Discordant Discipline: Implications of State-Legislated Medicine for the Regulation of Physicians

Kristin Madison*

ABSTRACT

When a state disciplines a physician who holds multiple licenses, other states may respond by imposing similar discipline. This response makes sense when states have similar views on unprofessional conduct. Information sharing about out-of-state conduct can improve discipline as a regulatory tool and help ensure that a physician cannot evade discipline. But what happens when state views are discordant? Recent legislative activity in areas such as reproductive care and gender-affirming care have set the stage for discordant discipline; physician conduct permissible in one state may be prohibited in another. If states functioned completely independently of one another, the implications of discordance would be straightforward: contested conduct in the "permissive" state would not trigger any discipline, while similar conduct in the "restrictive" state would result in discipline in that state only. In practice, however, states do not function independently of one another; their regulatory regimes take account of conduct occurring outside their borders. Should a permissive state discipline a physician who engages in prohibited conduct in a restrictive state? Should a restrictive state discipline a physician for engaging in conduct it deems unprofessional, if the conduct occurs in a permissive state? This article explores these and related questions by considering the goals of state-based regulation of physicians. Drawing on examples from state statutes, Federation of State Medical Boards guidelines, the Interstate Medical Licensure Compact, and the American Bar Association's Model Rules of Professional Conduct, it considers how

* Professor of Law and Health Sciences, Northeastern University. I thank Martha Davis, Claudia Haupt, Rachel Rebouché, Nadia Sawicki, Tara Sklar, and participants in the 2023 Health Law Professors' Conference and Northeastern Law's faculty colloquium for their insightful comments. I thank the editors of the Penn State Law Review for their assistance in editing this article. I also thank those involved in the work of the Uniform Law Commission for many conversations that have both increased my understanding of and piqued my interest in variations in state law. All errors are my own.

regulatory regimes might grapple with situations involving discordant discipline. It then evaluates potential implications of alternatives to current regulatory approaches.

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I. INTRODUCTION

Physicians have long had considerable discretion in determining how best to treat their patients. Historically, neither state legislatures nor state medical boards have had much to say about how health care should be delivered. In recent years, however, state legislatures have emerged as an important force in the medical world. State legislators have expanded their roles with respect to the delivery of medical care, limiting or prohibiting certain types of care, such as conversion therapy, abortion services, and

care for transgender youth. In some cases, these newly enacted laws may operate through the actions of state professional boards. For example, a law that expressly classifies a particular type of care as unprofessional conduct could subject a physician who provides that care to professional discipline by the state medical board.

Differing state laws result in discordant regulatory regimes. While physicians who practice in multiple states have become accustomed to navigating different regulatory structures, the differences produced by recent legislation have been particularly stark. Discordance has become more common and more pronounced. Moreover, given the post-pandemic growth in telemedicine, more physicians may find themselves practicing across state lines, amplifying the potential impact of discordant state rules.

Does discordance matter? Because a physician is required to adhere to the rules of the state where a patient is located,[1] regardless of the physician's state of residence, primary practice location, or physical location, differences in rules increase the need for physician education as to state requirements. The costs associated with the need for education can serve as a barrier to cross-state practice, which in turn may prevent patients from realizing the full potential benefits of telehealth. But the potential impact of discordance could be even broader. In determining whether to issue a license or to impose discipline, states' scrutiny of physicians' conduct is not limited to conduct that occurs within the licensing state. States can and do take disciplinary action against physicians' licenses based on activities occurring within other states.[2] Cross-state discipline raises the stakes of regulatory compliance.

When state regulatory regimes mirror one another, physicians can expect that sanctionable conduct could subject them to sanction, regardless of where they are licensed. But when professional regulatory regimes are discordant, questions arise. For example, Massachusetts's shield law, adopted in response to one type of discordance, legally protects reproductive health care and gender-affirming health care, even if delivered to patients located out of state.[3] In this example, a permissive state is declining to sanction its licensed provider, even if the provider's conduct is sanctionable or actually sanctioned in a more restrictive state. But what would happen if the shield law had not been adopted? Furthermore, what would happen if a provider holding a license in a restrictive state provides care that the restrictive state has deemed

1. *See infra* Section II.A (discussing norm that care is deemed to occur in the state where the patient is located).

2. *See infra* Part III (discussing states' statutory provisions authorizing discipline on the basis of conduct and discipline occurring within another state).

3. *See infra* Section IV.B (discussing shield statutes).

unprofessional, but has done so only for patients located in a permissive state? What *should* happen in each of these cases?

What the law allows or requires with respect to professional sanctions turns in part on how each state statute defines sanctionable conduct. It may also turn on the specifics of interstate compacts, which establish agreements regarding the management of disciplinary action. But normatively, sanctions should depend on the goals that professional regulation is intended to achieve. They should also depend on views about the potential extraterritorial impact of discordant professional regulation.

To explore the impact of discordant discipline, this Article examines the roles of medical boards in regulating physicians, analyzes reasons for and consequences of cross-state discipline, and suggests potential implications of alternative approaches to physician regulation. Part II of this Article examines the goals of state-based licensure systems, discusses features state licensure systems share, and explores how they differ. Part III analyzes the implications of the practice of disciplining physicians based on events occurring in other states. This Part uses examples drawn from states and the Interstate Medical Licensure Compact ("IMLC") to illustrate how cross-state discipline might impact physicians. Part III then offers reasons why a state might choose to make use of cross-state discipline, but highlights the challenges and tradeoffs states may face when discipline becomes discordant due to differences in state laws. Part IV evaluates potential implications of measures intended to alleviate or otherwise address disciplinary discordance. Part V concludes that as state-legislated medicine becomes more prevalent, out-of-state conduct may become less relevant for processes intended to serve patients within a state. Disciplinary discordance will pressure states to reexamine their goals in licensing and disciplining medical professionals, and in some cases, regulatory regimes may need to be more carefully applied, amended, or clarified.

II. STATE-BASED PHYSICIAN REGULATION

In the 1889 case *Dent v. West Virginia*,[4] the Supreme Court rejected a constitutional challenge to West Virginia's recently adopted licensure law.[5] In doing so, the Court considered the justification for state regulation of physicians. Justice Stephen Field explained that "[t]he power of the state to provide for the general welfare of its people authorizes it to prescribe all such regulations as in its judgment will secure or tend to secure them against the consequences of ignorance and incapacity, as well

4. Dent v. West Virginia, 129 U.S. 114 (1889).
5. *See id.*

as of deception and fraud."[6] Justice Field highlighted the public's reliance on licensure, emphasizing that medicine must "deal with all those subtle and mysterious influences upon which health and life depend," and that "comparatively few can judge of the qualification of learning and skill which [the physician] possesses."[7] The opinion concluded by stating that "[t]he law of West Virginia was intended to secure such skill and learning in the profession of medicine that the community might trust with confidence those receiving a license under authority of the state."[8] *Dent* made clear that each state has constitutional authority to establish licensure regimes to provide for the general welfare of "its people,"[9] because of the need to guard against the effects of ignorance and fraud.

Subsequent Supreme Court opinions have similarly recognized states' authority to regulate professionals providing care within their borders. More than 60 years after *Dent*, in *Barsky v. Board of Regents,* the Supreme Court opined that:

> It is elemental that a state has broad power to establish and enforce standards of conduct within its borders relative to the health of everyone there. It is a vital part of a state's police power. The state's discretion in that field extends naturally to the regulation of all professions concerned with health.[10]

More than 80 years later, in *Goldfarb v. Virginia State Bar*, the Supreme Court again recognized states' broad authority to regulate within their borders, commenting that "[t]he States have a compelling interest in the practice of professions within their boundaries, and . . . as part of their power to protect the public health, safety, and other valid interests, they have broad power to establish standards for licensing practitioners and regulating the practice of professions."[11]

In short, states' constitutional authority to regulate the medical profession arises from their powers to protect the health of those within their borders. States use that authority to create regulatory regimes that establish licensure requirements and standards governing the conduct of medical professionals. Section II.A of this Article explains that in doing so, states have embraced broadly similar objectives. Therefore, it is not surprising that many state regulatory regimes share common features. Section II.B describes these common elements, tracing their evolution from the mid-twentieth century until today. Section II.C shows that regulatory regimes nevertheless differ in some ways. Section II.D

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6. *Id.* at 122.
7. *Id.*
8. *Id.* at 128.
9. *Id.*
10. Barsky v. Bd. of Regents of Univ., 347 U.S. 442, 449 (1954).
11. Goldfarb v. Va. State Bar, 421 U.S. 773, 792 (1975).

examines one of the most significant drivers of disciplinary discordance in modern regulatory regimes: legislated medicine, which occurs when state legislatures adopt statutes imposing specific mandates or restrictions with respect to the provision of medical care.

A. Protection of Patients Within a State's Borders

The Supreme Court's views of professional licensure are reflected in medical practice acts across the country. The Federation of State Medical Boards ("FSMB"), which has supported medical boards since 1912,[12] articulates the purposes of physician regulation in its *Guidelines for the Structure and Function of a State Medical and Osteopathic Board* ("Guidelines").[13] The 2024 version of FSMB's Guidelines advises that a "medical practice act should be introduced by a statement specifying the purpose of the act," and suggests that relevant concepts include "public health, safety, and welfare," "protect[ing] the public from any unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine," and "protecting the public through licensing, regulation and education."[14] State statutes often echo these ideas. For example, Minnesota's medical practice act states that "[t]he primary responsibility and obligation of the Board of Medical Practice is to protect the public" and that the state's licensing laws are provided "[i]n the interest of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, and unlawful practice of medicine."[15] Oregon's medical practice act describes granting a license and regulating its use as "necessary in the interests of the health, safety and welfare of the people of this state . . . to the end that the public is protected from the practice of medicine by unauthorized or unqualified persons and from unprofessional conduct by persons licensed to practice . . . ."[16] Other statements are more succinct; North Carolina's medical practice act indicates that its medical board's purpose is "to regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina."[17]

These statements focus on benefits to the public. But state descriptions of policy goals tend not to be precise in identifying the populations they target. In the context of a state policy goal, for example,

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12. *History*, FED'N OF STATE MED. BDS., https://perma.cc/7CG8-FHW9 (last visited Feb. 12, 2024).

13. *See generally* FED'N OF STATE MED. BDS., GUIDELINES FOR THE STRUCTURE AND FUNCTION OF A STATE MEDICAL AND OSTEOPATHIC BOARD (2024), https://perma.cc/5L56-TPCD.

14. *Id.* at 8.

15. MINN. STAT. § 147.001 (2022).

16. OR. REV. STAT. § 677.015 (2023).

17. N.C. GEN. STAT. § 90-2(a) (2022).

the term *public* could conceivably refer to the residents of a state, or, alternatively, to those individuals physically located within state borders. In the context of health care delivery regulation, the prevailing approach has focused on individuals' physical location. States have long agreed that when care processes extend across state lines, such care is deemed to occur at the patient's location.[18] Under this logic, if a state regulates the care provided by licensed medical professionals to protect the public, its regulatory focus should be on the activities of medical professionals that affect care delivered to patients physically located in the state. FSMB's Guidelines reflects this view; it states that "[t]he practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient."[19] The Interstate Medical Licensure Compact, the language of which is reflected in the majority of state statutes, "affirms that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located."[20] If care is deemed to occur where the patient is located, then physicians are subject to the medical practice act and its associated regulations in the state where the patient is located, and are potentially subject to disciplinary action by that state's medical board.[21]

18. *See* Carl F. Ameringer, *State-Based Licensure of Telemedicine: The Need for Uniformity but Not a National Scheme*, 14 J. HEALTH CARE L. & POL'Y 55, 58 (2011) (noting that consensus had emerged among state boards that the practice of medicine occurred at the patient's location, "notwithstanding the physician's location in another state"); *see also* Ctr. for Telemedicine L., *Telemedicine and Interstate Licensure: Findings and Recommendations of the CTL Licensure Task Force*, 73 N.D. L. REV. 109, 110, 119 (1997) (noting that states adopting legislation addressing interstate practice had required out-of-state physicians to obtain a license to treat patients located in the state). The District of Columbia makes the location-of-the-patient rule explicit, by noting that with certain exceptions, "[i]n order to practice telemedicine for a patient located within the District of Columbia, a license to practice medicine in the District of Columbia is required," while "[f]or any services rendered outside the District of Columbia, the provider of the services shall meet any license requirement of the jurisdiction in which the patient is physically located." D.C. Mun. Regs. tit. 17, § 4618.1 (2024).

19. FED'N OF STATE MED. BDS., *supra* note 13, at 7; *cf.* Katherine Florey, Dobbs *and the Civil Dimension of Extraterritorial Abortion Regulation*, 98 N.Y.U. L. REV. 485, 499 (2023) (noting that "courts applying state conflicts principles in malpractice cases typically find that the law of the place of treatment applies," but that "they do not do so universally").

20. *See*, *e.g.*, FLA. STAT. § 456.4501 (2024) ("Interstate Medical Licensure Compact"); NEB. REV. STAT. § 38-3602 (2024) ("Purposes of Interstate Medical Licensure Compact"); NEV. REV. STAT. § 629A.100 (2024) ("Text of Compact"); WIS. STAT. § 448.980 (2024) ("Interstate medical licensure compact"); *see also infra* Section IV.C (describing the IMLC).

21. *See* Eric M. Fish, Shiri A. Hickman & Humayun J. Chaudhry, *State Licensure Regulations Evolve to Meet Demands of Modern Medical Practice*, SCITECH LAW., Spring 2014, at 18, 20 (discussing relevance of patient location).

B. Commonalities in Physician Regulation

Unless an exception applies, physicians seeking to provide care to a patient physically located within a state will need to seek licensure within the state. Prospective licensees considering applications in multiple states will encounter broadly similar regulatory structures. State medical practice acts typically define the practice of medicine, specify the composition of the state medical board, and grant medical boards or state agencies responsible for regulating professionals the power to enact regulations effectuating the purposes of the act.[22] The acts explain the licensure requirements, which are often quite similar from state to state. All states require United States medical graduates to hold a MD or DO degree; all require at least one year of postgraduate training; all require candidates to complete either the United States Medical Licensing Exam or the Comprehensive Osteopathic Medical Licensing Examination; and "[a]ll state medical boards are concerned with the physical, mental, and moral fitness of prospective licensure candidates."[23] Medical practice acts articulate requirements for those already holding licenses elsewhere and for those seeking special forms of licensure, and describe exemptions to licensure requirements.[24] They also describe the consequences for those who practice medicine without appropriate authorization.[25]

In addition to describing the requirements for licensure, medical practice acts impose requirements on licensed physicians, such as the completion of continuing medical education.[26] They also identify conduct

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22. *See, e.g.*, UTAH CODE ANN. § 58-1-202 (West 2023) (describing as a duty of a professional board "recommending to the director appropriate rules and statutory changes to improve the health, safety, and financial welfare of the public . . . ."); *id.* § 58-1-106 (describing as a duty of the Division of Professional Licensing "prescribing, adopting, and enforcing rules to administer this title"); *see also* 63 PA. STAT. AND CONS. STAT. ANN. § 422.8 (West 2023) (granting Pennsylvania medical board power to adopt regulations); *cf.* Rebecca Haw Allensworth, *Foxes at the Henhouse: Occupational Licensing Boards Up Close*, 105 CAL. L. REV. 1567, 1572 (2017) (finding that majority of occupational licensing boards have rulemaking authority).

23. *About Physician Licensure*, FED'N OF STATE MED. BDS., https://perma.cc/D7BY-G8JK (last visited Sept. 1, 2024).

24. *See, e.g.*, UTAH CODE ANN. § 58-67-102(19)(a) (West 2023) (defining practice of medicine); *id.* § 58-67-201 (describing board); *id.* § 58-67-302(1) (listing requirements for licensure); *id.* § 58-67-302(2) (describing requirements for applicants currently licensed elsewhere); *id.* § 58-67-305 (describing exemptions from licensure requirements, such as an exemption for emergency care).

25. *See, e.g.*, *id.* § 58-1-501 (defining unlawful conduct to include practicing in professions requiring licensure, without a license or an applicable exemption); *id.* § 58-67-503 (stating that any person who violates § 58-1-501 is guilty of a third-degree felony and indicating that unlawful conduct may be punished by administrative penalties or other appropriate administrative action).

26. *See, e.g.*, *id.* § 58-67-304 (requiring continuing professional education in accordance with "division rules made in collaboration with the board" as a condition of license renewal).

that would constitute grounds for discipline. Medical boards have the authority to suspend and revoke licenses in response to physician misconduct, and to take other forms of disciplinary action.[27]

The grounds for discipline identified in medical practice acts have expanded over time and have changed in character. An American Medical Association ("AMA") committee found that in 1953, nine grounds for discipline existed in medical practice acts in 30 states, including "drug addiction, unprofessional conduct, fraud in connection with examination or obtaining a license, alcoholism, advertising, illegal abortions, conviction of an offense involving moral turpitude, and mental incompetence."[28] Robert Derbyshire, FSMB president in 1965-66,[29] authored a report that identified 938 licensure actions nationwide from 1963 to 1967; nearly half involved narcotics and other actions were based on mental incompetence, fraud, felony convictions, abortions, unprofessional conduct, alcoholism, and moral turpitude.[30] The FSMB's 1970 predecessor to Guidelines suggested that "[t]o promote more endorsement and reciprocity" with respect to state licenses, "mutual understanding on the grounds for suspension and revocation of licenses is necessary," and recommended 13 such grounds.[31] The list included several grounds related to fraud, such as "dishonorable, unethical or unprofessional conduct likely to . . . harm the public," as well as grounds related to fitness to practice.[32] It also included "commission or conviction of a felony."[33] Another ground was "unethical or unprofessional" advertising.[34] Grounds arising out of a physician's practice of medicine included "prescribing . . . a narcotic, addicting or dangerous drug to a habitue or addict," "[v]iolating . . . any provision or terms of a medical practice act," and "willful violation of privileged communication."[35] Typical grounds for discipline did not include incompetence until the mid-

27. *See, e.g.*, *id.* § 58-1-502 (describing penalties for unlawful and unprofessional conduct).

