

Boundary Violation

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Regulation of the interstate practice of medicine represents a challenge to state medical boards. Although laws prohibiting the unlicensed practice of medicine were originally enacted to protect the public from unqualified practitioners, they could be invoked in a whole host of common clinical situations such as calling in prescriptions to a patient in another state, giving expert testimony in another jurisdiction, or reviewing radiology films on the internet, with potentially serious criminal ramifications. In this article a recent case describing a physician's being prosecuted for the illegal practice of medicine across state lines is presented and followed by a discussion of the numerous ways in which contemporary practitioners are likely to engage in such acts. The function of state medical legislation is explored as it relates to prohibitions on interstate practice. It is suggested that states, and possibly the federal government, should devise legislative solutions to allow for the good faith intermittent practice of interstate medicine.

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In May, 2007, the California Court of Appeals decided to charge James Hageseth, a psychiatrist who possessed a restricted medical license in the state of Colorado, with a felony for the unlicensed practice of medicine in California.¹ The circumstances of the case involved a Stanford student who used an Internet pharmacy Website that employed Dr. Hageseth to procure a prescription for Prozac after merely filling out an online medical questionnaire and subsequently committed suicide.

Although the case raised necessary questions about the legality and responsibility of Internet prescribing and the potential perils of such activities, the ruling also has potential ramifications on the enforcement of the "illegal" practice of medicine across state lines.

Despite the prosecuting Deputy District Attorney's apparent reassurance that California has not "filled jails with well meaning un-licensed physicians,"² the case raises concern for physicians across the United States. As Dr. Hageseth's attorney aptly noted, "There are potentially thousands of practitioners who can be affected" (Ref. 1, p 1).

Consider the following scenario. A patient who commutes to see you from an adjacent state, where you do not hold a license, telephones you to say that she has been unable to sleep following the death of her parent and to request a sleeping pill. After assess-

ing her mental status and safety over the telephone, you call in a prescription for zolpidem to a pharmacy in the adjacent state where your patient resides and schedule a follow-up appointment.

Although the case described may seem unremarkable, few physicians are aware that in many states, the aforementioned act would constitute the unlicensed practice of medicine and, in many jurisdictions, a felony. It seems bizarre indeed that such a seemingly innocuous and potentially therapeutic act may be considered to be a crime on par with offenses such as rape and arson and places physicians at risk of fines, licensure penalties, and even jail time.

The recent mushrooming of the Internet and the expansion of telemedicine have compelled many states to address some of the problems associated with the interstate practice of medicine. And while some have devised creative legislation to deal with the new techno-geographical realities of 21st century medicine, the legality of everyday clinical practice, such as calling in a prescription for a patient in another state, remains problematic.

Some states, such as Alabama, have recognized that there are instances in which physicians licensed in other states may from time to time engage in the practice of medicine within Alabama without requiring full licensure. Thus, Alabama's Medical Practice Act allows physicians who have less than one percent of their practices within the state or who practice less than 10 days per annum to be unlicensed.³ In Missouri, in contrast, any act, even a phone call from a New York physician for his vacationing patient, con-

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stitutes the practice of medicine and ostensibly requires full licensure. Furthermore, under a strict interpretation of the law, the phone call by an unlicensed practitioner appears to constitute a crime.⁴ (Apparently, rather than calling in a refill, the prudent Empire State practitioner would either instruct his patient to return home or refer him to a local emergency room or practitioner—both options seemingly clinically unnecessary.)

By virtue of the police power entrusted by the Constitution, individual states have historically been responsible for regulating the practice of medicine within their borders. This power is based on the states' responsibility to protect and oversee the well-being of its citizenry. Based on this premise, state legislators enacted medical practice legislation resulting in the establishment of a body, typically a state medical board that is empowered not only to determine the standards for licensure but also to regulate the practice of the profession by handling complaints regarding practitioners and by meting out punishment and/or corrective action to its registrants as indicated.

Medical practice legislation also protects residents by proscribing medical practice by individuals not recognized by the state as being proficient in the provision of such care and by establishing penalties for said violations. Such laws against practicing medicine without a valid state license have served, and continue to serve, a valuable function. Charlatans and other unscrupulous or incompetent individuals who purport to practice medicine may seriously injure people and should be subject to the stiff penalties of the law. However, it is less apparent why physicians recognized by one state as qualified to practice medicine might be subjected to these same stiff penalties when they find themselves practicing irregularly in a state in which they are not licensed.

While well intended, laws that fail to allow for the intermittent practice of interstate medicine simply do not fit with the realities of everyday clinical practice. Practitioners are likely to be aware of multiple scenarios in which it is reasonable and perhaps even preferable to provide care across state lines. Instances in which providing such care include calling in medications for existing patients who forget their medication while on vacation or business, following up on patients away at college, treating side effects of a medication, sending pathology specimens to an out-of-state laboratory, or furnishing expert testimony to

name a few. In fact, it is likely that hundreds of such potentially felonious medical acts are committed every day by doctors all across the United States.

This being said, there certainly are good reasons to keep such interstate treatment occurrences to a minimum. In general, sound clinical care is best provided in person. In most instances, face-to-face encounters are desirable and should remain the preferred modality of treatment. State laws function to encourage such sound practice. In addition, such laws have been used as one legal vehicle to address the mushrooming problem of Internet pharmacies that provide medications to patients often without adequate assessments. On the other hand, evolving technology and telemedicine in particular has allowed the latest clinical advances to be brought to underserved rural areas, and this progress, in some instances, has been limited by archaic medical practice legislation.⁵

There are many ways in which intermittent or irregular interstate practice can be accommodated without compromising the well-being of patients. One option is to enact sister state clauses whereby neighboring states adopt reciprocal agreements in their medical practice legislation that allow for limited interstate practice. Other options include a federal licensure program or perhaps a more limited reciprocal licensing arrangement, as already exists with at least 20 states for nursing licensure.

Law should be dictated by common sense. Perhaps an example would be illustrative. As a Pennsylvania resident, I possess a Pennsylvania driver's license. When I drive to New York, as at times I do, I am not committing a crime by operating a motor vehicle in that state, even though I am not licensed there. The state and the law allow for such actions. Nor should I be required to obtain a different license for every state I wish to drive through. Is there any reason why the same logic should not apply to the intermittent practice of interstate medicine?

It is time to re-examine state laws regarding unlicensed medical practice. Clinicians know of instances in which out-of-state practice is acceptable and, in fact, indicated. Despite these realities, states, with few exceptions, have been generally resistant to recognizing these exceptional situations and, instead, continue in large measure to label most out-of-state practice as criminal. And while criminal enforcement of these statutes happens rarely and discipline usually proceeds in an administrative manner, if at all, it is

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time that we push our state medical boards and legislatures to modify these provisions so that well-meaning practitioners can engage periodically in the interstate practice of medicine without the possibility of being branded felons.

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