



HB 4582 - Interstate Medical Licensure Compact

Today, I am representing Trinity Health (Trinity; St. Joseph Mercy Health; Mercy Health) to testify in support of the Interstate Medical Licensure Compact. Trinity is the only national health system headquartered in Michigan, has 29,000 Michigan colleagues, and credentials over 4,000 physicians in Michigan.

I am Dr. Ramesh Madhavan, Medical Director of Telemedicine, Michigan Stroke Network (MSN) and Director, Comprehensive Stroke Program, St Joseph Mercy Oakland (SJMO), Pontiac. I was previously Director of Telemedicine, Associate Professor of Neurology, and Director of Neurology Residency in Wayne State University. I have been actively involved since 2006 promoting Telemedicine in the state, nationally and internationally. I have published book chapters, journal articles and presented in International conferences in the field of Telemedicine.

Trinity Health founded the Michigan Stroke Network in 2006. Since this time, we have been the pioneers in Telemedicine and cover 22 network sites that range in bed capacity from 20 to 350 beds, 8 critical access hospitals, 5 Joint Commission Certified Primary Stroke Centers (PSC) , and 2 centers applying for PSC certification. The Michigan Stroke Network (MSN) has conducted more than 3000 remote consults and transferred approximately 800 patients SJMO from remote sites for advanced care. Our patients have experienced positive outcomes, and SJMO is seen as the Stoke Center in Northern Oakland County. We are one of the largest Telestroke networks providing community service for the Michigan population and wish to expand similar quality service in Neurology and other specialties' in Michigan and other states.

The challenges faced by Trinity Health, which covers hospitals and clinics within the network and out of network health facilities are in credentialing, licensing and reimbursement domains. When we started MSN where shortages exist for Neurologists in the rural and semi urban areas, credentialing of the stroke experts was a major limiting factor with delays up to a year. With the advent of The Joint Commission and the Centers for Medicaid and Medicare Services (CMS) excepting credentialing by proxy, providers have been able to start covering Telemedicine in a matter of a few months. This has paved the way for improved health care delivery within the state. Recent changes in reimbursement is helpful, however, many services are still not eligible for reimbursement. The bill HB 4582- Interstate Medical Licensure Compact will help Michigan physicians at a national level.

With future physician shortages Michigan needs to ensure the ability to retain graduating physicians. How can Michigan be the desired location for providers? Improve the process of allowing physicians to cover multiple states. Medical graduates, residents, and fellows many times leave after training to practice in other states for better salaries and weather conditions. By passing the Interstate Medical Licensure Compact we would be able to retain a majority of this 'migratory' group.

The passing of this bill along with the expertise gained within Trinity Telemedicine will allow Michigan providers to contribute to the changing landscape, improve access to patient care nationwide, reduce healthcare costs, reduce overburden of specialty physicians and improve performance capabilities, placing Michigan as an industry leader in Telehealth.

Thank you for your attention and support!



ESSENTIAL ELEMENTS *of* **BUILDING a PEOPLE-CENTERED HEALTH SYSTEM**

Trinity Health is one of the largest Catholic health systems in the U.S., serving more than 30 million people in 21 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. We advocate for public policies that support better health, better care and lower costs to ensure affordable, high quality, people-centered care for all.

BETTER *the* **HEALTH of POPULATIONS**



The health of the people of our nation needs to be improved. Paramount to this goal is advancing effective payment models that will hold providers accountable for better health outcomes, which will reduce cost and accelerate the necessary transformation of the health system. Public policy must be improved to:

- Advance alternative payment models that hold providers accountable for outcomes with simplified, uniform quality and performance measures.
- Ensure new payment models include sufficient savings for patients, payers and providers to expand and sustain participation.
- Expand community-based services for high-need and complex patients, including those in need of advanced illness care.
- Increase coverage of and access to behavioral health services.
- Develop a workforce that will deliver population health outcomes, which include increasing the numbers of primary care physicians and advanced practice clinicians, and enabling providers – including nurses – to practice at their highest level of licensure.
- Foster personal engagement to promote self-management and shared decision-making.
- Advance interoperability standards that will securely enable providers and patients to seamlessly access data for better decision making.
- Modernize fee-for-service regulatory and payment restrictions to allow effective coordination of care across the continuum with waivers, including telehealth and home health.
- Support cross-payer alignment with private sector in federal and state demonstration models to speed industry transformation.
- Promote care models for elders, persons with disabilities, dual-eligible Medicare & Medicaid beneficiaries, and persons with chronic conditions to receive services in the most appropriate setting; for instance, Program of All-Inclusive Care for Elders (PACE).

IMPROVE COMMUNITY HEALTH *and* WELL-BEING



Health systems play a significant role in improving the health of communities. To create a People-Centered Health System that guarantees access to high-quality care for all, public policy improvements must be taken to:

- Ensure a strong safety net with Medicaid expansion in every state.
- Promote enrollment in health insurance with high functioning insurance exchanges.
- Address social determinants of health through improved linkages between medical and non-medical social services.
- Safeguard providers serving vulnerable populations with adjustments for sociodemographic factors.
- Assure equity in health care access, services, quality and outcomes regardless of race, gender, citizenship or socio-economic status.
- Guarantee affordability of services for vulnerable and low income populations, for example, the 340B program drug discount program.

DELIVER EFFECTIVE EPISODIC HEALTH CARE MANAGEMENT *for* INDIVIDUALS



In a People-Centered Health System, people should be at the center of every behavior, action and decision. Public policy should advance the ability to meet patients at their point of need, and must:

- Advance high quality patient outcomes with alternative payment methods that hold providers accountable.
- Ensure access to full-array of services for vulnerable populations with sustainable financing.
- Promote transparency of quality and cost data.
- Ensure affordability for all by maintaining access to high-value coordinated networks of care.
- Increase access to care through telehealth and other long-distance clinical health care services.

<http://advocacy.trinity-health.org> | advocacy@Trinity-Health.org



Mission

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Core Values

Reverence • Commitment to Those Who are Poor • Justice • Stewardship • Integrity



Dr. Ramesh Madhavan MD. DM

Medical Director of Michigan Stroke Network

Date: March 1, 2016



BeRemarkable

We are growing our

Population Health Expertise

2 Insurance Plans

27 ACOs* in 21 RHMs

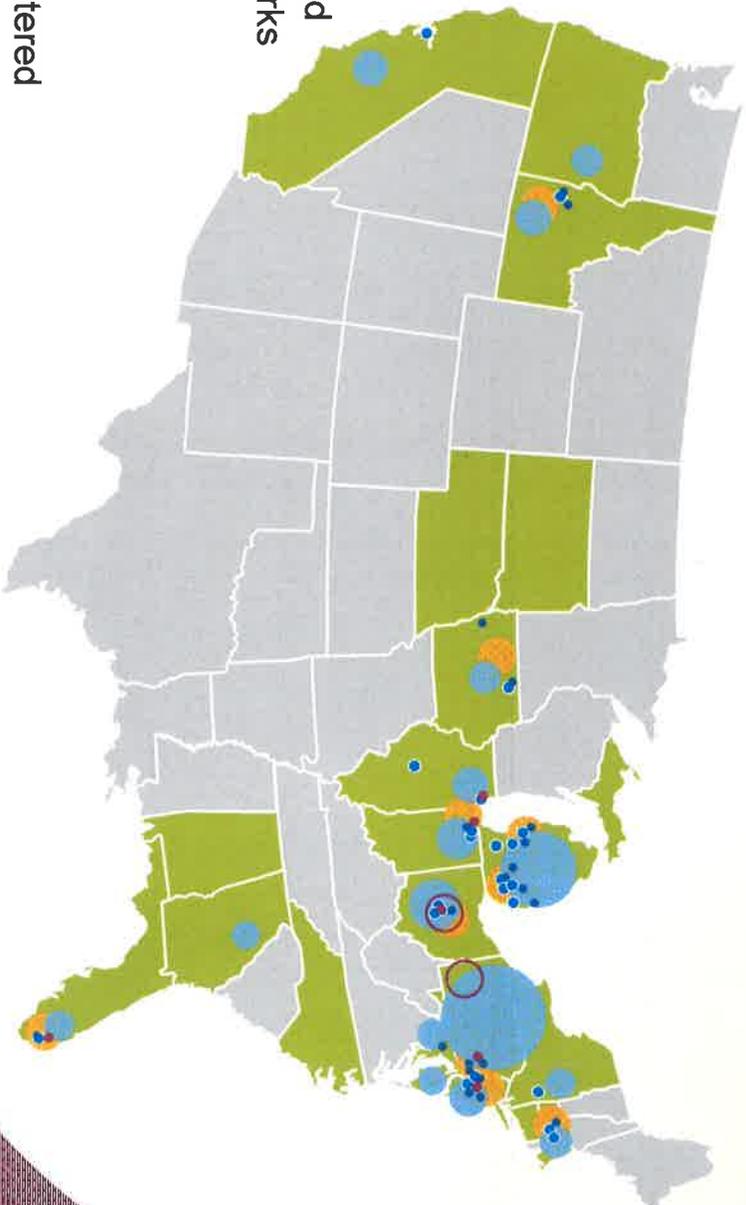
10,677

Physicians & Advanced
Practice Professionals Committed
to 16 Clinically Integrated Networks

6 RHMs** pursuing Bundled
Payment Programs

27 RHMs with 65 Patient-Centered
Medical Home Programs

1.1M Attributed Lives, through 61 Risk- or
Value-Based Reimbursement Programs



- Insurance Plans
- ACOs
- Physicians
- RHMs w/Bundled Payment Programs
- RHMs w/Patient Centered Home Programs
- Attributed Lives

*13 Medicare Shared Savings Program ACOs (8 under CMS review) and 5 Commercial ACOs
**Operations are organized into Regional Health Ministries ("RHMs"), each an operating division which maintains a governing body with managerial oversight subject to authorities.



