

CYBERMEDICINE: DEFYING AND REDEFINING PATIENT STANDARDS OF CARE

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INTRODUCTION

In November 2001, MyDoc.com¹ went online treating Indiana patients over the Internet.² On October 16, 2002, the Illinois Department of Professional Regulation issued a Cease and Desist Order prohibiting MyDoc.com (“MyDoc”) from treating Illinois patients.³ The decision was monumental. MyDoc, an Indiana-based company which called itself “the nation’s first round-the-clock Internet-based health service offering doctor diagnosis, treatment, prescriptions and follow-up care,” intended to expand nationwide within two years.⁴ Instead, it was shut down in only its first expansion state after just six months.⁵ The decision seemed to answer the question that everyone has been asking: What is the standard of care in the cybermedicine context? In Illinois, the answer is clear. Physicians may not treat patients by prescribing medication absent a physical examination or a physician-patient relationship.⁶

The practice of medicine is regulated by the individual states. The Illinois MyDoc.com decision is not yet the uniformly accepted view across the country, as evidenced by MyDoc’s continued operation in Indiana.⁷ The regulation of cybermedicine is currently a line-drawing exercise. As the Internet continues to grow in popularity and accessibility, authorities will be forced to determine what kinds of information and interaction they are going to allow on it. Further, with the advent of online medicine, regulators are now forced to decide just how far to let the practice of medicine go. Illinois appears to have drawn their line.

This Note analyzes whether, in a cybermedicine context, the diagnosis and treatment of patients without a prior patient relationship constitute a violation of conventional medical practice standards of care. This Note further analyzes what

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1. Mydoc.com, at <http://www.homedoc.com> (last visited Feb. 7, 2004). The company was later sold and changed its name to HomeDoc. However, for consistency, the company will still be called Mydoc for purposes of this Note.

2. Jeff Swiatek, *Illinois Sidelines MyDoc.com Service*, INDIANAPOLIS STAR, Oct. 31, 2002, at C01 [hereinafter Swiatek, *Illinois*].

3. Illinois Dep’t of Prof’l Regulation v. Mydoc.com, No. 200202945-1 (Oct. 16, 2002).

4. Jeff Swiatek, *Revolutionary Medical Web Site Dispenses Advice Day or Night*, INDIANAPOLIS STAR, Dec. 22, 2001, available at 2001 WL 32034743 [hereinafter Swiatek, *Revolutionary*].

5. Swiatek, *Illinois*, *supra* note 2.

6. *Mydoc.com*, No. 200202945-1.

7. Swiatek, *Illinois*, *supra* note 2.

those standards should be, assuming conventional practice standards of care are indeed violated. Part I of this Note provides the trends and current usage of the Internet, both generally and in the context of healthcare. Additionally, it will define both telemedicine and cybermedicine and distinguish the two disciplines. Part II describes the online medicine company MyDoc.com, as well as the Cease and Desist Order issued against it by Illinois. Part III defines the conventional physician-patient relationship. It also reviews the various sources of medical standards of care, including law, policy, and ethics. Part IV analyzes the major issues and implications of cybermedicine, including patient exams and histories, questionnaires, medical records, response time, verifying physician credentials, follow-up care, drug prescriptions, patient self-diagnosis, patient accountability, and physician liability. The Note concludes that revisions are needed to the Federal of State Medical Boards (FSMB) guidelines in the context of the issues described in Part IV. It also suggests that in light of the recent inconsistent MyDoc.com decisions, all states need to adopt uniform online medicine guidelines and that the FSMB model is the most appropriate.

I. HEALTHCARE AND THE INTERNET

A. Trends in Healthcare

The face of healthcare has changed dramatically in recent years, for better and for worse. According to one study, more than one quarter of Americans rate the American healthcare system as poor, up from 15% in 1998.⁸ Part of the impetus behind patient dissatisfaction is the decline in health insurance coverage. In 2001, the number of our nation's uninsured rose to 41.2 million people, or 14.6%.⁹ This number will likely continue to grow with changes in employment coverage.¹⁰ Without insurance, most Americans cannot afford to pay for healthcare.¹¹

Additionally, there is an "ongoing backlash" against the cost-competitive and overburdened managed care.¹² The number of consumers who think managed care companies are doing a good job has decreased annually from 51% in 1997

8. EBRI, 2003 Health Confidence Survey, Summary of Findings 1 (Sept. 2003), available at <http://www.ebri.org/hcs/2003/03hcssof.pdf>.

9. Mike Bergman, U.S. Dept. of Commerce News, *Health Insurance in America: Numbers of Americans with and Without Health Insurance Rise*, Census Bureau Reports, Sept. 30, 2002, available at <http://www.census.gov/Press-Release/www/2002/cb02-127.html>.

10. *Facing the Future*, 22 J. HEALTH CARE MARKET 2427 (Oct. 1, 2002) (predicting that a significant portion of local employers will likely shift to a defined contribution strategy in the next two to five years, leaving thousands of workers with no health insurance), available at 2002 WL 18253370.

11. John O'Malley, *Smart Thinking for Challenged Health Systems*, 22 J. HEALTH CARE MARKET 2428 (July 1, 2002) (stating 80% of Americans can't afford to pay for healthcare out of pocket), available at 2002 WL 18253347.

12. *Facing the Future*, *supra* note 10.

to 33% in 2002.¹³ This growing dissatisfaction has increased with the prevalence of managed care. House calls are non-existent,¹⁴ the frequency¹⁵ and length¹⁶ of office visits have decreased, the length of waiting times in offices has increased,¹⁷ physicians are penalized for sending too many patients to a specialist,¹⁸ and patients are given cheaper medication.¹⁹ These problems are expected to worsen.²⁰ Patients do not want to wait months for an appointment and like the option of “bypassing secretaries, busy signals, nurses, and switchboards.”²¹ At the same time that our healthcare system has transformed, so too has consumer reliance on the Internet, facilitating another change in the face of healthcare.

B. Internet Usage and Trends

1. *Consumer and Physician Usage.*—The advent of the Internet has revolutionized modern society.²² Numerous studies have calculated the tremendous increase in Internet usage. One study estimated that in 2002, there were over 665 million Internet users worldwide, 160 million of which were in the United States.²³ Another study concluded that the number of American adults online increased from an estimated 17.5 million people, or 9%, in 1995 to an

13. Humphrey Taylor, *Public Perceptions of Health Insurers, Airlines, Oil Companies and Hospitals Improve While Respect for Computer Hardware and Software Companies Falls Sharply*, THE HARRIS POLL No. 28 (June 19, 2002), available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=306.

14. Kelly K. Gelein, Note, *Are Online Consultations a Prescription for Trouble? The Uncharted Waters of Cybermedicine*, 66 BROOK. L. REV. 209, 234 (2000).

15. Arnold J. Rosoff, *Informed Consent in the Electronic Age*, 25 AM. J.L. & MED. 367, 370 (1999).

16. SUSANNAH FOX & LEE RAINIE, PEW INTERNET & AMERICAN LIFE PROJECT: ONLINE LIFE REPORT, THE ONLINE HEALTH CARE REVOLUTION: HOW THE WEB HELPS AMERICANS TAKE BETTER CARE OF THEMSELVES 8 (Nov. 26, 2000) [hereinafter FOX & RAINIE, REVOLUTION] (finding that a typical doctor's visit is less than fifteen minutes and many patients leave a physician's office without getting answers to all the questions they have).

17. Dennis Hamilton, *Online Health Services Step up Their Offerings*, 22 IND. BUS. J., Jan. 28, 2002, at 23 (“The average doctor's visit today is four hours. . . . You have to make the appointment, go to the office, sit in the waiting room with a 3-year-old National Geographic, and finally you get to see the doctor.”).

18. Gelein, *supra* note 14, at 234.

19. Kristen Green, *Marketing Health Care Products on the Internet: A Proposal for Updated Federal Regulations*, 24 AM. J.L. & MED. 365, 386 (1998).

20. *Facing the Future*, *supra* note 10 (predicting that a shortage of physicians could occur in the next two to five years, increasing patient wait times and travel distances).

21. Gelein, *supra* note 14, at 240 (citation omitted).

22. For an excellent discussion of the history of the Internet, see *id.*

23. Press Release, Computer Industry Almanac, Inc., USA Tops 160M Internet Users (Dec. 16, 2002), available at <http://www.c-i-a.com/pr1202.htm>. The number of Internet users is expected to top one billion in 2005. *Id.*

estimated 137 million people, or 66%, in 2002.²⁴ One result of this increased Internet usage is the rapid growth of the healthcare industry on the Internet.

2. *Internet Application to the Healthcare Industry.*—The Internet has become a resource for both health-related information and treatment. There are an estimated 100,000 medical and health-related web sites on the Internet.²⁵ Studies suggest that somewhere between 77 million (66%)²⁶ and 109 million (78%)²⁷ of adult American Internet users have gone online in search of health or medical information. These cyberchondriacs are using sites of established organizations—academic, governmental, pharmaceutical, etc.—rather than using “pure e-health” sites.²⁸ For example, the number of National Library of Medicine Medline database searches increased from 7 million in 1996 to 120 million in 1997 when free public access was opened; the new searches are attributed primarily to non-physicians.²⁹

A number of explanations exist for the increase in medical information readily available on the Web. Some factors which contribute to demands for information, “pull factors,” include demographic shifts, increased education levels, increased comfort with new technologies, new consumer activism/involvement, changing profile of the healthcare system, and changing technology.³⁰ Entities creating demand for such information, “push factors,” include governmental agencies, medical healthcare providers, marketers of

24. Humphrey Taylor, *Internet Penetration at 66% of Adults (137 Million) Nationwide*, THE HARRIS POLL No. 18 (Apr. 17, 2002) [hereinafter Taylor, *Internet Penetration*], available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=295.

25. Gunther Eysenbach, *Shopping Around the Internet Today and Tomorrow: Towards the Millennium of Cybermedicine*, 319 BRIT. MED. J. 1294 (1999) [hereinafter Eysenbach, *Shopping*].

26. SUSANNAH FOX & DEBORAH FALLOWS, PEW INTERNET & AMERICAN LIFE PROJECT, INTERNET HEALTH RESOURCES: HEALTH SEARCHES AND EMAIL HAVE BECOME MORE COMMONPLACE, BUT THERE IS ROOM FOR IMPROVEMENT IN SEARCHES AND OVERALL INTERNET ACCESS 1 (July 16, 2003) [hereinafter FOX & FALLOWS, INTERNET HEALTH RESOURCES], available at http://www.pewinternet.org/reports/pdfs/PIP_Health_Report_July_2003.pdf.

27. *No Significant Change in the Numbers of “Cyberchondriacs”—Those Who Go Online for Health Care Information, Says Latest National Survey*, HARRIS INTERACTIVE (March 29, 2003), available at <http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=600>. But see Ha T. Tu & J. Lee Hargraves, *Seeking Health Care Information: Most Consumers Still on the Sidelines*, CENTER FOR STUDYING HEALTH SYSTEM CHANGE (March 2003) (suggesting the number is really only 30 million, or 16%).

28. Humphrey Taylor, *Cyberchondriacs Update*, THE HARRIS POLL No. 21 (May 1, 2002), available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=299.

29. Gunther Eysenbach, *Towards the Millennium of Cybermedicine*, 1 J. MED. INTERNET RES. e2 (1999) [hereinafter Eysenbach, *Millennium*] (citation omitted); see also Eysenbach, *Shopping*, *supra* note 25 (suggesting that patient access to databases increases consumer knowledge, pushing clinicians to higher quality standards and evidence based medicine).

