



May 21, 2026

Dr. Ayanna Bennett, Director, DC Department of Health
Ms. Emilia Moran, Interim Executive Director, DC Board of Medicine
899 North Capitol Street, NE
Washington, DC 20002

RE: ATA ACTION REQUEST FOR GUIDANCE ON ASYNCHRONOUS TELEHEALTH AND PHYSICIAN-PATIENT RELATIONSHIP FORMATION

Dear Dr. Bennett and Ms. Moran:

On behalf of ATA Action, I am writing with significant concerns regarding reports that the District of Columbia Board of Medicine (the “Board”) has taken the position – and may have issued disciplinary action on the basis – that physicians utilizing telehealth may only establish a physician-patient relationship through real-time, synchronous technologies. We are very concerned because the District of Columbia has no governing law or regulation to support this interpretation. To the contrary, the District recently enacted a law, [B25-0545](#), that explicitly permits the use of asynchronous technology to form a patient relationship.

ATA Action is the affiliated policy and legislative advocacy arm of the American Telemedicine Association. ATA Action is the leading advocacy organization dedicated to advancing policy in support of and accelerating the adoption of technology-enabled healthcare. Working collaboratively with federal and state legislators and policymakers, our organization drives industry momentum and patient access to care by influencing legislative and regulatory developments in telehealth, virtual care, remote patient monitoring, artificial intelligence in healthcare, health data privacy, private sector healthcare investment, and more. We represent a diverse membership – including hospital systems, technology companies, professional associations, direct-to-consumer digital health providers, payers, pharmaceutical manufacturers, digital therapeutics developers, and remote monitoring organizations.

We respectfully request that the Board issue guidance to clarify the current legal framework and make clear that physicians may use asynchronous technologies to form a relationship with a patient when that modality meets the standard of care.

I. The 2024 Act Expressly Permits Asynchronous Telehealth for Relationship Establishment

In July 2024, the District enacted the Health Occupation Revisions General Amendment Act (the “Act”), DC Act 25-0479 which included the “first-ever general guidelines for telehealth services provided by licensed health professionals in the District,” with the stated goal of “encouraging consistent and high-quality telehealth services.”¹ The Act’s telehealth provisions were drawn directly from the Uniform Telehealth Act of 2023, a bill (B25-0125) introduced at the request of the Uniform Law Commission.

The Act’s telehealth requirements are intentionally technology-neutral and provide that “a practitioner-patient or practitioner-client relationship may be established through telehealth in accordance with the appropriate standard of care and the practitioner’s competence and scope of practice.” The Act defines

¹ [B25-0545 - Health Occupations Revision General Amendment Act of 2023](#)



“telehealth” to mean “the use of synchronous or asynchronous telecommunication technology to provide access to health assessment, diagnosis, intervention, consultation, supervision and information across distance, in which a practitioner and a patient or client or supervisee are located at different physical locations.” Taken together, these provisions make clear that a physician or other practitioner may use asynchronous technologies to form a patient relationship where clinically appropriate, and that a real-time interaction is not mandated in all cases.

ATA Action testified in strong support of both the Act and the Uniform Telehealth Act of 2023 precisely because of this technology-neutral approach. As we stated during our testimony at multiple hearings, ATA Action believes that licensed practitioners should be able to utilize the full range of available telemedicine technologies while delivering virtual care, so long as the technologies used are appropriate to meet the standard of care for the condition presented by the patient. Asynchronous telehealth modalities are not novel – across the country, telehealth providers, including major health systems, use asynchronous modalities to evaluate patients and identify underlying conditions prior to prescribing medication, for both new and established patients, in fields including primary care, dermatology, ophthalmology and sexual health.

The vast majority of states and the Federation of State Medical Boards (FSMB) have likewise recognized that asynchronous technologies can appropriately be used in patient care. FSMB’s *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (2022) states that “a physician-patient relationship may be established via either synchronous or asynchronous telemedicine technologies without any requirement of a prior in-person meeting, so long as the standard of care is met.”² The technology-neutral framework enshrined in the Act reflects this national consensus, and ATA Action’s strong support for the legislation was grounded in that alignment.

II. The 2024 Act Supersedes the Real-Time Mandate in 17 DCMR § 4618

We understand that the Board may be grounding its real-time mandate in 17 DCMR § 4618, a 2016 regulation providing that “the physician may use real-time telemedicine to establish the physician-patient relationship” where no prior in-person interaction has occurred. The Act, and its legislative history, make clear that it overrides 17 DCMR § 4618 generally and the real-time mandate specifically.

