CHAPTER 1

Telemedicine:
Legal and Regulatory Issues

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§ 1.01 Introduction

Telemedicine has arrived. In fact, it actually has been with us for quite some time. Some commentators have suggested that the first telemedicine consultation took place on March 20, 1876, when Alexander Graham Bell, having just spilled acid on his leg, exclaimed to his assistant over the first telephone: “Mr. Watson, come here, I want you.” Today, telemedicine applications employ


2 “[W]ith those few words the telecommunications industry was born. Telemedicine was born that day as well.” Hodson, “Telemedicine: A New Frontier”, available at http://www.bicsi.org/Content/Index.aspx?File=news07_03.htm (last visited Sept. 11, 2008). It was not until over 25 years later that research into telephotography produced a working product in 1902, a device that today we would simply call a fax machine, available at http://www.ideafinder.com/history/inventions/story051.htm (last visited Aug. 20, 2004).
advanced interactive imaging, robotic surgery, and virtual technologies.\(^3\) However, in its simplest form, a physician providing clinical advice over the telephone or by mail is practicing telemedicine.

Telemedicine has the potential for dramatically improving the delivery of health care services—particularly in rural areas—by providing access to specialty services where little, if any, were available before.\(^4\) It also should significantly reduce costs. However, for physicians and

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institutions considering participation in a telemedicine program, there are a variety of legal and other obstacles that first must be addressed.\textsuperscript{5}

\textsuperscript{5} “Telemedicine represents a vivid example of the difficulties posed by the ongoing need to meld existing legal principles with evolving technologies.” Blum, “Telemedicine: The Cyber Physician and Credentialing,” HC Law Monthly 3 (Mar. 2000). See also, Government Accounting Office, “HHS’s Efforts to Promote Health Information Technology and Legal Barriers to Its Adoption” (Aug. 13, 2004) (reporting that beyond legal issues related to privacy and security of health information, there are various laws—some specifically health-related, some not—that present barriers to the full adoption of health information technology, including fraud and abuse, antitrust, federal income tax, intellectual property, malpractice liability and state licensure requirements).
§ 1.02 Regulation of Telemedicine

[1]—Defining the “Practice of Telemedicine”

As telemedicine technology has advanced from telephone advice to Internet-facilitated review of slides, x-rays, and other images, to virtual and robotic surgery, new terminology has been added to the medical lexicon. The most commonly encountered—and often confusingly misused—terms are electronic- or e-health (or “telehealth”), cybermedicine (or Internet medicine), and telemedicine. While there is substantial overlap among these futuristic sounding terms, the distinctions among the health-related practices they encompass are relevant to the legal and regulatory hurdles each faces.

[a]—E-Health

E-health is the broadest of these terms and, to date, has had the greatest impact on the health care industry.1 E-health has been described as “an emerging field in the intersection of medical informatics, public health and business, referring to health services and information delivered or enhanced through the Internet and related technologies.”2 E-health encompasses a wide range of Internet-based, health-related activities, including patient education; the provision of exercise, diet, life-style and general health information; continuing medical education; and health care marketing. For the most part these are static websites with little, if any, personal interaction between the website visitor and host.3

[b]—Cybermedicine

The greater the personal interaction between a health-information website and an individual user, and the more the health-related information is tailored to the user’s questions, personal data, and other

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1 “More than 52 million adults in the United States have searched the World Wide Web for health and medical information. It is estimated that one-third of physicians are adopting or planning to adopt Internet technologies as a vehicle to enhance patient care.” (Citations omitted). Blum, “Internet Medicine and the Evolving Legal Status of the Physician-Patient Relationship,” 24 J. Leg. Med. 413, 415 (2003).


3 “At first blush, use of the internet to secure medical information is best equated to accessing an electronic encyclopedia.” Blum, supra N. 1, at 415.
user-specific information, the more the site starts to look like the practice of medicine. Where the website visitor seeks and receives personalized medical information from a physician over the Internet, the interaction generally is referred to as cybermedicine, Internet medicine, or online medicine.4

[c]—Telemedicine

Telemedicine is a broader concept than cybermedicine. While cybermedicine generally refers to the practice of medicine on-line,5 telemedicine also encompasses the provision of medical care by telephone, mail, facsimile, electronic mail, and other modes of communication. Different definitions of telemedicine abound. It is best described simply as “the use of communication equipment to link health care practitioners and patients in different locations.”6


5 One prevalent use of e-health/telemedicine sites is for the sale of prescription drugs and devices. “The rapid escalation of internet websites offering prescription medications directly to consumers has resulted in an unprecedented challenge to medical boards and added confusion to telemedicine and e-health licensure discussions.” Center for Telemedicine Law, Telemedicine Licensure Report 14, p. 6 (June 2003) (“2003 CTL Licensure Report”). The regulation of the online sale of drugs, medical devices and dietary supplements is discussed infra in Chapter 3.

6 Center for Telehealth and E-Health Law, “Frequently Asked Questions”, available at http://www.telehealthlawcenter.org/content/?page=18 (last visited Sept. 15, 2008). “Telemedicine” also describes the technology used by health care providers for reasons other than linking doctors and their patients, such as increased cost efficiency, reduced transportation expenses, improved patient access to specialists and mental health providers, improved quality of care, and better communication among providers. Id. Moreover, various medical specialties have tailored the definition of telemedicine to fit the particularities of the specific practice. For example, “telepathology” has been defined as “the practice of pathology (consultation, education and research) using telecommunications to transmit data and images between two or more sites remotely connected to each other. University of Pittsburgh Medical Center, “Frequently Asked Questions on TelePathology 1”, available at http://telepathology.upmc.edu/faqsp.htm (last visited Sept. 15, 2008). Similarly, “Teleradiology” has been described as “the electronic transmission of radiologic images from one location to another for the purposes of interpretation and/or consultation.” American College of Radiology (“ACR”), ACR Technical Standard for Teleradiology § I (2003). A variety of related “teleterms” have also emerged, including telemonitoring, teleconsulting, tele-treatment, telecounseling, telemangement, telesurgery, telehomecare, and telementoring.
Telemedicine often is used to refer to the remote, i.e., distant and thus “tele-”, provision of medical care, and is usually envisioned to encompass a common infrastructure (e.g., physical facilities and equipment which captures, transmits, stores, processes and displays voice, data and images).7

If the potential benefits of telemedicine are myriad, so too are the legal issues that have arisen as legislators and regulators try to adapt old laws to new practices of medicine. As medicine moves into the electronic age, perhaps the most significant restraints on its full growth and development, in the United States and throughout the world, are the legal barriers that remain—and are still being created.7,1

[d]—Is It the Practice of Medicine?

Most of the legal issues raised by telemedicine arise from the assumption that the provision of telemedicine services is the practice of medicine. And, while a given state’s statutory definitions, administrative interpretations, and court rulings may differ, “it will be hard to argue that activities, which can be seen as treatment or diagnosis, even though electronically delivered, do not constitute the practice of medicine.”8 Moreover, the fact that a number of states already have amended their medical practice acts to include (explicitly or implicitly) the practice of telemedicine, or enacted specific medical practice laws to govern various aspects of telemedicine activities, not the least of which is the requirement for full medical licensure, “provide[s] an explicit, or inherent, recognition that this area constitutes the practice of medicine.”9

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7 “[T]elemedicine uses a variety of transmission modes including ISDN, T1, asynchronous transfer mode, digital wireless, local telephone lines and the Internet. The combination of equipment and transmission technology enables health providers to relate with other providers or patients using either live audio and video or through ‘storing’ and later ‘forwarding’ multimedia information through email.” Business Briefing: Global Healthcare 2003, “Advances in Telemedicine Technology”, available at www.touchbriefings.com/download.cfm?fileID=1012&action=downloadFile (last visited Sept. 15, 2008). Technological advances such as fiber optics, satellite communications, and compressed video techniques have been critical in the growth of the telemedicine industry and the utilization of telemedicine generally. “Definition and History of Telemedicine,” supra note 6.


8 Blum, supra N. 1, at 422.

9 Id. at 419. See, e.g.:

Arkansas: Ark. Code Ann. § 10-3-1702(10) (2008) (defining telemedicine as “an interactive telecommunications system that” uses “information technology, audio, video, and other appropriate elements and is compatible with other telemedicine networks” “for the purpose of enhancing the delivery of medical information and health care to medical facilities in rural and urban areas throughout Arkansas”).

California: Cal. Bus. & Prof. Code § 2290.5(a)(1) (defining telemedicine as “the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications”).

Colorado: Colo. Rev. Stat. § 12-36-106(1)(g) (defining the practice of medicine to include “[t]he delivery of telemedicine, which means the delivery of medical services and any diagnosis, consultation, or treatment using interactive audio, interactive video, or interactive data communication”).

Georgia: Ga. Code Ann. § 33-24-56.4(a)(3) (defining telemedicine “the practice, by a duly licensed physician or other health care provider acting within the scope of such provider’s practice, of health care delivery, diagnosis, consultation, treatment, or transfer of medical data by means of audio, video, or data communications which are used during a medical visit with a patient or which are used to transfer medical data obtained during a medical visit with a patient”).

Hawaii: Haw. Rev. Stat. § 432:1-601.5(e) (defining telehealth as “the use of telecommunications services [], including but not limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced health care services and information to parties separated by distance”).

Illinois: Ill. Ann. Stat., Ch. 225, 60/49.5 (2004) (defining telemedicine as “the performance of any of the activities listed in Section 49 [of the Illinois Medical Practice Act], including but not limited to rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication from within this state”).

Indiana: Ind. Code § 25-22.5-1-11(a)(4) (2004) (the definition of the practice of medicine includes providing, on a “regular, routine, and non-episodic basis,” diagnostic or treatment services to a person in Indiana where such services are “transmitted through electronic communications”). Some states define “telemedicine” in terms of interstate medical practice.

Kentucky: Ky. Rev. Stat. Ann. § 205.510(15) (defining telehealth consultation as “a medical or health consultation, for purposes of patient diagnosis or treatment, that requires the use of advanced telecommunications technology, including, but not limited to: (a) Compressed digital interactive video, audio, or data transmission; (b) Clinical data transmission via computer imaging for teleradiology or telepathology; and (c) Other technology that facilitates access to health care services or medical specialty expertise”).

Maryland: Md. Code Ann., Health Occ. § 2-101(u) (defining telehealth as “the use of telecommunications and information technologies for the exchange of information from one site to another for the provision of health care to an individual from a provider through hardwire or Internet connection”).

Minnesota: Minn. Stat. § 147.032(e) (defining telemedicine as “the practice of medicine as defined in section 147.081, subdivision 3, when the physician is not in the physical presence of the patient”).
[2]—Licensure Requirements

One of the most formidable barriers to the broad expansion of telemedicine services in the United States is the potential need for multiple state licenses for physicians who practice across state lines.10 “Telemedicine invites clinical applications that ignore the geographic borders on which our current licensure system is based. . . . 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.”11

[a]—Background: State Police Power

States regulate the practice of medicine under the police power reserved to the states by the Tenth Amendment to the Constitution of the United States to adopt laws to protect the health, safety and welfare

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Nebraska: Neb. Rev. Code § 38-2024(7) (2008) (defining the practice of medicine and surgery to include the provision of services to “persons who are physically located in another state but who, through the use of any medium, including an electronic medium, perform for compensation any service which constitutes the healing arts that would affect the diagnosis or treatment of an individual located in this state [except for physician-to-physician consultations]”).

Ohio: Ohio Rev. Code Ann. § 4731.296(A) (2008) (“the ‘practice of telemedicine’ means the practice of medicine in this state through the use of any communication, including oral, written, or electronic communication by a physician located outside this state”).

West Virginia: W. Va. Code Ann. § 30-3-13(a) (2003) (providing that “a person engaged in the practice of telemedicine [defined as the use of electronic information and communication technologies to provide diagnostic or treatment services when the patient is located in the state and the physician providing the services is outside the state] is considered to be engaged in the practice of medicine within [the] state”).


11 Sulentic, “Crossing Borders: The Licensure of Interstate Telemedicine Practitioners,” 25 J. Legis. 1, 7 (1999). “The unique problem posed by telemedicine is that a physician must comply with the licensure laws of each jurisdiction in which he practices medicine.” Id. See also, American Medical Association, “Physician Licensure: An Update of Trends” (last updated Sept. 27, 2008) (available at www.ama-assn.org/ama/pub/category/print/2378.html, last visited Sept. 15, 2008) (“2003 AMA Physician Licensure Update”) (“Medical practice may now be conducted over wide geographic areas. This challenges the current state-based medical licensure system to facilitate the growth of this evolving mode of patient care while maintaining a high standard of medical care and ensuring public protection.”).
of their citizens. Pursuant to this power, each of the fifty states, the District of Columbia and the United States territories has adopted a scheme to license physicians and other health care providers who practice within their borders. The right of the states to regulate the practice of medicine has been recognized by both federal and state courts.

[b]—Current Law

[i]—State Law Development

Individual state boards, the Federation of State Medical Boards (FSMB), physician organizations, and academics have studied the issues that are raised by state licensure for telemedicine. Some states have enacted laws to facilitate telemedicine, whereas others have tightened their laws, to ensure that anyone practicing medicine (whether in person or remotely) in their state has a full medical license. Most states, however, have recognized at least a limited exception to the licensure requirement for out-of-state physicians providing in-state “consultations.” Historically, some states, like Illinois, were willing to interpret out-of-state telereview of slides and x-rays as a form of physician-to-physician consultation, and not require an in-state license for the out-of-state specialist. Today, most states are unlikely to read the consultation exception so broadly. In fact, the trend clearly is moving in the opposite direction:

“Until recently, a physician could provide an opinion or interpretation to a physician in another state who had primary patient care responsibility, and this practice was not regarded as practicing out of his/her state. Today, however, the out-of-state practice of medicine without a license is prohibited, whether the physician is

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12 U.S. Const. amend. X.
13 Most state statutes delegate the authority for enforcing licensure laws to their respective Boards of Medical Examiners or similar agencies. 2003 AMA Physician Licensure Update, supra N. 11.
14 See, e.g.: Supreme Court: Dent v. West Virginia, 129 U.S. 114 (1889) (upholding the right of the State of West Virginia to license physicians).
State Courts:
Kentucky: Reynolds v. Walz, 278 Ky. 309, 314 (Ky. 1939).
treating the patient in person or from a distant location. In this day and age, a physician is considered to be practicing medicine in the state where the patient is located and is subject to that state’s laws regarding medical practice, which typically means a license in that particular state is necessary.”

For example, in 1997, the Illinois legislature amended the state’s Medical Practice Act to prohibit the practice of telemedicine without a license. “Telemedicine” is defined to include “rendering written or oral opinions concerning diagnosis or treatment of a patient in Illinois by a person located outside the State of Illinois as a result of transmission of individual patient data by telephonic, electronic, or other means of communication within this State.”

The Act provides exceptions for “periodic” consultations, second opinions, and medical care provided in follow-up to care originally provided in the provider’s state of license. It also provides that an out-of-state physician treating a patient in Illinois through the practice of telemedicine submits himself or herself to the jurisdiction of the courts of Illinois, and could face criminal penalties for the unlicensed practice of telemedicine. Thus, an out-of-state radiologist providing regular interpretations of films from patients located in Illinois must be fully licensed in Illinois or risk serious consequences.

Texas is another example. Texas had a rather liberal exemption for physicians who “entered” the state for consultative purposes. In 1999, however, Texas passed legislation expressly limiting the exemption to “episodic consultation,” and requiring a Texas medical license for any physician:

“who is physically located in another jurisdiction but who, through the use of any medium, including an electronic medium, performs an act that is a part of a patient care service initiated in [Texas], including the taking of an x-ray examination or the preparation of

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15 2003 AMA Physician Licensure Update, supra N. 11. But where does treatment, i.e., the practice of medicine, actually “take place?” The AMA, several specialty societies, and all states that have considered the issue have determined that the physician is practicing medicine in, and therefore must be licensed by, the state where the patient is located. If, however, the treatment/practice of medicine were to be viewed as taking place in the state where the physician is located, one could argue that multiple licensure would not be necessary.

16 Public Act No. 90-99 (codified at Ill. Ann. Stat., Ch. 225, 60/49.5(b) (2004)).
17 Ill. Ann. Stat., Ch. 225, § 60/49.5(c).
18 Id. at § 49.5(c)(1)-(3).
19 Id. at § 49.5(e).
20 Id. at § 59.
pathological material for examination, and that would affect the diagnosis or treatment of the patient. . . ."21

Violation of the Texas law is a Class A misdemeanor, punishable by a fine of up to $4,000 and/or a jail sentence of up to one year. Conviction of a second offense is punishable as a third degree felony which may result in a fine of up to $10,000 and imprisonment for two to ten years. Each day of violation constitutes a separate offense.

Statutes such as those enacted in Illinois and Texas threaten not only the future expansion of interstate, national and international telemedicine activities, they also imperil long-standing patterns of radiology and pathology consultations conducted by mail and other non-electronic means. In several other states, the state medical board has interpreted its statute to require full licensure of out-of-state telemedicine physicians. For example, the General Counsel of the Massachusetts Board of Registration in Medicine has opined that, if a biopsy performed on a Massachusetts patient by a Massachusetts physician is received and diagnosed by an out-of-state physician, that out-of-state physician is practicing medicine without a license in Massachusetts.22

Physicians who practice telemedicine “without a license” risk criminal as well as civil penalties, state disciplinary proceedings, and denial of coverage under medical malpractice insurance policies which generally require licensure as a condition of coverage. Moreover, licensed physicians who send patient specimens or data out-of-state also may be sanctioned. For example, regulations of the Massachusetts Board of Registration in Medicine provide that a physician licensed in Massachusetts may be disciplined for “[k]nowingly permitting, aiding or abetting an unlicensed person to perform activities requiring a license.”23 Further, hospitals and managed care organizations whose physicians send biopsies or pap smears to large national reference laboratories for processing and interpretation by pathologists also may face charges of aiding and abetting the unlicensed practice of medicine.

[ii]—Current Status of State Licensure Laws and Regulations Affecting Telemedicine

Any physician who seeks multiple state licenses, for any reason, will find the current state-by-state licensure system burdensome.

