Panel responses to all these questions varied, sometimes fundamentally, but there was general agreement on three points: (1) that governments and the international support community now recognize the seriousness of water problems; (2) that answers are necessarily complex both because of the nature of the resource and the conflicting user demands; and (3) that there is still time for most countries and regions to adjust and modernize their water policies before a crisis occurs, but that action is necessary.

BRING TELEMEDICINE TECHNOLOGY TO THE AMERICAN PEOPLE

HON. RON WYDEN

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Friday, June 30, 1995

Mr. WYDEN. Mr. Speaker, the House will consider H.R. 1555, the Communications Act of 1995 after the Fourth of July district work period.

If done properly, telecommunications legislation will open the doors to radical advances in technology for our constituents. In reshaping America's telecommunications laws, the Congress must consider as many potential applications of telecommunications technology as possible. After all, it's been 60 years since the last rewrite to telecommunications law.

During Commerce Committee consideration of H.R. 1555, the Communications Act of 1995, I raised the issue of telemedicine in an effort to expand the use and development of this exciting health care technology. Telemedicine is a diverse collection of technologies and clinical applications. The defining aspect of telemedicine is the use of electronic signals to transfer information from one site to another. Telemedicine's potential is immense; including for rural care, emergency care, home care, medical data management, and medical education.

I offered and withdrew an amendment to allow licensed physicians in one State to conduct consultations with licensed health care practitioners in another State. I withdrew the amendment at the request of Members who sought additional time to explore the issue with the objective of crafting a bipartisan floor amendment.

Bipartisan discussions continue today. It remains my objective, working with colleagues from both sides of the aisle, to produce bipartisan legislation to bring telemedicine's many benefits across State lines to the American public.

I call the attention of my colleagues to the report printed below titled, "Telemedicine and State Licensure." The report outlines current problems facing telemedicine and the need for a bipartisan solution.

H.R. 1555, the Communications Act of 1995 is our opportunity to free telemedicine from the regulatory morass which threatens to keep this technology from the American people.

THE AMERICAN TELEMEDICINE ASSOCIATION—TELEMEDICINE AND STATE LICENSURE

INTRODUCTION

The primary purpose of telemedicine is to give all citizens immediate access to the appropriate level of medical care as disease or trauma requires. Currently, each state must license each physician or dentist who desires to practice medicine within its borders. This mode of licensure, while appropriate for practices limited by state boundaries, unduly constricts the practice of telemedicine. As a result, medical services today stops at state boundaries. American consumers are blocked from accessing medical care available in other states absent their ability to travel away from their own homes and communities.

The challenge facing all concerned with advancing medicine, and the sincere intent of our effort, is to preserve the credentializing and monitoring efforts of each state while providing instant and immediate access to appropriate levels of care where not otherwise available.

THE CURRENT STATE OF PHYSICIAN LICENSURE IN THE UNITED STATES

In some states, there are limited exceptions to the rule that a physician or dentist must possess a license in each state to which he practices medicine. Statutory ''consultation exceptions'' allow an out-of-state physician or dentist to enter a state to see a patient at the behest (and in the presence) of a locally licensed physician or dentist. However, consultations are often required to be limited in duration, and a number of states which possess them are acting to close them for telemedicine practitioners. In 1995, Colorado, South Dakota, and Texas have considered amendments to their consultation statutes prohibiting out-of-state telemedicine practitioners from ''entering'' without being licensed in their state. Utah repealed its consultation exception effective in 1993, and the Kansas Board of Healing Arts passed a regulation (which conflicts with its statutory consultation exception) which requires out-of-state telemedicine practitioners to be licensed in Kansas.

Additionally, a number of states prohibit out-of-state consultants from establishing regularly used hospital connections. If consultants cannot use telemedical facilities at out-of-state hospitals, this limits the availability of specialized healthcare to underserved areas. The ''consultation exceptions'' are simply not useful or dependable for the future of telemedicine. They are easily amended to exclude telemedicine practitioners, they require the presence of a locally licensed physician (which may not always be possible), and only one-half of the states possess exceptions broad enough to be used by telemedicine consultants.

While some have argued that the distant patient is ''transported'' to the physician or dentist via telecommunications, this is a weak legal argument unlikely to stand up in trial. It is instead probable that a majority of state courts would find that a telemedicine practitioner is practicing medicine in the patient's state. If the telemedicine practitioner is not licensed in the patient's state, this would have an extremely negative impact upon the physician's malpractice liability, malpractice insurance coverage, exposure to criminal prosecution, and potential loss of licensure in his home state as well as remedial legal recourse for an injured patient.

Licensure by reciprocity and licensure by endorsement have long served physicians or dentists who wished to be licensed in two or three states. However, reciprocity and endorsement fall short of the needs of physicians or dentists practicing via a telecommunications network. Today, reciprocity is rarely used, and licensure by endorsement still requires that applications, personal interviews, fees, pictures, school and hospital records, and even letters from locally licensed physicians or dentists be submitted to each state where a license is desired. Each state's requirements are minutely different, and the expense and time involved in receiving licensure by endorsement in more than one or two states makes it prohibitive, if not impossible, to achieve.

