The Interstate Medical Licensure Compact
Making the Business Case

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  Analysis of North Carolina Medical Board Data, 2002–2012
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Could an Interstate Compact for Medical Licensure Better Facilitate the Needs of Modern Medical Practices?

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Societies develop...by adjusting themselves to the problems that they find before them.¹
—George Herbert Mead

AS MEAD SUGGESTS, medical boards must work to take the perspectives of patients in their efforts to adapt to new realities. This issue of JMR presents us with a number of problematic areas that medical boards must face. First, we have a difficult issue concerning telemedicine: How can we create a system that ensures the best possible care is delivered across state lines to those patients who cannot sit in the same physical place with a physician? And at the same time, how can we ensure that our state medical licensing procedures are non-burdensome and keep up with the increasing pace of those physicians who want licenses to practice in multiple states using telemedicine? Confronting this issue may mean thinking beyond the borders of “what we do in my state.” Some have suggested that development of an interstate compact for physician licensing may provide answers. The legal basis of interstate compacts is well analyzed and multiple, well-thought-through arguments are provided by Blake Maresh on page 8. Interstate compacts have worked in many other areas, he argues. Secondly, board members are faced with physicians who seem unable to see health care from patients’ perspectives; they don’t communicate well and need to change. The North Carolina Medical Board, according to Phil Davignon, et al., found that communication issues were the basis for the largest category of their actions. Learning to see the world from the perspectives of patients might help physicians engage productively (page 28). Boards need to think about what they can contribute to improving physician/patient communications. These issues both require that boards face the need for complicated changes.

Ruth Horowitz, PhD
Editor-in-Chief

FSMB 2014 Board Attorneys Workshop to be Held October 23–24 in Savannah, Georgia

The FSMB will host its annual Board Attorneys Workshop, designed for attorneys and legal staff of state medical and osteopathic boards—including individuals involved with the investigation and prosecution of physician licensure and disciplinary cases—October 23–24, 2014, at the Embassy Suites Savannah in Savannah, Georgia.

The two-day workshop provides participants with the opportunity to share and exchange information on case experiences, best practices and current issues pertinent to board attorneys. Upon completion of this educational activity, attendees will be able to:

- Identify and discuss dynamics and legal issues that may influence how state medical boards discipline physicians in the future.
- Describe strategies used by state medical board attorneys to protect the public.
- Investigate options for improving state medical boards’ performance and effectiveness in protecting the public.

There is no fee to attend the workshop for medical board legal counsel and staff. The fee for non-members is $795. All participants must register in advance.

Those wishing to register for the 2014 Board Attorneys Workshop online and pay using a credit card should register at the FSMB’s secured online site. To access the site, please visit www.fsmb.org/state-medical-boards/education-meetings/board-attorneys-workshop.

For more information about the workshop, please call (817) 868-4007.

Free CME on Safe Prescribing of Extended-Release and Long-Acting Opioids Available

As a part of its ongoing effort to better educate prescribers about the risks of opioids and how to prescribe them responsibly, the FSMB has joined with several partners to offer “ER/LA Opioids: Assessing Risks, Safe Prescribing,” a free online continuing medical education (CME) activity for physicians and other health professionals licensed by state medical boards.

ER/LA Opioids: Assessing Risks, Safe Prescribing offers comprehensive, up-to-date training and educational resources about opioid prescribing, developed by the University of Nebraska Medical Center, Center for Continuing Education, the FSMB and the FSMB Foundation, online education-provider CECity, and The France Foundation.

The user-friendly program places strong emphasis on better understanding opioid prescribing and building risk assessment into prescribing practices. Six clinical-practice modules offer a consistent and reliable approach to safe prescribing, designed to help clinicians:

- Appropriately assess patients for the treatment of pain with ER/LA opioid analgesics, including analyzing risks versus potential benefits.
- Assess patients’ risk of abuse, including substance use and psychiatric history.
- Identify state and federal regulations on opioid prescribing.
- Develop effective strategies for starting therapy, modifying dosing or discontinuing use of ER/LA opioid analgesics in patients with pain.
- Learn new ways of managing ongoing therapy with ER/LA opioid analgesics.
- Incorporate effective counseling of patients and caregivers.
- Learn about product-specific drug information related to ER/LA opioid analgesics.

ER/LA Opioids: Assessing Risks, Safe Prescribing qualifies for Continuing Medical Education AMA PRA Category 1 Credit(s)™ and AOA Category 2B Credit(s).

To participate, please visit www.fsmb.org/safeprescribing. For more information about the program, contact the FSMB at (817) 868-5160.
Message from the Chair

Sensible Regulatory Guidelines for a New Era of Telemedicine: How the FSMB is Leading

Donald H. Polk, DO
Chair, Board of Directors
Federation of State Medical Boards

IN BRIEF Dr. Polk highlights the FSMB’s work in creating new guidelines for telemedicine and advancing a model Interstate Medical Licensure Compact, which is helping pave the way for the safe and secure practice of telemedicine as it continues to grow in the United States.

The United States’ health care system is in the midst of tremendous change, facing challenges that range from physician shortages to the expected arrival of millions of newly insured patients as a result of the Affordable Care Act. Other trends, such as dwindling interest among medical students in primary care as a practice specialty and a lack of access to care in rural areas of the nation, complicate the medical landscape.

In the midst of this transitional time in American health care, telemedicine is on the rise, offering solutions to some of our most pressing problems. Increasingly, physicians are turning to technological innovations — some of which make the delivery of medical care possible across great distances — to treat patients.

This creates new responsibilities for the medical regulatory community, which must balance the fast growth of new technologies and new ways of delivering medical care with its traditional role of vigilance to ensure patient safety. Our longstanding commitment to public protection is once again at the forefront.

Recognizing the pressing and complex challenges that telemedicine poses for medical regulation, the FSMB has taken action via two initiatives this year that will contribute to the health and safety of patients as telemedicine continues to advance in the United States. The first was the adoption in April by the FSMB House of Delegates of a model policy with new suggested guidelines for the regulation of telemedicine. Second, state medical boards have taken the lead in developing an Interstate Medical Licensure Compact, which will significantly streamline the medical licensure process for physicians who wish to practice in multiple states.

Model Policy for Telemedicine Practice

The first of these initiatives — our new telemedicine model policy — has brought much-needed guidance to help state regulators deal with the changing environment brought by telemedicine practice. With representation and input from both the medical regulatory community and telemedicine experts, an FSMB Workgroup developed the Model Policy for the Appropriate Use of Telemedicine Technologies.

