

REALIZING THE BENEFITS AND AVOIDING THE PITFALLS OF TELEMENTAL
HEALTH CARE FOR WOMEN VETERANS

BY

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LIST OF ABBREVIATIONS

ACA	American Counseling Association
APA	American Psychological Association
ATA	American Telemedicine Association
CVT	Clinical Video Telehealth
HIPAA	Health Information Portability and Accountability Act
HITECH	Health Information Technology for Economic and Clinical Health Act
MST	Military Sexual Trauma
NASA	National Aeronautics and Space Administration
NSA	National Security Agency
PHI	Protected Health Information
PTSD	Post-Traumatic Stress Disorder
TIP	Telemedicine Instrumentation Pack
VA	Department of Veterans Affairs
VHA	Veterans Health Administration

ABSTRACT

The mental health of women veterans is influenced by gender-specific social and biological factors, and thus, they have gender-specific mental health care needs. The Department of Veterans Affairs (VA) telemental health system promises to improve the availability and quality of care for women veterans. This thesis begins with a brief history of telemedicine and a description of telemedicine practices available to women veterans through the VA. The second chapter discusses how the VA health care system is failing to serve the gender-specific mental health needs of women veterans and how telemental health services are a promising strategy to improve the accessibility and quality of mental health care. The third chapter examines the challenges and advantages of telemental health care for fulfilling the moral responsibilities of obtaining informed consent to treatment, protecting patient privacy and confidentiality, and establishing an effective therapeutic relationship. Finally, the fourth chapter argues that, with appropriate safeguards, the benefits of telemental health care outweigh its risks, and that the expansion of telemental health services to meet the need for accessible and effective mental health care for women veterans is justified by considerations of reciprocal and compensatory justice.

INTRODUCTION

The mental health care of US women military veterans is impaired by the lack of accessible and effective mental health services in the Department of Veterans Affairs (VA). Both social and biological factors create gender-specific mental health care needs for women veterans. These factors, such as responsibilities for child and elder care, make it more difficult for women veterans to access mental health services at a VA center. The culture and environment of the VA can trigger unpleasant memories and emotions for women suffering from conditions related to military sexual trauma (MST). Women veterans have served our country and often sustained psychological trauma while doing so; thus, they deserve accessible and effective mental health services. Telemental health services are a promising strategy for providing women veterans with increased access to female-only care options, a greater variety of mental health services, and care in less-triggering environments.

The first chapter of this thesis provides a brief history of the development of telemedicine in the National Aeronautics and Space Administration (NASA), which led to telemedicine as it is practiced today. NASA piloted the use of telemedicine technology to collect patient data and to enable teleconsultation between astronauts and physicians on the ground. The organization's use of telemedicine has evolved with the increasing complexity of its space missions and has informed contemporary telemedicine. The chapter then shifts to an overview of the telemedicine services provided by the VA. The three major categories of VA telemedicine are defined: Clinical video telehealth (CVT),

Home telehealth, and Store-and-Forward telehealth. The remaining chapters of this thesis focus on the applications of CVT for telemental health care for women veterans.

Chapter 2 focuses on the need for gender-specific mental health care for women veterans. It examines the social and biological factors specific to women that affect their mental health and accessibility to mental health services. The chapter then shifts to an examination of the inadequacies of the VA mental health care services for women veterans. Women struggle to receive effective mental health care at the VA due to a lack of female-only options, the burden of traveling to a VA medical center, and the triggering environment and culture of the VA. The chapter then proposes telemental health services as a strategy to both increase access to care and improve the quality of mental health care for women veterans.

In Chapter 3, I analyze the effect of telemental health care on the moral responsibilities of obtaining informed consent to treatment, protecting patient privacy and confidentiality, and establishing an effective therapeutic relationship. The chapter sections describe the essential elements of each moral responsibility and then discuss how each is affected by the characteristics of telemental health care. I argue that while telemental health care poses challenges to informed consent, privacy and confidentiality, and the therapeutic relationship, these challenges can be managed with the appropriate safeguards. Furthermore, telemental health care has the potential to support providers' efforts to fulfill each of these moral responsibilities.

The fourth and final chapter of this thesis asserts and defends the claim that telemental health care should be expanded to better serve the unmet mental health care needs of women veterans. I argue that, with the appropriate safeguards, the benefits of

telemental health care outweigh its risks. Then, I appeal to studies that interviewed women veterans about health care in the VA to exemplify women veterans' unmet mental health care needs. In the final portion of the chapter, I argue that the expansion of telemental health care services for women veterans is justified by considerations of reciprocal and compensatory justice. Women veterans deserve appropriate mental health care in recognition of their service and to compensate for MST and other psychological injuries suffered during that service.

The purpose of this thesis is to bring attention to the gender-specific mental health care needs of women veterans, to highlight the potential for VA telemental health services to serve those needs more adequately, and to establish that women veterans are deserving of more accessible and effective mental health care.

CHAPTER ONE

INTRODUCTION TO TELEMEDICINE

This chapter discusses both the history of telemedicine and the current categories of telemedicine used in the Department of Veterans Affairs (VA). First, the chapter defines telemedicine as it will be used in this thesis. Then, the chapter provides a brief discussion of the history and development of telemedicine in the National Aeronautics and Space Administration, which led to telemedicine as it is known today. The focus of the chapter then shifts to telemedicine in the VA and provides an overview of the categories of telemedicine services available to women veterans.

HISTORY AND DEVELOPMENT OF TELEMEDICINE

Telemedicine is generally defined as “the use of digital technologies by health care professionals for remote medical practice” (Bardy 3). Telemedicine is a response to current challenges in the medical field including limited access to care, especially specialty care, a diverse and often geographically distant patient population, and the limited time and resources of providers (Bardy 3). It is important to differentiate telemedicine from telehealth. Telehealth encompasses all online resources related to health that provide services to patients and practitioners (Bardy 4). For example, the MyWakeHealth communication system used in the Wake Forest Baptist Health system is a type of telehealth, not telemedicine. Mobile health or mHealth technologies are also sometimes differentiated from telemedicine, but in this thesis, mobile health will be

included under the umbrella of telemedicine. Mobile health involves the use of wireless devices or cell phone technologies for the delivery of care, and those technologies are generally viewed as a tool for the practice of telemedicine (“Telehealth FAQs - ATA Main”). The term ‘telemedicine’ will be used in this paper to refer to the delivery of clinical services by a provider in one location to a patient in a different geographical location.

The origins of telemedicine are rooted in the National Aeronautics and Space Administration (NASA) (Williams et al. 2). Telemedicine has been used throughout the history of NASA to monitor the health of astronauts from the ground. Engineers, technicians, and physicians collaborate to “address human health, spacecraft system functions, and environmental parameters” (Nicogossian et al. 1). The growing complexity of space expeditions and the challenges of the space environment have resulted in a corresponding growth in the complexity and abilities of telemedicine (Nicogossian et al. 1).

NASA’s use of telemedicine initially focused on efforts to monitor the physiology of crew members and environmental data before, during, and after space flight (Nicogossian et al. 3). Preflight and postflight health monitoring allows NASA to establish a baseline for the astronauts’ health against which in-flight monitoring is compared. In-flight monitoring consists of a “combination of subjective and objective analytical methods that allow flight and ground personnel to sustain human health in the space flight environment” (Nicogossian et al. 4). Telemedicine also allows in-flight crews to consult with ground controllers and agree upon a medical protocol to respond to challenges. NASA’s goal is to “ensure the health and safety of its astronauts and to

respond to unexpected medical or health-related events without compromising mission objectives” (Nicogossian et al. 5). Telemedicine thus plays a key role in the safety and success of NASA’s missions.

Project Mercury (1961-1963) was the first NASA mission to use telemedicine technology (Nicogossian et al. 6). These missions proved that humans are able to survive and function in microgravity. Telemedicine was used to collect and analyze flight suit data, including physiological parameters such as blood pressure, pulse, ventilation, and EKG data, and environmental data such as oxygen, carbon dioxide, and water levels. Telemedicine systems used today, such as home telehealth, collect the same physiological parameters. Project Mercury missions also used private medical conferences for communication between crew members and physicians (Nicogossian et al. 6). This was the first use of teleconferencing, as it is known today, and allowed physicians to see and hear patients and have a discussion about their health in real-time. This same technology is now widely used in telemental health care.

Another important development in the NASA telemedicine program was the Telemedicine Instrumentation Pack (TIP), which was first incorporated during the Space Shuttle program. TIP was the size of a small suitcase and included a “compact, integrated suite of tools and utilities to conduct telemedical examinations” (Nicogossian et al. 8). TIP allowed crew members to provide care to one another under the direction of physicians on the ground, and data were transmitted from the Space Shuttle to the Mission Control Center (Nicogossian et al. 8). Current teleconsultation services that enable communication and collaboration between physicians in different locations were pioneered by the communication between physicians and astronauts through TIP.