SAINT JOSEPH MERCY HEALTH SYSTEM

SAINT JOSEPH MERCY HEALTH SYSTEM

A Leading Investor in Michigan's Health



Only National Health System Headquartered in Michigan

20555 Victor Parkway, Livonia, MI 48152

- Our Michigan Presence:
- **Over 4,000 credentialed physicians in Michigan**
 - 9 hospitals, 9 nursing homes, 10 home health care agencies, 6 hospices, 27 senior living communities, 40 subsidized health clinics
 - Serving 30 counties
 - 9 Senior ERs
 - Mercy Cancer Network with 17 locations
 - **Almost 29,000 Michigan colleagues**
 - Invests about \$1 billion annually in the state's economy
 - \$200 Million in Community Benefit

Trinity Health has 9 Michigan Hospitals
MERCY HEALTH SYSTEM
Mercy Health Saint Mary's Grand Rapids
Mercy Health Muskegon- General Campus
Mercy Health Muskegon – Hackley Campus
Mercy Health Muskegon – Lakeshore Campus
ST. JOSEPH MERCY HEALTH SYSTEM
St Joseph Mercy Ann Arbor
St. Joseph Mercy Oakland
St. Joseph Mercy Livingston
St. Mary Mercy Livonia
St. Joseph Mercy Chelsea



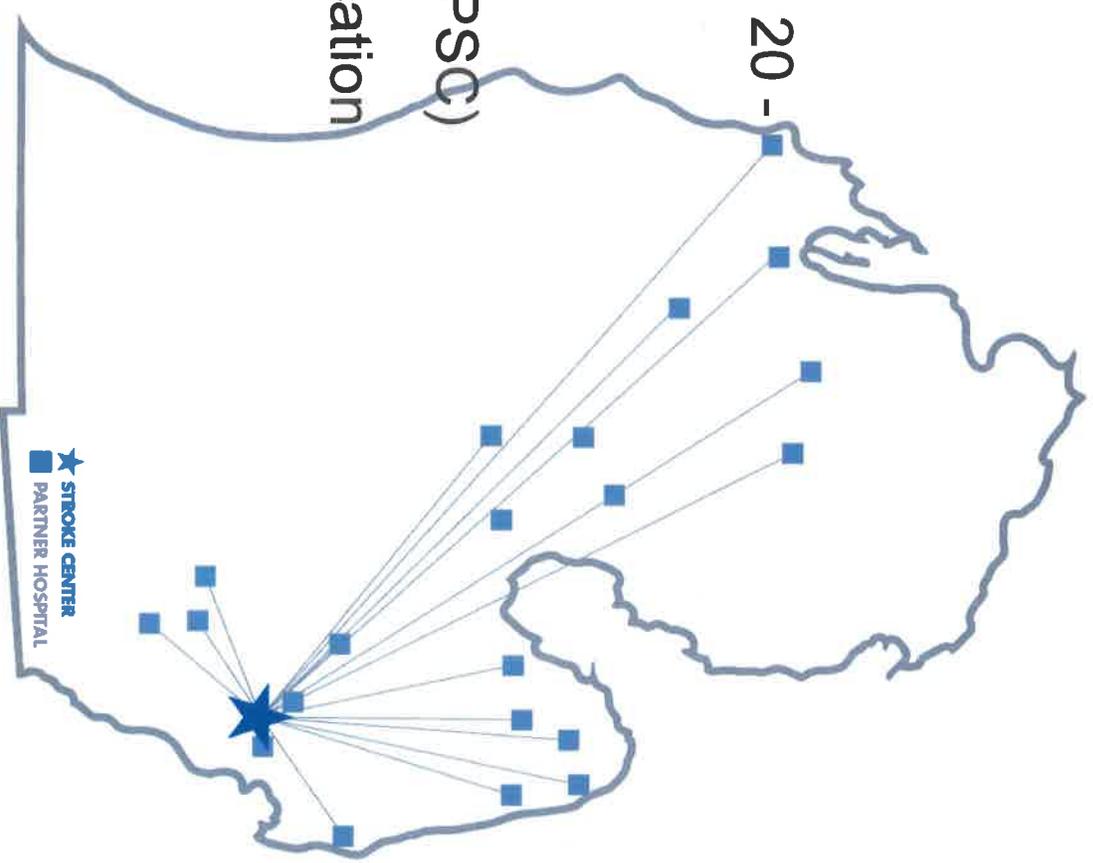
SAINT JOSEPH MERCY HEALTH SYSTEM

BeRemarkable.

Michigan Stroke Network

...a leader in telemedicine services

- Launched Oct. 2006
- 22 network sites
- Sites with bed capacity ranging from 20 - 350
- 8 critical access hospitals
- 5 Certified Primary Stroke Centers (PSC)
- 2 additional applying for PSC certification
- >3000 remote consults
- >800 transfers



Future State of Telemedicine at SJMO

- Expansion of MSN to include other specialties to partner sites
 - **Begin with General Neurology and Psychiatry**
- Provide telemedicine services to community partners
- Paramedicine program
- Transitions of Care – Home Monitoring
- Direct to Consumer
- Virtual Medical Office



Challenges of Telemedicine

➤ Reimbursement

- Limited reimbursement
- Michigan still required to meet HPSA requirements

➤ Legal Issues

▪ **Physician Licensing**

- Professional Liability
- Contract and Payment Relationships

➤ Credentialing

- Meeting the requirements of each originating site



Benefits of IMLC to Michigan

- AAMC predicts a 45,000 PCP shortage and 46,000 Specialist shortage by 2020
- Allowing the Interstate Medical Licensure Compact will attract medical students and residents to Michigan
- Allowing physicians to cover multiple states will retain graduating physicians as well as those who 'move'
- Help to share Michigan's medical expertise to neighboring states and country
- Improve the state revenue



Telemedicine Facts

- Contributions to growth: aging population, increase number of consumers in market (ACA), limited availability to providers (*high demand + low supply*)
- 84% of survey respondents rank Telemedicine as important or very important (*Foley & Ladner LLP)
- Reimbursements still #1 barrier
- 64% of Americans would be willing to use telemedicine (*Health Forum – AHA)
- Advisory Board Company and Fierce Health IT, telemedicine is predicted to show a compound annual growth rate of 18.5% over the next three years.
- Telemedicine is one of the fastest growing segments in healthcare. According to Health Affairs, the U.S. telehealth market is expected to reach **\$1.9 billion by 2018** - an annual growth rate of 50 percent.





Myths and Facts about the Interstate Medical Licensure Compact

MYTH: The definition of a physician in the Compact is at variance with the definition of a physician by all other state medical boards.

FACT: The definition of a physician in the Interstate Compact relates only to the eligibility to receive a license through the process outlined in the Compact. The Compact definition does not change the existing definition of a physician in a state's existing Medical Practice Act, nor does it change the basic requirements for state medical licensure of a physician seeking only one license within a state or who chooses to become licensed in additional states through existing processes.

FACT: In order for the Compact to be acceptable in ALL states, the definition of a physician was drafted by state medical boards in a manner that meets the highest standards already required for expedited licensure or licensure by endorsement (many states already have standards in place for expedited licensure or licensure by endorsement that require specialty-board certification.)

FACT: Physicians who do not meet the requirements, including those not specialty certified, are still eligible to apply for state medical licensure in a member state through the current process. Initial estimates show that up to 80% of licensed physicians in the U.S. are currently eligible to participate in the Compact, if they choose to do so.

MYTH: Physicians participating in the Compact would be required to participate in Maintenance of Certification (MOC), or that MOC is an eligibility requirement for the Compact.

FACT: The Compact makes absolutely no reference to Maintenance of Certification (MOC) or its osteopathic counterpart, Osteopathic Continuous Certification (OCC). The Compact does not require a physician to participate in MOC at any stage, nor does it require or even make mention of the need to participate in MOC as a licensure renewal requirement in any state. Board certification is only an eligibility factor at the initial entry point of participation in the Compact process.

FACT: The full and unrestricted medical license issued by a state to a physician through the Compact expedited process is the exact same license as would have been issued through the traditional licensure pathway. Once a physician is issued a license via the Compact from a state, he or she must adhere (as now) to the existing renewal and continuing medical education requirements of that state. No state requires MOC as a condition for licensure renewal, and therefore, this will not be required for physicians participating in the Compact.

MYTH: The Compact would "supersede a state's authority and control over the practice of medicine."

FACT: The Compact reflects the effort of the state medical boards to develop a dynamic, self-regulatory system of expedited state medical licensure over which the participating states maintain control through a coordinated legislative and administrative process.

Coordination through a compact is not the same as commandeering state authority. It is the ultimate expression of state authority.

FACT: Some of the groups that are distorting the facts about the Compact are contradicting their own policies and goals: The American Legislative Exchange Council (ALEC), for example, which is now criticizing the Compact, has supported interstate compacts as solutions to other multi-state-based legislative challenges in the past.

MYTH: The Compact would change a state's Medical Practice Act.

FACT: The Compact clearly states that it would not change a state's Medical Practice Act. From the Compact's preamble: "The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act."

FACT: The Compact also adopts the prevailing standard for state medical licensure found in the Medical Practice Acts of each state, affirming that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter.

MYTH: It would be expensive for a state to extricate itself from the Interstate Medical Licensure Compact.

FACT: State participation in the Compact is, and will remain, voluntary. States are free to withdraw from the Compact and may do so by repealing the enacted statute. The withdrawal provisions of the Interstate Compact are consistent with interstate compacts currently enacted throughout the country.

MYTH: The Compact represents a regulatory excess, and costs and burdens on the state will be increased.

FACT: The process of licensure proposed in the Compact would reduce costs, streamlining the process for licensees. Rather than having to obtain individual documents for multiple states, which is both expensive and time consuming, member states can rely on verified, shared information to speed the licensee through the licensing process. Licensees would have to pay the fees set by their state in order to obtain and maintain a license via the Compact, just as with licenses currently obtained via current methods. The Compact is not an example of regulatory excess but an example of regulatory common sense.

MYTH: The Compact will allow out-of-state physicians to circumvent the laws of the state.

FACT: A state's existing Medical Practice Act and related regulatory laws apply once a physician obtains state licensure through the Compact. Therefore, a physician licensed by a state via the Compact pathway **MUST** abide by all of the laws, rules, and regulations of that state where the patient is located and the practice of medicine occurs.

For more information about the Compact, visit www.licenseportability.org.

About the Federation of State Medical Boards: The Federation of State Medical Boards (FSMB) is a national non-profit organization representing all medical boards within the United States and its territories that license and discipline allopathic and osteopathic physicians and, in some jurisdictions, other health care professionals. FSMB leads by promoting excellence in medical practice, licensure and regulation as the national resource and voice on behalf of state medical boards in their protection of the public. To learn more about FSMB visit: <http://www.fsmb.org/>.

You can also follow FSMB on Twitter (@theFSMB and @FSMBPolicy) and Facebook by liking the Federation of State Medical Boards page.

Telehealth: Connecting People-Centered Care

LEAD
the **WAY**

Building a People-Centered Health System



Trinity Health is one of the largest Catholic health systems in the U.S., serving more than 30 million people in 21 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming and healing presence in our communities. We advocate for public policies that support better health, better care and lower costs to ensure affordable, high quality, people-centered care for all.

