](http://www.fsmb.org/pdf/2002_grpol_Outpatient_Surgery.pdf).

physician assistants, radiographers, respiratory care practitioners, and athletic trainers.<sup>127</sup>

*B. Assuring Fitness to Practice, Not Adherence to Technical Standards*

The legal grounds for disciplining physicians are generic, not specialty-based.<sup>128</sup> They include fraud, sexual misconduct, intoxication, substance abuse, and professional or mental incompetence—behaviors that often are unprofessional, may be illegal, and sometimes implicate poor quality performance.<sup>129</sup> Such provisions do not apply to any particular practice setting or specific means of communication. Nor do they customarily involve matters of technical error or ordinary negligence.<sup>130</sup> Whether a board should discipline a physician, in other words, has little to do with a discrete area of practice or technology, such as telemedicine. Because boards' main task is to assure "fitness to practice,"<sup>131</sup> a physician's behavior and overall qualifications are the central focus. "Someone must be left to handle the distasteful task of culling. . .the bad apples," legal scholar Timothy Jost has noted with reference to boards' role in consumer protection.<sup>132</sup>

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127. See, e.g., *What is the Maryland Board of Physicians?*, MD. BD. OF PHYSICIANS, <http://www.mbp.state.md.us/pages/whatis.html> (last visited Oct. 31, 2010) (listing physician assistants, radiographers, respiratory care practitioners, and athletic trainers among those that are monitored by the Board of Physicians).

128. See Sandra H. Johnson, *Regulatory Responses to Professional Misconduct: Sexual Misconduct, Controlled Substances, and Impairment*, in *REGULATION OF THE HEALTHCARE PROFESSIONS* 45, 45–46 (Timothy S. Jost ed., 1997) (discussing three of the most prominent grounds for discipline found in most licensure statutes—sexual misconduct, controlled substances, and impairment). Specialty medical boards serve a qualitatively different function from the state boards the license and discipline physicians. See Gregory Dolin, Comment, *Licensing Health Care Professionals: Has the United States Outlived the Need for Medical Licensure?*, 2 *GEO. J.L. & PUB. POL'Y* 315, 325 n.102 (2004) (explaining the difference between specialty medical boards and licensing boards, and stating that specialty certification has no effect on licensure); see also *Who We Are & What We Do*, AM. BD. MED. SPECIALTIES, [http://www.abms.org/About\\_ABMS/who\\_we\\_are.aspx](http://www.abms.org/About_ABMS/who_we_are.aspx) (last visited Nov. 2, 2010) (listing the common objectives of medical specialty boards and discipline is not among them).

129. Johnson, *supra* note 128, at 45–46.

130. See, e.g., *REPORT OF THE AM. MED. ASS'N & THE FED'N OF STATE MED. BDS., ETHICS AND QUALITY OF CARE* (1995), [http://www.fsmb.org/pdf/1995\\_grpol\\_Ethics\\_and\\_Quality\\_of\\_Care.pdf](http://www.fsmb.org/pdf/1995_grpol_Ethics_and_Quality_of_Care.pdf); *THE FED'N OF STATE MED. BDS., REPORT OF THE SPECIAL COMM. ON EVALUATION OF QUALITY OF CARE AND MAINT. OF COMPETENCE* (1999), [http://www.fsmb.org/pdf/1999\\_grpol\\_Evaluation\\_of\\_Quality\\_Care.pdf](http://www.fsmb.org/pdf/1999_grpol_Evaluation_of_Quality_Care.pdf) (emphasizing the importance of identifying patterns of incompetence, rather than individual incidents of ordinary negligence).

131. *FED'N OF STATE MED. BDS., REPORT OF THE SPECIAL COMM. ON LICENSE PORTABILITY* § 2(A), <http://www.telehealthlawcenter.org/?c=155&a=1231>.