One of the earliest examples of implementing NASA telemedicine technology in caring for patients on the ground was the creation of a pulmonary hypertension monitor. The collaborative efforts of Dr. Anthony Nunez, a cardiothoracic surgeon, and researchers at NASA's Glenn Research Center in Cleveland, Ohio, led to the formation of the telemedicine company Endotronix (Terry 528). Nunez sought a way to monitor the pulmonary artery blood pressure of his patients during their daily routines. At that time, the only way to monitor pulmonary hypertension was "via a monitor inserted with a catheter into the artery," and, in order to take pressure readings, the monitor and catheter had to remain in place (Terry 528). Essentially, this meant that doctors could take pulmonary hypertension readings only when the patient was at rest. Felix Miranda and Rainee Simons of the Glenn Center adapted space communications technology for biomedical uses and developed the biological-related microelectromechanical telemetry system. In this system, "the sensor is implanted into the heart during a catheterization and left in place," and the patient can then "use the reader to obtain aortic pressure levels as many times as necessary throughout the day" (Terry 530). This can be done in multiple settings, including the patient's own home. Endotronix exemplifies the potential for NASA telemedicine technology to transform the delivery of health care on the ground.

The development of telemedicine in NASA has greatly influenced telemedicine services available on the ground today, such as the VA teleconferencing services discussed in this thesis. We can expect that the evolution of telemedicine services on the ground will continue to be informed by NASA's development of increasingly sophisticated telemedicine technologies to respond to the challenges of new missions.

TELEMEDICINE IN THE VA

The VA offers telemedicine services for use in a variety of medical specialties. There are three types of VA telemedicine programs: clinical video telehealth, home telehealth, and store-and-forward telehealth. While these programs are designated by the VA as telehealth programs, they fall under my definition of telemedicine because they involve the delivery of clinical services by a provider in one location to a patient in a different geographical location. Here is a brief description of each of these programs:

1. Clinical video telehealth (CVT) is used to make diagnoses, manage care, perform check-ups, and provide other types of care (*Real-Time Clinic Based Video Telehealth - VA Telehealth Services*). The VA has over 700 community-based outpatient clinics that refer patients to a VA medical center for specialty care or prescription changes. CVT is a real-time video encounter between a patient in an outpatient clinic and a specialist in a VA center. The term CVT is used interchangeably with the term teleconferencing. The major CVT specialty programs are Polytrauma, Telerehabilitation, Telesurgery, and notably, Telemental Health (*Real-Time Clinic Based Video Telehealth - VA Telehealth Services*).

2. Home telehealth services connect patients to VA clinicians via regular telephone lines, cellular modems, and cell phones, and make it possible to check symptoms and measure vital signs in the patient's home (*Home Telehealth - VA Telehealth Services*). This type of telemedicine is recommended for older veterans who would otherwise need to be in a nursing home or have full-time in-home care. The veteran is trained on how to operate the home telehealth device over the phone, at a local

VA clinic, or in his or her home. A care coordinator acts as a point of contact for the veteran. The care coordinator is typically a nurse or social worker who communicates with the providers and arranges treatment changes, clinic appointments, and hospital admissions (*Home Telehealth - VA Telehealth Services*).

3. Store-and-Forward telehealth involves the acquisition and storage of clinical information, including data images, sound, and video, that is forwarded to another site for clinical evaluation (*Store-and-Forward Telehealth - VA Telehealth Services*). The store-and-forward telehealth specialties are TeleDermatology and TeleRetinal Imaging.

Clinical video telehealth, home telehealth, and store-and-forward telehealth provide access to medical services for veterans who are unable or unwilling to travel long distances to receive care at a VA hospital. The following chapters will focus on the potential for CVT, referred to generally as teleconferencing, to provide more accessible and higher quality mental health care for women veterans.

This chapter defined telemedicine as it will be used in this paper and then provided a brief overview of its history and development in NASA. The use of telemedicine services during space missions revealed its potential to transform health care on the ground as well. NASA's telemedicine services are reflected in the current CVT, home telehealth, and store-and-forward telehealth programs available through the Department of Veterans Affairs. This chapter also provided a brief description of these VA telemedicine programs and of how they are typically used by providers to deliver care to patients. The next chapter of this thesis will continue to discuss the use of

telemedicine in the VA, but focus on how such programs specifically affect the mental health and health care of women veterans.

CHAPTER TWO
THE EXPERIENCE OF WOMEN IN THE VA MENTAL HEALTH CARE
SYSTEM

This chapter examines the gender-specific needs and challenges of women veterans in the VA mental health care system. It first discusses the social and biological factors that affect the mental health and well-being of women. The chapter then focuses on how the VA health care system is failing to serve important mental health care needs of women veterans. Finally, telemental health services are proposed as a strategy to improve the accessibility and quality of mental health care for women veterans.

SOCIAL AND BIOLOGICAL FACTORS THAT AFFECT THE
MENTAL HEALTH CARE OF WOMEN

Several factors, of both social and biological origin, have a disproportionate effect on the mental health care of women veterans. Sex-specific social factors and roles can “create, maintain, or exacerbate underlying biological health differences” between men and women (Bird and Rieker 745). Therefore, mental health care services for women must not only account for how the biology of women is different from that of men, but also for how their social roles, such as being the primary caregiver for minor children and elderly relatives, influence their health. To provide women with comprehensive and accessible mental health care, it is crucial to understand the significance and interaction of these social and biological factors.

Gender differences in opportunities are an example of a factor that “shape[s] men’s and women’s choices and expectations regarding social roles and role-related activities, which in turn affect their exposures to various risks (including stress, role overload, occupational health problems such as carpal tunnel syndrome and exposure to toxic chemicals) and their access to protective resources (including income, wealth, health and disability insurance and social support” (Bird and Rieker 748). To cite a specific example, studies have shown that “women are more likely to become single parents and to become caretakers to their elderly relatives” (Bird and Rieker 749). The time commitment and stressors related to such roles can both negatively affect the mental health of a woman and also make it more difficult for her to find the time to seek and receive treatment. VA mental health care services for women veterans must therefore recognize and address the social roles of women in society and how those roles shape their overall health and well-being.

In addition to their social roles and responsibilities, women veterans have particular needs reflective of their biology. Mental health needs distinct from those of men veterans include “conditions associated with reproductive life stages, such as premenstrual dysphoric disorder or postpartum depression, and access to providers familiar with the use of psychotropic medications during pregnancy and lactation” (Moreau et al. 182). One pilot study sought to “ascertain the prevalence of self-reported premenstrual, perinatal, and perimenopausal influences on mental health, and of gynecological conditions that could interact with psychiatric conditions, among women veterans receiving psychiatric care within a Veterans Administration (VA) Women’s Health Clinic” (Miller and Ghadiali 93). The study found “high rates of self-reported

premenstrual, perinatal, and perimenopausal influences on mental health” and “substantial comorbidity of psychiatric disorders with dyspareunia and pelvic pain” (Miller and Ghadiali 93). These findings emphasize the need to consider gender-specific biological factors when providing mental health care services for women. VA mental health care services should specifically address both the social and the biological factors that affect the mental health of women.

INADEQUACIES IN VA MENTAL HEALTH CARE SERVICES FOR WOMEN VETERANS

The VA health care system is failing to address factors that specifically affect the mental health care of women, and thus is not adequately serving important needs of women veterans. As the number of women in the armed forces grows, this issue becomes increasingly significant. Women are one of the fastest growing population subgroups of the VA health system. A recent national study of women veterans who are VA primary care users inquired about these veterans’ use of VA mental health services (Kimerling et al. S97). This study reports that “women are more likely to be diagnosed with a mental health condition, more likely to use mental health services, and on average have more mental health visits” (Kimerling et al. S97). This finding indicates that women veterans do seek and use mental health care services when they are accessible. The study found that fifty percent of women using VA primary care services reported a high level of need for mental health care. These women veterans used mental health services more often than the general population, in which “20-30% of individuals report a perceived need for

mental health care in the past year, and only 50-60% of individuals with perceived need receive mental health services” (Kimerling et al. S101). The study reported “very good access to mental health services,” noting that “84% of women with perceived need used mental health care in the past year, and nearly all of those women used VA for at least some of that care” (Kimerling et al. S101). However, only half of the women who used mental health care services at the VA reported that their needs were met very well or completely (Kimerling et al. S101). While this data indicates that a high number of women veterans need and use VA mental health services, it also reveals that many women believe that the VA is not serving their gender-specific needs adequately.

