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**Note**

**Is There a Doctor in the House? Licensing and Malpractice Issues Involved  
in Telemedicine**

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**Table of Contents**

I. Introduction.....[1]

II. What is Telemedicine?.....[4]

    A. Telemedicine and Its Possible Benefits.....[4]

    B. Overview of Current Projects.....[10]

        1. Texas Tech University Health Sciences Center.....[12]

        2. Medical College of Georgia.....[13]

        3. Eastern Montana Telemedicine Project.....[16]

    C. H.R. 3909, "The Rural Telemedicine Enhancement Act" .....[18]

III. Telemedicine Licensing.....[22]

    A. Current Licensing Practices.....[22]

    B. Proposed Telemedicine Licensing System.....[25]

    C. Potential Constitutional Issues.....[28]

    D. Proposed Requirements for a National Licensing System.....[31]

IV. Telemedical Malpractice.....[33]

    A. The Physician-Patient Relationship.....[34]

    B. The "Reasonable" Telemedical Doctor Standard of Care.....[39]

        1. Current Standards of Care.....[39]

        2. Proposed Standard of Care for Telemedicine.....[42]

        3. Telemedicine Practice Parameters.....[44]

    C. National Malpractice Suits.....[48]

IV. Conclusion.....[52]

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# Is There a Doctor in the House? Licensing and Malpractice Issues Involved in Telemedicine†

Lynette A. Herscha\*

## I. INTRODUCTION<sup>1</sup>

Imagine a typical accident in rural America: in an isolated area of Michigan, a car hits a small child on her bicycle. X-ray analysis would help the local doctor ascertain the extent of the injuries. Due to the rural nature of the area, however, the radiologist must spread his resources throughout the region, making him unavailable at the time of the accident. Rather than travel for hours to the nearest radiologist, local doctors take the x-ray themselves and send it through a phone line

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<sup>1</sup> It is beyond the scope of this Note to cover all of the many issues quickly emerging from the developing field of telemedicine. Other recent sources of information to consult include: Peter D. Blanck, *Celebrating Communication Technology for Everyone*, 30 FED. COM. L.J. 185 (1994); Douglas D. Bradham et al., *The Information Superhighway and Telemedicine: Applications, Status and Issues*, 30 WAKE FOREST L. REV. 145 (1995); Fred H. Cate, *The First Amendment and the National Information Infrastructure*, 30 WAKE FOREST L. REV. 1 (1995); Robert W. Crandall & J. Gregory Sidak, *Competition and Regulatory Policies for Interactive Broadband Networks*, 68 S. CAL. L. REV. 1203 (1995); Michael P. Donahue, *The Outer Limits of IVDS: We Now Return Control of Your Television Set to You*, 3 COMMLAW CONSPECTUS 157 (1995); Robert J. Enders et al., *Antitrust Issues Under Health Care Reform*, 16 WHITTIER L. REV. 117 (1995); Ilene K. Gotts, *Navigating the Global Information Superhighway: A Bumpy Road Lies Ahead*, 8 HARV. J. L. TECH. 275 (1995); Warren G. Lavey, *Universal Telecommunication Infrastructure for Information Services*, 42 FED. COM. L.J. 151 (1990); Daniel McCarthy, *The Virtual Health Economy*, 21 AM. J.L. & MED. 111 (1995); Jane Smith Patterson, *North Carolina: The First Statewide Public-Switched Broadband Network or the World's First Information Superhighway*, 30 WAKE FOREST L. REV. 127 (1995); Joel R. Reidenberg & Françoise Gamet-Pol, *The Fundamental Role of Privacy and Confidence in the Network*, 30 WAKE FOREST L. REV. 105 (1995); Laura L. Sigal, Note, *Challenging the Telo-Cable Cross-Ownership Ban: First Amendment and Antitrust Implications for the Interactive Information Highway*, 22 FORDHAM URB. L.J. 207 (1994); Comment, *TeleKansas and the Future of Alternative Telecommunications Regulation in Kansas*, 43 KAN. L. REV. 687 (1995).

digitizer to the radiologist's computer. The radiologist examines the x-ray and makes the diagnosis without leaving his office.<sup>2</sup> [1]

Recent innovations in data communication have fostered the development of telemedicine, which the American Medical Association ("AMA") defines as "medical practice across distance via telecommunications and interactive video technology."<sup>3</sup> The use of technologies such as "full-scale interactive audio-visual, still and motion pictures, . . . pan, tilt or zoom video . . . transmitted over fiber-optic cable to wide area community networks,"<sup>4</sup> allows metropolitan doctors and specialists to communicate with rural general practitioners, or even treat patients in remote areas themselves.<sup>5</sup> Because telemedicine enables doctors to treat patients over potentially great distances, the practice of telemedicine can span large geographic areas. This potential to practice across state lines raises medical licensing issues, such as who will license physicians inevitably practicing in several states via telemedicine, as licensing currently falls under state regulation. The practice of telemedicine also raises malpractice issues, such as to what standard of care courts will hold physicians practicing on telemedicine systems, how patients will pursue their malpractice claims and whether patients will have the ability to sue these physicians at all. [2]

This Note describes telemedicine and how it affects the state of the law. Part II discusses existing telemedicine projects. Part III addresses current and proposed licensing schemes for physicians. Part IV examines malpractice issues involved with telemedicine by addressing the factors that give rise to the physician/patient relationship and the appropriate standard of care. Finally, Part V urges the creation of a national license for telemedicine, a national standard of care, and the institution of regional tribunals to screen out frivolous malpractice claims arising from the practice of telemedicine. [3]

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<sup>2</sup> Larry LaRocco, *Why Wait for the Future? We Can Start Now with a Rural Telemedicine Project*, ROLL CALL, June 27, 1994, available in LEXIS, News Library, Papers file.

<sup>3</sup> T. Reginald Harris & George Lukemeyer, *Evolving Impact of Telemedicine*, JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON MEDICAL EDUCATION 1994, at 2 [hereinafter JOINT REPORT].

<sup>4</sup> Hilary Lane, *Telemedicine: Health Care Goes On Line*, BOULDER COUNTY BUSINESS REPORT, July 1994, § 1, at 17, available in LEXIS, News Library, PAPERS file.