RECOGNIZING THE PRESSING AND COMPLEX CHALLENGES THAT TELEMEDICINE POSES FOR MEDICAL REGULATION, THE FSMB HAS TAKEN ACTION VIA TWO INITIATIVES THIS YEAR THAT WILL HAVE A POSITIVE IMPACT AS TELEMEDICINE CONTINUES TO ADVANCE IN THE UNITED STATES.

in the Practice of Medicine over the last year — a document that lays out guidelines for the safe and secure regulation of telemedicine as it continues to grow.

The model policy, which includes key definitions for telemedicine and practical standards of care for physician practice, was adopted unanimously by the FSMB House of Delegates at its 2014 Annual Meeting in late April.

From my perspective, the policy represents one of the most important developments in medical regulation in recent years. It provides much-needed definitions, principles and clarifications that divers...
stakeholders can refer to for guidance in utilizing and regulating telemedicine.

As it has many times over the course of its history, the FSMB has stepped forward to play a leadership role in sorting out the challenges faced by medical regulators in a changing environment, seeking a reasonable balance between patient-protection and helping facilitate the growth and development of telemedicine.

One of the greatest challenges to the creation of consistent regulatory policy in the current environment—identified early in the FSMB’s work in developing its new policy—is the variation in laws, policies and regulations that apply to telemedicine in individual U.S. states and territories.

Current approaches to telemedicine can be remarkably different. In some states, for example, a preexisting patient-physician relationship must exist in order for a prescription to be considered valid. In other states, a preexisting patient-physician relationship or patient facilitator must be in place in order for a clinical consultation to take place electronically.

Many state and territorial laws have been in place for years. Some are difficult to interpret and others have evolved as a result of efforts to address other problems—such as illegal Internet pharmacies.

Over the last decade, much has changed in the practice of telemedicine—and it makes good sense for state medical boards to now review their various approaches to its regulation. The FSMB’s telemedicine guidelines seek consistency of policy in an environment that has much more variation than is warranted.

Since the policy was approved in April, a variety of organizations have endorsed it publicly, and there has been much public commentary indicating that the FSMB’s action in this matter has helped move regulatory policy in the right direction. You can view the new policy at www.fsmb.org.

**Interstate Medical Licensure Compact**

Closely related to, but separate from, the FSMB’s new model policy on telemedicine is the Interstate Medical Licensure Compact—a new model for physician licensing that would significantly reduce barriers for physicians who want to practice in multiple states.

In this new licensing pathway, qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all states participating in the Compact. States that participate would retain their licensing and disciplinary authority, but would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders.

The FSMB has been assisting in the development of this concept since 2013, working with a team of state medical board representatives and policy experts from the Council of State Governments. After multiple drafts, a basic framework has emerged that is likely to be distributed to all state legislatures and state medical boards late this year for formal consideration.

Compacts—which are basically agreements between states allowing them to jointly address topics of mutual concern that cross state borders—have been used by U.S. states for many years in response to a wide variety of policy issues. Participation in the Compact envisioned by state medical board representatives and the FSMB would be voluntary, for both states and physicians.

While the proposed Compact is not exclusively intended to facilitate telemedicine, it would have
that effect because it would make the process of obtaining multiple licenses for physicians who practice telemedicine much more streamlined and less cumbersome.

An initial draft of the Interstate Medical Licensure Compact was distributed for comment in December 2013 and several revised drafts have been circulated since then. Guided by the feedback received from state medical boards, provider groups, telehealth organizations, and other interested stakeholders, the team that is drafting the Compact expects a final draft soon. After the final draft is circulated among the states, the next step will be for those interested in participating in the Compact to prepare legislation for their legislative sessions in 2015.

I believe that the drafting team that is working on the Compact’s organization and requirements has done an excellent job of creating a system that truly expedites the licensing process, while putting in place very strong patient protections. This is extremely important, as the fundamental responsibility of all state medical boards is to ensure the safe practice of medicine within their states. Much of this protection is afforded by the robust eligibility standards of the Compact, which stipulate that physicians who wish to participate must meet the following requirements:

• Possession of a full and unrestricted license in a compact state.
• Successful completion of a graduate medical education program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association.
• Specialty certification or possession of a time unlimited certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association’s Bureau of Osteopathic Specialists.
• A clean disciplinary record.
• No discipline from any agency related to controlled substances.
• No pending investigations by any agency or law enforcement.

In short: Physicians who participate in the Compact will have the strongest possible track record of safe and responsible medical practice.

Physicians who don’t meet these criteria can still receive licenses to practice in multiple states. But they won’t have access to the expedited pathway available to Compact-eligible physicians.

There are many other features in the proposed Compact that make it attractive to state medical boards, including new information-sharing agreements between states that would make it possible to better track and investigate physicians who have been disciplined or are under investigation.

You can read much more detail about the proposed Compact, including the legal underpinnings of compacts in general, how they evolved, and why

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**THIS IS A TIME WHEN HEALTH CARE ORGANIZATIONS MUST THINK AND ACT INNOVATIVELY. WE ALL HAVE A RESPONSIBILITY TO OFFER IDEAS FOR THE PUBLIC GOOD.**

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the time is right for the use of a compact for medical regulation, starting on page 8 of this issue of the *Journal*.

Public response to the Compact has been strong, including a front-section feature about it in The *New York Times* (June 30, 2014). A variety of health care organizations have commended it as a major step in the right direction for medical regulation in general — like the FSMB’s telemedicine guidelines.

I was also encouraged to see earlier this year a public commendation of the FSMB’s efforts from a bipartisan group of 16 U.S. Senators.

This is a time when health care organizations must think and act innovatively. We all have a responsibility to offer ideas for the public good.

And in my view, the *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* and the Interstate Medical Licensure Compact are two very strong contributions to that effort. ■
The Interstate Medical Licensure Compact: Making the Business Case

Blake T. Maresh, MPA

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

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

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

Depending upon one’s point of view, an interstate compact might conjure up different visions of the future. For some, the interstate compact offers a tested Constitutional precept that could creatively forestall federal intervention that might otherwise supplant the long-standing authority of state medical boards. The power of interstate compacts might also provide state boards with valuable new tools with which to do their work. For others, the possibility of other state boards licensing physicians who practice in their states, coupled with the establishment of new governmental organizations, leaves them uneasy at best. Dissenters also raise questions about how boards will obtain the necessary financing to do their work. This paper will show how the interstate compact is the best solution for adapting to the forces of current and future trends. With a common understanding of the utility and widespread use of the interstate compact, we will turn our attention to how it emerged as a viable option, key specifics of an interstate compact for medical licensure, and the extent to which the model that has been crafted by the FSMB can complement the existing authority of state medical boards.

