Liability in the Telehealth Era

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Healthcare Alert
6.18.20

The COVID-19 pandemic has thrust upon the healthcare industry countless profound and likely permanent changes, not the least of which is in telehealth. Over the next several months, White and Williams will publish a series of articles that address how this rapid surge in telehealth and the related regulatory developments will impact liability and other issues across the healthcare industry — including, among other things, professional liability, health information technology, medical and remote monitoring devices and privacy and cybersecurity.[1] This initial article focuses on professional liability.

As is often the case with technological advances, the law needs time to adapt. Telehealth laws are no exception. Should a healthcare provider treating a patient using telemedicine be held to the same standard of care applicable to an in-person encounter? Stated differently, should some consideration should be given to the obvious limitations imposed by a telemedicine exam? It is time for state legislatures to revamp current laws so that providers, who are spending countless hours helping people, are on a level playing field.

TELEMEDICINE OR TELEHEALTH?

Tele*medicine* generally refers to the delivery of healthcare services through electronic or other technological means to a patient located at a different site from the healthcare provider. Tele*health*, although often used interchangeably with telemedicine, is broader and generally means the use of information and communications technologies, including remote patient monitoring devices, to support long-distance clinical healthcare, patient and professional health-related education, public health and health administration. Telemedicine focuses on the curative aspects of healthcare, whereas telehealth focuses on the preventive and promotional aspects as well as the curative aspects.

TELEMEDICINE IS A VITAL TOOL TO FIGHT THE PANDEMIC

The U.S. Congress and federal agencies have rapidly removed barriers to telemedicine throughout the healthcare industry to provide more tools to fight the COVID-19 pandemic. Congress has enacted multiple relief packages to inject substantial funds into telemedicine expansion and the Centers for Medicare and Medicaid Services (CMS), the Department of Health and Human Services (HHS) and the Federal Communications Commission (FCC) temporarily suspended several regulations that previously created barriers to telemedicine in areas of modalities, infrastructure, privacy, funding and licensure to name a few.

CMS has removed several traditional payment barriers to foster the growth of telemedicine. New Medicare and Medicaid laws relax requirements that (1) restricted reimbursement to real-time audio-visual technology, thereby allowing providers to conduct initial assessments by phone; and (2) required a care provider to have seen a patient in-person within the past three years. "It's all hands on deck during this crisis," said CMS Administrator Seema Verma in a statement. "All frontline medical professionals need to be able to work at the highest level they were trained for. CMS is making sure there are no regulatory obstacles to increasing the medical workforce to handle the patient surge during the COVID pandemic." Many commercial payors have followed suit in order to help address the crisis. Administrator Verma recently expressed support for permanently expanding these telemedicine access measures beyond the pandemic.

HHS has also promoted widespread telemedicine by removing privacy and security barriers. The Office of Civil Rights (OCR), tasked by HHS to enforce the Health Insurance Portability and Accountability Act of 1996 (HIPAA) which protects the privacy and security of protected health information, has informed healthcare providers that it will not enforce HIPAA rules that may be violated during the good-faith provision of telemedicine. This relaxation of enforcement has freed up providers to administer telemedicine through non-public facing audio or video communication products such as Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, Zoom or Skype without the fear that such products may not fully comply with HIPAA regulations.

The FCC has also played a critical role in the recent expansion of telemedicine with programs that encourage broadband companies to support telemedicine and by relaxing rules that give those companies the freedom to provide improved connections and telemedicine technology. "The increase in COVID-19 patients is presenting unique challenges to America's hospitals and healthcare providers," FCC Chairman Ajit Pai said. "Telemedicine will play an increasingly critical part in treating patients and helping healthcare providers maximize their impact on their communities. By waiving certain FCC rules . . . , we are giving service providers the chance to step up and give healthcare providers more tools to fight the ongoing pandemic and serve patients more effectively, like increased capacity, more equipment, additional services and other tools that will help them deliver the best possible patient care," Pai added.

The FCC recently awarded $9.5 million from a $200 million broadband program to 17 healthcare providers in 10 states for telehealth platforms, including $714,322 to Delaware's Christiana Care Health Services for expansion of its telehealth and remote patient monitoring platforms to low income and vulnerable patients in New Castle County. In addition, the FCC announced that it will distribute up to $9 billion through the Universal Service Fund across rural America for 5G wireless broadband connectivity with a goal of improving healthcare connectivity.