28. CARL F. AMERINGER, STATE MEDICAL BOARDS AND THE POLITICS OF PUBLIC PROTECTION 33–34 (1999).

29. *Past Chairs*, FED'N OF STATE MED. BDS., https://perma.cc/3UV6-B5F5 (last visited July 19, 2023).

30. *See* DAVID A. JOHNSON & HUMAYUN J. CHAUDHRY, MEDICAL LICENSING AND DISCIPLINE IN AMERICA: A HISTORY OF THE FEDERATION OF STATE MEDICAL BOARDS 166 (2012).

31. FED'N OF STATE MED. BDS., A GUIDE TO THE ESSENTIALS OF A MODERN MEDICAL PRACTICE ACT 9–10 (1970, Rev. Ed.).

32. *Id.*

33. *Id.* at 9.

34. *Id.* at 10.

35. *Id.* at 9–10.

1960s;[36] between 1963 and 1967, there were seven reported cases related to incompetence, but between 1986 and 1996, there were 1,677.[37]

Physician disciplinary processes have continued to evolve. In 2023, 3,016 physicians were disciplined by medical and osteopathic boards, and sanctions included license suspensions and revocations, restrictions on practice, conditions, reprimands, fines, and continuing education requirements.[38] In contrast to the 13 grounds for license suspension or revocation included in the 1970 publication, FSMB's 2024 Guidelines lays out a list of 58 types of "unprofessional or dishonorable conduct" warranting discipline.[39] Categories that emerged between 1970 and 2024 include those related to disruptive behavior, sexual misconduct, and experimental treatments. Much of the increased length and complexity of the 2024 list, however, arises from increased specificity and additional examples aligned with previously recognized categories of conduct. FSMB's suggested approach to criminal convictions has grown more nuanced. The 1970 recommended ground for discipline was "[t]he commission or conviction of a felony," while the 2024 ground is described in part as:

> The commission or conviction . . . of: a. A misdemeanor related to the practice of medicine and any crime involving moral turpitude; or b. A felony related to the practice of medicine. The Board shall take disciplinary action against a practitioner's license following conviction of a felony as outlined in the medical practice act.[40]

While advertising has been removed from FSMB's list of grounds for discipline, grounds related to fraud continue to feature prominently, with more than ten items now related to fraud or false or deceptive statements.[41] Grounds related to drugs, reporting requirement compliance, and other compliance mandates have also expanded substantially.[42] Perhaps the largest growth area relative to the 1970 list, however, is discipline relating to substandard medical treatment. Disciplinary grounds now include "[p]rofessional incompetency as one or more instances involving failure

36. *See* AMERINGER, *supra* note 28, at 21.
37. *See id.* at 6.
38. *See Physician Discipline in 2023*, FED'N OF STATE MED. BDS. (last visited July 23, 2024), https://perma.cc/XT2C-PMVM.
39. FED'N OF STATE MED. BDS., *supra* note 13, at 33–36.
40. *See* FED'N OF STATE MED. BDS., *supra* note 31, at 9 (1970 version); FED'N OF STATE MED. BDS., *supra* note 13, at 33 (2024 version). These grounds have narrowed since the 2015 version of *Essentials*. The 2015 guidelines categorized as potential grounds for discipline misdemeanors or felonies "whether or not related to the practice of medicine." FED'N OF STATE MED. BDS., ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT 18 (2015), https://perma.cc/WST2-D3NQ.
41. *See* FED'N OF STATE MED. BDS., *supra* note 13, at 33–36.
42. *See id.*

to adhere to the applicable standard of care to a degree which constitutes negligence, as determined by the Board"; "[f]ailure to follow generally accepted infection control procedures"; "[f]ailure to offer appropriate procedures/studies"; "[p]roviding treatment . . . recommendations . . . unless the physician has obtained a history and physical evaluation . . . adequate to establish diagnosis and identify underlying conditions and/or contraindications"; "[f]ailing to obtain adequate patient informed consent"; "[c]onduct which violates patient trust"; and "[a]ny conduct that may be harmful to the patient or the public."[43]

States need not adhere to FSMB's recommendations in defining grounds for discipline, but they often follow a similar path. For example, New Hampshire authorizes discipline for a licensed physician upon a finding that the physician "[h]as displayed medical practice which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine or any particular aspect or specialty thereof," "[h]as engaged in dishonest or unprofessional conduct or has been grossly or repeatedly negligent," or "[h]as been convicted of a felony under the laws of the United States or any state."[44] In New Mexico, "unprofessional or dishonorable conduct" includes "conduct likely to deceive, defraud[,] or harm the public" and "repeated similar negligent acts or a pattern of conduct otherwise described in this section or in violation of a board rule." It also includes "conviction of an offense punishable by incarceration in a state penitentiary or federal prison or conviction of a misdemeanor associated with the practice of the license."[45] Iowa administrative code indicates that grounds for discipline include "willful or gross negligence," "willful or repeated departure from or the failure to conform to the minimal standard of acceptable and prevailing practice of medicine and surgery or osteopathic medicine and surgery in the state of Iowa," and a felony criminal conviction.[46]

The broad alignment across states with respect to grounds for physician discipline is unsurprising, given states' similar concerns about care delivered within their borders. States hope to protect patients by ensuring integrity and competence, which are the foundation for providing appropriate care. While the prevalence of diseases, conditions, or injuries may vary across states, the need for appropriate care is universal.

Moreover, the definition of what constitutes appropriate care has become increasingly national in scope. With respect to ethics and integrity, some states already explicitly reference national standards, such as the

43. *Id.*
44. N.H. REV. STAT. ANN. § 329:17(VI) (2023).
45. N.M. STAT. ANN. § 61-6-15(D) (West 2023).
46. *See* IOWA ADMIN. CODE R. 653-23.1 (2021).

AMA's code of ethics.[47] The same forces that courts have identified as grounds for recognizing a national rather than local standard of care in a tort case, such as consistency in medical education and training, physician mobility, national access to journals and seminars, national certification of specialists, and similarities in patient biology, may also push states nationwide to share similar expectations regarding physician conduct.[48] As the grounds for discipline have expanded beyond questions related to integrity and basic capacity to encompass substandard delivery of care, national influences on standards of care have become increasingly important.[49]

C. Variation in Physician Regulation

Increasingly national standards of care have not yet resulted in full alignment of regulatory regimes. The same 1953 AMA study that identified nine disciplinary grounds common across 30 states also found more than 80 other disciplinary grounds that were not common across states.[50] The potential reasons for variation are many. Health conditions and patterns of health care delivery vary geographically,[51] potentially causing differences in issues deemed regulatory priorities across states. Personal experiences or local media coverage may motivate legislators or regulators to address particular areas of concern. When new health problems, technologies, treatments, or patterns of health care delivery

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47. *See, e.g.*, OHIO REV. CODE ANN. § 4731.22 (West 2023) (including among its grounds for discipline "violation of any provision of a code of ethics of the American medical association, the American osteopathic association, the American podiatric medical association, or any other national professional organizations that the board specifies by rule").

48. *See* Hall v. Hilbun, 466 So.2d 856, 870–71 (Miss. 1985) (highlighting these factors when abandoning the locality rule and recognizing a competence-based national standard of care in a medical malpractice case).

49. One source of national influence on the practice of medicine has been medical specialty boards. As of 2022, more than 975,000 individuals held board certifications in specialties approved by the American Board of Medical Specialties. *See* AM. BD. OF MED. SPECIALTIES, ABMS BOARD CERTIFICATION REPORT 2021–2022 3 (2023), https://perma.cc/LQ5P-MAXN.

50. *See* AMERINGER, *supra* note 28, at 34.

51. *See, e.g.*, DARTMOUTH INST. FOR HEALTH POL'Y & CLINICAL PRAC., THE DARTMOUTH ATLAS OF HEALTH CARE: 2018 DATA UPDATE 18 (Aug 18, 2021), https://perma.cc/EJ6V-FP4T (concluding that "the influence of place in health and healthcare has only become more important"); *U.S. State Opioid Dispensing Rates*, *2013*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://perma.cc/26RC-RFGS (last visited July 24, 2023) (showing significant geographic variation in opioid dispensing rates in 2013); *SUDORS Dashboard: Fatal Overdose Data*, U.S. CTRS. FOR DISEASE CONTROL & PREVENTION, https://perma.cc/5C9H-USXG (last visited July 24, 2023) (showing variation in rate of prescription opioid-related deaths by state in 2021); S. Michaela Rikard et al., *Chronic Pain Among Adults – United States, 2019-2021*, 72 MORBIDITY AND MORTALITY WEEKLY REPORT 379, 381–84 (2023), https://perma.cc/G88M-DKG2 (documenting regional variation in chronic pain).

emerge, the ideal regulatory path forward may be unclear; as a result, some states may act quickly, adopting varying approaches, while other states might not act at all.

These forces and others have resulted in grounds for physician discipline that vary across states both in form and substance.[52] For example, New Hampshire authorizes its board to take disciplinary action against a licensed physician on 12 grounds, including that the physician "[h]as failed to provide adequate safeguards in regard to aseptic techniques or radiation techniques,"[53] while Vermont's list of 39 types of unprofessional conduct does not include any conduct related to infection prevention.[54]

However, state medical boards may largely agree about what constitutes unprofessional conduct, even when their lists differ. While Vermont's list does not reference aseptic techniques, it does define unprofessional conduct to include "failure to use and exercise on repeated occasions, that degree of care, skill, and proficiency that is commonly exercised by the ordinary . . . physician."[55] In addition, under Vermont law, "[t]he Board may also find that failure to practice competently by reason of any cause on a single occasion or on multiple occasions constitutes unprofessional conduct."[56] As a result, while New Hampshire's aseptic techniques ground for discipline has no counterpart in Vermont's statute, the conduct that is the basis for discipline in New Hampshire might also merit discipline under Vermont law. Similarly, Vermont defines unprofessional conduct to include "disruptive behavior that involves interaction with physicians, hospital personnel, office staff, patients, or support persons of the patient or others that interferes with patient care."[57] By contrast, New Hampshire states that physicians can be disciplined if they have "engaged in . . . unprofessional conduct"[58] or have engaged in "medical practice which is incompatible with the basic knowledge and competence expected of persons licensed to practice medicine."[59] A Massachusetts statute listing grounds for discipline does not reference disruptive behavior,[60] but the Massachusetts Board of Registration in Medicine has adopted a policy that states that "[p]hysicians must recognize that disruptive behavior, if it directly impacts patient care or

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52. *See* Ameringer, *supra* note 18, at 79 ("The grounds for disciplinary action vary widely from state to state.").
53. N.H. REV. STAT. ANN. § 329:17(VI)(f) (2023).
54. *See* VT. STAT. ANN. tit. 26, § 1354(a) (West 2023).
55. *Id.* § 1354(a)(22).
56. *Id.* § 1354(b).
57. *Id.* § 1354(a)(35).
58. N.H. REV. STAT. ANN. § 329:17(VI)(d) (2023).
59. *Id.* § 329:17(VI)(c).
60. *See* MASS. GEN. LAWS ch. 112, § 5 (2023) (listing grounds for discipline).

safety, may reach a threshold for discipline."[61] In short, states may take different approaches to defining grounds for discipline but nevertheless make similar decisions as to whether particular conduct merits discipline. Narrowly defined grounds for discipline in some states may map onto more broadly defined categories in other states.

The potential for mapping, however, may not always be clear. For example, West Virginia authorizes discipline for "[c]onspiring with any other person to commit an act or committing an act that would tend to coerce, intimidate, or preclude another physician or podiatrist from lawfully advertising his or her services."[62] This conduct does not directly impact patient care, so it would likely not be captured within other states' health care delivery-focused categories of unprofessional conduct, although it might fall within more broadly defined categories of unprofessional conduct. In Florida, "[i]mplanting a patient . . . with a human embryo created with the human reproductive material . . . of the licensee"[63] is grounds for discipline, but it is unclear the extent to which this conduct would be captured in other states' more general categories.

Substantive variation in medical practice acts may also arise from differing approaches to implementation. For example, most states now have decided that it is important for physicians to engage in continuing medical education ("CME") and have adopted regulations requiring them to do so.[64] However, differences in regulations could mean that a physician holding licenses in two states complies with one state's requirements, but not the other's.[65] For example, one state might require 25 hours of CME per year, while another requires 50 hours every two years, or 150 hours every three years. States might require education for certain topics, such as opioid prescribing, medical errors, cultural competency, or sexual harassment. Some states might impose requirements that education be provided through an accredited program.

Another area of regulatory variation relates to health care delivery. As state medical boards have expanded their focus beyond ethical issues and basic competence to include the delivery of care, they have adopted guidelines and regulations in a number of areas.[66] Massachusetts's regulations regarding the practice of medicine, for example, include a provision that describes the steps that a licensee must take to prescribe

61. BD. OF REGISTRATION IN MED., COMMONWEALTH OF MASS., POLICY 01-01, DISRUPTIVE PHYSICIAN BEHAVIOR (2001).

62. W. VA. CODE § 30-3-14 (2023).

63. FLA. STAT. § 458.331 (2022).

64. *See Continuing Medical Education: Board-by-Board Overview*, FED'N OF STATE MED. BDS. (June 2024), https://perma.cc/3G42-TTRY (describing CME requirements).

65. *See id.*

66. *See* Ameringer, *supra* note 18, at 74 (noting that medical boards issue guidelines in many areas).

hydrocodone-only extended release medication.[67] Georgia regulates physician administration of sedation in office-based surgeries.[68] Oregon requires licensed physicians to provide written notice of risks associated with prescribing controlled substances for the treatment of intractable pain.[69] These statutes and regulations vary in their level of detail and the extent to which they require changes in a physician's practices within the state. In some cases, regulations may merely clarify a board's expectations of adherence to prevailing practices, such that most physicians already are in compliance. Moreover, to the extent that regulations are consistent with emerging national standards of care, physicians may alter their care to comply with a single state's newly adopted regulations, and extend that same approach to other states that regulate similarly, or not at all.

It is certainly possible, however, that state statutes or regulations might require a significant change to a licensed physician's delivery of care within a state or lead a physician to alter the care provided in one state, but not another. Any time that a state chooses to adopt a new ground for discipline or impose a new regulation on a licensed professional, it has the potential to cause geographical divergence in the practice of medicine. Recent state legislative activity has highlighted the potential for discordant regulatory regimes.[70]

D. Legislated Medicine as a Driver of Discordance

The modern history of professional regulation has been characterized by increasing uniformity. The activities of national organizations such as the AMA, FSMB, and the Association of American Medical Colleges have promoted greater alignment across states in both licensure requirements and grounds for physician discipline. State medical boards may look to national organizations as a source of standards or for guidance in formulating rules.[71] As the previous Section explains, while variation in state statutes and regulations persists, state regulatory approaches are broadly similar.

Recently, however, state legislatures have become increasingly active in regulating the practice of medicine by statute, particularly in areas characterized by societal disagreement. As this Section illustrates,

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67. *See* 243 MASS. CODE REGS. 2.07(25) (2023).

68. *See* GA. CODE ANN. § 43-34-47 (2023); *see also* GA. COMP. R. & REGS. 360-41 (2023).

69. *See* OR. ADMIN. R. 847-015-0030 (2023).

70. *See* Melissa Suran, *As Laws Restricting Health Care Surge, Some Physicians Choose Between Flight or Flight*, 329 JAMA 1899, 1899 (2023) (describing recent state statutes restricting physicians' provision of health care).

71. *See, e.g.*, OHIO REV. CODE ANN. § 4731.22 (West 2023) (example from Ohio); *see also* IOWA ADMIN CODE r. 653-13.20 (2023) (requiring the board to use AMA's Code of Ethics as guiding principles in practice of medicine and surgery).

frequent areas of legislative intervention have included conversion therapy, gender-affirming care, COVID-related treatment, and abortion. In some cases, legislation specifically targets licensed practitioners, potentially adding to the list of conduct classified as grounds for professional discipline. In other cases, legislation takes the form of a criminal prohibition on activities, including those typically undertaken by licensed physicians. Because medical practice acts typically define illegal activity as grounds for discipline, such criminal prohibitions could also result in professional sanctions.

More than 20 states now prohibit the provision of conversion therapy to minors.[72] These bans typically prohibit certain categories of licensed practitioners (such as physicians, psychologists, counselors, social workers, or mental health practitioners) from engaging in conversion therapy with a person under 18 years of age, and classify such therapy as unprofessional conduct that is grounds for disciplinary action.[73] Many statutes use definitions of conversion therapy that resemble Virginia's: "any practice or treatment that seeks to change an individual's sexual orientation or gender identity, including efforts to change behaviors or gender expressions or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same gender."[74] The conversion therapy ban is an example of a form of legislated medicine that is aligned with positions taken by leading medical organizations, including the AMA, the American Psychiatric Association, the American College of Physicians, and the American Academy of Pediatrics.[75] Nevertheless, many states remain silent on whether conversion therapy constitutes unprofessional conduct,[76] and proposed bans have faced political opposition.[77] As a result, physicians may be able to engage in conversion therapy without sanction in some states, while in others, the same conduct could lead to professional discipline.

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72. *See Conversion "Therapy" Laws*, MOVEMENT ADVANCEMENT PROJECT, https://perma.cc/9M5C-FHQ9 (last visited July 20, 2024).

73. *See, e.g.*, VA. CODE ANN. § 54.1-2409.5 (2023); MD. CODE ANN., HEALTH OCC. § 1-212.1 (West 2023); N.M. STAT. ANN. § 61-1-3.3 (2023).