Origins of State-Based Physician Licensing

Readers of this article, and of this journal, are likely to be familiar with important recent works on the history of medical regulation, such as Medical Licensure and Discipline in America, authored by David Johnson and Humayun Chaudhry (2012) and Ruth Horowitz’s In the Public Interest: Medical Licensing and the Disciplinary Process (2013). Though it is not necessary to repeat the efforts of these and other authors, it is instructive for this
EFTS TO REGULATE THE PRACTICE OF PHYSICIANS PREDATE THE FOUNDING OF THE UNITED STATES, WITH THE EARLIEST LEGISLATION DATING TO 1639 IN THE VIRGINIA COLONY.

Massachusetts Bay Colony in 1649 and in New York in 1665. Precursory state requirements to have a license issued through a medical society comprised of physician peers (such as New York in 1760, New Jersey in 1772, Pennsylvania in 1794, and Maryland in 1798) and to have an examination (New Jersey in 1772 and New York in 1797, for example) were commonplace. However, between 1826 and 1852 nearly every state (except New Jersey) repealed laws requiring licensure of physicians, due primarily to consumer confusion and skepticism about the efficacy of the many types of physicians practicing in the day. Nevertheless, as a result of multiple effects, not the least of which were public sanitation and scientific advances, states gradually established (or reestablished) licensing boards and independent examinations of their own by 1910.

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

- While the founding of the National Board of Medical Examiners (NBME) in 1915 might have hastened movement toward a more unified examination process for medical students, states only gradually gave up the use of their own licensing examinations. However, it became apparent that educators were embracing new and better methods of testing, as a means to truly measure fitness for practice and not just factual recall. Over time, state examinations gave way to national examinations—the NBME, the Federation Licensing Examination (FLEX), the National Board of Osteopathic Medical Examiners (NBOME) Examination, and ultimately, the U.S. Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)—that promoted greater consistency in content and standards, in contrast to the variability of state examinations.

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

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

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

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

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

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

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

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

It is well known by many in the field of medical regulation that the Federation of State Medical Boards resulted from the 1912 merger of the National Confederation of State Medical Examining and Licensing Boards (National Confederation) and the American Confederation of Reciprocating Examining and Licensing Boards (American Confederation). What may be less broadly understood is that the issues of license reciprocity and barriers to physician mobility across state lines were pivotal to the fracture of the National Confederation and the creation of the American Confederation a decade earlier. At the heart of the American Confederation’s mission was to create a national examining board to help eliminate obstacles to interstate practice. Shryock also describes the “continued efforts of the Reciprocity Confederation” during this period “to encourage inter-board agreements.”

However, due to the practical constraints of limited financial resources for both organizations, combined with a public perception that two contending organizations did not serve the public interest, leaders from the organizations began merger discussions in 1910 and, on February 28, 1912, the National Confederation and the American Confederation adopted a constitution and by-laws creating the Federation of State Medical Boards.

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

Looking back, these aspirations for a broadly influential Federation while flattering and well intentioned, expected perhaps too much from the fledgling organization. In some ways and at a fundamental level, writers such as those...
from Harper’s and the Times misunderstood the true nature and authority of the Federation. They seemed to conflate an annual gathering of representatives from individual state agencies with a truly national body akin to a federal agency.28

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

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

The Legal and Constitutional Context of State-Based Physician Regulation

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

reserves those powers not explicitly granted to the U.S. government to the states.30 Derbyshire states the impacts of the Tenth Amendment plainly: “the practice of medicine for many years has been regulated by the states; this policy will not change since the federal government cannot assume this function without an amendment to the Constitution.”31 Two U.S. Supreme Court rulings were critical in reinforcing the doctrines laid out in the Tenth Amendment.32 In the first, Dent v. West Virginia, Frank Dent, an eclectic physician challenged the authority of West Virginia due to failing to meet state licensing standards. In 1889, stating the unanimous opinion of the court, Justice Field said in part: “Few professions require more careful preparation by one who seeks to enter it than that of medicine. It has to deal with all those subtle and mysterious influences upon which health and life depend…Reliance must be placed upon the assurance given by his license, issued by an authority competent to judge in that respect, that he possesses the requisite qualifications. Due consideration, therefore, for the protection of society may well induce the State to exclude from practice those who have not such a license, or who are found upon examination not to be fully qualified.”33

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

The Tenth Amendment remains a cornerstone upon which the state regulation argument, such as that for physician practice, is built.
For most of our national existence, federalism has been structured as a “layer cake” with distinct and separate roles for federal and state governments, also known as dual federalism. These distinctions were preserved by the courts, through common law rulings, but with a series of Supreme Court decisions in 1937 and 1938, an era of greater federal preemption began with the New Deal and lasted for nearly six decades. During this time, the Supreme Court simultaneously shrank its own role in preserving federalism via common law to mere interpretation and allowed that of Congress to expand. This is most explicitly illustrated in the 1985 Garcia ruling where, writing for the majority, Justice Blackmun questioned whether the Court could even define what activities are so within the sphere of state regulation as to be exempted from federal regulation. This loosening of Congressional restraint manifested itself as cooperative federalism, where the federal government sets a broad policy direction yet allows states flexibility and creativity in how to implement and administer program requirements, and it resulted in the expansion of federal regulation in a number of new areas. It also gave rise to a more coercive federalism, where the federal government sought to impose policies via regulatory mandates, funding restrictions and/or federal preemption.

While President Reagan heralded a new relationship between a more limited federal government (i.e., his pronouncement that “government is the problem”) and the states in the early 1980’s, cooperative federalism abruptly ended, at least from the perspective of the Supreme Court, with New York v. United States in 1992. The ruling solidified New Federalism, and the Supreme Court’s rulings reversed a decades-old pattern of accommodating federal preemption. Although the essence of cooperative federalism remains today in tools such as bloc and categorical grants to states, a tension continues to exist between Congress’s more intergovernmental approach of cooperative federalism and the Supreme Court’s more restrictive new federalism approach.

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

Second, the potential implications are unclear of a national licensure scheme where sharing revenue with the state medical boards occurs, as it may present an opportunity to attach policy conditions to state regulation of physicians. A well cited example of this is the withholding of federal highway funds to states for not raising the legal state drinking age to 21. Moreover, the message in New York v. United States was not that federal funding could not be tied to the storage and disposal of low-level radioactive wastes, but that state regulatory authority may not be commandeered by the federal government. It is conceivable then that, as part of partial preemption of physician licensing, the federal government could seek to leverage its control over state medical boards via a modified form of conditional spending power.