Local states are also taking similar steps to broaden telemedicine within their respective borders.

In **New Jersey**, the second hardest hit COVID-19 state in the nation, new legislation expanded access to telemedicine services and permitted professional and occupational licensing boards to expedite licensure of out-of-state professionals. New Jersey has (1) waived any site of service requirements to allow licensed clinicians to provide telemedicine from any location and individuals to receive services via telemedicine at any location; (2) permitted providers to use alternative technologies for telemedicine such as an audio-only telephone or video technology commonly available on smart phones and other devices; (3) eliminated the requirement that providers review a patient's medical history and medical records prior to an initial telemedicine encounter; (4) permitted waivers to allow professional and occupational licensing boards to expedite licensure of out-of-state professionals during the pandemic; and (5) permitted providers to bill for any Medicaid billable service using the same billing codes and rates that are provided for in-person services. New Jersey Governor Phil Murphy explained the rationale for these changes: "As we continue to strengthen our healthcare system to meet the medical demands of the COVID-19 pandemic, access to telehealth and tele-mental health services for New Jerseyans will be more important than ever before. These actions will ensure that our most vulnerable residents have flexible access to vital healthcare services from the comfort and safety of their homes."

The **Delaware** Division of Medicaid and Medical Assistance (DMMA) recently updated a longstanding telehealth policy to provide additional flexibility for its usage in response to the pandemic, and encouraged providers to consider using telemedicine services. The DMMA removed barriers created by requirements that patients present in-person before telemedicine services may be provided and allowed out-of-state healthcare providers to provide services if they hold an active license in another jurisdiction. DMMA will also expand allowable interfaces.

In **Pennsylvania**, the Office of Medical Assistance Programs (OMAP) announced a preference for use of telemedicine as a delivery method for medically necessary healthcare services beyond physician consultations and will remove multiple barriers toward payment for such services during the pandemic. In addition, the Pennsylvania Department of State's (DOS) Bureau of Professional and

Occupational Affairs (BPOA) has released guidance clarifying that healthcare professionals licensed under any of BPOA's licensing boards can provide services to patients via telemedicine during the COVID-19 emergency. Furthermore, DOS suspended laws during the emergency to allow licensed practitioners in other states to provide services to Pennsylvanians via the use of telemedicine without obtaining a Pennsylvania license.

TELEMEDICINE IS HERE TO STAY

Although much of the dramatic expansion described above is limited to the duration of the pandemic emergency, government officials, healthcare industry executives and analysts do not believe telemedicine will retract to where it was before the pandemic — in fact, quite the opposite. Many believe the widespread use of telemedicine during the pandemic will permanently change how healthcare is delivered to millions of patients throughout the world.

Physician practice groups throughout the country are ramping up telemedicine platforms not only to address COVID-19 patients, but also to address care after the pandemic. For example, in an area unfortunately familiar with disaster and emergency relief due to multiple hurricanes, the Houston Methodist Primary Care Group recently began expanding its telemedicine platforms to address chronic care management, health and wellness and other ancillary services that will be the backbone of its care after the pandemic. "What we're learning here will change healthcare permanently. The genie is out of the bottle. Telehealth is our passion now. . . We basically jumped forward 10 years on the adoption curve," said Stephen Spielman, president of the group.

The pandemic-related reduction in regulatory and payment barriers to telehealth has lead a network of approximately 2,900 physicians spread across eastern Massachusetts to "jump in and try things out," according to Alexa Boer Kimball, CEO of Harvard Medical Faculty Physicians at Beth Israel Deaconess Medical Center. Her network is treating thousands of more patients each week by telemedicine than it had just a few weeks prior.

Similarly, in Renton, Washington, the Providence St. Joseph Health System, caught in the middle of the first wave of the pandemic, has seen a tenfold increase in telehealth visits and a sevenfold jump in care providers joining the platform. Although that system saw the value of telemedicine six years ago when it began investing in the platform, it had to nevertheless "move very quickly from feature-driven (virtual health offerings) to scale-driven. We basically jumped forward 10 years on the adoption curve," said Aaron Martin, Executive Vice President and Chief Digital Officer for the six-state, 51-hospital health system.

