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Georgia's Telemedicine Laws and Regulations: Protecting Against Health Care Access

Adelyn B. Boleman

Comment

Georgia's Telemedicine Laws and Regulations: Protecting Against Health Care Access*

I. INTRODUCTION

Georgia currently ranks 44th in the nation in terms of patient access to physicians.[1] Roughly 52% of Georgia's physicians are located in five areas that serve just 38% of the state's population.[2] However, technological advancements present opportunities to bridge the gap between physicians willing to treat patients through non-traditional means and patients simply wanting access to physicians.[3] Telemedicine, sometimes referred to as telehealth, is generally known as the use of audio, video, and other types of data communication to exchange medical information

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1. *Physician Access Index, A State-by-State Compilation of Benchmarks and Metrics Influencing Patient Access to Physicians and Advanced Practitioners*, MERRIT HAWKINS, https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Pdf/Merritt_Hawkins_Physician_Access_Index.pdf (last visited Feb. 23, 2017). This Physician Access Index, created by Merritt Hawkins, compiles thirty-three benchmarks and metrics that influence patient access to physicians by state. Each benchmark was assigned a score. Low scores correlate with positive effects on patient physician access while high scores indicate a negative effect. States were ranked from 1st to 50th based on all 33 variables. However, according to the Georgia Department of Public Health, Georgia ranks 40th in the nation in terms of adequate distribution of doctors by geographic location and specialty. *Office of Telehealth & Telemedicine*, GA. DEP'T OF PUB. HEALTH, http://dph.georgia.gov/office-telehealth-telemedicine (last visited Feb. 23, 2017). This statistic appears to be at least two years old. *Id.*

2. *Office of Telehealth & Telemedicine, supra* note 1.

3. *Id.*

from one site to another to connect healthcare professionals with patients.[4] While telemedicine can extend patient access to health care across state lines, particularly to patients in rural areas where medical care is often sparse, many states, including Georgia, currently maintain restrictive regulations and standards on telemedicine that inhibit its growth.[5]

States justify the stringent telemedicine standards as a necessary exercise of state police power to protect citizens.[6] The Tenth Amendment to the United States Constitution[7] expressly allows this state regulation by reserving for the states those powers not delegated by the Constitution nor prohibited by it to the states.[8] Thus, states have long used the Tenth Amendment as their source of power to regulate certain activities affecting the health, safety, and welfare of their citizens.[9] Specifically, states enact laws and regulations outlining the practice of medicine and the responsibility of each state's medical board to regulate such in order to protect the public from the fraudulent, unauthorized, or incompetent practice of medicine.[10] The Supreme Court of the United States has also recognized this reserved state power.[11]

However, there are legal and regulatory barriers to the growth of telemedicine on both the state and local level because of the varying state laws and regulations pertaining to its use.[12] Because the regulations of certain states stifle widespread implementation of telemedicine, some advocate for a federal licensure system for physicians using telemedicine.[13] While proponents for the state policing system argue the Tenth

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4. *About Telemedicine*, AM. TELEMEDICINE ASS'N, http://www.americantelemed.org/about/telehealth-faqs-# (last visited Feb. 23, 2017).

5. *See Office of Telehealth & Telemedicine*, *supra* note 1.

6. Bill Marino et al., *A Case for Federal Regulation of Telemedicine in the Wake of the Affordable Care Act*, 16 COLUM. SCI. & TECH. L. REV. 274, 297-98 (2015).

7. U.S. CONST. amend. X.

8. *Id.*

9. *See* Marino, *supra* note 6, at 299.

10. Jessica Sun Choi, *Mental Health Services Via Skype: Meeting the Mental Health Needs of Community College Students Through Telemedicine*, 25 S. CAL. REV. L. & SOC. JUST. 331, 345 (2016).

11. Hawker v. New York, 170 U.S. 189, 195 (1898) (determining that the states have the power to decide the qualifications necessary to practice medicine in the state); Dent v. West Va., 129 U.S. 114, 122 (1889).

12. Avery Schumacher, *Telehealth: Current Barriers, Potential Progress*, 76 OHIO ST. L.J. 409, 424 (2015) (advocating for the federal government to create a separate national licensure system for services provided through telemedicine).

13. *Id.* at 432.

Amendment constitutionally bars the federal government from regulating health care, proponents of a federal licensure system for telemedicine argue that such federal regulation is constitutional and authorized under the Commerce Clause[14] and the Taxing and Spending Clause.[15]

Many states have proposed or enacted legislation that would adopt the Federation of State Medical Board's (FSMB) Model Language for an Interstate Medical Licensure Compact (Compact).[16] While Georgia has not yet adopted the Compact, the Georgia Composite Medical Board (Board) is beginning to take steps towards eventual adoption.[17] This Compact is one attempt by states to engage in "self-help" by enacting legislation that promotes the expansion and use of telemedicine while still maintaining control of the regulatory aspects of telemedicine health care.[18] Essentially, the Compact aims to alleviate the licensing burdens of physicians without compromising the safety of patients.[19] Nonetheless, the Compact is by no means perfect.

Based on the unique nature of telemedicine, this Comment addresses the need for Georgia to adopt the FSMB Compact, loosen the rigid requirements for the establishment of a physician-patient relationship prior to a telemedicine encounter, and for Georgia to adopt a separate national standard of care for telemedicine. First, the background section provides an overview of telemedicine, Georgia's current laws and regulations governing the use of telemedicine, and problems presented by these laws and regulations. Next, these problems are assessed in the analysis section, followed by a conclusion that Georgia should adopt the Compact, loosen the rigid burden for establishing the physician-patient relationship prior to a telemedicine encounter, and adopt a separate national standard of care for services provided through telemedicine.

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14. U.S. CONST. art. I, § 8, cl. 3.

15. U.S. CONST. art. I, § 8, cl. 1; Schumacher, *supra* note 12, at 431.

16. The Nat'l Telehealth Policy Res. Ctr., *State Telehealth Laws and Medicaid Program Policies: A Comprehensive Scan of the 50 States and District of Columbia* (Mar. 2016), CTR. FOR CONNECTED HEALTH POL'Y, at 9, www.cchpca.org/sites/default/files/resources/50%20State%20FINAL%20April%202016.pdf.

17. *See Minutes of the November 6, 2016 Meeting*, GA. COMPOSITE MED. BD., at 2, http://medicalboard.georgia.gov/sites/medicalboard.georgia.gov/files/imported/GCMB/GCMB/Files/Minutes%202016-11.pdf (last visited Feb. 23, 2017).

18. *See State Telehealth Laws and Medicaid Program Policies*, *supra* note 16, at 9.

19. *See id.*

II. BACKGROUND

A. Types of Telemedicine Services

Telemedicine use began over forty years ago by hospitals providing care to patients in remote areas.[20] It is now being utilized in the operation of specialty departments, hospitals, home health agencies, consumers' homes and workplaces, as well as by private physician offices.[21] Telemedicine is not a separate medical specialty, but rather the services and products are typically part of an investment by healthcare institutions to provide advanced information technology or clinical care.[22]

Furthermore, when it comes to the reimbursement fee structure and coding for billing, there is typically no distinction made between traditional services provided on-site and services provided through means of telemedicine.[23] The American Telemedicine Association (ATA) considers "telemedicine" and "telehealth" to be interchangeable terms covering many types of remote healthcare practices.[24] Activities typically considered to be within this definition are transmissions of still images, patient consultations through video conferencing, remote monitoring of vital signs, e-health, including patient portals, continued medical education, and consumer-focused wireless applications and nursing call centers.[25] It should be noted that each state has its own definition of telemedicine, which will be addressed below.

There are three main types of telemedicine: (1) remote monitoring; (2) store-and-forward; and (3) interactive services.[26] First, remote monitoring, which is also referred to as "self-monitoring" or "self-testing," is a type of telemedicine that allows a patient to utilize various technological devices from his or her own home.[27] The data from the devices is then transmitted back to the telemedicine system.[28] This way, a physician has the ability to remotely monitor patients. This type of monitoring is used mainly for managing chronic diseases and specific conditions such as

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20. *Telemedicine Benefits*, AM. TELEMEDICINE ASS'N, http://www.americantelemed.org/main/about/about-telemedicine/telemedicine-benefits (last visited Feb. 23, 2017).

21. *About Telemedicine*, *supra* note 4.

22. *Telemedicine Glossary*, AM. TELEMEDICINE ASS'N, http://thesource.americantelemed.org/resources/telemedicine-glossary (last visited Feb. 23, 2017).

23. *Id.*

24. *Id.*

25. *Id.*

26. *What are the types of Telemedicine?*, INNOVATE US, http://www.innovateus.net/health/what-are-types-telemedicine (last visited Feb. 23, 2017).

