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LICENSE TO SCREEN: A REVIEW OF THE MEDICAL LICENSURE SCHEMES IMPACTING TELEHEALTH PROLIFERATION IN THE UNITED STATES, THE EUROPEAN UNION, AND AUSTRALIA

INTRODUCTION

A. *A Stroke of Luck: A Telehealth Scenario*¹

A fifty-five year old man awoke one Sunday morning in his hometown of Fountain Lake, Arkansas, to enjoy breakfast with his wife of twenty-five years.² For some reason, he did not have an appetite and told his wife he was going to lie down.³ An hour-and-a-half later, his wife found him slumped over in his chair, clutching his left arm, drooling, and unable to speak.⁴ His wife—a nurse at a nearby long-term care facility—recognized that her husband was having a stroke.⁵ Within ten minutes, emergency responders arrived at the couple’s home and rushed the gentleman to Hot Springs’ St. Joseph Mercy-Health Center (Mercy).⁶ In a remarkably serendipitous turn of events, Mercy had just finished installing its new telestroke program eighteen days earlier.⁷

The program allows a board-certified neurologist located in Miami, Florida, to see a patient presenting stroke symptoms within minutes via a two-way video system.⁸ Each neurologist participating in the program is licensed to practice medicine in both Florida and Arkansas.⁹ Prior to implementing this program, a neurologist would have needed to leave his home or practice and travel to the emergency room to conduct a face-to-face consultation.¹⁰ Doing so wasted valuable minutes and greatly reduced the likelihood the patient would recover full brain function.¹¹ Thankfully, by the time the gentleman here

¹ The following scenario is based on a real account. Jeffrey Slatton, *Stroke Care Everywhere at Mercy*, MERCY (Oct. 24, 2011), <https://www.mercy.net/newsroom/2011-10-24/stroke-care-everywhere-at-mercy>.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

arrived at the emergency department, one of the Miami-based neurologists had been acquired.¹² Using an E-Care cart, a powerful camera, two monitors, speakers, a microphone, and a computer, the neurologist was able to assess the man's condition and assist the emergency room physician in diagnosing a stroke.¹³ The neurologist was then able to speak to the man's wife and ask her if she would administer tPA (tissue Protein Activator), a protein involved in the breakdown of blood clots.¹⁴ The wife consented, administered the tPA, and within thirty minutes, her husband had recovered his power of speech.¹⁵ The man returned home twelve days later, thankful to the doctors for "giving [him] [his] life back."¹⁶

B. *The Telehealth Solution*

Chronic, noncommunicable diseases—such as asthma, chronic obstructive pulmonary disorder (COPD), diabetes, heart disease, and stroke—represent costly conditions affecting the price of healthcare across the globe.¹⁷ In many cases, the negative effects of these diseases and the associated expenses can be mitigated or eliminated with proper preventative care.¹⁸ Unfortunately, these illnesses proliferate in subpopulations that have reduced access to clinical services.¹⁹ Those living in remote, rural settings may have to travel dozens of miles to reach the nearest treating physician.²⁰ Elderly patients may no longer have the means to travel at all.²¹ As such, many people suffer through chronic illnesses until their symptoms rise to a level of severity necessitating

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ D.E. BLOOM ET AL., WORLD ECON. FORUM & HARVARD SCH. OF PUB. HEALTH, THE GLOBAL ECONOMIC BURDEN OF NON-COMMUNICABLE DISEASES (2011), <http://apps.who.int/medicinedocs/documents/s18806en/s18806en.pdf>.

¹⁸ CTR. FOR DISEASE CONTROL, THE POWER OF PREVENTION: CHRONIC DISEASE . . . THE PUBLIC HEALTH CHALLENGE OF THE 21ST CENTURY (2009), <http://www.cdc.gov/chronicdisease/pdf/2009-power-of-prevention.pdf>.

¹⁹ *Id.*

²⁰ Frederico G. Toledo et al., *Telemedicine Consultations: An Alternative Model to Increase Access to Diabetes Specialist Care in Underserved Rural Communities*, 1 J. COMMUNITY HEALTH 14 (2012).

²¹ See Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976, 981 (2013).

intervention.²² At this point, however, the damage is done, and the cheaper preventative treatment options are no longer feasible.²³

As the introductory scenario illustrates, telehealth services offer patients, payers, and healthcare providers with the means to help combat this public health crisis.²⁴ Defined by the Center for Connected Health Policy as “[t]he use of electronic information and telecommunications technologies to support long-distance clinical healthcare, patient and professional health-related education, [and] public health and health administration,”²⁵ telehealth offers the capabilities to deliver healthcare across distances at reduced costs while maintaining, or even increasing, the quality of care.²⁶ In doing so, telehealth serves to complement the traditional face-to-face patient encounter between patients and providers, as well as between providers when clinically prudent.²⁷

Despite the potential for telehealth to combat many problems associated with chronic disease, regulatory barriers prevent the United States from fully integrating telehealth into the existing in-person, encounter-based healthcare delivery system.²⁸ Specifically, licensure incongruences at the state level often limit clinicians from practicing across state lines.²⁹ In the introductory scenario, the Miami-based neurologist could treat the stroke patient located in Arkansas, but only after obtaining licensure in both states.³⁰ According to Massachusetts Institute of Technology Professor Amur Gupta, “[this] lack of consensus among states on licensing requirements, and telemedicine licensure requirements in particular, force[s] health care providers to incur higher business costs in order to meet compliance with differing state statutes.”³¹

²² Sultan Rahaman, *Chronic Disease Management: Key to Reducing Healthcare Costs*, DOCTORS FOR AMERICA: PROGRESS NOTES (Nov. 8, 2010), <http://www.dr sforamerica.org/blog/chronic-disease-management-key-to-reducing-healthcare-costs-826>.

²³ *Id.*

²⁴ Shiva Gopal Reddy, *Telemedicine Cuts Costs and Improves Outcomes in Chronic Disease Management*, INNOVATEMEDTEC (Apr. 22, 2015), <http://innovatemedtec.com/content/telemedicine-cuts-costs-and-improves-outcomes-in-chronic-disease-management>.

²⁵ *What Is Telehealth?*, CTR. FOR CONNECTED HEALTH POLICY, <http://www.cchpca.org/what-is-telehealth> (last visited Nov. 16, 2017).

²⁶ Deth Sao et al., *Legal and Regulatory Barriers to Telemedicine in the United States*, in THE GLOBALIZATION OF HEALTH CARE: LEGAL AND ETHICAL ISSUES 359, 360 (Oxford University Press, 2013).

²⁷ Diane Hoffman & Virginia Rowthorn, *Legal Impediments to the Diffusion of Telemedicine*, 14 J. HEALTH CARE L. & POL’Y 1, 3 (2011).

²⁸ Sao et al., *supra* note 26, at 361.

²⁹ *Id.* at 362.

³⁰ Slatton, *supra* note 1.

³¹ Sao et al., *supra* note 26, at 360.

The question of how to resolve the licensure portability issue as it relates to telehealth has existed for decades.³² During this time, the American Medical Association and other trade associations have suggested a range of alternative licensure schemes to promote the exchange of cross-border telehealth services.³³ To date, however, none of these authorities have analyzed licensure systems abroad and applied the successes and failures of foreign systems to their analyses. Other nations and supranational entities have implemented more progressive licensure and registration systems.³⁴ In the European Union, Member States operate under a mutual recognition scheme whereby practitioners licensed in one member state can practice medicine in any other member state.³⁵ In Australia, physicians registered with the Medical Board of Australia can practice medicine in every Australian state and territory.³⁶ By looking at how other licensure schemes have fared abroad, one can eliminate certain options on the table and proceed with those positioned to succeed. This Comment analyzes the schemes implemented in the European Union and Australia, concluding that the United States should adopt a hybrid federal-state licensure framework that combines the most favorable aspects of these two international examples.

I. TELE-WHAT?: DEFINING TELEHEALTH AND RELATED TERMS

While the integration of telecommunications and information systems within healthcare is not a new phenomenon, the corresponding lexicon has yet to solidify.³⁷ Even within the United States, terms and definitions vary across states and agencies.³⁸ This is due in part to the inability of the terms to keep pace with the ever-shifting innovation landscape as well as efforts by drafters to impute legislative intent.³⁹ Nevertheless, most authorities agree on a terminology hierarchy and core components of each definition.⁴⁰

³² See Joseph P. McMenamin, *Telemedicine and the Law*, 21 INT'L LEGAL PRAC. 126, 126 (1996).

³³ Hoffman & Rowthorn, *supra* note 27, at 11–13.

³⁴ See e.g., Dana Pirvu & Rachel Snyder, *E.U. Way Ahead of the Game on Telehealth*, EPSTEIN BECKER GREEN: TECHHEALTH PERSPECTIVES (Mar. 21, 2013), <http://www.techhealthperspectives.com/2013/03/21/e-u-way-ahead-of-the-game-on-telehealth/>.

³⁵ Vera Lucia Raposo, *Telemedicine: The Legal Framework (or Lack of It) in Europe*, 12 GMS HEALTH TECH. ASSESSMENT 1, 3 (2016).

³⁶ See generally UPDATE (Med. Bd. of Austl., Melbourne, Austl.), <http://www.medicalboard.gov.au/News/Newsletters.aspx> (last visited Nov. 16, 2017).

³⁷ Charles R. Doarn et al., *Federal Efforts to Define and Advance Telehealth—A Work in Progress*, 20 TELEMEDICINE & E-HEALTH 409, 409 (2014).

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

Although a relatively new term, “telehealth” is generally recognized as the overarching category describing the use of telecommunications and information systems to deliver healthcare services.⁴¹ According to the Center for Connected Health Policy, telehealth covers “the wide range of diagnosis and management, education and other fields of healthcare.”⁴² The U.S. Department of Health & Human Services identifies telehealth’s definition as broader than associated terms, covering remote healthcare services that are both clinical and non-clinical.⁴³ For this reason, it has recently become the favored term.⁴⁴ Throughout this Comment, the term “telehealth” will be used to refer to both telehealth and the related term “telemedicine.”

Although the term “telemedicine” is often used interchangeably with the term “telehealth,” authorities agree that telemedicine constitutes a subset of telehealth and refers specifically to patient care.⁴⁵ While the etymology of telemedicine (i.e., “distance medicine”) provides context into functions embodied by the term, the word also lacks a settled definition. The World Health Organization broadly defines telemedicine as:

[t]he delivery of healthcare services, where distance is a critical factor, by health care professionals using information and communications technologies for the exchange of valid information for diagnosis, treatment, and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interest of advancing the health of individuals.⁴⁶

In this sense, telemedicine refers to the practice of medicine via any telecommunication medium, whether that be a video consultation through a webcam or the exchange of medical advice over the telephone. Thus, telemedicine covers a broad range of technologies and services.⁴⁷ Traditionally, telemedicine has arisen in two forms: (i) real-time communications involving a two-way interface between the physician and the

⁴¹ *Id.* at 412.

