

Licensing Physicians for Telehealth Practice: Issues and Policy Options

Raymond W. Pong and John C. Hogenbirk

Introduction

The vastness of Canada has made the delivery of health care to its widely dispersed population difficult at the best of times, and the adoption of innovative approaches or technologies is often a necessity. The emergence of telehealth is a case in point. Canada is one of the first countries in the world to apply telecommunications technology to health care delivery—in fact, Dr. Albert Jutras, a Montreal radiologist, pioneered teleradiology in 1958.¹

Telehealth,² broadly defined, is the use of communications and information technologies to overcome geographic distances between health care practitioners or between practitioners and service users for the purposes of diagnosis, treatment, consultation, education and health information transfer. Telehealth is increasingly seen as an important tool for enhancing health care delivery, particularly in rural and remote areas where health care resources and expertise are often scarce and sometimes non-existent. Services and expertise from major centres can be brought to such communities with the help of telecommunications technology. Over the last few years there has been a sharp increase in telehealth activities. A recent nation-wide survey conducted by Industry Canada has identified over 70 telehealth projects. The founding of the Canadian Society of Telehealth and the Telehealth Association of Ontario in 1998 reflects the upsurge in interest in telehealth.

Until recently, most telehealth projects and studies have focused on the technological, clinical and economic aspects. But more and more people are beginning to ask questions

about the policy aspects of telehealth. They are interested in finding out how telehealth can be integrated into the health care system and how certain policies may facilitate or impede the application of telecommunications technology to health services delivery. One of the major concerns is practitioner licensure. Potential problems pertaining to licensure have received considerable attention and discussion, but there has been little concrete action to date.

Although telehealth can be used for many purposes, including home care, triage, emergency alert, health information hot line, and continuing education for practitioners, in this paper we focus exclusively on the diagnosis and treatment of diseases and physician consultations.³ Also, while many categories of health care practitioners are involved in telehealth services, much of the discussion in this paper centres on physicians because at this stage of telehealth

development, the impact of licensure is mostly on medical practitioners. However, many of the issues and policy options discussed are equally pertinent to practitioners in other disciplines. Finally, although cross-border telehealth practice can be interprovincial or international in nature, the focus of this paper is on inter-jurisdictional telehealth services within Canada, rather than across national borders.

This paper is divided into several major sections. Following the Introduction, the research methodology is outlined. In Section 3, the policy issues are identified and their significance discussed. The major findings and analysis are presented in the two following sections. Section 4 describes the current status of licensure as it relates to telehealth, and also examines how Canada and selected foreign countries deal with this problem. Section 5 presents a number of policy options in addressing the licensure issue. Each option

The vastness of Canada has made the delivery of health care to its widely dispersed population difficult at the best of times, and the adoption of innovative approaches or technologies is often a necessity. The emergence of telehealth is a case in point.

is also examined in terms of its pros and cons. Section 6 identifies several other issues related to licensure.

Research Methodology

The core of the present analysis is an examination of several policy options and some factors that may complicate the licensure issue in the telehealth context. The policy analysis is informed by an extensive review of the literature and suggestions from many individuals in Canada and selected foreign countries who were surveyed in relation to this study.

Although telehealth technology and activities are developing at a breakneck pace, the amount of literature available on licensure issues in conventional print format is still limited. For this reason, in addition to searches in academic and professional publications, we have expanded the literature search to include other sources such as World Wide Web sites and unpublished reports and documents from various government agencies and telehealth projects.⁴

Information was also obtained from over 30 telehealth experts. This purposive sample of experts included government officials, individuals knowledgeable about telehealth and representatives of professional associations and licensing authorities in Canada and other countries. Foreign experts contacted were mostly from Australia, selected European nations and the United States (U.S.).

A bilingual questionnaire was developed by the research team with suggestions and comments from a number of knowledgeable persons. In most cases, the questionnaires were sent out via e-mail. Individuals were given the choice of responding by e-mail or a telephone interview. About half of those contacted chose to be interviewed. Francophone subjects were interviewed in French. Telephone interviews lasted from 30 to 50 minutes and were tape-recorded with the permission of the interviewees. The recording was transcribed or summarized and then content-analyzed.

Nature of the Issue

The advantage of telehealth lies in the fact that it is not constrained by geographic distance in health care delivery and that it recognizes no provincial or national boundary.

However, statutory regulation of health care practitioners and related licensure requirements tend to erect barriers between jurisdictions.⁵ This is particularly true in countries like Canada where the licensing of health care practitioners is the responsibility of the provinces. Licensure is the formal process by which an official agency grants an individual the legal right to practise an occupation. Although professional regulation is meant to protect the health and safety of the public by ensuring that practitioners are qualified and accountable to their regulatory authorities, it sometimes imposes constraints that may stifle flexibility or inhibit innovation. For instance, practitioners licensed in one jurisdiction may not be allowed to provide services in another without going through some cumbersome, time-consuming and costly processes, thus greatly attenuating the utility of telehealth.

The advantage of telehealth lies in the fact that it is not constrained by geographic distance in health care delivery and that it recognizes no provincial or national boundary. However, statutory regulation of health care practitioners and related licensure requirements tend to erect barriers between jurisdictions.

another without going through some cumbersome, time-consuming and costly processes, thus greatly attenuating the utility of telehealth.