22 Letter from Penelope Wells, Esq., General Counsel, Massachusetts Board of Registration in Medicine (Sept. 18, 1995) (“Massachusetts Medical Board Opinion”).
23 Id.
These difficulties are greatly exacerbated for the telemedicine physician who may seek to provide care to patients around the country—or around the world. Nevertheless, more and more states have enacted legislation, promulgated regulations, and issued opinions which restrict rather than expand the ability of a telemedicine physician to practice across state lines. Moreover, the variation in medical practice acts and other laws and regulations regarding, inter alia, informed consent, confidentiality, medical records and mandatory reporting, further complicate the problem. A telemedicine practitioner who seeks multiple state licenses may find the current system burdensome because of the time and expense of applying for multiple licenses. A patchwork of medical record, patient confidentiality, continuing medical education, and mandatory reporting laws, along with differing medical practice acts, complicate the process. The National Broadband Plan, released by the FCC in March 2010 noted, “state-by-state licensing requirements limit practitioners’ ability to treat patients across state lines. This hinders access to care, especially for residents of states that do not have needed expertise in-state.”

[A]—Full License Required

A large number of states require out-of-state telemedicine physicians to obtain a full, unrestricted medical license in order to “see” patients in the state via telemedicine. As of June 2003, at least twenty-one states required full licensure. Further, more states seem to be moving in that direction. In Pennsylvania, in April 2003, for example, Senate Bill 585, entitled the “Telemedicine Act” was introduced and referred to the Senate Committee on Consumer Protection and Professional Licensure. Section 4 of the bill provides as follows:

(1) Licensure.—Any physician who is physically located in and/or licensed by another jurisdiction but who through the use of telemedicine or teleradiology performs an act that is part of a patient-care service initiated in this Commonwealth and that would

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24 2003 AMA Physician Licensure Update, supra N. 11.
directly affect the diagnosis or treatment of the patient is engaged in the practice of medicine in this Commonwealth.

(2) Regulation.—The nonresident physicians who perform these services through electronic media, since they are engaged in the practice of medicine in this Commonwealth, shall obtain a license without restriction to practice medicine in this Commonwealth and shall be subject to the same requirements, including requirements to purchase malpractice insurance and participate in the Medical Professional Catastrophe Loss Fund, as other physicians with full and unrestricted licenses practicing in this Commonwealth.\textsuperscript{29}

\textit{(Text continued on page 1-15)}

\textsuperscript{29} \textit{Id.} at § 4.
As is typical for most “full- licensure-for-telemedicine” laws, the Pennsylvania bill would allow for a number of “consultation” exceptions, including episodic consultation without compensation, consultation to a medical school or resident training program, and consultation by an out-of-state-licensed physician who is in Pennsylvania solely to consult with Pennsylvania-licensed physicians and does not have offices in the state or any other arrangement for seeing, examining or treating patients in the state.\footnote{Id. at § 5.} Sanctions for violating the law would include criminal prosecution.\footnote{Id. at § 6.}

\section*{[B]—Special License/Certificate Required}

A number of states have enacted legislation or promulgated regulations requiring out-of-state physicians to obtain a “special,” “limited,” or “telemedicine” license or certificate in order to provide care to in-state patients. Some states have adopted a variation of a model act proposed by the Federation of State Medical Boards (“FSMB”) which provides for a “special purpose” license for telemedicine.\footnote{Act to Regulate the Practice of Medicine Across State Lines (Federation of State Medical Boards 1995 (“FSMB Model Act”)). As of June 2005, only nine states had adopted variations of the FSMB special purpose model.}

\section*{[C]—Aiding and Abetting}

Some states also discipline physicians who knowingly assist in the “unlicensed” practice of telemedicine. Tennessee, for example, includes as grounds for license denial, suspension, or revocation:

“Transferring of patient medical information to a person in another state who is not licensed to practice medicine or osteopathy in the state of Tennessee using any electronic, telephonic of fiber optic means or by any other method if such information is employed to diagnose and/or treat persons physically located within the state of Tennessee.”\footnote{Tenn. Code Ann. § 63-6-214(b)(21)(A) (2004). This recent amendment to the Tennessee Medical Practice Act provides a number of exceptions, including the transfer of information for an uncompensated second opinion or an “occasional academic consultation” for treatment of a patient outside of Tennessee, for clinical investigations, or for insurance review. Id. at (B).}

Similarly, in Pennsylvania, the board of medicine has the authority to discipline a physician who knowingly aids, assists, procures or
advises an unlicensed person to practice in violation of state law, or maintains a professional relationship with such person.34

[D]—No Specific Telemedicine-Related Law

While every state requires physicians to hold a state-issued license to practice medicine in the state, some have not yet addressed—or could not come to agreement on—specific licensure requirements for telemedical practice by an out-of-state physician. For example, the medical practice laws of the State of Washington do not specifically address telemedicine. They do, however, appear to allow the practice of medicine by a physician licensed in another state by permitting: “[t]he practice of medicine by any practitioner licensed by another state or territory in which he or she resides, provided that such practitioner shall not open an office or appoint a place of meeting patients or receiving calls within [Washington].”35

[iii]—Federal Law

Although no federal legislative action has been taken to date, several telemedicine bills addressing licensure have been proposed. In 1995, Representative Ron Wyden proposed a bill that would have forbidden states from restricting interstate commerce by prohibiting licensed physicians from conducting interstate telemedicine consultations.36 In 1996, Senators Kent Conrad and Bob Kerry introduced a bill that would have directed the Secretary of Health and Human Services to make an annual report to Congress on licensure barriers to “telehealth.”37 In March 1997, Senator Conrad introduced the “Comprehensive Telehealth Act of 1997” which would have, inter alia, provided that “if States are not making progress in facilitating interstate telehealth services by eliminating unnecessary requirements, adopting reciprocal licensing arrangements, implementing uniform licensure requirements, or other means, the Secretary [of the Department of Health and Human Services (“HHS’’)] must include in [an annual report to Congress] recommendations on the Federal actions required to reduce licensure as a barrier to the interstate provision of telehealth services.”38

On April 21, 2004, John Edwards (D-NC) introduced Senate Bill 2325, the “Telehealth Improvement Act of 2004.”\textsuperscript{39} S.2325 would have required, \textit{inter alia}, that, “[w]ithin 1 year of the date of enactment . . . the Secretary [of HHS] shall convene a conference of State licensing boards, local telehealth projects, health care practitioners, and patient advocates to promote interstate licensure for telehealth projects.”\textsuperscript{40}

There even have been serious discussions relating to the establishment of \textit{national} or \textit{federal} medical licensure. Although licensure of physicians has traditionally been the purview of the states, the federal government is beginning to show some interest where telemedicine is concerned. In 1996, the Health Resources and Services Administration (\textit{“HRSA”}) solicited comments on “Legal Issues Related to Telemedicine.”\textsuperscript{41} HRSA sought comments identifying, and suggestions for overcoming, legal barriers to the cost-effective use of telemedicine. In particular, the agency sought “suggestions for easing licensure barriers to physicians and other health care professionals providing telemedicine services across state lines.”\textsuperscript{42} HRSA encouraged respondents to explore the pros and cons of “a wide range of options,” including limited licensure, registration, reciprocity, and national licensure. In his presentation of the “Telemedicine Report to Congress” on January 31, 1997, U.S. Commerce Secretary Michael Kantor reported that one of the key issues that must be settled before telemedicine can proliferate is “the licensure of telemedicine professionals who work across state lines or who provide services on a multi-state basis.”\textsuperscript{43}

[c]—Proposals for Alternative Licensure Arrangements

While the motive behind these laws and policy recommendations is laudable—i.e., ensuring that out-of-state telemedicine physicians meet the same standards as those licensed within the state\textsuperscript{44}—there

\textsuperscript{39} S.2325, 108th Cong. (2004). S.2325 has not been passed into law.
\textsuperscript{40} \textit{Id.} at § 4.
\textsuperscript{42} \textit{Id.}
\textsuperscript{44} Over the phone, and particularly “on the Internet, nobody knows you’re a dog. . . . [Similarly] in many cases, nobody knows if the physician . . . on the other end of the line is a properly licensed physician . . . , where they are located, what the knowledge level or training [of the physician is].” Silverman, “Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards,” 26 Am. J. L. and Med 255, 255 (2000) (citations omitted). “Reliance must be placed upon
are those who would argue that multiple state licensure is unnecessary to achieve that goal. Given that most states have strikingly similar, albeit not identical, licensure requirements, opponents contend that the substantial and ongoing administrative, financial, and legal burdens that a particular telemedicine statute imposes on out-of-state practitioners, and on interstate commerce, may well outweigh any potential benefits to the public health.45 Recognizing the practical problems caused by multiple state licensure, several bodies have proposed alternative arrangements for telemedicine practitioners:

[i]—2001 Telemedicine Report to Congress

The 2001 Telemedicine Report to Congress identified several alternatives to full in-state licensure for out-of-state telemedical practice.46 These include:

[A]—Licensure Based on Negotiated Reciprocity

Licensure based on reciprocity would require a negotiated agreement between states that a license valid in a physician’s home state would be sufficient to allow the physician to practice in the reciprocating state(s) without further review of individual credentials.47

[B]—Licensure Based on Mutual Recognition

Similar to reciprocity, a mutual recognition system would require agreement between two or more states to recognize each other’s medical licensure. Usually this would be accomplished by statute and includes an attempt to harmonize standards.48 While such a model has

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45 “Telemedicine in particular has crystallized the tension between the states’ role in protecting patients from incompetent physicians and protecting in-state physicians from out-of-state competition, and the desirability of ensuring patients’ access to the highest quality medical advice and treatment possible wherever located.” 2003 AMA Physician Licensure Update, supra N. 11.

46 2001 Telemedicine Report to Congress, U.S. Dept. of Health and Human Services, Health Resources and Services Admin., Office for the Advancement of Telehealth (“2001 Telemedicine Report”). The 2001 Telemedicine Report notes that at the time of the 1977 Telemedicine Report to Congress, only 11 states had telemedicine licensure laws. By 2001, 26 states had introduced licensure laws pertaining to telemedicine “that may make it more difficult for physicians to practice medicine across state lines.” Id. at 21-22. It is also noteworthy that, while the 1997 Telemedicine Report was issued by the U.S. Department of Commerce, the 2001 Telemedicine Report was prepared by a new agency, the “Office for Advancement of Telehealth.”

47 Id. at 22.

48 Id.
not been attempted for physician licensure, the National Council of State Boards of Nursing’s ("NCSBN") "Interstate Nurse Licensure Compact" is based on such a mutual recognition model.49

[C]—Registration

Under a registration system, state A would allow a physician from state B to practice (generally, part-time) in state A without meeting state A's licensure requirements, if the physician agrees to operate under the legal authority and jurisdiction of, and be accountable for breaches of professional conduct in, state A.50 In September of 1996, California enacted legislation which gave its medical board authority to develop a registration program to permit a licensed out-of-state physician to register with the board to practice medicine “in this state across state lines,” which is defined as follows:

“A physician and surgeon practices medicine in this state 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, or advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or diagnoses, 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.”51

To date, the board has not exercised that authority.

49 The NCSBN has developed an interstate “Nurse Licensure Compact” which, when adopted by two or more states, allows a registered nurse holding a license in one compact state to practice in any other compact state, provided that he/she complies with the laws and regulations of the state in which he/she is practicing. Model Nurse Licensure Compact (National Council of State Boards of Nursing 2000). Under the compact, any state participating in the compact may take action against the multi-state licensure, but only the nurse’s home state may take action against the primary license. As of July 2008, 23 states had enacted and implemented the RN and LPN/VN Nurse Licensure Compact. National Council of State Boards of Nursing, “Nurse Licensure Compact (NLC) Implementation” (last updated July 2008) available at https://www.ncsbn.org/158.htm (last visited Sept. 15, 2008). In addition to physicians and nurses, “other [health] professions are facing unique professional and regulatory issues in dealing with telepractice and other practice across state lines. Professionals in such fields as mental and behavioral health; speech-language-hearing; teledentistry; occupational therapy; and dietetics; are engaged in discussions about whether licensure changes should be made to accommodate telepractice.” 2003 CTL Licensure Report, supra N. 5, at 4.


[D]—Limited Licensure

A limited licensure scheme would allow a physician licensed in one state to obtain a license in another state for the delivery of specific medical services and/or under specified circumstances. Thus, the scheme would limit the telemedicine physician’s scope of practice as well as location of practice. The FSMB has proposed a model act based on a limited licensure scheme.52

[E]—National Licensure

National licensure would allow for administration at the individual state (or the federal) level but would be based on national standards, including educational and training qualifications for licensure, continuing education requirements, and discipline.53 This system could still require physicians to obtain a license from every state in which they practice, but a common set of requirements would greatly facilitate the process.

[F]—Federal Licensure

Under a federal licensure scheme, physician licensure requirements would be established, and licensure would be granted, by the federal government. Licensure would be based on federally-established standards and would pre-empt state licensure laws. Federal agencies would administer the system, but states could participate in implementation.54

As the 2001 Telemedicine Report recognizes, the federal government has the authority to establish standards and regulations, such as the Medicare regulations that set specific national eligibility requirements for reimbursement.55 This is particularly true where interstate commerce is impacted.56 However, a strong legal presumption against federal preemption of state licensure laws prevails. Therefore, “unless Congress

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52 See supra N. 32 and text accompanying Ns. 58 and 59.
54 Id.
55 Id. at 21. “Congress has previously passed legislation establishing certain national health and safety standards. For example, Congress passed the Mammography Quality Standards Act (MQSA) of 1992, which allows the FDA to establish national standards for mammography facilities and associated staff.” Id. at 4.
acts to regulate telemedicine licensure, the states themselves must
decide to harmonize their standards and laws.”

[ii]—The Federation of State Medical Boards

In 1995, the FSMB proposed that states establish a special license
limited to the practice of telemedicine. The Federation’s model
would make the special telemedicine license available to licensed
physicians who “regularly” practice medicine across state lines by
electronic or other means. It would narrow the consultation exemp-
tion to “informal[.] or irregular,” consultations which are performed
without expectation of compensation. It also would subject the
licensee to the jurisdiction of the medical board in the state of
issuance for all matters, including discipline. Violators would be sub-
ject to criminal prosecution for the unlicensed practice of medicine.
While organized medicine has not wholeheartedly embraced this pro-
posal, some states have adopted legislation incorporating the use of
a “special purpose license” for interstate telemedicine practice.

[iii]—The American Medical Association (“AMA”)

The AMA’s policy is that “medical boards of states and territories
should require a full and unrestricted license in that state for the prac-
tice of telemedicine, unless there are other state-based licensing meth-
ods, with no differentiation by specialty, for physicians who wish to
practice telemedicine in that state or territory.” The AMA would
apply this policy in situations where there is “a telemedical transmis-
sion of individual patient data from the patient’s state that results in
either: (i) provision of a written or otherwise documented medical
opinion used for diagnosis or treatment or (ii) rendering of treatment
to a patient within the board’s state. . . .” The AMA would exempt
from this licensure requirement “traditional informed physician to
physician consultations (‘curbside consultations’) that are provided
without expectation of compensation,” and interstate telemedicine

57 Id. at 21.
58 FSMB Model Act, supra N. 32.
59 See supra N. 32.
60 AMA, Policy Statement H-480.969, “The Promotion of Quality Telemedicine,”
Statement H-480.969”). The AMA “firmly supports state-based licensure for physi-
cians . . . , and opposes national licensure approaches for telemedicine.” 2003 AMA
Physician Licensure Update, supra N. 11.
61 AMA Policy Statement H-480.969, supra N. 60.
practice in “emergent or urgent circumstance” as determined by the
attending and consulting physicians and the patient.”

(iv)—Medical Specialty Associations

Several medical specialty associations have adopted guidelines
regarding licensure for interstate telemedicine activities. Most notable
is the American College of Radiology (“ACR”), the professional
association for radiologists, which has been in the forefront of
telemedicine. The ACR recommends that “[p]hysicians who provide
the official interpretation of images transmitted by teleradiology
should maintain licensure as may be required for provision of radi-
ologic service at both the transmitting and receiving sites.” Similarly,
the College of American Pathologists has published the following
position statement on licensure requirements for telepathology:

“[A] pathologist who engages in the interstate practice of pathology
(including telepathology) and issues a pathology diagnosis that is
contained in the patient’s medical record should have a full, unre-
stricted license to practice medicine from the state in which the
patient presents for diagnosis or where the specimen is taken or
image is made.”

The position statement provides an exception for intraspecialty
consultation.

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62 Id. The AMA also recommends licensure requirements that are “non-burden-
some, issued in an expeditious manner, have fees no higher than necessary to cover
the reasonable costs of administering this process, and that utilize principles of reci-
procity with the licensure requirements of the state in which the physician in ques-
tion practices.” Id.

63 “[T]eleradiology is perhaps the oldest and most mature telemedicine specialty.
Other medical applications have benefited greatly from the research and experience
gained in teleradiology. A significant amount of the enabling technologies (e.g., com-
munications infrastructure, network protocols, image display, and standards) used in
telemedicine were first developed for use in teleradiology.” Krupinski, “Teleradiology
citations omitted).

64 ACR Technical Standard for Teleradiology, supra N. 6, at § V. The ACR defines
“official interpretation” as “that written report (and any supplements or amendments
thereof) that attach to the patient’s permanent record.” Id. at footnote 1.

65 College of American Pathologists, “Licensure Requirements for Interstate Diag-

66 Intra-specialty consultation from an out-of-state pathologist should not require
in-state licensure provided that the consultation is at the request of a in-state pathol-
ologist licensed within the state and if the consultation is reflected in a pathology report
issued by a in-state pathologist. Similarly, pathologists examining specimens and/or
[3]—Credentialing

[a]—Providers

“Credentialing” generally refers to an institutional procedure for evaluating and verifying the qualifications of health care providers for medical staff appointment, reappointment, delineation of privileges, and determining whether individual practitioners possess the necessary qualifications to provide certain services to patients. Credentialing is closely related to, but narrower than, licensure. That is, just because a practitioner is licensed in a particular state does not mean that he or she may see patients at all institutions in that state. Typically, each hospital has its own credentialing procedures to determine which practitioners may see patients at that hospital. Hospitals owe a duty of care to their patients and are, therefore, required to assure that their health care providers meet certain educational and training requirements.

