

A BOLD STEP: WHAT FLORIDA SHOULD DO CONCERNING THE HEALTH OF ITS RURAL COMMUNITIES, LICENSURE, AND TELEMEDICINE

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I. INTRODUCTION

In a rural Oregon community a local doctor treated a patient for more than three years for the same skin condition.¹ The doctor did not consult a dermatologist because the community did not have such a specialist to consult.² When telemedicine was introduced to the area, information and photographs of the patient's skin condition were transmitted to a dermatologist via the Internet. As a result, the doctor prescribed the correct treatment, and the condition cleared up in one week.³ Telemedicine made the difference between sickness and health for the patient.

Telemedicine is "the delivery of health care and sharing of medical knowledge over a distance using telecommunications systems."⁴ Telemedicine entails a wide range of interactions including phone calls; teleconferencing; the Internet; and sophisticated machines that allow for transmission of pulse oximetry, respiratory flow data, and blood glucose monitoring.⁵ Most programs provide either video-mediated clinical consultations or "store-and-forward" technology.⁶ Few telemedicine programs include both types of technology.⁷ The most common usage of telemedicine is teleradiology using the "store-

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1. See Vera Tweed, *The Brave New Reality of Telemedicine*, BUS. & HEALTH, Sept. 1998, at 34.

2. See *id.*

3. See *id.*

4. Steven W. Strode & Susan Gustke, *Technical and Clinical Progress in Telemedicine*, 281 J. AM. MED. ASS'N 1066, 1066 (1999).

5. See *id.* at 1067; see also Linda C. Fentiman, *The Legal Questions From Telemedicine, Five Major Issues Emerge*, N.Y. L.J., Aug. 3, 1998, at 7.

6. Strode & Gustke, *supra* note 4, at 1067.

7. See *id.*

and-forward” technology: about 250,000 teleradiology studies were done in 1997.⁸ The busiest medical specialties using these “store-and-forward” teleconsultations were psychiatry (17.9%), cardiology (16.7%), ophthalmology (9.6%), and orthopedic (5.7%).⁹ Advocates claim telemedicine has the potential to “dramatically expand access to quality health care, eroding the barriers of distance, time, money and language that prevent people in medically under-served rural and urban areas from receiving state-of-the-art diagnosis and treatment.”¹⁰

Recognizing the importance of telemedicine, Dr. Guillermo Gutierrez spent two years creating a company that enables doctors and patients outside the United States to communicate with doctors in the United States.¹¹ Dr. Gutierrez began the project to help people he met while travelling throughout Latin America.¹² The company, VistaLink, employs a computer program that matches patients with the best physician available on a company-maintained list.¹³ The program pages a physician, and the physician has two hours to accept the patient’s case.¹⁴ If the first doctor does not take the case, VistaLink contacts the next doctor on the list. Finally, the doctor who accepts the case types a recommendation and sends it electronically to the patient’s personal doctor.¹⁵ The VistaLink program is efficient and easy to use. Because the information is transferred to doctors outside the United States, it avoids the legal issues that plague the domestic use of telemedicine.¹⁶

The National Information Infrastructure set up a hypothetical scenario to demonstrate the potential for telemedicine, on September 20, 1994.¹⁷ The hypothetical involved a Maryland woman, injured in a car collision in Southern California. The group created a communication link between a small California facility and Maryland’s John Hopkins Medical Center to demonstrate how the diverse equipment and systems could be linked to transmit patient information, including the woman’s radiology scans and health care identification card.¹⁸ Doctors helped the hypothetical woman through the use of advanced

8. *See id.*

9. *See id.* at 1066.

10. Fentiman, *supra* note 5, at 7.

11. *See* Ruth Sorelle, *Vision for the Future, Medicine On-Screen*, HOUS. CHRON., July 5, 1998, available in 1998 WL 3586741.

12. *See id.*

13. *See id.*

14. *See id.*

15. *See id.*

16. *See id.*

17. *See* Robin Elizabeth Margolis, *Law and Policy Barriers Hamper Growth of Telemedicine*, 11 HEALTHSPAN 14, 14 (1994).

18. *See id.*

telemedicine technology.¹⁹ The example demonstrates the vast potential telemedicine offers to people worldwide.

While telemedicine's potential is exciting and promising, many legal barriers prevent its use and expansion in the United States. In particular, state-based licensure systems impede the use and spread of telemedicine.²⁰ Supporters of telemedicine criticize states that require full licensure for physicians practicing telemedicine in their state. For instance, Dr. James S. Logan, former treasurer of the American Telemedicine Association, called state medical licensure a "toll road" and "a dinosaur that is ill-equipped to deal with the real world."²¹

Many proponents of telemedicine criticize recent moves by states that restrict the practice of telemedicine through strict licensure laws; yet, the majority of states appear to be heading toward such restrictions. Part II of this Comment examines Florida's need for adequate medical facilities in many rural areas and proposes that telemedicine may be the answer. Part III addresses Florida's current licensure law and a proposed licensure bill that died in committee during the 1999 Legislative Session. Part IV explains different licensing approaches to telemedicine and the approaches several states presently take. Finally, Part V suggests how states, specifically Florida, can best protect and serve its rural population's health needs by moving toward a less restrictive licensure regime.