30. Pamela C. Sieving, *Factors Driving the Increase in Medical Information on the Web—One American Perspective*, 1 J. MED. INTERNET RES. e3 (1999).

medical care or products, libraries, and organizations and support groups.³¹ Once consumers retrieve health information from the Internet, they use it to actively participate in their treatment and diagnosis.

Patients also go online to seek actual treatment advice and prescriptions from a physician. In what has become a “quiet revolution,” patients now use the Internet’s “point-and-click convenience” to obtain advice and seek medication, without ever seeing a doctor or visiting a pharmacy.³² According to one study, about 6 million Americans go online for medical advice on a typical day, which is more than the number who actually visit health professionals.³³ These numbers will increase as consumers push for more online interaction with their doctors. For example, while only 3.7 million U.S. adults have e-mailed a doctor’s office, 33.6 million more are interested in doing so.³⁴ Not only do consumers ask for advice, but they also assume an active role in managing their own healthcare. For instance, 25% of adults who visit disease sites have requested specific brand-name prescriptions from their doctors.³⁵

While physicians have been slower to use the Web, they are no longer “cybervirgins.”³⁶ Although only 30% of physicians using the Internet have a website, the amount of physicians who use the Internet increased from 54% in 1997 to 78% in 2002.³⁷ Further, the amount of time physicians spend online has increased.³⁸ As physicians grow more comfortable with using the Internet, they are beginning to use it more for patient care. Currently, 49% of medical professionals occasionally engage in e-mail correspondence with their patients.³⁹ However, many physicians are still cautious of e-health information. While most physicians say that discussing the results of patients’ Internet searches is helpful, the majority of those do not say it is because of the risk of patient self-treatment.⁴⁰

31. *Id.*

32. Katy Ellen Deady, Note, *Cyberadvice: The Ethical Implications of Giving Professional Advice over the Internet*, 14 GEO. J. LEGAL ETHICS 891, 892 (2001) (citation omitted).

33. SUSANNAH FOX & LEE RAINIE, PEW INTERNET & AMERICAN LIFE PROJECT, VITAL DECISIONS: HOW INTERNET USERS DECIDE WHAT INFORMATION TO TRUST WHEN THEY OR THEIR LOVED ONES ARE SICK 27 (May 22, 2002) [hereinafter FOX & RAINIE, VITAL DECISIONS], available at http://www.pewinternet.org/reports/pdfs/PIP_Vital_Decisions_May2002.pdf.

34. Information Technology Association of America, *e-Health: Cyber Dialogue Releases Cybereitizen Health 2000* (Sept. 2000), available at <http://www.ita.org/isec.htm>.

35. *Id.*

36. Robert Lowes, *Don't Let This Revolution Leave You Behind*, MED. ECON., Apr. 26, 1999.

37. AMA, News Release, *Study: Physicians' Use of Internet Steadily Rising* (July 17, 2002), available at <http://www.ama-assn.org/ama/puib/print/article/1616-6473.html>.

38. *Id.*

39. Health on the Net Foundation, *Excerpt of the 8th HON's Survey of Health and Medical Internet Users*, available at http://www.hon.ch/Survey/8th_HON_results.html (2002).

40. *Id.* Patient self-treatment will be further discussed infra Part IV.H.

C. New Forms of Healthcare

1. *e-Health Generally*.—Technology is outpacing the law⁴¹ and medicine. The product resulting from the synergy of technology and medicine is e-health. E-health covers two distinct areas: health information and delivery of patient care.⁴² The latter, online medical services, are considered the “next transformation” in healthcare.⁴³ There are more than 3000 medical advice sites on the Internet.⁴⁴ The largest limitation to this new method of patient care is not the technology itself, but physician restrictions. The practice of medicine is regulated by the individual state in which the patient resides.⁴⁵ Physicians who practice medicine across state lines⁴⁶ without physically being located in the state where the patient encounter occurs are required to either have a full and unrestricted license in that state or are unregulated. Patient care that takes place across state lines is defined as one of two types: telemedicine or cybermedicine.

2. *Telemedicine*.—Telemedicine can be defined in various ways. Generally, it is “the use of electronic communication and information technologies to provide or support clinical care at a distance.”⁴⁷ It is performed “by allowing a consulting physician at one location to observe a patient or data concerning the

41. Judith F. Darr & Spencer Koerner, M.D., *Telemedicine: Legal And Practical Implications*, 19 WHITTIER L. REV. 3, 15 (1997).

42. SPECIAL COMM. ON PROF'L CONDUCT AND ETHICS, FED'N OF STATE MED. BOARDS, MODEL GUIDELINES FOR THE APPROPRIATE USE OF THE INTERNET IN MED. PRAC. (Apr. 2002) [hereinafter FSMB, MODEL GUIDELINES] (“The Committee focused the guidelines on the latter due to its direct impact on patient safety and welfare and the physician-patient relationship.”), available at <http://www.fsmb.org>.

43. Gelein, *supra* note 14, at 227 (citation omitted).

44. Hamilton, *supra* note 17.

45. AMA, Board of Trustees Report 6-A-02, *Guidance for Physicians on Internet Prescribing* (2002) [hereinafter AMA, Report], available at <http://www.ama-assn.org/ama1/upload/mm/annual02/bot6a02.doc>.

46. See SPECIAL COMM. ON PROF'L CONDUCT AND ETHICS, FED'N OF STATE MED. BOARDS, REPORT ON PROFESSIONAL CONDUCT AND ETHICS § 4 (Apr. 2000) [hereinafter FSMB, CONDUCT AND ETHICS] (defining the practice of medicine as offering or undertaking to prescribe, order, give or administer any drug or medicine for the use of any other person), available at <http://www.fsmb.org>; see also REPORT OF THE AD HOC COMM. ON TELEMEDICINE, FED'N OF STATE MED. BOARDS, TELEMEDICINE, A MODEL ACT TO REGULATE THE PRAC. OF MED. ACROSS STATE LINES: AN INTRODUCTION AND RATIONALE (Apr. 1996) [hereinafter FSMB, MODEL ACT] (defining the practice of medicine across state lines to include any medical act that occurs when the patient is physically located within the state and the physician is located outside the state), available at <http://www.fsmb.org/Policy%20Documents%20and%20White%20Papers/telemed.htm>.

47. *Telemedicine Report to Congress Executive Summary*, 73 N.D. L. REV. 131, 131-32 (1997).

patient at another location.”⁴⁸ Telemedicine is not a recent development.⁴⁹ While telemedicine has been evolving in the United States and abroad for the past thirty-five years, interest in the field has increased dramatically since 1990 because of the demand for accessible and cost-effective healthcare.⁵⁰ The telemedicine industry is predicted to grow 40% annually over the next ten years to represent at least 15% of all healthcare expenditures by 2010.⁵¹

3. *Cybermedicine*.—Commentators have struggled with how to define and characterize cybermedicine. While some use telemedicine as the broader term and consider e-medicine, or cybermedicine, a subset of telemedicine,⁵² others view cybermedicine as the broader concept because it encompasses areas beyond telemedical treatments.⁵³ In light of the breadth of available services, the latter definition is preferred. Cybermedicine is “the internet driven practice of medicine where patients communicate with physicians . . . through electronic mail”⁵⁴ and online bulletin boards.⁵⁵ It includes nearly every facet of the practice of medicine, such as “marketing, relationship creation, advice and prescribing and selling drugs and devices.”⁵⁶ Its potential is unpredictable and unbounded and its “levels of interactivity [are] as yet unknown.”⁵⁷ However, cybermedicine is void of one level of interactivity: direct patient interaction. The cyberpatient never actually meets the physician, and information is only provided through the typed word.⁵⁸

Cybermedicine provides many advantages over conventional medicine. The Internet can enhance medical care by providing a vehicle to facilitate communication between healthcare providers, refill prescriptions, obtain laboratory results, reschedule appointments, monitor chronic conditions,⁵⁹

48. Daniel McCarthy, *The Virtual Health Economy: Telemedicine and the Supply of Primary Care Physicians in Rural America*, 21 AM. J.L. & MED. 111, 113 (1995).

49. See generally, KRISTINE SCANNELL ET AL., *TELEMEDICINE, PAST, PRESENT, FUTURE: JANUARY 1966-MARCH 1995* (1995).

50. FSMB, MODEL ACT, *supra* note 46.

51. *Telemedicine Will Grow 40 Percent Annually over the Next 10 Years, Says Industry Expert*, BUS. WIRE (NY), Dec. 2, 1999.

52. See Deady, *supra* note 32, at 893.

53. Jessica W. Berg, *Ethics and E-Medicine*, 46 ST. LOUIS U. L.J. 61, 61 n.1 (2002); see also Kim Solez & Sheila Moriber Katz, *Cybermedicine: Mainstream Medicine By 2020/Crossing Boundaries*, 19 J. MARSHALL J. COMPUTER & INFO. L. 557, 557 (2001) (“Cybermedicine is not a sub-set of something else: it is the embodiment of 21st Century medicine.”).

54. Ranney V. Wiesemann, *On-Line or On-Call? Legal and Ethical Challenges Emerging in Cybermedicine*, 43 ST. LOUIS U. L.J. 1119, 1119 (1999).

55. Deady, *supra* note 32, at 893.

56. *Id.*

57. Nicholas P. Terry, *Cyber-Malpractice: Legal Exposure for Cybermedicine*, 25 AM. J.L. & MED. 327, 328 (1999) (citation omitted).

58. Deady, *supra* note 32, at 893.

59. Gelein, *supra* note 14, at 230-31 (discussing diabetes and cardiac patients).

maintain anonymity,⁶⁰ provide healthcare information and clarify medical advice.⁶¹ The most frequently reported problem by consumers is inconvenient access to care.⁶² The healthcare delivery system finally found a solution: bring the service to the consumer.⁶³ Internet medical consulting services are expected to reduce the number of in-patient visits and force overall improvements in medical care.⁶⁴ However, because cybermedicine lacks direct physician-patient interaction, it is difficult to monitor abuse,⁶⁵ there is less prevalence of an ongoing physician-patient relationship,⁶⁶ patients may lack the skills to use the technology,⁶⁷ and there is an increased possibility of adverse outcomes.⁶⁸

4. *Distinguishing Cybermedicine and Telemedicine.*—The best way to understand both cybermedicine and telemedicine is by distinction. Unlike telemedicine, cybermedicine eliminates the middleman, the licensed, in-state provider, and it is generally paid for out of pocket.⁶⁹ Cybermedicine deals with global exchange of open, non-clinical information, mostly from patient to patient, sometimes between patient and physician or from physician to physician. Telemedicine, on the other hand, mainly deals with the restricted exchange of clinical data in a closed setting, for the most part from patient to physician and from physician to physician.⁷⁰ Telemedicine for the most part is applied to diagnostic and curative medicine, while cybermedicine is applied to preventative

60. Joshua Rosenbaum, *Health: The Typing Cure, Online Therapy Isn't for Everybody; But Proponents Say It Can Fill a Crucial Gap*, WALL ST. J., Sept. 16, 2002, at R10 (discussing the stigma associated with mental health and reluctance to seek treatment due to embarrassment).

61. FSMB, MODEL GUIDELINES, *supra* note 42.

62. Robert J. Blendon et al., *Inequities in Health Care: A Five-Country Survey*, 21 HEALTH AFFAIRS 182, 187 (2002) (reporting 41% of adult U.S. citizens say it is very or somewhat difficult to get care on nights or weekends).

63. Adam Katz-Stone, *E-medicine: Bedside Manner Can Be Miles Away*, WASH. BUS. J. (Dec. 21, 1998), available at <http://www.bizjournals.com/>.

