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A Message from the Section Chair

For those of you who attended the Health Law Section's day of seminars during the recent Annual Meeting of the Bar Association, I do not have to tell you the extent to which the seminars were successful and well received. The morning session on Human Cloning was informative and enlightening. Although few of our individual practices touch this scientific frontier, it is rewarding and stimulating to learn of scientific advances and to speculate on how these technological changes will impact upon the practice of law. As we were listening to the scientific progress, questions of informed consent, inheritance and even the "rights of laboratory created citizens" moved through my mind. While it is unlikely that we will face these issues in the immediate future, I consider expanding our field of knowledge and interest, both in a scientific and legal context, a valuable function of our Section. To be effective, a Bar Association Section should be more than a place distributing legal forms. I believe that by offering forums such as Human Cloning we are accomplishing this goal.

The afternoon session dealt with another developing area of the law, this one more disturbing—the growing focus of government interest in fraud and abuse detection, and how our health care clients can best respond to the increased scrutiny. The capacity crowd of 100 or so were rooted in their seats as the speakers presented updates on recent developments in this area.

I want to extend thanks to the Program Chairs who made these fine presentations possible, and to the two outstanding panels of speakers. A special thanks also goes to Henry A. Greenberg, Esq., General Counsel of the New York State Department of Health, who enlivened the Annual Meeting luncheon with his views on the important health care issues facing the 1999 legislative session

As our membership rolls increase, it is important for the Section to reach out to those members who have joined and paid dues, but have not availed themselves of any of the programs or services we offer. It is my hope that the questionnaire recently distributed to all members will provide a vehicle for the Section membership to express itself as to the additional services the Section should provide, and how we might better improve communication among members. If you have not yet completed the questionnaire and returned it, please do so. If you have misplaced your copy, please contact Lisa Bataille at the Association at (518) 487-5680 and she will be pleased to provide you with a duplicate copy. We are hoping to receive a "statistically valid" response so that we can be in a position to

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address concerns expressed by the Section membership and improve service.

Please watch your mail for upcoming events. The Section will again present the Basic Health Law Primer program, which provides an orientation for new lawyers and those who are just getting into health law. The basic program can be a good refresher for attorneys who practice in the area. As the Section continues to grow, more and various efforts will be undertaken to meet the needs of our members.

It is an exciting time to practice in this field, and we can only benefit by a full exchange of information and contributing to the good of the profession and the skill levels of our members.

I hope to see you all soon at Section functions.

Jerome T. Levy

From the Editors

This issue of the Health Law Journal contains an in-depth article by Bob Scher and Crystal Elder concerning the burgeoning field of telemedicine and its implications for health care and health law practitioners. We are also happy to include Howard Krook's Elder Law Update, and an article written by two Pace Law School students, Rachel Filasto and Maziar Ghodsian, discussing the recent U.S. Supreme Court ruling in *Roberts v. Galen* that rejected an improper motive requirement for EMTALA claims.

We welcome and encourage the submission of articles on topics of interest to the health law practitioner. We also invite letters and comments relating to articles or columns printed in the Journal. You can reach us at the following address:

Professor Barbara Atwell
Pace University School of Law
78 North Broadway
White Plains, NY 10603
(914) 422-4257
batwell@genesis.law.pace.edu

or

Professor Audrey Rogers
Pace University School of Law
78 North Broadway
White Plains, NY 10603
(914) 422-4068
arogers@genesis.law.pace.edu

Barbara Atwell and Audrey Rogers

Telemedicine: More Than a Phone Call, a New Legal World

Bob Scher and Crystal Elder*

To prepare every American for the 21st century, we must harness the powerful forces of science and technology to benefit all Americans . . . [b]ut we've only begun to spread the benefits of a technology revolution that should become the modern birthright of every citizen . . . we should connect every hospital to the Internet so that doctors can instantly share data about their patients with the best specialists in the field.

President William Jefferson Clinton[1]

Medicine has always been a creature of advanced technology, whether it was the discovery of the analgesic properties of aspirin, human organ transplantation or the development of advanced techniques in genetic engineering that seem so common today.[2] The latest medical advancement is the remote delivery of health care services. The use of telecommunications technology to expand and improve delivery of health care services is just beginning to be fully explored, although the basic technology has existed since the early 1950s.[3]

Introduction to Telemedicine

Most broadly defined, telemedicine is the use of telecommunications to provide the medical services of diagnosis or treatment.[4] The term encompasses medical use of the telephone and ancillary devices such as speakerphones and fax machines.[5] The earliest practice and use of telemedicine is credited to the National Institute of Mental Health (NIMH) and studies conducted by Dr. Cecil Wittson.[6] In the early 1950s, the project funded a basic "hot line," an audio-only closed-circuit microwave telephone link between the state mental health hospitals in North Dakota, South Dakota, Iowa and Nebraska.[7] The project's four-state success led to further studies in 1961 using an audio-visual closed-circuit television link for telepsychiatry consultations. Close study of the project indicated no difference in group sessions conducted with the psychiatrist on site or by remote transmission.[8]

I. Early Applications of Telemedicine

Wittson was not alone in his thinking. At the same time, radiologists in New York and Philadelphia were studying the application and accuracy of television to the transmission of radiographs under the generic term "telemedicine."[9] The early projects used slow-scan black and white television to build on the foundation of telemedicine.[10] By 1958, Dr. Albert Jutras of Montreal, who had pioneered the development of daylight teleflouroscopy,[11] saw his efforts become commonly used to simultaneously observe a patient and radiograph in progress without the need for bulky lead shielding, since the radiologist could remain in an x-ray remote location to make observations.[12] In 1959, closed-circuit television used for physician/clinician conferencing and case consultation suggested the arrival of "the day when radiological consultations for sparsely populated areas [could] be conducted by television."[13]

Interestingly, while telemedicine continued to evolve into telemetry, fax, computer and other applications, none of the early interactive television (IATV) programs (pre-1986) survived.[14] Emergency medicine continued to develop through the 1960s and 1970s through the efforts of community volunteer rescue services. Fire and emergency medical technician groups developed ad hoc links between emergency field personnel in ambulances and those on the scene via police radio and FM telephone. The advantages of emergency personnel having expert medical advice on site was recognized in both morbidity and mortality rates. Telephone and telemetry links from remote trauma centers and emergency rooms indicated the potential of telemedicine applications to diagnose, treat, and save additional lives where remoteness or population densities would not economically justify or support a medical facility.[15]

II. Telemedicine Today

Two commonly used terms are "telehealth" and "telemedicine." Telehealth refers to the "health-related" use of communications technology for educating health care providers, public health purposes, community health education, research and administration.[16] The typical application is multi-site educational conferencing. Telehealth is primarily a training tool where expert teaching clinicians can observe procedures and inexperienced clinicians or clinicians in training can be observed and guided while performing procedures.

Telemedicine is used to describe "the use of telecommunications for medical diagnosis and patient care"[17] or as the "real-time or near real-time transfer of medical information between places."[18] The difference between "real time" and "near-real time" transmissions refers to images stored, then forwarded as either static images or video "clips" ("store" and "forward" technology) for later review and consultation (replay) by the consulting clinician.[19] The near-real time or stored technique removes the requirement that referring and consulting clinicians be simultaneously available.[20] It also reduces the required bandwidth of transmission, since the data

is moving in only one direction, obviating return communication other than normal random data verification.[21]

The term telemedicine is more often applied to remote observation, instruction or advice to an on-site clinician. Video links can provide the off-site expert with the same laproscopic viewpoint as the on-site clinician. Instant consultation, advice and instruction is available as if the off-site expert were actually there. Telemedicine for emergency on-scene application is termed "single server," usually involving one or more ambulance EMT teams. More widespread telemedicine applications, such as rural general medicine networking, is referred to as "multiple-server."[22] In those applications, multiple unrelated users may network to share expert services, advice and guidance.

In the past, physicians who engaged in telemedicine simply used telephone conversations to discuss patient cases.[23] More recently, telemedicine has expanded to include fax machines and computer e-mail, telemetry between health care facilities and ambulances, and orbital spacecraft and health care-related base stations.[24] Teleconferencing and consulting between physicians and hospitals are accepted forms of care and are regular practices.[25] American health care providers plan to stress telemedicine in their projected five-year information technology budget of $15 billion.[26] The dramatic increase in interest in telemedicine is reflected in state and federal budgets; annual spending on telemedicine now surpasses $100 million,[27] of which $85 million is federal spending[28] under 13 different grant programs.[29] Since more than 40 states now have some level of telemedicine programs in place, virtually all physicians' practices will somehow be involved with telemedicine by the year 2000.[30] Georgia, for example, has an $8 million annual budget funding six facilities, with plans to expand the network to 40.[31]

III. Remote Conferencing Abilities

The latest information technology now allows interactive conferencing, cost effective satellite uplinks, and the transmission of complex digitized x-rays, tissue photomicrographs and real-time digitized television microscope single frame and motion transmissions anywhere.[32] The most important recent telecommunication development for telemedicine is the digitization of radio signal transmissions.[33] Older systems used modulated wave signals (CW) which were prone to atmospheric interference. Periodic sunspot activity, heavy storms and coincidental cloud densities could produce signal skip, an effect that bounces signals past their intended reception area, distorting the wave modulation of the signal and breaking the signal up through echoes that distort the received image. Digital signal transmission works on the same principal as a binary computer by sending a series of 0 and 1 signals or on and off signals to make up the audio and visual signals. Since the signal is considerably less complex than a modulated wave signal, simple error matching can correct inaccuracies and eliminate interference.

Where fully interactive and simultaneous two-way audio-visual communication (IATV) is required, such as in psychiatric group sessions, on-scene emergency treatment or surgical proctoring, instruction and consultation technical problems still exist. Technology has yet to solve limitations such as the carrying capacity or the bandwidth of signal necessary to transmit the information in the requisite time period and within reasonable cost constraints.[34] IATV signals require 1,300 times more bandwidth than normal telephone transmissions.[35] Therefore, despite all the technological equipment advances that allow more than mere voice transmission over telephone lines, the simplest methodology is still the voice-only telephone. It is "cheap, ubiquitous and ideal for rapid consultation and some aspects of patient management."[36]

IV. Effect of Telemedicine on the Information Technology Market

A significant and unintended result of digitization of signals has been the consolidation of formerly discrete information markets (telephone, fax, image transfer, teleconferencing and video transmissions) into one industry. This has ignited competition in fees, access charges and bandwidth access that can only drive down prices and increase the breadth of services offered, which will further encourage telemedicine uses.

However, while signal strength and accuracy problems have been improved through digitization of signals, and costs are likely to come down by economies of scale, the off-site clinician is still limited to monitoring equipment telemetry, verbal description and visual representations. That, too, is changing. While current space and national security technology has rapidly been transferring into the commercial sector for tactical imaging and "touch screen" applications, clinicians will soon be able to touch and manipulate the patient. Blood pressure and heartbeat are already directly transferable by electronic pressure cuffs and electronic stethoscope. An electronic glove is currently being developed that will allow physicians full tactile sensation from a remote location.[37] The glove or hand will allow actual manipulation in treatment and, eventually, even surgery. Today we enjoy the technology to do what was only forecast in a 1924 "Buck Rogers"[38] cartoon—to have a patient "at home, sitting on the edge of his bed, with his mouth open showing his sore throat to his physician . . . except the physician is not at his bedside . . . [but, instead is in] his office looking at that [patient's] throat."[39]

While the bandwidth problems remain, even with signal compression technologies, telemedicine may be part of the solution.[40] Major commercial carriers have begun offering use incentives.[41] Telemedicine provides an argument for the Federal Communications Commission (FCC) to make concessions on bandwidth licensing that will allow expansion of services at lower prices.[42]

V. Legal Issues

Telemedicine can improve patient health care and significantly lower costs through economies of scale to level the "uneven geographic distribution of health care resources, [and the] inconsistent quality of care available to members of different economic classes."[43] However, telemedicine also presents legal issues such as interstate licensing/regulation, standards of care, the doctor-patient legal relationship, and issues surrounding corruption, interception, confidentiality and data ownership within the telecommunication network system.[44] "Telemedicine is a compelling healthcare delivery option that allows physicians in isolated and rural areas to access a full range of specialists and cutting-edge technologies usually available only at large, urban medical centers."[45] Telemedicine presents daunting legal challenges due to convergence of state laws with federal statutes to regulate national electronic communications under the plenary Commerce Clause powers given Congress in the U.S. Constitution.[46] "There is uncertainty in the healthcare community about the impact this new technology will have on professional liability. A lack of legal precedents makes it difficult to determine how the courts would respond to malpractice claims related to the practice of telemedicine."[47]

VI. Data Ownership and Privacy Issues

Data ownership and transfer consent issues are currently addressed under the Federal Privacy Act of 1974[48] and the Uniform Health Care Information Act of 1988.[49] The Privacy Act provides that the physician or health care provider owns the data contained in the patient's medical chart, but the patient must authorize any disclosure, including administrative review for policy reimbursement: "[n]o agency shall disclose any record which is contained in a system of records by any means of communication to any person, or to another agency, except pursuant to a written request by, or with the prior written consent of, the individual to whom the record pertains."[50] However, such data may be released without patient consent only upon "a showing of compelling circumstances affecting the health or safety of an individual if upon such disclosure, notification is transmitted to the last known address of such individual."[51]

Although the Uniform Health Care Information Act of 1988 also provides for data release procedures and a consent policy to protect the patient's privacy interest, it has only been adopted in Montana and Washington state.[52] While some state hospital licensing schemes "guarantee the patient an opportunity to restrict access to the dat,." thus recognizing patient privacy interests, those statutes are state-specific, leaving the question of interstate data transfers unresolved.[53] Data transfer privacy concerns are similar to those of patient consent and provider confidentiality. Telemedicine implicates not only consent and privacy regarding conferencing, case consultations, and image transfers such as x-rays, but also the misuse and possible unauthorized or even mistaken interception or corruption of that data.[54]

