

TELEMEDICINE AND MALPRACTICE: CREATING
UNIFORMITY AT THE NATIONAL LEVEL

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INTRODUCTION

Picture this: an elderly gentleman living alone, isolated in a rural, midwestern locale. One day, this elderly gentleman awakes to find a distinct rash forming on his chest. The nearest doctor capable of performing an examination is located over a hundred miles away, and this man has not driven more than ten miles in twenty years. Shambling into his living room, the elderly man logs onto his computer and begins typing. Within twenty minutes he is video-conferencing with a doctor who examines the rash remotely and makes a diagnosis.¹

Through advances in telemedicine, the scenario described above is becoming an increasingly common occurrence, and, for many, a life-altering opportunity.² Yet many legal uncertainties exist in the realm of telemedicine, particularly in regard to medical malpractice.³ Are doctors held to the same standard of care as they would be in traditional medicine? What standard of care should a court look to when a doctor, practicing over state borders via telemedicine, finds himself enmeshed in a malpractice suit? When is the physician-patient relationship established for the purpose of determining malpractice liability? These uncertainties create potential barriers to the widespread adoption of telemedicine

1. See Winifred V. Quinn et al., *Using Telehealth to Improve Home-Based Care for Older Adults and Family Caregivers*, AARP POLY INST., May 2018, at 2, <https://www.aarp.org/content/dam/aarp/ppi/2018/05/using-telehealth-to-improve-home-based-care-for-older-adults-and-family-caregivers.pdf> [<https://perma.cc/9F3X-JRU5>] (describing home-based video visits with specialists and primary care providers as a telehealth service).

2. See, e.g., Thomas Sullivan, *The Expected Impact of Telemedicine on the Elderly*, POLY & MED. (Aug. 12, 2018), <https://www.policymed.com/2018/08/the-expected-impact-of-telemedicine-on-the-elderly.html> [<https://perma.cc/S6AT-X43H>] (reporting that the company BDO USA, LLP predicted that an increased usage of telemedicine services for seniors in underserved communities would create greater access to medical services and lead to better clinical outcomes).

3. See, e.g., Bonnie G. Ackerman, *Is the Doctor In? Medical Malpractice Issues in the Age of Telemedicine*, NAT'L L. REV. (Apr. 17, 2019), <https://www.natlawreview.com/article/doctor-medical-malpractice-issues-age-telemedicine> [<https://perma.cc/6NMG-N5HD>] (stating that telemedicine creates unique malpractice risks that complicates malpractice claims).

services.⁴ If these barriers are to be overcome, legislative action must establish uniformity and certainty.⁵

Telemedicine has become the answer to that desperate question of where to seek medical consultation and care, a question that has long plagued rural American communities.⁶ Through telemedicine, doctors are able to virtually see patients “face-to-face” using video communication systems.⁷ Healthcare professionals can monitor high-risk patients’ health parameters over long distances, diminishing the need to travel for routine testing.⁸ In short, telemedicine presents the United States with a number of benefits, from reducing the costs associated with traditional medical services,⁹ to providing increased access to medical services in underserved communities.¹⁰

Despite the promising potential of telemedicine, the American health system has been relatively slow to adopt this emerging technology, though the utilization of telemedicine services increased in recent years.¹¹ One of the reasons for this slow uptake is the

4. See Christopher J. Caryl, Note, *Malpractice and Other Legal Issues Preventing the Development of Telemedicine*, 12 J.L. & HEALTH 173, 193 (1997) (stating that the uncertainty of malpractice liability is an impediment to widespread telemedicine usage, as unsure physicians may not provide care to rural communities due to liability concerns).

5. See discussion *infra* Part III.

6. See *Access to Health Services*, HEALTHYPEOPLE (Sept. 23, 2019), <https://www.healthypeople.gov/2020/leading-health-indicators/2020-lhi-topics/Access-to-Health-Services> [<https://perma.cc/BU8V-SBCR>] (stating that nearly 25 percent of Americans lack either primary care providers or health centers that provide routine medical services); *Healthcare Access in Rural Communities*, RHIHUB (Jan. 18, 2019), <https://www.ruralhealthinfo.org/topics/healthcare-access#barriers> [<https://perma.cc/3KPL-NYYW>] (detailing how a lack of primary care providers in rural areas and the lack of access to hospitals presents significant barriers to care for rural inhabitants).

7. See Quinn et al., *supra* note 1, at 2-3 (listing and explaining common forms of telemedicine).

8. See *id.* at 2.

9. See Adelyn B. Boleman, Comment, *Georgia’s Telemedicine Laws and Regulations: Protecting Against Health Care Access*, 68 MERCER L. REV. 489, 494 (2016) (describing how the Veterans Health Administration (VHA) reduced costs for veterans suffering from a number of conditions through the use of telemedicine). In 2012, the VHA estimated that around \$6500 was saved per patient, amounting to almost \$1 billion of system-wide savings that year. *Id.*

10. See Sarah Klein & Martha Hostetter, *Using Telemedicine to Increase Access, Improve Care in Rural Communities*, COMMONWEALTH FUND (Mar. 30, 2017), <https://www.commonwealthfund.org/publications/newsletter-article/2017/mar/using-telemedicine-increase-access-improve-care-rural> [<https://perma.cc/52VJ-43JN>].

11. Compare MEDICARE PAYMENT ADVISORY COMM’N, *Mandated Report: Telehealth Services and the Medicare Program*, in REPORT TO THE CONGRESS: MEDICARE PAYMENT POLICY 471, 473 (2018), http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch16_

traditional lack of healthcare coverage for a broad range of telemedicine services.¹² This barrier gradually dissipated over the last decade as coverage expanded.¹³ As the usage of telemedicine increases,¹⁴ the legal uncertainties that characterize telemedicine malpractice should be resolved in order to attract the greatest number of skilled medical professionals.¹⁵ Without legal certainty, or by the adoption of overly plaintiff-friendly precedent and legislation, these practitioners may be disincentivized from participating.¹⁶

This Note argues for uniformity in the physicians' standards of care for the purpose of determining malpractice liability, arguing for an approach that holds doctors practicing telemedicine to a national standard that considers the differences between virtual and in-person care. This Note additionally argues that the factors which establish the physician-patient relationship for the purpose of determining telemedicine malpractice liability should be clearly delineated through legislation. Part I will lay out the elements that plaintiffs must establish in a medical malpractice case, identify the major differences in how jurisdictions determine the appropriate

sec.pdf [<https://perma.cc/7BR2-VRBA>] ("The use of telehealth services under the PFS has grown rapidly in recent years but remained low in 2016. Between 2014 and 2016, telehealth visits per beneficiary increased 79 percent. In 2016, 108,000 beneficiaries accounted for over 300,000 telehealth visits totaling \$27 million in spending. These amounts were 0.3 percent of Medicare FFS Part B beneficiaries and 0.4 percent of Medicare PFS spending."), with Phil Galewitz, *Medicare Slow to Adopt Telemedicine Due to Cost Concerns*, KAISER HEALTH NEWS (June 23, 2015), <https://khn.org/news/medicare-slow-to-adopt-telemedicine-due-to-cost-concerns/> [<https://perma.cc/BKY6-ZAC7>] (stating that Medicare paid only about \$5 million for telemedicine services in 2012).

12. See Hana Sahdev, *Can I Skype My Doctor? Limited Medicare Coverage Hinders Telemedicine's Potential to Improve Healthcare Access*, 57 B.C. L. REV. 1813, 1827-28 (2016) (discussing limitations to reimbursement for telemedicine services under Medicare, including limiting reimbursement to only certain healthcare practitioners); Galewitz, *supra* note 11 ("[T]he traditional Medicare program has tightly limited telemedicine payments to certain rural areas. And even there, the beneficiary must already be at a clinic, a rule that often defeats the goal of making care more convenient.").

13. See MEDICARE PAYMENT ADVISORY COMM'N, *supra* note 11, at 479.

14. Given the current trends, an increase in usage seems inevitable. Even the notoriously tightfisted Medicare program is beginning to increase coverage of telemedicine services. See Eric Wicklund, *CMS Proposes More Medicare Reimbursement for Telehealth*, RPM, MHEALTH INTELLIGENCE (July 13, 2018), <https://mhealthintelligence.com/news/cms-proposes-more-medicare-reimbursement-for-telehealth-rpm> [<https://perma.cc/68NP-SAWG>].