<sup>5</sup> *Id.* These technologies allow video images taken at a rural site to be transmitted immediately to urban centers. Mark Mehler, *Digital Compression Delivers Medical Specialists to Rural America*, INVESTOR'S BUSINESS DAILY, Aug. 17, 1994, at A4, available in LEXIS, News Library, INVDLY file (saying that "new digital compression technology . . . enables high-quality video images to be transmitted over T-1 telephone lines, [so] specialists in a large urban hospital can see exactly what the local physician sees"). Images may also be transmitted via modem or fax. *Id.*

## II. WHAT IS TELEMEDICINE?

### A. *Telemedicine and Its Possible Benefits*

The major benefit of telemedicine in the United States lies in improving “the quality and accessibility of health care in rural areas.”<sup>6</sup> In some parts of the country, patients live as far as 150 miles away from the nearest specialist.<sup>7</sup> Such long distances mean that people waste hours in travel time for routine visits,<sup>8</sup> and in emergencies can mean the difference between life or death.<sup>9</sup> Telemedicine sites in rural areas allow patients to see doctors within a matter of minutes, instead of hours.<sup>10</sup> [4]

Quicker response time through telemedicine fosters “earlier intervention and diagnosis.”<sup>11</sup> As one professor of medicine explains, “[y]ou hate to send someone to see a physician three hours away unnecessarily, but you want to catch problems as early as possible . . . . [T]elemedicine will give physicians the chance to intervene at an earlier stage.”<sup>12</sup> [5]

Consider an example from a clinic in McAllen, Texas.<sup>13</sup> Before the advent of telemedicine, a general practitioner uncertain about a lesion in a child's ear would

<sup>6</sup> H.R. 3909, 103d Cong., 2d Sess. § 1711 (1994). After the bill was introduced, no further action was taken on it during the 103d Congress. Recent legislation would establish telemedicine pilot projects. H.R. 851, 104th Cong., 1st Sess. (1995). In addition, new legislation would establish a National Commission on Telemedicine to assess the effect of telemedicine on health care. H.R. 426, 104th Cong., 1st Sess. (1995). This Note focuses on H.R. 3909 because it is the most comprehensive telemedicine regulation proposed to date.

<sup>7</sup> Lane, *supra* note 4.

<sup>8</sup> *Id.*

<sup>9</sup> LaRocco, *supra* note 2 (writing that “[i]n hard economic times, good, interactive communication with the rest of the country will make the difference between which communities survive and which die”). LaRocco notes that access to health care will be one of the most important forms of communication. *Id.*

<sup>10</sup> *Id.*

<sup>11</sup> Lane, *supra* note 4, at 23 (quoting Nola Berg, marketing manager of the Denver office of Northern Telecom, Inc., a telemedicine provider for hospitals and universities).

<sup>12</sup> Janice Rosenberg, *Telemedicine System to Link Patients with Specialists*, ILLINOIS MEDICINE, Oct. 21, 1994, at 4 (quoting Michael Pfeifer, M.D., Associate Professor of Medicine at Southern Illinois University).

<sup>13</sup> Mehler, *supra* note 5.

have sent the child 350 miles to a specialist in Houston. Uprooted for at least three days, the child's family would incur enormous costs in lost work time and travel expenses.<sup>14</sup> Instead, using telemedicine, the physician can bring a specialist directly into his office for an immediate "teleconsultation."<sup>15</sup> [6]

Currently, medical professionals differ in their opinions on the quality of patient care provided by telemedicine.<sup>16</sup> As one professional notes, "you can't replace hands-on care, you can't touch and feel whether a bone is set properly, or you can't use it to replace delicate surgery."<sup>17</sup> Others, however, note the increased quality of care for those in remote areas, due to faster response times to emergency situations and more rapid diagnosis and treatment.<sup>18</sup> [7]

Telemedicine provides a further benefit in the form of continuing medical education to rural physicians often isolated from cutting-edge trends and new technologies. Rural physicians might not communicate with their peers and therefore might lack the skills and knowledge that urban physicians possess.<sup>19</sup> With the benefits of "real-time"<sup>20</sup> telemedicine, "[d]octors could participate in lectures and conferences without leaving home."<sup>21</sup> [8]

Telemedicine may also lower the costs of health care to patients in rural areas. Although no one has yet performed a comprehensive study, it seems obvious that the money saved in less absenteeism and lower travel expenses alone would lower costs tremendously for patients in remote areas.<sup>22</sup> [9]

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14 *Id.*

15 *Id.*

16 *Id.*

17 Lane, *supra* note 4, at 23 (quoting Betsey Blakeslee, Managing Director of the Institute of Telemedicine at the Center for the New West in Denver).

18 *Id.* at 17, 23; *see generally* Mehler, *supra* note 5 (discussing the innovation of telemedicine, and the possible pros and cons of telemedicine).

19 Lane, *supra* note 4, at 23.

20 "Real time" is defined as the "time in which the occurrence of an event and the reporting or recording of it are almost simultaneous." WEBSTER'S NEW WORLD DICTIONARY OF AMERICAN ENGLISH 1118 (3d. College Ed. 1994). For telemedicine, real-time means that little or no time elapses between the action at the remote site and the transmission received at the urban center.

21 LaRocco, *supra* note 2.

22 JIM GRIGSBY ET AL., HEALTH CARE FINANCING ADMINISTRATION (HCFA), ANALYSIS OF EXPANSION OF ACCESS TO CARE THROUGH USE OF TELEMEDICINE AND MOBILE HEALTH SERVICES: CASE STUDIES AND CURRENT STATUS OF TELEMEDICINE (REPORT 2) (May 1994), at 3.2-3.3. A study

## B. Overview of Current Projects

The study of telemedicine began as early as 1964.<sup>23</sup> Its main purpose was medical education.<sup>24</sup> Pathology and radiology professionals have continued to use telemedical technologies since then.<sup>25</sup> Physicians can send pictures using video and fax equipment, and other professionals can make a diagnosis without the physical presence of the patient.<sup>26</sup> As interest in telemedicine and available technologies continues to develop, telemedicine will begin to enter areas where physicians treat patients in live clinical settings.<sup>27</sup> [10]

Telemedicine projects are currently in development at colleges and hospitals around the country.<sup>28</sup> Using technologies such as video, facsimile, and digital equipment,<sup>29</sup> physicians consult with specialists and other physicians in remote areas.<sup>30</sup> The following briefly summarizes three representative telemedicine sites.<sup>31</sup> [11]

### 1. Texas Tech University Health Sciences Center

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performed by Arthur D. Little, Inc. in 1992 suggests that a telemedicine system may “cut the costs of the nation’s health care bill by as much as \$36 billion.” *Id.* at 3.2. The study has been attacked, however, because telemedicine was only a small part of the project, and the study actually focused on telecommunications and information transmission. *Id.* at 3.2-3.3; LaRocco, *supra* note 2.