132. Jost, *supra* note 38, at 20.

Confusion over the nature and purpose of medical discipline has obscured the policy debate regarding telemedicine. Pointing to “widespread criticism of the effectiveness of licensing boards to deal with substandard medical care or physician incompetence,”<sup>133</sup> Peter Jacobson and Elizabeth Selvin have sought “complete federalization” of all activities that involve telemedicine.<sup>134</sup> “The primary goals of national licensure for telemedicine,” Jacobson and Selvin claim, “are to allow standardized review of licensing, to maintain a central repository of information on telemedicine-related malpractice claims and verdicts, and to develop and enforce uniform standards for the practice of telemedicine.”<sup>135</sup> Acknowledging that “complete federalization of telemedicine licensure is highly unlikely,”<sup>136</sup> however, Jacobson and Selvin also have proposed “a joint state-federal system” in which the federal government would issue licenses and establish standards for telemedicine that state boards would then enforce.<sup>137</sup> Rashid Bashshur, another proponent of national licensure, supports an arrangement similar to that of Jacobson and Selvin, though he would split the disciplinary responsibilities between federal and state authorities.<sup>138</sup> Federal authorities, Bashshur says, “would focus on competency” and state authorities “would focus on policing professional misconduct.”<sup>139</sup>

Though national standards concerning telemedicine may be desirable, reliance on state boards to enforce such standards fails to acknowledge boards’ distinct role in public protection. First, any technical standards that other entities enact may have little, if any, connection to the specific grounds or reasons for disciplining physicians. Indeed, none of the grounds for disciplining doctors contained in the Federation’s 2010 Model Act<sup>140</sup> would appear to be related to the standards that the American Telemedicine Association (ATA) and the American Psychiatric Association (APA) have compiled for telemedicine.<sup>141</sup> The ATA’s Telemental Health Standards

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133. *Id.*

134. Jacobson & Selvin, *supra* note 15 at 436.

135. *Id.* at 435.

136. *Id.* at 436.

137. *Id.*

138. Bashshur, *supra* note 33 at 311.

139. *Id.* at 311.

140. See FED’N OF STATE MED. BDS., *supra* note 75 (detailing disciplinary actions against licensees).

141. See AM. TELEMEDICINE ASS’N, CORE STANDARDS FOR TELEMEDICINE OPERATIONS, [http://www.americantelemed.org/files/public/standards/CoreStandards\\_withCOVER.pdf](http://www.americantelemed.org/files/public/standards/CoreStandards_withCOVER.pdf) (outlining guidelines and standards for providing uniform telemedicine treatment to patients); See also AM. TELEMEDICINE ASS’N, PRACTICE GUIDELINES FOR VIDEOCONFERENCING-BASED TELEMENTAL HEALTH, 7–17, <http://www.americantelemed.org/files/public/standards/PracticeGuidelinesForVideoconferencing-Based%20TelementalHealth.pdf> (detailing the applicable standards to telemental health).

encompass detailed clinical and technical specifications ranging from room size to transmission speed and bandwidth.<sup>142</sup> APA guidelines, though less detailed and complex, cover features such as technical training and videoconferencing equipment.<sup>143</sup> Of far greater relevance, it seems, are the Federation's guidelines on the "Appropriate Use of the Internet."<sup>144</sup> While issued for Internet use, Federation guidelines stress proper modes of professional conduct regarding privacy, confidentiality, security, informed consent, and disclosure of information—legal and ethical considerations that would apply to most any practice setting.

Second, state medical boards are not the best arbiters of particular performance-based standards. In an era of intense medical specialization and industry consolidation, practitioners seek more than a medical license in order to advance their careers. Board certification, not a medical license, is the hallmark of technical achievement;<sup>145</sup> specialty boards, not licensing boards, set the standards for technical competence;<sup>146</sup> regional systems or integrated delivery networks, not medical boards, oversee the delivery of medical services.<sup>147</sup> Indeed, the standard of care in a lawsuit for medical malpractice is tied to a doctor's specialty area,<sup>148</sup> and few plaintiffs will succeed at trial if they fail to produce a specialist who can testify that the applicable standard was violated.<sup>149</sup>

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142. See AM. TELEMEDICINE ASS'N, *supra* note 141 at 13–16 (<http://www.americantelemed.org/files/public/standards/PracticeGuidelinesForVideoconferencing-Based%20TelementalHealth.pdf>(noting that the videoconferencing shall operate at certain bandwidths and meet certain room and lighting requirements)).