15. See Caryl, *supra* note 4, at 198.

16. See *id.*

standard of care, and discuss differences regarding the establishment of the physician-patient relationship for malpractice cases. Part I will also address the negative consequences of the lack of uniformity regarding telemedicine. Part II will argue for uniformity and clarity, proposing that Congress should enact legislation which establishes or encourages an appropriate telemedicine standard of care and clarifies the formation of the physician-patient relationship in such circumstances. Part III will address several avenues of federal action that could institute the desired changes to telemedicine malpractice standards, balancing them against each other to determine the most practical approach.

I. PROBLEMS PRESENTED BY LACK OF UNIFORMITY IN TELEMEDICINE MALPRACTICE

While the application of malpractice standards differs in subtle ways from jurisdiction to jurisdiction, there are generally four components to a malpractice claim: (1) the defendant medical practitioner owed a duty of care to the plaintiff; (2) the practitioner breached his or her duty by deviating from the standard of care; (3) the breach caused recoverable damages to the plaintiff; and (4) there was a causal relationship between the breach and injury.¹⁷ Beyond these four components, most jurisdictions recognize that there must be an established doctor-patient relationship for there to be a duty of care owed to a patient.¹⁸ In terms of relevancy to telemedicine malpractice, differences in establishing the relevant standard of care and how jurisdictions recognize the establishment of a doctor-patient relationship are vitally important.

This Part first explores the differences in how jurisdictions establish the standard of care for the practice of telemedicine, and how the existence of these differences is detrimental to the public policy goal of increased access to medical care. Then this Part highlights the relative lack of consensus and clarity in how the doctor-patient relationship is formed in certain situations and the problem this poses.

17. See, e.g., Stephen McDonald, *Where Does It Hurt? The Practice of Telemedicine Beyond State Lines and Personal Liability*, 11 CHARLESTON L. REV. 553, 562 (2017).

18. See, e.g., *id.*

A. *Differences: Standards of Care*

No matter the jurisdiction, in order for a plaintiff in a medical malpractice case to be successful, he or she must establish that the defendant-physician deviated from a specific standard of care.¹⁹ This is typically accomplished by bringing in an expert witness to testify to the court about what that standard was and how it was breached.²⁰ Generally, the standard of care differs from one medical specialty to another,²¹ regardless of whether the physician provided care on-site or remotely.²² A major point of concern for the purposes of this Note is the disparity in how jurisdictions establish the standard of care within whatever specialty is being practiced.

1. *The Locality Rule vs. National Standard of Care*

There are several overarching ways that jurisdictions establish the standard of care of a physician: either the standard of care is set at a local level, based on what standard a physician practicing medicine in that locality would be held to, or it is set at a national standard within a particular specialty.²³ The locality rule “requires that an expert testifying be from the defendant’s same community and compare the actions of a physician to the applicable standard in the community or locality in which healthcare services are provided.”²⁴ On the other hand, the national standard of care requires the physician to provide a patient with “care comparable to the care provided to patients anywhere in the United States, regardless of

19. See Brian K. Cooke et al., *The Elusive Standard of Care*, 45 J. AM. ACAD. PSYCHIATRY & L. 358, 359 (2017).

20. See, e.g., *Shirley v. McCraney*, 241 F. Supp. 2d 677, 682 (S.D. Miss. 2001) (holding that the plaintiff could not sustain a medical malpractice claim without expert witness testimony establishing that the defendant-physician deviated from the standard of care).

21. See Cooke et al., *supra* note 19, at 360.

22. See Jarred Kibbey, Note, *Health Law—A Call for the Arkansas General Assembly to Modernize the Standard of Care Requirement in Medical Malpractice Cases*, 36 U. ARK. LITTLE ROCK L. REV. 673, 684 (2014).

23. See Cooke et al., *supra* note 19, at 361.

24. Boleman, *supra* note 9, at 511.

the skill and knowledge of the particular professional and the area in which the care is provided.”²⁵

Currently, courts in most jurisdictions recognize a national standard of care, though several states adhere to some vestige of the locality rule.²⁶ The state courts that recognize the locality rule generally cite the desire to protect doctors who practice in rural communities.²⁷ Rural physicians are assumed to lack the same access and knowledge as doctors practicing in major metropolitan areas.²⁸ As the locality rule fell into disfavor,²⁹ some states that maintain the rule adjusted it to fit more readily into the modern medical landscape,³⁰ while others left it largely untouched.³¹

The national standard of care and the locality rule represent one of two variables used to determine the standard of care in a jurisdiction.³² The other variable, dubbed by one scholar as the “means of comparison variable,”³³ refers to the way in which the

25. Tristan Serri, Comment, *An Examination of the Impact of Malpractice Law on Telepsychiatry Clinicians & Clients with Suicidal Ideations*, 50 AKRON L. REV. 933, 944 (2016).

26. See Cooke et al., *supra* note 19, at 361 (stating that forty-five states follow a national standard of care in medical malpractice cases, while five states follow some form of the locality rule).

27. See, e.g., *Brown v. United States*, No. 08-6537, 2009 WL 4641747, at *1, *6 (6th Cir. Dec. 8, 2009) (Rogers, J., concurring) (“The purpose of the strict locality rule was to relieve rural or small town doctors of the necessity of practicing up to a big city standard when that was not reasonably required.”).

28. See, e.g., *id.*; Cooke et al., *supra* note 19, at 359-60 (“It was believed that rural practitioners lacked the equipment of the urban health centers and did not benefit from the latest advances in science and practice that emanated from medical research conducted at urban hospitals.”).

29. See Cooke et al., *supra* note 19, at 361.

30. See, e.g., Boleman, *supra* note 9, at 513 (describing Rhode Island’s modified “similar locality” rule as setting a standard of care which reflects the degree of care taken by physicians practicing the same type of medicine in *similar localities*); Bradley J. Kaspar, Note, *Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, 99 IOWA L. REV. 839, 847 (2014) (stating that physicians in Iowa are held to a reasonable-physician standard, and the factfinder may consider the locality of the physician, but the standard is not explicitly set at the local level).

31. See, e.g., Boleman, *supra* note 9, at 511-12 (stating that Idaho’s strict locality rule holds the practicing physician to the same standard of care as physicians practicing in the community where that care took place).

32. Kaspar, *supra* note 30, at 845 (“Two variables determine the traditional standard of care within a given jurisdiction: (1) the means of comparison between the conduct of the defendant-physician and other physicians, and (2) the pool of physicians that the defendant-physician is compared to.”).

33. *Id.* at 846.

conduct of the defendant-physician in a malpractice case is compared to that of other physicians.³⁴ The traditional “custom-based” standard compares a particular physician’s treatment to the customary medical treatment when determining whether the physician acted within the bounds of “industry norms.”³⁵ Many states have diverged from using the custom-based means of comparison and, instead, utilize the reasonable-physician standard.³⁶ This standard considers whether the defendant-physician acted as a reasonable physician would have under similar circumstances.³⁷

In terms of the usage of telemedicine services, determining the standard of care is of vital importance for the treating physician.³⁸ Differences in the standard of care can be problematic for physicians who use telemedicine services to provide care outside of the state in which they practice.³⁹ Such differences could burden physicians by forcing them to learn and follow numerous standards of care, potentially to the point where they must familiarize themselves with subtle nuances in the standards present in specific townships and counties.⁴⁰ This risk of liability is likely detrimental to the widespread use of telemedicine, as health providers may avoid using telemedicine services to treat patients outside of their jurisdiction.⁴¹ While legislative bodies in many jurisdictions have already ad-

34. *Id.* at 845.

35. *Id.* at 846.

36. *Id.*

37. *Id.*

38. See Brandon Ge, *Telehealth and Standards of Care*, TECHHEALTH PERSPECTIVES (May 13, 2013), <https://www.techhealthperspectives.com/2013/05/13/telehealth-and-standards-of-care/> [<https://perma.cc/9Z2W-24PH>] (stating that it is “critical” that healthcare providers know the standard of care that applies in order to protect themselves from malpractice liability).