Telehealth is critical to Trinity Health's commitment to build a People-Centered Health System that puts the people we serve at the center of every behavior, action and decision we make. Building a People-Centered Health System requires providing the communities we serve with the highest level of access to care across the continuum, and telehealth is an important mechanism for reaching those in need when they need it.

What Can Telehealth Achieve?

Telehealth includes a wide range of technologies, including videoconferencing, internet-based applications, store-and-forward imaging, streaming media, and phone and wireless communications¹. Telehealth has demonstrated a wide-range of positive outcomes across settings of care and between providers and consumers, including:

- Better access—providing patients the opportunity to get care no matter where they are.
- Increased patient satisfaction, and improved patient engagement in community-based settings.
- Facilitation of communication with providers.
- Reduced costs by moving care to lower cost, more appropriate settings.

Telehealth leads to Better Health, Better Care and Lower Costs

- Demonstrating positive outcomes by reducing use of acute services—especially for those with multiple chronic diseases, such as congestive heart failure (CHF), stroke, and chronic obstructive pulmonary disease (COPD)².
 - Reduced hospital admissions, readmissions, and emergency department visits.
 - Improved patient outcomes – patients served via hub-and-spoke telestroke network were more likely to be discharged home³.

What Can Policymakers Do?

Use Telehealth to Build a People-Centered Health System and Achieve Population Health Goals

Recommendations:

- Encourage use of telehealth to promote health and well-being across outpatient, inpatient and community-based settings.
- Focus expansion of telehealth on high-need areas that are critical to managing population health in communities
 - Leverage telehealth to provide coordinated, team-based care, to address behavioral health workforce shortages, and to more effectively care for those with co-morbid behavioral health conditions

¹ United States, Department of Health and Human Services, "What is Telehealth? How is Telehealth Different from Telemedicine?" Healthit.gov. Accessed March 24, 2015. Available at:

<http://www.healthit.gov/providers-professionals/faqs/what-telehealth-how-telehealth-different-telemedicine>

² Rashid L. Bashshur, et al, "The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management," *Telemedicine and e-Health*, September 2014. Accessed March 24, 2015. Available at: <http://online.liebertpub.com/doi/abs/10.1089/telem.2014.0001>

³ Jeffrey A. Switzer, et al., "Cost-effectiveness of a Hub-and-Spoke Telestroke Networks for the Management of Acute Ischemic Stroke from the Hospitals' Perspectives," *Circulation: Cardiovascular Quality and Outcomes*, December 4, 2012. Accessed March 24, 2015. Available at: <http://circoutcomes.ahajournals.org/>

Telehealth: Connecting People-Centered Care

- Expand use of telepharmacy, which includes drug utilization review, prescription verification and patient counseling, to address access issues in rural areas, improve medication adherence and decrease medication-related errors.
- Permit providers to remain in each stage of Meaningful Use (MU) for at least three years.

Ensure Telehealth Provides High-Quality Care to Consumers

Recommendations:

- Apply quality measurement and standards to ensure adequate safeguards and protections for consumers; metrics could include:
 - Consumer/patient experience and satisfaction.
 - Changes in access to care.
 - Changes in utilization of acute services.
 - Impacts on medication adherence, compliance with care guidelines, and self-management of conditions.

Promote Continuity of Care by Facilitating Use of Telehealth within and Across State Lines

Recommendations:

- Update licensing regulations – especially for systems operating across state lines.
 - Eliminate requirements for out-of-state providers to have special licenses to provide telehealth care across state lines.
 - Create an all-purpose license that applies to all telehealth care across state lines in order to harmonize licensing and credentialing requirements.
- Support the Interstate Physician Licensure Compact to improve license portability and increase patient access to care.
- Promote use of telehealth in medically underserved areas – including both rural and urban geographies – to reduce health disparities.

Advance Adoption of Telehealth by Harmonizing Use and Payment Across Payers and Programs

Recommendations:

- Public and private payers should provide telehealth payment regardless of origination site.
- Include waivers for telehealth payment in value-based payment initiatives (e.g. accountable care organizations (ACOs), patient-centered medical homes (PCMHs), bundled payments) in Medicaid and Medicare, and in Medicare Advantage.
- Use consistent definitions for telemedicine and telehealth in Medicare and Medicaid.
- Align payment across settings of care, especially for remote monitoring technologies.
- Maintain continuity of care and provider choice by allowing for use of eVisits regardless of consumer's location.
- Promote standardized documentation of telehealth encounters without narrow mandates on methods.

Ways Telehealth is Helping Build a People-Centered Health System across Trinity Health

- Improved access for those in rural areas.
- Better, more informed clinical decision making in a timely manner.
- Decreased readmissions for CHF, preventable admissions for chronic disease.
- Increased capacity to serve patients.
- Increased productivity from providers.
- Greater ability for patients to engage in self-management.
- Better ability to monitor patients remotely, make adjustments in nutrition, medication to prevent downstream problems.

Digital Access: <http://advocacy.trinity-health.org/> • advocacy@Trinity-Health.org • #TeleHealth #TeleMedicine #PeopleCentered

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CRITICAL THINKING ON ISSUES
OF MEDICAL LICENSURE AND DISCIPLINE

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The Interstate Medical Licensure Compact

Making the
Business Case

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Complaints against
Physicians Due to
Communication:**

Analysis of North
Carolina Medical Board
Data, 2002–2012

State Regulatory News

Federation of
STATE
MEDICAL
BOARDS

The Interstate Medical Licensure Compact: Making the Business Case

Blake T. Maresh, MPA

ABSTRACT: The United States Constitution established and the Supreme Court has affirmed the proper role of states in regulating medicine throughout American history. However, the opportunities and mounting pressures of modern medical practice have called into question the viability of state-based regulation to address the increasing practice of physicians across state lines. This article will argue that the crossroads at which state medical boards find themselves provides an opportunity for an interstate compact as the best solution for adapting to the forces of current and future trends.

A brief examination of the history of state-based licensing, and the dynamics that led up to the formation of the Federation of State Medical Boards will provide a basis for consideration of interstate compacts as a constructive response to critiques of the present regulatory structure. With a common understanding of the utility and widespread use of the interstate compact, we will turn our attention to how it emerged as a viable option, key specifics of an interstate compact for medical licensure, and the extent to which the model that has been crafted by the FSMB can complement the existing authority of state medical boards.

“One believes things because one has been conditioned to believe them.”

— Aldous Huxley, *Brave New World*

“The choice for mankind lies between freedom and happiness and for the great bulk of mankind, happiness is better.”

— George Orwell, 1984

An interstate compact offers the prospect of taking a giant leap forward in expedited licensure, a means to facilitate multistate practice within a state-based licensing framework, and a response to those who would bypass state-based regulation entirely through federal legislation. An interstate compact would also represent a departure from how medical boards have operated, in many cases, for over a century.

Depending upon one’s point of view, an interstate compact might conjure up different visions of the future. For some, the interstate compact offers a tested Constitutional precept that could creatively forestall federal intervention that might otherwise supplant the long-standing authority of state medical boards. The power of interstate compacts might also provide state boards with valuable new tools with which to do their work. For others, the possibility of other state boards licensing physicians who practice in their states, coupled with the establishment of new governmental organizations, leaves them uneasy at best. Dissenters also raise questions about how boards will obtain the necessary financing to do their work. This paper will show how the

interstate compact is the best solution for adapting to the forces of current and future trends. With a common understanding of the utility and widespread use of the interstate compact, we will turn our attention to how it emerged as a viable option, key specifics of an interstate compact for medical licensure, and the extent to which the model that has been crafted by the FSMB can complement the existing authority of state medical boards.

Origins of State-Based Physician Licensing

Readers of this article, and of this journal, are likely to be familiar with important recent works on the history of medical regulation, such as *Medical Licensure and Discipline in America*, authored by

AN INTERSTATE COMPACT OFFERS THE PROSPECT OF TAKING A GIANT LEAP FORWARD IN EXPEDITED LICENSURE, A MEANS TO FACILITATE MULTISTATE PRACTICE WITHIN A STATE-BASED LICENSING FRAMEWORK.

David Johnson and Humayun Chaudhry (2012) and Ruth Horowitz’s *In the Public Interest: Medical Licensing and the Disciplinary Process* (2013). Though it is not necessary to repeat the efforts of these and other authors, it is instructive for this

discussion to underscore several key themes through highlighting specific historical episodes and milestones of the long history of state-based medical regulation.

Efforts to regulate the practice of physicians predate the founding of the United States, with the earliest legislation dating to 1639 in the Virginia Colony, the

EFFORTS TO REGULATE THE PRACTICE OF PHYSICIANS PREDATE THE FOUNDING OF THE UNITED STATES, WITH THE EARLIEST LEGISLATION DATING TO 1639 IN THE VIRGINIA COLONY.

Massachusetts Bay Colony in 1649 and in New York in 1665.¹ Precursory state requirements to have a license issued through a medical society comprised of physician peers (such as New York in 1760², New Jersey in 1772³, Pennsylvania in 1794⁴, and Maryland in 1798⁵) and to have an examination (New Jersey in 1772 and New York in 1797, for example) were commonplace.⁶ However, between 1826 and 1852 nearly every state (except New Jersey) repealed laws requiring licensure of physicians, due primarily to consumer confusion and skepticism about the efficacy of the many types of physicians practicing in the day. Nevertheless, as a result of multiple effects, not the least of which were public sanitation and scientific advances, states gradually established (or reestablished) licensing boards and independent examinations of their own by 1910.^{7,8,9}

In other words, even prior to the nation's founding, the basic infrastructure of how we regulate physicians at the state level emerged, and it has since evolved into a model (well over a century ago) that is easily recognizable as similar to what universally exists in the U.S. today. How state medical boards have responded to changes in their operating environment, including the expectations placed on them by the public and key stakeholders can be easily illustrated:

- While the founding of the National Board of Medical Examiners (NBME) in 1915 might have hastened movement toward a more unified examination process for medical students, states only gradually gave up the use of their own licensing examinations. However, it became apparent that educators were

embracing new and better methods of testing, as a means to truly measure fitness for practice and not just factual recall.^{10,11} Over time, state examinations gave way to national examinations—the NBME, the Federation Licensing Examination (FLEX), the National Board of Osteopathic Medical Examiners (NBOME)¹² Examination, and ultimately, the U.S. Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)—that promoted greater consistency in content and standards, in contrast to the variability of state examinations.¹³

- Although medical boards' initial focus was on the licensing of physicians, as time went on, public skepticism grew about how licensing (sometimes licensing for life) was protecting the public. Relatively few complaints resulted in professional discipline, and most often, these were in the realm of substance abuse or sexual or other misconduct, not substandard practice. In response, Dr. Walter Bierring called for boards to broaden their perspective in the January 1960 *Federation Bulletin*:

"If a state cannot, or does not, for just cause, revoke a license or discipline a physician...a fatal weakness exists. If no machinery exists for investigations and hearings...discipline does not really exist. If there is nothing beyond what the state or county society can do, a license to practice becomes a potential license for abuse."¹⁴

Today, the range and volume of state medical board discipline has expanded greatly, with substandard practice comprising a significant percentage of the disciplinary work of boards.