II. FLORIDA'S RURAL COMMUNITIES

Baker County is one example of a rural Florida community desperately needing medical facilities and physicians. Baker County leads Northeast Florida in the percentage of people living below the poverty line and has the lowest per capita income.²² There is no obstetrician in the county and no hospital where a woman can have a baby.²³ About half the women see a public nurse practitioner in the county health department; the other half see a private nurse practitioner or do not receive prenatal care.²⁴ In this day, one would assume that all women in Florida at least have access to an obstetri-

19. *See id.*

20. *See* Alison M. Sulentic, *Crossing Borders: The Licensure of Interstate Telemedicine Practitioners*, 25 J. LEGIS. 1, 3 (1999) (discussing the problems with the current state-based licensing system and the need for a cooperative approach to licensure between the states); *see also* Center for Telemedicine Law, *Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force*, 73 N.D. L. REV. 109, 124 (1997) [hereinafter *CTL Task Force*] (discussing how patients will be harmed by the "chilling effect" that state licensure laws impose on telemedicine consultations).

21. Sorelle, *supra* note 11.

22. *See* Marcia Mattson, *Beyond Care: Medical Services Not Reaching Towns*, FLA. TIMES-UNION, Feb. 16, 1999.

23. *See id.*

24. *See id.*

cian. However, Baker County not only needs adequate prenatal care specialists, but also family doctors, specialists, physical therapists, pharmacists, dentists, and other health care workers.²⁵ In most categories, Baker County ranks in the bottom third in the ratio of residents to medical providers.²⁶ Alarming, Baker County is one among many tragic examples of the healthcare shortages in Florida. Liberty County, for instance, ranks last, with one physician for its 6500 residents.²⁷

The health department in Baker County provides most of the health services, including immunizations, primary care to adults and children, and dental care. The health department wants to triple its size and create more space to treat people.²⁸ Even so, more space will not solve the problem if the facility does not attract more physicians. The only hospital in the area does little more than emergency care and does not perform procedures requiring more than a one-night stay.²⁹ The most serious problem, however, arises when a patient needs a specialist. In such cases, the patient is usually referred to Jacksonville, but because most Baker County residents do not drive or have access to a car, the trip is impossible. The director of the health department, Kerry Dunlavey, explained that "if you diagnose something, then what do you do? . . . We need an affordable referral system for clients who need specialty care."³⁰

Florida does not yet have an active telemedicine program, which would allow specialists to consult with doctors via satellite.³¹ Telemedicine could make a significant difference by meeting the health needs of the rural population in Florida.

Telemedicine offers more to rural communities than just consultations. Telemedicine also allows doctors to supervise treatment and conduct examinations remotely, "instantly bridging the gap between the demand for care in rural settings and the larger supply of physicians in urban settings."³² Moreover, telemedicine may provide incentive for doctors to locate in rural areas.³³

25. *See id.*

26. *See id.*

27. *See State Ready for Boomer's Medical Needs Medical Experts Say Florida Can Handle Retirees*, FLA. TODAY, Jan. 25, 1999, at 6B.

28. *See Mattson, supra* note 22 at A1.

29. *See id.*

30. *Id.*

31. *See id.*

32. Daniel McCarthy, *The Virtual Health Economy: Telemedicine and the Supply of Primary Care Physicians in Rural America*, 21 AM. J.L. & MED. 111, 112 (1995).

33. A number of factors motivate doctors to choose a geographic location. *See id.* Income level, professional status and prestige, the availability of continuing education, professional contact, and the physician's geographic origin all influence a physician's decision to locate to a particular area. All of these factors normally weigh against rural communities. In rural communities doctors generally have lower income levels, typically have less recognition from the medical community, may suffer from a sense of isolation, and have

Telemedicine can diminish the problems associated with rural medical practice. First, telemedicine consultations allow physicians to have more contact with the professional community, which lessens the sense of isolation a rural physician faces.³⁴ Second, telemedicine already successfully provides continuing education programs to rural physicians.³⁵ Third, by keeping rural patients and their money in community hospitals, telemedicine may improve the economic viability of rural hospitals and increase the economic health of rural communities.³⁶ Physicians' incomes might increase, because more money in the community and better facilities enables more residents to obtain adequate health care in their own community. Rural hospitals and facilities are hurt when rural patients must seek medical care outside of the community.³⁷

Furthermore, telemedicine may be capable of paying for itself "because it allows rural physicians to treat patients locally who would otherwise have to spend money to travel to urban areas."³⁸ The money patients save by not travelling is kept in the community. One commentator concluded: "A small hospital might be able to recover its costs in three years if one additional patient a day is attracted to the hospital."³⁹ A 14% decrease in "costs for patient transfer and provider travel" is observed, in contrast to "traditional health delivery costs."⁴⁰ As the technology becomes more readily available the costs decrease while the benefits increase.⁴¹ While it is true that rural communities have the least resources to pay for telemedicine technology, the possibility of telemedicine paying for itself seems promising, especially not that Medicaid reimburses some telemedicine uses.⁴²

the burden of travelling for required continuing education. Also, more medical students are from urban settings rather than rural; as such, they are more likely to want to work in an urban community. *See id.*; *see also* Christopher J. Caryl, *Malpractice and Other Legal Issues Preventing the Development of Telemedicine*, 12 J.L. & HEALTH 173, 176 (1998) (stating that a recent survey found 23% of rural physicians unsatisfied with their position and planning to leave).

34. *See* Caryl, *supra* note 33, at 177.

35. *See* McCarthy, *supra* note 32, at 127.

