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BEYOND THE SCREEN

TELEHEALTH AND CARE IN NEW MEXICO'S BEHAVIOURAL HEALTH SYSTEM

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Thesis submitted for the degree of Doctor of Philosophy

Department of Anthropology

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Abstract

This thesis explores the use of telehealth in the behavioural health system of New Mexico (US), a state in which large portions of the population are rural and where residents live hours away from healthcare resources that tend to be concentrated in urban cities. In the effort to address gaps in the access to care, the state turned to telehealth technologies to provide secure, virtual, face-to-face doctor-patient encounters to rural residents. Drawing from ethnographic material collected across 2018 and 2019 at both sites that provide and receive such services, this thesis argues that telehealth shifts the nature of care by reconfiguring the mobilities, spaces and materials involved in the antecedent practices. These shifts afford changes in health worker roles and patient trust in the health system, as well as both the reduction and reproduction of inequities in healthcare. This thesis explores how the transformation of the doctor-patient encounter via telehealth produces new forms of distance, relations and entanglements that extend far beyond the basic technologies that so often characterise this type of care. These implications are felt throughout the communities and state-run health system and become part of the social geography of this sparsely populated state. Ultimately, in taking seriously the ambiguous realities of telehealth, this thesis contends that these technologies not only shape the way care is provided, but the functioning of health systems and the sociality of our daily lives.

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Abbreviations

AAFP	American Academy of Family Physicians
AMA	American Medical Association
ANT	Actor Network Theory
BRAC	Base Realignment and Closures
CATS	Clovis Area Transport System
CYFD	Children Youth & Families Department
HIPAA	Health Insurance and Portability and Accountability Act
HPSA	Health Professional Shortage Area
HRSA	Health Resources and Services Administration
IRB	Institutional Review Board
PES	Psychiatric Emergency Service
SAMHSA	Substance Abuse and Mental Health Services Administration
SRMC	Sandoval Regional Medical Centre
UNM	University of New Mexico
US	United States

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Chapter 1: Introduction

*Bonnie agrees for me sit in on her session with Amanda, one of the tele-therapists at the Clovis Clinic. We walk into Amanda's office. It is empty besides a desk with a computer monitor and a couple of chairs. The air is stale. The computer screen is blank. There is a chair pushed up against the desk that Bonnie pulls out and sits in. I take a seat in the corner of the room opposite the desk. I can see the back of Bonnie, the rest of the room and the computer screen. I try my best to sit in a place that is far enough behind Bonnie that she cannot see me in her periphery, but not too much behind her that I show up in the small square on the computer screen that displays her video image. The screen wakes up with an incoming call from Amanda. Bonnie clicks the circular green answer button. Now, taking up almost the entire screen is a large window with Amanda's face, neck and shoulders in front of a white wall. This wall could be anywhere – "*maybe she's on the other side of town*" Bonnie wonders out loud later during our interview. We are constantly reminded during the session that Amanda is not looking directly at Bonnie, she is looking first and foremost at a computer screen. Her glasses catch the glare of her own screen, often eclipsing her eyes. A much smaller window, in the top right corner of the screen, shows Bonnie and I what Amanda sees on her side. There is Bonnie's curly hair, Bonnie's face and the top of her shoulders. Amanda cannot see much of what Bonnie is wearing. She cannot see the big purse that Bonnie lugged in, already having set it down on the desk next to her, off camera, before their session started.*

The desk chair is a little high and Bonnie's feet are dangling. Sometimes she kicks them back and forth, sometimes she rests them on the wheeled legs of the chair. She plays with the computer mouse, rolling the scrolling wheel, moving the mouse to-and-fro on the desk. The cursor mirrors this motion, flying across and back over Amanda's two-dimensional face. Bonnie moves on to playing with a pen chained to the desk, then the computer keyboard and ultimately her phone which lays in front of her, all out of the camera's view.

Bonnie and Amanda generally take turns talking. Sometimes Bonnie starts talking over Amanda and it takes a moment for Amanda to realise this and then to stop talking so she can hear what Bonnie is saying. At several points, Bonnie wipes tears with a tissue she grabbed from somewhere off camera. She picks at her nails, then plays with the sleeve of her sweatshirt and then the used tissue. She pulls, twists and wrings the tissue until it is completely shredded, forming a small pile of tissue bits on the desk in front of her.

There is an entire life off camera. Bonnie's emotions are displayed materially and spatially, through the shredded tissue on the desk. Through her constant movement in space, fiddling, scrolling and kicking. However, this is all on the periphery of the camera; all outside Amanda's view. Waiting for us on the outside of Amanda's office is the busy clinic waiting room. Lines of people waiting to check in or out from the understaffed front desk. There is the smell of vomit lingering in the clinic's halls from someone who got sick earlier in the day. Past the clinic walls is the heaviness of the mid-day heat.

At the end of the session, Bonnie gushes with thanks for Amanda. She tells Amanda that her words are with her all the time and that she thanks her for her help from the bottom of her heart. Although Amanda and Bonnie do not share the same space, although Amanda is unable to see any of the goings on below Bonnie's shoulders, and although she is not there to experience the crowded clinic or the heat outside, care has still happened here. Bonnie leaves the session feeling calmer, supported and listened to.

This thesis is about the use of telehealth in the New Mexican behavioural health system and the ways in which it articulates with both care and daily life. Telehealth makes accessible specialist care to populations that otherwise would not have access. However, this care is of a different nature than care in-person; it is made up of alternate mobilities, spaces, materials and forms of distance. It involves the empty room with the blank screen, the shredded tissue, the busy waiting room and the heat outside. This shift in the nature of care has many implications. It articulates with inequities in healthcare, feelings of trust in the health system, experiences of state absence and presence, and imaginations of what forms of care are possible. It bears on health worker roles and responsibilities, and the negotiations of when care should and should not happen. Ultimately, this thesis makes two overarching arguments: that telehealth changes care and that the use and implications of telehealth extend far beyond the basic technologies that make up remote patient encounters.

What is telehealth?

Telehealth describes any form of healthcare delivered at a distance. Following the rapid development of telecommunications in the second half of the 20th century alongside deepening awareness of global inequities in the access to healthcare, telehealth technologies were initially designed to deliver clinical services to remote populations (Bashshur 1995). Connections between health workers and patients via telehealth started out on telephones and closed-circuit networks. Currently, care over

telehealth is provided via wireless devices like smartphones and video applications such as Skype and Zoom. Telehealth comes in many forms[1] and is used across the spectrum of healthcare services. In this thesis, telehealth takes the form of secure, internet-based video-conferencing technologies that enable face-to-face therapy and psychiatry encounters across geographical distance.

Before the COVID-19 pandemic, telehealth most commonly reflected a 'hub and spoke'-type system, whereby medical specialists based in urban hospitals and clinics were linked to rural health centres to care for geographically marginalised populations. In doing so, telehealth offered a potential solution to health systems struggling with time and financial pressures, as well as systems trying to reduce disparities in the access to healthcare services between urban and rural populations (World Health Organisation 2019).

The United States (US) has long been at the forefront of the drive to integrate telehealth into healthcare services. Telehealth was initially developed as a medical technology for military settings (Edwards & Motta 1997), such as remote naval populations (Nice 1987; Melcer et al. 2002), as well as in prisons (Hipkins 1997). By the 2010s, the federal government took an active role in imagining the technology as a solution for health inequity, particularly regarding the pressing crises in rural healthcare (Bagchi 2020)—hospital closures (National Rural Hospital Association 2016), increased healthcare costs, decreased access to specialist doctors, exacerbation of chronic conditions and health risks (Taylor 2019), particularly those associated with poor mental health (Case & Deaton 2015). During the Obama administration (2009-2017), the Affordable Care Act facilitated the use of telehealth as a way to follow up with patients after discharge from hospital in an attempt to reduce hospital readmissions, patient mortality and costs (Malykhina 2013). By 2016, The Office of Health Policy (2016) estimated that more than 60% of all healthcare institutions in the US had implemented some form of telehealth programme. Since the start of the COVID-19 pandemic, the use of telehealth expanded rapidly as a means through which to control the spread of viral infection. A cohort study of medical billing claims in the US found that in-person health services decreased by 37% from 2019 to 2020, while telehealth services increased from 0.3% of all services provided in 2019 to 23.6% in 2020 (Weiner et al. 2021). The increasing rate at which telehealth changes the spatial and temporal organisation of care raises important questions about the social relations of medicine, the experience of those who provide and receive this care, and the wider influences on the functioning of the health system as well as the realities of daily life.

