THE STATUS OF PHYSICIAN LICENSING STATUTES AND TELEMEDICINE

A Report to the
Business and Economic Development Committee
of the Maine Legislature
December 29, 1995

As charged by the 1995 Legislature the Board of Licensure in Medicine (BOLIM) and the Board of Osteopathic Licensure have jointly undertaken a review of their respective statutes regarding the proper licensure of physicians wishing to practice medicine within Maine while actually being physically present outside Maine state borders. The resolve specifically noted service delivery mechanisms as courier service, mobile imaging and laboratory facilities and telecommunications.

The review has identified a complex technology which will assist health care professionals to provide the most broad array of services imaginable from and to any location using electronic equipment and transmissions. Obviously the impact of such technological capabilities - and the economic pressures which go hand in hand - on medicine, the regulation of practitioners, and the protection of the public will be dramatic.

SUMMARY CONCLUSIONS

Careful examination has confirmed that current statute clearly requires full licensure of any physician practicing medicine in this state, without consideration to the means of provision. Current board rulings and policies reinforce this requirement. The medical board has ruled that only a provider, fully licensed in another jurisdiction and practicing within that jurisdiction, whose knowledge and skill are sought on a consultive basis are exempt from the Maine licensure requirement. Consulting services are those provided on an occasional basis to a health care provider in this state who has primary responsibility for the care of the patient. In other words - if you want to practice medicine within Maine you must be licensed in Maine.

Further, the review concludes that changes in regulatory statutes will be required to accommodate expected and unseen future changes in the provision of health care. But those regulatory changes can only occur in a cooperative environment, with the full goodwill and cooperation of medical boards in many states. Extensive efforts to create such regional cooperative agreements are now under way, as detailed in the body of this report. As plans are articulated and coordinated programs developed the regulatory boards will return to the Legislatures of their respective states seeking well considered changes to the regulatory statutes. In the meantime, current statute and rulings satisfy the concerns expressed by the sponsors of the original bill, and are being respected and honored by providers wishing to apply the technology of "telemedicine" in Maine.

REPORT ON FINDINGS

THE RESOLVE:

Chapter 24 of the First regular Session of the 1995 Legislature requires that -- The Board of Osteopathic Licensure an the Board of Licensure in Medicine shall jointly review licensure laws to determine whether those laws provide for proper licensing of out-of-state physicians who may wish to provide services to residents of the State by utilizing courier services, mobile imaging or laboratory facilities, or telecommunications.

THE STATUTES AND RULINGS:

The following statutes and rulings, now "on the books" require full licensure in order to perform any medical acts within the state. While in the short term long distance medicine may not be regulated in the most convenient way for the practitioner, the conservative nature of the regulations will protect Maine citizens while multi state coordination and systems are developed and technical enhancements are prepared to assure quality of care through proper regulation.

BOARD OF LICENSURE IN MEDICINE (allopathic medicine)

> MSRA Title 32, §3270: "Unless licensed by the board, an individual may not practice medicine or surgery or claim to be legally licensed to practice medicine or surgery or a branch of medicine or surgery within the State by diagnosing, relieving in any degree or curing, or professing or attempting to diagnose, relieve or cure a human disease, ailment, defect or complaint whether physical or mental, or of physical and mental origin, by attendance or by advice, or by prescribing or furnishing a drug, medicine, appliance, manipulation, method or a therapeutic agent whatsoever or in any other manner unless otherwise provided by statutes of this State.

BOARD OF OSTEOPATHIC LICENSURE (osteopathic medicine)

> MRSA Title 32, §2571: "An individual, before engaging in the practice of osteopathic medicine in this State, shall make application for a license to the board, on a form prescribed by the board. The application must be filed with the board at least 60 days before the date of examination ..."
>
> MRSA Title , 32, 32, §2572: ... "If the examination is passed in a manner satisfactory to the board, the board shall issue to the applicant a license granting the applicant the right to practice osteopathic medicine in this State."

RULING OF BOLIM by unanimous vote in regular meeting of August 11, 1993:

> "In order to practice primary psychotherapy in the State of Maine, physicians must be licensed in Maine and available to the patient."

RULING OF BOLIM by unanimous vote in regular meeting of November 11, 1993:

> "The Board considers teleradiology to be helpful for consultation but that the primary physician doing the radiological study should be licensed to practice medicine in Maine and accountable for the outcome."

CLARIFICATION OF RULING regarding Teleradiology, at regular BOLIM meeting of May 10, 1994:

> "No radiological studies will be performed in the State of Maine by physicians not licensed by our board."

ISSUES IDENTIFIED:

The following is an attempt to identify the types of issues which must be clarified and resolved when dealing with long distance medicine.

The concepts of medical practice identified in the resolution, i.e. transmitting radiologic images, doing lab tests, seeing patients using couriers, mail, or telecommunications lines to cross state lines has grown rapidly, and will grow at an ever increasing rate. The technology exists for the full practice of medicine and surgery and is now being demonstrated in a number of locations nationwide. Seeing, diagnosing, and treating patients using technicians to perform physical contact is being performed daily in Georgia. A member of the review committee witnessed this fall a demonstration of eye surgery performed by a robot guided from a remote location. A health care system based in Massachusetts plans to begin telemedicine practice in 1996 in the northern New England states.

As Health Maintenance Organizations (HMOs) grow and press innovation in medicine, often based on economics, concerns relating to quality of care are also growing. HMOs ever broadening market share and geographic reach raise issues from simple migration of staff care givers crossing state lines to the impact and liabilities of clinical decisions controlled by remotely located Medical directors. Regulation should anticipate the need to assure minimum competence and acceptable quality of performance, wherever the work is being performed.