⁴² Sarah Olson, *Staying Well, Virtually*, DELTA SKY, Jan. 2017, at 85, 89.

⁴³ Beth Principi, *The Difference Between Telehealth and Telemedicine*, AM. WELL: AM. WELL BLOG (May 11, 2015, 11:08 AM), <https://www.americanwell.com/the-difference-between-telehealth-and-telemedicine/>.

⁴⁴ Olson, *supra* note 42, at 89.

⁴⁵ Doarn et al., *supra* note 37, at 413.

⁴⁶ WHO, TELEMEDICINE: OPPORTUNITIES AND DEVELOPMENTS IN MEMBER STATES: REPORT ON THE SECOND GLOBAL SURVEY ON eHEALTH (GLOBAL OBSERVATORY FOR eHEALTH SERIES VOLUME 2) 9 (2010), www.who.int/goe/publications/goe_telemedicine_2010.pdf (citing WHO, A HEALTH TELEMATICS POLICY IN SUPPORT OF WHO’S HEALTH-FOR-ALL STRATEGY FOR GLOBAL HEALTH DEVELOPMENT: REPORT OF THE WHO GROUP CONSULTATION ON HEALTH TELEMATICS, 11–16 DECEMBER, GENEVA, 1997 (1998)).

⁴⁷ *Id.*

patient; and (ii) asynchronous store-and-forward communications where a clinician will receive health data from an “outgoing site” and interpret the data from a “distant site” location.⁴⁸ Generally, an appropriate clinician—such as a registered nurse or a physician assistant—will serve as a proxy for the physical presence of the physician by assisting with the examination at the outgoing site.⁴⁹

II. THE TELEHEALTH POTENTIAL

Telehealth offers the means to reduce healthcare expenditures and deliver healthcare to underserved populations by offering treatment from a distant location.⁵⁰ Several factors allow telehealth to achieve savings for those providing healthcare services. It allows providers to expand their patient base beyond their local communities, lower overhead costs by reducing the amount of time doctors spend in the clinic seeing patients, reduce transportation costs for patients seeking specialist care, and eliminate the need for in-person follow-up visits.⁵¹ Additionally, telehealth would allow for offshore outsourcing of diagnostic services, resulting in decreased workloads and lower costs.⁵² In addition to cost-saving measures, telehealth promotes continued learning and dispersion of innovative methodologies.⁵³ For instance, telehealth facilitates participation in grand round and educational opportunities previously unavailable to isolated clinicians.⁵⁴ Professor Amar Gupta provided a comprehensive overview of these various mechanisms operating in tandem, stating:

Powerful IT networks crisscrossing the globe will change the way much of health care is delivered: Outsourcing and offshoring of medical and nonmedical services will increase, providing more efficient health care at the most cost-effective rates; systems integrations will allow more medical records to be transferred swiftly and securely; efforts to monitor the safety of medicines will gain

⁴⁸ Edie Brous, *Legal Considerations in Telehealth and Telemedicine*, 116 J. AM. NURSING 64, 64 (2016).

⁴⁹ *Id.*

⁵⁰ Sao et al., *supra* note 26, at 360.

⁵¹ *How Can Telemedicine Save You Money?*, AMD TELEMEDICINE (May 15, 2015), <http://www.amdtelemedicine.com/blog/article/how-can-telemedicine-save-you-money>.

⁵² Amar Gupta, *Prescription for Change*, WALL ST. J. (Oct. 20, 2008), <http://www.wsj.com/articles/SB122426733527345133>.

⁵³ Lu Ann E. White et al., *Technology Meets Healthcare: Distance Learning and Telehealth*, 3 OCHNER J. 22, 25, 27 (2001).

⁵⁴ *How Can Telemedicine Save You Money?*, *supra* note 51.

global access to data; and professionals and patients will find authoritative and up-to-date information on every specialty online.⁵⁵

Recognizing this immense potential, innovators and policymakers in the United States have endeavored to facilitate the growth of telehealth services, albeit with mixed results.⁵⁶

III. TELEHEALTH & LICENSURE—THE UNITED STATES

A. *The Need for Telehealth in the United States*

Telehealth, in one variety or another, has existed in the United States for longer than one might expect. Some commentators have suggested the first telehealth consultation occurred on March 20, 1876, when Alexander Graham Bell, having spilled acid on himself, called his associate Thomas A. Watson to his assistance via the first telephone.⁵⁷ Telehealth has spawned into a much larger, more complex phenomenon since that fateful encounter. Telehealth's modern form began to take shape in the 1960s, and has continued to expand with the proliferation of advanced communication technologies.⁵⁸ In 2016, over sixty percent of U.S. hospitals had adopted telehealth technology, and data suggests telehealth adoption will experience continued growth.⁵⁹ Additionally, telehealth technology represents a sizeable market in the United States and is expected to be worth \$2.83 billion by 2022.⁶⁰

Telehealth has the potential to alleviate two central failings of the U.S. healthcare system.⁶¹ First, telehealth would lower the exorbitant costs associated with healthcare services.⁶² Per capita healthcare spending in the United States exceeds that of any other Organization for Economic Cooperation and Development (OECD) country, making many services

⁵⁵ Gupta, *supra* note 52.

⁵⁶ See generally Cynthia LeRouge & Monica J. Garfield, *Crossing the Telemedicine Chasm: Have the U.S. Barriers to Widespread Adoption of Telemedicine Been Significantly Reduced?*, 10 INT'L J. ENVTL. RES. PUB. HEALTH 6472, 6472 (2013).

⁵⁷ Nicholas Genes, *Alexander Graham Bell and the Birth of Telemedicine*, TELEMEDICINE MAG., <http://www.telemedmag.com/article/alexander-graham-bell-and-the-birth-of-telemedicine/> (last visited Nov. 16, 2017).

⁵⁸ David Pratt, *Telehealth and Telemedicine in 2015*, 25 ALB. L.J. SCI. & TECH. 495, 497 (2015).

⁵⁹ Brendan FitzGerald, *Telemedicine Adoption Continues Growth in 2016 and Beyond*, HIMSS ANALYTICS (Apr. 27, 2016), <http://www.himssanalytics.org/news/telemedicine-adoption-growing-35-annually-2014>.

⁶⁰ *U.S. Telehealth Market Size to Reach \$2.83 Billion by 2022*, GRAND VIEW RESEARCH, <https://www.grandviewresearch.com/press-release/us-telehealth-market-analysis> (last visited Nov. 16, 2017).

⁶¹ Sao et al., *supra* note 26, at 360.

⁶² *Id.*

unaffordable for the vast majority of consumers.⁶³ To offset these high costs, both public and private insurers have raised insurance premiums—at a rate that has outpaced the growth of U.S. wages and cost of living.⁶⁴ By allowing hospitals to consult with specialists via telehealth instead of employing them directly, hospitals can cut costs.⁶⁵ Second, it would allow citizens in areas with low-specialist saturation to consult with otherwise inaccessible clinicians.⁶⁶ Currently, many individuals lack access to healthcare because of geographic limitations, including those requiring home healthcare, those interned within correctional facilities, and those living in remote, rural areas.⁶⁷

Telehealth also provides a mechanism for increasing the efficiency of available medical resources.⁶⁸ Currently, the United States faces a shortage of healthcare professionals, particularly within its specialty fields.⁶⁹ In Arkansas, for example, fifty-seven counties have been designated “Health Professional Shortage Areas” and are in desperate need of additional physicians.⁷⁰ As the introductory scenario illustrates, hospitals in Arkansas have created telehealth programs to provide greater access to specialist services. Yet these efforts, while successful, have not kept pace with the pending specialist shortage. One report published by the Association of American Medical Colleges estimates that by 2025, the United States would lack as many as 90,000 physicians to cover the healthcare needs of the nation.⁷¹ This disparity between available resources and services demanded is driven by two major factors: (1) the American population is increasingly aging, and thus requires greater medical attention,⁷² and (2) recent healthcare reforms at the federal level have increased

⁶³ *How Does Health Spending in the United States Compare?*, OECD (July 7, 2015), <https://www.oecd.org/unitedstates/Country-Note-UNITED%20STATES-OECD-Health-Statistics-2015.pdf> (“Health spending in the United States (excluding expenditures in the health sector) was 16.4% of GDP in 2013, well above the OECD average of 8.9% and the next highest spenders – The Netherlands (11.1%), Switzerland (11.1%) and Sweden (11%).”).

⁶⁴ Sao et al., *supra* note 26, at 360.

⁶⁵ *Id.* at 361.

⁶⁶ See generally Roger A. Rosenblatt et al., *Physicians and Rural America*, 173 W. J. MED. 348 (2000).

⁶⁷ Sao et al., *supra* note 26, at 361.

⁶⁸ *Id.*

⁶⁹ Bill Frist, *Telemedicine: A Solution to Address the Problems of Cost, Access, and Quality*, HEALTH AFFAIRS BLOG (July 23, 2015), <http://healthaffairs.org/blog/2015/07/23/telemedicine-a-solution-to-address-the-problems-of-cost-access-and-quality/>.

⁷⁰ *Id.*

⁷¹ *New Physician Workforce Projections Show the Doctor Shortage Remains Significant*, ASS’N AM. MED. CS. (July 23, 2015), <https://www.aamc.org/newsroom/newsreleases/426166/20150303.html>.