[1] For example: home-based monitors that send physiological data to clinicians in hospitals, camera phones that capture and send pictures of skin conditions and video-conferencing technologies that enable secure, face-to-face doctor-patient encounters.

Telehealth is an umbrella term (Doarn et al. 2014) and different authors employ it in various ways. I use the term to denote the use of the specific technologies I observed in this ethnography, as well as the wider use of information and communication technology in the provision of care. I approach the technical terminology as such for several reasons. First, my informants used multiple terms interchangeably to describe the virtual therapy and psychiatric consultations upon which my research was focused. These included telehealth, telemedicine, video-conferencing, remote care and "the TV". Second, burgeoning literature in the field has drawn distinctions between 'teletherapy' (Zeavin 2021)—remote psychotherapy—and 'tele-psychiatry', which is encompassed by 'telemedicine' and is situated within the distinct culture of biomedicine (Greene 2022). In this thesis, I explore both remote therapy and psychiatry services in order to understand the ways in which these particular technologies and the care they afford have arrived in New Mexico's behavioural health system. Both teletherapy and tele-psychiatry contribute to the health and care of New Mexican residents and are intimately intertwined with each other as well as the larger social, historical and geographic forces that make up everyday life. As such, I use the term telehealth as a way to encompass both fields within behavioural healthcare and attend to their implications more widely.

The origins of this thesis

My initial interest in the social implications of telehealth was sparked when I was working at University of Edinburgh's Usher Institute, contributing to research exploring the implementation of health information technologies in British hospitals. On the periphery of this research was a pilot project investigating the use of telehealth in general practices in Scotland (Donaghy et al. 2019; Hammersley et al. 2019). After following this project for some time, I became curious about what the use of telehealth comes to mean when it is used routinely in care and becomes embedded within a health system. Existing literature on telehealth in the medical and healthcare fields had primarily focused on the utility and efficacy of the technologies themselves, as well as processes of implementation and cost effectiveness. Most of the authoritative knowledge around telehealth came from evaluation studies and health technology assessments, defined by quantitative outcome measures established in advance of empirical exploration (Strathern 2000). Studies approaching telehealth qualitatively had been driven predominantly by satisfaction surveys. Despite work demonstrating the limitations of these surveys, Likert-scale based questionnaires persisted as the main measure of the experience of telehealth in healthcare (Williams et al. 2001). While some research has lauded telehealth for its promises of cost-effective and efficient care (e.g., Snoswell et al. 2020), other studies have considered whether telehealth offers services that are truly comparable to those that are in-person (Armfield et

al. 2014). Furthermore, the social worlds in which telehealth systems are situated and the ethical considerations around their use have garnered less attention (Mort et al. 2015); even fewer studies have engaged with telehealth practices via long-term, in-depth and iterative ethnography. Aiming to address the paucity of anthropologically informed research in this growing field and to approach questions surrounding the nature and meaning of care over telehealth, I put together a proposal for this work.

Initially I neither had a specific field site in mind nor a particular field within medicine or healthcare in which to base my ethnography. However, as I explain in Chapter 3, the Department of Psychiatry at University of New Mexico (UNM) Health Sciences Centre showed great interest in my research. They were willing to support me throughout my fieldwork and invited me to conduct this ethnography alongside their telehealth programmes. In this way, I initially approached New Mexico and behavioural health as a particular window through which to understand the use of telehealth. As will become apparent throughout this thesis, telehealth equally transformed into a particular lens through which to understand the social geography of New Mexico and the unique challenges of its behavioural health system.

Background: American and New Mexican health systems

In order to understand the daily lives of the New Mexicans in this ethnography, as well as their relationship to health, care and the state, it is important to understand the wider health systems in which they are situated. This includes the US health system, the New Mexican state health system and, more specifically, the state's behavioural health system.

The American health system is fiercely for-profit and market based; publicly funded healthcare is actively resisted. It is infamous for its high cost of healthcare per capita, as compared to other countries with remarkably lower expenditures yet comparable health outcomes and similar life expectancies. With exceptional costs of healthcare, health insurance coverage is a crucial component of the health, care and daily lives of Americans. The general lexicon of the American health system revolves around bewildering insurance terms such as premiums, deductibles, co-pays, out-of-pocket costs and consumers—in place of patients. The first question asked to anyone seeking healthcare, following their first name and date of birth, is which insurance carrier they have. The answer to this question dictates the type of care someone can receive: the specific doctors they are able to see, the locations at which they can see those doctors, the types of appointments, procedures and specialty care they can access. This corporatised health system is fragmented, composed of a complex,

dysfunctional fabric of private and public forms of insurance that cover 66.5% and 34.8% of Americans respectively, as well as 8.6% of Americans who do not have any form of health insurance coverage (US Census Bureau 2020). The majority of Americans receive private insurance through their employer. Employment considerations are often made in view of the benefit packages offered to employees, particularly the healthcare benefits.

Public healthcare includes four primary programmes. Medicare is managed by the federal government and is available to anyone over 65 as well as those who are younger and experience certain disabilities. Medicaid programmes are managed both federally and by individual states and help to cover medical costs for people and families with low-income, defined by the Federal Poverty Level (Becerra 2022). The federally managed Department of Veterans Affairs helps to cover healthcare costs for military veterans and their families. Finally, the Indian Health Service provides funding for tribal and urban Indian health programmes which then, in turn deliver care to American Indians and Alaska Natives. While these programmes are ultimately government-run and subsidised for certain vulnerable populations, the day to day running of these programmes are outsourced to multiple private companies. This further complicates the underlying incentives of care provision and obscures who is responsible for health system failures (Willging 2005).

As many New Mexicans either live in poverty or are considered low-income, nearly 40% of the state population is eligible for Medicaid, compared to 17.8% of all Americans. With so many New Mexicans relying on the state's public health system, combined with New Mexico's paucity of economic resources, challenging geography and inequities in access to care, among other factors, the already thin public health resources are spread even thinner. Connected to the barriers to healthcare are New Mexico's health outcomes, which are some of the worst in the US. Rural New Mexicans, in particular, who are more likely to live in poverty than their urban counterparts, face higher rates of food insecurity and violence. Further, as New Mexico is vast and sparsely populated, spread across nearly 315000 square kilometres of deserts, mountain ranges and forests, rural populations experience much longer distances to the nearest health centres.

Struggles with land, distance and precarious financial situations all intertwine to create the specific healthcare reality of many New Mexicans. There is so much need and so few resources. Long waiting lists are a common characteristic of the state health system. The responsibility is often laid on patients living in rural and remote areas to make the long trips to better-resourced urban areas for care. The model of the state government affords further instability to the health system. Changing every four years alongside election cycles and often switching between Republican and Democratic parties, there

is a seemingly continuous overhaul of the health system. Incoming administrations focus on new strategies to address the existing gaps in resources, often taking on differing priorities in the delivery of care than the administration before them, and often incurring opposition from whichever party is no longer in power.

Many rural areas in the US have ageing populations, as educated youth often move away for better job opportunities (Carr & Kefalas 2011). In New Mexico, it is common for a healthcare provider to come to a rural clinic, work for a year and then resign (Treeson 2003). In some parts of the state, residents live so far away from any brick-and-mortar health infrastructure it can take hours for an ambulance to arrive in a medical emergency. As many people in the state struggle financially—nearly one out of every five New Mexicans live below the poverty level—some might not have enough money to buy minutes for their phone to call a doctor. Health conditions that need close monitoring by professionals in clinics are difficult to care for as many people do not have enough money to pay for transportation to get to the clinic often; or they do not have the ability to take off work to make their appointments.

The New Mexican health system requires patients to travel to other parts of the state, or to other states for treatment and care. Health programmes are piecemeal—with various disconnected parts that individual patients are often required to fit together themselves to address their own gaps in care. "*People shouldn't have to get up before dawn to get to a doctor's appointment in Albuquerque*", expressed Silvia, a doctor based in Albuquerque. Projecting her own expectations onto the state's health system, she shared her frustration with the current framework, with many of the resources centralised in the largest cities and patients from rural parts of the state required to travel great distances for doctor appointments.