A key issue in telemedicine is whether a physician needs to be credentialed at the institution from which the telemedicine physician’s services are requested, in addition to the physician’s “home” institution. Similar to the situation with licensure requirements, requiring credentialing beyond the physician’s home institution creates significant administrative and financial burdens both for physicians and for hospitals and other health care organizations. However, it can be

67 Blum, “Telemedicine: The Cyber Physician and Credentialing,” HC Law Monthly 3 (Mar. 2000). “Since the Illinois case of Darling v. Charleston Community [sic] Hospital, credentialing has become a capstone process in fulfilling a hospital’s common and statutory obligations in the quality of care area.” Id. (citing Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (Ill. 1965)).

68 Another issue concerns whether telemedicine physicians must undergo special credentialing specifically in connection with the telemedical procedures they perform. Blum, supra N. 67, at 3. “With the evolution of telemedicine into virtual reality, and the accompanying use of robotics, practitioners involved in the delivery of such services will have to demonstrate adequate training and requisite competence in the use of these technologies. . . .” Id. at 5.

69 “Telemedicine faces the potential where every site in which services are provided may conduct an independent assessment of a health professional’s credentials. The medical site where telemedicine services originate, the “hub” facility, will certainly credential specialists who are providing services to patients in outlying facilities, the so-called “spoke” institutions. The issue that arises is whether the spoke facilities must conduct an independent credentialing of the specialists who are electronically treating their patients, or whether these facilities can rely on the credentialing of the job facility. A secondary issue concerns whether the hub facility has a relationship with the patient being treated at the spoke institution, and if so, whether telemedical personnel involved in the spoke’s telemedicine program must be evaluated by the hub facility’s credentials committee.” Id. at 6.
argued that such credentialing serves to protect patients, as well as the institutions that are relying upon the remote practitioner to treat their patients. For example, hospitals that accommodate telemedicine “visits” by remote physicians may be at increased risk for medical malpractice and other types of negligence liability under the doctrine of “ostensible agency.”

Under this doctrine, the telemedicine physician, who is an independent contractor, may be considered an ostensible agent of the hospital if: (1) the patient looks to the hospital for care; and (2) the hospital holds the physician out as its employee, or does not clarify that the physician is not on the hospital’s staff.

Various organizations, including the Joint Commission on Accreditation of Health Care Organizations (“JCAHO”) and the National Commission on Quality Assurance (“NCQA”), have specific requirements for credentialing physicians and other health care providers. Accreditation is important because many government and private payors require that health care institutions achieve independent accreditation. For example, state and federal governments rely upon JCAHO accreditation for both hospital licensure and Medicare certification. The AMA has urged national accrediting bodies such as JCAHO to “require that medical care organizations which establish ongoing arrangements for medical delivery from remote sites require practitioners at those sites to meet no less stringent credentialing standards and participate in quality review procedures that are at least equivalent to those at the site of care delivery.”

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70 See Capan v. Divine Providence Hospital, 430 A.2d 647, 648 (Pa. Super. Ct. 1980). The Capan court explained there are two factors that, together, lead to a finding of ostensible agency between an independently contracted physician and a hospital: (1) “... the changing role of the hospital in society creates a likelihood that patients will look to the institution rather than the individual for care,” and (2) “... [situations] where the hospital ‘holds out’ the physician as its employee.” Id. at 649.


72 JCAHO provides accreditation for hospitals, nursing homes, and other health care facilities. NCQA accredits health maintenance organizations.


74 AMA Policy Statement H-480.969, supra N. 60. More specifically, the AMA has recommended that organized medical staffs “identify to the governing body of the hospital/medical care organization those clinical services that can be provided by telemedicine; and recommends that organized medical staffs (a) amend the medical staff bylaws to allow physicians providing telemedicine to be granted and maintain
[i]—JCAHO: Telemedicine Credentialing Standards

In 2001, JCAHO introduced standards for institutional credentialing of telemedicine providers.75 According to JCAHO: “These standards introduce the concept of credentialing and privileging by proxy. Under special circumstances, the originating site (the site where the patient is located at the time the service is provided) is allowed to accept the credentialing and privileging decisions of the distant site (the site where the practitioner providing the professional service is located).”76 This approach is meant to reduce the credentialing and privileging burden for the originating site; recognize that the distant site has more relevant information upon which to base its privileging decisions; and acknowledge that the originating institution may lack experience in credentialing certain specialties.77

Specifically, JCAHO’s policy provides that, if a telemedicine physician prescribes, renders a diagnosis, or provides clinical treatment to a patient, the physician must be credentialed and have privileges at the institution at which the patient receives the telemedicine service. JCAHO’s standard states that: “Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.”78 The standard requires originating sites to credential and privilege distant-site telemedicine physicians through one of the following three methods:

(1) The originating site may fully privilege and credential the physician according to the traditional privileging and credentialing standards;79

 medical staff membership if they meet other obligations of such membership and (b) incorporate [policies] regarding their responsibility for supervision of non-physician providers and technicians delivering services via telemedicine, in the medical staff bylaws or rules and regulations.” AMA, Policy Statement H-225.962, “Medical Staff Membership Category for Physicians Providing Telemedicine” (1997) available at www.ama-assn.org (last visited Sept. 15, 2008).

75 JCAHO revised its standards for institutional credentialing of telemedicine providers, which became effective January 1, 2004. These standards are contained in the “Medical Staff” chapter of JCAHO’s 2004 Comprehensive Accreditation Manual for Hospitals (“2004 JCAHO Manual”). To date, NCQA has not developed specific telemedicine credentialing standards.

76 Id. at Introduction.

77 Id.

78 Id. at Standard MS.4.120.

79 Id. at Standards MS.4.10 through MS.4.110.

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(2) The physician may be privileged at the originating site using credentialing information from the distant site if the distant site is a JCAHO accredited organization, or

(3) The originating site may use the credentialing and privileging information from the distant site if all the following requirements are met: the distant site is JCAHO-accredited; the physician is privileged at the distant site for the services to be provided at the originating site; and the originating site has evidence of an internal review of the physician’s performance of these privileges and sends to the distant site information that is useful to assess the physician’s quality of care, treatment and services for use in privileging and performance improvement, including, at a minimum, all relevant complaints, adverse outcomes and sentinel events resulting from the telemedicine services provided.

The JCAHO standards also require the medical staffs at both the originating and distant sites to recommend the clinical services to be provided by physicians through a telemedical link at their respective sites.

The JCAHO telemedicine standards begin to guide hospitals regarding how to credential practitioners who provide remote consultations and care to its patients. However, they are not comprehensive. For one thing, the majority of telemedicine services performed in the United States today are not addressed by the JCAHO telemedicine standards. Two groups that have historically delivered their services via telemedicine, but fall outside the scope of the JCAHO standards, are physicians who provide “interpretive services” and those who provide “consultations.”

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80 Id.
81 The originating site retains responsibility for overseeing the safety and quality of services offered to its patients. Id.
82 Id. at Standard MS.4.130.
83 “The services covered under these standards are narrowly defined, focusing solely on physicians who have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine link.” Id. at Introduction. JCAHO also recognizes that telemedical services may be required on an emerging basis. Id. “If the critical access hospital has a pressing clinical need and a physician can supply that service through a telemedicine link, the critical access hospital can evaluate the use of temporary privileges ([Standard] MS.4.100) for this clinical situation.” Id.
84 “Interpretive services” are services in which a physician provides official readings of images, tracings, or specimens through a telemedicine link, such as radiologists and pathologists. Usually, these services are obtained under contract. When this is the method of obtaining the services, the credentialing and privileging of these
Further, while JCAHO’s telemedicine credentialing standards may help to alleviate some of the burden on hospitals in performing remote credentialing, hospitals must carefully consider the legal implications of using another organization’s credentialing and privileging information. For example, notwithstanding JCAHO’s standards, an originating site’s reliance on the distant site’s credentialing and privileging decisions could expose the originating site to claims of negligent credentialing. Such claims may arise, for example, if the distant site fails to exercise reasonable care in credentialing physicians, fails to revoke privileges of an incompetent physician, or fails to monitor the ongoing competency of a credentialed physician and the originating site knew or should have known of these failures.

[ii]—Specialty Credentialing Standards

Several medical specialty organizations have begun to establish their own telemedicine credentialing standards or recommendations, including the American College of Radiology. Today, for example, it is common practice for on-call or “nighthawk” radiologists to interpret images via computer remotely. The ACR recommends that: “When providing the official interpretation of images from a hospital, the physician should be credentialed and obtain appropriate privileges at that institution.”

physicians is addressed under JCAHO’s contracted services standard, LD.3.50, which requires that “services provided by consultation, contractual arrangements, or other agreements are provided safely and effectively.” “Consultations” are services provided by physicians for the sole purpose of offering an expert opinion to and/or advising the treating physician—without the telemedicine physician directing the patient’s care. There are no specific JCAHO credentialing and privileging requirements for such consultative services.

85 See Blum, supra N. 67, at 3-12.
86 2004 JCAHO Manual, supra N. 75. Further, while the JCAHO standards help to clarify some issues related to credentialing inter-institution telemedicine physicians, some states may impose different, and more burdensome, requirements.
87 ACR Technical Standard for Teleradiology, supra N. 6, at § V. The ACR also has issued guidelines regarding “offshore” interpretation of radiological images. The guidelines call for offshore radiologists to be “licensed in the state where the image was originally obtained; be credentialed and maintain privileges at the health care facility where the image was obtained; have appropriate liability insurance for the state where the exam was obtained; and be responsible for the quality of the images being interpreted.” Chin, “Radiologists Weigh In On Outsourcing Of Imaging Work” (June 14, 2004) available at http://www.ama-assn.org/amednews/2004/06/14/bise06 14.htm (last visited Sept. 15, 2008).
[b]—Telemedicine Sites

Telemedicine credentialing is most commonly discussed with regard to individual telemedicine physicians. However, in recent years, there has been discussion regarding institutional credentialing for telemedicine sites. Unlike institutional accreditation, institutional telemedicine credentialing would be narrowly targeted to evaluate an organization’s technical and other capabilities to perform or receive telemedicine services. To date, comprehensive standards for credentialing telemedicine facilities have not appeared. Such standards would go far in establishing appropriate institutional requirements and, in addition, might assist in reducing the potential liability of credentialed sites.

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88 See Blum, supra N. 67.
89 JCAHO recognizes, however, that: “Clinical privileging decisions encompass consideration of the appropriate use of telemedicine equipment by the telemedicine practitioner,” and refers to its “Management of the Environment of Care” chapter standards EC.6.10 and EC.6.20 for standards related to maintaining telemedical equipment. The ACR Technical Standard for Teleradiology also addresses, inter alia, equipment specifications, quality control and improvement, safety, and documentation requirements. ACR Technical Standard for Teleradiology, supra note 11, at § I.
§ 1.03 Corporate Practice of Medicine Prohibitions

In addition to running afoul of state laws prohibiting the unlicensed practice of medicine, some interstate telemedicine arrangements may violate state prohibitions on the corporate practice of medicine. The corporate practice of medicine doctrine derives from the premise that only individual persons are capable of practicing medicine and of receiving licenses to practice medicine. Thus, a corporation cannot practice medicine because it cannot be so licensed. A number of states historically have interpreted this doctrine to mean that a corporation which employs physicians to practice medicine is itself practicing medicine—without a license.¹

The corporate practice of medicine doctrine restricts the practice of medicine to physicians and prohibits lay corporations from practicing medicine through employment of physicians and other arrangements whereby the corporation receives profits from the provision of a physician’s professional services.² Prohibitions against fee-splitting also seek to prevent a lay corporation from receiving profits from the provision of a physician’s professional services, and, in some states, prohibit the sharing of profits among differently licensed medical professionals (e.g., a dentist and a physician).³ The prohibitions on the corporate practice of medicine and fee splitting seek “to prevent the commercial exploitation of the practice of medicine and undue interference by lay persons in medical decisions.”⁴ As the public policy concerns behind both the doctrines overlap, many commentators examine the two together.

¹ “The ‘principal evils’ thought to spring from the corporate practice of medicine are the ‘conflict between the professional standards and obligations of the doctors and the profit motive of the corporate employer.’” Conrad v. Medical Board of California, 55 Cal. Rptr. 2d 901 (Cal. Ct. App. 1996) (quoting People v. Pacific Health Corp., 82 P.2d 429 (Cal. 1938)). See also, e.g.:


New York: People v. John H. Woodbury Dermatological Institute, 192 N.Y. 454, 459 (N.Y. App. Ct. 1908) (No “corporation may undertake to practice medicine without authority of law”).


³ Id.


(Rel. 8)
§ 1.03 TELEMEDICINE & E-HEALTH LAW

At least forty-one states have corporate practice prohibitions in their statutory or case law, or both.\(^5\) Although many of those states do not strictly enforce the prohibitions, “in the opinion of many the doctrine stands today as a formidable threat to entities attempting to establish health care provider services.”\(^6\) Two states in particular—California and Texas—have broad prohibitions on the corporate practice of medicine and fee-splitting. In addition, Illinois, New York, and Tennessee stand out as having broad corporate practice of medicine and anti-fee-splitting prohibitions that might prohibit certain telemedicine arrangements.

California is considered by many to be one of the most restrictive states with respect to corporate practice of medicine and fee-splitting prohibitions. California has long had a strong public policy against permitting the practice of medicine to be unduly influenced by lay persons.\(^7\) Judicial and administrative interpretations of the prohibition emphasize the importance of preventing business interests from unduly influencing medical judgment.\(^8\) California’s standard for determining whether undue control exists is relatively low—the mere potential for control may suffice.\(^9\) The determination is one of degree and requires analysis of both the written instrument governing the arrangement and the actual practice. For example, decisions regarding equipment purchases, selection of patients, and hiring/firing of health care staff are considered inappropriate for delegation to non-physicians.\(^10\)

Texas is also quite restrictive with respect to the corporate practice of medicine and fee-splitting. The Medical Practice Act prohibits physicians from paying or promising to pay any person, including a

\(^5\) Id. The following states do not have a corporate practice of medicine prohibition, either developed by statute or case law: Alabama, Alaska, Arizona, Florida, Louisiana, Mississippi, Nebraska, New Mexico, and Virginia. Id.

\(^6\) Id at 2. In some states, such as Illinois, the fee-splitting laws will not apply (1) if the physicians practice “in a partnership, Professional Association, limited liability company, or Medical or Professional Corporation,” or (2) if the physicians are “concurrently rendering professional services to a patient . . ., the patient has full knowledge of the division, and . . . the division is made in proportion to the services performed and responsibility assumed by each.” Ill. Ann. Stat., Ch. 225, 60/22(A)(14) (2008). Not all states, however, provide such exceptions.


corporation, for securing or soliciting patients.\textsuperscript{11} Texas courts have aggressively enforced these provisions and repeatedly upheld the constitutionality of the provisions of the Texas Medical Practice Act that prohibit the corporate practice of medicine.\textsuperscript{12} Indeed, the Texas Attorney General has issued an opinion prohibiting the corporate practice of veterinary medicine.\textsuperscript{13}

Illinois also has consistently taken a hard line against the corporate practice of medicine. Illinois courts have enforced the prohibition on numerous occasions.\textsuperscript{14} The question as to whether a particular arrangement violates the prohibition on the corporate practice of medicine turns on whether or not the physician’s professional judgment is “safeguard[ed] from lay interference.”\textsuperscript{15} Arrangements whereby the lay corporation sets the physician’s patient schedule, sets forth the procedures for physician vacation time, or furnishes the physician with equipment, services, supplies or personnel may trigger a violation.\textsuperscript{16}

\begin{itemize}
  \item \textsuperscript{11} Tex. Occ. Stat. § 102.051. In addition, payments to any entity to encourage the referral of patients could implicate the Federal Anti-Kickback Statute, 42 U.S.C. 1320a-7(b). See the discussion of the Anti-kickback Statute in Chapter 9.
  \item \textsuperscript{12} See Flynn Brothers, Inc. v. First Medical Associates, 715 S.W.2d 782 (Tex. Ct. App. 1986) (notwithstanding the lack of an employment relationship, a management services organization that was empowered to direct the physicians’ schedules and receive a portion of the physicians’ profits was found to violate the prohibition on corporate practice of medicine); see also, Garcia v. Texas State Board of Medical Examiners, 384 F. Supp. 434, 436 (W.D. Tex. 1974) (stating that the corporate practice of medicine raised serious policy concerns regarding the doctor-patient relationship and the quality of medical care and upholding the prohibition on corporate practice of medicine).
  \item \textsuperscript{13} 1998 Tex. AG LEXIS 179 (Dec. 22, 1998).
  \item \textsuperscript{14} See: Carter-Shields, M.D. v. Alton Health Institute, 777 N.E.2d 948 (Ill. 2002) (holding that a general not-for-profit corporation is not exempt from the general prohibition on corporate practice of medicine and citing to seminal Illinois cases that enforce the prohibition on corporate practice of medicine); People ex rel. Ill. Society of Orthodontists v. United States Dental Institute, Inc., 373 N.E.2d 635 (Ill. App. Ct. 1978) (finding that a dental school that gave advice to students concerning specific patient problems was engaged in unlawful practice of dentistry). See also, Vine Street Clinic v. Healthlink, Inc., 856 N.E.2d 422 (Ill. 2006).
  \item \textsuperscript{15} Carter-Shields, id., 777 N.E.2d at 957.
  \item \textsuperscript{16} Id. at 950. Notably, the Illinois Supreme Court carved out an exception to its corporate practice of medicine prohibition for hospitals (both for-profit and non-profit) in Berlin v. Sarah Bush Lincoln Health Center, 688 N.E.2d 106 (Ill. 1997). When Berlin was decided, it appeared that perhaps Illinois might discontinue its hard line against the corporate practice of medicine. However, five years later, the Court made clear in Carter-Shields that the hospital exception was not to be extended to other entities. Carter-Shields, 777 N.E. 2d at 958 (holding that the public policy rationale behind the hospital exception is that hospitals are authorized under state law to provide medical services and are regulated by state agencies to ensure compliance). Illinois courts have affirmatively declined to extend the exception.
\end{itemize}
New York also has broad prohibitions on corporate practice of medicine and fee-splitting practices. Physicians can be employed or engaged to provide professional services only by a professional corporation (or other professional practice), or by licensed entities such as hospitals, diagnostic centers, or home health agencies. Moreover, New York decisions have suggested that fee-splitting arrangements that are not specifically excepted by statute likely are in violation of the anti fee-splitting rules.