143. See AM. PSYCHIATRIC ASS'N, *supra* note 8.

144. FED'N OF STATE MED. BDS., MODEL GUIDELINES FOR THE APPROPRIATE USE OF THE INTERNET IN MEDICAL PRACTICE, 5-6 ([http://www.fsmb.org/pdf/2002\\_grpol\\_Use\\_of\\_Internet.pdf](http://www.fsmb.org/pdf/2002_grpol_Use_of_Internet.pdf)(briefly outlining the categories of evaluation of patient, treatment, electronic communications, informed consent, medical records, and compliance with state and federal laws and web standards)).

145. See Jerome P. Kassirer, M.D., *The New Surrogates for Board Certification: What Should the Standards Be?* 337 NEW ENG. J. MED. 43, 43 (1997) (describing how board certification provides employers and patients with a more accurate method of assessing physician competence and performance).

146. *Id.*

147. Alain C. Enthoven, *Integrated Delivery Systems: The Cure for Fragmentation*, 15 AM. J. MANAG. CARE S284, S285 (2009), ([http://www.ajmc.com/media/pdf/A264\\_09dec\\_Hlth\\_Facul\\_S274to6.pdf](http://www.ajmc.com/media/pdf/A264_09dec_Hlth_Facul_S274to6.pdf)).

148. Vivak Nayar, *Tele-radiology: Images of an Improved Standard of Medical Care?*, 35 RUTGERS COMPUTER & TECH. L.J. 104, 119 (2008) (discussing common law medical negligence barriers to the growth of telemedicine).

149. Tim Cramm et al., *Ascertaining Customary Care in Medical Malpractice Cases: Asking Those Who Know*, 37 WAKE FOREST L. REV. 699, 700 (2002) (“[T]estimony must be presented by an expert witness who is familiar with the way in which the relevant population of professionals practice medicine.”).

The link between medical malpractice and physician incompetence that proponents of national licensure profess is itself rather tenuous. Professional incompetence, a common ground for disciplining doctors, requires a higher threshold for action than does a typical case of medical malpractice. “The term ‘incompetent’ [refers to] professionals who consistently cause harm or fail to provide appropriate care,”<sup>150</sup> Timothy Jost has stated. Professional incompetence could result from “impairment due to physical or mental disability or substance abuse; fundamental lack of adequate intelligence to do the job; superannuation or other failure to keep abreast of developments; chronic carelessness; ‘burn out’ attributable to overwork, personal problems, or other sources; or venality,” Jost says.<sup>151</sup> “A single malpractice settlement or judgment, even a very large one, reveals little about the competence of the doctor against whom it was rendered,” he claims.<sup>152</sup> Protecting the public from incompetent physicians is consistent with boards’ overall mission. Requiring boards to enforce technical standards for telemedicine would hamper that mission.

Finally, as a practical matter, few boards would have the capacity to handle cases involving breaches of technical standards related to telemedicine. Relatively small units of state government, medical boards have limited resources.<sup>153</sup> Arguably, those resources should go toward the investigation and prosecution of the most egregious offenders—the “bad apples” who are not fit to practice medicine. Other units of government and, in particular, private sector organizations (regional health systems, national accrediting bodies) are better equipped and demonstrably more successful in the application and enforcement of practice standards.<sup>154</sup>

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150. Jost, *supra* note 38 at 20.

151. *Id.*

152. *Id.* at 27.