Small, rural hospitals are often referred to as "*pack and ship hospitals*". As there are not often substantial resources locally, rural emergency care aims to stabilise patients and send them by helicopter to better-equipped hospitals in urban localities. The geography of hospitals in New Mexico is centralised around Albuquerque. Three of the largest hospitals in the state, as measured by number of hospital beds, are clustered within the same square mile: UNM Hospital, Presbyterian Hospital and Lovelace Medical Centre. Driving on the interstate towards the triangle of hospitals, there are billboards for Lovelace, the only for-profit hospital of the three. One billboard displays the current wait time in the Emergency Room. Another displays a smiling pregnant woman and reads "Expecting? Join Lovelace Labour of Love". These billboards anticipate patients travelling into Albuquerque from other parts of the state, seeking care. Helicopters flying overhead are constant. Contributing to the

everyday sounds of life in this central part of Albuquerque, they transport patients from far away to the better-equipped Albuquerque hospitals.

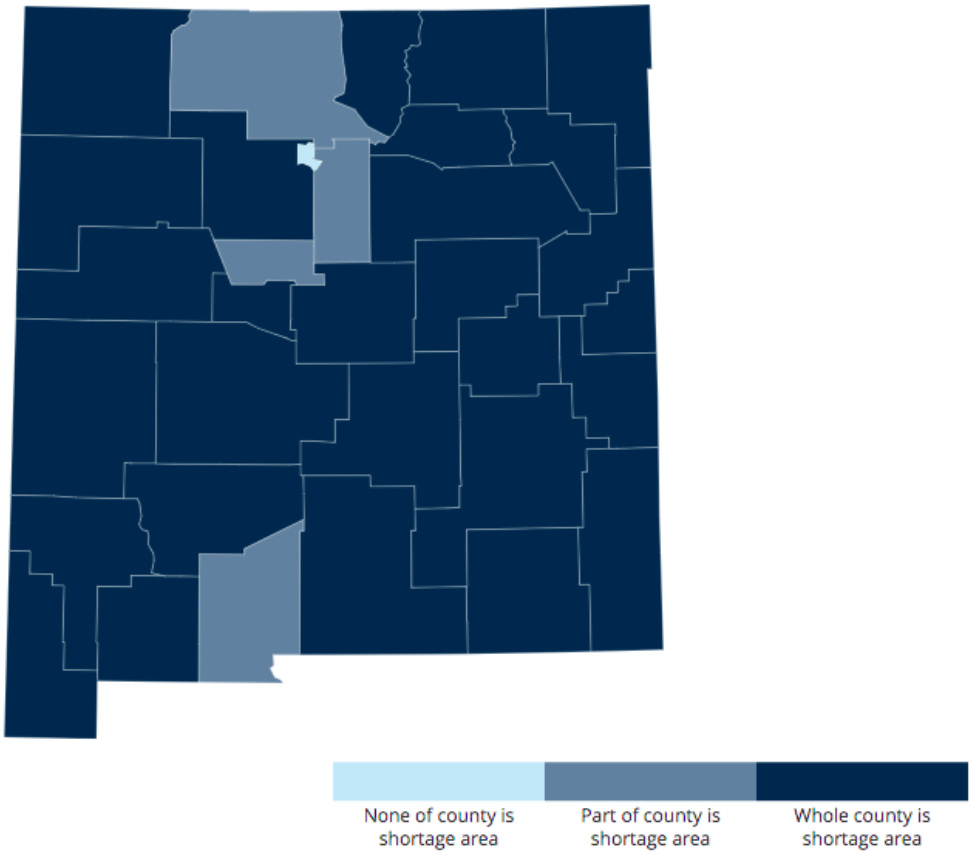

Figure 1. 1 Health Professional Shortage Areas in primary care by county in New Mexico, 2022. In the entire state, all but one county experiences shortages in the healthcare workforce (Health Resources and Services Administration 2022).

The New Mexican state health system also struggles from vast workforce shortages (see Figure 1.1). Over forty percent of the state's population lives in a primary care Health Professional Shortage Area (HPSA), as defined by the US Department of Health and Human Services (Gallagher 2018: 65). This designation identifies regions and populations experiencing a shortage of health workers, determined by a provider-to-population ratio. The Bureau of Health Workforce, Health Resources and Services Administration (HRSA), part of the US Department of Health and Human Services, found in March 2022 that only 18.18% of the behavioural health need in New Mexico is met (HRSA 2022). Moreover, the need in rural communities is disproportionately large compared to their urban counterparts. While in urban areas, there is one psychiatrist for every 3000 individuals, there is only one psychiatrist for every 20000 individuals in rural areas (New Mexico Health Care Workforce Committee 2021). In Clovis,

the rural city of 50000 people on the eastern border of New Mexico where part of this research is based, there is neither a resident psychiatrist within the entire county, nor in the four surrounding counties. "*There's no in-patient anything for 110 miles*", one of my informants in Clovis told me. These figures illustrate the forms of inequities and disparities in access to care within the New Mexican health system.

This is where telehealth has come in: aiming to address the gaps in the access to care in rural areas, the New Mexican state government, along with public and private health systems turned to these technologies to provide care to the state's residents who otherwise lack access to many healthcare resources in their local areas.

Telehealth in New Mexico's behavioural health system

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) within the US Department of Health and Human Services, 'behavioural health' means "the promotion of mental health, resilience and wellbeing; the treatment of mental and substance use disorders; and the support of those who experience and/or are in recovery from these conditions, along with their families and communities" (SAMHSA 2015). In this thesis, 'behavioural healthcare' denotes the forms of psychiatric and counselling services that were provided via telehealth. Behavioural healthcare is the term most commonly used in New Mexico for this type of care. New Mexico's Behavioural Health Services Division is the mental health and substance abuse authority for the state, working to comprehensively address the behavioural health needs of the state's population through interfacing with and regulating health organisations throughout the state, including those in this thesis.

New Mexico has a high incidence of mental ill health. The rate of suicide in the state, for example, has been at least 50% higher than the national rate across the past 20 years. In 2017, New Mexico had the fourth highest rate of suicide in the US (Moss 2019). Substance abuse and mental ill health are also serious challenges for public health in the state; New Mexico ranks ninth in the US among states with the highest rates of serious mental ill health (Lipari et al. 2017). Precarity in the state's healthcare workforce and provision of behavioural health services have existed for a long time. However, this precarity was exacerbated in 2013 when the state government froze all Medicaid payments to the 15 largest public behavioural health providers across the state due to allegations of medical billing fraud—i.e., billing for services that were not provided (Apodaca 2013; Frosch 2013). With the suspended payments, clinics across the state could not afford to maintain their services; the majority of clinics and health organisations closed down. In 2016, the New Mexican Attorney General cleared

all 15 service providers from these allegations; no evidence of fraud was found (Balderas 2016). This crisis remains divisive among health workers and health policy makers in the state—particularly as many behavioural health workers were suddenly left unemployed and patients stranded without care. This led to a loss of trust amongst both health workers and patients in the health system. Health workers were scared they might lose their job again, and so sought work elsewhere in private health systems or in other states. The public health system still struggles to get patients to return to the clinic for help, as in 2013, many people lost their therapists and doctors overnight. Telephones rang off the hook as no one was there to answer; patients were abandoned.

For these reasons, the behavioural health system was in dire need of help, for more providers to care for struggling populations and for the system to build stability, to regain the trust of its health workers and patients. It is in this context that telehealth was deployed to provide behavioural healthcare to rural communities in the state (Myers 2019). During the time of my fieldwork, the state health system was still working at the government and policy level to enact laws that would enable state-wide expansion of telehealth programmes. However, UNM Hospital, the largest hospital in the state and the only academic medical institution, had several ongoing and pilot projects around the use of telehealth, several within the Department of Psychiatry. These programmes facilitated the provision of care from behavioural health workers in Albuquerque to rural community clinics around the state. Patients in these communities would go into their local clinic and through the coordination of local support and health workers, would be connected with the therapists, psychologists and psychiatrists in Albuquerque via secure video-conferencing technology. There were also several rural behavioural health clinics around the state that set up their own telehealth programme, independent of UNM. One of these, the Clovis Clinic in which I was based for part of my research, provided therapy and psychiatric services to their patients through a private contracting company which connected remote health workers within their network to the Clovis Clinic via telehealth. The Clovis Clinic also provided telehealth services through maintaining relationships with health workers who had initially worked at the clinic in-person and had since moved away. By keeping active their licences to provide care in New Mexico, these health workers continued to work with the clinic remotely. Further the Clovis Clinic offered in-person therapy and social work services, as well as care provided through short term grant funding. Through this piecemeal combination of services, through continuous cycles of applying for money, proving through mountains of paperwork that the money was used correctly and that patients received appropriate treatment—bureaucratic work in place of patient care (Strong 2020)—through applying for extensions and navigating relations with contractors and remote employees, the clinic was able to bring in enough money to provide behavioural healthcare to the Clovis community.