Although Tennessee does not have an express statutory prohibition on the corporate practice of medicine, a seminal Tennessee Supreme Court decision often has been cited as precedent to enforce the prohibition. In *State ex rel. Loser v. National Optical Stores Co.*, the court made clear that public policy concerns, such as the potential conflict between a physician’s patient responsibilities and duties to a corporate employer, counseled against a loose corporate practice of medicine standard. Since *National Optical*, not many Tennessee cases have been decided in this area; however, the few that have been decided have rigidly upheld the corporate practice prohibition. Nevertheless, the lack of recent cases makes the actual enforcement risk unclear.

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17 N.Y. Educ. L. § 6522 (2004), N.Y. Pub. Health L. § 2801-a (2004); see, e.g.: People v. John H. Woodbury Dermatological Institute, 85 N.E. 697 (N.Y. 1908) (finding that a corporation may not practice medicine absent express legislative authority); Albany Medical College v. McShane, 489 N.E.2d 1278 (N.Y. 1985) (finding that a college’s treatment of patients was not in violation of prohibition on corporate practice of medicine because the college’s corporate charter empowered it to promote medical science and instruction); United Calendar Manufacturing Corp. v. Huang, 463 N.Y.S.2d 497 (N.Y. App. Div. 1983) (finding that a corporation not licensed under section 6522 could not practice medicine and thus could not have patients).

18 In the Matter of Odrich, M.D. v. Trustees of Columbia University, 747 N.Y.S.2d 342 (N.Y. Sup. Ct. 2002) (stating that New York courts have consistently held fee-splitting arrangements to be illegal unless the arrangement fits within an exception). Legislation may, however, have the effect of lessening New York’s corporate practice of medicine restriction. Article 31 of the Labor Law, which became effective in 2003, permits Professional Employer Organizations (“PEO”) to be the employer of record for physicians, nurses, and other licensed professionals who provide services to the PEO’s clients. “Professional employer organization” means any person whose business is entering into professional employer agreements with clients. N.Y. Lab. Law § 916 (2004). Factors that suggest that a particular entity is in fact a PEO include evidence that the PEO employs all or a majority of the employees of a client. *Id.* Given this definition of PEO, it appears that a management services organization might qualify as a PEO and therefore, might be able to be the employer of record for physicians, nurses, and other licensed professionals who provide services to the organization’s clients.

19 225 S.W.2d 263, 269 (Tenn. 1949) (holding that a corporation cannot employ a physician).

20 See 1994 Tenn. AG LEXIS 54 (Apr. 12, 1994) (holding that neither for-profit nor non-profit hospitals may employ physicians; such a practice would be in violation of the prohibition on the corporate practice of medicine); see also, Medical
Thus, under most state corporate practice and fee splitting prohibitions, in-state telemedicine physicians may not share compensation derived from patient services with other providers, be they in-state or out-of-state physicians. Nor may the physicians be employed—except by an entity composed only of physicians—to provide the telemedicine services. Moreover, as these prohibitions are grounded in state law, they vary considerably from state to state and may pose significant obstacles for telemedicine “practices” wishing to operate on a national basis. One potential remedy may be to organize the telemedicine practice as a physician-only professional medical corporation, partnership, or professional services association, since such entities may not run afoul of state corporate practice/fee splitting prohibitions.\textsuperscript{21} Non-physicians may, in some states, provide management and other non-patient-related services for the practice.\textsuperscript{22}

\begin{flushright}
Education Assistance Corporation v. State of Tennessee, 19 S.W.3d 803, 813 (Tenn. App. Ct. 1999) (although declining to apply the corporate practice of medicine doctrine because the plaintiff failed to raise the claim in a timely manner, the court states the general prohibition). The only notable exception to the strict application of the doctrine is that Tennessee does not apply the prohibition on corporate practice of medicine to the practice of physical therapy. See 1994 Tenn. AG LEXIS 144 (Nov. 8, 1994).
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\textsuperscript{21} See Serbaroli supra N. 6.

\textsuperscript{22} See Serbaroli \textit{supra} text accompanying Ns. 9-10, 15-16.
§ 1.04 Telemedical Malpractice Liability

Logic would suggest that the practice of telemedicine should reduce liability exposure by providing more comprehensive patient care, by promoting communication with distant specialists, by facilitating access to cutting-edge diagnostic and treatment options, and by improving documentation. In fact, however, the practice of telemedicine may increase the risk of liability for physicians and hospitals who choose to use it—and for those who choose not to.

While the traditional elements of a medical malpractice claim are well-established, a telemedical malpractice case is complicated by a number of new factors, not the least of which is distance. As a result, it raises a variety of new issues, including:

(1) Jurisdiction and choice of laws:
   (A) Which state’s law applies—the law of the state in which the patient resides or the law where the physician is located?
   (B) Which state’s standard of care applies?

(2) Is the standard of care the same for an in-person consultation vs. a telemedicine consultation? Would it be helpful to establish telemedicine practice guidelines to help define or set the standard of care in a telemedicine consultation?

(3) Are the requirements for informed consent different with telemedicine?
   (A) What additional or different information, if any, should patients have for a telemedicine consult, and who should make that determination?
   (B) Does a patient have to be informed that the provider might be out of state?

(4) If telemedicine becomes widely available in rural areas, is a local physician negligent for not recommending it?

(5) Who, if anyone, is responsible for the failure of the equipment or internet connection?
   (A) Can any steps be taken to minimize risks and responsibilities for communication failures—such as prohibiting telemedicine consultations when a communication failure could lead to serious injury or death?
   (B) What degree of internet availability should be required for telemedicine and who should make that determination? Does it depend on the type of telemedicine service being offered—i.e. a higher degree of availability for telesurgery vs. teleradiology?¹

[1]—Procedural Issues

[a]—Jurisdiction: Where a Telemedicine Suit May Be Filed

[i]—Background

In malpractice cases arising out of the interstate practice of telemedicine, one of the issues that the parties may have to deal with is whether the defendant physician—or institution—is subject to personal jurisdiction in the plaintiff’s home state. Whether a defendant located in one state is subject to personal jurisdiction in a court in another state is a matter of Constitutional and statutory law.

The United States Supreme Court has held that for a defendant to be subject to personal jurisdiction in another state, the Due Process Clause of the Constitution requires that the defendant have some “minimum contacts” with the forum in which the suit is filed such that he has “fair warning” that he may be required to defend a lawsuit there.\(^2\) The fair warning requirement is met if the defendant “purposely avails itself of the privilege of conducting activities within

the forum State, thus invoking the benefits and protections of its laws.”

Even if jurisdiction over a defendant is constitutionally appropriate, however, the parties must consider whether jurisdiction is appropriate under applicable state law. Several states have laws providing that personal jurisdiction may be exercised to the full extent permitted by the Constitution, making the constitutional and statutory analyses coextensive.

[ii]—Personal Jurisdiction and the Internet

In the late 1950s, the United States Supreme Court observed that “as technological progress has increased the flow of commerce between States, the need for jurisdiction has undergone a similar increase.” The recent explosive growth of e-commerce has forced courts to apply established principles of jurisdiction law to novel disputes over personal jurisdiction. For example, if a company with physical operations and employees only in Illinois establishes an Internet website, is the company subject to suit in all fifty states? Does it make a difference whether the website is informational or interactive?

The starting point for questions of personal jurisdiction remains International Shoe Co. v. Washington. In that case, the Supreme Court held that a defendant must have sufficient “presence” within a state to make that state’s exercise of personal jurisdiction reasonable. This minimum contacts requirement protects an out-of-state defendant from being sued in a state merely as a result of infrequent or irregular contacts. Specifically, the placement of a product into the stream of commerce, the Court said, does not necessarily mean that the defendant is “present” within the forum state, even if the product finds its way to the forum state, unless the defendant purposely directed itself, its agents, or its product into the state. On the other hand,

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5 Hanson, 357 U.S. at 250-5.
6 International Shoe, 326 U.S. at 310.
7 Id. at 320.
8 Id. at 317.
“systematic and continuous” contacts with a state constitutes sufficient presence such that a defendant could be sued in the forum state even if the specific conduct giving rise to the claim brought by the plaintiff did not occur in that state.9

The leading early case on personal jurisdiction over Internet activities is Zippo Manufacturing Company v. Zippo Dot Com.10 In Zippo, the court had to decide whether Zippo Dot Com, a subscription news service operated exclusively on the Internet and based in California, could be sued for trademark infringement in Pennsylvania. The court held that it could, because it had over 3,000 paying customers in Pennsylvania and had entered into contracts with Pennsylvania-based Internet service providers to make its news service available to Pennsylvania residents. The court reasoned:

“The Internet makes it possible to conduct business throughout the world entirely from a desktop. With this global revolution looming on the horizon, the development of the law concerning the permissible scope of personal jurisdiction based on Internet use is in its infant stages. . . . Our review of the available cases and materials reveals that the likelihood that personal jurisdiction can be constitutionally exercised is directly proportionate to the nature and quality of commercial activity that an entity conducts over the Internet. This sliding scale is consistent with well developed personal jurisdiction principles.”11

The court went on to describe the various extremes of the sliding scale. At one end, a company intentionally and purposefully conducts business over the Internet with out-of-state customers. In such a case, involving contracts and “knowing and repeated” transmission of data over the Internet, personal jurisdiction would be proper in the customer’s home state.12 At the other end, a company posts information on a passive website. Here the Zippo court said that where “[a] passive Web site . . . does little more than make information available to those who are interested,”13 courts should not exercise personal jurisdiction. The court acknowledged that it is the middle ground which presents the most difficult legal questions. In this gray area, the court considered “the level of interactivity and [the] commercial nature of the

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9 Id. at 320.
11 Id. at 1124.
12 Id.
13 Id.
exchange” of data or other products via the company’s website as the standard by which to determine whether the exercise of personal jurisdiction is appropriate.\(^\text{14}\)

Other courts, while not necessarily relying on the Zippo analysis, have found that a passive website, by itself, cannot serve as the basis for personal jurisdiction over an out-of-state defendant. For example, in \textit{Rannoch, Inc. v. Rannoch Corp.}, a Texas company that used its website to post its toll-free numbers and to advertise its products to a national customer base, but not to sell products, was not subject to personal jurisdiction in Virginia.\(^\text{15}\)

Similarly, in \textit{Cybersell, Inc. v. Cybersell, Inc.}, the court held that a Florida defendant’s passive website was not sufficient to subject the defendant to personal jurisdiction in Arizona.\(^\text{16}\) The Cyber\-sell court said that “[c]reating a site, like placing a product into the stream of commerce, may be felt nationwide—or even worldwide—but, without more, it is not an act purposefully directed toward the forum state.”\(^\text{17}\) The court also noted that the defendant did not encourage Arizona residents to use the website and transactions could not be conducted on the website.\(^\text{18}\) Although some cases have held that a passive website is sufficient to establish personal jurisdiction over a company in another state,\(^\text{19}\) these cases have been criticized; the Zippo standard appears to be the majority rule across federal courts.\(^\text{20}\)

\(^{14}\) \textit{Id.}


\(^{16}\) 130 F.3d 414, 419 (9th Cir. 1997).

\(^{17}\) Cybersell, 130 F.3d at 417 (quoting Bensusan Restaurant Corp v. King, 937 F. Supp. 295, 301 (S.D.N.Y. 1996)).

\(^{18}\) In contrast, a passive website, together with an advertising campaign targeting the State of Ohio, was sufficient to subject a company advertising consulting services to the jurisdiction of Ohio courts. Quality Solutions, Inc. v. Zupanc, 993 F. Supp. 621 (N.D. Ohio 1997).

\(^{19}\) See, e.g.: Inset Systems, 937 F. Supp. 161; Telco Communications Group, Inc. v. An Apple a Day, Inc., 977 F. Supp. 404 (E.D. Va. 1977) (agreeing with Inset Systems and holding that an Internet advertisement that can be accessed 24 hours a day constitutes repeated solicitation sufficient to subject an out-of-state defendant to Virginia courts).

\(^{20}\) See:

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Thus, based on current case law, companies that maintain passive websites should not be subject to the courts of foreign jurisdictions solely by virtue of their Internet presence. However, anything more than a passive website—for example, selling products through the web site, posting a toll-free number, or targeting advertisements toward a specific geographic region—may be sufficient to require a company to litigate a customer dispute in the customer’s home state.

[iii]—Jurisdiction and Telemedicine

While the above principles should hold true for health information Internet sites,21 other issues are raised by the on-line practice of medicine. In theory, a telemedicine practitioner may be practicing medicine not only in his or her state of residence, but also the state in which the patient resides, the state where the telemedicine consultation originates, and each state where the practitioner is licensed to practice telemedicine. Several states that require a full in-state license for telemedical practice have responded to the jurisdiction issue with statutes and/or regulations requiring out-of-state telemedicine physicians who treat in-state patients to submit themselves to the jurisdiction of that state.22

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Third Circuit: Toys “R” Us, Inc. v. Step Two, S.A., 318 F.3d 446, 454 (3d Cir. 2003) (finding that, under Zippo, mere operation of a commercially interactive website does not subject the out-of-state defendant to the court’s jurisdiction; rather, there must be a showing that the out-of-state defendant “purposefully availed” itself of conducting activity in the forum state).


Eighth Circuit: Lakin v. Prudential Secs., 348 F.3d 704, 711 (8th Cir. 2000) (“We agree with our sister circuits that the Zippo model is an appropriate approach in cases of specific jurisdiction—i.e., ones in which we need only find ‘minimum contacts.’”).

21 See, e.g., Townsend v. University Hospital-University of Colorado, 83 S.W.3d 913, 922 (Tex. Ct. App. 2002) (neither a Colorado hospital that maintains a website with contact and product information nor the Colorado physicians who are listed on the website, are subject to personal jurisdiction in Texas).

22 See, e.g.:


In general, although there do not appear to be any cases specifically addressing telemedicine-related jurisdictional issues, a number of courts that have considered jurisdiction in traditional interstate practice of medicine cases appear to protect the physician from unexpected lawsuits outside of his or her home state.

In Bradley v. Mayo Foundation d/b/a Mayo Clinic,\textsuperscript{23} for example, a Kentucky resident filed suit against the Mayo Clinic, located in Minnesota. Although the plaintiff sought diagnosis and treatment at the Minnesota facility, the plaintiff argued that Kentucky had jurisdiction over the dispute because: (1) certain Mayo subsidiaries were located in Kentucky, (2) there were several telephone contacts between the plaintiff and the Minnesota facility, (3) at least two Mayo websites were accessible to Kentucky residents, (4) Kentucky physicians received unsolicited Mayo publications from time to time, and (5) Mayo and its subsidiaries engaged in telemedical practices with facilities throughout the country. The court disagreed, finding that there was “no specific evidence that telemedicine services have been provided in Kentucky.”\textsuperscript{24} The court held that the plaintiff failed to demonstrate sufficient contacts between the Mayo Clinic and the State of Kentucky to permit a Kentucky court to exercise jurisdiction over the defendant.\textsuperscript{25} The court’s opinion in Bradley may suggest that courts will require more than mere virtual presence in a state before exercising jurisdiction over a telemedical physician.

Similarly, in Wright v. Yackley, the court held that, in cases involving personal services, the focus is on where the service is rendered.\textsuperscript{26} In that case, an Idaho patient had originally been treated in South Dakota. Upon moving to Idaho, the patient called her South Dakota physician to request that a copy of an existing prescription be mailed across the state line.\textsuperscript{27} The Idaho patient later sued for injuries incurred while taking the drug.\textsuperscript{28} The court found that no tort had been committed within the state of Idaho sufficient to establish jurisdiction over the South Dakota physician.\textsuperscript{29} The court stated that “if

\textsuperscript{24} Id. at *14.
\textsuperscript{25} Id. at *27.
\textsuperscript{26} Wright v. Yackley, 459 F.2d 287 (9th Cir. 1972).
\textsuperscript{27} Id. at 288.
\textsuperscript{28} Id.
\textsuperscript{29} Id.
the appellee was guilty of malpractice, it was through acts of diagnosis and prescription performed in South Dakota. The mailing of the [existing] prescriptions to Idaho did not constitute [a] new prescription. It was simply confirmation of an old diagnosis and prescription.”

Wright suggests that physician follow-up with a patient who has moved to a different state will not alone result in personal jurisdiction over the physician in the patient’s new home state.

This approach is not, of course, universal. Other courts have found that jurisdiction is proper in the state where the patient resides,

while still others have held that the patient’s state of residency is not the dispositive factor.

30 Id. at 288-89.

31 On the other hand, if the physician had initiated a physician-patient relationship with a patient in another state via mail, telephone, or electronic transmission, Wright suggests that courts in the patient’s home state would be able to exercise personal jurisdiction over the physician. Id. at 289 n.4 (“The balance of factors involving a due process determination might be different if a doctor could be said to have treated an out-of-state patient by mail or to have provided a new prescription or diagnosis in such fashion.”). See, e.g.:

Ninth Circuit: McGee v. Riekhof, 442 F. Supp. 1276, 1278 n.1 (D. Mont. 1978) (holding that personal services cases involve a focus on where the service is performed).

State Courts:

Maryland: Presbyterian University Hospital v. Wilson, 654 A.2d 1324, 1335 (Md. 1995) (finding that an out-of-state hospital was subject to the jurisdiction of Maryland courts because the hospital purposefully directed activities at Maryland residents by registering as a Maryland provider and designating itself as a liver transplant referral center).

32 See, e.g.:

Florida: Dean v. Johns, 789 So.2d 1072 (Fla. Dist. Ct. App. 2001) (finding an out-of-state neurologist was subject to the jurisdiction of Florida courts because, even though he was not present in the State of Florida at the time of the patient’s treatment, he saw the Florida patient in his Alabama office, knew the patient was from Florida, had referral relationships with Florida physicians, and had maintained his Florida license).