36. *See* Caryl, *supra* note 33, at 178; *see also* McCarthy, *supra* note 32, at 128.

37. *See* Caryl, *supra* note 33, at 178. A rural hospital in Ohio asserts that telemedicine allows the hospital to retain more patients because consultations with outside physicians often determine that the rural physician's medical care is satisfactory. Additionally, the Eastern Montana Telemedicine Network kept 98.7% of its patients during its second year of operation. *See id.*

38. McCarthy, *supra* note 32, at 128.

39. *Id.*

40. *Id.*

41. Interactive video equipment in 1992 cost more than \$100,000. Today the same technology can be purchased for less than \$20,000, and it has more capabilities. *See* Strode & Gustke, *supra* note 4, at 1066.

42. *See* Health Care Financing Administration, *Medicaid and Telemedicine* (last modified Mar. 31, 1999) (visited May 28, 2000) <<http://www.hcfa.gov/medicaid/> tele-

While state-based licensure systems do not bar the development of intrastate telemedicine systems, they do raise serious obstacles to interstate telemedicine practice. Florida could begin solving their rural health care problems by creating an intrastate telemedicine system; however, if telemedicine is really to flourish and the health care industry is to begin supporting the use of telemedicine, physicians must not be restricted to intrastate practice. By placing a barrier to interstate commerce, the spread of telemedicine is restricted and the medical industry is less likely to see the financial advantage behind it. In addition, often the necessary or best medical specialist is not located within a patient's state. As a result, intrastate restrictions may deprive patients of the best available health care and treatment.

III. FLORIDA'S LICENSURE LAW

All fifty states have laws governing the medical profession, including physician licensure.⁴³ States derive this power under the Tenth Amendment of the United States Constitution, which allows the states to enact legislation pursuant to their police power to protect the health, safety, and general welfare of their people.⁴⁴ In 1889, the United States Supreme Court specifically found that the State of West Virginia had the right to license physicians.⁴⁵

Current Florida physician licensure statutes do not specifically address telemedicine. Several bills were proposed during the 1999 and 2000 Legislative Sessions addressing telemedicine, a practice the Florida Legislature refers to as telehealth. However, the only bill that passed was 1999 House Bill 2125, creating a telehealth task force.⁴⁶ The bill provides the intent of the legislature to "protect the health and safety of all patients in this state receiving services by means of such technology [telemedicine] and to ensure the accountability of the health care professions with respect to unsafe and incompetent practitioners using such technology to provide health care services to patients in this state."⁴⁷ The bill also proposes that the task force recommend the appropriate level of regulation, including an analysis of the current licensure law.⁴⁸ Additionally, the task force

med.htm> (stating that Medicaid reimbursement for medical services supplied through telemedicine technology is available at the state's option as a more cost-effective alternative).

43. See *CTL Task Force*, *supra* note 20, at 113.

44. See U.S. CONST. amend X; see also Sulentic, *supra* note 20, at 4 (discussing the power).

45. See *Dent v. West Virginia*, 129 U.S. 114, 122 (1889) (finding that West Virginia had the right to license physicians).

46. See Fla. HB 2125, § 175 (1999).

47. Fla. HB 2125, § 175(1) (1999).

48. See Fla. HB 2125, § 175(3)(c) (1999).

looked at the effect of telemedicine on rural health care.⁴⁹ The task force reported to Florida's legislature and executive branch on Jan. 1, 2000, setting the tone for determining future legislative action on telemedicine and licensure.⁵⁰ Due to the creation of the task force, this year is important for Florida in its determination of what future steps will be taken regarding telemedicine and licensure.

Florida licensure law is fairly stringent. It requires the applicant pay not more than a \$500 application fee; be at least twenty-one years old, have good moral character; have no offense of record which would be a basis for physician discipline; have completed two years of pre-professional, postsecondary education; meet further medical education and postgraduate requirements; pass the Federation of State Medical Boards' exam; and submit fingerprints.⁵¹ These requirements are fairly similar to other states licensure laws.⁵² The purpose of physician licensure is to protect the public from the "potentially dangerous" practice of medicine "if conducted by unsafe and incompetent practitioners . . . [and] to ensure that every physician practicing in this state meets minimum requirements for safe practice."⁵³

The *Florida Statutes* also provide for licensure by endorsement. This happens when a Florida license is issued to a physician licensed to practice in another jurisdiction.⁵⁴ However, the applicant must meet most of the qualifications for licensure under the first section of the traditional licensure statute and may also be required to take and pass the appropriate licensure exam.⁵⁵ Practically, then, a licensure by endorsement is no easier to receive than a traditional license under section 485.311.

Florida also provides a licensing exception for physicians licensed in other jurisdictions when they consult with a licensed Florida physician.⁵⁶ Lastly, Florida only allows Florida licensed physicians to order electronic-communications diagnostic-imaging services from a person outside the state.⁵⁷ Thus, the use of telemedicine dealing with electronic images, such as teleradiology, is lawful as long as a Florida licensed physician orders the service.

During the 1999 Legislative Session, a bill was introduced that would require any physician, exerting primary authority over the

49. See Fla. HB 2125, § 175(3)(e) (1999).

50. See Fla. HB 2125, § 175(4) (1999).

51. See FLA. STAT. § 458.311 (Supp. 1998).

52. Basic requirements for practicing medicine have become fairly uniform. Most states require graduation from an accredited medical school, a uniform licensing examination, postgraduate experience requirements, and a centralized credentials verification system. See *CTL Task Force, supra* note 20, at 113.