<sup>23</sup> JOINT REPORT, *supra* note 3, at 2.

<sup>24</sup> *Id.*

<sup>25</sup> *Id.*

<sup>26</sup> LaRocco, *supra* note 2.

<sup>27</sup> GRIGSBY, *supra* note 22, at 4.2, 5.1. *Cf.* JOINT REPORT, *supra* note 3, at 6.

<sup>28</sup> GRIGSBY, *supra* note 22, at 2.1-2.19.

<sup>29</sup> Lane, *supra* note 4, at 23; Mehler, *supra* note 5.

<sup>30</sup> *See generally* GRIGSBY, *supra* note 22; JOINT REPORT, *supra* note 3, at 5.

<sup>31</sup> For a sample of other such projects, see GRIGSBY, *supra* note 22, at 2.1-2.5, 2.11-2.13 (describing the NASA Johnson Space Center in Houston, Texas and the Tripler Army Medical Center on Oahu, Hawaii).

Texas Tech University currently runs the MEDNET project, which provides both telemedicine treatment to patients and remote education to physicians.<sup>32</sup> MEDNET uses facsimile transmission, interactive video<sup>33</sup> and slow-scan video. These technologies link together two remote sites for telemedicine, a rural hospital and a health clinic.<sup>34</sup> Physician-to-physician consultations occur frequently, as Texas Tech pushes to expand the project.<sup>35</sup> Most of the consultations conducted to date include dermatology, trauma care, and the management of complicated pregnancies.<sup>36</sup> Other specialties within the system include ophthalmology, orthopedics, and physical therapy.<sup>37</sup> [12]

## 2. Medical College of Georgia

The Medical College of Georgia ("MCG") began its telemedicine project in 1991.<sup>38</sup> MCG links two care center hubs with nine secondary care centers and three or four primary health care facilities, using technologies that include videoconferencing<sup>39</sup> and an on-line medical literature service.<sup>40</sup> Videotape records consultations occurring between any of the participants, for risk management, quality assurance and teaching purposes.<sup>41</sup> The project uses high-resolution cameras so that doctors at each location can share examinations.<sup>42</sup> [13]

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<sup>32</sup> GRIGSBY, *supra* note 22, at 2.19.

<sup>33</sup> *Id.* For the purposes of this Note, "interactive video" means two-way audio and video communication over which individuals can communicate instantaneously with each other. See Lane, *supra* note 4, at 17; H.R. 3909, § 1717(5).

<sup>34</sup> GRIGSBY, *supra* note 22, at 2.19.

<sup>35</sup> *Id.* (noting that "Texas Tech has conducted a pilot project [using telemedicine] with state prisoners in West Texas" and has projected providing health care services for 33,000 such prisoners).

<sup>36</sup> *Id.* at 2.20.

<sup>37</sup> *Id.*

<sup>38</sup> *Id.* at 2.8.

<sup>39</sup> Users can control the videoconferencing equipment from each end to conduct real-time discussions and diagnoses. *Id.*

<sup>40</sup> The medical literature service provides access to current medical information, and uses the personal-computer component of the technological system to provide such information. *Id.*

<sup>41</sup> *Id.*

<sup>42</sup> *Id.* MCG specialists also use electronic stethoscopes, otoscopes, and laryngoscopes to examine a patient's heart, lungs, eyes, and throat. LaRocco, *supra* note 2 n.1.

Physicians note that the inability to touch the patients directly during remote examinations is a significant drawback.<sup>43</sup> In response to this problem, MCG and Georgia Tech have joined to develop a "data glove," which uses virtual reality technology to allow a physician in a city to "feel" a patient located in a remote area.<sup>44</sup> [14]

The telemedicine system at MCG provides care to a rural, low-income population.<sup>45</sup> One significant benefit of the telemedicine system lies in its cost-effectiveness. Roughly eighty-three percent of the patients who otherwise would have had to travel 130 miles from Eastman to MCG were either treated at the Eastman location for a cost of \$800 per day (versus the \$1300 treatment cost at MCG), or sent home with no in-patient costs at all.<sup>46</sup> [15]

### 3. Eastern Montana Telemedicine Project

A private hospital, with funding from US West and the Rural Electrification Administration, established the Eastern Montana Telemedicine Project ("EMTP").<sup>47</sup> Deaconess Medical Center in Billings serves as the center of a hub for five remote sites in eastern Montana.<sup>48</sup> EMTP transmits computerized tomography, or CT, scans<sup>49</sup> digitally, uses voice-activated videoconferencing equipment that allows cameras to track a speaker,<sup>50</sup> and has the capacity to transmit low-resolution radiographs.<sup>51</sup> [16]

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43 GRIGSBY, *supra* note 22, at 2.9.

44 *Id.*

45 *Id.*

46 LaRocco, *supra* note 2 n.1.

47 GRIGSBY, *supra* note 22, at 2.10.

48 *Id.*

49 CT scans are computerized cross-sectional images from within the body. See WEBSTER'S, *supra* note 20, at 234.

50 GRIGSBY, *supra* note 22, at 2.10.

51 *Id.* "Radiograph" is defined as "a photographic image produced by the action of x-rays or rays from radioactive substances." WEBSTER'S, *supra* note 20, at 1186.



Eastern Montana is vast and remote: seventeen counties span 48,000 square miles, with a population density of fewer than two people per square mile.<sup>52</sup> Accordingly, various specialists in Montana make use of telemedicine, with psychiatry providing over fifty percent of the consultations.<sup>53</sup> [17]

C. *H.R. 3909, "The Rural Telemedicine Enhancement Act"*

On February 24, 1994, Representative Larry LaRocco (D-ID) introduced the Rural Telemedicine Enhancement Act ("Telemedicine Act").<sup>54</sup> The purpose of the bill was "the establishment and development of telemedicine technologies to increase the quality and accessibility of health care in rural areas and to reduce the costs of such care."<sup>55</sup> The bill proposed providing federal grants to Rural Health Care Networks ("Networks") to establish telemedicine systems and "advanced" telemedicine networks ("Advanced Networks").<sup>56</sup> The bill proposed giving preference to those Networks with broad geographic ranges in the state or states in which they intended to establish telemedicine systems.<sup>57</sup> The bill would have allowed grants for Advanced Networks to those applicants consisting of two or more Networks.<sup>58</sup> [18]

The bill also proposed a Health Care Data Interchange System to make health care data available on a uniform basis to all participants in the Health Care System ("System").<sup>59</sup> The bill would have established a Health Care Data Panel ("Panel")

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52 GRIGSBY, *supra* note 22, at 2.10.