New Hampshire: Phelps v. Kingston, 536 A.2d 740 (N.H. 1987) (finding that a Maine dentist who practiced solely in Maine was subject to the jurisdiction of New Hampshire courts because the dentist maintained a New Hampshire dental license and advertised his services in New Hampshire and because the patient’s injury manifested itself in New Hampshire).

33 See, e.g.:

Ninth Circuit: Wright, 459 F.2d 487, 289 (9th Cir. 1972) (recognizing that solicitation or issuing prescriptions in the forum state may be sufficient contacts to assert personal jurisdiction over the out-of-state physician).

State Courts:

New York: Ingraham v. Carroll, 687 N.E.2d 1293 (N.Y. 1997) (holding that an out-of-state physician who consulted with a New York physician on a patient residing in New York and possessed a license to practice in New York was not subject to the jurisdiction of New York courts because the out-of-state physician did not derive substantial revenue from the New York residents and practiced solely in his home state).
[b]—Choice of Law

[i]—Background

In a case involving the interstate practice of telemedicine, parties cannot assume that the law of the forum in which a lawsuit is heard will be the governing law. In addition to the jurisdictional question, litigants in such cases will need to address the issue of which forum’s substantive law applies. Where the laws from the candidate forums are largely identical, it may be that the choice of law will not be important. However, in medical malpractice cases, there can be significant differences among states with respect to laws governing issues such as statutes of limitation,34 medical malpractice damages caps,35 state arbitration laws36 and informed consent rules.37 Where there are material differences in the laws sought to be applied, the choice of law may be a substantial factor in determining the outcome of a case.38

Unless predetermined by state statute,39 choice of law doctrine is governed by legal precedent in the jurisdiction hearing the case.40 The

Additionally, if a medical malpractice action meets the diversity of citizenship requirements, a plaintiff could choose to bring suit in a federal district court which sits in the state where the plaintiff lives. See 28 U.S.C. § 1332 (setting forth the requirements for diversity actions). In diversity cases brought in federal court, a defendant who is subjected to personal jurisdiction in federal court in another state may nevertheless seek to have the case transferred to another district. Under the federal venue transfer statute, 28 U.S.C. § 1404(a), federal district courts have the discretion to transfer a case from one federal court to another based on an analysis of: (1) the convenience of the parties, (2) the convenience of the witnesses, and (3) the interests of justice. Whether transfer is appropriate will depend on the unique facts of each case.

34 See Dean, 789 So.2d at 1079 (concluding that when a cause of action arises in another state and its laws forbid maintenance of action because of lapse of time, no action shall be maintained); see also, Heinrich ex rel. Heinrich v. Sweet, 49 F. Supp. 2d 27, 34 (D. Mass. 1999).
35 Grover v. Isom, 53 P.3d 821, 825 (Idaho 2002) (determining that damages and punishments where substantive law and choice of law decision controlled damages).
38 See Poe, “Telemedicine Liability: Texas and Other States Delve Into the Uncertainties of Health Care Delivery via Advanced Communications Technology,” 20 Rev. Litig. 681, 699 (2001); see also: Cepelewicz, “Professional Practice on the Internet and Telemedicine,” 1237 PLI/Corp 159, 165 (2001); Rensberger, supra N. 37, at 64.
39 For example, the Uniform Commercial Code requires the application of the law chosen by the parties (§ 1-105(1)) in certain situations and in other instances for the application of the law of a particular state (§§ 2-402, 4-102, 6-102, 8-106, 9-103). Restatement of the Law (Second), Conflict of Laws § 6 (1971).
precise factors for determining choice of law differs from state to state. However, there are several broad factors that courts generally will consider in determining which state’s law should be applied to a dispute, including: (1) the relevant policies of the forum state; (2) the relevant policies of other interested states in the determination of the particular issue; (3) the protection of justified expectations; (4) the basic policies underlying the particular field of law; (5) certainty, predictability, and uniformity of result; and (6) the ease of determination and application of the law to be applied.

Applying these traditional conflict of law principles to the issues in dispute, courts will decide which state’s laws have the “most significant relationship to the occurrence and the parties.” In tort cases (including malpractice cases), courts generally will consider the following factors in deciding which state’s law applies: (1) the place where the injury occurred; (2) the place where the conduct causing the injury occurred; (3) the residence, domicile, and principle place of business of the parties; and (4) the place where the relationship, if any, between the parties is centered.

[ii]—Choice of Law and Telemedicine

Courts have not yet been asked to consider the above issues in the context of a malpractice action that involves telemedical practices such as, for example, video conferencing, transmission of medical data over electronic networks, or cybermedicine. When such cases do arise, states are likely to apply—or at least attempt to apply—traditional medical malpractice choice of law principles. In the medical

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40 See generally, Dugan v. Mobile Medical Testing Services, Inc., 830 A.2d 752, 759 (Conn. 2003). See also:


State Courts:


41 For example, the Uniform Commercial Code requires the application of the law chosen by the parties (§ 1-105(1)) in certain situations and in other instances for the application of the law of a particular state (§§ 2-402, 4-102, 6-102, 8-106, 9-103). Restatement (Second) of the Law, Conflict of Laws § 6 (1971).

42 Restatement (Second) of the Law, Conflict of Laws, § 145 (1971).

43 Id. at § 145(1).

44 Id. at § 145(2). See also: Dugan, 830 A.2d at 759; Grover, 53 P.3d at 825.
malpractice context, courts generally look to either: (1) where the underlying events leading to the injury took place (e.g., the place of treatment), or (2) where the injured party is domiciled (e.g., the place of injury).45

Reliance on the place of injury is supported by findings that citizens who receive medical attention in their own states, regardless of the medium used to provide that care, presume that they may avail themselves of the remedies available pursuant to the laws of their state.46 However, a strong argument can be made that the place of treatment should dictate choice of law in interstate telemedical malpractice disputes.

“. . . We apply the place of treatment [in interstate medical malpractice claims] rule for two reasons: it is fair and it is more sensible than the place of injury rule. As for the latter reason, the place of injury remains subject to criticism as merely double-counting the plaintiff’s domicile. Indeed this criticism is even more true in telemedicine cases than in traditional ones because the patient predictably will be injured in his home state. The place of treatment rule also continues to serve the goal of allowing the state in which the physician practices to set standards for him.”47

While the place of treatment rule may be one approach to the choice of law issue in telemedical malpractice cases, it begs the question that is at the heart of most disputes regarding applicable telemedicine laws: Where does the “treatment” occur?48

[2]—Providing Health Law Information v. Practicing Medicine

To the extent that a website provides health-related information or generalized medical information, information that is not personalized to a specific user, it should not raise issues of medical malpractice.

45 Rensberger, supra N. 37, at 31.
47 Rensberger, supra N. 37, at 74-76. This view is in keeping with general conflict of law principles including, inter alia, the predictability of the result, the ease of application of the laws, and the promotion of interstate order. Restatement (Second) of the Law, Conflict of Laws, § 6.
48 See Rensberger, supra N. 37.
That is not to say, however, that such sites do not have an obligation to provide accurate information under a general negligence theory.\textsuperscript{49}

If a user is injured allegedly as a result of relying on information provided or, perhaps, not provided on the site, the user may sue the website author and/or the site owner. With respect to the content author, one theory would be that the user would not have been injured had the author not negligently provided the user with information that was incorrect, incomplete, or otherwise not in keeping with the established standard of care. This theory of liability would be analogous to that which a book author may face if a reader detrimentally relied on inaccurate information contained in the author’s book.

Such liability for errors in content has not been firmly defined by the courts but will depend on a variety of factors, including the nature of the “publication,” the ability of the defendant to verify the accuracy of its facts, the intended audience, causation in fact, and the foreseeability of reliance and of injury. It is not unlikely that an author could face liability for negligence where an intended user relied on clearly erroneous health information and injury resulted.\textsuperscript{50}

With respect to a website owner/operator who is not responsible for the content of the health information, its role would be analogous to that of a book publisher or broadcaster. In general, broadcasters and publishers that are not responsible for content and do not endorse the published material have not been held liable for injuries arising from the content of the information they publish or broadcast.\textsuperscript{51}

\textsuperscript{49} See, e.g., Croco, and Jadad, “Two Wrongs Don’t Make a Right: Harm Aggravated by Inaccurate Information on the Internet,” 109 Pediatrics 522 (Mar. 2002) (describing “the first reported case of harm in children associated with the use of information found on the Internet).

\textsuperscript{50} A negligence standard does not require that the information be “error free,” but rather that due care be exercised to reasonably minimize errors. Restatement (Second) of Torts § 282 (1965).

\textsuperscript{51} See, e.g., Jones v. J. B. Lippincott Co., 694 F. Supp. 1216, 1217 (D. Md. 1988) (publisher of a medical textbook not liable to a nursing student injured after following treatment described in the book because publisher had no duty of care with respect to the book’s contents). See also, Libertelli v. Hoffman-LaRoche, Inc., 7 Media L. Rptr. 1734, 1735-36 (S.D.N.Y. 1981) (publisher of Physicians Desk Reference (“PDR”) not liable for patient’s addiction to a drug listed in the PDR, which clearly states that all product descriptions are supplied by drug manufacturers and that the publisher does not advocate the use of any of the drugs). Even where a publisher/broadcaster arguably makes some editorial or discretionary decisions concerning content, courts have found that the First Amendment precludes liability absent some other factor, such as incitement, willfulness, or a special relationship. See, e.g.: Fifth Circuit: Herceg v. Hustler Magazine, Inc., 565 F. Supp. 802 (S.D. Tex. 1983) (absent incitement, publisher not liable for harm caused by explicit description of dangerous sexual practice in magazine article; relying on First Amendment).
Moreover, a website owner/operator that qualifies as a provider of “interactive computer services” will be immune from civil liability under the Communications Decency Act,\textsuperscript{52} under which interactive computer services are immunized “from any cause of action that would make them liable for publishing information provided by a third-party user of the service.”\textsuperscript{53} Where the website is providing health care information to users based on a contract with the users’ physician, hospital, or managed

\textit{District of Columbia Circuit:} S.C. State Ports Authority v. Booz-Allen & Hamilton, Inc., 676 F. Supp. 346, 348 (D.D.C. 1987), the creator-publisher of a consultant report was not immune from liability for negligent factual misrepresentations about the competitors analyzed in the report. The court held that the consultant had a duty to the competitor being critiqued when it undertook an objective analysis and comparison “for the purpose of giving one a market advantage over the other.” The court concluded that such limited liability would have little chilling effect on the free flow of commercial information. 676 F. Supp. at 350.

\textbf{State Courts:}

\textit{New York:} Daniel v. Dow Jones & Co., 520 N.Y.S.2d 334 (N.Y. Civ. Ct. 1987) (absent special relationship, publisher of electronic database not liable to subscriber who was injured by reliance on negligent misstatements; also finding that instantaneous, interactive, computerized delivery of services does not alter the result; relying on First Amendment). Where, however, the publisher is responsible for the content, the First Amendment may not insulate it from liability.

\textsuperscript{52} 47 U.S.C. § 230(c)(1) (the “CDA”). The CDA states that “no provider or user of an interactive computer service shall be treated as the publisher or speaker of any information provided by another information content provider.” The term “interactive computer service” is defined as “any information service, system, or access software provider that provides or enables computer access by multiple users to a computer server, including specifically a service or system that provides access to the Internet and such systems operated or services offered by libraries or educational institutions.” 47 U.S.C. § 230(f)(2).


\textit{Fourth Circuit:} Zeran v. America Online, Inc., 129 F.3d 327, 330 (4th Cir. 1997) (describing the CDA as creating “a federal immunity to any cause of action that would make service providers liable for information originating with a third-party user of the service”).

\textit{Seventh Circuit:} Chicago Lawyers’ Committee for Civil Rights Under Law, Inc. v. Craigslist, Inc., 519 F.3d 666 (7th Cir. 2008) (the CDA does not provide blanket immunity from liability from third-party content, but that the Act prevented the online classified listing service from being treated as publisher or speaker).

\textit{Ninth Circuit:} Carafano v. Metrosplash.com, Inc. 339 F.3d 1119, 1122 (9th Cir. 2003) (under the CDA, “Congress granted most Internet services immunity from liability for publishing false or defamatory material so long as the information was provided by another party”).

If, however, the Internet services provider also functions as an information content provider, then the provider is not immunized for those portions of a statement of which it contributed to or for which it authored content. MCW, 2004 U.S. Dist. LEXIS at *22.
care organization (“MCO”), the site may face liability to the user based on the site’s negligence in performing its contractual obligations. Although the case law regarding third party liability for negligent performance of an undertaking varies widely, a number of courts have permitted recovery, often relying on § 324A of the Restatement (Second) of Torts (Liability to Third Persons for Negligent Performance of an Undertaking). If a user sues under this theory, it is not unlikely that a court would find that by contracting with, for example, an MCO to provide health information, the health care site specifically had undertaken a duty to perform a service that it should recognize as necessary for the protection of third parties—the MCO’s patients. If, in addition, the court finds that the site failed to exercise reasonable care in providing the health information, the author could be liable if such failure caused the injury complained of by the user.

Interactive health care websites, particularly those that obtain and respond to personal data from users, present additional liability issues. The risks and liabilities associated with such a website will depend upon the type of content displayed on the site and the activities that will be conducted through the site. In general, the more personally interactive the site, the higher the risk of liability and the greater the need for risk-reducing procedures, including appropriate disclaimers and notices. The provision of health care information, particularly personalized health care information delivered via an interactive site, raises the potential for medical malpractice—telemedical malpractice—liability.

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54 For example, an Illinois court has held that a fire alarm installation and monitoring company has a duty to exercise reasonable care with respect to third parties adjacent to the area that it is required to protect. Scott & Fetzer Co. v. Montgomery Ward & Co., 493 N.E.2d 1022 (Ill. 1986). See also, Wood v. National Computer Systems, Inc., 814 F.2d 544 (8th Cir. 1987) (suit by teacher against computer company which contracted with state to perform test scoring). But see, e.g.:

Seventh Circuit: U.S. Ecology, Inc. v. Carlson, 638 F. Supp. 513 (C.D. Ill. 1986) (third party hired by Environmental Protection Agency to evaluate plaintiff’s site owed no duty to plaintiff and any damages were not foreseeable).

State Courts:


55 Not the least of these issues is the confidentiality and security of personal health information. Confidentiality and security issues are discussed infra in Chapter 5.

56 “It would seem that a physician who provides generic medical information, or directs users to medical web sites, would not be practicing medicine as it is defined under medical practice or telemedicine laws (such activity may be classified as e-health or telehealth). On the other hand, if a physician provides information that is...
[3]—The Practice of Telemedicine

Drawn from the traditional elements of tort law, the prima facie case for a malpractice liability claim is relatively uniform across jurisdictions.\(^57\) In order to prevail, the patient-plaintiff must show each of the following elements: the physician had a duty to act according to accepted professional standards; the physician breached the applicable standard of care; the patient suffered injury; and a causal connection exists between the breach of care and the patient’s injury. For telemedicine physicians, the most significant issues will be: (1) Does the telemedicine physician owe the “patient” a duty of care: has a physician-patient relationship been established? (2) What is the applicable standard of telemedical care or, more accurately, the applicable standards of care?

[a]—Duty: The Physician-Patient Relationship

In a traditional medical malpractice action, the physician’s duty arises from the physician-patient relationship.\(^58\) In the context of tailored to an individual patient, based on the physician’s awareness of the individual’s condition...
telemedicine, several factors need to be considered in determining when, or if, a physician-patient relationship exists.\textsuperscript{59} 

\textit{[i]—Teleconsultations with the Patient}

A physician-patient relationship will likely be found where: the telemedicine physician and the patient see each other during the telemedicine visit; where an actual exam takes place; where the physician provides diagnosis, treatment or other care on which the patient relies; where the physician has access to the patient’s medical records; and where the physician accepts a fee for the telemedicine consultation.\textsuperscript{60} When considering whether a physician-patient relationship has been established, however, actual contact between the two may not be the dispositive factor. “Although it may be difficult in some circumstances, particularly in an online setting, to define precisely the beginning of the physician-patient relationship, it tends to begin when an individual seeks assistance from a physician with a health-related matter for which the physician may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient and the

\textsuperscript{59} See generally, Blum, supra N. 1, at 413-55. The FSMB’s “Model Guidelines for the Appropriate Use of the Internet in Medical Practice” distinguish between a “General Health Information Site,” which is “a noninteractive Internet site that is accessible by anyone with access to the Internet and intended to provide general, user non-specific information or advice about maintaining health or the treatment of an acute or chronic illness, health condition or disease state,” and a “Medical Practice Site,” which is “a patient-specific Internet site, access to which is limited to licensed physicians, associated personnel and patients. It is an interactive site and thus qualifies as a practice location.” Only the Medical Practice Site “requires a defined physician-patient relationship.” FSMB, “Model Guidelines for the Appropriate Use of the Internet in Medical Practice.” (2002) (“FSMB Model Guidelines”) available at http://www.fsmb.org/pdf/2002_grpol_Use_of_Internet.pdf (last visited Oct. 7, 2008).

patient agrees, whether or not there has been a personal encounter between the physician (or other supervised health care practitioner) and patient. . ." 61

Indeed, courts have held that a traditional physician-patient relationship can be created in the absence of the physician meeting the patient face-to-face. 62 In Dougherty v. Gifford, the Texas Appellate Court held that a physician-patient relationship existed between a pathologist and a patient whose biopsy was incorrectly interpreted as malignant. 63 The pathologist had never met the patient and never reviewed the patient’s records. 64 The court found that a physician-patient relationship was created by the acceptance of the pathology work, the conduct of the tests, the preparation of a lab report, and the acceptance of a fee for the services rendered. 65 The court stated that even though the physician and patient had never met, there could be no doubt that the diagnostic services were furnished for the benefit of the patient. 66 Other courts similarly have found physician-patient relationships between pathologists and patients. 67 Thus, in the telemedicine context, it is unlikely that courts will allow a physician to avoid responsibility for a missed diagnosis or other negligent act on the basis of never having met or directly examined the patient. 68

61 FSMB Model Guidelines, supra N. 59. “[P]hysicians [must] recognize the obligations, responsibilities and patient rights associated with establishing and maintaining an appropriate physician-patient relationship whether or not interpersonal contact between physician and patient has occurred.” Id.


63 826 S.W.2d 668, 674 (Tex. App. 1992).