53. FLA. STAT. § 458.301 (1997).

54. FLA. STAT. § 458.313 (1997).

55. See *id.*

56. See *id.* § 458.303.

57. See *id.* § 458.3255.

care and diagnosis of a patient located in Florida to obtain a license as provided under the *Florida Statutes*.⁵⁸ If the physician engages in a consultation with a Florida licensed physician and does not have “primary authority over the patient’s care and diagnosis,” then the physician is exempt from licensure.⁵⁹ Finally, the bill proposed that any physician who supplies ongoing, regular, official, authenticated interpretations of radiographic images to any health care person in Florida, be considered to exert primary authority over the patient and, thus, be required to be licensed in Florida.⁶⁰ However, the bill died in committee, as did similar proposals in the 2000 Legislative Session. This is fortunate because the bill would have imposed difficult barriers to the spread of interstate telemedicine and would have created endless litigation attempting to determine what constitutes primary authority of care and diagnosis over a patient. This lack of clarity would probably also cause a chilling effect as physicians seeking consultation decided that trying to determine when a consultation might be considered “primary authority” is not worth the risk.⁶¹ The task force returned a recommendation for special licensing for telemedicine practitioners.⁶² Though it has not officially adopted the task force recommendation, the Florida Legislature explicitly clarified that all unlicensed medical practice in Florida is prohibited.⁶³ No special laws have been enacted, to date.

IV. ALTERNATIVE APPROACHES TO LICENSURE

In 1997, the Joint Working Group on Telemedicine (JWGT)⁶⁴ reported to Congress “findings from federally funded telemedicine studies and demonstrations,” including an examination of the legal, medical, and economic issues involved in telemedicine.⁶⁵ In the report, the JWGT identified seven approaches to licensure of telemedicine health professionals: (1) state-based statutory consultation ex-

58. See Fla. HB 1703 (1999). The Committee did not adopt the proposed bill, however. See Fla. HB 1953 (2000); Fla. SB 1718 (2000). Neither the House nor the Senate committee adopted the proposed bill.

59. *Id.*

60. See *id.*

61. *CTL Task Force*, *supra* note 20, at 124 (discussing the harm to patients caused by the chilling effect created by the recent state statutes requiring licensure for regular consultations).

62. See Dep’t of Health Taskforce on Telemedicine, Report to the H.R. Healthcare Licensing Regulation Comm. (Jan. 2000) (on file with comm.).

63. See Fla. HB 591 § 35 (2000).

64. U.S. Dep’t Com., *Telemedicine Report to Congress* (Jan. 31, 1997) (visited May 28, 2000) <<http://www.ntia.doc.gov/reports/telemed/execsum.htm>> [hereinafter *Telemedicine Report*] (Vice President Al Gore originated the JWGT concept, and he identified telemedicine as an area demanding some attention. The JWGT was created in 1995 to allow the Secretary of Health and Human Services to meet the Vice President’s request for a telemedicine report.)

65. *Id.*

ceptions; (2) state-based full, special, or limited licensure of health professionals; (3) state endorsement of out-of-state health professionals; (4) registration of out-of-state health professionals; (5) mutual recognition of out-of-state health professionals' home state licenses; (6) reciprocity agreements between two or more states to recognize each other's medical licenses; and (7) a national licensure system.⁶⁶ These approaches represent three distinct forms of licensure. First, an individual state may take independent action to license telemedicine practitioners by implementing consultation, full or special endorsement, or registration licensure approaches. Second, mutual recognition and reciprocity approaches to licensure require states to take cooperative action. Third, state action may be preempted by a national licensure approach.

A. *Independent State Action*

As explained in Part III of this Comment, a state has the power to regulate the activities of medical professionals under its police power to protect the public health, safety, and welfare.⁶⁷ Thus, states have the power to pass their own telemedicine licensure laws. Currently, every state addressing licensure of telemedicine practitioners did so independently without cooperation from other states.⁶⁸ In June 1996, the American Medical Association adopted a report recommending full licensure from each state in which a physician practices telemedicine.⁶⁹ Thus, a strict individual state approach appears to be the form the medical profession is leaning toward.

Accordingly, many states enacted licensure statutes, which created stronger barriers to interstate telemedicine practice.⁷⁰ This is frequently done by narrowing a state's already existing consultation exception.⁷¹ Additionally, some states modified their medical act to require full or special licensure for telemedicine practitioners.⁷²

1. *Consultation Exceptions*

Even prior to telemedicine, most state medical licensure laws included an exception, which allowed a state-licensed physician to consult with an out-of-state physician.⁷³ Thus, a consultation exception

66. *See id.*

67. *See supra* notes 44-45 and accompanying text.

68. *See* Linda Gobis, *An Overview of State Laws and Approaches to Minimize Licensure Barriers*, TELEMEDICINE TODAY MAG. (visited May 28, 2000) <<http://www.telemetoday.com/mainpages/Statelaw.htm>>.

69. *See* Kerry A. Kearney, *Medical Licensure: An Impediment to Interstate Telemedicine*, 4 HEALTH L. 14, 15 (1997).

70. *See CTL Task Force, supra* note 20, at 119.

71. *See id.*

72. *See id.*; *see also* Kearney, *supra* note 69, at 15.