Confidentiality of and access to patient records is also an area of significant concern. Problems have been cited recently in citizen advocacy communications regarding deliberate stealing of information. The electronic "peeping Tom" may become more problematic as more confidential information is entrusted to various databases. In addition to looking or stealing there is great concern about the inappropriate change of records available through electronic means.

The electronic "superhighway" has presented still another great concern, that being security over what is being transmitted. The unintentional or intentional interruption, disruption, or manipulation of transmission during treatment could have disastrous consequences as long distance medicine is more aggressively pursued. Before the boards are ready to attempt authorization of these practices through regulation capabilities should be enhanced in order to properly protect Maine citizens.

The technologies now available and rapidly expanding in use appear to provide better access to health care. Claims of high quality care are regularly made. The citizens of Maine deserve the right to full protection for services rendered. To do this not only must the boards act, they must be assured of the active support of every other state board in the region in order to ensure minimum competence and acceptable quality of care.

POSSIBLE IMPACTS:

A review of the history of the boards regarding complaints and disciplinary actions indicates that there has been little problem in the past. If specific situations have occurred they appear to have been resolved through other means without report or complaint being filed with either board. By contrast, this year alone BOLIM has received nearly 150 complaints, an all time record. At least part of this increase may be credited to the boards' efforts to publicize that a significant part of board function is to investigate complaints, and that anyone can easily file a complaint.

The ability to regulate minimum competence, and thereby protect the quality of care for citizens is a primary goal of Maine's health related regulatory boards. Technology, location, access, and jurisdiction can create significant challenges to ensuring that responsibility.

- There are economic benefits to mass production of certain tests or procedures which "long distance" medicine can satisfy. But the application of cost saving mass production techniques applied to high level professionals often results in diminished quality and high turnover among over used professionals who burn out or tire of the pressure. For example, radiologists may be required to read film without break all day every day. All health related boards need to be prepared to deal with these kinds of quality issues.

- Lack of ability to influence quality control other than through oversight of high technology linkages to service facilities within this state will be a concern. There are major cost and logistical problems which will have to be overcome by the regulatory bodies.

- The initial impact on rural access to highly technical care by "dial a doc medicine" may be positive. However caution should be observed lest the cost cutting needs of such absentee business erode the current generous base of free care now offered across the state.

While the economic impact that a physician has on the Maine economy is unmeasured, care should be given to the trade off between "lowering" the cost of medicine and loosing the impact and benefits of proximate physicians. While not being protectionist, pure economics should not give way to personal contact and local support.

REGIONAL AND NATIONAL ACTIVITY:

The Federation of State Medical Boards (FSMB) is the single national coordinating organization for all medical licensing boards. This fall the FSMB released a discussion draft of a model act to anticipate and respond to the broad range of regulatory issues being created by long distance medicine. The FSMB is now in the process of collecting input nationwide on the model, with an all day meeting scheduled in Dallas in January, 1996, and additional meetings planned around the country. This model act, proposed to be implemented on a regional basis, requires that physicians receive a limited license for long distance medicine from every state in which they will practice. It also requires that complaints be filed and answered in the state in which the aggrieved patient resides.

The Maine boards, along with every medical licensing board from Maine to Washington DC met together in Ogunquit, Me., at a regional meeting sponsored by the Maine and Vermont Boards in

November, 1995. At those meetings the FSMB model was reviewed and discussed in detail. The boards unanimously recognized that any plan will require the full cooperation and coordination of every board present to be successful. The group agreed unanimously to meet again in March, 1996, to continue discussions. The participating boards agreed that more consideration should be given to the issue of jurisdiction, i.e., that discipline reside in the state of residency of the licensee rather than the complainant. It was recognized that a critical element of such a plan would be the agreement by every state that "out of state " complaints be treated with the same concern and urgency as "in state" complaints. This would eliminate a good deal of regulation hassle and assure best possible jurisdictional issues for disciplinary action. Such agreements and commitments are now being worked out among the boards, including the identification of necessary statutory changes.

CONCLUSIONS:

Because Maine law regarding regulation of the practice of medicine is clear, conservative, and controlling, and since there are so many critical issues to be identified and worked through, the boards recommend no immediate changes in statute. Given the statutes and rules in place the boards feels the function of protecting the citizens is being properly performed. The boards recognize that a great deal of ground work must yet be done to create the cooperative relationships that must be developed to protect all citizens, no matter what the invisible geographic boundaries, as the practice of medicine moves into the twenty first century.

It is also noted that there is a great dampening effect on inappropriate or excessive risk in innovative medical practice created by liability managers, the institutional regulation and accreditation processes placed on hospitals and other health care providers. It is these groups who will have sufficient capital to develop the "long distance" medical models of the future. For a time those very processes will help maintain a reasonableness to innovation, and thus help ensure protection of citizens.

Further, after careful review it has been confirmed that the concerns of the health care professionals expressed during public testimony last year are currently answered. In fact, planning for and proposals of changes in regulation to anticipate long distance medicine will be coming from the boards themselves.

Any action to regulate long distance medicine will only be successful if there is a strong level of cooperation and standardization of regulatory practices among many neighboring states. There is a high level of commitment among medical boards in the eastern region of the United States to work together quickly to develop the systems and create the alliances necessary to successfully protect all citizens. The Medical and Osteopathic boards will return to this committee as soon as appropriate to continue this work of protecting Maine citizens into the future.