64. Gelein, *supra* note 14, at 239 (citation omitted). *But cf.* Kathryn E. Kerwin & James Madison, *The Role of the Internet in Improving Healthcare Quality*, 47 J. HEALTHCARE MGMT. 225, 236 (July 1, 2002) (suggesting physicians may become barraged with questions by patients with online information); News Release, Saint Louis Univ., *Cybermedicine Expert Explores Health Care on Web: Cybermalpractice Is One Reality Facing Explosive New Industry* (Nov. 8, 1999) (predicting some services will eventually be offered exclusively on the Web making access to healthcare much more difficult for some), available at <http://www.slu.edu/publications/nb/new/110899.shtml>.

65. Deady, *supra* note 32, at 902-03.

66. Gelein, *supra* note 14, at 240 (stating two out of every three adults are less likely to establish an ongoing relationship with their primary care physician than in the past).

67. Rosenbaum, *supra* note 60.

68. FSMB, MODEL ACT, *supra* note 46.

69. Ross D. Silverman, *The Changing Face of Law and Medicine in the New Millennium: Regulating Medical Practice in the Cyber Age: Issues and Challenges for State Medical Boards*, 26 AM. J.L. & MED. 255, 265-66 (2000).

70. Eysenbach, *Shopping*, *supra* note 25.

medicine and public health.⁷¹

One commentator has suggested there are three discrete categories of e-medicine,⁷² which translate into discrete categories of liability:⁷³ (1) patient education, which has very little liability;⁷⁴ (2) specialist consultations and advice,⁷⁵ which has moderate liability;⁷⁶ and (3) the actual practice of medicine, diagnosis, and treatment of patients on the Internet,⁷⁷ with the potential for serious liability.⁷⁸ MyDoc.com is a recent example of this last category.

II. MYDOC.COM

A. *About MyDoc.com*

Roche Diagnostics of Indianapolis, a division of F. Hoffman-La Roche Ltd., the global pharmaceutical, diagnostics and vitamin company in Switzerland, partnered with Community Health Network, a four-hospital system in Indianapolis, to create MyDoc.com in the fall of 2001. MyDoc hires only board-certified primary care physicians to treat patients for the eight most commonly identified ailments.⁷⁹ It promises to diagnose and treat these ailments “within 15 to 20 minutes instead of the three to four hours an office visit typically involves.”⁸⁰

The software MyDoc uses is the same as that used by many telephone-based nurse call centers. When patients go online, they answer questions about their symptoms. Each answer generates a specific set of questions. After the questionnaire is completed, the software generates an assessment that is reviewed by a physician. If a case appears to be serious, the system immediately tells the patient to seek emergency care. If the case appears to be treatable, the physician can prescribe medication; however, MyDoc does not prescribe controlled substances or lifestyle drugs.⁸¹

71. Eysenbach, *Millennium*, *supra* note 29.

72. E-medicine is used in this context to generally include both telemedicine and cybermedicine.

73. Barbara J. Tyler, *Cyberdoctors: The Virtual Housecall—The Actual Practice of Medicine on the Internet Is Here; Is It a Telemedical Accident Waiting to Happen?*, 31 IND. L. REV. 259, 263 (1998).

74. *Id.*

75. This is considered telemedicine and is beyond the scope of this Note.

76. Tyler, *supra* note 73, at 263.

77. This is referred to as cybermedicine and is the focus of this Note.

78. Tyler, *supra* note 73, at 263.

79. Hamilton, *supra* note 17 (“There are approximately 100 million instances of the top ailments Those include sinusitis, vaginitis, influenza, ear infection, upper respiratory infection, urinary tract infection, gastroenteritis, and fungal nail infection.” (citation omitted)).

80. Tyler Chin, *Firm Pushes Online Medicine to New Level*, AMNEWS, Apr. 15, 2002 [hereinafter Chin, *Firm Pushes*].

81. MyDoc, Quick Summary, at <http://www.homedoc.com/md/quicksummary.jsp> (last visited

MyDoc targets employers to find busy professionals and their family members who do not want to miss work or take time off to go to the doctor for a minor, acute condition when they think they recognize their symptoms because they have had it before.⁸² After approximately a year of operation, MyDoc was serving more than 17,000 patients in Indiana.⁸³ MyDoc expanded its service into Illinois in April 2002 through the use of three Illinois-licensed physicians serving over 2000 patients.⁸⁴ Mydoc intended to expand nationwide.⁸⁵ However, MyDoc's plans came to an abrupt halt.

B. Illinois Pulls the Plug on MyDoc.com

After just six months of operation, on October 16, 2002, the Illinois Department of Professional Regulation issued a Cease and Desist Order prohibiting MyDoc.com from treating Illinois patients.⁸⁶ The grounds for the order were two-fold: (1) violating the Illinois Medical Practice Act, which requires MyDoc to be licensed as a physician, surgeon or medical corporation and (2) doctors diagnosing and prescribing drugs online for patients with whom they had no relationship and without performing a physical examination.⁸⁷ Illinois' action was not well grounded in its existing law. In fact, Illinois does not have a statute requiring a patient physical exam. Rather, the Illinois action was based on a standard of care argument. According to Illinois regulators, Mydoc's practice of diagnosing strangers online was a "deal-breaker."⁸⁸

The Illinois order leaves MyDoc operational only in Indiana. While Indiana has not taken any issue with MyDoc's practices,⁸⁹ several others have supported the Illinois decision, including the Illinois State Medical Society,⁹⁰ the Florida Board of Medicine,⁹¹ and the American Medical Association.⁹² More

Oct. 22, 2003). Lifestyle drugs are those for such conditions as impotence, hair loss, and weight loss.

82. Chin, *Firm Pushes*, *supra* note 80.

83. Swiatek, *Illinois*, *supra* note 2.

84. *Id.*

85. Michael Woods, *Patients Go to the Doctor Online*, CINCINNATI POST, May 10, 2002, at 7B.

86. *Mydoc.com*, No. 200202945-1.

87. *Id.*

88. Tyler Chin, *Firm Treating Strangers by Web Shut out by Illinois Directive*, AMNEWS, Nov. 4, 2002 [hereinafter Chin, *Firm Treating*].

89. Ann Carrns, *Illinois Orders Indiana Site to Cease Medical Service*, WALL ST. J. ONLINE, Oct. 30, 2002, at D4 [hereinafter Carrns, *Illinois Orders*] ("A spokeswoman for the Indiana attorney general's office said no action is pending against Mydoc in that state."), at <http://online.wsj.com>.

90. Ronald Ruecker, Chairman of the Illinois State Medical Society's Board of Trustees, stated: "They're running an electronic doc-in-the box." Ann Carrns, *Is There a Doctor on the Desktop?*, WALL ST. J., May 2, 2002, at D6 [hereinafter Carrns, *Desktop*].

91. John Dorschner, "Protect the Patient" Panel Aims at Web Druggists, MIAMI HERALD, June 21, 2002, at 1 (The Florida Board of Medicine rejected MyDoc.com's application to operate

importantly, the Federation of State Medical Boards (FSMB) may have dealt the final blow when it adopted model guidelines stating that treating or prescribing based “solely on an online questionnaire consultation doesn’t constitute an acceptable standard of care.”⁹³

III. THE USUAL COURSE OF PRACTICE

The FSMB is not alone. In recent years there has been proliferation of rules, regulations, guidelines, and policies being established by states and medical organizations to control the practice of online medicine. Analysis of these guidelines first requires an understanding of the cornerstones of medical practice: physician-patient relationships and medical standards of care.

A. Physician-Patient Relationship

1. *The Nature of the Physician-Patient Relationship.*—State and federal law require that in order for a doctor to be acting in the usual course of professional practice, there must be a bona fide doctor-patient relationship.⁹⁴ Traditionally, this relationship is developed through face-to-face interaction.⁹⁵ Medical communication is the “most central aspect” of the physician-patient relationship.⁹⁶ However, electronic communications and interactions between the physician and patient should supplement and enhance, but not replace, crucial interpersonal interactions that create the very basis of the physician-patient relationship.⁹⁷

2. *Establishing the Physician-Patient Relationship.*—This relationship is framed by the law of both torts and contracts. The physician-patient relationship can be established through express and implied contract, reliance, and payment. The implied contract theory is based on a request and agreement for services. The physician-patient relationship begins when an individual seeks assistance from a physician with a health-related matter for which the physician may provide assistance. The relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, whether or not there

in Florida, stating, “We have no desire to stop technology Our desire is to protect the patient.”).

92. Chin, *Firm Treating*, *supra* note 88 (quoting AMA President-elect Donald J. Palmisano, M.D., “The AMA applauds the efforts of state authorities to aggressively police Web prescribing sites that bypass medical safeguards with disclaimers that suggest a physical examination or review of reliable medical history are irrelevant to the safety of the patient.”).

93. Carms, *Illinois Orders*, *supra* note 89.

94. Dispensing and Purchasing Controlled Substances over the Internet, 66 Fed. Reg. 21,181, 21,182 (Apr. 27, 2001).

95. Berg, *supra* note 53, at 63 (“gold standard”).

96. Alissa R. Spielberg, *Online Without a Net: Physician-Patient Communication by Electronic Mail*, 25 AM. J.L. & MED. 267, 277 (1999).

97. FSMB, MODEL GUIDELINES, *supra* note 42.

has been a personal encounter between the physician and patient.⁹⁸ Therefore, a physician-patient relationship will be created prior to advice, diagnosis or treatment under the pure contract model.⁹⁹

A patient also may be able to demonstrate a physician-patient relationship if he or she can show reliance. The following criteria must be present: (1) the physician affirmatively advises the patient regarding a particular course of treatment; (2) it was foreseeable that the prospective patient would rely upon the advice; and (3) the prospective patient in fact relies upon this advice.¹⁰⁰ If the patient does not rely on the physician's advice, there may not be any physician-patient relationship.¹⁰¹

Finally, a physician may be held to have established a physician-patient relationship if he or she either accepts payment in advance,¹⁰² bills the patient,¹⁰³ or is reimbursed for his or her services,¹⁰⁴ despite a physician's disclaimer.¹⁰⁵

3. *Obligation to Treat and Ability to Discontinue Treatment.*—Absent contractual agreement, physicians have no legal obligation to engage in the practice of medicine or accept every patient who applies for treatment.¹⁰⁶ Therefore, they have the ability to screen applicants prior to accepting them. If this were not the case, physicians would lose all control of their practices and would be at the mercy of any and all care-seeking patients. The implications of this are even greater in cybermedicine, where there are fewer barriers to access.

If a physician-patient relationship is created, physicians must be cautious about how and when they discontinue treatment. If they are not, they will be subject to liability for patient abandonment. In a traditional care context, discontinuance is easier to identify. It generally requires reasonable written notice to the patient.¹⁰⁷ However, because of the transient and limited nature of the cyberpatient relationship, discontinuance is more difficult to define. One possibility is providing written notice to the patient. Another possibility is that the relationship is terminated as soon as a cyberpatient seeks follow-up care from another physician.¹⁰⁸ Regardless of the means of communication or delivery of

98. *Id.*; see also Darr & Koerner, *supra* note 41, at 19 ("Physicians who never interact with patients are held to owe a duty of care to those patients if the doctor has in the past agreed to provide medical services to that class of patient.").

99. Terry, *supra* note 57, at 349.

100. James L. Rigelhaupt, Jr., Annotation, *What Constitutes Physician-Patient Relationship for Malpractice Purposes*, 17 A.L.R.4th 132, 14 (Supp. 2003).

101. See *Weaver v. Univ. of Mich. Bd. of Regents*, 506 N.W.2d 264, 266 (Mich. Ct. App. 1993); see also *Miller v. Sullivan*, 625 N.Y.S.2d 102, 103-04 (N.Y. App. Div. 1995).

102. *Hand v. Tavera*, 864 S.W.2d 678, 679 (Tex. 1993) (health plan premiums).

