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Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force

TELEMEDICINE AND INTERSTATE LICENSURE: FINDINGS AND RECOMMENDATIONS OF THE CTL LICENSURE TASK FORCE

THE CENTER FOR TELEMEDICINE LAW*

I. OVERVIEW

This report outlines the key initial findings of the Licensure Task Force (Task Force) of the Center for Telemedicine Law (CTL), and incorporates the suggestions and comments received from CTL members. The Task Force conducted a work session in February of 1996 to examine the relationship between state and federal licensure laws and telemedicine. Task Force participants represented all sectors of the field of telemedicine including large and small health care institutions, physicians, nurses, telecommunications companies, vendors, and congressional and executive branch policy makers. Presentations were made by the Federation of State Medical Boards, the National Council of State Boards of Nursing, the Medical Board of California, and CTL staff. It was decided that CTL should: 1) play an active role in collecting information about state and federal licensure initiatives; 2) serve as a resource for telemedicine providers and federal and state policy makers interested in telemedicine licensure issues; and 3) develop a White Paper outlining the findings of the Task Force regarding licensure issues and telemedicine.

During the spring of 1996, the Task Force completed a fifty-state survey of licensure laws and regulations. Throughout the following summer and fall, Task Force members and CTL staff met with and advised the federal Joint Working Group on Telemedicine and numerous other groups regarding licensure issues. An extensive report on this subject was developed and presented to the Department of Health and Human Services' Office of Rural Health Policy in October, 1996.[1]

* This article was originally published by the Center for Telemedicine Law (CTL); it is reprinted here with the permission of CTL. CTL is a non-profit organization started in 1995 to educate health care providers and the general public regarding legal and regulatory issues related to telemedicine. CTL was founded by the Mayo Foundation, the Cleveland Clinic Foundation, Texas Children's Hospital, and the Midwest Rural Telemedicine Consortium. Its members include large and small health care institutions involved in the provision of telemedicine services as well as individual telemedicine practitioners.

1. *See* NATIONAL TELECOMMUNICATIONS AND INFORMATION ADMIN., U.S. DEP'T OF COMMERCE, TELEMEDICINE REPORT TO CONGRESS (1997).

This White Paper fulfills the third initial objective of the Task Force.[2] The key conclusions of the Task Force are discussed in detail in the following sections. The findings are as follows:

1. Telemedicine has the potential to substantially improve access to needed health care services and medical expertise.
2. The basic standards to qualify to practice medicine in each state are, to a large extent, uniform.
3. State requirements for "licensing by endorsement" (i.e., granting a license to a physician licensed in another state) are time consuming, costly, and confusing. The requirements vary so much that, in some cases, it may be impossible for a qualified physician to obtain a license in that state without retaking the licensing exam and/or undergoing burdensome procedural requirements.
4. Several states have recently adopted legislation that addresses licensing requirements for interstate practice. These statutes have:
   a) required out-of-state physicians to obtain a license to provide medical services to patients located in the state that are being treated through electronic communications;
   b) with one noteworthy exception, placed strict restrictions on physician-to-physician consultations which will limit traditional communications as well as telemedicine.
5. State and federal policy makers should examine strategies to encourage the adoption of uniform standards and administrative requirements for licensure coupled with local responsibility for monitoring and enforcement of the quality of physician services.
6. Disciplinary activities and the enforcement of licensure laws are functions which can best be conducted by the states.
7. Many of the issues related to the licensing of allied health professionals in an environment of increasing interstate activity are similar to those discussed in this report. There are, however, a sufficient number of unique issues that

2. The CTL Task Force would like to gratefully acknowledge CTL Board Members Leo Whelan, Counsel to Mayo Foundation; Lynn Berner, Staff Attorney to Cleveland Clinic Foundation; and CTL Counsel Robert Waters of the Arent Fox law firm, for their contributions to this report. In particular, the Task Force was able to draw on research by CTL staff and information developed by Mr. Whelan and Dr. Michael Wood, which has also been published in *Telemedicine & Telehealth Networks*.

apply to allied health professional licensees that deserve separate and in-depth attention.

These findings will serve as the basis for further work by the Task Force. Priority for future work has been placed on:

- providing practical guidance on licensure requirements;
- encouraging harmonization of initial licensure standards;
- supporting the creation of incentives for standardization of administrative requirements;
- promoting the elimination of duplicative functions;
- identifying and advancing multi-state licensure models which provide strong state-based disciplinary procedures; and
- examining the role of telehealth services and the licensure of other health professionals.[3]

II. TELEMEDICINE AND THE DELIVERY OF HEALTH CARE SERVICES

Health care providers are just beginning to take advantage of advanced communications technologies as a tool to expand and improve the delivery of health care services. In the last decade, there has been a tremendous expansion in the number and scope of telemedicine projects. In 1985, there were only a few reported telemedicine projects in the entire country. Today, various forms of telemedicine have reached every state in the union. Clinical services currently provided by telemedicine include:

- Radiology. Perhaps the most extensive application of telemedicine to date is teleradiology. Radiologists review X-ray images, sonograms, CAT scans and MRIs that are sent from the patient's hospital or clinic to the physician who may be located at home or another hospital.[4] This capability is particularly useful for small facilities that do not have full-time radiologists on staff.
- Mental Health. The provision of telepsychiatric and other telemental health services has already become an attractive method

3. While this report focuses on the regulation of physicians, CTL's Licensure Task Force notes that interstate licensure issues also affect other health professionals involved in telemedicine or telehealth projects. Future work of the Task Force will examine these issues in greater depth. CTL's initial focus was placed on medical practice in light of the recent state legislative activity in this area.

