

ARTICLES

Crossing Borders: The Licensure of Interstate Telemedicine Practitioners

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I. Introduction

At the close of the nineteenth century, two inventions heralded a new age of medical care. The telephone and the automobile simultaneously increased access to the services of physicians and reduced the costs of medical care.¹ A century later, the delivery of medicine is poised to undergo another transformation, as communications technology enables health care providers to examine, diagnose and treat patients in remote localities. Telemedicine² enables health care providers to use electronic communications devices³ in order to monitor fetal development,⁴ analyze X-rays,⁵ ob-

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1. PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 65-71 (1982); Center for Telemedicine Law, Telemedicine and Interstate Licensure; Findings and Recommendations of the CTL Licensure Task Force, 73 N.D. L. REV. 109, 114 (1997) (originally published by the Center for Telemedicine Law)[hereinafter CTL White Paper].

2. The California legislature has defined telemedicine as "the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications." CAL. BUS. & PROF. CODE § 2290.5(a) (West Supp. 1998). For a discussion of the definition of telemedicine, see Kathleen M. Vyborny, *Legal and Political Issues Facing Telemedicine*, 5 ANNALS HEALTH L. 61, 68-74 (1996). See also Jay Sanders, *The Revolution in Health Care Delivery*, 73 N.D. L. REV. 19, 19-20 (1997). For a detailed discussion of the history of the development of telemedicine and a description of many different applications of telemedicine, see Douglas D. Bradham, Sheron Morgan, & Margaret Dailey, *The Information Superhighway and Telemedicine: Applications, Status, and Issues*, 30 WAKE FOREST L. REV. 145, 146-61 (1995). See also Douglas A. Perednia & Ace Allen, *Telemedicine Technology and Clinical Applications*, 273 J. AM. MED. ASS'N 483 (1995). For a general discussion of the uses of electronic communications in the delivery of health care, see Jerome P. Kassirer, *The Next Transformation in the Delivery of Health Care*, 332 NEW ENG. J. MED. 52 (1995). For a useful bibliography of telemedicine resources, see KRISTINE SCANNELL, DOUGLAS A. PEREDNIA AND HENRY M. KISSMAN, *TELEMEDICINE: PAST, PRESENT, FUTURE: JANUARY 1966 THROUGH MARCH 1995* (1995).

3. A typical telemedicine arrangement involves the transmission to a hub site of data collected at remote locations. The necessary technological infrastructure includes equipment designed to gather and store the data at the remote location for transmission to and retrieval at the hub. See Jim Grigsby et al., *Synopsis of Telemedicine Research Studies 1-2* (1994), reprinted in HEALTH CARE FIN. ADMIN., REPORT TO CONGRESS (1997) (visited September 2, 1998) <<http://www.hcfa.gov/pubforms/telemed.htm>> [hereinafter HCFA 1997 REPORT]; Jim Grigsby et al., *Analysis of Expansion of Access to Care through Use of Telemedicine and Mobile Health Services. Report 2: Case Studies and Current Status of Telemedicine 2.1-2.15* (1994), reprinted in HCFA 1997 REPORT, *supra*; PHYSICIAN PAYMENT REV. COMM'N, ANNUAL REPORT TO CONGRESS 136-37 (1995) [hereinafter PPRC 1995 REPORT]. For an explanation of an organizational plan of a hub-and-spoke telemedicine network, see VA Health Care and

serve and offer advice on surgeries⁶ and perform a host of other activities without examining the patient in person.⁷ Whether telemedicine will transform health care delivery in the twenty-first century with the same force that the telephone and the automobile shaped our expectations regarding the physician/patient relationship in the twentieth century remains to be seen.⁸ Whether widespread or confined in its growth,

Technology, 1994: Testimony Submitted to the House Comm. on Vet. Aff., 103d Cong., 1st Sess. (1994) (testimony of Francis J. Tedesco, M.D. and Jay H. Sanders, M.D.) available in 1994 WL 377916, which describes a system that has a comprehensive medical care facility as the "hub," connected to four satellite facilities as "spokes."

4. Domiciliary fetal monitoring (DFM) permits an obstetrician to monitor the progress of a fetus through the transfer of digital signals via a modem. In Wales, for example, a test project permitted pregnant women or community midwives to collect data concerning fetal heart movements by using an external transducer placed on the mother's abdomen. The data were transferred to the obstetrics unit of a hospital and analyzed by a computer program that notified an obstetrician of any abnormalities. MARJORIE GOTT, *TELEMATICS FOR HEALTH: THE ROLE OF TELEHEALTH AND TELEMEDICINE IN HOMES AND COMMUNITIES* 31-45 (1995).

5. A survey of rural hospitals conducted in 1995 and 1996 found that teleradiology was the most commonly used telemedicine application. See generally Grigsby, *Synopsis, supra* note 3, at 5. Not surprisingly, teleradiologists have developed the first standards for the practice of telemedicine. PPRC 1995 REPORT, *supra* note 3, at 151.

6. Sanders, *supra* note 2, at 26.

7. The Physician Payment Review Commission suggests four categories of applications for telemedicine: (1) interactive communication between physician and patient or consultations between physicians; (2) noninteractive transmission of data; (3) medical administration; and (4) medical education. PPRC 1995 REPORT, *supra* note 3, at 137. These applications are often cited as reasons for assuming that telemedicine can enhance access to care in rural communities and other medically underserved areas. Because of the potential for cost-savings, telemedicine obviously holds interest for managed care organizations as well. See generally William Goodall, *The Development of a Successful Telemedicine Network Within a Managed Care Organization*, 73 N.D. L. REV. 151 (1997). See also *Electronic Commerce and Healthcare, 1998: Hearings Before for the Subcomm. on Health and Environ. of the House Comm. on Commerce, 105th Cong., 2d Sess. (1998)* (testimony of Jay Sanders, M.D., President and C.E.O., The Global Telemedicine Group) available in 1998 WL 296419 [hereinafter 1998 Hearings].

8. A detailed analysis of the desirability and/or the probability of the successful development of telemedicine is beyond the scope of this Article. For a recent assessment of the future of telemedicine, see 1998 Hearings, *supra* note 7 (testimony of Jay Sanders, M.D.).

There is little doubt that telemedicine has piqued the curiosity of health policy makers. See generally PPRC 1995 REPORT, *supra* note 2, at 135-54; Paul M. Orbuch, *A Western State's Effort to Address Telemedicine Policy Barriers*, 73 N.D. L. REV. 35 (1997). Indeed, in February 1997, the General Accounting Office was able to identify 35 federal organizations, 10 state governments and an unspecified number of private organizations that offer telemedicine projects. U.S. GEN. ACCT. OFF., *TELEMEDICINE: FEDERAL STRATEGY IS NEEDED TO GUIDE INVESTMENTS 0:4.1* (1997) [hereinafter GAO 1997 REPORT].

Despite such initiatives, the practice of telemedicine has developed in a manner that can at best be described as erratic. For example, a 1995 study of several telemedicine networks showed that the number of interactive physician/patient teleconsultations tripled between 1994 and 1995. However, the same study showed that the extent to which the sites were utilized varied dramatically according to location. See A. Allen and M. Scarbrough, *Third Annual Program Review, TELEMEDICINE TODAY* (1996), cited in Grigsby, *Synopsis, supra* note 3, at 3-4.

Some of the erratic growth of telemedicine may be attributed to uncertainty concerning the possibilities of obtaining reimbursement. Led by the Health Care Financing Administration, third-party payors and those who conduct research on their behalf have urged caution in reimbursing telemedicine procedures until concerns about efficacy and quality of telemedical treatments have been examined. See, e.g., Letter from Donna Shalala (Secretary of Health and Human Services) to Al Gore (President of the Senate) (December 4, 1997), reprinted in HCFA 1997 REPORT, *supra* note 3; PPRC 1995 REPORT, *supra* note 3, at 144-51. However, HCFA is scheduled to begin paying for telemedicine services in certain rural and medically underserved areas on a limited basis. See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4206(d), 111 Stat. 251 (1997); 1998 Hearings (testimony of Jay Sanders, M.D.), *supra* note 7. Ten state Medicaid programs reportedly provide coverage for telemedicine. *Id.* (statement

however, telemedicine will require new interpretations of health care law. "Remote-access" health care challenges not only the conventional concepts of the clinical physician/patient relationship, but also the foundations of the legal structure that has traditionally governed that relationship.

Compliance with each state's licensure laws presents legal and practical difficulties for many conscientious telemedicine practitioners.⁹ Telemedicine invites clinical applications that ignore the geographic borders on which our current physician licensure system is based.¹⁰ Physicians and patients no longer need to be located in the same place in order for diagnosis and treatment to take place. Despite the newfound mobility of the physician/patient relationship, each state nonetheless retains the prerogative to license the physicians who practice within its borders.¹¹ The state-based licensure system may thus prevent a physician who holds a valid license in one state from offering medical services in another through the use of computer technology. Similar problems confront the use of communications technology by other health care workers whose professional activities are subject to state licensure laws. The barrier imposed by the state-based licensure requirements impedes the effective use of telemedicine across borders and limits its utility to intrastate activities.

The proposed responses to this dilemma are varied in their impact on the states' ability to uphold their own determinations of quality standards and on the ability of telemedicine practitioners to practice their profession. In the most stark terms, the dilemma pits technological developments, which literally enable health care workers to offer their services across the nation, against the necessarily parochial role played by states in monitoring the quality and the conduct of practitioners who provide care to their citizens. In the struggle to define the appropriate model for the licensure of telemedicine practitioners whose practice must cross state lines, it is possible that these interests may both be served by the adoption of an interstate compact promoting the recognition of valid out-of-state professional licenses by participating states. The Nurse Licensure Compact¹² recently proposed by the National Council of State Boards of Nursing allows nurses to obtain recognition of their licenses in each participating state. Drawing on the tradition of interstate compacts that predates the United States Constitution, the model for interstate licensure exemplified by the Compact may offer a time-tested solution to the licensure problems posed by this most modern of medical practices.

of David Balch, East Carolina School of Medicine).

9. See U.S. DEP'T COM., *TELEMEDICINE REPORT TO CONGRESS* v-viii, 27-47, 89 (1997) (the executive summary of this report has been reprinted at 73 N.D. L. REV. 131 (1997)) [hereinafter *JWGT 1997 REPORT*]; GAO 1997 REPORT, *supra* note 8, at 5:2.1; PPRC 1995 REPORT, *supra* note 3, at 152. See also Bradham, Morgan & Dailey, *supra* note 2, at 163-64; Barry B. Cepelewicz, *New Technology Raises Questions. Telemedicine: A Virtual Reality, But Many Issues Need Resolving*, 13 No. 9 MED. MALPRACTICE L. & STRATEGY 1 (1996); CTL White Paper, *supra* note 1, *passim*; Grigsby, *Analysis*, *supra* note 3, at 3.8; Orbuch, *supra* note 8, at 46-48; Vybomy, *supra* note 2, at 77-84; Stacey Swatek Huie, Note, *Facilitating Telemedicine: Reconciling National Access with State Licensing Laws*, 18 HASTINGS COMM. & ENT. L.J. 377, 395-408 (1996).

10. See, e.g., Vybomy, *supra* note 2, at 65, 77-84.

11. See, e.g., CAL. BUS. & PROF. CODE § 2000 et seq. (West Supp. 1998); TEX. REV. CIV. STAT. ANN. art. 4495b (West Supp. 1998).

12. On March 14, 1998, Utah became the first state to enact the Nurse Licensure Compact. See Utah Code Ann. § 58-31c-101 (1998) (enacted). See Arent Fox Kitner, *Nurse Licensure Compact* (visited September 2, 1998) <http://www.arentfox.com/telemed/articles/nurse_lic_compact.html> [hereinafter *Nurse Licensure Compact*].

This Article examines the legal challenges that a state-based system of physician licensure poses for the practice of telemedicine across state lines. Part I of the Article presents the structure of current licensure requirements in the health care field. Part II considers the extent to which telemedicine should fall within the scope of such licensing requirements. Part III examines the application of current licensure requirements to telemedicine and the most prominent proposals for reform.

II. Occupational Licensure in Health Care

Occupational licensure has historically fallen within the province of the state, rather than the federal government.¹³ The constitutional basis for the states' authority to regulate the health care professions is long-established. The Tenth Amendment reserves to "the states and to the people" the powers not specifically delegated to the United States.¹⁴ The state's responsibility to enact legislation to protect the general welfare of the people extends in particular to the regulation of occupations.¹⁵ Moreover, the state plays the foremost role in regulating matters pertaining to health and health care.¹⁶ Under the current licensure system for health care providers,¹⁷ each state has therefore established a scheme to license physicians, nurses and other health care providers who offer services within its borders. Both federal and state courts have ratified the right of the state legislatures to set standards for the exercise of the health care professions.¹⁸ In *Dent v. West Virginia*,¹⁹ the Supreme Court specifically upheld the right of the State of West Virginia to license physicians.

Licensure is the process by which a person obtains the state's permission to practice a particular profession. At the most elementary level, an occupational licensure statute defines the minimum criteria which a person must satisfy in order to practice a particular profession.²⁰ In some cases, the applicant merely needs to register his intention to practice a particular profession without further inquiry into his background or

13. See Timothy S. Jost, *Introduction—Regulation of the Healthcare Professions*, in REGULATION OF THE HEALTHCARE PROFESSIONS 7 (Timothy S. Jost, ed., 1997).

14. U.S. CONST. amend. X.

15. See generally BENJAMIN SHIMBERG & DOUG ROEDERER, OCCUPATIONAL LICENSING: QUESTIONS A LEGISLATOR SHOULD ASK 4 (Ralph Marcelli, ed., 1978).

16. *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 661 (1995).

17. For a discussion of the history of physician licensure in the United States, see STARR, *supra* note 1, at 102-07; see also ROBERT C. DERBYSHIRE, MEDICAL LICENSURE AND DISCIPLINE IN THE UNITED STATES (1969). For a discussion of the origins of modern licensure in general, see Lawrence M. Friedman, *Freedom of Contract and Occupational Licensing 1890-1910: A Legal and Social Study*, 53 CAL. L. REV. 487 (1965).

18. See, e.g., *Armstrong v. North Carolina State Bd. of Dental Exam'rs*, 499 S.E.2d 462 (N.C. Ct. App. 1998). But see *England v. Louisiana State Bd. Med. Exam'rs*, 263 F.2d 661 (5th Cir. 1959) (discussing constitutional limitations on the legislature's ability to impose licensure requirements). For a discussion of constitutional challenges to licensure statutes, see generally Mitch Altschuler, Note, *The Dental Health Care Professionals Nonresidence Licensing Act: Will it Effectuate the Final Decay of State Discrimination Against Out-of-State Dentists?*, 26 Rutgers L.J. 187 (1994) (noting the difficulties in successfully using the Privileges and Immunities Clause, the Equal Protection Clause and the burden on the right to interstate travel to challenge licensure of the health care professions).

19. *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) ("The power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well as of deception and fraud.").

20. SIMON ROTTENBERG, *Introduction*, in OCCUPATIONAL LICENSURE AND REGULATION 2-3 (Simon Rottenberg, ed., 1980).

training.²¹ In other cases, a state simply sets the requirements which must be fulfilled by a person who desires to advertise himself as "certified" in a profession.²² At its most aggressive, an occupational licensure statute defines the nature of the occupation at issue, establishes entry-to-practice criteria which must be met in order to practice that occupation and prohibits unlicensed individuals from engaging in specified activities.²³ The medical practice acts, nursing practice acts and their corollaries follow the pattern of a more aggressive occupational licensure arrangement.

Taken at face value, licensure statutes establish and enforce minimum levels of quality control in a given professional field.²⁴ Both courts and legislatures emphasize the importance of the licensure laws in protecting the public from the dangers of unqualified practitioners. In the words of one court, licensure statutes provide "legal safeguards" against "insipid and often harmful patent medicines and the ministrations of untrained healers."²⁵ Proponents of licensure statutes suggest that the state is better positioned to assess and to communicate its assessment of professional competency than individual citizens who may lack the ability to gather data or the capacity to analyze technical information.²⁶ According to this viewpoint, a state that grants a professional license essentially warrants that the licensee has met the minimum quality

21. See MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* 144 (2d ed. 1982) (defining registration as "an arrangement under which individuals are required to list their names in some official register if they engage in certain kinds of activities [with] no provision for denying the right to engage in the activity to anyone"); SHIMBERG & ROEDERER, *supra* note 15, at 4-5.