- In stark contrast to the stated mission of state medical boards to protect the public, for many years these boards were populated only by licensees. However in 1961, that changed for the first time with the appointment of one "public member" to the Medical Board of California.¹⁵ This began a movement that has resulted in virtually all state medical boards having public member representation today; moreover, these members are not merely tolerated, but appreciated for bringing an important alternative perspective. As Horowitz notes "[t]he idea that the public should have its own representatives on a board is generally accepted today, but it was once controversial."¹⁶
- In recent years, state medical boards have responded positively to license portability efforts

led by the FSMB. Sixty-seven of 69 state medical boards that engage in licensing activities now accept or require the FSMB's Federation Credentials Verification Service, which provides a centralized process for boards to obtain primary source verified physician records for credentialing.¹⁷ Twenty-two states use the FSMB's Uniform Application, which standardizes and simplifies the licensure application process for physicians.¹⁸

- In response to growing sentiment that better communication between states was needed to prevent physicians from using increased mobility to evade detection, medical boards began to rely on databases such as the National Practitioner Data Bank (NPDB) and the FSMB's Physician Data Center as a part of their licensing activities. The NPDB, for example, was created in 1986 with the express purpose of "encouraging State licensing boards, hospitals and other health care entities, and professional societies to identify and discipline those who engage in unprofessional behavior, and to restrict the ability of incompetent physicians...to move from State to State without disclosure or discovery of previous...adverse action history."¹⁹ Today, reporting to these databases, and checking them during the licensure process, is a commonplace activity for state boards.

It is true that the earliest licensing efforts in this country may have been aimed more at securing reimbursement for physicians than the virtue of patient safety, and that the repeal of many laws during the mid-nineteenth century reflected inter-professional squabbles, along with a dose of public suspicion. Nevertheless, with respect to the re-establishment of medical licensing, Horowitz notes "[t]he fact that legislatures first granted licensure to occupations concerned with health and cleanliness confirms a vital link between the successes of licensure and the public health movement."²⁰ Further, she states that "[w]ith the onset of the Progressive era, it was common for physicians to mention patients as main beneficiaries of the licensure policies advanced by medical societies."²¹ These statements are powerful in that they not only capture the essence of why state medical boards were created and exist to this day, but that responsible physicians themselves recognize the value of state medical boards as a means of ensuring the safety of their patients and the general public. State boards have not wavered from that overarching mission, yet their responsibilities and activities continued to evolve through the twentieth century.

License Reciprocity and the Formation of the Federation of State Medical Boards

It is well known by many in the field of medical regulation that the Federation of State Medical Boards resulted from the 1912 merger of the National Confederation of State Medical Examining and Licensing Boards (National Confederation) and the American Confederation of Reciprocating Examining and Licensing Boards (American Confederation). What may be less broadly understood is that the

AT THE HEART OF THE AMERICAN CONFEDERATION'S MISSION WAS TO CREATE A NATIONAL EXAMINING BOARD TO HELP ELIMINATE OBSTACLES TO INTERSTATE PRACTICE.

issues of license reciprocity and barriers to physician mobility across state lines were pivotal to the fracture of the National Confederation and the creation of the American Confederation a decade earlier.^{22,23,24} At the heart of the American Confederation's mission was to create a national examining board to help eliminate obstacles to interstate practice. Shryock also describes the "continued efforts of the Reciprocity Confederation" during this period "to encourage inter-board agreements."²⁵ However, due to the practical constraints of limited financial resources for both organizations, combined with a public perception that two contending organizations did not serve the public interest, leaders from the organizations began merger discussions in 1910 and, on February 28, 1912, the National Confederation and the American Confederation adopted a constitution and by-laws creating the Federation of State Medical Boards.^{26,27}

A more nuanced understanding of the schism between the two organizations illustrates that the difficult questions of how to license and regulate physicians at the state level, yet allow movement of medical practice across state lines, have eluded leaders in this field for over 100 years and continue to resonate in today's debates. Interestingly, Johnson and Chaudhry speak to the public's expectations of the role of that newly-formed FSMB:

Looking back, these aspirations for a broadly influential Federation while flattering and well intentioned, expected perhaps too much from the fledgling organization. In some ways and at a fundamental level, writers such as those

from *Harper's* and the *Times* misunderstood the true nature and authority of the Federation. They seemed to conflate an annual gathering of representatives from individual state agencies with a truly national body akin to a federal agency.²⁸

More than a century ago, there was an acknowledgement of the important issues of license reciprocity and physician mobility across state lines, even in an era before telehealth²⁹. In that day, the concern was to prevent unscrupulous physicians from fleeing across state borders. But the passage above also highlights an acknowledgement of the need and desire for interstate coordination, in a way that the Federation was not empowered to provide.

Concurrently, the use of interstate compacts in the early 20th century was beginning to evolve, but they did not yet possess the mechanisms to accommodate ongoing and complex regulation, such as that of interstate medical practice. As we shall observe below, important changes in interstate compact design and use place us today at a unique confluence point in history, one where the need is there and the tool has developed to ideally suit the need.

The Legal and Constitutional Context of State-Based Physician Regulation

As we examine the history of state-based physician regulation as it relates to contemporary challenges, we would be remiss not to also briefly consider the constitutional and legal contexts in which state medical boards exist. The Tenth Amendment to the U.S. Constitution, which embodies the principle of federalism, is generally the starting point for such conversation. The Tenth Amendment, which echoes language from Article II of the Articles of Confederation,

THE TENTH AMENDMENT REMAINS A CORNERSTONE UPON WHICH THE STATE REGULATION ARGUMENT, SUCH AS THAT FOR PHYSICIAN PRACTICE, IS BUILT.

reserves those powers not explicitly granted to the U.S. government to the states.³⁰ Derbyshire states the impacts of the Tenth Amendment plainly: "the practice of medicine for many years has been regulated by the states; this policy will not change since the federal government cannot assume this function without an amendment to the Constitution."³¹

Two U.S. Supreme Court rulings were critical in reinforcing the doctrines laid out in the Tenth Amendment.³² In the first, *Dent v. West Virginia*, Frank Dent, an eclectic physician challenged the

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authority of West Virginia due to failing to meet state licensing standards. In 1889, stating the unanimous opinion of the court, Justice Field said in part: "Few 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...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. Due consideration, therefore, for the protection of society may well induce the State to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified."³³

A decade later, in 1898, in *Hawker v. New York*, Dr. Benjamin Hawker had been previously convicted of a felony and served jail time, after which he sought to resume his medical practice. However, the State of New York had, in the interim, passed laws prohibiting felons from practicing medicine, and Dr. Hawker was again convicted under these laws, which form the basis for many "good moral character" provisions in current licensing laws. Writing for the majority, Justice Brewer stated "...it is insisted that within the acknowledged reach of the police power, a State may prescribe the qualifications of one engaged in any business so directly affecting the lives and health of the people as the practice of medicine...we are of opinion that this argument is the more applicable and must control the answer to the question."^{34,35}

The Tenth Amendment remains a cornerstone upon which the state regulation argument, such as that for physician practice, is built; nevertheless, the debate rages today as to whether Congressional action in recent decades has, in practical terms, eroded its strength. Its federalist canons are

often described through three touchstone concepts: enacting limitations on the power of the federal government in order to protect against tyranny, placing the locus of governance as close as practicable to the people, and fostering innovation in governance at the state level.^{36,37} However, how Congress and the Supreme Court have interpreted the core tenets of federalism over our nation's history have shifted significantly.

For most of our national existence, federalism has been structured as a "layer cake" with distinct and separate roles for federal and state governments, also known as dual federalism. These distinctions were preserved by the courts, through common law rulings, but with a series of Supreme Court decisions in 1937 and 1938, an era of greater federal preemption began with the New Deal and lasted for nearly six decades. During this time, the Supreme Court simultaneously shrank its own role in preserving federalism via common law to mere interpretation and allowed that of Congress to expand.^{38,39,40} This is most explicitly illustrated in the 1985 *Garcia* ruling where, writing for the majority, Justice Blackmun questioned whether the Court could even define what activities are so within the sphere of state regulation as to be exempted from federal regulation.^{41,42} This loosening of Congressional restraint manifested itself as cooperative federalism, where the federal government sets a broad policy direction yet allows states flexibility and creativity in how to implement and administer program requirements, and it

FOR MOST OF OUR NATIONAL EXISTENCE, FEDERALISM HAS BEEN STRUCTURED AS A 'LAYER CAKE' WITH DISTINCT AND SEPARATE ROLES FOR FEDERAL AND STATE GOVERNMENTS ALSO KNOWN AS DUAL FEDERALISM.

resulted in the expansion of federal regulation in a number of new areas. It also gave rise to a more coercive federalism, where the federal government sought to impose policies via regulatory mandates, funding restrictions and/or federal preemption.

While President Reagan heralded a new relationship between a more limited federal government (i.e., his pronouncement that "government is the problem") and the states in the early 1980's, cooperative federalism abruptly ended, at least from the perspective of the Supreme Court, with *New York v. United States* in 1992.^{43,44} The ruling solidified New

Federalism, and the Supreme Court's rulings reversed a decades-old pattern of accommodating federal preemption. Although the essence of cooperative federalism remains today in tools such as bloc and categorical grants to states, a tension continues to exist between Congress's more inter-governmental approach of cooperative federalism and the Supreme Court's more restrictive new federalism approach.

The historical vicissitudes of federalist theory in the United States and the concomitant risks of federal preemption bear on the question of state regulation of physicians in at least two respects. First, the extent to which the regulation of medicine ceases to be a "layer cake" and becomes a "marble cake" is vitally important. Chemerinsky, in his assessment of the risks of federal overreach, cites Jonathan Tribe's remarks: "no one expects Congress to obliterate the states at least in one fell swoop. If there is any danger, it has to be in the tyranny of small decisions."⁴⁵ Is it idle speculation to suggest that, when a sufficiently large health care regulatory portfolio has been created at the federal level (i.e., when the cake has become sufficiently "marbled"), this creates a clearer path to full federal preemption, and does it simultaneously make it harder for states to retain their sovereignty in those areas?