Industry surveys indicate the depth of telemedicine's pandemic-related expansion and the recognized need for telemedicine to adapt to the new marketplace. A survey taken at the end of March 2020 of over 600 medical practices and 140 medical billing companies by Kareo, an industry software company, found that 75% of the practices were reporting either a current telemedicine option or the intent to deploy one soon, 28% of practices were only offering telemedicine visits and 9% of practices already closed, with many more concerned about the risk of future closure. While 63% of practices were still delivering on-site care, most of these practices were exploring options to move to hybrid or exclusively telemedicine-based care according to the survey. Ongoing analysis of actual patient encounters across over 50,000 medical providers found that by late March 2020, independent medical practices had experienced an approximately 35% decline in patient volume, raising alarm around both the apparent inability for patients to access care and the operational viability of medical practices if this trend continues.

Recently released medical claims data demonstrates that the transition to telemedicine has been monumental. FairHealth, the nation's largest repository of private medical claims data, reported telehealth claim lines in the Northeast region grew 15,503% in March 2020 compared to March 2019 (0.07% to 11.07% of total medical claim lines). The growth in nationwide telehealth claim lines was also staggering with an increase from March 2019 to March 2020 of 4,346.94% (0.17% to 7.52% of total medical claim lines).

A public perception survey during the beginning of the pandemic indicates that patients are rapidly adapting to the telehealth expansion. A survey of 2,000 adults by Sykes Enterprises, an IT consulting and services company, represents some of the first data gathered during the pandemic concerning public perception of telemedicine. Approximately 75% of those surveyed said they would consider using telemedicine to be remotely screened for COVID-19 and two-thirds said the pandemic has increased their willingness to try telemedicine. Greater than 50% said their health insurer provided coverage for telemedicine, with only 10% saying they were not covered. About 75% also said they were adequately informed on how to use telemedicine. Although only about 20% reported using telemedicine thus far, about 40% said they would consider using it. 36% of survey respondents cited convenience of not traveling to a doctor's office and sitting in a waiting room as a reason to use telemedicine. About 40% cited quality of care or accuracy of diagnosis as concerns about telemedicine and approximately 32% said that telemedicine is not comparable to in-person care but is a good option for an initial consult and/or basic care.

A telehealth satisfaction study by J.D. Power in the last quarter of 2019 indicated that telehealth was poised for considerable growth even before the pandemic. That nationwide study of telehealth early adopters demonstrated that customer satisfaction with the experience ranks among the highest of any consumer category studied by J.D. Power. The overall customer satisfaction score for telehealth services (851 on a 1,000-point scale) was among the highest of all healthcare, insurance and financial services industry studies conducted by J.D. Power. Only direct banking customer satisfaction ranked higher, with an average score of 855.

"We are looking at telehealth services similar to mobile banking and its early adoption rates," said Greg Truex, Managing Director, Health Intelligence at J.D. Power. "Early attempts at trying to convince consumers to bank via their phone failed, and initiatives were abruptly canceled. Now, with mobile banking apps having grown to become the third-most-used application among consumers, we expect telehealth to follow a similar path. Telehealth offers an alternative avenue to receive quality care that is cost efficient and accessible. Once providers and payers refine the formula for awareness and adoption, telehealth will change the landscape of how affordable and quality care is delivered."

TELEMEDICINE STANDARD OF CARE IN THE DELAWARE VALLEY

Telemedicine legislation is at various stages of development within the Delaware Valley with New Jersey law being the most developed, Delaware somewhere in the middle and Pennsylvania on the cusp of passing laws. However, none of the region's courts have published decisions regarding medical malpractice involving telemedicine and courts nationwide are no different. Consequently, with the imminent proliferation of telemedicine, the time is ripe to consider how the region's current or expected legislation may impact how healthcare providers will be judged for administering telemedicine for years to come.

The central question in most medical malpractice cases is whether the provider complied with the generally accepted "standard of care" when evaluating, diagnosing or treating a patient. This standard typically takes into consideration the provider's particular specialty as well as all the circumstances surrounding the encounter. Medical providers, not state legislators, usually define the standard of care for medical professionals. In malpractice cases, medical experts explain the applicable standard of care to the jury and guide its determination of whether, in the particular case, the standard of care was met. In this way, the law has long recognized that the medical profession itself is best suited to establish the appropriate standards of care under any particular set of circumstances.