4. DIVISION OF HEALTH CARE SERVICES, INST. OF MED., TELEMEDICINE–A GUIDE TO ASSESSING TELECOMMUNICATIONS IN HEALTH CARE 42 (Marilyn J. Field ed., 1996); COUNCIL ON COMPETITIVENESS, HIGHWAY TO HEALTH: TRANSFORMING U.S. HEALTH CARE IN THE INFORMATION AGE 8 (1996).

of expanding access to individuals who live in rural communities and cannot easily obtain these professional services.[5]

- Pathology. It is now possible for a pathologist to manipulate and read a slide mounted on a microscope at a distant location. As the technologic and staffing techniques continue to evolve, it is expected that telepathology may become more widespread.
- Home Care Services. There are a number of pilot projects examining the use of telecommunications technologies to assist in caring for home bound patients.[6] Telehomecare offers easy access to physician and nursing staff and may provide for monitoring and intervention which reduce hospitalizations and enable early release.[7]
- Specialty Consultations. General practitioners in clinics at remote sites often call upon specialists at remote locations to assist in the diagnosis of individual patient health care problems. While the local health facility may be adequately staffed to handle most patient presentations, in certain cases the local practitioner may need to consult with a specialist located at a distant site.
- Prison Populations. Many telemedicine projects provide services to individuals who are either incarcerated or institutionalized.[8] The high costs and risks associated with transporting these individuals to health care providers makes telemedicine an attractive strategy for screening patients in some situations.[9]
- Managed Care. Telemedicine could permit managed care providers to efficiently deploy medical specialists and could serve as a mechanism to control costly hospitalizations through improved monitoring and electronic interaction with high-risk patient populations.
- Direct Consumer/Patient Information and Care. The Internet and e-mail afford patients and health care providers access to a much wider array of health care information. There are hundreds of disease specialty home pages on the World Wide Web sponsored by health care institutions and voluntary associations. Many of these pages include opportunities for individuals to share information and ideas regarding the appropriate treatment for specific conditions.

5. DIVISION OF HEALTH CARE SERVICES, INST. OF MED., *supra* note 4, at 47 (describing RODEO-NET, a project in Oregon and its efforts to become self sustaining).

6. *Id.*

7. COUNCIL ON COMPETITIVENESS, *supra* note 4, at 12 (describing several home care telemedicine providers and products).

8. *Id.* at 11.

9. *Id.*

Most telemedicine authorities have concluded that while additional data is needed, these applications of telemedicine hold great potential for expanding access to health care services and reducing the costs associated with servicing certain populations. However, there are a number of legal and regulatory barriers that will inhibit the full development of telemedicine.[10] Problems associated with our nation's state-based licensure system are often listed at the top of these concerns.[11]

III. STANDARDS FOR INITIAL STATE LICENSURE TO PRACTICE MEDICINE

Over the last century, the basic standards for practicing medicine in the United States have become surprisingly uniform. Our state-based licensure system is now structured around certain national standards, including: graduation from an accredited medical school; a uniform licensing examination sequence; post-graduate training requirements; and even the initial development of a centralized credentials verification system.

Historically, states have assumed primary responsibility for licensing physicians and other health care professionals. All fifty states and territories have laws governing the practice of medicine, nursing, and a variety of other health professions.[12] These laws were enacted under the police powers reserved to the states by the Constitution, which allows states to adopt laws to protect the health, safety, and general welfare of their citizens.[13] While the federal government has the authority to play a more active role in regulating issues of health and safety, this authority has been used only on a limited basis with regard to setting standards for health care professionals.[14]

Most of the current state physician licensure statutes were adopted before the turn of the century.[15] At that time, there were wide discrepancies in the skill and training of health care professionals. Obtaining

10. *Id.* at 20.

11. *Id.*

12. CENTER FOR TELEMEDICINE LAW, LICENSURE TASK FORCE BRIEFING BOOK (1996) (appearing in the "Summary of State Licensure Laws" section).

13. U.S. CONST. amend. X; Dent v. West Virginia, 129 U.S. 114, 122 (1888); *see also* People v. Mulford, 125 N.Y.S. 680, 681 (App. Div. 1910), *aff'd mem.*, 96 N.E. 1125 (N.Y. 1911).

14. One example is the National Practitioner Data Bank, created by the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1996). Another example would be the regulations setting forth the criteria and procedures by which information is reported to and disclosed by the Data Bank. 45 C.F.R. § 60 (1996). In addition to establishing this Data Bank of physician malpractice, the federal government has also taken a role in establishing minimum standards for the operation of clinical laboratories and mammography facilities. *See* Clinical Laboratories Improvement Act of 1967, 42 U.S.C. § 263(a) (1996); Mammography Quality Standards Act, 42 U.S.C. § 263 (Supp. 1997).

15. ROBERT C. DERBYSHIRE, M.D., MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES 8 (1969).

reliable information on individual "physicians" and their "cures" was a difficult, if not impossible, task for the average citizen. Consequently, Americans that purchased large quantities of patent medicines at traveling medicine shows were not uncommon.[16] While urban centers in the east and the north generally enjoyed access to trained health care providers, some frontier states would welcome anyone purporting to have medical skills. In this environment, it is not surprising that our country adopted a state-based licensure system.