39. *Id.*

40. See Kibbey, *supra* note 22, at 682.

41. See Caryl, *supra* note 4, at 193 (stating that the uncertainty of malpractice concerns is an impediment to widespread telemedicine usage, as unsure physicians may not provide care to rural communities due to liability concerns).

dressed standards of telemedicine care,⁴² others are still scrambling to address the issue.⁴³

2. *In-Person Care vs. Telemedicine Care*

Beyond the jurisdictional differences in the standards of care for traditional in-person medical practices, there are additional differences in how states determine the appropriate standards of care for telemedical practices. Those states that have addressed the telemedicine standard of care generally favor an approach which sets the standard at the same level as a physician practicing traditional in-person care.⁴⁴ This holds true for those states still in the process of enacting legislation addressing this standard of care.⁴⁵ Yet Hawaii presents an exception to this approach: its relevant statute establishes that a physician's treatment recommendations made through telemedicine are held to the same standards as recommendations made "in traditional physician-patient settings that do not include a face-to-face visit."⁴⁶

The implication of the differences between these approaches is that a physician practicing telemedicine in a state such as Texas may be held to a higher standard of care than a physician practicing telemedicine in Hawaii.⁴⁷ If a locality rule state adopts statutory language similar to Texas's, its courts would likely hold the practicing physician to the same standard of care as a physician

42. See, e.g., HAW. REV. STAT. § 453-1.3(c) (2018) ("Treatment recommendations made via telehealth ... shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit."); 22 TEX. ADMIN. CODE § 174.6(a)(1) (2019) (stating that health practitioners providing healthcare services through telemedicine services are held to the same standard of care as health practitioners providing such services in an in-person setting); VA. CODE ANN. § 54.1-3303(B) (2019) (stating that for the prescribing of controlled substances through telemedicine services, the standard of care must conform to the standard of care observed during in-person care).

43. See Erik Wicklund, *North Carolina Lawmakers Ready to Take on New Telehealth Legislation*, MHEALTHINTELLIGENCE (May 21, 2018), <https://mhealthintelligence.com/news/north-carolina-lawmakers-ready-to-take-on-new-telehealth-legislation> [<https://perma.cc/Z2DT-RVZT>].

44. See, e.g., 22 TEX. ADMIN. CODE § 174.6(a)(1).

45. See Wicklund, *supra* note 43 (stating that a yet-to-be-enacted bill will hold telehealth standards of care to the same level as in-person care).

46. HAW. REV. STAT. ANN. § 453-1.3(c).

47. See Kaspar, *supra* note 30, at 856 (indicating that Hawaii's statutory language creates a lower standard of care than a state that enacts legislation similar to Texas's).

practicing in-person, and in the same locality as the patient for whom the care was provided.⁴⁸ New York is an example of a state that applies a locality rule and holds physicians practicing telemedicine in that state to the same standard of care as a physician practicing traditional in-person care.⁴⁹

On the reverse side, if a physician practicing in a locality rule state used telemedicine to practice in a state that observed a national standard of care, they may find themselves held to a potentially higher standard of care.⁵⁰ This may dissuade such physicians from utilizing telemedicine services. Studies show that more modern techniques are adopted by states which replace their locality rule with a national standard of care.⁵¹ Such trends indicate that physicians do respond to changes in the malpractice standard of care by implementing more current practices.⁵² This lends support to the argument that the locality rule may be hindering the adoption of telemedicine services where it is observed.

While there is currently a dearth of settled case law regarding standard of care determinations in interstate telemedicine malpractice cases,⁵³ case law indicates that courts would first look to

48. This assertion relies on the finding that a physician practicing telemedicine is subject to the laws of the state in which the patient resides. This has not yet been established by case law but would likely be determined by a state court absent legislation addressing the issue. See J. Kelly Barnes, *Telemedicine: A Conflict of Laws Problem Waiting to Happen—How Will Interstate and International Claims be Decided?*, 28 HOUS. J. INT'L L. 491, 524 (2006) (“[M]ost courts will usually end up applying their own local law in an effort to protect their local citizen and to provide the easiest mode of determination.”).

49. Boleman, *supra* note 9, at 510-11.

50. This situation goes against the purpose of the locality rule, which is meant to protect rural physicians. See Caryl, *supra* note 4, at 197.

51. Michael D. Frakes, *The Surprising Relevance of Medical Malpractice Law*, 82 U. CHI. L. REV. 317, 371-72 (2015) (stating that the differences between local and national usage for various procedures was narrowed by 40 to 60 percent after states switched from a local to national standard of care).

52. *Id.*

53. The lack of settled case law is not indicative of a lack of such suits, but reflects the fact that most malpractice suits settle. See Jonathan D. Glater, *Study Finds Settling Is Better than Going to Trial*, N.Y. TIMES (Aug. 7, 2008), <https://www.nytimes.com/2008/08/08/business/08law.html> [<https://perma.cc/87RJ-J9WA>] (stating that 80 to 92 percent of medical malpractice suits settle). The terms of these settlements are usually subject to nondisclosure agreements, making it even more difficult to find relevant information and statistics. See Gregg Stevens & Lorin Subar, *Confidentiality in Settlement Agreements Point/Counterpoint: Confidentiality Is a Virtual Necessity*, 29 GPSOLO 24, 28 (2012).

state law to determine the appropriate standard of care.⁵⁴ In *White v. Harris*, the Supreme Court of Vermont reviewed a case in which a psychiatrist engaged in a ninety-minute consultation with a patient via videoconference and submitted recommendations for a treatment plan to the patient's treatment team.⁵⁵ That patient later committed suicide, and the plaintiffs filed a malpractice suit, alleging that the care provided by the psychiatrist fell below the required standard of care.⁵⁶ While this case primarily focused on whether a doctor-patient relationship was established by videoconference,⁵⁷ the court did address the standard of care to a degree.⁵⁸ The court indicated that the general standard of care was set by state statute,⁵⁹ though it did not expound upon the particulars of the standard of care.⁶⁰ This reveals that the courts do look to statutory provisions for guidance on the standard of care for telemedicine malpractice cases.⁶¹ Therefore, if state law equates the standard of care for telemedicine to that of traditional in-person care, as a majority of states do,⁶² then the courts would defer to the statute rather than adhering to the established common law.⁶³

A major issue with equating the standard of care of a telemedical practice to that of in-person care is the fact that physicians may have an increased chance of misdiagnosis if they are unable to perform an in-person exam.⁶⁴ While settled case law has

54. See generally *White v. Harris*, 36 A.3d 203, 205, 207-08 (Vt. 2011); *MacDonald v. Schriro*, No. CV 04-1001-PHX-SMM (MHB), 2008 WL 4277828, at *1 (D. Ariz. Sept. 18, 2008).

55. 36 A.3d at 204.

56. *Id.*

57. *Id.* at 205.

58. *Id.* at 207-08.

59. *Id.* at 207 ("Under 12.V.S.A. § 1908(1), a doctor must exercise 'the degree of care ordinarily exercised by a reasonably skillful, careful, and prudent health care professional engaged in a similar practice under the same or similar circumstances,'" whether or not within the State of Vermont. (quoting VT. STAT. ANN. tit. 12. § 1908 (West 2018))).

60. *Id.* at 208 (stating that it was not the court's responsibility to determine the standard of care at the time of the proceedings).

61. The phrase "overall standard of care" here refers to the national versus local standard and custom-based versus reasonable-physician standards.