74. VA. CODE ANN. § 54.1-2409.5 (2023). This definition is nearly identical to sample legislation drafted in 2015 by the Human Rights Campaign and the National Center for Lesbian Rights. *See* Alison Gill & Samantha Ames, *Sample Legislation to Protect Youth from Conversion Therapy*, NAT'L CTR. FOR LESBIAN RTS. (2015), https://perma.cc/B3K2-NC4M.

75. *See Sexual Orientation and Gender Identity Change Efforts (So-Called "Conversion Therapy")*, AM. MED. ASS'N & GLMA, https://perma.cc/MEW9-69PU (last visited July 22, 2024).

76. *See Conversion "Therapy" Laws*, *supra* note 72 (describing legislative activity).

77. *See, e.g.*, Harm Venhuizen, *Wisconsin Republicans Block Ban on 'Conversion Therapy,'* PBS (Jan. 12, 2023), https://perma.cc/73E3-BD52.

Gender-affirming care for minors is another form of treatment that may subject physicians to discordant disciplinary regimes. The AMA has criticized "state legislation that would prohibit medically necessary gender transition-related care for minors" because it "represents a dangerous intrusion into the practice of medicine."[78] Nevertheless, more than 15 states have enacted legislation targeting medication and/or surgical care for transgender youth, and similar bills continue to be proposed in state legislatures.[79] Georgia amended its laws to prohibit sex reassignment surgeries and hormone replacement therapies for the treatment of gender dysphoria in minors, providing that "[a] licensed physician who violates this Code section shall be held administratively accountable to the board for such violation."[80] Iowa prohibits health care professionals from engaging in practices such as prescribing certain drugs or performing certain surgeries "for the purpose of attempting to alter the appearance of, or affirm the minor's perception of, the minor's gender or sex, if that appearance or perception is inconsistent with the minor's sex" and states that a violation of this prohibition is unprofessional conduct.[81] Not all activity in this area has been driven by legislation; in Florida, for example, the medical board, acting pursuant to its rulemaking authority to define practice standards, prohibited sex reassignment surgeries and puberty blocking therapies to treat gender dysphoria in minors.[82] However, the majority of bans have been initiated by legislators, not members of professional boards.[83]

Other states have remained silent with respect to gender-affirming care, which means that providing such care would be permissible, as long as it does not run afoul of general prohibitions against substandard medical care. In other words, gender-affirming care that meets the standard of care would not be grounds for discipline within these states. At least 14 states have gone further by enacting legislation that supports the continued provision of gender-affirming care, such as by providing that access to gender-affirming health care services is a legal right.[84] These shield laws will be discussed further in Section IV.B.

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78. Press Release, Am. Med. Ass'n, AMA to States: Stop Interfering in Health Care of Transgender Children (Apr. 26, 2021), https://perma.cc/2657-LXRA.

79. *See Bans on Best Practice Medical Care for Transgender Youth*, MOVEMENT ADVANCEMENT PROJECT, https://perma.cc/U5Y7-LQ23 (last visited July 22, 2024).

80. GA. CODE ANN. § 43-34-15 (2023).

81. IOWA CODE § 147.164 (2023).

82. *See* FLA. ADMIN. CODE ANN. r. 64B8-9.019 (2023).

83. *See Bans on Best Practice Medical Care for Transgender Youth*, *supra* note 79.

84. *See Transgender Healthcare "Shield" Laws*, MOVEMENT ADVANCEMENT PROJECT, https://perma.cc/N8QZ-R4CT (last visited July 22, 2024) (identifying states with shield laws); *see also* VT. STAT. ANN. tit. 12, § 7302(a) (2023) (stating that "[a]ccess to reproductive health care services and gender-affirming health care services is a legal right in this state.").

Legislated medicine could also generate discordance with respect to treatment for COVID-19. Early in the pandemic, some studies suggested the potential effectiveness of the inexpensive drug ivermectin in treating COVID-19, and physicians began to prescribe it; these studies had limitations, however, and later clinical trials suggested that the drug was ineffective.[85] By 2021, medical organizations such as the AMA and the American Pharmacists Association made strong statements opposing the prescribing of ivermectin for COVID-19 outside of a clinical trial context.[86] In December 2021, the U.S. Food and Drug Administration sent a letter to FSMB noting that while clinical trials involving ivermectin remained ongoing, "currently available data do not show that ivermectin is safe or effective for the prevention or treatment of COVID-19."[87] These statements raise the question of whether continued prescription of ivermectin for COVID-19 could be viewed by a medical board as negligent practice, unprofessional conduct, or some other type of action warranting professional discipline.[88] Given the early confusion surrounding ivermectin, and the lawfulness of prescribing it for COVID-19 even though the drug has not been specifically approved for that purpose, states may be reluctant to discipline providers for its use. Disciplinary actions based on related issues, such as informed consent, may be more likely.[89] However, with evidence of ivermectin's

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85. *See* Steven Chee Loon Lim et al., *Efficacy of Ivermectin Treatment on Disease Progression Among Adults with Mild to Moderate COVID-19 and Comorbidities*, 182 JAMA INTERNAL MED. 426, 426 (2022) (discussing previous studies of use of ivermectin and presenting results of a trial that "do not support the use of ivermectin for patients with COVID-19").

86. *See* Press Release, Am. Med. Ass'n et al., AMA, APhA, ASHP Statement on Ending Use of Ivermectin to Treat COVID-19 (Sept. 1, 2021), https://perma.cc/QL82-R85P.

87. Letter from Shannon Glueck to Humayun J. Chaudhry 1 (Dec. 13, 2021) (on file with author).

88. *Cf.* OFF. OF THE ATT'Y GEN., STATE OF TENN., OPINION NO. 21-19, DISCIPLINARY PROCEEDINGS AGAINST PHYSICIANS WHO PRESCRIBE MEDICATIONS "OFF-LABEL" FOR COVID-19 (2021) (describing grounds for disciplinary action that could encompass inappropriate prescribing as a general matter but explaining that Tennessee statute requires the board to promulgate a rule before disciplining physicians with respect to COVID-19 medications).

89. *See* OFF. OF THE ATT'Y GEN., STATE OF NEB., OPINION NO. 21-017, PRESCRIPTION OF IVERMECTIN OR HYDROXYCHLOROQUINE AS OFF-LABEL MEDICINES FOR THE PREVENTION OR TREATMENT OF COVID-19 (2021) (reviewing studies and finding that "available data does not justify filing disciplinary actions against physicians simply because they prescribe ivermectin or hydroxychloroquine," but noting that "[i]f . . . healthcare providers neglect to obtain informed consent, deceive their patients, prescribe excessively high doses, fail to check for contraindications, or engage in other misconduct, they might be subject to discipline"); *see also* Brian Maass, *Colorado Doctor Admits "Unprofessional Conduct" in Giving Ivermectin to COVID-19 Patients*, CBS NEWS COLO. (Jan. 27, 2023), https://perma.cc/9BFB-6EXA (discussing the Colorado Medical Board's disciplinary

ineffectiveness continuing to accumulate,[90] states could potentially target its prescription as grounds for discipline in the future.

Perhaps in anticipation of this possibility, numerous states have considered bills that would shield physicians who choose to prescribe ivermectin.[91] In 2022, Missouri's legislature adopted a statute providing that "[t]he act of lawfully dispensing, prescribing, administering, or otherwise distributing ivermectin tablets or hydroxychloroquine sulfate tablets for human use shall not be grounds for denial, suspension, revocation, or other disciplinary action by the board."[92] If other states choose to discipline physicians in the future for prescribing ivermectin, Missouri's legislative intervention in the practice of medicine could create discordance in states' disciplinary practices.

Finally, in the aftermath of the Supreme Court decision in *Dobbs v. Jackson Women's Health Organization*,[93] legislated medicine will increasingly make the provision of abortion subject to discordant discipline. State legislation restricting or prohibiting physicians from providing abortion services reshapes disciplinary regimes, typically through direct modification or through the imposition of criminal prohibitions, the violation of which would constitute grounds for discipline. In 2022, for example, West Virginia adopted a law that prohibits abortions from being performed or induced, subject to certain exceptions.[94] At the same time, it adopted a provision that requires its licensing board to revoke the license of a medical professional who knowingly and willfully performs or induces an abortion with the intent to violate this law.[95] With an exception for serious health risks to the mother, Alabama prohibits any person from intentionally performing an abortion, and abortions performed in violation of this prohibition are a felony.[96]

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action against a physician for prescribing ivermectin without properly providing risk information or discussing FDA-approved treatments).

90. *See, e.g.*, Gilmar Reis et al., *Effect of Early Treatment with Ivermectin Among Patients with Covid-19*, 386 NEW ENG. J. MED. 1721, 1721 (2022) (concluding that ivermectin treatment did not lower COVID-19-related hospital admissions).

91. *See* Adrianna Rodriguez, *Lawmakers Push Legislation to Protect Doctors Who Prescribe Ivermectin for COVID-19. Can They Do That?*, USA TODAY (Mar. 10, 2022), https://perma.cc/B6KZ-W7KN (describing ivermectin-related legislative activity).

92. MO. REV. STAT. § 334.100(8) (2022); *see also* N.D. CENT. CODE § 43-17-31.2 (2023) (prohibiting board from disciplining physicians "based solely on . . . prescribing or dispensing ivermectin for the off-label treatment or prevention of . . . SARS-CoV-2," although also indicating that discipline could be based on the provision of substandard care).

93. Dobbs v. Jackson Women's Health Org., 597 U.S. 215 (2022).

94. *See* W. VA. CODE § 16-2R-3 (2022).

95. *See id.* § 16-2R-7 (2022).

96. *See* ALA. CODE §§ 26-23H-4, 26-23H-6 (2023).

Alabama's grounds for physician discipline include "[c]onviction of a felony."[97]

These states and others with similar laws stand in contrast to states where abortion remains broadly legal, such as Alaska,[98] as well as states with less restrictive abortion regulations, such as New Hampshire, which prohibits most abortions after 24 weeks of gestation.[99] Physicians in these states, like physicians in states with more restrictive abortion regulations, remain subject to abortion-related board discipline. For example, the Alaska legislature has required its medical board to "define ethical, unprofessional, or dishonorable conduct as related to abortions" and to "set standards of professional competency."[100] Under Alaska's administrative code, for abortions provided after the first trimester, physicians are required to adhere to guidelines provided by the American College of Obstetricians and Gynecologists.[101] Health care providers who violate New Hampshire's gestational age-based abortion restriction are subject to criminal penalties,[102] and physicians convicted of a felony are subject to disciplinary action.[103] In short, physicians who provide care to patients located in less abortion-restrictive states are subject to similar types of discipline as those in more restrictive states. However, the disciplinary regimes are still discordant because the underlying legislative prohibitions are different. Physicians may provide services to patients that would not result in discipline in New Hampshire but would result in discipline in West Virginia or Alabama.

III. CROSS-STATE PHYSICIAN DISCIPLINE

Disciplinary discordance does not generally pose an issue for a physician who holds a single license and treats patients within the state where they are licensed. The fact that another state has different rules has no bearing on such a physician's practice, as long as the physician's patients remain within the state. But when a physician's activities begin to cross state boundaries, disciplinary discordance may matter. Geographic location becomes important because different states regulate the practice of medicine differently.

As described in Part II, state regulation of physicians' delivery of care is arguably patient-centric in its goals: medical boards seek to protect

97. *Id.* § 34-24-360(4) (2023).

98. *See Interactive Map: US Abortion Policies and Access After Roe*, GUTTMACHER INST., https://perma.cc/P2T5-TM7Y (last visited Sept. 2, 2024).

99. *See* N.H. REV. STAT. ANN. § 329:44 (2022).

100. ALASKA STAT. § 08.64.105 (2022).

101. *See* ALASKA ADMIN. CODE tit. 12 § 40.110 (2022).

102. *See* N.H. REV. STAT. ANN. § 329:46 (2022).

103. *See id.* § 329:17(VI)(j) (2022).

patients located in their state.[104] If a patient is physically located in Connecticut at the time of care,[105] then Connecticut's laws apply to the delivery of care to that patient. At the same time, however, state regulation of the delivery of care is provider-centric in its mechanisms: states regulate the care that patients receive by regulating the providers who give it. Connecticut regulates care provided to patients by prohibiting the unauthorized practice of medicine,[106] issuing licenses to qualified practitioners,[107] and laying out requirements applicable to licensed practitioners.[108] Unless an exception applies, a Rhode Island-licensed practitioner who seeks to treat Connecticut-located patients will need to obtain a Connecticut license and adhere to any standards enforced by the Connecticut medical board.

Nearly a quarter of physicians hold two or more licenses, and so are authorized to treat patients in multiple states. [109] Disciplinary discordance imposes burdens on such physicians because they need to understand the content of each state's laws and disciplinary regimes. In its guidelines, FSMB recommends, as a minimum requirement for full medical licensure, that "[t]he applicant should attest to a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances."[110] Physicians holding licenses and treating patients in multiple states, including physicians with telehealth practices that could span many states, face an especially difficult challenge because of the need to have a good understanding of how all of the relevant laws differ.

In theory, these state-based licensure and disciplinary regimes could exist independently of one another. Connecticut and Rhode Island could independently review a physician's qualifications to practice and consider only activities occurring within their own borders when determining

104. In some cases, medical boards may have other goals, such as reducing competition. *See, e.g.*, Ateev Mehrotra et al., *Telemedicine and Medical Licensure—Paths for Reform*, 384 NEW ENG. J. MED. 687, 688 (2021) ("There are also long-standing concerns that state licensing boards are overly focused on protecting their members from competition rather than on serving the public's interest."). This Article focuses on goals related to patient protection.

105. The use of the phrase "time of care" obscures additional uncertainties, such as how to think about care that occurs over an extended period, or how to think about asynchronous care in which there may be separation between the time at which a physician sends a communication and the time at which a patient receives it. The questions considered by this Article do not turn on these distinctions.

106. *See* CONN. GEN. STAT. ANN. § 20-9 (West 2023).

107. *See id.* (describing licensure qualifications).

108. *See, e.g.*, *id.* § 20-14*o* (West 2023) (regulating licensed providers' prescription of opioids).

109. *See Physician Licensure in 2023*, FED'N OF STATE MED. BDS., https://perma.cc/5EJU-MNJR (last visited July 17, 2024).

110. FED'N OF STATE MED BDS., *supra* note 13, at 26.

whether discipline is merited. Under independent disciplinary regimes, the direct impact of each state's decisions about how to regulate physicians and the care that they provide would be limited to the state itself. There might be indirect effects on care within other states because a physician engaging in multi-state practice might try to reduce the burdens of discordant discipline by adopting practices that satisfy all relevant rules simultaneously. But very different regimes could exist alongside one another with minimal interactive effect.

In practice, however, state regulatory regimes are not fully independent. Complete independence would require a state to sacrifice the benefit of information generated from physician activities occurring in other states. In issuing licenses and in determining whether and what form of discipline might be appropriate, states will often want to take advantage of all information available about a physician's activities, wherever they occur. If all states shared the same views on what constitutes appropriate medical care and what kinds of conduct should be grounds for discipline, the main effect of cross-state discipline—discipline arising from one state's use of information generated as a result of activities in another state—would be to improve the quality of regulation. A state would have better information through which to assess physician competence, for example.

When disciplinary regimes are discordant due to differences in state statutes or regulations, however, cross-state discipline can have more significant implications. If Connecticut and Rhode Island both permit physicians to provide a particular type of care, then if the care were medically appropriate, neither state medical board would discipline the physician for providing that care, regardless of where the care was delivered. If both states prohibit a type of care, each of the boards would discipline the physician when the care occurred within their own borders, and each board might also consider disciplining a physician holding its license, when the care occurred within the other state's borders.[111]

But what happens when one state prohibits care that another state permits? Imagine that a Connecticut-licensed physician provides care to a patient located in Rhode Island, where the physician also holds a license. If Connecticut permits the care provided, but Rhode Island regulations prohibit it, should Connecticut discipline the physician? What if the care in question was instead prohibited in Connecticut, but permitted in Rhode Island? Should Connecticut discipline the physician? The below table depicts the uncertainties that arise when a state where a physician is licensed views things differently from the state where the physician's patient received treatment:

111. *See infra* Section III.D for more discussion of this scenario.

TABLE 1
When a Physician Is Authorized to Treat Patients in Two States, and a Form of Treatment is Prohibited in One State but Not the Other, How Should Treatment in One State Affect the Physician's License in the Other State?

<table>
<tr><td colspan="2" rowspan="2"></td><td colspan="2">State Where Treatment Occurred</td></tr>
<tr><td>Permissive</td><td>Restrictive</td></tr>
<tr><td rowspan="2">State of Physician Licensure</td><td>Permissive</td><td>No discipline in either state</td><td>?</td></tr>
<tr><td>Restrictive</td><td>?</td><td>Discipline in both states?</td></tr>
</table>

This Part examines the extent to which one state's regulatory regime for physicians might consider activities occurring within another state. Section III.A considers discipline based on activities within another state, without regard to whether discipline has occurred, while Section III.B examines discipline imposed as a result of disciplinary activity within another state. Section III.C discusses cross-state discipline in the context of the IMLC, which in the aftermath of *Dobbs*, modified its regulations concerning cross-state discipline. The efforts to amend the IMLC's rules hint at the challenges discordant discipline can pose for cross-state discipline. Section III.D analyzes potential justifications for cross-state discipline. Finally, drawing on Part III's examples of cross-state discipline and the justifications Section III.D identifies, Section III.E considers how Table 1's questions might be answered.