27. *Id.*

28. *See id.*

asthma, heart disease, and diabetes mellitus.[29] These devices may be used to collect vital signs, blood tests, and electrocardiograms.[30]

Second, store-and-forward telemedicine involves one physician collecting medical data and conveying this data to a physician or medical specialist.[31] Instead of both parties having to be present together for a physical exam, this method relies on documented information or images and a history report.[32] Store-and-forward telemedicine is commonly used in the fields of dermatology, pathology, and radiology.[33] This technique can save time and provides physicians the ability to serve the public by having more say in the time for assessment.[34] However, because this technique relies on documented information and a history report, there is risk of misdiagnosis.[35]

Third, interactive telemedicine services offer concurrent interactions between physicians and patients.[36] Methods used to facilitate the communications are phone conversations, home visits, and online communication.[37] Certain evaluations can be performed through telemedicine in a similar manner as traditional face-to-face treatments, such as physical tests, history assessments, psychiatric assessments, and ophthalmology evaluations.[38] Additionally, "clinician-interactive" telemedicine services may be a less expensive alternative to personal clinical visits.[39] Interactive services can provide immediate advice to patients who require medical attention.[40]

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29. *Id.*

30. The Nat'l Telehealth Policy Res. Ctr., *Remote Patient Monitoring, What is Telehealth?*, CTR. FOR CONNECTED HEALTH POL'Y, http://www.cchpca.org/remote-patient-monitoring (last visited Feb. 23, 2017).

31. *What are the types of Telemedicine?*, *supra* note 26.

32. *Id.*

33. *Id.*

34. The Nat'l Telehealth Policy Res. Ctr., *Store and Forward, What is Telehealth?*, CTR. FOR CONNECTED HEALTH POL'Y, http://www.cchpca.org/store-and-forward (last visited Feb. 23, 2017).

35. Yolanda Smith, *Types of Telemedicine*, NEWS MED. LIFE SCIS. (June 14, 2015), http://www.news-medical.net/health/Types-of-Telemedicine.aspx.

36. *What are the types of Telemedicine?*, *supra* note 26.

37. *Id.*

38. *Id.*

39. *Id.*

40. *Types of Telemedicine*, *supra* note 35.

Accordingly, telemedicine has the ability to improve cost, efficiency, quality, and patient access to health care.[41] One telling example is the success seen with telemedicine use by the Veterans Health Administration (VHA), which first introduced telehealth programs in the 1990s.[42] Through telemedicine, the VHA had the ability to provide routine care to veterans with congestive heart failure, hypertension, diabetes, post-traumatic stress disease, depression, and chronic obstructive pulmonary disease.[43] In 2012, the VHA served over 150,000 beneficiaries through telemedicine services.[44] That year, the annual cost for the telehealth program per patient was $1,600, compared to an amount exceeding $13,000 for traditional home-based care and over $77,000 for care through nursing homes.[45] Further, telemedicine "also was associated with a 25 percent reduction in number of bed days of care and a 19 percent reduction in hospital admissions across all VHA patients utilizing telehealth."[46]

In all, the VHA estimated $6,500 in average annual savings for each patient participating in the telemedicine program in 2012 alone.[47] This amount "equates to nearly $1 billion in system-wide savings associated with the use of telehealth in 2012."[48] Additional savings come in the form of fewer lost work-days, travel avoided, and all other costs imposed upon patients.[49]

While most state Medicaid programs provide some form of coverage for telehealth services, the particular coverage criteria varies by state.[50] For example, Georgia Medicaid provides live-video reimbursement for certain services that are deemed medically necessary, not in excess of the member's needs, and procedures that are specific, individualized, and

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41. Bradley J. Kaspar, Note, *Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 857-58 (2014).

42. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, AM. HOSP. ASS'N (Apr. 22, 2016), at 2, http://www.aha.org/content/16/16telehealthissuebrief.pdf.

43. *Id.*

44. *Id.*

45. *Id.*

46. *Id.*

47. *Id.*

48. *Id.*; *see* Christopher Wasden, *The Department of Veterans Affairs Health Case Study*, HEALTHCARE INFO. & MGMT. SYS. SOC'Y (Aug. 1, 2014), http://www.himss.org/department-veterans-affairs-mhealth-case-study?ItemNumber=30310.

49. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, *supra* note 42, at 2.

50. *Id.* at 1.

consistent with symptoms or a confirmed diagnosis.[51] These eligible services for Georgia Medicaid are "professional office visits, pharmacologic management, limited office psychiatric services, limited radiological services and a limited number of other physician fee schedule services."[52] However, Connecticut Medicaid only provides live-video reimbursement for behavioral health services.[53]

A concern of policymakers is whether advancements in technology and improved access to telemedicine care will actually result in increased utilization of services, which could create additional Medicare and Medicaid program expenses.[54] This concern likely comes from the Congressional Budget Office (CBO), which has maintained a position that increasing telehealth access would increase spending as a result of higher utilization.[55] Upon Congress's authorizing limited guidelines on telehealth coverage for Medicare in 2001, the CBO estimated that, in the first five years after the law was passed, telemedicine would cost Medicare around $150 million.[56] In reality, "[s]ince 2001, [the Centers for Medicare & Medicaid Services'] Medicare reimbursement for distant site services totals $51 million and $6.5 million for originating site fees, for a total of $57.6 million over fourteen years."[57] Therefore, some dismiss the CBO's concerns regarding increased spending as overstatements.[58]

A source of research for the coming year is the 21st Century Cures Act (Cures Act),[59] signed into law on December 13, 2016, which directs both the Medicare Payment Advisory Commission (MedPAC) and the Centers for Medicare & Medicaid Services (CMS) to study current Medicare cov-

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51. *Georgia Medicaid Telemedicine Handbook*, GA. DEP'T OF COMM. HEALTH (Nov. 2012), at 3, https://www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/HANDBOOKS/georgiatelemedicine%20handbook%20v5%20final%2023-09-2014%20215055.pdf.

52. *Id.* at 2.

53. *State Telehealth Laws and Medicaid Program Policies*, *supra* note 16, at 6 (citing CT Provider Manual. Physicians and Psychiatrists, § 17b-262-342, at 9 (Aug. 2013); CT Provider Manual. Psychologists. § 17b-262-472, at 7; CT Provider Manual. Behavioral Health. § 17b-262-918, at 6 (Feb. 1, 2013)).

54. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, *supra* note 42, at 1.

55. David Pittman, *Telemedicine Fans Point to CBO's History of Cost Overestimates*, POLITICO (Dec. 21, 2015), http://www.politico.com/story/2015/12/telemedicine-fans-point-to-cbos-history-of-cost-overestimates-216915.

56. *CMS Medicare Reimburses Nearly $14 million for Telemedicine in 2014*, CTR. FOR TELEHEALTH & E-HEALTH L. (May 8, 2015), http://ctel.org/2015/05/cms-medicare-reimburses-nearly-14-million-for-telemedicine-in-2014/.

57. *Id.*

58. *Telehealth: Helping Hospitals Deliver Cost-Effective Care*, *supra* note 42, at 1.

59. Pub. L. No. 114-255 (2016).

erage of telehealth and report the findings back to the congressional committees of jurisdiction.[60] More specifically, Section 3021 of the Cures Act requires CMS to identify and report on populations of Medicare beneficiaries who would benefit most from the expansion of telehealth services under the Social Security Act,[61] as well as the types of services suitable to furnish telehealth services, and potential barriers to the expansion of telehealth services under the Social Security Act.[62]

Further, the Cures Act requires MedPAC to use quantitative and qualitative research methods to report to the committees of jurisdiction information on the particular telehealth services for which payment can be made under the fee-for-service program of title XVIII of the Social Security Act.[63] Additionally, information must be reported regarding the telehealth services for which private health insurance plans can pay, as well as the ways these service payments might be incorporated into a fee-for-service program.[64]

The Cures Act includes language demonstrating the belief of Congress that any expansion of telehealth services under Medicare should acknowledge telemedicine as a "delivery of safe, effective, quality health care services," as well as the need to "meet or exceed the conditions of coverage and payment with respect to the Medicare program" under title XVIII.[65] While the findings of CMS and MedPAC are yet to be determined, the Cures Act does seem to indicate, if nothing else, Congress' acknowledgement of the need for additional research considering the benefits and costs of expanding Medicare coverage of telehealth services.

In addition to potentially improving health care costs, telemedicine has the ability to increase patient access to health care services.[66] Rural areas around the country, notably in Georgia, experience a significant shortage of primary care physicians, with an even greater shortage of physician specialists.[67] Telehealth can expand methods of treatment access to these areas from a distance.[68] These communications improve the

60. Rebecca Burke, *What Does the Cures Act Mean for Medicare Telehealth Coverage?*, AHLA (Jan. 13, 2017), http://www.powerslaw.com/wp-content/uploads/2017/01/What-Does-the-Cures-Act-Mean-for-Medicare-Telehealth-Coverage.pdf.

61. 42 U.S.C. § 1395 ch. 7 (2012).

62. 21st Century Cures Act §§ 4012(a)(1), (3)-(4).

63. 21st Century Cures Act § 4012(b)(1) (2016).

64. 21st Century Cures Act §§ 4012(b)(2)-(3).