To date, most telehealth activities in Canada have occurred within a province/territory and the same is true in the U.S. However, this situation is bound to change as the

number and diversity of telehealth services grow and as technology becomes more powerful and affordable. The wider application of telehealth (i.e., allowing practitioners in one jurisdiction to provide clinical services in another by means of telecommunications) requires the removal of some of the constraints imposed by licensure. It is not surprising that people with an interest in telehealth increasingly see licensure laws, in their current form, as an important issue in relation to inter-jurisdictional or cross-border telehealth activities. According to the U.S. Department of Commerce, until recently, few states had addressed issues concerning out-of-state physicians engaging in telehealth practice.⁶ The situation in Canada is no different.

Two aspects of licensure are particularly important for telehealth practice: qualification and locus of accountability. The former refers to the fact that if different jurisdictions impose divergent entry-into-practice requirements, it may be difficult for physicians with one set of qualifications to get permission to practise in another jurisdiction that has very different qualification requirements. The latter refers to the jurisdiction that has the ultimate authority to investigate and discipline telehealth practitioners when things go wrong or when patients lodge complaints. In other words, in situations involving cross-border telehealth practice, to whom is a telehealth practitioner accountable? Is it to the jurisdiction

in which he/she is licensed to practise or to the jurisdiction in which the patient resides? As Wood and Whelan have pointed out, tort jurisdiction may well prove to be one of the most contentious issues in telehealth practice.⁷

Current Status

Prior to discussing various policy options, the current status of licensure arrangements in relation to telehealth in Canada and several foreign countries is highlighted as follows.

(a) Canada

A few provincial/territorial medical licensing authorities have begun to develop policies or rules to regulate telehealth activities within their jurisdictions or inter-jurisdictional telehealth activities. For example, New Brunswick has made it a form of professional misconduct to practise medicine

...in any manner or by any means in another jurisdiction without being licensed or otherwise authorized to do so by the appropriate medical regulatory authority for that jurisdiction.⁸

Some preliminary discussions among representatives of provincial colleges of physicians and surgeons have taken place. A background paper on telehealth was prepared by Dr. John Carlisle, Deputy Registrar of the College of Physicians and Surgeons of Ontario, for the Federation of Medical Licensing Authorities of Canada in April 1997.⁹ The paper discusses various regulatory issues that are likely to emerge when telehealth is conducted across provincial/territorial borders. Regulatory issues in telehealth were also discussed by the Federation of Medical Licensing Authorities of Canada at its annual meeting in April 1998. A number of options were proposed, including regulation in the jurisdiction where the physician is located and regulation in the jurisdiction where the patient resides. Most of the colleges appeared to prefer the latter option. There seemed to be a general reluctance on the part of the colleges to relinquish control either to another province/territory or to a national body. There is also a strong view that patients should have to look no further than their own provincial/territorial regulatory authority for protection and to regulate the care they receive. As well, most colleges supported the idea of instituting a “tele-licence” as a way to regulate telehealth activities by medical practitioners.

Several current telehealth projects are inter-jurisdictional in nature. For example, the Children’s Telehealth Network links a number of hospitals in Nova Scotia, New Brunswick

and Prince Edward Island. The University of Ottawa Heart Institute delivers medical services to Baffin Island via telehealth. In most of these cases, licensure has not been an issue because informal or temporary arrangements have been made to enable clinical services to be delivered across provincial/territorial boundaries via telehealth.

(b) Australia

In Australia, physician licensure is a state matter and physicians are not permitted to practise in a state where they are not licensed. At this time, if a physician provides services across state borders, he/she is required to be licensed in more than one state. All states, however, recognize most professional registrations in another state without re-examination.¹⁰

(c) Europe

An April 5, 1993 Council Directive of the European Communities stipulates the free movement of physicians, as well as other health care practitioners, between the member states of the European Economic Community (EEC). This Directive establishes mutual recognition of diplomas, certificates and other evidence of formal qualifications between the member states. Article 2 of the Directive states that “Each Member State shall recognize the diplomas, certificates and other evidence of formal qualifications awarded to nationals of Member States by the other Member States..., as far as the right to take up and pursue the activities of a doctor is concerned, the same effect in its territory as those which the Member State itself awards”.¹¹

The above-noted Directive has shaped policies and legislation within EEC member states. For instance, the Directive stipulations have been made a part of Norwegian law by regulation in 1994.¹² The Norwegian law stipulates that an applicant who meets the requirements of the Directive is allowed to practise medicine in Norway. However, as far as telehealth practice is concerned, there is no legislation pertaining to licensure requirements. It appears that with a medical licence, a physician in Norway can practise medicine in the conventional way or via telehealth.

In the United Kingdom, only physicians licensed in that country can practise medicine on-site or via telehealth. However, within the EEC, it is not difficult to obtain licensure in any EEC country because of reciprocal agreements.

(d) The United States

The situation in the U.S. regarding telehealth licensure requirements is mixed. While there is progress in some states in removing licensure obstacles, new barriers have been erected in other states. In addition, several influential organizations have stated their official positions on this matter. At the Congressional level, no concrete action has been taken to date.