Mental health conditions like post-traumatic stress disorder (PTSD) can have a significant effect on the life and well-being of women veterans. One qualitative study focused on the significance of PTSD for the health-related quality of life of women veterans, using a “multidimensional approach to understanding health and wellness (e.g., physical, cognitive, emotional, social)” (Haun et al. E1470). Participants in the study reported that “PTSD had deleterious effects on many aspects of their lives, including social participation, relationship issues (e.g., marital and parenting), emotional functioning, cognition, and physical health” (Haun et al. E1474). The results of this study exemplify the effect of mental health conditions on the health and well-being of women veterans, and they support the need for the VA to provide accessible and effective mental health services. Men veterans suffer from the same psychological conditions, but they do not experience the same barriers to mental health care.

Several factors and social roles are associated with women veterans’ unmet mental health care needs. Women who use VA services, as compared to men who use

those services, are younger and more racially and ethnically diverse, and these characteristics may also contribute to women veterans' low ratings of comfort in treatment settings (Kimerling et al. S102). Living in a rural area is also associated with unmet mental health needs in women veterans. Rural areas may not have enough women veterans to warrant specialized services like women's clinics or therapy groups. Additionally, "women who were parents or caring for children also reported poorer perceived access to mental health services" (Kimerling et al. S103). Caregiving responsibilities can be both financial and logistical barriers to access to mental health care. As I discuss in further detail in the next section of this chapter, telemedicine has the ability to provide those services to women regardless of their location, and it does not require them to arrange childcare in order to travel to a VA clinic.

The studies of women veterans cited in this chapter indicate a need for gender-specific mental health programs. Among the questions addressed by the Kimerling et al. national study were "if a female provider was available as often as preferred; whether same-gender group treatments were available as often as preferred; whether gender-specific settings were available as often as preferred; and the frequency that women felt uncomfortable or out of place in VA mental health treatment settings because of gender" (Kimerling et al. S98). A lack of gender-related care was correlated with women veterans choosing to not use VA mental health services. The study found that "the most frequently reported gender-related access issue was a lack of access to designated women's mental health treatment settings, as often as desired" and "substantial proportions of women also reported lack of access to same-gender therapy groups" (Kimerling et al. S101). These findings reveal the strong desire of women veterans for female-only mental health

services and indicate that many women lack adequate access to such gender-specific services in the VA system.

Women veterans also report feeling uncomfortable receiving mental health services in the VA environment. The Kimerling et al. study found that “one in five women reported frequently feeling uncomfortable or out of place in their mental health treatment setting because of their gender” (Kimerling et al. S102). In another study, many female participants reported “feeling vulnerable and being uncomfortable with receiving care services in the VHA, mainly because of their perception of the VHA as a male dominant health care culture” (Haun et al. E1474). Women veterans in a third study shared that “VA staff at health care facilities sometimes assume that they are wives accompanying their husbands and not themselves veterans” (National Academies of Sciences et al. 329). The prevailing VA culture makes the experience of receiving mental health care at VA facilities more difficult and frustrating for women veterans. The women also reported that there are times when they are “uncomfortable in VA clinic waiting rooms because they get unwanted sexual attention, which can be particularly unsettling for women veterans who have experienced military sexual trauma” (National Academies of Sciences et al. 329). MST is defined by the VA as “sexual assault or repeated, threatening sexual harassment that occurred while the Veteran was in the military” (National Academies of Sciences et al. 53). It is a significant health care issue for the growing number of women veterans. A study in 2012 of 108,478 service members found that 6.1% of active duty women and 1.2% of active duty men experienced MST (National Academies of Sciences et al. 53). Women veterans deserve safe and accessible treatment for MST-related conditions.

The environment and culture of the VA can trigger memories of past trauma in women veterans suffering from MST-related conditions and make it impossible for them to receive effective care at a VA center. The heavily male-dominated environment of the VA “has the potential to cue MST-related memories and distress, presenting a potential barrier to receiving treatment for female veterans with MST histories” (Gilmore et al. 60). Data suggests that trauma cues at VA facilities can be so severe that female veterans are actually re-victimized. One strategy for addressing this barrier to mental health care for women veterans is to create female-only waiting rooms and entrances (Gilmore et al. 62). This strategy does not, however, address other barriers such as the burden of travel and arranging childcare.

TELEHEALTH SERVICES AS A STRATEGY TO ADDRESS THE MENTAL HEALTH NEEDS OF WOMEN VETERANS

Telemental health care has proven to be an effective method for serving the mental health needs of patients. A 2015 review of the use of telemental health services in the diagnosis and treatment of various psychiatric conditions supported the use and expansion of such services (Aboujaoude et al. 223). This review found that advantages of telemental health include “improved access to care, especially for patients who live in areas that are under-served by mental health professionals, who have physical limitations that limit their ability to obtain traditional care, or whose work or other responsibilities prevent them from commuting to a regular clinic” (Aboujaoude et al. 227). Additionally, telemental health services can reduce the stigma attached to visiting a mental health

facility and reduce patient anxiety by providing care in the patient's own home. The review evaluated the efficacy of several forms of telemental health care including those discussed in this thesis. It concluded that the available research shows that these telemental health services have proven successful across several psychiatric disorders and supports the use of these services in treating patients (Aboujaoude et al. 228).

Telemental health services can provide treatment for military sexual trauma-related conditions without exposing women veterans to trauma cues at VA facilities or requiring them to spend time and money on travel and childcare. Counseling and therapy via telemedicine allow "veterans with MST histories to receive mental health services in a manner and location they prefer, thereby enhancing force readiness, and ultimately, reducing psychological suffering" (Gilmore et al. 63). Telemental health services have the potential to both increase access to care and improve the quality of mental health care for women veterans.

With the expansion and increased use of telemedicine, there is a correlated increase in "the need to understand how telemental health may be tailored to better meet the mental health needs of different patient populations" (Moreau et al. 182). Telemental health can increase access to mental health for women and also provide them with more female-only care options (Moreau et al. 182). Instead of providing gender-specific mental health services at every VA center, women across the country can support one another and receive counseling together via a telemental health service. Telemental health is particularly beneficial for women veterans due to their responsibilities for child, spousal, and elder caregiving (Moreau et al. 184). When mental health services are provided through a computer, phone, or home-telehealth device, it removes the burden of having to

travel to a VA clinic and arrange childcare in order for women veterans to receive the care they need.

Surveys of leaders and clinicians in VA medical centers support the potential of telemedicine to provide more accessible and gender-specific mental health care for women veterans. One study, which consisted of semi-structured qualitative interviews with stakeholders in VA medical centers and VA outpatient clinics, found that “stakeholders expressed enthusiasm for telemental health’s potential and supported the expansion of services to reach more women veterans” (Moreau et al. 184). The stakeholders in this study included “primary care and mental health leaders, primary care and mental health providers, gynecology staff, nurses, pharmacists, telehealth staff, and other VA staff members directly involved in the care of women patients” (Moreau et al. 183). The stakeholders considered telemental health services to be the most frequently used and most available telemedicine service. Telemental health services were perceived to reduce the overall travel burden on patients seeking care, “especially for rural patients and patients with limited flexibility to travel long distances, or those with disabilities or other medical conditions that limit mobility or travel” (Moreau et al. 184). The ability of telemedicine services to reduce the travel burden on patients was viewed as particularly advantageous for patients receiving telemental health services because mental health care typically requires multiple sessions over a period of time (Moreau et al. 184). When women live in rural or remote areas, the burden of travel time and arranging childcare is even greater, and thus the ability of telemental health services to remove those barriers is even more valuable.

Importantly for women veterans, telemental health services can provide treatment and counseling for MST-related conditions from the patient's own home. Telemental health services can "not only increase access to mental health care overall, but also increase access to gender-sensitive mental health care by facilitating same-gender care if requested by the patient, and providing access to providers with specialized training in women's mental health issues" (Moreau et al. 184). The most frequent mental health concern for women veterans noted by stakeholders was a trauma-related need. During an interview, a women's clinic social worker discussed the use of telemental health services for women veterans with MST-related conditions and those who live in rural or remote areas. She said, "I think telehealth's a wonderful thing. I've seen it work well. I've seen it work in a lot of different areas. I've seen it work with military sexual trauma. We have folks who are so far away they can't get there" (Moreau et al. 184). Telemental health services can also "connect women at multiple, distant community outpatient clinics with a mental health provider for group therapy" (Moreau et al. 184). Telemedicine can provide women veterans with convenient, accessible mental health care from their own homes, a less triggering environment than the VA center.