65. 21st Century Cures Act §§ 4012(c)(2)(A)-(B).

66. 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, 390 (2011).

67. *Id.*

68. *Telemedicine Benefits*, *supra* note 20.

clinical health status of patients because these methods allow patients to receive remote diagnoses, consultations, and treatments that would otherwise be impossible.[69] Since telemedicine has been used to reach remote areas for decades, one must ask why these rural areas are still lacking in access to health care.

B. The Federation of State Medical Boards Interstate Medical Licensure Compact

States regulate the practice of telemedicine through statutes, guidance of the attorney general, and state medical board guidance, regulations, and disciplinary actions.[70] Through legislation, many states have addressed the licensure of physicians providing these services, what establishes the physician-patient relationship, the standard of care for telemedicine, the informed consent requirements, and the ability to prescribe prescriptions based on a telemedicine encounter.[71] In fact, during the 2016 legislative session, 44 states introduced over 150 telehealth-related pieces of legislation.[72]

One organization that has been integral in this surge of telemedicine-related legislation is the Federation of State Medical Boards.[73] The FSMB is a non-profit based in Washington, D.C. and is comprised of roughly seventy medical boards and regulatory agencies.[74] As part of its role, the FSMB assists state medical boards in developing medical regulations that both promote quality health care and protect the public.[75] Additionally, the FSMB advocates for initiatives that promote regulatory best practices, patient safety, and quality health care.[76]

A compact is a legal agreement between states that allows the involved states to work together collectively to confront shared needs and issues.[77] While states may not enter into treaties, states may enter into compacts

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69. *See id.*

70. *See State Telehealth Laws and Medicaid Program Policies*, *supra* note 16.

71. *See id.*

72. *Id.* at 10.

73. *About FSMB: Promoting Excellence in Medical Practice, Licensure, and Regulation*, FED'N OF STATE MED. BDS., http://www.fsmb.org/about-fsmb/fsmb-overview (last visited Feb. 23, 2017).

74. *Id.*

75. *Id.*

76. *Id.*

77. *U.S. Medical Regulatory Trends and Actions*, FED'N OF STATE MED. BDS., at 6, https://www.fsmb.org/Media/Default/PDF/FSMB/Publications/us_medical_regulatory_trends_actions.pdf (last visited Feb. 23, 2017).

or agreements with other states, and these compacts must be upheld unless incompatible with the U.S. Constitution.[78] The Compact Clause of the U.S. Constitution[79] authorizes the creation of such compacts.[80] Thus, as long as the joint state activity is not incompatible with federal authority, states have the ability to grant each other immunity or to acknowledge established limits on liability.[81]

Some driving factors for the FSMB's acknowledgement of the need for a Compact have been physician shortages, the influx of millions of new patients as a result of the Affordable Care Act,[82] and the ever increasing need to expand health care access for individuals in rural areas.[83] In April 2013, the FSMB began to formally explore the use of an Interstate Compact for Physician Licensure.[84] By September 2014, the FSMB completed the drafting process for model legislation to create such a compact.[85] On May 19, 2015, Alabama became the seventh state to enact the Compact, which triggered the formation of the Interstate Medical Licensure Compact Commission (Compact Commission).[86]

Currently, eighteen states are part of the Compact, while Arkansas, Michigan, Nebraska, North Dakota, and Washington have introduced legislation pertaining to Compact adoption.[87] In June 2016, the U.S. Health Resources and Services Administration, a U.S. Department of

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78. New York v. O'Neill, 359 U.S. 1, 11-12 (1959).

79. U.S. CONST. art. I, § 10, cl. 3 (providing that "[n]o State shall, without the Consent of Congress, [. . .] enter into any Agreement or Compact with another State, or with a foreign Power. . .").

80. *U.S. Medical Regulatory Trends and Actions*, *supra* note 77.

81. Nevada v. Hall, 440 U.S. 410, 426-27 (1979).

82. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

83. *Frequently Asked Questions about the Interstate Medical Licensure Compact*, INTERSTATE MED. LICENSURE COMPACT, at 2, http://www.licenseportability.org/faq/ (last visited Feb. 23, 2017).

84. *Federation of State Medical Boards to Explore Use of Interstate Compact for Physician Licensure*, FED'N OF STATE MED. BDS. (Feb. 7, 2013), http://www.licenseportability.org/assets/pdf/fsmb_news_rrelease_multistate_compacts.pdf.

85. *Interstate Medical Licensure Compact Ready for Consideration by States*, FED'N OF STATE MED. BDS. (Sept. 5, 2014), http://www.fsmb.org/Media/Default/PDF/Publications/FSMB_statement_on_final_compact_09032014FINAL.pdf.

86. *Interstate Medical Licensure Compact Established with Seventh State Enactment; Formation of Compact Commission Triggered*, FED'N OF STATE MED. BDS. (May 19, 2015), http://www.licenseportability.org/assets/pdf/5192015_Seven_States_Enact_Compact.pdf.

87. *About the Compact*, INTERSTATE MED. LICENSURE COMPACT, http://www.licenseportability.org/ (last visited Feb. 23, 2017). These states are: Alabama, Arizona, Colorado, Idaho, Illinois, Iowa, Kansas, Minnesota, Mississippi, Montana, Nevada, New Hampshire, Pennsylvania, South Dakota, Utah, West Virginia, Wisconsin, and Wyoming. *Id.* at 1.

Health and Human Services agency, announced that it would provide funding to the FSMB in the amount of a $750,000 grant to aid the FSMB in managing the Compact and support educational outreach to expand participation in the Compact by other states.[88] This funding began in July 2016, and the grant is to be dispersed over the course of three years.[89]

The Compact is developing its administrative process for expedited licensure, and it will soon be available.[90] Essentially, the Interstate Medical Licensure Compact provides a new, voluntary pathway for qualified physicians to obtain licensure in multiple states, while also increasing patient-access to physicians in rural and underserved areas by allowing them the opportunity to be treated by physicians through telemedicine technologies.[91] The Compact streamlines the process for a physician to obtain multiple state medical licenses by requiring the states participating in the Compact to formally adopt common procedures and rules.[92] As a result, the time it traditionally takes to obtain a license is significantly reduced.[93]

However, while the Compact expedites the process for physicians to obtain licensure to practice in multiple states, the Compact also enhances the ability of states to collaborate and share disciplinary and investigative information, thereby strengthening protection of the public.[94] The Compact Commission assists with administration of the Compact.[95] It is estimated that roughly 80% of physicians possessing a United States medical license could be eligible to use the Compact process for expedited licensure.[96]

In order to be eligible for expedited licensure, a physician: (1) must possess an unrestricted and full license to practice medicine in a participating Compact state, (2) must possess either specialty certification or a time unlimited specialty certificate, (3) cannot have discipline on any

88. *Federal Grant Awarded to Support State Medical Boards in Implementing Interstate Medical Licensure Compact*, FED'N OF STATE MED. BDS. (June 17, 2016), http://licenseportability.org/wp-content/uploads/2016/06/Compact-HRSA-Grant_June-2016_ FINAL.pdf.

89. *Id.*

90. *About the Compact*, *supra* note 87.

91. *Id.*

92. *U.S. Medical Regulatory Trends and Actions*, *supra* note 77, at 7.

93. *Id.*

94. *Id.* at 6.

95. *Id.* at 7.

96. *Expanding Access, Protecting Patients: The Interstate Medical Licensure Compact*, INTERSTATE MED. LICENSURE COMPACT (May 2016), http://licenseportability.org/wp-content/uploads/2016/05/InterstateCompactMay24_2016.pdf.

state medical license, (4) cannot have discipline relating to controlled substances, (5) must not be under investigation by any law enforcement or licensing agency, and (6) must have successfully completed a graduate medical education program.[97] If a physician cannot meet these requirements, the physician still has the option of obtaining a license to practice medicine in a member state if the physician follows all laws and requirements, except the Compact, pertaining to the issuance of a license necessary to practice medicine within that state.[98]

This is because the Compact does not otherwise change each state's Medical Practice Act or the licensure process.[99] Even though the Compact Commission creates and enforces rules in order to govern the processes of the Compact, each state retains authority to issue licenses, investigate complaints brought before the state board, and discipline physicians practicing within that state.[100] Thus, physicians who do not qualify for a Compact license or who do not wish to engage in practices in multiple jurisdictions may continue to use the traditional licensing process.[101]

Additionally, each Compact state retains the ability to set practice standards.[102] Nonetheless, in April 2014, the FSMB adopted a Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine (Model Policy) with the goal of providing guidance to state medical boards in assessing care utilizing telemedicine.[103] The Model Policy confronts many concerns of state medical boards involving telemedicine practices, including the appropriate online medical care, HIPAA compliance and patient privacy, physician-patient relationships, and prescribing drugs based on a telemedicine encounter.[104] Since its implementation, many state boards of medicine have adopted portions of the Model Policy.[105] However, just as issues remain for states that have not yet

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97. *Model Legislation for an Interstate Medical Licensure Compact*, INTERSTATE MED. LICENSURE COMPACT, at 3, http://www.licenseportability.org/assets/pdf/Interstate-Medical-Licensure-Compact-(FINAL).pdf (last visited Feb. 23, 2017).