53 As GRIGSBY ET AL. discusses, there are only five regional community mental-health centers for the population area described above. In addition, "[t]here are no psychiatrists or inpatient psychiatric units in any of those counties, and there are only two or three child psychiatrists in the entire state." *Id.* This may explain the large percentage of psychiatric teleconsultations that occur.

54 H.R. 3909 § 1711.

55 *Id.*

56 H.R. 3909 defines the Rural Health Care Network as a group of rural health care providers that have entered into a formal relationship with each other or with health care providers in an area that is not a rural area for the purpose of improving the delivery of health care in a rural area, or for the purpose of improving the access of their patients to the services of a telemedicine project. *Id.* § 1717(7). Advanced Telemedicine Projects consist of two or more Rural Health Care Networks. *Id.* § 1713(a).

57 *Id.* § 1712(b)(4).

58 *Id.* § 1713(a).

59 *Id.* § 201.

and a National Health Informatics Commission ("Commission") to advise the Panel.<sup>60</sup> Through consultation with the American National Standards Institute ("ANSI"),<sup>61</sup> the Panel would have promulgated rules for Networks concerning the electronic interchange of data that the Panel found necessary for effectiveness and efficiency.<sup>62</sup> The Panel, operating in connection with the Office of Management and Budget ("OMB"), would also have had the power to regulate the System's implementation and operation.<sup>63</sup> The regulations would have involved hospital and network admission requirements, as well as requirements for continuing operation within the System (such as privacy provisions). The bill would also have empowered the Panel to establish civil and criminal fines and penalties for participants who failed to comply with the regulations.<sup>64</sup> [19]

Considering the broad goals of telemedicine, and the large geographical range emphasized under the Telemedicine Act, telemedicine will likely impact many states.<sup>65</sup> Although the bill proposes its own rules and regulations for Networks involved in the System, it does not account for how to license the individual physicians who work within the Networks.<sup>66</sup> [20]

Telemedicine raises many questions for the entire medical profession, including ethical issues about treating patients in remote areas, and the possibilities of economic benefits for patients treated through telemedicine. Physicians are divided as to the benefits and uses of telemedicine.<sup>67</sup> Although some physicians envision more cost-effective and faster medical treatment in rural areas, others

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<sup>60</sup> *Id.* § 202(a).

<sup>61</sup> ANSI comprises industrial firms, trade associations, technical societies, labor and consumer organizations, and government agencies, and "[s]erves as a clearinghouse for nationally coordinated voluntary standards for fields ranging from information technology to building construction." ENCYCLOPEDIA OF ASSOCIATIONS 691 (Carol A. Schwartz & Rebecca L. Turner eds., 2d ed. 1995).

<sup>62</sup> H.R. 3909 § 204(a).

<sup>63</sup> *Id.* § 203.

<sup>64</sup> *Id.* § 210.

<sup>65</sup> See *id.* § 1711 (discussing the bill's goals of improving access to and quality of healthcare); see also JOINT REPORT, *supra* note 3, at 8.

<sup>66</sup> See Christine Woolsey, *Health Care Cost Savings Delivered Via Telemedicine But Quality of Information and Care May Suffer*, CRANE COMMUNICATIONS, INC., Feb. 20, 1995, available in LEXIS, News Library, CCI File.

<sup>67</sup> GRIGSBY, *supra* note 22, at 3.4.

foresee ethical problems.<sup>68</sup> The latter believe that the benefits of personally treating patients face to face, and the ability to touch and see patients in live settings, outweigh some of the benefits of telemedicine.<sup>69</sup> While advancement of telemedicine raises a great number of non-legal issues, this Note focuses on the unique legal issues that have evolved with the growth of telemedicine: licensing and malpractice. [21]

### III. TELEMEDICINE LICENSING

#### A. Current Licensing Practices

State legislatures can require physicians to obtain licenses to practice medicine, and can make practicing without a license a crime.<sup>70</sup> Currently, all states provide that a person must obtain a license to practice medicine,<sup>71</sup> although licensing requirements may vary from state to state.<sup>72</sup> Some conditions include specific pre-medical education, medical education, state exams, and good moral character.<sup>73</sup> Each state also has the ability to revoke any license for cause.<sup>74</sup> Finally, each state retains control over the licensing and regulation within its borders of physicians already licensed to practice elsewhere.<sup>75</sup> [22]

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<sup>68</sup> *Id.*

<sup>69</sup> LaRocco, *supra* note 2 n.1 (describing the potential benefits of telemedicine).

<sup>70</sup> *See, e.g., Sembler v. Oregon State Bd. of Dental Examiners*, 294 U.S. 608, 611 (1935); *see generally* 70 C.J.S. *Physicians and Surgeons* § 11 (1987).

<sup>71</sup> *See, e.g., CAL. BUS. & PROF. CODE* § 2052 (West 1990); *GA. CODE ANN.* § 43-34-37 (1994); *N.Y. EDUC. LAW* § 6509 (McKinney 1995 & Supp. 1996); *see generally* 70 C.J.S. *Physicians and Surgeons* § 12 (1987).

<sup>72</sup> *See, e.g., Marlar v. Patterson*, 135 P.2d 218 (Ariz. 1943) (referencing Arizona state medical licensing requirements); *Leo v. Board of Medical Examiners*, 97 P.2d 1046 (Cal. App. 2d 1940) (referencing California state medical licensing requirements).

<sup>73</sup> *See, e.g., MASS. GEN. L. ch. 112, § 2* (1995) (requiring that an applicant submit an application, take a state exam, and possess a degree from an accredited medical school); *N.Y. EDUC. LAW* § 6524 (requiring an age of at least twenty-one years, payment of a fee, and good moral character); *P.R. LAWS ANN. tit. 20, § 43* (1989) (requiring residency within Puerto Rico for at least six months).