22. See FRIEDMAN, *supra* note 21, at 144 (defining certification as the process by which the government certifies that an individual has certain skills, but does not prevent the practice of any occupation using these skills by people who are not so certified); SHIMBERG & ROEDERER, *supra* note 15, at 4-5.

23. See FRIEDMAN, *supra* note 21, at 145; ROTTENBERG, *Introduction*, *supra* note 20, at 2-3.

24. See generally Jost, *Introduction*, *supra* note 13, at 1-2; Timothy S. Jost, *Oversight of the Quality of Medical Care: Regulation, Management, or the Market?*, 37 ARIZ. L. REV. 825, 827 (1995); Keith B. Leffler, *Physician Licensure: Competition and Monopoly in American Medicine*, 21 J.L. & ECON. 165, 172-176 (1978) (noting that common arguments in favor of licensure include the high cost of obtaining information concerning quality, the risk that people who choose less qualified providers will pass disease on to others [consumption externality] and the "society knows best" argument). Also, it is suggested that it may be more appropriate to consider the purpose of a professional licensure statute in the context of its ability to enhance the public's assessment of the risk of using a particular provider. See Sandra Johnson, *Regulatory Theory and Prospective Risk Assessment in the Limitation of Scope of Practice*, 4 J. LEGAL MED. 447, 449, 456-464 (1983).

25. *Garcia v. The Texas State Bd. of Med. Exam'rs*, 384 F. Supp. 434, 438 (W.D. Tex. 1974). See also *State v. Rich*, 339 N.E.2d 630, 632 (Ohio 1975) ("The statutes evidence the intent of the General Assembly to protect the public from the practice of medicine by unlicensed, and perhaps unqualified, practitioners"); *Erlanger v. Regents*, 10 N.Y.S.2d 1013, 1019 (N.Y. App. Div. 1939) (state must protect "the home of the sick and distressed from the intrusion therein in a professional character of those destitute of the proper qualifications").

26. Proponents of occupational licensure statutes suggest that minimal levels of competence may be achieved by setting appropriate entry-to-practice standards and enabling ill-informed consumers to rely on the state's certification that an individual has met those standards. In *Dent v. West Virginia*, 129 U.S. at 122-23, for example, Justice Field specifically noted, . . . "[r]eliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications . . . No one has a right to practice medicine without having the necessary qualifications of learning and skill" See also *Erlanger*, 10 N.Y.S.2d at 1019. See generally Jost, *Oversight of the Quality of Medical Care*, *supra* note 24, at 827; Elton Rayack, *Medical Licensure: Social Costs and Social Benefits*, 7 LAW & HUM. BEHAV. 147, 148-149, 155 (1983). For a review of the literature addressing the question of whether licensure results in a higher quality of practice, see Daniel B. Hogan, *The Effectiveness of Licensing: History, Evidence, and Recommendations*, 7 LAW & HUM. BEHAV. 117, 121-133 (1983) (arguing that "licensing may be more a liability than an asset").

standards prescribed by its statutes. In keeping with this objective, the texts of the licensure statutes specifically suggest three major concerns: first, controlling the quality of practitioners through establishing standards for entry-to-practice²⁷ and scope of practice;²⁸ second, prescribing standards of professional conduct to be observed by licensees;²⁹ and, third, enforcing those standards through designated disciplinary procedures.³⁰ The disciplinary components of the statutes, usually authorizing civil and criminal penalties, theoretically enable the state to reprimand transgressors in order to uphold its quality standards.³¹

Despite the rhetorical emphasis placed on quality control, scholarly and public debate has suggested that licensure statutes also serve the less beneficent purpose of limiting competition among providers.³² In practical terms, a state-based occupational licensure scheme functions as a gatekeeper to a state's markets.³³ As gatekeeper to the practice of medicine, for example, the medical practice act's role in prohibiting certain persons from practicing medicine is at least as significant as its authorizing others to do so. The combination of an expansive definition of the practice of medicine³⁴ and a

27. See, e.g., PA. STAT. ANN. tit. 63 § 216 (West 1996) (requirements for licensure as a registered nurse).

28. See, e.g., *id.* § 200 (clarifying that a nursing license does not entitle holder to practice medicine); *id.* §212(1) (defining the "practice of professional nursing"); *id.* §214 (defining unauthorized practice of nursing).

29. See, e.g., *id.* § 224 (listing reasons for refusing or suspending a nursing license).

30. See, e.g., *id.* § 223; *id.* § 224; *id.* §§ 225-225.5 (punishments and disciplinary procedures applicable to licensed registered nurses).

31. The enforcement component of a physician licensing statute has been described as "a constitutionally valid exercise of the state's discretion in safeguarding the public's health and welfare." *People v. Kleiner*, 664 N.Y.S.2d 704, 706 (N.Y. 1997). For a discussion of the major administrative law issues arising in connection with professional disciplinary activities, see Eleanor Kinney, *Administrative Law Issues in Professional Regulation*, in REGULATION OF THE HEALTHCARE PROFESSIONS, 103 (Timothy S. Jost, ed., 1997). The effectiveness of the disciplinary system is, however, in question. See, e.g., Hogan, *supra* note 26, at 124; Timothy S. Jost, *Oversight of the Competence of Healthcare Professionals*, *supra* note 24, at 17, 22-26.

32. See, e.g., MICHAEL H. COHEN, COMPLEMENTARY & ALTERNATIVE MEDICINE: LEGAL BOUNDARIES AND REGULATORY PERSPECTIVES 24-26 (1998); Jost, *Introduction*, *supra* note 13, at 2-3 (noting that licensure has been concerned not only with professional competency, but also with professional identity, orthodoxy, economic power and social and educational elitism).

33. Critics of occupational licensure stress that such statutes often hold significant value for incumbent practitioners by protecting the health care providers within a state from out-of-state providers or alternative practitioners. See COHEN, COMPLEMENTARY MEDICINE, *supra* note 32, at 21-23, 33-38; FRIEDMAN, *supra* note 21, at 154; Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. CHI. L. REV. 6 (1976); By barring alternative practitioners who cannot meet the threshold requirements for obtaining a license, the licensure statute may protect the financial and ideological interests of incumbent practitioners who have met the established criteria. Lee Benham, *The Demand for Occupational Licensure*, in OCCUPATIONAL LICENSURE AND REGULATION, *supra* note 20, at 14-19 (describing licensure as using entry barriers to create "rents" or windfall gains for licensees and restrictions on the production process to provide "security" against the loss of those rents). Critics of occupational licensure have noted that despite the "consumer-oriented" focus of pro-licensure arguments, consumers rarely lobby for licensure statutes, while established occupants of a field often do so. Indeed, by raising barriers for prospective practitioners, occupational licensure statutes may increase the cost of entering a profession in a manner that raises the price of services beyond a consumer's reach. See ROTTENBERG, *Introduction*, *supra* note 20, at 6; Hogan, *supra* note 26, at 121. See also LORI B. ANDREWS, DEREGULATING DOCTORING: DO MEDICAL LICENSING LAWS MEET TODAY'S HEALTH CARE NEEDS? 4, 19 (1983) [hereinafter DEREGULATING DOCTORING]; Charles H. Baron, *Licensure of Health Care Professionals: The Consumer's Case for Abolition*, 9 AM. J.L. & MED. 335, 340-347 (1983); Jonathan Rose, *Occupational Licensing: A Framework for Analysis*, 1979 ARIZ. ST. L.J. 189, 190-193 (1979); SHIMBERG & ROEDERER, *supra* note 15, at 3.

34. See *infra* text accompanying notes 69-83.

strict delineation of the requirements that a candidate must satisfy to obtain a license to practice medicine³⁵ effectively limits the number of people who qualify to practice medicine within a particular state.³⁶ A state's medical practice act may thus restrict the professional opportunities available to alternative providers and hinder out-of-state providers from competing within its borders.³⁷ Critics argue that licensure limits the health care consumer's access to a full range of providers and thus unnaturally depresses both the nature and the quality of care that he might receive.³⁸ It is indeed possible that the ease with which telemedicine allows providers to cross state lines will ignite yet another battle over the merits of occupational licensure.³⁹

Regardless of debate concerning the merits and demerits of occupational licensure, however, today's telemedicine practitioners must still contend with the fact that licensure laws govern the practice of medicine and related health care activities in every state. The medical practice act governing physician licensure is normally the lynchpin of a state's scheme to license health care providers.⁴⁰ A physician licensure statute typically defines the "practice of medicine" and specifies the requirements that a person must have in order to engage in the practice of medicine. The initial distinction between a physician and a non-physician is then further refined to account for a host of other providers who function in today's health care system. It is within this framework that telemedicine practitioners⁴¹ must function if they are to comply with existing occupational licensure requirements.

The unique problem posed by telemedicine is that a physician must comply with the licensure laws of each jurisdiction in which he practices medicine. The threshold requirements for physician licensure are normally straightforward and relatively uniform among jurisdictions.⁴² A candidate must meet the minimum standards set forth in the state's physician licensing statute in order to obtain a license to engage in the practice of medicine. The requirements typically include the attainment of a degree as a doctor of osteopathy or allopathy, successful completion of the United States Medical Licensing Examination, completion of an accredited residency program and certification of good character.⁴³ Physicians who satisfy these criteria may obtain a license to

35. See *infra* text accompanying notes 41-42.

36. For a discussion of some of the adverse consequences of occupational licensure, including anticompetitive effects, see generally Gellhorn, *supra* note 33, at 13-19.

37. For an interesting defense of the right of the State of New York to demand rigorous compliance with endorsement requirements in order to protect its resident physicians from competition by foreign doctors, see *Erlanger v. Regents*, 10 N.Y.S.2d 1013, 1020 (N.Y. App. Div. 1939); *Marburg v. Cole*, 36 N.E.2d 113, 115 (N.Y. 1941).

38. See FRIEDMAN, *supra* note 21, at 156-58.

39. The opposition of the American Medical Association to proposals for a national license for telemedicine practitioners will renew inquiry into the motives of physicians who oppose free access to markets. JWGT 1997 REPORT, *supra* note 9, at 43.

40. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4495b (West Supp. 1998).

41. Telemedicine practitioners may include physicians, nurses and many other health care providers.

42. CTL White Paper, *supra* note 1, at 113.

43. See, e.g., 49 PA. CODE § 17.1 (1998) (setting forth requirements for unrestricted physician licensure, including attainment of passing scores on licensure examination, graduation from medical school and completion of graduate medical training); 49 PA. CODE § 16.12 (1998) (requiring applicants for medical license and other nonphysician licenses to be of legal age and good moral character, to refrain from the intemperate use of alcohol, narcotics or other habit-forming drugs, and, with certain exceptions, not to have been convicted of certain substance abuse felonies). See generally CTL White Paper, *supra* note 1, at 113; Report on Medical Licensure, 259 J. AM. MED. ASS'N 1994, 1995 (April

practice medicine within the limitations prescribed by the relevant statute. Persons who do not meet the requirements simply cannot obtain a license that would allow them the freedom to practice medicine as a licensed physician.

Yet physicians do not practice medicine in isolation. Nurses, physician assistants, midwives and a host of other professionals perform activities that contribute to the diagnosis of illness and the treatment of patients who are under the care of physicians. By linking the right to practice medicine to the satisfaction of minimum criteria for licensure as a physician under the medical practice act, a state necessarily must carve out exceptions to enable non-physicians to perform tasks which, although central to carrying out the physician's orders and to their own roles as health care professionals, might otherwise be susceptible to classification as the practice of medicine.⁴⁴ Each state therefore provides for the licensing of a variety of health care professionals other than physicians.⁴⁵ Many states also license alternative providers who practice independently of physicians, including chiropractors, acupuncturists and massage therapists.⁴⁶

The extent to which a health care professional other than a licensed physician may provide medical services and the conditions under which he may do so vary according to jurisdiction. Each state may establish the specifications regarding entry-to-practice standards and the scope of authorized practice within its borders.⁴⁷ Variations exist not only with respect to entry-to-practice standards⁴⁸ and the terminology applicable to each practice specialty,⁴⁹ but also with respect to the tasks that the health care professional may undertake and the supervision necessary to comply with state law.⁵⁰

1, 1988).

44. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06b (West Supp. 1998) (exempting from the Medical Practice Act licensed dentists, optometrists, chiropractors, nurses, podiatrists, psychologists and physical therapists who confine their practices within the limits prescribed by law).

45. See ANDREWS, *supra* note 33, at 24-25; WILLIAM M. SAGE & LINDA H. AIKEN, *Regulating Interdisciplinary Practice*, in REGULATION OF THE HEALTHCARE PROFESSIONS, 74-78 (Timothy S. Jost, ed., 1997).

46. COHEN, *supra* note 32, at 39-45. See also Lori B. Andrews, *The Shadow Health Care System: Regulation of Alternative Health Care Providers*, 32 HOUS. L. REV. 1273 (1996); Kathleen Boozang, *Western Medicine Opens the Door to Alternative Medicine*, 24 AM. J.L. & MED. 185 (1998).

47. See, e.g., Op. No. 88-303, 71 Op. Cal. Atty. Gen. 296 (1988) at 1988 WL 385181. Oklahoma Bd. of Med. Licensure and Supervision v. Oklahoma Bd. of Exam'rs in Optometry, 893 P.2d 498 (Okla. 1995) (Oklahoma statute authorizes board to determine whether the use of lasers by optometrists constitutes the unlicensed practice of medicine). See generally Johnson, *supra* note 24, at 454-456.

48. PEW HEALTH PROF. COMM'N, REPORT OF THE TASKFORCE ON HEALTH CARE WORKFORCE REGULATION. REFORMING HEALTH CARE WORKFORCE REGULATION. POLICY CONSIDERATIONS FOR THE TWENTY-FIRST CENTURY 5 (December 1995) [hereinafter PEW TASKFORCE REPORT].

49. The technical language of each state's licensing scheme also varies according to jurisdiction. Critics of the current state-based licensure system have noted that states are inconsistent in the use of terms such as 'licensure,' 'certification,' and 'registration.' PEW TASKFORCE REPORT 1-4; National Council St. Bd. Nurs., *National Council of State Boards of Nursing's Response to the Pew Taskforce on Health Care Workforce Regulation* (visited September 2, 1998) <<http://www.ncsbn.org/files/pewresponse.html>>. See also Johnson, *supra* note 24, at 454-55.