Beyond the screen

Telehealth offered a lot of promise to the struggling New Mexican health system. It also enabled the provision of care to rural populations who otherwise would not have received any specialist behavioural healthcare. However, the use of telehealth in this particular context introduces many questions. In this place of resource scarcity, long distances and a public behavioural health system that, in the recent past, nearly disappeared, what does telehealth mean to those who intersect with its use? How does telehealth fit into the imagination of what the health system could be and how it could work, and how does this compare to the realities of telehealth in everyday practice? What forms of care are provided and received via telehealth, and how do these articulate with conventional forms of care and the existing health system? What sort of spaces are implicated in the use of these technologies that are based on forms of distance? Can telehealth be used indiscriminately, or are there limits to its use? And what factors are involved in the determinations of these limits?

In this thesis, I approach these questions through ethnographic investigation of the New Mexican behavioural health system, including health workers providing telehealth services, a rural clinic and its patients who receive telehealth services. Drawing on the anthropological literatures of telehealth, care, space and infrastructure, and taking seriously the particularities of everyday life in New Mexico and the state's health system, I find that telehealth changes the nature of care. It does so through shifts in the spaces, materials, practices and relations of care. I further find that the implications of telehealth reach far beyond the specific doctor-patient relationship. Telehealth does not exist solely in fibre-optic cables and computer screens. Telehealth can change, reinforce, twist and introduce new ways of thinking about health and care in the state. It influences the ways in which patients approach their local health systems, in which health workers experience their roles and responsibilities, and in which everyday mobilities are conceived and practiced on the ground. Furthermore, in the translations from in-person care to care over telehealth, things are missed. The margins of the healthcare encounter have been neglected, and yet are essential dimensions of care. I attend ethnographically to the gaps between in-person and remote care, and the implications of these gaps, and I show that there are entire worlds beyond the technology and digital connection, as well as multiple and ambivalent outcomes.

In carrying out this research, I fell into the anthropological trope of arriving in the field with one idea and leaving with another, having assumptions about what I had aimed to study disproved. I came to New Mexico thinking that I was going to be uncovering what it means to be a 'virtual patient' or how 'virtual care' might unfold in practice. In other words, I imagined my ethnographic attention would be

primarily focused on the online—as opposed to the physical—nature of the encounters; on practices of care guided by forms of 'telepresence'[2].

Instead, I was drawn away from the basic technologies involved in telehealth and the internet-based encounters. I was drawn to the spaces (Oudshoorn 2011a, 2012), materials, relations and distances in which the use of telehealth was embedded; as well as the geographies, histories and daily lives that both shaped and were shaped by the use of these technologies.

While this thesis is about telehealth, and approaches questions about how care is shifted with the use of these technologies, this thesis is also about New Mexico, about life in a place with scarce healthcare resources, big skies, long highways and cars. It is about the room in which Bonnie usually sits alone, staring at the computer screen; and the other room, perhaps across town, with the white wall, where Amanda sits providing care. I argue, in fact, that the use of telehealth and the forms of care involved cannot be understood without these dimensions. They do not merely make up the context in which telehealth has been implemented. These are the factors, agents, integral components that underpin, define and shape its use.

In the next chapter, I frame the anthropological literatures that informed my approach to studying telehealth in the New Mexican behavioural health system.

[2] Telepresence, while an ill-defined (Lombard & Jones 2015) and heterogenous (Hilty et al 2020) concept, has been adopted by several scholars in the healthcare arenas as a way to describe technologically mediated practices that afford a remote presence (Vaughn et al 2015) between health workers and patients. Telepresence comprises the shared, virtual space in a healthcare encounter.

Chapter 2: Anthropological Framings of Telehealth, Care, Space and Infrastructure

Introduction

In this thesis, I argue that the use of telehealth in New Mexico changes practices of care in the behavioural health system. This argument has been influenced and framed by the social science scholarship on telehealth as well as the anthropologies of care, space and infrastructure. In this chapter, I attend to each of these literatures, outlining the most pertinent areas of exploration as well as the ways in which I have brought them into conversation to form a theoretical foundation for this work.

This thesis takes as its point of departure the interdisciplinary approaches to contemporary issues in telehealth. Telehealth has already attracted the attention of anthropologists (Ahlin 2018, 2020a, 2020b; Ahlin and Sen 2020; Cartwright 2000; Helman 2007), sociologists (Dyb & Halford 2009; May et al. 2001; Mort et al. 2003), geographers (López & Sánchez-Criado 2009), empirical ethicists (Pols 2010, 2012, 2015, 2017; Pols & Willems 2011) and those in science and technology studies (Oudshoorn 2008, 2009, 2011, 2012; Zeavin 2021). Previous approaches to telehealth have explored the ways in which these technologies are 'actants' in the healthcare encounter, altering the space, materiality and practices of care. In doing so, several scholars have argued that in-person care is not merely replicated when provided over telehealth; instead, these new technologies change the nature of the care provided. Others have attended to the ways in which the use of telehealth extends beyond the direct doctor-patient encounter, into the clinic and further into the political and economic climate of the wider health system.

This thesis builds on two formative approaches from this previous scholarship on telehealth. I take as my starting points (1) the malleable and plural concept of care, as well as (2) the understanding that both care and the implications of telehealth can extend beyond the clinic. I trace the ways in which the use of telehealth in the New Mexican behavioural health system shifts meanings, perceptions and experiences of care. This happens through changes in the spaces and materials involved in behavioural healthcare within several components of the health system: the clinical encounter, the functioning of the clinic, the ways in which healthcare fits into the daily lives of New Mexicans, and how healthcare is viewed and managed by the state[3]. I am also interested in developing a distinctively anthropological

[3] In focusing on the ways state- and nationally- provided healthcare play out through the use of telehealth on the ground, I attend indirectly to the economic imperatives that dictate, at least partially, what healthcare is and how it happens in this context. Considering corporate involvement (Benson & Kirsch 2010) in approaches to telehealth is crucial for understanding the ways in which these technologies have come into and articulated with

approach to telehealth and have approached the multidimensional implications of telehealth by drawing from and bringing together three primary literatures in anthropology: care, space and infrastructure.

Care as a lens is central to this thesis. I argue that telehealth is not in opposition to conventional in-person care. Instead, it involves a reformulation of care, as observed through changes in relations, practices, space, materials and immaterial aspects of daily life. To understand this reformulation, I grapple with the plural, ubiquitous and often times contradictory meanings of care. Particularly important for this work is the consideration of care as a meshwork (Ingold 2007, 2011). This orientation attends to the coalescing of people, spaces and materials through both formal and improvised practices (Livingston 2012) which intersect with daily life on multiple scales (Thelen & Coe 2019).

In order to explore the ways in which telehealth shifts care through the reorganisation of space, I situate this research within the dynamic interplay of literature from anthropology and geography. The literature that forms the framework for approaching space in this research draws on the understanding that space is always under construction; that space and social relations are simultaneously established and inseparable (Massey 2005). I attend to the particularity and heterogeneity of American space (e.g., Greenhouse 1986; Schmalzbauer 2014) as well as the ways in which space and care have intersected in anthropological research, with a particular focus on the concepts of closeness and distance in medicine. I draw on the recent anthropological tradition of hospital ethnography, much of which takes space as an object of inquiry. This literature frames my exploration of telehealth which implicates a particular set of spaces in which care happens that extends within and beyond clinic walls in new ways. Ultimately, I argue that telehealth is not spaceless; it is instead deeply implicated in and intimately intertwined with understandings and experiences of space. This, in turn, reformulates the clinic and the clinical encounter.