IS INDIVIDUAL STATE LICENSURE REQUIRED?

The Tenth Amendment of the U.S.Constitution reserves to the states the power to protect the health and safety of state citizens, hence the ability of the states to regulate and license healthcare providers. Almost every state statutorily defines the practice of medicine, and a typical statute reads:

''The practice of medicine means . . . to diagnose, treat, correct, advise or prescribe for any human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary, by any means or instrumentality.''

It appears that despite the presence of a primary/referring physician, the physician consulting via telemedicine who attempts to diagnose the patient is practicing medicine where the patient is located. The phrase ''by any means or instrumentality,'' while not common to all states, frequently appears in state definitions. Courts would determine that telemedicine was the ''instrumentality'' used to reach a diagnosis, and find that the state definitions bring telemedicine consultants under their jurisdiction. States guard their power to regulate for health and safety purposes, and the U.S. Supreme Court has upheld their ability to do so.[2] Therefore, it is unlikely that state courts would surrender jurisdiction over an out-of-state physician or dentist who practiced medicine via telecommunications on a patient located in their state. Courts will find that the medicine was being practiced where the patient was located, and therefore the physician or dentist should have been licensed in the patient's state. Such a finding would have a chilling effect on telemedicine, since licensure cannot be obtained in every state by every specialist who participates in even one consultation.

The means for attaining these goals are to have the patient under the care of a physician licensed in the same state of residence but allowing consultative evaluations of the patient by specialists licensed in another state. Other health care professionals, such as physician assistants, must be under the supervision of a licensed physician.

IS INTERSTATE TRANSMISSION OF TELEMEDICINE REQUIRED?

Just as the technology for the transmission of sound and images has witnessed revolutionary change, so too has medicine. These advances in telecommunications and medicine have made advanced medical care available where not thought possible before. Today, there are compelling needs to use interstate transmission of telemedicine from medical, social welfare, and economic perspectives:

The unpredictable immediacy of eruptions of disease or trauma may command the services of unpredictable types of specialists requiring licensure reciprocity in all 50 states. Epidemic outbreak of disease is not limited to state boundaries. The interstate mobility of specialty expertise is needed throughout the United States to meet the demands for combating injury or illness wherever and whenever it may occur.

Medicine has witnessed the emergence of super-specialized medical care centers in numerous critical areas. These centers are located in regional tertiary care facilities serving multi-state areas. Receiving medical attention through these centers currently requires the transport of most referred patients out of state. In addition, the lack of proper recuperative care in their home community after a patient returns home has prohibited the patient from returning home sooner. The development of telemedical

links to local primary care facilities will enable many patients to remain in-state under the primary responsibility of physicians or dentists licensed in their home state. The development of telemedical links to specialty care centers can reduce the cost of transport and can lead to substantial reductions in the costs of patient care.

Developing metropolitan-wide systems of care for many cities also requires crossing one or two state boundaries. There are 25 major metropolitan areas in the United States that include more than one state. In each of these areas, state licensing requirements effectively limit the ability of physicians or dentists and other health care practitioners to serve the health care needs, via metropolitan wide telemedical systems, of the population base residing in their own communities. This limitation can lead to great disparities in access to health care due to the consumer's place of residence.

The widespread shortage of health professionals in many parts of rural America has long been recognized as a critical public policy issue. In many cases, access to health care could be greatly improved with the development of telemedical links with health facilities located in nearby states.

CONCLUSION

Statutes are being considered among the states which would require out-of-state physicians or dentists treating patients across state lines via telecommunications to possess licenses in the state ''entered.'' Already in the vast majority of states the telemedicine practitioner would be considered to be practicing medicine upon a patient located there, thus providing the patient's state with jurisdiction over any malpractice action. Additionally, malpractice insurance coverage is generally predicated upon the physician being licensed where he practices. In other words, a physician sued for malpracticing via telemedicine in a state where he is not licensed might find himself without coverage, as well as responsible for his own defense costs. Failure to possess a state license would be used to establish negligence upon the part of the consulting physician. Criminal prosecution for practicing without a license could result, and the physician's home state could institute disciplinary action against him for his actions in the distant state. Telemedicine possesses incredible potential to increase healthcare accessibility, but is severely hampered by legal impediments of which licensure is one of the most obvious. Fortunately, licensure problems have the greatest potential to be alleviated by the passage of statutes aimed at addressing these issues.

Emerging from these careful considerations is the need to preserve the credentializing and monitoring efforts of each state while providing instant and immediate access to appropriate levels of care where not otherwise available. Such actions should allow for immediate response to instances of disease and trauma while securing for each state and its citizens the continuance of the credentializing and monitoring of quality within its boundaries with additional specialized back-up as needed.