103. BARRY R. FURROW ET AL., *HEALTH LAW* § 6-1(a), at 261 (2d ed. 2000).

104. Christopher J. Caryl, Note, *Malpractice and Other Legal Issues Preventing the Development of Telemedicine*, 12 J.L. & HEALTH 173, 194 (1998).

105. Gelein, *supra* note 14, at 246.

106. FURROW, *supra* note 103, § 6-1(a), at 260.

107. See, e.g., IND. ADMIN. CODE tit. 844 r. 5-2-16 (2003).

108. Gelein, *supra* note 14, at 244 (citing *Weaver v. Univ. of Mich. Bd. of Regents*, 506

healthcare services, while the relationship exists, acceptable standards of medical practice must be upheld.¹⁰⁹

B. Standard of Care

Cybermedicine must provide sufficient quality to avoid falling short of the standard of care required in traditional medicine.¹¹⁰ Standards of care are developed from various sources, including common law, state statutes, federal and state agencies, and professional ethics. Although in negligence law the “jury’s wisdom” or the “legislature’s fiat” define the standard of care, courts look to customary medical practices as the benchmark of acceptable behavior in medical malpractice cases.¹¹¹ The standard of care will either be evaluated in terms of a local standard or a national standard, depending on where a physician is located. The locality standard compares the degree of professional skill or knowledge exercised by a physician to that of “members of his profession in good standing in the same locality.”¹¹² Other jurisdictions subscribe to a national standard of care that requires a physician to possess the same degree of professional skill or knowledge when compared to other physicians on a national basis.¹¹³ The conduct of general practitioners and specialists is measured by a national standard of care in most courts.¹¹⁴ The national standard minimizes “conspiracy of silence” and limitation concerns with witnesses,¹¹⁵ ensures uniformity, certainty and consistency, and prevents physicians from forum shopping.¹¹⁶ Various commentators have suggested that the national standard of care is most appropriate in the e-medicine context as well.¹¹⁷

Various states have passed statutes and rules regulating online medicine.¹¹⁸ Some of these will be discussed in the context of specific identified issues in Part

N.W.2d 264, 267 (Mich. Ct. App. 1993)).

109. FSMB, CONDUCT AND ETHICS, *supra* note 46, § IV.

110. Spielberg, *supra* note 96, at 292.

111. James A. Henderson, Jr. & John A. Siliciano, *Universal Health Care and the Continued Reliance on Custom in Determining Medical Malpractice*, 79 CORNELL L. REV. 1382, 1384 (1994).

112. James O. Pearson, Jr., Annotation, *Modern Status of “Locality Rule” in Malpractice Action Against Physician Who Is Not a Specialist*, 99 A.L.R.3d 1133, 1140 (1990).

113. *Id.* at 1148.

114. FURROW, *supra* note 103, § 6-2, at 264.

115. *Id.* at 265.

116. Heather L. Daly, *Telemedicine: The Invisible Legal Barriers to the Health Care of the Future*, 9 ANNALS HEALTH L. 73, 104-05 (2000).

117. Tyler, *supra* note 73, at 289 (“Standards of care can be discerned through each board certified practice specialty.”).

118. See, e.g., N.M. ADMIN. CODE tit. 16, §10.8.8(I) (2001) (prohibiting prescribing drugs or medical supplies absent an established physician-patient relationship); see also N.Y. EDUC. LAW § 6530 (McKinney 2003) (prohibiting prescribing medication without conducting a proper clinical assessment of the patient).

IV. The Federation of State Medical Boards,¹¹⁹ the American Medical Association,¹²⁰ and the Food and Drug Administration¹²¹ have developed policies and guidelines regarding online medicine. Additionally, the Federation of State Medical Boards has encouraged state medical boards to adopt consistent language, standards and approaches for the regulation of medical practice, including regulations governing practicing medicine utilizing the Internet.¹²² Many states have done so.¹²³ These policies and guidelines will be discussed in the context of specific issues in Part IV.

Another crucial issue is whether and to what extent the provision of medical care through electronic media enables or prevents physicians from meeting ethical standards of care. What is legally required of physicians is a “decent minimum.”¹²⁴ However, these minimums likely will not satisfy ethical

119. FSMB, CONDUCT AND ETHICS, *supra* note 46, § IV.

120. AMA, Report, *supra* note 45, at 1.

121. FDA, Buying Medicines and Medical Products Online, at <http://www.fda.gov/oc/buyonline/> (last visited Oct. 22, 2003).

122. FSMB, CONDUCT AND ETHICS, *supra* note 46, § IV.

123. *See, e.g.*, Medical Board of California, Internet Prescribing, at <http://www.medbd.ca.gov/buyerbeaware.htm> (last visited Oct. 22, 2003) [hereinafter California]; *see also* Colorado Board of Medical Examiners, Policy 40-9, Guidelines Regarding Prescribing for Unknown Patients (Nov. 16, 2000) [hereinafter Colorado], available at <http://www.dora.state.co.us/medical/Policy40-9.htm>; Kentucky Board of Medical Licensure, Guidelines for Prescribing Controlled Substances (June 20, 1996) [hereinafter Kentucky], available at <http://www.state.ky.us/agencies/kbml/controlledsub.pdf>; Louisiana State Board of Medical Examiners, Statement of Position, Internet/Telephonic Prescribing (May 24, 2000) [hereinafter Louisiana], available at <http://www.lsbme.org/documents/positionstatements/InternetTelephonicPrescribing.pdf>; COMMONWEALTH OF MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE, PRESCRIBING PRACTICES POLICY AND GUIDELINES 10 (Dec. 12, 2001) [hereinafter Massachusetts], available at <http://www.massmedboard.org/regs/pdf/prescribe2.pdf>; MISSISSIPPI STATE BOARD OF MEDICAL LICENSURE, RULES AND REGULATIONS, LAWS AND POLICIES 4 (Sept. 2002) [hereinafter Mississippi], available at <http://www.msbl.state.ms.us/2003%20policy%20book.PDF>; MISSOURI TASK FORCE ON MISUSE, ABUSE AND DIVERSION OF PRESCRIPTION DRUGS, A GUIDE TO PRESCRIBING, ADMINISTERING AND DISPENSING CONTROLLED SUBSTANCES IN MISSOURI 10 (June 2001) [hereinafter Missouri], available at <http://www.dhss.state.mo.us/Publications/taskforce.pdf>; New York State Department of Health, Annual Report 1999: The Year in Review (1999) [hereinafter New York], available at <http://www.health.state.ny.us/nysdoh/opmc/annual/anrept99.htm>; North Carolina Medical Board, Position Statement, Contact with Patients Before Prescribing (Feb. 2001) [hereinafter North Carolina], available at <http://www.ncmedboard.org/contact.htm>; Warren Foote, *On-Line Medical Practice*, BME REPORT (Oregon Bd. of Med. Examiners), Fall/Winter 2001, at 3 [hereinafter Oregon], available at <http://www.bme.state.or.us/newsletter/FallWinter01.pdf>; Tennessee Board of Medical Examiners, Position Statement, Prerequisites to Prescribing or Dispensing Drugs—In Person, Electronically or Over the Internet (Sept. 12, 2000) [hereinafter Tennessee], available at <http://www2.state.tn.us/health/Downloads/g3010259.pdf>; Texas State Board of Medical Examiners, Internet Prescribing Policy (Dec. 8-11, 1999) [hereinafter Texas], available at <http://www.tsbme.state.tx.us/guidelines/ipp.htm>.

124. Robyn Meinhardt & Kenneth W. Landis, *Bioethics Update: The Changing Nature of the*

requirements and expectations imposed upon physicians.¹²⁵ In fact, some commentators have suggested that cyberdoctors exhibit a “lack of clinical responsibility.”¹²⁶

Medical ethics are fundamental principles upon which all medical decisions should be based. They are not the law, but are often enforceable by state medical licensing boards through standard of care arguments.¹²⁷ The body of medical ethics is not uniform, but it is well developed. Numerous entities and commentators have identified core ethical principles for purposes of protecting cyberpatients. One of these principles is trust.¹²⁸ Indeed, one survey has shown that adults trust doctors more than nearly any other professional.¹²⁹ The Federation of State Medical Boards has identified five ethical standards that should be observed: candor, privacy, integrity, informed consent, and accountability.¹³⁰ Other ethics policies have also been created by the AMA,¹³¹ e-Health Ethics Summit,¹³² Hi-Ethics,¹³³ Health on the Net Foundation,¹³⁴ and the American Accreditation HealthCare Commission (URAC).¹³⁵

IV. CYBERMEDICINE

Because it is conducted online without the benefit of face-to-face interaction, cybermedicine presents unique issues that seem to defy traditional standard of

Doctor/Patient Relationship, 16 WHITTIER L. REV. 177, 182 (1995).

125. *Id.*

126. See Tyler, *supra* note 73, at 289.

127. American Medical Association, AMA Policy, H-120.956 Internet Prescribing (urging states to investigate and sanction physicians who fail to meet the local standards of medical care when issuing prescriptions through Internet web sites that dispense prescription medications). Admittedly, this is exactly what Illinois did to MyDoc.com. See *supra* Part II.B.

128. Berg, *supra* note 53, at 65-66 (citing Ezekiel J. Emanuel & Nancy Neveloff Dubler, *Preserving the Physician-Patient Relationship in the Era of Managed Care*, 273 JAMA 323, 324 (1995) (identifying the six elements of the ideal patient-physician trusting relationship as choice, competence, communication, compassion, continuity, and (no) conflict of interest)).

129. Humphrey Taylor, *Trust in Priests and Clergy Falls 26 Points in Twelve Months*, THE HARRIS POLL #63 (Nov. 27, 2002), available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=342 (indicating 77% of adults surveyed trust doctors, following only teachers (80%)).

130. FSMB, MODEL GUIDELINES, *supra* note 42, § II.

131. COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, AMA, CODE OF MEDICAL ETHICS; REPORT OF THE COUNCIL ON MEDICAL SERVICE, MEDICAL CARE ONLINE, 4-A-01 (June 2001).

132. Helga Rippen & Ahmad Risk, *Policy Proposal, E-Health Code of Ethics*, 2 J. MED. INTERNET RES. 2, e9 (MAY 24, 2000).

133. Hi-Ethics, Ethical Principles for Offering Internet Health Services to Consumers, at <http://www.hiethics.org/Principles/index.asp> (last visited Oct. 22, 2003).

134. Health On the Net Foundation, HON Code of Conduct (HONcode) for Medical and Health Web Sites, at <http://www.hon.ch/HONcode/Conduct.html> (last modified Apr. 23, 2003).

135. URAC, HEALTH WEB SITE ACCREDITATION STANDARDS (vers. 1.0, n.d.).

care conventions. As a result, physicians, patients, and states are forced to compensate for its differences and deficiencies by altering their usual practices and behavior. This Part addresses the unique and controversial issues associated with cybermedicine. Because no one single standard of care can be applied to all physicians treating all patients,¹³⁶ each parties' interests should be balanced through consideration of the factors discussed below.

A. Patient Exam and History

The most critical question regarding cybermedicine is "how one can practice good medicine without percussion, auscultation, and inspection of the patient."¹³⁷ According to most authorities, one cannot. Physicians determine what is wrong with patients by using all of their senses, not just by vision or by questions and answers. For example, a patient examination usually involves checking vital signs, listening to the heart, etc. However, with electronic communication, physicians are stripped of the ability to use their senses and confined to evaluation of the written word. As a result, failure to examine a patient face-to-face, using all the senses, creates an "incomplete picture."¹³⁸

"An after-the-fact physical does not take the place of establishing a doctor/patient relationship."¹³⁹ The FSMB¹⁴⁰ and several states¹⁴¹ require that a documented patient evaluation, including history and physical evaluation adequate to establish diagnoses and identify underlying conditions and/or contraindications to the treatment recommended/provided, must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Some states specify that a medical record is an essential part of a physician-patient relationship, and that it must include documentation of a patient exam and a medical history.¹⁴² The Drug Enforcement Agency (DEA)¹⁴³ and other

136. Henderson & Siliciano, *supra* note 111, at 1397 ("Given the existing degree of economic stratification and technological proliferation, [requiring tort law to identify a single, customary standard of care that applies to all patients] this is, in our view, an impossible task.").