Second, the potential implications are unclear of a national licensure scheme where sharing revenue with the state medical boards occurs, as it may present an opportunity to attach policy conditions to state regulation of physicians. A well cited example of this is the withholding of federal highway funds to states for not raising the legal state drinking age to 21⁴⁶. Moreover, the message in *New York v. United States* was not that federal funding could not be tied to the storage and disposal of low-level radioactive wastes, but that state regulatory authority may not be commandeered by the federal government.^{47,48} It is conceivable then that, as part of partial preemption of physician licensing, the federal government could seek to leverage its control over state medical boards via a modified form of conditional spending power.⁴⁹

According to Learner, if a critical mass of states forges a policy consensus on a policy issue, "courts should apply the Supremacy Clause with more restraint."⁵⁰ His assertion is more narrowly in the context of federal preemption of environmental regulation, yet it is well worth contemplating whether the message is the same—that is, a show of solidarity in resolving the policy question of

interstate physician licensure at the state level, using a Constitutionally-authorized tool like an interstate compact, should carry weight with Congress and, if necessary, the courts. The “chaotic, conflicting, and rather rudimentary”

STATE MEDICAL BOARDS' FIAT DERIVES BOTH FROM THE U.S. CONSTITUTION AND FROM THEIR LONGEVITY OF OPERATION.

Tenth Amendment jurisprudence⁵¹, and the accompanying uncertainty of whether federal mandates will come to states cloaked in full preemption, partial preemption, collective federalism, and/or constraints on federal licensing revenue, beg the question of whether states are better off to simply embrace the pure federalist spirit to operate as policy laboratories and proactively fill in the policy gap themselves.

State medical boards' fiat derives both from the U.S. Constitution and from their longevity of operation. State medical boards and their predecessors have functioned in America as regulators of physician practice since the mid-17th century. This structure has been firmly underwritten by the 10th Amendment to the U.S. Constitution and has been reinforced by the U.S. Supreme Court. These provide a solid foundation to argue that maintaining the regulatory structure for physicians through state boards is reasonable. Yet those associated with state medical regulation would be unwise to stop here, as the complex and changeable landscape of federalism suggests. Additional compelling arguments, beyond mere historical or Constitutional entitlement, are warranted.

Emerging — and Emergent — Forces on State Medical Boards

The first sentence of the 2013 Congressional Research Service (CRS) report, “Physician Supply and the Affordable Care Act,” plainly states the relationship between physician supply and patient care: “[a]n adequate physician supply is important for the effective and efficient delivery of health care services and, therefore, for population health and the cost and quality of health care.”⁵² Consider that the Affordable Care Act projects that 32 million newly-insured Americans will enter the health care marketplace by 2019.⁵³ The nation also continues to grow older and more populous. By 2050, U.S.

Census numbers indicate the U.S. population will grow by over 85 million to 400 million, and the over-65 population, which statistically tends to use more health care services, will nearly double from 43.1 million to 83.7 million, or more than 20 percent of the overall population.⁵⁴ Yet another factor that will affect the public's future utilization of health care is the growing prevalence of chronic disease, responsible for seven out of ten deaths in the U.S. in 2010, and of “lifestyle” conditions, such as obesity, which afflicts more than one-third of adults.⁵⁵

At the same time, a shortage of physicians and other health care professionals is anticipated, which is likely to be exacerbated in certain clinical specialties and in certain geographic areas, especially rural and underserved communities. The Association of American Medical Colleges has estimated for some time that the nation will face a shortage of more than 90,000 MDs by 2020 and more than 130,000 by 2025.⁵⁶ Moreover, the maldistribution of physicians in the United States has been well documented, both through research and through federal reimbursement policy.^{57,58,59}

The interrelated issues of physician training and reimbursement also guide where and in what specialties physicians practice. The CRS report states that “some specialties, such as general surgery, geriatrics, the pediatric subspecialties, and psychiatry, have...widely acknowledged shortages.”⁶⁰ In addition, a 2009 study by the Robert Graham Center noted that “[c]urrent U.S. graduate interest falls short of maintaining the current proportion of primary care in the physician workforce...This loss in production of primary care physicians may join the problem of maldistribution and further erode access to primary care services.”⁶¹ The relationship of medical school debt to selection of medical specialty is complex and not clearly determined, but there is evidence to demonstrate that post-educational salary does strongly correlate to choice of specialty.⁶² Further, it has been chronicled by the Council on Graduate Medical Education that “[n]othing affects the location decision of a physician more than specialty. Unfortunately for rural areas, the more highly specialized the physician, the less likely it is the physician will settle in a rural area,”⁶³ a conclusion echoed by Rosenblatt and Hart.⁶⁴ For some physicians, the costs, professional challenges and/or lifestyle limitations of service in rural or underserved areas may be decisive in their choice of practice location and specialty.⁶⁵ These elements in turn bear directly on the ease or difficulty of the population accessing medical care.⁶⁶

Taken together, the above factors paint a picture of more Americans, more insured Americans, and more elderly Americans taxing our health care system in the years to come. In tandem, despite more physicians entering the workforce every day, evidence suggests there may not be enough, in the right specialties, or in the needed geographic locations, to meet all patients' needs. As the final gatekeeper to physician practice in the U.S., state medical boards are an essential ingredient in innovatively connecting physicians with patients.

A second force reshaping medicine, and the expectations around how it is delivered, is the exponential expansion of technology in health care. As in most every other aspect of modern life, the ubiquity of technology has fundamentally reshaped the practice of medicine. Plumbing the foundations of human existence through gene and stem cell therapies, implanting wireless devices that monitor and regulate vitals, operating artificial limbs with thought-controlled pressure sensors, performing simulated and robotic surgery, and accessing electronic health records and health information exchanges are but a few examples of how technology has altered how physicians care for patients. Consider that, as of 2012, more than 13,000 health-related apps were available for download at Apple's Appstore.⁶⁷ In addition, Healthcare IT News reported earlier this year that "[m]ore than half of people with chronic conditions say the ability to get their electronic medical records online outweighs the potential privacy risks."⁶⁸

But perhaps no other aspect of technology has broader transformational potential to provide high quality and more accessible care to patients than telemedicine. Telemedicine is often seen as a remedy to geographic and access barriers by allowing patients the freedom to directly seek out specialists who may practice remotely, facilitating virtual staffing of rural health care facilities, and allowing physicians in centers of excellence to treat and consult on patient care without the time and expense of arranging face-to-face patient visits. Using telemedicine to care for pediatric patients in the ER⁶⁹, placing technology on board ambulances to facilitate treatment en route to hospitals⁷⁰, delivering eye care in rural and underserved areas of India⁷¹, using Google Glass to display information and digitally record surgical procedures⁷², and remotely treating hepatitis C virus infection in underserved communities⁷³ are but a few examples of how the advent of technology in patient care across state lines seems destined to rapidly accelerate into the future.

However, a common misconception persists among proponents of the broader use of telemedicine, as a means to facilitate the multistate practice of medicine, that state medical boards oppose the use of technology. Although this is untrue, many are concerned that the unchecked spread of telemedicine may endanger patients. The practice of

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telemedicine, in whatever the form, is still the practice of medicine, and the same care and protection must be afforded patients whether they are being seen by their community primary care doctor or a highly-focused specialist from across the country. This is the charge state legislatures have given to state medical boards—to ensure that the public in their jurisdictions have access to competent medical care, not unfettered access, lacking the proper accountability.

Unfortunately, some critics of state-based medical regulation have sought to portray medical boards as the source of the problem. In some cases, these critics are major corporations that appear to have vested interests in promoting the proliferation of technology in the health care system.⁷⁴ The American Telemedicine Association (ATA), a leading organization in the advocacy of telemedicine, represents a large number of corporate communications and telehealth interests,⁷⁵ and the ATA has repeatedly called for Congressional action to preempt state regulatory authority for medicine. In 2011, the ATA launched a website, fixlicensure.org, to elicit public support for this policy position, stating that "requiring health providers to obtain multiple state licenses and adhere to diverse and sometimes conflicting state medical practice rules, is a barrier to progress, quality, competition and economy. This partitioned approach also presents a concern for patient safety as state-by-state licensing and enforcement inhibits tracking down and disciplining bad doctors located in other states."⁷⁶

The Chief Executive Officer of the ATA, Jonathan Linkous, has further expounded on the alleged failings of state licensure on a number of occasions, stating that "we estimate it costs about \$300 million a year to do extra licenses...that's growing

because physicians are increasingly holding multiple medical licenses. It's an access problem."⁷⁷ He has been quoted as saying "the patchwork of state-by-state licensing creates a mire of costly red tape and has become an untenable barrier for both providers and patients."⁷⁸ Mr. Linkous has further opined "It is wrong to deny a patient health care because of state boundaries and overly cumbersome state licensing rules."⁷⁹

As recently as March 10, 2014, Mr. Linkous provided testimony to the Federal Trade Commission on telemedicine and competition.⁸⁰ In it, he indicated that the ATA did not necessarily oppose state-based regulation, but warned that any proposed alternative must be "accomplished without delay and with a specific timeline included for implementation." Mr. Linkous's testimony referenced an interstate compact model but detailed ATA's concern that, after 15 years in existence, the Nurse Licensure Compact only operates in 24 states, implying that only a true national solution is acceptable to his organization. Ultimately, Mr. Linkous reprised the tenor of his earlier statements, saying that state-based licensure requirements are "costly and serve as a barrier to fair competition. Licensure costs professionals and the taxpayer hundreds of millions of dollars each year. Separate licensing is without justification for clinical services that do not require face-to-face interactions such as the interpretation of images or peer-to-peer consultations."⁸¹

It remains unclear whether the motivation for organizations such as the ATA to preempt the states in favor of a federal solution for physician licensure is purely financial, or a true belief that the access to be gained through federal action outweighs any

STATE MEDICAL BOARDS HAVE BEEN VOCAL SUPPORTERS OF RESPONSIBLY USING TELEMEDICINE TECHNOLOGIES TO EXPAND ACCESS, ESPECIALLY IN RURAL AND UNDERSERVED AREAS.

collateral damage to patient safety, or a combination of the two. At the very least, such statements demonstrate a fundamental misunderstanding of the vital role of state medical boards by implying that the current system does not work.