<sup>74</sup> *See Coe v. United States District Ct.*, 676 F.2d 411, 414 (10th Cir. 1982).

<sup>75</sup> Elizabeth Neus, *Telemedicine: Huge Promise, Many Big Questions*, GANNETT NEWS SERVICE, Mar. 17, 1995, available in LEXIS, News Library, GNS File. For example, Ms. Neus notes that currently Kansas requires out-of-state physicians to possess Kansas licenses to diagnose and treat patients within Kansas. *Id.*

As discussed earlier, the use of telemedicine could impact a large geographical range. The Telemedicine Act would create economic incentives to establish larger Networks and Advanced Networks by awarding federal grants first to those Networks that "demonstrate . . . broad geographic representation of rural areas."<sup>76</sup> Such large telemedicine networks would cross state lines, and the resulting interstate telemedical practices would affect medical licensure. [23]

Under current state licensing systems, physicians must obtain a license from each state in which they practice.<sup>77</sup> In telemedicine networks that operate in many states, however, requiring multiple licenses will place discouraging burdens on physicians.<sup>78</sup> The current system requires the physician to go through re-examination, re-filing of fees, and more waiting to obtain each additional license.<sup>79</sup> As a result of the hardship of multiple licensing, physicians may decline to practice telemedicine until the significant burdens of multiple licensure change. [24]

#### B. *Proposed Telemedicine Licensing System*

Those currently involved in telemedicine advocate establishing "a national medical license limited to telemedicine consultation within an area of specialty expertise."<sup>80</sup> Some have suggested creating a national license for practice on telemedicine systems as an alternative. The Federation of State Medical Boards, Inc. ("FSMB") has been working on reforming the licensure of physicians for all areas of medicine to allow physicians the mobility necessary in their profession.<sup>81</sup> According to the FSMB, a national licensing system would issue a "'well-tempered license' . . . reflecting reliably evaluated qualifications considered essential by all other jurisdictions."<sup>82</sup> [25]

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<sup>76</sup> H.R. 3909 § 1712.

<sup>77</sup> See CAL. BUS. & PROF. CODE § 2052; GA. CODE ANN. § 43-34-37; N.Y. EDUC. LAW § 6509.

<sup>78</sup> See JOINT REPORT, *supra* note 3, at 8.

<sup>79</sup> See, e.g., 20 P.R. LAWS ANN. tit. 20, § 43(1) (requiring six-month residency prior to licensure). Nevertheless, some states do waive certain requirements if they have reciprocity with the home state, or if the physician has taken the Federation of State Medical Boards FLEX exam. *Id.* § 43(3).

<sup>80</sup> JOINT REPORT, *supra* note 3, at 8.

<sup>81</sup> THE AMERICAN MEDICAL ASSN. BOARD OF TRUSTEES & THE FEDERATION OF STATE MEDICAL BOARDS, INC., AGENDA, Tab Y-1 (December 3, 1994) (unpublished manuscript on file with the author) [hereinafter AGENDA].

<sup>82</sup> *Id.* at Tab Y-2.

This licensing system could work in tandem with the Telemedicine Act, under which the Panel would appoint the members of the Commission for advice on its activities. The bill would establish a Commission consisting of fifteen members from different professions and geographic areas.<sup>83</sup> They would represent federal or state health programs and "applicable standard-setting groups" (including the National Uniform Billing Committee, the Uniform Claim Form Task Force, and ANSI).<sup>84</sup> The bill also would require the members of the Commission to be experts in electronic data interchange, financing health care, research and development of technological and scientific advances in health care, and health care enrollment and claims administration.<sup>85</sup> The Commission and the Panel could work together in developing and administering the national license. [26]

The Commission, or other national board that would issue national licenses, should require that physicians take a uniform national exam. National exams should draw from various state exams,<sup>86</sup> and should test both medicine and technology used on telemedicine systems. Exams should test physicians on their specialties (or general practice) as well as on applications of the technologies available on the system. Without knowledge of the tools before them, physicians may not work effectively on a telemedicine system or network. Therefore, national licensing should require testing of skills in the use of equipment for telemedicine practice.<sup>87</sup> [27]

### C. *Potential Constitutional Issues*

The Supreme Court recognized in *Semler v. Oregon State Bd. of Dental Examiners*<sup>88</sup> that states have a reasonably necessary right to establish licensing and regulation procedures regarding the profession of dentistry, and stated that the power of the state to do so was "not open to dispute."<sup>89</sup> The Court also noted the

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<sup>83</sup> H.R. 3909 § 214.

<sup>84</sup> *Id.* § 214(C).

<sup>85</sup> *Id.* § 214(B)(2)(e).

<sup>86</sup> See AGENDA, *supra* note 81.

<sup>87</sup> See James Rosenblum, *Medical Liability in Cyberspace*, THE CONNECTICUT LAW TRIBUNE, Feb. 27, 1995, at 13A, available in LEXIS News Library, CLT File.

<sup>88</sup> 294 U.S. at 608.

<sup>89</sup> *Id.* at 611.

existence of a legislative concern about the "vital interest of the public health, and with a profession treating bodily ills and demanding different standards of conduct"<sup>90</sup> from those who normally compete in the market place. As a result, states currently license and regulate physicians that practice within their borders. This gives states exclusive control over whom they allow to practice medicine. A national telemedicine license could create constitutional conflicts between the states' rights and federal control of the licensing of physicians. [28]

The United States Constitution divides and allocates powers between the national government and the states.<sup>91</sup> Article I of the Constitution enumerates the powers of Congress, and the Tenth Amendment reserves for the states those powers not given to Congress.<sup>92</sup> Thus, Congress cannot assume powers not directly granted to it by the Constitution. Congress does have broad discretion when using its powers under the Commerce Clause, however, to "regulate Commerce . . . among the several States."<sup>93</sup> States may fear that because the practice of telemedicine crosses borders, Congress could have the power to regulate telemedicine through the Commerce Clause, thus usurping state power to regulate the medical field.<sup>94</sup> The creation of a dual licensing system would resolve this tension. States should continue licensing the intrastate practice of medicine and telemedicine, while the national government should create a license for the interstate practice of telemedicine. This scheme would limit to two the number of licenses needed by a physician to practice on an interstate telemedicine system. [29]

The first requirement of this proposed licensing system is that a state must license a physician before that physician may apply to practice on a telemedicine network. This requirement ensures that a physician cannot make an end-run

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<sup>90</sup> *Id.* at 612.