A. Professional Regulation Based on Conduct in Another State

In regulating physicians, medical boards regularly consider the implications of conduct occurring outside of their state boundaries. Perhaps most obviously, in deciding whether to grant a license to a physician, boards consider applicants' previous activities, without regard to where they occurred. In its description of the requirements for full licensure, FSMB's Guidelines states that "[t]he applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act."[112] Guidelines lists many types of

112. FED'N OF STATE MED. BDS., *supra* note 13, at 26.

conduct that are grounds for disciplinary action, without limiting the reach of the provisions to conduct occurring within the state of licensure.[113] It also indicates that boards should be authorized to engage in discipline when a licensee "[v]iolat[es] any state or federal law or regulation relating to controlled substances"[114] or "[p]ractic[es] in another state or jurisdiction without appropriate licensure."[115]

State medical practice act provisions largely align with FSMB's recommended approach, often specifically referencing the relevance of actions occurring within other states. Such references are particularly common in provisions relating to dishonest or criminal conduct, as well as in provisions addressing violations of laws relating to medicine. For example, Georgia authorizes boards to deny licensure to or impose discipline on a physician who has "[b]een convicted of a felony in the courts of this state or any other state."[116] In addition, Georgia includes among its grounds for discipline violations of laws or regulations of "any other state" when the law or regulation "relates to . . . the practice of medicine, when the licensee . . . knows or should know that such action violates such law . . . or regulation."[117] Arizona's definition of unprofessional conduct encompasses "[v]iolating any federal or state laws, rules or regulations applicable to the practice of medicine," "whether occurring in this state or elsewhere."[118] Similarly, Iowa lists among its grounds for discipline "[v]iolating a statute or law of this state, another state, or the United States, without regard to its designation as either felony or misdemeanor, which statute or law relates to the practice of medicine."[119] Moreover, Iowa's administrative code defines unprofessional conduct to include "the committing by a licensee of an act contrary to honesty, justice or good morals . . . whether committed within this state or elsewhere."[120] In Ohio, the state medical board, by a vote of at least six members, "shall, to the extent permitted by law," take one of a list of actions, including potentially denying a license, revoking a license, or issuing a reprimand, for "[c]ommission of an act that constitutes a felony in this state, regardless of the jurisdiction in which the act was committed."[121] Vermont takes a particularly broad approach to

113. *See, e.g.*, *id.* at 33 (identifying certain misdemeanors or felonies as grounds for discipline, without any reference to the location the underlying conduct occurred).
114. *Id.* at 34.
115. *Id.* at 35.
116. GA. CODE ANN. § 43-34-8(a)(3) (2023).
117. *Id.* § 43-34-8(a)(10).
118. ARIZ. REV. STAT. ANN. § 32-1401(27) (2023).
119. IOWA CODE § 148.6(2)(b) (2023).
120. IOWA ADMIN. CODE r. 653-23.1(4) (2023).
121. OHIO REV. CODE ANN. § 4731.22(B)(10) (West 2023); *see also* Anja Alexander, *Bans Beyond Borders: Entrenching Out-of-State Abortion Bans and California's Attempt to Shield Its Medical Providers from Liability*, 57 LOY. L.A. L. REV. 83, 104 (2024)

considering conduct elsewhere: it indicates that a nearly forty-item list of types of conduct falling within the category of unprofessional conduct applies "whether the conduct at issue was committed within or outside the State."[122]Arizona takes a similar approach with an even longer list, sweeping into its definition of unprofessional conduct acts "whether occurring in this state or elsewhere."[123]

B. Professional Regulation Based on Discipline in Another State

As described in Part II, grounds for discipline often consist of some form of problematic conduct, or, in the modern era, deficient care. As described in Section III.A, in determining whether to grant a license or impose discipline, state medical boards may look at activities occurring in other states. But practically speaking, in many cases, medical boards are not undertaking full original investigations of evidence of conduct occurring in other states to determine whether discipline is appropriate. Instead, medical boards may make decisions that rely in significant part on disciplinary actions undertaken in other states.

As described in Section III.A, FSMB's Guidelines indicates that applicants for a full license should not have engaged in conduct that would have been grounds for disciplinary action. But to be more precise, Guidelines states that applicants "should not have been found guilty by a competent authority, United States or foreign" of such conduct.[124] In other words, boards have been encouraged to look to decisions made by other boards to determine whether a physician's past actions should preclude full licensure. States generally give their boards authority to deny licenses to sanctioned physicians; in Georgia, for example, the board may deny a license to an applicant who has had their license revoked, has had disciplinary action taken against them, or who has been denied a license "by any lawful licensing authority."[125] Applicants may be required to provide information about discipline directly in applications for licensure.[126] In addition, all medical boards are required to report certain disciplinary actions based on competence or conduct to the National

(discussing implications of Ohio statute). This provision's focus on an act in another state would seem to have quite different implications from a provision that says that a crime committed in another state should be treated as a felony in the licensing state, if it would have been a felony in the licensing state. *See, e.g.*, VA. CODE ANN. § 54.1-2915(B) (2024) ("The commission or conviction of an offense in another state . . . which if committed in Virginia would be a felony, shall be treated as a felony . . . .").

122. VT. STAT. ANN. tit. 26, § 1354(a) (2023).

123. ARIZ. REV. STAT. ANN. § 32-1401 (27) (2023).

124. FED'N OF STATE MED. BDS., *supra* note 13, at 26.

125. GA. CODE ANN. § 43-34-8(a)(5) (2023).

126. *See*, *e.g.*, OFF. OF PRO. LICENSURE & CERTIFICATION, STATE OF N.H., BD. OF MED., APPLICATION FOR LICENSURE INSTRUCTIONS 1 (2022) (requiring New Hampshire applicants to provide disciplinary information).

Practitioner Data Bank, and other medical boards can obtain information about these actions and the reasons for them by querying the Data Bank.[127] FSMB also facilitates the sharing of information provided by medical boards.[128]

Similarly, boards may discipline a licensed physician based on actions taken by medical boards in other states. FSMB's Guidelines suggests that grounds for discipline should include disciplinary action of another state based on "conduct . . . similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof."[129] State boards may learn of actions in other states through required reporting by licensees or notifications provided by FSMB's disciplinary alert service.[130] In 2021, 1,059 of the actions taken by medical boards—approximately 15% of board actions—were taken in response to another board's sanctions.[131] Sanctions in these reciprocal actions often mirror those imposed by the board that initially investigated the physician's conduct, but in some cases, they may differ from the initial sanction.[132]

The authorization for reciprocal actions is granted by state medical practice acts, typically by identifying discipline by another state as grounds for discipline. For example, Iowa's grounds for discipline include "[h]aving the license to practice medicine and surgery . . . revoked or suspended, or having other disciplinary action taken by a licensing authority of another state," with a certified copy of the record serving as

127. *See* 45 C.F.R. § 60.8 (2023) (requiring boards of medical examiners to report certain actions to the National Practitioner Data Bank); *see also* 45 C.F.R. § 60.18 (2023) (indicating that information reported under § 60.8 is made available to state medical boards).

128. *See U.S. Medical Licensing and Disciplinary Data*, FED'N OF STATE MED. BDS., https://perma.cc/79MR-5JKK (last visited July 17, 2024) ("State medical boards discipline physicians who have engaged in inappropriate behavior and share their disciplinary information with the FSMB to distribute to other medical boards where a physician is licensed or seeking licensure.").

129. FED'N OF STATE MED. BDS., *supra* note 13, at 34.

130. *See, e.g.*, WIS. ADMIN. CODE MED. § 10.03(3)(a) (2022) (classifying as unprofessional conduct "[f]ailing, within 30 days, to report to the board any final adverse action taken against the licensee's authority to practice medicine and surgery by another licensing jurisdiction concerned with the practice of medicine and surgery"); *see also About Physician Discipline*, FED'N OF STATE MED. BDS., https://perma.cc/23AR-PFWJ (last visited July 27, 2023) (describing how FSMB facilitates sharing of information among boards).

131. *See* FED'N OF STATE MED. BDS., MESSAGING AND PARTNERSHIP: ADVANCING IDEAS THROUGH COLLABORATION, ANNUAL REPORT 21 (2022).

132. *See* Milton Heumann et al., *Prescribing Justice: The Law and Politics of Discipline for Physician Felony Offenders*, 17 B.U. PUB. INT. L.J. 1, 30 (2007) (reporting sanctions in reciprocity actions taken by New Jersey Board of Medical Examiners in early to mid-2000s).

prima facie evidence of what has occurred.[133] Washington, like Iowa, confers on its medical board the authority to discipline based on disciplinary actions occurring elsewhere.[134]

In keeping with FSMB guidelines, other states expressly limit reciprocal discipline to situations where the disciplinary grounds of the state initially imposing discipline mirror those of the state considering reciprocal discipline.[135] For example, New Mexico lists as grounds for discipline "discipline imposed on a licensee by another state . . . based upon acts by the licensee similar to acts described in this section," with the certified copy of the record serving as "conclusive evidence" of the action.[136] Similarly, Colorado classifies discipline in another state as unprofessional conduct, but only when the act or omission giving rise to the discipline is "defined substantially the same" as unprofessional conduct under Colorado law.[137] Arizona references capacity issues, as well as other forms of unprofessional conduct. It includes in its unprofessional conduct definition action taken by another licensing jurisdiction due to "that doctor's mental or physical inability to engage safely in the practice of medicine or the doctor's medical incompetence or for unprofessional conduct as defined by that jurisdiction and that corresponds directly or indirectly to an act of unprofessional conduct prescribed by this paragraph."[138] Another Arizona statutory provision requires investigation of outside disciplinary action if the other state's regime is aligned with Arizona's: the board must "initiate an investigation . . . if a medical regulatory board in another jurisdiction in the United States has taken disciplinary action against a licensee for an act that occurred in that jurisdiction that constitutes unprofessional conduct pursuant to this chapter."[139]

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133. IOWA CODE § 148.6(2)(c) (2023).

134. *See* WASH. REV. CODE § 18.130.180(5) (2023) (stating that unprofessional conduct includes "[s]uspension, revocation, or restriction of the individual's license to practice any health care profession by competent authority in any state, federal, or foreign jurisdiction, a certified copy of the order, stipulation, or agreement being conclusive evidence of the revocation, suspension, or restriction").

135. A similar phenomenon may occur when a state considers the implications of out-of-state conduct. When Georgia's medical board considers convictions occurring elsewhere, for example, it considers whether "if committed in this state" the offense "would be deemed a felony under either state or federal law, without regard to its designation elsewhere." GA. CODE ANN. § 43-34-8(a)(3) (2023).

136. N.M. STAT. ANN. § 61-6-15(D)(14) (2023).

137. COLO. REV. STAT. § 12-240-121(4) (2023).

138. ARIZ. REV. STAT. ANN. § 32-1401(27)(p) (2023).

139. *Id.* § 32-1451.02 (2023).

C. *Discipline in the Context of an Interstate Licensure Compact*

As Sections III.A and III.B illustrate, state legislatures have chosen to authorize medical boards to deny licenses or impose discipline based on conduct or discipline that has occurred in another state. They have authorized reciprocal discipline unilaterally, in the sense that its imposition does not depend on whether another state has also adopted a reciprocal disciplinary regime. In short, individual states have decided to allow boards to take advantage of information emerging from other states in determining whether a physician should be authorized to practice medicine.

Recently, many states have embraced a more formalized reciprocal disciplinary structure as a result of joining the IMLC, which FSMB helped to develop as a way of facilitating multistate physician practice.[140] As this Section illustrates, the IMLC is built on existing structures for cross-state discipline. At the same time, in some ways, the IMLC pushes beyond these structures in its effort to facilitate and support cross-state discipline. Given the IMLC's emphasis on state coordination, it is perhaps not surprising that the rise of discordant state regulations may pose challenges to the IMLC's structure. Hints of these challenges are apparent in recent efforts to amend the rules governing the IMLC.

Eligible licensed physicians who seek to practice in one or more additional state(s) can obtain multiple licenses after submitting a single application through the IMLC.[141] This process is typically much quicker than applying directly for each of the individual licenses. Forty states, the District of Columbia, and Guam have now joined the IMLC.[142] The IMLC became operational in 2017; by 2023, it had facilitated the processing of more than 100,000 license requests.[143]

A state that wishes to join the IMLC must enact legislation that authorizes the state to join the compact, using the statutory language specified by the compact itself.[144] The IMLC contains a series of provisions related to physician discipline.[145] These provisions contemplate

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140. *See A Faster Pathway to Physician Licensure*, INTERSTATE MED. LICENSURE COMPACT, https://perma.cc/QQ2R-DKFX (last visited July 28, 2023) (describing development and operation of the IMLC).

141. *See id.*

142. *See Physician License*, INTERSTATE MED. LICENSURE COMPACT, https://perma.cc/F3RB-YDBQ (last visited July 17, 2024) (providing a map of adopting states).

143. See *id.* (providing data on licenses issued).

144. *See Compact Policies, Rules and Laws*, INTERSTATE MED. LICENSURE COMPACT, https://perma.cc/XMR3-Y4Q5 (last visited July 28, 2023) ("Each state that joins the Compact must enact the same legislation as every other state that has joined previously.").

145. *See* Interstate Med. Licensure Compact §§ 8–11 (2015), https://perma.cc/8TM4-2F2V.

active coordination by states in both investigating physicians and imposing discipline. Sections 8 and 9 of the IMLC facilitate cross-state discipline by authorizing joint investigations and ensuring broad information-sharing.[146] Section 8 requires member boards to report to the IMLC Commission ("Interstate Commission") "any public action or complaints against a licensed physician who has applied or received an expedited license through the Compact" and requires reporting of certain "disciplinary or investigatory information."[147] It further requires boards to "share complaint or disciplinary information about a physician upon request of another member board."[148] Section 9 authorizes member boards to engage in joint investigations of physicians and provides that "[a] subpoena issued by a member state shall be enforceable in other member states."[149] In short, while medical practice acts authorize the use of information gleaned from the outcomes of other state boards' investigative work, the IMLC establishes a structure for more proactive cooperation among boards investigating potential grounds for disciplinary action.

The IMLC also goes beyond otherwise applicable state statutes in facilitating cross-state discipline concerning physicians who have obtained their licenses through the compact. Section 10 indicates that "[a]ny disciplinary action taken by any member board against a physician licensed through the Compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that state."[150] It could be argued that by labeling a physician sanction as unprofessional conduct that *may* be subject to sanction, the IMLC is deferring to existing state law that may limit grounds for professional discipline. However, because the IMLC indicates that this form of reciprocal discipline is "in addition to any violation of the Medical Practice Act or regulations," the provision does seem to invite expansion of the potential grounds for cross-state professional discipline beyond otherwise applicable state law.[151] Because this provision does not require equivalence between the grounds for discipline of the initial disciplining state and the state the IMLC authorizes to take action, this provision potentially expands upon existing grounds for discipline.

146. *See id.* §§ 8–9.
147. *Id.* §§ 8(b)–(c).
148. *Id.* § 8(e). Under rules promulgated by the Interstate Commission, member boards are expected share investigatory information as soon as possible upon request. *See* Interstate Med. Licensure Compact Comm'n, Rule on Coordinated Information System, Joint Investigations and Disciplinary Actions, R. 6.3(f) (2022), https://perma.cc/8WZ2-Y2ZS.
149. Interstate Med. Licensure Compact, *supra* note 145, § 9(c).
150. *Id.* § 10(a).
151. *Id.*

Mechanically, the IMLC implements cross-state discipline through provisions describing steps taken in the aftermath of a license suspension or revocation. One important concept underlying the IMLC's structure is the "state of principal license," which determines a physician's eligibility to apply for licenses under the IMLC.[152] A physician seeking to take advantage of the IMLC process must hold an unrestricted license in an IMLC member state that the physician designates as a state of principal license.[153] To make this designation, the physician must meet one of four statutory criteria that tie the physician to the state, such as maintaining a principal residence in the state or working for an employer located in the state.[154] Under the IMLC, if the license granted by the state of principal license is revoked or suspended, "then all licenses issued to the physician by member boards shall automatically be placed . . . on the same status."[155] If disciplinary action is taken by a board outside the state of principal license, then other member boards "may deem the action conclusive as to matter of law and fact decided" and, if consistent with the state medical practice act, "[i]mpose the same or lesser sanction(s) against the physician."[156] Alternatively, other member boards could pursue separate disciplinary action under their medical practice acts.[157] If a member board revokes or suspends a physician's license, then all other licenses granted by member boards are "suspended, automatically and immediately," to permit investigation.[158]

The IMLC's provisions repeatedly reference and defer to states' medical practice acts; existing state law provides the foundation for the IMLC's structure. At the same time, the IMLC's policies encourage states to rely on one another's efforts in both issuing licenses and imposing discipline, sometimes going beyond what would occur under more traditional forms of physician regulation. For example, as Section III.B explained, some states already have adopted the approach of treating another state's record as conclusive, which is in line with the IMLC approach, but Iowa treats the record as "prima facie evidence."[159] The IMLC's automatic suspension and revocation provisions, which are supported by the IMLC's reporting and information-sharing structures, also may go beyond what is typical of traditional physician disciplinary processes.

152. *Id.* § 5.
153. *Id.* § 4(a).
154. *See id.*
155. *Id.* § 10(b).
156. *Id.* § 10(c).
157. *See id.*
158. *Id.* § 10(d).
159. *See supra* notes 133–139 and accompanying text.