Still, these voices have been heard by lawmakers. A litany of bills considered or passed by Congress in recent years reflects a trend toward the gradual erosion of states' responsibilities:⁸²

- **HR 1832 — the STEP Act.** Introduced on May 11, 2011 by Rep. Glenn Thompson (R-PA), this bill expanded the current Department of Defense state licensure exemption for credentialed health care professionals, regardless of where they or patients are located. This expansion includes civilian employees of the Department of Defense, personal services contractors, and other health care professionals credentialed and privileged at a Federal health care institution. The bill became law on December 31, 2011.
- **HR 1540 — 2012 National Defense Authorization Act.** Introduced on April 14, 2011 by Rep. Howard P. "Buck" McKeon (R-CA), the bill authorized Department of Defense civilian employees and other health care professionals credentialed and privileged at a federal health care institution or location designated by the Secretary of Defense to practice at any location, regardless of where the health care professional or patient are located, so long as the practice is within the scope of authorized federal duties. The bill became law on December 31, 2011.
- **HR 6179 — The Telehealth Promotion Act of 2012.** Introduced on December 30, 2012 by Rep. Mike Thompson (D-CA), the bill would redefine telehealth services as originating from the site of the treating provider and not the patient. This stance on the location of physician practice has traditionally been viewed as inconsistent with how medicine is defined and as contrary to patient safety.
- **HR 6107 — The VETS Act.** Introduced on July 12, 2012 by Rep. Charles Rangel (D-NY) the bill would allow any licensed health care professional employed in the VA system, either employed or contracted, regardless of state of licensure, to practice in any facility nationally through the use of telemedicine.
- **HR 3077 — The TELE-MED Act of 2013.** Introduced on September 2013 by Rep. Devin Nunes (R-CA), the bill would allow for a Medicare provider, licensed in one state, to treat any Medicare beneficiary in any other state via telemedicine without requiring licensure where the patient is located. The bill currently has 58 bipartisan co-sponsors. The ATA has voiced strong support for this bill.⁸³

• **The Increasing Credentialing and Licensing Access to Streamline Telehealth (ICLAST) Act.**

Not introduced, this bill authored by Sen. Tom Udall (D-NM) in 2011 would initially create a voluntary national license, issued in tandem with a state license, which would allow physicians to practice across state lines. This system would transition to a mandatory system for physicians accepting Medicare or Medicaid payment, and would eventually be expanded to all types of health care providers. The bill would reserve investigation of complaints and discipline to the states, but the bill does not stipulate how these activities would be paid for.⁸⁴

There is little to dispute about the many potential benefits of the use of technology in the delivery of health care. Weighing the implications of how our population's demographics and geography drive utilization of health care, or how the economics of medical education and reimbursement shape not merely how doctors practice but in what specialties they choose to practice, also does not dispute the myriad possibilities of technology in serving the health care needs of the public. Finally, it is critical to reemphasize that mere identification of the troubling aspects of legislative proposals or stakeholder critiques should not and does not constitute a *de facto* indictment of either telemedicine or interstate practice.

State medical boards have been vocal supporters of responsibly using telemedicine technologies to expand access, especially in rural and underserved areas. However, state medical boards must also recognize that the statements of influential critics, proposed—and enacted—federal bills, and changes in technology, demographics and financing, all represent fundamental challenges to how they have operated for decades. By natural extension, should the boards choose not to adapt to changing conditions and expectations, these elements can pose risks to the ability of state medical boards to continue their enduring public protection mission. As Ameringer counsels, “If state medical boards fail to put aside their differences and create a uniform approach to regulating the practice of medicine across state lines, the federal government would have cause to intervene.”⁸⁵ How then might state medical boards operationalize Ameringer’s advice?

Interstate Compacts: A Primer

The purpose of this article is twofold. Thus far its focus has been to set out how state medical boards have historically safeguarded the public

through the licensure and discipline of physicians, and to describe how this role is consistent with federal legal and constitutional principles. In response to a rapidly changing landscape within health care prompted by technology, multistate medical practice and evolving consumer expectations, the remainder of this inquiry will center on the concept of an interstate compact for physician licensure, how it has been developed and why it is the ideal mechanism to meet these challenges.

To evaluate the compact mechanism, it is necessary to gain a working understanding of how compacts exist. Broun, Buenger, McCabe, and Masters, in *The Evolving Use and the Changing Role of Interstate Compacts: A Practitioner's Guide*, provide what may be the quintessential “elevator” speech for the utility of interstate compacts:

[C]ompacts can effectively preempt federal interference into matters that are traditionally within the purview of the states but that have regional or national implications. Unlike federal actions that impose unilateral, rigid mandates, administrative compacts afford states the opportunity to develop dynamic, self-regulatory systems over which the member states can maintain control through a coordinated legislative and administrative process. The very nature of an interstate compact makes it an ideal tool to meet the need of cooperative state action...⁸⁶

Multiple factors contribute to the merit of interstate compacts as a means of collective state governance. First, despite the relative obscurity of interstate compact law in the field of jurisprudence, its bedrock lies squarely in the U.S. Constitution, and

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the forerunners of interstate compacts even precede the nation’s founding. The Constitutional authority of compacts uniquely suits them to resolving statutory and regulatory differences between states, and they have been successfully applied across the gamut of regulation. Furthermore, inter-

state compacts have adapted over time to address progressively more challenging public policy issues. Finally, in contrast to anxiety over a perceived erosion of state sovereignty, the long history of compacts demonstrates that the benefits for states far outweigh any loss of authority.

Ironically, interstate compacts are widely used in American government and yet are not well understood by the general public.⁸⁷ At the same time, interstate compacts are one of the oldest forms of cooperative government. As with the history of medical regulation in the United States, the history and use of compacts dates to colonial times, where they were used for boundary settlement negotiations where land charters were vague or incorrect. When appointed parties forged an agreement, it was then submitted to the Crown for approval.⁸⁸ Indeed, in the 1838 United States Supreme Court case *Rhode Island v. Massachusetts*, Justice Baldwin, writing for the Court, hearkens back to “the Crown of England to the Plymouth Company in 1621; to Massachusetts in 1629; to Rhode Island in 1663; the new charter to Massachusetts in 1691; together with sundry intermediate proceedings of the council of Plymouth.”⁸⁹ This framework remains the basis for interstate compacts today.

Compacts are a hybrid of contract law and statutory law that states are specifically authorized to use under the “Compact Clause” of the U.S. Constitution (Article 1, Section 10, Clause 3):

“No State shall, without the Consent of Congress, lay any Duty of Tonnage, keep Troops, or Ships of War in time of Peace, enter into any Agreement or Compact with another State, or with a foreign Power, or engage in War, unless actually invaded, or in such imminent Danger as will not admit of delay.” (emphasis added)⁹⁰

Compacts are unique in American governance in that they rely on the premise of states’ rights, yet they exist between state and federal authority. Because states enter into a contractual relationship with other states via the passage of state legislation, once entered, the terms of a compact cannot be changed unless agreed to by all the member states of the compact.⁹¹ As a result, the authority of compacts supersedes that of state laws, rules, courts, and even state constitutional provisions, unless specifically exempted.⁹²

The question is often asked of whether the Compact Clause requires Congress to affirmatively consent to every compact, or whether the lack of explicit

consent is an obstacle to establishing a compact. Although it might imply this, according to the Council of State Governments, “[t]o clear up the ambiguity of the Compact Clause, the U.S. Supreme Court in *Virginia v. Tennessee* held that Congress must approve only two types of compacts: those compacts that alter the balance of political power between the state and federal government; or those compacts that intrude on a power reserved to Congress.”⁹³ Others have similarly noted that

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Congressional consent may be implicit or explicit, depending on whether the compact would have a bearing on the balance of federal/state powers as laid out in the Constitution.^{94,95,96} Congress’s consent to an interstate compact can be either prospective or after a compact has already been established. Congress also has the authority to deny or withhold its consent to any interstate compact that it believes would violate either the federally-enumerated powers test or the federal-state balance of power test. However, a threat of withdrawal or denial is, practically speaking, extremely remote.⁹⁷ Indeed, especially in regard to the regulation of physicians, this article has laid out multiple reasoned arguments for it to remain within the domain of the states.

A final note regarding the issue of Congressional Consent relates to what becomes of compacts, and the interstate organizations created by them, when formal consent is given. The answer, in operational terms, is absolutely nothing. Only in one respect does having formal consent “transform” the compact into federal law. As Justice Brennan wrote for the majority in the 1981 Supreme Court case *Cuyler v. Adams*, “[b]ecause congressional consent transforms an interstate compact within this Clause into a law of the United States, we have held that the construction of an interstate agreement sanctioned by Congress under the Compact Clause presents a federal question.”⁹⁸ Thus, unlike any other type of federal legislation, compacts with consent are

“federalized” only in that they fall exclusively within the jurisdiction of federal courts and enjoy protection against attacks on Constitutional grounds.⁹⁹

An indication of the true significance of interstate compacts is that disputes arising from compacts are one of the few areas where the United States Supreme Court may exercise original jurisdiction.^{100,101} As a result, there is an important body of U.S. Supreme Court case law related to interstate compacts, including some of the most important cases the High Court has heard. One such case, relating to the enforceability of interstate compacts, is *West Virginia ex. Rel. Dyer v. Sims* in 1951. The case involved a dispute in West Virginia as to whether or not a payment of \$12,250 to support the Ohio River Valley Water Sanitation Compact represented an illegal (per West Virginia’s Constitution) delegation of the state’s police power to other states and the federal government. Edgar B. Sims, the state’s auditor, refused to issue the warrant to pay for the compact’s expenses.¹⁰²

Writing the majority opinion, Justice Felix Frankfurter found the compact to be a “conventional grant of legislative power” and that the language of the compact, in which states agree to appropriate funds for its administrative expenses, did not represent a conflict with the West Virginia Constitution.^{103,104} Justice Reed, in a concurring opinion specifically noted that “under the Compact Clause...the federal

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questions are the execution, validity, and meaning of federally approved state compacts. The interpretation of the meaning of the compact controls over a state’s application of its own law through the Supremacy Clause, and not by any implied federal power to construe state law.”^{105,106}

An especially important feature of interstate compacts, for the purposes of this discussion, is the evolution of compacts in the 20th century to include governmental organizations for ongoing regulation. This occurred as a result of interstate compacts not having the necessary tools to respond to changing conditions and complexities,

as well as not being able to effectively enforce the provisions of compacts with member states. The New York/New Jersey Port Authority, created by a bi-state compact in 1921, was significant in that it was the first interstate government agency created in the western hemisphere and was the first interstate agency created by interstate compact.¹⁰⁷ In more recent times, ongoing regulatory agencies have become fixtures in interstate compacts. In some cases, existing compacts have even been renegotiated to incorporate interstate commissions, such as with the Interstate Compact for Adult Offender Supervision, the Interstate Compact on Juveniles, and the Interstate Compact for the Placement of Children.¹⁰⁸