<sup>91</sup> See U.S. CONST. amend. X; see generally GERALD GUNTHER, CONSTITUTIONAL LAW 65 (12th ed. 1991) (noting that the Constitution specifies federal powers while leaving undelegated powers to the states).

<sup>92</sup> U.S. CONST. art. I; U.S. CONST. amend. X.

<sup>93</sup> U.S. CONST. art. I, § 8, cl. 2.

<sup>94</sup> Because states license physicians, the creation of a national license raises an issue of state autonomy versus the commerce power. As Professor Gunther puts it, "[t]he question here is whether a State's activities, even though they [] are 'in' or 'affect' commerce, are nevertheless immune from federal regulation, either because of the Tenth Amendment or because of structural considerations drawn from the constitutional scheme." GUNTHER, *supra* note 91, at 157. The Supreme Court addressed this limitation in a series of cases beginning with *United States v. California*, 297 U.S. 175 (1936) and leading up to *Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985). As a lengthy discussion of how jurisprudence in this area would specifically affect licensing of telemedicine is beyond the scope of this Note, for present purposes it will be assumed that Congress has the right to create such federal schemes, and that states would oppose such action.

around state regulations. It also ensures that states continue to retain control over licensing physicians who practice solely within their borders. The national license would apply only to practice on a telemedicine system, and would not apply to general practice within the state. Therefore, each state would still retain absolute control over doctor-patient interactions occurring exclusively within its jurisdiction. Also, each state would remain entirely responsible for those physicians not connected to the telemedicine system. [30]

#### D. *Proposed Requirements for a National Licensing System*

Obtaining a national license should require possession of a state license. Since individual physicians would work in multiple states, they would need to obtain a license from the state in which they reside and practice in order to obtain a national license for the telemedicine system. In addition, the national license would only be valid on the telemedicine system. Physicians would still need to hold a state license for the face-to-face treatment of patients. [31]

The remaining requirements for a national telemedicine license should combine common state requirements.<sup>95</sup> For example, physicians should possess a degree from a recognized medical school within the United States or one of its territories. Further, the licensing scheme should make exceptions for doctors with degrees from foreign medical schools, where those applicants can show that they also possess a medical license from that foreign country and practiced there for a specific number of years.<sup>96</sup> Physicians who already possess a state license would likely satisfy the foreign license requirement, because of existing state requirements.<sup>97</sup> Therefore, neither applicants nor the certifying Board would face additional burdens. [32]

### IV. TELEMEDICAL MALPRACTICE

Telemedicine also creates several malpractice issues.<sup>98</sup> Malpractice is defined as "a breach of the duty owed by one rendering professional services to a person who

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<sup>95</sup> See AGENDA, *supra* note 81.

<sup>96</sup> See MASS. GEN. L. ch. 112, § 2; N.Y. EDUC. LAW § 6524.

<sup>97</sup> See MASS. GEN. L. ch. 112, § 2; N.Y. EDUC. LAW § 6509.

<sup>98</sup> For example, Rosenblum questions whether physicians in one state would be subject to the jurisdiction of other states, and believes that if they would, this would prevent the development of telemedicine technology. Rosenblum, *supra* note 87.

has contracted for such services."<sup>99</sup> The physician-patient relationship creates the contractual duty necessary for a malpractice claim.<sup>100</sup> A physician acting outside of the standard of care required in her jurisdiction faces potential liability for malpractice.<sup>101</sup> Insofar as telemedicine creates a new medium in which physicians may practice, questions arise concerning the standard of care to which courts should hold the physicians practicing on the system, and how courts might resolve malpractice claims. [33]

#### A. *The Physician-Patient Relationship*

The relationship between a physician and a patient generally begins when the physician agrees to provide a professional service to the patient.<sup>102</sup> Malpractice liability may turn not only on acts performed on the patient, but also on communications made to the patient.<sup>103</sup> Thus, it is important to define when exactly this relationship arises.<sup>104</sup> [34]

"Cases focusing on the verbal behavior of physicians are becoming more numerous" and the "telephone is starting to become 'one of the most potentially dangerous instruments in terms of a physician's professional liability.'"<sup>105</sup> Agreeing to treat a specific problem may give rise to a duty of care on the part of the physician, even if the physician never sees the patient.<sup>106</sup> For example, in *Bienez v. Central Suffolk Hospital*,<sup>107</sup> a patient's phone call to a physician's office for the purpose of initiating treatment resulted in the physician committing malpractice when he

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<sup>99</sup> *Weaver v. University of Mich. Bd. of Regents*, 506 N.W.2d, 264, 266 (Mich. App. 1993); *see also* CAL. CIV. PRO. CODE § 340.5 (West 1990); *Winona Mem. Found. v. Lomax*, 465 N.E.2d 731, 733 (Ind. App. 1984); *Hutchinson v. Patel*, 637 So. 2d 415, 419-420 (La. 1994); *Hill v. Kokosky*, 463 N.W.2d 265, 1266 (Mich. App. 1990).

<sup>100</sup> *Weaver*, 506 N.W.2d at 265.

<sup>101</sup> *Id.*

<sup>102</sup> George E. Stevens, *Physician's Liability Created by Telephone and Other Communications*, TRAUMA, Apr. 1993, at 45.

<sup>103</sup> *Id.*

<sup>104</sup> *Id.*

<sup>105</sup> *Id.* (quoting *The Perils of Telephone Diagnosis*, 36 OHIO MEDICINE 230 (Mar. 1990)).

<sup>106</sup> *Id.* at 49.