153. See David A. Johnson, et al., *Role of State Medical Boards in Continuing Medical Education*, 25 J. OF CONTINUING EDUC. IN THE HEALTH PROFESSIONS 183, 185 (2005) (noting that “State medical boards are hampered by limited resources and sometimes the absence of any control over their operational budget and revenue.”).

154. See AMERINGER, *supra* note 80, at 80 (noting that professional associations and the medical staff of hospitals are better equipped to pursue disciplinary actions for malpractice); Arnold S. Relman, *Regulation of the Medical Profession: A Physician’s Perspective*, in REGULATION OF THE HEALTHCARE PROFESSIONS 199, 205 (Timothy S. Jost ed., 1997) (outlining the ways in which board resources are limited). An oft-cited Harvard study from 1984 found that the connection between victim compensation and malpractice was tenuous, that insurance companies settled many cases for nuisance value or costs of litigation, and that few cases for medical malpractice involved repeat offenders. See HARVARD MED. PRACTICE STUDY, PATIENTS, DOCTORS, AND LAWYERS: MEDICAL INJURY, MALPRACTICE LITIGATION, AND PATIENT COMPENSATION IN NEW YORK 6 (1990) (discussing the results of a study of malpractice litigation and showing no concrete link between malpractice injury and the claims that are litigated); see also Troyen A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I*, 324 NEW ENG. J. MED. 370, 373 (1991) (detailing the results of the Harvard Medical Practice Study); Troyen A. Brennan et al.,

### C. Choice of Law Problems

The investigation, prosecution, and resolution of disciplinary cases would become more complex if there were duplicate licenses administered by different jurisdictions, one for the practice of medicine and one for the practice of telemedicine, particularly if telemedicine becomes the way most physicians communicate with their patients, a likely occurrence. A threshold issue in a disciplinary case involving a doctor who possesses a license in State A, but who telemedically treats a patient in State B under the auspices of a national license, would be which state's laws would apply.<sup>155</sup> State A might assert jurisdiction based on the doctor's State A license, while State B might claim jurisdiction based on the patient's State B location. Federal authorities might even claim jurisdiction on the grounds that the services were rendered under the auspices of a national license. The national license, in any case, would complicate the situation since the State A doctor would not have to be licensed in State B.

The pertinent grounds for disciplining offenders,<sup>156</sup> the applicable statute of limitations, the relevant scope of practice constraints, and many other important legal issues would hinge on which state's laws applied. No matter how decided, the choice of law disproportionately would affect certain parties and boards. If State B laws apply, the State A doctor might be adversely affected notwithstanding the lack of or need for a State B license. If State A laws apply, the State B patient might be adversely affected because of the need to travel to or interact with State A. Moreover, the State A and State B boards might expend substantial resources in determining the choice of law. Uncertainty over the choice of law could undermine administrative efficiency and jeopardize case investigation, prosecution, and resolution.

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*Relation Between Negligent Adverse Events and The Outcomes of Medical-Malpractice Litigation*, 335 NEW ENG. J. MED. 1963, 1963, 1966-67 (1996) (discussing the results of the Harvard Medical Study and a 10-year follow-up study and noting that the settlements of malpractice claims are more tied to the severity of the injury than the negligence itself, and that malpractice suits appear to have little deterrence effect).

155. See also, P. Greg Gulick, *The Development of a Global Hospital Is Closer Than We Think: An Examination of the International Implications of Telemedicine and the Developments, Uses and Problems Facing International Telemedicine Programs*, 11 IND. INT'L & COMP. L. REV. 183, 209-10 (2000) (mentioning the uncertainty that surrounds choice of law issues in the context of international telemedicine, as well as factors considered by courts in determining the appropriate law to apply).

156. The grounds for disciplinary actions against physicians vary widely from state to state. Compare N.H. REV. STAT. ANN. § 329:17 (2010) (listing 12 grounds for disciplinary actions against physicians) with W. VA. CODE ANN. § 30-3-14 (2011) (listing 21 grounds for disciplinary actions against physicians) and S.D.CODIFIED LAWS § 36-4-30 (2010) (listing 24 grounds for disciplinary actions against physicians).