64 Id.

65 Id. at 675.

66 Id.


See also, Townsend v. Turk, 218 Cal. App. 3d 278 (Cal. Ct. App. 1990) (confining the patient’s claim against a consulting radiologist to theories of medical negligence and not permitting a claim that the radiologist should have obtained independent informed consent from the patient).

68 Other courts have also found medical malpractice liability in instances where the consultant has not met the patient. For example, the Supreme Court of New York held that a telephone call was sufficient to create a doctor-patient relationship. Bienz v. Central Suffolk Hospital, 163 A.D.2d 269 (N.Y. App. Div. 1990) (even though the advice was communicated over a telephone wire rather than in person, the existence of a doctor-patient relationship was an issue of fact for the jury). See also, Diggs v.
[ii]—Physician-to-Physician Consultations

In contrast to the above scenarios, where the telemedicine physician is merely a consultant, and does not interact directly (for example, via the Internet or the telephone) with the patient—or the patient’s specimen—a physician-patient relationship may not be created. Existing case law suggests that consulting physicians do not necessarily establish a physician-patient relationship with a patient solely by virtue of the physician-to-physician consult. In Lopez v. Aziz,69 an obstetrician was consulted once over the telephone by the primary care physician responsible for a pregnant woman. The court ruled that a physician-patient relationship had not been established because the obstetrician did not “conduct any laboratory tests or review the result of any laboratory tests, did not prepare any reports, and did not bill the plaintiff or the primary care physician.”70

In cases such as Lopez,71 physician-to-physician consultations generally will be shielded from malpractice liability. However, not all

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70 Id. at 306. The consultant in Lopez “did no more than answer the professional inquiry of a colleague.” Id. The court noted that “[t]he extension of potential malpractice liability to doctors with whom a treating physician has merely conferred, without more, would unacceptably inhibit the exchange of information and expertise among physicians. This would benefit neither those seeking medical attention nor the medical profession.” Id. (quoting Hill By Burston v. Kokosky, 463 N.W.2d 265, 268 (Mich. Ct. App. 1990)).
71 See:

Arizona Cardiologists, Ltd., 8 P.3d 386, 389 (Ariz. Ct. App. 2000) (finding that the test to be applied is “whether a sufficient relationship existed between the [doctor and patient] such that, as a matter of policy [the doctor] owed [the patient] a duty of reasonable care”). Indeed, courts have found physician-patient relationships in the most casual of circumstances. For example, in Wilson v. Teng, 786 So.2d 485 (Ala. 2000), a pediatrician who had a previous relationship with a patient may have had a duty to the patient when she encountered her in the emergency room while she was seeing another patient and simply stopped by to say “hello.” The Alabama Supreme Court held that there was a genuine issue of fact as to whether Dr. Teng breached the standard of care by not admitting the patient to the hospital despite the fact that, at the time of Dr. Teng encountered the patient, she was neither an emergency physician nor was she even in the emergency room to see that particular patient.

Alabama: Oliver, 342 So. 2d 1 (Ala. 1977), (finding no physician-patient relationship where the physician had been asked, without knowledge of the patient’s name, general questions about the patient’s recommended treatment).

California: Rainer v. Grossman, 31 Cal. App. 3d 539 (Cal. Ct. App. 1973) (finding no physician-patient relationship where a professor of medicine, who was presented with the plaintiff’s x-ray at a lecture and stated he thought surgery was indicated, never met, saw, or treated the plaintiff and had not been consulted by the plaintiff’s doctor regarding the plaintiff’s condition).

cases are so clear cut. Where the “consultant” reviews test results or medical records, interprets them, and makes a diagnosis, a court may be willing to find that a physician-patient relationship was created.\footnote{See Bovara v. St. Francis Hospital, 700 N.E.2d 143, 147-149 (Ill. App. Ct. 1998) (distinguishing the facts from Lopez, and finding that the consulting physicians in Bovara had done more than merely answer the question of a peer; they had made a diagnosis based on the review of medical records, which arguably created a physician-patient relationship despite the fact that neither defendant physician had personally examined the plaintiff). See also, Lection v. Dyll, 65 S.W.3d 696, 712 (Tex. Ct. App. 2001) (distinguishing Lopez and finding that a duty of care could arise where the defendant doctor was on call and was contractually obligated to see the hospital’s patients).}

The consistent theme running through these cases is that a contractual agreement or affirmative act on the part of a physician to interpret test results, make a diagnosis or otherwise provide an informed analysis rather than mere consultation will establish a physician-patient relationship and, thereby, a duty on the part of that physician to provide reasonable care—even if he or she never examines or even meets the patient.\footnote{See also, Greenberg v. Perkins, 845 P.2d 530, 538 (Colo. 1993) (holding that, even when a traditional physician-patient relationship does not exist, a physician who undertakes to examine a non-patient owes a duty to conduct the examination in a manner which will not cause harm to the person being examined). If a physician’s actions harm a patient, or if a physician fails to act and has a duty to do so, then the physician may be liable for damages. Id.}

At first blush, it would seem that this analysis should not differ whether the physician-to-physician consultation occurs face-to-face or via the telephone, Internet or some other new form of telecommunication. However, there may be significant differences between a face-to-face or telephone consultation and a consultation performed via more high-tech telemedical devices. The face-to-face/telephone discussion merely allows the treating physician and the consulting physician to speak to one another; many telemedical devices present opportunities for the consultant to be “virtually present” in the patient’s room. Thus, there is much greater potential for a consulting telemedical physician to “examine” the patient and/or to offer a medical opinion that is seen or heard by the patient. The greater the interaction between the consulting

\textit{Nebraska:} Flynn v. Bausch, 469 N.W.2d 125 (Neb. 1991) (finding no physician-patient relationship where the physician had a general conversation with the plaintiff’s personal physician and did not undertake any part of the care or treatment of the plaintiff).

telemedicine physician and the patient, the more likely that a physician-patient relationship will be found to exist.\textsuperscript{74}

[b]—Standard(s) of Care

As in traditional medical malpractice cases, once a physician-patient relationship has been established, a plaintiff suing for telemedical malpractice must prove that the physician breached the requisite standard of care. The standard of care element of a malpractice case is a two-part inquiry. First, the applicable standard of care must be established. Second, a determination must be made as to whether the physician defendant breached that standard. Historically, the accepted standard of care for malpractice cases was defined as the degree of care exercised by clinicians in good standing in the same or similar locality as the defendant physician.\textsuperscript{75} In recent years, national standards of care, particularly specialty care, have been recognized and accepted by most courts.\textsuperscript{76}

Initially, the same clinical standard of care that applies to a physician providing traditional medical services should apply if the care is provided at a distance. This certainly has been the case with respect to pathology specimens, genetic samples, and radiology films sent out for testing and/or interpretation by mail or messenger. However, the practice of telemedicine is likely to bring additional standards into play—standards relating to the tele part of telemedicine. And most of those standards do not yet exist.

\textsuperscript{74} Caryl, supra N. 60, at 181 (stating that a physician-patient relationship is established if the physician participates in a diagnosis and/or has a duty to be available for consultation). See, e.g.: Lopez, 852 S.W.2d at 303 (citing Salas v. Gambou, 760 S.W.2d 838 (Tex. Ct. App. 1988)); Childs v. Weis, 440 S.W.2d 104 (Tex. Civ. Ct. App. 1969).

\textsuperscript{75} See, e.g.:

- Seventh Circuit: Liebig-Grigsby v. United States, No. 00 C 4922, 2003 U.S. Dist. LEXIS 3682, *33 (N.D. Ill. Mar. 11, 2003) (“In Illinois, the standard of care against which a defendant’s conduct is measured is not the highest degree of skill possible, but the reasonable skill which a physician in good standing in the community would use in a similar case.”).

\textsuperscript{76} Caryl, supra N. 60, at 197 (citing Spencer v. Seikel, 742 P.2d 1126, 1128 (Okla. 1987)). See also:

[i]—Suitability of Telemedicine

Among the myriad “tele”-specific issues that may arise in a telemedical malpractice suit are questions regarding whether the use of telemedicine was appropriate in the specific circumstances of the patient’s care; whether the best available technology, e.g., store and forward vs. dynamic imaging, was used; and whether it was sufficient, for example, to have a pathology assistant rather than a physician select and transmit patient images. Few standards currently exist to address these issues.

In light of the paucity of established standards, and the ever-present risk of liability, some physicians may be reluctant to rely upon telemedicine, particularly new telemedical technology, for patient care. Does a physician increase his or her risk of malpractice liability by utilizing new technologies—or by not using them? With respect to the first inquiry, if the physician utilizes new telemedicine technology, a patient that suffers a poor outcome might allege that the physician negligently utilized the new technology in place of customary practices (e.g., a “hands-on” evaluation). Specifically, for example, the patient might claim that he suffered injury because the remote consult prevented the teleconsulting physician from diagnosing a condition that would have been detected during a face-to-face encounter.

On the other hand, there may be legal imperatives to incorporating telemedicine technologies. For example, a patient whose slide was interpreted by a local pathologist, and who allegedly suffers an injury as a result of an incorrect diagnosis, may argue that her specimen or slide would have been interpreted correctly had it been sent to a distant expert for review. As telemedicine links become more available, and less expensive, this argument may not seem unreasonable. In litigation based on such a claim, one of the major issues will be whether the use of telemedicine services in the circumstances of the particular patient’s case constituted the standard of care at the time the incorrect diagnosis was made. And while this issue certainly will be influenced by the prevalence of the use of telemedicine in similar circumstances, that factor will not always be determinative.77 As

77 In Helling v. Carey, 519 P.2d 981 (1974), the Washington Supreme Court held that two ophthalmologists were negligent for failing to administer a glaucoma test to a young patient even though undisputed expert testimony established that the universal practice of ophthalmologists was not to administer the test to patients under 40. The court applied a reasonable prudence standard, stating that “there are precautions so imperative that even their universal disregard will not excuse their omission.” Id. at 983 (quoting Justice Learned Hand’s opinion in The T.J. Hooper, 60 F.2d 737 (2d. Cir. 1932)).

(Rel. 8)
telemedicine becomes more widespread, courts are likely to hear arguments that “failure to obtain a subspecialty consultation or definitive reading of a complex image or data may violate the standard of care when [such consultation] is readily available using telemedicine technology.”

[ii]—Clinical Standards Specific to Telemedicine

With respect to some medical procedures and services, there will be little distinction between the way a physically-present physician and a telemedicine physician should perform. In such circumstances, the standard of care in both cases should be the same. In other instances, certain uses of telemedicine, such as the transmission of digitized pathology images, already have become part of the customary practice of care for that specialty. In these cases, standard practice is fairly well-established and both physicians and patients are comfortable with the use of telemedicine in the provision of care. In many cases, however, the customary standard of care for a particular procedure may have to be modified significantly to accommodate, inter alia, the fact that the physician will not be able to touch the patient.

Some states already have promulgated regulations that attempt to specify applicable standards of care for telemedicine practice. Colorado’s regulation requires the standard of care for telemedicine treatment to be the same as the standard of care for in-person treatment. Florida’s regulation states that prescribing medicine based solely on an electronic medical questionnaire fails to meet the required standard of care. Texas has a rule similar to Florida’s, which states that the standard of care is not met merely by an online or telephonic evaluation of the patient. The Texas regulation requires the physician to

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79 See Caryl, supra N. 60, at 197.
80 Id. at 199. In California, the University of California-Davis’ Telemedicine Learning Center trains physicians on how to conduct a proper telemedicine examination, available at http://www.ucdmc.ucdavis.edu/cht/services/education/curriculum.html (last visited on Sept. 11, 2008). Although the Center does not appear to provide training specific to any subspecialty, the Center’s curriculum focuses on the general standard of care for any telemedical provision of care. Id.
84 22 Tex. Admin. Code § 174.4 (2004). The statute states that “Treatment and consultation recommendations made in an online setting, including issuing a prescription
diagnose the patient using acceptable medical practices, discuss treatment options with the patient, and be available for follow up care, if necessary.\textsuperscript{85} At least two states require that a physician treating a patient via telemedicine keep that patient’s records confidential.\textsuperscript{86} Although these and other states may have begun to establish a telemedicine standard of care, that standard is a moving target.\textsuperscript{87} New technology will drive revisions to such standards, and physicians who practice telemedicine will be held responsible for staying current with respect to those changes.

\textit{[iii]—Voluntary Standards for Telemedicine Practitioners}

Development of national standards specific to telemedicine is still in its infancy, but the need for telemedicine guidelines, both within and across specialties, has not gone unnoticed. For a number of years, the AMA has been urging national medical specialty societies to develop and implement “comprehensive practice standards and guidelines to address both the clinical and technological aspects of telemedicine.”\textsuperscript{88} In the teleradiology area, the ACR has established national guidelines for the electronic transmission of radiological images for medical interpretation and consultation.\textsuperscript{89} The ACR standard addresses equipment specifications, personnel qualifications, licensing, credentialing, documentation, quality control and improvement, and other issues.\textsuperscript{90} Similar efforts by other specialty associations

via electronic means, will be held to the same standards of appropriate practice as those in traditional (face-to-face) settings.” \textit{Id.}

\textsuperscript{85} Id.


\textsuperscript{90} Id.
are helping to promote uniformity and certainty for telemedicine practitioners, and may provide a strong basis to assist courts in establishing appropriate specialty standards of care for telemedicine practitioners.91

The AMA also has proposed guidelines for the supervision of non-physician providers and technicians where telemedical procedures are used. Notably, the guidelines emphasize that “[t]he physician is responsible for, and retains the authority for, the safety and quality of services provided to patients by nonphysician providers through telemedicine.”92 The guidelines also recommend, inter alia, that “[p]hysicians should visit the sites where patients receive services from non-physician providers or technicians through telemedicine, and must be knowledgeable regarding the competence and qualifications of the non-physician providers utilized.”93

In 2002, the FSMB Special Committee on Professional Conduct & Ethics published “Model Guidelines for the Appropriate use of the Internet in Medical Practice” for adoption by state medical boards.94 The FSMB Model Guidelines provide, inter alia, that:

(1) A documented patient evaluation, including a history and physical exam “adequate to establish diagnosis and identify underlying conditions and/or contra-indications” must be obtained prior to providing any treatment, including issuing prescriptions.

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93 Id. at 2.

94 FSMB Model Guidelines, supra N. 59. “In developing the guidelines . . . the Committee evaluated current and projected use of the Internet in the delivery of health care services and identified two distinct areas of e-health: health information and delivery of patient care. The Committee focused the guidelines on the latter due to its direct impact on patient safety and welfare and the physician-patient relationship.” Id.
(2) Treatment and consultation recommendations must be “held to the same standards of practice as those in traditional (face-to-face) settings.”\(^{95}\)

(3) Written policies and procedures should be maintained regarding physician-patient e-mail.\(^{96}\)

(4) Use of a written informed consent agreement documenting, *inter alia*, patient consent for the use of physician-patient e-mail.\(^{97}\)

(5) Patient medical records must be kept and should include copies of all patient-related electronic communications, including physician-patient e-mail and informed consent documentation.

The Guidelines also specify that “[p]hysicians who treat or prescribe through Internet Web sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients reside.”\(^{98}\)

[c]—**Informed Consent**

[i]—**Background**

Informed consent refers to a “process of communication between a patient and physician that results in the patient’s authorization or agreement to undergo a specific medical intervention.”\(^{99}\) The doctrine of informed consent was first recognized in *Schloendorff v. New York Hospital*, which found that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”\(^{100}\) In most states, a physician who fails to obtain informed consent

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\(^{95}\) *Id.* Specifically, “[treatment . . . based solely on an on-line questionnaire or consultation does not constitute an acceptable standard of care.” *Id.*

\(^{96}\) *Id.* Policies and Procedures should address such issues as privacy, security, turnaround time for physician responses, and availability of alternative forms of communication for emergencies. *Id.*

\(^{97}\) *Id.* The Guidelines call for including such issues as permissible types of transmissions (e.g., prescription refills, appointment scheduling); security measures; and circumstances in which alternate forms of communication or office visits should be utilized. *Id.*

\(^{98}\) *Id.* In addition, the Guidelines prohibit “[a]dvertising or promotion of goods or products from which the physician receives direct remuneration, benefits or services,” and links to web sites from which the physician may benefit financially. *Id.*


\(^{100}\) Schloendorff v. Society of N.Y. Hospital, 105 N.E. 92, 103 (N.Y. 1914).
from a patient may face liability for assault, battery, fraud and/or negligence.\textsuperscript{101}

A majority of states use a “professional standard” as the basis for determining the adequacy of disclosure,\textsuperscript{102} although a sizable minority of states apply a “reasonable patient standard.”\textsuperscript{103} The reasonable patient standard requires that the physician explain the medical procedure to the patient in plain English, because the average patient will not understand medical terminology.\textsuperscript{104} Additionally, some states require the disclosure of specific factors including diagnosis, nature and purpose of treatment, risks and outcomes, skill or status risks, alternatives, prognosis without intervention, prognosis with intervention, and potential conflicts of interest as part of the informed consent process.\textsuperscript{105}

\textsuperscript{101} See, e.g.:

\textit{Alabama:} Cain v. Howorth, 877 So.2d 566 (Ala. 2003) (discussing various theories of physician liability, including fraud and battery, for failure to obtain informed consent).

\textit{Alaska:} Korman v. Mallin, 858 P.2d 1145 (Alaska 1993) (citing Alaska Stat. § 09.55.556(a) as creating a “but for” standard for physician liability for failure to obtain informed consent in appropriate circumstances).


\textsuperscript{103} Martin and Bjerknes, supra N. 102, at 451 (describing the reasonable patient standard as requiring that “the physician inform the patient of all the information that a reasonable patient in the patient’s position would want to know to make an informed decision about a treatment option”). See, e.g.:


\textbf{State Courts:}


\textsuperscript{104} Canterbury, 464 F.2d at 780.

\textsuperscript{105} See, e.g.:

\textit{Connecticut:} Alswanger v. Smego, 776 A.2d 444, 449 (Conn. 2001) (stating that informed consent is adequate only if all four of the following disclosures are properly made: (1) the nature of the procedure; (2) the risks and hazards of the procedure; (3) the alternatives to the procedure; and (4) the anticipated benefits of the procedure).