50. Some critics have suggested that strict scope-of-practice laws prohibit the efficient use of health care providers other than physicians. See, e.g., Hogan, *supra* note 26, at 129-30. Much controversy exists, for example, over the scope of practice of advanced practice nurses. In particular, some states have broken with the traditional prohibition against the prescription of drugs by a nurse practitioner, while others have retained the traditional limitation on scope of practice. In 1994, for example, the Physician Payment Review Commission reported that 21 states and the District of Columbia permitted a nurse practitioner to prescribe drugs independent of physician supervision, while 21 other states granted prescriptive authority subject to physician control and eight did not grant any authority. PHYSICIAN PAYMENT REV. COMM'N, ANNUAL REPORT TO CONGRESS 272 (1994), (citing Pearson, 1992-93 Update: How Each State Stands on Legislation Issues Affecting Advanced Practice Nursing, 18

Within a particular jurisdiction, the delineation of the entry-to-practice standards and the definition of the scope of practice of licensed individuals permit states to identify "unauthorized practice."⁵¹ In particular, the unauthorized practice of medicine occurs in at least three ways. First, and most obvious, the "unauthorized practice of medicine" occurs when an unlicensed person engages in activities that constitute the practice of medicine.⁵² Courts have readily upheld the convictions of unlicensed persons who have engaged in the signal elements of diagnosis and treatment.⁵³ The analysis in such cases commonly turns on whether the activities constituted the practice of medicine and whether the defendant held a valid license. Among those found to have engaged in the practice of medicine without a license are naturopaths who prescribe healing salves,⁵⁴ midwives who perform obstetrical exams and prescribe prenatal regimens,⁵⁵ and foreign medical graduates who examine and write prescriptions for patients.⁵⁶ Similar concepts govern the prosecution of unlicensed practitioners of nursing or other health care professions.⁵⁷ Second, and of equal importance, the "unauthorized practice of medicine" also occurs when the activities of a licensed practitioner fall outside the scope of his license.⁵⁸ Here, the inquiry must focus on whether the person held a license, whether the activities in which he engaged exceeded the authority of that license and whether, to the extent that they did so, they could be viewed as the practice of medicine. For example, a physician assistant who is authorized to per-

NURSE PRACTITIONER 23-38 (1993)). See generally Mary Beck, *Improving America's Health Care: Authorizing Independent Prescriptive Privileges for Advanced Practice Nurses*, 29 U.S.F. L. REV. 951, 959-61 (1995) (arguing that such restrictions impermissibly delegate to individual physicians the regulatory authority that should be exercised by the state legislature through its statutory directives); Barbara J. Safriet, *Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing*, 9 YALE J. ON REG. 417 (1992); Susan E. Baker, Note, *The Nurse Practitioner in Malpractice Actions: Standard of Care and Theory of Liability*, 2 HEALTH MATRIX: J. LAW & MED. 325, 338-43 (1992); Nancy L. Shore, Note, *Advanced Nursing Practice and Prescriptive Authority: A Victory for New Jersey Nurses*, 17 SETON HALL LEGIS. J. 576 (1993).

51. See generally BARRY R. FURROW, et al., HEALTH LAW § 3-4 (1995).

52. See *Magit v. Board of Med. Exam'rs*, 366 P.2d 816 (Cal. 1961) (since administration of anesthesia falls within the definition of the practice of medicine, unlicensed graduates of foreign medical schools who administer anesthesia violate the prohibition against unauthorized practice of medicine).

53. See generally FURROW, *supra* note 51, at § 3-6.

54. See *State v. Howard*, 337 S.E.2d 598 (N.C. Ct. App. 1985).

55. See *State ex rel. Missouri State Bd. of Regulation for the Healing Arts v. Southworth*, 704 S.W.2d 219 (Mo. 1986).

56. See *People v. Varas*, 487 N.Y.S.2d 577 (N.Y. App. Div. 1985).

57. See, e.g., *People v. Stults*, 683 N.E.2d 521 (Ill. App. Ct. 1997) (upholding conviction for the unauthorized practice of nursing).

58. See, e.g., *Magit*, 366 P.2d at 820 (nurses would be guilty of illegally practicing medicine or surgery only if acting outside the permissible scope of a nurse's functions as set forth in the applicable statute) (dicta); *Rich*, 339 N.E.2d at 633 (practice of acupuncture falls within the practice of medicine and one who holds a limited license to practice chiropractic medicine may not go beyond the rules and regulations promulgated by the State Medical Board concerning the scope of chiropractic medicine); *Kelley v. Texas State Bd. of Med. Exam'rs*, 467 S.W.2d 539 (Tex. Civ. App. 1971) (licensed dentist who represented himself as a physician by professing to diagnose or treat cancer or who actually attempts to diagnose or cure cancer is acting outside the scope of his license as a dentist); *De Hay v. State*, 254 S.W.2d 513 (Tex. Crim. App. 1952) (whether defendant was licensed as a naturopath was irrelevant to inquiry as to whether he practiced medicine without a license when the law expressly provided that a license to practice naturopathy did not authorize the practice of medicine). The mere fact that an individual's training exceeds the minimal qualifications necessary to practice in his field does not entitle him to be exempted from the statutory requirements. See *State v. Wilson*, 528 P.2d 279 (Wash. App. 1974) (chiropractor who practiced acupuncture and took blood samples engaged in the practice of surgery, which was beyond the scope of his license).

form medical services subject to a medical doctor's supervision acts outside the scope of his license if he performs those services without supervision.⁵⁹ Third, the medical practice act commonly imposes penalties for holding oneself out as a physician without possessing a valid license.⁶⁰

The consequences of engaging in the practice of a profession without a license can be severe. In Texas, for example, a first-time offender who is found to be in violation of the Medical Practice Act is subject to prosecution of a Class A misdemeanor regardless of whether his actions result in harm to a patient.⁶¹ Third-degree felony charges apply to any repeat offenders,⁶² as well as to any unlicensed person whose actions cause physical or psychological harm to another person.⁶³ A person who practices medicine without a license may also be subject to prosecution for a state jail felony if his actions cause financial harm to another person.⁶⁴ There may also be additional repercussions for licensed health care professionals whose actions fall outside the scope of practice for which they are licensed. For example, if a nurse is found to have exceeded the scope of her nursing license, she may also be subject to discipline by the state's nursing board.⁶⁵ A state may also extend penalties to physicians who aid and abet an unlicensed person to practice medicine. In Pennsylvania, for example, the Board of Medicine has the authority to discipline a board-regulated practitioner who knowingly aids, assists, procures or advises an unlicensed person to practice a profession in violation of the applicable statute or regulations or maintains a professional association with such person.⁶⁶

III. Telemedicine as the 'Practice of Medicine'

Must our understanding of the "practice of medicine" embrace the practice of *telemedicine* and hold it to physician licensing standards? Some states have provided an easy answer to this question by amending their medical practice acts to include the

59. See, e.g., PA. STAT. ANN. tit. 63, § 422.21(a) (West 1996).

60. See, e.g., *id.* § 422.10(3); *Id.* § 422.10(4). See also *People v. Doneski*, 679 N.E.2d 462 (Ill. App. Ct. 1997) (upholding conviction of unlicensed individual who falsified her resume, referred to herself as "Dr." and instructed others to do the same); *State v. Bain*, 295 P.2d 241 (Mont. 1956); *State v. Low*, 74 P.2d 458 (Wash. 1937) (an unlicensed person who advertised free consultations and "wonderful treatment" and included references to himself as a "doctor" held himself out as practicing medicine, even though the state made no showing that the "wonderful treatment" involved the use of drugs or medicinal preparations).

61. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.07(a) (West Supp. 1998).

62. *Id.* § 3.07(a)(1).

63. *Id.* § 3.07(a)(2).

64. *Id.* § 3.07(a)(3). See also CAL. BUS. & PROF. CODE § 2053 (West Supp. 1998) (in addition to any other remedies available under law, for up to one year's imprisonment in the county jail or state prison if an unlicensed person's acts "cause or create risk of great bodily harm, serious physical or mental illness or death")

65. See Beck, *supra* note 50, at 967-68.

66. PA. STAT. ANN. tit. 63, § 422.41(7) (West 1996). See *Carmichael v. Riley*, 534 So. 2d 280 (Ala. 1988) (person who holds himself out as a physician's assistant without first obtaining approval by the Board engages in the unauthorized practice of medicine and physician who performs services with his aid is guilty of aiding and abetting the unauthorized practice of medicine); *State Bd. of Med. Educ. & Licensure v. Ferry*, 94 A.2d 121 (Pa. Super. 1953) (unlicensed person who made diagnoses and administered treatments and medicines was guilty of practicing medicine without a license and licensed doctor who aided and abetted him was guilty of unprofessional conduct under § 1911 Medical Practice Act). See generally, *Armstrong*, 499 S.E.2d 462 (sanctions against dentist who hired unlicensed assistant neither arbitrary nor capricious).

practice of medicine through electronic communications devices.⁶⁷ In the absence of specific statutory guidance, however, the preliminary question is, of course, whether the practice of telemedicine in and of itself is close enough to our traditional understanding of the "practice of medicine" or the practice of another licensed health care profession to be appropriate for regulation by state licensing boards.

The response to this question is neither obvious nor trivial. If the answer to this question is "no," then the state occupational licensure statutes simply do not apply to telemedicine practitioners. The mere fact that telemedicine can segregate the physical location of the physician from the patient will mean that a patient can no longer rely on the minimum level of competency established by his state as a guarantee of his physician's competence. If the answer to this question is "yes," then the state occupational licensing statute and the concerns of quality and enforcement must be brought to bear on practitioners who may never actually set foot within the state's borders.⁶⁸

The telemedicine practitioner must wade through a maze of statutory definitions and judicial and administrative interpretations in order to determine whether his activities are subject to regulation as the practice of medicine by a given state. Indeed, with respect to each state in which he operates, he faces a three-part analysis. First, he must determine whether the substantive services that he renders would fall within that state's interpretation of the practice of medicine or any other practice area that requires a license (such as nursing). Second, he must determine whether the fact that his services are provided through the medium of electronic communications would create a difference in this analysis. Third, assuming that his activities as a telemedicine practitioner are indeed subject to regulation as the practice of medicine or as the practice of another regulated profession, he must determine how to comply with state licensure laws and the scope of practice authorized by those laws.

In many ways, the first issue presents a familiar question by forcing the telemedicine practitioner to set aside consideration of the medium through which he renders his services and to analyze his conduct in light of statutory definitions and judicial and administrative interpretations. It is clear that the many different applications of telemedicine will lead to as many different conclusions regarding whether the activities conducted through telemedicine should be classified as the practice of medicine. The outcome will depend upon the application of statutory language and judicial interpretation to the facts of each case—a formula that produces hard-and-fast answers only after courts have had the opportunity to examine several generations of cases. As the telemedicine practitioner examines his activities, however, he will be able to draw upon the rich history of cases mapping the limits of the practice of medicine in more traditional settings in order to find his answer.

Even the briefest review of the definitions of the "practice of medicine" applicable in the different states demonstrates the expansive and varying interpretations of this

67. See, e.g., S.D. CODIFIED LAWS § 36-4-41 (Michie Supp. 1998).

68. The traditional justification for the state's regulation of the practice of medicine is the protection of public health. See, e.g., *Smith v. People*, 117 P. 612 (Colo. 1911). When viewed from this perspective, the importance of quality controls on telemedicine practitioners may be increased by the fact that telemedicine has not proven to be free from technical difficulties. Grigsby, et al., state that the clinical effectiveness of telemedicine has been compromised by problems such as the poor quality of digitized chest and bone films, the inability of cardiologists to hear properly through electronic stethoscopes and other similar technological difficulties. Grigsby, *supra* note 3, at 2.

term.⁶⁹ This labyrinth is due in part to the differences in statutory language used by the states and in part to differences among judicial approaches. To begin with, it is worth remembering that the definition of the practice of medicine is a legislative prerogative and, as such, varies from state to state.⁷⁰ The statutory definition is normally quite broad and is not necessarily instructive as to whether particular activities fall within its scope.⁷¹ In Pennsylvania, for example, the Medical Practice Act of 1985 defines "medicine and surgery" as "the art and science of which the objectives are the cure of diseases and the preservation of the health of man, including the practice of the healing art with or without drugs, except healing by spiritual means or prayer."⁷² Moreover, there is no standard or model definition of the practice of medicine that is favored by state legislatures;⁷³ the language varies from the barebones definition set forth in the Pennsylvania statute to the fulsome language employed by the State of California, which includes within the practice of medicine the activities of a person who "diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury or other physical or mental condition of any person."⁷⁴ The statutory definitions frequently provide that a person who holds himself out as capable of these activities should also be classified as practicing medicine.⁷⁵

Because of the typically broad sweep of the statutory language, judicial interpretations often play a significant role in clarifying whether a particular activity constitutes the practice of medicine.⁷⁶ As the administrative agency charged with issuing physician licenses, a state's Board of Medicine may also have considerable influence in determining whether a particular practice falls within the statutory definition of the practice of medicine.⁷⁷ In some states, a Board of Nursing may also influence the in-

69. See generally COHEN, *supra* note 32, at 26-29.

70. *State v. Wilson*, 528 P.2d 279 (Wash. App. 1974) (the legislature may adopt such regulations as it considers necessary for the public good and the courts will not question the wisdom or desirability of such legislative requirements as long as they have a reasonable basis).

71. Even when the term "practice of medicine" has been used without specific definition, courts have declined to find it unconstitutionally vague. *State v. Errington*, 355 S.W.2d 952, 956 (Mo. 1962).

72. PA. STAT. ANN. tit. 63, § 422.2 (West 1996).

73. For a list of the citations of state statutes that define the "practice of medicine," see Michael H. Cohen, *A Fixed Star in Health Care Reform: The Emerging Paradigm of Holistic Healing*, 27 ARIZ. ST. L.J. 79, 154-56 (1995). Cohen suggests that each state statute includes a combination of some of the following elements:

"(1) diagnosis, preventing, treating and curing disease; (2) holding oneself out to the public as able to perform the above; (3) intending to receive a gift, fee, or compensation for the above; (4) attaching such titles as 'M.D.' to one's name; (5) maintaining an office for reception, examination, and treatment; (6) performing surgery; and (7) using, administering, or prescribing drugs or medicinal preparations." *Id.* at 96.

74. See CAL. BUS. & PROF. CODE, §§ 2038, 2051, 2052 (West 1998). For a discussion of the common components of statutory definitions of the practice of medicine, see COHEN, *supra* note 32, at 26-29.

75. See COHEN, *supra* note 32, at 26-27. See also ANDREWS, *supra* note 33, at 20-21.

76. See Mark Hall, *Institutional Control*, 137 U. PA. L. REV. 431, 453 n.80 (1988) (noting that magnetism, mental suggestion, faith healing, color wave therapy, nutritional advice, reflexology, massage and hypnosis have been classified as the practice of medicine).

77. See *Joseph v. District of Columbia Bd. of Med.*, 587 A.2d 1085 (D.C. 1991). See generally FURROW, ET AL., *supra* note 51, at § 3-6(a); Hogan, *supra* note 26, at 117 (describing licensure as "an example of government control through administrative regulation, as opposed to regulation by the judicial, legislative, or executive branches of government"); Kinney, *supra* note 31, at 106-07 (describing the organizational structure and functions of professional licensing boards); DAVID ORENTLICHER, *The Role of Professional Self-Regulation*, in REGULATION OF THE HEALTHCARE PROFESSIONS, 129

terpretation of the scope of nursing practice and its relationship to the practice of medicine.⁷⁸

Courts and administrative agencies have struggled to adapt the essential elements of the statutory language to the ever-changing healing arts. Courts have observed that the varied and, to some extent, idiosyncratic statutory definitions of the "practice of medicine" share a common emphasis on the examination of a patient's symptoms with the purpose of diagnosis and/or treating his ailments.⁷⁹ These common elements have proved to be a useful tool for judges faced with cases that raise the issue of the practice of medicine. In *State v. Miller*, for example, the Iowa Supreme Court recently identified the diagnosis and proper treatment of a patient's ailments as "duties incident to the practice of medicine."⁸⁰ The terms "diagnosis"⁸¹ and "treatment,"⁸² of course, are also subject to statutory definition and judicial or administrative interpretation.⁸³

(Timothy S. Jost, ed., 1997); Rayack, *supra* note 26, at 155-56 (arguing for lay control of medical boards); Jonathan Rose, *Professional Regulation: The Current Controversy*, 7 LAW & HUM. BEHAV. 103, 104-09 (1983) (discussing the tradition of self-regulation of the professions).

78. FURROW, ET AL., *supra* note 51, at §§ 3-9, 3-10.

79. Judicial opinions concerning the licensure of health care professionals frequently identify the practice of medicine with the concepts of diagnosis and treatment. *State v. Errington*, 355 S.W.2d 952 (Mo. 1962) (practice of medicine commonly understood to refer to training in diagnosis, treatment, and cure of ailments of human body); *State v. Scopel*, 316 S.W.2d 515 (Mo. 1958) (while declining to define the practice of medicine, the court notes that diagnosis and treatment of the sick fall within the concept as defined by state law).

80. *State v. Miller*, 542 N.W.2d 241, 246 (Iowa 1995) (duties incident to the practice of medicine include diagnosis and treatment).