In the past several years, at least eleven states, including Connecticut, Indiana, Kansas, Oklahoma, Nevada, and Texas, have enacted regulations or legislation governing licensure of out-of-state telehealth practitioners. In all cases, except California, an out-of-state physician is required to obtain a full and unrestricted licence in order to provide clinical services directly to patients in the state on a regular basis. These regulatory requirements have created difficulties for interstate telehealth practitioners.¹³

In 1994, the American College of Radiology adopted a “Standard for Teleradiology” which includes the recommendation that physicians engaging in teleradiology should maintain licensure appropriate to the delivery of radiologic services at both the transmitting and receiving sites. The American Medical Association House of Delegates voted in June 1996 to adopt a policy which stipulates that “states and their medical boards should require a full and unrestricted licence for all physicians practising telemedicine within a state”.¹⁴ Similarly, the College of American Pathologists has taken the position that a physician rendering primary diagnosis and/or treatment should have a full and unrestricted licence to practise medicine in the state in which the patient presents for diagnosis. This proposal would require physicians to have their licences endorsed in each state from which they receive patient specimens or information.

The Federation of State Medical Boards has drafted a Model State Act designed to address telehealth-related issues. The Act proposes to create a special limited licence for physicians who practise medicine across state lines. Such physicians would be required to be licensed in the state where the patient is located.¹⁵

Policy Options

As long as telehealth practice is conducted on a trial basis or solely on an intra-provincial/territorial basis, there is no compelling need to address the licensure issue. But as soon as telehealth is practised beyond its base jurisdiction, the issue of physician licensure emerges. Most of the experts surveyed in relation to this study believe that licensure barriers are a real obstacle.

As long as telehealth practice is conducted on a trial basis or solely on an intra-provincial/territorial basis, there is no compelling need to address the licensure issue. But as soon as telehealth is practised beyond its base jurisdiction, the issue of physician licensure emerges.

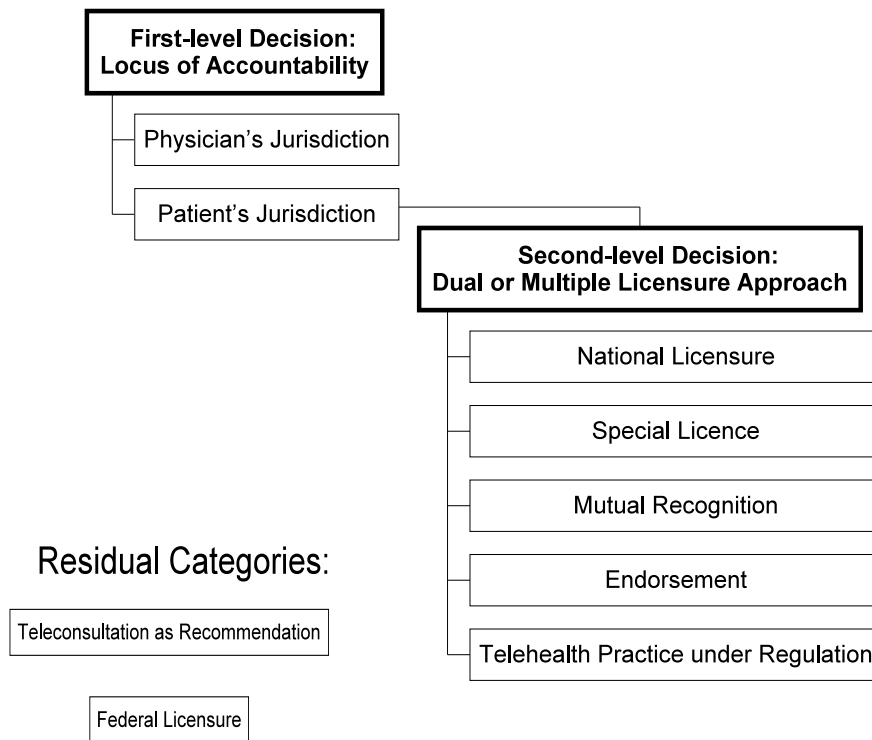
A number of policy options are presented for consideration. In order to facilitate deliberation and decision-making, each policy option is examined in terms of its

strengths and weaknesses from a policy-implementation perspective.

In relation to physician licensure, policy decision-making will likely take place at two levels. First, decisions will have to be made on matters pertaining to locus of accountability. Decisions on where accountability rests will influence, to a large extent, decisions to be made at the next level. If the locus of accountability is the jurisdiction where the physician is licensed to practise, this will obviate the need for physicians to be licensed in multiple jurisdictions. On the other hand, if the locus of accountability is the jurisdiction in which the patient resides, physicians will have to be licensed in more than one jurisdiction. Second, assuming that the locus of accountability is the jurisdiction in which the patient resides, the task will then be to make the process of obtaining dual or multiple licences as easy and as inexpensive as possible. Again, there are several options.

The two stages of policy decision-making and the various policy options are schematically displayed in Figure 1.