The invention of the automobile, the airplane, and the telephone at the turn of the century, and the widespread proliferation of computer and information technologies during the last two decades, have had a dramatic impact on our society. Knowledge, skill, and expertise now move relatively freely and rapidly across state and international boundaries. These developments have also had an impact on the training of health care professionals and the expectations of the American public with regard to health care services.

Over the last century, the basic educational and competency requirements for obtaining an initial state medical license have become relatively standardized. All states now require new applicants to have graduated from an accredited medical school and to have passed the United States Medical Licensing Exam (USMLE).[17] The USMLE is a single examination divided into three parts. Each section of the test is administered over a two day period. The exam consists of multiple choice questions designed to test the physician's ability to apply knowledge, concepts, and principles that are important in health and disease and constitute the basis of safe and effective patient care. The same passing score is necessary in order to be licensed in any of the fifty states.

Prior to the implementation of the USMLE in 1994, most physicians that are currently practicing in the United States were required to take either the Federated Licensing Examination (FLEX) or the Special Purpose Examination (SPEX) to obtain their state licenses.[18] Foreign medical school graduates were required to pass the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS). Even applicants who took the FLEX exam prior to 1985 were held largely to the same standard. According to the Federation of State Medical Boards,

16. DAVID ARMSTRONG & ELIZABETH METZGER ARMSTRONG, THE GREAT AMERICAN MEDICINE SHOW 159 (1991) (citing Samuel Hopkins Adams, *The Great American Fraud*, COLLIERS WEEKLY, Oct. 7, 1905, who said "[g]ullible Americans will spend this year some seventy-five millions of dollars in the purchase of patent medicine. . .").

17. *Medical Licensure in the United States* (visited May 29, 1997) <http://www.usmle.org/medlic.htm>.

18. AMERICAN MED. ASS'N, U.S. MED. LICENSURE STATISTICS AND CURRENT LICENSURE REQUIREMENTS 46-47 (1995).

forty-four states accept a weighted average score of 75 on the pre-1985 FLEX exam.[19]

There are still differences between the states over issues such as whether all components of the old FLEX exam must be passed at the same sitting, how many times an applicant can take a component of the examination, and how recently an applicant must have completed the exam.[20] States also have different standards regarding post-graduate training.[21] Applicants are required to have between one and three years of additional training after medical school.[22] However, these differences are relatively minor when compared with the difficulties that have already been overcome in obtaining national agreement on acceptable medical schooling and the components of a nationwide licensing examination.

IV. REQUIREMENTS FOR LICENSURE IN A SECOND STATE

Physicians who have a valid medical license in one state usually can secure a second license in another state through a process known as *endorsement*. Under this process, a state does not require the applicant to retake the basic licensure examination. There has been a substantial increase in the use of endorsement during the last sixty years. The percentage of new licenses issued via endorsement increased from seven percent in 1935 to sixty-nine percent in 1993.[23] This increase probably reflects both the acceptance of this alternative method of licensure and an increase in the mobility of physicians.

A. INITIAL LICENSES ISSUED BY STATE MEDICAL BOARDS

On the surface, it would appear that endorsement might serve as an effective mechanism to deal with both the issue of physician mobility and telemedicine. However, the process is often time consuming, costly, and confusing. Each state has established its own set of paperwork

19. *Id.* at 18-22 tbl.11.
20. *Id.*
21. *Id.*
22. *Id.*
23. *See id.* at 5 tbl.4. This chart compares the portion of initial licenses obtained by exam with those obtained by endorsement.

Year	Total	Exam	Endorsement	Percent
1935	5,510	5,099	411	7%
1945	6,965	4,979	769	11%
1955	7,737	6,211	1,526	19%
1965	9,147	5,699	3,448	37%
1975	16,859	8,990	7,869	47%
1985	18,288	6,496	11,792	64%
1993	20,182	6,281	13,901	69%

Id.

requirements including unique fees, forms, and procedures.[24] For example, the Minnesota Board of Medical Practice requires applicants to list their degrees, their post-graduate training, their medical licenses, all hospitals where they have or had privileges, and their board certification.[25] Meeting these requirements can be a substantial task even when the physician is only applying for a single additional state license. Even though many of these questions are extremely valuable in the Board's assessment of the candidate's moral fitness to practice medicine, there is no rational reason why the state should not facilitate interstate practice by creating an efficient, centralized accreditation process.[26]

In summary, the telemedicine provider has several bureaucratic hurdles to overcome. First, he or she must obtain the correct procedures from each state. Second, applications requiring original documents must be sent periodically to each state with the attendant processing delays. Third, most states require the applicant to list all licenses held by the applicant, requiring the multi-state applicant to continually modify his or her applications to reflect the attainment of additional licenses. In addition, forty states require some or all endorsement applicants to make a physical appearance before the local licensing board.[27] The time and air transportation costs alone make this an unreasonable burden on out-of-state physicians. Fourth, the endorsement and registration fees are not insignificant. They range from $100 in Pennsylvania to over $1,000 in California and Texas.[28]

There are, moreover, two significant areas of difference in state requirements for licensure that can make it impractical or impossible for a qualified physician from one state to secure a license in another. There is, in some states, a requirement that the licensing exam be retaken if it has been more than a specified number of years since the applicant passed the exam.[29] It is hard to understand why a specialist with good credentials and an active practice should undergo the time and expense required to retake the general licensing exam (which covers areas of no relevance to their practice).

24. *See id.* at 18 tbl.11.