In any event, legal proceedings to determine the choice of law would delay disciplinary action and potentially upset any efforts to resolve a particular matter. Attorneys representing the State A doctor, for instance, might not negotiate with State A unless they knew for certain that the State A board had jurisdiction. Such confusion might limit attempts to remove and rehabilitate offenders. Legal and administrative expenses, no doubt, would increase substantially.

Finally, conflicts might ensue among federal and state authorities on any number of issues related to case handling, investigation, and decisions to prosecute or sanction. These differences might involve the application and interpretation of federal and state laws concerning the sharing of information, for instance. Many board statutes contain provisions relating to the disclosure, exchange, and use of information between boards and various public and private entities, such as hospitals, insurers, law enforcement agencies, and even state medical societies.<sup>157</sup> Indeed, Maryland law requires that “hospitals and related institutions” provide certain reports and information to the state medical board.<sup>158</sup> The potential for widespread disclosure and dissemination of information concerning physician performance might inhibit the activities of peer review committees of hospitals and related facilities.<sup>159</sup> Federal criminal and civil investigations could enter the mix, causing delays in gaining access to documents and witnesses. Though problems relating to case coordination undeniably already exist, a national license for telemedicine would further complicate board investigations.

#### *D. Issues Related to Case Management*

Even when board jurisdiction is clear, efforts to bring and resolve cases against physicians can be painstaking and difficult.<sup>160</sup> Several individuals or stakeholders typically will be involved—board members (who oversee both licensing and discipline), administrators (who are assigned to either or both functions), investigators (who may work for either the board or another unit of state government), prosecutors (who may work for the board or a separate office, such as the state attorney general),

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157. See e.g. WASH. REV. CODE § 70.02.050 (2) (listing agencies and organizations that health care providers shall disclose information to without the patient’s authorization)

158. MD. CODE ANN., HEALTH OCCUPATIONS § 14-413 (LexisNexis 2009).

159. §14-410.

160. See Jost, *supra* note 38 at 17, 25 (stating that the disciplinary process is lengthy, tedious, and expensive). For more detail about the many steps involved in physician discipline, see generally RANDALL R. BOVBERG ET AL., THE URBAN INST., HEALTH POLICY CENTER, STATE DISCIPLINE OF PHYSICIANS: ASSESSING STATE MEDICAL BOARDS THROUGH CASE STUDIES 20–29 (2006), available at

<http://aspe.hhs.gov/daltcp/reports/2006/stdiscp.htm>.

and hearing officers or administrative law judges (whose connection to the board may be close or quite limited). Conflicts inevitably will arise among these stakeholders over the direction a case should take; the formulation of the charges; the collecting and assembling of facts, and what the evidence means; the use of experts, consultants, and peer reviewers; and the sanctions a doctor should receive. Board members, many of whom are doctors, may and frequently will differ with government lawyers and administrators.

Certain types of cases may span several years and then come together all at once, calling for immediate action. A doctor who drinks alcohol in excess, for example, may have done so for several years before showing signs of incompetence.<sup>161</sup> Or, as sometimes occurs, colleagues may ignore the drinking problem until mistakes become more apparent or other health professionals, such as nurses, raise concerns.<sup>162</sup> Cases involving sexual misconduct also demand quick action once the facts are known. Most often, there is more than one victim and the misconduct will have occurred over several years or even decades.<sup>163</sup> For a variety of reasons, including guilt, confusion and fear, many victims of sexual misconduct will not alert the appropriate authorities until others have done so.<sup>164</sup>

Not all states handle physician misconduct the same way, perhaps because their emergency powers differ or the applicable statute of limitations prevents certain action.<sup>165</sup> Perhaps it is because different

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161. See e.g., MD. CODE ANN., HEALTH OCC. §§ 14-404(a)(4), (7), (9)(i) (LexisNexis 2009); N.H. REV. STAT. ANN. § 329:17(VI)(b) (LexisNexis 2010); VA. CODE ANN. §§ 54.1-2915(2), (4), (13) (2009).