137. Gelein, *supra* note 14, at 215 (quoting Jan Greene, *Sign on and Say "A-H-H-H-H-H,"* 71 HOSPS. & HEALTH NETWORKS, Apr. 20, 1997, at 46).

138. Shira D. Weiner, Note, *Mouse-To-Mouse Resuscitation: Cybermedicine and the Need for Federal Regulation*, 23 CARDOZO L. REV. 1107, 1117 (2002).

139. Dispensing and Purchasing Controlled Substances over the Internet, 66 Fed. Reg. 21,181, 21,183 (Apr. 27, 2001).

140. FSMB, MODEL GUIDELINES, *supra* note 42, § V; FSMB, CONDUCT AND ETHICS, *supra* note 46, § IV.

141. See California, *supra* note 123; see also Colorado, *supra* note 123; Kentucky, *supra* note 123; Mississippi, *supra* note 123, at 4; Missouri, *supra* note 123, at 10; New York, *supra* note 123; North Carolina, *supra* note 123; Oregon, *supra* note 123, at 3; Tennessee, *supra* note 123.

142. See Massachusetts, *supra* note 123, at 10; Texas, *supra* note 123; Virginia, *supra* note 123.

143. Dispensing and Purchasing Controlled Substances over the Internet, 66 Fed. Reg. at 21,183 ("[I]t is unlikely for [the physician-patient] relationship to be formed through Internet

commentators¹⁴⁴ agree with this concept as well.

Certain exceptions have been recognized to the exam requirement, however, including: (1) an emergency; (2) patient care in consultation with another physician who has an ongoing relationship with the patient, and who has agreed to supervise the patient's treatment, including use of any prescribed medications; and (3) on-call or cross-coverage situations in which the physician has access to patient records.¹⁴⁵ An additional view is that a physical exam is not required for every patient treatment situation and should be evaluated on a case-by-case basis.¹⁴⁶

However, one shortcoming of those guidelines is that they do not specify how recently the exam and history must have been performed in order to be sufficient. Therefore, the guidelines should be revised to include time limits indicating how long a physician can reasonably rely on prior patient exams or history, absent physician knowledge of a change in patient circumstances. Some state statutes or regulations define "active patient" for notification purposes.¹⁴⁷ States could use those time frames as guides. As another alternative, health insurance coding manuals often define who is a "new patient" for billing purposes.¹⁴⁸

B. Questionnaires

As an alternative to physical examinations, cybermedicine companies and doctors are using questionnaires as a way to assess the patient's medical history and current medical condition. Numerous entities, including states,¹⁴⁹ the

correspondence alone. . . .").

144. See, e.g., Caryl, *supra* note 104, at 194.

145. FSMB, CONDUCT AND ETHICS, *supra* note 46, § IV; see also Colorado, *supra* note 123; Louisiana, *supra* note 123; Mississippi, *supra* note 123, at 4; North Carolina, *supra* note 123; Tennessee, *supra* note 123.

146. Medem, eRisk Working Group for Healthcare: Guidelines for Online Communications (Nov. 2002), available at http://www.medem.com/corporate/corporate_erisk_guidelines.cfm ("when clinically appropriate").

147. See, e.g., IND. ADMIN. CODE tit. 844 r. 5-2-16 (2003) (defining an active patient as one treated by the physician within the last two years).

148. See *How to Define "New" Patients and Code Flu Shots*, ACP-ISIM OBSERVER (Dec. 2000), available at <http://www.acponline.org/journals/news/dec00/definecode.htm> (Current Procedural Terminology (CPT) defines a new patient as "one who has not received any professional services from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years").

149. See California, *supra* note 123; Mississippi, *supra* note 123, at 4; Missouri, *supra* note 123, at 10; North Carolina, *supra* note 123; Oregon, *supra* note 123, at 3; Tennessee, *supra* note 123, at 1.

AMA,¹⁵⁰ the FSMB,¹⁵¹ the DEA,¹⁵² and the FDA,¹⁵³ all agree that treatment based on a questionnaire alone is not sufficient, particularly when issuing a prescription. Specifically, the FSMB provides that treatment 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 (face-to-face) settings.¹⁵⁴ Treatment, including issuing a prescription, based solely on an online questionnaire or consultation does not constitute an acceptable standard of care.¹⁵⁵ The primary reason is that “a questionnaire does not provide sufficient information for a health-care professional to determine if that drug is for you or safe to use, if another treatment is more appropriate, or if you have an underlying medical condition where using that drug may be harmful.”¹⁵⁶ If the patients cannot travel to the physician’s office, one alternative is for the physician to supervise an exam given by a nurse or other professional and then to prescribe the needed medication based on the results, to the extent that State law allows. In this case, the decision as to the appropriateness of the medication is based on facts (e.g., symptoms and vital signs) that have been verified by a qualified third party and observed by the physician electronically.¹⁵⁷

C. Medical Records

1. *Traditional Medical Records.*—Medical records include all “records kept in the usual course of the practice of the healthcare provider’ or, more generally, any personal information that relates to a person’s health care.”¹⁵⁸ This record usually consists of entries by medical professionals and diagnostic data. When a patient visits a physician, the patient relates his or her conditions or symptoms to the physician, who then “filters” or “distills” out the impressions or descriptions relevant to isolating the specific medical diagnoses.¹⁵⁹ The records and progress notes are crafted pursuant to a strict, industry-accepted standard called the “SOAP” format: “subjective—usually a quotation, selected by the health care worker, from the patient; objective—the physical exam; assessment—where the physician diagnoses and assesses the patient’s symptoms;

150. AMA, Report, *supra* note 45, at 2.

151. FSMB, MODEL GUIDELINES, *supra* note 42.

152. Dispensing and Purchasing Controlled Substances over the Internet, 66 Fed. Reg. 21,181, 21,183 (Apr. 27, 2001).

153. FDA, *supra* note 121.

154. FSMB, MODEL GUIDELINES, *supra* note 42.

155. *Id.*

156. FDA, *supra* note 121.

157. Dispensing and Purchasing Controlled Substances over the Internet, 66 Fed. Reg. 21,181, 21,183.

158. Spielberg, *supra* note 96, at 271.

159. *Id.* at 272-73.

and plan—what treatment options the physician should follow.”¹⁶⁰ As a result, neither the patient’s own words, nor a transcription of the physician-patient communication are found in the medical records.

2. *Cyber Medical Records.*—In cybermedicine, patients and physicians engage in the practice of medicine online, through the use of email, online questionnaires, and chats. Therefore, their communications are automatically recorded in paper or electronic format. Internet medicine guidelines developed by entities such as the FSMB¹⁶¹ and Medem¹⁶² require that these physician-patient communications be stored and filed in the patient’s medical record. As a result, the patient’s own words and “[t]he very interactions themselves will be recorded verbatim, serving as a transcript of the encounter,”¹⁶³ and “codified in a new or existing medical record.”¹⁶⁴

The implications of the storage of physician-patient communications are enormous. First, the full record of physician-patient communications will be available for use as evidence in potential subsequent lawsuits.¹⁶⁵ An estimated ninety percent of medical malpractice cases result from failure to document actions taken, rather than failure to take appropriate action.¹⁶⁶ Therefore, new Internet medicine guidelines requiring that the entire online communication be retained could have multiple effects. One possibility is that it will decrease the number of claims filed because the documentary record is complete. Another possibility is that malpractice judgments will decrease overall.¹⁶⁷ A third possible effect is that it will increase the number of claims because patients will be able to present written proof to substantiate their claims.

Second, some cyberphysicians will store patient records online, rather than in their office file room. As a result, consumers will have the ability to “own” their own electronic medical records and make changes and additions as necessary.¹⁶⁸

Third, the online medium may not provide protection for patient confidentiality and privacy. The Health Insurance Portability and Accountability

160. *Id.* at 274 n.62.

161. FSMB, MODEL GUIDELINES, *supra* note 42.

162. Medem, *supra* note 146.

163. Spielberg, *supra* note 96, at 274.

164. Darr & Koerner, *supra* note 41, at 10.

165. Caryl, *supra* note 104, at 183 (citing Robert F. Pendrak & R. Peter Ericson, *Telemedicine May Soon Spawn Long-Distance Lawsuits*, NATIONAL UNDERWRITER LIFE & HEALTH FINANCIAL SERVICES EDITION, Nov. 4, 1996, at *4).

166. Ann Davis Roberts, Comment, *Telemedicine: The Cure for Central California's Rural Health Care Crisis?*, 9 S.J. AGR. L. REV. 141, 160 (1999) (citing Jeff L. Magenau, *Digital Diagnosis: Liability Concerns and State Licensing Issues are Inhibiting the Progress of Telemedicine*, COMM. & LAW, Dec. 1997, at 25).

167. *Id.*

168. Kerwin & Madison, *supra* note 64 (citing R.C. COILE, JR., NEW CENTURY HEALTHCARE: STRATEGIES FOR PROVIDERS, PURCHASERS, AND PLANS 201-23 (Chicago: Health Administration Press 2000)).

Act of 1996¹⁶⁹ calls for the development of standards for the electronic transmission of health information and addresses the need to protect the security, integrity and authenticity of patient health information. However, the regulation does not cover a significant portion of the health-related activities that take place online¹⁷⁰ because many of the Web sites are run by organizations that are not “covered entities”¹⁷¹ protected under the privacy rule.¹⁷² Websites that do not accept health insurance or do not process health claims electronically in a standard format are not covered by the regulation.¹⁷³ Ironically, as a result, patients who seek online treatment may actually be sacrificing their privacy, rather than protecting it.

D. Response Time

Patients visiting a physician in a traditional clinical setting receive an immediate, real-time response from the physician when they communicate their information or concerns. Cyberpatients, on the other hand, must wait for an online response. Currently, Internet medicine guidelines provide that turnaround time should be established for patient-physician email.¹⁷⁴ However, the guidelines do not specify what that online response time should be or how it should be determined.¹⁷⁵ Guaranteed response time could significantly encourage patients and physicians to engage in cybermedicine. Failure to do so could have a chilling effect.

One primary reason for the development of cybermedicine has been patient dissatisfaction with managed care and its associated time delays.¹⁷⁶ Similarly, “patients relying on cyberdoctors to promptly answer their questions could be wasting valuable time waiting for a response.”¹⁷⁷ Therefore, patients will not switch to online medicine if it fails to meet their efficiency needs. Indeed, one study has indicated that patients are very receptive to communicating with their doctor online so long as the doctor actually replies in a timely manner.¹⁷⁸ It is also in physician’s best interest to guarantee and adhere to response times.

169. Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 29 U.S.C. and 42 U.S.C.).

170. ANGELA CHOY ET AL., PEW INTERNET & AMERICAN LIFE PROJECT, EXPOSED ONLINE: WHY THE NEW FEDERAL HEALTH PRIVACY REGULATION DOESN’T OFFER MUCH PROTECTION TO INTERNET USERS 1 (Nov. 2001), available at http://www.pewinternet.org/reports/pdfs/Pip_Hpp_HealthPriv_report.pdf.

171. Security and Privacy, 45 C.F.R. § 164.104 (2001) (regulating health plans, healthcare clearing houses, and healthcare providers who transmit health information in electronic form).

172. CHOY, *supra* note 170, at 7.

173. *Id.* at 19.