Despite the fact that the complex and often nebulous concept of "standard of care" has been traditionally left to the experts to define, state legislators and regulators throughout the nation have chosen to weigh in on this issue in the context of telemedicine. As discussed below, in the case of telemedicine, legislators have eliminated a jury's consideration of the actual circumstances under which the healthcare is rendered. However, these legislative pronouncements fail to recognize or address the fact that the healthcare provider has not met with or examined the patient in-person when judging whether the care met the standard. This is known as a "legal fiction" and is typically created to promote some form of public policy. In light of the proliferation of telemedicine throughout the nation,

legislators should reconsider whether this "legal fiction" does more harm than good to the public policy of promoting telemedicine.

New Jersey

New Jersey's telemedicine/telehealth statute became effective in 2017 and related regulations applicable to licensed physicians and podiatrists became effective on April 20, 2020. N.J.S.A. §§ 45:1-61 *et seq.*; N.J.A.C. §§ 13:35-6B.1 *et seq.* The statute and regulations define telemedicine as follows:

> "Telemedicine" means the delivery of a healthcare service using electronic communications, information technology, or other electronic or technological means to bridge the gap between a healthcare provider who is located at a distant site and a patient who is located at an originating site, either with or without the assistance of an intervening healthcare provider, and in accordance with the provisions of P.L.2017, c.117 (C.45:1-61 et al.). "Telemedicine" does not include the use, in isolation, of audio-only telephone conversation, electronic mail, instant messaging, phone text, or facsimile transmission.

N.J.S.A. § 45:1-61; N.J.A.C. § 13:35-6B.2.

Both the New Jersey telemedicine statute and its regulations mandate a standard of care that differs from the one that has traditionally applied to healthcare professionals. In medical malpractice cases in New Jersey, physicians must exercise the level of care any "similarly credentialed member of the profession would exercise **in a like scenario**." *Cowan v. Doering*, 111 N.J. 451, 462 (1988) (emphasis added). This duty to act as a reasonable physician "**under the circumstances**" has been in place with respect to healthcare professionals for well over half a century. *See Schueler v. Strelinger*, 43 N.J. 330 (1964) (emphasis added). In fact, New Jersey judges are required to instruct a jury to determine the standard of care the physician was "required to observe in his/her treatment of a patient under the circumstances of this case." *See* New Jersey Model Civil Jury Charge 5.50.

New Jersey's telemedicine statute and regulations, however, dramatically alter this approach and eliminate the jury's consideration of the circumstances under which the diagnosis/treatment was rendered. The New Jersey statute/regulations require a jury to ignore the fact that diagnosis/treatment was provided via telemedicine technologies and pretend that diagnosis/treatment was instead provided in-person by the healthcare provider. Specifically, the statute/regulations state that a healthcare provider using telemedicine will be **subject to the same standard of care as is applicable to in-person settings for all healthcare services**, including diagnosis, treatment, consultation recommendations, risk/benefit treatment option discussions and issuing prescriptions. N.J.S.A. § 45:1-62(d)(1), (2); N.J.A.C. § 13:35-6B.3; N.J.A.C. § 13:35-6B.6(a). If telemedicine services cannot be rendered consistent with this in-person standard of care, the healthcare provider must direct the patient to seek in-person care. N.J.S.A. § 45:1-62(d)(1); N.J.A.C. § 13:35-6B.3(c).

Delaware

The Delaware Code defines "telemedicine" as:

> [A] form of telehealth which is the delivery of clinical health-care services by means of real time 2-way audio, visual, or other telecommunications or electronic communications, including the application of secure video conferencing or store and forward transfer technology to provide or support health-care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, care management and self-management of a patient's healthcare by a health-care provider practicing within his or her scope of practice **as would be practiced in-person with a patient**, and legally allowed to practice in the State, while such patient is at an originating site and the health-care provider is at a distant site.

18 Del. C. § 3370(a)(5) (emphasis added).

The Delaware Code also states that "[t]reatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the **same standards of appropriate practice as those in traditional (encounter in person) settings**." 24 Del. C. § 1769D(c) (emphasis added).