According to Learner, if a critical mass of states forges a policy consensus on a policy issue, “courts should apply the Supremacy Clause with more restraint.” His assertion is more narrowly in the context of federal preemption of environmental regulation, yet it is well worth contemplating whether the message is the same—that is, a show of solidarity in resolving the policy question of
interstate physician licensure at the state level, using a Constitutionally-authorized tool like an interstate compact, should carry weight with Congress and, if necessary, the courts. The “chaotic, conflicting, and rather rudimentary”

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

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

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

Emerging — and Emergent — Forces on State Medical Boards

The first sentence of the 2013 Congressional Research Service (CRS) report, “Physician Supply and the Affordable Care Act,” plainly states the relationship between physician supply and patient care: “[a]n adequate physician supply is important for the effective and efficient delivery of health care services and, therefore, for population health and the cost and quality of health care.”52 Consider that the Affordable Care Act projects that 32 million newly-insured Americans will enter the health care marketplace by 2019.53 The nation also continues to grow older and more populous. By 2050, U.S. Census numbers indicate the U.S. population will grow by over 85 million to 400 million, and the over-65 population, which statistically tends to use more health care services, will nearly double from 43.1 million to 83.7 million, or more than 20 percent of the overall population.54 Yet another factor that will affect the public’s future utilization of health care is the growing prevalence of chronic disease, responsible for seven out of ten deaths in the U.S. in 2010, and of “lifestyle” conditions, such as obesity, which afflicts more than one-third of adults.55

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

The interrelated issues of physician training and reimbursement also guide where and in what specialties physicians practice. The CRS report states that “some specialties, such as general surgery, geriatrics, the pediatric subspecialties, and psychiatry, have...widely acknowledged shortages.”60 In addition, a 2009 study by the Robert Graham Center noted that “[c]urrent U.S. graduate interest falls short of maintaining the current proportion of primary care in the physician workforce...This loss in production of primary care physicians may join the problem of maldistribution and further erode access to primary care services.”61 The relationship of medical school debt to selection of medical specialty is complex and not clearly determined, but there is evidence to demonstrate that post-educational salary does strongly correlate to choice of specialty.62 Further, it has been chronicled by the Council on Graduate Medical Education that “[n]othing affects the location decision of a physician more than specialty. Unfortunately for rural areas, the more highly specialized the physician, the less likely it is the physician will settle in a rural area.”63 a conclusion echoed by Rosenblatt and Hart.64 For some physicians, the costs, professional challenges and/or lifestyle limitations of service in rural or underserved areas may be decisive in their choice of practice location and specialty.65 These elements in turn bear directly on the ease or difficulty of the population accessing medical care.66
Taken together, the above factors paint a picture of more Americans, more insured Americans, and more elderly Americans taxing our health care system in the years to come. In tandem, despite more physicians entering the workforce every day, evidence suggests there may not be enough, in the right specialties, or in the needed geographic locations, to meet all patients’ needs. As the final gatekeeper to physician practice in the U.S., state medical boards are an essential ingredient in innovatively connecting physicians with patients.

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

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

However, a common misconception persists among proponents of the broader use of telemedicine, as a means to facilitate the multistate practice of medicine, that state medical boards oppose the use of technology. Although this is untrue, many are concerned that the unchecked spread of telemedicine may endanger patients. The practice of telemedicine, in whatever the form, is still the practice of medicine, and the same care and protection must be afforded patients whether they are being seen by their community primary care doctor or a highly-focused specialist from across the country. This is the charge state legislatures have given to state medical boards — to ensure that the public in their jurisdictions have access to competent medical care, not unfettered access, lacking the proper accountability.

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

The Chief Executive Officer of the ATA, Jonathan Linkous, has further expounded on the alleged failings of state licensure on a number of occasions, stating that “we estimate it costs about $300 million a year to do extra licenses...that’s growing...”
because physicians are increasingly holding multiple medical licenses. It’s an access problem.”  
He has been quoted as saying “the patchwork of state-by-state licensing creates a mire of costly red tape and has become an untenable barrier for both providers and patients.” Mr. Linkous has further opined “It is wrong to deny a patient health care because of state boundaries and overly cumbersome state licensing rules.”

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

It remains unclear whether the motivation for organizations such as the ATA to preempt the states in favor of a federal solution for physician licensure is purely financial, or a true belief that the access to be gained through federal action outweighs any collateral damage to patient safety, or a combination of the two. At the very least, such statements demonstrate a fundamental misunderstanding of the vital role of state medical boards by implying that the current system does not work.

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

- **HR 1832 — the STEP Act.** Introduced on May 11, 2011 by Rep. Glenn Thompson (R-PA), this bill expanded the current Department of Defense state licensure exemption for credentialed health care professionals, regardless of where they or patients are located. This expansion includes civilian employees of the Department of Defense, personal services contractors, and other health care professionals credentialed and privileged at a Federal health care institution. The bill became law on December 31, 2011.

- **HR 1540 — 2012 National Defense Authorization Act.** Introduced on April 14, 2011 by Rep. Howard P. “Buck” McKeon (R-CA), the bill authorized Department of Defense civilian employees and other health care professionals credentialed and privileged at a federal health care institution or location designated by the Secretary of Defense to practice at any location, regardless of where the health care professional or patient are located, so long as the practice is within the scope of authorized federal duties. The bill became law on December 31, 2011.

- **HR 6179 — The Telehealth Promotion Act of 2012.** Introduced on December 30, 2012 by Rep. Mike Thompson (D-CA), the bill would redefine telehealth services as originating from the site of the treating provider and not the patient. This stance on the location of physician practice has traditionally been viewed as inconsistent with how medicine is defined and as contrary to patient safety.

- **HR 6107 — The VETS Act.** Introduced on July 12, 2012 by Rep. Charles Rangel (D-NY) the bill would allow any licensed health care professional employed in the VA system, either employed or contracted, regardless of state of licensure, to practice in any facility nationally through the use of telemedicine.

- **HR 3077 — The TELE-MED Act of 2013.** Introduced on September 2013 by Rep. Devin Nunes (R-CA), the bill would allow for a Medicare provider, licensed in one state, to treat any Medicare beneficiary in any other state via telemedicine without requiring licensure where the patient is located. The bill currently has 58 bipartisan co-sponsors. The ATA has voiced strong support for this bill.
• The Increasing Credentialing and Licensing Access to Streamline Telehealth (ICLAST) Act.