Figure 1 Licensure Approaches and Decision Model



(a) Locus of Accountability

For policy makers, the overriding concern is the location in which telehealth practitioners are to be held accountable. Under the existing licensure system, a physician can examine, diagnose and treat a patient from another province/territory as long as the patient travels to the physician. Viewing telehealth as a form of travel allows telehealth to be implemented within the current legal framework.¹⁶

(i) Physician’s Jurisdiction as Locus of Accountability

If a telehealth patient is seen as having been “electronically transported” to his/her doctor, the patient is being treated in the jurisdiction where the physician is licensed to practise, and not in the patient’s home province/territory. This approach has been advocated by the U.S. Health Care Financing Administration which has stated that
 ...the use of telecommunications to furnish a medical service effectively transports the patient

to the consultant...Therefore, we believe that the site of service for a teleconsultation is the location of the practitioner providing the consultation.¹⁷

The Children’s Treatment Network of Atlantic Canada also treats the physician’s location as the place where the medical act occurs and, therefore, the patient is considered to be “transported electronically” to the physician. But, as noted previously, most professional organizations in the U.S. have publicly stated their opposition to this approach. Similarly, in Canada, most of the provincial regulatory authorities polled by Dr. Carlisle have not supported this approach.¹⁸

Pros:

- This interpretation could avoid a dual- or multiple-licensure problem. The advantage of having the locus of accountability in the physician’s province/territory is that it would require no new licensing scheme, nor, for that matter, any new licence by the physician. A physician would have to deal with a single set of rules, that of his/her own jurisdiction.
- By applying the same “electronic travel” analogy, physicians may not need to be credentialled in other

hospitals or institutions where his/her telehealth patients are located (see the section on “Credentialling,” below, for a more detailed discussion of this matter). This is because the physician is seen as practising from his/her base hospital and the patients are seen as having been “electronically transported” to the physician’s hospital.

Cons:

- Some people believe that this approach would not afford out-of-province/territory patients sufficient protection. Opposition to this approach is based on the belief that the agency best able to ensure the maintenance of standards in the protection of the patient is the regulatory authority in the province/territory of the patient’s residence.¹⁹
- There may be practical problems involved in investigating complaints, misconduct or substandard care if the physician providing services is regulated in a jurisdiction different than that of the patient. For example, a patient may find it difficult or inconvenient to participate in a disciplinary proceeding in another province/territory.

(ii) Patient’s Jurisdiction as Locus of Accountability

This is the reverse of the previous approach. The physician is seen as having been “electronically transported” to the patient’s province/territory. Thus, the locus of accountability is the jurisdiction where the patient resides.

Pros:

- Provinces have always controlled the definition and content of what constitutes medicine within their jurisdictions. This favours an interpretation that would give each province the most control over the medical care received by its residents. Thus, the location of the patient should remain the location where the practice of medicine is deemed to occur.
- Some licensing authorities feel that if the locus of accountability is the jurisdiction where the patient resides, they can better ensure standards of practice and can better exert control by the threat of licence suspension or revocation.
- Although this approach would require physicians to be licensed in more than one jurisdiction, the requirement should not be overly onerous because of the fairly uniform qualification requirements in Canada. This is also because Canada, though very large in size, has a relatively small number of constituent jurisdictions,

making obtaining multiple licences less laborious than, say, in the U.S.

Cons:

- Unless a telehealth doctor is licensed in the province/territory where the patient resides, the physician would be practising medicine without a licence. In other words, the medical practitioner would need to have dual or multiple licences. If the process of obtaining multiple licences is complex and costly, this approach might deter telehealth practice on a wider scale.

(b) Dual or Multiple Licensure Approaches

If it is decided that the locus of accountability is the jurisdiction where the patient resides, physicians practising telehealth will need to obtain licences in more than one jurisdiction. Since all dual or multiple licensure systems require physicians to spend extra time, effort and funds, it behoves policy makers and those in charge of the licensing process to find the most efficient and least costly approach. There are several possibilities.

(i) National Licensure System

One possible solution is to implement a dual licensure system that combines a national licensing scheme with the existing provincial/territorial licensing scheme. A system of this type would maintain provincial/territorial control over medical practice within a province/territory, but would provide a national solution to the problem of practising medicine across provincial or territorial boundaries. Advocates of this approach suggest adopting two requirements for obtaining a dual licence. First, a physician must have a provincial or territorial licence before he/she can apply for a national telehealth licence, thereby preventing a possible end-run around provincial/territorial regulations. Second, the national licence would only be valid for telehealth practice. A provincial/territorial licence would still be needed for face-to-face medical practice. According to Gitlin,²⁰ a national licensure precedent already exists in the U.S. for physicians serving in the military, the Department of Veterans Affairs, the Indian Health Service and the Public Health Service. While several Canadian provinces have expressed an interest in examining or adopting a “tele-licence” approach, it is not known whether the proposed “tele-licence” is equivalent to the national licence discussed here.

Pros:

- A national licensure system implies having a uniform set of entry-into-practice criteria. This would have the



benefit of establishing some national standards for telehealth practice.

- A physician engaging in telehealth would be required to obtain only one additional licence, i.e., the national telehealth licence, instead of a licence from every province or territory where he/she wishes to conduct telehealth practice.
- Some of the preconditions for a national licensure system already exist. For instance, there is an impressive similarity in the requirements to practise medicine in Canada.²¹ As one medical-legal expert has observed,

the graduate of a Canadian medical school, who has passed the examinations of the Medical Council of Canada and is registered in the Canadian register...and has satisfactory post qualification training, will be unlikely to have any problem in becoming licensed in any province or territory in Canada.²²

Cons:

- New legislation and/or extensive statutory amendments may be required in order to introduce a national licensure system. The time and expense involved in implementing such a system could be significant.
- This type of system may require the creation of another layer of regulatory bureaucracy, the cost and administrative implications of which have yet to be determined.