62. See Kaspar, *supra* note 30, at 855.

63. See *White*, 36 A.3d at 207.

64. Paul Spradley, *Telemedicine: The Law Is the Limit*, 14 TUL. J. TECH. & INTELL. PROP. 307, 329 (2011) (stating that patients may be at an increased chance of misdiagnosis if doctors and patients do not have a physical encounter, which may lead to arguments that the physician may be held to a higher or lower standard of care).

not directly addressed this problem, the facts of *MacDonald v. Schriro* illustrate the issue.⁶⁵ In *MacDonald*, a medical malpractice case stemming from a telemedicine conference, a plaintiff-prisoner injured his knee after falling from his bunk.⁶⁶ The plaintiff received an MRI and saw the defendant-physician through a telemedicine videoconference.⁶⁷ During that appointment, the plaintiff wore long pants and remained seated, as the defendant-physician did not require him to stand in order to demonstrate mobility.⁶⁸ Based on the appointment, the defendant-physician failed to order any form of surgery, instead recommending that the plaintiff wear a knee brace and take anti-inflammatory drugs.⁶⁹ Three years later, the plaintiff again saw the defendant, and the defendant ordered a surgery which resulted in a loose bone fragment being removed from the plaintiff's knee.⁷⁰ The defendant had previously overlooked this bone fragment.⁷¹

The court ultimately rejected the defendant's motion for summary judgment for the medical malpractice claim, citing in part that a jury could find that the physician did not perform an exam and reviewed the wrong MRI results.⁷² In this particular case, the physician's wrongdoing is clear in regard to reading the incorrect MRI, but there is still the question of the examination. The defendant-physician in this case claimed in his medical report that a "physical examination" revealed mobility in the plaintiff's knee,⁷³ but what if the proper standard of care for an in-person examination required that the knee be physically touched by the doctor? If state statutory law held the standard of care for telemedicine examinations to the same level as in-person examinations, then the doctor would likely be found to have violated the proper standard of care simply by using the telemedicine service to perform the examina-

65. No. CV 04-1001-PHX-SMM (MHB), 2008 WL 2783472, at *1 (D. Ariz. July 17, 2008).

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.*

71. *Id.*

72. *See id.* at *3.

73. *Id.* at *11. It is assumed that the reference to a physical examination in this case refers to a demonstration of mobility, not a physical interaction between the defendant and the plaintiff.

tion. It may be more difficult for a physician to diagnose a condition like this via telemedicine services. Yet, in situations where a qualified doctor is not readily available, it is likely that some level of care is preferable to none at all.⁷⁴

The United States clearly has a fractured approach to the standard of care for medical practitioners. This is the result of fifty states independently establishing their own standards, though the country has moved toward uniformity in recent years.⁷⁵ To alleviate physician concerns with regard to telemedicine malpractice, there needs to be greater uniformity.⁷⁶ Furthermore, the current majority approach of holding telemedicine physicians to the same standard as physicians practicing in-person does not consider the inherent limitations of telemedicine.⁷⁷ This may cause concern among physicians who wish to utilize this increasingly popular practice.

B. Establishing the Doctor-Patient Relationship

As mentioned previously, for a medical malpractice case to be successful, a physician-patient relationship must be established in order for the physician to hold a duty of care toward the patient.⁷⁸ This relationship is widely viewed as contractual in nature, either being established expressly by a written contract, or implied through the conduct of the doctor and patient.⁷⁹ While not necessarily problematic for malpractice cases involving traditional care,⁸⁰ uncertainty remains as to when this relationship is established in

74. This is not meant to be construed as support for questionable medical practices, so much as an illustration of the problems that can arise when applying an infeasibly high standard of care to telemedicine practice.

75. See Cooke et al., *supra* note 19, at 361.

76. See Caryl, *supra* note 4, at 193.

77. See *supra* Part I.A.2.

78. See Phyllis Forrester Granade, *Medical Malpractice Issues Related to the Use of Telemedicine—An Analysis of the Ways in Which Telecommunications Affects the Principles of Medical Malpractice*, 73 N.D. L. REV. 65, 68 (1997).

79. *Id.*

80. See McDonald, *supra* note 17, at 563-64 (describing ways in which courts have established the physician-patient relationship in traditional care).

telemedicinal care.⁸¹ This uncertainty should be resolved if doctors are to utilize telemedicinal services without undue fear of liability.⁸²

Without legislation determining the formation of the physician-patient relationship, the existence of the relationship is determined on a factual basis and will vary from case-to-case, even being left entirely for the jury to decide.⁸³ As it so happens, many states have enacted some form of statute or issued policy statements addressing what steps must be taken before a physician-patient relationship has been formed in a telemedicine encounter.⁸⁴ That said, it appears that many of these are not meant to define the relationship for the purpose of determining malpractice liability, but establish the steps that a physician must take in order to properly participate in telemedicine services.⁸⁵ Presently, common law appears to determine when this relationship forms for the purpose of determining malpractice liability.

At common law, courts varied in their determinations of what conduct establishes a physician-patient relationship.⁸⁶ Despite these variations, it is relatively clear that physicians will not be able to escape malpractice liability by claiming that the lack of an in-person meeting or examination precludes the physician-patient

81. See Marilyn L. Higdon, *Trading Your Health: Assessing the Need for Domestic Regulation of Telemedicine and Ability to Conform to U.S. Trade Agreements*, 30 LOY. CONSUMER L. REV. 393, 411 (2018) (“Telemedicine has made it exceedingly difficult to establish duty by removing the physical proximity and hands-on care present in the traditional doctor-patient relationship.”).

82. See McDonald, *supra* note 17, at 566 (indicating that a legislative approach that definitively establishes when the physician-patient relationship is formed via telemedicine could help avoid liability).

83. *Id.* at 565-66.

84. *50-State Survey: Establishment of a Patient-Physician Relationship Via Telemedicine*, AM. MED. ASS’N, <https://www.ama-assn.org/system/files/2018-10/ama-chart-telemedicine-patient-physician-relationship.pdf> [<https://perma.cc/F6W7-92N6>].

85. See, e.g., DEL. CODE ANN. tit. 24, § 1769D(a) (2017) (“Physicians may practice telemedicine and telehealth. Provided that telemedicine shall not be utilized by a physician with respect to any patient in the absence of a physician-patient relationship.”).

86. Compare *Hord v. United States*, No. CA-96-3401-7-13, 1999 WL 249061, at *4 (4th Cir. Apr. 28, 1999) (holding that the physician must offer some benefit to the patient in order for the relationship to be formed, and that even an examination does not establish the relationship unless there was an agreement to benefit the patient), with *Bienz v. Cent. Suffolk Hosp.*, 163 A.D.2d 269, 270 (N.Y. App. Div. 1990) (holding that a telephone call to a doctor’s office regarding the beginning of treatment may be sufficient to create a physician-patient relationship).

relationship.⁸⁷ The relationship is likely formed when the patient has sought medical care from a physician and both the physician and patient agree to that care.⁸⁸ The relationship is most likely established without the need for an in-person meeting.⁸⁹

A potential issue arises when a physician-to-physician consultation occurs through telemedicine.⁹⁰ In these scenarios, the physician does not actually interact with the patients, and such consultations generally do not form the physician-patient relationship.⁹¹ Despite this, it appears that doctors who provide anything more than a mere consultation may expose themselves to malpractice liability by establishing the relationship, even if they never spoke with the patient.⁹² Therefore, doctors walk a fine line when they take part in such practices, and telemedicine may further complicate matters, as prior cases generally dealt with consultation via telephone.⁹³ With the current telemedicine technology, the consulting physician may have the opportunity to be “virtually present” in the patient’s room, as opposed to simply speaking with the treating physician over the telephone.⁹⁴ This may create further uncertainty for physicians as to whether they are consulting with another physician or providing recommendations and treatment, thus establishing a physician-patient relationship.⁹⁵ This uncertainty may be addressed by uniform standards that clearly state when the relationship has been formed.

II. UNIFORMITY OF THE TELEMEDICINE STANDARD OF CARE AND ESTABLISHMENT OF PHYSICIAN-PATIENT RELATIONSHIP

In order for telemedicine to reach its maximum potential, the current differences in the standards of care and establishment of the physician-patient relationship must be resolved. First, this Part will

87. See LYNN D. FLEISHER & JAMES C. DECHENE, *TELEMEDICINE AND E-HEALTH LAW* § 1.04[3][a][i] (2011).

88. *See id.*

89. *See id.*

90. *See id.* at § 1.04[3][a][ii].

91. *See id.*

92. *See id.*

93. *See id.*

94. *Id.*

95. *See id.*

argue for the national adoption of a uniform standard of care for telemedicine practices that reflects Hawaii's statutory approach,⁹⁶ does away with the locality rule,⁹⁷ and utilizes the reasonable-physician standard as opposed to the custom-based standard.⁹⁸ Adopting such a standard will incentivize the use of telemedicine and more properly reflect the potential limitations of current technology. Next, this Part will argue for the creation of a national standard for the establishment of a physician-patient relationship through telemedicine that clearly explains when the relationship has been formed for the purposes of determining malpractice liability.