98. *Id.* at 4.

99. *About the Compact*, *supra* note 87.

100. *U.S. Medical Regulatory Trends and Actions*, *supra* note 77, at 6, 8.

101. *Id.* at 7.

102. *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, FED'N OF STATE MED. BDS., at 2, www.fsmb.org/Media/Default/PDF/FS MB/Advocacy /FSMB _Telemedicine_Policy.pdf (last visited Feb. 23, 2017).

103. *Id.* at 1.

104. *Id.* at 2.

105. *See* Latoya Thomas, *State Telemedicine Gaps Analysis, Physician Practice Standards & Licensure*, AM. TELEMEDICINE ASS'N (Jan. 2016), http://www.mtelehealth.com/50-state-telemedicine-gaps-analysis-physician-practice-standards-licensure/ [hereinafter *State Telemedicine Gaps Analysis*].

adopted the Compact, physician-patient relationship and standard of care issues remain present for states that have adopted the Compact.

C. State-Specific Regulations for Telemedicine

1. Licensing

Most state medical boards consider a provider of telemedicine services to be practicing medicine in the state in which the patient is located at the time of the services, even if the physician has no actual physical presence within the state.[106] For example, Georgia's telemedicine statute provides:

> A person who is physically located in another state [. . .] who, through the use of any means, including electronic, radiographic, or other means of telecommunication, through which medical information or data are transmitted, performs an act that is part of a patient care service located in this state, [. . .], and that would affect the diagnosis or treatment of the patient is engaged in the practice of medicine in [Georgia].[107]

Georgia therefore requires a physician located outside of Georgia who diagnoses or treats patients within the state to have a license to practice medicine in Georgia and be subject to Georgia board regulations.[108]

A telemedicine report released by the American Telemedicine Association (ATA) early in 2016 focused on physician practice standards and licensure by analyzing the policy landscape of all fifty states and each state's differing telemedicine policies.[109] Specifically, the ATA assessed each state's licensure requirements for telemedicine providers located out-of-state, including physician-to-physician consultation exemptions, reciprocity for bordering states, and conditional telemedicine licenses.[110]

There are many discrepancies between states' regulations. For example, while many states allow a telemedicine encounter to establish the physician-patient relationship, Texas and Arkansas have adopted practice standards with higher specifications for a telemedicine encounter

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106. *See id.* For example, the State Medical Board of Ohio deems medical services provided through telemedicine to take place in the state in which the patient is located. *State Medical Board of Ohio Position Statement on Telemedicine*, STATE MED. BD. OF OHIO, http://med.ohio.gov/DNN/PDF-FOLDERS/Prescriber-Resources-Page/Telemedicine/Telemedicine-Position-Statement.pdf (last visited Feb. 23, 2017).

107. O.C.G.A. § 43-34-31(a) (2012).

108. *Id.*

109. *See State Telemedicine Gaps Analysis*, *supra* note 105.

110. *Id.*

than in-person care.[111] However, Arkansas stands alone as the only state requiring an in-person visit prior to most telemedicine encounters.[112] Washington D.C., Maryland, New York, and Virginia are the only states that include language within their regulations that permits licensure reciprocity from bordering states.[113] Furthermore, only nine states extend a conditional or telemedicine license to out-of-state physicians.[114] It should be noted that, while Georgia ranks lower in health care access than all of these states other than Nevada and New Mexico, Georgia extends no such license to out-of-state physicians.[115]

Additionally, Georgia is one of two states that require an in-person follow-up after a telemedicine encounter.[116] This "requirement" is loosely written to require the physician, physician assistant, or nurse practitioner who provided the treatment or care through telemedicine means to make a diligent effort to ensure the patient is seen for an in-person follow-up by a Georgia licensed physician, physician assistant, or nurse practitioner annually, if not more frequently.[117]

Further, of the eighteen Compact states, only three have lower ratings than Georgia in terms of patient access to physicians,[118] while three states ranked in the top ten are Compact states.[119] State treatment of

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111. *See* 22 TEX. ADMIN. CODE § 172.12 (2016); Arkansas 2015 Regular Session Act 887, *available at* http://www.arkleg.state.ar.us/assembly/2015/2015R/Acts/Act887.pdf (last visited Feb. 23, 2017). In Arkansas, in order for a "professional relationship" to be established under this subsection between a healthcare professional and a patient, Arkansas requires that either (1) the healthcare professional has conducted an in-person examination at a prior time and is available to administer the appropriate follow-up care when necessary; (2) the healthcare professional personally know the patient; (3) the treatment is conducted upon or by the referral of another physician; (4) a type of on-call or cross-coverage arrangement has been set up with the patient's regular healthcare provider; (5) another type of permissible relationship exists, as defined by the Arkansas State Medical Board; (6) or a relationship exists under other circumstances as defined by either a certification or licensing board for other healthcare professionals. *Id.*

112. ARK. CODE ANN. § 17-80-118(a)(4) (2016).

113. *See State Telemedicine Gaps Analysis*, *supra* note 105, at 11.

114. *Id.* These states are Alabama, Louisiana, Minnesota, Nevada, New Mexico, Ohio, Oregon, Tennessee, and Texas. *Id.* For example, Louisiana's statute pertaining to telemedicine licenses provides that "[t]he board shall issue a telemedicine license to allow the practice of medicine across state lines to an applicant who holds a full and unrestricted license to practice medicine in another state or territory of the United States." LA. STAT. ANN. § 37:1276.1(A) (2012).

115. *Office of Telehealth & Telemedicine*, *supra* note 1.

116. GA. COMP. R. & REGS. 360-3-.07 (2014).

117. *Id.*

118. *Physician Access Index*, *supra* note 1, at 10. These states are Montana, Mississippi, and Nevada. *Id.*

119. *Id.* These states are New Hampshire, Minnesota, and Pennsylvania. *Id.*

laws governing medical malpractice in the telemedicine context also lacks consistency.

2. Malpractice

Medical malpractice law is meant to protect patients from substandard medical care and provide a means of compensation for patients whose care, or lack thereof, falls below this standard.[120] Under Georgia law, there are three elements required to establish liability in an action for medical malpractice: (1) a duty inherent in the physician-patient relationship, (2) a breach of this duty by the physician failing to use the requisite level of care and skill, and (3) that such failure proximately causes the injury sustained.[121] For purposes of this Comment, focus will be placed on the first two elements.

a) The Creation of the Physician-Patient Relationship through Telemedicine

The FSMB Model Policy recommends that, for telemedicine encounters, all states adopt language that the physician-patient relationship be established once the physician agrees to diagnose and treat a patient and the patient subsequently agrees to be so treated.[122] Each state, nevertheless, maintains the power to determine what establishes the relationship on its own.[123] Establishing this relationship based on a telemedicine consultation may be a more difficult endeavor for a plaintiff-patient than would be the case in a traditional in-person encounter.[124]

While the records for many cases involving telemedicine have been sealed, those still available demonstrate the variability among states when addressing the physician-patient relationship in a telemedicine encounter.[125]

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120. Michelle Lewis et al., *The Locality Rule and the Physician's Dilemma: Local Medical Practices vs the National Standard of Care*, 297 JAMA 2633, 2634 (June 20, 2007), http://jamanetwork.com/journals/jama/fullarticle/207496.

121. Zwiren v. Thompson, 276 Ga. 498, 499, 578 S.E.2d 862, 864 (2003); *see* O.C.G.A. § 51–1–27 (2012).

122. Lisa Jones et al., *Barriers to the Interstate Practice of Telemedicine*, DUKE UNIV. PRACTICUM, at 9, http://healthitnow.org/wp-content/uploads/2014/09/Duke-UniversityTelemedicine-Study.pdf (last visited Feb. 23, 2017).

123. *See id.*

124. *See State Telemedicine Gaps Analysis*, *supra* note 105, at 7-8.

125. *See* Kelley v. Middle Tenn. Emergency Physicians, P.C., 133 S.W.3d 587, 596-97 (Tenn. 2004); *see also* Miller v. Sullivan, 625 N.Y.S.2d 102, 104 (N.Y. App. Div. 3d Dep't 1995).