162. Roger Cicala, *Substance Abuse Among Physicians: What You Need to Know*, HOSPITAL PHYSICIAN, June 2003, at 39.

163. AMERINGER, *supra* note 80, at 92.

164. *Id.*

165. See Andrew L. Hyams, *Expert Psychiatric Evidence in Sexual Misconduct Cases Before State Medical Boards*, 18 AM. J.L. MED. 171, 175 (noting that it often takes victims of physician sexual misconduct years to file a complaint because they are so damaged by the experience). There is considerable disparity among boards concerning the onset and length of time for filing disciplinary charges against a licensee, particularly in cases for sexual misconduct or those in which a doctor's pattern of conduct over time is involved. Compare, e.g., Peter W. Mosseau & Stephen D. Coppolo, *Representation of Physicians Before the Board of Medicine*, 49 N.H. B.J., 30, 34 (2008) (advising that a six-year statute of limitations applies to discipline for physician misconduct in New Hampshire, but that the limit does not apply when the board is considering long-running behavior as long as some misconduct occurred within the statutory period), and Carol Gentry, In 49 Cases, Time Ran Out, HEALTH NEWS FLA. (Aug. 21, 2009), <http://www.healthnewsflorida.org/index.cfm/go/public.articleView/article/13595> (reporting that there is a six-year statute of limitations in professional discipline cases, but that the time limits do not apply to sexual misconduct cases), with Complaint Process—Frequently Asked Questions, MED. BD. CAL., [http://www.medbd.ca.gov/consumer/complaint\\_info\\_questions\\_process.html](http://www.medbd.ca.gov/consumer/complaint_info_questions_process.html) (last visited Nov. 2, 2010) (explaining California's seven-year statute of limitations on charges against a physician's license and noting that the Board's investigation must be concluded and the case sent to the Attorney General before the seven years expires). See also Christi Parsons, Lawmakers

philosophies or approaches exist. Notwithstanding variations in laws and management styles, the need to act quickly, decisively, and sometimes discretely to protect the public requires close coordination among case managers, investigators, and licensing authorities.<sup>166</sup> Multi-jurisdictional activity increases the number of persons and organizations involved. In order to mitigate conflicts and to reduce delay, there must be shared access to information and general agreement on the relevant facts and the violations taking place.

The addition of a federal agency with independent authority over activities occurring telemedically could hamper ongoing state board investigations and efforts to settle or otherwise resolve cases. Could a national licensing body take action if a state board does not, possibly suspending the national license to practice telemedicine while one or more state licenses to practice medicine remain in place? What would be the effect of national action if the doctor was licensed in more than one state? Could the doctor continue to practice telemedicine between or among the licensing states? Could federal authorities initiate action if the state board is slow to respond, perhaps due to limited resources? Could a state board take action in a telemedicine-related matter if the federal agency objects? These as well as many other questions are likely to surface.

#### *E. The Close Connection Between Licensure and Discipline*

Licensing and discipline are intertwined. Some of the areas in which they intersect include initial licensure, licensure renewal, and post-sanction monitoring (probationary review, mentoring, and rehabilitation, for instance).<sup>167</sup> Examining the close link between licensing and discipline in each of these areas will demonstrate why state-based licensure for telemedicine should continue if medical boards can reduce or eliminate barriers to interstate practice.

Initial state licensure, whether for graduates of U.S. and foreign medical schools or for doctors seeking licensure in another state, calls for

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Target Bad Doctors, CHI. TRIB., May 1, 2005, at C1 (noting that it is difficult to punish a doctor in Illinois because there is a five-year window for establishing a poor "pattern of practice").