(ii) Telehealth Practice Under Special Licence

It may be possible to conduct telehealth practice under a special register or limited licence. Many provincial/territorial licensing authorities have one or more special licences or registers which are known by different names in different jurisdictions, such as consulting and courtesy licences. Most of these special licences limit the scope of practice or allow the delivery of services under particular circumstances. However, the process for obtaining a special licence is usually less burdensome than for full licensure.

Pros:

- Practising telehealth under a special licence could reduce the administrative burdens for physicians from another jurisdiction who otherwise would have to obtain a full licence.

- If special licences can be used for the purpose of telehealth practice, there would be no need for major statutory or regulatory change.

Cons:

- There may be differences among licensing authorities regarding such matters as, for example, retention of medical records and mandatory reporting of professional misconduct. This would mean that the physician would be treating different patients under different schemes.
- Special registers or licences usually impose limits on medical practice. For instance, some limit the practice to special settings where the registrant must be supervised, while others limit the practice to underserved communities. Thus, the special registers or licences may not always be suitable for telehealth practice.

(iii) Licensure by Mutual or Reciprocal Recognition

There are subtle distinctions between reciprocal recognition and mutual recognition, but for the sake of brevity, these minor differences will be overlooked and the two approaches will be discussed together. A compromise between licensure by individual province/territory and national licensure, mutual recognition is a method of inter-jurisdictional licensure in which regulatory authorities enter into agreements to recognize the licensure policies and processes of a licensee's home jurisdiction and, therefore, a separate licence is not required. Mutual recognition could allow licensed physicians to engage in the full range of medical practice or in a limited scope of practice, such as providing medical care via telecommunications only. Mutual recognition typically entails a harmonization of standards and other conditions for licensure.

Pros:

- The mutual recognition approach allows a physician to practise in any of the jurisdictions that have entered into an agreement. Although dual or multiple licences are still needed, this approach would substantially reduce the time and effort needed to obtain licences to practise in other jurisdictions.

Cons:

- This approach requires two or more jurisdictions to agree on a set of uniform conditions such as qualifications, continuing medical education requirements, character references, etc. If there are substantial discrepancies among the regulatory authorities in relation to licensure policies and processes, agreement on uniform requirements may be difficult to achieve.

(iv) Licensure by Endorsement

Licensure by endorsement means the recognition by one jurisdiction of a licence given by another jurisdiction, when the qualifications and standards required by the licensing jurisdiction are equivalent to or higher than those of the endorsing jurisdiction. Under this process, the applicant for endorsement is generally not required to re-take the basic licensure examination. New Mexico, for instance, allows telehealth licensure by endorsement if a physician meets the requirements of the *Medical Practice Act* of New Mexico.²³

Pros:

- Licensure by endorsement minimizes, to a certain extent, the burden of obtaining dual or multiple licences since the licensure examination is sometimes waived.

Cons:

- Licensing by endorsement can still be time-consuming, costly and confusing because the requirements vary so much that, in some cases, it may be impossible for an endorsement applicant to obtain a licence without re-taking the licensing examination and/or going through some complicated procedures. For instance, according to the Centre for Telemedicine Law,²⁴ 40 states in the U.S. require some or all endorsement applicants to make a physical appearance before the local licensing board. In addition, the endorsement or registration fees vary considerably, ranging from \$100 in Pennsylvania to over \$1,000 in California and Texas.

(v) Telehealth Practice under Registration

Under a registration system, a physician licensed in one jurisdiction would inform the authority of another jurisdiction that he/she wishes to conduct telehealth practice therein. Typically, he/she would not be required to meet all entrance and related requirements imposed upon those licensed in the host jurisdiction. However, by registering, the physician would submit to the legal authority of the host jurisdiction and would be held accountable for breaches of professional conduct or other problems.²⁵

Pros:

- As registration is generally a less restrictive form of occupational regulation than licensure, the process of registering tends to be less burdensome and costly than obtaining full licensure in another jurisdiction.

Cons:

- It is likely that medical practice under registration would entail certain conditions or restrictions which may constrain what a physician can do.

(c) Residual Categories

There are a couple of approaches that do not fit the categories described above. This is because while they are designed to deal with the problems confronting cross-border telehealth practitioners, they bypass the need to regard telehealth as a form of “electronic travelling” and do not belong to the family of dual or multiple licensing schemes. Although they have not been advocated by Canadian telehealth or licensure experts, they should not be dismissed.

(i) Teleconsultation as Recommendations

One way to bypass the locus-of-accountability dilemma is to view a telehealth consultant working from another jurisdiction as making recommendations only, with the referring physician in the patient’s home jurisdiction retaining overall responsibility for the care of the patient.²⁶ California has come close to adopting this approach. It has enacted legislation that allows for very liberal telehealth consultations between in-state and out-of-state physicians about patient conditions, with the proviso that the local physician retains ultimate control over the diagnosis and treatment of the patient.