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

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

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

Interstate Compacts: A Primer

The purpose of this article is twofold. Thus far its focus has been to set out how state medical boards have historically safeguarded the public through the licensure and discipline of physicians, and to describe how this role is consistent with federal legal and constitutional principles. In response to a rapidly changing landscape within health care prompted by technology, multistate medical practice and evolving consumer expectations, the remainder of this inquiry will center on the concept of an interstate compact for physician licensure, how it has been developed and why it is the ideal mechanism to meet these challenges.

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

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

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

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

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

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

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

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

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

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

A final note regarding the issue of Congressional Consent relates to what becomes of compacts, and the interstate organizations created by them, when formal consent is given. The answer, in operational terms, is absolutely nothing. Only in one respect does having formal consent “transform” the compact into federal law. As Justice Brennan wrote for the majority in the 1981 Supreme Court case Cuyler v. Adams, “[b]ecause congressional consent transforms an interstate compact within this Clause into a law of the United States, we have held that the construction of an interstate agreement sanctioned by Congress under the Compact Clause presents a federal question.” Thus, unlike any other type of federal legislation, compacts with consent are
“federalized” only in that they fall exclusively within the jurisdiction of federal courts and enjoy protection against attacks on Constitutional grounds.99

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

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

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

An especially important feature of interstate compacts, for the purposes of this discussion, is the evolution of compacts in the 20th century to include governmental organizations for ongoing regulation. This occurred as a result of interstate compacts not having the necessary tools to respond to changing conditions and complexities, as well as not being able to effectively enforce the provisions of compacts with member states. The New York/New Jersey Port Authority, created by a bi-state compact in 1921, was significant in that it was the first interstate government agency created in the western hemisphere and was the first interstate agency created by interstate compact.107 In more recent times, ongoing regulatory agencies have become fixtures in interstate compacts. In some cases, existing compacts have even been renegotiated to incorporate interstate commissions, such as with the Interstate Compact for Adult Offender Supervision, the Interstate Compact on Juveniles, and the Interstate Compact for the Placement of Children.108

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

As for concerns related to the loss of individual state sovereignty, there is no question that the parties to interstate compacts necessarily give up the right to unilaterally control the joint agencies they create. But when measured against the nature of congressional intervention and the loss of authority that can result from federal preemption of a particular field, the state legislative and regulatory control that states jointly retain under interstate compacts is usually preferred by states. Viewed through this lens, the decision to empower an interstate
agency is more likely to be seen as a welcome protection of ‘collective state sovereignty’ than it is to be resisted as an unacceptable sacrifice of individual state authority.109

Interstate compacts have been widely applied in the history of American government, with more than 200 active compacts, including 22 truly national ones. The average U.S. state is a party to 25 interstate compacts.110 They have evolved in their form and application throughout American history and are effectively employed for purposes as varied as boundary disputes, resource management, taxes, insurance, criminal justice, health care, education, emergency management, transit, and economic development. Indeed, as Supreme Court Justice Felix Frankfurter noted, “that a legislature may make rules and decide particular cases is one of the axioms of modern government.”111 More than sufficient evidence exists to reasonably infer that compacts can be just as effective for the regulation of physician practice across state lines.

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

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

For the purposes of this discussion, however, we will focus on the most immediate events, beginning with a 2012 resolution to the FSMB House of Delegates from the Maine Board of Licensure in Medicine. Resolution 12-4, dubbed the Platinum Standard Model, directed the Federation to “convene and charge Member Boards with defining and developing a set criteria of qualifications for a Platinum Standard Certification, and a system to allow State Medical Boards to make rapid licensing available to the highest caliber of licensed physicians by September 1, 2012.”112 The intent of the resolution was that states, in collective examination of their licensing standards, could establish a “highest common denominator” of requirements and, if a physician were to qualify for the Platinum Standard and be licensed by one state, other coordinating states could then license him or her based on that distinction, without further evaluation.

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

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

In order to further delve into these alternatives, the FSMB, in coordination with Administrators in Medicine, hosted a meeting in January 2013 for the purpose of examining existing state licensure processes and exploring innovative licensure approaches that could facilitate multistate practice. The meeting, which included representatives of 48 of the 69 licensing boards in the United States and its territories, was intended to move forward a more concrete discussion of one or several models that boards could pursue to better accommodate the practice of medicine across state lines, including via telemedicine.
Crady DeGolian, Director of the National Center for Interstate Compacts with the Council of State Governments, was one of the featured speakers at this meeting and provided the audience with an overview of interstate compacts. It was the first time that a detailed examination of interstate compacts explicitly entered the conversation, and although the participants did not leave the meeting having coalesced around any single methodology, the notion of an interstate compact for physician interstate practice emerged from the meeting with substantial support.

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

Therefore, be it hereby resolved, that the FSMB convene representatives from state medical boards and special experts as needed to aggressively explore the development of an Interstate Compact to facilitate license portability hereinafter known as the Medical License Portability Interstate Compact project, and be it further resolved that the Medical Licensure Portability Interstate Compact project be initiated no later than July 2013.115,116

The passage of Resolution 13-5 by the FSMB House of Delegates at the 2013 Annual Business Meeting is extraordinary in at least two respects. First, despite no shortage of membership discomfort about a loss of state authority, about whether a compact was a suitable scheme for regulating physicians, and about a general lack of familiarity with compacts as a governing tool, the Resolution passed the House unanimously, and with virtually no discussion on the House floor. Second, given that discussions about how to facilitate physician mobility and practice across state lines has divided the regulatory community since the foundation of the FSMB, that the membership should unite in singular fashion behind such a proposal, even merely to study its feasibility, is remarkable.

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

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

The license to practice medicine may be revoked by any or all of the compact states.

Following the groundwork and consensus-building in the June and September meetings, which created a clear set of parameters around which to construct a compact, a small drafting team met with FSMB staff in November of 2013 to craft and refine the provisions of a draft document. In drafting the compact, the drafting team identified several essential themes to address:

- Participation in the compact should not adversely affect state medical boards either because of reduction in licensing revenue or an increase in fees.

- States participating in a compact should be aware of the physicians who are, or are capable of, practicing within their borders. It is recognized as critical to boards’ patient safety missions that they must not only have jurisdiction over physicians practicing in their states, but they must have clear knowledge of their physician population in their states. Under the compact, all states, when selected by a physician who is deemed eligible by their principal state, would issue a full license to that physician, creating a clear regulatory linkage. Moreover, states will report to one another, again, using an interstate commission as a hub, any changes in physicians’ licensing or disciplinary statuses.