73. *See* Sulentic, *supra* note 20, at 19.

for telemedicine is merely an extension of this same idea, allowing a “physician who is unlicensed in a particular state [to] practice medicine [telemedicine] in that state at the behest and in consultation with a referring physician.”⁷⁴ Florida has such an exception, but has not specifically determined whether it includes telemedicine consultations.⁷⁵ The 1999 and 2000 proposed bills, however, would have more specifically narrowed the consultation exception regarding telemedicine.⁷⁶

Indiana recently revised their licensure statute and amended the practice of medicine to include “diagnostic or treatment services” provided to Indiana residents, which are “transmitted through electronic communications” and provided “on a regular, routine, and non-episodic basis.”⁷⁷ Thus, the consultation exception does not apply if telemedicine is used on a routine basis. The statute also excludes licensure to physicians who originally treat patients outside of Indiana and subsequently provide treatment services to that same patient after he or she is in Indiana. It also excludes physicians who provide second opinions to Indiana physicians.⁷⁸ As a result, Indiana narrowed its consultation exception in a way that requires physicians and the courts to determine what constitutes a routine or regular basis.

The Center for Telemedicine Law Task Force (CTLTF)⁷⁹ criticizes narrowing the consultation exception. It states: “There have been no reported disciplinary actions for out-of-state physicians performing consultations with a local physician even in states with a narrow or no statutory exception.”⁸⁰ Thus, the CTLTF claims that these new limitations are unjustified and not supported by evidence.⁸¹ Furthermore, the CTLTF report states that such restrictions will create confusion for the courts and lead to a chilling effect on physicians practicing telemedicine.⁸² Other states have similarly restricted their consultation exceptions.⁸³ Florida’s recently proposed bills would have been restrictive along these same lines.⁸⁴

74. *Telemedicine Report*, *supra* note 61.

75. *See* FLA. STAT. § 458.303 (1997).

76. *See supra* Part III.

77. IND. CODE § 25-22.5-1-1.1(4) (1999).

78. *See id.*

79. The Licensure Task Force of the Center for Telemedicine Law conducted a work session in February, 1996 and examined state telemedicine licensure law. The Task Force participants represented “large and small health care institutions, physicians, nurses, telecommunications companies, vendors, and congressional and executive branch policy makers.” *CTL Task Force*, *supra* note 20, at 109.

80. *Id.* at 123.

81. *See id.* at 124.

82. *See id.*

83. *See* Gobis, *supra* note 68 (listing states’ recent amendments to licensure laws).

84. *See supra* Part III.

2. Full and Special Licenses

Full licensure states require any person practicing any type of telemedicine within the state to have a license. A full licensure requirement "obviously least disturbs the state's current quality standards and its disciplinary system."⁸⁵ On the other hand, requiring a physician to obtain a full license in every state where they utilize telemedicine is burdensome and expensive, because a physician must comply with each state's requirements and pay each state's licensing application fee.⁸⁶ Additionally, forty states require the physician to personally appear before the state licensing board.⁸⁷ Consequently, full licensure is the alternative least likely to encourage the spread of telemedicine and its potential benefits to rural areas.

Georgia, which has an extensive intrastate telemedicine system, amended its licensure law to require full licensure of any "person 'physically located' outside Georgia who 'performs an act that is part of a patient care service located in this state.'"⁸⁸ The Georgia Act only provides a narrow exception for an out-of-state physician who makes a consultation at the request of a Georgia physician as long as the consultation is occasional.⁸⁹ Although the Georgia act is similar to the narrow consultation exception passed by Indiana, Georgia's definition of who is required to obtain or possess a license contains broader language. Nevertheless, the outcome is the same; state action is restricting the benefits of telemedicine. Accordingly, Dr. Jay Sanders, an advocate of national licensure, characterized the Georgia act as near-sighted and self-centered.⁹⁰

In contrast, special or limited licensure requires the physician to obtain a license from each state in which he practices, but the license is restricted to a "specific scope of health services under particular circumstances."⁹¹ Additionally, the special license would be easier to obtain by reducing administrative burdens.⁹²

In 1995, the Federation of State Medical Boards, Inc. created the Model Act to Regulate the Practice of Medicine Across State Lines

85. Sulentic, *supra* note 20, at 23.

86. See Gobis, *supra* note 68; see also Joy Elizabeth Matak, *Telemedicine: Medical Treatment via Telecommunications Will Save Lives, But Can Congress Answer the Call?: Federal Preemption of State Licensure Requirements Under Congressional Commerce Clause Authority & Spending Power*, 22 VT. L. REV. 231, 242-43 (1997).

87. See Gobis, *supra* note 68.

88. Katie Wood, *Physicians, Physician's Assistants, and Respiratory Care: Require Out-of-State Physicians Who Provide Patient Care in Georgia Via Telemedicine to Hold Georgia License*, 14 GA. ST. U.L. REV. 238, 241 (1997) (quoting Georgia SB 107 (1997)).

89. See *id.*

90. See *id.* at 240.

91. *Telemedicine Report*, *supra* note 61.