In addition to shifts in space, the use of telehealth involves rearrangements of both material and immaterial components of care. To bring into relief the ways in which the material and immaterial are tightly wound with the practice of telehealth and how these relate to our understanding of the dynamics of care, I draw on approaches from the anthropology of infrastructure. Importantly, theories in this branch of anthropology enable the simultaneous consideration of multiple levels of infrastructure and the ways in which they may interact or exist in tension with one another (e.g.,

the American health system. However, a comprehensive understanding of this dimension falls outwith this research.

Dalakoglou & Harvey 2012; Harvey & Knox 2015). The lens of infrastructure considers the physical, material aspects of care, particularly those that are 'mundane' (Maller 2015), 'taken for granted', 'quiet' (Pink et al. 2014), and which are not acknowledged as part of the telehealth system. This lens also puts attention onto the intangible infrastructures that are just as important to the use of telehealth and provision of care: the beliefs, values and imaginaries around telehealth that guide its implementation, use and blending into New Mexican daily life. Building on the literature of infrastructure, including considerations of the materiality of care (Mol et al. 2010; Winance 2010), I argue that telehealth is not solely virtual; it is entangled with both material and immaterial aspects of daily life. This thesis is about the mobilities, spaces, materials, forms of distance, relations and belief systems that create the conditions for virtual connections and that make up the meshwork (Ingold 2007, 2011) of care.

Social science perspectives on telehealth

To give insight into the social, relational and ethical questions surrounding the use of telehealth in healthcare, I draw on theoretical and empirical scholarship from beyond anthropology to include geography, sociology and science and technology studies. While the use of information and communication technologies in healthcare has a long history (e.g., Zeavin 2021), questions around the implications of telehealth have only become objects of the social science gaze since the turn of the 21st century. Over the past two decades, several recurring themes have been explored in this work. Most notably, the transformations in care through changes in spaces, materialities and practice, and the implications of telehealth that extend beyond the clinic emerge as primary concerns of this literature. In this section, I explore these two themes and draw attention to the questions that still persist.

Telehealth shapes care

In 2001, May and colleagues published findings from an ethnographic study on the use of a video-conferencing technology in the provision of psychiatric care in the United Kingdom (May et al. 2001). The "videophone" investigated in this research connected patients located at their general practice surgery who were experiencing anxiety and depression with mental healthcare professionals at a hospital nearby. May et al. drew on six months of observation of the technology in practice as well as interviews with health workers (clinicians in general practice, nursing and mental health), those providing technical support and patients. They found that the videophone was ultimately abandoned

due to clashes between the novel technology and formerly established clinical workflows and practices. There was particular tension around the ways the psychiatric interview was conducted via videophone as compared to in-person. May et al. found that the mental health workers perceived that the "hard" technology of the videophone altered the ways in which they were able to mobilise their "soft" skills during in-person patient encounters—skills that enabled engagement with their patients and produced specific types of knowledges that could subsequently be employed in diagnosis, treatment and longer-term care. Importantly, however, May et al. argue that the challenges with integrating the videophone into clinical practice were not solely due to failures within the technological system. Instead, the challenges arose from the interrelations between the system and existing clinical practices. This is a general pattern in the literature; the technologies involved in care over telehealth do not merely sit alongside and augment established clinical workflows, they shape and are shaped by embedded care practices. These findings reinforce the scholarship on technologies in healthcare more broadly, be they medicines, work practices or tools for diagnosis: technologies do not slot into healthcare, seamlessly facilitating existing issues, they actively create, transform, destabilise and multiply forms of care (Berg & Mol 1998).

In the fifth edition of *Culture, Health and Illness*, one of the first medical anthropology textbooks to include a section on telemedicine and the internet, Helman (2007) considered the ways in which telehealth technologies influence healthcare and what this means for the social relations of medicine. Questioning the implications of May et al.'s (2001) research, Helman ponders how the technologies involved in telehealth fit into the provision of care: does the computer itself become a healer in the doctor-patient encounter? Zeavin (2021) offers one approach to this question in her monograph *The Distance Cure*. Employing the lens of media studies, Zeavin traces the history of teletherapy—the use of telecommunication technology in the provision of psychological therapy. Zeavin focuses on the triad in teletherapy, which she sees as made up of therapist, client and media. This triad, she argues, has always and already been present in the therapeutic encounter. Therapy has always been mediated, whether via postal mail, radio, telephone, the screen or the distance between the Freudian therapist's chair and client's couch. In her examination of the media involved in teletherapy, Zeavin affords telehealth technology agency, equitable to that of the healthcare professional and the patient. Sitting together, these three actors and their interrelations make up the therapeutic encounter.

Pols (2012) also argues that the media through which care is provided—in her research, several telecare devices—moulds that care. In one of her case studies, Pols observes that an informant, a project manager, initially perceived the telecare device as a way to provide an existing form of care. The technology was thought of as a "means toward an end where the end does not change if the

means do" (2012: 120). This informant anticipated the telecare device to "just be a new tool that nurses would use to achieve what they were already trying to achieve… [she] did not expect the webcam to change the very nature of care" (ibid.). Similarly, Oudshoorn (2009) finds that clinical encounters were not merely translated from in-person to virtual in her comparative study of healthcare services provided in-person and those provided via telehealth to patients with heart failure. "Instead", she argues, "it is more useful to conceptualise these (tele-) healthcare provisions as practices that create and value other kinds of care, incorporating different forms of proximity to patients" (2009: 390). Care over telehealth cannot simply be substituted for in-person care, she argues, as it changes the nature of the care provided.

The intersections of telehealth, space and place

Telehealth changes the nature of care in various ways and multiple contexts. Of particular salience to this dissertation is the interaction between telehealth and space. In the domestic realm, Ahlin (2018, 2020a, 2020b; Ahlin and Sen 2020) traces the ways in which information and communication technologies enable caring practices within transnational families, connecting elderly parents in Kerala, South India with their adult children who migrated to Oman with the hope of providing familial financial security. Ahlin's ethnography follows the younger family members as they move overseas for work, and the ways in which these families continue to provide and receive care. She shows how the use of information and communication technologies alters experiences of space and distance, enabling new forms of care as well as reconfiguring filial roles and power relations.

At the intersection of domestic and clinical spheres, Pols (2012) offers empirical findings and analyses from several case studies showing that the use of telecare devices shifts the place and space of care. The telecare devices in her research connect older adults who experience particular illnesses, such as hypertension, to a team of nurses in a telecommunication setting or clinic. Throughout the day, the older adults take their own clinical measurements at home. These metrics are sent via the telecare device to the nursing team who then reviews the measurements and sometimes ask follow-up questions. Depending on the consistency of the measurements and whether they fall within normal range, the nurses may request the older adult come into the clinic for further evaluation. Importantly in these cases, people receive care at home; care that is provided by nurses located elsewhere. In one of her case studies, carers and patients are connected via webcam. Pols finds that in these situations, both parties felt "as if they were in the same room together when they weren't in the same physical space" (2012: 104). Pols considers what this space is, a geographically disparate yet shared space in which carer and patient find themselves "'together'" (ibid.). She argues that telecare technologies

create potentially new spaces within and between domestic and clinical domains, and that these new spaces influence the ways in which care is perceived and experienced.

López and Sánchez-Criado (2009) put forth a similar yet inverse argument: telecare technologies influence the ways in which the home is perceived and experienced. The use of telehealth in the domestic space, they assert, multiplies the types of spaces and subjectivities encompassed within the home and experienced by older adults. These multiple and dynamic spaces arise from interfaces between the various telecare technologies employed, the multiple and existing spaces in the home, as well as the existing technologies already in use therein.

Telehealth also influences understandings of place and space when enabling care across and between clinical settings. Dyb and Halford (2009) investigate the use of telemedicine in a rural hospital in Norway that connects pregnant women and midwives to obstetricians at larger, more geographically central hospitals. The telemedicine programme they describe is shaped by the specific place in which it is embedded: a small, isolated town surrounded by mountains and sea, without roadway connections to the rest of the country. The community is supported by the local fishing industry and holds a great deal of pride in weathering hardships, such as uncertain financial conditions and a dwindling healthcare workforce. Dyb and Halford find that the telemedicine programme alters the way in which healthcare professionals working in the rural hospital perceive and understand the local place in which they work. Ultimately, they argue that while telemedicine is implemented with the aim of "overcom[ing] place" (2009: 232), "dissolv[ing] the local" (ibid., 246), and is understood as a "place-less" (ibid.) practice, the implications of the use of these technologies can only be understood through perspectives centred around place.