⁷² See Sally Morton et al., *Addressing the Health Needs of an Ageing America: New Opportunities for Evidence-Based Policy Solutions*, STERN CTR. FOR EVIDENCE-BASED POL’Y 1, 4, available at <http://www.healthpolicyinstitute.pitt.edu/sites/default/files/SternCtrAddressingNeeds.pdf>.

the amount of people who have health insurance.⁷³ Because the cost of obtaining services is now subsidized, a large number of previously uninsured Americans have access to care and are seeking services.⁷⁴ Telehealth provides a potential way to increase the effectiveness of available clinicians by allowing them to increase their treatment radius.⁷⁵

B. Legislative Efforts to Increase Telehealth Services in the United States

To date, several key pieces of legislation have shaped the development of telehealth and its incorporation into the health industry infrastructure.⁷⁶ At the federal level, the Balanced Budget Act (BBA) of 1997 authorized partial Medicare reimbursement for telehealth services in rural areas experiencing healthcare worker shortages.⁷⁷ In 2000, Congress enacted the Benefits Improvement Act (BIPA), which expanded payment for telehealth items by removing telepresenter requirements and by extending reimbursement to areas beyond rural health professional shortage zones.⁷⁸ The Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 has also contributed to the adoption of telehealth by providing incentives for the creation of health IT infrastructure.⁷⁹ For instance, communities can receive grants for installing telehealth services through the Beacon Community Cooperative Agreement Program.⁸⁰ In 2012, Congress passed the National Defense Authorization Act, which expanded state licensure exemptions for qualified health professionals who provide specified telehealth services to military members.⁸¹

The U.S. Supreme Court's decision to uphold the Patient Protection and Affordable Care Act (ACA) also provided an impetus for the deployment of

⁷³ See DEPT. OF HEALTH & HUM. SERVICES, 20 MILLION PEOPLE HAVE GAINED HEALTH INSURANCE COVERAGE BECAUSE OF THE AFFORDABLE CARE ACT, NEW ESTIMATES SHOW (2016), <http://wayback.archive-it.org/3926/20170128080500/https://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates>.

⁷⁴ Aaron E. Carroll, *A Doctor Shortage? Let's Take a Closer Look*, N.Y. TIMES (Nov. 7, 2016), https://www.nytimes.com/2016/11/08/upshot/a-doctor-shortage-lets-take-a-closer-look.html?_r=0.

⁷⁵ Devon Lathrop, *Increase Your Treatment Radius with E-Healthcare*, MEMD BLOG (Nov. 19, 2013), <https://www.memd.me/increase-your-treatment-radius-with-e-healthcare/>.

⁷⁶ Sarah Jacobson & Teresa Wang, *How Laws Are Shaping Telemedicine*, ROCK HEALTH (Feb. 18, 2015), <https://rockhealth.com/how-laws-policies-shaping-telemedicine-market/>.

⁷⁷ *Id.*

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ Joy Sadalay, *Telemedicine's Role in Health Care Reform Blocked by State Licensure Barriers*, 9 SCITECH LAW. 24, 24 (2012).

telehealth technologies.⁸² Indeed, in its press release following the passage of the ACA, the America Telemedicine Association (ATA) declared that the Supreme Court's "ruling will further accelerate the deployment rate for telemedicine, mHealth, and remote health care technologies. . . . The announcement lifts the cloud of uncertainty that has caused many health providers to delay decisions to modernize and invest in such areas as telemedicine and related technologies."⁸³ For instance, Section 3021(b) of the ACA tasks the Center for Medicare and Medicaid Innovation (CMMI) with testing new care models that rely on "electronic monitoring" of inpatients by remote means.⁸⁴ CMMI can also distribute grants to applicants whose proposals test new care models, including projects that use telehealth.⁸⁵ Additionally, the ACA provides funding for those providers who use telehealth in delivering home health under Medicare and Medicaid.⁸⁶

At the state level, numerous pieces of legislation have also catalyzed telehealth efforts.⁸⁷ New York, for instance, passed a landmark piece of legislation in 2015 that requires insurers to cover the cost of telehealth services.⁸⁸ Tennessee has also passed telemedicine parity legislation that focuses on expanding Medicaid coverage to services rendered through telemedicine technologies.⁸⁹ Despite these efforts, numerous legal and regulatory barriers impede telehealth's progress in the United States.⁹⁰ One of the most formidable impediments to the expansion of telehealth is an anachronistic licensure system that requires physicians to obtain multiple state licenses should they wish to practice in more than one state.⁹¹

⁸² Marlene M. Maheu, *Health Care Reform Has Arrived with PPACA – Telehealth is the Vehicle*, TELEMENTAL HEALTH INST. (July 2, 2012), <http://telehealth.org/blog/health-care-reform-has-arrived-with-ppaca-telehealth-is-the-vehicle/>.

⁸³ *Id.*

⁸⁴ Lisa W. Clark, *Strategic Perspectives: When is Telemedicine "Practicing Medicine" in Violation of the Law? An Emerging Framework for Compliance*, WOLTERS KLUWER (May 28, 2014).

⁸⁵ *Id.*

⁸⁶ *Id.*

⁸⁷ Jacobson & Wang, *supra* note 76.

⁸⁸ Katherine Clark Ross, *NY Gov. Cuomo Signs Telehealth Bill*, GOV'T TECH. (Jan. 9, 2015), <http://www.govtech.com/health/NY-Gov-Cuomo-Signs-Telehealth-Bill.html>.

⁸⁹ Jacobson & Wang, *supra* note 76.

⁹⁰ *See generally* Sao et al., *supra* note 26.

⁹¹ Katie Dvorak, *State Licensure Problems Plague Telemedicine*, FIERCE HEALTHCARE (Feb. 26, 2015), <http://www.fiercehealthcare.com/it/state-licensure-problems-plague-telemedicine>. For other legal and regulatory impediments to the uptake of telemedicine, see Sao et al., *supra* note 26, at 360.

C. *Medical Licensure: An Overview*

To appreciate the forces preventing a more effective licensure system from being introduced, one must understand the purpose of licensure and the actors invested in perpetuating a state-based model. Licensure serves a dual function. It allows a government to ensure that individuals seeking to practice an occupation satisfy minimum qualifications.⁹² It also allows professional organizations—like state medical boards—to establish controls over and restrict entry into the professional field.⁹³ Both functions work to protect the public from frauds and incompetents.⁹⁴ By overseeing the entry process through examinations and an application process, the government and professional groups ensure that only those with extensive training and technical knowledge can practice medicine.⁹⁵

Two divergent schools of thought have developed regarding the impetus for medical licensure.⁹⁶ One asserts a paternalistic view grounded in a commitment to public service.⁹⁷ According to this school of thought, the public is in no position to judge physician interests, to determine appropriate standards of care, or to enforce ethical standards.⁹⁸ Former American Medical Association President, Milford Rouse, espoused this philosophy in 1968, stating: “[t]he public recognizes it does not have the knowledge or other qualifications to evaluate medical education, medical practice, or medical competence. The public has of necessity been forced to put its trust in physicians to insure that physicians practice competently and ethically.”⁹⁹ In other words, society should defer to the expertise of the professional community to safeguard the greater public good.

Certainly, licensure signals to the public that a physician is qualified to practice medicine. However, a second school of thought suggests a less magnanimous motivation for relegating licensure determinations to professional medical boards.¹⁰⁰ Some commentators have suggested that

⁹² Norman Gevitz, “A Coarse Sieve”: *Basic Science Boards and Medical Licensure in the United States*, 43 J. HIST. MED. & ALLIED SCI. 36, 36 (1988).

⁹³ *Id.*

⁹⁴ RUTH HOROWITZ, IN THE PUBLIC INTEREST: MEDICAL LICENSING AND THE DISCIPLINARY PROCESS 32 (2012).

⁹⁵ *Id.*

⁹⁶ *Id.* at 33–34.

⁹⁷ *Id.*

⁹⁸ *Id.* at 33.

⁹⁹ *Id.*

¹⁰⁰ *Id.* at 34.

physicians support licensure boards because these associations limit competition and allow well-established practitioners to reap financial benefits from closing the market.¹⁰¹ As current litigation demonstrates, these rival philosophies surface when debates concern proper licensure domain.¹⁰²

D. State-Based Licensure in the United States

The American experience of regulating the practice of medicine is deeply rooted in the country's history and dates as far back as the colonial period.¹⁰³ Following independence, states began to regulate the practice of medicine according to the police powers afforded by the Tenth Amendment to the United States Constitution.¹⁰⁴ In 1889, the Supreme Court upheld that the state's interest in protecting its citizens extended to regulation of medical licensure.¹⁰⁵ Here, Justice Stephen J. Field embraced the necessary public service rationale for licensure and reasoned that:

[f]ew professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend, and requires not only a knowledge of the properties of vegetable and mineral substances, but of the human body in all its complicated parts, and their relation to each other, as well as their influence upon the mind. The physician must be able to detect readily the presence of disease, and prescribe appropriate remedies for its removal. Every one may have occasion to consult him, but comparatively few can judge of the qualifications of learning and skill which he possesses. Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications.¹⁰⁶

By the early 1900s, every state or territory in the union had established a medical board, with the board's primary function being to examine and verify the credentials of physicians seeking licensure.¹⁰⁷ To this day, every state has

¹⁰¹ *Id.*

¹⁰² See, e.g., Michelle Casady, *Texas Medical Board Claims Immunity from Telemedicine Suit*, LAW360 (June 21, 2016), <http://www.law360.com/articles/808961/texas-medical-board-claims-immunity-from-telemedicine-suit>.

¹⁰³ David Johnson & Amy Gerald, *AM Last Page: History of Medical Licensure and Regulation*, 89 ACAD. MED. 953, 953 (2014).

¹⁰⁴ Humayun J. Chaudhry et al., *Maintenance of Licensure: Protecting the Public, Promoting Quality Health Care*, 96 J. MED. REG. 13, 13 (2010).

¹⁰⁵ *Dent v. West Virginia*, 129 U.S. 114, 122–23 (1889).

¹⁰⁶ *Id.*

¹⁰⁷ Johnson & Gerald, *supra* note 103, at 953.

the power to regulate medical professionals who practice within its territory.¹⁰⁸ Each state has enacted its own medical practice act for granting a health professional licensure, renewing a license, and regulating medical practice.¹⁰⁹ Notably, these acts delegate the power to regulate licensure to the state medical board.¹¹⁰ Traditionally, states have prevented an out-of-state practitioner from consulting, accessing, or treating a patient in a state where the physician does not have a full medical license.¹¹¹

The advent of telehealth has compelled many states to reconsider their approach to medical licensure.¹¹² Currently, state medical practice acts contain significant variations, including differences over the definition of the practice of medicine, what constitutes the unlawful practice of medicine, and licensure obligations.¹¹³ These state-specific requirements impose significant burdens on practitioners who wish to incorporate telehealth technologies into their practice, as telehealth invites clinical applications that ignore state borders.¹¹⁴ Despite the differences in scope, the requirements used by states to initially grant a license are remarkably similar. For instance, all states rely on the United States Medical Licensing Examination to qualify potential physician candidates.¹¹⁵ Additionally, all states accept a candidate's credentials if the candidate has graduated from a nationally accredited medical school and residency program, regardless of the school's location.¹¹⁶

As the benefits of telehealth have become more apparent, many state legislators have amended their state's regulatory schemes to reflect these commonalities.¹¹⁷ Yet, as of 2016, state-based policy continues to vary wildly.¹¹⁸ Ten states—Alabama, Louisiana, Minnesota, Montana, Nevada, New Mexico, Oregon, Tennessee, Texas, and Washington—have established

¹⁰⁸ Amar Gupta & Deth Sao, *The Constitutionality of Current Legal Barriers to Telemedicine in the United States: Analysis and Future Directions of its Relationship to National and International Health Care Reform*, 21 HEALTH MATRIX 385, 393 (2011).