92. See *id.*

(Model Act), which proposes a uniform limited licensure model.⁹³ The Model Act defines the practice of medicine across state lines as follows:

1. the rendering of a written or otherwise documented medical opinion concerning diagnosis or treatment of a patient within this State by a physician located outside this State as a result of transmission of individual patient data by electronic or other means from within this State to such physician or his agent; or
2. the rendering of treatment to a patient within this State by a physician located outside this State as a result of transmission of individual patient data by electronic or other means from within this State to such physician or his agent.⁹⁴

The Model Act suggests that each state's Medical Board should issue a limited license to practice medicine across state lines. This limited license would still be subject to each issuing state's rules and regulations, and the issuing state's Medical Board would handle disciplinary actions.⁹⁵ The Model Act creates exceptions from the limited license for the practice of medicine in emergencies, on an irregular basis, and without compensation.⁹⁶

While no states have specifically adopted the Model Act, Tennessee adopted a special licensing requirement that is comparable to the provisions of the Model Act.⁹⁷ Texas also mandates a special license for any out-of-state physician who provides regular telemedicine services to patients in Texas.⁹⁸ The special license does not grant authority to those physicians "to physically practice medicine in the state of Texas."⁹⁹ One commentator urges states to adopt the Model Act because it allows physicians to obtain a license to practice telemedicine more easily, while protecting "patients by keeping the authority to regulate physicians within the patient's state."¹⁰⁰ While this approach is certainly less restrictive, it still requires physicians to obtain a special license from each state in which they provide telemedicine services. Just the burden of submitting an application to each state would likely discourage many physicians from obtaining these special licenses.

93. Federation of State Medical Boards Ad Hoc Committee on Telemedicine, *A Model Act to Regulate the Practice of Medicine Across State Lines* (1996) (visited May 28, 2000) <<http://www.fsmb.org/telemed.htm>>.

94. *Id.*

95. *See id.*

96. *See id.*

97. *See* TENN. CODE ANN. § 63-6-209 (1997) (providing that the medical "board has the authority to issue restricted licenses and special licenses based upon licensure to another state for the limited purpose of authorizing the practice of telemedicine").

98. *See* 22 TEX. ADMIN. CODE § 174.4 (West 1999).

99. *Id.*

100. Caryl, *supra* note 33, at 191.

3. *Endorsement*

A majority of states currently use the endorsement approach to grant a license to physicians who are already licensed in another state.¹⁰¹ The physician seeking a license by endorsement must request that the state review and endorse his or her credentials.¹⁰² However, a state may demand additional qualifications or documents before endorsing a license. At a minimum, a health professional seeking licensure by endorsement must submit an application, original transcripts, letters of recommendation, and fees to the state board for review and approval.¹⁰³ As discussed in Part III of this Comment, Florida's endorsement provision requires that the physician meet basically the same requirements as a physician obtaining an initial license in Florida.

While endorsement allows the state to keep its traditional power over the medical profession, the burden of complying with diverse administrative requirements and standards might dissuade physicians from seeking a license.¹⁰⁴ The endorsement approach is more burdensome than the consultation exception approach. Thus, proponents of telemedicine are critical of such an approach.¹⁰⁵ Nevertheless, with the recent restrictions of the consultation exceptions regarding telemedicine, this may not be true.

4. *Registration*

The final approach under which a state can independently regulate telemedicine practitioners is registration. Registration allows a physician licensed in one state to inform the medical board of another state that he desires to practice part-time in that state.¹⁰⁶ The physician is not obligated to comply with the entrance requirements necessary to receive a regular license in the host-state.¹⁰⁷ However, the registered physician is subject to the jurisdiction and legal authority of the host-state. The physician "would be held accountable for breaches of professional conduct in any state in which they are registered."¹⁰⁸

Registration is the least burdensome type of individual state-based licensure because it does not require the physician to overcome any administrative hurdles or require the physician to determine what type of consultation would be allowed under the narrow consul-

101. See *Telemedicine Report*, *supra* note 61.

102. See Sulentic, *supra* note 20, at 21.

103. See *Telemedicine Report*, *supra* note 61.

104. See *id.*

105. See Sulentic, *supra* note 20, at 22.

106. See *Telemedicine Report*, *supra* note 61.

107. See *id.*

108. *Id.*

tation exceptions. However, physicians must still be familiar with each registered state's medical act and professional code of conduct in order to ensure that they do not violate some provision and that they may be held accountable in that state. While this is not as burdensome as the other state-based licensure approaches, it still leaves much work in the physician's hands. On the other hand, allowing the state to have legal authority over the registered physician enables the state to exert some of its traditional control over the profession. In the end, the state will worry less about unsafe practitioners because it has the authority to prosecute and discipline any negligent action.

California is the only state that proposed a registration approach to license telemedicine practitioners. Under the Telemedicine Development Act of 1996, the California Legislature authorized the medical board to create a registration program that would be submitted to the legislature for possible future implementation.¹⁰⁹ The proposed registration program defines a physician in that state as practicing medicine across state lines

when that person is located outside of this state but, through the use of any medium, including an electronic medium, practices or attempts to practice . . . any system or mode of treating the sick or afflicted in this state, or diagnosis, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person in this state.¹¹⁰

The definition is broad and encompasses virtually all telemedicine physicians. The act also states that the proposed program should include possible requirements for registration including licensure, education, and training requirements.¹¹¹ California also provides a consultation exception, which is not to be considered part of the registration program.¹¹² While the California Legislature has yet to enact any registration program, at least California is looking at the possibility. Registration definitely offers the least restrictive means for an individual state to regulate telemedicine practitioners without giving up its traditional control over the physicians.

109. CAL. BUS. & PROF. CODE § 2052.5(c) (West Supp. 1998).

110. *Id.* § 2052.5(a)(1).