Contributing to this scholarship, Oudshoorn (2012) draws attention to an important reciprocity: the spaces in which telecare is implemented shape the ways these technologies are used, and the use of these telecare devices shape the specific spaces that make up people's daily lives. Drawing on interviews with patients and care providers across several European countries, all who use telecare systems set up in patient homes for cardiac care, Oudshoorn proposes that one of the ways to understand how telehealth shifts the provision of care is to focus on how place and space are reconfigured in the use of these technologies. This dissertation takes seriously this proposition. It traces the ways in which New Mexican space influences the use of telehealth. It further seeks to understand how the use of telehealth shapes New Mexican space, and what these changes in space mean for the multiple forms of care that exist there.

The intersections of telehealth, materiality and practices of care

The intersections between telehealth and space are shaped by the social and material environments where telehealth takes place. In other words, the changes in experience and understanding of space and place afforded by the use of telehealth are intertwined with shifts in the materials involved in the provision of care. Pols (2012) offers an example that shows the complexity of the relationship between telehealth and the various materialities of care that comprise it. She details the use of a logbook which is kept in patients' homes, and into which each professional who visits and cares for the patient communicates their assessment. One of Pols' informants, a project manager, explains how the logbook works: "You can tick a box if you want to point your colleagues to more information in the dossier… the log is the most reliable and complete system we have…If the staff cannot write in the log…they have to call or send a message to [another healthcare professional who cares for the patient]" (2012: 122). The nurses who use telecare devices to monitor patients from a distance are unable to contribute directly to the patient's logbook. Instead, the telecare nurses are forced to depend on their patients' in-person carers to relay the information they wish to impart. Pols draws attention to the materiality of and practices around the logbook that rely on shared physical space, and how these sit in tension with the use of the telecare system. With new formulations of space come new formulations of the materiality and practices that make up that space – and vice versa.

One of the primary ways care practices have changed with the use of telehealth, as outlined in this body of literature, is through the reconfiguration of professional roles. In the logbook example outlined above, the use of telecare devices led to the transfer of responsibilities and workload from telecare nurses to their in-person colleagues (Pols 2012). This redistribution of responsibility has also been observed elsewhere in research on telehealth. In their ethnography of a pilot tele-dermatology programme in the United Kingdom, Mort et al. (2003) explored the ways in which healthcare professionals interfaced with a technology that enabled remote diagnosis of skin lesions via digital imaging. This "store-and-forward" (2003: 275) system involved nurses at community clinics sending images and patient medical histories digitally for subsequent review by dermatologists working in a specialist hospital. Mort et al. observed that the community-based nurses took up new mediator roles, becoming essential agents in fostering doctor-patient relationships as well as interpreting clinical information. Nurses helped to create an image of the patient from "fragmented" pieces (ibid., 292)—a medical history, an image—that the doctor could examine and diagnose remotely, and in turn, helped to provide a "fragmented" clinical service to the patient (ibid.). Tasks that the doctors may have completed in an in-person encounter were delegated to the nurses who were physically present

with the patient. Mort et al. put forward an important question: will the mediatory role the nurses came to inhabit continue into future practice as unacknowledged and "invisible" (ibid.), or will more formalised roles precipitate from this shifted form of care work?

Several years later, Oudshoorn (2008) observed a similar type of "invisible work" (ibid., 272). In her research on cardiac telemonitoring technologies, Oudshoorn identified a divorce in the way these technologies are portrayed in public discourse—as technologies that mitigate the workload of healthcare professionals—and the ways in which these technologies both redistribute existing tasks as well as create new types of work for patients, nurses and doctors. The proliferation and use of telehealth have been pushed forward in healthcare agendas through promises of cost-effectiveness, increased quality of care and time savings for overworked health systems. The cost reduction potential of telehealth relies partly on the delegation of responsibilities from doctors to less expensive actors in the healthcare encounter (van Montford & van der Helm 2006). Nurses and other clinical staff are expected to "[plug] the gaps" (Mort et al. 2003: 292), however many and however large, between how care happened in-person and how it now happens at a distance. Each case of responsibility and role reconfiguration in the research cited above is specific to the particular telehealth technology, composition of the local workforce and the surrounding health system. This thesis finds that, indeed, the use of telehealth in New Mexico alters the nature of who delivers what in the process of care. These shifts are informal and fluid, often as ad hoc responses to the needs of a specific programme. In this thesis, I will explore several questions around these reconfigured roles: how are healthcare workers prepared for these changes? Who bears the weight of the reconfigured responsibilities? And what does all this mean for professional roles in healthcare?

Telehealth extends beyond the doctor-patient encounter

Cartwright (2000), a scholar on visual culture in science, health and medicine, was one of the first social scientists to approach the use and implications of telemedicine from a critical medical anthropology perspective. In the context of an expansion in telecommunications capacity in the 1990s, she introduces questions around the goals of telemedicine. She considers whom and what are being managed by the use of these technologies, and wonders where patient experiences and understandings of care might fit into the wider, system level management goals of governments and health systems. These goals, according to Cartwright, are cost efficiency and forms of population control.

In achieving these goals, Cartwright argues that the use of telemedicine introduces novel dynamics in healthcare. These arise from changes in the geography, temporality and social relations in the provision and organisation of care, including new constructions of individual and community identity. This observation about the use of telemedicine is pivotal: that the implications of telemedicine extend much further than the direct doctor-patient encounter. One way this happens, Cartwright contends, is through the creation and deployment of new ways to define who are and what is 'rural' and 'remote'. Telemedicine "is a method of reorganising geography and identity through new styles of health management that involve new configurations of population and different ways of imagining what global health is and will be" (2000: 348). Ultimately, Cartwright argues that telemedicine is not simply a means through which to provide healthcare; it also creates the idea about specific types of communities that are linked to the globalising healthcare economy.

Following on from their discussion about the reconfiguration of professional roles in a teledermatology programme, Mort et al. (2003) argue that a necessary component for forthcoming telehealth systems is "a recognition that a new kind of network will be formed, one in which clinical skills are reconfigured and spread more widely and in which the clinic itself becomes seen as part of the whole technology" (2003: 293). On a different scale—that of the clinic, rather than the health system—their understanding of telehealth reflects that of Cartwright (2000): the technology extends further than the computer screen, electronic medical records and virtual images of the patient. It implicates the wider healthcare environment.

This dissertation pays particular attention to the ways in which the care and the use of telehealth extend beyond the clinic. It also attends to the ways in which daily life in New Mexico seeps into the clinic, influencing the use of telehealth and the practices of care involved. I argue that these elements cannot be considered in isolation. Care, the use of telehealth and the particular surrounding world are intimately intertwined. In my case, understanding the implications of telehealth requires a close understanding of the specific historical and geographical experience and phenomenology of the people of New Mexico.

Tracing and describing the textured, everyday life that extends beyond the doctor-patient telehealth encounter leads to several important questions. To where does the use of telehealth extend? For example, how does the use of telehealth speak to the experience of driving to the clinic to receive telehealth services? How might telehealth be experienced by patients who have lived their whole lives in a place without many doctors? How do people in New Mexico feel about telehealth vis a vis the

wider health system? These questions have been elicited in this research ethnographically as I have followed the links between practices, systems, health workers, patients and communities.

Conclusion: Social science perspectives on telehealth

While some of the scholarship outlined above offers comparative examples between 'virtual' and 'face-to-face' care, and while others consider how and whether the use of telehealth influences the experiences of physical proximity in healthcare, many of the social scientific accounts of telehealth aim to understand more fluid questions about the use of these technologies in the provision of care. How does telehealth shape the values, logics, experiences and beliefs around what care is and can be? What might the new forms of care afforded by telehealth come to mean for those involved? The use of these technologies forces us to question how we think about the clinic in the classic sense. How might the exploration of telehealth offer a way to approach the shifting and increasingly relevant transformations in the provision of healthcare and the implications of how we understand medicine? The scholarship presented in this section mirrors the wider literature I draw on to situate my thesis: the anthropologies of care, space and infrastructure. To approach and understand the questions outlined above, I attend to each of these lenses respectively in the three subsequent sections.