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ Hoffman & Rowthorn, *supra* note 27, at 9.

¹¹² See Alex Ruoff, *Varying State Laws Cause Headaches for Telehealth Docs*, BLOOMBERG BNA, Apr. 25, 2016, at 1, BLOOMBERG L. REP.

¹¹³ Gupta & Sao, *supra* note 108, at 394.

¹¹⁴ *Id.*; see also Sadalay, *supra* note 81, at 25 (“Inconsistencies among state physician licensure laws . . . deter physicians from participating in telemedicine programs for fear of civil and criminal penalties, disciplinary action, and invalidation of malpractice insurance policies.”).

¹¹⁵ *Who is USMLE?*, FED’N ST. MED. BOARDS, <http://www.usmle.org/about/> (last visited Nov. 16, 2017).

¹¹⁶ *Id.*

¹¹⁷ See Ruoff, *supra* note 112.

¹¹⁸ LATOYA THOMAS & GARY CAPISTRANT, 50 STATE TELEMEDICINE GAP ANALYSIS: PHYSICIAN PRACTICE STANDARDS & LICENSURE 2 (2016).

limited licensure provisions to allow physicians licensed in another state to treat patients via telemedicine.¹¹⁹ Maryland, Pennsylvania, and South Dakota allow licensure reciprocity from other states.¹²⁰ Some states, however, have tightened restrictions on the practice of telehealth within their borders.¹²¹ According to a recent state gap analysis performed by the American Telemedicine Association, the licensure schemes in both Arkansas and Texas largely precluded the advancement of telehealth within the state.¹²²

Indeed, Texas's restrictions on telehealth have resulted in recent bouts of litigation.¹²³ In 2015, the Texas Medical Board issued a rule requiring physicians to conduct a face-to-face encounter with a patient before providing telehealth consultations.¹²⁴ While the regulatory board cited a need for patient safety, critics of the Texas Medical Board's rule allege the restrictions are meant to protect doctors from increased competition.¹²⁵ In response to the rule, Teladoc, Inc.—a major supplier of telehealth technologies in the state—brought a lawsuit alleging anticompetitive behavior perpetrated by the Texas Medical Board.¹²⁶ The Texas Medical Board defended its decision to promulgate the rule claiming that state-action immunity should shield it because “the Sherman-Antitrust Act was never meant to affect the State's abilities to regulate their economies.”¹²⁷

In December 2015, a federal judge dismissed this argument and granted a preliminary injunction halting the implementation of Texas's telehealth rules.¹²⁸ Federal agencies have also demonstrated their support for Teladoc, Inc.¹²⁹ Both the Justice Department and the Federal Trade Commission (FTC) told the U.S. Court of Appeals for the Fifth Circuit to ignore the Texas Medical Board's appeal, saying the rule should be discarded because the Texas Medical

¹¹⁹ Christina Thielst, *State by State Telemedicine Licensure*, HEALTHCARE IT NEWS (Dec. 31, 2012, 8:37 AM), <http://www.healthcareitnews.com/blog/state-state-telemedicine-licensure>.

¹²⁰ Nicole A. Liffbrig Molfie et al., *Telehealth—The Newest Age of Health Care Delivery*, in REPRESENTING HOSPITALS AND HEALTH SYSTEMS HANDBOOK 577, 581 (Traci S. Thompson & Amy S. Leopard eds., 2016).

¹²¹ THOMAS & CAPISTRANT, *supra* note 118, at 2.

¹²² *Id.*

¹²³ Ericha Tichert, *Feds Support Teladoc Challenge to Texas Telemedicine Rules*, MOD. HEALTHCARE (Sept. 12, 2016), <http://www.modernhealthcare.com/article/20160912/NEWS/160919987>.

¹²⁴ *Id.*

¹²⁵ *Id.*

¹²⁶ *Id.*

¹²⁷ Casady, *supra* note 102.

¹²⁸ Tichert, *supra* note 123.

¹²⁹ *See id.*

Board failed to review it properly.¹³⁰ The Texas Medical Board has since dropped its appeal and the case is scheduled to go to trial in district court.¹³¹

The Teladoc, Inc. litigation illustrates the need for the United States to deviate from its current licensure model, at least as it relates to telehealth. The American Medical Association and other trade associations have suggested a range of alternative licensure schemes to promote the exchange of cross-border telehealth services.¹³² Significantly, in 2015, states began to enact the Federation of State Medical Boards' Interstate Licensure Compact (Interstate Compact).¹³³ States that adopt the Interstate Compact provide a licensing option under which qualified physicians wishing to practice medicine interstate are eligible for expedited licensure.¹³⁴ As of January 2017, eighteen states have chosen to implement this model legislation.¹³⁵ While the Interstate Compact has received support from the American Medical Association and the American Telemedicine Association for its potential to promote telehealth, others have criticized the Interstate Compact for not embracing licensure portability.¹³⁶ Shirley Svorny, a Professor of Economics at California State University-Northridge, notes that the Interstate Compact does not expressly absolve the requirement that providers employing telehealth services be licensed in every state in which they practice.¹³⁷ Additionally, the Interstate Compact preserves the multiple fees physicians must pay to each state board.¹³⁸ The Association of American Physicians and Surgeons has also criticized the Federal State Medical Boards (FSMB), arguing that its status as a private, tax-exempt organization presents a conflict of interest.¹³⁹ While the Interstate Compact represents a step in the right direction, these factors illustrate the need for more intervention by the federal government in reforming licensure requirements.¹⁴⁰

¹³⁰ *Id.*

¹³¹ *Id.*

¹³² Hoffman & Rowthorn, *supra* note 27, at 11–13.

¹³³ Molfie et al., *supra* note 120, at 581; *see also Interstate Medical Licensure Compact—Legislative Status*, available at <http://www.licenseportability.org> (last visited Nov. 16, 2017) (listing states that have adopted the Interstate Compact).

¹³⁴ Molfie et al., *supra* note 120, at 581.

¹³⁵ *Frequently Asked Questions About the Interstate Medical Licensure Compact*, INTERSTATE MED. LICENSURE COMPACT, available at <http://licenseportability.org/faq/> (last visited Nov. 16, 2017).

¹³⁶ *Is the Interstate Medical Licensure Compact Good or Bad for Telehealth?*, MHEALTH INTELLIGENCE (July 18, 2016), <http://mhealthintelligence.com/news/is-the-interstate-medical-licensure-compact-good-or-bad-for-telehealth>.

¹³⁷ Shirley Svorny, *Telemedicine Runs into Crony Doctoring*, WALL ST. J., July 23, 2016, at A11.

¹³⁸ *Id.*

¹³⁹ *Is the Interstate Medical Licensure Compact Good or Bad for Telehealth?*, *supra* note 136.

¹⁴⁰ *See Svorny, supra* note 137, at A11.

On April 16, 2010, the Law and Health Care Program at the University of Maryland School of Law held a Roundtable on the Legal Impediments to Telemedicine.¹⁴¹ Part of the Roundtable's discussion focused on physician licensure—"the greatest challenge to the interstate practice of medicine."¹⁴² In addition to the models already embraced by the states (full licensure only, consultation exception, limited license, reciprocity), the Roundtable considered the merits of a number of additional schemes.

These additional schemes included two national models: (1) a fully national model resulting in the federalization of licensure, and (2) a hybrid model that merged aspects of national licensure with state regulation.¹⁴³ Under the federalization model, "a license would be issued based on a standardized set of criteria for the practice of health care through the [United States]."¹⁴⁴ Under the hybrid model, states would "voluntarily incorporate" national standards into their laws, but would retain sovereign control over requirements concerning the acquisition of a license as well as disciplinary proceedings.¹⁴⁵ International examples in Australia and the European Union suggest a hybrid federal-state model would work best in the United States.

IV. TELEHEALTH & LICENSURE—THE EUROPEAN UNION

While the majority of its citizens enjoy excellent healthcare, the twenty-five EU Member States grapple with many of the same health concerns confronting the United States.¹⁴⁶ With a rapidly aging population and the isolation of many citizens, telehealth provides a means for the Member States to reduce rising expenses for public healthcare.¹⁴⁷ Despite its need to align principles with the substance of its directives, the EU's physician licensure scheme already provides more flexibility for physicians wishing to practice medicine across borders than the U.S. state-licensure model.¹⁴⁸ Nonetheless, practical flaws highlight concerns that should compel the United States to veer away from a state-based mutual recognition model and to adopt a hybrid federal-state scheme.

¹⁴¹ Hoffman & Rowthorn, *supra* note 27, at 5.

¹⁴² *Id.* at 5, 8.

¹⁴³ *Id.* at 15.

¹⁴⁴ *Id.*

¹⁴⁵ *Id.* at 11–13.

¹⁴⁶ Helena Spogenberg, *Chronic Diseases – The Biggest Killer in Europe*, EUOBSERVER (Sept. 22, 2014), <https://euobserver.com/chronic-diseases/125636>.

¹⁴⁷ Hilko J. Meyers, *Current Legislation on Cross-Border Health Care in the European Union*, in *THE GLOBALIZATION OF HEALTH CARE: LEGAL AND ETHICAL ISSUES* 83, 84 (Glenn Cohen ed., 2013).

¹⁴⁸ Pirvu & Snyder, *supra* note 34.

As a preliminary measure, it is necessary to briefly outline the relevant legal schemes governing both the cross-border exchange of telehealth services and the mutual recognition of physicians' licensing or registration in the European Union. Central competencies in the European Union over healthcare only extend to special aspects of common safety concerns in public health matters and to the coordination and support of the actions of Member States.¹⁴⁹ While EU Member States are responsible for the management of healthcare services and resources, the principles of free movement of persons, products, services, and capital require free cross-border trade of healthcare services and products between Member States.¹⁵⁰ These principles stem from instruments such as the Charter of Fundamental Rights of the European Union (the Charter)¹⁵¹ and the Treaty on the Functioning of the European Union (TFEU).¹⁵² Given the same legal value as the EU treaties by the Treaty of Lisbon,¹⁵³ the Charter emphasizes the common right to health services, professing "[e]veryone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be insured in the definition and implementation of all Union policies and activities."¹⁵⁴ Although lacking the Charter's impassioned tone, the TFEU also safeguards the right to obtain healthcare. Article 56 of the TFEU prohibits Member States from placing restrictions on the free movement of persons providing services and Article 57 includes "activities of the professions" within its definition of "services."¹⁵⁵ The European Court of Justice has ruled numerous times that health services fall within the definition of services as defined by the TFEU.¹⁵⁶ Thus, it is undisputed that health services generally enjoy freedom of movement within the European Union.¹⁵⁷

While European law protects the practice of medicine via telehealth from outright prohibitions enacted by Member States, clinicians encounter a separate set of legal hurdles concerning recognition of their licensure or

¹⁴⁹ Meyers, *supra* note 147, at 84.