There are several challenges to the implementation of telemental health services and telemedicine generally. Stakeholders in the VA medical system mentioned the need for "sufficient internet bandwidth over which to conduct telehealth sessions; accessing telehealth equipment such as computers, monitors, and video cameras; the availability of private, dedicated rooms in which to conduct telehealth sessions; and hiring trained personnel to manage the equipment and help to ensure proper functioning of the interface at the beginning of each session" (Moreau et al. 185). In addition to the technological

challenges of telemedicine, there are risks associated with the mental health conditions of the veterans. The stakeholders noted the need for “adequate, locally adapted safety precautions in place to care for patients who may be at risk of acting out against themselves or others” (Moreau et al. 185). While further research and additional policies are needed to address these challenges, telemental health services have demonstrated their ability to provide women veterans with accessible, gender-specific care.

This chapter has provided an account of the biological and social factors that result in gender-specific mental health care needs. It has discussed how the culture, environment, and inaccessibility of VA health care facilities prevent them from serving the mental health care needs of women veterans effectively. Telemental health services were examined as a strategy to provide more women veterans with access to mental health care without the traumatic cues of VA facilities that make it more difficult for women with histories of military sexual trauma to receive care. The next chapter will examine the moral questions regarding the implementation of telemental health services with a focus on the informed consent process, patient privacy and confidentiality, and the therapeutic relationship.

CHAPTER THREE

**POTENTIAL BENEFITS AND MORAL CONCERNS OF TELEMENTAL
HEALTH CARE FOR WOMEN VETERANS**

In this chapter, I examine how the practice of telemental health care addresses three fundamental moral responsibilities: obtaining informed consent to treatment, protecting patient privacy and confidentiality, and establishing an effective therapeutic relationship. The chapter sections describe each of these moral responsibilities and then focus on how specific characteristics of telemental health care consultations affect their fulfillment. I argue that while telemental health does pose challenges to informed consent, privacy and confidentiality, and the therapeutic relationship, it also has the potential to support each of those elements.

INFORMED CONSENT

The informed consent process is an important aspect of the telemental health consultation. The American Telemedicine Association's *Practice Guidelines for Videoconferencing-based Telemental Health* specify that "telemental health organizations and practitioners shall comply with the specific consents to treat and for medication administration that apply to the area of mental health" and "procedures shall be in place between organizations and telemental health practitioners for the purpose of obtaining and sharing consents" (Yellowlees, Shore, et al. 1078). While telemental health consultations should comply with all requirements of informed consent for a traditional

consultation, there are also additional considerations specific to informed consent in the telemedicine context.

An effective informed consent process is crucial to the ethical implementation of telemental health care, as it is essential to patient autonomy. In the 1970s, scholars of medical ethics began to emphasize the emerging legal duty to obtain informed consent as “a valuable mechanism for encouraging a more equal relationship between patients and physicians and a more active role for patients in making treatment decisions” (Moskop, “Informed Consent to Treatment” 102). The patient’s right to informed consent includes a corresponding right to informed refusal of treatment. The two primary moral grounds for these rights are “respecting patient autonomy and promoting patient well-being” (Moskop, “Informed Consent to Treatment” 102). Informed consent shows respect for the patient’s autonomy, that is, her ability and authority to make health care decisions. Respecting a patient’s right to informed consent also promotes patient well-being because it enables “the patient to make choices in light of his or her own values and interests, and treatments chosen based on those values and interests are most likely to achieve the best outcome for that patient” (Moskop, “Informed Consent to Treatment” 103).

There are three essential elements to informed consent. The patient must have decision-making capacity, must receive the information required to make an informed decision, and must be able to make the decision voluntarily. If the patient does not have decision-making capacity, then “the provider must ordinarily obtain consent to treatment from a surrogate decision-maker authorized to act on behalf of the patient” (Moskop, “Informed Consent to Treatment” 110). These three elements are essential to valid

informed consent, whether it is a telemental health consultation or a traditional medical encounter.

The process of providing the information required for informed consent to a specific treatment should be held to the same standard in a telemental health consultation as in a traditional clinic. The types of information needed for a patient to provide informed consent include “the patient’s medical condition, and the expected consequences of that condition without treatment; the reasonable or standard treatment alternatives for that condition; the significant expected benefits and harms of the treatment alternatives, and their probabilities; and in most cases, a treatment recommendation” (Moskop, “Informed Consent to Treatment” 106). While the patient and provider are in different physical locations during a telemental health consultation, the provider is still responsible for providing this information in order to enable the patient to make informed health care decisions. There are two widely recognized legal standards of information disclosure: the professional standard and the reasonable person standard. The professional standard “requires health professionals to communicate that amount of information that other professionals with similar training and experience would communicate in similar situations” (Moskop, “Informed Consent to Treatment” 107). The professional standard would require telemental health care providers to communicate the information that other mental health professionals would communicate in a traditional clinic. The reasonable person standard “directs professionals to provide the amount of information that a reasonable person would want to have in order to make a treatment decision in the given situation” (Moskop, “Informed Consent to Treatment” 107). Similar to the professional standard, the reasonable person standard would require

telemental health providers to provide the same standard of information as mental health professionals in a traditional clinic, but that standard would be guided by judgments about what information patients find relevant and important for their treatment choices.

While the standards for informed consent to a specific treatment remain similar in both telemental health care and a traditional clinic, the general consent to treatment in a telemental health consultation should include elements specific to the telemedicine context. There are requirements established by the American Telemedicine Association (ATA) for the informed consent process in a telemental health consultation. The ATA states that a mental health professional providing care through a telemental health service should “have a comprehensive informed consent that should be reviewed and completed with a client in real-time” (Swenson et al. 315). The informed consent document should still contain the information of a typical informed consent document for an in-person counseling session. This would include information regarding “session length, scheduling, cancellations, fees, record keeping, mandatory reporting requirements, and confidentiality” (Swenson et al. 315). Additionally, the ATA recommends that telemental health informed consent documents contain “an agreed upon emergency plan, what happens in case of technological failure, how contacts between sessions will be handled, under what conditions might videoconferencing no longer be appropriate and an in-person referral would need to be made (such as when a client begins using substances heavily or becomes suicidal), and finally, issues related to confidentiality and telemental health” (Swenson et al. 315). This kind of information is specific to the telemedicine context and is necessary for the patient to provide general informed consent to telemental health care.

In addition to the ATA's practice guidelines, the Department of Veterans Affairs has specific guidelines of its own for obtaining informed consent for treatments recommended or provided via telemedicine. The VA guidelines state that the objective of the informed consent discussion is to inform patients about the risks, benefits, and alternatives of the recommended treatment before deciding whether or not to accept it (*Signature Informed Consent Workflows: "Gurney Consent" 1*). This objective is true regardless of the setting or the mechanism of informed consent. The VHA policy asserts that the consent discussion "can occur in person, by telephone or via teleconference, and can be conducted by the practitioner or delegated to trained team members" (*Signature Informed Consent Workflows: "Gurney Consent" 1*). This statement affirms that the informed consent process can take place via teleconferencing during a telemental health consultation. The policy also explicitly states that while written education materials can be used to supplement the informed consent discussion, "written materials cannot be provided to the patient (or surrogate) in lieu of the informed consent discussion" (*Signature Informed Consent Workflows: "Gurney Consent" 1*). This means that the provider is still required to have a discussion with the patient regarding informed consent during a telemental health consultation. The minimum requirement for the informed consent process is that the patient is provided with the relevant information and is then given the opportunity to discuss any questions or concerns with the practitioner (*Signature Informed Consent Workflows: "Gurney Consent" 1*). The relevant information provided to the patient should include the unique features of the telemental health process.

One telemedicine informed consent practice used by the Department of Veterans Affairs is the iMed consent form. It is a software package that allows for electronic completion, signature, and storage of documents (*Signature Informed Consent Workflows: "Gurney Consent" 2*). The iMed consent form allows for asynchronous signature, which means that the provider and the patient do not have to be in the same location, and completion of the informed consent form can be placed on hold (*Signature Informed Consent Workflows: "Gurney Consent" 2*). While the iMed consent form may be a convenient method for documenting consent, it should not take the place of an informed consent discussion. The provider, or whoever is having the informed consent discussion with the patient, should carefully review the informed consent documents in real time with the patient and have a dynamic conversation about the technological, privacy, security, and referral processes specific to a telemental health consultation. The standards for informed consent to a specific treatment should remain equivalent in both a telemental health consultation and a traditional clinic visit, but the general consent to telemental health care should include additional information regarding the significant features of the consultation that are specific to telemedicine.