Pros:

- This approach obviates the need to pretend that the patient has been “electronically transported” to the physician’s location or vice versa.
- Dual or multiple licensure is rendered unnecessary, thus saving physicians, and indirectly the health care system, a lot of time and resources.

Cons:

This approach puts the onus on the referring physician, and it may not be acceptable or fair to him/her to have to bear complete responsibility. Furthermore, it is still unclear who would be held liable when a mishap occurs or in a situation involving negligence or malpractice. According to some, when liability is at issue, the court will ultimately look to the substance of the transaction and not the licence category under which it takes place. Thus, those acting as telehealth consultants in another jurisdiction may not be immune from liability arising from negligence.²⁷

- If the referring physician has to retain ultimate clinical responsibility, he/she may be obligated to be present at all telehealth sessions. In other words, at least two

physicians would have to be present at all times. Such an arrangement could prove to be inconvenient to referring physicians, particularly those in very busy rural practices, and expensive to the health care system.

(ii) Federal Licensure

This approach has been suggested in the U.S. According to the U.S. Department of Commerce,²⁸ under a federal licensure system, health care practitioners would be issued one licence by the U.S. federal government based on federally established standards and qualifications. This licence would be valid throughout the country and the federal regulations would preempt existing state licensure laws. In Canada, although health care is generally considered a provincial responsibility, many areas which were previously local and provincial matters have come under the federal umbrella due to their growing interprovincial nature. There is also the argument that there may well be a federal role or interest in ensuring equality of access to medical care across the country, which would legitimately trigger greater federal involvement.

Pros:

- This approach would eliminate the need for dual or multiple licences for those who wish to conduct telehealth activities across jurisdictional boundaries and would avoid problems of inconsistencies among jurisdictions in relation to entry-into-practice requirements, standards and licensing processes. Because there is only one jurisdiction (that being the nation), the problems of locus of accountability no longer exist.

Cons:

- This approach could trigger a federal-provincial jurisdictional squabble because under the *Constitution Act* of 1867, the regulation of health care practitioners is a responsibility assigned to the provinces.
- It would be a very time-consuming, complex and costly process to design and implement a brand new licensure mechanism to replace the existing system.
- Provincial/territorial government is generally seen to be more accountable to the residents of the province/territory and more responsive to their needs than a large, distant bureaucracy.

Related Issues

Although practitioner licensure is the focus of this paper, a number of important related issues bear mention. Practitioner licensure is an integral part of the Canadian health care system. Major changes in one aspect of the system are likely to affect, directly or indirectly, other aspects. However, because an in-depth examination of such issues is beyond the scope of the present study, the following discussion is cursory in nature. The intent is to alert readers to the fact that licensure issues cannot be considered in isolation.

(a) Credentialling

One issue related to licensure is hospital or institutional credentialling. Credentialling refers to the institutional policies and procedures that determine whether a health care practitioner has the qualifications to be employed or be granted privilege to practise. This regulatory function is not usually discharged by the provincial or federal government. Typically, the institution in which the practitioner works assumes this responsibility. Credentialling applies to both in-province and out-of-province practitioners who do not have privileges at the hospital where the patient is admitted. A yet to be resolved issue is whether a telehealth consultant is required to be credentialled at both his/her base institution and the remote institution which has requested his/her consultation service.

As Picard and Robertson have pointed out, a hospital's first responsibility to its patients is the selection of competent staff.²⁹ More recently, this responsibility has been extended so that a hospital may be vicariously responsible for the actions of its employees, even if they are practitioners of self-regulating occupations. In view of the fact that it is not uncommon to have hospitals sued for failure to select competent staff, one should expect hospitals to scrutinize telehealth projects and personnel carefully. On the other hand, if all telehealth practitioners are required to be credentialled and if a significant number of institutions are involved, it could create administrative headaches for both practitioners and institutions. Also, the question arises whether a hospital has a duty to continuously monitor the competence and skill of remote practitioners to the same degree as it does with members of its own medical staff.

(b) Accreditation

Accreditation is the process by which an agency evaluates and recognizes an institution or a facility and its programs as meeting certain predetermined standards. In provinces/territories where accreditation of facilities is required, a question may arise: How does one go about requiring, enforcing and performing accreditation of telehealth operations which, in many cases, are "virtual

facilities”? To date, there are no satisfactory answers to this question. A related issue is the need to ensure the technical competence of those who use or operate diagnostic telehealth equipment. As well, there may be a need to ensure that equipment in all sites is compatible, reliable and meets certain standards.

(c) Physician Workforce Planning

In the past decade, some provinces (e.g., British Columbia, Manitoba and Ontario) have placed restrictions on the issuance of billing numbers to new physicians in an attempt to cap health care spending by controlling the number of doctors. Other provinces (e.g., New Brunswick, Ontario and Quebec) have used differential fee schedules, hospital-privilege granting and other approaches as a means to improve the geographic distribution of physicians within the province. Such policies, regardless of their intent, could become largely ineffectual if telehealth is widely adopted, because this mode of service delivery transcends spatial distances and geopolitical boundaries. Physician workforce planning in the future, particularly in relation to the geographic distribution of physicians, will have to take telehealth practice into consideration.³⁰