- The interstate compact contains mechanisms, such as rulemaking authority, to allow member state boards to clarify important areas of policy. Because the compact itself is essentially a multi-state contract enacted as legislation, by necessity its provisions must remain broad. When substantive changes to a compact are necessary, member states must go through the excruciating process of amending the statutory language in every member state, with the amended provisions not taking effect until every state has enacted the change. Consequently, rulemaking authority is essential for addressing many operational details of the compact. A prime example of this is the issue of requiring federal background checks via fingerprint as part of the licensure process. Likely to be a subject of rulemaking by an interstate Commission, to explicitly require in the compact that such checks be performed by fingerprinting could preempt new future methodologies that might be even more effective.

- States participating in a compact will have regulatory responsibility for an Interstate Commission, not the other way around. Participation in the compact requires state legislatures’ and governors’ authorizations, but this does not equate to a ceding of authority to a “superboard.” As noted above, state boards will collectively comprise an Interstate Commission and oversee its operation. This governance of the compact by a Commission is needed due to the complexity of medical practice and the ongoing interstate coordination needed to maintain the compact’s currency, but it is administrative in nature and does not extend to direct licensure or discipline of any physician.

- States should not have to pay to participate in the compact. Undue concern has been raised about...
Compacts, as noted above, are as old as the Constitution itself, and have been used throughout American history. Over 200 interstate compacts currently exist, including 22 that are truly national in membership. While the concept of compacts may be novel within the medical community, they are well-tested and operate with great effectiveness across the spectrum of government.

For Wyoming Governor Jim Geringer spoke at the January 2013 FSMB meeting about his preference for interstate compacts as a means for states to collectively solve their policy problems. In January 2014, sixteen U.S. senators (including one MD) wrote to the FSMB and expressed their appreciation for the work of the state boards in exploring development of an interstate compact, saying “[a]s you continue the development process, we would like to express our support for an interstate compact to provide a solution to expedite the process whereby physicians can be licensed in multiple states and practice tele-medicine in a safe and accountable manner.”

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

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

4. Given that state medical boards are contemplating an interstate compact, the opportunity exists via the compact mechanism to make important process improvements that would be challenging for states to enact individually. Allowing for boards to jointly investigate licensees and to share data between boards during the investigative process are two key examples. In addition, an interstate compact would streamline the licensure process for qualifying physicians by eliminating the need to reproduce documents multiple times for different jurisdictions once they have been primary-source verified by another state. Interstate compacts serve ideally to allow states to focus more broadly in problem resolution without resorting to federalization.

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

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

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

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

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

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

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

Mostly, it will require many, many additional hours of dialogue, consultation and even debate among those of us in the medical regulatory community. Recall that it was the very issue of states honoring “candidates presenting themselves based upon their license having been obtained through examination in another state”126 that split the American Confederation from the National Confederation for over a decade at the beginning of the 20th century. Still, just as the leaders of that day resolved their differences for the greater good, creating the FSMB to serve a vital collaborating role for all the state medical boards, those of us within this profession today must exercise the same intrepidness and sagacity to confront the new and more complicated obstacles of the present and the future, and to push onward.

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

One might say, a brave new world.

About the Author
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Introduction

In 2012, the 69 state and territorial medical boards of the United States took 9,219 actions against the licenses of 4,479 physicians. The vast majority of these actions originated as a complaint reported by patients or their family members. The literature addressing the bases for patient complaints leading to disciplinary actions by state medical boards is minimal as the focus to date has been on state-specific and aggregate actions. Several studies, however, have examined communication as a factor in negative outcomes. One study found “significant differences” in the communication behaviors of primary care physicians that aligned with malpractice claims history. A study of obstetricians showed that those physicians sued more often were cited for the “interpersonal care” they provided. Similarly, one study found that scores on the communication and clinical decision-making components of Canada’s licensing examination were predictive of later complaints to that country’s medical regulatory authorities.

The importance of communication as a core competency critical to physicians’ effectiveness in practice has been affirmed across the continuum of medical education by accrediting, certifying and licensing bodies. Communication and interpersonal skills have been identified as a critical competency for physicians in graduate medical education, specialty board certification, and since 2004, for inclusion in the examinations accepted for medical licensure in this country (United States Medical Licensing Examination and Comprehensive Osteopathic Medical Licensing Examination).

Conversations with various executive directors and members of state medical boards on this subject routinely include personal observations that communication issues are a factor in many of the complaints received by state medical boards each year. Our objective is to begin moving the discussion beyond anecdotal evidence by examining complaints against physicians licensed by the North Carolina board to determine the extent to which communication issues contribute to complaints against physicians. An analysis of this data reveals that physician complaints based on communication issues are consistently the most prevalent reason for complaints against physicians in the state of North Carolina. In addition, communication-based complaints account for more than one in five complaints made against North Carolina physicians. These results are discussed in light of their implications for the field of medicine as it seeks to improve patient care.

Methodology

The North Carolina Medical Board’s Complaint Department maintains records on complaints filed against physicians licensed in the state. The department is vital to the North Carolina Medical Board’s mission to protect the public through physician discipline, as complaints submitted by patients and/or family members are the primary means by which

ABSTRACT: Anecdotal evidence suggests that communication issues are one of the primary reasons for physician complaints, but quantitative studies have yet to examine this assertion. The North Carolina Medical Board’s Complaint Department maintains data on physician complaints and categorizes each complaint based on its primary cause. Using data from 2002–2012, our research focused on complaints against physicians licensed by the North Carolina board to determine the extent to which communication issues contribute to complaints against physicians. An analysis of this data reveals that physician complaints based on communication issues are consistently the most prevalent reason for complaints against physicians in the state of North Carolina. In addition, communication-based complaints account for more than one in five complaints made against North Carolina physicians. These results are discussed in light of their implications for the field of medicine as it seeks to improve patient care.

Medical Board Complaints against Physicians Due to Communication: Analysis of North Carolina Medical Board Data, 2002–2012

Phil Davignon, PhD; Aaron Young, PhD; David Johnson, MA
the board learns about physician impropriety. In addition to patient complaints, the department also receives complaints that originate from other sources, including disciplinary actions from other states. Complaints are received and evaluated by staff within the department, who review each case and determine whether the complaint relates to a violation of board policy or state law, thereby warranting a formal investigation and possible disciplinary action against the physician. According to state law, individuals who file complaints against physicians licensed in North Carolina are entitled to learn the outcome of their complaint. Thus, decisions to open an investigation (or a determination not to) are communicated to the party making the original complaint.