In the aftermath of *Dobbs*, it became clear that state laws related to abortion, including rules governing physician conduct, would increasingly diverge. Increased divergence is likely to put pressure on provisions in the IMLC related to cross-state discipline. When states fundamentally disagree about the types of conduct that warrant discipline, provisions under which one state's actions require cooperation or automatically trigger responses by another state become increasingly problematic. The IMLC itself cannot be modified without returning to state legislatures; modifications require unanimous consent of member states.[160] However, in August 2022, the Interstate Commission, the rulemaking entity established by the IMLC,[161] issued proposed amendments to previously adopted rules that would clarify state flexibilities with respect to the IMLC.[162]

The proposed amendments related to member boards' responses to other states' disciplinary actions. For example, Rule 6.5(a), adopted in 2018, stated:

> Any disciplinary action by a Disciplining Board shall be considered unprofessional conduct and is subject to discipline by other Member Boards. This shall include any action that does not have a corresponding ground by the other member Board's Medical Practice Act or in addition to any other specific violation of the Medical Practice Act in the other member state.[163]

This language reinforced the idea that the IMLC may reach beyond previously existing disciplinary regimes of at least some states to permit discipline even though no corresponding ground for discipline is present. The proposed rule change considered in early fall 2022, however, would have shifted the rule's focus from a potential disciplinary expansion to the core idea that the IMLC confers authority on boards to act in response to another state's discipline. The proposed amendment would have replaced "is" subject to discipline with "may be" subject to discipline and would have deleted the second sentence entirely.[164] Ultimately, however, in November 2022, the Interstate Commission adopted a revised amendment

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160. *See* Interstate Med. Licensure Compact, *supra* note 145, § 20(d).

161. *See* Interstate Med. Licensure Compact, *supra* note 145, § 11.

162. *See* Interstate Med. Licensure Compact Comm'n Exec. Comm., Meeting Minutes, at 2 (Sept. 13, 2022), https://perma.cc/FL2R-9UE4 (referencing late August meetings of Rules & Administrative Procedures Committee and authorization of rulemaking); Interstate Med. Licensure Compact Comm'n Exec. Comm., Meeting Minutes, at 2 (Oct. 4, 2022), https://perma.cc/KUE2-AHFL (referencing previous Rules & Administrative Procedures Committee meetings considering comments regarding draft changes to Chapter 6 of IMLC rules).

163. Interstate Med. Licensure Compact Comm'n, Proposed Amendments to Chapter 6, R. 6.5(a) (Aug. 29, 2022) (on file with author).

164. *See id.*

that seems to stake a middle ground between authority and expansion: the rule now states, in relevant part, that disciplinary action "may be a basis for discipline by other member Boards," and that "[t]his includes any action that does not have a corresponding ground . . . ."[165]

A second set of proposed rule changes related to the IMLC's automatic reciprocal action provisions. Under the 2018 rule 6.5(e): "[u]pon receipt of notice from the Interstate Commission of an action taken by the state of principal license, the other member Boards shall immediately place the Compact physician on the same status as the state of principal license."[166] The August 2022 proposed amendment would have replaced the command to immediately engage in reciprocal action with an authorization to boards to follow their own medical practice acts: "[u]pon receipt of notice from the Interstate Commission of an action as outlined in the IMLC Statute, Section 10 a Member Board may take action in a manner consistent with the Medical Practice Act of that state."[167] Like the August 2022 version of the proposed amendment to 6.5(a), the August 2022 proposed amendment to 6.5(e) preserved the IMLC's focus on the interaction among boards but sought to move away from the idea that the IMLC might require a board to respond to another board's action, when they might have not otherwise done so. However, the proposed amendment to 6.5(e) was subsequently abandoned and the November 2022 version retains the 2018 formulation of the rule.[168]

While 6.5(e) focuses on actions by the state of principal license, 6.5(g) focuses on actions initiated by other states. The August 2022 proposed changes to this rule, like those to 6.5(e), sought to ensure flexibility for boards. Rule 6.5(g) required member boards to suspend a physician for 90 days after notification of disciplinary action elsewhere to permit investigation. [169] Under the proposed amendment, boards would have been authorized to suspend disciplined physicians ("may suspend"), rather than required to suspend these physicians ("shall suspend").[170] Like the proposed changes to 6.5(e), this proposed change to 6.5(g) was abandoned. In November 2022, the Interstate Commission adopted significant changes to the language of 6.5(e), but the requirement for a 90-day suspension—the use of the term "shall" rather than "may" in connection with the suspension – remains in place.[171]

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165. Interstate Med. Licensure Compact Comm'n, *supra* note 148, R. 6.5(a).
166. Interstate Med. Licensure Compact Comm'n, *supra* note 163, R. 6.5(e).
167. *Id.*
168. *See* Interstate Med. Licensure Compact Comm'n, *supra* note 148, R. 6.5(e).
169. *See* Interstate Med. Licensure Compact Comm'n, *supra* note 163, R. 6.5(g).
170. *See id.*
171. *See* Interstate Med. Licensure Compact Comm'n, *supra* note 148, R. 6.5(g). Rule 6.5(g) was modified to clarify the circumstances under which the requirement is triggered. The 2018 rule referred to suspension in response to an "action taken by a non-

While the Interstate Commission ultimately maintained the requirements that boards respond to discipline imposed by other member boards, in November 2022 it promulgated a new rule that made clear that member medical boards have the flexibility to take further action in the immediate aftermath of these required responses. The new rule states that boards "required to impose an automatic licensing action against a Compact physician . . . may immediately terminate, reverse, or rescind such automatic action pursuant to the Medical Practice Act of that state."[172] In other words, the revised rules make clear that if permitted by their own medical practice acts, state boards have the authority to immediately undo the cross-state discipline triggered by the IMLC provisions, shielding physicians from the significant effects that this provision might otherwise have.

The IMLC's structure facilitates information flow across member boards, enabling them to evaluate physicians more accurately and quickly than if they had to act on their own. The IMLC's design should help reduce barriers that have long frustrated both boards and critics concerned about physicians' ability to evade sanctions. However, the recently proposed and adopted amendments to IMLC rules hint at the reality that mandated interactions among boards can sometimes have unwanted consequences. The same dynamics at work in the IMLC context have become increasingly visible outside the IMLC, as states consider and, in some cases, respond to the implications of their own medical practice acts. Section III.D explores these dynamics by considering the justifications for the use of cross-state discipline.

D. Making Sense of Cross-State Discipline

Given the growth of variation in state regulation, questions about the nature, value, and implications of cross-state discipline are likely to begin to arise more frequently. The answers to these questions will turn in part on the purposes of cross-state discipline. Medical practice acts are typically silent with respect to the reasons they permit boards to consider events occurring in other states in determining whether to authorize a physician to practice. However, as described in Part II, medical practice

state of principal license," language that could be interpreted to refer to any kind of disciplinary action. Interstate Med. Licensure Compact Comm'n, *supra* note 163, R. 6.5(g). Under the modification, the suspension occurs when a license is "revoked, surrendered, or suspended or relinquished in lieu of discipline," a list which constitutes only a subset of potential board actions. Interstate Med. Licensure Compact Comm'n, *supra* note 148, R. 6.5(g). This more precise list replicates the language of the IMLC. *See* Interstate Med. Licensure Compact, *supra* note 145, § 10(d).

172. Interstate Med. Licensure Compact Comm'n, *supra* note 148, R. 6.6. This rule applies to automatic licensing actions under IMLC sections 10(b) (relating to actions by state of principal license) and 10(d) (relating to actions by other member states). *See id.*

acts may discuss the goals of physician regulation in general, a topic that has been explored in scholarly work. These broader goals help illuminate why states might look to other states in making decisions regarding licensure.

1. Reasons to Look Beyond State Boundaries

As described in Part II, the fundamental purpose of medical practice acts is to protect the public. FSMB's most recent articulation of the purpose of licensing regimes—"protect[ing] the public from any unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine"[173]— is more precise than, but in line with the aims articulated by the Supreme Court in *Dent*, such as protecting the public from "the consequences of ignorance and incapacity, as well as of deception and fraud"[174] and ensuring that "the community might trust with confidence" licensed physicians.[175] Similarities in goals across states likely drove the similarities in disciplinary regimes discussed in Section II.A, including common focuses on issues such as unprofessional conduct, fraud, and conviction of crimes involving moral turpitude.

As described previously, one obvious reason to consider out-of-state conduct and discipline is that it might provide information that would otherwise be lacking about a physician's competence or capacity. If a physician is deemed to be sufficiently impaired, such that the physician cannot safely or effectively practice in one state, then it is likely that the physician cannot safely or effectively practice in another. If a physician delivers care that does not meet medical standards, such that a medical board feels compelled to impose requirements for further medical education, patients in the other state may be at risk until those remedial requirements are satisfied. As one Pennsylvania court has noted, "geographical distinctions are irrelevant to the quality of professional conduct."[176] A state might therefore wish to respond immediately to out-of-state discipline on these kinds of grounds to shield the public from the possibility of deficient care. If the medical board does not need to conduct a full independent investigation but can rely on a finding by a court (such

173. FED'N OF STATE MED. BDS., *supra* note 13, at 8. Similar language is found in state law. For example, Georgia has classified as unprofessional conduct having "[e]ngaged in any unprofessional, unethical, deceptive, or deleterious conduct or practice harmful to the public, which need not have resulted in actual injury to any person." GA. CODE ANN. § 43-34-8 (2023).

174. Dent v. West Virginia, 129 U.S. 114, 122 (1889).

175. *Id.* at 128.

176. DeMarco v. State Bd. of Med. Educ. & Licensure, 408 A.2d 572, 575 (Pa. Commw. Ct. 1979). *See generally* WILLIAM OTIS MORRIS, REVOCATION OF PROFESSIONAL LICENSES BY GOVERNMENTAL AGENCIES 28 (1984) (discussing discipline based on out-of-state activities).

as in a situation involving incapacity) or another medical board, the board can move more swiftly.[177]

A second reason for a state to want to act based on activity occurring elsewhere is a concern that past problematic conduct is predictive of future problematic conduct that could affect the patients the state board aims to protect. For example, one concern may be that engaging in fraud, committing crimes involving moral turpitude, or failing to be attentive to practice standards indicates a propensity for future conduct that, if not appropriately addressed through discipline, may harm future patients.[178] To prevent potential harm, a board might deny, suspend, or revoke a license or impose other discipline that subjects a physician to greater oversight or limits a physician's ability to practice within the state, even if the conduct (and resulting discipline) occurred in another state.

One concern about reasoning based on the propensity for future harmful conduct is that past behavior may not accurately predict future behavior. But, even if past behavior's utility as a predictor is limited, past out-of-state conduct could be viewed as a reason for discipline, given its implications for the profession as a whole. As the Supreme Court in *Dent* highlighted, one function of licensure regimes is to ensure that the "community might trust with confidence" the medical profession.[179] Under this theory, if members of the community become aware of physician engagement in deceptive or harmful behavior, such as fraud or crimes of moral turpitude, then the awareness may lead to public distrust of not just the physician but also the profession as a whole. In a case involving discipline related to unregistered submachine gun possession, the Supreme Judicial Court of Massachusetts explained that "[d]isciplining physicians for lack of good moral character, and for conduct that undermines public confidence in the integrity of the profession, is reasonably related to promotion of the public health, welfare, and safety" and indicated that "[t]he board has the authority to protect the image of the profession."[180]

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177. FSMB's *Guidelines* suggests as grounds for discipline "[b]eing found mentally incompetent or of unsound mind by any court of competent jurisdiction." FED'N OF STATE MED. BDS., *supra* note 13, at 33. In a 1980 case, a Pennsylvania court held that "the Legislature's authorization of suspension or revocation following disciplinary action taken by another state against a holder of a Pennsylvania license . . . is neither unreasonable nor arbitrary and constitutes a valid exercise of the state's police power," given the difficulty of monitoring out-of-state practice. Johnston v. State Bd. of Med. Educ. & Licensure, 410 A.2d 103, 105 (Pa. Commw. Ct. 1980). *See generally* MORRIS, *supra* note 176, at 27–40 (discussing discipline occurring within another state).

178. This is in essence another form of a fitness or capacity argument, but not one based on knowledge or physical limitations.

179. *See* Dent v. West Virginia, 129 U.S. 114, 128 (1889).

180. Raymond v. Bd. of Registration in Med., 443 NE 2d 391, 395 (Mass. 1982).

FSMB has recommended as a ground for discipline "[e]ngaging in conduct . . . having the effect of, bringing the medical profession into disrepute,"[181] and states have included among their grounds for discipline provisions referencing moral character or the impact of conduct on the profession.[182] Because state boundaries do not impede the flow of information about a physician's conduct, a physician's actions may impact a profession's image, regardless of where they occur. As a New York court opined in a case involving an optometrist, "to the extent regulation of the profession is undertaken in order to preserve high ethics within the professions, it would make no sense to require the regulatory agency to ignore misconduct committed outside this State."[183] Robust licensure regimes in which boards are empowered to look to other states help prevent a physician's individual actions from bringing disrepute to the profession.

Finally, there is at least one other dimension to cross-state discipline that is important to consider, although it might be more aptly described as a benefit of cross-state discipline, rather than a reason for cross-state discipline. The primary purpose of disciplinary information sharing, and reciprocal actions by state boards, may be to provide immediate protection to patients located within their borders. But when states engage in reciprocal actions, they also reinforce the work of other state boards. If a physician disciplined in one state can evade the impact of the discipline by practicing in another state without limitation, then the discipline imposed will become less effective as a sanction, and, as a result, less effective as a deterrent to problematic conduct. By contrast, when states act in concert with one another, the initial state's action is reinforced and its impact on the physician will be more meaningful than it otherwise might be. This is one reason why the IMLC's facilitation of information-sharing and cross-state discipline is so important: it helps to strengthen each member state's disciplinary efforts. But even outside of the IMLC, states' longstanding practice of reciprocal discipline has a similar effect.

2. Insights from the Legal Profession

While some grounds for discipline are specific to the medical profession, others are not. The need to preserve trust, for example, is common among professions; clients, like patients, lack the expertise of the professionals they engage with and need to be confident in relying on the

181. FED'N OF STATE MED. BDS., *supra* note 13, at 35.

182. *See, e.g.*, GA. CODE ANN. § 43-34-8(a)(11) (2023) ("[c]ommitted any act or omission which is indicative of bad moral character or untrustworthiness"); *see also* GA. CODE ANN. § 43-34-8(a)(17) (2023) ("[e]ntered into conduct which discredits the profession").

183. Miles v. Nyquist, 400 N.Y.S.2d 868, 871 (N.Y. App. Div. 3d Dept. 1977).

professionals' guidance.[184] The reasons that medical boards may want to consider conduct and discipline occurring in other states may also apply to other kinds of professions regulated at the state level. If so, then other professions may also need to confront questions about the relevance of geographic location and the impact of divergent state laws.

The legal profession has devoted considerable attention to issues of multijurisdictional practice.[185] Rule 8.5(a) of the American Bar Association ("ABA") Model Rules of Professional Conduct, which is entitled "Maintaining the Integrity of the Profession," states, "[a] lawyer admitted to practice in this jurisdiction is subject to the disciplinary authority of this jurisdiction, regardless of where the lawyer's conduct occurs . . . . A lawyer may be subject to the disciplinary authority of both this jurisdiction and another jurisdiction for the same conduct."[186] This model rule, which has been adopted in the same or substantially similar form in most states,[187] reflects some of the same principles evident in physician disciplinary processes: lawyers can be disciplined in a state where they hold a license based on unprofessional conduct, without regard to where that conduct occurred. Cross-state discipline may occur for lawyers, just as it may occur for physicians.[188]

Given the nature of legal practice, cross-state discipline may be a more complex endeavor in law than in medicine. As previously discussed, the prevailing view among medical boards is that physicians are obligated to adhere to applicable law in the state where the patient is located. In the legal world, by contrast, it is not just the physical location of the client that matters. With respect to professional discipline, the ABA's Model Rule 8.5 has a choice of law provision that lays out a more nuanced framework for determining applicable rules. If the conduct at issue relates to a matter pending before a court, the rules of the jurisdiction in which the court sits may apply.[189] If the conduct does not involve a pending matter before a

184. *See*, *e.g.*, Eliot Freidson, *Theory and the Professions*, 64 IND. L.J. 423, 427–28 (1989) (describing roles that limited knowledge and trust may play in discussions of professions).

185. In 2002, the American Bar Association's House of Delegates adopted a series of recommendations made by a commission focused on multijurisdictional practice. *See* ABA COMM. ON MULTIJURISDICTIONAL PRAC., CLIENT REPRESENTATION IN THE 21ST CENTURY ii (2002).

186. MODEL RULES OF PRO. CONDUCT r. 8.5(a) (AM. BAR ASS'N 1983).

187. *See* Am. Bar. Ass'n, CPR Policy Implementation Committee, Variations of the ABA Model Rules of Professional Conduct, R. 8.5 (June 2024), https://perma.cc/C582-75D5.

188. Rule 8.5(a) also provides that "[a] lawyer not admitted in this jurisdiction is also subject to the disciplinary authority of this jurisdiction if the lawyer provides or offers to provide any legal services in this jurisdiction." MODEL RULES OF PRO. CONDUCT r. 8.5(a) (AM. BAR ASS'N 1983). By practicing within a state, lawyers subject themselves to the regulatory authority of the state.

189. *See* MODEL RULES OF PRO. CONDUCT r. 8.5(b)(1).

court, then the relevant rules may be the ones associated with the location of the lawyer's conduct, or, "if the predominant effect of the conduct is in a different jurisdiction," then the rules of that jurisdiction would apply.[190] In a 2023 formal opinion, the ABA's Standing Committee on Ethics and Professional Responsibility suggested factors that might be considered in locating the predominant effect. They included factors such as the client's location, residence, and/or principal place of business; the location of the transaction; the relevant substantive law; the location of the lawyer's principal office; and "the jurisdiction with the greatest interest in the lawyer's conduct." [191] The relevance of specific factors depends on the nature of the potential ethics issue involved.

In short, a state that licenses a lawyer may discipline the lawyer for unprofessional conduct, regardless of where the conduct occurs. However, whether misconduct is present will depend on choice-of-law principles because choice-of-law principles determine the rules that apply to the conduct in question. The applicable ethics rules depend on the nature of the conduct at issue; the applicable rule might potentially be that of the licensing state, or of the client's state, or even of a third state where a transaction occurs. Choice of law matters because state requirements vary, despite the considerable influence of the ABA's model rules.