¹⁵⁰ *Id.*

¹⁵¹ Charter of Fundamental Rights of the European Union, 2000 O.J. (C 364).

¹⁵² Consolidated Version of the Treaty on the Functioning of the European Union, arts. 56–57, 2008 O.J. (C 115) 47 [hereinafter TFEU].

¹⁵³ *Id.* art. 6.

¹⁵⁴ Charter of Fundamental Rights of the European Union, *supra* note 151, art. 35.

¹⁵⁵ TFEU, *supra* note 152, art. 57.

¹⁵⁶ Meyers, *supra* note 147, at 90.

¹⁵⁷ Raposo, *supra* note 35, at 3.

registration status.¹⁵⁸ Currently, there is no inter-jurisdictional license issued by an EU medical board or comparable entity permitting physicians to practice medicine via telehealth in all Member States.¹⁵⁹ Instead, most Member States delegate this competency to an appointed licensing or registration body within the Member State.¹⁶⁰ As in the United States, health professionals must abide by the rules and regulations established by the licensing authority and submit to disciplinary proceedings in the event of non-observance.¹⁶¹

Despite the absence of a uniform licensure model, the European Union has endeavored to facilitate cross-border recognition of medical licensure through a mutual recognition program.¹⁶² Under this system, Member States recognize the professional qualifications of regulated professionals who have obtained licensure in another Member State.¹⁶³ While the European Union launched the program in 2005, the initial Directive failed to encompass telehealth, as it only applied to situations where clinicians physically moved to a different Member State to provide services.¹⁶⁴ In March 2011, the European Parliament corrected this discrepancy by expanding the scope of its mutual recognition program.¹⁶⁵ Under the complementary Directive entitled “On the Application of Patients’ Rights in Cross-Border Healthcare,” healthcare professionals only need to register in the Member State of Treatment.¹⁶⁶ In the case of telehealth, the Directive considers the Member State of Treatment to be “the Member State where the healthcare provider is established.”¹⁶⁷

¹⁵⁸ For a discussion on the differences between licensure and registration systems, see Eszter Kovacs et al., *Licensing Procedures and Registration of Medical Doctors in the European Union*, 14 *CLINICAL MED.* 229, 230–31 (2014).

¹⁵⁹ Celine Deswarte, Policy Officer, Health & Well-Being Unit, Eur. Comm’n, *Regulating Telemedicine: The EU Perspective*, Presentation at the ETSI eHealth Workshop on Telemedicine (May 6–7, 2014).

¹⁶⁰ *Commission Staff Working Document on the Applicability of the Existing EU Legal Framework to Telemedicine Services*, at 8–9, COM (2012) 736 final (June 12, 2012) [hereinafter *Commission Staff Working Document*].

¹⁶¹ *Id.* at 11.

¹⁶² European Council for Accreditation of Medical Specialist Qualifications [ECAMSQ], *ECAMSQ Presentation*, at 2 (Oct. 2011), https://www.uems.eu/_data/assets/pdf_file/0009/1206/ECAMSQ_presentation.pdf.

¹⁶³ Raposo, *supra* note 35, at 3.

¹⁶⁴ *Commission Staff Working Document*, *supra* note 160, at 12.

¹⁶⁵ Cathy Bahr & Nicole Denjoy, *Industry Report on Telemedicine Deployment for European Healthcare*, UNITED4HEALTH 1, 13–15 (Jan. 16, 2015), <http://united4health.eu/wp-content/uploads/2015/10/D5.5-v1.0-U4H-Industry-Report-on-Telemedicine-Legal-and-Regulatory-Framework.pdf>.

¹⁶⁶ Directive 2011/24, of the European Parliament and of the Council of 9 March 2011 on the Application of Patients’ Rights in Cross-Border Healthcare, 2011 O.J. (L 88) 45, 55 [hereinafter *Directive 2011/24*]; Raposo, *supra* note 35, at 5.

¹⁶⁷ Directive 2011/24, *supra* note 166, at 45, 55.

While the EU mutual recognition model requires Member States to accept a medical practitioner's credentials, the practical scope of this acceptance is complicated by, and varies according to, each Member State's regulatory framework.¹⁶⁸ Each national entity still retains control over interpreting what constitutes the "practice of medicine" and determining which activities are reserved for qualified physicians.¹⁶⁹ The acceptance of telehealth as a health service varies wildly between Member States.¹⁷⁰ Of all the Member States, Spain harbors the most accommodating views on telehealth and considers it "an undisputed and legally approved service" and "a complement to traditional healthcare . . . not posing any threat."¹⁷¹ Most other Member States either lack laws specifically addressing telehealth or limit its applicability by requiring a face-to-face encounter.¹⁷² For instance, Germany's professional code of conduct requires physicians "to refrain from diagnosis and starting therapy" until they have physically examined the patient.¹⁷³ France has created a separate class of clinicians, dubbed "tele-experts," who must meet specific qualifications before practicing medicine via telehealth.¹⁷⁴ Additionally in France, a physician can only utilize telehealth technologies when a patient's health status allows for it (i.e., in an emergency situation, where there is an insufficient number of physicians in a given area).¹⁷⁵ Thus, even though some of the administrative barriers have been removed for practicing medicine via telehealth across Member State borders, the divergent standards governing telehealth in the individual Member States preclude optimal efficiency.¹⁷⁶

A. *Telehealth Scenario—The European Union*

Although a host of additional factors inhibit the uptake of telehealth by service providers in the European Union (e.g., reimbursement, protection of patient information, standard of care, etc.),¹⁷⁷ several qualitative studies conducted in recent years illustrate how the mutual recognition system for

¹⁶⁸ Bahr & Denjoy, *supra* note 165, at 15.

¹⁶⁹ *Id.* at 16–21.

¹⁷⁰ *See id.* at 15.

¹⁷¹ *Id.* at 19.

¹⁷² While Member States are generally prohibited from adopting any national law expressly prohibiting health professionals from providing telemedicine services, Member States may indirectly do so if "justified by imperative reasons of public interest." *Id.* at 15–16.

¹⁷³ *Id.* at 18.

¹⁷⁴ *Id.* at 17.

¹⁷⁵ *Id.*

¹⁷⁶ *See generally* Isabel Risso-Gull et al., *Processes and Regulatory Procedures of Doctors in the European Union*, 19 EUROHEALTH 1, 6–7 (2013).

¹⁷⁷ *See generally* Raposo, *supra* note 35.

professional licensure has both facilitated and complicated cross-border telehealth projects.¹⁷⁸ One such study focused on a teleneuromonitoring¹⁷⁹ collaboration between hospitals in the Netherlands, Germany, and Switzerland.¹⁸⁰ The project under analysis allowed a surgeon in Aachen, Hamburg, or Bern to perform open surgical repair of the aneurysm of the thoracoabdominal aorta (TAA), while a neurophysiologist in Maastricht simultaneously monitored the spinal functions of the patient.¹⁸¹ In doing so, the team of physicians reduced the risk of the patient suffering from paraplegia and paraparesis.¹⁸² The collaboration also allowed the hospitals in the Netherlands and Germany to utilize the expensive skillsets of the neurophysiologist without having to directly employ one.¹⁸³ As such, the project allowed the parties to realize two major benefits associated with telehealth:¹⁸⁴ improved patient outcomes and cost reduction stemming from operational efficiency.¹⁸⁵

As part of the teleneuromonitoring study, the authors interviewed hospital administrators and surgeons participating in the project to discern legal factors helping or hindering its viability.¹⁸⁶ Of note, prior agreements between the collaborating centers allowed the entities to resolve many potential legal liabilities.¹⁸⁷ Although none of the parties involved discussed how the European Union's mutual recognition policies enabled the program's operation, it permitted the neurophysiologist located in Maastricht to use his Dutch credentials to monitor patients in Germany.¹⁸⁸ The interviewees also revealed that different standards for medical training created an additional

¹⁷⁸ See generally Vanessa Saliba et al., *Telemedicine Across Borders: A Systematic Review of Factors That Hinder or Support Implementation*, 81 INT'L J. MED. INFORMATICS 793 (2012).

¹⁷⁹ Nora Doering et al., *A Success-Story in Cross-Border Telemedicine in Europe: The Use of Intra-Operative Teleneuromonitoring During Aorta Surgery*, 2 HEALTH POL'Y & TECH. 4, 4–5 (2013) (“Teleneuromonitoring can be seen as a combination of telemonitoring and teleconsultation and is a relatively small field of telemedicine.”).

¹⁸⁰ *Id.* at 4, 6. It should be noted that while the Netherlands and Germany are EU Member States, Switzerland is not.

¹⁸¹ *Id.* at 5.

¹⁸² *Id.*

¹⁸³ *Id.* at 5, 7.

¹⁸⁴ *Id.* at 4 (“The European Commission (EC) identified telemedicine as a potential means of contributing to improve health outcomes and quality of life; to ameliorate the shortage of health professionals; but perhaps most importantly from the viewpoint of the Commission, of making a substantial improvement to the European economy.”).

¹⁸⁵ *Id.* at 8.

¹⁸⁶ *Id.* at 5.

¹⁸⁷ *Id.* at 6.

¹⁸⁸ *Id.*

obstacle for the program.¹⁸⁹ As a result, one respondent called for more EU involvement in standardizing the training amongst specialists, stating “[w]e need a European standard—a kind of driver’s license for neuromonitoring.”¹⁹⁰ While a European standard for the provision of telehealth has yet to materialize, such a program is underway in another state-based sovereignty: Australia.