81. Diagnosis has been defined as "the act or art of recognizing the presence of disease from its symptoms." *State v. Horn*, 422 P.2d 172 (Ariz. Ct. App. 1967); *Reams v. State*, 279 So. 2d 839 (Fla. 1973) ("diagnosis" means "the discovery of the source of a patient's illness or the determination of the nature of the disease from its symptoms").

82. Treatment of illness or disease—whether by the use of drugs, surgery or therapy—is normally recognized as a method of practicing medicine unless it is excluded by the statute or by judicial interpretation. *State v. Bain*, 295 P.2d 241 (Mont. 1956) (the practice of medicine includes the practice of the healing art in any of its branches); *Reams*, 279 So. 2d at 842 (prescription of diets to cure or alleviate symptoms constituted treatment even when the substances prescribed were vitamins or food rather than medicine).

83. Indeed, just what these terms mean in a practical sense may differ according to whether a court views the patient or the physician as the focus of its inquiry. On one level, the very use of the terms "diagnosis" and "treatment" focuses our attention on their object—the patient. By identifying activities which are integral components of the practice of medicine, these terms direct us to examine the impact of the alleged activities on the patient. In other words, the conduct that is subject to regulation as the "practice of medicine" is intended to, or does impact, a patient or someone who might in the future become a patient. In theory, a principled, patient-focused interpretation of these key terms in the licensure statutes, whether by state boards or by courts, advances the goal of protecting the patient's health by regulating the conduct of the physician that is most likely to impact it. Thus, prescribing a medication to treat a patient's condition is the practice of medicine; testifying as an expert witness is not. See *Missouri Bd. of Registration for the Healing Arts v. Levine*, 808 S.W.2d 440 (Mo. Ct. App. 1991) (testifying as an expert witness is not the practice of medicine within the meaning of the statute). In the first instance, the diagnosis and treatment affects the patient's health; in the second, information may be conveyed, but neither a patient nor his health is likely to be directly implicated. A rigorous patient-focused interpretation draws a tight circle around the patient and excludes from the practice of medicine any activities which do not have a connection with his fate.

In contrast, a court that shifts its focus to the physician's actions may produce a different result. In *Joseph v. District of Columbia Bd. of Med.*, 587 A.2d 1085 (D.C. 1991), for example, the court drew from the familiar definition of diagnosis drawn from Webster's dictionary to conclude that its interpretation of the practice of medicine should not be limited to activities in furtherance of patient care. As a result, in that case, the definition of the practice of medicine was broad enough to encompass the activities of a physician who falsely testified as an expert witness in a medical malpractice case. This type of analysis would allow the practice of medicine to encompass activities that do not

Even though, for practical purposes, the varying definitions of the practice of medicine may be distilled to the essential components of diagnosis and treatment, a telemedicine practitioner who plans to practice in a variety of states still faces the problems of inconsistencies among state laws. Obstetrics, for example, seems to be a discipline which now demands the personal interaction between the patient and the caregiver.⁸⁴ At least one commentator has suggested, however, that the Internet will play an increasingly active role in disseminating information about pregnancy and childbirth and facilitating communication between pregnant women and their health care providers.⁸⁵

Indeed, that day may already be upon us; not only do Internet users log in regularly to medically related bulletin boards,⁸⁶ but very recently, for example, millions of Internet subscribers were able to witness the birth of a baby.⁸⁷ Since advanced telecommunication procedures now enable a telemedicine practitioner to monitor fetal heart rates and provide other information and services without being in physical contact with the pregnant woman,⁸⁸ it is not at all inconceivable that a telemedicine practitioner who offers domiciliary fetal monitoring to women in different states may have to confront a variety of state laws concerning whether these practices constituted the practice of medicine, the practice of midwifery or something different. To complicate the matter, there has been much debate as to whether the practice of midwifery should be considered to fall within the definition of the practice of medicine.⁸⁹

States have resolved this question in different ways, with the result that a lay midwife may attend a woman in labor without fear of prosecution under Tennessee law,⁹⁰ while the same activities would be viewed as the practice of medicine and would require a professional midwife's license in Missouri.⁹¹ Thus, whether the use

necessarily require a physician/patient relationship. In one much criticized case, for example, a Texas court ruled that the publication of a book that urged self-help remedies for cancer patients constituted the unauthorized practice of medicine.

84. See, e.g., ARLENE EISENBERG, ET AL., *WHAT TO EXPECT WHEN YOU'RE EXPECTING* 8, 14 (1991) (noting the change in obstetrical practice from "no-questions-asked obstetrical care" in the past and advising pregnant women to determine whether an obstetrician's philosophies and personality are "in sync" and "mesh comfortably" with her own).

85. See Kristin B. Keltner, Note, *Networked Health Information: Assuring Quality Control on the Internet*, 50 FED. COMM. L. J. 417, 418 (1998).

86. In an informal sense, much of Ms. Keltner's vision of the exchange of information is already taking place on the Internet through bulletin boards such as those sponsored by Ask Dr. Weil (visited September 2, 1998) <<http://www.drweil.com>> and ParentsPlace.com (visited on September 2, 1998) <<http://www.parentsplace.com>>.

87. Mike Schneider, *Baby Takes First Bow on the Internet; Birth on Web Site is Seen by Thousands*, SAN DIEGO UNION TRIBUNE, June 17, 1998, at A10.

88. GOTT, *supra* note 4, at 31-45.

89. See generally FURROW, ET AL., *supra* note 51, at § 3-7(c).

90. See *Leggett v. Tennessee Bd. of Nursing*, 612 S.W.2d 476 (Tenn. Ct. App. 1980) (noting that Tennessee law specifically excludes midwifery from the definition of the practice of medicine).

91. MO. ANN. STAT. § 334.010 (West 1989). See Bd. of Registration for the Healing Arts, 704 S.W.2d at 225 (defendant who concedes to acting as a midwife without a license to do so engages in the unauthorized practice of midwifery even though she does not have an office, does not advertise and does not habitually earn her living from midwifery). See also *Smith v. State*, 459 N.E.2d 401 (Ind. Ct. App. 1984) (defendant who provided prenatal care and delivered babies without first obtaining a license to practice as a midwife or a physician unlawfully practiced medicine). In *Leigh v. Board of Registration in Nursing*, 481 N.E.2d 1347, 1354 n. 12 (Mass. 1985), the court did not interpret Massachusetts law to classify midwifery as the unauthorized practice of medicine per se, but argued that use of obstetrical instruments and prescriptions (a conclusion that was not supported by the evidence in that case) would constitute the unauthorized practice of medicine.

of telemedicine to provide domiciliary fetal monitoring constitutes the practice of medicine or the practice of midwifery may differ according to the jurisdiction at issue. And, in all likelihood, the privileges and obligations incumbent upon the telemedicine practitioner will differ as well.

Second, the telemedicine practitioner must determine whether the fact that his activities are conducted through the medium of electronic communications should affect whether the activities are classified as the practice of medicine. Here, some states have concluded that it makes no difference.⁹² These states have specifically brought the practice of telemedicine within the definition of the practice of medicine by amending their statutes or are considering bills that would do so.⁹³ Texas, for example, specifically asserts its authority over out-of-state telemedicine practitioners by including within the definition of the practice of medicine the activities of any practitioner 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 preparation of pathological material for examination, and that would affect the diagnosis or treatment of the patient⁹⁴

A bill presented to the West Virginia legislature, for example, minces no words in declaring that "[a] person engaged in the practice of telemedicine is considered to be engaged in the practice of medicine"⁹⁵ Telemedicine practitioners who offer telemedicine services in these states will therefore be deemed to be practicing medicine within the state.

Where there is no statutory response, however, the telemedicine practitioner will be forced to look elsewhere for advice. Despite the growing interest in telemedicine, many states have yet to change their statutes in order to clarify whether telemedicine should fall within the practice of medicine. To date there are no reported cases that specifically consider whether, in the absence of specific statutory guidance, the practice of telemedicine falls within the parameters of a state's definition of the practice of medicine. It does seem, however, that the state boards of medicine are disposed toward classifying the practice of telemedicine in this way, regardless of the novel form through which physician/patient communications take place.

As described above, the diverse statutory definitions of the practice of medicine found in the state licensing statutes mandate an inquiry into whether the disputed activities rise to the level of diagnosis or treatment. It is not surprising, then, that the few informal decisions that have made their way into the public sensibility suggest that the board's decision may turn on the familiar questions of whether the telemedicine provider's activities amount to providing or suggesting diagnosis and/or treatment. More importantly, they do *not* seem to be affected by the medium through which these activities are conducted. The Boards seem to view a diagnosis reached through telemedicine as indicative of the practice of medicine. The Pennsylvania Board of Medicine, for example, reportedly has advised one telemedicine provider that an out-

92. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(i) (West Supp. 1998).

93. See *infra* note 134 and accompanying text. For a frequently updated list of state legislative initiatives, see (visited September 2, 1998) <<http://www.arentfox.com>>.

94. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(i) (West Supp. 1998).

95. H.B. 4073, 73d Leg., 2d Reg. Sess. (W. Va. 1998).

of-state physician who "routinely" performs telemedical services that result in medical reports or opinions must be licensed to practice medicine in Pennsylvania.⁹⁶ Similar opinions have been offered by the state boards of medicine in Arizona, Florida, Iowa, Maine and Massachusetts.⁹⁷ Likewise, the familiar concepts of medical practice may include a telemedicine practitioner who takes steps to provide treatment to patients. A telemedicine practitioner who gives orders to an in-state practitioner may have engaged in the practice of medicine.⁹⁸ In December 1995, for example, the Office of the Attorney General for the State of Mississippi opined that the supervision of home health nurses by out-of-state physicians constituted the practice of medicine.⁹⁹

In the absence of specific statutory guidance, a strict adherence to the familiar diagnosis/treatment test embodied in state law offers an attractive method of determining whether a telemedicine practitioner is engaged in the practice of medicine. First, the statutory language remains a highly appropriate means for testing what it is that telemedicine practitioners do. Like all health care professionals, telemedicine practitioners engage in some activities that are directed at the diagnosis and treatment of patients and some activities that fall outside those parameters. The fact that these activities are conducted through electronic communications should not be the decisive factor in determining whether the activities should be classified as the practice of medicine. The main distinction between the practice of medicine and the practice of telemedicine is the medium through which physician-patient communications take place.

Focusing on the medium through which care is given ignores the essential similarity between the diagnosis and/or treatment that may be rendered through telecommunications technology and the diagnosis and/or treatment that is performed in person. This is a mode of analysis that was rejected when courts began to recognize that a physician could create a relationship with a patient even when his diagnosis and treatment of that patient was conducted through telephonic communications.¹⁰⁰ Focusing on whether diagnosis and treatment have taken place, rather than on the medium through which these acts are accomplished, permits the state licensure board to examine the telemedicine practitioner's activities in terms of their impact on the patient.¹⁰¹

96. JWGT 1997 REPORT, *supra* note 9, at 47-48. In contrast, the Mississippi Attorney General has also opined that an out-of-state radiologist is not practicing medicine when he has a contract with an in-state hospital to interpret x-rays, CAT scans, MRIs or other radiological workups communicated to him via computer modem or satellite. Op. Miss. Att'y Gen. No. 95-0610 (Dec. 8, 1995), available in 1995 WL 779738.

97. JWGT 1997 REPORT, *supra* note 9, at 47-48.

98. Two members of the law firm of Arent Fox have suggested that a state board of medicine is likely to conclude that an out-of-state physician who is consulting only with the patient or with para-professionals is practicing medicine within the state. Howard J. Young & Robert J. Waters, *Licensure Barriers to the Interstate Use of Telemedicine*, (visited September 2, 1998) <<http://www.arentfox.com/telemed/articles/licensenimplic.html>>.

99. Requirement of License for Out-of-State Physicians, Op. Miss. Att'y Gen. No. 95-0610 (Dec. 8, 1995), available in 1995 WL 779738.

100. See, e.g., *Gilinsky v. Indelicato*, 894 F. Supp. 86, 93 (E.D.N.Y. 1995) (neurologist who conducted extensive telephone conversations with chiropractor concerning chiropractor's patient should have foreseen that chiropractor was relying on his opinion and therefore created a physician/patient relationship with patient).

101. The Multistate Regulation Task Force of the National Council of State Boards of Nursing proposes to resolve the more narrow issue of whether an electronic interaction constitutes the practice of nursing by asking whether the interaction would have fallen within the definition of nursing had it occurred on a face-to-face basis. NATIONAL COUNCIL ST. BD. NURS., MULTISTATE REGULATION RESOURCE PACKET (April 3, 1997).

Such a focus seems particularly important in light of the board's expressed interest in protecting the public. Indeed, states that have amended their statutes to take into account the development of telemedicine normally just add the words "through the use of any medium, including an electronic medium" to their previously enacted definition of the practice of medicine.¹⁰²

Second, applying the diagnosis/treatment test to telemedicine practitioners places them on a level playing field with other medical practitioners. Some commentators have argued persuasively that the diagnosis/treatment paradigm discriminates unfairly against alternative practitioners whose modalities of treatment lie at the fringes of or outside traditional biomedical concepts of patient care.¹⁰³ In contrast, telemedicine practitioners do not necessarily reject the premises of conventional medical care. The most common applications of telemedicine do not seriously challenge the fundamental assumptions on which the protocols for diagnosis and treatment are based; instead, the most basic telemedicine procedures challenge the method through which data are collected and diagnosis and treatment are communicated. It is perhaps ironic that a profession which has been criticized for poor bedside manner has now found a way to render services without coming near the patient's bed. Nonetheless, to argue that the distance between physician and patient is an appropriate basis for concluding that the practice of medicine is not implicated would force the ultimate estrangement between physician and patient.¹⁰⁴

In general, then, it seems that a prudent telemedicine practitioner will need to plan for the probability that his contact with a patient in a different state will be classified as the practice of medicine if he engages in diagnosis or treatment. Depending on the nature of his activities, other professional disciplines, such as nursing, may be at issue. In this case, the telemedicine practitioner should turn to the traditional statutory test applicable to his discipline in order to determine whether he is engaging in activities that require compliance with local licensure laws. Once this determination is made, he must then turn to the state's licensing statutes to determine how to comply with the occupational licensing requirements to which he will be subject.

IV. Options for State Regulation of Telemedicine Licensure

If the practice of telemedicine falls within our understanding of the practice of medicine, the state-based licensure system must address whether and how telemedicine practitioners should be licensed to carry out their professions. In 1997 the Joint Working Group on Telemedicine¹⁰⁵ identified seven models for resolving the licensure problems that arise from the interstate practice of telemedicine: (1) statutory exceptions

102. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(i) (West Supp. 1998); CAL. BUS. & PROF. CODE § 2052.5(a)(1) (West Supp. 1998).

103. See, e.g., COHEN, *supra* note 32, at 24; Andrews, *supra* note 46, at 1298-1317.

104. Commentators addressing the application of malpractice laws to telemedicine practitioners have similarly suggested that the laws governing the creation of physician/patient relationships remain applicable to telemedicine relationships. See generally Phyllis Forrester Granade, *Medical Malpractice Issues Related to the Use of Telemedicine—An Analysis of the Ways in Which Telemedicine Affects the Principles of Medical Malpractice*, 73 N.D. L. REV. 65, 68-74 (1997); Phyllis F. Granade & Jay H. Sander, M.D., *Implementing Telemedicine Nationwide: Analyzing the Legal Issues*, 63 DEF. COUNS. J. 67 (1996).