Similar to New Jersey, the Delaware regulations create a standard of care for physicians practicing telemedicine that ignores the circumstances under which the treatment was rendered and significantly departs from the traditional standard of care applicable to Delaware healthcare providers. Traditionally, Delaware healthcare providers must meet the "degree of skill and care ordinarily employed in the same or similar field of medicine" and use "reasonable care and diligence." 18 Del. C. § 6801(7) (definition of medical negligence). The standard of care must consider the given circumstances and be based upon expert testimony. *Larrimore v. Homeopathic Hospital Association of Delaware*, 176 A.2d 362, 367-68 (Del. Super. Ct. 1961), *aff'd*, 181 A.2d 573, 576-77 (Del. 1962) (standard of care for nurses, as for physicians, is a matter of applying the appropriate standard required of the nursing profession in the given circumstances) (cited as source to Del. P.J.I. Civ. § 7.1A (2000)). Delaware jurors are told that the healthcare provider committed medical negligence if the provider did not meet the applicable standard of care. Del. P.J.I. Civ. §7.1A (2000). Read together, Delaware's telemedicine laws seemingly alter the traditional standard of care that considers the given circumstances by forcing upon the jury the legal fiction that the telemedicine care was rendered in-person.

Pennsylvania

Despite being generally supportive of telemedicine during the pandemic, Pennsylvania has yet to pass any legislation addressing its role in the Commonwealth. In fact, on April 29, 2020, Governor Tom Wolf vetoed a comprehensive telemedicine bill (SB857) based entirely upon its restriction on using telemedicine to deliver or administer mifepristone, a medication used to end early-term pregnancies. The U.S. Food and Drug Administration currently requires mifepristone to be delivered at a medical facility.

The recently-vetoed telemedicine bill and others that have circulated in Pennsylvania during the past few years generally define telemedicine as the delivery of healthcare services provided through electronic information and telecommunications to a patient by a healthcare provider who is at a different location. *See* SB857, HB15. These bills have excluded from the definition of telemedicine audio-only medium, voicemail, facsimile, e-mail, instant messaging, text messaging, or online questionnaire, or any combination thereof. Although the recently-vetoed telemedicine bill only mandated a telemedicine standard of care identical to the in-person standard of care during audio-only telemedicine (Section 4105(A)(3)), another bill has required the in-person standard of care be applied for all forms of telemedicine. *See* HB15, §§ 3(b) and 4(a)(8). All of the Pennsylvania bills, however, have required the professional licensure boards to promulgate regulations that regulate telemedicine within the scope of practice and standard of care controlled by the boards. Consequently, each board may consider creating a telemedicine standard of care imposing the same "legal fiction" judging a provider as though the patient was treated in-person.

Similar to New Jersey and Delaware, any legislatively mandated in-person standard of care for telemedicine in Pennsylvania would be a drastic departure from the Commonwealth's jurisprudence since it ignores the circumstances under which the care was rendered. Pennsylvania physicians are required to possess skill and knowledge normally used in the medical profession and employ such with the care and judgment of a reasonable person in like circumstances. *Incollingo v. Ewing*, 282 A.2d 206, 213-214 (Pa. 1969) (citing *Donaldson v. Maffucci*, 156 A. 2d 835 (Pa. 1959)). *See also* Pa. SSJI (Civ.) 14.10, Medical Malpractice - Standard of Care (2015) ("A physician must have the same knowledge and skill and use the same care normally used in the medical profession. A physician whose conduct falls below this standard of care is negligent."). Ignoring the "circumstances" under which the physician practicing telemedicine rendered his or her care by pretending the care was rendered in-person undermines the "bedrock" reasonable care standard. *See Ragan*

v. Steen, 331 A.2d 724, 727-28 (Pa. Super. 1974); *Pringle v. Rapaport*, 980 A.2d 159, 170-71 (Pa. 2009) (quoting Pa. SSJI (Civ.) 11.01 (2009) (Subcommittee Note)) (internal citations omitted).

New Jersey, Delaware and Pennsylvania are not alone in legislating the in-person standard of care for telemedicine. In fact, the vast majority of states throughout the nation have passed or are considering similar legislation. Hawaii appears to be the lone notable exception. Its telemedicine law specifically recognizes that a separate standard of care should apply to telemedicine treatment. *See* Haw. Rev. Stat. Ann. § 453-1.3(c) ("[t]reatment recommendations made via telehealth, including issuing a prescription via electronic means, shall be held to the same standards of appropriate practice as those in traditional physician- patient settings that do not include a face-to-face visit…").