V. TELEHEALTH & LICENSURE—AUSTRALIA

A. *Australia and the United States: Similarities and Differences*

Australia is a large continent with the majority of its population clustered in coastal cities.¹⁹¹ Although Australia is a highly urbanized country, the World Bank estimated that in 2016, ten percent of Australians resided in rural communities.¹⁹² Unsurprisingly, health outcomes for people living in these locations have declined as resources have continued to migrate towards the country’s population centers.¹⁹³ While the Australian government provides physicians with scholarships and financial incentives to increase the number of practitioners in pastoral communities, access to specialist care remains a problem for these citizens.¹⁹⁴ Like the United States and the European Union, telehealth offers a means of improving access and reducing costs associated with traveling for services and employing specialists.¹⁹⁵

Australia’s similarities to the United States regarding the need and feasibility of telehealth implementation do not end with its specialist shortage in rural areas. The legal systems in both the United States and Australia evolved from British common-law origins.¹⁹⁶ To this day, Australia and the

¹⁸⁹ *Cf. id.* (“[The neurophysiologist] can only perform neuromonitoring in Germany at a distance from the Netherlands, because neuromonitoring in Germany requires a special certificate.”).

¹⁹⁰ *Id.*

¹⁹¹ Natalie K. Bradford et al., *Awareness, Experiences and Perceptions of Telehealth in a Rural Queensland Community*, 15 BMC HEALTH SERV. RES. 427, 427 (2015).

¹⁹² WBG, *Rural Population (% of Total Population)*, WBG, <http://data.worldbank.org/indicator/SP.RUR.TOTL.ZS?locations=AU> (last visited Nov. 16, 2017).

¹⁹³ Bradford et al., *supra* note 191, at 427.

¹⁹⁴ *Id.*

¹⁹⁵ *See supra* notes 61–67, 181–185 and accompanying text.

¹⁹⁶ Ian R. Landgreen, “*Do No Harm*”: A Comparative Analysis of Legal Barriers to Corporate Clinical Telemedicine Providers in the United States, Australia, and Canada, 30 GA. J. INT’L & COMP. L. 365, 369 (2002).

United States both operate under a federal system of government, in which various levels of government preside over different healthcare programs.¹⁹⁷

Additionally, Australia's population is aging at a rapid rate.¹⁹⁸ The Australian Institute for Health and Welfare estimates that the number of Australians aged sixty-five and over has more than tripled since the 1970s, rising to 3.7 million in 2016.¹⁹⁹ According to the Australian Bureau of Statistics, this figure will increase to 8.7 million people by 2056.²⁰⁰ This proportionate increase in senior citizens will heighten pressure on Australia's healthcare system, as a significantly older population saddled with chronic illness requires longer hospital stays and more follow-up care.²⁰¹ Moreover, Australia has experienced a dramatic increase in the cost of healthcare in recent decades, which has caused healthcare professionals, policymakers, and government officials to opine that although citizens enjoy high quality care, the nation's economy cannot sustain the exorbitant costs.²⁰²

Despite high expectations surrounding the deployment of health services through telehealth vehicles, the uptake of telehealth has been sluggish.²⁰³ These worrisome statistics aside, Australia—like the United States—has the infrastructure necessary to justify investing in and fostering telehealth projects.²⁰⁴ The number of households with Internet access reached 7.3 million by the end of 2012, representing eighty-three percent of all households.²⁰⁵ Australia also has an advanced healthcare system and achieved a better ranking than the United States in the World Health Organization's only study of national health systems completed in 2000.²⁰⁶

¹⁹⁷ Kees van Gool et al., *From Flying Doctor to Virtual Doctor: An Economic Perspective on Australia's Telemedicine Experience*, 8 J. TELEMEDICINE & TELE CARE 249, 250 (2002); see also Peter D. Jones et al., *Differences and Similarities in the Practice of Medicine Between Australia and the United States of America: Challenges and Opportunities for the University of Queensland and the Ochsner Clinical School*, 11 OSCHSNER J. 253, 254 (2011).

¹⁹⁸ *Older Australia at a Glance*, AUSTL. INST. HEALTH & WELFARE, <https://www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/summary> (last updated Apr. 21, 2017).

¹⁹⁹ *Id.*

²⁰⁰ *Id.*

²⁰¹ Chris Bartlett et al., *Australia's Healthcare System: An Opportunity for Economic Growth*, STRATEGY & (June 22, 2016), <http://www.strategyand.pwc.com/reports/australias-healthcare-system>.

²⁰² *Id.*

²⁰³ Bradford et al., *supra* note 191, at 429.

²⁰⁴ See generally Landgreen, *supra* note 196, at 369.

²⁰⁵ *8146.0 – Household Use of Information Technology, Australia 2012-2013*, AUSTL. BUREAU OF STATISTICS (Feb. 25, 2014), <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/8146.0Chapter12012-13>.

²⁰⁶ WORLD HEALTH ORG., THE WORLD HEALTH REPORT 2000: HEALTH SYSTEMS: IMPROVING PERFORMANCE 200 (2000).

While the similarities between the United States and Australia create a need and opportunity for telehealth, Australia's differences help explain why it has experienced greater, albeit limited, success with telehealth initiatives.²⁰⁷ While the United States has a largely market-driven healthcare system, Australia's healthcare system has been heavily influenced by socialist policy.²⁰⁸ Australia employs a universal healthcare system, at the heart of which is Medicare: a tax-funded health insurance scheme providing all citizens and international visitors with access to public hospital care and community health services.²⁰⁹ Increased government involvement has allowed for telehealth initiatives to take root in Australia despite industry wariness stemming from a multitude of legal, ethical, and economic concerns.²¹⁰ Government intervention also helps to explain why Australia's healthcare system ranks significantly higher than the United States in terms of efficiency.²¹¹ According to the 2016 Bloomberg Health-Care Efficiency Index,²¹² Australia ranked tenth out of the fifty-five nations assessed while the United States placed fiftieth.²¹³ Australia's government has historically made a more concerted effort than the United States to disseminate health services to rural locales, as evidenced by its Royal Flying Doctors Service established in 1928.²¹⁴ Lastly, and most importantly for the purposes of this Comment, Australia has abandoned its state-based physician registration system in favor

²⁰⁷ Compare Bartlett et al., *supra* note 201, with Bradford et al., *supra* note 191, at 429.

²⁰⁸ Landgreen, *supra* note 196, at 370.

²⁰⁹ van Gool, *supra* note 197, at 250.

²¹⁰ See generally *Telehealth Pilots Programme*, AUSTRALIAN GOVERNMENT DEPARTMENT OF HEALTH, <http://www.health.gov.au/internet/main/publishing.nsf/Content/health-nbntelehealth-pilots> (last updated Feb. 25, 2014).

²¹¹ Bartlett et al., *supra* note 201; Lisa Du et al., *U.S. Health-Care System Ranks as One of the Least Efficient*, BLOOMBERG (Sept. 28, 2016), <https://www.bloomberg.com/news/articles/2016-09-29/u-s-health-care-system-ranks-as-one-of-the-least-efficient>; van Gool, *supra* note 197, at 249 ("Well documented market failures in health-care have resulted in governments around the world playing a major role in its provision and funding. An important part of this role is to allocate health-care resources efficiently.").

²¹² Bloomberg based the efficiency score on three weighted metrics: life expectancy (sixty percent), relative health expenditure (thirty percent), and absolute health expenditure (ten percent). *Most Efficient Health-Care*, BLOOMBERG (2016), available at <http://assets.bwbx.io/images/users/iqjWHBFdfxIU/iNK1THx4aD20/v3/-1x-1.png>. To be considered, countries needed to have a population of at least five million, GDP per capita of at least \$5,000, and life expectancy of at least seventy years of age. *Id.*

²¹³ *Id.*

²¹⁴ van Gool, *supra* note 197, at 250; see *What We Do*, ROYAL FLYING DOCTOR SERVICE, <https://www.flyingdoctor.org.au/what-we-do/> (last visited Nov. 16, 2017) ("Using the latest in aviation, medical and communications technology, the Royal Flying Doctor Service works to provide emergency medical and primary health care services to anyone who lives, works or travels in rural and remote Australia.").

of a single national agency that enforces the registration and accreditation program for all medical practitioners.²¹⁵

B. The Emergence of Australia's National Scheme

As a general matter, the laws and regulations governing the practice of medicine in Australia do not distinguish between the traditional practice of medicine and the practice of medicine through telehealth.²¹⁶ The same standards apply irrespective of the delivery mode.²¹⁷ While the Medical Board of Australia has issued guidance on technology-based consultations, the guidance does little more than place the onus on the practitioner to determine the clinical appropriateness of telehealth technologies.²¹⁸ Instead of legislative bodies creating a comprehensive and uniform scheme, medical colleges and professional bodies have traditionally determined the standards of practice within particular medical disciplines.²¹⁹ Examples of these policies as they relate to telehealth include the Royal Australian College of General Practitioner's "Implementation Guidelines for Video Consultations in General Practice"²²⁰ and the Rural Doctor's Association of Australia's "Telehealth Key Principles."²²¹

Regardless of the service delivery model, professional registration is required for any medical practitioner seeking entry into the health labor force.²²² To obtain registration, the individual must satisfy all eligibility requirements promulgated by the appropriate registration board.²²³ For physicians, the process preceding registration loosely resembles the licensure

²¹⁵ Jonathan Lee Wardle et al., *Is Health Practitioner Regulation Keeping Pace with the Changing Practitioner and Health Care Landscape? An Australian Perspective*, 4 FRONTIERS PUB. HEALTH 91, 92 (2016).

²¹⁶ Michael Regos, *Telehealth: Medico-Legal Aspects of Telehealth Services for Victorian Public Health Services*, DLA PIPER AUSTL. (Mar. 2015) ("The laws, regulations, and regulatory bodies governing medical practitioners who practice via telehealth are the same as those who do not practice via telehealth.").

²¹⁷ *Id.*

²¹⁸ *See generally* MED. BD. OF AUSTL., GUIDELINES: TECHNOLOGY-BASED PATIENT CONSULTATIONS (2012) [hereinafter TECHNOLOGY-BASED PATIENT CONSULTATIONS] ("Medical practitioners who advise or treat patients in technology-based consultations should . . . make a judgment about the appropriateness of technology-based patient consultations and in particular, whether a direct physical examination is necessary.").

²¹⁹ MED. BD. OF AUSTL., GOOD MEDICAL PRACTICE: A CODE OF CONDUCT FOR DOCTORS IN AUSTRALIA 4 (2014).

²²⁰ *See generally* ROYAL AUSTL. COLL. OF GEN. PRACTITIONERS, IMPLEMENTATION GUIDELINES FOR VIDEO CONSULTATIONS IN GENERAL PRACTICE (3d ed. 2014).

²²¹ *See generally* RURAL DOCTORS ASS'N OF AUSTL., TELEHEALTH KEY PRINCIPLES (2014).

²²² Belinda Bennett, *New Challenges for Old Laws? The Development of E-Health in Australia*, 23 SYDNEY L. REV. 405, 416 (2001).