25. Leo J. Whelan, J.D., & Michael B. Wood, M.D., *Unresolved Issues Snarl Licensure Laws*, TELEMEDICINE AND TELEHEALTH NETWORKS, Sept. 1996, at 33, 35-36.

26. Whelan & Wood, *supra* note 25, at 37. The AMA advises physicians even with "a perfect and clean track record" to call the board where they are seeking licensure and ask how long it will take to process their application, then add two months to the answer when planning the start of their practice. AMERICAN MED. ASS'N, *supra* note 18, at 66.

27. AMERICAN MED. ASS'N, *supra* note 18, at 18-22 tbl.11.

28. *Id.* at 37-38 tbl.22.

29. Whelan & Wood, *supra* note 25, at 36 (noting that states can require physicians to take the exam again).

The second area is the difference in the post-graduate training required.[30] For graduates of United States medical schools, the number of years of post-graduate training required varies from one to three. There is much greater variation in the requirement for foreign medical school graduates because some states require a greater number of years of post-graduate training in a United States program for these applicants. This can make it impossible for a foreign graduate or a primary care physician who is licensed in one state to obtain a license in certain states, without regard to the applicant's other credentials or experience.

30. *Id.*

B. 40 STATES AND GUAM REQUIRE SOME OR ALL ENDORSEMENT APPLICANTS TO APPEAR IN PERSON

		REQUIREMENTS UPON APPEARANCE	
STATE	WHO MUST APPEAR	INTERVIEW	ORAL EXAM
Alabama	Some		
Alaska	All	X	
Arizona	Some	Some	
Arkansas	IMGs	Some	
California	Some		X
Delaware	All	X	
Florida	Some	X	
Georgia	Some	X	
Guam	All	X	
Idaho	All	X	Some
Illinois	Some	X	
Indiana	Some	X	
Iowa	Some	X	
Kansas	Some	X	
Louisiana	Some	X	
Maine	All		X
Massachusetts	Some	X	
Minnesota	All	X	
Mississippi	All	X	
Missouri	Some	X	
Montana	Some	X	
Nevada	All		X
New Hampshire	Some	X	
New Jersey	Some	X	
New Mexico	All	X	
North Carolina	All	X	Possibly
North Dakota	Some	X	
Oklahoma	Some	X	
Oregon	All	X	
Rhode Island	All	X	
South Carolina	All	X	
South Dakota	All	X	
Tennessee	IMGs	X	
Texas	All	X	
Utah	Some	X	
Vermont	All	X	

Virginia	Some	X	
Washington	Some	X	
West Virginia	All	X	
Wisconsin	Some		X
Wyoming	All	X	X[31]

V. RECENT STATE ACTIONS HAVE INCREASED BURDENS ON DIRECT ACCESS TO TELEMEDICINE SERVICES

The difficulties telemedicine practitioners face in meeting differing state licensure requirements have been compounded by recent state actions. During the last two and a half years, at least eleven states have modified their state licensure requirements.[32] In general these states have: 1) narrowed the consultation exception; and 2) required all out-of-state physicians to possess a license in a state in order to provide diagnostic or therapeutic services directly on a regular and ongoing basis to patients located in the state. The implications of these actions are significant for telemedicine providers. These new state laws are particularly noteworthy because they not only address direct physician-patient contacts, but also appear to restrict many consulting arrangements that have long been considered acceptable within the medical profession.

Laws adopted by several of these states are described below:

> Indiana: Earlier this year, Indiana amended its licensure statute. The practice of medicine is now defined to include "providing diagnostic or treatment services to a person in Indiana when the diagnostic or treatment services: (A) are transmitted through electronic communications; and (B) are on a regular, routine, and non-episodic basis or under an oral or written agreement to regularly provide medical services."[33] The revised statute specifically excludes from the licensure requirement providing "a second opinion" to an Indiana licensed physician, and providing "diagnostic or treatment services to a patient in Indiana following medical care originally provided to the patient while outside of Indiana."[34] Moreover, the pre-existing state consultation exception, discussed in more detail below, was not modified.[35]

31. AMERICAN MED. ASS'N, *supra* note 18, at 18-22 tbl.11.

32. States which have adopted restrictive licensure laws or regulatory provisions include: Arizona, Connecticut, Florida, Indiana, Kansas, Massachusetts, Nevada, New Mexico, Oklahoma, South Dakota, and Texas.

33. IND. CODE ANN. § 25-22.5-1-1.1(a)(4) (Michie Supp. 1996).

34. *Id.*

35. *Id.* § 25-22.5-1-2(a)(4) (excepting from the licensure requirement physicians who are

Nevada: The Nevada legislature amended its state licensure act following an opinion by the Executive Director of the State Board of Medical Examiners that the act did not cover out-of-state telemedicine providers.[36] The revised act now includes within the practice of medicine the diagnosis or treatment of human illnesses and diseases "by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics."[37]

Oklahoma: In 1995, the Oklahoma state code was modified to expand the definition of the practice of medicine to include "performance by a person outside of this state, through an ongoing regular arrangement, of diagnostic or treatment services through electronic communications for any patient whose condition is being diagnosed or treated within this state."[38] The statute further specifies individuals performing these functions will be considered to have submitted to the jurisdiction of the Oklahoma courts for any causes of actions arising out of these services. The new language is clearly directed toward the direct provision of services. It is less clear how it will affect consultations, since the Oklahoma consultation exception was not altered by this new provision.[39]

South Dakota: South Dakota adopted a telemedicine related amendment in 1996. The South Dakota provision states that "[a]ny nonresident physician or osteopath who, while located outside this state, provides diagnostic or treatment services through electronic means to a person located in this state . . . is engaged in the practice of medicine or osteopathy in this state."[40]

Texas: The Texas practice of medicine act was modified in 1995 to include the following provision: "A person who is physically located in another jurisdiction but who, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this state, including the taking of an X-ray examination or the

licensed in other states called in consultation by Indiana physicians).