111. *See id.* § 2052.5(b)(1).

112. *See id.* § 2052.5(a)(3). The consultation exception requires that the out-of-state physician not have "ultimate authority over the care or primary diagnosis of a patient." *Id.* § 2060. This is the identical language that Florida proposed in House Bill 1703; however, California does not yet have any case law interpreting the provision.

B. Cooperative State Action

1. Reciprocity

Reciprocity requires a relationship between two states in which each state provides certain privileges to the residents of the other state, on the condition that its own residents will receive the same privileges from that other state.¹¹³ Thus, a reciprocity licensure approach necessitates that states enter into agreements to recognize each other's medical licenses without further review or administrative hurdles.¹¹⁴ Negotiations to create such agreements can take place on a bilateral or multilateral basis.¹¹⁵ Reciprocal agreements have already been in force for many years in limited situations. For example, in Texas the Medical Board may grant a Texas license to a physician licensed in another state or Canadian province that has similar requirements and standards.¹¹⁶ These reciprocal agreements, however, have yet to be specifically applied to the practice of telemedicine.¹¹⁷

Reciprocity offers advantages that individual state-based licensure does not. First, through cooperation between states, long-term relationships between physicians and medical providers are likely to be established.¹¹⁸ Additionally, states may negotiate simpler and less costly administrative processes in providing reciprocal licenses. On the other hand, "the reciprocity model does not address the differences between state laws regarding the scope of practice."¹¹⁹ Also, the process of negotiations between states would be difficult and time consuming. Finally, because reciprocity does not mandate that states harmonize their administrative and procedural standards, health professionals may still face the burden of varied requirements.¹²⁰

2. Mutual Recognition of Licenses

Mutual recognition is a cooperative approach where states enter into a compact to accept the licensure standards and policies of a licensee's home state.¹²¹ Thus, mutual recognition "requires the participating states to agree to a common harmonized set of standards

113. See *Telemedicine Report*, *supra* note 61.

114. See *id.*

115. See *id.*

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

117. See Gobis, *supra* note 68.

118. See Sulentic, *supra* note 20, at 28.

119. *Id.* "Scope of practice" describes the activities that a license authorizes a physician to perform. For a more thorough discussion of the scope of practice under physician licenses, see generally Sulentic, *supra* note 20.

120. See *Telemedicine Report*, *supra* note 61.

121. See *id.*

governing qualification, conduct and discipline.”¹²² Mutual recognition or a multistate compact has been touted as the answer to the telemedicine licensing situation.¹²³ A multistate compact would allow for a uniform licensure system that would “establish consistent licensure requirements and allow physicians to qualify for practice in another state without significant delay and costs.”¹²⁴ Additionally, enforcement authority can still be left to the host-state so that the host-state maintains control over its medical professionals.¹²⁵ Of course, these negotiations would also be difficult and time consuming.

The standards for practicing medicine have become almost uniform.¹²⁶ However, states may be unwilling to adopt higher or lower standards, and “the fact that states have maintained marginal differences in application requirements, despite the existence of a standardized national licensing exam and national accrediting agencies for medical education and training, is evidence for the difficulties associated with developing common standards.”¹²⁷ Proponents of telemedicine claim that state medical boards are protectionist and do not want to open their markets to out-of-state providers.¹²⁸

The adoption of the Nurse Licensure Compact by the National Council of State Boards of Nursing (NCSBN) is a recent example of mutual recognition of licenses.¹²⁹ Under the Compact, a nurse who holds a license in his or her home state will be considered as having a multistate licensure privilege that allows medical practice in any state that adopts the compact.¹³⁰ A licensed nurse in a state that adopts the Compact does not have to obtain a license from any state that is also party to the act. Therefore,

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

122. *Id.*

123. See Sulentic, *supra* note 20, at 29-37; see also *CTL Task Force*, *supra* note 20, at 128.

124. *CTL Task Force*, *supra* note 20, at 128.

125. See *Telemedicine Report*, *supra* note 61.

126. See *CTL Task Force*, *supra* note 20, at 113.

127. *Id.* at 129.

128. See *id.*; see also Sorelle, *supra* note 11 (stating that after the Harris Corporation in Melbourne, Florida contracted with Univ. Cal. Los Angeles to interpret X-ray studies, state radiologists were at the Florida Legislature touting the necessity to protect the Florida population).

129. Utah was the first state to enact the Nurse Licensure Compact, on March 14, 1998. See UTAH CODE ANN. § 58-31c-102 (1998). For additional materials concerning the Nurse Licensure Compact, see National Council of State Boards of Nursing, <<http://www.ncsbn.org>> [visited June 27, 2000].

130. See *id.*

their initial license within the state or who do not reside in a party state at the time they apply for licensure.¹³¹

Furthermore, the Nurse Licensure Compact maintains the majority of the state's traditional disciplinary procedures. Still, the remote state—the state which is not the primary residence of the nurse—may not extend its disciplinary power past its borders.¹³² The remote state is only allowed to limit or revoke the licensure privilege within its own borders and may not do anything to limit or harm the nurse's original license in his or her home state.¹³³ This allows each state to discipline the nurse within its own borders.