²²³ *Id.*

track present in the United States.²²⁴ Upon earning their medical degree from an accredited institution, Australian physicians receive provisional registration and enter the workforce as interns.²²⁵ After completing their twelve-month internship, graduates are eligible to receive general medical registration through the Medical Board of Australia.²²⁶ However, physicians have only recently been able to obtain general medical registration through the Medical Board of Australia and only as a result of legislative reform.²²⁷

The Australian Constitution does not expressly confer legislative powers addressing health policy to the Commonwealth government; thus, the states and territories of Australia initially assumed control over registering and regulating medical practitioners and other health professionals.²²⁸ Prior to developments in the 1990s and late 2000s, Australia's registration process resembled the current model in the United States.²²⁹ Statutes vested state-based "registration boards" with the authority to determine qualification requirements and to discipline parties guilty of professional misconduct.²³⁰ Physicians seeking to practice cross-border medicine encountered difficulties in that registered practitioners only had permission to practice in their respective jurisdictions, and regulatory hurdles impeded clinicians wishing to expand their practices across territorial lines.²³¹

Recognizing that the registration scheme stifled economic opportunity,²³² the Australian Federal Parliament enacted the Mutual Recognition Act of 1992 "for the purpose of promoting the goal of freedom of movement of goods and service providers in a national market in Australia."²³³ By 1995, each state and territory had enacted complementary acts in accordance with a mirror

²²⁴ See generally Jones et al., *supra* note 197, at 255–257 (noting that Australia lacks a uniform national examination system and instead relies on medical school-administered undergraduate examinations).

²²⁵ *Becoming a Doctor*, AUSTL. MED. A'SSN, <https://ama.com.au/careers/becoming-a-doctor> (last visited Nov. 16, 2017).

²²⁶ *Id.*

²²⁷ See generally UPDATE, *supra* note 36.

²²⁸ Anne-Louise Carlton, *National Models for the Regulation of the Health Professions*, in REGULATING HEALTH PRACTITIONERS 21, 22 (Ian R. Freckelton ed., 2006). While the framers of the Australian Constitution favored a strict division of powers between the Commonwealth and state levels of government, Australia's High Court has since interpreted the Constitution to accommodate a more centralized version of federalism. See Alan Fenna, *The Malaise of Federalism: Comparative Reflections on Commonwealth-State Relations*, 66 AUSTL. J. PUB. ADMIN. 298, 298 (2007).

²²⁹ Carlton, *supra* note 228, at 21, 23, 31.

²³⁰ *Id.* at 21, 23.

²³¹ Bennett, *supra* note 222, at 416.

²³² See Steven Mark, *Harmonization or Homogenization? The Globalization of Law and Legal Ethics – An Australian Viewpoint*, 34 VAND. J. TRANSNAT'L L. 1173, 1175–76 (2001).

²³³ *Mutual Recognition Act 1992* (Cth) pt 1(3) (Austl.).

legislation scheme.²³⁴ In the wake of this legislation, medical practitioners registered in one state could practice medicine in other jurisdictions provided they (1) notified the receiving jurisdiction of their intention to do so; (2) forwarded details of their registration in their home jurisdiction to the registration authority in the receiving jurisdiction; (3) applied for recognition of their existing license; (4) signed a consent form enabling the receiving jurisdiction's authority to conduct a reasonable investigation relating to the practitioner's application; and (5) paid any associated fees mandated by the receiving board.²³⁵

However, the Mutual Recognition Act did little to assuage difficulties associated with the state-based registration system.²³⁶ Specialists such as pathologists and radiologists providing services in multiple jurisdictions via telehealth found the requirements of multiple registrations cumbersome.²³⁷ To frustrate matters, Registration Acts varied significantly across jurisdictions.²³⁸ Legislative mapping exercises conducted in the years following the Mutual Recognition Act's passage revealed incongruences in terminology, registration application criteria and processes, requirements for continuing professional development, and requirements for indemnity insurance.²³⁹

In an effort to correct these inconsistent standards and to minimize duplicative hurdles, Australian state and territory registration boards began working in unison to establish cooperative national structures.²⁴⁰ The fruits of these labors included the various state and territory medical registration boards ceding both the power to accredit undergraduate training courses and to administer the professional registration examination for international practitioners to the Australian Medical Council.²⁴¹ Despite these limited efforts, policy makers and professionals alike agreed that Australia's professional registration system needed greater uniformity to afford medical practitioners optimal flexibility and to alleviate conflicting compliance concerns.²⁴²

²³⁴ Mark, *supra* note 232, at 1191.

²³⁵ Carlton, *supra* note 228, at 21, 24; *see, e.g., Mutual Recognition Act 1992* (Cth) pt 3, div 1(17) (Austl.).

²³⁶ Carlton, *supra* note 228, at 24.

²³⁷ *Id.*

²³⁸ *Id.* at 25.

²³⁹ *Id.*

²⁴⁰ *Id.*

²⁴¹ *Id.*

²⁴² *Id.* at 25–26.

As a result, various state authorities began to devise alternative schemes promoting a national vision of professional registration.²⁴³ In 2001, the New South Wales Medical Board prepared a draft model for medical registration for the Australian Council for Safety and Quality in Health Care, which advanced a model for national portability of medical registration for practitioners who met nationally defined standards.²⁴⁴ The proposal noted, “[p]ublic interest recognizes no borders, and emerging technologies such as telemedicine demand a consistent approach to medical registration.”²⁴⁵ In 2003, the Victorian Department of Human Services published a discussion paper featuring a number of legislative approaches aimed at developing national registration structures.²⁴⁶ In the paper, the agency affirmed its “support [for] the establishment of national structures and processes for the registration and regulation of practitioners and [its continued desire] to contribute to harmonisation efforts.”²⁴⁷

C. *The National Scheme*

In 2006, the Council of Australian Governments (COAG) agreed to abandon the State and Territory-based registration boards in favor of a single National Registration and Accreditation Scheme (National Scheme).²⁴⁸ In doing so, Australia became the first country in the world to institute a national program regulating health practitioners.²⁴⁹ As the Commonwealth does not have the power to regulate health professionals, each state and territory legislature separately enacted the legislative framework—the Health Practitioner Regulation National Law Act of 2009 (National Law).²⁵⁰ The National Scheme commenced operation in each state and territory on July 1, 2010, and October 18, 2010, in Western Australia.²⁵¹ In adopting this new framework, each state and territory committed itself to the common objectives

²⁴³ See generally *id.* at 34–36.

²⁴⁴ Bennett, *supra* note 222, at 417.

²⁴⁵ *Id.*

²⁴⁶ Carlton, *supra* note 228, at 35.

²⁴⁷ *Id.*

²⁴⁸ Finance and Public Administration References Committee, Parliament of Australia, *The Administration of Health Practitioner Registration by the Australian Health Practitioner Regulation Agency (AHRPA)* (2011) 112, 112, available at https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/Completed_inquiries/2010-13/healthpractitionerregistration/report/index [hereinafter *The Administration of Health Practitioner Registration*].

²⁴⁹ Jason Warnock et al., *The National Registration and Accreditation Scheme*, 4 J. FOOT & ANKLE RES. 12 (2011).

²⁵⁰ *The Administration of Health Practitioner Registration*, *supra* note 248, at 5.

²⁵¹ Ian Freckelton, *Regulation of Health Practitioners: National Reform in Australia*, 18 J.L. & MED. 207, 207 (2010).

stated in the National Law, including “facilitate[ing] workforce mobility across Australia” and “enabling innovation in the education of, and service delivery by, health practitioners.”²⁵²

In succeeding the former system, the National Scheme consolidated seventy-five acts of Parliament and ninety-seven health professions boards.²⁵³ The new framework established fourteen national boards²⁵⁴ for each health profession and created the Australian Health Practitioner Regulation Agency (AHPRA) to oversee and administer all national boards.²⁵⁵ Each national board controls: the registration of health professionals; investigations concerning practitioner conduct; the development of standards, codes and guidelines; and the imposition of national fees.²⁵⁶ Under the National Scheme, a national board may establish a state or territory board to help provide local responses to health practitioners within the jurisdiction.²⁵⁷ These provincial boards administer the national registration in partnership with the national boards and continue to make regulatory decisions governing medical practitioners in their jurisdictions, who are assessed against national standards.²⁵⁸ All states and territories have a jurisdictional medical board.²⁵⁹ However, clinicians seeking to practice their respective profession need only register once with their respective national board, renew their registration on an annual basis, and pay one fee to the national board.²⁶⁰ Upon doing so, the health professional can practice in any state or territory in Australia.²⁶¹ Later guidance issued by the Medical Board of Australia suggests that medical practitioners who register under the National Scheme can engage in cross-border “technology-based

²⁵² KIM SNOWBALL, INDEPENDENT REVIEW OF THE NATIONAL REGISTRATION AND ACCREDITATION SCHEME FOR HEALTH PROFESSIONS 34, 71 (2014).

²⁵³ *Id.* at 6.

²⁵⁴ Initially, the National Scheme only established ten national boards, but the number was expanded to fourteen in 2012. *See* Freckleton, *supra* note 251, at 209–10.

²⁵⁵ SNOWBALL, *supra* note 252, at 16.

²⁵⁶ *The Administration of Health Practitioner Registration, supra* note 248, at 9. *But cf.* Regos, *supra* note 216 (“The AHPRA investigates allegations of professional misconduct in all states and territories except New South Wales (where this is undertaken by the Health Professional Councils Authority and the Health Care Complaints Commission) and Queensland (where this is undertaken by the Queensland Health Ombudsman, as of July 1, 2014).”).

²⁵⁷ *See e.g., Health Practitioner Regulation National Law of 2010 (ACT)* s 36 (Austl.).

²⁵⁸ Martin Fletcher, *AHPRA Responds to Critique of the National Registration Scheme for Health Professionals*, CROAKEY (Mar. 7, 2016), <https://croakey.org/ahpra-responds-to-critique-of-the-national-registration-scheme-for-health-professionals/>.

²⁵⁹ AUSTRALIAN HEALTH PRACTITIONER REGULATION AGENCY, NATIONAL BOARDS STRUCTURE 2 (2015), <http://www.ahpra.gov.au/national-boards.aspx>.

²⁶⁰ *See* Lee Thomas, *The Health Practitioner Regulation National Law Act*, 17 AUSTL. NURSING J. 21 (2010).