While privacy concerns have surrounded technology-enhanced conferencing since the earliest attempts, the issues were considered less damaging and less legally significant.[55] Increased modern technological transmission has exposed more patient data than ever to unauthorized intrusion and misuse, leading to the current legal concerns.[56] The problem becomes extremely complex[57] when you consider that each side of the transmission not only receives but creates data based on the received information.[58] This implies that property issues and interests exist on both sides of the transmission, often under two different state jurisdictions, and does not even account for jurisdictions through which the information is transmitted and whose law may thereby apply, even for microseconds.[59] The question is whether statutory patient privacy protection is sufficient or is even necessary given the deterrent value of civil remedies under actions for invasion of privacy or invasion of privacy-false light claims. Civil remedies alone, while presenting a deterrent factor, are not necessarily swift, certain or often severe. The patient must pursue his or her claim through the courts at great expense. In addition, the patient must show that "publication," or release of the information, was so repugnant to the ordinary "reasonable person" as to justify a monetary damage award. Yet, that standard fails to address the interstate nature of telemedicine and any unprivileged disclosure which might thereby occur. Given the state of development of modern telemedicine technology, sending information over many states' borders simultaneously is fast, easy and common. Therefore, many states' "reasonable person" standards are simultaneously implicated, and they complicate enormously any contemplated privacy tort analysis.[60]

As health care providers computerize records, they have been forced to address privacy interests.[61] Encryption presents technological barriers in addition to statutory proscriptions against intrusion.[62] Encryption, however, raises negligence and standard of care issues regarding how much encryption is sufficient to prevent intrusion and whether such encryption or password protection is technologically sufficient and up-to-date to satisfy the legal duty to protect file privacy.[63]

Since privacy is a particular concern, acceptance of telemedicine is severely impacted when it is used to diagnose or treat illnesses that traditionally have associated social stigma, like mental illness, substance abuse and HIV.[64] While privacy concerns can effectively be dealt with and still allow health authorities to conduct contact tracing—as demonstrated by public health laws regarding anonymous HIV status reporting in New York and California[65]—no system, administrative or technological, is totally secure from unauthorized intrusion or misuse. Unlike standard medical practice, where a provider has selective discretion in recording many observations and facts (statutory reporting requirements excepted), telecommunications allows no such discretion. Not only do clinicians lack any editing access, all transmissions in both directions are automatically and completely recorded as part of the communication transaction for error correction purposes and billing requirements of both carriers and communication service providers.[66] The problem is further exacerbated by policies

and statutes, such as the Digital Telephony Act of 1994, requiring lawful wiretap accessibility by enforcement agencies.[67]

VII. Unresolved Data Issues

What has yet to be litigated, and thereby remains unresolved, is whether a telemedicine consultation is a computer-like file transfer or on-site consultation.[68] Although the Privacy Act clearly regulates on-site consultation files, the simple transfer of data files may not be regulated.[69]

This illustrates the complex legal issues of telemedicine, since it involves multiple jurisdictions and the transmission of information in both directions and diagnosis and possibly treatment across many state lines. Overarching the state law issues are federal mandates that may or may not take precedence by preemption under article VI of the Constitution.

Given the practice of telemedicine for more than 40 years, and given its enormous potential to save lives, increase health care access and decrease spending on health care through technology, Congress asked the Secretary of Commerce and the Secretary of Health and Human Services, along with other appropriate departments, to submit a report on telemedicine under requirements of the Telecommunications Act of 1996.[70] As a result of this program and Vice-President Gore's interest in developing the National Information Infrastructure (NII) as part of the administration's technology campaign, the Vice-President asked the Department of Commerce to further development of the NII and the Joint Working Group on Telecommunications was formed.[71] The group is charged with assessing the federal role in telemedicine.[72]

Since the Telecommunications Act of 1996 has targeted "widespread availability of basic communication services at affordable prices," Congress has enumerated provisions to require that the FCC make certain rural health care providers possess the telecommunication access "necessary for the delivery of health care at rates that are comparable to those for similar services in urban areas."[73] Therefore, under joint authority, the federal and state commissioners regulate and support telemedicine access to the broad range of telecommunications services through lowered, if not controlled, costs and bandwidth accommodation where possible.

VIII. Fundamental Legal Concerns

One of the current fundamental legal concerns is the patient-doctor relationship in the practice of telemedicine. Traditionally, the common law has held that there is no duty to rescue.[74] Therefore, absent legislation such as EMTALA, section 504 of the Rehabilitation Act, and the Americans With Disabilities Act (ADA), a physician has no affirmative duty under traditional common law theory to treat a patient. But, as the court held in *Ricks v. Budge*,[75] where a doctor or surgeon undertakes a case, unless there is a previous agreement that clearly limits the scope of services prior to treatment, the provider has a duty of continuing care so long as the case requires attention. The physician may only withdraw under three conditions: (1) the patient's condition is stable or he or she is cured; (2) the physician provides ample and advance notice and referral to other providers; or (3) the physician's services are terminated by the patient. Under no circumstance may the physician simply resign and withdraw without notice and referral to other physicians or providers. Therefore, the critical question becomes: When does the physician-patient relationship arise?

A. The Physician-Patient Relationship

In normal, face-to-face medical practice, that answer is evidenced in the facts. The issue is not so clear in telemedicine. For example, does the consulting physician have a patient-physician relationship as would an on-site physician? Clearly, the physician could argue telemedical consultation implicitly creates no physician-patient relationship but is simply a physician-physician encounter absent any patient involvement. If the specific use of telemedicine in a case is considered consultation, then questions of termination either by the patient or by the physician/clinician are moot since the encounter is of short duration, is for a specific interpretation and is not meant to be a long-term care relationship by implied mutual agreement. The relationship becomes critical where telemedicine replaces the on-site physician.

The Buck Rogers cartoon mentioned earlier is exactly such a scenario. There, the patient could be miles or even many states away from the treating clinician, with no on-site clinician. In such a setting, the remote physician would have established a patient-doctor relationship at least for the duration of the transmission and perhaps longer. This is precisely the setting the *Ricks* court noted, when it held that the law was settled where there was prior agreement as to the scope of services. As the court held in *Childs v. Weis*,[76] there is no duty to rescue or treat; such duty will only be found if it is evidenced by prior arrangement, contract or agreement of employment.

IX. Legal Implications of the Physician-Patient Relationship

Since traditionally the doctor-patient relationship has been characterized under contract, a doctor may control the terms of the relationship, including the scope of services.[77] As in legal ethics and public policy proscriptions against any limitation by contract of an attorney's liability for errors, inattention, or omissions, a physician cannot contractually limit liability for provided services. Courts have held such practices void as against public policy.[78]

A physician may, however, proscribe the scope and extent of his or her practice by specialty, time schedules, or geographic region, absent other licensing or credentialing limitations, with no obligation to offer services outside of his or her choice of practice.[79] Clearly, telemedicine is impacted by a physician who elects to limit his or her practice geographically. Conversely, since a physician has the right to limit geo-

graphic practice area, a physician who engages in telemedical consultation arguably has waived that right of limitation.

A doctor may not be forced to treat a patient, even in an emergency, because the law does not recognize a duty to rescue absent a special relationship: "The duty to do no wrong is a legal duty. The duty to protect against wrong is, generally speaking and excepting certain intimate relations in the nature of a trust, a moral obligation only, not recognized or enforced by law."[80]

Likewise a doctor is not required to accept a patient under the American Medical Association's Principles of Medical Ethics, even in an emergency.[81] A hospital emergency room does not change the voluntary contract nature of the physician-patient relationship unless the doctor works for or is affiliated with the hospital in such a manner as to obligate service.[82] However, once the physician-patient relationship is created, the doctor is bound to observe a duty of "continuing attention."[83]

It is settled law that the physician-patient relationship must exist for a duty of care to be imposed upon the physician.[84] This doctrine flows from substantive due process recognized under the Fourteenth Amendment liberty interest in selective right of contract and was first seen in *Allgeyer v. Louisiana*[85] and evidenced throughout the Supreme Court's *Lochner* era.[86] *Lochner* was effectively overruled by *Bunting v. Oregon* [87], but survived until the better-known *Nebbia v. New York*[88] ultimately signaled the end of the Court's substantive due process reasoning. *Nebbia* signaled a shift in constitutional analysis to require economic state statutes merely to have a rational relationship to their intended purpose. The new constitutional standard was a "means/end" approach, which was later expanded even further in *U.S. v. Carolene Products*[89] to the presumption of constitutionality where the purpose of legislation was economic regulation.

X. The Duty of Care under Contract Theory

The underlying theory that imposes a duty of care (in effect, the duty to rescue) on a physician is the physician-patient relationship, legally analyzed as a voluntary contract. Absent acceptance of the patient by the physician, the relationship does not exist, and no duty of care may be imposed. The duty is clearly evident where the relationship is expressly established by contract, such as where a couple contracts for fertility services, a patient contracts for a treatment over time or where documentary evidence of the relationship is normally produced.[90] Where consent forms are in evidence, courts will often allow parol evidence to supply the terms of the physician-patient relationship.[91] Implied physician-patient relationships, never reduced to a writing, are more problematic.

When treatment takes place in the typical doctor's office setting, the physician may accept or reject the patient, absent any ADA considerations, thus avoiding any liability since there is no duty to rescue. When the physician treats the patient, even absent a written agreement of the relationship, the implied physician-patient relationship for diagnosis, care and treatment is clearly established from the circumstances.[92]

Physician-patient relationships that take place in emergency room settings are more difficult to define. There, the exigencies of the moment, if not custom and practice, preclude written agreements to define what physician-patient relationship exists.[93] If an on-call doctor treats a patient in his or her role as a hospital physician, he or she often is later named as an additional defendant with the treating hospital if negligence is alleged to have caused death or injury associated with care or the lack of follow-up care. Courts have gone both ways in deciding the duty based on whether a physician-patient relationship had been formed beyond the emergency room or in-hospital encounter. The cases tend to be very fact-driven, and the decisions, therefore, are ad hoc.

In *Easter v. Lexington Memorial Hospital*,[94] an emergency room physician gave instructions to another doctor who was not on call and who was leaving for the day, to help out when multiple burn victims were admitted. The doctor giving the directions was later held not to have had a physician-patient relationship with a patient who was treated and later died; this is contrary to what vicarious liability theories of ostensible agency or apparent authority would seem to indicate.[95]

Other cases more closely follow ostensible agency, establishing physician-patient relationship where there is mere examination or diagnosis and even where the diagnosis is designated at the outset for a limited purpose. This runs counter to the theory of *Nebbia* and the substantive liberty interest in an implicit contract, which allows the parties to limit the scope of their relationship. In *Lodico v. Cohn*,[96] where the examining physician was instructed by the patient's disability insurance carrier, the State Insurance Fund, to examine the patient and render an opinion regarding only a work-related disability, the court ignored the express limitation of the arrangement. The patient later successfully sued the doctor for failure to discover an unrelated, undiagnosed brain tumor. Although the physician argued in a motion for summary judgment that no physician-patient ongoing relationship existed, the court found a duty to perform more than a cursory examination. The court concluded that during the short period in which the examination was performed, a relationship existed sufficient to withstand the defendant's motion.

Similarly, the court found the physician-patient relationship existed under an implied expectation of treatment in *Willoughby v. Wilkins*.[97] There, an emergency room physician at Wayne County Memorial Hospital examined a pregnant patient who exhibited normal vital signs, inability to urinate and flu-like symptoms. The doctor prescribed typical flu medications and advised her to see her family physician, get rest, and drink plenty of fluids. Three days later she arrived at Duke University Medical Center with renal failure and acute respiratory distress, and miscarried. Although the emergency room doctor argued that he had not accepted the plaintiff as a patient or admitted her for care, "the fact that [the doctor] evaluated

[her] condition and rendered medical advice to her" was held sufficient to send the inquiry of patient-doctor relationship to a jury.[98]

Thus, the state of the law regarding the physician-patient contract in the emergency room varies widely by state.[99] The physician-patient relationship will be found to exist where the doctor provides services to a person who has contracted for such service.[100] What constitutes contract for service is the question. The current trend seems to be for courts to weigh several factors to find an implied relationship where an express relationship is arguably absent. The factors include examination/diagnosis (*e.g., Willoughby*), some treatment (*Lodico*) or an implied expectation by the patient of continued care and treatment.[101]

XI. The Trend to Find Liability Absent an Express Relationship or Duty to Rescue

Traditionally, courts have been unwilling to find physician-patient relationships based on limited and minor physician action, and have looked for evidence of affirmative acceptance of the patient by the physician.[102] In *Childers v. Frye*,[103] an emergency room doctor was held not to have accepted the patient treated as his patient, even though the doctor had examined the patient when he arrived at the emergency room with severe head injuries after an automobile accident, bandaged his right eye, and examined his head, arms and legs for injuries. "[W]hen the injured man was brought into the hospital . . . the defendant [doctor] looked him over, and upon discovering that the patient had been drinking, declined to accept as a patient or to undertake necessary treatment."[104] Where the patient is examined and treated, as in *Childers,* and is referred to another on-staff physician, that physician will not be held to have affirmatively accepted the patient in a physician-patient relationship and, thus, will avoid the obligation of "continuing attention" found under *Ricks*.[105]

The theory of affirmative acceptance of the patient does not inoculate the physician from a duty of care under the theory of *Ricks*, absent express denial of acceptance. Emergency room on-call rosters that hospitals routinely maintain may imply acceptance of a patient beyond the emergency room encounter, whether the physician accepts the patient or not.[106] This becomes important in light of telemedicine, since telephone consultation is traditional telemedicine in its most basic form. In the past, courts have held that a telephone call to a doctor asking for assistance does not create the physician-patient relationship.[107] What is dispositive, according to the courts, is evidence that the doctor has accepted the person as a patient, even where acceptance is implied.