36. Letter from Patricia R. Perry, Executive Director, State Board of Medical Examiners, to B.J. Manaster, M.D., Professor and Vice Chair of Radiology, University of Utah School of Medicine (Oct. 20, 1994), *in* CENTER FOR TELEMEDICINE LAW, LICENSURE TASK FORCE BRIEFING BOOK (1996).

37. NEV. REV. STAT. ANN. § 630.020 (Michie 1996).

38. OKLA. STAT. ANN. tit. 59, § 492(c)(3)(b) (West Supp. 1997).

39. *See id.* § 622(B)(1) (showing the consultation exception).

40. S.D. CODIFIED LAWS § 36-4-41 (Michie Supp. 1996). Consultations with a licensed physician or osteopath within the state are excepted if the consultations are "on an irregular" basis. *Id.*

preparation of pathological material for examination, and that would affect the diagnosis or treatment of the patient, is engaged in the practice of medicine in this state for the purposes of this Act."[41]

As these examples illustrate, the most common restriction in these amendments is to make any "regular" provision of medical services subject to the state's licensing requirement.[42] The Federation of State Medical Boards (FSMB) has drafted a Model State Act designed to respond to telemedicine related issues. The Model Act creates a special limited license for physicians who want to"practice medicine across state lines." Practicing medicine across state lines is defined as rendering any "written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient" located in another state.[43] Physicians engaged in the practice of medicine across state lines would be required to be licensed in the state where the patient is located. The Model Act provides these exceptions: (a) an emergency; (b) when the opinion is provided without compensation; or (c) if the service is provided on an "irregular or infrequent basis."[44] "Irregular or infrequent" is defined to be "less than once monthly or involves less than ten patients on an annual basis, or comprises less than one percent of the physician's diagnostic or therapeutic practice."[45] In short, the FSMB proposal, like most states that have addressed this issue, requires out-of-state physicians who directly treat or diagnose in-state patients to obtain a special local license. In addition, the proposals and recent legislation have, with one noteworthy exception, placed restrictions on physician-to-physician consultations which may affect traditional medical practices as well as telemedicine.

VI. RECENT STATE ACTIONS HAVE PLACED UNREASONABLE RESTRICTIONS ON THE CONSULTATION EXCEPTION

Some of the new state laws and the FSMB Model Act will not only inhibit telemedicine consultations, but may reach many customary and useful physician-to-physician communications. Specifically, many of the new amendments to state licensure laws will also affect the long-standing exceptions for physician consultations. This is a particularly

41. TEX. REV. CIV. STAT. art. 4495b (West Supp. 1997). The act retains a consultation exception for "episodic" consultations on request to a person licensed in Texas who practices in the same medical specialty. *Id.*

42. In June, 1996, the House of Delegates of the AMA also adopted a resolution stating that full licensure should be required for physicians "who wish to regularly practice telemedicine."

43. *The Health Law Resource–Draft Model Act to Regulate the Practice of Telemedicine Across State Lines* (visited May 29, 1997) <http://www.netreach.net/~wmanning/fsmb.htm>.

44. *Id.*

45. *Id.*

troubling development because it could actually limit the scope of the accepted consulting relationships based solely on the medium used for consultation.

Physician-to-physician communications which could be interpreted to be subject to licensure under the telemedicine statutes include:

- reference laboratory services and related consultations with the pathologist;
- cross-specialty and subspecialty reviews;
- imaging interpretations;
- communications between the primary care physician and the specialist who treated the patient in another state; and
- second opinions on the interpretation of biopsies, images, tests, or exams.

Most state licensure statutes have traditionally exempted an out-of-state physician who consults with a licensed in-state physician. Although the legislative history is incomplete, the apparent purpose of the consultation exception is to allow the state's physicians, and indirectly their patients, to have access to medical expertise from other areas of the nation and world. The exception reflects the fact that licensure protects the public from the solicitations of unqualified professionals. Unlike the typical patient, a physician has the ability to evaluate a colleague's credentials and experience. An important principle behind the consultation exception is that the physician who seeks a consultation remains ultimately responsible for the care of the patient. Hence, the patient does not lose the protection of the state.

The wording of state consultation exceptions varies considerably from state to state. For example, the Ohio provision is quite broad, permitting the practice of medicine by: "[a] physician or surgeon residing in another state or territory who is a legal practitioner of medicine or surgery therein, when in consultation with a regular practitioner of this state."[46]

Four states do not have a statutory consultation exception, but even in these states, many of the medical boards or attorneys general have ruled that out-of-state consulting physicians are not practicing medicine.[47] Sixteen states have narrow consultation exceptions. For example,

46. OHIO REV. CODE ANN. § 4731.36(A) (Anderson 1996); *see also* ALASKA STAT. § 08.64.370(2) (Michie 1996) (dealing with out-of-state physicians or osteopaths not covered when "asked by a physician or osteopath licensed in this state to help in the diagnosis or treatment of a case"); CAL. BUS. & PROF. CODE § 2060 (West Supp. 1997) (dealing with exemptions, out of state practitioners, and consultations); DEL. CODE ANN., tit. 24, § 1726 (1987) (dealing with consulting physicians from other states).