PRIVACY AND CONFIDENTIALITY

The responsibility to protect a patient's privacy and confidentiality is another important ethical consideration for telemental health consultations. Both the telemedicine process and the general provision of mental health care include inherent risks to patient privacy and confidentiality. The American Telemedicine Association's *Practice*

Guidelines for Videoconferencing-based Telemental Health specify that “telemental health organizations and practitioners shall be aware of the enhanced requirements for privacy and confidentiality that is afforded to patients receiving mental health care” (Yellowlees, Shore, et al. 1078). In order to safeguard protected health information, the guidelines advise encryption of video sessions, consistent resolution between images and display monitors, interoperability of teleconferencing equipment, use of computers that comply with all facility, state, and federal regulations, and use of a minimum aggregate of 6 phone lines into a single-bandwidth connection to ensure transmission of information. Additionally, the guidelines advise the implementation of billing and coding processes that “share information across systems for the purpose of payment that do not risk exposure of mental health patients’ personal health information” (Yellowlees, Shore, et al. 1078). These guidelines specifically address the processes of telemedicine that threaten the privacy and confidentiality of patients, namely the sharing of data and use of teleconferencing technology.

Implementing safeguards to protect patient data in telemental health care is essential for carrying out the fundamental moral responsibility to respect the privacy and confidentiality of patients. Respect for patient confidentiality is an ancient and fundamental professional responsibility in health care; it is explicitly recognized in the Hippocratic Oath (Moskop, “Privacy and Confidentiality” 79). Privacy, in the health care context, includes physical privacy, informational privacy, and decisional privacy. Physical privacy is understood as “important personal interests in freedom from unwanted contact with others or exposure of one’s body to others” (Moskop, “Privacy and Confidentiality” 81). It can be argued that physical privacy is less threatened in the

teleconferencing context compared to the traditional clinic context. In the environment of the patient's own home, it is less likely that physical privacy will be breached than in a hospital setting. Decisional privacy is understood as "important personal interests in making and carrying out decisions about one's own life without interference from others" (Moskop, "Privacy and Confidentiality" 81). Similar to physical privacy, the patient's decisional privacy is not more threatened by a teleconferencing context than in a traditional clinic context, and in fact, the patient may perceive that teleconferencing enhances her decisional privacy. The patient may feel more comfortable making decisions that are not in agreement with the provider's advice when she is teleconferencing from her own home or local clinic rather than discussing the decision with the provider in-person at a VA facility.

The patient's informational privacy is arguably the type of privacy that is most at risk in a telemental health teleconferencing context. Informational privacy includes "important personal interests in preventing disclosure of information about oneself, especially sensitive or embarrassing personal information" (Moskop, "Privacy and Confidentiality" 81). The patient's informational privacy is breached if personal health information is improperly shared. This is more likely to occur when patient data is shared between different providers and offices, as is the case in telemedicine. Additionally, the technological systems that telemedicine services rely on could be hacked and lead to a breach of patient data. Teleconferencing also presents the risk that whoever else is in the patient's home may overhear the patient's confidential discussion with the provider. This risk is amplified in a group therapy setting where multiple patients, all in different locations, are simultaneously teleconferencing with the provider and one another.

Confidentiality is virtually synonymous with informational privacy, and so it requires many of the same protections in the telemental health teleconferencing context. Health care providers “accept a duty of confidentiality when they pledge to protect the personal health information of their patients” (Moskop, “Privacy and Confidentiality” 82). The provider’s commitment to protect the patient’s confidentiality is an essential element of the relationship. When patients trust their health care providers to protect their privacy and confidentiality, they are “more likely to seek care and to communicate health-related information openly and accurately,” and they are “more likely to accept and adhere to the treatment plan those providers recommend” (Moskop, “Privacy and Confidentiality” 83). Due to the impact of trust on the provider’s relationship with the patient, it is vital that the provider protects the patient’s confidentiality when providing telemental health care. An important limit to the duty of a health care provider to protect a patient’s privacy and confidentiality, however, may apply when the patient poses a risk of harm to a third party or to herself (Moskop, “Privacy and Confidentiality” 85). This limit is especially relevant to this discussion of telemental health, as identifying when a patient poses a risk of harm is often an important responsibility of the mental health professional. Policies regarding psychiatric emergencies in telemental health care will be discussed later in this chapter.

Studies of the response of patients to telemental health services indicate the significance of patient privacy and confidentiality in telemental health services. A study by Whealin et al. “evaluated whether ethnically/racially diverse U.S. veterans residing in the rural Pacific Islands would find the delivery of evidence-based treatment for posttraumatic stress disorder via home telehealth tablet devices useful and helpful”

(Whealin et al. 3). Seven percent of veterans reported having technical or privacy concerns. One participant commented “I do not like not knowing who else is in the room with the therapist” (Whealin et al. 10). This statement reflects a threat to the patient’s informational privacy that is not present in the traditional clinic environment. Three veterans withdrew from the study because they lacked the necessary privacy, but eight percent of the veterans who completed the study program responded that they did so because of the increased privacy/confidentiality of the sessions (Whealin et al. 7). Mental health teleconferencing has the potential to increase or decrease the patient’s privacy. While the patients can have increased control over their physical and decisional privacy in their own homes, there is also an increased risk of inappropriate sharing of information outside of a traditional clinic environment.

Government surveillance programs also pose a threat to the privacy and confidentiality of patients engaging in telemental health programs. For example, analysts and contractors of the National Security Agency have a “49% likelihood of incorrectly targeting a domestic citizen of the U.S. ” (Lustgarten and Colbow 164). Additionally, Skype, a popular system used for teleconferencing, has been used by the NSA to collect data on a target, and if one member of the Skype conversation is a target, then “both parties’ data, video, audio, and messages are collected synchronously with conversation” (Lustgarten and Colbow 164). Like Skype, Google Hangouts is a popular teleconferencing program used for telemental health programs. The NSA has infiltrated data centers at Google and Yahoo which means that unless providers “encrypted all e-mails, data, and videoconferences prior to using either service, it is possible that PHI [protected health information] was disclosed in the process” (Lustgarten and Colbow

164). In view of this threat to patient confidentiality, there are several practices that mental health professionals who regularly provide telemental health services should implement to protect their clients' data. Investigators advise that mental health professionals providing telemental health services use end-to-end encrypted software to reduce the risk of unintended data breaches, dedicate a computer solely for telemental health services, and employ two-factor authentication on devices (Lustgarten and Colbow 166). As the use of telemental health services in the VA grows, it is important that providers are aware of the risk of NSA surveillance and take measures to protect patient privacy.

In order to protect patient privacy and confidentiality, the American Counseling Association (ACA) recommends that those using telehealth technologies in practice and research “consult with a lawyer who specializes in healthcare policy and privacy” (Lustgarten and Elhai 3). The ACA also requires those using technology to have a clear understanding of technological threats to privacy and security and work with patients to ensure the security of devices. Privacy and security risks are not mathematical or computational challenges, but rather are human factors that are influenced by the ways in which people interact with technology (Lustgarten and Elhai 2). The two regulatory frameworks that regulate the conduct of mental health providers, and thus would apply to those providing telemental health care, are regulations adopted to implement the federal Health Information Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH). HIPAA requires that “reasonable precautions must be met when creating or transmitting PHI” (Lustgarten and Elhai 3). A provider's ability to comply with the ethical and legal

restrictions of HIPAA and HITECH can be affected by the wireless networks and devices used for telemental health services. HITECH also makes providers responsible for “signing business associate agreements (BAAs) when entering into data and cloud storage services controlled by third parties” (Lustgarten and Elhai 3). It is important for providers of telemental health services to understand the impact of the technology services they use on their ability to comply with legal and ethical restrictions.

The American Psychological Association (APA) has also recognized the risks to patient privacy and confidentiality when providing telemental health care. The APA has proposed Guidelines for the Practice of Telepsychology, and guideline three not only “notes that psychologists provide informed consent in telepsychology” but also “suggests talking with clients about privacy and security risks associated with treatments via digital means” (Lustgarten and Colbow 163). This statement reflects the need for the telemental health care informed consent process to include disclosure of risks specific to teleconferencing. The fourth guideline requires that “psychologists ‘make reasonable effort’ to ensure privacy and confidentiality in technological environments” including security measures such as passwords and encryption (Lustgarten and Colbow 163). Additionally, to prevent unnecessary breaches of the patient’s privacy, providers should acquire and maintain the technological competency to address minor technological issues without involving third parties. The fifth guideline addresses various risks to client privacy, such as viruses, hackers, security flaws, and software bugs, and encourages psychologists to conduct risk assessments. The APA guidelines assign significant responsibility to mental health professionals to ensure that their telemental health care services protect patient privacy and confidentiality. This reflects an understanding that

protection of patient privacy and confidentiality is a core element of the therapeutic relationship.