The rules that define the obligations of medical professionals with respect to the delivery of care do not have the level of indeterminacy inherent in rule 8.5: the patient's location dictates applicable law. But it could be argued that the patient-location approach is consistent with the ABA's predominant effect rule, because presumably any effects of substandard medical treatment (or other physician conduct that puts the quality of care at risk) would begin to arise, or become more impactful, when patient treatment is initiated. In a world of in-person medicine in particular, this presumption has considerable appeal: when treatment is delivered by a physician to a patient in real time, and both are in the same room, both can easily identify the location of treatment and therefore understand the applicable rules. If a patient knows where they are during treatment, they know enough to determine applicable law; if anything goes awry, the patient can easily understand which state to turn to for an appropriate regulatory response.

To summarize, state-based regulators of lawyers, like state-based regulators of physicians, will consider relevant conduct in disciplining physicians, without regard to where it occurs. But to determine the nature of lawyers' professional obligations, both lawyers and their regulators may need to look beyond their state of licensure to consider whether another

190. *See* MODEL RULES OF PRO. CONDUCT r. 8.5(b)(2).
191. *See* Am. Bar. Ass'n Comm. on Ethics & Pro. Resp., Formal Op. 504 2–3 (2023).

state's rules might be more appropriately applied. If medical boards took a similar approach, then arguably they should engage in discipline if the physician has violated the rules of the patient's state. In this hypothetical world, medical boards would not evaluate the physician's conduct under their own rules.

In practice, however, medical boards may diverge from the approach of the ABA model rule. Some medical practice acts authorize discipline for conduct in other states, but only if it is defined as unprofessional in the licensing state. Further, because medical boards apply their own ethical rules in disciplining physicians, not the rules of other states, it remains possible that conduct acceptable in the patient's state could still subject a physician to discipline in the licensing state. Perhaps there is an argument that the predominant effect of the physician's conduct in such a case would be in the licensing state, rather than the patient's state, given the licensing state's more restrictive views of appropriate conduct. But ultimately, the medical profession does seem to take a different approach than the legal profession when engaging in cross-state discipline; one possible explanation may be differences in the nature and extent of state variation in professional practice between the two professions. The ABA's choice-of-law approach provides another way of thinking about how best to manage cross-state discipline in the medical context, particularly in an era of disciplinary discordance.

E. Navigating Cross-State Discipline in an Era of Discordance

Table 1 raised questions about the extent to which states should engage in cross-state discipline. Most of Part III's analysis so far has focused not on this normative question, but instead on the extent to which states' regulatory regimes already authorize cross-state discipline. As illustrated in Table 2 below, Part III's review suggests that state law regularly authorizes medical boards to impose discipline based on conduct and discipline occurring in other states. However, current law does not always directly confront the question of whether disciplinary discordance should alter a state's approach to cross-state discipline.

The most straightforward example of cross-state discipline occurs when two states share the view that a particular type of conduct warrants discipline. In the parlance of Tables 1 and 2, if both states are restrictive, then both the state where the conduct occurred and any other state where the physician holds a license could very likely discipline the physician for their suspect conduct. A licensing state where the conduct did not occur could impose discipline because it has a provision authorizing discipline for the conduct in question, without regard to where the conduct occurs, or because it has a provision authorizing discipline if a physician is

disciplined in another state, either in general or when the two states' disciplinary grounds are similar.

When the licensing state is instead permissive, the case for cross-state discipline is less strong because the licensing state does not view the physician's conduct as inherently problematic. Some state medical practice acts have anticipated the difficulties created by discordant discipline by clearly indicating that if there would be no grounds for discipline under the state's own medical practice act, the state should not discipline a physician based on discipline that has occurred elsewhere. In declining to discipline such a physician, the state acts according to its own view of appropriate disciplinary policy, furthering its own regulatory goals. This approach allows the state to put its limited disciplinary resources to more effective use by focusing on types of unprofessional conduct that it views as most harmful to patients.

Other states, however, may choose to impose discipline because the physician has violated the laws of another state. This approach may make sense, despite the differing views of the two states, because as described previously in Section III.D, a physician who violates the law or engages in unprofessional conduct as defined by another state may put patient trust at risk. Acting contrary to regulations in another state undermines a regulatory structure intended to protect patients and has the potential to bring disrepute to the profession. One of the AMA's principles of medical ethics is that "[a] physician shall respect the law,"[192] and disciplining a physician who has not adhered to regulations elsewhere reinforces this principle.

In contemplating this scenario, state legislators and boards must weigh two competing considerations: first, a desire to act in accordance with a regulatory structure that they believe best protects patient interests; and second, a desire to reinforce the principle that physicians should adhere to the laws and regulations that govern their conduct. The IMLC's immediate-reciprocal-action presumption, which tells states to disregard whether they have a corresponding ground for discipline in taking reciprocal action, leans toward the second goal in a discordant discipline context. States that expressly call for an evaluation of whether the conduct in question falls within their own definitions of unprofessional conduct lean toward the first goal.

In part, the balance between these considerations may hinge on the extent to which the disciplinary policies in question diverge. If differences are generally minor, then a state might want to pursue the second goal (and avoid the costs of case-by-case evaluation of equivalence of disciplinary

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192. AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS, principle III (2001), https://perma.cc/VX4Q-WYCU.

grounds) by engaging in discipline anyway. But if a state legislature or medical board views another state's approach as potentially harming patients, then presumably the legislature will be less likely to grant, and the board less likely to exercise, authority to discipline a physician due to a failure to adhere to another state's regulations.[193] States with these concerns might limit board disciplinary authority to situations when they would have been authorized to impose discipline had the conduct occurred within their own borders. Alternatively, states could carve out from their general approach particular areas of disagreement that are especially problematic.

At first glance, the situation in which the licensing state is restrictive, and the conduct state is permissive, might seem to be merely the inverse of the situation in which the licensing state is permissive, and the conduct state is restrictive. The two states have different views. If the restrictive licensing state defers to the permissive conduct state by taking the same enforcement approach as the conduct state (non-enforcement), it reinforces the conduct state's view of the situation and evidences respect for the conduct state's law. If instead the restrictive licensing state acts consistent with its own views, it does what it thinks is right, and that matters most if the states have highly divergent views. As in the permissive licensing state/restrictive conduct state example, the restrictive licensing state must weigh reinforcing respect for the law against pursuing a policy it thinks best. This analysis has clear parallels with the permissive licensing state/restrictive conduct state example.

However, a closer examination reveals that this characterization overlooks key considerations. If the state where the conduct occurs is permissive, then the physician has not engaged in unprofessional conduct by delivering the care in question and no discipline will occur in the conduct state, at least not initially. In most cases, the restrictive licensing state will never learn about the lawful conduct, and even if they do, investigating it may be difficult. But what if the licensure board does obtain evidence of the out-of-state conduct? Might it discipline the physician? One argument is that because the physician has acted in accordance with the law and policy of the state where the patient was located, evidencing respect for the law of the state responsible for protecting the patient, then a licensing state committed to the rule of law should decline to discipline the physician. If the physician's conduct (or lack thereof) meets the conduct state's professional standards, the

193. Indeed, the same AMA principle of medical ethics that emphasizes the importance of adherence to law also emphasizes the responsibility to address laws that cause harm: "A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient." *Id.*

licensing state should do nothing.[194] To do otherwise would have a chilling effect on the dually licensed physician's behavior in the conduct state, undermining that state's regulation of medicine.

This approach—mimicking the conduct state's disciplinary approach—resembles what might happen under the ABA's rules of professional conduct, which take seriously the notion that it is important to respect policy decisions made by other states. As previously explained, states have long viewed the law of the patient's location as the law governing the delivery of care. Given that the state of the patient's location has taken responsibility for overseeing the care given to that patient, it seems reasonable that the restrictive licensing state should adhere to the principles recognized by the permissive conduct state and decline to take disciplinary action. The restrictive licensing state's unprofessional conduct rules should be read to apply only to conduct within the licensing state, or to conduct elsewhere that would be deemed unprofessional by *both* the licensing state and the conduct state.

In a recent statement, the Interstate Commission articulated a position that comes close to this approach.[195] After acknowledging disciplinary discordance arising from legislative actions, the statement notes that the IMLC's Section I states that the practice of medicine occurs where the physician is located.[196] The Commission's statement emphasizes the constitutional authority of each state to define the practice of medicine and discipline physicians.[197] They also argue that "the sovereign authority of each state, under the Constitution, must be protected."[198] Their statement indicates that under the IMLC, a physician who attempts to provide care in a state where it is prohibited is subject to discipline in that state.[199] The statement then says:

> That same physician who performs abortions or gender affirming care under a license issued by a state [that] permits such care to a patient is

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194. This would be consistent with states' past approaches to responding to criminal behavior. In a recent article, Professor Katherine Florey observes that "states have for the most part declined to test the limits of their extraterritorial criminal jurisdiction." Katherine Florey, Dobbs *and the Civil Dimension of Extraterritorial Abortion Regulation*, 98 N.Y.U. L. REV. 485, 491 n.25 (2023). Professor Florey cites Professor Seth Kreimer, who explained that "when citizens leave their home states, those states rarely seek to enforce their moral visions by criminally prosecuting their citizens' lawful activities in other states." Seth F. Kreimer, *Lines in the Sand: The Importance of Borders in American Federalism*, 150 U. PA. L. REV. 973, 974–75 (2002).

195. *See generally* INTERSTATE MED. LICENSURE COMPACT COMM'N, ANALYSIS OF PROTECTION OF LICENSEES UNDER SCOPE OF PRACTICE PROVISIONS (2023), https://perma.cc/F3QR-9FR7.

196. *See id.* at 1.

197. *See id.* at 1–2.

198. *Id.* at 4.

199. *See id.*

> protected against other states attempting to impose discipline on physicians providing such care to a patient located in that state at the time of treatment under those scope of practice provisions.[200]

In reaching this conclusion, the statement does not reference a specific IMLC provision. Instead, this conclusion seems to be drawn from the more general principles discussed in the statement, such as state constitutional authority to regulate and the sovereignty of states.

The problem with this analysis, however, is that it does not engage with the content of the state medical practice acts that the IMLC reinforces.[201] As discussed in Part II, states do regulate medical professionals with the goal of protecting patients within their borders, and each state may have a different conception of what this task may require. However, as discussed in Sections III.A and III.B, state medical boards often consider a physician's conduct, wherever it occurs, in issuing licenses and disciplining licensed physicians. Some state statutes say this explicitly; any type of conduct named on the unprofessional conduct list, regardless of where it occurs, could be grounds for discipline within the state. As a result, a board may be authorized to respond to conduct it deems unprofessional, even if the state where the conduct occurred does not agree with this assessment. The restrictive state might argue that this result makes perfect sense; a licensing state should act to protect the patients within its own state borders, and if it perceives conduct by one of its currently licensed physicians as bringing disrepute to the profession, then the conflicting view of the conduct state is irrelevant.[202]

This logic may be consistent with the licensure regimes of some states but is problematic in situations when physicians can and do adhere to the laws of each state where they practice. In cases where physicians adhere to the laws in each state where they practice, it seems unlikely that lawful conduct outside the state would bring a profession within the state into disrepute. Such conduct provides no information about the competence of a physician, or the quality of in-state care that would be

200. *Id.*

201. *See supra* Section III.C (discussing the IMLC's structure).

202. If a state is willing to discipline a provider for conduct permitted elsewhere, the potential scope of liability could be quite broad. Consider, for example, a pharmacist who is authorized to provide care in both a permissive state that allows a pharmacist to refuse to fill a prescription for reasons of conscience, *see*, *e.g.*, GA. COMP. R. & REGS. 480-5-.03(n) (2023) ("It shall not be considered unprofessional conduct for any pharmacist to refuse to fill any prescription based on his/her professional judgment or ethical or moral beliefs."), and a restrictive state that has narrower grounds for refusal, s*ee*, *e.g.*, 02-392-19 ME. CODE R. § 11 (2024). Would the disciplinary framework allow a restrictive state to impose discipline when the pharmacist invokes the conscience clause in the permissive state? There is no direct harm to the patients located in the restrictive state, but one question is whether the refusal could have broader implications for the profession in the restrictive state.

provided by the physician, much less the profession as a whole; it provides information only about a physician's willingness to engage in conduct that states disagree about.

Professor Nadia Sawicki has criticized the recognition of character-related, as opposed to clinical competence-related, grounds for discipline, calling for adherence to principles of public protection, fitness to practice, and disciplinary minimalism.[203] While Professor Sawicki's analysis focuses on discipline for conduct outside the clinical sphere, the principles she emphasizes would be consistent with a board refraining from pursuing a case involving lawful care, as lawful conduct does not reflect on a physician's competence. Discipline in some such cases would be in tension with the principles underlying FSMB's longstanding policy against imposing licensure requirements that are "not reasonably related to the qualifications and fitness of individuals to practice medicine, and, instead, have in view the implementation of social, economic or political policies of the jurisdiction at a particular moment, however well-intentioned or justified those policies may appear."[204]

If a medical board in a restrictive state has the authority to discipline a physician based on lawful conduct in the permissive state and actually does so, despite the IMLC's position and the concerns articulated above, there is one further implication to consider: whether the restrictive state's discipline would lead to reciprocal actions in the permissive conduct state. As discussed in Section IV.B, medical practice acts may contemplate a medical board denying a physician's application for a license or revoking a current license if the physician's license in another state has been revoked. Moreover, if the restrictive licensing state revokes the physician's license and the physician has obtained a license in the permissive state through the IMLC, the permissive state may be *required*, at least as an initial matter, to revoke the physician's license. This potential result, which is in tension with the underlying policy of the permissive state, is illustrated in Table 2.

203. *See* Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTH CARE L. & POL'Y 285, 285 (2010).

204. FED'N OF STATE MED. BDS., PUBLIC POLICY COMPENDIUM 11 (2024), https://perma.cc/NL76-Y7BM (Policy 160.4).

TABLE 2
When a Physician Is Authorized to Treat Patients in Two States, and a Form of Treatment is Prohibited in One State but Not the Other, How Might Treatment in One State Affect the Physician's License in the Other State?

		State Where Treatment Occurred	
		Permissive	Restrictive
State of Physician Licensure	Permissive	No discipline in either state	Discipline authorized in treatment state; potential authorization for discipline in permissive state of licensure based on legal violation, or based on discipline, unless similar-grounds provision applies
	Restrictive	No immediate discipline in treatment state; potential authorization for discipline in restrictive state of licensure; potential authorization for reciprocal discipline in permissive treatment state unless similar-grounds provision applies	Discipline authorized in both states

However, even if the restrictive state does decide to impose discipline, the restrictive licensure/permissive conduct state scenario may not ultimately result in discipline in the permissive state. As previously described, one reason is that provisions authorizing discipline in response to discipline in another state may limit that authority to situations in which

the other state's discipline is on grounds that would be recognized in the licensing state, as the term is used in Table 2.[205] A second reason is that instead of mandating that a medical board discipline a physician, a state statute may *authorize* discipline. Iowa's statute, for example, says that "the board may discipline a licensee who is guilty of . . . [h]aving the license to practice medicine and surgery . . . revoked . . . by a licensing authority of another state."[206] Given the underlying policy considerations of the permissive state, the medical board would seem well-justified in declining to exercise authority to engage in reciprocal discipline. Furthermore, the Interstate Commission has made clear that after disciplining a physician as the IMLC requires, the permissive state can "immediately terminate, reverse, or rescind such automatic action pursuant to the Medical Practice Act of that state."[207] This IMLC rule would potentially allow the permissive state to reverse the revocation, although the ability to do so, and the ability to do so quickly, would turn on the content of the permissive state's medical practice act.

State medical boards have long considered conduct and discipline occurring in other states when issuing licenses and undertaking disciplinary processes. Doing so increases the information available to a board about a physician's character and patterns of practice. Doing so also allows a board to take steps that may help prevent evasion of board sanctions and preserve trust in the profession. Information sharing is especially valuable when disciplinary processes are aligned; rules that require consideration of events in other states can support well-informed, high quality disciplinary regimes. Because out-of-state information can improve board decision-making, modern rules that require consideration of out-of-state information make sense. But when states' policy goals or approaches to implementation begin to diverge, this structure generates confusion and potentially unintended or unwanted consequences.[208] Part

205. *See supra* Section III.B (discussing similar-grounds provisions).

206. *See* IOWA CODE § 148.6(2)(c) (2023).

207. Interstate Med. Licensure Compact Comm'n, *supra* note 148, R. 6.6.

208. *See*, *e.g.*, Claire Marblestone, *Three Considerations for Health Care Providers After the Dobbs Decision*, FOLEY BLOGS (June 27, 2022), https://perma.cc/69RB-CXMU (warning physicians to "[b]eware of potential interstate challenges," including restrictive-state discipline for legal abortions and disciplinary action based on another state's discipline). Leslie Francis and John Francis highlight states that deny licenses to medical professionals based on their performance of abortions, explaining that the "statutes do not specify whether the reference is only to abortions performed within the state." Leslie Francis & John Francis, *Federalism and the Right to Travel: Medical Aid in Dying and Abortion*, 36 J. HEALTH CARE L. & POL'Y 49, 55 (2023). They note that providers might be concerned about the impact of this law on their licenses, illustrating this possibility with the example of a medical student who wishes to return to their home state after receiving abortion training elsewhere. *See id.*

IV considers ways to avoid the problematic effects of disciplinary discordance.