²⁶¹ *See id.*

patient consultations.”²⁶² It should be noted that there is no “Telehealth Board of Australia,” and that telehealth providers remain subject to regulation by AHPRA and their relevant national board.²⁶³

While the National Scheme has been considered a positive step forward in the regulation of health professionals,²⁶⁴ the transition proved—and continues to prove—a complex task.²⁶⁵ Practitioners criticized the rapid pace of implementation, claiming it did not provide adequate time for strategic planning, data system troubleshooting, and staff training.²⁶⁶ As a result, health professionals had difficulty learning the new registration requirements and often received inconsistent or incorrect advice from the AHPRA staff.²⁶⁷ Often times, practitioners were not informed of their registration renewals and received misinformation about their registration even when paperwork had been filed and fees had been paid.²⁶⁸ These inefficiencies culminated in the lapse of registration for many practitioners, who risked legal sanctions if they continued to practice.²⁶⁹ In one case, a trauma specialist who, despite having contacted AHPRA for a registration renewal, was deregistered in the midst of a flooding crisis and ordered to leave an evacuation center or face a \$30,000 AUD fine.²⁷⁰ The poor administration of the National Scheme bred uncertainty among practitioners in its initial years and led to losses in income, damage to reputation, inconvenience, and stress.²⁷¹ Perhaps even more significant, as a result of these inefficiencies, patients experienced lapses in specialist availability and quality of care.²⁷²

Despite these early pitfalls, evidence suggests the National Scheme has facilitated the interstate practice of medicine in Australia.²⁷³ According to a report conducted by the Parliament of Victoria, eleven percent of all registered practitioners claimed to benefit from the easing of interjurisdictional

²⁶² TECHNOLOGY-BASED PATIENT CONSULTATIONS, *supra* note 218; *see also* Regos, *supra* note 216.

²⁶³ Regos, *supra* note 216.

²⁶⁴ SNOWBALL, *supra* note 252, at 3.

²⁶⁵ *The Administration of Health Practitioner Regulation*, *supra* note 248, at 112.

²⁶⁶ *Id.* at 17, 18, 20.

²⁶⁷ *Id.* at 31–32.

²⁶⁸ *Id.* at 58.

²⁶⁹ *Id.* at 74–78.

²⁷⁰ *Id.* at 59.

²⁷¹ *Id.* at 57.

²⁷² *Id.* at 78–81.

²⁷³ Kerry J. Breen, *National Registration Scheme at Five Years: Not What It Promised*, 40 AUSTL. HEALTH L.R. 674, 675 (2016).

restrictions.²⁷⁴ Even one critic, who deemed the National Scheme “an expensive experiment that has partly failed,” noted that any legislative reform should maintain “a central database for national portable registration.”²⁷⁵ The National Scheme has even garnered international acclaim for its promotion of workforce mobility, with the OECD commenting in 2015 that “Australia’s move from a state-based to a national system . . . now makes it a leader in the OECD in the regulation of health professionals.”²⁷⁶

While the uptake of telehealth has grown steadily in the years following the enactment of the National Scheme,²⁷⁷ no studies have considered the National Scheme’s role in this proliferation.²⁷⁸ Moreover, studies that have assessed the effectiveness of telehealth platforms since 2010 have only analyzed intrastate²⁷⁹ telehealth projects.²⁸⁰ The dearth of interstate telehealth projects in Australia is due in part to Australia’s nascent national broadband network.²⁸¹ As recently as 2011, telehealth networks failed to extend nationwide.²⁸² The Australian Government sought to remedy this problem by creating the National Broadband Network Company (NBN Co.), a government-owned corporation tasked with implementing a national broadband network.²⁸³ Nevertheless, several isolated success stories published by the NBN Co. illustrate how the National Scheme has enabled interstate telehealth services in Australia. For instance, one account described a woman in Somerset, Australia (New South Wales), who used to have to fly regularly to Melbourne, Australia (Victoria),

²⁷⁴ PARLIAMENT OF VICT., SOCIAL AND LEGAL ISSUES COMMITTEE INQUIRY INTO THE PERFORMANCE OF THE AUSTRALIAN HEALTH PRACTITIONER REGULATION, at 70 n.196 (2014).

²⁷⁵ Breen, *supra* note 273, at 677.

²⁷⁶ Org. for Econ. Co-operation and Development (OECD), *OECD Review of Health Care Quality: Australia* 61 (2015).

²⁷⁷ Nat’l Rural Health All., *Fact Sheet: Ehealth and Telehealth in Rural and Remote Australia* (Aug. 2013), <http://ruralhealth.org.au/sites/default/files/publications/nrha-factsheet-ehealth.pdf>.

²⁷⁸ See generally *Publications – Australian Telehealth*, AUSTL. TELEHEALTH SOCIETY, <http://www.aths.org.au/resources/publications-australian-telehealth/> (last visited Nov. 16, 2017) (lacking any study or article discussing any interstate telehealth projects).

²⁷⁹ Here, intrastate telehealth refers to telehealth encounters where both the distant site and the outgoing site are located within the same state or territory.

²⁸⁰ See generally *Publications – Australian Telehealth by State*, AUSTL. TELEHEALTH SOCIETY, <http://www.aths.org.au/resources/publications-australian-telehealth-by-state/> (last visited Nov. 16, 2017).

²⁸¹ *Telehealth and the NBN: A Submission to the Australian House of Representatives Infrastructure and Communications Committee Inquiry into the Role and Potential Benefits of the National Broadband Network*, AUSTL. TELEHEALTH SOCIETY, at 12–13 (Feb. 2011), http://www.aths.org.au/wp-content/uploads/2016/06/ATHS_NBN_submission_Final_for_web.pdf.

²⁸² *Id.*

²⁸³ Renai LeMay & Suzanne Tindal, *NBN Company Established, Looks for CEO*, ZDNET (Apr. 28, 2009), <http://www.zdnet.com/article/nbn-company-established-looks-for-ceo/>.

for specialist visits.²⁸⁴ As a result of the National Scheme, she can take advantage of telehealth services without having to see a specialist registered in New South Wales.²⁸⁵ In another testimonial, two health professionals described how they now use telehealth technologies to treat patients located in other states and territories, with one commenting “there’s no reason not to see people interstate.”²⁸⁶

VI. HYBRID FEDERAL-STATE SCHEME

The licensure and registration schemes employed in the European Union and Australia illustrate the need and prudence of a hybrid federal-state licensure scheme in the United States. While the European Union’s mutual recognition scheme and Australia’s National Scheme have promoted the portability of medical licensure as it relates to telehealth, both systems have flaws that a hybrid federal-state licensure system would avoid or mitigate. In the European Union, the mutual recognition scheme has hampered physicians in providing cross-border care via telehealth because each member state can adjust its scope of practice laws to require a face-to-face consultation before a telehealth consultation can occur.²⁸⁷ These issues also frustrated Australian physicians during its period of mutual recognition.²⁸⁸ While Australia has remedied this problem by adopting a nationwide registration scheme, the implementation of the country’s National Scheme demonstrates the practical difficulties associated with overhauling a state-based system and replacing it with a federal system overnight.²⁸⁹ Confusion between providers and agency officials alike coupled with administrative inefficiencies harmed providers and patients following the implementation of the National Scheme.²⁹⁰ Australia might have mitigated these harms had it partnered with established state and territory medical boards during the early stages instead of abolishing them.²⁹¹

In adopting a hybrid federal-state licensure model, the United States would minimize its risk of succumbing to these same pitfalls. Under this approach,

²⁸⁴ ‘Telehealth Transformed Our Life, and Saved Us Money Too’, NAT’L BROADBAND NETWORK (Mar. 20, 2016), <http://www.nbnco.com.au/blog/health/telehealth-transformed-our-life-and-saved-us-money-too.html>.

²⁸⁵ *Id.*

²⁸⁶ *Time to See the Doctor? It’s Just a Click Away*, NAT’L BROADBAND NETWORK (Apr. 21, 2015), <http://www.nbnco.com.au/blog/health/time-to-see-the-doctor-its-just-a-click-away.html>.

²⁸⁷ *See supra* notes 164–172 and accompanying text.

²⁸⁸ *See supra* notes 235–240 and accompanying text.

²⁸⁹ *See supra* notes 265–273 and accompanying text.

²⁹⁰ *Id.*

²⁹¹ *Id.*

states would retain jurisdiction over professional standards and conduct, while a federal agency would approve physicians for a nationally recognized license to practice medicine and offer telehealth services.²⁹² This new federal agency would resemble a scaled-down version of Australia's AHPRA in that it would not control the receipt and handling of practitioner complaints.²⁹³ Instead, it would be in charge solely of administering a new federal license and establishing practice standards for the individual states to enforce.²⁹⁴ These new practice standards would expressly allow for the practice of medicine via telehealth. Such a system would eliminate the current variance in state standards, as observed in both the United States and the European Union.²⁹⁵ To resolve jurisdictional issues, state medical boards would retain authority to investigate and sanction physicians from other states treating patients via telehealth.²⁹⁶ While states could feasibly use these national practice standards to restrict the interstate practice of medicine via telehealth, the federal agency would be able to avoid this concern through clear drafting and periodic issuances of standards revisions.

While the administration of a new licensure program would add an additional level of bureaucracy, the United States could avoid some of the problems observed in the rollout of Australia's National Scheme by partnering with its state medical boards in educating practitioners. Additionally, operating under a cautious timeline and ensuring that staff receive adequate training on the new scheme would help streamline the process. Although frustrations and inefficiencies would inevitably surface during this phase-in period, the potential to revolutionize the practice of medicine in the United States would justify the transition.

CONCLUSION

Telehealth technologies represent a means of alleviating the current burdens on the United States healthcare system.²⁹⁷ Unfortunately, absent reform of the United States' state-based licensure system, telehealth will not reach its full potential.²⁹⁸ Considering the effectiveness of more progressive

²⁹² See Peter D. Jacobson & Elizabeth Selving, *Licensing Telemedicine: The Need for a National System*, 6 *TELEMEDICINE J. & E-HEALTH* 429, 436 (2000).

²⁹³ See *supra* notes 256–57 and accompanying text.

²⁹⁴ Jacobson & Selving, *supra* note 292, at 436.

²⁹⁵ See *supra* notes 117–122, 164–172 and accompanying text.

²⁹⁶ Jacobson & Selving, *supra* note 292, at 436.

²⁹⁷ See *supra* notes 61–75 and accompanying text.

²⁹⁸ See Jacobson & Selving, *supra* note 292, at 436.

alternatives in the European Union, the United States should adopt a hybrid federal-state licensure system.²⁹⁹ A hybrid federal-state model would bring the patchwork of state-based standards into harmony while leaving the state medical board system relatively intact. While other hurdles exist to the nationwide proliferation of telehealth, the implementation of a hybrid federal-state model would represent an enormous stride in ushering in a new age of medicine.

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²⁹⁹ See *supra* notes 286–295.

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