THERAPEUTIC RELATIONSHIP

The nature and quality of the therapeutic relationship are morally significant features of health care. Characteristics of the relationship that give it special moral significance include that “health care professionals care for people who are vulnerable” and “health care professionals protect and promote fundamental human values of life, health, physical and mental functioning, and relief of pain and suffering” (Moskop, “Professionalism: Responsibilities and Privileges” 128). Health care professionals pledge to promote the best interests of their patients over their own self-interest. Additionally, the therapeutic relationship “requires a distinctive kind of intimacy in which patients disclose confidential personal information and give health care professionals access to private parts of their bodies for examination and treatment” (Moskop, “Professionalism: Responsibilities and Privileges” 128). These aspects of the relationship warrant its recognition as a special relationship with moral significance. Patient trust, as previously discussed in the context of protecting patient confidentiality, is also vital to the therapeutic relationship since “patients must trust in the knowledge, skill, and good intentions of professionals, and professionals must rely on the trust of their patients in order to care for them effectively” (Moskop, “Professionalism: Responsibilities and Privileges” 128). The quality of the relationship is thus essential to providing adequate health care. When providing telemental health care, as when providing care in the

traditional clinic context, the integrity of the therapeutic relationship is morally important and therefore must be preserved.

While the telemental health teleconferencing context may alter the therapeutic relationship, the changes are not necessarily detrimental to the relationship, and in some cases, are beneficial. In one recent study, psychiatric medicine trainees, who are typically 25-30 years old, found telepsychiatry appealing and more patient-focused than a traditional clinic visit (Yellowlees, Richard Chan, et al. 477). Telemental health care may appeal to younger providers because it aligns with their daily use of technology. Providers of the millennial generation “do not have to be convinced that it is possible to have empathetic and powerful relationships through video, as they already have these in their personal social media-enabled lives” (Yellowlees, Richard Chan, et al. 477). As time passes, more millennials become providers, and more baby boomers retire, there will be more providers who are comfortable with the use of telemedicine technology. On the provider side of the therapeutic relationship, there is evidence for increased acceptance of telemental health care.

Patients also report high satisfaction with telemental health care. One factor that contributes to high patient satisfaction is “the empathic connection that patients feel that they can make with their telemedicine providers” (Yellowlees, Richard Chan, et al. 478). Factors that enhance the therapeutic connection are increased eye contact in a teleconsultation as compared to a traditional office visit and decreased patient anxiety by being seen in a location close to their home. Patients report high satisfaction due to the travel time and money saved by participating in a telepsychiatry service nearby rather than traveling to see a specialist in person (Yellowlees, Richard Chan, et al. 478).

Telemental health consultations also alter the power relationship between the provider and the patient. In a traditional clinic visit, the provider “typically has more authority, and the psychological advantage of being in his or her own clinic or environment” (Yellowlees, Richard Chan, et al. 478). During a telemental health consultation, the patients often perceive that they have more control. They have the ability to “literally ‘switch off’ the doctor at their end, and leave the consultation without any physical embarrassment or loss of face” (Yellowlees, Richard Chan, et al. 478). The increased patient control in a telemental health consultation allows patients to be more trusting of mental health professionals and more open to treatment, and thus enhances the therapeutic relationship.

A telemental health consultation also provides a virtual space, with physical and psychological components, between the patient and provider that can actually be beneficial to the therapeutic relationship. The physical distance between the provider and patient “enhances a feeling of safety [for providers], particularly when seeing patients who are physically dangerous or who inhabit potentially dangerous environments” (Yellowlees, Richard Chan, et al. 480). That physical distance is also beneficial for patients who feel uncomfortable in the traditional clinic environment or uncomfortable being alone in a room with the provider. For example, women veterans who are victims of MST often feel more comfortable receiving care in their own homes than in a VA facility (Gilmore et al. 63). The provider’s physical distance from the patient also allows him or her to feel safer in providing “much more direct feedback to patients...especially if this feedback involves comments on substance-related, behavioral or personality-focused issues that the patient may not wish to hear about, or may disagree with” (Yellowlees,

Richard Chan, et al. 480). Additionally, patient confidentiality can be enhanced by seeing providers who do not live in their community, especially if they live in a small community (Yellowlees, Richard Chan, et al. 480). In an unexpected way, the physical distance between a patient and mental health professional in a telemental health consultation can actually increase the intimacy of the therapeutic relationship.

Similar to physical distance, psychological space between a patient and provider can benefit their relationship. The psychological space between the provider and the patient in a telemental health consultation “frequently allows [patients] to have more intimate conversations with their providers than they would have in a physical consultation” (Yellowlees, Richard Chan, et al. 480). People find it easier to discuss embarrassing, stigmatizing, or awkward topics and give more honest responses when communicating via a teleconsultation than in a traditional office visit. The psychological space between patients and providers in a telemental health consultation can benefit the relationship by providing an environment in which the patient is more comfortable having difficult conversations with the mental health professional.

It is also important to note that for some patients, the advantages of telemental health care for the therapeutic relationship will not outweigh its disadvantages. Those patients may experience a significant loss of connection to their provider when discussing difficult topics through a teleconferencing system, and they may feel that telemental health does not adequately serve their needs.

The American Telemedicine Association recognizes the importance of preserving the integrity and quality of the therapeutic relationship in telemental health consultations. The ATA’s *Practice Guidelines for Videoconferencing-based Telemental Health* specify

that “health professionals shall ensure that the standard of care delivered via telemedicine is equivalent to any other type of care that can be delivered to the patient/client, considering the specific context, location and timing, and relative availability of in-person care” (Yellowlees, Shore, et al. 1078). Additionally, the guidelines state that “health professionals shall be responsible for maintaining professional discipline and clinical practice guidelines in the delivery of care in the telemedicine setting, recognizing that certain modifications may need to be made to accommodate specific circumstances” (Yellowlees, Shore, et al. 1079). These guidelines establish that the therapeutic relationship in the telemental health context is held to the same expectations as the relationship in the traditional clinic context. Guidelines specifically regarding the procedures of video teleconferencing state that all persons present for the consultation at both sites should be disclosed to both the patient and provider. The presence of a third party may be required in situations where “safety concerns mandate the presence of another individual or if the patient is being legally detained” (Yellowlees, Shore, et al. 1079). These third parties should sign confidentiality agreements and should follow HIPAA and HITECH restrictions. This guideline recognizes that protecting patient privacy and confidentiality is an essential element of a quality therapeutic relationship. The ATA also recognizes how videoconferencing technology can be beneficial in these relationships. Videoconferencing technology allows telemental health users to “display static pictures, diagrams, or objects; view and share a computer desktop or applications; play videos or CDs so people at other locations can see and hear them; record meetings when clinically appropriate and with patient permission; and share information on a common white board or via computer files” (Yellowlees, Shore, et al. 1081). These

technologies allow for enhanced communication between the mental health professional and patient, which can result in a stronger relationship and better care for the patient.

The ATA's guidelines specifically address the responsibilities of a provider using telemental health technology in responding to a psychiatric emergency. A provider's response to a psychiatric emergency is an important element of the therapeutic relationship when providing mental health care. In a psychiatric emergency, the *Practice Guidelines for Videoconferencing-based Telemental Health* state that "a patient site assessment shall be undertaken that includes obtaining information on local regulations and emergency resources" (Yellowlees, Shore, et al. 1080). The guidelines also advise that providers become familiar with local regulations and make arrangements to work with local staff. This includes the creation of an emergency protocol, becoming familiar with local civil commitment regulations, and being aware of "safety issues with patients displaying strong affective or behavioral states upon conclusion of the session, and how patients may then interact with remote site staff" (Yellowlees, Shore, et al. 1080). When providing telemental health care, the mental health professional is required to ensure that psychiatric emergencies are handled as they would be in a traditional clinic and that the physical distance between the patient and the provider does not prevent the patient from receiving the help she needs. Psychiatric emergencies are an example of a situation in which extra measures are required of telemental health professionals to ensure that the quality of the therapeutic relationship is maintained. While telemental health may present challenges to the relationship between providers and patients, strategies are available to address these challenges such as the security measures and guidelines described above. Moreover, several features of telemental health consultations can enhance the satisfaction

and comfort of both patients and mental health professionals, thus strengthening their relationship.

This chapter explored the risks and benefits of telemental health care in obtaining informed consent to treatment, protecting patient privacy and confidentiality, and maintaining effective therapeutic relationships. The standards for informed consent to a specific treatment should remain equivalent in both a telemental health consultation and a traditional clinic visit. Telemental health complicates the general consent to treatment process, and informed consent discussions should include specifics regarding the technological and safety aspects of telemental health care. Though the general consent to treatment process is more demanding for telemental health care, it is still possible to adequately inform patients of the risks and obtain their valid informed consent.