105. The Joint Working Group on Telemedicine was created in 1995 in order to enable the Secretary of Health and Human Services to comply with the Vice President's request for a report on telemedicine issues.

for out-of-state health care professionals who occasionally consult with in-state colleagues; (2) registration by licensed out-of-state health care professionals who wish to practice in the state on a part-time basis; (3) endorsement of a license held by an out-of-state health care professional after review of his qualifications and the standards for licensure in his home state; (4) limited licensing of out-of-state health care professionals for specific purposes; (5) reciprocity negotiated by two or more states to permit out-of-state licensees to practice in a reciprocal state without creating common standards for licensure or conducting an individualized review of an applicant's credentials; (6) a mutual agreement among states to coordinate licensure standards and to recognize the validity of the licensing policies and procedure of the licensee's home state; and (7) a national licensure system under which licensees would be required to meet a uniform national standard.¹⁰⁶

The models identified by the Joint Working Group represent three approaches to the problems presented by the interstate practice of telemedicine. First, a state may make independent efforts to regulate telemedicine practitioners by adopting licensure provisions based on the consultation, registration, endorsement and full or limited licensure models. Second, states may join together in a cooperative effort to regulate telemedicine practitioners by entering into reciprocal agreements to recognize the licenses of practitioners who have met the requirements for licensure in reciprocal states. Third, states may defer to a national or federal system of licensure, ceding authority to determine baseline quality standards to a common national organization or to Congress.

In this section of my Article, I examine these three broad categories in light of the concerns that are central to the state's reason for licensing professionals in the first place, namely, the need to establish quality controls in order to set forth the minimum level of competence that the state will tolerate in the practice of telemedicine and the need to enforce those standards. My analysis does not go so far as to examine what the specific competence standards should be or, stated differently, how high should the bar be raised. Rather, for purposes of this portion of my Article, I assume that a state has a basic interest in setting entry-to-practice standards and disciplinary procedures for health care practitioners and turn instead to consider the manner in which each alternative affects the state's authority to do so.¹⁰⁷

In approaching this topic, it must be noted that proposals addressing the licensure of interstate telemedicine practitioners have principally drawn from and focused on our understanding of the licensure of physicians. Yet, in some respects, the interstate practice of telemedicine poses more significant barriers to practitioners who are not licensed physicians. Since the requirements for an unrestricted medical license are relatively uniform, the main obstacles which a physician faces in obtaining a license in a second state are administrative and financial. While these barriers can be formidable, a physician who has filled out the paperwork and paid the fee has a good chance of success in his quest for licensure in a second state. In contrast, the differences among the states' approaches to the entry-to-practice and scope-of-practice standards applica-

106. JWGT 1997 REPORT, *supra* note 9, at iii-viii, 36-41.

107. A detailed examination of the anticompetitive aspects of the current approaches to telemedicine licensure is beyond the scope of this article. Empirical and theoretical investigation of this topic would doubtless be of interest in furthering the debate on the use of licensure statutes for anticompetitive motives. See *supra* note 33 and accompanying text.

ble to nonphysicians mean that a person who holds a valid license to practice his profession in one state may not even be eligible to obtain a license in a second state. The barriers facing a nonphysician who wishes to offer his services in a different state through telemedicine may in fact be impossible to surmount. Thus, the fact that the models outlined by the Joint Working Group on Telemedicine and other commentators draw primarily from physician models should not distract us from realizing that nonphysicians may have a genuinely higher stake in finding a solution to the interstate licensure problem.¹⁰⁸

A. Category One: Individualized State Action

A state need not wait upon its sister states in order to regulate out-of-state telemedicine practitioners. Indeed, the states which currently regulate the activities of telemedicine practitioners do so at their own initiative and without cooperation from the other states.¹⁰⁹ Two distinct approaches have emerged. First, some states effectively rely on the quality controls that are set forth in the practitioner's home state rather than developing their own criteria for licensing telemedicine practitioners. States which permit telemedicine practitioners to offer services through consultation exceptions, registration or endorsement of an out-of-state license effectively affirm another state's evaluation of whether the practitioner is competent. Under a second approach, a state may continue to insist that a practitioner comply with its own standards for licensure by requiring a full or a limited license in order for telemedicine practice to occur.¹¹⁰

1. Consultation Model

The majority of states have not yet addressed the practice of telemedicine in the context of their physician licensing statutes.¹¹¹ However, the physician licensing statutes in these states nonetheless provide guidance for an out-of-state physician who wishes to practice medicine within the state's borders. Even before the advent of telemedicine, state laws recognized exceptions under which a physician who was licensed in one state might perform medical services in another. The least formal and most commonly used procedure is the practice of consultation.¹¹²

Most states permit out-of-state physicians to consult with their licensed colleagues on a limited basis.¹¹³ The extent of the consultation exception varies from

108. Moreover, many existing telemedicine programs have been designed to utilize the services of nonphysicians. See 1998 Hearings (statement of Ralph V. Frasca, Jr., C.E.O. and President, Moon Communications, Inc.), *supra* note 7 (describing the use of a telemedicine system at Helen Ellis Hospital in Tarpon Springs, Florida by "hundreds of doctors, nurses, visiting nurses, occupational therapists and physical therapists").

109. See, e.g., TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(i) (West Supp. 1998), which includes telemedicine within the definition of the practice of medicine and therefore requires most telemedicine practitioners to comply with the licensure laws.

110. See, e.g., *Id.*

111. As of February 1997, 38 states had not addressed telemedicine specifically through legislation. GAO 1997 REPORT, *supra* note 8, at 5:2.1. For a regularly updated list of state legislative initiatives, see (visited September 2, 1998) <<http://www.arentfox.com>>.

112. In addition to traditional consultation and endorsement exceptions, some states recognize "extraterritorial" or "border" exceptions for physicians from neighboring states. See, e.g., PA. STAT. ANN. tit. 63, § 422.34(a) (West 1996); 49 PA. CODE § 17.4 (1998). See generally Huic, *supra* note 9, at 398. In addition, some states also recognize temporary licenses for limited duration. See, e.g., 27 TEX. ADMIN. CODE. § 217.5 (West 1998) (12-week temporary license for nurses).

113. For a discussion of the scope of the consultation exception in each state, see CTL White Pa-

state to state.¹¹⁴ In Pennsylvania, for example, the scope of the consultation exception is quite broad: "A person authorized to practice medicine or surgery or osteopathy without restriction by any other state may, upon request by a medical doctor, provide consultation to the medical doctor regarding the treatment of a patient under the care of the medical doctor."¹¹⁵ Similar provisions exist in all physician licensing statutes.

If a telemedicine practitioner is engaged in practicing medicine, he must comply with the state's licensing requirements or find an exception in the law that permits him to offer his services.¹¹⁶ Surely the consultation exception is the provision to which the occasional telemedicine practitioner will first turn, simply because it requires no administrative effort on his own part and is little monitored. Indeed, the consultation exception may offer some assistance to telemedicine practitioners who offer services outside their states on an occasional basis.¹¹⁷

Yet the consultation exception is of dubious utility for the practitioner who intends to engage in the regular practice of telemedicine.¹¹⁸ While the language of the Pennsylvania statute, for example, is considered permissive in comparison to the consultation exceptions of other states its plain emphasis on infrequent physician-to-physician communications in fact does little to facilitate telemedicine services.¹¹⁹ The plain language of the statute suggests that an out-of-state consultant who maintains an ongoing involvement in the care of a single in-state patient is not likely to find solace in the consultation exception; nor is the frequent telemedicine practitioner likely to find the consultation exception of much comfort.

First, the statute does not define the term "consultation" and thus leaves unclear the extent to which the out-of-state practitioner may actually engage in patient care.¹²⁰ Second, the consultation exception extends only to physicians: the out-of-state practitioner must be a physician and the care of the patient must remain in the hands of a licensed Pennsylvania physician.¹²¹ Even if the in-state physician may arguably delegate to a physician assistant or nurse the task of communicating with the consultant, he or she must provide the supervision required under the Medical Practice

per, supra note 1, at 121-27 (noting, *inter alia*, that Illinois, Maine, Louisiana and New Mexico lack consultation exceptions).

114. Among the states considered to promote broad consultation exceptions are California, Oregon, New York, South Carolina, Florida and Georgia. In contrast, more limited exceptions permitting consultations over a specified period of time exist in Alabama and South Dakota. *Telemedicine: Malpractice Liability, Licensure May Hinder Spread of Technology*, BNA HEALTH CARE DAILY (Aug. 30, 1995).

115. PA. STAT. ANN. tit. 63, § 422.16 (West 1996).

116. See *People v. Gelb*, 549 N.Y.S.2d 768, 769-70 (N.Y. App. Div. 1990) (consultation exemption from licensure requirements is an affirmative defense against a charge of unauthorized practice).

117. See, e.g., *CTL White Paper*, *supra* note 1, at 121-27 (noting the limitations recently imposed on the use of the consultation exception by telemedicine practitioners and suggesting that consultation provisions be structured to preserve the physician's ability to consult with out-of-state physicians); JWGRT REPORT, *supra* note 9, at 37 (noting that consultation exceptions are well-suited to some telemedicine situations, but unlikely to apply to on going regular links).

118. In recent years, many states have specifically amended their physician licensure statutes to limit the ability of telemedicine practitioners to operate within the parameters of the consultation exception. See generally, *CTL White Paper*, *supra* note 1, at 119-21.

119. PA. STAT. ANN. tit. 63, § 422.16 (West 1996). For an assessment of the relative breadth of the consultation exceptions to the various state medical practice acts, see *CTL White Paper*, *supra* note 1, at 123.

120. See generally, *CTL White Paper*, *supra* note 1, at 125-27.

121. PA. STAT. ANN. tit. 63, § 422.16 (West 1996).

Act.¹²² Direct unsupervised contact between the out-of-state physician and an in-state patient or an in-state nonphysician would not fall within the scope of this exception.¹²³ Third, the exception does not authorize an ongoing relationship between the out-of-state physician and the in-state physician or his patient.¹²⁴

If the interests of the telemedicine practitioner are ill-served by the statutory exception, the goals of the state seem to be even less likely to be achieved by endorsing the widespread use of the consultation exception. Simply stated, one purpose of the licensure statute is to ensure that health care providers possess the minimum credentials established by the state. The consultation exception, however, does not require a candidate to do so. Instead of requiring the provider to meet the state's own requirements, the statute defers to the criteria established by the state where the provider is licensed, regardless of what these criteria might be. In theory, a person licensed in a state with relatively low expectations of its physicians could consult with physicians licensed in a different state with more rigorous standards without obtaining the more difficult license.¹²⁵ In the case of the Pennsylvania statute, for example, additional quality control depends on the fact that the out-of-state communications must be monitored by an in-state physician who retains the final decision-making authority with respect to the patient.¹²⁶ In essence, the statute relies on the in-state physician's judgment of the consultant's competence rather than on uniform state standards. Likewise, little threat is posed by the disciplinary component of the statute to a consultant who works within the statutory guidelines for consultations regardless of the quality of services he renders.

2. Endorsement

The endorsement procedure enables a physician who is licensed in one state to gain permission to practice in a second state by requesting the review and endorsement of his credentials.¹²⁷ Similar provisions may also be available to nurses and physician assistants who wish to be licensed in a second state.¹²⁸ The applicant must normally be in good standing in his own state and meet all of the requirements for licensure in a second state.¹²⁹

122. See, e.g., *id.* § 422.13(d) (requiring physician assistant to perform medical services only with the supervision and personal direction of physician); *Id.* § 422.13a(d) (requiring physician supervision of respiratory care practitioners); *Id.* § 422.17 (stating requirements for delegation of certain tasks by physicians); *Id.* § 422.21 (explaining effect of not obtaining required involvement of doctor).

123. Some lawyers whose practice involves consideration of the issues facing telemedicine practitioners have argued that an out-of-state physician who is consulting with a patient alone or only with the assistance of paraprofessionals may be subject to prosecution for the unlicensed practice of medicine. See Young & Waters, *supra* note 98.

124. This is made very clear in other state statutes, which place a numerical limit on the number of contacts that an out-of-state physician may have.

125. As discussed above, unlike nonphysicians, the entry-level criteria for physicians are relatively uniform. Thus, this criticism is more likely to come into play in the event that the consultation model is adopted with respect to nonphysicians.

126. PA. STAT. ANN. tit. 63, § 422.16 (West 1996).

127. See, e.g., 49 PA. CODE § 17.2 (1997) (medical doctors); *Id.* § 25.242 (osteopathic physicians). See generally SHIMBERG & ROEDERER, *supra* note 15, at 7-8.

128. See, e.g., 49 PA. CODE § 21.28 (1997) (a registered nurse who has earned a license in another jurisdiction of the United States or Canada by passing the National Council Licensure Examination may receive a license by endorsement if she meets the requirements of the Nurse Practice Act); *Id.* § 21.155 (1997) (stating similar requirements for endorsement of licenses held by practical nurses).

129. Report on Medical Licensure, *supra* note 43, at 2000.

The endorsement procedure places more obstacles in the way of telemedicine practitioners who wish to gain access to state markets than those presented by a consultation exception. Proponents of telemedicine have thus criticized the endorsement procedures as cumbersome and expensive.¹³⁰ Moreover, if a state sets rigorous entry-to-practice standards, the existence of an endorsement procedure will be of little use to candidates who were first licensed in a state with less stringent requirements.¹³¹ In addition, a provider who is successful in obtaining an endorsement may face practical difficulties in tracking the activities which he is permitted to undertake in the new state.¹³² From a pragmatic standpoint, the state's willingness to endorse licenses does not eliminate the problem of lack of uniformity in scope of practice regulations; a provider whose license was endorsed by State A would presumably be subject to the scope of practice regulations promulgated by State A even though the scope of practice accommodated under the license offered by his home state may differ.

When the administrative and practice-related difficulties to the individual telemedicine practitioner are overlooked, however, the endorsement procedure seems a more effective means of promoting the state's goals than consultation. Because in-state decision makers may pass on the appropriateness of the provider's credentials, the endorsement procedure respects the integrity of the state's own legislative and administrative decision-making process.¹³³ Moreover, an endorsement procedure permits the state to discipline providers for infringements of the disciplinary code. Finally, since endorsement provisions are available to nonphysicians as well as to physicians, telemedicine providers may employ their nonphysician personnel in a more efficient manner.

3. Full and Special Licensure

As of February 1997, at least twelve states had enacted legislation that may impact the provision of health care through telemedicine.¹³⁴ Most of the states have approached telemedicine with skepticism and have required telemedicine practitioners to obtain a license in order to offer health care services within their borders.¹³⁵ In Il-

130. According to the Center for Telemedicine Law, the procedure for obtaining a license by endorsement can be so burdensome that a physician may have to take a licensing exam in addition to fulfilling administrative requirements. *CTL White Paper*, *supra* note 1, at 110, 115-16.

131. See, e.g., *Tinner v. District of Columbia Dept. of Consumer Affairs*, 703 A.2d 833, 838 (D.C. 1997) (upholding denial of licensure by endorsement to a New Hampshire physician who did not, at the time of his original licensure, meet the stricter D.C. standards for examination scores); *Roberts v. District of Columbia Bd. of Med.*, 577 A.2d 319, 324 (D.C. 1990). See also *Binkley v. Zollar*, 681 N.E.2d 153, 156 (Ill. App. Ct. 1997) (state that permits a person to take nurse licensing exam an unlimited number of times does not have requirements substantially equivalent to those required in Illinois and therefore denial of nursing license by endorsement is appropriate).

132. See, e.g., *supra* note 50 and accompanying text (regarding the jurisdictional differences in the authorized scope of practice of advanced nurse practitioners.)

133. See, e.g., *Erlanger*, 10 N.Y.S.2d at 1017 (endorsement should only apply in cases where Regents are satisfied that applicant has substantially met all requirements); *Guidotti v. Mangon*, 55 N.Y.S.2d 11 (N.Y. App. Div. 1945) (New York Regents are not required to endorse the license of a New Jersey physician who, in their opinion, did not meet New York requirements for licensure).