In *Thomas v. Corso*,[108] an emergency room physician admitting an accident victim listed himself as the admitting physician. The doctor was twice telephoned regarding the victim's condition and gave advice to the hospital staff over the telephone. That was held as evidence that he impliedly accepted the patient and thereby was bound to provide "continuing attention." A Maryland court has gone even further. It found the physician-patient relationship established where the hospital admitted a patient under an on-call doctor's name, and the doctor was only advised of the man's condition by telephone, but never actually examined or met the patient before the patient's death.[109]

In *Moeller v. Hauser*, a Minnesota court held a doctor liable in supervising a resident physician's treatment of a young patient as acceptance by the supervising doctor of the patient as his own.[110] There, the plaintiff did not argue negligent supervision but rather a direct physician-patient relationship based on the staff physician's affirmative acts in assigning the case and a previous patient interview. The court found those acts sufficient to establish the physician-patient relationship by implication.

Since 1991, and the decision in *Mozingo v. Pitt County Memorial Hospital*,[111] the law appears unsettled regarding affirmative acceptance of a patient alone as dispositive of the physician-patient relationship. Maryland examined the issue differently in *Homer v. Long,*[112] where duty to third parties was analyzed based not on the third-party beneficial contract relationship, but on the common law duty of care. *Homer* held that a provider's duty of care to diagnose, evaluate and treat flowed only to the patient and not to third-party collateral relatives, as opposed to spouses, sexual partners or needle-sharing partners. While providers have a duty to inform patients of their illness that is distinct from informed consent to treat and the duty thereunder to accurately and correctly inform patients,[113] any malpractice (negligence or misrepresentation) that flows from such a duty to inform does not inure to third parties to provide standing.

However, where the law can find indicators of the key physician-patient relationship, malpractice can be argued.[114] *Mozingo* represents a new judicial direction with grave implications not only for physicians' generally accepted standard of practice in soliciting consultation in topics with which they are unfamiliar, but for telemedicine currently limited to diagnosis and advice. If *Mozingo* represents a trend among courts to expand liability by defining the physician-patient relationship to allow the courts to hold more potential wrongdoers accountable for malpractice, then the promise of telemedicine will never be realized.

In *Mozingo*, Dr. Kazior was an employee of Eastern OB/GYN Associates ("Eastern") on contract to Pitt County Hospital under an agreement with the East Carolina University Medical School (ECUMS) to provide on-call supervision of interns and residents in the obstetrics residency program at the hospital. Except for a call from one of the hospital residents for help, Kozior had never met, interviewed, or consulted on the patient's case. The trial court held that no express or implied physician-patient relationship had been established and granted the defendant's motion for summary judgment. However, the North Carolina Court of Appeals held that the doctor owed a duty of care to the plaintiff as a third-party beneficiary of the agreement between the doctor's employer, Eastern, and the

medical school in supervising the residents. The North Carolina Supreme Court affirmed the Court of Appeals decision, but for different and more narrowly drawn reasons, holding:

> . . . we recognize the general principle that a physician may contractually limit the extent and scope of his employment. E.g., Childers v. Frye, Nash v. Royster (citations omitted). Here however the defendant stipulated that he undertook the duty of on-call supervision of—not merely consultation with—the resident physicians actually caring for the plaintiff.[115]

XII. The Implications of *Mozingo* for Telemedicine

The *Mozingo* case has enormous implications. It will have an absolutely chilling effect in telemedicine and medical practice since it implicates the medical practice standard of care that requires consultation where a new or unfamiliar ailment is presented by a patient.[116] It will stifle the number of doctors willing to participate in what the federal government hopes will be a widespread proliferation of medical knowledge and availability in rural and sparsely populated regions of the United States.[117] *Mozingo* stands for the proposition that even where physicians demand written agreements limiting the scope of their advice and consultation, they may be held to a duty of care by virtue of their employment by a third party such as a telemedicine service.[118]

After *Mozingo* a basic question of telemedicine is when the duty of care arises under consultation among physicians. *Mozingo* dramatically expands the number of possible defendants to any parties who contractually participate in health care delivery, even where the ultimate patient is not in privity with the providing physician. This is a departure from traditional interpretation of the right of free association under contract theory and the First Amendment.[119] This destroys any risk management planning that medical malpractice insurers can devise, and probably leaves contract providers uninsured. Moreover, the voluntary participant in telemedicine may find himself or herself bound and liable to an unknown third-party beneficiary of an implied contract to which he or she was never a party.

The implication of a consulting and remote physician by any telemedical relationship is clear. Where a third-party beneficiary relationship can be implied, liability may also be implied. Hence, even where a physician does not set foot in, is not licensed and does not practice in, and has no ties to a state other than the state of his or her residence, he or she may still be liable for torts committed in that remote state by others based on his or her advice. Moreover, given the *Mozingo* theories, a physician may be considered, under telemedical technology, to have purposely availed of the host state medical community. He or she may be seen as having minimum contacts. Under case law theories of fairness or purposeful availment, the physician may be subject to jurisdiction and suit in a host state to an injured plaintiff who was neither a patient nor a responsibility.

While there has been a cry for universal interstate licensing, credentialing and regulation of physicians given telemedicine and interstate consultation, existing legal theories have the ability to address potential damage and injuries. Perhaps the better rule is to continue the traditional police powers role of the states for the general health, safety and welfare of their individual citizens, without the need for federal licensing and credentialing.

A. Licensure and Credentialing Concerns in Telemedicine

Even though telemedicine has existed in some form for nearly 40 years, contemporary, progressing computer technologies and communications technologies are rapidly changing the milieu and the possibilities of telemedicine today. The "Information Age," into which we have already entered, affords health care providers access to high-speed data lines, advanced data compression technologies, highly pixilated image technologies, the computerization of patient records, clinical outcomes and physician practices, and the privatization of defense technologies.[120] These technical innovations continue the trend of health care practitioners updating their diagnoses, treatments, and medical services based on the latest and best scientific information and mechanical products available to them. Telemedicine, therefore, shows the potential to substantially improve access to much-needed medical expertise and health care services.[121]

Many clinical services already are being provided by telemedicine,[122] including radiology,[123] mental health services,[124] pathology,[125] home care services,[126] specialty consultations,[127] prison populations,[128] managed care[129] and direct consumer/patient information and care.[130] Legal concerns regarding licensure are being raised now that telemedicine is being practiced across state borders (interstate), not just within them (intrastate). Licensure authority is defined as "who has the legal responsibility to grant a health professional the permission to practice their profession."[131] This vesting of licensing authority in the state, federal, or regional arenas also raises legal and constitutional concerns. All of these must be considered in the licensure issue.

XIII. State Licensing Procedures

Historically, states have assumed the primary authority for "regulat[ing] activities that affect the health, safety, and welfare of their citizens including the practice of the healing arts within their borders."[132] In fact, every state has enacted a Medical Practice Act that directs the processes and procedures for granting a health care practitioner's license, renewing that license and regulating medical practice within that state.[133] This power has been granted to the states by Amendment X of the U.S. Constitution.[134] In *Goldfarb v. Virginia State Bar*,[135]

the Supreme Court recognized this authority: "The States have a compelling interest in the practice of professions within their boundaries, and that as part of their power to protect the public health, safety, and other valid interests, they have broad power to establish standards for licensing practitioners and regulating the practice of professions."[136] The states' power to regulate health care may not, however, be absolute. The Commerce Clause limits states' ability to erect barriers against interstate trade,[137] and the practice of health care has been held to be interstate trade for the purpose of antitrust laws.[138] Since "telemedicine consultations affect the health and well-being of individuals physically located in a state, states have a legitimate local interest in ensuring that out-of-state telemedicine health professionals meet the same standards as those health care professionals currently licensed within the state."[139] At this point, the potential conflict between the states' power to regulate health care professionals and the prohibition against restraints on interstate commerce has not been addressed by the courts.

XIV. Federal Licensing Procedures

Even though the states have clear authority to license health care professionals, the federal government has the authority to establish national licensing standards.[140] The government has constructed national requirements for nursing homes and other providers to participate in the Medicare and Medicaid programs,[141] and Congress has established health and safety standards for any actions or measures that can affect interstate commerce.[142] These standards include the Mammography Quality Standards Act of 1992,[143] the Occupational Safety and Health Act of 1970,[144] and the Clinical Laboratory Improvement Amendment of 1988.[145]

The Supremacy Clause of the Constitution[146] gives the federal government the right to preempt state laws that interfere with, or are contrary to, the laws of the federal government. There is, however, a strong presumption against federal preemption of state law.[147] In *Fort Halifax Packing Co. v. Coyne*,[148] the Supreme Court acknowledged that the regulation of health and safety matters has primarily and historically been an exclusive state concern; therefore, the preemption of any state law should not occur unless Congress has a clear intent to supersede that state law.[149] If Congress intends to preempt a state law, such intention must be explicitly stated in the federal statute's language or implicitly contained in its structure and purpose.[150] Courts have implied preemption in two situations if there is no explicit preemptive language.[151] One situation occurs where the scheme of federal regulation is "so pervasive as to make reasonable the inference that Congress left no room for the states to supplement it."[152] The other situation occurs where "compliance with both Federal and state regulations is a physical impossibility" or when the purposes behind the two regulations are inconsistent.[153] According to *De Canas v. Bica*,[154] however, the Supremacy Clause mandates that even state regulation designed to protect vital state interests is superseded by paramount federal legislation.[155]

If Congress should decide to regulate telemedicine licensure, it certainly could do so. Many federal systems currently use telehealth to supply clinical services. Federal organizations like the Veterans Administration, the Department of Justice-Bureau of Prisons, the Department of Defense and the Indian Health Service are exempt from the intricacies and inconsistencies of multistate licensure.[156] In these federal organizations, a health care practitioner can practice in any federal facility in any state within the organization's system as long as the practitioner is properly and currently licensed in at least one state.[157] The practitioner must continue to meet the requisite number of continuing education credits required by that state to maintain the license to continue working within the system.[158] These federal organizations have concluded that there is little difference in the substantive licensing requirements across the states and territories.[159] Notwithstanding this, if Congress did not completely preempt state regulation of telemedicine, the states would continue their own licensing systems.[160] Consequently, the ultimate question of preemption lies with Congress and its intent.

XV. Regional/Multi-State Authority

Our form of government gives states the sovereignty to assert those powers not ceded to the federal government. One of these powers recognized by the Constitution is the states' authority to enter into compacts or agreements with one another subject to congressional consent.[161] An interstate compact is "a voluntary agreement between two or more states established for the purpose of remedying a particular problem of multistate concern."[162] Interstate compacts enable states to attack problems or situations where they experience a lack of control over the subject matter or a lack of resources.[163] The delivery of interstate medical services currently is being explored by regional or multi-state compacts, such as the Interstate Compact on Mental Health, which requires states to treat mental health patients based on their clinical needs, not their place of residence.[164] Once a patient has been stabilized, the compact allows the treating psychiatrist to extradite the patient to his or her state of residence.[165]

Another example of a regional solution is the Western Governors Association (WGA).[166] Western state governors have become united by the need to improve medical services in remote areas throughout the western region.[167] Each governor realizes that access to basic health care is limited by geographic isolation, physician reimbursement, the relative scarcity of rural physicians, weather vagaries that impede travel and poor public transportation to the larger cities.[168] The WGA, through a Telemedicine Policy Review Group (the "Group"), has found that telemedicine can improve and enhance health care delivery to people in rural areas.[169] Technical improvements in equipment and delivery mechanisms and significant cost reductions of that equipment and telecommunications technology open up promising possibilities for rural areas.[170] Based on its analysis and study, the Group also finds other significant barriers to implementing telemedicine across the west-

ern states at this time. The Group's report lists six areas that are current barriers to implementing regional telemedicine networks:

1. Inadequate information infrastructure and uncoordinated infrastructure planning;
2. Regulatory distortions, limitations on competition, and fragmented demand;
3. Public and private reimbursement policies that do not compensate for telemedicine series;
4. Physician licensing and credentialing rules that discourage physicians from practicing telemedicine within states and across state lines;
5. Concerns about malpractice liability associated with telemedicine;
6. Concerns about the confidentiality of patient information.[171]

To overcome or reduce these barriers, the Group has recommended to the governors actions that would allow the WGA to develop, advocate and implement strategies to address these telemedicine barriers and foster experimentation that stimulates the development and use of telemedicine networks in the west.[172] One of the barriers the Group addresses is licensure and credentialing.[173]

The Group found that health care practitioners currently must meet many requirements to get a license to practice in each state and to be credentialed at individual health care facilities.[174] Many practitioners are reluctant to become involved in multi-state telemedicine networks because of the administrative burdens and costs of complying with multiple licensing and credentialing rules.[175] Two main reasons exist for these various licensing requirements: to ensure the delivery of quality health care services and to regulate the commercial activities of health care practitioners.[176] Credentialing by health care facilities also limits the license which the state has granted to health care professionals.[177] As an offshoot from this, in-state health care practitioners use licensure and credentialing to protect their economic markets from out-of-state competition.[178] This type of market regulation conflicts with the proposed policies of the WGA, which are to optimize health care delivery within the western region.[179] This is the reality in the microcosm, much less the macrocosm, and must be addressed in any recommended actions. The Group addresses this and other potential concerns of the affected states by suggesting that the governors direct a task force to analyze the costs and benefits for both patients and telemedicine practitioners if the health care market is opened via the use of telemedicine.[180] The Group also recommends that the governors use the task force to draft a Uniform State Code for Telemedicine Licensure and Credentialing for use within the western region.[181] Alternatively, the task force could explore expanded interstate reciprocity in licensing and credentialing instead of constructing a model code.[182] Regardless of the result, the WGA could very well demonstrate the states' capacity to develop solutions to this complex problem.