Telemental health care poses risks to the patient's privacy and confidentiality through the increased sharing of patient data, the possibility of hacking and data breaches, and the uncontrolled elements of teleconferencing to a non-traditional clinic site. While these risks are serious, telemental health care also has the potential to increase the patient's privacy and confidentiality by allowing her to receive care in her own home and have more control over her physical and decisional privacy. The therapeutic relationship, though altered by the characteristics of telemental health care, is enhanced in several ways by the increased physical and psychological distance. This distance between the patient and provider allows some patients to feel more comfortable talking about painful topics and increases patient satisfaction by saving travel time and money. Although telemental health care does pose challenges for informed consent, privacy and

confidentiality, and the therapeutic relationship, it also has the potential to support each of these elements.

CHAPTER FOUR
JUSTIFYING THE EXPANSION OF TELEMENTAL HEALTH CARE
FOR WOMEN VETERANS

In this chapter, I argue that telemental health care should be expanded to serve the mental health care needs of women veterans more adequately. First, I discuss the ability of telemental health care to provide more accessible care and address the gender-specific needs of women veterans. Then, I briefly reexamine the influence of the telemental health context on the moral responsibilities of obtaining informed consent to treatment, protecting patient privacy and confidentiality, and establishing an effective therapeutic relationship, as discussed in chapter three. I argue that with appropriate safeguards, the benefits of telemental health care to women veterans outweigh its risks. Then, the focus of the chapter shifts to a discussion of studies that establish there is an unmet need for accessible and effective mental health care for women veterans. Finally, I argue that the expansion and implementation of telemental health care for women veterans is justified in terms of both reciprocal and compensatory justice.

THE BENEFITS OF TELEMENTAL HEALTH CARE MERIT ITS EXPANSION
BUT SAFEGUARDS ARE NEEDED

As previous chapters have established, there are several benefits of telemental health services for women veterans. There are both social and biological factors that affect the mental health care of women differently from that of men and necessitate

gender-specific services. For example, conditions during premenstrual, perinatal, and perimenopausal stages can affect psychiatric conditions and the general mental health of women (Moreau et al. 182). Women are also more likely to be single parents and caregivers to elderly relatives (Bird and Rieker 749). These factors affect the ability of women veterans to travel to VA facilities to receive mental health care. Additionally, studies cited in this thesis have reported a desire for increased access to gender-specific mental health services. Many women veterans have indicated that they feel uncomfortable in VA settings because of their gender and would prefer female-only mental health services (Kimerling et al. S98). The VA culture and environment is especially triggering to women veterans suffering from MST-related conditions (Gilmore et al. 62).

Telemental health services can provide more accessible and effective mental health care for many women veterans. Counseling and therapy via telemedicine allow women veterans to receive care without exposing them to trauma cues at VA facilities or requiring them to spend time and money on travel and childcare. Additionally, telemedicine can make female-only care options more accessible by connecting women veterans with female mental health professionals regardless of their location (Moreau et al. 182). It is important to note that providing female-only care options is not a matter of convenience or preference but rather a matter of providing effective treatment options for women suffering from military sexual trauma or other psychological trauma. Furthermore, due to limited funding and resources, it is not clear whether existing VA telemental health services can adequately address the needs of all women veterans who could benefit from receiving telemental health care.

While telemental health services do pose challenges to fulfilling the moral responsibilities of obtaining informed consent to treatment, protecting patient privacy and confidentiality, and establishing an effective therapeutic relationship, they can also support each of those responsibilities. The informed consent process can protect the patient's rights and better inform her by including information specific to the technological aspects of telemental health services. This enhances the patient's autonomy and promotes her well-being. If providers understand the importance of discussing the telemedicine-specific aspects of care as well as the material information about the treatments they recommend, then the informed consent process is not jeopardized.

The patient's privacy and confidentiality can also be strengthened through telemental health services. The physical privacy of the patient is less threatened when the patient receives care via teleconferencing than in the traditional clinic context. The patient's decisional privacy is no more threatened by a teleconferencing context than in a traditional clinic context, and the patient may actually feel more comfortable making decisions that are not in agreement with the provider's advice when she is teleconferencing from her own home or local clinic rather than discussing the decision with the provider in-person at a VA facility. While the patient's personal health information is arguably at higher risk of breach in the telemedicine context, practices can be implemented to protect patient confidentiality. Providers should use added security measures like passwords and encryption and talk with clients about privacy and security risks (Lustgarten and Colbow 166). Additionally, providers should comply with the informational privacy protections of the HIPAA and HITECH regulations (Lustgarten and Elhai 3). With the appropriate safeguards, telemental health services do not present

insurmountable risks to the patient's informational privacy and may actually enhance her physical and decisional privacy.

The nature and quality of the therapeutic relationship is also potentially strengthened by the context of telemental health services. Teleconferencing allows for increased eye contact as compared to a traditional office visit, and receiving care in a location close to home can decrease patient anxiety (Yellowlees et al. 478). Additionally, telemental health services provide a virtual space, with physical and psychological components, between the patient and provider (Yellowlees et al. 480). This space can be beneficial to the therapeutic relationship by enhancing patients' sense of control over their care. Patients can receive care in a convenient and less-triggering environment where they may feel more comfortable having difficult conversations with the provider. In sum, although telemental health care poses challenges to professionals in fulfilling their moral responsibilities of obtaining informed consent to treatment, protecting patient privacy and confidentiality, and establishing an effective therapeutic relationship, these challenges can be managed with the appropriate safeguards. The potential of telemental health care to satisfy these moral requirements and to provide more accessible and effective care for women veterans provides significant support for its implementation and expansion.

WOMEN VETERANS SEEK MORE ACCESSIBLE AND EFFECTIVE MENTAL HEALTH CARE

Women veterans have expressed difficulty accessing VA mental health care services that satisfy their gender-specific needs. A 2016 study included five focus groups with women veterans from North Carolina, Colorado, Georgia, Hawaii, California, Washington, and Texas (Brooks et al. 977). The women veterans in the study all lived in rural or highly rural areas. The focus group session consisted of a Services Identification Task in which participants received a list of health services and were asked to indicate the services needed by women veterans in their area (Brooks et al. 977). Each session also included a semi-structured interview and group discussion during which participants were asked about the quality and accessibility of local VA services and telehealth options (Brooks et al. 977). The majority of participants took issue with the distance required to travel to VA medical centers and voiced several problems related to extended travel including work conflicts and childcare. One woman veteran who is also a student is quoted in the study as stating “They [the VA] seem to have no idea that you can’t simply take sick leave from school” (Brooks et al. 978). The study also revealed unfavorable opinions about the VA shuttle options. Fifteen participants reported that the shuttle was not time efficient, and only one participant regularly used the service. One woman veteran stated that “she felt uncomfortable using the shuttle because she was the only woman among a group of men” (Brooks et al. 978). Other women also stated that they were uncomfortable receiving care from the VA because of their gender. Three of the participants stated that they “felt ‘stared at’ while waiting for medical appointments and two said that male veterans made them feel like they did not belong at the [VA] hospital” (Brooks et al. 979). These concerns voiced by women veterans emphasize how traveling to a VA medical center disproportionately burdens women veterans.

The 2016 study also revealed that access to VA mental health care is a significant issue for women veterans. In the Services Identification Task, the women veterans ranked mental health as the second highest need in their local communities, following only dental care (Brooks et al. 978). One participant emphasized the difficulty of receiving a mental health appointment if she did not have urgent problems. She stated ““They [the VA] see women functioning, you know, having a job, raising a family and, basically you need to be suicidal [to get help].”” (Brooks et al. 978). While the women veterans in the study noted a general preference for in-person care, they viewed video teleconferencing as providing two primary advantages. Video teleconferencing reduced time-consuming travel for medical appointments and “allowed for more consistency in providers-- particularly for mental health” (Brooks et al. 979). As this study indicates, women veterans identify a lack of access to mental health services and recognize the potential for telemental health to address their needs.

Another recent study, consisting of in-person interviews with 22 women veterans in Los Angeles, California, examined factors that affect women veterans’ use of VA health care services (Evans et al. 3). One participant in the study reported her frustration with VA staff who were not experienced in treating women who had been in combat:

I’m a combat veteran. They don’t know how to deal with female combat veterans. Males...are extroverted with their anger...and females...they’re introverted with their anger, and that to me is more deadly...than being extroverted angry...It’s more detrimental to the veterans...to keep it in...It doesn’t make any sense to me why there’s so many female combat veterans now and we’re not getting the help.

We're not even getting the recognition as being combat veterans because women aren't supposed to be in combat (Evans et al. 13).

Another women veteran in the study reported that she had been “treated by clinical staff who did not recognize her combat-related trauma because it was assumed that, as a woman, she would not have been in combat” (Evans et al. 13). These statements suggest that the culture of the VA is insensitive to women veterans and is not providing effective mental health care for them.