The North Carolina Medical Board began compiling, categorizing, and maintaining its current database of information about complaints towards physicians in 1978, and by the late 1980s, the board began to accumulate significant data that might be useful for longitudinal analysis. Complaints have steadily risen since the turn of the century, an increase that can be partly attributed to the board beginning to accept complaints by email in 2006. The North Carolina Medical Board categorizes complaints into nearly 100 categories, reporting the primary reason, as well as up to four secondary reasons for the complaint. Using data from 2002 to 2012, our research focuses on complaints against physicians licensed by the North Carolina Medical Board, to determine the extent to which communication issues contribute to complaints against physicians.

**Results**

An examination of the data revealed communication issues, out-of-state actions and quality of care as the top three reasons for complaints against physicians licensed in North Carolina. As demonstrated in Figure 1, communication issues have frequently been the top reason for complaints against physicians. In the mid 2000s, out-of-state actions* and quality-of-care complaints surpassed

* The North Carolina Medical Board resolved a backlog of formal out-of-state actions between 2003 and 2004, resulting in a temporary spike in complaints during that time frame.
communication complaints as the most prevalent reason for complaint, but from 2008 to 2012 communication issues were again the top reason for physician complaints. Between 2010 and 2012, more than 500 complaints made to the North Carolina Medical Board involved communications with the physician as the primary reason for the complaint.

Communication issues are also the top reason for complaints against physicians when examining both primary and secondary reasons. Since 2008, communication issues have been the top reason for physician complaints, being a primary or secondary reason for over 800 physician complaints in 2012. Communication issues also represent a sizeable proportion of the total number of complaints made against physicians each year in North Carolina.

Since 2008, more than one in five complaints made to the North Carolina Medical Board were related to communication issues. It should also be noted that the prevalence of communication-based complaints may even be understated, as communication may have also played a role in complaints that are categorized as out-of-state actions.

The nature of the communication complaints against physicians varied markedly. Frequently cited reasons included the following: failure by the physician to consider the patient’s unique intellectual or cultural background; failure of the physician to maintain an appropriate level of professionalism when confronted with a difficult or contentious patient; lack of timely follow-up communication with patients about abnormal laboratory studies; and the insufficient attention to properly communicating appropriate details of the physician’s plan of care or treatment decisions.

Discussion

This analysis suggests that communication issues may be one of the most prevalent reasons for complaints...
against physicians to state medical boards. Communication skills are vital for physicians to effectively provide patient care, and poor communication skills are tied to negative outcomes such as malpractice claims. In addition, a comprehensive analysis of studies examining the effects of physician-patient communication found a strong relationship to patient outcomes, while another meta-analysis revealed that communication is highly correlated with patient adherence to treatment.

Medical schools, specialty boards, and assessment organizations such as the National Board of Medical Examiners and the National Board of Osteopathic Medical Examiners recognize the importance of communication skills to the successful practice of medicine, as they require physicians to demonstrate competency in clinical skills such as communication. This paper lends further support to the idea that clinical skills such as communication are vital to effective medical practice, perhaps suggesting that healthcare entities should focus on physician communication skills as they seek to improve patient care and decrease patient complaints.

CLINICAL SKILLS SUCH AS COMMUNICATION ARE VITAL TO EFFECTIVE MEDICAL PRACTICE, PERHAPS SUGGESTING THAT HEALTHCARE ENTITIES SHOULD FOCUS ON PHYSICIAN COMMUNICATION SKILLS AS THEY SEEK TO IMPROVE PATIENT CARE AND DECREASE PATIENT COMPLAINTS.

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The increases are due to several factors, according to the report, including “more physicians establishing office practice in the state or employed by hospitals or clinics, more non-resident physicians working on temporary assignment in Iowa, or who are using telecommunications from non-Iowa locations to practice specialties such as radiology and pathology to diagnose patients in Iowa.”

At the end of 2013, the Board was administering 11,578 active physician licenses, up 4% from 11,134. These numbers include physicians whose primary practice is in another state but are licensed to practice in Iowa.

On the disciplinary front, the Board reported that it received 661 complaints and mandatory reports in 2013, down from 792 in 2012. The Board charged 44 physicians, up from 32 in the previous year, and took 92 public disciplinary actions, down from 107. The Board issued 101 confidential letters of education or warning, up from 92 in 2012.

Fines were down substantially in 2013, with $74,500 in fines imposed on 16 physicians, as compared to $185,000 in fines imposed on 29 physicians in 2012.

Source: Iowa Board of Medicine news release, May 22, 2014

Iowa Launches New Effort Encouraging Physicians to Treat Patients’ Pain Responsibly

The Iowa Board of Medicine has re-issued its 2009 policy statement on pain management to reinforce that Iowa physicians who responsibly diagnose and treat patients’ pain should not be at risk of disciplinary action.

Source: Iowa Board of Medicine news release, May 22, 2014

Alabama

Number of Licensed Physicians in Alabama on the Rise

Figures recently released by the Alabama Board of Medical Examiners and Medical Licensure Commission of Alabama show that the state experienced another increase in the number of newly licensed physicians in 2013, with 912 approved applicants by endorsement and 54 approved applicants by examination — 122 more approved applicants than in 2012.

The Board also licensed 63 physician assistants and 240 physician assistants registered to physicians.

The Board received 522 complaint inquiries during 2013, with 295 resolved without formal investigation. Formal investigations were opened in 166 cases, 85 letters of concern were issued, and 61 inquiries were pending. There were six summary license suspensions and one revocation during the year. Four licenses were voluntarily surrendered.

Source: Alabama BME/MLC Newsletter and Report, Issue 1, 2014

Iowa

Iowa Board of Medicine Releases Licensure and Disciplinary Statistics for 2013

A trend of growth in the number of physicians in Iowa continued in 2013, with the Iowa Board of Medicine issuing 863 new licenses, up from 815 in 2012. The figure, highlighted in the Board’s 2013 Annual Report, represents a 6% increase in the number of licensed physicians in the state over 2012 and an 11% increase since 2011.

The report shows 6,829 physicians with active licenses in Iowa in 2013, up from 6,700 in 2012. There were 737 physicians in Iowa residency training programs in 2013, up from 691 in 2012. The state licensed 50 acupuncturists, up from 46 the previous year.
North Carolina

North Carolina Board Adopts New Policy on the Use of Opioids to Treat Pain

The North Carolina Medical Board has adopted a sweeping new position statement on the use of opioid medications for the treatment of pain. The Board approved the position at its May 2014 meeting, with the statement becoming effective in June.