<sup>107</sup> 557 N.Y.S.2d 139 (N.Y. App. Div. 1990).



negligently gave the patient erroneous advice over the telephone as to what treatment to pursue.<sup>108</sup> [35]

Malpractice liability for consultations with other physicians differs from malpractice liability for telephone communications directly with patients. The physician who offers advice about treatment procedures to the treating physician finds protection from malpractice liability. For instance, the Michigan Court of Appeals found no malpractice where allegedly incompetent advice given by a consulting physician to a treating physician caused a woman to give birth to an impaired child.<sup>109</sup> The consulting physician addressed the advice to the treating physician and not to the patient, and the treating physician could choose to follow or disregard the advice. Although the woman might have had a claim against her treating physician, the conversations between the two physicians did not create a relationship between the patient and the consulting physician.<sup>110</sup> [36]

The definition of the physician-patient relationship merits consideration in any discussion of telemedicine. Physicians in locations many miles away from patients will offer treatment in ways that may differ from those used by physicians who treat patients in live settings.<sup>111</sup> One could analogize that the telemedical situation creates a physician-patient relationship and a duty of care similar to the telephone advice cases. In both situations, physicians offer advice and possible treatment using communication devices outside the physical presence of the patient. Where physicians practicing on telemedicine systems actually interact with patients for the purpose of giving advice or treatment, this contact gives rise to the physician-patient relationship, as in the telephone cases. On the other hand, no duty exists for patients under the care of general practitioners, where those practitioners alone contact specialists via telemedicine, because the general practitioner can choose whether or not to follow the advice. [37]

Although these are fact-sensitive issues that should be decided on a case-by-case basis, one can conclude from the cases above that where a physician actually sees and consults with a patient, then a contractual duty of care arises. When the consulted physician speaks only with the attending physician, it does not create such a duty. Thus, when contact occurs between patients and remote specialists, liability may indeed arise over telemedicine systems. [38]

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108 *Id.* at 170.

109 *Hill*, 463 N.W.2d at 266.

110 *Id.* at 267.

111 See discussion of telemedical technologies, *supra* parts II.A and II.B.

B. *The "Reasonable" Telemedical Doctor Standard of Care*

1. *Current Standards of Care*

To define a physician's duty of care to patients, some jurisdictions adopt the "Same Locality Rule," which requires courts to hold physicians to the level of care possessed by physicians of the same specialty practicing in the same locality.<sup>112</sup> This rule defines the "reasonable physician" as a physician in good standing in his or her own community and a "reasonable specialist" as a specialist in good standing in the same community.<sup>113</sup> [39]

Other courts have expanded this rule to create the "Similar Locality Rule," which determines reasonableness by comparing physicians or specialists in the same *or similar* localities.<sup>114</sup> This test differs from the Same Locality Rule in that the reviewing court does not limit the comparison to the physician's exact location, but also includes similar locations based on such factors as available medical facilities.<sup>115</sup> [40]

The remaining courts follow the national standard, which defines the reasonable physician or specialist as one who possesses the skill expected of a reasonably competent physician or specialist acting in the same or similar situation nationwide.<sup>116</sup> Courts in this last category realize that modern technologies and improved, standardized medical education allow physicians broader access to medical knowledge and information.<sup>117</sup> [41]

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<sup>112</sup> See, e.g., *Mariano v. Tanner*, 497 So.2d 1066 (La. App. 5th. Cir. 1986) (holding that plaintiffs bear the burden of proving that physician deviated from the standard of care of physicians in the local community); *Malila v. Meacham*, 211 P.2d 747 (Or. 1949) (holding that the dental patient suing for malpractice had burden of proving that the doctor did not measure up to the skills of other physicians in the same neighborhood and general line of practice).

<sup>113</sup> *Tallbull v. Whitney*, 564 P.2d 162, 165 (Mont. 1977) (finding that advances in technologies and communication made the Same Locality Rule obsolete).

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<sup>114</sup> See, e.g., *Chapel v. Allison*, 785 P.2d 204, 1206-07 (Mont. 1990) (holding that the Similar Locality Rule extends to communities outside the state).

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<sup>115</sup> *Weekley v. Solomon*, 510 N.E.2d 152, 155 (Ill. App.Ct. 1987).

<sup>116</sup>

<sup>116</sup> See, e.g., *Robbins v. Footer*, 553 F.2d 123, 127 (D.C. Cir. 1977) (finding that a national standard of care applied to nationally certified medical specialists); *McMillan v. Durant*, 439 S.E.2d 829, 832 (S.C. 1993) (finding that the adoption of a national standard of care eliminated the locality standard of care).

<sup>117</sup> See, e.g., *King v. Williams*, 279 S.E.2d 618, 621 (S.C. 1981) (abandoning the locality standard of care for that of a competent practitioner acting in similar circumstances).

## 2. Proposed Standard of Care for Telemedicine

Telemedicine proposes a new and different way of practicing medicine, one that requires both a knowledge of unconventional equipment and a recognition and understanding of the unique interaction between physicians and patients in remote locations using video, electronic, and digital equipment. Insofar as telemedicine practitioners possess knowledge and skills far different from those of traditional practitioners, courts should judge them in comparison with others in their own specialty. Accordingly, telemedicine should follow the national standard of care. [42]

The national standard of care, as adopted for the purposes of telemedicine, should require that a "reasonable telemedical practitioner" possess the skill expected of a reasonably competent telemedical practitioner acting in the same or similar circumstances nationwide. The need for a national standard arises because telemedical practitioners could foreseeably practice nationwide.<sup>118</sup> Thus, the telemedical physician does not work in any "locality" or "similar locality," but rather with many patients in remote areas unbounded by geographic borders. Further, even the physicians on a telemedicine network may practice from several different medical centers. A national standard would avoid the difficulties that the unique nature of telemedicine creates in determining a locality for comparison. [43]

## 3. Telemedicine Practice Parameters

Many medical groups, including the AMA, have "practice parameters" under development for use in the medical field.<sup>119</sup> These practice parameters act as guidelines created by physicians for physicians in the practice of medicine. Such guidelines may be useful in the new and expanding realm of telemedicine. [44]

The AMA defines practice parameters as "strategies for patient management designed to assist physicians in clinical decision making."<sup>120</sup> The AMA warns, however, that to rely strictly on these parameters to determine liability in malpractice suits may be overly simplistic.<sup>121</sup> The AMA encourages physicians and

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118 See generally H.R. 3909; JOINT REPORT, *supra* note 3.

119 Michael Daly, *Attacking Defensive Medicine Through the Utilization of Practice Parameters: Panacea or Placebo for the Health Care Movement?* J. OF LEGAL MED. 101, 106 (1995).

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120 American Medical Association, POLICY COMPENDIUM § 410.987 (1993)(on file with the author).