\textit{Illinois:} Coryell v. Smith, 653 N.E.2d 1317, 1319 (Ill. App. Ct. 1995) (stating that the informed consent doctrine requires that a physician discuss the following with the
Physicians and investigators must obtain the informed consent of patients and subjects prior to any substantial intervention. Such consent may be written or oral, depending on the risks associated with the procedure. For example, if a patient is receiving a routine blood test, the physician may informally obtain consent from the patient rather than seeking written consent. On the other hand, if the patient is to undergo surgery, the physician must fully inform the patient of the risks and benefits associated with the surgery and obtain documentation of the patient’s informed consent. Moreover, where
more than one physician is involved in providing care, each physician that has a physician-patient relationship with the patient may have an independent duty to obtain informed consent.\footnote{110}

\[\text{[ii]—Informed Consent in the Telemedicine Context} \]

\[\text{[A]—General Framework} \]

Physicians practicing telemedicine also are obligated to obtain informed consent from their patients. Indeed, a few states already mandate by statute that such consent be obtained if a patient is receiving telemedical care.\footnote{111} However, unlike the traditional scenario where physicians may obtain oral consent when the risks associated with a procedure are relatively low, prudence suggests that telemedicine practitioners should obtain written consent from the patient regardless of the level of risk involved, unless oral consent alone is permitted by statute.\footnote{112}

Moreover, the practice of telemedicine raises novel informed consent issues and more than one type of consent may be necessary. A practitioner should consider documenting consent for the general risks of a treatment or procedure, as well as special consent for the

\footnote{110} See Prooth v. Wallsh, 432 N.Y.S. 2d 663 (N.Y. Sup. Ct. 1980) (in a malpractice suit against a hospital, a treating physician, a consultant cardiologist, a surgeon, and an assisting surgeon, both the treating physician and the surgeon can be liable for lack of informed consent because each had a direct relationship with the patient).

But see, e.g.:

California: Townsend v. Turk, 266 Cal. Rptr. 821 (Cal. Ct. App. 1990) (consulting radiologists who provided advice to the treating physician but never examined the patient had no obligation to obtain informed consent).

Hawaii: O’Neal v. Hammer, 953 P.2d 561 (Haw. 1998) (distinguishing between a “referring physician,” who neither performs a procedure nor retains control over the patient’s treatment and does not have a duty to obtain informed consent, and a “second opinion physician,” who owes a duty to the patient to inform the patient of risks associated with a proposed procedure).

Missouri: Nicoli v. Thompson, 731 S.W. 2d 577 (Mo. Ct. App. 1986) (oncology consultant has no obligation to discuss alternative treatments with patient).


\footnote{111} See:


\footnote{112} Thus far, only Arizona permits oral consent alone. Ariz. Rev. Stat. Ann. § 36-3602. And even when consent is obtained orally, it must be documented on the patient’s record. Id. at A. California requires both verbal and written consent. Cal. Bus. & Prof. Code § 2290.5.
specific risks associated with the use of telemedicine for that treatment or procedure. Additionally, in the context of the interstate practice of telemedicine, both the teleconsulting physician’s home state and the patient’s home state may impose informed consent duties on the physician.\textsuperscript{113}

More specifically, particularly because the use of telemedicine will be a new experience for most patients, the treating physician should explain to the patient the risks and benefits associated with receiving medical care from a telemedicine physician and/or through the use of telemedical technology. At a minimum, the patient should know that a telemedicine consult: (1) necessitates that the treating physician and the telemedicine physician discuss the patient’s health information via telecommunication technology, (2) may require that non-medical staff be involved in the consult for the purposes of operating the technology, both at the treatment site and at the teleconsult physician’s site, and (3) may be recorded by audio, video, or some other medium.\textsuperscript{114}

The patient also should be advised that, as with any technology, telemedicine systems are vulnerable to failure and unauthorized access,\textsuperscript{115} and should be informed of the features of the technology that attempt to protect against such problems. In addition, the patient should be advised of his or her rights to privacy and informed consent. Finally, the patient should be informed regarding the state(s) in which the telemedicine physician is licensed and should be advised of the procedure for follow-up.\textsuperscript{116}

\textit{[B]—Current State Regulation}

Like licensure requirements, informed consent requirements vary from state to state. Indeed, consent requirements are even more difficult to clarify because they often derive from state common law. Currently, only four states—Arizona, California, Oklahoma, and Texas—statutorily mandate that physicians obtain the informed consent of the patient before proceeding with telemedical treatment.\textsuperscript{117}

\textsuperscript{113} See, e.g., Ill. Ann. Stat., Ch. 225, 60/49.5(e) (scheduled to be repealed on Dec. 31, 2008) (No additional information about a replacement section is available). In such circumstances, it may be prudent for the consent documentation to be retained in the records of both the on-site provider and the telemedicine consultant.

\textsuperscript{114} See Caryl, \textit{supra} note N. 60, at 200-01.

\textsuperscript{115} \textit{Id.}

\textsuperscript{116} Patients should be told up front which physician—the referring physician or the teleconsult physician—should be contacted if the patient has any follow up questions.

\textsuperscript{117} See:


Arizona requires a “treating health care provider” to obtain the patient’s informed consent—verbal or written—before delivering health care through the use of telemedicine.\(^{118}\) If the physician obtains oral consent, such consent must be documented in the patient’s medical file.\(^{119}\) However, the consent requirements do not apply “if the patient is not directly involved in the telemedicine interaction,” if the patient is unconscious or unable to give consent, or “to the transmission of diagnostic images to a health care provider serving as a consultant or the reporting of diagnostic test results by that consultant.”\(^{120}\)

California requires that the health care practitioner “who has ultimate authority over the care or primary diagnosis of the patient” must obtain verbal and written informed consent prior to the delivery of health care via telemedicine.\(^{121}\) The statute specifically defines telemedicine to include “consultation” and the “transfer of medical data.”\(^{122}\) The informed consent procedure must ensure that the patient receives at least all of the following information verbally \textit{and} in writing:

\begin{enumerate}
\item The patient retains the option to withhold or withdraw consent at any time without affecting the right to future care or treatment nor risking the loss or withdrawal of any program benefits to which the patient would otherwise be entitled;
\item A description of the potential risks, consequences, and benefits of telemedicine;
\item All existing confidentiality protections apply;
\item Patient access to all medical information transmitted during a telemedicine conference is guaranteed, and copies of this information are available for a reasonable fee; and
\item Dissemination of any patient identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without the consent of the patient.\(^{123}\)
\end{enumerate}

\begin{itemize}
\item \textit{Oklahoma:} 36 Okla. Stat. § 6804(B) (requiring written consent).
\item \textit{Texas:} Tex. Occ. Stat. § 111.002 (permitting oral consent for in-state telemedicine services; requiring written consent for out-of-state telemedicine services).
\item \(^{119}\) \textit{Id.} at (A).
\item \(^{120}\) \textit{Id.} at (F).
\item \(^{121}\) Cal. Bus. & Prof. Code § 2290.5.
\item \(^{122}\) \textit{Id.} at (a)(1). Furthermore, telephone conversations and e-mail communications are specifically excluded from the definition. \textit{Id.}
\item \(^{123}\) \textit{Id.} at (c).
\end{itemize}
The signed written consent statement must become part of the patient’s medical record. Similar to Arizona, these requirements do not apply when the patient is not directly involved in the telemedicine interaction (e.g., a consultation) or in emergency situations where the patient is unconscious or unable to give consent.

Oklahoma’s telemedicine law provides that the health care provider “who is in physical contact with the patient shall have the ultimate authority over the care, and shall obtain informed consent from, the patient” prior to the delivery of health care via telemedicine. The information required in the informed consent procedure is virtually identical to that required by California; however, Oklahoma requires only written consent. Moreover, the Oklahoma statute also provides that the consent provisions do not apply to consultations where the patient is not directly involved, consultations where the patient is in an Oklahoma prison, and emergency situations where the patient is unconscious or unable to give consent.

Texas also requires the patient’s consent when telemedicine services are provided by a physician. Although the statute is silent as to whether such consent may be obtained orally, a Texas regulation requires that written consent be obtained from Texas patients who are “the subject of out-of-state consultation by electronic means other than telephone or telefacsimile.” Principles of statutory construction might suggest, therefore, that physicians may obtain only oral consent from patients who are the subject of in-state telemedicine consultations. Prudence, however, cautions otherwise.

[d]—Apportionment of Liability

The use of telecommunications to access health care services from more than one provider raises the issue of who is responsible if malpractice occurs. The question of ultimate responsibility for patient care when more than one physician is involved often has been

124 Id. at (e).
125 Id. at (h) - (i).
127 Compare id. with Cal. Bus. & Prof. Code § 2290.5(c).
128 36 Okla. Stat. § 6801(B). Such consent must become part of the patient’s medical record. Id. at (E).
129 Id. at (C), (F)-(G).
131 The most recent Texas Admin Code does not contain the quoted language at all. I searched other section of the Code, too, and could find no guidance as to whether consent must be obtained orally or written. I checked Chap. 165 (Med Records) and found no support there, either.
addressed in medical malpractice cases. As a general rule, where one physician’s acts are clearly distinguishable from those of the other involved physician(s), and the injury is divisible, a physician will be held liable only for the damage caused by his or her own actions. Where the independent acts of multiple physicians supplement one another and contribute to an indivisible injury, the physicians are considered to be joint tortfeasors; that is, they may be jointly and severally liable for any harm to the patient that results from the advice of any of the physicians. Where it is not clear whether the injury suffered by the plaintiff is divisible in terms of which physician caused the harm, however, there is a trend toward allowing joint and

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132 See, e.g.:

**California:** Marina Emergency Medical Group v. Superior Court of Los Angeles County, 100 Cal. Rptr. 2d 866, 868-9 (Cal. Ct. App. 2000) (a tortfeasor physician is liable not only to the injured patient for the original injury, but also for any aggravation of the injury caused by another physician whose services were subsequently secured).

**Illinois:** Barowski v. Von Solbrig, 303 N.E.2d 146 (Ill. Ct. App. 1973) (finding that a surgeon treating a preexisting injury was only responsible for his own negligent treatment, not for the negligence of the physician who initially treated the injured patient, where the injury caused by each physician was separate and divisible).

**New York:** Ravo v. Rogatnick, 514 N.E.2d 1104, 1106 (N.Y. 1987) (stating that when liability can be apportioned, independent and successive liability will apply to medical malpractice actions).

133 See, e.g.:


Moreover, absent evidence of agency, concerted action, or negligent referral, one physician generally will not be liable for the negligent acts of a physician to whom he or she referred a patient. See, e.g., Stovall v. Harms, 522 P.2d 353 (Kan. 1974) (defendant physician who referred patient to psychiatrist not liable for negligence of psychiatrist absent concerted action or negligence in the referral).


**New Mexico:** Lujan v. Healthsouth Rehabilitation Corp., 902 P.2d 1025, 1028 (N.M. 1995) (articulating indivisibility rule for concurrent torts that contribute to a single injury); Merrimen v. Toothaker, 515 P.2d 509, 513 (Wash. Ct. App. 1973) (joint and several liability will attach unless there is “substantial proof” as to what damage was caused by each physician).

**New York:** Ravo v. Rogatnick, 514 N.E.2d 1104, 1106 (N.Y. 1987) (holding a pediatrician jointly and severally liable with an obstetrician for injuries negligently inflicted on a child, resulting in brain damage that rendered her severely and permanently retarded).

See also, Restatement (Third) Torts: Apportionment of Liability, § A18(a) (2000); see also, id. at § 26 (Apportionment of Liability When Damages Can Be Divided by Causation).
several liability against independently treating physicians.\textsuperscript{135} Therefore, if it cannot be shown which physician is responsible for a patient’s injury, a court may find all of the physicians involved in the patient’s treatment to be jointly and severally liable.\textsuperscript{136}

Although relevant cases have not yet arisen in the telemedicine context, general principles of joint and several liability should apply when apportioning liability between, for example, the local treating physician and the remote telemedicine specialist. However, as with many legal issues arising from telemedical practice, apportionment of liability will be a matter of state law, and thus will vary from state to state.\textsuperscript{137}

[e]—Insurance

Exacerbating concerns over potential telemedical malpractice liability is the fact that medical malpractice liability insurance policies may not cover allegations of “telemedical malpractice.” Yet, physicians who are involved in the practice of telemedicine may be in particular need of such coverage.

For one thing, malpractice liability insurance policies may not cover telemedicine activities that cross state lines, or where the physician is found to be practicing telemedicine “without a license.”\textsuperscript{138} Thus, a physician may wish to limit the provision of telemedicine services to patient(s) in the state(s) in which the physician is licensed or state(s) in which licensing laws permit out-of-state physicians to practice in-state via telemedicine.\textsuperscript{139} A liability insurer also may not provide telemedicine coverage where the alleged malpractice arises from actions or omissions relating to the telecommunications rather than the medical aspects of the service.\textsuperscript{140} Accordingly, physicians

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{135} McMahon, supra N. 134, at 758.
\item \textsuperscript{136} See, e.g., Ravo, 514 N.E.2d at 1109. Although treatment by the physicians was not concurrent, the responsibility for the injury was not divisible.
\item \textsuperscript{137} Some states undoubtedly will address the issue by statute. In California, the Telemedicine Development Act of 1996 prevents out-of-state consultants (those not licensed in California) from having “ultimate authority over the care or primary diagnosis of a patient” located in California. Cal. Bus. & Prof. Code § 2060. This was a reform of the state’s licensing law, but it has implications for malpractice liability.
\item \textsuperscript{138} The ACR Technical Standard for Teleradiology, supra N. 89, at § V, recommends that physicians consult with their professional liability insurance carrier to ensure coverage in both the sending and receiving states. However, it is highly unlikely that a policy would provide coverage in any state where the radiologist was found to be practicing teleradiology “without a license.”
\item \textsuperscript{140} Terry, supra N. 139, at 607.
\end{itemize}
\end{footnotesize}
should ensure that their malpractice liability insurance policy covers such telemedicine-related telecommunications errors.

In short, prior to participating in telemedicine activities, physicians should seek written assurances from their liability insurer that their medical malpractice liability insurance policies cover allegations of telemedicine malpractice. Specifically, a telemedicine physician's medical malpractice liability insurance policy should contain an endorsement specifying that the policy covers medical malpractice and related claims arising from medical diagnosis, treatment, consultation and/or referral, including claims arising in connection with the use of telecommunications technology, and that such coverage is provided for every state the telemedicine physician "enters."¹⁴¹

If a malpractice carrier does agree to extend coverage to multiple states for telemedicine services, practitioners likely will pay increased premiums for such coverage. "A current lack of consensus on [telemedicine's] core issues makes anticipating telemedicine malpractice outcomes problematic for insurance carriers, which may affect rates for liability coverage."¹⁴³ Some insurance companies may believe that telemedicine encourages physicians to work together, and that patient treatment will be more comprehensive and result in less overall risk of malpractice.¹⁴⁴ However, others may believe that increased technology raises patient expectations and, when those expectations are not met, results in additional medical malpractice claims.¹⁴⁵ Further, telemedicine adds the additional risk of equipment failures and transmission errors. Because of these unresolved issues,


¹⁴¹.¹ Indeed, several states now forbid private insurers from discriminating against telemedicine providers. See, e.g., Georgia House Bill 291 (2005), which requires that health insurance policies include coverage for telemedicine services. (Signed into law by Governor on May 2, 2005. Act. No. 82.)


¹⁴⁴ Id.

¹⁴⁵ Id.
telemedicine practitioners are likely to find that, if in fact they can obtain comprehensive telemedicine coverage, it is likely to come at a significantly higher price.\footnote{146}

[4]—Telemedicine Equipment

[a]—Technical Standards

In addition to the promulgation of clinical telemedical practice standards,\footnote{147} a number of technical standards and guidelines have been developed in an effort to assure the clarity, reliability, interoperability, and interconnectivity of telemedicine equipment. For example, the 2001 Telemedicine Report to Congress proposed that “[t]he clinical technical standard for image quality in a video transmission would specify the technical standards needed by a specialist, such as a dermatologist, to achieve the high levels of image clarity and color required to correctly diagnose a patient.”\footnote{148}

Similarly, the ACR states that “[t]eleradiology is not appropriate if the available teleradiology system does not provide images of sufficient quality to perform the indicated task. When a teleradiology system is used to render the official interpretation, there should not be a clinically significant loss of data from image acquisition through transmission to final image display.”\footnote{149} ACR recommends compliance with the Digital Imaging and Communication in Medicine (“DICOM”) standard developed by the ACR and the National Electrical Manufacturers Association (“NEMA”).\footnote{150}

\footnotetext[146]{If a malpractice insurer is unwilling to cover failures of telecommunications problems, telemedicine equipment failure or similar “non-medical” claims, a telemedicine practitioner may wish to seek a general negligence insurance policy to cover such failures.}

\footnotetext[147]{See supra text accompanying Ns. 79-87.}


\footnotetext[149]{ACR Technical Standard for Teleradiology, supra N. 89, at § 1.}

[b]—Physician and Hospital Liability for Equipment Problems

A physician using telemedical equipment, and the hospital furnishing such equipment, may be at risk of liability for the equipment’s failure or malfunction if it causes injury to a patient. 151 A physician may be held responsible for any harm to a patient caused by his lack of knowledge or skill, or the failure to use reasonable care and diligence when selecting or using any equipment for treating a patient. 152 Thus, telemedical malpractice liability may result from a physician’s negligent selection of telemedical equipment, misuse of the equipment, or misdiagnosis or mistreatment based on faulty data received from the equipment.

Courts have considered whether a physician may be liable for an injury caused by a defect which the physician should have noticed. 153 Accordingly, a practitioner should inspect the telemedical equipment he or she uses for obvious defects. 154 Indeed, all health care providers who use telemedicine to deliver health care information or services should be adequately trained in the use of the equipment so that they are qualified to identify obvious defects in telemedical equipment. 155

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151 See Shipley, Annot., “Hospital’s Liability to Patient for Injury Sustained From Defective Equipment Furnished by Hospital for Use in Diagnosis or Treatment of Patient,” 14 A.L.R.3d 1254, 1256-58 (1967).