A. The Appropriate Standard of Care for Telemedicine

Due to the interstate aspects of telemedicine and the unique issues implicit in its usage,⁹⁹ the proper standard of care for its practice should reflect a national reasonable-physician standard, while doing away with the intricacies involved in balancing national standards with locality rules. Furthermore, the majority approach of holding physicians that utilize telemedicine to the same standard as physicians practicing traditional in-person care should be abandoned,¹⁰⁰ and Hawaii's approach should be adopted in its stead.¹⁰¹ The federal action needed to institute these changes will be addressed in Part III.¹⁰²

96. See HAW. REV. STAT. § 453-1.3(c) (2018) ("Treatment recommendations made via telehealth ... shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit.").

97. See *supra* Part I.A.

98. See *supra* Part I.A. In his Note, *Legislating for a New Age in Medicine: Defining the Telemedicine Standard of Care to Improve Healthcare in Iowa*, Bradley Kaspar argues a similar point, but his recommendations were focused on the state of Iowa, while this Note argues for the adoption of the standard at a national level, resolving all state discrepancies. See Kaspar, *supra* note 30, at 861-64.

99. See *supra* Part I.A.

100. See, e.g., 22 TEX. ADMIN. CODE § 174.6(a)(1) (2019).

101. See HAW. REV. STAT. § 453-1.3(c).

102. To clarify, this Note only proposes legislative adjustments for telemedicine, not for in-person care, due to its unique interstate potential.

1. *The Appropriateness of the National Reasonable-Physician Standard*

First, the locality rule creates uncertainties among physicians who wish to provide care across state lines, making it a problematic impediment to the widespread usage of telemedicine.¹⁰³ Abandoning the locality rule, at least for the practice of telemedicine, would maximize telemedicine's potential and introduce useful health services to underserved populations.¹⁰⁴ The argument that the locality rule protects rural practitioners is no longer relevant now that we have nationally standardized medical training, and in light of telemedicine's growing prominence.¹⁰⁵ Therefore, legislation establishing a new standard of care for telemedicine practices should reject any form of the locality rule and replace it with the modern national standard.¹⁰⁶ A majority of states would likely support this proposal, as most jurisdictions have already abandoned the locality rule.¹⁰⁷ Such a measure potentially heightens the standard of care for some physicians, as the national standard is often a higher standard than that of a rural locale with limited resources.¹⁰⁸ Therefore, adopting a national standard of care for the practice of telemedicine accomplishes two public policy goals: (1) eliminating a point of concern for physicians, thereby incentivizing the usage of telemedicine, and (2) pressuring all telemedicine practitioners to hold themselves to a higher standard of care, ensuring that they educate themselves about national standards and updated practices.

Second, legislation establishing the uniform telemedicine standard of care should adopt a reasonable-physician standard

103. See *supra* Part I.A.1.

104. See, e.g., Boleman, *supra* note 9, at 519 ("Anything short of uniformity across states not only burdens physicians and creates higher compliance costs for companies promoting telemedicine, it also disadvantages potential plaintiff-patients and inhibits the full expansion of health care services for patients in rural areas.").

105. See *id.* ("[T]oday we have a national accrediting system, which has contributed to the standardized medical school training all throughout the country. The justification provided 150 years ago for a locality rule or a rule based on similar communities cannot be reconciled with the realities of telemedicine, technological advancement, and modern health care practices.").

106. *Id.*

107. See Cooke et al., *supra* note 19, at 361.

108. This is not necessarily the case, but the standard justification for the locality rule is to protect rural practitioners who may not be up to date. See *id.* at 359-61.

as opposed to a custom-based standard. The reasonable-physician standard is a logical choice for an emerging medical practice such as telemedicine.¹⁰⁹ The reason for this is that the custom-based approach determines the appropriate standards of care using well-established practices as the benchmarks.¹¹⁰ It is therefore a difficult and ineffective approach to use for assessing the standards of an emerging medical practice.¹¹¹ One potential outcome of applying the custom-based approach would be that, under the approach, all new telemedicine practices would lie outside the standard of care.¹¹² While this is an extreme outcome, courts applying such a standard would likely run into difficulties determining appropriate customs.¹¹³ This approach does not promote ingenuity in the medical field, and would likely hinder it.¹¹⁴ Physicians may hesitate to participate in new telemedicine practices if there are uncertainties regarding the standards of care, even if those practices offered improved patient outcomes.¹¹⁵

Unlike the custom-based standard, the reasonable-physician standard requires that physicians perform as reasonable physicians would in similar circumstances in order to avoid malpractice liability.¹¹⁶ Because of this, the reasonable physician standard does not implicate the emerging medicine concerns of the custom-based approach.¹¹⁷ Freedom from outdated customs may allow physicians more flexibility—with fewer liability concerns—permitting the adoption of updated practices.¹¹⁸ This would facilitate the public policy goal of promoting the most cutting-edge treatment options, as physicians may be less likely to shy away from new telemedicine practices.¹¹⁹

109. See McDonald, *supra* note 17, at 555-58.

110. See Kaspar, *supra* note 30, at 846.

111. See *id.* at 853.

112. *Id.*

113. See *id.*

114. See *id.*

115. See Ackerman, *supra* note 3; Caryl, *supra* note 4, at 193.

116. See Kaspar, *supra* note 30, at 846.

117. See *id.* at 853.

118. See *id.*; Caryl, *supra* note 4, at 193.

119. See Caryl, *supra* note 4, at 193.

2. *Telemedicine vs. In-Person Care: The Propriety of Hawaii's Approach*

As telemedicine becomes increasingly utilized and related legislation is promulgated, it is important that the legislation considers the inherent differences between in-person care and telemedicine care. Currently, a majority of state legislatures equate telemedicine care to traditional in-person care for the purpose of establishing the appropriate standard of care.¹²⁰ Hawaii presents an exception to this rule, establishing that recommendations made through telemedicine “shall be held to the same standards of appropriate practice as those in traditional physician-patient settings that do not include a face-to-face visit.”¹²¹ Considering the potential differences in diagnostic capabilities of a physician examining a patient through telemedicine services versus a physician examining a patient in person, Hawaii’s statutory language is a more appropriate approach if the goal is to incentivize usage.¹²² As one scholar acknowledges:

If application of this standard requires that a physician, in order to comply with the standard of care, must detect everything he or she would have during an in-person examination, the standard would significantly disincentivize providers' use of telemedicine because the lack of an in-person examination necessarily inhibits the diagnostic ability of physicians.¹²³

It is true that the diagnostic capabilities of a physician remotely examining a patient are more limited than those available during the performance of an in-person exam.¹²⁴ A physician is unable to employ all five senses when using telemedicine services, meaning that the examination may be considered incomplete.¹²⁵ This, in turn,

120. See Kaspar, *supra* note 30, at 855; see, e.g., 22 TEX. ADMIN. CODE § 174.6(a)(1) (2019).

121. HAW. REV. STAT. § 453-1.3(c) (2018).

122. See Kaspar, *supra* note 30, at 856.

123. *Id.* (footnotes omitted). When Kaspar refers to “this standard,” he is referring to the standard that holds physicians practicing telemedicine to the same standard as in-person care. See *id.* at 855-86.

124. *Id.* at 859.

125. *Id.*

can lead to a greater potential for misdiagnosis.¹²⁶ Such a scenario is an inherent risk of practicing through telemedicine.