121 *Id.* § 450.999.

physicians' groups to help formulate these practice parameters to ensure the best possible level of care for patients.<sup>122</sup> [45]

Currently, medical groups and legislatures continue to experiment with practice parameters. The Maine Legislature passed the Maine Medical Liability Demonstration Project,<sup>123</sup> which applies to four specialty areas: anesthesia, obstetrics/gynecology, emergency medicine, and radiology.<sup>124</sup> The law provides a defense in a medical malpractice suit to those practicing in conformity with the guidelines.<sup>125</sup> [46]

Developing and researching practice parameters to guide physicians new to telemedicine will avoid problems. Physicians currently working with telemedicine should establish guidelines to create tested procedures for physicians new to telemedicine.<sup>126</sup> The AMA, however, warns against relying on the guidelines as specific malpractice standards for determining physician liability.<sup>127</sup> "Only where a variation involves provision of a service or procedure deemed by the preponderance of medical opinion to be inappropriate in any clinical situation should it be used as a per se indicator for judgments regarding quality . . . ."<sup>128</sup> The courts should look at these parameters for telemedicine as guidelines for aiding physicians, not hard and fast rules that may not be violated. [47]

### C. *National Malpractice Suits*

Given the potentially broad geographical reach of a telemedicine system, malpractice suits originating from such systems may often involve multiple states. As a result, most of the malpractice cases could constitute diversity suits. Moreover, as telemedical systems become more widespread, telemedical malpractice claims could overburden federal courts. Therefore, Congress should implement a plan

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<sup>122</sup> *Id.* § 410.998.

<sup>123</sup> The Medical Liability Demonstration Project, ME. REV. STAT. ANN. tit. 24, § 2972 (West 1994 & Supp. 1995).

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<sup>124</sup> *The Maine Experiment*, PARAMETERS, GUIDELINES & PROTOCOLS, Nov. 1994 at 4 (on file with the author).

<sup>125</sup> ME. REV. STAT. ANN. tit. 24, § 2975.

<sup>126</sup> See POLICY COMPENDIUM, *supra* note 120.

<sup>127</sup> See *id.* § 410.999.

<sup>128</sup> *Id.*

combining various state malpractice regulations to limit the number of potential federal suits. [48]

Similar to the current Massachusetts malpractice scheme,<sup>129</sup> a telemedicine regulatory scheme should assemble regional tribunals, separated by state, to exclusively handle malpractice claims arising from telemedicine systems. The tribunals should consist of members of both the legal and medical communities, to ensure the highest level of accuracy in the tribunals' decisions.<sup>130</sup> The tribunals would consist of one judge from the trial court level; one physician, licensed to practice medicine according to the laws of the state; and one attorney authorized to practice law in the state.<sup>131</sup> The judge would choose from submitted lists a physician and an attorney previously uninvolved with the claim.<sup>132</sup> The chosen attorney and physician should also have familiarity with the area of law or medicine involved in the particular case, to maximize the accuracy of their decisions.<sup>133</sup> [49]

The tribunals would determine if malpractice claims merited going to trial. This would entail separating claims into two groups: those appropriate for judicial review, and those that were unfortunate medical accidents.<sup>134</sup> The tribunal would hear the claims and the plaintiff's evidence, and then would determine whether the plaintiff had a valid claim.<sup>135</sup> The test of a valid claim would be whether the claim could withstand a motion for directed verdict.<sup>136</sup> If the case could not sustain such a motion, then the plaintiff could not file suit.<sup>137</sup> Patients and doctors could appeal the judgments of the tribunal.<sup>138</sup> Once the claim went to trial, as in any other

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129 MASS. GEN. L. ch. 231, § 60B (1995).

130 *Id.*

131 *Id.*

132 *Id.*

133 *Id.*

134 *See* *Leininger v. Franklin Medical Ctr.*, 534 N.E.2d 1151, 1152 (Mass. 1989).

135 *See* MASS. GEN. L. ch. 231, § 60B.

136 *See id.*; *Little v. Rosenthal*, 382 N.E.2d 1037, 1041 (Mass. 1978).

137 MASS. GEN. L. ch. 231, § 60B.

138 *Id.*

diversity case, the judge, using the Rules of Decision Act<sup>139</sup> and the *Erie* doctrine,<sup>140</sup> would determine which state's law to apply.<sup>141</sup> [50]

This type of system would limit the cases that reach the federal court by weeding out meritless claims. This would enable federal courts to better handle the claims that did come before them. Further, the proposed system would be simpler than establishing a separate federal court system to hear only telemedical malpractice claims. A separate court system would require high costs and far more regulatory control.<sup>142</sup> Setting up a new system would in effect entail creating a "mini-judicial" system. Therefore, using the existing federal court system would lower administrative costs. [51]

#### IV. CONCLUSION

Telemedicine has the potential to greatly benefit society, especially by providing medical care to rural areas of the country that are presently cut off from many modern technologies. At the same time, unique legal and medical issues arise as the telemedical field expands. Such issues include how to license physicians who practice telemedicine and how to treat malpractice suits arising out of telemedical practice. [52]

Congress should create a national license for telemedicine systems to alleviate burdens created by existing state licensing schemes. A bifurcated licensing system would relieve physicians of the burdens of obtaining numerous state licenses, yet would still allow the states to require a state license from physicians who practice telemedicine from that state prior to obtaining a national license. Further, courts should hold physicians to a national standard of care when practicing telemedicine, to ensure uniformity of practice. A uniform standard of care will avoid the uncertainty and inconsistency that would be created if courts used the varying standards for each region. Finally, a national telemedicine regulatory scheme should establish regional tribunals to screen out frivolous telemedical malpractice claims. Regional tribunals would prevent telemedical malpractice claims from

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<sup>139</sup> The Rules of Decision Act states that "[t]he laws of the several states, except where the Constitution or treaties of the United States or Acts of Congress otherwise require or provide, shall be regarded as rules of decision in civil actions in the courts of the United States, in cases where they apply." 28 U.S.C. § 1652 (1994).

<sup>140</sup> *Erie R.R. v. Tompkins*, 304 U.S. 64 (1938). See *Feinstein v. Mass. Gen. Hosp.*, 643 F.2d 880, 889 (1st Cir. 1981).

<sup>141</sup>

<sup>141</sup> See *Feinstein*, 643 F.2d at 883.

<sup>142</sup> James A. Martin, *The Proposed "Science Court,"* 75 MICH. L. REV. 1058, 1089-1090 (1977) (discussing the pros and cons of creating a separate court system for scientific issues).

overburdening the federal courts, and would avoid the high administrative costs of creating a separate court system. While the growth of telemedicine may prove beneficial, the legal problems discussed in this Note require attention at the outset to ensure the smooth integration of this technology into the existing medical and legal systems. [53]