(d) Payment for Cross-border Telehealth Services

Unless there are agreements among jurisdictions to reimburse cross-border telehealth services, seeking mutual recognition of licences is largely an academic exercise. A physician in, for example, Manitoba is unlikely to provide telehealth services to Saskatchewan patients if he/she is not paid by Saskatchewan. Currently, through reciprocal billing arrangements, Canadian provinces and territories pay for medical services incurred by their residents when they are in another jurisdiction. It is not certain if such arrangements will be extended to include cross-border telehealth services. New Brunswick, for example, reimburses for specialist services provided at the IWK Grace Hospital in Halifax as part of the Maritime Telehealth Network. In addition, Quebec Medicare is compensated for the services of neurologists who read the EEGs of patients from northern New Brunswick.³¹ But these are special billing arrangements. Arrangements on a much broader scale are needed to facilitate cross-border telehealth services. Related issues include variations in fee schedules and inconsistencies in reimbursement policies among jurisdictions.

Also, as noted earlier, some provinces have imposed strict controls on physician numbers in an attempt to control health care spending. These provinces, as well as those that

see the control of medicare expenditure as a high priority, are unlikely, except in special circumstances, to reimburse out-of-province physicians for providing cross-border telehealth services, regardless of their licensure status.

(e) Other Health Care Practitioners

This paper has focused on physicians, but providers in other health disciplines will likely play a significant role in telehealth and they are equally interested in understanding the impact of telehealth on them. For instance, the federation of health regulatory colleges in Ontario, a coalition of the licensing bodies of regulated health professions, has formed a working group to discuss various telehealth issues. Many of the issues related to the licensing of other health care practitioners are similar to those discussed in this paper. There are, however, some unique issues pertaining to non-physician providers which warrant separate treatment. For example, some nursing organizations have voiced other concerns such as difficulties involving collective bargaining when the employer is in one jurisdiction and nurses are working in two or more jurisdictions via telehealth.³²

Conclusion

The discussion of licensure is timely because it is relevant not only to telehealth practice but also to a broader issue, namely, labour mobility. As the world is transformed by telecommunications into a “global village”, people become much more mobile. “Mobility” is not just the physical movement of people from one location to another; increasingly, it refers to mobility without physical mobility. People can now conduct business and work in another city, province or country without being there in person. This has posed a major challenge to laws and regulations which have been developed over decades or generations, governing how work is to be done, the relationships between service providers and clients and the roles of the state in regulating such relationships.

The *Agreement on Internal Trade* was developed partly in response to the reality of an increasingly mobile and fluid society. It was signed by all First Ministers in 1994. The Labour Mobility Chapter of the Agreement establishes obligations for governments and occupational regulatory authorities in three areas: (1) removal of residency requirements as a condition of access to employment and of professional or occupational licensing, certification or registration; (2) modification of licensing, certification or registration requirements, such that they are based principally on competence, readily accessible and do not present

unnecessary delays or financial burdens for workers from other Canadian jurisdictions; and (3) mutual recognition of occupational qualifications and occupational standards.³³

The issues discussed in this paper are consonant with the spirit of the *Agreement on Internal Trade*. Even without the challenges posed by telehealth, regulatory authorities and jurisdictions are obligated by the Agreement to harmonize their licensure and certification requirements, to demolish artificial barriers to mobility and streamline licensing processes in order to make them less cumbersome. Telehealth has given the tasks of implementing the Agreement another dimension of complexity and an added sense of urgency.

Raymond W. Pong, Ph.D., is the Research Director and a Faculty Investigator of the Centre for Rural and Northern Health Research, Laurentian University. John C. Hogenbirk, M.Sc., is a Senior Project Researcher with the Centre for Rural and Northern Health Research, Laurentian University, Sudbury, Ontario.

An earlier version of this paper was commissioned by and prepared for the Advisory Council on Health Info-structure of Health Canada. The opinions expressed in this paper are those of the authors and do not necessarily reflect the views of the Advisory Council on Health Info-structure. The authors would like to thank the Office of Health and the Information Highway, Health Canada, for financially supporting the research, upon which this paper is based. The authors are grateful to those who participated in the survey and generously contributed their ideas, and to Mr. Stephen Vail and Dr. André Gareau for commenting on an earlier draft of the paper. Lastly, the authors would like to thank Mr. Dave A. Pearson and Ms. Frederique Picker for assisting in the research process.

1. D. Wright, "Telemedicine and developing countries: A report of Study Group 2 or the ITU Development Sector" (1998) 4 (Supplement 2) *J. Telemedicine and Telecare* 1.
2. The term "telehealth" is used in this document instead of "telemedicine" even though physician services are the focus of this study. This is because "telemedicine" is a copyright-protected term in Canada.
3. What is emphasized in this discussion paper corresponds to the first ("all forms of medicine at a distance") of the five categories of telehealth application identified by Picot. See J. Picot, "Telemedicine and telehealth in Canada: Forty years of change in the use of information and communications technologies in a publicly administered health care system" (1998) 4:3 *Telemedicine J.* 199.
4. For more information on the literature search process, the results of website searches and a complete list of the interviewees, see R.W. Pong, J.C. Hogenbirk & D.A. Pearson, *Telehealth and Practitioner Licensure Issues: A Discussion Paper Prepared for the Advisory Council on Health Info-structure* (Working Paper Series No. W99-02, Centre for Rural and Northern Health Research, Laurentian University, 1999).