For example, in *Kelley v. Middle Tennessee Emergency Physicians, P.C.*,[126] the Supreme Court of Tennessee held that due to the increasing complexity of the health care system in the United States, in which patients routinely are diagnosed by specialists or other consulting physicians without a face-to-face encounter, it was unrealistic "to apply a narrow definition of the physician-patient relationship in determining whether such a relationship exists for purposes of a medical malpractice case."[127] In this case, the issue was whether a physician-patient relationship was established between the plaintiff and one of the defendant physicians simply by the physician speaking with another physician on the telephone and providing treatment advice.[128] The court held that the physician-patient relationship can be implied when a physician affirmatively undertakes or affirmatively participates in the diagnosis or treatment of a person.[129]

In *Miller v. Sullivan*,[130] the Supreme Court of New York, Appellate Division, held that, though a physician rendered professional services to an individual directly over the phone, a physician-patient relationship was not established due to what the "patient" did with the information.[131] Here, there was "evidence that during the telephone conversation decedent stated that he thought he was having a heart attack because he was sweaty, had back pain and was having trouble breathing."[132] While the plaintiff claimed the defendant told the decedent to come see him immediately, it was undisputed that the telephone conversation took place between the hours of 9:30 A.M. and 10:00 A.M. and the decedent did not immediately go to the defendant's office.[133] Rather, the decedent left his own office in the early afternoon and "went into cardiac arrest within minutes after he arrived at defendant's office."[134] The court determined that assuming professional services are rendered when a physician tells a caller to come to his office right away, there was evidence that in this case, the caller did not accept the professional services by not coming in right away.[135] By choosing to pursue a different course of conduct than that recommended by the defendant, the court held that it was evidenced

126. 133 S.W.3d 587 (Tenn. 2004).
127. *Id.* at 596.
128. *Id.* at 588-91.
129. *Id.*
130. 625 N.Y.S.2d 102 (N.Y. App. Div. 1995).
131. *Id.* at 104.
132. *Id.*
133. *Id.*
134. *Id.*
135. *Id.*

that the decedent did not rely on the defendant's advice.[136] Further, it was not reasonably foreseeable that the caller would ignore the physician's advice and wait several hours before seeking medical treatment, despite believing he was having a heart attack.[137] Therefore, the court held that the evidence was insufficient as a matter of law to prove the creation of a physician-patient relationship based on the telephone call between the decedent and the defendant.[138]

In *White v. Harris*,[139] the parents of a child who committed suicide sued the medical provider, which employed a psychiatrist who was briefly involved with the child's case through a telepsychiatry research study.[140] Ultimately, the Supreme Court of Vermont held that there was a physician-patient relationship between the parties, which warranted a duty of care.[141] In coming to this conclusion, the court assessed the scope of the interactions between the parties.[142] While the consultation between the parties was only ninety minutes, a confidentiality agreement was signed, "and the doctor stated in writing that the scope of his services was limited," the court found that there was "no dispute that the doctor performed a psychiatric evaluation of decedent, following which the doctor offered recommendations for decedent's treatment."[143] Further, "the record reveal[ed] the parties' expectation that the doctor would aid in decedent's treatment through his expertise" and provide a diagnostic impression and recommendations, regardless of the mechanism of doctor-patient contact.[144] Though the "decedent's medical records may not have been provided to the doctor, the doctor was provided with a very recent medical evaluation of decedent performed by another doctor, which was supplemented by additional information about decedent from decedent's treatment team."[145] Therefore, the court held that the services provided were within "the scope of the professional relationship from which defendant's duty arose and it help[ed] to frame the applicable standard of care."[146] Accordingly, the court found a duty of care existed.[147]

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136. *Id.*
137. *Id.*
138. *Id.*
139. 36 A.3d 203 (Vt. 2011).
140. *Id.* at 204.
141. *Id.*
142. *Id.* at 206.
143. *Id.*
144. *Id.*
145. *Id.*
146. *Id.*
147. *Id.*

Providing an additional wrinkle for establishing the physician-patient relationship, nineteen states currently have some form of an informed consent requirement.[148] Many of these states indicate the type of information a provider must convey to a patient, regarding the telemedicine services, prior to obtaining the patient's consent.[149] For example, prior to providing telemedicine services, Texas law requires that physicians provide their patients with notices regarding telemedicine medical services.[150] The section gives examples of the types of information that should be communicated, such as "the risks and benefits of being treated via telemedicine, how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure."[151] Further, a presumption of notice is established by a signed and dated notice.[152]

Under Georgia law, a malpractice action requires a duty on the part of a physician.[153] For there to be a duty on the part of the physician, a physician-patient relationship must exist because this consensual relationship is what establishes a legal duty to exercise a specific standard of care.[154] A consensual relationship is formed where a patient knowingly seeks a physician's assistance and the physician knowingly accepts the individual as a patient.[155] However, due to the unique nature of telemedicine encounters, Georgia details the specific circumstances under which a physician-patient relationship can be established through telemedicine.[156]

Though Arkansas and Texas have the most stringent clinical practice standards for providers of telemedicine services as compared to traditional in-person practice, Georgia is close behind.[157] While some states simply allow the physician-patient relationship to be established through the telemedicine encounter without a prior in-person examination, Georgia requires this prior, in-person exam, unless one of four exceptions is

148. *State Telemedicine Gaps Analysis*, *supra* note 105, at 9.

149. *See* Lisa Robin, *New Horizons in Medical Regulation: Successful Strategies for a Changing Health Care Environment*, FSMB 2016 ANNUAL MEETING, FED'N OF STATE MED. BDS., http://www.fsmb.org/Media/Default/PDF/FSMB/Education/RobinAnnual_Meeting_Telemedicine_Presentation.pdf (last visited Feb. 23, 2017).

150. 22 TEX. ADMIN. CODE § 174.5(b) (2015).

151. *Id.*

152. *Id.*

153. Bradley Ctr., Inc. v. Wessner, 250 Ga. 199, 200, 296 S.E.2d 693, 695 (1982).

154. *Id.*

155. Anderson v. Houser, 240 Ga. App. 613, 615, 523 S.E.2d 342, 345 (1999).

156. *See* GA. COMP. R. & REGS. 360-3-.07(a)(3) (2014).

157. *See State Telemedicine Gaps Analysis*, *supra* note 105, at 8.

met: (1) the provider has examined or seen the patient in-person previously and provides ongoing care by electronic means; (2) the services are provided at the request of a practitioner who has personally seen and examined the patient in Georgia; (3) the physician is providing care at the request of a Public Health Nurse, a Public School Nurse, the Department of Family and Children's Services, or a member of law enforcement; or (4) the physician is capable of examining the patient using technological means equal to or superior to a personal exam by a provider within the provider's standard of care.[158] A plaintiff must thereafter establish that the physician failed to exercise the requisite level of skill and care.[159]

b) Telemedicine Standard of Care

Under Georgia law, after a physician-patient relationship is established, a physician owes a duty to exercise the requisite standard of care.[160] If Georgia adopts the Model Policy, issues will remain regarding the standard of care for telemedicine encounters. This is because, while the Model Policy ultimately recommends that consultations and treatment made in an online setting be held to the same standards of acceptable practice as in the traditional in-person settings and encourages physicians to comply with nationally recognized standards and codes of ethics for online health services, it is ultimately for the states to decide.[161]

Many states do, in fact, require the same standard of care for telemedicine encounters as in traditional in-person encounters.[162] Twenty-nine boards, including Georgia's, require the same standard of care for telemedicine encounters as is required for traditional face-to-face encounters.[163] For example, in Alabama, a Compact state, medical care such as treatment, evaluations, and consultation recommendations made

158. GA. COMP. R. & REGS. 360-3-.07(a)(3)(a)-(d) (2014).

159. *Zwiren*, 276 Ga. at 499, 578 S.E.2d at 864; *see* O.C.G.A. § 51-1-27 (2016).

160. *See* Med. Ctr. of Cent. Ga., Inc. v. Landers, 274 Ga. App. 78, 84, 616 S.E.2d 808, 813-14 (2005).

161. *See generally Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, *supra* note 102, at 7.

162. *See, e.g.*, MISS. CODE ANN. § 83-9-353(2) (2014) ("Treatment recommendations made via electronic means shall be held to the same standards of appropriate practice as those in traditional provider-patient setting."); COLO. REV. STAT. ANN. § 10-16-123(2) (2017) ("Any health benefits provided through telemedicine shall meet the same standard of care as for in-person care."); DEL. CODE ANN. tit. 24, § 1769D(c) (2016); W. VA. CODE ANN. § 30-14-12d(e) (LexisNexis 2016); LA. STAT. ANN. § 37:1271(B)(2)(a) (2016); ALA. CODE § 34-22-83(c) (LexisNexis 2014); TENN. CODE ANN. § 63-1-155(c)(1)(A) (2015); VT. STAT. ANN. tit. 18, § 9361(a) (2012); N.H. REV. STAT. ANN. § 329:1-d(V)(a) (LexisNexis 2016); N.H. REV. STAT. ANN. § 326-B:2(XII)(e) (LexisNexis 2016).

163. Robin, *supra* note 149, at 6; *see* GA. COMP. R. & REGS. 360-3-.07(f).

through telemedicine means, including prescription issuance, is held to the same practice standards as is the case in traditional in-person clinical settings.[164] In the Alabama Code, the only standard of care that actually references telemedicine services relates to optometric encounters.[165]

Georgia's regulations specifically indicate that physicians practicing by electronic means are held to the same standard of care as physicians engaging in traditional, in-person medical care.[166] The issue is that the standards of care for traditional in-person encounters vary by state.[167] This presents problems when care is provided and received from different states.