166. FEDERATION OF STATE MEDICAL BOARDS, STATE OF THE STATES: PHYSICIAN REGULATION 2009 6, 11, 19–21, 23 (2009) (identifying that medical boards monitor and prevent physician conduct by coordinating to identify individuals with problems prior to issuance of a license and by employing investigators and other staff to coordinate with patients, health professionals, government agencies, health care organizations, and other state medical boards to protect the public, while attempting to maintain the physician as a community resource where possible).

167. See BOVBERG ET AL., *supra* note 160 at 8–26 (describing the process boards follow to certify and discipline doctors, and demonstrating that the process of licensing and relicensing takes into account the number and severity of disciplinary proceedings that a physician underwent).

the coordination of the licensing and the disciplinary functions.<sup>168</sup> Boards collect a variety of information from multiple sources to assess a doctor's candidacy to practice.<sup>169</sup> In addition to test results, boards consider workplace performance, disciplinary actions taken, pending criminal matters, and any other evidence that bears on fitness to practice.<sup>170</sup> What would be the criteria for issuance of a national license to practice telemedicine? Doctors presumably would need a state license, but which state's license would provide the basis for the national license if a doctor is licensed in more than one state?

In addition to initial licensure, the process for renewing a license demonstrates why the choice of states would be significant. Not all states use the same criteria for license renewal, nor are state boards privy to the same information. Many boards, for instance, require licensed physicians to participate in programs of continuing medical education, the criteria varying depending on the particular state.<sup>171</sup> How would a federal agency that grants or renews licenses to practice telemedicine treat requirements for continuing education? Boards may delay the reissuance of a license, moreover, if a disciplinary action is pending.<sup>172</sup> How would a federal agency handle pending disciplinary actions?

Finally, the coordination of licensing and discipline are important to the monitoring of physicians post-sanction. Formal case resolutions most often occur by consent order, the terms of which vary according to the facts of each case.<sup>173</sup> In such instances, a number of contingencies can arise. These contingencies may include the conditions for license reapplication (in

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168. See FEDERATION OF STATE MEDICAL BOARDS, *supra* note 166, at 11 (identifying the Uniform Application for Physician State Licensure will likely identify individuals with misconduct problems during the licensing process).

169. See *id.* at 8 (discussing the many sources required for a doctor's candidacy); See also *Protecting the Public: How State Medical Boards Regulate and Discipline Physicians*, FED'N OF STATE MED. BDS., [http://www.fsmb.org/smb\\_protecting\\_public.html](http://www.fsmb.org/smb_protecting_public.html) (last visited Oct. 7, 2010) (showing the variety of information that boards collect when considering whether to grant or renew a physician's license).

170. BOVBERG ET AL., *supra* note 160, at 8–9; FED'N OF STATE MED. BDS., *supra* note 125.

171. See AM. MED. ASS'N, STATE MEDICAL LICENSURE REQUIREMENTS AND STATISTICS 2010 53–56 (2010) (reporting that sixty-two boards require continuing medical education for license re-registration and providing a chart indicating each board's re-registration requirements).

172. See, e.g., 72 Op. Att'y Gen. Md. 147 n.9 (1987) (stating that if the medical board believes that physician who has applied for license renewal has committed a prohibited act, it must defer action and report the action to the Commission on Medical Discipline). The opinion further notes that a physician's whose renewal application is so deferred may continue to practice under his or her old license until a resolution is reached. *Id.* at 147 n.10; *Online M.D. License Renewals, NOTES FROM YOUR LICENSING BOARD* (Me. Bd. of Licensure in Med., Augusta, Me.), Winter 2007, available at [http://www.docboard.org/me/newsletters/dw\\_winter2007.pdf](http://www.docboard.org/me/newsletters/dw_winter2007.pdf) (stating that adverse actions could delay the renewal of a medical license).