XVI. Current State Standards

In the last century, the basic educational and competency requirements for obtaining a state medical license have been standardized.[183] In fact, the state-based licensing system currently in use is built around certain national standards: (1) graduation from an accredited medical school; (2) passing a uniform licensing exam sequence;[184] (3) post-graduate training; and (4) developing a centralized credentials verification system.[185] But the states do not agree on every issue. Each state differs on its definition of the "practice of medicine."[186] Each state also has inconsistent or conflicting disciplinary standards, variations in the accountability of out-of-state health professionals and the degree and type of licensing required for any out-of-state consultation, and disagreements over the number and types of documents and required fees necessary for acquiring and maintaining licenses.[187]

These differences cause problems in extending telemedicine networks over multiple states. Recent modifications to state health care licensing requirements in 11 states demonstrate this ongoing battle. Generally, these modifications either narrow the consultation exception or require all out-of-state physicians to have a state license to provide diagnostic or therapeutic services on a regular and ongoing basis.[188] These modifications not only affect telemedicine providers but also restrict consulting arrangements that have long been considered acceptable medical practices.[189] Indiana, Nevada, Oklahoma, South Dakota and Texas amended their licensing statutes to include diagnostic or treatment services provided through electronic communications in their definitions of the practice of medicine.[190] Many other states addressed intrastate telemedicine but ignored interstate telemedicine, except for consultations.[191]

Consultation exceptions are long-standing acceptable medical practices.[192] The restrictions to consultations under many of the new state statute modifications could be construed to reach beyond telemedicine. Physician-physician communications that could be affected by these modifications include:

1. Reference laboratory services and related consultations with a pathologist;
2. Cross-specialty and sub-specialty reviews;
3. Imaging interpretations;
4. Communications between the primary care physician and the specialist who treated the patient in another state; and
5. Second opinions on the interpretation of biopsies, images, tests or exams.[193]

The consultation exception varies by state. Four states have no statutory consultation exceptions,[194] 16 states have

narrow exceptions [195] and 30 states have broad exceptions.[196] Many states restrict consulting physicians by limiting the frequency of contacts.[197] There are no reported disciplinary actions of out-of-state physicians performing consultations with local physicians,[198] so it remains unclear why states felt the consultation restrictions were justified. It may well be left to the courts to sort through the probable conflicts.

XVII. Federation of State Medical Boards

In response to the burgeoning telemedicine-related issues confronting the states and the country as a whole, the Federation of State Medical Boards in 1995 drafted and adopted a Model State Act to regulate the practice of telemedicine across state lines.[199] The act would require physicians to obtain a special limited telemedicine license in each state in which they intend to practice medicine across state lines.[200] The act defines practicing medicine across state lines as "rendering any 'written or otherwise documented' medical opinion concerning the diagnosis or treatment of a patient located in another state."[201] Three exceptions to the limited license exist in the Model State Act: (1) an emergency where immediate treatment is required; (2) when an opinion is given without the benefit of compensation; or (3) if the service is provided on an infrequent or irregular basis.[202] Up to now, states have widely discussed the Model State Act, but no state has adopted it.[203] In fact, the AMA has stated:

> The proposed definition [of the practice of medicine across state lines] is too broad. As it is now, it could be held to apply to all services, including X-ray, EKG, and laboratory tests. Having these services included in the legislation would require some physicians to have licenses in many states. At present these services are provided across state lines apparently without problems and without being licensed in multiple states.[204]

Additionally, the AMA Board of Trustees in 1996 rejected the limited telemedicine license proposed by the Model State Act and any other proposals advocating anything short of full licensure in every state in which a physician wishes to practice telemedicine.[205]

XVIII. Alternative Approaches to Telemedicine Licensure and Credentialing

A variety of existing alternative telemedicine models could be applied to health care professionals providing telemedicine services. Some models vest partial or full authority for standards and administration of the licensing process in bodies other than the states themselves.[206] Some models propose uniform standards for credentials, professional conduct and discipline, while most models provide specific mechanisms for enforcement against out-of-state health professionals.[207] The following is a general listing of the best alternatives.

A. Consulting Exceptions

As discussed before, consultation exceptions would allow a physician who is unlicensed in a particular state to practice medicine in that state at the behest and in consultation with a referring state-licensed physician.[208] Most states consider a consulting physician to be the exception rather than the rule.

B. Endorsement

This alternative method is also currently used by most state boards. It allows state boards to grant licenses to health care professionals in other states that have standards equivalent to their own.[209] When a physician applies for a second license via endorsement, the state usually does not require the applicant to retake the basic licensing examination.[210] However, drawbacks exist for this method. The entire process of endorsement is usually time-consuming, costly and confusing. Each state has its own set of paperwork requirements, unique forms, procedures, background checks, character and fitness evaluations and fees.[211] Each state also retains separate disciplinary authority over its licensees, including those granted licenses by endorsement.[212] Additionally, 40 states and Guam require some or all of its endorsement applicants to appear before the state medical board in person,[213] substantially increasing the cost of endorsement for many. This entire process produces a compliance burden of meeting diverse administrative requirements and standards of professional conduct.[214] Until all the factors are harmonized, the burden is prohibitive for many health care professionals.

C. Mutual Recognition

This model is a system in which the licensing authorities voluntarily enter into an agreement to legally accept the processes and policies of a licensee's home state.[215] The system, currently used by the European Community and Australia,[216] consists of three parts: (1) a home state, (2) a host state, and (3) a harmonization of essential licensing standards and professional conduct.[217] Even though a health care professional need only obtain a license in the home state, he or she must inform the other states of the intent to practice medicine within their borders.[218] Mutual recognition has worked well in other countries, but it will involve lengthy negotiation in the United States. The issues of enforcement, administration, and standards all need to be negotiated in any mutual recognition system. Some states must be willing to accept higher or lower standards than they currently have for this to be successful. In fact, the WGA would have to settle these issues for their regional compact to work. Overall, the initiation of this system would be complicated and time consuming.

D. Reciprocity

Reciprocity denotes "the relationship between two states when each state gives the subjects of the other certain privi-

leges, on the condition that its own subjects shall enjoy similar privileges at the hands of the latter state."[219] State authorities would need to negotiate and agree to recognize licenses issued by the other state without subjecting the licensee to further review.[220] Agreements could be reached bilaterally or multilaterally. Although no state has entered into any public reciprocity agreement, many experts argue that reciprocity already exists when a patient physically travels to another state to receive health care.[221] While reciprocity negotiation may be complicated, reciprocity itself does not require a harmonization between states' standards and procedures. Thus, a regional reciprocity agreement could be the first step toward standardizing the licensing process.

E. Registration

Under this model, a currently licensed health care professional in one state would notify authorities of another state that he or she wished to practice part-time within that state.[222] By registering in this manner, the practitioner would be obliged to submit to the authority and jurisdiction of the other state.[223] This system exempts the health care professional from meeting the entrance requirements of the host state, but it mandates accountability for breaches of professional conduct in any state in which the practitioner is registered.[224] Only California has passed legislation that authorizes registration, but the state has not yet implemented it.[225] Issues that must be addressed under this system include the administrative procedures for registration, the appropriate process for disciplining out-of-state health care professionals and professional conduct standards.[226] Registration asserts jurisdiction over out-of-state health care professionals and eases the burden of holding them liable for their conduct.[227] One caveat is that some protection may be needed to guard against health care professionals obtaining a license in the jurisdiction with the lowest requirements and merely registering elsewhere.[228]

F. Limited Licensure

This system is a modification of the current system whereby a health care practitioner must obtain a license from each state in which he or she practices.[229] A limited license would only allow for the delivery of a specific set of health services under particular circumstances in a specific state.[230] This model system limits the scope of practice instead of the time period for practice.[231] Like the other systems, the health care professional must maintain a full and unrestricted license in at least one state.[232] It is up to each state legislature to adopt a limited licensing system. Unfortunately, this continues disparate state licensing requirements, albeit to a lesser extent.

G. National Licensure

Since the federal government has the right to implement a national licensing system, it could do so either at the state or national level. A national license would have to be based on strict standardized criteria for the practice of health care throughout the United States.[233] These criteria would include standards to: (1) ensure the clinical proficiency of the health care professional in his or her practice area; (2) gauge mental and physical competency; (3) identify incompetent practitioners; (4) resolve patient complaints; (5) address the misconduct of health care professionals; and (6) guarantee due process.[234] A national licensing system should establish strict entrance requirements for any potential practitioners. By doing this, the government would continue to reflect the states' interest in public safety by ensuring that unqualified practitioner-applicants are identified and denied access to this national program.[235] Another recommendation for this system would be to limit the number of physicians participating from each state, which also would simplify monitoring for abuse or negligence.[236] A smaller number of licenses may allow better privacy protection for patient information.[237] Even with these advantages, a central administration would raise concerns over state revenue loss, the mechanism for financing such a system, the legal authority of the states, and the logistics of collecting, processing and storing confidential licensing data.[238] These issues would need to be addressed by Congress prior to implementing this type of system.

XIX. The Near Future of Licensure and Credentialing

If the use of telemedicine remained strictly within each state's border, the current licensing procedures in each state would remain adequate for the task. But telemedicine, being a creation of technology, cannot and has not remained in isolation. It is a field of medicine intricately tied to a rapidly expanding technology that constantly enlarges and redefines its own boundaries. Telemedicine is already accepted by the majority of the populace; in fact, many people eagerly await the next inventions and innovations. Soon, a symptomatic person will enter a room, lie on a table or bed, and have his or her heart rate (EKG), respiration, blood pressure, temperature and pulse read automatically by small sensors and electrodes.[239] Since this information is electronic, it already exists in a state that is readily transmitted over telemedical networks to distant physicians and other health care practitioners. At the very least, state and federal authorities must come to consensual agreements on how to handle licensure and credentialing and the other thorny legal issues raised by the possibilities of telemedicine.

Neighboring states or regions will most likely take the first major strides toward solving the licensing problem. The necessity of each state to ensure that its constituents receive the best available health care will impel this action. For states with few urban centers and large rural areas, telemedicine is a viable answer.

Although regional groups like the WGA are actively working toward resolving the tangle of legal issues engendered by telemedicine, telemedical agreements between two or three

states should surface first. It is much easier for two states to negotiate alternative methods of licensing than it is for five to do so. Settled agreements will likely be a combination of alternative licensing methods.

The chosen methodologies need to reflect a reduction in administrative paperwork and fees and an increase in qualified, competent care. Until a national licensing system is passed by Congress, states will likely agree to pacts that combine the best of endorsement, mutual recognition and reciprocity systems. The framework for endorsement already exists in most states, where medical boards have evaluated the health care standards of many other neighboring states. These evaluations can form the basis of a system built on mutual recognition, since such a system rests on the acceptance of another state's policies and procedures. It could also be the basis of a reciprocal system, since knowledge of another state's policies and procedures is central to granting privileges to the program's health care participants. Details concerning professional conduct standards, jurisdiction and due process would have to be negotiated, but it is not an insurmountable task.

Agreements or compacts between the states or regions will be the first step toward eventually obtaining national licensure. In theory, the country is almost there, with national standards for physicians currently accepted as a base in all states. But the states must believe that they are not relinquishing control to a system that fails to effectively safeguard the competence and qualifications of any health care professional who enters the system. This will be realized as states agree to work with each other, thereby increasing health care selection and capabilities for their constituents.

Conclusion

Telemedicine is burgeoning within most of the states and territories at this time. The continuing improvements in telecommunications and computer technology, coupled with a decrease in the cost of the required support equipment, makes intrastate telemedicine projects one of the fastest growing areas in the health care industry. Licensing and credentialing problems, among others, are trapping telemedicine within states' borders. To expand telemedicine to bilateral, regional or national levels, the licensing and credentialing problem must be addressed. Even though the federal government could legitimately impose a national or federal licensing system, it has been reluctant to do so. However, several alternatives exist that either could eliminate the need for a federal system or ease the country toward its implementation. Currently, licensure's greatest champions are the regional or multi-state compacts. Enclaves of states with similar problems administering proper health care to their constituents are more likely to overcome the logistical standards and state sovereignty problems that accompany multi-state ventures than states that do not believe they have similar needs or problems. Regional compacts, like the one the western governors have proposed, will likely become the cornerstone and impetus for bringing telemedicine to its rightful place in the United States today, even though it is woefully behind other industrialized nations of the world. Once the states stop squabbling over jurisdictions and authorities and begin concentrating on the proposed outcome, telemedicine will help provide adequate health care to most people in the country, not just a privileged urbanized few.