Potential critics of Hawaii's approach may claim that the adjusted standard of care is an attack on the quality of care being provided.¹²⁷ The quality of care is unlikely to significantly suffer though. This approach is not intended to unfairly target patients by degrading the standards of care to their minimal level, but to create realistic standards of care that reflect current technological capabilities.¹²⁸ Under the proposed standards, courts would simply be able to consider the technology's fundamental limitations instead of blindly holding telemedicine practices to the same standard as in-person practices.¹²⁹

Despite the risks, the potential benefits offered by telemedicine far outweigh the possibility of isolated incidents of misdiagnoses.¹³⁰ Telemedicine facilitates greater access to care for rural citizens, care that they might otherwise have had to do without.¹³¹ Both rural and urban doctors may consult with more knowledgeable specialists from thousands of miles away, potentially making the difference between life and death for some patients.¹³² The benefits are not limited to rural inhabitants, as urban individuals also benefit from the convenience of checkups from the comfort of their homes or the remote monitoring of their vitals.¹³³ Greater adoption of telemedicine can dramatically reduce healthcare costs, and both doctors and patients can avoid costs associated with missing work and traveling.¹³⁴ These considerations alone should outweigh the potential risks and support a statutory scheme that incentivizes the usage of telemedicine.

126. *Id.*

127. *See id.*

128. *See id.* at 856.

129. *See id.*

130. *Id.* at 857-58 (listing cost and time savings, reduction in travel, alleviation of physician shortages, convenient treatment of chronic conditions, and reduction in spreading of disease as benefits).

131. *Id.* at 858.

132. *Id.*

133. *See* Quinn et al., *supra* note 1, at 1-4.

134. *See* Boleman, *supra* note 9, at 494 (stating that the Veterans Health Administration (VHA) estimated that system-wide savings totaled nearly one billion dollars in 2012 through the VHA's use of telemedicine); *see also* Kaspar, *supra* note 30, at 857.

For these reasons, legislation establishing the appropriate standard of care for telemedicine practices should adopt a national reasonable-physician standard, with a provision holding practitioners of telemedicine to a standard of care that reflects the limitations of telemedicine technology. Hawaii's statute provides an adequate template for the latter component, though greater specificity may be warranted if such legislation is implemented at the national level.

B. Uniform Determination of the Physician-Patient Relationship

While common law standards traditionally determined the formation of the physician-patient relationship,¹³⁵ the jurisdictional differences—and the potential difficulties of applying law developed around traditional care to telemedicine—support the argument that legislation should clearly delineate how this relationship is formed.¹³⁶ As a general rule, courts will look to statutory law over common law where the two conflict.¹³⁷ A statutory provision clearly demarcating the physician-patient relationship for telemedicine malpractice cases should be accepted by courts, just as they look to such legislation when determining the appropriate standard of care.¹³⁸ The implementation of such legislation would alert physicians as to when they have an established duty to their patients, providing them with more certainty as to what actions would expose them to malpractice liability.¹³⁹ If the states uniformly instituted such legislation, another level of certainty would be provided for physicians, alleviating their concerns and removing a barrier to the increased usage of telemedicine across state boundaries.¹⁴⁰

135. *See, e.g.*, *Hord v. United States*, No. CA-96-3401-7-13, 1999 WL 249061, at *4 (4th Cir. April 28, 1999).

136. *See McDonald, supra* note 17, at 565-66.

137. *See, e.g.*, *Hickerson v. Vessels*, 316 P.3d 620, 623 (Colo. 2014) (“Where the interaction of common law and statutory law is at issue, we acknowledge and respect the General Assembly’s authority to modify or abrogate common law, but only recognize such changes when they are clearly expressed.”).

138. *See, e.g.*, *Britt v. Taylor*, 852 So. 2d 1128, 1132 (La. Ct. App. 2003) (looking to state statute for standard of care).

139. *See McDonald, supra* note 17, at 566.

140. *See Caryl, supra* note 4, at 193.

Oklahoma's law provides a partial model for such legislation.¹⁴¹ In the statute's relevant part, it states that the duties of a physician-patient relationship do not apply "until the physician affirmatively ... [u]ndertakes to diagnose and treat the patient; or ... [p]articipates in the diagnosis and treatment of the patient."¹⁴² Clearly predicating the formation of the relationship on the affirmative action of the physician—as was done here—could help alleviate physician fears of accidentally assuming liability. The statute also includes a limitation: "A physician-patient relationship shall not be created solely based on the receipt of patient health information by a physician."¹⁴³ A provision such as this would help clarify, both to physicians and to courts, that the receipt and review of patient records, without more, does not establish a duty to the patient in telemedicine malpractice cases.

While this is a good starting point, the proposed legislation should also address the steps needed to "undertake" and "participate" in the diagnosis and treatment. This would help distinguish a physician who owes a duty of care from a mere consultant in situations where the telemedicine physician is interacting with another physician, and not the patient.¹⁴⁴

III. INITIATING THE CHANGES AT THE FEDERAL LEVEL

Given the current status of malpractice standards in the various states, it is unlikely that the states will adopt uniform standards on their own.¹⁴⁵ Therefore, the federal government will need to initiate the adoption of the proposed standards. First, this Part will argue that Congress could utilize the Commerce Clause in order to institute the desired changes, but this method would likely be challenged by the states. Next, this Part will argue that Congress could use its Spending Power to create uniformity by encouraging states to pass legislation instituting the proposed telemedicine malpractice

141. See, e.g., OKLA. STAT. tit. 59, § 478.1(D) (2019).

142. *Id.*

143. *Id.*

144. See FLEISHER & DECHENE, *supra* note 87, § 1.04[3][a][ii]. While this Note does not propose language for these steps, a comprehensive review of the states' common law determinations, combined with a review of typical medical practices in different fields, could provide guidance.

145. See *supra* Part I.A.

standards. An approach that would threaten to cut funding and an approach that would create additional funding will be considered. This Part will ultimately propose that an approach utilizing Congress's Spending Power to provide additional funding in order to encourage state action would be the most likely to survive the Supreme Court's scrutiny if challenged.

A. The Commerce Clause as a Method of Creating Uniformity

The Telehealth Modernization Act of 2015 reveals that there is precedent for legislation that institutes federal telemedicine standards,¹⁴⁶ but Congress did not address the standard of care issue and deferred to the states on this matter.¹⁴⁷ That proposed legislation further used permissive language that would allow states substantial leeway as to whether they would adopt Congress's proposals.¹⁴⁸

While that legislation was never enacted, it does show that members of the federal legislature are aware of state discrepancies in telemedicine issues and wish to reconcile these differences in a way that facilitates broad usage of telemedicine services.¹⁴⁹ It is interesting that the proposed goal of this legislation was to facilitate broad telemedicine usage,¹⁵⁰ yet the bill refused to address the appropriate standard of care and framed its language in such a permissive manner.¹⁵¹ It is likely that the authors of this bill had constitutional concerns in mind, given that states have generally regulated their own healthcare for over one hundred years under the authority of the Tenth Amendment.¹⁵² Yet telemedicine diverges

146. See generally H.R. 691, 114th Cong. (2015) (proposed bill).

147. *Id.* at § 3(c)(2) (stating that nothing in the proposed legislation should be construed to "affect the standard of care for medical or clinical appropriateness as established by State law or policy").

148. See *id.* at § 3(b) ("The following are conditions for the delivery of health care through telehealth by a health care professional to an individual that States *should consider* adopting." (emphasis added)).

149. See *id.* at § 2 (acknowledging the benefits of telemedicine and that the variations in state approaches create impediments to widespread adoption).

150. *Id.*

151. See *id.* at § 3(b), (c)(2).

152. See, e.g., Samuel P. Clancy, *Removing Barriers to Telehealth in Oklahoma: Increasing Access to Care and Improving Health Outcomes Across the State*, 68 OKLA. L. REV. 805, 813 (2016).

from the traditional practice of medicine, and its potential usage for interstate medical treatment presents a valid argument that it deserves to be regulated at the federal level.

It is true that states have generally retained the power to regulate the health of their citizens, but this power is not absolute.¹⁵³ The traditional argument made for the preservation of state regulation over matters of health is that the police power granted by the Tenth Amendment protects such regulation.¹⁵⁴ Yet in the aftermath of the Affordable Care Act, Congress has received increasing deference in matters related to its Spending Powers and the Commerce Clause.¹⁵⁵

As one scholar notes, “Under the Commerce Clause, Congress may regulate or license telemedicine as a channel of interstate commerce, as an instrumentality of interstate commerce, or as an activity that substantially affects interstate commerce, even over Tenth Amendment objections.”¹⁵⁶ This indicates that the federal government can regulate telemedicine malpractice, as it could readily be found that state discrepancies in this area limit the interstate usage of telemedicine.¹⁵⁷ As doctors are typically reimbursed for such care, the flow of money between states is a strong basis to argue that Congress could utilize the Commerce Clause to institute telemedicine malpractice reform at the federal level.¹⁵⁸ That said, states desiring autonomy and maintenance of the traditional police power protections would likely attack such an approach as unconstitutional.¹⁵⁹

Even if Congress has received increasing deference in the wake of the Affordable Care Act, states have a long history of regulating the health of their constituents and view such regulation as “a

153. See, e.g., *id.*

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

155. See *id.* at 296-97.

156. *Id.* at 304 (footnotes omitted).