It must be acknowledged that, for some, the notion of “giving” away the authority of state boards to their associates in other states, or to an interstate commission, is disquieting. That state-specific laws or rules may be overridden by an interstate compact mechanism gives rise to visions of “big brother” for skeptics. There is an undeniable relinquishing of some individual board autonomy to participate in a compact. Further, because the compact is intended to create uniform standards and processes across all states that enact it, it cannot by definition accommodate all the individual regulatory nuances of any given member state. However, it is also undeniable that, at present, state boards have no true jurisdiction over physicians who are licensed elsewhere, even when it is their states’ patients who are harmed by them. State laws do not give boards the ability to reach beyond those governed by their licensing statutes to investigate or take action on physicians providing unsafe or improper care from afar. The compact mechanism, however, gives states the authority to collectively act in a way that individual states, relying solely on their individual authority, cannot. Broun, Buenger, McCabe, and Masters further evaluate the trade-offs of individual versus collective state authority:

As for concerns related to the loss of individual state sovereignty, there is no question that the parties to interstate compacts necessarily give up the right to unilaterally control the joint agencies they create. But when measured against the nature of congressional intervention and the loss of authority that can result from federal preemption of a particular field, the state legislative and regulatory control that states jointly retain under interstate compacts is usually preferred by states. Viewed through this lens, the decision to empower an interstate

agency is more likely to be seen as a welcome protection of 'collective state sovereignty' than it is to be resisted as an unacceptable sacrifice of individual state authority.¹⁰⁹

Interstate compacts have been widely applied in the history of American government, with more than 200 active compacts, including 22 truly national

INTERSTATE COMPACTS HAVE BEEN WIDELY APPLIED IN THE HISTORY OF AMERICAN GOVERNMENT, WITH MORE THAN 200 ACTIVE COMPACTS, INCLUDING 22 TRULY NATIONAL ONES. THE AVERAGE U.S. STATE IS A PARTY TO 25 INTERSTATE COMPACTS.

ones. The average U.S. state is a party to 25 interstate compacts.¹¹⁰ They have evolved in their form and application throughout American history and are effectively employed for purposes as varied as boundary disputes, resource management, taxes, insurance, criminal justice, health care, education, emergency management, transit, and economic development. Indeed, as Supreme Court Justice Felix Frankfurter noted, "that a legislature may delegate to an administrative body the power to make rules and decide particular cases is one of the axioms of modern government."¹¹¹ More than sufficient evidence exists to reasonably infer that compacts can be just as effective for the regulation of physician practice across state lines.

The Interstate Medical Licensure Compact — Origins, Development, and Key Themes

The antecedents to development, or even consideration, of an interstate compact for physician licensure began some years ago. The FSMB has been engaged in activities for a considerable period to promote expedited licensure and to facilitate practice in multiple states. It is also clear from the above discussion that both Congressional activity and stakeholder interest in telehealth and multi-state practice were well underway by 2012.

For the purposes of this discussion, however, we will focus on the most immediate events, beginning with a 2012 resolution to the FSMB House of Delegates from the Maine Board of Licensure in Medicine. Resolution 12-4, dubbed the Platinum Standard Model, directed the Federation to

"convene and charge Member Boards with defining and developing a set criteria of qualifications for a Platinum Standard Certification, and a system to allow State Medical Boards to make rapid licensing available to the highest caliber of licensed physicians by September 1, 2012."¹¹² The intent of the resolution was that states, in collective examination of their licensing standards, could establish a "highest common denominator" of requirements and, if a physician were to qualify for the Platinum Standard and be licensed by one state, other coordinating states could then license him or her based on that distinction, without further evaluation.

Resolution 12-4 was initially defeated in the House of Delegates, in part based upon apprehension that such a designation would connote a two-tiered system of physicians. However, further floor action revived the resolution in a different form, referring the question of a Platinum Standard to the Board of Directors for study and a report back to the House of Delegates in 2013, which passed the House.¹¹³ The FSMB Board of Directors subsequently referred the matter for consideration to the FSMB Advisory Council of Board Executives, a standing group of state medical board executive directors.

The Advisory Council engaged in extensive debate on the Platinum Standard Model at its August 2012 meeting, yet it came to the same subdued conclusion as had the FSMB House of Delegates. Nevertheless, the Council remained in clear consensus that, as Resolution 12-4 stated, "a national trend [was] rapidly emerging, whereby state and federal policymakers [were] questioning the validity of the current state-based licensure system."¹¹⁴ This recognition prompted the Council in that meeting toward exploration of a number of other alternatives. This included an initial conceptual discussion of a multistate license, possibly offered through an interstate compact.

In order to further delve into these alternatives, the FSMB, in coordination with Administrators in Medicine, hosted a meeting in January 2013 for the purpose of examining existing state licensure processes and exploring innovative licensure approaches that could facilitate multistate practice. The meeting, which included representatives of 48 of the 69 licensing boards in the United States and its territories, was intended to move forward a more concrete discussion of one or several models that boards could pursue to better accommodate the practice of medicine across state lines, including via telemedicine.

Crady DeGolian, Director of the National Center for Interstate Compacts with the Council of State Governments, was one of the featured speakers at this meeting and provided the audience with an overview of interstate compacts. It was the first time that a detailed examination of interstate compacts explicitly entered the conversation, and although the participants did not leave the meeting having coalesced around any single methodology, the notion of an interstate compact for physician interstate practice emerged from the meeting with substantial support.

Not long afterward, the State of Wyoming Board of Medicine submitted to the FSMB, for consideration by the House of Delegates at the 2013 Annual Business Meeting, Resolution 13-5, which read in part:

Therefore, be it hereby resolved, that the FSMB convene representatives from state medical boards and special experts as needed to aggressively explore the development of an Interstate Compact to facilitate license portability hereinafter known as the Medical License Portability Interstate Compact project, and be it further resolved that the Medical Licensure Portability Interstate Compact project be initiated no later than July 2013.^{115,116}

The passage of Resolution 13-5 by the FSMB House of Delegates at the 2013 Annual Business Meeting is extraordinary in at least two respects. First, despite no shortage of membership discomfort about a loss of state authority, about whether a compact was a suitable scheme for regulating physicians, and about a general lack of familiarity with compacts as a governing tool, the Resolution

GENERALLY, PARTICIPATION IN AN INTERSTATE COMPACT CREATES ANOTHER PATHWAY FOR LICENSURE, BUT DOES NOT OTHERWISE CHANGE A STATE'S EXISTING MEDICAL PRACTICE ACT.

passed the House unanimously, and with virtually no discussion on the House floor. Second, given that discussions about how to facilitate physician mobility and practice across state lines has divided the regulatory community since the foundation of the FSMB, that the membership should unite in singular fashion behind such a proposal, even merely to study its feasibility, is remarkable.

To comply with the Resolution's timelines to begin work by July 2013, the FSMB convened two developmental meetings in June and September 2013. During the two two-day sessions, representatives from a cross-section of medical and osteopathic boards conferred and sometimes actively debated the principles and goals of what a compact might accomplish and what the organization of a compact system might resemble. The groups extensively probed the details of how a compact might be financed, how licenses might be issued, what qualifications might be necessary to participate, and what role an interstate commission would play. The representatives gave great thought to how discipline would be handled, both with respect to licenses issued by the physician's primary state of practice and those issued by other states in the compact, and they weighed how to enhance data sharing amongst the compact states. Finally, the groups carefully considered the need and methods to communicate with state medical boards, stakeholders and partners within the House of Medicine, and the broader public about how this complementary process would balance patient protection with changes in medical practice. The deliberations of the June and September meetings resulted in eight foundational principles upon which a compact would be structured:¹¹⁷

- Participation in an interstate compact for medical licensure will be strictly voluntary for both physicians and state boards of medicine.
- Generally, participation in an interstate compact creates another pathway for licensure, but does not otherwise change a state's existing Medical Practice Act.
- The practice of medicine occurs where the patient is located at the time of the physician-patient encounter and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.
- An interstate compact for medical licensure will establish a mechanism whereby any physician practicing in the state will be known by, and under the jurisdiction of, the state medical board where the practice of medicine occurs.
- Regulatory authority will remain with the participating state medical boards, and will not be delegated to any entity that administers the compact.
- A physician practicing under an interstate compact is bound to comply with the statutes, rules and regulations of each compact state wherein he/she chooses to practice.

- State boards participating in an interstate compact are required to share complaint/investigative information with each other.
- The license to practice medicine may be revoked by any or all of the compact states.

Following the groundwork and consensus-building in the June and September meetings, which created a clear set of parameters around which to construct

PARTICIPATION IN THE COMPACT SHOULD NOT ADVERSELY AFFECT STATE MEDICAL BOARDS EITHER BECAUSE OF REDUCTION IN LICENSING REVENUE OR AN INCREASE IN FEES.

a compact, a small drafting team met with FSMB staff in November of 2013 to craft and refine the provisions of a draft document. In drafting the compact, the drafting team identified several essential themes to address:

- Participation in the compact should not adversely affect state medical boards either because of reduction in licensing revenue or an increase in fees. The compact is designed to act as a clearinghouse, ensuring that licensing fees are collected and distributed to the appropriate states. Moreover, those fees would be set, as all fees currently are, by the states, and not by an interstate commission. All licensees would have to pay the fees set in those states in order to obtain and maintain a license via the compact, just as with licenses currently obtained via traditional methods.
- Participation in the compact should not afford a physician an opportunity, under the guise of multi-state practice, to elude discipline, nor should it impinge on states' ability to take action against their licensees. At the same time, participation in a compact should facilitate more effective disciplinary action than the present system of states reporting to one another, and it should foster protection of the public across all states. Under the compact, an interstate commission would not have disciplinary authority, but would, as with fees, serve as a clearinghouse for disciplinary information to states. The compact would also provide states the flexibility of whether to pursue action against a licensee or not when another state already has, except in the most serious of cases.
- State boards participating in a compact should be aware of the physicians who are, or are capable of, practicing within their borders. It is recognized as critical to boards' patient safety missions that they must not only have jurisdiction over physicians practicing in their states, but they must have clear knowledge of their physician population in their states. Under the compact, all states, when selected by a physician who is deemed eligible by their principal state, would issue a full license to that physician, creating a clear regulatory linkage. Moreover, states will report to one another, again, using an interstate commission as a hub, any changes in physicians' licensing or disciplinary statuses.
- The interstate compact contains mechanisms, such as rulemaking authority, to allow member state boards to clarify important areas of policy. Because the compact itself is essentially a multi-state contract enacted as legislation, by necessity its provisions must remain broad. When substantive changes to a compact are necessary, member states must go through the excruciating process of amending the statutory language in every member state, with the amended provisions not taking effect until every state has enacted the change. Consequently, rulemaking authority is essential for addressing many operational details of the compact. A prime example of this is the issue of requiring federal background checks via fingerprint as part of the licensure process. Likely to be a subject of rulemaking by an Interstate Commission, to explicitly require in the compact that such checks be performed by fingerprinting could preempt new future methodologies that might be even more effective.
- States participating in a compact will have regulatory responsibility for an Interstate Commission, not the other way around. Participation in the compact requires state legislatures' and governors' authorizations, but this does not equate to a ceding of authority to a "superboard." As noted above, state boards will collectively comprise an Interstate Commission and oversee its operation. This governance of the compact by a Commission is needed due to the complexity of medical practice and the ongoing interstate coordination needed to maintain the compact's currency, but it is administrative in nature and does not extend to direct licensure or discipline of any physician.
- States should not have to pay to participate in the compact. Undue concern has been raised about