IV. CONFRONTING DISCORDANCE

In 1970, FSMB highlighted the link between disciplinary concordance and reciprocity across states: "[t]o promote more endorsement and reciprocity . . . mutual understanding on the grounds for suspension and revocation of licenses is necessary."[209] With mutual understanding, endorsement and reciprocity are relatively straightforward next steps. Without mutual understanding, however, endorsement and reciprocity become problematic. As boards work toward greater cooperation with respect to licensure and discipline, discordant underlying rules create a potential for unintended effects. Discordant discipline can also create confusion and anxiety for medical professionals. Emerging technologies amplify these difficulties by increasing the quantity of care delivered across state lines, potentially bringing medical providers within the orbit of multiple disciplinary regimes. In such an environment, states may want to explore ways to avoid disciplinary discordance or to reduce its impact.

This Part explores several potential responses to the discordance reflected in Table 2. As in Table 2, this Part assumes that a physician holds licenses in both discordant states, so that unauthorized practice of medicine is not an issue. Rather, the question is how states might respond if they are repeatedly confronted with situations in which a dually licensed physician engages in conduct that only one of the two states condemns. Some states have already taken advantage of some approaches described in this Part. Other approaches may be more theoretical possibilities than realistic options, but nevertheless shed light on the challenges involved in confronting problems of disciplinary discordance.

One possible state response is to do nothing, preserving the current state-based, interconnected regulatory regime. The current system has three key features: first, treatment-related regulations and grounds for discipline vary across states; second, patient location determines which state's law applies to a patient's care; and third, one state's grounds for discipline may include unprofessional conduct that occurs in another state, discipline within another state, or failure to adhere to another state's rules. Section IV.A examines the implications of leaving all three of these features fully intact, highlighting the problematic consequences of this approach.

Part IV then turns to the question of what might happen if states are able to alter these features. The analysis begins with the third of the three

209. FED'N OF STATE MED. BDS., *supra* note 31, at 9.

features described above: cross-state discipline. How might the current structure for cross-state discipline be altered? Section IV.B focuses on altering just one quadrant of Table 2: it discusses how a permissive state might reinforce its own permissive approach by shielding physicians from the full effects of a restrictive state's discipline. Section IV.C considers a different approach to cross-state discipline: what would happen if all state medical boards deferred to the disciplinary regime of the state where the patient was located? If medical boards deferred to the disciplinary rules of the patient treatment state, the answers in both discordant cells in Table 2 would change.

Section IV.D then targets the second key feature of today's disciplinary regimes: the fact that substantive regulation is tied to patient location. In an environment characterized by disciplinary discordance, what would happen if this traditional approach were abandoned? Section IV.D analyzes the potential consequences of tying regulation to a physician's location, rather than a patient's. It then inquires into what might occur if instead of tying regulation to an ephemeral characteristic such as location, the applicable regulation is tied to a more persistent feature, such as the physician's primary state of licensure. Unlike the approaches considered in Sections IV.B and IV.C, these changes would not alter the contents of Table 2; however, they would likely shift patterns of care in ways that would reduce the frequency of conduct falling into the Table's discordant quadrants.

Finally, Section IV.E describes approaches that would alter the first listed feature of today's regulations: the fact that state regulations vary. Section IV.E evaluates two ways of increasing regulatory concordance across the United States, such that Table 2's discordant quadrants would decline in frequency or disappear entirely. The first approach is to attempt to shift the regulation of physicians to the federal level and ensure that there is a single set of expectations across the United States. The second is for individual states to promote regulatory concordance by deferring wherever possible to standards established at the national level, such as those set by specialty organizations.

A. *Preserving Discordant Discipline*

The current system for regulating physicians and the care they deliver arises out of states' commitments to protect those within their boundaries. Just as they do in so many other areas of policy, states exercise their constitutionally recognized police powers to promote health in ways they determine will best serve the public. These laws vary due to many factors, including differences in underlying conditions and legislators' or regulators' perceptions of public needs.

One significant cost of this variation for physicians and to some extent, for patients, is the need to invest in learning about legal differences. This cost is not unique to medical care; individuals who travel between states may encounter legal differences affecting their conduct in many domains. However, the consequences of violating state laws can be significant for physicians, who depend on unfettered licenses for their livelihoods; further, physicians in some specialties may be more likely to encounter meaningful legal variation than would an average consumer traveling between states. The costs associated with regulatory variation rise when populations become more mobile and care is provided across state lines, increasing the likelihood that providers will become subject to the laws of multiple states. When physicians are responsible for large numbers of patients, the fact that applicable law is tied to patient location also makes compliance more difficult because many patients find themselves in another state eventually, and physicians will be held responsible for determining patient location.

From a physician's perspective, the fact that states may consider conduct outside their borders in imposing discipline increases the potential costs of missteps. This is true even when disciplinary practices and substantive regulations are aligned because a violation in one state could trigger discipline in others. When discipline is discordant, however, cross-state discipline could also have meaningful implications for patient access to care. If a permissive state imposes discipline against a physician based on discipline imposed within a restrictive state, the reach of the restrictive state's sanctions is extended. If a restrictive state has the power to act against a licensed physician engaged in lawful practice in a permissive state, then that restrictive state could have a chilling effect on the practice of medicine within the permissive state, as a physician may alter their conduct wherever it occurs, so as not to run afoul of either state's expectations. Ultimately, discordant discipline can affect both physicians and patients, and decisions in one state can affect patient care in another. Professional licensure regimes may have extraterritorial effects.[210]

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210. Both the *Dobbs* decision and *Nat'l Pork Producers Council v. Ross*, 598 U.S. 356 (2023), have inspired scholars to consider the extent to which the dormant commerce clause might preclude states from adopting statutes with extraterritorial effects. *See*, *e.g.*, Paul Schiff Berman et al., *Conflicts of Law and the Abortion War Between the States*, 172 U. PA. L. REV. 399, 439–54 (2024) (exploring dormant commerce clause arguments in the case of anti-abortion laws targeting out-of-state activities); *see also* Note, *The Dormant Commerce Clause and Moral Complicity in a National Marketplace*, 137 HARV. L. REV. 980, 980 (2024) (arguing that "the Court should limit the dormant commerce inquiry to the question of whether a sufficient moral interest exists"). In a setting where the primary focus of states is protecting individuals within their borders by regulating the medical profession, with secondary effects on physicians who also hold licenses elsewhere, it seems unlikely that a dormant commerce clause argument would be successful. *Cf.* David S. Cohen et al., *The New Abortion Battleground,* 123 COLUM. L. REV. 1, 34–42 (2023) (discussing the

B. Shielding Against Cross-State Discipline

One response to the risks of cross-state discipline is to limit its use. When state policies are discordant, permissive states may choose to preserve their own policy focus and decline to reinforce a more restrictive state's policy by declining to impose additional discipline on a physician. One way that states already do this is by making clear that medical boards may only discipline physicians based on discipline in another state if the grounds for discipline in the two states are similar. As discussed in Part IV, this is the approach recommended by FSMB, and some states accomplish this through statutory language. Such provisions help prevent restrictive states from exporting their policies to other states. But as this subpart describes, there are additional ways to shield physicians from the effect of restrictive regulations elsewhere.

1. Board Discretion

States typically accord medical boards significant discretion in carrying out their duties. Boards or agencies have the authority to formulate regulations but are also tasked with applying their rules to individual physicians. Statutes often leave considerable room for board decision-making.[211] In its guidelines, FSMB indicates that applicants should be denied full licensure if they have been "found guilty by a competent authority . . . of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act," but also states that "[t]he Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner."[212] In states following this example, boards could choose to grant licenses despite legal violations in another state that might otherwise trigger discipline. Similarly, in the 2021 version of its guidelines, the FSMB contemplated board flexibility in determining whether to revoke a license based on a felony related to the practice of medicine:

> Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and

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difficulties of applying dormant commerce clause and other constitutional arguments based on the extraterritoriality of abortion-related laws).

211. *See* MORRIS, *supra* note 176, at 19 (discussing boards' regulatory authority, discretion, and flexibility, which "is needed to investigate and determine ultimately whether public interest requires the suspension or revocation of a professional license when the licensee has been convicted of a crime or does some other improper act"); *see also* JOHNSON & CHAUDHRY, *supra* note 30, at 110–12 (discussing how longstanding preferences for discretionary authority and concerns about legislative intervention slowed efforts to promote uniformity in medical practice acts).

212. FED'N OF STATE MED. BDS., *supra* note 13, at 26.

> voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust.[213]

While the 2024 Guidelines abandoned this language, it defers to state medical practice acts to determine the consequences for a felony, an approach that permits flexibility in state disciplinary responses.[214] If a state calls for licensure actions based on events occurring in other states but also adopts language specifically inviting boards to consider whether there are exceptional cases, it may make sense for a board to consider disciplinary discordance in deciding whether to decline to impose discipline.

FSMB's now-abandoned 2021 requirement that the Board revoke a license for a particular kind of misconduct differs from the more flexible approaches often taken in medical practice acts. As described in Parts III and IV, state statutes related to professional discipline may *authorize* the board to impose discipline on a series of grounds, rather than commanding the board to take specific actions.[215] Boards do not have the resources to investigate every potential violation of a medical practice act, and they have considerable discretion in responding to allegations they receive. It may be reasonable to decline to exercise authority to discipline a physician based on out-of-state conduct when states' substantive policies concerning that conduct differ.

2. Executive Orders and Statutory Shields

In the aftermath of *Dobbs*, state policymakers became more proactive in their efforts to avoid the unwanted results of cross-state discipline. Governors of more than ten states signed executive orders aimed at protecting reproductive rights.[216] These executive orders often included provisions directed at disciplinary processes. For example, such orders might preclude a disciplinary authority from imposing discipline against state-licensed providers who had provided care that was legal in the

213. FED'N OF STATE MED. BDS., GUIDELINES FOR THE STRUCTURE AND FUNCTION OF A STATE MEDICAL AND OSTEOPATHIC BOARD 34 (2021).

214. FED'N OF STATE MED. BDS., *supra* note 13, at 33.

215. *See, e.g.*, DEL. CODE ANN. tit. 24, § 1731 (2024) (indicating that physicians "may be disciplined by the Board for unprofessional conduct" by various means, but that the board "shall permanently revoke the certificate to practice medicine in this State of a person who is convicted of a felony sexual offense"); HAW. REV. STAT. § 453-8 (2023) ("any license to practice medicine and surgery may be revoked, limited, or suspended by the board at any time in a proceeding before the board, or may be denied, for any cause authorized by law . . . .").

216. *See* Cohen et al., *supra* note 210, at 42–52 (discussing abortion shield-related executive orders and statutes).

licensing state, but not in the state where the care was provided.[217] Orders specifically targeted cross-state discipline by prohibiting disciplinary authorities from acting based on criminal judgments or professional discipline arising out of care provided in a restrictive state.[218]

Legislatures have taken a similar route to shielding physicians from the consequences of activities that result in sanctions by another state. In 2023, for example, Illinois adopted a shield law that provides protection for reproductive health care and gender-affirming care that is lawful within Illinois.[219] Under this statute, the Illinois Department of Public Health is prohibited from revoking or taking other action against a license based solely on treatment that is "not unlawful under the laws of this State" or in response to a revocation or discipline elsewhere "based solely on the physician violating another state's laws prohibiting the provision of . . . any health care service" if the service was not unlawful in Illinois and was delivered consistent with the standards of conduct in Illinois.[220] As of January 2023, seven states had enacted abortion shield laws.[221] Several states have enacted shield laws that also apply to gender-affirming care.[222]

A carefully crafted shield statute addressing professional discipline issues can provide clarity and help ensure that a medical board's actions align with a state's substantive policies. To the extent that shield laws effect a change in disciplinary action relative to what otherwise would have occurred, as opposed to merely clarifying current law, they reflect a state's decision to prioritize the availability of care. The shield preserves the physician's authorization to provide needed care within the state.

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217. *See, e.g.*, Colo. Exec. Order No. D 2022 032 (July 6, 2022) (directing agency to work with professional boards to issue "rules that will ensure that no person shall be subject to disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care as provided is lawful and consistent with professional conduct and standards of care within the State of Colorado.").

218. *See id.*

219. *See* 2022 Ill. Legis. Serv. P.A. 102-1117 (H.B. 4554) (West).

220. 225 ILL. COMP. STAT. 60/22(C)(3)–(4) (2023). Arguably, if discipline relating to abortion in another state automatically triggered discipline in Illinois under IMLC rules, this shield law would give grounds for the board to immediately terminate, reverse, or rescind the IMLC-triggered actions. *See id.*

221. *See* David S. Cohen et al., *Abortion Shield Laws*, 2 NEW ENG. J. MED. EVIDENCE 1, 3–4 (2023) (identifying California, Illinois, New York, Massachusetts, Connecticut, New Jersey, and Delaware as abortion shield law states as of January 2023); *see also, e.g.*, N.Y. EDUC. LAW § 6531-b(2) (2024) ("The . . . provision of any reproductive health services or gender-affirming care . . . for a patient who resides in a state wherein the . . . provision of such reproductive health services or gender-affirming care is illegal, shall not, by itself, constitute professional misconduct . . . .").

222. *See* Randi Seigel & Alice B. Leiter, *State Abortion Shield Laws: Key Findings and Infographic*, MANATT (Sept. 26, 2023), https://perma.cc/4JLF-4VVX (identifying states that have adopted various shield provisions).

Alternatively, these laws may reflect a course correction in states that had not anticipated significant interstate disciplinary discordance when specifying grounds for discipline. States adopting shield provisions with respect to physician discipline seek to protect their own policy goals, elevating these substantive goals over a general expectation that physicians adhere to applicable law. In cases of policy disagreements, the state deems it sufficient that physicians adhere to its own law.

In practice, shield laws may reflect goals that go beyond shielding physicians from the state's own cross-state discipline.[223] For example, they may prohibit government agencies from providing information in support of an investigation when the conduct under investigation would not be subject to liability within the state.[224] Such provisions conserve state resources, reserving those resources for their own use in advancing state policy. These provisions have extraterritorial effects in the sense that they make it more difficult for other states to enforce their laws; the provisions impede other states from investigating allegations of unprofessional conduct.

Ultimately, in the context of discordant discipline, permissive states' shield laws help prevent extraterritorial effects that might otherwise arise as a result of the permissive state's response to prohibited conduct in a restrictive state. Shield laws modify existing state disciplinary regimes in ways that help protect the state against the incursion of another state's policy goals. At the same time, particularly if the norm is to assist other states' investigations, some aspects of shield laws hinder other states' efforts to advance their policy goals.

C. Abandoning Discordant Discipline

Instead of adopting shield laws that limit cross-state discipline and impede information flow, states could instead respond to discordance by abandoning it. Under this approach, states would continue to impose discipline based on conduct within their own borders as they see fit; differences among states would be preserved. However, states would not seek to apply their own policies when conduct occurs outside their borders. Essentially, they would abandon discord by not interfering with actions taken by the conduct state. As with the ABA choice-of-law approach and the IMLC position statement, the policy of the state where the conduct

223. *See* Cohen et al., *supra* note 221, at 2–4 (describing nine functions of abortion shield laws).

224. *See, e.g.*, N.M. STAT. ANN. § 24-35-3 (2023). They may also prohibit the extradition of individuals based on charges involving protected health care activities, such as reproductive or gender-affirming care, unless the individual was physically present in the other state at the time of the alleged offense. *See, e.g.*, N.M. STAT. ANN. § 31-4-6 (2023) (regarding extradition of persons not present in demanding state at time of commission of crime).

occurs would be the policy that applies to the physician who engages in that conduct.

The most straightforward application of this principle is the case of a restrictive licensure state and a permissive conduct state: in this scenario, the restrictive state would abandon its discordance by doing nothing. If a physician's conduct occurs in a state that permits it, other states would not interfere by imposing discipline based on that conduct. By abandoning the discordance, the licensure state avoids imposing on physicians something akin to a penalty for care that is legal in the state where it occurred.[225]

When the licensure state is permissive and the conduct state is restrictive, what it might mean to abandon discordance becomes less clear. Abandoning discordance may require that the licensing state assist in investigations of alleged misconduct, at least to the same extent the state would assist in cases when state policies are aligned. Abandoning discordance might also require the licensing state to engage in reciprocal disciplinary action to ensure that the physician cannot evade the reach of the conduct state's sanction. One might argue, however, that adding this layer of discipline goes beyond mere abandonment of discordance by magnifying the consequences beyond what the conduct state would be able to accomplish on its own.

Given modern regulatory regimes' calls for disciplinary action in response to misconduct or discipline in other states, these regimes tend to bolster the policy views of restrictive states. Against this backdrop, abandoning discordant discipline helps to restore balance by ensuring deference to the conduct state, regardless of whether that state is permissive or restrictive. However, because this rule requires states to systematically act against their own interests when conflict arises, it is not clear that states would be willing to fully embrace this approach.

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225. In discussing situations in which an action is legal in one state but illegal in another, Katherine Florey has pointed out that in a 2003 case involving punitive damages, the Supreme Court stated that a "[s]tate cannot punish a defendant for conduct that may have been lawful where it occurred." Florey, *supra* note 19, at 508 n.128 (citing *State Farm Mut. Automobile Ins. Co. v. Campbell*, 538 U.S. 408, 421 (2003)). In its opinion, the Court explained that "[a] basic principle of federalism is that each State may make its own reasoned judgment about what conduct is permitted or proscribed within its borders, and each State alone can determine what measure of punishment, if any, to impose on a defendant who acts within its jurisdiction." *State Farm Mut. Automobile Ins. Co. v. Campbell*, 538 U.S. 408, 422 (2003). This case did not involve professional discipline and its reasoning would not apply directly. Nevertheless, the approach described here as abandoning discordant discipline is broadly consistent with the approach reflected in the Court's comments, in that states would be empowered to pursue their own policy goals, but would not attach consequences to out-of-state conduct when that conduct is lawful. *See id*.