157. See *supra* Part II.A.

158. See James F. Blumstein, *A Perspective on Federalism and Medical Malpractice*, 14 YALE L. & POL'Y REV. 411, 425 (1996) (“The Supreme Court has construed the Commerce Clause so broadly that large-scale federal intervention in the medical malpractice area is almost certainly constitutionally valid.”).

159. See *id.*; Marino et al., *supra* note 154, at 296-97 (discussing possible constitutional challenges to federal malpractice reform).

quintessential component of [their] sovereign powers.”¹⁶⁰ If Congress utilizes the Commerce Clause to implement the suggested standards, states may view this as an attack on state sovereignty and challenge it at every step.¹⁶¹ Instead, a gentler approach could incentivize state action as opposed to forcing it.¹⁶² Such an approach allows states to maintain their health regulation autonomy while creating greater uniformity at the national level.¹⁶³

B. The Spending Power as a Method of Creating Uniformity

Congress’s utilization of its Spending Power presents a more viable—and less coercive—approach to achieving uniformity by incentivizing the adoption of the proposed standard of care and physician-patient relationship standards. In fact, Congress enacted a similar piece of legislation in the past, in the form of the Telemedicine Incentive Grants statute.¹⁶⁴ This statute, no longer in force, gave the Secretary of Health and Human Services authority to provide grants to state licensing boards that cooperated with other states to reduce telemedicine barriers.¹⁶⁵

Congress’s passage of federal legislation incentivizing the adoption of a minimum drinking age of twenty-one is one of the most notable examples of Congress successfully creating uniformity through its Spending Power.¹⁶⁶ This statute allows the federal government to withhold a percentage of federal funding for federal highway maintenance if states allow persons under the age of twenty-one to purchase alcohol.¹⁶⁷ In *South Dakota v. Dole*, South Dakota famously challenged the constitutionality of this federal

160. Marino et al., *supra* note 154, at 296 (quoting Florida *ex rel.* Att’y Gen. v. U.S. Dep’t Health & Human Servs., 648 F.3d 1235, 1305 (11th Cir. 2011)).

161. *See id.* at 296-97 (claiming that states would challenge any federal attempt at implementing national licensure reform for medical practitioners through the Commerce Clause).

162. *See infra* Part III.B. (discussing the use of Congress’s Spending Power to incentivize adoption of the proposed standards).

163. *See infra* Part III.B.

164. *See* 42 U.S.C. § 254c-18 (2012).

165. Carmen E. Lewis, *My Computer, My Doctor: A Constitutional Call for Federal Regulation of Cybermedicine*, 32 AM. J.L. & MED. 585, 607 (2006).

166. *See* 23 U.S.C. § 158 (2012); *see also* Mark Seidenfeld, *The Bounds of Congress’s Spending Power*, 61 ARIZ. L. REV. 1, 10-11 (2019).

167. *See* 23 U.S.C. § 158(a).

action.¹⁶⁸ There, the Supreme Court held that this was a valid use of Congress's Spending Power, but established several limitations.¹⁶⁹ These limitations are that: (1) the power must be used for the "general welfare"; (2) the conditions for receipt of the funds must be stated clearly; (3) the funding and the imposed conditions are connected to some degree; (4) the conditions cannot infringe upon the states' constitutional rights or force them to violate individuals' constitutional rights; and (5) the incentives offered cannot be so coercive that they force state action.¹⁷⁰

Applying this standard to legislation that incentivizes the adoption of the proposed uniform standards, it is clear that constitutional violations can be avoided. First, establishing uniformity in telemedicine malpractice standards is a benefit to the general public.¹⁷¹ The benefits of a broad adoption of telemedicine services are numerous, and the current lack of uniformity in telemedicine malpractice standards presents an impediment to its broad adoption.¹⁷² The proposals would advance the general welfare, as both doctors and patients would benefit from more widespread telemedicine usage, and there is the potential for enormous system-wide savings.¹⁷³ Importantly, the Supreme Court gives significant deference to Congress when determining whether the spending is being utilized for the general welfare.¹⁷⁴ This further supports the conclusion that such legislation would pass the first prong of the *Dole* analysis.¹⁷⁵

In order to pass the second prong of the *Dole* analysis, Congress must unambiguously assert the conditions on which the receipt of the federal funds is predicated, so that "the States ... exercise their choice knowingly, cognizant of the consequences of their participation."¹⁷⁶ In *Dole*, the Court found that Congress easily met this standard by requiring the states to adopt a minimum drinking age

168. See 483 U.S. 203, 205 (1987); Seidenfeld, *supra* note 166, at 11.

169. See *Dole*, 483 U.S. at 207-12.

170. *Id.*

171. See *supra* Part I.A-B.

172. See *supra* Part I.A-B.

173. See *supra* Part II.A.

174. See *Dole*, 483 U.S. at 207.

175. See *id.*

176. *Id.* (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)).

of twenty-one in order to receive specific federal highway funds.¹⁷⁷ With regard to uniformity in telemedicine malpractice standards, Congress would simply need to clearly condition the receipt of federal healthcare funding, whether Medicaid, Medicare, or some other health-related funding, on states passing legislation instituting the desired standards for telemedicine malpractice.¹⁷⁸ Such federal legislation would clearly establish the state action needed to receive the healthcare funding, allowing the states to make an informed decision. Barring poorly worded provisions, Congress should be able to meet the second prong of *Dole* without trouble.¹⁷⁹

The third prong of *Dole* is another which could easily be satisfied by linking the receipt of funding to a federal program such as Medicare, Medicaid, or another health-oriented program. While the Supreme Court has determined that there must be some connection between the funding and the conditions, it has not established exacting standards for how related the funding and conditions must be.¹⁸⁰ In *Dole*, the Court found that Congress met the third prong, as receipt of the specified federal highway funds was conditioned upon the adoption of a uniform drinking age of twenty-one.¹⁸¹ The reasoning behind this was that instituting a uniform drinking age of twenty-one was “reasonably calculated” to advance Congress’s goal of facilitating safe interstate travel, a goal that was impeded by the lack of state uniformity.¹⁸² As federal highway funds are expended, in part, to facilitate safe interstate travel, the conditions and funding were held to be sufficiently connected.¹⁸³

The connection between federal healthcare funds and telemedicine malpractice standards should be even more clear than that of highway funds and drinking ages. For example, federal courts have established that the purpose of the Medicaid Act is to aid states in providing assistance to “aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of

177. *Id.* at 208.

178. *See id.*

179. *See id.*

180. *See id.* at 208 n.3 (stating that the Supreme Court has not determined the limits of the relatedness prong).

181. *Id.* at 208-09.

182. *Id.*

183. *Id.*

necessary medical services.”¹⁸⁴ If Congress conditions the receipt of such health-oriented funding on the adoption of uniform telemedicine malpractice standards, it could readily point out that the states’ lack of uniformity dissuades qualified physicians from utilizing telemedicine.¹⁸⁵ Congress could then argue that limiting disabled and indigent patients’ access to telemedicine services impedes the purposes of such medical assistance funding. The proposed telemedicine malpractice standards would therefore be posed as a solution to the impediment, and would likely be sufficiently related to the purpose of the funding.¹⁸⁶ Similar arguments could be made for Medicare funding and other health assistance programs.