FOOTNOTES

[1] ALA. CODE §34–24–50 (1975).

[2] *Geiger* v. *Jenkins*, 316 F.Supp. 370 (N.D. Ga. 1970), aff'd, 401 U.S. 985, 91 S.Ct. 1236, 28 L.Ed. 2D 525 (1971).

CONFERENCE REPORT ON HOUSE CONCURRENT RESOLUTION 67, CONCURRENT RESOLUTION ON THE BUDGET, FISCAL YEARS 1996–2002

SPEECH OF

HON. JAMES L. OBERSTAR

OF MINNESOTA

IN THE HOUSE OF REPRESENTATIVES

Thursday, June 29, 1995

Mr. OBERSTAR. Mr. Speaker, I rise in opposition to the conference report on the budget resolution for fiscal year 1996 and to delineate for my colleagues the specific impacts this budget resolution is likely to have on the Federal Aviation Administration.

I say ''is likely to have'' because the conference report does not spell out the details of the cuts proposed for the FAA budget; but, given the general numbers and spending targets set down in the budget agreement we can calculate what the effects will be on specific FAA programs, such as the agency's new ''zero accident'' goal.

As ranking member of the House Aviation Subcommittee, I want all my House colleagues to understand the critical mission of the FAA. This Agency manages the world's largest air traffic control system, through which move half of all the 1 billion passengers who travel worldwide every year by air. They operate the Air Traffic Control system 24 hours a day, 365 days a year, handling, on average, two flights every second.

On an average day, FAA safety and security professionals will conduct nearly 1,000 inspections on pilots, planes and airports, ensuring that they remain airworthy and safe.

FAA maintains over 30,000 pieces of complex safety equipment and facilities across this Nation, operating at a reliability factor of 99.4 percent—a safety record envied by the rest of the world.

FAA issues more than 1,000 airport grants annually to improve airport safety and infrastructure.

FAA conducts 355,000 inspections annually to enforce safety standards and to issue certificates and licenses for aviation products and operators. FAA takes more than 12,000 enforcement actions each year.

The FAA has taken its share of cuts in the last 2 years as its contribution toward deficit reduction: FAA has cut 5,000 employees since 1993 for a current total of 48,000 employees. Of that number 36,000 have direct hands-on involvement in the ATC system, which includes 14 of the 15 busiest airports in the world.

In this era of deregulation, with extraordinary growth in both passengers and air traffic operations, we have seen a growth of 6 percent in air traffic during the last 2 years as the airlines have recovered from the serious economic decline and $12 billion in losses of 1990–92. But while air traffic has jumped 6 percent these last 2 years, the FAA budget has suffered a real decline of 6 percent, which translates into a $600 million cut.

This Budget Resolution Conference Agreement chops an additional $10 billion from transportation spending, which if spread, as expected, to the FAA will jeopardize the safety and efficiency of the Nation's aviation system.

Under this budget resolution, FAA's ability to improve weather and safety equipment and prevent accidents would be compromised.

Introduction of Global Positioning Satellite navigation technology would be delayed at least 5 years, costing airlines millions of dollars a year in lost efficiency.

The ability of the aviation security system to maintain its vigilance against domestic and international terrorism would be cut by one-third.

FAA's obligation to certify new aircraft engines and parts would be greatly compromised and might even have to be contracted out to private interests which, in my judgment, clearly is not in the best interest of safety.

The weather services to general aviation and to commercial aviation provided through the Nation's Flight Service Stations would be greatly impaired as FSS and control towers would be closed, costing jobs and air traffic services to hundreds of communities in all 50 States, and delays to an estimated 105,000 flights annually at an estimated cost to carriers and passengers of more than $2.3 billion.

I am just touching the tip of the iceberg on the impact of these cuts projected out over the next several years for the FAA as a result of this budget resolution.

The dedicated professionals of the FAA deserve better. They deserve our full support for full funding out of the Aviation Trust Fund to maintain our air traffic control system at its highest level of safety and efficiency.

FOREIGN OPERATIONS, EXPORT FINANCING, AND RELATED PROGRAMS APPROPRIATIONS ACT, 1996

SPEECH OF

HON. ROBERT A. UNDERWOOD

OF GUAM

IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 28, 1995

Mr. UNDERWOOD. Mr. Speaker, I rise in full support of this amendment. This amendment is necessary not only because of the profits from drugs, but because of the children who buy them and sometimes die from them. We know that there is a big drug problem in the Asia-Pacific region. There is even a big drug problem on my island of Guam. This amendment sends a message that this country will not tolerate drugs. This amendment will show that this country will not sit down while a country we help will transform the money we give to them into drugs. This amendment will show that this country will take a strong stand on drugs. This amendment is just one small step to making a big problem disappear. We may need a marathon of steps to follow, but this represents a good beginning. This amendment will make the street safer for our children here and in the Asia-Pacific region. This is why we have to thank Mr. RICHARDSON and Mr. ROHRABACHER for combining to make this amendment.