134. GAO 1997 REPORT, *supra* note 8, at 5:2.1.

135. See, e.g., CONN. GEN. STAT. ANN. § 20-9(d) (West Supp. 1998); 225 ILL. COMP. STAT. ANN. 60/49.5(b) (West Supp. 1998); IND. CODE ANN. § 25-22.5-1-1.1 (a)(4) (Michie Supp. 1998); TEX. REV. CIV. STAT. ANN. art. 4495b § 3.07(a) (West Supp. 1998). Many state legislative bills propose a similar approach. See S.B. 36, 61st Gen. Ass. 2d Reg. Sess. (Colo. 1998); H.B. 1855, 1998 Reg. Sess. (Fla. 1998); S.B. 447, 1998 Reg. Sess. (Md. 1998); H.B. 1298, 89th Gen. Ass., 2d Reg. Sess. (Mo. 1998);

linois, for example, out-of-state telemedicine practitioners must obtain a license to perform acts of patient care that are initiated within the state.¹³⁶ Some states are considering bills that limit the requirement of full licensure to instances when the out-of-state physician has primary authority for the diagnosis and care of the patient.¹³⁷

A requirement of full licensure obviously least disturbs the state's current quality standards and its disciplinary system.¹³⁸ Moreover, out-of-state telemedicine practitioners would incur the same licensure costs and compete on a level playing field with in-state telemedicine providers and other physicians. In addition, fully licensed physicians would clearly be subject to the state's disciplinary code, regardless of whether they were physically located in the state at the time telemedicine services were provided.¹³⁹

The full licensure requirement has been opposed by several advocates of telemedicine.¹⁴⁰ First, the critics of full licensure point out that the physician licensure process is costly and may outweigh the physician's incentive to engage in telemedicine services on a limited basis.¹⁴¹ Moreover, instead of developing their practices in response to health care needs, telemedicine practitioners may find it more advantageous to operate in states where licensure is least difficult to obtain and abandon states where full licensure is required.¹⁴²

The mere fact that a state opts to require telemedicine practitioners to obtain a license, however, does not mean that it must require *full licensure*. In 1995, the Federation of State Medical Boards, Inc., developed a Model Act (hereinafter FSMB Model Act) to Regulate the Practice of Medicine Across State Lines which attempts to facilitate such legislation.¹⁴³ Indeed, the Texas State Board of Medicine, among others, now requires out-of-state practitioners to obtain a license of limited scope.¹⁴⁴ An out-of-state physician who wishes to provide regular telemedical services to patients who are located in Texas must obtain a 'special purpose' license in order to do so. As its

H.B. 7588, 1997-98 Leg. Sess. (R.I. 1998).

136. 225 ILL. COMP. STAT. ANN. 60/49.5 (West Supp. 1998).

137. See, H.B. 1855, 1998 Reg. Sess. (Fla. 1998), which specifically includes within this limitation an out-of-state radiographer who operates under an ongoing contract for the interpretation of electronically transmitted x-rays; Also see S.B. 447, § 14-302(2), 1998 Reg. Sess. (Md. 1998), Section 14-302(2), which exempts physicians who do not reach a primary diagnosis.

138. See, e.g., 225 ILL. COMP. STAT. ANN. 60/49.5(e) (West Supp. 1998) (telemedicine practitioners who provide services to Illinois patients submit themselves to the jurisdiction of its courts).

139. See, e.g., 225 ILL. COMP. STAT. ANN. 60/49.5(a) (West Supp. 1998) (noting legislature's intent that telemedicine practitioners who provide services to Illinois patients submit themselves to its disciplinary procedures).

140. See, e.g., Jay H. Sanders & Rashid L. Bashshur, *Challenges to the Implementation of Telemedicine*, reprinted in JWGT 1997 REPORT, *supra* note 9 (describing the American College of Radiology's insistence on full licensure at both the transmitting and receiving sites as "very restrictive").

141. Letter from Kaliope Berdusis and C. Elise Duffy to Dena S. Puskin (September 10, 1996), reprinted in JWGT 1997 REPORT, *supra* note 9 (stating "[o]ur experience suggests that licensure is not necessary to ensure the competency of remote site staff in providing specialized services during telemedicine transmission as long as other standards are met").

142. See Daniel McCarthy, Note, *The Virtual Health Economy: Telemedicine and the Supply of Primary Care Physicians in Rural America*, 21 AM. J.L. & MED. 111 (1995) (for a discussion of the role of telemedicine in rural communities).

143. Federation of State Medical Boards of the United States, Inc., *An Act to Regulate the Practice of Medicine Across State Lines* (1996) [hereinafter FSMB Model Act].

144. 22 TEX. ADMIN. CODE § 174.4 (West 1997); See, e.g., ALA. CODE § 34-24-502 (1997). See also S.B. 245, 65th Adj. Sess. (Vt. 1997).

name implies, the special purpose license authorizes the recipient to provide services only to the extent authorized by the special purpose license and does not constitute authority to "physically practice medicine in the state of Texas."¹⁴⁵

The special purpose licensure statutes resolve several of the problems which have plagued telemedicine practitioners who practice in other jurisdictions. First, the special licensure statute typically clarifies that the practice of medicine does indeed include most established telemedicine practices. The FSMB Model Act specifies that "the practice of medicine across state lines" means "the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment" of or "the rendering of treatment" to an in-state patient by an out-of-state physician through "transmission of individual patient data by electronic or other means."¹⁴⁶ Likewise, the Texas Medical Practice Act specifies that the "practice of medicine" embraces the activities of out-of-state telemedicine practitioners that would affect the diagnosis or treatment of a patient whose care was initiated in Texas.¹⁴⁷ The statute specifically includes the preparation of X-rays and pathology services within the scope of the practice of medicine.¹⁴⁸ By clarifying that the practice of telemedicine is included within the concept of the practice of medicine, the statutes express the state's intent to regulate telemedicine and thus eliminate uncertainty on the part of telemedicine providers.

Second, the special licensure statutes clarify the application of the consultation exception to telemedicine providers. As discussed above, the extent to which consultation exceptions resolve a telemedicine practitioner's responsibility to comply with licensure laws is limited. The special licensure laws generally provide some guidance on this issue. Under Texas law, the consultation exception is available only to medical specialists who provide "only episodic consultation services on request to a person licensed in [Texas] who practices in the same medical specialty"¹⁴⁹ and physicians who provide consultation services to medical schools or certain educational institutions located in Texas.¹⁵⁰ Physicians who provide consultations¹⁵¹ on an informal basis "outside the context of a contractual relationship and on an irregular or infrequent basis without the expectation or exchange of direct or indirect compensation" may also

145. 22 TEX. ADMIN. CODE § 174.4 (West 1997). In fact, one recurring criticism of the FSMB Model Act and other special licensure statutes is the failure to require on-site patient examinations. See, e.g., Letter from Robert R. Waller, President, Mayo Foundation, to Dena S. Puskin (August 29, 1996), reprinted in JWGT 1997 REPORT, *supra* note 9; Letter from James G. Potter, Associate Director, Government Relations, American College of Radiology to Dena S. Puskin (August 29, 1996), reprinted in JWGT 1997 REPORT.

146. See FSMB Model Act, *supra* note 143. Paul Orbuch notes, however, that these terms lack precise definition, thus lowering the value of the FSMB Model Act as a "telemedicine barrier buster." Orbuch, *supra* note 8, at 47.

147. "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 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 and is subject to this Act and to appropriate regulation by the board." TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(d)(8)(C)(i) (West Supp. 1998).

148. *Id.*

149. *Id.* § 3.06(d)(8)(C)(i)(1).

150. *Id.* § 3.06(d)(8)(C)(i)(2)-(3).

151. In practical terms, a physician may not request the assistance of another doctor who is located outside Texas if they are not specialists in the same area without running afoul of the Medical Practice Act.

avoid licensure in the state.¹⁵² Regardless of whether telemedicine practitioners are satisfied with special purpose licensure as a compromise requirement, such statutes at least eliminate uncertainty concerning a variety of common telemedicine practices.

Third, the special purpose license allows the state to retain its prerogative to set entry-to-practice standards. In theoretical terms, the state could set whatever standards it desired in order to satisfy its quality concerns. The FSMB Model Act requires that a person hold a license to practice medicine in another state, but permits the State Board to refuse to grant a license to a physician who has experienced previous disciplinary action if it determines that the physician may be a potential threat to the public.¹⁵³

Fourth, even when the state does not attach special conditions on entry-to-practice, the special purpose license per se limits the scope of practice to the level which the state deems manageable.¹⁵⁴ In fact, the special purpose licensure statute clearly establishes the state's ability to discipline physicians who fail to observe the regulations of the State.¹⁵⁵

In many respects, then, the special purpose license answers the concerns that are posed by proponents of full licensure. Yet, because the special purpose license is an action that is taken by one state without the cooperation of others, the state must make a fundamental choice between setting its own standards for entry-to-practice and relying on the judgment of a different state. If the state elects to utilize its own entry-to-practice standards, telemedicine practitioners may find the process of obtaining a special purpose license as onerous as obtaining full licensure and abandon the practice completely. A state that is interested in obtaining telemedicine services to aid its rural communities, for example, may find that it is hard pressed to consider any alternative other than accepting the entry-to-practice standards in other states. Once that decision is made, the state can only police the quality of telemedicine practitioners by limiting and enforcing their scope of practice regulations.¹⁵⁶

The special purpose licensure statutes must also recognize the fact that many telemedicine practitioners are not physicians but nurses or other health care professionals.¹⁵⁷ Even if non-physicians were made the subject of individualized special purpose licensure regulation, the wide variation between scope of practice rules in different states would have to be addressed through special safeguards. As discussed

152. TEX. ADMIN. CODE tit. 22, § 174.2, 174.13 (1997). See also TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(b)(11) (West Supp. 1998). Alabama law imposes a 10-day limit on nonresident physicians who are called into Alabama in order to treat a patient in consultation with an Alabama physician. See ALA. CODE, § 34-24-74 (West 1998). The Wisconsin legislature recently considered a bill that specifically limited the use of the state's consultation exception to out-of-state providers whose consultations number less than 12 per year or who consult with Wisconsin doctors about fewer than 10 patients. Wisc. Ass. Bill No. 855, 93d Reg. Sess. (1998) (failed to pass).

153. FSMB Model Act, *supra* note 143. The College of American Pathologists has specifically criticized the FSMB Model Act for failing to provide requirements concerning the qualifications of physicians who practice across state lines. See Letter from Raymond C. Zastrow, President, College of American Pathologists, to Dena Puskin (August 28, 1996), reprinted in JWGT 1997 REPORT, *supra* note 9.

154. See, e.g., TEX. ADMIN. CODE, tit. 22, § 174.4 (1997) (prohibiting physicians with special licenses from physically practicing law in Texas).

155. See, e.g., *id.*, tit. 22, § 174.6.

156. Orbach, *supra* note 8, at 47, decries the failure of the FSMB Model to define key terms as a critical shortcoming of the Act which may give rise to inconsistent interpretations by local state medical boards.

157. See, e.g., TEX. ADMIN. CODE, tit. 22, § 174.12 (1997).

above, a health care professional's scope of authorized practice varies dramatically between states.¹⁵⁸ A state which elects to rely on the entry-to-practice standards applicable to nurses in their home states may find some difficulties in coordinating the scope of practice. If the state's scope of practice statute is broader than that of the nurse's home state, there is a risk that a person would be permitted to engage in activities via telemedicine that he or she simply would not be permitted to do in person in his or her home state. If the state's scope of practice regulations are more narrow than those of the nurse's home state, both the state and the nurse must be vigilant to ensure compliance with the state's expectations regarding scope of practice. While the special licensure approach may be workable with respect to non-physicians, special attention would have to be given to drafting the legislation in a manner which ensured that the telemedicine practitioner's scope of practice did not extend beyond that contemplated by his original license.

4. Registration

A third avenue for independent state regulation of telemedicine practitioners is registration.¹⁵⁹ In 1996 California took a step forward in facilitating the practice of telemedicine by out-of-state practitioners when it enacted the Telemedicine Development Act of 1996.¹⁶⁰ The Telemedicine Development Act created three major changes in California law. First, the Act clarified the manner in which telemedicine providers could utilize the consultation exception.¹⁶¹ Second, the Act required the Board of Medicine to propose guidelines for a program that would enable a registered telemedicine practitioner to offer services in California without obtaining a license.¹⁶² The Act specifically barred the Board from implementing the proposal, requiring it instead to provide the outlines of the proposal for consideration by the California legislature.¹⁶³ Third, the Act established the framework for reimbursement of telemedicine practitioners by third-party payors.¹⁶⁴

In many respects, however, existing California law does not differ tremendously from the combination of licensure and consultation requirements applicable in other states. In recognizing that a physician who communicates his diagnosis and plans for

158. See *supra* notes 47-50 and accompanying text.

159. Registration procedures normally require practitioners to indicate their intent to practice a particular profession by registering their names with the relevant government agency. See FRIEDMAN, *supra* note 21, at 144. See, e.g., Wash. H.B. No. 2953, 55th Leg. (1998), which proposes to allow Oregon physicians to register to render health care to economically disadvantaged residents of Washington State without formally obtaining a Washington license.

160. In 1996, the California state legislature enacted the Telemedicine Development Act of 1996 with the intention of enhancing access to health services in "medically underserved rural and urban areas." In the preamble to the Act, the California legislature noted that in June 1995, 49 California counties had been designated by the federal government as having medically underserved areas or populations. The health care providers in such areas were often isolated from colleagues and information resources. The Telemedicine Development Act was designed to facilitate the expansion of telemedicine services in order to increase access to care, decrease the external costs of obtaining care (such as the costs of transport and lost work time) and provide greater access to support resources. 1996 Cal. Legis. Serv. 864, § 1(a)-(c), (i).

161. CAL. BUS. & PROF. CODE § 2060 (West Supp. 1998).

162. *Id.*, § 2052.5(b).

163. *Id.*, § 2052.5(c).

164. CAL. HEALTH & SAFETY CODE, § 1374.13(c), § 1375.1(a)(3) (West 1998); CAL. INS. CODE § 10123.13, § 10123.85(c) (West Supp. 1998) (private insurance); CAL. WELF. & INST. CODE § 14132.72(c) (West Supp. 1998) (Medi-Cal).

treatment through an electronic medium is engaged in the practice of medicine, the Act moots the question of whether telemedicine falls outside the scope of the practice of medicine.¹⁶⁵ Like the Texas Medical Practice Act, however, the Act exempts out-of-state practitioners who consult with practitioners who are licensed in California from the need to obtain a license to practice in California.¹⁶⁶ The newly enacted consultation exception imposes strict limits on the ability of the telemedicine practitioner to provide direct services to California residents.¹⁶⁷ The statute relegates the telemedicine practitioner to the familiar role of a consultant and specifically precludes him from assuming the primary care of the patient.¹⁶⁸ In order to qualify for the exemption, the out-of-state practitioner must consult with an in-state practitioner.¹⁶⁹ Moreover, the telemedicine practitioner is prohibited from opening an office, appointing a place to meet patients, receiving calls from patients within California and giving orders or exercising "ultimate authority" over the care of the patient.¹⁷⁰ Thus, the important link between telemedicine services and patient contact must pass through a fully licensed California practitioner.¹⁷¹ Moreover, the Act requires the in-state practitioner to obtain informed consent from any patient who is directly involved in obtaining care through telemedicine.¹⁷² While telemedicine providers who plan to operate through a California partner may find the newly enacted consultation provisions of the Telemedicine Development Act to be useful, current California law poses serious problems for out-of-state entrepreneurs who do not intend to join forces with a California provider.

The proposed registration program, if enacted, may ease the burden of telemedicine practitioners who wish to operate in California. The Act requires the Board to promote a plan that would permit physicians who are licensed in their home states to register to provide direct telemedicine services in California, rather than limiting themselves to the more modest role of consultant.¹⁷³ The Board is charged with proposing requirements for registration, including licensure in the physician's home state and standards for his education and training.¹⁷⁴ In addition, the Act directs the

165. See, e.g., 1996 Cal. Legis. Serv. 864, § 1(j) (West) (preamble, noting that telemedicine does not change the existing scope of practice of any licensed health professional); CAL. BUS. & PROF. CODE § 2290.5 (West 1998) (definition of telemedicine to be used for procuring informed consent includes diagnosis, treatment, health care delivery, all of which are considered the practice of medicine under California law); *Id.*, § 2052.5(a)(1) (definition of practice of medicine to be used for proposed registration program).