The fourth prong of the *Dole* analysis also should not present a significant problem. Encouraging states to adopt a uniform telemedicine standard of care and physician-patient relationship standard would not force them to commit any unconstitutional acts or violate any individual’s constitutional rights. The proposals in Part II of this Note are largely based on standards already adopted by some jurisdictions, and there have not been any successful constitutional challenges to these standards.¹⁸⁷

States could challenge federal regulation of telemedicine malpractice standards on Tenth Amendment grounds,¹⁸⁸ but such a challenge was rejected in *Dole*.¹⁸⁹ There, the Court held that the Tenth Amendment did not preclude Congress from using federal funding to encourage constitutional state action, such as enacting a uniform drinking age.¹⁹⁰ A similar holding could be expected for the use of federal funds to encourage uniformity in telemedicine malpractice standards.

In terms of *Dole*’s fifth prong—the coercion prong—there is a potential issue regarding the method of encouraging states to adopt telemedicine malpractice standards. In a case addressing the

184. *In re Estate of Smith v. Heckler*, 747 F.2d 583, 585 (10th Cir. 1984).

185. *See supra* Part I.A-B.

186. *See Dole*, 483 U.S. at 208-09.

187. *See supra* Part II.

188. *See* U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”).

189. *See Dole*, 483 U.S. at 210.

190. *See id.*

Affordable Care Act's Medicaid expansion provisions, the Supreme Court held that Congress's Spending Power did not allow it to withdraw Medicaid funding if states did not participate in the expansion.¹⁹¹ This holding reveals that the Court carefully scrutinizes the withholding of important health-related funding, as such withholding can implicate coercion.¹⁹²

In *National Federation of Independent Business v. Sebelius*, the Court considered the constitutionality of a provision in the Affordable Care Act that required participation in Medicaid expansion.¹⁹³ There, the Court found the requirement unconstitutional, noting that not complying with the expansion would lead to the withdrawal of all existing federal Medicaid funding.¹⁹⁴ Chief Justice Roberts determined that the states were not actually given a choice as to whether they would join in the expansion, as the withdrawal of all Medicaid funding could result in a loss of over 10 percent of a state's budget.¹⁹⁵ This would make the provision unduly coercive, and therefore not within the scope of Congress's Spending Power.¹⁹⁶

Despite the holding in *NFIB*, Congress could avoid being unduly coercive by limiting the withholding of federal funds to a small percentage of funding, as was done for the statute that led to the adoption of a uniform drinking age.¹⁹⁷ While there is no explicit guide for determining the limits of what the Court considers unduly coercive, *NFIB* reveals that withholding 10 percent of a state's overall budget is far too high.¹⁹⁸ That said, withholding a smaller percentage of federal funding from some healthcare-oriented program, perhaps around 5 to 8 percent, may not stray into the territory of coercion.¹⁹⁹ Such a withholding would likely not represent even 1 percent of a state's overall budget, but would likely be significant enough to encourage action.²⁰⁰ This could still pose an

191. See *NFIB v. Sebelius*, 567 U.S. 519, 530-31 (2012).

192. See *id.* at 581-82.

193. See *id.*

194. See *id.*

195. *Id.*

196. See *id.*

197. See 23 U.S.C. § 158(a)(1)(B) (2012) (limiting the withholding of funding to 8 percent of the total highway funding).

198. See *NFIB*, 567 U.S. at 523.

199. See *South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987).

200. If, as in *NFIB*, the entirety of the federal government's Medicaid funding represented approximately 10 percent of a state's total budget, withholding less than 10 percent of that

issue though, as the Court held in *NFIB* that Congress cannot take away a state's existing Medicaid funding for its refusal to take part in a new program.²⁰¹ Whether the Court would treat other health-oriented programs in a similar manner is open to debate.

One scholar proposes a solution to this issue: "Instead of attaching telemedicine licensure reform to an existing program, drafters might position it as a 'new program,' attach a separate funding stream to it, and make applying for it wholly discretionary."²⁰² While the proposals in this Note do not address licensure issues, a similar approach can be taken. In this approach, the proposals for uniformity in the standard of care and the determination of the physician-patient relationship become part of a more expansive program. Congress could then offer additional funding as an incentive for states' adoption of the program, as opposed to threatening to withhold funding.²⁰³ This solution would also avoid the ethical issues inherent in the withholding of funding from important healthcare programs.

A question raised by this solution is whether it would be a strong enough incentive to bring states into uniformity. If the additional funding was marginal and purely discretionary, the states may not opt to enact new legislation just to receive an extra droplet in an already full bucket. That said, few states would consider their healthcare funding to already be a full bucket. For example, Connecticut's retirement healthcare fund for state employees is currently in a \$36 billion deficit,²⁰⁴ and a number of other states face similar deficits in this area.²⁰⁵ If Congress were to identify and

Medicaid funding would equate to less than 1 percent of the state's total budget.

201. See *NFIB*, 567 U.S. at 585; Marino et al., *supra* note 154, at 336-37. The proposals in this Note may not run into this problem, as this Note is not necessarily advocating for a "new program," but it is an issue to be wary of.

202. Marino et al., *supra* note 154, at 337.

203. See *id.*

204. Marc E. Fitch, *Connecticut Has \$36 Billion in Unfunded OPEB Liabilities*, YANKEE INST. FOR PUB. POLY (Mar. 29, 2018), <https://www.yankeeinstitute.org/2018/03/connecticut-has-36-billion-in-unfunded-opeb-liabilities/> [<https://perma.cc/J4M8-28H9>].

205. See, e.g., Jim Miller, *California's Retiree Healthcare Liability Grows to Almost \$77 Billion*, SACRAMENTO BEE (Jan. 25, 2017, 1:52 PM), <https://www.sacbee.com/news/politics-government/capitol-alert/article128736099.html> [<https://perma.cc/4BAQ-A99R>].

target such programs for additional funding, states would likely be incentivized to take the steps necessary to secure the funding.²⁰⁶

Overall, Congress likely has the authority to establish, or at least encourage, uniformity as proposed in this Note, either through the Commerce Clause or through its Spending Power.²⁰⁷ The Commerce Clause, while a potential avenue, is not the preferable method of enacting these changes, as it would likely be challenged by states wishing to protect their autonomy.²⁰⁸ Congress could utilize its Spending Power, on the other hand, to incentivize the adoption of the proposed standards.²⁰⁹ The proposed changes should pass the *Dole* standard, and concerns regarding the withholding of federal funds from important healthcare programs could be avoided.²¹⁰ These concerns could be avoided by framing the legislation as creating a new program which offers additional funds as an incentive to adopt it, and in turn the proposed standards.²¹¹ Alternatively, and for the sake of simplicity, the legislation could threaten to withhold a marginal amount of funding from Medicare, Medicaid, or another health-related program, though this approach has the potential to cross into the realm of coercion.²¹² While there may be other options available, the ones presented above are the most likely to survive the Supreme Court's scrutiny if challenged.

CONCLUSION

There are many potential benefits to the widespread adoption of telemedicine services, but concerns related to the lack of national uniformity in malpractice standards prevents telemedicine from reaching its full potential. The presence of numerous standards of care and jurisdictional differences in how the physician-patient relationship is formed are two issues which present novel problems to physicians who may wish to practice medicine across state lines,

206. This Note simply uses state retirement healthcare funds as an example. Other programs operating in a deficit could be targeted for additional discretionary funding.

207. See *supra* Part III.

208. See *supra* Part III.A.

209. See *supra* Part III.B.

210. See *supra* Part III.B.

211. See Marino et al., *supra* note 154, at 337.

212. See *NFIB v. Sebelius*, 567 U.S. 519, 585 (2012).

and therefore may discourage them from participating.²¹³ In order to resolve these problems, Congress should encourage a national reasonable-physician standard of care through legislation, doing away with the locality rule for telemedicine. This standard of care should additionally reflect the inherent differences between traditional in-person practices and telemedicine practices, using language similar to Hawaii's relevant statute²¹⁴ in order to create a standard of care that does not expose physicians to undue liability. Congress could quell further legal uncertainties by adopting a uniform standard for physician-patient relationship determinations which clearly states the steps needed to form the relationship in telemedicine scenarios. As the necessary legislation would pass the *Dole* standard, Congress may use its Spending Power as the basis for the proposed legislation, and with proper precautions, this legislation would not be found unconstitutional if challenged in court.

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213. *See supra* Part I.A-B.

214. *See* HAW. REV. STAT. § 453-1.3(e) (2018).

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