Endnotes

1. President William J. Clinton, *1997 State of the Union Address before Congress*, 33 WEEKLY COMP. PRES. DOCUMENTS 136, 140 (Feb. 10, 1997).
2. *See* The Center for Telemedicine Law, *Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force,* 73 N.D. L. REV. 109 (1997). The Center for Telemedicine Law (CTL) Licensure Task Force is a non-profit organization founded in 1995 by four foundations: the Mayo Foundation, the Cleveland Clinic Foundation, Texas Children's Hospital and the Midwest Rural Telemedicine Consortium. It is comprised of both large and small telemedicine health care provider institutions and practitioners and is designed to educate both the public and other health care providers regarding the legal and regulatory issues related to telemedicine.
3. *See* Douglas D. Bradham, Sheron Morgan, Ph.D., and Margaret E. Dailey, M.P.H., *The Information Superhighway and Telemedicine: Applications, Status and Issues*, 30 WAKE FOREST L. REV. 145 (1995).
4. *See* Douglas A. Perednia and Ace Allen, *Telemedicine Technology and Clinical Applications*, Feb. 8, 1995 JAMA 483, 1995 WL 10027039.
5. *See id.*
6. *See id.* at 149.
7. *See* Travis Wheeler, *In The Beginning: Telemedicine and Telepsychiatry,* TELEMEDICINE TODAY 2 (Summer 1994).
8. *See id.*, *quoting* Cecil L. Wittson, *Two Way Television in Group Therapy,* MENTAL HOSPITALS 22 (1961).
9. Bill Mahler, *The Technology and Language of Telemedicine*, KANSAS MEDICINE 354 (December 1992).
10. *See* Perednia & Allen, *supra* note 4.
11. Television cameras and monitors in another shielded room area are used to allow the radiologist, physician or health care professional to observe the patient without the need to be in the room while the equipment is used. The clinician enjoys the advantage of no radiation exposure and no need for heavy, bulky or cumbersome protective body shielding. The same remote operator site techniques are used today in radiation therapies, diagnostic protocols and magnetic resonance imaging (MRI).
12. *See* Ace Allen, *In The Beginning, Part II: Telemedicine and Teleradiology,* TELEMEDICINE TODAY 6 (Fall 1996).
13. *See id.*
14. *See* Perednia & Allen, *supra* note 4.
15. *See* Bradham, Morgan & Dailey, *supra* note 3, at 151.
16. *Telemedicine Report to Congress,* 73 N.D. L. REV. 131 (1997).
17. *Telemedicine: An Information Highway to Save Lives*, Hearing before the Subcomm. on Investigations and Oversight of the House Comm. on Science, Space and Technology, 103RD CONG., 2D SESS. 2 (1994).
18. Kathleen M. Vyborny, *Legal and Political Issues Facing Telemedicine,* 5 ANNALS OF HEALTH LAW 61 (1996).
19. *See* Jay H. Sanders & Rashid L. Bashur, *Challenges to the Implementation of Telemedicine*, U.S. Department of Commerce National Telecommunications and Information Admin. Report to Congress 1 (Jan. 31, 1997).
20. *See* Perednia & Allen, *supra* note 4.
21. *See id.*
22. *See* Bradham, Morgan & Dailey, *supra* note 3, at 151.
23. *See* Leslie G. Berkowitz, *Is There A Doctor In The House? The Rise of Telemedicine,* 25 COLO. LAW. 19 (June 1996).

24. *See* Phylllis F. Granade & Jay H. Sander, M.D., *Implementing Telemedicine Nationwide: Analyzing the Legal Issues*, 63 DEF. COUNSEL J. 67 (January 1996).

25. *See* Stacey Swatek Huie, *Facilitating Telemedicine: Reconciling National Access With State Licensing Laws*, 18 HASTINGS COMM. & ENT. L.J. 377 (Winter 1996).

26. *See* Arent, Fox, Kintner, Plotkin & Kahn, *Advanced Health Systems: Telemedicine and the Law*, HEALTH INFO. SYSTEMS & TELEMEDICINE (March 1995).

27. *See* Perednia & Allen, *supra* note 4, at 483.

28. *See id.*, *quoting* 2 TELEMEDICINE 5, 6 (Oct. 24, 1996).

29. *See id.*

30. *See id.*, *quoting* BUSINESS WEEK 117 (Oct. 3, 1994). Forty states currently have telemedicine programs in place, and 90 percent of those programs involve interactive conferencing and consultation, with 70 large multiple user networks planned and under construction.

31. *See id.*

32. *See* John P. Witherspoon et al., *Rural Telehealth: Telemedicine, Distance Education and Informatics for Rural Health Care Office of Rural Health Policy, Health Resources and Services Administration, Public Health Service,* U.S. Department of Health and Human Services (Sept. 1993). *See* Allen, *supra* note 12, at 212-217.

33. *See Telephone Videoconferencing Companies Vie for Telemedicine Market*, 2 TELEMEDICINE 1, 6 (August 1994).

34. *See* Perednia & Allen, *supra* note 4.

35. *See id.*

36. *Id.*

37. *See* Huie, *supra* note 25, at 381.

38. Buck Rogers was the name of an early popular science fiction cartoon series depicting futuristic inventions. It was part of the mid-20th century American social-economic optimism that forecast space travel, television, and future prosperity through science and technology.

39. Jay H. Sanders, M.D., *The Revolution in Health Care Delivery*, 73 N.D. L. REV. 19 (1997).

40. *See* Perednia & Allen, *supra* note 4.

41. *See id.*

42. *See id.*

43. *See* Sanders & Bashur, *supra* note 19.

44. Robert F. Pendrak & Peter Ericson, *Telemedicine and the Law,* HEALTHCARE FINANCIAL MANAGEMENT 46 (Dec. 1, 1996).

45. *Id.*

46. *See* The Telecommunications Act of 1996, which provides "to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for . . . health care providers." 47 U.S.C.A. § 254(h)(2)(A).

47. *See* Pendrak & Ericson, *supra* note 2, at 46.

48. Pub. L. No. 93-579, 88 Stat. 1896 (codified as amended 5 U.S.C. § 552a (1988)).

49. §§ 1-101 to 9-106, 9 U.L.A. 479-520 (1988).

50. 5 U.S.C. § 552a(b).

51. 5 U.S.C. § 552a(b)(8).

52. *See* Bradham, Morgan & Dailey, *supra* note 3, at 162.

53. *See id.*

54. *See id.*

55. *See* Allen, *supra* note 12, at 6.

56. *See* Sanders & Bashur, *supra* note 19, at 219.

57. *See id.* at 224.

58. *See* Bradham, Morgan & Dailey, *supra* note 3, at 163.

59. *See id.*

60. *See* Sanders & Bashur, *supra* note 19.

61. *See* Barry B. Cepelewicz, *Telemedicine: A Virtual Reality, But Many Issues Need Resolving,* 13 No. 9 MED. MALPRACTICE L. & STRATEGY 1 (July 1996).

62. *See* U.S. NEWS AND WORLD REPORT 58 (Jan. 23, 1995).

63. *See* Sanders & Bashur, *supra* note 19, at 230.

64. *See Telemedicine Report to Congress*, 73 N.D. L. REV. 131 (1997).

65. *See* Sanders & Bashur*, supra* note 19, at 230.

66. *See id.* at 139.

67. *See id.*

68. *See* Berkowitz, *supra* note 23, at 19.

69. Berkowitz & Sprague, *Potential Theories of Legal Liability for Defective Expert Software*, in MANAGING EXPERT SYSTEM PROGRAMS AND PROJECTS: IEEE CONFERENCE PAMPHLET (Sept. 9, 1990).

70. *See Telemedicine Report to Congress*, *supra* note 16, at 131.

71. *See* Julie A. Kearney, *Telemedicine: Ringing In a New Era of Health Care Delivery*, 5 COMM. LAW CONSPECTUS 289, 293 (Summer 1997).

72. *See Telemedicine Report to Congress*, *supra* note 16, at 133.

73. *See* Kearney, *supra* note 71, at 293.

74. *Buch v. Amory Mfg. Co.*, 44 A. 809, 811 (1897) (no common law duty to rescue another); *see also Lacey v. United States*, 98 F. Supp. 219 (D. Miss. 1951) (duty to continue to rescue once rescue is undertaken).

75. 64 P.2d 208 (Utah 1937).

76. 440 S.W.2d 104 (Tex. 1969).

77. *See* Barry R. Furrow, et al., HEALTH LAW CASES, MATERIALS & PROBLEMS 283 (West 1991).

78. *See id.*

79. *Nash v. Royster*, 127 S.E. 356 (1925). *See also* Furrow, *supra* note 77, at 284.

80. *Buch v. Armory Mfg. Co.*, 44 A. 809, 811 (1879).

81. Sharon M. Glenn, *Liability in the Absence of a Traditional Physician-Patient Relationship: What Every "On Call" Doctor Should Know: Mozingo v. Pitt County Memorial Hospital*, 28 WAKE FOREST L. REV. 747, 753 (1993).

82. *Hiser v. Randolph*, 617 P.2d 774 (1980).

83. *Ricks*, 64 P.2d at 208.

84. *See* Furrow, *supra* note 977, at 283.

85. 165 U.S. 578 (1897) (state statute prohibiting insurance purchase from any company not licensed is within the state unconstitutional restriction of freedom of contract).

86. *Lochner v. New York*, 198 U.S. 45 (1905).

87. 243 U.S. 426 (1917) (sustained daily maximum work hour law).

88. 291 U.S. 502 (1934).

89. 304 U.S. 144 (1938).

90. *Allgeyer*, 165 U.S. at 578.

91. *See id.*

92. *See Childs v. Weis*, 440 S.W.2d 104 (Tex. Civ. App. 1969).

93. *See* Deanne Morgan, *Emergency Room Follow-Up Care and Malpractice Liability*, 16 J. LEGAL MED. 373, 379 (Sept. 1995).

94. 271 S.E.2d 545 (N.C. App. 1980), *rev'd*, 278 S.E.2d 253 (N.C. 1981).

95. Ostensible agency is a theory of vicarious liability that extends *respondeat superior*, which holds the master liable for the acts of his or her servant to health care providers, in contrast to former charitable provider theories (*see Bing v. Thunig*, 143 N.E.2d 3 (N.Y. 1957)).

    Under the theory of ostensible agency, the master (in this instance a hospital) holds itself out as the provider and is a responsible party where

there is harm caused by the servant. *See Jackson v. Power*, 743 P.2d 1376 (Alaska 1987); *Hardy v. Brantley*, 471 So.2d 358 (Miss. 1985). *Jackson* held that since the patient seeks care from the institution, and that institution holds itself out as a provider of such care, then the institution—and not merely or solely the instrument (the physician) of the institution—may be held liable, based on section 429 RESTATEMENT (SECOND) OF TORTS (1965), which provides:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services to the same extent as though the employer were supplying them himself.

The usual tests of ostensible agency include whether the institution provides the equipment/facilities, clearly separates itself from or as the provider of care, and whether the clinician/provider may select patients or must take care of all who present themselves.

96. 505 N.Y.S.2d 818 (N.Y. 1986).
97. 310 S.E.2d 90 (N.C. App. 1983).
98. *Id.* at 94.
99. *See* Glenn, *supra* note 81, at 773.
100. *See* Morgan *supra* note 93, at 379.
101. *See* Glenn, *supra* note 81, at 747; Morgan, *supra* note 93, at 379.
102. *See* Furrow, *supra* note 77, at 283.
103. 158 S.E. 744 (1931).
104. *Id.; see also Willoughby v. Wilkens*, 310 S.E.2d 90 (N.C. App. 1983).
105. *See Easter v. Lexington Memorial Hospital*, 278 S.E.2d 253 (1981).
106. *See Fought v. Solce*, 821 S.W.2d 218 (Tex. Ct. App. 1991) (court implies that where physician is employed by hospital to render on call care, duty to treat may be established).
107. *Id.* at 221.
108. 288 A.2d 379 (Md. Ct. App. 1972).
109. *Id.* at 388.
110. *Moeller v. Hauser*, 54 N.W.2d 639, 647 (Minn. 1952).
111. 415 S.E.2d 341 (1992).
112. 599 A.2d 1193 (1992) (failure of physician, hospital or laboratory to inform patient's collateral relatives is not actionable since there is no common law duty to inform absent contrary statute or substantial infection risk).
113. *See, e.g.*, *Cleary v. Group Health Assoc. Inc.*, 691 A.2d 148 (D.C. Ct. App. 1997).
114. *See* Furrow, *supra* note 77, at 284.
115. 331 N.C. 191-192.
116. Lawlor, *Chiropractor's Liability for Failure to Refer Patient to Medical Practitioner*, 58 A.L.R. 3d 590 (1974).
117. *See* Clinton, *supra* note 1, at 140.
118. *See* Glenn, *supra* note 81, at 773.
119. *See* Furrow, *supra* note 77, at 284.
120. *See Telemedicine & Health Care Informatics: Legal Issues* (visited Oct. 10, 1997) <http://www.netreach.net/~wmanning/telmedov.htm>.
121. *See* The Center for Telemedicine Law, *Findings and Recommendations of the CTL Licensure Task Force* (February 1997) <http://www.ctl.org/ctlwhite.html> [hereinafter "*CTL Task Force*"].
122. *See id.* at 3-4. *See also* The Center for Telemedicine Law, *Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force*, 73 N.D. L. REV. 109, 111-12 [hereinafter "*Interstate Licensure*"].
123. Teleradiology is probably the most extensive application of telemedicine. Using the latest technology, radiologists analyze sonograms, MRIs, CAT scans, and x-rays sent from the patient's clinic or hospital to the reviewer who may be located at a remote hospital or at home. This is a very useful tool for small facilities that do not employ full-time radiologists. *See CTL Task Force*, *supra* note 121, at 4.
124. Telepsychiatry and other telemental health services already serve individuals living in rural communities who cannot easily obtain these types of professional services. *See id.* Georgia and Oregon are successfully using telemental health services. *See* Division of Health Care Services, Institute of Medicine, TELEMEDICINE—A GUIDE TO ASSESSING TELECOMMUNICATIONS IN HEALTH CARE 42, 47 (Marilyn J. Field, ed. 1996).
125. Telemedicine currently allows a pathologist to manipulate and read a slide mounted on a microscope at a distant location. *See CTL Task Force*, *supra* note 121, at 4.
126. Telehomecare offers home-bound patients easy access to physicians and nursing staff and allows for frequent monitoring and early intervention, which may reduce hospitalizations and generate earlier releases from hospital care. *See id.* Several pilot projects are currently under way. The Medical College of Georgia, in conjunction with the U.S. Army's Center for Total Access Program, the Georgia Institute of Technology and Jones Intercable, is arranging the "electronic house call." This project will link 25 homes of chronically ill patients to health care practitioners via the local cable television infrastructure. Two-way interactive video, audio, and medical diagnostic instrumentation will be transmitted over the network. *See* Council on Competitiveness, HIGHWAY TO HEALTH: TRANSFORMING U.S. HEALTH CARE IN THE INFORMATION AGE, ch. 2 at 8-9 (visited Oct. 10, 1997) <http://mii.mist.gov/pubs/coc_hghwy_to_hlth/chp2.html> [hereinafter the "Council"]. The Home-based Electronic Link to Professionals (HELP) Innovations Project is also using a regional cable television company to link chronically ill patients to practitioners for daily monitoring. *See id.* Similar projects are being tested in California, Minnesota, Illinois and Texas. *See id.*
127. General practitioners and health providers at small facilities and clinics at remote sites often call specialists at a distant location to aid in the diagnosis of individual patient problems. *See CTL Task Force*, *supra* note 121, at 4.
128. Telemedicine can reduce the high costs and risks associated with transporting incarcerated or institutionalized individuals to health care providers. In some situations, it also allows these individuals to be screened prior to transport. *See id.* One example of this is in Texas, where the University of Texas Medical Branch in Galveston and Texas Tech University provide telemedicine links to two-thirds of the Texas correctional system, the second largest correctional system in the United States. *See* Council, *supra* note 126, at 8.
129. Improved monitoring and electronic interaction with high-risk patients could allow managed care providers to efficiently deploy health care specialists and better control costly hospitalizations. *See CTL Task Force*, *supra* note 121, at 4.
130. Patients and health care providers alike can access a wide array of health care information on the Internet. Health care institutions and voluntary associations sponsor hundreds of disease specialty home pages on the World Wide Web. People can also share and ask for information regarding treatment for specific conditions on many of these pages. *See id.*
131. *Telemedicine Report to Congress: Legal Issues—Licensure and Telemedicine*, at 3 (January 1997) <http://www.ntia.doc.gov/reports/telemed/legal.htm> [hereinafter "*Telemedicine Report*"].
132. *Id. See also CTL Task Force*, *supra* note 121, at 5.
133. *See Telemedicine Report*, *supra* note 131, at 2. The basic standards for practicing medicine in the United States are now fairly uniform and are structured around certain national standards. These standards include graduation from an accredited medical school, a uniform licensing examination sequence based on the National Board of Medical Examiners or the Federation Licensure Exam, post-graduate training requirements and the initial development of a centralized credentials verification system. *See CTL Task Force*, *supra* note 121, at 5.