Under Georgia law, physicians must exercise a reasonable degree of care and skill in the practice of medicine.[168] Situations in which care provided falls short of this standard and an injury results create a tort for which recovery may be sought.[169] This reasonable degree of care and skill has been interpreted to encompass the level that the medical profession ordinarily employs under similar conditions and like circumstances, for which an expert witness must attest.[170]

Thus, because Georgia law uses the same standard of care for a telemedicine encounter as is used for the traditional in-person encounter, physicians utilizing telemedicine are held to the similar conditions and like circumstances standard of care.[171] The Georgia Supreme Court has defined this standard of care as that which is ordinarily administered by

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164. ALA. ADMIN. CODE r. 630-X-13-.02(3) (2016).

165. *Id.* This Alabama standard is providing "patient care that is less than the generally accepted standard of care." ALA. ADMIN. CODE r. 630-X-12-.06 (1990). The Alabama Code considers this as the failure of health-care provider "to exercise such reasonable care, skill, and diligence as other similarly situated health care providers in the same general line of practice ordinarily have and exercise in a like case." ALA. CODE § 6-5-548(a) (1975); *see* Morgan v. Publix Super Markets, Inc., 138 So. 3d 982, 986 (Ala. 2013).

166. GA. COMP. R. & REGS. 360-3-.07(f).

167. *See* Robin, *supra* note 149, at 6.

168. *See* O.C.G.A. § 51-1-27 ("Any injury resulting from a want of such care and skill shall be a tort for which a recovery may be had."). Similarly, in Florida the standard of care is the same "regardless of whether a Florida licensed physician or physician assistant provides health care services in person or by telemedicine." FLA. ADMIN. CODE ANN. r. 64B8-9.0141(2).

169. O.C.G.A. § 51-1-27.

170. Smith v. Finch, 285 Ga. 709, 711, 681 S.E.2d 147, 149 (Ga. 2009); Kapsch v. Stowers, 209 Ga. App. 767, 767, 434 S.E.2d 539, 540 (1993).

171. *See* GA. COMP. R. & REGS. 360-3-.07(f); *see also* O.C.G.A. § 51-1-27.

the medical profession generally under similar conditions and like circumstances, and not that which one individual physician believed should have been done under the circumstances.[172]

For example, in *Johnson v. Riverdale Anesthesia Associates*,[173] Dr. Lawhead was accused of committing medical malpractice for failing to administer pure oxygen prior to surgery on Claire Johnson.[174] Ultimately, the Georgia Court of Appeals held that it was not an abuse of discretion for the trial court to exclude evidence of whether or not defendants' medical expert, Dr. Robert Caplan, would have pre-oxygenated Johnson.[175] In so concluding, the court explained that, in a medical malpractice action, it is the standard of care utilized by the medical profession generally that is relevant, rather than what an individual medical expert would recommend or would have done in the situation.[176] Further, the court added that it is within the discretion of the trial court to determine whether evidence is relevant to the standard of care or whether the court should exclude such evidence as unduly prejudicial or irrelevant.[177]

Additionally, the plaintiffs asserted it was an abuse of the trial court's discretion to rule that the defendants had not opened the door for this type of testimony based on questioning their own witness regarding the matter.[178] In support of this assertion, the plaintiffs referred to the testimony of Dr. Caplan, in which he stated that Dr. Lawhead could have in no way made "it safer for Johnson to have the anesthesia."[179] The plaintiffs had objected to this testimony and the trial judge emphasized that the plaintiffs had the liberty to question Dr. Caplan about whether Dr. Caplan believed administering pure oxygen prior to surgery would have made any difference in Johnson's case.[180] The trial judge further explained that the ruling in limine, instead, merely prohibited either party from questioning Dr. Caplan as to whether he would have personally pre-

172. *See Smith*, 285 Ga. at 711, 681 S.E.2d at 149; Johnson v. Riverdale Anesthesia Assocs., 249 Ga. App. 152, 152, 547 S.E.2d 347, 348 (2001), *judgment aff'd*, 275 Ga. 240, 563 S.E.2d 431 (2002), *overruled on other grounds by*, Condra v. Atlanta Orthopaedic Grp., 285 Ga. 667, 681 S.E.2d 152 (2009).

173. 249 Ga. App. 152, 547 S.E.2d 347 (2001), *judgment aff'd*, 275 Ga. 240, 563 S.E.2d 431 (2002), *overruled on other grounds by*, Condra v. Atlanta Orthopaedic Grp., 285 Ga. 667, 681 S.E.2d 152 (2009).

174. *Id.* at 153, 547 S.E.2d at 348.

175. *Id.*

176. *Id.*

177. *Id.*

178. *Id.* at 153, 547 S.E.2d at 349.

179. *Id.*

180. *Id.*

oxygenated Johnson.[181] Thus, because Dr. Caplan's testimony did not include testimony of what he would have personally done, the Georgia Court of Appeals found no abuse in the ruling of the trial court.[182]

It should be noted, however, that the court will take locality and community standards into consideration. For example, in *West v. Breast Care Specialists, LLC*,[183] the plaintiff argued that the trial court should have stricken testimony of one of the defendant's medical experts, William Barber, M.D., because his medical opinion was based upon "the standard of care of surgeons under like circumstances and similar conditions in the metropolitan Atlanta area."[184] This argument by the plaintiff was based on Barber's testimony during cross-examination about his standard of care definition.[185]

During cross-examination, Barber testified that, to him, "standard of care" is defined as "the management of a patient as deemed appropriate by what would be considered reasonable standards within that community."[186] The court determined that, in cases requiring medical testimony, a jury is permitted to consider evidence and a medical expert is permitted to testify as to the practice standards in the specific locality or community where treatment of an injury takes place as long as the medical expert is qualified and familiar with the standards of care that the profession generally considers to represent a reasonable degree of care and skill.[187] Ultimately, the court held it was for the jury to determine what weight to place on the evidence.[188] While Georgia applies a "similar conditions and like circumstances" standard of care, several states still apply a locality rule.[189] Louisiana applies a modified rule, holding general practitioners to a community standard and specialists to a national standard.[190]

Interestingly, some of these states utilizing the locality rule are, in fact, among the states that require the same standard of care for a tele-

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181. *Id.*

182. *Id.*

183. 290 Ga. App. 521, 659 S.E.2d 895 (2008).

184. *Id.* at 523-24, 659 S.E.2d at 897.

185. *Id.* at 524, 659 S.E.2d at 897-98.

186. *Id.* at 524, 659 S.E.2d at 898.

187. *Id.*

188. *Id.*

189. *See* Lewis, *supra* note 120. These states are Arizona, Idaho, Washington, New York, Virginia, and Tennessee. *See, e.g.*, WASH. REV. CODE ANN. § 7.70.040 (2011); *see also* IDAHO CODE ANN. § 6-1012 (1976).

190. Ray v. Ameri-Care Hosp., 400 So. 2d 1127, 1138 (La. App. 1st Cir.), *writ denied*, 404 So. 2d 277 (La. 1981) (holding that specialists are subject to a higher standard of care than general physicians practicing in the same community).

medicine encounter as that of a traditional in-person encounter—meaning the locality rule is used for telemedicine encounters.[191] New York is one of these states.[192] The New York Department of Health addressed the standard of care directly by indicating that just because an electronic medium is used for an interaction between a physician and a patient does not mean that the standards of care applicable to the encounter change in the least.[193] Rather, in telemedicine encounters, New York applies all the existing standards of care for the practice of medicine.[194] Further, two of the states that apply the locality rule are part of the FSMB Compact.[195]

A standard of care based on locality requires that an expert testifying be from the defendant's same community and compare the actions of a physician to the applicable standard in the community or locality in which health care services are provided.[196] This "locality" or "community" may be defined by a small geographic area or the entire state in which the standard applies.[197] For instance, Washington's standard holds a health care provider to the reasonable degree of skill, care, and learning "of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances. . . ."[198]

In comparison, in Idaho, a Compact state, medical malpractice requires a plaintiff to prove that the defendant negligently failed to meet the requisite standard health care practice of the community from where such care was given or should have been provided.[199] Courts have interpreted this to mean that liability under Idaho law hinges upon whether the physician exercised the level of care and skill that is ordinarily employed by physicians and surgeons in the same or a similar locality or

191. *See, e.g.*, *Statements on Telemedicine Board for Professional Medical Conduct*, N.Y. STATE DEP'T OF HEALTH, https://www.health.ny.gov/professionals/doctors/conduct/telemedicine.htm#notes (last visited Feb. 7, 2017).

192. *Id.*

193. *Id.*

194. *Id.*

195. *See About the Compact*, *supra* note 87. These states are Idaho and Arizona. *Id.*

196. Sheeley v. Mem'l Hosp., 710 A.2d 161, 165 (R.I. 1998); *see, e.g.*, WASH. REV. CODE ANN. § 7.70.040; *see also* IDAHO CODE ANN. § 6-1012.