Approaching telehealth through the lens of care

In order to understand the ways in which telehealth alters the nature of care within and beyond the 'discrete' doctor-patient encounter, we need to start with an understanding of what care is, what care can be, and how the lens of care is useful for this research. In this section, I grapple with the plural, ubiquitous and often times contradictory meanings of care. I consider what 'good' care is and argue that it is not useful—nor possible—to label the care involved in telehealth in terms of 'good' or 'bad'. Finally, I suggest that the theoretical concepts of 'meshwork'—in contrast to network—and 'improvisation' are helpful in forming an understanding of care in the context of this thesis.

Care is multiple and open-ended

First and foremost, what is care? Care is often understood as a dynamic process that both acknowledges and attends to some form of needs—e.g., protection, welfare or health—and encompasses at least two participants: one that provides and the other that receives (Thelen 2021). The process of care can involve an intricate plait of actors, spaces and materials situated within

intimate relations, communities, institutions, systems and governments. Through the interaction of different dimensions of daily life, the meaning and shades of care evolve, as well as the people, things and places involved.

Care is fundamentally relational and ambivalent. Care practices interface with and mutually transform relations in multiple ways across different contexts, in ways that can be both nurturing and detrimental: generating and strengthening while also impeding and damaging relations (Rasell 2020). For example, several scholars have observed the unravelling relations between communities and the state, and the simultaneous strengthening of kinship ties in the aftermath of failed welfare and public health initiatives (Garcia 2010; Han 2012; Stevenson 2012, 2014). Care practices are thus implicated in the cultivation, nourishment, change and upending of social orders, as well as the reduction and reproduction of marginalisation, exclusion and forms of violence (Thelen 2015; Thelen & Coe 2019; Ticktin 2011; Yarris 2017).

Care is multiple and malleable across space and time (e.g., Bruckermann 2017). As such, anthropologists have focused on the ways in which the nature of care, as well as the practices and relations embedded therein shift and are shifted by the particular realities in which they are situated (e.g., Routon 2021). Further, scholarship on care has focused on how these changes play out on the ground; what these changes mean for the people whose lives they intersect. Cabot (2016), for example, observed a reconfiguration of care practices in a growing network of 'social clinics and pharmacies'[4] in Greece. In the context of national austerity and increasingly neoliberal trends in the healthcare sector, a growing population was unable to access healthcare services. The social clinics involved novel formulations of healthcare work, distribution of medicines and provision of care, which intersected with individual and community understandings of health. Cabot found that the reorganisation of and shifts in care influenced Greek experiences of belonging, citizenship and healing.

These examples offer three insights of particular resonance for this thesis: first, an appreciation of the ways in which care functions at the confluence of multiple different factors; second, the various contexts of and ways in which care is reconfigured; and third, an understanding into the wider influences of these changes in care, particularly those on the relations between the individual, the community and the state. Care weaves across and between practices in the direct doctor-patient

[4] The social clinics and pharmacies described in this research (Cabot 2016) refer to health services that sprung up as part of Greece's solidarity movement in the 2010s to provide services to people who otherwise would not have access to healthcare. These clinics and pharmacies were run by volunteer health workers and functioned on donations. They ran off community-based models of care provision, as opposed to the conventional state-run and private health systems.

encounter into other spaces, materials and relations: those in the wider healthcare clinic, between health workers, communities, the land and the state. Care as a concept is slippery; it can be used to describe many different forms of relations, processes and ways of being in the world. Because of its conceptual malleability, care can capture many levels and registers of experience and daily life. It is partly because of this slippery nature that care is particularly useful for this research, as it enables the simultaneous exploration of multiple intersections between telehealth and the New Mexican health system.

'Good' care

While care can mean a multitude of things, much of the literature on care—which stems from feminist scholarship on care as an ethical pursuit (Tronto 1993)—approaches the concept as largely positive. There have been several responses to this normative, philosophical trend. Murphy (2015), for example, calls for social scientists to face the uncomfortable hegemonic, colonial and racialised logics perpetuated in approaches to care in order to "unsettl[e]" (2015: 717) future scholarship in the field. She argues that this "reckoning" (ibid., 731) enables a move away from the contorted versions of care that exist solely in supportive and intimate relations. Another critique of these positivist notions underlines the violence embedded in biopolitical regimes of care (Stevenson 2014; Ticktin 2011). In a comparative example, Aulino (2019) complicates these critiques by showing how forms of oppression, inequity and structural violence within the Thai welfare state are perceived and received by constituents as care.

Following these critiques, Thelen (2015) offers a way forward with the study of care. Drawing from an historical review of theoretical approaches to care from Marxism, to feminism and disability studies, Thelen argues that care in anthropology is theorised narrowly. Often confined within kinship studies, Thelen observed that approaches to care focused on the formation and fostering of particular social ties, while remaining inattentive to other possible outcomes of care such as the disintegration of kin relations. She argues that care as a lens is vital for understanding the ways in which social relations converge in different dimensions of daily life, including economics and politics. To do this, she calls for a praxiographic approach that traces and analyses distinct care practices. In outlining this approach, Thelen aims to relinquish the positivist assumptions attributed to care in order to make space for diverse and dynamic developments in social relations. Importantly, this approach involves taking seriously practices that muddle conventional binaries of care: the market-driven, for-profit, state-provided care and the unpaid, intimate, reciprocal, communal and familial care (Aulino 2019; Buch 2013; Cook & Trundle 2020). It enables a move away from narrow discussions around who can be a

care giver and care receiver (Han 2012; Muehlebach 2012). Further, it opens up opportunities to consider the embedded incongruities in what care is and what it means in different social and cultural contexts (Aulino 2019).

As anthropologists look beyond positivist approaches to care and recognise that care can involve destructive and harmful processes, we are confronted with a critical question. How are we to understand what 'good' care is, or might be? McKearney (2020) offers two routes to approach this question. First is a deep understanding of context. Anthropologists have shown the impossibility of "fix[ing] care's morality without reference to the vicissitudes and variability of social life" (2020: 229); this is crucial to deciphering what care means. The second relies on the consideration of both the "intentions, rules and local understandings of the good" (ibid.) underlying acts of care as well as the ways in which these acts play out on the ground. Strong (2020) offers a supportive empirical example to McKearney's approaches to care, observing the harmful effects of bureaucratic practices on a Tanzanian obstetric ward that have been set up with the intention of providing safer care. Garcia (2010) also shows the discrepancy and ambiguity between the intent behind practices of sharing heroin as a form of care among intergenerational family members in Northern New Mexico.

Together, Thelen and McKearneys' approaches, which attend to both the wider contexts in which care happens and the particular ways in which care practices unfold on the ground, are resonant with the forms of care that emerge in this thesis; in a colonised, impoverished space with inadequate resources, a high burden of mental ill-health and legacies of state violence. The aim of this thesis is not to uncover whether telehealth enables 'good care' or indeed if its use opposes 'good care'. Instead, in order to understand how telehealth has landed in the New Mexican behavioural health system, this thesis sees the various and oftentimes opposing forms of care as in a necessary dialectic. While the use of telehealth shifts the nature of care, and even in some cases is considered inappropriate for care (see Chapter 8), it also enables forms of care—e.g., access to health workers and feelings of being cared for by the state (see Chapter 5). In this research, care is not merely 'good' or 'bad'; care is both present and absent, trusted and distrusted, inaccessible and accessible, conventional and altered. It is multidimensional, ambivalent and complicated.

Care as meshwork and improvisation

Moving forward from this discussion of multifaceted and open-ended care that extends beyond a distinct encounter between care giver and care receiver, and is also malleable, evolving across time, space, social and cultural contexts, we are confronted with another question. How, then, to approach

care? How to grapple with multiple and potentially contradictory forms of care simultaneously (Aulino 2019; Thelen 2015)? In this thesis I approach the slippery and seemingly unwieldy nature of care through two lenses: Ingold's concept of 'meshwork' (2007, 2011) and Livingston's theorisation of 'improvisation' (2012).