166. CAL. BUS. & PROF. CODE § 2060 (West Supp. 1998).

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. In one sense, the use of the term practitioner is deliberately broad. Under *id.*, § 2290.5(b) (West Supp. 1998), the term practitioner is defined as having the same meaning as the term licentiate.

172. *Id.*, § 2290.5(c). The practitioner is obliged to provide verbal and written information concerning (a) the individual's ability to refuse or withdraw consent at any time without jeopardizing the right to future care, (b) a description of the risks, consequences and benefits of telemedicine, (c) the existence of confidentiality provisions, (d) the patient's guaranteed access to medical information transmitted during the telemedicine consultation and (e) assurances that dissemination of identifiable images or information from the telemedicine interaction shall not occur without the patient's consent. The patient must provide both verbal and written informed consent. The written consent must include the patient's signed statement that he understands the written information and that he has discussed the information with his practitioner.

173. *Id.*, § 2052.5(b).

174. *Id.*, § 2052.5(b)(1).

Board to consider whether registered physicians should be required to submit to California laws concerning the practice of medicine.¹⁷⁵ While a physician who practices telemedicine would easily obtain the right to practice in California simply by registering with the Board, the Act does not seem to contemplate opening the door to a full-fledged practice that includes an active participation by other health care professionals. In particular, in a directive that is not likely to facilitate the widespread use of physician assistants and nurses, the Act suggests that the Board consider a proposal to discipline a registered physician who permits a nurse, physician assistant, medical assistant or other person to engage in acts that constitute the practice of medicine in California under the authority of his registration.¹⁷⁶

B. Category Two: Cooperative State Activity

1. Reciprocity

Cooperation among the states with regard to licensing matters have been in force for many years through the reciprocity model of licensure. Under a reciprocity model, health care providers may obtain a license from any state with which their home state has entered into a reciprocal arrangement.¹⁷⁷ The Texas Medical Board, for example, has the discretion to grant a Texas medical license to a licensee of another state or a Canadian province that requires substantially equivalent entry-to-practice standards and grants reciprocal privileges to Texas physicians.¹⁷⁸

The reciprocity model has many advantages. First, it enables states to enter into arrangements with states whose candidates are likely to have similar or better entry-to-practice credentials.¹⁷⁹ Second, it facilitates long-term relationships between providers in the sister states. Third, it clarifies the role of the disciplinary board.

The reciprocity model is not, however, without its drawbacks. Because it relies on existing statutes, there is no guarantee that any clarification will be achieved with respect to the question of whether a telemedicine practitioner's activities constitute the practice of medicine. Moreover, like the special licensure model, the reciprocity model does not address the differences between state laws regarding the scope of practice. Finally, the reciprocity model does not necessarily respond to the telemedicine practitioner's concerns regarding the expense and delay involved in obtaining a reciprocal license.¹⁸⁰

175. *Id.*, § 2052.5(b)(3)(A).

176. *Id.*, § 2052.5(b)(3)(C).

177. *See, e.g.*, MO. ANN. STAT. § 334.043 (West Supp. 1998) (authorizing board of medicine to enter into reciprocal compacts); PA. STAT. ANN. tit. 63, § 422.27 (West 1996).

178. TEX. REV. CIV. STAT. ANN. art. 4495b, §3.03 (West Supp. 1998).

179. Whether this will lead to a higher standard of care within the state is open to question. There is some empirical evidence suggesting that dental boards in states with reciprocity fail fewer recent dental graduates than dental boards in states without reciprocity. *See Hogan, supra* note 26, at 127, (citing Lawrence Shepard, *Licensing Restrictions and the Cost of Dental Care*, 21 J. L. & Ec. 187, 189 (1978)).

180. The 1998 *Report on Medical Licensure* published in the Journal of the American Medical Association noted that physicians often misunderstand reciprocity arrangements as creating an automatic right to practice medicine in another state. In fact, the *Report* noted that all existing reciprocity arrangements for physician licensure were simply variations of the provisions for endorsement of licenses, which required formal applications and accompanying fees. *Report on Medical Licensure, supra* note 43, at 2000.

2. *Multistate Compact for Mutual Recognition of Licenses: The Proposal of the National Council of State Boards of Nursing*

Perhaps the most innovative solution to the problems of interstate telemedicine practitioners comes from the field of nursing. In order to facilitate interstate practice by nurses, the National Council of State Boards of Nursing (hereinafter NCSBN) recently proposed a system for states to enter into an agreement for the mutual recognition of nursing licenses.¹⁸¹ Although nurses are currently licensed on a state-by-state basis, the boundaries of their practices have been opened not only by the development of telemedicine, but also by hospital systems and managed care organizations that operate in several states. After weighing the potential benefits of a variety of models for dealing with the problem of interstate licensure, the NCSBN developed a proposal for states to enter into compacts to recognize one another's licenses. Under the proposal for multistate licensure, states would voluntarily agree to participate in an agreement that would permit nurses to practice in each of the signatory states without obtaining a separate license in each state. In March 1998, the State of Utah became the first state to enact the Nurse Licensure Compact.¹⁸²

The major analytical contribution of the work of the NCSBN is its acknowledgment that the advent of telemedicine, which embodies the very essence of technological progress, merely restates a problem which predates the Constitution itself: how are the legislatures and the courts to deal with industrial or commercial problems that simply will not confine themselves to the boundaries of the states? In 1925, Professors Frankfurter and Landis posed the problem and its solution in the context of the development of the electrical power industry across state borders:

The integration of the power industry is . . . assuming regional forms. . . . No single State in isolation can wholly deal with the problem. The facts equally exclude the capacity of the Federal government to cover the field. Coordinated regulation among groups of States, in harmony with the Federal administration over developments . . . in the public domain, must be objective. . . . The vehicle for this process of legal adjustment is at hand in the fruitful possibilities inherent in the Compact Clause of the Constitution.¹⁸³

The "fruitful possibility" envisioned by Frankfurter and Landis was the interstate compact. Simply defined, an interstate compact is an agreement between two or more states to resolve problems of common concern.¹⁸⁴ A compact may be formed by the enactment of reciprocal legislation or by the establishment of a joint organization for the purpose of regulation.¹⁸⁵ Although the Constitution authorizes interstate compacts

181. MULTISTATE REGULATION TASK FORCE, COMMUNIQUE, BOARDS OF NURSING APPROVE PROPOSED LANGUAGE FOR AN INTERSTATE COMPACT FOR A MUTUAL RECOGNITION MODEL OF NURSING REGULATION (April 1998) (available at www.ncbsn.org/files/msrtf.html).

182. Utah, S.B. 146 (1998) (enacted) (effective January 1, 2000).

183. Felix Frankfurter & James Landis, *The Compact Clause of the Constitution—A Study in Interstate Adjustments*, 34 YALE L. J. 685, 717 (1925).

184. BLACK'S LAW DICTIONARY 736 (5th ed. 1979). See e.g. *Interstate Agreement on Detainers Act*, 18 U.S.C.A. § 2 (1985 & Supp. 1998) (interstate compact among 48 states, the District of Columbia and the Federal Government enabling a participating state to gain custody of a prisoner incarcerated in another jurisdiction in order to try him on criminal charges).

185. *Seattle Master Builders Ass'n v. Pacific N.W. Elec. Power & Cons. Planning Council*, 786 F.2d 1359, 1363 (9th Cir. 1986), citing *Northeast Bancorp, Inc. v. Board of Gov'rs of the Fed. Reserve System*, 472 U.S. 159 (1985).

only with Congressional consent,¹⁸⁶ the Supreme Court has ruled that a compact that does not "impermissibly enhance state power at the expense of federal supremacy"¹⁸⁷ may go forward without formal Congressional approval.¹⁸⁸ A compact that features reciprocal legislation which a state may unilaterally revoke is not likely to require Congressional consent.¹⁸⁹

Unlike uniform laws,¹⁹⁰ which enable states to enact similarly worded legislation on certain key topics, the focus of an interstate compact is not simply uniformity but also cooperation or, as Frankfurter and Landis called it, "harmony," between the states.¹⁹¹ Interstate compacts have offered creative solutions to problems of "regional

186. U.S. CONST. art. I, § 10, cl. 3. Congressional consent may be express or implied. However, once Congress consents to a cooperative agreement in an area that is an appropriate subject for congressional legislation, the states' agreement becomes federal, rather than state, law. *Cuyler v. Adams*, 449 U.S. 433, 440, 101 S.Ct. 703, 708. *Accord*, *NYSA-ILA Vacation & Holiday Fund & NYSA-ILA GAI Fund v. Waterfront Comm'n of N.Y. Harbor*, 732 F.2d 292 (2d Cir. 1984) (Waterfront Commission Compact to which Congress consented and the subject of which appropriate for Congressional legislation is a federal law and is not preempted by ERISA).

187. *United States Steel Corp. v. Multistate Tax Comm'n*, 434 U.S. 452, 472 (1978).

188. At the heart of the question of whether Congressional approval is required in order to validate an interstate compact lies the balance of authority between state and federal governments. As a recent case explains:

The Compact Clause was drafted at a time when the states were relatively powerful and independent entities. The drafters of the Constitution sought to ensure the supremacy of federal power in interstate affairs. Although the drafters spoke of congressional consent, it is clear that they hoped not just to vindicate the legislative power of Congress, but to protect the power of the entire federal government with the Clause. Indeed, the Supreme Court has since recognized that the Compact Clause required congressional consent for interstate compacts only when the compact infringes upon federal power. *Milk Indus. Found. v. Glickman*, 132 F.3d 1467, 1479 (D.C. Cir. 1998) (Rogers, C.J., concurring).

In *Virginia v. Tennessee*, 148 U.S. 503 (1893), therefore, the Court held that the Compact Clause could not have been intended to require congressional approval in every case of interstate cooperation. Instead, the Compact Clause was intended to prohibit "the formation of any combination tending to the increase of political power in the states, which may encroach upon or interfere with the just supremacy of the United States." In *United States Steel Corp. v. Multistate Tax Comm'n*, 434 U.S. 452 (1978), the Supreme Court upheld the Multistate Tax Compact, an agreement between several states to create uniform standards for the taxation of income generated by interstate businesses. Citing *Virginia v. Tennessee*, *supra*, and *New Hampshire v. Maine*, 426 U.S. 363 (1976), the Court held that the creation of an administrative body to oversee the Multistate Tax Compact should be judged in terms of whether it enhanced State Power at the expense of the federal government. Since the Compact did not authorize the states to exercise any powers that they could not exercise in its absence and permitted each state to withdraw on its own initiative, it could not be said to enhance state powers in a manner that would jeopardize the supremacy of the federal government.

Some areas are so clearly within the power of the state that neither individual nor joint action by the states can be said to threaten the federal government. *See, e.g.*, *Interstate Compact on Mental Health*, PA. STAT. ANN. tit. 62, § 1121 et seq. (West 1996); *New England Compact on Radiological Health*, ME. REV. STAT. ANN. tit. 22, § 751 et seq. (West 1991).

Even in cases where Congressional consent is required and obtained, "it simply means that the states are restored to that much of their original sovereignty as would permit them to enter into compacts with each other." *Tobin v. United States*, 306 F.2d 270 (D.C. Cir. 1962). Congress may also limit the restoration of this sovereignty by conditioning its consent to a compact. *See, e.g.*, *Milk Ind. Found. v. Glickman*, *supra*, at 1472 (Congress did not impermissibly delegate its authority to consent to an interstate compact for minimum prices in the sale of milk when it conditioned consent upon a finding of a compelling public interest in the legislation by the Secretary of Agriculture and limited the duration of its consent).

189. *LAURENCE TRIBE, AMERICAN CONSTITUTIONAL LAW* § 6(33) (1988), citing *Northeast Bancorp, Inc. v. Board of Gov'rs of the Fed. Reserve System*, 472 U.S. 159 (1985).

190. *See, e.g.*, *Uniform Commercial Code*.

191. In *Northeast Bancorp, Inc. v. Board of Gov'rs of the Fed. Reserve Syst.*, *supra* note 188, at 174, the Supreme Court suggested that an interstate compact required such cooperative activity and

concern,¹⁹² such as boundary disputes¹⁹³ or issues pertaining to common natural resources.¹⁹⁴

The technological advances that have made the development of telemedicine possible have now enabled farflung states to share both concerns about and responsibilities for the quality of care rendered through communications technology. Although telemedicine redefines the concept of "regional concerns," the starting premise—that independent states might have a mutual interest in regulating a common problem—is still valid. The Multistate Tax Compact and similar tax and business oriented legislation offers precedent for an interstate compact between states whose concerns are based on the common denominator of shared business concerns rather than shared geography.¹⁹⁵

The Nurse Licensure Compact, unveiled by the NCSBN in January 1998, is one example of how an interstate compact might be used to resolve licensure issues. The Compact is designed to permit states to regulate nurses who practice telemedicine without relying on the idiosyncracies inherent in state licensure laws.¹⁹⁶ Under the terms of the Nurse Licensure Compact, a registered nurse or a licensed practical nurse who holds a license in his state of residence will be recognized as holding a multistate licensure privilege that permits him to practice in any state that has adopted the compact.¹⁹⁷ A multistate licensure privilege is defined as "current, official authority from a remote state permitting the practice of nursing as either a registered or a licensed practical/vocational nurse in such party."¹⁹⁸ A nurse who holds a license from a party state need not (and, in fact, may not) obtain a license from any other party state in order to practice within its borders.¹⁹⁹ Nurses who do not reside in a state that has adopted the compact do not enjoy the benefits of the multistate licensure privilege and must continue to apply for licensure in the traditional manner.²⁰⁰ In essence, a state that adopts the Compact agrees to waive its traditional entry-to-practice standards for licensees of party states, but continues to enforce those standards with respect to nurses who apply for their initial license within the state or who do not reside in a party state at the time they apply for licensure.

could not be found when reciprocal state statutes were not conditioned on action by other states.

192. For a good discussion of the use of interstate compacts to resolve regional issues, see Carlton James Gausman, Comment, *The Interstate Compact as A Solution to Regional Problems: The Kansas City Metropolitan Culture District*, 45 U. KAN. L. REV. 897 (1997). On the difficulties implicit in the interstate compact process, see Stephen David Galowitz, *Interstate Metro-Regional Responses to Exclusionary Zoning*, 27 REAL PROP. PROB. & TR. J. 49, 118-23 (1992).

193. Frankfurter & Landis, *supra* note 184, at 705.

194. See Marlissa S. Brigggett, Comment, *State Supremacy in the Federal Realm: The Interstate Compact*, 18 B.C. ENVTL. AFF. L. REV. 751 (1991).

195. Interstate compacts that deal with adoption practices are also based on common interests that are not specifically geographic in focus.

196. For materials related to the Nurse Licensure Compact, see the website maintained by the National Council of State Boards of Nursing, available at <<http://www.ncsbn.org>>.

197. Nurse Licensure Compact, *supra* note 12, art. III, § (a). The Nurse Licensure Compact does not exempt a nurse from complying with the requirements for licensure as an advanced practice registered nurse. However, a registered nurse may exercise her multistate licensure privilege in order to satisfy any preconditions to obtaining authorization to practice as an advanced practice registered nurse. *Id.*, art. III, § (d).

198. *Id.*, art. II, § (g).

199. *Id.*, art. IV, § (b). Article IV of the Compact includes specific provisions governing the licensure status of a nurse who relocates.

200. *Id.*, art. III, § (e).