WHY LEGISLATE AN IN-PERSON TELEMEDICINE STANDARD OF CARE

The legislatively mandated in-person telemedicine standard of care followed in the majority of states likely stems from the model policy adopted by the Federation of State Medical Boards in April 2014. This model policy states that "[t]reatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter **in person**) settings." *See* Model Policy For The Appropriate Use Of Telemedicine Technologies In The Practice Of Medicine Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup (April 2014). This Model Policy is meant to provide "guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients via telemedicine technologies." *Id.* at 1.[2]

Proponents of the in-person telemedicine standard argue that the standard is necessary to ensure patient safety. Holding the provider to the in-person standard, it is argued, forces the physician to err on the side of caution and require an actual in-person encounter to ensure the advantages of sight, touch and smell are fully available. However, this standard not only unfairly exposes physicians to liability, but it actually discourages the use of telemedicine. Moreover, there is little indication that when adopting this requirement, state boards of medicine considered the chilling effect this "legal fiction" would have on the use of telemedicine.[3]

WHY AN IN-PERSON TELEMEDICINE STANDARD OF CARE IS COUNTERPRODUCTIVE

From the World Health Organization down to the Federation of State Medical Boards, telemedicine's wide ranging pre-pandemic benefits and goals were uniformly acknowledged and extoled. Telemedicine overcomes geographical barriers, increases clinical support, improves health outcomes, reduces healthcare costs, encourages patient input, reduces travel and fosters continuity of care. *See* World Health Org., Telemedicine Opportunities and Developments in Member States (2010); Model Policy For The Appropriate Use Of Telemedicine Technologies In The Practice Of Medicine Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup (April 2014); Telehealth Policy Trends and Considerations, National Conference of State Legislatures (2015). As one commentator so aptly put it: "[A]t least for certain medical needs, telemedicine could achieve a previously unthinkable logistical achievement in healthcare: obtaining the right medical attention at the right time, in the right place, at the right price." King, Michael W., Esquire, *Telemedicine: Game Changer or Costly Gimmick?*, 95 Den. L. Rev. 289, 299-300 (2018).

The pandemic, which has significantly limited the ability of providers to see patients in-person, only underscores the benefits of telemedicine. As the world continues to become more and more connected, the need to safely and efficiently gather massive amounts of medical information via telemedicine, in order to hopefully stave off and control future pandemics, will only grow.

Telemedicine's goals are too worthy and its benefits are too great to run the risk that the in-person standard of care will have a chilling effect on its progress. Healthcare providers may be reluctant to practice telemedicine under a standard of care that ignores the circumstances under which the care was rendered.

In light of the expansion of telemedicine nationwide, states should adopt the "reasonable professional under the circumstances" standard that has applied to physicians and other healthcare professionals for decades. This standard has served the medical community and public well and should not be altered by legislation, particularly when doing so may present an obstacle to patient health. The traditional barriers to telemedicine — technology, capital and patient acceptance — have all been toppled by the pandemic. The in-person telemedicine standard of care, however, remains a significant barrier. Eliminating this legal fiction will further encourage the use of telemedicine to improve overall population health.

If you have questions or would like additional information regarding these issues, please contact Mike Horner (hornerm@whiteandwilliams.com; 856.317.3658), Steve Milewski (milewskis@whiteandwilliams.com; 302.467.4502), or Josh Gajer (gajerj@whiteandwilliams.com; 215.864.6837).

As we continue to monitor the novel coronavirus (COVID-19), White and Williams lawyers are working collaboratively to stay current on developments and counsel clients through the various legal and business issues that may arise across a variety of sectors. Read all of the updates here.

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[1] For telehealth/telemedicine regulatory guidance see here.

[2] State legislatures in the Delaware Valley and throughout the country delegate the authority to regulate telemedicine licensure and practice to their respective state medical boards.

[3] For example, when questioned why the proposed New Jersey telemedicine regulations hold physicians to an in-person standard when telemedicine by definition is not in-person, the State Board of Medical Examiners simply stated that the legislators required that standard in the statute authorizing the regulations. There was no indication whether the Board questioned this legal fiction.