THE UPDATED POLICY PRESENTED TAKES INTO CONSIDERATION RECENT EVIDENCE THAT RISK ASSOCIATED WITH OPIATES HAS SURGED, WHILE EVIDENCE FOR BENEFITS HAS REMAINED CONTROVERSIAL AND INSUFFICIENT: THE BOARD SAID IN ITS ANNOUNCEMENT.

mental health professionals, neurologists, pain management experts and physical therapists.”

The Board is also encouraging Iowa physicians to complete mandatory continuing medical education activities on pain management by an Aug. 17, 2016 deadline. It released its “Joint Statement on Pain with the state’s boards of nursing, pharmacy and physician assistants.

Source: Iowa Board of Medicine news release, June 10, 2014

THE BOARD SAID IN A NEWS RELEASE THAT IT WANTED TO ‘ASSURE IOWA PHYSICIANS IF THEY HAVE A REASONABLE AND RESPONSIBLE APPROACH TO SUCH TREATMENT THEY ARE UNLIKELY TO COME UNDER BOARD SCRUTINY.’

North Carolina Board Adopts New Policy on the Use of Opioids to Treat Pain

The North Carolina Medical Board has adopted a sweeping new position statement on the use of opioid medications for the treatment of pain. The Board approved the position at its May 2014 meeting, with the statement becoming effective in June.

The new statement provides detailed clinical guidelines and information about the Board’s expectations for patient management.

According to an announcement of the new statement, issued recently by the Board, the publication of a “considerable body of research and experience” since the Board’s last position statement on the use of opioid medications in 2004 made it necessary to update the statement.

“The updated policy presented takes into consideration recent evidence that risk associated with opiates has surged, while evidence for benefits has remained controversial and insufficient,” the Board said in its announcement. “Over the last decade opioid sales have increased in parallel with an increase in the morbidity and mortality associated with these drugs. At the same time approximately one in four patients seen in primary care settings suffers from pain that interferes with the activities of daily living.”
The challenges faced by North Carolina medical licensees who care for patients taking opioids for pain are significant, according to the Board. The majority of its updated policy applies to the treatment of chronic pain and the use of opioid analgesics, with guidance for assessing and managing acute pain in primary care provided as well.

The Board’s updated policy contains several sections, including a preamble of information and a statement of the Board’s goals; a conceptual overview discussing responsibility for appropriate pain management and opiate prescribing and prevention of opiate diversion and abuse; and guidelines for physicians that are linked to concepts presented in the first section.

To learn more, visit www.ncmedboard.org/notices. ■

Source: North Carolina Medical Board announcement, June 4, 2014

Oklahoma

Oklahoma Medical Board Streamlines Physician Licensure Process

The Oklahoma Board of Medical Licensure and Supervision (OBMLS) recently became the latest state to launch the FSMB’s Uniform Application for Physician State Licensure (UA) to streamline the licensure process for physicians.

The Uniform Application makes it easier for physicians to become licensed in multiple states by providing a “core” application used by the 23 state medical boards using the UA. It eliminates the need for physicians to re-enter data multiple times and makes it easier for physicians to apply for licensure in multiple states.

The UA auto-populates key data, saving physicians time by eliminating the need to re-enter information multiple times. Information provided by physicians is stored in a permanent data repository, which is available to physicians when they apply for licensure in another of the growing number of states using the UA. The UA also auto-populates credentialing data for users of the Federation Credentials Verification Service (FCVS).

“This is a huge move forward in convenience for physicians,” said Lyle Kelsey, Executive Director of the OBMLS. “Many physicians practice in multiple states, and the old process could be very tedious and cumbersome. Now it’s a much simpler, faster process.”

In addition, Oklahoma is the first state to implement a web-service call between the FCVS application form and the existing OBMLS licensing database. The web-service allows the two systems to share information to provide a more seamless user experience.

In layman’s terms, the OBMLS system sends FSMB a Unique ID that the user provides and FSMB sends back all the info the user had entered on FSMB’s application form. Approximately 70 percent of applicant data for the UA can be pre-populated when the applicant uses FCVS. As UA usage continues to grow, the number of the more than 170,000 FCVS users accessing this added convenience is expected to increase as well.

OBMLS developed the application in collaboration with the FSMB and OK.gov, Oklahoma’s official website managed by the eGovernment firm, NIC Inc. (Nasdaq: EGOV).

For more information about the UA, please visit www.fsmb.org/ua.html. ■

Source: FSMB/ OSBMLS joint news release, June 4, 2014
INFORMATION FOR AUTHORS

The Journal accepts original manuscripts for consideration of publication in the Journal of Medical Regulation. The Journal is a peer-reviewed journal, and all manuscripts are reviewed by Editorial Committee members prior to publication. (The review process can take up to eight weeks.) Manuscripts should focus on issues of medical licensure and discipline or related topics of education, examination, postgraduate training, ethics, peer review, quality assurance and public safety. Queries and manuscripts should be sent by email to editor@fsmb.org or by mail to: Editor Journal of Medical Regulation Federation of State Medical Boards 400 Fuller Wiser Rd., Suite 300, Euless, TX 76039

Manuscripts should be prepared according to the following guidelines:

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2. The title page should contain only the title of the manuscript. A separate list of all authors should include full names, degrees, titles and affiliations.

3. The manuscript pages should be numbered, and length should be between 2,750 and 5,000 words, with references and tables attached. Please ensure that references adhere to the AMA Manual of Style. For more information, visit www.amamanualofstyle.com.

4. The manuscript should include an abstract of 200 words or less that describes the purpose of the article, the main finding(s) and conclusion. Footnotes or references should not be included in the abstract.

5. Any table or figure from another source must be referenced. Any photos should be marked by label on the reverse side and “up” direction noted. Tables and figures can be supplied in EPS, TIF, Illustrator, Photoshop (300 dpi or better) or Microsoft PowerPoint format.

6. The number of references should be appropriate to the length of the text, and references should appear as endnotes, rather than footnotes.

7. Commentary, letters to the editor and reviews are accepted for publication. Such submissions and references should be concise and conform to the format of longer submissions.

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Are physicians in your state prescribing safely?

The FSMB is pleased to announce a free, online CME Risk Evaluation and Mitigation Strategy (REMS) activity for extended-release (ER) and long-acting (LA) opioid medications that is available at www.fsmb.org/safeprescribing.

The “Extended-Release and Long-Acting Opioids: Assessing Risks, Safe Prescribing” activity provides prescribers with comprehensive, up-to-date training and educational resources – with the goal of reducing serious adverse outcomes from inappropriate prescribing while maintaining patient access to pain medications.

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