In addition to providing a mechanism to enable nurses to gain the right to engage in interstate practice, the Nurse Licensure Compact also coordinates disciplinary activity. In all respects but one, the nurse's primary state of residence (known as the "home state") and the state in which the patient is located (known as the "remote state") retain their traditional disciplinary prerogatives. The home state's obligation to enforce its disciplinary standards continues to apply to actions that the nurse takes within the home state and, in some cases, extends to conduct that is reported from the remote state.²⁰¹ In addition, the Compact authorizes the remote state to regulate and discipline the manner in which the nurse conducts her duties, thus enabling the remote state to retain its traditional prerogative to regulate its health care workers.²⁰² A nurse who offers his services in a remote state must therefore comply with that state's practice laws and submit to the jurisdiction of its licensing board and courts.²⁰³

While the Compact retains most substantive aspects of each state's traditional disciplinary procedures, the disciplinary authority of the remote state does not extend beyond its own borders. The remote state may limit or revoke a nurse's multistate licensure privilege within its borders in order to "protect the health and safety of citizens."²⁰⁴ The remote state is not authorized, however, to take action against the license that was originally issued by the nurse's home state. At first blush, this limitation may seem to diminish the capacity of the remote state to remove or admonish nurses whom it deems incompetent or in violation of its disciplinary code. Yet, the limitation is in keeping with the essence of traditional licensure laws, which have never authorized one state's licensure board to revoke a license issued by another state. The remote state's authority to prohibit the nurse from functioning within its borders is no less effective than it would be in the absence of the Compact. The home state retains the exclusive right to revoke its own license and, by extension, to unilaterally terminate the nurse's ability to practice in other party states.²⁰⁵

The Compact relies on the sharing of information as a critical component of its disciplinary process. Under the terms of the Compact, each state must share information concerning disciplinary actions with other party states through a centralized information system known as the Coordinated Licensure Information System.²⁰⁶ While the remote state's disciplinary sanctions extend only to the nurse's ability to practice within that state, it is required to report any such disciplinary action to the Coordinated Licensure Information System.²⁰⁷ Although the remote state may not actually revoke the nurse's primary, home-state license, referral to the Coordinated Licensure Information System insures that the licensure board of the home state is apprised of the disciplinary action imposed by the remote state.²⁰⁸ Moreover, the home state is bound to treat a remote state's account of the nurse's reported conduct in the same manner that

201. *Id.*, art. V, § (d).

202. *Id.*, art. III, § (b); art. III, § (c); art. V, § (c).

203. *Id.*, art. III, § (c).

204. *Id.*, art. III, § (b).

205. *Id.*, art. V, § (c).

206. *Id.*, art. V, § (a); art. III, § (b). The "Coordinated Licensure Information System" is defined as "an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities." Article II, § (c).

207. *Id.*, art. V, § (a).

208. *Id.*, art. V, § (c).

it would treat such conduct had it occurred in the home state.²⁰⁹ In investigating and allegations of disciplinary violations, each state is required to follow its own established procedures.²¹⁰ However, the Compact also provides that subpoenas issued by a nurse licensing board in a party state shall be enforced in any other party state.²¹¹

The interstate compact model answers some of the major problems raised in connection with the individualized, idiosyncratic approach favored by proponents of full licensure. It also resolves some of the contradictions that arise from the current cooperative approaches embodied in the notions of reciprocity and endorsement. The NCSBN itself has analogized its own model Compact to the interstate cooperative system with respect to driver's licenses: any driver who is licensed in one state may drive in another state without obtaining a license, as long as he obeys local laws for the operation of motor vehicles. Depending on the features on which interstate cooperation may be reached, an interstate compact for the mutual recognition of professional licenses could prove attractive to health care workers who plan to offer services across state lines, while offering states the opportunity to uphold the bulk of their laws monitoring the quality of the services rendered by these out-of-state workers. From the perspective of the health care worker, eliminating the need for separate licensure (whether through full licensure, special licensure or endorsement) eases the administrative burdens that currently restrict access to another state's markets.

When viewed in terms of the state's objectives of assuring quality control, a compact similar to the Nurse Licensure Compact preserves the state's autonomy in designing scope-of-practice regulations, disciplinary standards and malpractice laws. Although, in particular, the Nurse Licensure Compact requires a party state to accept the entry-to-practice standards of other states (regardless of whether the licensees of other states would meet its own criteria), this approach is not a necessary component of an interstate compact and could be altered to suit the needs of other health care professions. For example, in theory, an interstate compact could be designed to require compliance with uniform entry-to-practice standards before a person would become eligible for recognition of his home license by other member states.

The concept of a multistate compact is not without its critics. While the Nurse Licensure Compact is only one example of the manner in which an interstate compact could be drafted, it serves to illustrate the difficulties that may arise with respect to any effort to engage the states in cooperative activity. The chief criticisms levied against the Nurse Licensure Compact focus on its potential effect on quality standards within the nursing profession and infringement on the rights of individual nurses.²¹²

In particular, one area in which the Nurse Licensure Compact is vulnerable to criticism is in the area of quality control. As it stands, the Compact does not require contracting states to adopt uniform standards for entry to practice or for the scope of

209. *Id.*, art. V, § (d).

210. *Id.*, art. V, § (e).

211. *Id.*, art. VI, § (b).

212. Criticism has come from within the nursing profession as well as from other sources. In May 1998, for example, the National Council of State Boards of Nursing issued a statement to each of the governors and attorneys general of the fifty states in response to criticisms brought by the National Association of Pediatric Nurse Associates and Practitioners. For the National Council's defense of the Compact in light of these criticisms, see NATIONAL COUNCIL ST. BDS. NURSING, INC., *NURSE LICENSURE COMPACT: SETTING THE RECORD STRAIGHT* (1998) (<<http://www.ncsbn.org/files/msrtf.html>>) [hereinafter *SETTING THE RECORD STRAIGHT*].

practice, an accomplishment that would itself take much political persuasion. Indeed, a state that adopts the Compact may be able to study the practice standards of states that have already approved the Compact, but it effectively agrees to accept a reciprocal relationship with any subsequent state that enters the Compact without having the opportunity to review its practice standards.²¹³ While each state retains the prerogative to deny a nurse the right to practice within its borders,²¹⁴ a blanket refusal to recognize the licenses of nurses whose home states have different or lower entry-to-practice standards would challenge the very goal of the Compact itself—harmonious cooperation among the states. Moreover, even if uniform standards were adopted, there is no guarantee that the consensus produced as a result of negotiations within and between individual states would produce standards that were superior to those currently in effect. The Federation of State Medical Boards in particular has expressed its concern that mutual recognition “leads us down the path to licensure at the lowest common denominator.”²¹⁵ A second area of concern has to do with the information problems that will be faced by nurses who take advantage of the Compact’s licensure provisions in order to practice in multiple jurisdictions. Each nurse will bear the considerable burden of determining the difference between the scope of practice regulations in effect in each jurisdiction. The effective implementation of the Compact will require the development of information systems that are designed to assist such nurses in judging the parameters to which they must confine their practices in each state.

A third criticism that might be levied against the Compact is the strong preference given to the state licensing boards, perhaps at the expense of the individual nurses who may be subject to disciplinary actions. “Adverse actions,” including “any administrative, civil, equitable or criminal action” and other “injunctive or equitable orders,” must be reported to the central information reporting system.²¹⁶ Moreover, a state must also report “any significant current investigative information yet to result in a remote state action.” Thus, a nurse may find that the Coordinated Licensure Information System has opened and made available to other licensing agencies’ files on activities that have not been the subject of final administrative action.²¹⁷ In the face of a clause which grants immunity to states, licensing boards and their employees, officers or agents,²¹⁸ the assurance that due process will be observed is likely to be of little comfort to a nurse who has yet to defend himself against charges.²¹⁹ Many of the

213. The NCSBN has noted that some critics have suggested that this feature could lead to “forum shopping”, whereby a nurse could seek out a state with lower entry-to-practice requirements and then use the Compact’s provisions for mutual recognition to enable her to practice in states with more rigorous standards. The NCSBN’s response to this criticism suggests that by requiring nurses to obtain licensure in the state of residence, forum shopping would require relocation of one’s principal residence and is therefore “impossible.” *Id.* But for the assertion that entry-to-practice standards are increasingly uniform within nursing, this response seems disingenuous and begs further empirical research to determine whether less qualified nurses do in fact seek residence in states with lower licensure standards.

214. Nurse Licensure Compact, art. III, § (b).

215. FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC., REFORMING HEALTH CARE WORKFORCE REGULATION: POLICY CONSIDERATIONS FOR THE 21ST CENTURY. RECOMMENDATIONS FROM THE PEW TASKFORCE ON HEALTH CARE WORKFORCE REGULATION. THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC. RESPONSE 5 (December 1996).

216. Nurse Licensure Compact, art. §§ (a), (e), (k); art. V §§ (a), (b).

217. *Id.*, art. VII, § (b).

218. *Id.*, art. IX.

219. See, e.g., SETTING THE RECORD STRAIGHT, *supra* note 213 (“the due process rights of all

criticisms that have been made concerning the Health Care Quality Improvement Act and other data-collecting clearinghouses may also be of concern with respect to the Compact. The speed and accuracy of data transmission will have a significant effect on the efficacy of coordinated state efforts to root out incompetent nurses and on the ability of nurses to challenge unfounded or unwarranted disciplinary actions.

Despite these criticisms, the Compact offers a workable model for resolving the problems of telemedicine practitioners. The Compact now offers a model that permits an integrated approach to licensing telemedicine practitioners without sacrificing the states' ability to decide for themselves the scope of practice and the standards of practice that will be tolerated within their borders. A nurse who is licensed in his home state may perform telemedicine services in a remote state without fear of discipline for practicing medicine without a license. A state that carefully crafts its scope of practice rules will be able to accomplish many of its quality control interests, even though it may not specify the entry-to-practice standards applicable to the nurse. Moreover, the nurse will be subject not only to the malpractice laws in effect in that jurisdiction, but also to the disciplinary requirements of the licensure statutes.

C. Category Three: National Solutions

Federal legislation may offer a uniform solution to the problems faced by telemedicine practitioners who offer services in several different states. The Joint Working Group on Telemedicine notes two distinct solutions which might be offered by federal legislation.²²⁰ First, Congress could enact national minimum standards for the licensure of physicians (and, presumably, for other health care professionals), which the states would be free to amplify.²²¹ Second, Congress could enact federal legislation which would enable health professionals to obtain a federal license that would be valid in each of the fifty states, regardless of the independent requirements of individual state or local laws.

Although the states have traditionally stood in the limelight of health care regulation, the federal government has always played a supporting role and, in recent years, Congress and the Executive Branch have seem poised to upstage the states in regulating health care affairs. The federal government's role in regulating health care originates, in a legal sense, in Congress' power to regulate interstate commerce and, in a practical sense, in the increasing significance of the federal government as provider of medical services to veterans and military personnel and as a third-party payor through the Medicare and Medicaid programs. Congress has seen fit to exercise its authority in the realm of health care finance²²² and has exercised considerable influence in using

nurses, as well as the due process obligations of each state, are unchanged by the Compact").

220. JWGT 1997 REPORT, *supra* note 9, at 40-41. See also Huie, *supra* note 9, at 406-07. For an interesting analysis of national and federal licensure in the context of the "new Federalism," see Vyborny, *supra* note 2, at 96-105.

221. As the JWGT 1997 REPORT also notes, the same goal could be achieved by agreement among the states. JWGT 1997 REPORT, *supra* note 9, at 40. In this respect, national licensure standards would resemble the mutual recognition model embodied in the Nurse Licensure Compact.

222. In many respects, the Congressional legislation which had the most notorious impact in the area of health care finance simply negated state control of a large portion of the health care finance market. By enacting the Employee Retirement Income Security Act of 1974, for example, Congress effectively exempted self-insured employer-sponsored health insurance plans from most forms of state regulation. See 29 U.S.C.A. §1001 et. seq. (West 1985 & Supp. 1998). In recent years, Congress has exercised control that reaches these plans, as well as more traditional forms of insurance, by enacting

the Medicare and Medicaid programs to set standards that are often emulated by the rest of the health care industry.

One model for a federal licensure scheme operating with preemptive force is already in existence. The Veterans Administration, the Bureau of Indian Affairs and the United States military have all implemented programs that enable licensed physicians to offer services without obtaining local licenses. Under military law, for example, a health care professional who is a member of the armed forces and holds a valid license issued by a state, the District of Columbia or a commonwealth, territory or possession of the United States may practice his profession anywhere in the United States.²²³ This liberty extends to physicians, dentists, clinical psychologists, nurses and any other person designated by the Secretary of Defense as being engaged in direct patient care.²²⁴ Such a person may offer his services in a military hospital or a civilian hospital affiliated with the Department of Defense, but he may not act independently as a health care professional unless he is independently licensed to do so.²²⁵ Thus, military law and regulations offer a health care professional the opportunity to extend his practices beyond the geographic limitations of his original licenses for the primary purpose of providing care to military personnel.²²⁶ The military license borrows the quality assessment of the state in which the health care professional was originally licensed and, in a sense, allows those standards to preempt the local standards in force in the jurisdiction where he may actually render services.

In a practical sense, the telemedicine practitioner has much to gain from a full-fledged federal licensure scheme, whether it is fashioned after the preemption model applicable to the military or enacted in the more limited form of imposing baseline national standards. By obtaining a federal license that is enforceable in all jurisdictions, the telemedicine practitioner would be able to avoid the administrative burden of obtaining licenses in every jurisdiction in which he offers services. Moreover, if the need to obtain a license in each jurisdiction in which he practices were eliminated, he would enjoy a greater degree of flexibility in his practice with the confidence that his compliance with basic quality standards was assured. While it is unlikely that a federal licensure scheme would enable a telemedicine practitioner to physically practice medicine in every state in the Union, it would go a great deal further than any other proposal in facilitating the practitioner in setting up a national practice.

The states themselves may conceivably benefit from the enactment of a uniform, federal license for telemedicine practitioners. By eliminating a significant barrier to the practice of telemedicine, federal licensure standards may increase access to health care. A state which experiences some difficulty in attracting health care professionals to serve its rural population or residents of its medically underserved areas might benefit from the expanded use of telemedicine. Moreover, in theory, the population served by telemedicine practitioners who offer services in medically underserved areas may benefit by receiving services from highly qualified telemedicine practitioners who are willing to work, but not live, in their locale. Local practitioners would be able to enlist the

legislation such as the Newborn and Maternal Health Protection Act, as well as the Health Insurance Portability and Accountability Act.

223. 10 U.S.C. § 1094(d) and (e)(1) (West 1998).

224. 10 U.S.C. § 1094(e)(2) (West 1998).

225. 10 U.S.C. § 1094(a) and (d)(1) (West 1998).

226. See 32 C.F.R. § 728.1 (1998).

aid of telemedicine specialists or out-of-state paraprofessionals without the difficulties imposed by current licensure laws. In theory, higher national standards for entry-to-practice may translate to a higher standard of practice through easier access to state markets and enhanced competition.

On the other hand, the state has more to lose from a federal proposal. The transfer of licensure authority to the federal government and/or compliance with national standards of licensure may be distasteful to state legislatures jealous of their sovereignty.²²⁷ First and foremost, in order to function effectively, federal licensure would need to preempt state licensure requirements with respect to telemedicine practitioners. If federal licensure were imposed, the states would lose their ability to set the quality standards applicable to physicians and other health care professionals who practice within their borders. Even if Congress were to enact the less intrusive proposal for baseline national standards, the states would lose their ability to judge whether local conditions might justify lesser entry-to-practice standards. The loss of authority in licensure could also drain the state's ability to regulate the manner in which a particular profession is practiced. Unless carefully crafted, federal licensure could disturb the state's judgment about the scope of practice permissible within each licensed profession. Finally, any proposal to create a federal licensure scheme would also have to examine the traditional role of the states in disciplining physicians and other health care professionals for violations of professional standards.

V. Conclusion

At the turn of the twentieth century, states turned to licensure as a means of ensuring that their citizens could expect a minimum level of competence from their physicians. Communications technology has come of age during this century and, in telemedicine, as in so many fields, that technology is now pressing a new set of questions before the states. When a state considers whether and how to license telemedicine practitioners, however, its basic concern should be a familiar one: how best to protect the health of its citizens. A new answer to this familiar question may be found in the concepts that make telemedicine possible. If a physician and his patient may communicate across borders, why should the states not do the same? An integrated, cooperative approach to the licensure of telemedicine practitioners should be the states' approach to the concerns of their citizens.

227. Orbuch, *supra* note 8, at 46, reports that the Western Governors' Association opposes transferring the responsibility for licensure to the federal government and believe that it is possible for the states to reach a cooperative solution.