whether an interstate compact could require states to pay dues or fees as cost of that participation. There is no intention to charge states a fee to join or remain in the compact; those developing it specifically envision that an interstate commission would be financially self-supporting through physician fees, as is the case with most state medical boards currently. That said, there are important reasons that the draft compact contains language specifically authorizing direct state financial support. The compact, and an interstate commission, would exist as instruments of the states that join it. It is their authority they are expressly giving to the compact, and with that goes the ultimate fiduciary responsibility for that governmental entity. Without the member states underwriting its authority, an interstate commission might not be considered a government organization for tax purposes. Moreover, those who would serve on the interstate commission might not enjoy the same qualified immunity that they now enjoy as members of their state boards. It does not mean, however that your colleagues that crafted the proposed interstate compact, visualized in any way that boards or states would have to “pay to play.”

- The full utility of an interstate compact should be used to develop additional tools to assist boards in their licensing and regulatory responsibilities. Because of the uniqueness of the authority of compacts, they allow states to innovatively address problems they share. One such area for state medical boards is in the area of out-of-state investigations. The proposed compact contains language intended to empower the sharing of investigative information between states and still maintaining the proper confidentiality. Joint investigations between state boards, the sharing of investigative information, and the enforcement of subpoenas across state lines are all examples of what could be accomplished with an interstate compact for physicians.

The Interstate Compact: The Better Alternative for State Medical Boards

Despite evidence of the long history of state board regulation of medicine, and the mandate from their state legislatures to do so, state boards cannot rely merely on those facts as a defense of the status quo. As a strategy, they are certainly necessary elements, but are not by themselves sufficient. However, an interstate compact is the optimal policy response for boards, for a variety of reasons:

1. Compacts, as noted above, are as old as the Constitution itself, and have been used throughout American history. Over 200 interstate compacts currently exist, including 22 that are truly national in membership. While the concept of compacts may be novel within the medical community, they are well-tested and operate with great effectiveness across the spectrum of government.
2. Former Wyoming Governor Jim Geringer spoke at the January 2013 FSMB meeting about his preference for interstate compacts as a means for states to collectively solve their policy problems. In January 2014, sixteen U.S. senators (including one MD) wrote to the FSMB and expressed their appreciation for the work of the state boards in exploring development of an interstate compact, saying “[a]s you continue the development process, we would like to express our support for an interstate compact to provide a solution to expedite the process whereby physicians can be licensed in multiple states and practice telemedicine in a safe and accountable manner.”¹¹⁸

THE PROPOSED COMPACT CONTAINS LANGUAGE INTENDED TO EMPOWER THE SHARING OF INVESTIGATIVE INFORMATION BETWEEN STATES AND STILL MAINTAINING THE PROPER CONFIDENTIALITY.

Elected officials at both the federal and state levels, including Democrats and Republicans, liberals and conservatives, understand the role of interstate compacts and broadly support their use in lieu of federal intervention. And, as noted above, development of an interstate compact by states forestalls the uncertainties that may come with federal mandates.

3. Some have asserted that we can achieve many of the same goals without such drastic steps, that states can respond to these forces in more organic and less formal ways. I counter-assert that if this were so, states would have already taken the initiative. Today’s state regulation of physicians reflects an evolutionary process, for which boards deserve credit; that said, absent an imperative to weigh the merits of an interstate compact, it is fair to ask whether boards would still be doing so. For those seeking a substantive change in how state boards operate, the creation of an interstate compact represents a good faith

effort to be responsive to their needs yet safeguard the public.

4. Given that state medical boards are contemplating an interstate compact, the opportunity exists via the compact mechanism to make important process improvements that would be challenging for states to enact individually. Allowing for

AN INTERSTATE COMPACT WOULD STREAMLINE THE LICENSURE PROCESS FOR QUALIFYING PHYSICIANS BY ELIMINATING THE NEED TO REPRODUCE DOCUMENTS MULTIPLE TIMES FOR DIFFERENT JURISDICTIONS ONCE THEY HAVE BEEN PRIMARY-SOURCE VERIFIED BY ANOTHER STATE.

boards to jointly investigate licensees and to share data between boards during the investigative process are two key examples. In addition, an interstate compact would streamline the licensure process for qualifying physicians by eliminating the need to reproduce documents multiple times for different jurisdictions once they have been primary-source verified by another state. Interstate compacts serve ideally to allow states to focus more broadly in problem resolution without resorting to federalization.

5. There is an important distinction between the harmonization of state standards and the ceding of state authority to a uniform national standard. An interstate compact would foster more consistent standards across the country in how state boards carry out their licensure and discipline activities, but it would not usurp that state authority to an interstate compact, a federal bureaucracy, or any other entity. In fact, because compact terms cannot be altered except by unanimous consent of the member states, compacts offer a remarkable degree of constancy. Only through the rulemaking process of an interstate commission can changes be implemented. Because the interstate commission concept is, as yet, an abstraction, it is an easy target for skeptics. However, once implemented, the commission will be comprised of members of state boards, not strangers. There is no reason to assume that fellow board members and executives from other states, serving on such a commission, would exercise any less care and

caution in administering the compact than would the skeptics themselves.

6. Consider the premise that, due to the combined effects of federal action and the explosion in the interstate practice of medicine (either in person or by telemedicine), health care is becoming a type of interstate commerce; consequently, it merits asking whether it could eventually subject it to the Commerce Clause. If so, the provision of health care could become subject to either "field preemption" where federal regulation is already sufficiently pervasive to crowd out state regulation, or "conflict preemption," where state and federal regulation are inconsistent or state law essentially impedes the intent of Congress.¹¹⁹

7. Some national licensing schemes that have been discussed could enable some or all licensing at the federal level, yet leave the matter of physician discipline to the state boards.¹²⁰ Given that the essential task of public protection through enforcement is paid for through licensing and renewal fees, this could become an unfunded mandate, seriously impairing the ability of state boards to take appropriate and timely action when needed.¹²¹ If, as noted above, some partial preemption of licensure was coupled with a method of allocating funds back to the states, there is no assurance that the funds will not come with policy strings attached. Finally, investigating and imposing discipline, at the state level, on a national license could prove jurisdictionally challenging, as would the question of coordination of federal licensing with state disciplinary actions.^{122,123}

8. A federal system would necessarily require a significant new bureaucracy, and it is unclear whether or how such an organization could take advantage of the significant existing expertise and board infrastructure within the states. While the federal government does have some limited experience overseeing physicians in its systems, they are still licensed by and accountable to state boards. The federal government's experience is also limited to closed systems such as the Department of Defense and the Veterans Administration, where physicians are employees or contractors of the government and see only defined populations. According to Gilman, "there is no federal agency with the authority, experience, and expertise to perform the various licensing functions undertaken by the states and it would not be trivial to create one."¹²⁴

The Future of Physician Regulation— To Compact or Not?

Social critic Neil Postman, in the foreword of his book, *Amusing Ourselves to Death: Public Discourse in the Age of Show Business*, contrasted the fictitious futures of Aldous Huxley and George Orwell:

Orwell feared those who would deprive us of information. Huxley feared those who would give us so much that we would be reduced to passivity and egotism. Orwell feared that the truth would be concealed from us. Huxley feared the truth would be drowned in a sea of irrelevance. Orwell feared we would become a captive culture.

Huxley feared we would become a trivial culture, preoccupied with some equivalent of the feelies, the orgy porgy, and the centrifugal bumblepuppy. As Huxley remarked in *Brave New World Revisited*, the civil libertarians and rationalists who are ever on the alert to oppose tyranny “failed to take into account man’s almost infinite appetite for distractions.” In 1984, Huxley added, people are controlled by inflicting pain. In *Brave New World*, they are controlled by inflicting pleasure. In short, Orwell feared that what we hate will ruin us. Huxley feared that what we love will ruin us.¹²⁵

It is clear that neither Huxley and Orwell, nor Postman in his critique of the two authors, envisaged the future as an enchanted utopia. Certainly care must be taken not to spin too fine of an allegorical thread between the future worlds of these authors and what an Interstate Medical Licensure Compact might portend for the state-based medical regulatory system. Still, we also should have no illusions that bringing an interstate compact to life will be uncomplicated or a consequence-free panacea. Such a sea change will require continued critical thinking to refine the compact’s language; extensive communication and change management efforts with the public and our licensees, partners, and stakeholders; and the passage of new laws in Legislatures across the country. It will require the establishment of an interstate commission, including physical offices, staff, bylaws, rules, and complex information and financial systems.

Mostly, it will require many, many additional hours of dialogue, consultation and even debate among those of us in the medical regulatory community. Recall that it was the very issue of states honoring “candidates presenting themselves based upon their license having been obtained through examination in another state”¹²⁶ that split the American Confederation from the National Confederation for over a decade at the

beginning of the 20th century. Still, just as the leaders of that day resolved their differences for the greater good, creating the FSMB to serve a vital collaborating role for all the state medical boards, those of us within this profession today must exercise the same intrepidity and sagacity to confront the new and more complicated obstacles of the present and the future, and to push onward.

All that said, the hard work will be worth it. The U.S. Constitution and important Supreme Court case law have affirmed the proper role of states in regulating medicine, a practice that has progressed over nearly four centuries. The question of physicians practicing across state borders has vexed those charged with regulating it since even before the founding of the Federation of State Medical Boards in 1912, although both the opportunities and mounting pressures of modern medical practice have elevated this question’s significance to an existential level for boards. Yet these same boards possess the capacity and the expertise to answer the question, springing from decades, even centuries, of responsibility for physician licensure. Finally, the interstate compact, widely used in the collective solution of state problems, has also grown and evolved since the colonial era, and it stands as both a feasible and powerful tool for state medical boards to retain the best aspects of what they do as they continue to adapt to a changing world.

One might say, a brave new world. ■

About the Author

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