47. 225 ILL. COMP. STAT. ANN. 60 (West 1996); LA. REV. STAT. ANN. § 37:1262, 1271 (West 1988); 32 ME. REV. STAT. ANN. § 3270 (West 1995); PA. STAT. ANN., tit. 63, § 422 (West 1996); *see also* 1987 S.C. Op. Att'y Gen. 62 (noting that out-of-state physicians who enter state to harvest organs for transplant are exempted from medical practice under consultation exception); 1971 S.C. Op. Att'y

Alabama limits the number of days of consulting.[48] Most states restrict the consulting physician by limiting the frequency of contacts through such words as "occasional," "infrequent," "incidentally," or "irregular."[49]

A. CONSULTATION EXCEPTIONS

No Statutory Exceptions:	Illinois	Maine	
	Louisiana	New Mexico	
Narrow Exceptions:	Alabama	Mississippi	North Carolina
	Arizona	Missouri	Oklahoma
	Arkansas	Montana	South Dakota
	Colorado	Nebraska	Texas
	Kansas	Nevada	
	Michigan	New Hampshire	
Broad Exceptions:	Alaska	Iowa	Rhode Island
	California	Kentucky	South Carolina
	Connecticut	Maryland	Tennessee
	Delaware	Massachusetts	Utah
	District of Columbia	Minnesota	Vermont
	Florida	New York	Virginia
	Georgia	New Jersey	Washington
	Hawaii	Ohio	West Virginia
	Idaho	Oregon	Wisconsin
	Indiana	Pennsylvania	Wyoming

Historically, consultation exceptions have been interpreted broadly. In fact, there have been no reported disciplinary actions of out-of-state physicians performing consultations with a local physician even in states with a narrow or no statutory exception.[50] However, in many states these

Gen. 186 (stating that a physician licensed in another state may lawfully treat patient in South Carolina when in consultation with a South Carolina physician).

48. ALA. CODE § 34-24-74 (1995).

49. ARIZ. REV. STAT. ANN. § 32-1421(B) (Supp. 1996); ARK. CODE ANN. § 17-95-203(2) (Michie 1995); IOWA CODE ANN. § 148.2(5) (West Supp. 1997); MONT. CODE ANN. § 37-3-103(b) (1995); NEB. REV. STAT. §§ 71-1, -103(6), -103(7) (1995); NEV. REV. STAT. § 630.047(b) (1995); N.H. REV. STAT. ANN. § 329.21(II) (1995); N.C. GEN. STAT. § 90-18 (1996); W. VA. CODE § 30-3-13(b)(2) (1997).

50. Based on searches of the case law available on LEXIS™ database. There are cases where the consultation exception was offered as a defense to allegations that a practitioner located in the state was practicing without a license. *See, e.g.*, People v. Gelb, 565 N.E.2d 474, 475-76 (N.Y. 1990) (finding that an unlicensed dentist who examined and treated patients was not entitled to a jury instruction on the consultation exception because he had not put in evidence sufficient facts to raise a colorable claim that he had acted only as a consultant).

new restrictive telemedicine laws coexist with freestanding pre-existing consultation exceptions. These new restrictions on common physician-to-physician communications are not justified by any evidence of abusive consulting practices under traditional consultation exceptions. It is unclear how the courts will reconcile some of these conflicting provisions.

Troubling terms used in these new laws include: "regular communications;" "under contract;" "services rendered;" and "specialist consultations." The concerns with each of these types of restrictions on consultations are described below:

1. *Requiring Licensure for Regular Communications*

Using *regular communications* as the threshold for licensure raises several hurdles to consultations regardless of whether telemedicine is involved. A prohibition against the regular provision of services could impose a new record-keeping burden on physicians.[51] The physician will have to determine each state's definition of regular consultations and keep track of the number of consultations performed in each state.[52] Physicians seeking consultation may decide that it is not worth the trouble of determining whether the consultant of choice is licensed or, if not, has performed more than occasional consultations. Specialists may be reluctant to answer an inquiry from a colleague in a particular state. Patients will ultimately be harmed by this chilling effect on physician-to-physician communications.

2. *Under Contract or For Compensation*

Laws that tie licensure to compensation for a consultation are vague and incompatible with the wide array of financial arrangements for health care services in today's marketplace.

The FSMB's Model Act uses compensation as a criterion for licensure. This fails to consider the use of bundled, capitated, and other managed care fee arrangements in which physician compensation is not tied to the actual utilization of services. Capitated payments and global surgery fees are not billed separately, but nevertheless are compensated. A common occurrence in multi-state physician group practices, for example, is for a physician to seek advice from another member of the group who may be located in another state.[53] That communication is

51. This requirement also exists in states where licensing statutes exempt only "occasional" or "infrequent" consultations. *See supra* note 49 (listing states that exempt "occasional" consultations). As previously stated, the restriction against "regular" consultations have not been strictly enforced to date.

52. Whelan & Wood, *supra* note 25, at 35.

53. *Id.*

effectively part of the service and, therefore, *compensated.* Must the consulted physician be licensed in both states?