197. *See* WASH. REV. CODE ANN. § 7.70.040(1) (2011); *see also* IDAHO CODE ANN. § 6-1012.

198. WASH. REV. CODE ANN. § 7.70.040(1).

199. IDAHO CODE ANN. § 6-1012.

community, in light of scientific knowledge of and professional advancement in the subject.[200] The section defines "community" as the geographical area typically served by the hospital in the area or that nearest to where the disputed care, or lack there of, was provided.[201] If there is no similar provider in the community, rendering the "community" standard of care indeterminable, Idaho allows evidence of the standard utilized at the time in similar Idaho communities.[202]

The locality rule can be traced back to a series of cases from the 1800s.[203] As a product of the United States, the locality rule was created as a way to protect small town practitioners who were presumed to possess less information and experience than physicians from large cities.[204] This is evidenced by one of the early cases discussing the locality standard, *Tefft v. Wilcox*.[205] In *Tefft*, the Supreme Court of Kansas determined that those who practice medicine and surgery in smaller towns do not have the same opportunities for exposure as physicians practicing in metropolitan areas, and therefore, the physicians in rural areas should not be held to such a high standard and be expected to practice such a high level of skill and possess the level of knowledge as those with better facilities and greater exposure.[206] Thus, the court refused to impose upon rural physicians such a high standard.[207]

Even in the 1970s, courts recognized that, because of significant technological advancements and standardization in training, the locality rule

200. Kingston v. McGrath, 232 F.2d 495, 498 (9th Cir. 1956); Flock v. J. C. Palumbo Fruit Co., 118 P.2d 707, 711 (Idaho 1941). Though more broad, Washington requires a plaintiff to demonstrate that "[t]he health care provider failed to exercise that degree of care, skill, and learning expected of a reasonably prudent health care provider at that time in the profession or class to which he or she belongs, in the state of Washington, acting in the same or similar circumstances. . . ." WASH. REV. CODE ANN. § 7.70.040(1).

201. IDAHO CODE ANN. § 6-1012.

202. *Id.*

203. *See, e.g.*, Leighton v. Sargent, 7 Fost. 460 (N.H. 1853); Tefft v. Wilcox, 6 Kan. 46 (1870); Smothers v. Hanks, 11 Am. Rep. 141 (Iowa 1872) (per curiam); Hathorn v. Richmond, 48 Vt. 557 (1876), Small v. Howard, 35 Am. Rep. 363 (Mass. 1880).

204. Shilkret v. Annapolis Emergency Hosp. Ass'n, 349 A.2d 245, 248 (Md. 1975).

205. 6 Kan. 46 (1870).

206. *Id.* at 63-64.

207. *See id.* at 64.

no longer makes sense and is too narrow.[208] Acknowledging these advancements, some states have moved to a national standard of care.[209] For example, at one time, a "similar locality" rule governed the admissibility of expert testimony in Rhode Island medical malpractice actions.[210] This standard looked at "the same degree of diligence and skill which is commonly possessed by other members of the profession who are engaged in the same type of practice in similar localities having due regard for the state of scientific knowledge at the time of treatment."[211]

In *Sheeley v. Memorial Hospital*,[212] the defendant asserted that though a physician had a national certification, attended national conferences, and studied medical journals and treatises, the physician expert witness did not qualify to testify about the specific local standard of care.[213] Essentially, the defendant argued that the expert needed to be disqualified due to lack of direct knowledge about the local standard of care employed under the "similar locality" rule limitations.[214] The court concluded that the locality rule could no longer be used, because the geographic impediments that previously justified a locality analysis were no longer applicable given the advancements in the medical profession.[215]

As evidenced above, there are discrepancies among states regarding the manner in which services provided through telemedicine should be governed. Since telemedicine allows physicians in one state to treat patients in another state, these varying regulations and standards must be reconciled. Because this endeavor must be dealt with on the individual state level, Georgia's regulations and laws should be altered to more effectively regulate and govern care provided through telemedicine services.

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208. *See, e.g.*, *Shilkret*, 349 A.2d at 249 (concluding that the locality rule could be sustained no longer given the advances in medical science). The court also noted that national boards dictate residency training length, the subjects covered, and the types of examinations given to those seeking certification. *Id.* at 251.

209. *Sheeley*, 710 A.2d at 167; Morrison v. MacNamara, 407 A.2d 555, 565 (D.C. App. 1979) (holding that "[v]arying geographical standards of care are no longer valid in view of the uniform standards of proficiency established by national board certification"); *Shilkret*, 349 A.2d at 249.

210. *See Sheeley*, 710 A.2d at 163.

211. *Id.* at 165.

212. *Id.* at 161.

213. *Id.* at 163-64.

214. *Id.* at 164. The court looked to justifications presented by the Court of Appeals of Maryland in *Shilkret*, 349 A.2d at 251. *Sheeley*, 710 A.2d at 165.

215. *Sheeley*, 710 A.2d at 166-67.

III. ANALYSIS

While Georgia's legislature has not yet adopted the FSMB Compact, doing so would be a step in the right direction, though the path would not end there.[216] The FSMB Model Compact is a solution that preserves both the interest of Georgia in protecting its citizens and the interest of protecting the economic market of Georgia physicians. Below is a description of the ways in which Georgia should reconsider approaches to telemedicine in terms of licensing regulations and standards governing telemedicine services. Ultimately, Georgia should adopt the Compact, loosen the stringent requirements for the establishment of the physician-patient relationship in telemedicine encounters, and adopt a separate, national standard of care for telemedicine.

A. Licensure

With the use of telemedicine and the development of technology comes a more nationalized medium of providing health care services. However, some states maintain restrictive telemedicine regulations, justifying such as a means of protecting their citizens. These barriers created by state licensure regulations may actually cause more harm than good. State-by-state approaches can prevent patients from receiving critical medical services for which a patient located just over the state line has access. This is because physicians are undoubtedly less likely to offer telemedicine services to states with rural populations that, in addition to being less lucrative, have time-consuming and costly licensure barriers. Thus, patients living in rural areas with the least access to health care, for whom telemedicine was developed to serve, may remain among the most underserved.

For example, while Georgia is not a Compact state, this does not prevent Georgia-licensed physicians from reaching patients in rural areas of Georgia by way of telemedicine. In fact, these services and means were accounted for to provide Georgia's rank as forty-fourth in the nation in terms of physician access across the state.[217] Therefore, telemedicine services provided by Georgia-licensed physicians must lack the capabilities of treating all of those needing treatment within the state. A more honest justification would be for Georgia to admit to paternalistically restricting

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216. However, one piece of good news is that the Board of Directors of the Medical Association of Georgia recently voted to support Georgia's participation in the Compact. *See Highlights from MAG's recent BOD, HOD meetings*, MED. ASS'N OF GA., http://www.mag.org/newsletter/Highlights-from-MAGs-recent-BOD-HOD-meetings_ (last visited Feb. 23, 2017). While this is merely the beginning of the process to adopt the Compact, it provides much needed momentum.

217. *Physician Access Index*, *supra* note 1, at 10.

patient access to medical services in order to minimize physician competition and protect the economic market for Georgia physicians. While this is also important, it may be in the best interest for both those in rural areas and physicians to adopt the Compact when looking at what may be the result if Georgia does not join the Compact.

An alternative is for federal legislation to be passed that allows a physician to be licensed only in the state in which they are located, rather than needing to be licensed in each state they "treat" patients. This would be done by the federal government using its Commerce Clause power to preempt the state's historical power to regulate the scope of practice of physicians. Essentially, proponents of federal regulation of telemedicine argue that, though states do have the police power to regulate health care, this power is not exclusive and must give way when conflicting with an area Congress has been given the power to regulate.[218]

As the Supreme Court held in *United States v. Lopez*,[219] when an intrastate economic activity has a substantial effect on interstate commerce, legislation regulating the specific economic activity will be perpetuated.[220] Studies do indicate that the telemedicine market will only grow in the coming years, and the United States telemedicine market is projected to surpass $13 billion by 2021.[221] Therefore, telemedicine likely has, or will have, a substantial effect on interstate commerce.[222]

Because this potentially authorizes Congress to regulate telemedicine under the Commerce Clause, states should strive to adopt regulations and standards that facilitate growth of telemedicine, even across state lines, in order to avoid the federal government's involvement while minimizing the legal barriers to expansion of the practice. This may be necessary for states to maintain the power to regulate the use of telemedicine. However, there are problems associated with this "solution." Medical malpractice and related claims are state law claims. If states, like Georgia, are willing to be proactive and adopt telemedicine regulations conducive to the expansion of telemedicine, while preserving state sovereignty, this seems like a better alternative than for Congress to legislate in the area.

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218. Schumacher, *supra* note 12, at 436.

219. 514 U.S. 549 (1995).

220. *Id.* at 560.