152 See, e.g.: Georgia: Davis v. Glaze, 354 S.E.2d 845 (Ga. Ct. App. 1987) (finding a hospital surgeon, and manufacturer of a electrocautery grounding pad liable for the pad’s malfunction during an operation where the plaintiff’s thigh was severely burned).

Missouri: Reeves v. Lutz, 162 S.W. 280, 283 (Mo. Ct. App. 1913) (finding that a physician is obligated to exercise reasonable care to protect his patient from burns likely to occur during the application of a hot water bottle).


153 See, e.g., Anderson v. Somberg, 386 A.2d 413 (N.J. Super. Ct. App. Div. 1978). In Anderson, an injured patient sued his neurosurgeon, the hospital, and the manufacturer of a metal instrument after part of the instrument broke off during surgery and became lodged in the patient. Although the court affirmed the dismissal of the claims against the neurosurgeon, and found the instrument manufacturer and distributor liable to the patient, the neurosurgeon’s liability for alleged negligence or malpractice was a question of fact at the trial level. Id. at 415.

154 See, e.g., ACR Technical Standard for Teleradiology, supra N. 89, at footnote 2 (a diagnostic radiologist should interpret radiographs and other images only when, inter alia, “the radiologist reasonably participates in the quality of the medical imaging”).

155 Telemedicine physicians should seek training on how to inspect equipment from the manufacturers of the equipment or from health institutions that provide training on this issue. For example, the University of California-Davis’ Telemedicine Learning Center offers training on how to appropriately inspect telemedical equipment for defects, available at http://www.ucdmc.ucdavis.edu/cht/services/education/curriculum.html (last visited Oct. 7, 2008).
Although it is unlikely that a provider will be found strictly liable for telemedical equipment containing a latent defect which causes an injury to a patient, the provider should be aware that liability for negligent use of the equipment remains a possibility.

In instances where a hospital, clinic, or other health care delivery entity provides the telemedical equipment used by a physician, that entity also may be charged with the responsibility to select and maintain the equipment with reasonable care. In *Berg v. United States*, the Tenth Circuit held that the defendant hospital was liable for the patient’s stroke caused by the hospital’s attempted cerebral angiogram because the hospital failed to maintain its cardiac equipment properly and failed to train its technologists on proper use of the equipment. A facility’s liability for equipment failure is typically limited to the failure to detect obvious defects. Nevertheless, hospitals and other health care entities that provide telemedical equipment for use by physicians should ensure that regular maintenance is provided, and that reasonable and customary safeguards and back-up systems are in place and operating effectively.

[c]—Manufacturer Liability for Equipment Failure

While physicians and health care entities may be held liable for negligence in the care, maintenance, or use of telemedical equipment, providers will not likely be liable for latent defects. However, plaintiffs who are injured by telemedical equipment that is defective and unreasonably dangerous may sue the manufacturers and distributors of the equipment under a theory of strict liability. A strict liability

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*Pennsylvania*: Cafazzo v. Central Medical Health Services, Inc., 668 A.2d 521 (Pa. 1995) (holding that a physician and hospital cannot be held liable for a design defect in a mandibular prosthetic)

157 *Berg v. United States*, 806 F.2d 978, 982 (10th Cir. 1986).


159 See Carmichael, Annot., “Liability of Hospital or Medical Practitioner Under Doctrine of Strict Liability in Tort, or Breach of Warranty, for Harm Caused by Drug, Medical Instrument, or Similar Device Used in Treating Patient,” 54 A.L.R.3d 258, 261 (1973). See, e.g., Cafazzo, 668 A.2d at 524 (“[t]he policy behind strict liability is to insure that the costs of injuries resulting from defective products are borne by the manufacturers who put such products on the market rather than by the injured persons who are powerless to help themselves.” (internal quotes citations omitted)).
claim against a manufacturer could arise from a misdiagnosis based upon defective machinery that produced, for example, defective image resolution, sound quality, speed of encoding, or delivery of data. Under a theory of strict liability, manufacturers and distributors of defective and unreasonably dangerous telemedical products may be jointly and severally liable for injuries to the patient caused by such products unless one defendant party can prove that its co-defendant was solely at fault.\(^{160}\)

[d]—FDA Issues

In the United States, the safety and effectiveness of medical devices is regulated by the Federal Food and Drug Administration (the “FDA”). Essentially, the FDA has the authority to regulate devices intended for use in the diagnosis, treatment, or prevention of disease.\(^{161}\) Given the breadth of that definition, it is not surprising that telemedicine systems—and many of their components—fall within the regulatory purview of the FDA. The FDA Working Group on Telemedicine has defined “clinical telemedicine” as the “delivery and provision of health care and consultative services to individual

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This rule applies even if the seller has used all possible care in developing its product. The rationale is that manufacturers and sellers are responsible to the public, who might be injured by the equipment, and are in the best position to bear the cost of liability insurance. See also, Anderson, 386 A.2d at 413.

\(^{160}\) Hospitals and practitioners, in general, are not subject to strict liability claims, since they are not engaged in the business of selling or supplying products but instead provide professional services. In Silverhart v. Mt. Zion Hospital, 98 Cal. Rptr. 187, 189 (Cal. Ct. App. 1971), a patient was injured when a surgical needle broke and became lodged in her pelvic area. The plaintiff contended that the hospital was strictly liable if the needle was defective. The court responded that the process of manufacturing and distribution ended with the entity supplying the defective needle to the hospital. At that point the needle became part of the surgical equipment of the hospital. \textit{Id.} at 188. The court concluded that a hospital furnishing a surgical needle as part of the medical services it provides was not a seller for strict liability purposes, but was instead a consumer of the needle. \textit{Id.} 191. As a consumer of the defective equipment, the court reasoned that the liability of the hospital would depend on whether it was negligent in its use. \textit{Id.}

\(^{161}\) By the terms of the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301 \textit{et seq.}, the term “device . . . means an instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including any component, part, or accessory, which is—(1) recognized in the official National Formulary, or the United States Pharmacopoeia, or any supplement to them, (2) intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals, or (3) intended to affect the structure or any function of the body of man or other animals, and which does not achieve its primary intended purposes through chemical action within or on the body of man or other animals and which is not dependent upon being metabolized for the achievement of its primary intended purposes.”
patients and the transmission of information related to care, over distance, using telecommunications technologies,” including the following activities:

(1) direct clinical, preventive, diagnostic, and therapeutic services and treatments impacting the clinical care of a specific patient;
(2) consultative and follow-up services;
(3) remote monitoring, including the remote reading and interpretation of patient’s procedures;
(4) rehabilitation services; and
(5) patient education delivered in the context of delivering health care to individuals.\textsuperscript{162}

A 1996 Report of the FDA noted CDRH’s responsibility for ensuring the safety and efficacy of the medical devices used in telemedicine systems, and described its telemedicine-related activities, including premarket review of telemedicine devices, postmarket surveillance, quality systems regulations (good manufacturing practices), control, and standards development.\textsuperscript{163} The FDA is likely to have the greatest impact on the development and future use of telemedicine technology through its premarket review activities.\textsuperscript{164}

In 1996, the FDA published in the Federal Register proposed classifications for five generic categories of radiology devices related to medical image communication, storage, processing, and display.\textsuperscript{165} The proposed classifications were intended “to establish a framework for the regulation of these products to provide reasonable assurances

\textsuperscript{162} Center for Devices and Radiological Health ("CDRH"). FDA, “Telemedicine Related Activities” (July 11, 1996) (available at http://www.fda.gov/cdrh/telemed.html, last visited Oct 6, 2008). The FDA has determined that devices used in activities 1 through 4 are subject to CDRH regulatory authority, and those related to activity 5 are integral to that authority when the “education” delivered is medical device labeling information. Id.

\textsuperscript{163} Id.

\textsuperscript{164} Many of the telemedicine devices cleared for marketing by the FDA in recent years have been classified into Class II. See, e.g., 21 C.F.R. § 876.1500 (Endoscope and accessories). Manufacturers of Class II medical devices must meet performance standards and/or comply with the requirements of Section 510(k) of the Food, Drug, and Cosmetic Act, 21 U.S.C. § 360(k) and the regulations promulgated thereunder. See 21 C.F.R. §§ 807.81 through 807.100. Once a medical device has been cleared for marketing, any modification to the device made by the manufacturer that “could significantly affect the safety and effectiveness of a device,” such as an alteration in the device’s indications for use, may trigger further review by the FDA. 21 C.F.R. § 807.81.

of the safety and effectiveness of the devices.” 166 Among the classified devices is the picture archiving and communications system (“PACS”) and its components. PACS devices provide capabilities relating to the acceptance, transfer, display, storage, and digital processing of medical images. 167 PACS devices may range from small, portable devices that transmit images over telephone lines to large fixed systems that can transmit and store images for an entire hospital. They also may include medical image workstations, computers, video monitors, communication devices, and software related to data communications, file management, and image processing. 168 Since 1996, the FDA has classified several other telemedicine-related devices. In 2001, for example, the FDA approved for marketing the first implantable medical device capable of remote data transmission, a pacemaker containing a tiny transmitter that automatically sends the patient’s cardiac data to the physician’s office. 169

The FDA also has been active in the regulation of “robotic” devices. In 2001, for example, the FDA created a new classification for robotic telemedical devices. 170 One of the first such devices, the SOCRATES Robotic Telecollaboration System, “allows a surgeon at a remote location to connect to an operating room and share video and audio, use a telestrator to annotate anatomy or surgical directions

167 21 C.F.R. § 892.2050.
168 Software is an important component of a PACS device. PACS component software is included in the classification of, and regulated as part of, the PACS device. See 21 C.F.R. § 892.2050. Stand-alone software, even if marketed for use in PACS devices (such as separately sold spread-sheet programs), is not included in the PACS regulations. Such “stand-alone” medical software, which is neither a component of nor an accessory to another medical device, and which is “intended to receive medically related data as input, and to output (relay) the results to a health care practitioner or other user” is regulated under a 1989 draft policy issued by FDA. “Draft FDA Policy for the Regulation of Computer Products.” (Nov. 13, 1989). To date, the only stand-alone software that has been classified as a medical device is software that performs a laboratory function. See 21 C.F.R. § 862.2100. The FDA has defined a “calculator/data-processing module for clinical use” as “an electronic device intended to store, retrieve, and process laboratory data.” Id.
and control [other networked devices].  

At about the same time, the FDA cleared the Zeus Robotic Surgical System (to assist surgeons in holding and controlling retractors and graspers during laparoscopic and thoracic surgery) and the da Vinci Surgical System (to assist in the control and manipulation of sharp dissectors, scissors, scalpels and forceps for cutting, dissecting and suturing during laparoscopic and thorascopic surgeries). Most recently, the FDA cleared the da Vinci Endoscopic Instrument Control System to assist in coronary artery bypass surgery using standard open-chest techniques.

While FDA’s regulatory interest in telemedicine technology has obvious implications for telemedicine equipment manufacturers, its impact on physicians, hospitals and other “users” of the equipment is less than clear. The issue of whether a manufacturer may distribute a medical device is a separate matter from the issue of whether a physician who receives the device—or manufactures it himself—may use it. More specifically, physicians’ decisions to use a particular telemedicine device within the scope of their medical practice may be implicitly exempt from regulation under the federal Food, Drug, and Cosmetic Act. Although there is no express provision in the Act, both the courts and the FDA have recognized that the Act was never intended to limit a physician’s ability to treat patients. In September 1996, FDA officials testified before Congress that “once a product is approved for marketing for a specific use, FDA generally does not regulate how, and for what uses, physicians prescribe that [product].”

Further, it is not unusual for physicians to modify a medical device significantly, or change its indications for use for one or more of their patients. As a general rule, unless the physician is involved in

174 Michael Friedman, Deputy Commissioner for Operations, Statement before the House Committee on Human Resources and Intergovernmental Relations (Sept. 12, 1996).
active marketing or commercialization of the modified device, particularly in interstate commerce, the practice-of-medicine doctrine should effectively immunize the physician from regulation by the FDA. However, even if a physician’s use of an unapproved—or a modified—telemedicine device does not run afoul of the Food, Drug, and Cosmetic Act, it would no doubt greatly increase the risk of medical malpractice liability should a patient be injured in connection with the use of the device.

Moreover, a physician or hospital’s requests for reimbursement for telemedicine services involving the use of an unapproved medical device may raise false claims or fraud and abuse concerns. Certain interpretative rules in Medicare Manuals state that investigational devices may not be covered by Medicare. Section § 260.1 of CMS’s Hospital Manual provides in pertinent part:

“Medical devices which have not been approved for marketing by the FDA are considered investigational by Medicare and are not reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Program payment, therefore, may not be made for medical procedures or services performed using devices which have not been approved for marketing by the FDA.”

Regulations that became effective in November 1995 provide Medicare coverage for “non-experimental/investigational” devices as to which the initial questions about the devices’ safety and effectiveness had been resolved. In contrast to the apparent exclusion from

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177 Id. at 253-54. It is noteworthy, however, that in the most recent amendments to the Food, Drug, and Cosmetic Act, the practice-of-medicine exemption was articulated as follows: “Nothing in this Act shall be construed to limit or interfere with the authority of a health care practitioner to prescribe or administer any legally marketed device to a patient for any condition or disease within a legitimate healthcare practitioner-patient relationship.” 21 U.S.C. § 396. What constitutes “a legitimate healthcare practitioner-patient relationship” in the context of telemedicine is yet to be determined.

178 Section 260.1, the Centers for Medicare and Medicaid Services (“CMS”) Hospital Manual (Pub. 10) (Coverage of Hospital Services). Section 3151.1 of the CMS Intermediary Manual (Pub. 13) is identical. Section 2303.1 of CMS Medicare Carriers Manual also had contained an identical provision. Even in the face of these provisions, however, Medicare did reimburse for at least some devices subject to Investigational Device Exemptions (“IDEs”) including Intra-Ocular Lenses that were marketed under IDEs. Ultimately, the Health Care Financing Administration (now CMS) modified its position in a formal rule-making proceeding (although it has not changed the text of the Hospital Manual or Intermediary Manual).

179 See 42 C.F.R. §§ 405.201(b), 405.203, 405.211(b).
coverage of such devices under the Manual provisions, the new
degulations classify such devices as either experimental/investigational
(“Category A”) for which there continues to be no coverage, or non-
experimental/investigational (“Category B”) which are eligible for
Medicare coverage. 180

A number of teaching hospitals that had submitted claims to
Medicare for reimbursement for certain cardiac devices (including
defibrillators, stents and pacemakers) prior to the effective date of the
regulations were named as defendants in qui tam actions suggesting
that the submission of claims to Medicare for those devices were false
and fraudulent. 181 Some of the hospitals have settled those claims by
re-paying Medicare for the reimbursement that they received for
services in connection with implantation of devices subject to an IDE.
Other hospitals remain in litigation over the issue. 181.1

[5]—Risk Reduction

A number of physicians and institutions have jumped (or stumbled)
into telemedicine arrangements without even considering the need for
a written agreement—or more precisely, agreements. Given the poten-
tial legal risks associated with telemedicine, it would be prudent to
spell out roles and responsibilities clearly and early on. Agreements
between participating physicians and institutions should spell out
terms such as:

(a) Ownership and maintenance of telemedicine equipment;
(b) Responsibility for transmission verification and other technical
issues;
(c) Reimbursement, billing, and other financial arrangements; 182
(d) Responsibility for record retention and back-up of computer-
zied patient data, including video images;
(e) Responsibility for regulatory compliance, including licensure,
certification, and credentialing of physicians and allied health care
providers;

180 See 42 C.F.R. §§ 405.201, 405.203(a), 405.205, 405.209, 405.211. In general,
devices that are subsequent generation refinements of already approved technologies
are placed in Category B. Brand new and unproven technologies tend to be placed in
Category A until the FDA initially accepts the new technology as safe and effective.
181 See In re Cardiac Device Qui Tam Litigation, No. 3:03MD1505, 2004 WL
1078124 (D. Conn. May 12, 2004), reversed in part, remanded in part by U.S. v.
Baylor University Medical Center, 469 F.3d 263 (2d Cir. 2006).
181.1 Id.
182 Reimbursement for telemedicine services is discussed infra in Chapter 8. Fraud
and abuse risks resulting from financial arrangements are discussed infra in Chapter 9.
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(f) Responsibility for training, competency testing, and supervision of other personnel, particularly remote site staff;

(g) Development and/or implementation of equipment specifications and performance standards, clinical protocols, and other guidelines;

(h) Responsibility for obtaining and documenting informed consent;

(i) Responsibility for privacy and security issues; \(^{(183)}\)

(j) Control over advertising and promotion of the program;

(k) Choice of law forum selection; \(^{(184)}\) and

(l) Insurance and indemnification.

Physician/hospital agreements with telemedicine equipment vendors and subcontractors should clarify, among other things: (a) the capabilities of the technology, including internal back-up systems; (b) availability of technical and maintenance services; (c) technical requirements for accuracy, durability, and security of patient records; (d) responsibility for regulatory compliance, including compliance with FDA requirements; and (e) insurance and indemnification.

Further, for Internet-related health-information sites and telemedical practice, appropriate terms of use (including “click-on” agreements), disclaimers, and statements of nonendorsement should be considered. \(^{(185)}\) Particularly, care should be taken, and appropriate legal review obtained, for any prescription product advertising and promotion. \(^{(186)}\)

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\(^{(183)}\) Any identifiable patient information retained by a telemedicine physician or health care entity will be subject to state and federal laws regarding privacy and security. See infra Chapter 6. Moreover, information arising from a telemedical “patient encounter” is likely to be treated as a medical record. See infra Chapter 5.


State Courts:
California: Net2Phone, Inc. v. Consumer Cause, Inc., 135 Cal. Rptr. 2d 149, 152 (Cal. Ct. App. 2003) (forum selection clauses play an important role in interstate commerce, provide a degree of certainty for business and their customers, and “accord[ ] with ancient concepts of freedom of contract and reflect[ ] an appreciation of the expanding horizons of American contractors who seek business in all parts of the world”) (quoting M/S Bremen v. Zapata Off-Shore Co., 407 U.S. 1, 10 (1982)).

\(^{(185)}\) See infra Chapter 2.

\(^{(186)}\) See infra Chapter 3. Intellectual property issues, including copyrights, trademarks, and nondisparagement are also relevant. See infra Chapter 4.