174. See FSMB, MODEL GUIDELINES, *supra* note 42; see also Medem, *supra* note 146.

175. Weiner, *supra* note 138, at 1125.

176. See *supra* notes 12-21 and accompanying text.

177. Wiesemann, *supra* note 54, at 1143.

178. FOX & RAINIE, VITAL DECISIONS, *supra* note 33, at 27.

Patients who have continuous access to their physician may be more satisfied and loyal due to the timeliness of their communications.¹⁷⁹ Also, as cyberpatients summon physicians to their computers¹⁸⁰ more and more, patients will likely grow more comfortable with the online process and their expectations will increase. As a result, a cyberpatient may attempt to hold his or her physician liable for failure to respond quickly enough.¹⁸¹

Although this issue probably does not necessitate a regulatory solution, cyberphysicians would be well advised to give patient expectations and response time added consideration. There are a number of possible solutions to these efficiency concerns. First, online practices could post guaranteed response times on their websites. In this way, patients would be on notice and would be able to choose whether or not to continue to “visit” that physician. Additionally, online practices could tailor their response times based on feasibility and reasonableness. Second, the FSMB could modify its guidelines to specify cyberphysician response time. The disadvantage of this option is that it is not flexible for the day-to-day operations of a medical practice and it does not take into consideration a physician’s availability. Finally, cyberpractices could create a “cyberreceptionist” to perform intake of patient emails and online inquiries, much like a receptionist in a brick-and-mortar practice. The cyberreceptionist could then inform the patient of the expected response time based on current practice situations and physician availability. While this may seem like an unnecessary expenditure of time and resources, it does have an added advantage. A cyber-receptionist will be able to screen the inquiry to determine the feasibility and desirability of treatment. In this way, a cyberpractice may be able to screen patients and limit a physician’s duty to treat an unknown patient online.¹⁸²

E. Verification of Physician Credentials

Cybermedicine can mask physician identity, thereby inhibiting patient needs and desires.¹⁸³ Unfortunately, there is often no way for the patient to know

179. Kerwin & Madison, *supra* note 64 (citing J. Sharma, *Using Internet Tools to Improve Care, Save Time, and Enhance Financial Performance*, HEALTH INTEGRATION TECHS. TODAY (2001), at <http://lw.healthit.com/resources.internettools.htm>).

180. See Deady, *supra* note 32, at 895; see also Ann Carns, *Desktop*, *supra* note 90; Tyler, *supra* note 73, at 283 (“Those beepers physicians carry can now signal, not just physicians on-call for their office patients, but physicians on-call for any potential Internet patient who signs on to their web site worldwide.”).

181. See *St. Charles v. Kender*, 646 N.E.2d 411, 412-14 (Mass. App. Ct. 1995) (stating a physician may be negligent for failing to return a patient’s telephone call during a reasonable period); *Smith v. United States*, 119 F. Supp. 2d 561, 577 (D.S.C. 2000) (suggesting physicians may be negligent for failing to follow reasonable communication procedures in place).

182. See *supra* Part III.A.3.

183. FOX & FALLOWS, *INTERNET HEALTH RESOURCES*, *supra* note 26, at 9 (finding that 21% of health seekers have looked for information about a particular doctor or hospital); see also ELLIOT M. STONE ET AL., *THE COMMONWEALTH FUND*, *ACCESSING PHYSICIAN INFORMATION ON THE*

whether the person purporting to provide the services is licensed or competent to do so,¹⁸⁴ primarily because “there are no national or local standards for format, content, or documentation.”¹⁸⁵ Medical websites are maintained by various entities, but none have all the content and structure needed by consumers, as they exhibit deficiencies in quantity, quality, and choice of information.¹⁸⁶ Because the current disjointed system prevents state licensing boards from sharing information with each other, there is often no way for a state to know if a physician is licensed, under suspension, or has lost his or her license to practice in a given state.¹⁸⁷ Other sites that are self-reported by physicians are not independently verified and are inaccurate.¹⁸⁸ Commercial websites may include physicians without their knowledge, require physicians to pay a fee, prohibit them from editing their records, contain a “preponderance of empty fields,” and not provide a disclosure as to verification or authenticity.¹⁸⁹ Because a publisher has no duty to investigate and warn its readers of the accuracy of the contents of its publications, absent a guarantee, a publisher will be deterred by potential liability from doing so.¹⁹⁰

Internet medicine websites should identify their treating physicians, as it will provide added assurance to patients. A patient who has difficulty in discerning the identity and practice location of physicians participating in Internet Web sites challenges the accountability and questions the legitimacy of the Web site.¹⁹¹ There are numerous options for providing physician identification. The most basic option is professional guidelines, which recommend that physicians be identified on their websites,¹⁹² including name, practice location, and all states in which licensure is held.¹⁹³ A second option is state action. The FSMB recommends that state medical boards require physicians to list any Web-based professional activities on their license applications and to provide identifying information on any Web sites for which they prescribe.¹⁹⁴ Additionally, states could pass physician-profiling legislation. The profiles would include gender,

INTERNET 2 (Jan. 2002) (“Healthy consumers, on the other hand, may be more likely to be interested in information about convenience and logistics. Ill consumers may be interested in the doctor’s experience with a certain illness or the number of procedures of a certain type the physician has performed (and the outcomes).”), available at <http://www.cmwf.org>.

184. Dedy, *supra* note 32, at 906.

185. STONE, *supra* note 183, at 9.

186. *Id.* at 4.

187. Daly, *supra* note 116, at 88.

188. STONE, *supra* note 183, at 7.

189. *Id.* at 8.

190. Terry, *supra* note 57, at 355-56.

191. AMA, Report, *supra* note 45, at 3.

192. Medem, *supra* note 146.

193. AMA, Report, *supra* note 45, at 3.

194. Berkeley Rice, *The Growing Problem of Online Pharmacies*, MED. ECON. (June 4, 2001); see also Wiesemann, *supra* note 54, at 1153 (recommending physicians be required to post resumes on their Websites).

medical school, and specialty board certification on all physicians licensed in the state.¹⁹⁵ A third option is federal action. Regulations on National Provider Identifiers, required by the administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) but not yet legislated, would make doctors easier to locate across organizations and websites.¹⁹⁶ Additionally, the Federal Trade Commission has urged Congress to require Internet pharmacy sites to disclose prescribing physicians' identities and traits, including name, address, phone number, and states in which they are licensed.¹⁹⁷

The most efficient and effective option is the establishment of a national database. This Cyberdoctor Data Bank could be used "to review qualifications posted over the Internet and to confirm that they coincide with the cyberdoctor's credentials."¹⁹⁸ Currently, many state medical boards maintain electronic databases of physicians licensed in their state. However, a cyberpatient attempting to research a cyberphysician could potentially be forced to search all fifty states to verify a physician's licensure or to try to get the "full picture." A national databank would give patients, physicians, and states one central location to submit and seek information. This databank could be established and maintained by the Federation of State Medical Boards. The information could be stored by physician name, the Unique Physician Identifier under HIPAA, or the "digital credentialing" system for which the AMA is lobbying.¹⁹⁹ In the alternative, the National Practitioner Data Bank (NPDB) already tracks physician malpractice claims and disciplinary actions against physicians' licensure, privileges, and professional membership.²⁰⁰ Currently, the information contained in the NPDB is confidential and inaccessible to the public.²⁰¹ However, because a reporting mechanism already exists between the states and the NPDB,²⁰² Congress could pass legislation creating a separate division of the NPDB to which physicians and states must submit and verify information on practitioners for consumer access.

F. Follow-Up

One pitfall of cybermedicine is that Internet medicine companies do not require follow-up care. Brick-and-mortar physician offices generally set up a follow-up appointment with the patient either when he or she is leaving the office or notifies the patient by mail or telephone. In a fee-based online consultation,

195. STONE, *supra* note 183, at 7-8 (citing California as an example).

196. *Id.* at 10.

197. Rice, *supra* note 194.

198. Wiesemann, *supra* note 54, at 1154.

199. *Terry Advocates Overhaul of Cybermedicine Practices*, ST. LOUIS BUS. J. (Feb. 4, 2000), available at <http://stlouis.bizjournals.com/stlouis/stories/2000/02/07/focus6.html>.

200. Health Care Quality Improvement Act, 42 U.S.C. §§ 11131-11133 (1994).

201. 42 U.S.C. § 11136 (1994). See 45 C.F.R. 60.13 (1996) (explaining that access to the National Practitioner Data Bank is strictly controlled and not granted to consumers).

202. See 42 U.S.C. § 11132 (1994).

the healthcare provider has the same obligations for patient care and follow up as in face-to-face, written and telephone consultations.²⁰³ Online medicine guidelines specify that an online consultation should include an explicit follow-up plan that is clearly communicated to the patient.²⁰⁴ In addition, some states require insured availability of the physician or coverage for the patient for appropriate follow-up care, regardless of the consultation medium.²⁰⁵ Failure to perform proper patient follow-up may present potential hazards to the patient in the event of side effects, if the condition worsens, or if there is a drug interaction.²⁰⁶ Therefore, in order to satisfy this standard of care, cyberdoctors will either have to guarantee their availability and commit to being the patient's follow-up physician or create and maintain a relationship with the patient's follow-up physician, much like a consulting physician in a telemedicine setting.

G. Prescribing

The ability to prescribe medication over the Internet, one of cybermedicine's most attractive features, may be one of its most problematic. One of the primary reasons patients like to purchase prescription drugs online is privacy. Consumers are increasingly seeking out the opportunity to buy these drugs from the privacy of their own homes.²⁰⁷ However, patients may be sacrificing their safety in exchange for anonymity. By definition, prescription drugs are not safe for use except under a properly licensed physician's supervision.²⁰⁸ Therefore, the act of prescribing and taking medication absent a physician examination, monitoring, and/or follow-up is inherently dangerous. In fact, the FDA has issued a tip to consumers to not buy from sites that offer to prescribe a prescription drug for the first time without a physical exam.²⁰⁹ In addition, physicians have much greater liability exposure when they prescribe online. Finally, online prescribing may have public health implications.

1. Fraud, Deceit and Mistake.—The anonymity of the Internet is convenient, but it is dangerous for physicians who may become victims of patient fraud, deceit, and mistake. A physician treating a patient online “cannot know whether the patient is a poor historian, a liar, a charlatan, or someone with Munchausen's syndrome.”²¹⁰ A consumer can more easily provide false information in a questionnaire than in a face-to-face meeting with a practitioner.²¹¹ In fact, “consumers often lie, withhold information, or mask their identity on the Web to

203. Medem, *supra* note 146.

204. *Id.*

205. See Tennessee, *supra* note 123, at 1; see also Texas, *supra* note 123.

206. California, *supra* note 123.

207. Kara M. Friedman, *Internet Prescribing Limitations and Alternatives*, 10 ANNALS HEALTH L. 139, 141 (2001).

208. Food and Drug Act, 21 U.S.C. § 353(b)(1)(A) (2002).

209. FDA, *supra* note 121.

210. Tyler, *supra* note 73, at 288.

211. Missouri, *supra* note 123, at 10.

maintain anonymity.”²¹² According to a 1999 survey, almost one out of six U.S. adults have taken extraordinary steps to maintain the privacy of their medical information.²¹³ “They withhold information from their doctors, provide inaccurate or incomplete information, doctor-hop to avoid a consolidated medical record, pay out-of-pocket for care that is covered by their insurance, and even avoid care altogether.”²¹⁴

One reason cyberpatients may exhibit this behavior is due to drug addiction. The reality is, any person with a computer, without regard to age, capacity, medical condition, or otherwise, can go online and obtain prescription medications. At a time when an estimated one-third of drug abuse comes from prescription drugs,²¹⁵ cybermedicine compounds an already existing problem. Rejected drug buyers can simply resubmit their orders as many times as they need to, omitting or changing troubling information, in order to avoid online barriers to access.²¹⁶ The problem is, a patient with an addiction might appear quite reasonable when requesting medication, but could actually be hiding behind a cybermask. Therefore, the cyberphysician would be unable to observe any obvious warning signs of substance abuse, such as the smell of a patient’s breath or the fact that the patient has not showered for two weeks.²¹⁷

A second explanation is that patients may make an honest, or a presumed harmless, omission. They may not understand the questionnaire or remember everything that they’re taking when they answer it.²¹⁸ Or, even worse, they may purposely leave off information that they think is unimportant, given the isolated purpose and brief nature of their “e-visit.” As a result, a cyberpatient may omit important information by mistake or intention.