Women veterans in the study also expressed their frustration with the VA over treatment for MST. One participant noted the difficulty of receiving treatment for MST when female-only options are not accessible:

They [the VA in a Southeastern state] had a women's clinic, but it was separate; it was off to the side, and it was all male doctors...And so...how are you supposed to open up about anything that happened to you, period. I didn't know that I had had military sexual trauma until I had gotten here [at the VA in a Western state], and then I was like, “Yeah, that's happened to me, that's happened to me” (Evans et al. 14).

Women veterans also reported that military-specific stressors in the VA medical centers affected their ability to receive care. A woman veteran with combat-related trauma stated, “I couldn't stand to see anybody in uniform, you know; it triggered too much shit for me” (Evans et al. 18). Another woman veteran suffering from depression described her reluctance to receive care at a VA facility. She stated “I was like, ‘Well, I'm not going to ask the military. I don't want to be on base. I don't want to be around that’” (Evans et al. 18). These statements emphasize the burden of the VA environment on women suffering

from mental health conditions and the benefit of receiving telemental health care from their own homes or a local clinic.

In regard to potential improvements in the mental health services offered by the VA, study participants expressed a desire for greater access to psychologists and therapists and for classes on meditation and coping with stress. One woman veteran stated, “I feel like you go to a psychiatrist and they’re there for your medications and then you go to a psychologist and they’re there for your head, but they need to talk, and I just don’t feel like that happens, because the VA just seems to want to give you a pill, and it sucks” (Evans et al. 17). Another participant stated, “I just think nowadays that maybe they could do some stuff like, for stress relief. I think more psychologists or therapists [are needed]...” (Evans et al. 17). These statements reflect a desire for greater access to a broader range of mental health services. The expansion of telemental health would allow more women to be connected to female counselors and therapists regardless of their location. The studies cited in this chapter clearly show that our women veterans are asking for more accessible and effective mental health care. This is a need that deserves our attention and can be adequately addressed through the implementation of telemental health services.

THE EXPANSION OF TELEMENTAL HEALTH SERVICES IS JUSTIFIED

In this section, I argue that enhancing access to mental health care services for women veterans is justified by considerations of both reciprocal and compensatory justice. In return for their service in the armed forces, I propose that the US government, acting on behalf of the nation at large, should reciprocate by providing accessible and

effective mental health care for women veterans. This argument is supported by Aristotle's conception of justice. Aristotle describes justice as a virtue of individuals and of constitutions and political arrangements (LeBar and Slote 3). His conception of the formal structure of justice is rooted in the idea of desert, and his understanding of justice in distribution is governed by a proportional relationship between what each person contributes and what each receives (LeBar and Slote 3). The person who contributes more, in whatever terms merit is measured, deserves more. Aristotle's understanding of justice as rectification similarly involves proportionality between deprivations suffered and recompense for those deprivations (LeBar and Slote 3). In the *Nicomachean Ethics*, Aristotle writes that "...if they are not equal, they will not have what is equal, but this is the origin of quarrels and complaints-when either equals have and are awarded unequal shares, or unequals equal shares...for all men agree that what is just in distribution must be according to merit in some sense, though they do not all specify the same sort of merit" (Aristotle 3).

The military service of both men and women has made a substantial contribution to the safety and security of the United States and its citizens. Members of the armed forces accept significant risk to their personal safety and frequent separation from loved ones during their military service. In recognition of their contributions and personal sacrifices, society has decided to provide veterans with health care and the US government has established and maintains a system of health care services specifically for military veterans through the VA. For the VA health care system to achieve its purpose, however, its health care services must be accessible to veterans and must effectively address their health care needs. This means providing care for all their major

health needs, both physical and mental. It is, therefore, not enough that the VA simply provides mental health care services for women veterans, if those services are not accessible or beneficial. Women veterans identify mental health care as a significant need that is not adequately addressed by the VA health care system. Because the VA system is committed to serving veterans equitably in response to their needs for care, it should take action to provide women with mental health care that does not require them to spend considerable time away from their families to travel to a VA medical center and that is offered in a non-triggering environment by clearly qualified professionals.

Considerations of compensatory justice also warrant the implementation and expansion of telemental health services for women veterans. Compensatory justice is understood as “the provision of resources to a victim with the goal of minimizing or reversing the impact of the harm done by the injustice” (Mullen and Okimoto 478). Women veterans have a persuasive claim to receive mental health care to help them recover from harms they suffered during their military service. Those who sustained MST, combat-related trauma, or other psychological trauma experienced a significant loss, and they deserve appropriate and accessible treatment for the associated conditions. In addition to physical harm, injustice can also diminish a victim’s symbolic resources, such as power and control. Recent research on workplace injustices supports the provision of services to restore these symbolic resources in order to achieve compensatory justice (Mullen and Okimoto 480). Providing women veterans with telemental health services can compensate for the loss of power they felt as victims of military-related trauma. When receiving care in their own home or a local clinic via telemedicine, women veterans are not faced with the VA culture and environment that

can trigger feelings of fear, shame, or powerlessness. The added physical and psychological space of telemental health care allows women veterans to feel more in control and more comfortable having difficult conversations with providers (Yellowlees et al. 480).

If women veterans should receive effective mental health care to compensate for the mental trauma they endured while serving in the military, then an important question is, who should be held accountable for that compensation? There are three possible candidates to pay the costs of compensation. The first candidate is the perpetrator of the injustice “whose unjust actions gave rise to the need for compensation” (Amdur 230). This reasoning does not hold the VA accountable since the organization did not directly perpetrate the injustice to women veterans. In situations of repeated psychological trauma related to the environment or culture of the armed forces and VA, it would likely be impossible to identify a single perpetrator to compensate a women veteran.

The second candidate to pay the costs of compensation is whoever directly or indirectly benefited from the injustice (Amdur 230). The United States government and society benefit from the service of women veterans, and so it can be argued that the VA, as a public institution, should pay the costs of compensation to women veterans. It is not about blaming those who benefitted from the injustice and making them pay but rather restoring the victims to the competitive balance that would be in place if the injustice had never occurred. In other words, it asks “those who have gained from injustice to give up what they have gained” (Amdur 231). By providing telemental health services to women veterans, the VA is compensating them for the injustices and harms they endured during their military service, from which the government and society indirectly benefited.

The third candidate to pay the costs of compensation to women veterans is society because “when it is not possible to assign the costs of compensation either to the perpetrators or to the beneficiaries of injustice, those costs should be distributed evenly among the entire community” (Amdur 234). If it is argued that the United States government is not truly an indirect benefiter of the injustices suffered by women veterans during their military service, the VA is still held accountable for the costs of compensation under this reasoning. Society is responsible for compensating women veterans for the psychological trauma they endured while protecting our society. An important objection to this argument is that “it will be impossible to maintain that *everyone* is responsible for *every* unjust practice” (Amdur 235). While this is true, a fundamental purpose of the VA is to provide equitable health care for veterans, and thus it should address the significant mental health consequences of injustices suffered by women veterans. Similar to reciprocal justice, compensatory justice cannot be achieved if women veterans are not able to access the mental health services provided by the VA. Through telemental health services, women veterans can receive care in a non-traumatizing and convenient context, and thus be compensated by the VA for the psychological harm they endured during their military service.

This chapter briefly discusses the gender-specific social and biological factors that affect the mental health care of women and the potential for telemental health services to allow women veterans to receive care without exposing them to trauma cues at VA facilities or requiring them to spend time and money on travel and childcare. It also reexamined how telemental health care poses challenges to the moral responsibilities of

obtaining informed consent to treatment, protecting patient privacy and confidentiality, and establishing an effective therapeutic relationship, and how these challenges can be managed with the appropriate safeguards. The potential of telemental health care to satisfy each of those moral responsibilities and provide more accessible and effective care for women veterans supports my claim for its implementation and expansion.

The studies cited in this chapter emphasize that there is unmet need in mental health care for women veterans. Participants in these studies emphasize that traveling to a VA medical center for care disproportionately burdens women veterans, that the culture and environment of the VA is triggering, and that it is uncomfortable to discuss military sexual trauma without female-only care options. Women veterans also expressed a desire for greater access to a broader range of mental health services.

Finally, I have argued that addressing the unmet mental health care needs of women veterans is justified by considerations of reciprocal and compensatory justice. Women veterans have served in the armed forces protecting our nation, and their service, like the contributions of male veterans, should be reciprocated with accessible and effective mental health care. Women veterans should be recompensed for psychological trauma they suffered during their military service, and the VA should be responsible for providing care to minimize the harms of wrongful acts that inflicted military-related trauma. Women veterans have provided an indispensable service to our country that should not be forgotten. Telemental health care should be further expanded and implemented to provide women veterans with the accessible and effective health care they deserve.

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