3. *Requiring Consultations Between Physicians of Same Specialty*

New requirements that consultations occur only between physicians in the same specialty also will needlessly encumber the rendering of accurate diagnoses and treatment options. Often a patient's case will require an inquiry of a physician in another specialty, but not an actual referral to a specialist. The appropriate consultant in such a case may practice in another state. The new restriction will prevent that important inquiry from being made. Alternatively, it may prompt an actual patient referral, prematurely or unnecessarily, requiring the patient to travel to another state. This barrier is not necessary to protect the patient. Professional, ethical, and legal obligations give physicians great incentive to find qualified consultants on behalf of their patients. There is no evidence of physicians using out-of-state consultations to the detriment of the patient.

These restrictions on regular, compensated, or different specialty consultations will each have an adverse effect on a cross-section of providers who seek to improve the access to, and quality and efficiency of, medical care using telemedicine. Rural health providers will face barriers in their efforts to establish regional networks and recruit individual physicians. Academic medical centers, which are often responsible for the care of the very sickest within our population, will be prohibited from accessing experts across the nation as is often required for a particular case. Patients who are chronically ill or who have rare or complex diseases may need to travel to different states for treatment. The multi-state group practices which rely on cross-disciplinary collaboration also may be restricted in their communications among specialists in different locations.

Concerns about the impact of the Model Act on customary medical practices have been expressed by the AMA, which generally supports full state licensure. Commenting on FSMB's Model Act, the AMA stated:

> The proposed definition [of the practice of medicine across state lines] is too broad. As it is now, it could be held to apply to all services, including X-ray, EKG, and laboratory tests. Having these services included in the legislation would require some physicians to have licenses in many states. At present

> these services are provided across state lines apparently without problems and without being licensed in multiple states.[54]

In contrast to some of these other states and the Model Act, California was careful to preserve the traditional consultation exception when it updated the state's licensure law. The new statute, which was signed by Governor Wilson on September 24, 1996, protects this exception with the following language:

> Nothing in this chapter applies to any practitioner located outside this state, when in actual consultation, whether within this state or across state lines, with a licensed practitioner of this state . . . if he or she is, at the time of the consultation . . . a licensed physician and surgeon in the state or country in which he or she resides.[55]

These consulting physicians are prohibited from opening a local office, receiving calls from patients, giving orders, or having ultimate authority over the primary diagnosis of local patients.[56] In contrast to some of the other state actions, the California law does not do any appreciable harm to the traditional consultation exception. This approach reflects the state's interest in protecting the public by ensuring that the physician principally responsible for the patient is accountable to the state's medical board and by allowing its physicians to access the expertise of physicians licensed in other states. [57]

A large volume of telemedicine services involve physician-to-physician communications which have long been permitted under consultation exceptions in licensure statutes. Consultations have not been abused by the medical community, and have become a vital element of the high quality medical care in this country. Consultations enhance the quality of care, provide education, collegiality, and support to a wide variety of providers. As states begin to explore how to handle the licensing of health professionals in light of the new telecommunications technologies, care should be taken to protect the ability of physicians to consult. Restrictions on consultations are not necessary to protect the pa-

54. *See* Letter from James Todd, M.D., Executive Vice President of the American Medical Association, to James Winn, M.D., Executive Vice President of the Federation of State Medical Boards, (Sept. 22, 1995) (on file with the NORTH DAKOTA LAW REVIEW) (responding to the Federation's request for comments on the draft Model Act).

55. CAL. BUS. & PROF. CODE § 2060 (West Supp. 1997).

56. *Id.*

57. It should be noted that California also approved legislation that authorizes the Medical Board of California to develop a proposed registration program that would permit a physician, surgeon, or doctor of podiatry medicine located outside California to practice medicine or podiatry medicine across state lines. *Id.* § 2052.5. The law requires the Board to prescribe requirements and procedures in the proposed registration program. *Id.*

tient, so long as the physician in the state where the patient is being diagnosed or treated retains ultimate responsibility for the care of the patient.

To date, only California has held to this long-standing principle in its response to telemedicine. We recommend that state laws addressing telemedicine, at a minimum, protect the physician's ability to consult with physicians in other states.

VII. DISCIPLINARY ACTIVITIES AND THE ENFORCEMENT OF LICENSURE LAWS IS AN ACTIVITY WHICH CAN BEST BE CONDUCTED AT THE STATE LEVEL

Most state statutes delegate authority for enforcing licensure laws to a State Board of Medical Examiners. The state statute may or may not provide great detail about the manner in which disciplinary proceedings are to be conducted, with most states leaving much discretion to the Boards to establish rules and procedures governing disciplinary proceedings. These procedures may vary greatly from one state to the next.

A physician who is not licensed in the state where the patient is physically located may not be subject to that state's disciplinary rules of the Board of Medical Examiners. States generally may regulate such interstate practice with statutory provisions prohibiting the "unlicensed practice of medicine." These provisions are enforced by the State Attorney General. Potential penalties for practicing without a license may include civil fines and even criminal prosecution. Any licensed physician who aids or abets a non-licensed physician in practicing medicine may also face civil fines and possible suspension or revocation of their medical license. The state licensure boards, not the State Attorneys General, would have jurisdiction over the latter violations.

In addition to referring the matter to the State Attorney General for prosecution, the state Medical Board may report the unauthorized practice of medicine to the Medical Board(s) of the state(s) where the physician is licensed or to the Federation of State Medical Boards' (FSMB) practitioner databank. The FSMB will release reports of physician sanctions to appropriate authorities who can use this information in credentialing or recredentialing decisions. Therefore, reporting the complaint to the FSMB databank of practitioners may adversely affect the physician's ability to obtain a license, become affiliated with certain health plans, or participate in the Medicare or Medicaid programs.