221. *US Telemedicine Market to Cross $ 13 billion by 2021: Pharmaion Consultants Report*, PRNEWSWIRE (Feb. 15, 2016), http://www.prnewswire.com/news-releases/us-telemedicine-market-to-cross-13-billion-by-2021-pharmaion-consultants-report-568841771.html.

222. Schumacher, *supra* note 12, at 437.

B. Medical Malpractice

Georgia's current laws pertaining to medical malpractice actions do not efficiently govern services provided through telemedicine. Because state medical malpractice laws governing telemedicine are inconsistent, telemedicine providers have no choice but to navigate the medical practice laws in the states for which they provide telemedicine services or risk punitive action by their board and the board in which the patient is located. Instead, Georgia should develop regulations for telemedicine that do not place such a heavy burden on both patients and physicians, because these are the very parties medical malpractice laws were designed to protect.

1. Less Stringent Requisites for the Creation of Physician-Patient Relationship through Telemedicine Encounter

Proving a physician-patient relationship for a telemedicine encounter is more difficult and places a greater burden on a plaintiff than in a traditional in-person encounter. This is because the physician and the patient may never see one another face-to-face through telemedicine. Establishing this relationship is nonetheless imperative for a medical malpractice case and in order for a plaintiff to present evidence that a standard of care was breached. Another area of concern with Georgia's requirements for telemedicine is the need for the physician-patient relationship to be established in-person prior to a telemedicine encounter.

This presents a question of, when a physician does not have an initial in-person consultation with the patient and the encounter is not the result of one of the four exceptions listed in the Georgia Composite Rules & Regulations,[223] is a patient effectively barred from bringing a malpractice claim because a physician-patient relationship was never established? Though this requirement may have been well-intended by Georgia's legislature, it appears to exempt patients from bringing claims if their situation does not fall within one of the four exceptions. Thus, while the Board may have been targeting out-of-state physicians without a Georgia medical license, the victims, in reality, may be the patients who have already suffered harm. From a policy standpoint, how does this promote protection of patients, which is the purpose of medical malpractice claims? Further, how can use of state police power be justified when the parties harmed by the use, citizens of the state, are the ones who are supposed to be protected by state police power?

The overarching question is for what purpose did Georgia enact the portion of the statute requiring a face-to-face, in-person consultation in

223. GA. COMP. R. & REGS. 360-3-.07(a)(3)(a)-(d).

order for the physician-patient relationship to be established prior to a telemedicine encounter? Additionally, other important questions remain without answers. These include: Whether Georgia is holding physicians accountable who do not establish this relationship before administering care? What is the actual purpose for this law? Can Georgia pursue claims against physicians outside of Georgia who do not meet Georgia's requirements for establishing a physician-patient relationship prior to administering care through telemedicine?

Unfortunately, these questions remain unanswered.[224] For this reason, based on the potential implications of Georgia Regulation 360-3-.07(a), Georgia's best option is to eliminate the current requirement for an in-patient consultation prior to the telemedicine encounter in order to establish the physician-patient relationship. Nonetheless, some states have adopted more stringent standards for physicians utilizing telemedicine to provide care than is required for establishing the relationship in an in-person encounter. These policies have monumental consequences.

2. National Standard of Care for Telemedicine

A national standard is the most appropriate standard of care for telemedicine based on the very nature of how the services allow health care to be provided across the nation. These services should be the same regardless of where the physician or patient is located in order to protect both the physician and the patient. Varying standards based on a similar community's standard, similar resources, or local custom do not promote this uniform level of care. Rather than Georgia changing its standard of care for physician health care services generally, a more efficient and better suited solution is for Georgia to adopt a separate national standard of care for telemedicine encounters.

In the context of telemedicine, there are several big problems with each state utilizing the same standard of care as in traditional in-person encounters. Many of these problems involve continued state-use of the locality rule. First, if a physician is a sole practitioner in a community, the physician may be immunized from malpractice liability if the state uses the locality rule, no matter how substandard the care provided by the physician. This is because there is no other physician to testify as to the local standard of care. Second, if no other physician in the area provides services through telemedicine, then there is, once again, no one to

224. The Author did contact the Georgia Composite Medical Board for comment and clarification. On November 21, 2016, the Author was referred to a Licensing Enforcement Specialist of the Georgia Composite Medical Board. Despite multiple attempts to contact the Licensing Enforcement Specialist, including a voicemail with contact information, the Author received no response as of the time of publication.

serve as an expert witness in a medical malpractice case involving telemedicine. Third, a locality standard can encourage substandard care—especially in the context of telemedicine. If a standard of care is based on the custom in an area, any new and innovative telemedicine service introduced in the community would fall outside of the community custom, stifling technological advancement. Fourth, any variance in the standard of care among areas where a physician and a patient are located can create ambiguity.

While a standard of care based on locality was once justified and Georgia's "similar conditions and like circumstances" standard may remain justified for in-person encounters, a major goal of telemedicine is to eradicate geographical barriers. Why then should telemedicine be constrained by ill-suited standards that vary by geographical location? Not only does the locality standard disadvantage those located within a state still utilizing it, it also disadvantages physicians and patients in all other states that interact with physicians and patients in the states still using the locality rule.

A standard of care based on locality can create ambiguity when a physician from a rural location treats a patient in an urban area. From which location should the standard of care be derived? Because Georgia, as well as many other states, considers telemedicine services to take place in the location of the plaintiff, regardless of where the physician is located, physicians must submit to the jurisdiction and regulations of the patient's state. In the event that a patient, in a state with a locality or similar circumstances standard, receives health care services through telemedicine means and subsequently files a malpractice action against an out-of-state physician or a physician from a community with different common practices, the physician may be judged according to the common practice in the patient's location, though the physician is a member of a different community with a different common practice.

If the locality rule seeks to protect physicians based on what is the common practice in the physician's community, how can one advocate for a locality standard in a telemedicine context when the telemedicine services are deemed to take place where the patient, not the physician, is located? If courts look to the community standard from the patient's location, then the locality rule cannot be justified in the telemedicine context so long as the patient and the physician are not both located within the same locality. If, instead, the physician's location determines the applicable standard of care, when a physician from a rural area treats a patient located in an urban area, the physician may only be held to a standard based on the practices in the rural area. Though the patient receives care through new means of technology, a physician may be held only to this rural level of care, no matter how substandard and far behind

the national standards the physician's care. This would not encourage rural physicians to remain up to date on current trends and new developments in the scientific community, which, in turn, causes patients to suffer.

However, even if the states that still abide by the locality rule for medical malpractice adopt a national standard of care for telemedicine encounters, there remains variability among other states' standards. Some states continue to use a modified locality rule based on what is done in "similarly situated communities," while other states like Georgia use a "similar conditions and like circumstances" standard. Anything short of uniformity across states not only burdens physicians and creates higher compliance costs for companies promoting telemedicine, it also disadvantages potential plaintiff-patients and inhibits the full expansion of health care services for patients in rural areas.

In an age of internet and advanced technology, physicians can easily access resources detailing new techniques and discoveries. Further, today we have a national accrediting system, which has contributed to the standardized medical school training all throughout the country. The justification provided 150 years ago for a locality rule or a rule based on similar communities cannot be reconciled with the realities of telemedicine, technological advancement, and modern health care practices. In sum, anything short of a national standard for telemedicine no longer fits in with the present day nature of medical knowledge and access.

Instead, it seems to make more sense for Georgia, as well as other states, to adopt a national standard of care specifically tailored for telemedicine encounters. This would be more efficient and more effective than Georgia changing the existing standard of care, which currently addresses physicians providing non-telemedicine health care services as well as those providing services through telemedicine. This way, each state's individual standard of care for in-person encounters remains viable, thereby protecting state autonomy. At the same time, a separate national standard of care for telemedicine provides adequate protection for physicians in terms of predictability, while also encouraging these physicians to remain up to date on national standards, discoveries, and best practices.

Training, educational opportunities, equipment, and access to research and studies do not vary from place to place as they once did. Since the medical profession itself recognizes national standards for specialists and educating medical students that are not determined by geography, so should the laws governing the practice of telemedicine. In this way, telemedicine standards would model telemedicine practices in terms of its national nature. In summary, because medical malpractice law is meant to protect patients from substandard medical care and allow for

patient compensation when health care falls below this standard, Georgia, as well as other states, should eliminate state laws that place such a high burden on plaintiffs in establishing a physician-patient relationship in telemedicine encounters as compared to plaintiffs who receive care in traditional in-person encounters. Further, the standard of care utilized in a telemedicine encounter needs to benefit and protect both patients and physicians.

IV. CONCLUSION

In conclusion, because telemedicine will undeniably continue to grow as a means of providing health care, Georgia should take active measures to remain up to date on policies promoting its growth and expansion. Further, Georgia especially needs to take active steps to promote services that could help minimize the disparity in health care access in rural parts of the state. Therefore, Georgia should adopt the FSMB Compact, loosen the stringent standards for the creation of the physician-patient relationship in telemedicine encounters, and adopt a separate national standard of care for telemedicine.

ADELYN B. BOLEMAN