5. B. Johnson & R.W. Pong, *Labour Mobility Issues in the Health Sector: An Analysis of Responses to the National Survey of Practices* (Ottawa: Federal/Provincial/Territorial Advisory Committee on Health Human Resources, Health Canada, 1997).
6. U.S. Department of Commerce, *Telemedicine Report to Congress* (Washington, D.C.: Department of Commerce, 1997).
7. M.B. Wood & L. J. Whelan, "Telemedicine and the N.I.I.: Implementation barriers, legal licensure and confidentiality issues" (1998) (at www.mayo.edu/telmed/nii.html).
8. College of Physicians and Surgeons of New Brunswick, "Bulletin April 1999" (1999) (at www.cpsnb.org/english/Bulletins/April-1999.html).
9. J.R. Carlisle, *Background paper on telemedicine: Submission to the Federation of Medical Licensing Authorities of Canada* [Unpublished 1997].
10. J. Mitchell & Associates, "Discussion paper on telemedicine: Topic No. 2: Telemedicine Policy Issues" excerpts from article written by M. Egan (1997) *Medical Imaging & Monitoring*, 24. www.jma.com.au/telemeddp2.htm.
11. Council of the European Communities, "Council Directive 93/16/EEC of 5 April 1993 to facilitate the free movement of doctors and the mutual recognition of their diplomas, certificates and other evidence of formal qualification" (1998) (at <http://europa.eu.int/scadplus/leg/en/lvb/l23021.htm>).
12. *Norwegian Medical Practitioners Act*, 1980, Art. 16.
13. Center for Telemedicine Law, "Telemedicine and interstate licensure: Findings and recommendations of the CTL Licensure Task Force" (1997) (at wwwctl.org/ctlwhite.html); L. Gobis, "An Overview of state telemedicine laws" (1998) 6 (1) *Telemedicine Today*; U.S. Department of Commerce, *supra* note 6.
14. Gobis, *ibid.*
15. Center for Telemedicine Law, *supra* note 13.
16. B. Darer, "Telemedicine: A state-based answer to health care in America" (1998) 3 *Virginia J.L. & Tech.* 1522; J.N. Gitlin, "Teleradiology" in R.L. Bashshur *et al.*, eds., *Telemedicine: Theory and Practice*, (Springfield, Ill.: Charles C. Thomas, 1997).
17. U.S. Health Care Financing Administration, "HCFA Regulations for Rural Reimbursement Released" (1998) (at www.atmeda.org/news/ruralregtxt.html).
18. Carlisle, *supra* note 9.
19. Darer, *supra* note 16; Federation of State Medical Boards, "A model act to regulate the practice of medicine across state lines: An introduction and rationale" (1998) (at www.fsmb.org/telemed.htm).
20. Gitlin, *supra* note 16.
21. D.A. Crolla, "Health care without walls: Responding to telehealth's emerging legal issues" (1998) 19:1 *Health L. Can.* 1.
22. G. Sharpe, *The Law and Medicine in Canada* (Toronto: Butterworths, 1987) at 228.
23. 61 *New Mexico Stat. Ann.* ss. 6-11, 6-13 (1978).
24. Center for Telemedicine Law, *supra* note 13.
25. Carlisle, *supra* note 9.

26. S.G. Berger, & B.B. Cepelewicz. "Medical-legal issues in teleradiology" (1996) 166 Am. J. Radiology 505.
27. Crolla, *supra* note 21.
28. U.S. Department of Commerce, *supra* note 6.
29. E. I. Picard & G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, 3d ed. (Toronto: Carswell, 1996) at 392.
30. R. Pitblado & R.W. Pong, *Geographic Distribution of Physicians in Canada* (Ottawa: Health Canada, 1999)
31. New Brunswick Provincial Telemedicine/Telehealth Coordinating Committee, *Physician Reimbursement for Telemedicine/Telehealth* (Fredericton, New Brunswick: Department of Health and Community Services, 1998).
32. C. Helmlinger & K. Milholland, "Telehealth discussions focus on licensure" (1997) 97:6 Am. J. Nursing 61.
33. Johnson & Pong, *supra* note 5.

Upcoming Events

Telehealth & Multimedia - First International Congress on Telehealth and Multimedia Technologies. Edmonton, Alberta. August 16-18, 1999. To register call (780) 492-4082; Fax (780) 492-9406; email: ttri@ualberta.ca.

13th Annual Conference of the European Society for Philosophy of Medical Health Care. Linkoping, Sweden. August 18-21, 1999. To register Fax: 1 31 24 354 02 54

11th Annual Canadian Bioethics Society Conference, Westin Hotel, Edmonton, Alberta. October 28-31, 1999. To register call (780) 492-6676; Fax (780) 492-0673; email: cbs1999@ualberta.ca.

6th Canadian Conference on International Health. Ottawa/Hull, Ontario. November 14-17, 1999. Canadian Society for International Health. To register call (613) 241-5785; Fax (613) 241-3845; email: obissierf@csih.org.

Ethics and Genetics: Advanced European Bioethics Course. Nijmegen, The Netherlands. November 18-20, 1999. Application forms call 31 24 361 53 20; Fax 31 24 354 02 54; email: b.gordijn@efg.kun.nl.