If patients are allowed to abuse the system, it will not only compound our country’s already serious prescription drug-abuse problem, but it will also subject physicians to greater liability risk. In fact, one commentator has suggested imposing a greater burden on physicians.²¹⁹ Another commentator has suggested that “[f]rom a public relations perspective, prosecuting physicians for Internet prescribing is a can’t-lose proposition.”²²⁰

There are a number of ways to minimize or eliminate these concerns. The

212. CHOY, *supra* note 170, at 20.

213. *Id.* at 4 (citing PRINCETON SURVEY RESEARCH ASSOCIATES, CALIFORNIA HEALTHCARE FOUNDATION, CONFIDENTIALITY OF MEDICAL RECORDS: NATIONAL SURVEY (Jan. 1999)).

214. *Id.*

215. Eric M. Peterson, *Doctoring Prescriptions: Federal Barriers to Combating Prescription Drug Fraud Against On-Line Pharmacies in Washington*, 75 WASH. L. REV. 1331, 1335 (2000).

216. Rice, *supra* note 194.

217. Gelein, *supra* note 14, at 237 & 253.

218. Rice, *supra* note 194.

219. Gelein, *supra* note 14, at 253 (suggesting a heightened expectation to “read between the lines” and inquire about a cyber-patient’s medical history or surrounding circumstances).

220. Silverman, *supra* note 69, at 273 (citing public protection, prompt execution of cyber-justice, and the fact that Internet prescribing physicians are seen as outliers or mavericks, so disciplinary action would not run afoul of conservative state medical societies).

most basic is to require identification of the actual patient who is signing on for the medical service.²²¹ Additionally, some online doctors may not fill a prescription without a referral from another physician who has seen the patient. Perhaps the most effective means “[t]o make sure fakers don’t hoodwink the site”²²² is to prohibit the issuance of controlled substance prescriptions pursuant to an online consultation. The DEA may be the most appropriate entity to promulgate these regulations, as it would be more efficient than the individual states doing it.

2. *Threat of Over-Prescribing.*—By eliminating barriers to prescribing practices, cybermedicine may have public health impacts. The majority of patients are going online for prescriptions²²³ or prescription refills.²²⁴ Without a physical exam, physicians may not have or may not think they have the ability to screen for the clinical appropriateness of those prescriptions. In fact, a survey has shown that 41% of physicians prescribe unnecessary antibiotics out of fear of malpractice liability.²²⁵ Compounding this problem is the fact that antibiotic resistance is a public health crisis today.²²⁶ The proliferation of online treatment will only further the problems our society faces from over-prescribing, including added costs and increased antibiotic resistance. Therefore physicians should be prohibited from prescribing medication online absent a pre-existing physician-patient relationship, which should include a “current” physical examination. In addition, states should provide guidelines for physicians regarding online prescriptions, including conditions that can be treated pursuant to an online consultation and whether refills should be allowed.

H. Self-Education and Self-Diagnosis

1. *The Result of Education: Empowerment.*—The most compelling

221. Gelein, *supra* note 14, at 215 (quoting Jan Greene, *Sign on and Say “A-H-H-H-H,”* 71 HOSPS. & HEALTH NETWORKS, Apr. 20, 1997, at 46).

222. Lisa Ramirez, *Online Doctors Stirring Debate Internet Consultations Are Becoming More Popular, but Some Physicians Call Them Prescriptions for Trouble*, THE PRESS-ENTERPRISE (Riverside, CA), Aug. 9, 1999, at A01.

223. Carrns, *Desktop*, *supra* note 90 (according to MyDoc’s General Manager, so far it has completed more than 800 “visits,” 65% of which resulted in a prescription).

224. See Spielberg, *supra* note 96, at 287 (showing some patients will want to limit e-mail use to administrative messages such as prescription refills); see also Gelein, *supra* note 14, at 228-29 (Cyberdocs.com has reported that approximately 90% of their online consultations result in a prescription request.).

225. Humphrey Taylor, *Most Doctors Report Fear of Malpractice Liability Has Harmed Their Ability to Provide Quality Care: Caused Them to Order Unnecessary Tests, Provide Unnecessary Treatment and Make Unnecessary Referrals*, HARRIS POLL #22 (May 8, 2002), available at http://www.harrisinteractive.com/harris_poll/index.asp?PID=300.

226. WORLD HEALTH ORGANIZATION REPORT ON INFECTIOUS DISEASES 2000, OVERCOMING ANTIMICROBIAL RESISTANCE (2000), available at <http://www.who.int/infectious-disease-report/2000/intro.htm>.

psychological aspect of Internet medicine is empowerment. Patient empowerment can be attributed to three factors. The first is that the number of Internet users continues to rise.²²⁷ The computer is becoming a “patient’s assistant,” through which he or she can access medical information and participate in making his or her own clinical decisions.²²⁸ The second is that the profile of Internet users has a bias towards more affluent, better-educated consumers.²²⁹ The third is the increasing availability of information on the Internet. This is contributed to not only by private companies, but also by the federal government.²³⁰

2. *The Shift of Control: Balance.*—The advent of cybermedicine has left commentators, physicians, and patients squabbling over who should have control on the continuum of patient healthcare. The traditional view is that “physicians . . . should control all aspects of medical practice.”²³¹ In this case, power is “asymmetrically distributed, resting entirely in the hands of the physician.”²³² The success of this approach relies on trust. At least one study has shown that patients do trust physicians,²³³ which leaves one wondering why patients are demanding more control over their healthcare decisions. The answer: because they need it, they want it, and they can get it.

The centrist viewpoint emphasizes a balance between the physician and patient, or “shared decision making.”²³⁴ Under this approach, physicians’ most important function is to “help their patients make decisions among competing options of therapeutic interventions.”²³⁵ In this way, the physician and the patient are partners in the healthcare decision making process and share “mutual responsibility.”²³⁶ Part of the reason for the need to seek information and participate in their own decision-making has been the increase in managed care and the limited access to health resources.²³⁷ Additionally, access to online information can help bridge the medical knowledge gap between physicians and

227. Taylor, *Internet Penetration*, *supra* note 24 (indicating that the number of adult online users went up from 127 million in fall 2001 to 137 million in spring 2002).

228. WARNER V. SLACK, M.D., *CYBERMEDICINE: HOW COMPUTING EMPOWERS DOCTORS AND PATIENTS FOR BETTER HEALTH CARE* Ch. 3 (2d ed. 2001).

229. Taylor, *Internet Penetration*, *supra* note 24.

230. Green, *supra* note 19, at 385 (suggesting Federal regulation of drug and medical device Internet advertising is aimed at enabling current and potential medical supply consumers to obtain as much access as possible to accurate information concerning the legal drugs and devices that may be prescribed for them).

231. Wiesemann, *supra* note 54, at 1136 (quoting JAY KATZ, M.D., *THE SILENT WORLD OF DOCTOR AND PATIENT* 17 (1984)).

232. *Id.* at 1135.

233. *See supra* note 129 and associated text.

234. FOX & RAINIE, *REVOLUTION*, *supra* note 16, at 8.

235. Sieving, *supra* note 30 (quoting R.F. Brubaker, *Decisions, decisions*, 106 *OPHTHALMOLOGY* 165-68 (1999)).

236. Wiesemann, *supra* note 54, at 1135.

237. Tyler, *supra* note 73, at 264.

patients, facilitate discussion between the parties, and help effect true informed consent.²³⁸ However, sometimes patients take this process to the extreme.

The final view represents patients' desires to have full control,²³⁹ i.e., perform self-diagnosis. Some argue that this is a means for patients to take back control from politicians and government regulators.²⁴⁰ The concerns associated with this approach are two-fold. First, self-diagnosis can be dangerous and may prevent determination of the actual underlying cause.²⁴¹ Second, physicians have been trained to become skillful artisans of the practice of medicine. Failure of patients to allow physicians to practice that art will not only directly impact physicians and their livelihoods, but it will "shortchange the patient" by preventing the physician from adequately using all his or her skills.²⁴² After all, "[w]hat seems to be a cold . . . could be something more serious."²⁴³

Patients are definitely taking a more active role in their own healthcare. While it is suggested that there is no actual evidence people are doing "completely whacky self-diagnoses,"²⁴⁴ it is clear they are doing some form of it. Not only are the majority of patients using the Internet to gather healthcare information,²⁴⁵ but nearly one in five health seekers say they have gone online to diagnose or treat a medical condition on their own, without consulting their doctor.²⁴⁶ The best solution seems to be a balance of physician authority and patient informed consent. In order to do that, consumers should take ample time to search for health advice,²⁴⁷ visit multiple sites²⁴⁸ to verify their validity and timeliness,²⁴⁹ and "discuss the information with a health care provider before making a treatment decision."²⁵⁰

238. Silverman, *supra* note 69, at 260.

239. Kyle L. Grazier, Editorial, 47 J. HEALTHCARE MGMT. 281 (Sept. 1, 2002); Henderson & Siliciano, *supra* note 111, at 1392.

240. Silverman, *supra* note 69, at 267.

241. California, *supra* note 123.

242. Wiesemann, *supra* note 54, at 1141.

243. Marc Davis, *Internet Doctors Make a Cyber Move to Illinois*, CHI. TRIB., May 5, 2002, at 6A (quoting Donald Palmisano, M.D., of the AMA Board of Trustees).

244. Angela Stewart, *Medical Knowledge Is Power for Most Web Users, Survey Finds—Although Many Don't Verify Sources, They also Don't Self-Diagnose*, STAR-LEDGER (Newark, NJ), May 23, 2002, at O49.

245. FOX & RAINIE, VITAL DECISIONS, *supra* note 33, at 5 (indicating 55% of health seekers have gathered information before visiting a doctor).

246. *Id.* at 21 (18%).

247. *Id.* at 24 (recommending spending at least 30 minutes on a search).

248. See Tyler, *supra* note 73, at 271 (suggesting second and third opinions); see also FOX & RAINIE, VITAL DECISIONS, *supra* note 33, at 17 (suggesting visiting four to six sites).

249. Stewart, *supra* note 244, at O49 ("[O]nly a quarter [of health seekers] follow recommended procedures for checking the source and timeliness of the information.").

250. FOX & RAINIE, VITAL DECISIONS, *supra* note 33, at 17.

I. Patient Accountability

The increased levels of patient empowerment, decision making, and control in cybermedicine beg one question: who should be held responsible when something goes wrong. Most often, it is the physician. However, as is the fact in face-to-face interactions, patients still retain some responsibility and accountability for their decisions to seek medical advice solely on the Internet.²⁵¹ That accountability is dependent upon a duty:

“Not every casual response, not every idle word, however damaging the result, gives rise to a cause of action Liability in such cases arises only where there is a duty, if one speaks at all, to give the correct information. And that involves many considerations. There must be knowledge, or its equivalent, that the information is desired for a serious purpose; that he to whom it is given intends to rely and act upon it; that, if false or erroneous, he will because of it be injured in person or property. Finally, the relationship of the parties, arising out of contract or otherwise, must be such that in morals and good conscience the one has the right to rely upon the other for information, and the other giving the information owes a duty to give it with care.”²⁵²

One question that arises is whether cybermedicine liability will be evaluated under contract or tort principles. The answer is both, depending on the circumstances of the case. Once a contract is formed, both parties have a duty to perform in satisfaction of its terms. A contract is voidable if either party engaged in fraud in creating it.²⁵³ Therefore, if a patient seeks out a physician, fraudulently concealing his or her personal information or condition, the contract may be voidable, extinguishing the physician’s duty to perform.