First, the Act’s sponsor and the Mayor’s Office repeatedly acknowledged during the legislative process that the Board of Medicine had an existing policy in 17 DCMR § 4618 and that the Act sought to replace it with a “uniform” statutory approach applicable to all practitioners seeing District patients. For example, the Act made clear that a practitioner in any field could see an existing patient in the District for up to 120 days without a District-issued license, negating the requirement in 17 DCMR § 4618 that required physicians to have a license except for limited circumstances. Indeed, the committee record reflects the Act sought to align the professions with a single set of standards to avoid confusion:

“The bill proposes the first-ever uniform guidelines for telehealth services in the District. Currently, each Board is responsible for responding to questions from professionals about the

² Federation of State Medical Boards, *The Appropriate Use of Telemedicine Technologies in the Practice of Medicine*, April 2022. <https://www.fsmb.org/siteassets/advocacy/policies/fsmb-workgroup-on-telemedicineapril-2022-final.pdf>



use of telehealth, and only the Board of Medicine has developed written telehealth guidance.”³

This legislative history reflects a clear intent to supplant, not supplement, the Board’s prior regulatory guidance.

Second, the Act specifically intended to override the real-time mandate in 17 DCMR § 4618 because it was an outdated approach that failed to reflect current telehealth practice. Mr. James McKay, Chair of the Uniform Law Commission for the District, directly addressed the deficiencies of 17 DCMR § 4618 in his testimony explaining the telehealth provision included in the Act:

“Moreover, this regulation [17 DCMR § 4618] is overly restrictive compared to the rest of the country because it mandates that only ‘real-time’ – i.e., ‘synchronous’ – telemedicine technologies can be used to form a patient relationship. This precludes the use of asynchronous visits to communicate and treat patients, although that approach is recommended by the Federation of Medical Boards and has been taken by a majority of states. The Uniform Act would permit both synchronous and asynchronous telehealth visits, so long as the standard of care is met.”⁴

ATA Action and other commentators who testified in support of the Act likewise cited the technology-neutral approach and ability to use asynchronous care as a reason for their strong support.⁵

Finally, the Act explicitly permits the Mayor to “add additional requirements through rulemaking” for specific health professionals to establish a provider-client relationship. This provision was added specifically to address concerns raised by veterinarians and to preserve “the discretion to issue regulations requiring an initial in-person examination to establish a [patient] relationship.”⁶ Accordingly, while the Board may – at the Mayor’s direction – issue future regulations imposing additional requirements on relationship formation, no such rulemaking has occurred in the nearly two years since the Act’s enactment. The real-time mandate in 17 DCMR § 4618 therefore has no continuing legal force.⁷

We respectfully request that the Board of Medicine promptly issue guidance clarifying that the District does not impose any specific modality mandate with respect to forming a physician-patient relationship, and that physicians may establish such a relationship via asynchronous or synchronous technologies where appropriate and consistent with the applicable clinical standard of care.

³ Council of the District of Columbia Committee on Health Committee Report (“Comm Report”), Mar. 21, 2024, page 2, <https://tinyurl.com/4vyeah3f>. See also, Testimony of District Council Office of Racial Equity, Mar. 21, 2024, page 491 (“The parameters established by the bill will create uniformity”).

⁴ Statement of James C. McKay Before the Comm. On Health on Bill 25-125, July 6, 2023, p. 13 https://lims.dccouncil.gov/downloads/LIMS/52325/Hearing_Record/B25-0125-Hearing_Record1.pdf?Id=196655

⁵ ATA Action letter in support of HORA, Dec. 5, 2023, Comm. Report p 361; Letter of Support from Technet, Comm. Report p. 440; ATA Action Testimony on B25-125, Comm. Hearing on Bill 25-125 p.7.

⁶ Comm Report”, Mar. 21, 2024 at p. 8.

⁷ Further, the Council subsequent passed the Certificate of Need Improvement Amendment Act of 2025, DC Act 26-44, which exempted telehealth providers from the overly burdensome certificate of need process. This is further evidence of the District’s policy intent to lean into telehealth due to its ease of access and reduced cost. Taken together, the District has attempted to make it easier for DC residents to access telehealth and is another indication of the District’s policy intent.



Without such clarity, inconsistent Board interpretations will cause precisely the confusion that the Act was designed to eliminate, and the unwarranted fear of discipline will deter practitioners from utilizing lawful and clinically appropriate telehealth modalities. If the Board determines that a synchronous interaction should now be required for all new patients, that substantive policy change must occur only pursuant to the Mayor's directive, via rulemaking as set forth in the Act, and with an opportunity for public comment through rulemaking, as the Act expressly contemplates.

We appreciate your prompt attention to this matter and would welcome the opportunity to meet with the Board to bring resolution to this issue. If you have any questions or would like to discuss the telehealth industry's perspective further, please contact me at hyoung@ataaction.org.

Kind regards,

A handwritten signature in black ink that reads "Hunter Young" in a cursive script.

Hunter Young
Head of State Government Relations
ATA Action