173. David R. Dearden, *Defending Your Professional License*, PHYSICIAN NEWS DIG., Dec. 2005, available at <http://www.physiciansnews.com/business/1205dearden.html>.

the event of a revocation),<sup>174</sup> the conditions for removal of certain license restrictions (such as the suspension of operating room privileges in the event of a partial suspension),<sup>175</sup> and the conditions for relicensure (such as reeducation or rehabilitation in the event of a full suspension).<sup>176</sup> How would the various stakeholders interact if a national license is involved? What would be the role of the federal agency in case resolution, particularly if most of the services were provided electronically and interstate? Could federal authorities impede board efforts to fashion appropriate relief? The addition of a national license to practice telemedicine might call for the resolution of these and many other questions.

### III. CONCLUSION

State licensing laws that limit the use of telemedicine constrain innovative approaches that would control costs and increase access to health care.<sup>177</sup> Hospital systems, insurance carriers, professional associations, and other groups and organizations have raised serious concerns about state licensure restrictions.<sup>178</sup> The existing state-based approach to physician licensing and discipline has been slow to respond to regionalizing and nationalizing trends. Recent federal legislation calling for increased access to health care will place added pressure on states to harmonize their disparate licensing laws. Change is needed, but a national license for the “practice of telemedicine” is not the answer.

Though boards’ first priority is public protection, professional interests also are at stake. Professional self-regulation has a long history in the United States. “Despite today’s increasing reliance on market-driven arrangements in healthcare delivery,” legal scholar Thomas Greaney has noted, “there has been no wholesale rejection, either in public policy or in legal doctrine, of professional control over the instruments of quality

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174. *Id.* (“For less severe, but serious matters, the Board is able to impose probationary terms which may include continuing medical education, drug and alcohol testing, public service requirements and the like. The Board can also order the professional’s license to be suspended for a set time and then grant a ‘stay’ of the suspension, subject to acceptable compliance with certain probationary terms.”)

175. *Id.*

176. *Id.*

177. *See supra* notes 9, 13–14 and accompanying text.

178. *See, e.g.,* AM. MED. ASS’N, *supra* note 15 (acknowledging the challenges and threats that the current state licensure system faces as traditional medical practice evolves, and advocating for a new state licensure scheme); Jacobson & Selvin, *supra*, note 15 at 431 (arguing that the state based licensure model restricts the development and growth of medical practice and technology, and suggesting an expanded national telemedicine licensure system).

monitoring.”<sup>179</sup> A federal role in physician licensing, no matter the initial limitations, will grow as telemedicine becomes more widespread. While critics of state boards may applaud this result, policy makers should weigh the benefits of a national scheme against the attenuation of state control and professional self-regulation.

The incongruities of a national licensure scheme for telemedicine do not alter the fact that states should alleviate jurisdictional barriers to interstate practice. If board members and professional organizations want to preserve self-regulation and maintain state control of licensing and discipline, they must find common ground. No clear consensus has emerged, but there has been some progress. The Federation reports that thirty-three state medical and osteopathic boards currently utilize its Uniform Application for licensure by endorsement.<sup>180</sup> Until boards reach agreement on a uniform approach to interstate medical practice, inconsistent and overly restrictive state laws will continue to jeopardize technological innovation and inhibit telemedicine’s diffusion.<sup>181</sup>

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179. Thomas L. Greaney, *Public Licensure, Private Certification, and Credentialing of Medical Professional: An Antitrust Perspective*, in REGULATION OF THE HEALTHCARE PROFESSIONS 150 (Timothy S. Jost ed., 1997)

180. Response to Licensure Case Study, Fed’n of State Med. Bds., to Univ. of Md. Sch. of Law Roundtable on Legal Impediments to Telemedicine (April 16, 2010) (on file with author).

181. Relman, *supra* note 154, at 209 (stating that state boards will have to agree on some uniform modifications in their licensing regulations in order to accommodate telemedicine); William M. Sage & Linda H. Aiken, *Regulating Interdisciplinary Practice*, in REGULATION OF THE HEALTHCARE PROFESSIONS 71, 84 (Timothy S. Jost ed., 1997) (stating that state laws present a barrier to cost-effective, collaborative services like telemedicine).