The role of State Licensure Boards in identifying and responding to concerns or complaints regarding physician competence or impairment is a function which is probably best conducted at the state level. Government by the states is perceived to be more accountable and responsive to the states' citizens. There is, moreover, no justification for

dismantling the existing state investigation and enforcement mechanism and creating in its place a new federal bureaucracy. For this reason we would recommend that this function remain at the state level regardless of whether efforts are taken to standardize or nationalize the initial licensure requirements.[58]

VIII. STATE AND FEDERAL POLICY MAKERS SHOULD PROMOTE STRATEGIES TO ACHIEVE UNIFORM LICENSURE STANDARDS AND ADMINISTRATIVE REQUIREMENTS COUPLED WITH LOCAL RESPONSIBILITY FOR MONITORING AND ENFORCEMENT

The license application requirements, the inconsistencies in the state laws applicable to physicians, and the lack of coordination between the state medical boards make licensing requirements an effective barrier to the conduct of interstate medical activity. These barriers inhibit improvements in access and patient care through telemedicine.

A uniform interstate licensure system is needed to solve this problem. The system, whatever form it may take, should establish consistent licensure requirements and allow physicians to qualify for practice in another state without significant delays or costs. It should define the law which governs the professional conduct of a physician practicing across state lines and holding a license in both states and should *not* subject the physician to the demands of separate and inconsistent state laws.

It would be best at the outset to attempt to establish a uniform licensure system through harmonization of state licensing requirements. Professional licensing has traditionally been considered an area of state authority. State medical boards should be recognized for their valuable service and should not be displaced without strong justification. Moreover, it may serve the public best to have certain functions such as the investigation and adjudication of complaints performed at the state level.

There are several possibilities for establishing a state-based uniform licensing system. A state-based uniform licensing system would generally require a uniform medical practice act with consistent license application requirements, and provisions for a streamlined licensing of physicians holding a license in another state is one alternative. The National Council of State Boards of Nursing is in the process of developing one type of uniform system in its proposal for a multi-state license.[59]

58. It should be noted that interstate cooperation in monitoring and tracking impaired physicians is very important given the mobility of physicians. In this regard, the National Practitioner Data Bank and the FSMB Reporting System are critical to the multi-state protection of patients from incompetent or impaired providers.

59. This model was developed by the Nursing Regulation Task Force of the National Council of

States participating in the multi-state license system would agree to a uniform set of licensing requirements and a coordinated method for handling the investigation and adjudication of complaints against multi-state license holders. Uniform professional conduct standards would be established; however, the states would define the scope of nursing practice individually with reference to a mutually acceptable core definition. A centralized application processing system would be established. Other alternatives include a "special purpose license" along the lines of that proposed by the FSMB[60] or a uniform medical registration program similar to that outlined in California Senate Bill 2098.[61]

Under any uniform state-based licensing system, it will also be necessary to address the differences in state laws governing the license holders' practice. Consistent laws must be adopted by all states or a rule established to determine which state's law governs the interstate delivery of patient care. If the latter approach is taken, we strongly recommend that telemedicine practitioners be held to the laws established by their home state. Any other approach is impractical. Physicians should not be required to maintain expensive administrative systems to accommodate differences in, for example, authorization requirements for the disclosure of medical records.[62] Approaches such as the one proposed by the FSMB's Model Act, which would require patient medical records to be maintained in compliance with the law of the patient's state, ignore the difficulties and inconsistencies associated with applying different state laws.

There is considerable reason to question whether it is possible for states to develop a uniform interstate licensing system in an effective and timely manner. The fact that states have maintained marginal differences in application requirements, despite the existence of a standardized national licensing exam and national accrediting agencies for medical education and training, is evidence for the difficulties associated with developing common standards. Moreover, the onerous process for obtaining licensure by endorsement and the restrictive nature of recent telemedicine legislation may also reflect a reluctance on the part of states to open their market to out-of-state providers.

State Boards of Nursing (NCSBN). At its 1996 Delegate Assembly, the NCSBN directed its board of directors to continue the development of the model and report to the 1997 Delegate Assembly in August.

60. This should not be taken as an endorsement of the FSMB's Model Act. We have strong reservations regarding a number of the Model Act's provisions. In particular, we are concerned about its impact on traditional consultative practices and its provisions regarding conflicting confidentiality requirements.

61. S.B. 2098, 1995-96 Regular Session (Cal. 1996) (enacted) (directing the State Board to develop a registration program for out-of-state physicians).

62. An alternative solution to this problem could be the enactment of a uniform national health records privacy statute.

A federal impetus is necessary to bring about a uniform interstate licensure system. Federal incentives to promote a state-based but uniform interstate licensing system should be devised and promptly implemented.[63] The incentives should address licensing for allied health professionals as well as physicians.

If it becomes apparent that it will not be possible in the near future to develop a uniform interstate licensure system that is state-based, then a national licensing system should be considered. This would allow the creation of uniform licensing requirements, a single application procedure, and legal standards to govern interstate practice. As previously noted, however, it may be best for the disciplinary authority to remain with the states which, by nature of their size, are more accountable to their citizens.

63. Federal incentives could include: promoting harmonization of licensure requirements; development of a model state act; convening meetings of stakeholders; establishing financial incentives for interstate cooperation; and conditioning participation in certain programs on the adoption of harmonized licensure systems.