The Nurse Licensure Compact has yet to be widely adopted to see how well it works, but it will hopefully provide a testing ground for this mutual recognition approach to licensure. Such an approach has appeal, because it more easily allows physicians or nurses to practice telemedicine in another state. Hence, it facilitates the spread of telemedicine. However, the Nurse Licensure Compact has one potential drawback. The Compact does not have uniform requirements for entry to practice or for scope of practice standards.¹³⁴ Each nurse will have to know *each state's* scope of practice regulations. Even more problematic are the different entry to practice standards in various states. A nurse who is initially licensed with a state with particularly low standards will be allowed to practice in states with higher standards, and a refusal to license all nurses from a state with lower standards would erode the basis of the Compact.¹³⁵ Furthermore, if uniform standards are negotiated, there is a fear it would lead to licensure by the lowest common denominator.¹³⁶ Despite these concerns, the mutual recognition approach could enable the spread of telemedicine and access to its benefits.

C. National Licensure

Proponents of telemedicine claim that national licensure is the solution to the telemedicine licensing problem.¹³⁷ Congress could most likely enact a national licensure program under either its commerce clause power or spending power.¹³⁸ Congress already utilizes its

131. Sulentic, *supra* note 20, at 31 (giving a brief analysis of the Nurse Licensure Compact).

132. *See id.* at 32.

133. *See id.*

134. *See id.* at 33-34.

135. *See id.*

136. *See id.*

137. *See CTL Task Force, supra* note 20, at 130; Matak, *supra* note 86, at 245; Fentiman, *supra* note 5, at 12.

138. *See* Matak, *supra* note 86, at 245-48 (discussing Congress's commerce clause and spending powers and what would be necessary to enact a national licensure law under either of these powers); *see also Telemedicine Report, supra* note 61.

power to regulate medicine through the Medicare and Medicaid programs.¹³⁹ A national licensure system could be executed at either the state or national level and would require a standardized set of criteria.¹⁴⁰

The national licensure system enacted at the state level would require each state to adopt into its own laws, the national standards.¹⁴¹ Under this approach, the states might retain some ability to determine the administrative process and could retain disciplinary authority.¹⁴² Also, the physician would still be required to obtain a license in every state, but the uniform criteria would make the process less burdensome.¹⁴³

Alternatively, a nationally implemented approach or federal licensure would leave the administrative process to a national organization.¹⁴⁴ The physician would apply for one license from the federal government, and the federal regulations would preempt state licensure laws.¹⁴⁵ While this may eliminate many of the administrative hurdles placed on physicians, the difficulties of creating a federal central administration and enforcement mechanism would be difficult. Additionally, states would lose their traditional control of medicine, designed to protect their population, and they could not set standards reflecting the needs of their residents.¹⁴⁶

Nevertheless, a federal licensure approach would “go a great deal further than any other proposal in facilitating the practitioner in setting up a national practice.”¹⁴⁷ Also, states would benefit because the barriers to practice telemedicine would be significantly eliminated, thereby increasing states’ ability to attract physicians to its rurally underserved populations. “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.”¹⁴⁸ Hence, a federal or nationally implemented licensure system could be the solution to addressing the needs of the medically underserved. However, states are not likely to desire relinquishing their traditional role as regulator of their medical professionals.

139. See Sulentic, *supra* note 20, at 35.

140. See *Telemedicine Report*, *supra* note 61.

141. See *id.*

142. See *id.*

143. See *id.*

144. See *id.*

145. See *id.*

146. See *id.*

147. Sulentic, *supra* note 20, at 36.

148. *Id.*

V. WHERE DOES FLORIDA GO FROM HERE?

As Florida continues to examine the issue of telemedicine licensure, it should keep in mind the real needs of Florida's patients. If the purpose of the State's police power is to protect the health, safety, and welfare of its population, then a restrictive licensure approach to telemedicine will not further that purpose. While Florida certainly has an interest in protecting its population from unscrupulous or dangerous physicians, Florida should recognize that most states have fairly uniform standards and requirements for physician licensure.

Dr. Jay Sanders, the past president of the American Telemedicine Association, at a meeting of the Federation of State Medical Boards, asked the audience how many felt that their state had lower standards than the neighboring state.¹⁴⁹ No one raised their hand.¹⁵⁰ As this demonstrates, the medical industry may not really fear that opening state borders to telemedicine would be dangerous for patients. However, states may be reluctant to give up some of their traditional power. Thus, the Florida Legislature needs to remember that the people who need protecting are not the members of the state medical board, but people in places like Baker and Liberty Counties who have little to no access to the health care they need.

If Florida really wants to protect its population's health, it must create avenues whereby the rural populations can more readily gain access to much needed health care. Telemedicine offers a real and promising solution to the rural communities' health care crisis. Hopefully, Florida will address this crisis during the 2001 Legislative Session by promoting a licensure approach that provides out-of-state physicians greater access to the state by means of telemedicine.

Furthermore, if Florida wants to meet its population's health needs, but maintain some control over the profession, it should work towards developing a cooperative approach with other states for interstate licensure of telemedicine. If one state does not step up and begin the process of negotiations between states, then a reciprocal or interstate compact approach will never be realized. Additionally, states risk losing all of their traditional power if they continue to inhibit the growth of telemedicine through strict licensure regimes, and Congress decides to take matters into its own hands and create a federal licensure program. Florida should take a bold step and lead the way to a more cooperative approach to licensing telemedicine practitioners in order to protect the health of not only its citizens but of all citizens of the United States.

149. See Sorelle, *supra* note 11.

150. See *id.*