134. Amendment X states that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

135. 421 U.S. 773 (1975).

136. *Id.* at 792. *See also Ferguson v. Skrupa,* 372 U.S. 726 (1963); *Dent v. West Virginia*, 129 U.S. 114 (1889).

137. Art. I, § 8, part 3 of the Constitution says that Congress has the power "to regulate Commerce . . . among the several States . . . ."

138. *See, e.g.*, *Arizona v. Maricopa County Medical Soc'y*., 457 U.S. 332 (1982) (where price-fixing agreements of any industry, professional or otherwise, restrain market entry, experimentation, and development of new ideas, inventions and technology).

139. *Telemedicine Report*, *supra* note 131, at 3.

140. *See id.*

141. *See id.* If a health care facility or provider fails to meet any of these national standards, that facility or provider can lose its government subsidies, reimbursements and aid allotments. *See id.*

142. *See id.* at 4.

143. The Mammography Quality Standards Act (MQSA) allows the Food and Drug Administration to set national standards for all mammography facilities. Like any other federal act, states can mandate stricter mammography standards than those stated by the MQSA, but they cannot allow any lesser mammography standards. *See id.*

144. The Occupational Safety and Health Act, 29 U.S.C. § 651 (1988 & Supp. V 1993), assures "safe and healthful working conditions for working men and women." *Id.*

145. *See Telemedicine Report*, *supra* note 131, at 3.

146. U.S. Const., art. VI, cl. 2. The Supremacy Clause states: "This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." *Id.*

147. The U.S. Supreme Court first recognized the federal-state balance in *McCulloch v. Maryland*, 14 U.S. 316, 427 (1819). Since then, "it has been settled" that the doctrine of preemption constitutes the resolution between federal and state law, and all "state law that conflicts with Federal law is without effect." *Cipollone v. Liggett Group*, 505 U.S. 504, 516 (1992) (*quoting Maryland v. Louisiana*, 451 U.S. 725, 746 (1981)).

148. 482 U.S. 1 (1987).

149. *See id.* at 21.

150. *See Jones v. Rath Packing Co*., 430 U.S. 519, 525 (1977); *see also Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990) (court stated that to discern Congress' intent, one must examine the explicit statutory language and the structure and purpose of the stated statute).

151. *See Telemedicine Report*, *supra* note 131, at 4.

152. *Rath Packing Co.*, *supra* note 150, at 525 (*quoting Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)).

153. *See Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43 (1963).

154. 424 U.S. 351 (1976).

155. *See id.* at 357.

156. *See* Discussion Panel, *Telemedicine: The Intersection of Law, Medicine, and Technology*, 73 N.D. L. Rev. 171, 182 (1997).

157. *See id.*

158. *See id.*

159. *See id.* at 183.

160. *See Telemedicine Report to Congress*, 73 N.D. L. Rev. 131, 136 (1997).

161. U.S. Const., art. I, § 10, cl. 3 states in part that "No State shall, without the Consent of Congress . . . enter into any Agreement or Compact with another State . . . ."

162. Black's Law Dictionary.

163. Interstate compacts have been used to determine rights to property, taxes or natural resources, to settle jurisdictional issues, to establish formal cooperative arrangements between state agencies for the provision of services, and to establish uniformity in the regulation of people or goods. *See Telemedicine Report*, *supra* note 131, at 5.

164. *See id.* at 4.

165. Personal interview with Dr. Edward Hermann, M.D. of Psychiatry, Nov. 15, 1997.

166. The Western Governors' Association comprises North Dakota, Utah, Nebraska, Alaska, American Samoa, Arizona, California, Colorado, Guam, Hawaii, Idaho, Kansas, Montana, Nevada, New Mexico, Northern Mariana Islands, Oregon, South Dakota, Texas, Washington, and Wyoming. *See infra*, note 167, at 9-10.

167. *The Western Governors' Association Telemedicine Action Report*, at 3 (visited Oct. 20, 1997) <http://www.arentfox.com/telemed/telemed.western.html> [hereinafter "*WGA Report*"].

168. *See id.* at 2. Many western states' efforts to encourage health care professionals to set up practices in rural areas have been only partially successful. This has been attributed to a limited patient base, the extreme rural nature of the location, the lack of easy access to continuing education, the difficulty of consulting with other health care professionals, and the lack of access to health care specialists. *See id.*

169. Even though telemedicine should improve health care access and quality, retain more health care dollars in rural communities and reduce patient travel and time off from work, it will do so at a price. Studies show that telemedicine is likely to increase health care costs for any society. Society's limited experience with telemedicine to date, however, restricts the accuracy of any estimate or balancing of cost versus savings. *See id.* at 2-3.

170. *See id.* at 2.

171. *See WGA Report*, *supra* note 167, at 2-3.

172. *See id.*

173. *See id.* at 6.

174. *See id.*

175. *See id.*

176. *See WGA Report*, *supra* note 167, at 6.

177. *See id.*

178. *See id.*

179. *See id.*

180. *See id.*

181. *See WGA Report*, *supra* note 167, at 6. Similar in principle to the Uniform Commercial Code (U.C.C.), the Uniform State Code for Telemedicine Licensure and Credentialing would include results from discussions concerning the definition of telemedicine, the licensure of networks, the simplified licensure of health care practitioners, and the requirements and grant of credit for continuing medical education. *See id.*

182. *See id.*

183. *See Interstate Licensure*, *supra* note 122, at 114.

184. The United States Medical Licensing Exam (USMLE) was first implemented in 1994. This exam is divided into three parts, each of which is administered over two days.

> The [USMLE] consists of multiple choice questions designed to test the physician's ability to apply knowledge, concepts, and principles that are important in health and disease and constitute the basis of safe and effective patient care. The same passing score is necessary in order to be licensed in any of the fifty states.

Id. Prior to 1994, most physicians now practicing in the United States took either the Federated Licensing Examination (FLEX) or the Special Purpose Examination (SPEX); foreign medical school graduates took the Foreign Medical Graduate Examination in Medical Sciences (FMGEMS). Most states accepted the same weighted average score for these exams. *See id.* at 114-15.

185. *See id.* at 113-14.

186. *See Telemedicine Report*, *supra* note 131, at 5. States' definitions range from broad and general to specific and narrow.

187. *See id.* at 6; *see also Interstate Licensure*, *supra* note 122, at 113-17.

188. *See Interstate Licensure*, *supra* note 122, at 119.

189. *See id.*

190. *See id.* at 119-20.

191. *See State Telemedicine Legislation 1995* (visited Oct. 10, 1997) <http://www.arentfox.com/telemed/state.1995.html>; *State Telemedicine Legislation 1996* (visited Oct. 10, 1997) <http://www.arentfox.com/telemed/state.1996.html>; *State Telemedicine Legislation 1997* (visited Oct. 10, 1997) <http://www.arentfox.com/telemed/state.1997.html>.

192. *See Interstate Licensure*, *supra* note 122, at 121-22.

193. *Id.* at 122.

194. These states are Illinois, Maine, Louisiana, and New Mexico. *See id.* at 122-23. Even in these states, either the attorney general or the state medical board enforces rules that out-of-state consulting physicians not practice medicine. *See id.* at 122.

195. These states include Alabama, Arizona, Arkansas, Colorado, Kansas, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, North Carolina, Oklahoma, South Dakota and Texas. *See id.* at 122-23. Many of these states limit the number of days a physician may consult. *See id.* at 123.

196. These states are Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Indiana, Iowa, Kentucky, Maryland, Massachusetts, Minnesota, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, South Carolina, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming. *See Interstate Licensure*, *supra* note 122, at 123. The number of days of consultation and the amount of consultation are rarely regulated, as long as a state-licensed physician is the primary health care provider on the case. *See id.*

197. *See id.*

198. This is based on a search through the WestlawJ and LexisJ databases.

199. *See* Kerry A. Kearney, *Medical Licensure: An Impediment to Interstate Telemedicine*, 9 NO. 4 HEALTH LAW. 14 (1997); *see also CTL Task Force*, *supra* note 121, at 10.

200. Kearney, *supra* note 199, at 14; *see also CTL Task Force*, *supra* note 121, at 10.

201. *CTL Task Force*, *supra* note 121, at 10.

202. *See id*. Infrequent or irregular is defined as "less than once monthly or involves less than ten patients on an annual basis, or comprises less than one percent of the physician's diagnostic or therapeutic practice."

203. *See* Kearney, *supra* note 199, at 14.

204. *Interstate Licensure*, *supra* note 122, at 125-126.

205. *See id.* at 14-15.

206. *See Telemedicine Report*, *supra* note 131, at 7.

207. *See id.*

208. *See id.*; *see also* notes 191 through 198 and accompanying text.

209. *See Telemedicine Report*, *supra* note 131, at 7.

210. *See CTL Task Force*, *supra* note 121, at 6.

211. *See id.*

212. *See Telemedicine Report*, *supra* note 131, at 7.

213. *See CTL Task Force*, *supra* note 121, at 7-8. The list includes Alabama, Alaska, Arizona, Arkansas, California, Delaware, Florida, Georgia, Guam, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin and Wyoming. *See id.* at 8.

214. *See Telemedicine Report*, *supra* note 131, at 7.

215. *See id.*

216. *See id.* at 8.

217 *See id.*

218. *See id.*

219. *Telemedicine Report*, *supra* note 131, at 8.

220. *See id.*

221. *See id.*

222. *See id.*

223. *See id.*

224. *See id.* at 8-9.

225. *See id* at 9.

226. *See id.*

227. *See id.*

228. *See id.*

229. *See id.*

230. *See id.*

231. *See id*.

232. *See id.*

233. *See id.*

234. *See id.*

235. *See* Huie, *supra* note 25, at 407. High practice standards ensure that a national licensing system would not provide less protection to the public's health, safety, and welfare than any of the state licensing laws. *See id.*

236. *See id.*

237. *See id.*

238. *See Telemedicine Report*, *supra* note 131, at 9.

239. The 1960s television series *Star Trek* brought this possibility into homes weekly. Biobeds, then only science fiction, have already become scientific fact. The U.S. military, where telemedicine is a staple, has explored this concept and has found it to be sound and usable.

*** This paper is a joint effort by Bob Scher and Crystal Elder. The paper has been divided into the following sections: Bob Scher: Introduction to Telemedicine; The Physician-Patient relationship. Crystal Elder: Licensure and Credentialing Concerns in Telmedicine.**

Roberts v. Galen: The Supreme Court Rejects an Improper Motive Requirement for Asserting an EMTALA Claim

by Rachel J. Filasto and Maziar Ghodsian*

Introduction

On January 13, 1999, the United States Supreme Court ruled in *Roberts v. Galen*[1] that no allegation of improper motive was required to bring a claim under section 1395dd(b) of the Emergency Medical Treatment and Active Labor Act (EMTALA).[2] In so doing, it rejected the Sixth Circuit's interpretation of EMTALA that had caused it to be the lone circuit to require an allegation of improper motive. This article will discuss *Galen* and its implications for future EMTALA suits.

Congress enacted EMTALA to prevent and curtail the growing evils of "patient dumping."[3] The statute is divided into two main sections: subsection (a) requires hospital emergency rooms[4] to provide for an "appropriate medical screening" to individuals who come in for treatment[5]; subsection (b) requires such hospitals to stabilize patients before transferring them to other facilities.[6] In 1990, the Sixth Circuit, in *Cleland v. Bronson Health Care Group, Inc.*,[7] held that a motive of some kind, economic or otherwise, is required for a disparate treatment claim under subsection (a). It reasoned that the word "'appropriate' must . . . be interpreted to refer to the motives with which the hospital acts" so as to avoid federal liability under EMTALA for run-of-the-mill malpractice claims.[8] In *Galen*,[9] the Sixth Circuit extended the improper motive requirement to subsection (b) claims. Other circuits have specifically rejected the Sixth Circuit approach, setting the stage for resolution by the Supreme Court.[10]

Part I of this article discusses *Galen* and the factors that led the Supreme Court to reverse the Sixth Circuit and hold that section 1395dd(b) requires no allegation of an improper motive requirement. Part II predicts the ramifications that the reversal of *Galen* will have on courts that presently require an allegation of an improper motive in order to state a claim under section 1395dd(a).