D. Tying Applicable Law to the Physician Rather Than the Patient

As described in Part II, state medical boards' actions reflect a view that the law that governs a physician's conduct is the law of the state where the patient is located. This principle fits naturally with a state's authority to use its police power to protect those within its borders, and it minimizes burdens for patients looking for a response from regulators when care goes awry. This primacy of the patient's location is embedded in clear language in the IMLC, which states that the expedited license issued by one of its member boards "shall authorize the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state."[226] A physician authorized to practice in a state must follow its rules when treating a patient located in the state.

In an environment characterized by varying substantive laws and discordant discipline, however, regulating based on the location of the patient creates challenges for physicians. Physicians typically interact with many patients, and in a world increasingly characterized by mobile patients and telehealth, patients may find themselves in a multitude of locations, perhaps even crossing state lines during the course of treatment. If no exceptions apply, a physician must identify each relevant location, a potentially difficult and burdensome process; hold a license in each location; and gain familiarity with the applicable laws in each location. The multiplicity of potentially applicable laws increases the risk that physicians may find themselves relegated to the discordant cells of Table 2, where a form of conduct permitted in one state is prohibited in another. Physicians can try to control the dimensionality of the problem by being more selective in determining which patients to treat, but from a physician's perspective, the challenge may become more manageable if regulations were tied to the physician, rather than the patient.

1. Regulation Based on Physician Location

If all applicable regulations are based on physician location, rather than patient location, the physician would need to be located in a state where the physician holds a license and then practice in accordance with the laws of that state. Because physicians will typically have greater control over their own locations than their patients' locations, this approach to regulation will give physicians more flexibility as to the regulatory regime that governs their provision of care. By remaining within the state, the physician could avoid any costs or risks associated with regulatory variation or disciplinary discordance. If the physician

226. Interstate Med. Licensure Compact, *supra* note 145, § 5(d).

decides to obtain another license so that the physician can travel between locations, the physician can select a state that will minimize the risk of discordance. The physician would be able to treat patients using the same approach, regardless of where the patients are located.

Massachusetts shifted its regulatory focus to the physician, at least to some extent, in its recently adopted shield law. The law confers protection in connection with certain health care services provided "by a person duly licensed under the laws of the commonwealth and physically present in the commonwealth . . . regardless of the patient's location."[227] As a result, the shield provides legal protections not just to Massachusetts-licensed-and-located physicians providing care to patients located within the borders of Massachusetts, but also to Massachusetts-licensed-and-located physicians who provide care across state lines to patients located elsewhere.

However, in affording this protection, Massachusetts did not attempt to shift the location of care. In theory, Massachusetts or any other state could try to unilaterally assert that from a regulatory perspective, they deem care to occur at the location of the physician, and so they are entitled to regulate care provided by Massachusetts-located physicians, regardless of the location of patients. The difficulty, of course, is that other states might not adopt the same approach and might continue to assert that they are entitled to regulate care to patients located within their borders, including by regulating physicians, as they have long done.

Advocates for shifting the location of care to the physical location of the physician could try to shift to the new norm through an interstate compact but would likely encounter resistance from states and medical boards that view their roles as ensuring the quality of care for patients physically located within their boundaries. Medical boards might resist a structure that could lead to neighbors having differential access to care, or different regulatory protections, depending on the physical location of their physicians. The structure could also create confusion for patients, who are unlikely to contemplate the possibility that out-of-state regulatory structures apply to their physicians and their care. There may also be confusion because some statutes impacting care, such as statutes designating certain conduct as unprofessional, operate through medical practice acts, while others, such as some laws prohibiting abortion, are broader in scope. The mechanisms for and implications of designating care as occurring at the location of the physician remain unclear.

227. MASS. GEN. LAWS ch. 12, § 11I 1/2 (2023).

2. Regulation Based on Physician State of Licensure

A somewhat more straightforward way to avoid the effects of disciplinary discordance is to tie both professional regulation and regulation of the delivery of care to a physician's state of licensure. Imagine a structure that requires a physician to select a state to be licensed in, and then stipulates that the physician's state of licensure governs all of that physician's activities, without regard to either the physician's or the patient's location. There could be limits applied to the physician's choice of licensure state. For example, perhaps states could restrict licenses to those who fulfill criteria of the sort used in the IMLC to designate primary state of licensure, such as the physician's state of residence or employment location. But once a state issued a license, the physician would not need to seek a license in another state and would be subject to one, and only one, set of rules.[228]

In many ways, the effect of this switch would be similar to switching to physician location as a basis for regulation, and many of the concerns are the same. However, a licensure-based structure would be more stable because a physician could continue to treat patients while traveling without being required to adhere to a new set of expectations. The structure would be more transparent to patients too, as the physician need only disclose their state of licensure for patients to be able to identify the relevant regulatory authorities.

A physician's state of licensure has always been responsible for regulating physicians, so this shift in some ways might be more natural than regulating based on a physician's location. Historically, states have often recognized certain exceptions to licensure requirements, such as when physicians licensed elsewhere provide emergency care or follow-up care for patients within state borders; these states essentially rely on the licensing process of another state to confer protections on local patients.[229] Recent federal legislation provides that when physicians and athletic trainers associated with sports teams provide treatment to their teams in other states, these professionals will be deemed to have satisfied the licensure requirements of these states, as long as they are similar to their own licensure requirements.[230] In short, states have demonstrated a

228. *Cf.* Ashley Maru, *Single Medical Licensure Approach for Physicians Practicing Interstate Medicine*, 100 N.C. L. REV. F. 24, 42–46 (2021) (proposing a regulatory structure in which physicians need only obtain a single state license to deliver services to patients anywhere in the United States but focusing on licensing rather than discipline or other regulatory functions).

229. *See, e.g.*, ARIZ. REV. STAT. ANN. § 32-1421 (2022) (describing exceptions to licensure requirements).

230. *See* Sports Medicine Licensure Clarity Act of 2018, Pub. L. No. 115-254, § 11, 132 Stat. 3197 (2018).

willingness, at least under some circumstances, not to exert regulatory authority over physicians providing care within their borders.

However, asking states to defer to the state of licensure for substantive regulation of care would be a significant change in regulatory approach. With respect to this issue, regulating based on physician location has more logical appeal. When care involves direct contact, both physician and patient are in the same state, so there would be no substantive change from regulating based on patient location. When care is virtual and is flowing between physician and patient, it is not unreasonable to deem it as occurring at the location of the physician. Thus, under a physician location-based system, regardless of the care modality, the state where the physician is located would be regulating care flowing through its borders. By contrast, regulating solely based on the state of licensure would mean the laws applied might not be tied to the current location of either the physician or the patient. States would need to assume responsibility for regulating care provided by its licensed physicians, wherever that care is provided, while relinquishing the responsibility for regulating care provided to those within its boundaries by physicians licensed elsewhere. This would be a significant shift. Like a regulatory approach based on physician location, a regulatory approach based on physician state of licensure would eliminate discordance for physicians but would mean that patients located in the same state could have different experiences. While it may be possible to shift to a structure in which a physician holds only one license, it would be more difficult to prevent states from imposing requirements related to patient care within their borders.

E. Promoting Concordance

The responses to disciplinary discordance discussed so far do not seek to eliminate regulatory differences among states. Instead, they envision regulatory changes that would reduce the impact of these differences on individual physicians and potentially on states themselves. By contrast, this section discusses two ways to address the underlying variations in regulatory structures that lead to disciplinary discordance.

1. National Licensure

Health care and those who provide it have long been regulated at the state level; states exercise their police powers for the protection of the public. Historically, local and state regulations were a natural fit for the provision of health care. The nature of medical training and information sharing meant that standards were established locally, while the physical presence of both physicians and patients meant that both were located near the same set of local regulators. But over time, with improvements in

medical education and information sharing, medical standards have become increasingly national in scope.[231] Nationally and internationally distributed drugs and devices have become integral to care. Moreover, the growth of telehealth technologies means that for a significant subset of medical care, provision across state lines is both feasible and desirable. While federal entities do not directly regulate the practice of medicine, standards set in connection with federal financing programs such as Medicare influence the delivery of care.[232]

The case for federal involvement in regulation has become significantly stronger over time. While commentators sometimes raise questions about the constitutionality of a federal licensure system, many scholars have concluded that federal licensing is constitutional,[233] and some scholars have called for a national licensure system for physicians, particularly in the context of telehealth.[234] The bigger barriers to a nationally uniform licensing system seem to be political and practical in nature, given the significant disruption inherent in shifting from a state-based to a federal system.[235]

Even if these barriers could be overcome, there is no guarantee that full concordance would result. In 2010, for example, Australian states each adopted legislation that transformed Australia's state-based licensure system into a national one.[236] Today, a national regulatory entity, the Australian Health Practitioner Regulation Agency ("AHPRA"), works with 15 national health practitioner boards; registration occurs and

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231. *See supra* notes 47–49 and accompanying text (discussing shift to national standards).

232. *See*, *e.g.*, 42 C.F.R. §§ 482.1–482.70 (2023) (describing the Medicare conditions of participation for hospitals).

233. *See, e.g.*, Timothy Bonis, *Is a Federal Medical License Constitutional?*, BILL OF HEALTH (Jan. 3, 2023), https://perma.cc/49SV-JNEM (exploring constitutional questions related to licensing); Gabriel Scheffler, *Unlocking Access to Health Care: A Federalist Approach to Reforming Occupational Licensing*, 29 HEALTH MATRIX 293, 350 n.296 (2019) (collecting examples of scholars who have concluded that federal legislation may preempt state licensing laws without running afoul of the constitution).

234. *See, e.g.*, Ameringer, *supra* note 18, at 60 n.33 (providing examples of advocacy for national licensure for telemedicine while advocating for uniformity in state-based licensure in telemedicine); Kate Nelson, Note, *"To Infinity and Beyond": A Limitless Approach to Telemedicine Beyond State Borders*, 85 BROOK. L. REV. 1017, 1046–53 (2020) (proposing a federal telemedicine licensing system).

235. *See* Scheffler, *supra* note 233, at 347–53 (discussing obstacles to federal preemption of state licensing laws); *see also* Fazal Khan, *From Pixels to Prescriptions: The Case for Telehealth Licensing & AI-Enhanced Care*, 57 IND. L. REV. 581, 599–603 (2024) (discussing the challenges of turning away from state-based licensure systems).

236. *See* Peter Critikos III, *License to Screen: A Review of the Medical Licensure Schemes Impacting Telehealth Proliferation in the United States, the European Union, and Australia*, 32 EMORY INT'L L. REV. 317, 343–47 (2018).

standards of care are set at a national level.[237] The Medical Board of Australia issues codes, guidelines, and policies applicable across Australia.[238] Nevertheless, state and territory boundaries continue to matter. Some jurisdictions did not adopt all pieces of the national law.[239] There may be state or territory boards in addition to the national board,[240] and state-based tribunals are responsible for disciplinary proceedings.[241] As with state-based law in the United States, in Australia "[a] health practitioner can be subject to regulatory action in one state or territory for conduct occurring in another."[242] Further, different states may have different substantive rules affecting the provision of medical services; for example, the circumstances under which abortions can be provided by physicians differ across states and territories.[243] In short, even in a country where states have agreed to shift the regulation of physicians to the national level, decision-making occurring at the state level may affect physicians' provision of care.

A national licensure system could potentially eliminate some of the feedback loops that occur when a physician subject to discipline in one state also holds a license in another. In a mechanical sense, national licensure would eliminate discordant discipline because a single license is issued at a national level. However, if states retained a role in the regulatory process, whether by imposing substantive regulations on care or by maintaining a disciplinary entity operating under the auspices of a national system, physicians might still need to navigate differences in state law. Moreover, if some state roles were to remain but discipline is ultimately imposed in connection with the national license, then a decision made by a single state could have a national impact. Under a national licensure system, physicians might no longer struggle with conflicts between medical boards but still could be impacted by state law differences, while states might lose some policy levers they currently wield.

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237. *See What We Do*, AUSTL. HEALTH PRAC. REGUL. AGENCY, https://perma.cc/XU3F-93U2 (last visited Aug. 13, 2023).

238. *See Codes, Guidelines, and Policies*, MED. BD. OF AUSTL., https://perma.cc/FB6B-VTFX (last visited Aug. 13, 2023).

239. *See* AUST'L HEALTH PRAC. REGUL. AGENCY & NAT'L BDS., REGULATORY GUIDE 8 (2024) (discussing co-regulatory jurisdictions).

240. *See id.* at 7 (2024) (discussing delegation by national boards).

241. *See id.* at 46 (discussing tribunals).

242. *Id.* at 13 (discussing jurisdictional considerations).

243. *See Can I Have an Abortion in Australia?*, HEALTHDIRECT (Mar. 28, 2024), https://perma.cc/E4MN-LC9F.

2. State Adherence to National Standards

A final mechanism for addressing disciplinary discordance is simply to avoid creating it. States create compliance challenges for physicians whenever they adopt rules with variations that lead physicians to provide care differently in different states. A physician who cannot take an approach to care permissible in all states will need to study the rules and modify conduct accordingly in each state that a patient is located. Disciplinary discordance matters the most when one state chooses to adopt and enforce laws that prohibit care that another state allows; actions clearly defined as professional misconduct trigger sanctions that have broader effects.

The more closely states and their medical boards adhere to national standards for the provision of care, however, the less likely that disciplinary discordance becomes. As described in Section II.B, some medical boards have already implemented a regulatory approach tied to national standards by specifically referencing national guidelines in their regulations. Looking to national professional organizations may be particularly helpful when standards are unclear or evolving because embedding standards in state statutes could potentially lead to discordance if they lag behind a changing evidence base. Legislating medicine can exacerbate the problems associated with disciplinary discordance, potentially negatively impacting patient care.

V. CONCLUSION

After more than a century of evolution, and despite limited resources, state medical boards remain committed to the task of protecting the public through the regulation of physicians. States have settled on some common focuses in their regulatory efforts such as targeting instances of deception, fraud, and incompetence. Given boards' common goals and challenges, it is not surprising that they have sought to work together, both indirectly and directly, to ensure the quality of the physician workforce. If one state determines that a physician's license should be revoked due to incompetence, other states will likely want to do the same, and to do so quickly, to reduce the risk to patients within their borders. By creating a structure in which out-of-state conduct and discipline are considered, medical practice acts can improve the quality and efficiency of state regulation.

This structure becomes problematic, however, when states' views on medicine—and the professionalism of the physicians who practice it—diverge. Recent legislative intrusions into the practice of medicine create discordance in regulatory regimes: a practice specifically prohibited in one state may be clearly permitted in another. Disciplinary discordance forces

states to grapple with two questions: first, should a medical board discipline a physician because that physician has chosen to engage in out-of-state conduct deemed illegal or unprofessional by the other state, when the board does not view the conduct as problematic within its own state borders? Second, should a medical board discipline a physician it licenses for conduct it deems unprofessional, even though the state where the conduct occurred disagrees?

Some state statutes hint at an answer to the first question by expressly restricting reciprocal disciplinary actions to situations when the grounds for discipline in the states are similar. This approach has appeal because if the board does not see the physician's out-of-state conduct as problematic, it would have no objection to the physician continuing to practice the same way within the state's borders. The lingering concern, however, is whether the physician's decision to engage in prohibited conduct should itself warrant discipline in the licensing state. Would a physician willing to disregard laws related to medical practice put patients of the licensing state at risk? Perhaps conduct classified as a felony should weigh more heavily in a board's analysis, but states may nevertheless grant boards flexibility in imposing discipline.

If the licensing state decides that the fact of the out-of-state violation is irrelevant—that the only potential concern is the underlying conduct—it could structure its disciplinary regime such that out-of-state conduct would result in discipline only if its medical board determines that the conduct would have resulted in discipline had it occurred within state borders. But a state could also strike a different balance by adopting a more narrowly tailored disciplinary shield, one that applies only to a certain category of contested conduct. This narrower approach reduces the burden of case-by-case analysis and increases transparency. It may be particularly appealing when disciplinary discordance arises from standards in which medical and professional judgments have become intertwined with societal judgments characterized by deep divisions. In such cases, a state may be less inclined to defer to another state's judgment and less likely to view the physician as posing a risk to state residents. While the physician would still be subject to discipline within the other state, such a physician need not be subject to additional consequences in the licensing state. Provisions within recent shield laws that make clear that a physician will not be subject to in-state discipline for out-of-state conduct are consistent with this approach.

A licensing state that learns of out-of-state conduct that it deems unprofessional, but is permitted in the other state, faces a somewhat different set of considerations. Current licensing regimes may clearly indicate that the location of unprofessional conduct is irrelevant; this approach has appeal for the simple reason that unacceptable conduct

should be avoided everywhere. But in this case, too, discordance complicates the analysis. It may make sense for inquiries about unprofessional conduct to be boundaryless because such conduct renders a physician untrustworthy and can undermine trust in the profession in general. But when discipline is discordant, and particularly when the discordance arises from widely recognized differences in societal views, the broader implications of the physician's lawful treatment of an out-of-state patient become less clear. A physician's out-of-state conduct in such a setting conveys little information about the physician's fitness or likely behavior in a state where such conduct is impermissible. The state should therefore not assume that the physician poses a risk of harm to individuals within the state's boundaries and disciplinary action may not be warranted.

The rise of disciplinary discordance puts considerable pressure on medical boards to more carefully consider their roles in protecting the public and preserving societal trust in the medical profession. Structures that function well when boards share views about what is required of medical professionals may produce unintended consequences when these views diverge. In such cases, regulatory regimes may need to be amended or clarified, or more carefully applied on a case-by-case basis, with renewed attention to the underlying goals of professional regulation.

The confluence of disciplinary discordance, the emergence of telehealth, and other trends in medicine raise more fundamental questions about the suitability of our state-based, patient location-based system of health care regulation. Any proposal for transformation of our current system that entails a move away from practices that have been in place for so many years will necessarily require careful analysis, and continued discordance may serve as a barrier to moving forward. Ultimately, the rise of state-legislated medicine could have significant implications that reach beyond state borders and the patients who reside within them.