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In Reply We agree with Dr Porebski that when assessing drug hypersensitivity reactions, the assessment of causation requires an examination of factors other than temporality. This is possible at the bedside but not when examining large health care datasets. In other words, our study[1] presented associations that may or may not have been causal.

When conducting our study, we compiled a list of *ICD-10* codes related to drug exanthems based on the available literature. Since the operating characteristics of these codes are unknown, we included a broad range of codes possibly reflecting drug exanthems and, inevitably, included some that were nonspecific and less severe. To address this limitation, we conducted 2 sensitivity analyses focusing on patients with reactions that were presumptively more severe, those who were hospitalized for cADRs and those who were discharged with a prescription for oral steroids. In both analyses, the results were consistent with our primary results.

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Interstate Telemedicine in the Courtroom

To the Editor The use of telecommunications by patients and physicians to reduce unnecessary office visits is nearly as old as the telephone itself. A recent Viewpoint[1] argued compellingly for state medical boards to adopt enduring flexibilities to support interstate telemedicine, not just temporary measures during public health emergencies. However, the Viewpoint's analysis of the threat posed by legal challenges to jurisdictional licensure underestimated the scope of state authority in this area.

US states regulate the medical profession. Controlling the requirements and conditions of medical practice is a quintessential exercise of states' inherent authority, or police power, to protect the health, safety, and welfare of their inhabitants. Although the Constitution's interstate commerce clause prohibits states from placing undue burdens on national economic activity, courts have historically been loath to recognize a federal equivalent of state police power.[2] A federal court mandating that New Jersey or California allow out-of-state physicians to render telehealth in their state would upend nearly 150 years of jurisprudence and constitutional equipoise regarding medical regulation.

The argument that telemedicine is constitutionally protected speech is similarly tenuous, given the consistent holdings of courts that "states may regulate professional conduct, even though that conduct incidentally involves speech."[3] Although telehealth visits, like in-person ones, implicate speech, their primary purpose is to provide medical services, an activity falling squarely within the purview of state oversight.

The Viewpoint astutely referenced the North Carolina State Board of Dental Examiners[4] as a cautionary tale of regulatory overreach, but it is not particularly instructive in the context of cross-border care. The North Carolina board issued nearly 50 cease and desist letters to teeth-whitening purveyors throughout the state, seeking to clear the commercial field of nondentists charging lower prices. These actions raised the ire of antitrust enforcers, who questioned whether the board was acting as a government body or a business cartel. Whereas the North Carolina case has clear lessons for medical boards who may be tempted to impose onerous rules on economically disruptive telehealth companies employing appropriately licensed physicians, it does not require the boards to sanction in-state practice by out-of-state clinicians, whether physically or virtually.

As advocated by both the American Medical Association and the Federation of State Medical Boards, state regulators should champion reforms to facilitate multijurisdictional telehealth and enhance access to care.[5] The reason for doing so is not fear of litigation, but because it is the right thing to do for both physician mobility and patient health.

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In Reply Mr Kels and I agree on many things, including that telemedicine has a long tradition in US health care delivery, that states have historically been granted broad authority to regulate the practice of medicine, and that state regulators should use that power to facilitate interstate telemedicine because it is the right thing to do.

Our disagreement rests on our understanding of the current federal judiciary. Oliver Wendell Holmes famously said that "the prophecies of what the courts will do in fact, and nothing more pretentious, are what I mean by the law."[1] In plain language, this means that substantive legal constraints are products of what judges will do, not what judges have done. A rudimentary examination of where today's federal judiciary is going will tell us what the law effectively is.

Mr Kels asserts confidently that US states regulate the medical profession. One similarly could have asserted, barely 16 years ago, that states have wide latitude to regulate firearm ownership and use[2] and a mere 9 years ago that states could broadly regulate the definition of marriage.[3] Perhaps these have been extraordinary years and this is an extraordinary court, but the writing is on the wall: today's judiciary exhibits few inhibitions in offering interpretations of the constitution that dramatically change our regulatory framework and political order.

Indeed, court-led power is baked into current litigation strategies. The cases highlighted in my *JAMA* Viewpoint[4] involve lawyers seeking not just to change telemedicine, but to change constitutional law, and their record is impressive, with 18 victories before the Supreme Court, including 3 in just the last term.

Even the case Mr Kels cites to support his proposition that "courts have historically been loath to recognize a federal equivalent of state police power" included some watershed holdings that now limit the government's authority to regulate commerce. Regardless of whether one cheers or abhors these whiplashes in constitutional law, the last Supreme Court's term—one that included new presidential protections against criminal prosecution[5] and new limitations on administrative agency enforcement powers[6]—indicates that this trend continues.

Should medical boards use their power to be more encouraging of interstate telemedicine? We both agree they should. Should state medical boards be comfortable that their current power is enduring? I would issue a stern warning and, as I wrote in my Viewpoint, urge state licensure boards "to accede to common sense" and enable interstate telemedicine, so as not to "succumb to new sources of outside control."[4]

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3. *Obergefell v Hodges*, 576 US 644 (2015).

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Tranexamic Acid and Blood Transfusion in Liver Resection

To the Editor A recent study[1] reported that tranexamic acid did not reduce bleeding or transfusions in liver resection for cancer but increased perioperative complications. However, we have concerns.

First, there are discrepancies in patient counts between the tables reporting perioperative complications. Table 3 in the main article showed that the tranexamic acid group had more postoperative complications than the placebo group (271 [43.8%] vs 237 [37.9%]; P = .03) and more major complications than the placebo group (104 [16.8%] vs 78 [12.5%]; P = .03). Yet eTable 3 in Supplement 2 reported P values of .14 and .09, respectively. Table 3 may have overestimated the complications associated with tranexamic acid. The rationale for using these tables needs clarification.

Second, the most substantial difference in complications between the 2 groups was in wound-related complications (74 [12.0%] in the tranexamic acid group vs 47 [7.5%] in the placebo group). Factors influencing wound-related complications include surgical trauma, wound suturing, and locally administered tranexamic acid.[2] However, the article did not provide information related to the initial treatment of wound-related complications. These complications could also be associated with the use of anticoagulants. Therefore, providing detailed information on the use of anticoagulants in this trial might help explain the differences between the tranexamic acid and placebo groups. Attributing all wound-related complications to tranexamic acid may overestimate its adverse effects.

Third, it may be necessary to explore the dosage and timing of tranexamic acid administration. At our hospital, the recommended dose of tranexamic acid is 0.5 g. A recent study[3] demonstrated a modest but statistically significant reduction in the number of patients needing red blood cell transfusion with the use of high-dose vs low-dose tranexamic acid.

Fourth, tranexamic acid to reduce surgical bleeding[4] is standard of care in China and other countries. Given the lack of key data in this trial, caution should be exercised in interpreting the conclusions, even though the intervention and inclusion criteria closely align with clinical practice. It may be premature to alter medical practice based on these results.

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