Part I

The petitioner in *Galen*, Wanda Johnson, filed suit against the respondent, The Humana Hospital University of Louisville ("Humana"), in 1997.[11] In May 1992, Johnson was run over by a truck and was rushed to Humana for treatment.[12] She suffered numerous serious injuries to her brain, spine, right leg and pelvis.[13] Her injuries were so severe that she had to be treated in the intensive care unit of Humana.[14]

Johnson's stay at Humana lasted a total of six weeks, throughout which her condition remained "volatile."[15] In her precarious condition, Humana officials decided to transfer Johnson to Crestview Healthcare Facility, a long-term care institution.[16] Soon after the transfer, Johnson's condition deteriorated significantly and she suffered major setbacks. Based on her life-threatening condition, Johnson was then sent to Midwest Medical Facility, and remained there for many months during which she "incurred substantial medical expenses as a result of her deterioration."[17] Johnson's attempt to obtain financial assistance under Indiana's Medicaid Program was unsuccessful because she did not meet the residency requirements.[18]

Jane Roberts was appointed Johnson's guardian and filed a federal action alleging violations under section 1395dd(b) of EMTLA.[19] The District Court granted summary judgment for Humana on the grounds that "the plaintiffs had failed to show that 'either the medical opinion that Johnson was stable or the decision to authorize her transfer was caused by an improper motive.'"[20] The Sixth Circuit in *Galen* affirmed the lower court's ruling, and held that a plaintiff must demonstrate that an improper motive was the catalyst behind the violation of the stabilization requirement of EMTALA.[21] The Sixth Circuit reaffirmed its reasoning in *Cleland* that an improper motive was required to distinguish EMTALA claims from malpractice claims and noted that "[W]e see no rational reason to set forth differing standards when applying subsection (a) and (b)."[22] The Supreme Court granted certiorari to decide whether section 1395dd(b) of EMTALA requires an allegation of an improper motive.

In reversing the Sixth Circuit ruling in *Galen*, the Supreme Court held that the lower court erred in predicating its analysis on the *Cleland* rationale.[23] The Court noted that *Cleland* was based on the "appropriate medical screening" requirement under subsection (a) of section 1395dd while subsection (b) contains no requirement of appropriateness.[24] The Court reasoned that "there's no question that the text of § 1395dd(b) does not require an 'appropriate' stabilization, nor can it reasonably be read to require an improper motive."[25] The Court pointed out the respondent's concession that the Sixth Circuit's motive test "lacks support in any of the traditional sources of statutory construction . . . ."[26] The Court stated, however, that it was "express[ing] no opinion" on whether *Cleland* was correct in its interpretation of subsection (a), although it specifically noted that the interpretation of *Cleland* was in conflict with other circuits.[27]

Part II

In the wake of the *Galen* decision, the viability of the improper motive test for section 1395dd (a) EMTALA claims is doubtful. The Supreme Court reaffirmed that traditional rules of statutory construction should govern in assessing the meaning of a statute. Consequently, in *Galen*, the Court must have reasoned that injecting words or phrases that are not in the statute itself violates traditional notions of statutory construction. Since section 1395dd(a) is clear, unambiguous and unequivocal, it too should be interpreted by its plain language, which mentions no implicit or explicit improper motive requirement.

It is axiomatic that the clear and unambiguous language of the statute is the best evidence of Congress' intent. Congress could have easily included "improper motive" or a similar term in the language of the statute. As the court in *Broderson v. Sioux Valley Memorial Hosp.* stated in rejecting the Sixth Circuit approach with respect to the stabilization section, "the court should decline to frustrate the plain meaning of the words chosen by Congress."[28] Similarly, in *Jones v. Wake County Hosp. System Inc.*, the court, again turning to the canons of statutory construction, held that "federal courts are *not* free to rewrite statutes simply because Congress could have acted with greater clarity."[29] The court cautioned other courts not to look beyond the "plain words of the statute," given the fact that all statutory language is carefully written and voted into existence by members of Congress.[30]

Had Congress wanted to inject an improper motive requirement into EMTALA, it would have drafted the statute accordingly. In the briefs submitted to the Supreme Court in *Galen*, the petitioner correctly maintained that "[t]he total absence of any requirement in EMTALA that motive be proven demonstrates Congress' intent to spare patients the burden of proving they were denied treatment because of intentional discrimination based on some improper or non medical motive."[31] To support this contention, the petitioner pointed to title VII of the Civil Rights Act of 1964 to establish that Congress knows how to draft statutes that require an improper motive.[32] Title VII explicitly prohibits employment discrimination "because of" an "individual's race, color, religion, sex, or national origin."[33] This language clearly and unequivocally establishes that Congress requires an improper motive in order to state a claim under this provision. In contrast, under section 1395dd(a), Congress made no such implicit or explicit assertion and, therefore, did not require an improper motive under that section.

As the *Galen* Court recognized, every circuit to address the issue has disagreed with the improper motive requirement set forth by the Sixth Circuit. These circuits have predicated their reasoning on the traditional rules of statutory interpretation. Thus, the D.C. Circuit, in *Gatewood v. Washington Healthcare Corp.*,[34] stated that motive was not necessary in analyzing the appropriate medical screening requirement under section 1395dd(a); rather, what is critical is an allegation of differential or disparate treatment.[35]

Similarly in *Correa v. Hospital Ass'n of San Francisco*, the First Circuit found the assertion that an economic motive is necessary to make a claim under EMTALA lacked merit.[36] The court held that "[e]very court of appeals that has considered [the issue of improper motive] has concluded that a desire to shirk the burden of uncompensated care is not a necessary element of a cause of action under EMTALA."[37] The court reasoned that *Cleland*'s motive requirement was so broad "as to be no limit at all."[38]

This most fundamental problem with the motive requirement is what the Fourth Circuit in *Power v. Arlington Hosp. Ass'n* called the "proof predicament."[39] There, the court held that (1) there is nothing in the statute that explicitly requires, states or refers to an improper motive; (2) there are many different types of possible motives to defeat a motive requirement; and (3) it is virtually impossible to prove the inner thoughts and prejudices of the members of a healthcare team.[40]

Rejecting an improper motive test for subsection (a) EMTALA claims will not turn the statute into a substitute for a malpractice claim as the *Cleland* court feared. The circuit courts have disagreed with *Cleland* with regard to a requisite allegation of an improper motive; however, they have required a necessary showing of disparate treatment to state a claim under EMTALA. Disparate treatment exists when a hospital does not provide the same level of care to one patient as it would have to other similarly situated individuals seeking emergency treatment.

In *Correa*, a sixty-five-year-old woman arrived at the emergency room with chest pains, nausea, chills and a cold sweat. She died after the hospital failed to treat her. In upholding the estate's EMTALA claim, the court held that "regardless of motive, a complete failure to attend to a patient who presents a condition that practically everyone knows may indicate an immediate and acute threat to life can constitute a denial of an appropriate medical screening examination under section § 1395dd(a)." [41] The *Correa* court explained that an appropriate medical screening must include some type of screening procedure, and that it be administered even-handedly. The court specifically warned that EMTALA does not create a federal malpractice cause of action by distinguishing disparate screening from faulty screening.[42] Following such reasoning will protect hospitals against malpractice claims disguised as EMTALA actions.

Conclusion

Based on the Supreme Court's rejection of an improper motive requirement for EMTALA claims based on failure to stabilize, it appears that such a requirement for appropriate medical screening claims is improper.

Endnotes

1. *Roberts v. Galen*, ___ U.S. ___, 119 S. Ct. 685 (1999).
2. 42 U.S.C. § 1395dd (West 1988).

3. The term "patient dumping" refers to the practice of refusing to provide emergency medical treatment to patients unable to pay for services or transferring a patient before an emergency medical condition is stabilized. See *Howe v. Hall*, 874 F. Supp. 799 (N.D. Ohio 1994). *See also Power v. Arlington Hosp. Assoc*., 42 F.3d 851 (4th Cir. 1994).

4. Hospitals receiving Medicare funding fall under the statute. *See* 42 U.S.C. § 1395c (West 1988).

5. (a) Medical Screening Requirement

> In the case of a hospital emergency department, if any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1) of this section) exists.

6. (b) Necessary Stabilizing Treatment for Emergency Medical Conditions and Labor

(1) In General

> If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition, the hospital must provide either: (A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition, or (B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

7. 917 F.2d 266 (6th Cir. 1990).

8. *Id*.

9. 111 F.3d 405 (6th Cir. 1997).

10. *See, e.g*., *Correa v. Hosp. Ass'n of San Francisco,* 69 F.3d 1184 (1st Cir. 1995); *Power v. Arlington Hosp. Assoc*., 42 F.3d 851 (4th Cir. 1994); *Brooker v. Desert Hosp. Corp.,* 947 F.2d 412 (9th Cir. 1991); *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991).

11. *See* 119 S. Ct. at 686.

12. *See id.*

13. *See id.*

14. *See id*.

15. *See id.*

16. *See id*.

17. *See id.*

18. *See id.*

19. *See id*.

20. *See id.*

21. *See id.*; 11 F.3d 405 (6th Cir. 1997).

22. 111 F.3d at 409.

23. *See* 119 S. Ct. at 687.

24. *See id.* at 686.

25. *Id.* at 687.

26. *Id.*

27. *Id.*

28. 902 F. Supp. 931, 949 (N.D. Iowa 1995).

29. 786 F. Supp. 538, 543 (E.D.N.C. 1991) (emphasis added).

30. *See id*. at 543.

31. *Galen*, 119 S. Ct. 685 (1999); brief for petitioner at 16.

32. See *id.*

33. *See id.*

34. 933 F.2d 1037 (D.C. Cir. 1991).

35. *Id*. at 1040.

36. 69 F.3d 1184, 1192 (1st Cir. 1995).

37. *Id.* at 1193.

38. *Id*.

39. 42 F.3d 851, 858 (4th Cir. 1994).

40. 42 F.3d at 857. *See also* C. Celeste Creswell, *Power v. Arlington Hospital Association: Extending COBRA's Striking Distance While Weakening the Power of Its Venom*, 29 GA. L. REV. 1171, 1178 (1995).

41. *Correa*, 42 F.3d at 857.

42. *Id*.

***Rachel J. Filasto is a second-year student at Pace University School of Law. She received a B.A. from Manhattan College and an M.P.A. in Healthcare Administration from Pace University. Maziar Ghodsian is a third-year student at Pace University School of Law. He received a B.S. from University of California, Riverside, and a B.S. in nursing from John Hopkins University School of Nursing.**

Elder Law Update

by Howard S. Krooks*

The Elder Law Update column is designed to provide members of the Health Law Section with information regarding recent legislative changes and case law in the field of elder law. In this edition, I discuss the decision of the Appellate Division, Second Department, in *Brown v. Wing*, regarding the calculation of the Medicaid penalty period. In addition, I have provided an update regarding section 4734 of the Balanced Budget Act of 1997, which shifted potential criminal liability from those who transfer assets (as was the case under the former section 217 of the Health Insurance Portability and Accountability Act of 1996) to those who counsel or assist such individuals for a fee in connection with an application for nursing home Medicaid benefits. Finally, I discuss *Bourgeois v. Stadtler*, a recent case in which the Appellate Division, Fourth Department, held that the Cattaraugus County Department of Social Services could not prevent the distribution of assets placed in a trust to the children of a couple, both of whom were Medicaid recipients, on the grounds that the trust was created as a fraudulent conveyance under the Debtor and Creditor Law and that the trust violated the "trigger trust" provision of the Estates Powers and Trusts Law.

Appellate Division, Second Department, Determines that Medicaid Penalty Period Commences on the First Day of the Month in Which an Asset Transfer Has Been Made

In *In re Marie R.. Brown v. Brian J. Wing,*[1] the Appellate Division, Second Department, reviewed a determination of the New York State Department of Social Services (the "Department") pursuant to a fair hearing in which it determined to calculate the petitioner's Medicaid period of ineligibility from the first day of the month *following* the month in which asset transfers were made and, in addition, imposed a partial month penalty. The Supreme Court, Suffolk County, had directed the Department to recalculate the petitioner's penalty period, starting the penalty period in the month during which the asset transfer was made. This appeal to the Appellate Division, Second Department, was made by the Department pursuant to CPLR article 78.

The facts of this case are as follows: the petitioner, Marie R. Brown, entered a nursing home on February 2, 1995, and applied to the Suffolk County Department of Social Services for Medicaid benefits, requesting a date of financial eligibility as of May 1, 1995. Her application was approved on October 25, 1995; however, the eligibility date was determined to be August 1, 1995. The petitioner had transferred assets in the amount of $47,073.50 from November 1994 to March 1995, thereby subjecting her to a period of ineligibility. The Suffolk County DSS calculated the applicable period of ineligibility by dividing the total value of the uncompensated transfers by the average cost of residing in a nursing home in Suffolk County. The total period of ineligibility was determined to be 8.46 months ($47,073.50/$5,564 = 8.46). The Suffolk County DSS determined that the penalty period would commence in December 1994, the month following the month in which the initial asset transfer was made. This determination was upheld at the fair hearing level, and the petitioner commenced this proceeding in which she disputed the calculation of the penalty period from December 1994, rather than November 1994, and the imposition of a partial month penalty.