Under the tort law of negligence, both contributory negligence and assumption of risk principles may be applied. In order to avoid negligence liability, a physician’s duty is “to conform to the legal standard of reasonable conduct, in light of the apparent risk.”²⁵⁴ In contributory negligence, if a patient contributes to her own harm, she may be denied recovery, because her own conduct disentitles her to maintain an action.²⁵⁵ In addition, an injured patient can be held liable if she is found to have assumed the risk, either through express or implied agreement. In order to establish this defense, three elements must be shown: (1) the patient must know that the risk is present; (2) the patient must understand the nature of the risk; and (3) the patient’s choice to incur the risk must be free and voluntary.²⁵⁶ If the danger is out of all proportion to the value

251. Deady, *supra* note 32, at 907.

252. Terry, *supra* note 57, at 358 (quoting *Int’l Prods. Co. v. Erie R.R. Co.*, 155 N.E. 662, 664 (N.Y. 1927)).

253. JOHN EDWARD MURRAY, JR., *MURRAY ON CONTRACTS* § 18, at 356 (4th ed. 2001).

254. W. PAGE KEETON, *PROSSER AND KEETON ON THE LAW OF TORTS* § 53 (5th ed. 1984).

255. *Id.* § 65, at 451-52.

256. *Id.* § 68, at 486-87.

of any benefits involved, the patient may also be charged with contributory negligence for unreasonably choosing to confront the risk.²⁵⁷ If there is a reasonably safe alternative open, the patient's choice of the dangerous option may amount to assumption of risk, negligence, or both.²⁵⁸

There are currently two contradicting schools of thought on duty of care as they pertain to assumption of risk. One suggests that doctors practicing medicine over the Internet have a greater duty of care than traditional doctors because cyberdoctors assume the risk of possible misdiagnosis by relying on information provided by their patients.²⁵⁹ The other suggests that cyberdoctors owe patients a lesser duty of care than traditional doctors by placing the assumption of risk with the patients, especially in situations where patients choose to consult only one on-line doctor or where a patient misrepresented his or her ailments or neglected to seek follow-up care.²⁶⁰

Regardless of the body of law under which it will be evaluated, when a consumer seeks online treatment from a physician, he or she will likely create for himself or herself a duty. Under either body of law, a patient could and should be held partially or wholly liable if he or she knowingly gives insufficient or false information to the consulting physician, or knowingly disobeys instructions during the course of treatment which results in the patient's own harm. According to online medicine guidelines, patients should be put on notice that physicians are relying completely on information provided to them by the patient.²⁶¹ Additionally, documentation of all communications should be maintained so that each party has sufficient evidence available for their defense.²⁶² This is especially important for physicians, as patients have no legal duty to maintain their own medical records and may have added incentive to destroy them if they are going to be held liable for their behavior.

J. Physician Liability

Cybermedicine presents unique physician liability. Not only are physicians at a greater liability risk, but they may also find their cases harder to defend. One factor contributing to the increased liability risk is the inherent difficulty in identifying symptoms and indications without a visual encounter. A second factor is lack of a prior physician-patient relationship.²⁶³ A third factor is the enhanced ability of patients who have suffered adverse results to discover possible causes that can be attributed to the provider, or "information torts."²⁶⁴

257. *Id.*

258. *Id.*

259. Ruth Ellen Smalley, Note, *Will a Lawsuit a Day Keep the Cyberdocs Away? Modern Theories of Medical Malpractice as Applied to Cybermedicine*, 7 RICH. J.L. & TECH. 29, 41 (2001).

260. *Id.* at 42.

261. Medem, *supra* note 146.

262. Spielberg, *supra* note 96, at 274.

263. Tyler, *supra* note 73, at 288.

264. Terry, *supra* note 57, at 330-31.

There are differing opinions as to what law should apply in multi-state cybermedicine cases. Some authorities have suggested that the physician should be presumed as visiting the patient in the state in which the patient resides,²⁶⁵ while others have suggested that the patient should be presumed as visiting the physician in the state in which the physician is licensed.²⁶⁶ Choice of jurisdiction has widespread implications on physicians, patients, and states. Each state has different levels of patient and liability protections. Therefore, physicians need to know their liability exposure risk so they can insure it, patients need to know where they can bring a malpractice action and what their rights to recovery are, and states need to know who they are regulating and protecting. Guidelines should specify which jurisdiction's laws apply in cases of online medicine. Until this issue is settled, the proliferation of cybermedicine may be restricted by physician choice of cyberpractice.

Cyberphysicians and states both have an interest in the establishment of guidelines. Cyberphysicians may be placing their license to practice medicine at risk. Until states adopt guidelines pertaining to online medicine, physicians cannot be assured which practices are acceptable and which ones are not. Therefore, they may be deterred from engaging in such practices until they have sufficient confidence they will not be professionally sanctioned. States should put physicians on notice as to their rights and responsibilities. By adopting policies and guidelines, states can best ensure physicians' due process rights in disciplinary proceedings.²⁶⁷

Cybermedicine guidelines will assist physicians, courts, and expert witnesses in cybermalpractice cases. The guidelines can provide cyberphysicians with legitimate defenses to medical negligence actions.²⁶⁸ Courts will consider such standards when determining liability;²⁶⁹ however, courts are not obligated to accept and apply industry²⁷⁰ or government²⁷¹ guidelines in the determination of standard of care. If the courts do accept the cybermedicine guidelines standard, the jury will decide how much weight to accord it.²⁷² If courts think the industry standard is inadequate, they may apply their own standard.²⁷³ Until the practice of cybermedicine matures, the limited industry experts may be reluctant to testify in malpractice cases. These experts may engage in a "conspiracy of silence" in an effort to limit liability and support the development of the discipline.²⁷⁴ Establishment of industry guidelines would curb disincentives or expert witnesses and reduce the problem posed by ambiguous medical practice

265. See, e.g., FSMB, MODEL ACT, *supra* note 46; see also Deady, *supra* note 32, at 904.

266. See, e.g., Tyler, *supra* note 73, at 264.

267. Silverman, *supra* note 69, at 272.

268. Smalley, *supra* note 259, at 51.

269. Caryl, *supra* note 104, at 198-99.

270. Smalley, *supra* note 259, at 53.

271. Caryl, *supra* note 104, at 198-99.

272. Smalley, *supra* note 259, at 53.

273. Caryl, *supra* note 104, at 198-99.

274. Darr & Koerner, *supra* note 41, at 23.

standards.²⁷⁵

CONCLUSION

MyDoc.com is an excellent example of the need for states to define the appropriate cybermedicine standards of care. Two separate states, each observing the exact same company operating in their state with the exact same practices, have reached opposite conclusions.²⁷⁶ Illinois has stated that MyDoc violates patient standards of care, while Indiana has not.²⁷⁷ In addition, Illinois actually rendered two separate, juxtaposed opinions under the authority of two separate Department Directors.²⁷⁸ This inconsistency is unfortunate for everyone involved. Patients have a right to know what physicians they are allowed to “visit.” Similarly, physicians have a right to know what patients they are allowed to treat and how, and they should be able to rely on that information. Finally, state medical boards should have a way to ensure consistency not only within their own state, but also among other states, in light of cybermedicine’s mobility.

Cybermedicine is an amorphous medical specialty. Although it contains the same major players and serves the same patient treatment purposes, it defies nearly all traditional medical practice conventions. Its online nature allows both physicians and patients to maintain mobility and anonymity. Additionally, because cyberphysicians cannot use all the senses and skills upon which they would rely in a face-to-face encounter, they are handicapped by the degree and reliability of patient disclosure. Traditional medical standards of care have been developed and habitualized over time. However, in cybermedicine, many traditional medical practice customs and conventions cannot be applied. While the standard of care has not changed, the means of satisfying it must. Cyberphysicians can no longer take traditional customs and norms for granted. They must modify and redefine their practices and procedures, and the industry must help them.

275. EDWARD P. RICHARDS III & KATHARINE C. RATHBUN, *LAW AND THE PHYSICIAN: A PRACTICAL GUIDE* 68-69, 76-77 (1993).

276. *See* Dorschner, *supra* note 91, at 1 (stating a third state, Florida, refused to allow MyDoc for the same reasons).

277. As recently as December 5, 2002, the Medical Licensing Board of Indiana received testimony from MyDoc.com officials; however, it has not filed any charges against the company. A copy of these minutes is available at <http://www.ai.org/hpb/boards/mlbi/> (last visited on Feb. 27, 2004). As of July 1, 2002, Indiana finally promulgated Online Prescribing Rules, which were originally presented to the Board in October 2002. The Rules were filed October 1, 2003 and became effective October 31, 2003. Final Rule, 27 Ind. Reg. 521 (Nov. 1, 2003). *See* IND. ADMIN. CODE tit. 844, 5-3-1 (2003) and IND. ADMIN. CODE tit. 844, 5-4-1 (2003). As of the date of this publication, the Board has not pursued any disciplinary action.

278. Swiatek, *Illinois*, *supra* note 2, at C01 (according to MyDoc General Manager Daniel Briggs, the Illinois Cease and Desist order was issued only after a new director took over the Department of Professional Regulation; the previous director did not feel as though MyDoc was in violation).

Numerous authorities have suggested that the new threshold for satisfying the cybermedicine standard of care should be a prior physician patient relationship or a patient examination prior to treatment and diagnosis.²⁷⁹ However, because cybermedicine is so unique, new customs must also be developed in other areas, including medical records, response time, physician identification, follow-up, prescribing, and decision-making. In addition, because the control of patient care has shifted so much to the patient, theories of patient accountability should be advanced and enforced in the cybermedicine context. While some of these issues are covered by the newly created Federation of State Medical Boards guidelines, not all of them are. Therefore, the Federation should revise its Guidelines to address these deficiencies. Those provisions which the Federation does not address should be seriously considered by states when drafting and adopting their guidelines and by courts when they begin adjudicating cybermalpractice cases.

Although all states regulate medicine independently, cybermedicine is sufficiently different to demand nationwide attention. Adoption of uniform guidelines across the United States would prevent physicians from forum-shopping,²⁸⁰ prevent patients from physician-shopping,²⁸¹ provide patients and physicians with sufficient notice as to their rights and obligations, and prevent states from rendering arbitrary and unpredictable decisions. Additionally, while compliance with guidelines likely will not bar a finding of liability by the courts,²⁸² the existence of guidelines will take the burden off of both courts and expert witnesses.²⁸³ States should continue to define their own licensure and registration requirement for doctors, including cyberdoctors. Additionally, not only should states create policies and adopt guidelines to define cybermedicine standards of care, but all states should adopt and apply the same ones. The Federation of State Medical Board guidelines are the appropriate model, with the above-suggested modifications, for states to adopt.

279. *See supra* Part IV.A.

280. *See supra* Part IV.J.

281. S.B. 1828, 1999 Reg. Sess. (Cal. 2000), cmt. 2 (“Thus, the risk exists that people will be able to obtain dangerous drugs for the asking as long as they turn to the right physician on the right web site in the right state.”).

282. *See supra* notes 269-71 and accompanying text.

283. *See supra* notes 274-75 and accompanying text.