Pursuant to Social Services Law (SSL),[2] in determining the Medicaid eligibility of an institutionalized individual, any transfer of assets made by an individual for less than fair market value within or after the 36-month look-back period immediately preceding the date that the individual is both institutionalized and applies for Medicaid renders that individual ineligible for nursing home benefits. Applying this rule to the facts of this case, any prohibited transfer of assets made by the petitioner within 36 months of April 26, 1995—the date that she both was institutionalized and had applied for Medicaid, would render her ineligible to receive Medicaid benefits during a penalty period. The "period of ineligibility shall begin with the first day of the first month during or after which assets have been transferred for less than fair market value, and which does not occur in any other periods of ineligibility."[3]

The Department contended that the plain meaning of SSL section 366(5)(d)(4)[4] unequivocally gave it the option to commence the period of ineligibility on the first day during or after which the resources had been transferred. The Appellate Division reasoned that although the construction generally afforded by an agency responsible for its administration is entitled to the greatest weight,[5] and should be upheld if it is not irrational or unreasonable,[6] such is not always the case "when the question is one of pure statutory reading and analysis, dependent only on accurate apprehension [sic] of legislative intent."[7]

The Appellate Division, Second Department, concurred with the petitioner that the Department's interpretation of the SSL was contrary to the legislative intent as expressed in the U.S. House of Representatives Report and the House Conference Report to OBRA 1993. The House Report to OBRA 1993 indicated that "[t]he period during which benefits are denied will begin with the date on which the prohibited transfer occurred."[8] The House Conference Report also provided that "[t]he period of delay begins with the first month during which the assets were disposed of."[9] The court also relied on the legislative history contained in the New York State Register pertaining to a proposed amendment to 18 N.Y.C.R.R. section 360-4.4, which stated that "[t]he proposed regulatory amendments would provide for a new transfer rule, applicable to transfers made on or after August 11, 1993" so

that "a single period of ineligibility would be calculated," and further that the "period of ineligibility would run from the first day of the first month in which a transfer was made." Citing the *Chevron* rule,[10] the court noted that it was required to give effect to the unambiguously expressed intent of the Congress where the Congress has spoken on a particular issue.

With respect to whether the Department could impose a partial month penalty period, the Appellate Division relied upon an informational statement[11] issued by the state. The statement provided that if the penalty period resulted in a partial month penalty, the Department must count the uncompensated value of the transfer attributable to the partial month as part of the Net Available Monthly Income, which the institutionalized individual is required to contribute to the cost of nursing home care before becoming eligible for Medicaid in that month. This comported with the State Medicaid Manual issued in November 1994 by the Health Care Financing Administration,[12] which stated in section 3258.5(D) that "[w]hen the amount of the transfer is less than the monthly cost of nursing facility care, you have the option of . . . imposing a penalty for less than a full month." Accordingly, the Appellate Division determined that a local Department of Social Services could impose a partial month penalty period and that the Suffolk County Supreme Court incorrectly held that the imposition by the Suffolk County DSS of the partial month penalty was improper. Practitioners should note that under prior law,[13] when calculating the duration of a penalty period, if a calculation resulted in a partial month, local departments of Social Services were not permitted to impose a partial month penalty period but were required to round down a penalty period to the end of the preceding month (e.g., 8.46 months would be rounded down to 8 months).

Prior to OBRA 1993, which became effective August 11, 1993, the calculation of the Medicaid penalty period began on the first day of the month during which an asset transfer was made. However, when the informational statement referred to above was issued on October 27, 1995, local departments of Social Services shifted to a calculation whereby the penalty period commenced in the month following the month in which the asset transfer was made. This practice had broad implications for the elder law practitioner advising clients regarding asset transfers and the resulting Medicaid penalty period as it had the effect of increasing an individual's Medicaid penalty period by one month, thereby delaying the Medicaid eligibility date also by one month.

By way of example, if an individual was subject to an eight-month penalty period due to an asset transfer that was made in January 1999, under the method of calculating the penalty period as set forth in the informational statement, the penalty period would commence in February 1999 and expire in September 1999. However, under the method of calculating the penalty period as set forth in *Brown v. Wing*, the penalty period would commence in January 1999 (the month in which the asset transfer was made) and expire in August 1999. Thus, from a planning perspective, the method of calculating the penalty period under *Brown v. Wing* results in earlier expiration of the applicable Medicaid penalty period and, consequently, an earlier date of financial eligibility to receive Medicaid nursing home benefits. Practitioners should be aware that the New York State Department of Health has appealed the Appellate Division decision to the New York State Court of Appeals. Oral argument is currently scheduled to take place in May 1999. In the interim, many local departments of Social Services are continuing the policy of beginning calculating the penalty period on the first day of the month following the month in which the asset transfer is made. Thus, attorneys who counsel clients with respect to asset transfers should be mindful of the current practice of the local Medicaid agency and advise clients accordingly.

Section 4734 of the Balanced Budget Act of 1997 is Declared Unconstitutional and the Justice Department is Permanently Enjoined from Enforcing the "Granny's Advisor Goes to Jail Act"

In the Fall 1998 issue of the *Health Law Journal*, I reported that on April 7, 1998, Chief U.S. District Court Judge Thomas J. McAvoy granted the New York State Bar Association's motion for a preliminary injunction in its lawsuit[14] challenging the constitutionality of section 4734 of the Balanced Budget Act of 1997.[15] The preliminary injunction prohibited the enforcement of section 4734 on the grounds that this provision was unconstitutional. Notwithstanding U.S. Attorney General Janet Reno's assurances that she did not intend to defend the constitutionality of section 4734 or enforce its provisions,[16] the NYSBA proceeded with the litigation out of concern that section 4734 was still on the books, and that future attorneys general may not have concurred with Reno's interpretation of this provision.

On September 14, 1998, Justice McEvoy issued a decision which declared that section 4734 is unconstitutional, which permanently enjoined the U.S. Department of Justice from taking any action to enforce section 4734. While this was thought to be the end of the criminalization era in the context of Medicaid planning, that was not the case. On December 18, 1998, Attorney General Reno filed a Notice of Appeal with the U.S. Court of Appeals, Second Circuit, regarding the permanent injunction issued by the District Court in its September 14, 1998 decision. Although no papers have been filed in connection with the appeal as of the time of this writing, it is believed that the reason for the appeal concerns a procedural aspect of the case and will not challenge the determination that section 4734 is unconstitutional. I will keep readers of the *Health Law Journal* apprised of any future developments in this area.

The Appellate Division, Fourth Department, Restricts Medicaid's Reliance on Debtor-Creditor Law to Recover Benefits Paid to Couple

In *Bourgeois, Commissioner of Cattaraugus County Department of Social Services v. James P. Stadtler, individual-*

ly and as trustee of the Louis A. Stadtler Trust,[17] the Cattaraugus County Department of Social Services ("Cattaraugus County DSS") commenced an action to recover from the assets of the Louis A. Stadtler Trust certain Medical Assistance benefits paid on behalf of defendant Louis A. Stadtler and his wife, Dorothy. The trust, created in 1991, provided that the beneficial interests of Louis and Dorothy would each terminate either upon death or one day prior to his or her admission to a nursing home. When the events triggering termination of the interests of both Louis and his wife occurred, the trust terminated and the remaining principal was to be distributed to the two adult sons of Louis and his wife. Louis entered a nursing home in November 1994, and the trust terminated when his wife entered a nursing home in January 1996. Upon their admission to a nursing home, Louis and his wife applied for and received Medicaid benefits. The Cattaraugus County DSS sought to prevent the distribution of trust assets on the grounds that the trust was created as a fraudulent conveyance under Debtor and Creditor Law sections 275 and 276 and that the trust is void as a "trigger trust"[18] against the Cattaraugus County DSS pursuant to Estates Powers and Trusts Law (EPTL) 7-3.1(a).

The Appellate Division, Fourth Department, affirmed the determination of the Supreme Court, concluding that it properly denied the Cattaraugus County DSS's motion for summary judgment and granted the defendant's motion for summary judgment dismissing the complaint. The court concluded that since Louis and his wife's Medicaid benefits were correctly paid at the time assistance was granted, the Cattaraugus County DSS could not recover those benefits by seeking to set aside the trust as a fraudulent conveyance under the Debtor and Creditor Law or a void self-settled trust under the EPTL. With respect to the Debtor and Creditor Law argument, the Fourth Department noted Medicaid's limited scope of recovery, stating that "[u]nder both Federal and State law, plaintiff's recovery of medical assistance correctly paid is precluded except under limited circumstances not applicable here (*see* 42 U.S.C. 1396p[b][1]; Social Services Law § 369[2]; *Matter of Craig*, 82 N.Y.2d 388, 391; *Matter of Akullian*, 167 A.D.2d 596; *Matter of Rhodes*, 148 Misc. 2d 744, 746)." The court further noted that legislation which foreclosed the use of "trigger trusts" as a Medicaid planning device does not apply retroactively to invalidate the trust since the legislation set forth in EPTL 7-3.1(a) applies only to trusts created on or after April 2, 1992.

Endnotes

1. N.Y.L.J., June 30, 1998, p. 31, col 5.
2. § 366(5)(d)(3) and 18 N.Y. Comp. Codes R. & Regs. § 360-4.4(c)(2)(ii)(hereinafter "N.Y.C.R.R.").
3. Social Services Law § 366(5)(d)(4); 18 N.Y.C.R.R. § 360-4.4(c)(2)(iv)(b).
4. That "the period of ineligibility shall begin with the first day of the first month during or after which assets have been transferred."
5. *In re Tommy and Tina, Inc. v. Dep't of Consumer Affairs of the City of N.Y.*, 95 A.D.2d 724, *affd.,* 62 N.Y.2d 671, *quoting In re Herzog v. Joy*, 74 A.D.2d 372, 375.
6. *See In re Johnson v. Joy*, 48 N.Y.2d 689, 691; *In re Bernstein v. Toia*, 43 N.Y.2d 437, 448; *In re Howard v. Wyman*, 28 N.Y.2d 434, 438; *In re Allstate Ins. Co. v. Libow*, 106 A.D.2d 110, 118-119, *affd.,* 65 N.Y.2d 807.
7. *In re Rho v. Ambach*, 74 N.Y.2d 318 (*quoting Kurcsics v. Merchants Mut. Ins. Co.*, 49 N.Y.2d 451, 459).
8. H.R. 103-111, p.l. 103-166, at 533.
9. House Conf. Rep. 103-213, p. l.103-66, at 1523.
10. *Chevron USA, Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837.
11. General Informational Statement 95 MA/038.
12. HCFA Transmittal No. 64.
13. The prior law was contained in 92 ADM-38, effective until Sept. 1, 1994.
14. *New York State Bar Assoc. v. Reno* (N.D. N.Y., filed Dec. 4, 1997).
15. On August 5, 1997, President Clinton signed into law section 4734 of the Balanced Budget Act of 1997, which repealed the prior section 217 of the Health Insurance Portability and Accountability Act of 1996. Thus, as of August 5, 1997, no criminal liability attached to an individual who transferred assets to qualify for nursing home Medicaid. Section 4734 replaced section 217 and purported to make it a misdemeanor (punishable by up to one year in prison and/or a fine of up to $10,000) for a paid advisor to knowingly and willfully counsel or assist another to dispose of assets for the purpose of obtaining Medicaid, if the disposition resulted in the imposition of a penalty period.
16. In a March 11, 1998 letter to the House of Representatives, Attorney General Janet Reno stated that " . . . the Department of Justice will not defend the constitutionality of [section 4734] . . . because the counseling prohibition in that provision is plainly unconstitutional under the First Amendment . . . ." Ms. Reno adopted the New York State Bar Association's argument that section 4734 violates free speech protections afforded by the Fifth Amendment by precluding attorneys from giving advice to elderly clients about conduct which is otherwise lawful, stating that section 4734 "would prohibit attorneys and other professional advisors from 'counseling' their clients to engage in an estate planning strategy that itself is lawful." In her March 13, 1998 answer to the lawsuit, and in her March 27, 1998 opposition to the New York State Bar Association's motion for a preliminary injunction, Reno reiterated her intention not to enforce section 4734.
17. ____ N.Y.S.2d ____, 1998 (App. Div., 4th Dep't) WL 954969 (Dec. 31, 1998).
18. A "trigger trust" is a trust whereby the assets placed in the trust become unavailable upon the occurrence of a triggering event, typically the admission of the settlor into a nursing home.

***Howard S. Krooks is a partner in the law firm of Littman Krooks Roth & Ball P.C., with offices in New York City and White Plains. His practice focuses on Elder Law and Trusts & Estates, including representing elderly clients and their families in connection with hospital discharge and nursing home admission issues, preservation of assets, Medicaid, guardianship and related elder law matters. Mr. Krooks is Co-Chair of the Medicaid Committee of the Elder Law Section of the New York State Bar Association and a Co-Editor of the Fair Hearing Corner column of *Elder Law Attorney*, a publication of the Elder Law Section of the New York State Bar Association.**

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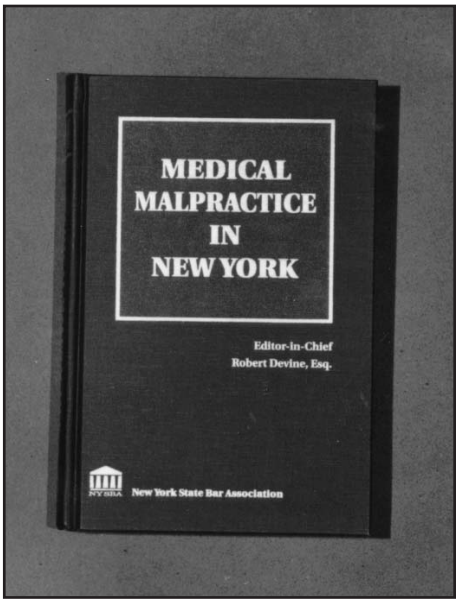

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