Meshwork, a term Ingold adopted from philosopher Henri Lefebvre (1991: 117-119), rests on the supposition that "life is fully encompassed in the relations *between* one thing and another—between the animal and its environment or the being and its world" (Ingold 2011: 83). In other words, the environment for Ingold does not exist independently of the beings within it. The environment exists only in co-creation with those that inhabit it, through relational tides that ebb and flow in a "continuous trajectory of becoming" (ibid., 84). These "lines of flow" (ibid., 70) and the complex web they comprise—the meshwork—are distinct from the connections that make up the network that Actor Network Theory (ANT) seeks to trace. ANT, which arose from the sociology of science and technology (e.g., Latour 2005; Law 2009), is a methodological orientation to understanding the world based on a particular perspective of agency. ANT has been employed ethnographically (e.g., Latour 1996a; Latour & Woolgar 1979) as a descriptive approach to trace the interactions between people and the objects around them, distributing agency across the array of components making up an environment rather than bestowing it solely within the human. This focus on the relational, on the connections between elements in a network, implies an inherent division between individual components and the connections between them (Larson et al. 2007). Ingold's meshwork, conversely, does not delineate connections between ostensibly egalitarian and separate points of agency. For Ingold, life is not comprised of things "entangled in relations" (Ingold 2011: 87). Instead, agency lies within the connections along which actions, events, perception, experience and relations unfold. Life in a meshwork emanates from the "entanglements" themselves (ibid.). Meshwork encourages us to move away from distinct points within a system towards interrelations in a web of daily life and the meanings embedded therein.

Meshwork is a useful concept for thinking about the specific issues in care that we shall see in this thesis because it draws attention to the infinite and complex connectedness of things. These things are not merely situated in a field of actors articulating around a particular event that we hope to understand (as in ANT), they are woven within the material world, the landscape, geography and "the currents of the media that surround them" (ibid., 93). The key concerns of this dissertation include how care extends well beyond the walls of the clinic. Forms of care in New Mexico lurk in many corners of everyday life, in many small instances including practices, spaces and materials. They are bound up in the state's history, the long highways, the doctors who come and go. Care as meshwork helps to

reveal the complex, intertwining connections of the New Mexican behavioural health system and the particular contours involved in the use of telehealth. In contrast to the biomedical endeavour of situating care in the clinic, of formulating care as singular and prescriptive, this ethnography attends to "care as an expansion" (Yates-Doerr 2014) by following its amplifications and relations. Understanding care as a form of meshwork enables a perspective also described by Thelen and Coe (2019): one that "move[s] across scales—from interpersonal relations between caregivers and care recipients to communal representations to state welfare policy" (2019: 292).

Livingston's (2012) exploration of 'improvisation' in care offers further fertile ground upon which to examine telehealth in New Mexico. In her ethnography, Livingston traces what might be called the "meshwork" of oncological care in Botswana. She brings together within the same frame the individual and social experiences of cancer with the complexities of biomedical practices of cancer treatment in a context where public and global health initiatives focus almost exclusively on the care of communicable diseases. In the context of unrelenting uncertainty in the availability of biomedical technologies for the diagnosis and treatment of cancer patients—and the concurrent ethical and moral dilemmas in which health workers and families find themselves—Livingston finds that improvisation becomes fundamental to and inseparable from care. Improvisation involves piecemeal strategies that health workers, patients and their families cobble together to counteract the persistent absence of biomedical technologies on the ward. It draws attention to healthcare contexts where actions are highly constrained and involve making do with what is available (Sangaramoorthy 2018; Street 2014). Behavioural healthcare in New Mexico is different from care on Botswana's only oncology ward in many ways; nevertheless, the care described in this dissertation is fluid, changing and uncertain. The introduction of telehealth reconfigures the meshwork of care in New Mexico, creating new paths and filling existing gaps while simultaneously creating new holes. These intersections and holes materialise through my ethnography. Improvisation helps us understand how the state government, behavioural health system, health workers and individuals work with and respond to these gaps in care.

This dissertation explores what emerges within the meshwork of care as it shifts as well as the ways in which these shifts are negotiated. For example, by building on Livingston's concept of improvisation, I trace the articulation of emerging forms of practice that come from the use of telehealth—both formalised and improvised—in order to uncover what these changes mean for health workers. I consider who is involved in which forms of practice and how these practices shape care. Improvisation in this context brings out insights into inequities in the labour of care (Thelen 2021), particularly among those who are tasked—both explicitly and implicitly—with navigating the 'informal' and under

acknowledged reconfigurations in the meshwork. This dissertation shows how the use of telehealth depends on the improvisations of health workers, often extending clinical responsibilities without commensurate payment, support or recognition.

Telehealth sits within and influences the meshwork of care. This ethnography grows from the understanding that care extends beyond the clinic with a complexity and texture that cannot be described solely by tracing actors in a network. Of course, it is impossible to trace the entirety of the meshwork as it is open-ended, dynamic, in constant flux, infinite. But in approaching care as a meshwork, we are able to understand the many entanglements of New Mexican healthcare and some of the implications of telehealth: not those merely confined to the healthcare sphere, but those shaped by daily lives, practices, relations, landscapes and histories.

Conclusion: Approaching telehealth through the lens of care

Care as a concept allows us to analyse concurrently different levels of the fragmented health system, different forms of relationality, different types of beliefs and experiences around health and healthcare. It enables the confluence of understandings from the therapist office, out to the clinic, into the community, driving and navigating around the state, to the programmes and people who have created and nurtured the implementation and use of telehealth, and to the committees and people who vote to allow telehealth to happen according to law. Care, in all its guises, in its productive and counter-productive, private and public, paid and unpaid forms allows us to take on the complexity, to grasp the tension and give it breath. Care offers a way to hold these diverse aspects of New Mexican life together, within the same frame. Importantly, approaching care as a form of meshwork reveals the spatialisation and infrastructural embeddedness of care. These are key dimensions in the use of telehealth which we will explore in the following two sections.

Telehealth has a space

Different formulations, understandings, experiences and meanings of space come alive in this ethnography, as it is experienced alongside and through ideas of care. Telehealth is seen as a solution to a problem that is partially conceived within the frame of space. Specifically, too much space. This surplus of space articulates with a dearth of resources and funding, contributing to the particular New Mexican landscapes in which telehealth has been deployed. Space is seen as a variable that telehealth can overcome. In this section I foreground three key concerns in the literature on space: engagements with the multiplicity and incompleteness of space, the particularities of North American space and the

intersections of space and care. Building on this literature, I argue that rather than overcoming space, telehealth is intimately implicated and intertwined in the construction of space; telehealth itself has a space. Through producing and reorganising various forms of space, the use of telehealth alters practices of care. This shifted spatiality brings our attention to the ways in which care and the implications of telehealth extend far beyond the spaces of the clinic.

Space as an ethnographic object

Whilst anthropological understandings of space and place have a long and complex history (see e.g., Cook et al. 2009; Cresswell 2015), this thesis draws primarily from Doreen Massey (2005), who has been influential far beyond her own discipline of geography in recent rethinkings of how to approach space. She calls for space to be centralised in our thinking, as an essential component of political, historical and philosophical inquiry. In previous streams of ethnographic exploration, scholars have relied on assumptions about space: space as a surface, as given, as singular in terms of its history and the particular agents creating that history. Massey unpicks these prior orderings of space that also draw on assumptions of space as a universal narrative, of a natural and sequential process. "What if", she asks, "we open up the imagination of the single narrative to give space (literally) for a multiplicity of trajectories?" (2005: 24). She questions further, what political and social implications might materialise from a shift in the way we approach space? Massey's approach to imagining space differently takes as its point of departure three propositions. First, "space [is] the product of interrelations; as constituted through interactions, from the immensity of the global to the intimately tiny" (ibid., 31). Building from there, as space is produced and reproduced through relations, Massey's second proposition puts forth that space is always multiple, comprising "distinct [and plural] trajectories" (ibid.). Third, space has always been and is always being made and remade. Space is not definite. It is "never finished; never closed" (ibid., 32); an entanglement of "loose ends and ongoing stories" (ibid., 222).

Massey's conception of space offers rich, theoretical purchase for this thesis. I take space as a dynamic entity that is "always under construction" (ibid., 32). I draw on Massey's understanding of space as relational and affective: space and social relations are both simultaneously established and inseparable; neither can be conceived without the other. Space comprises a living web of interrelations between the human and non-human; far more expansive than physical, flat, surface-level landscapes. Space coalesces and articulates in new and important ways in the use of telehealth, within the doctor-patient encounter, the functioning of the clinic, the health system and the memories, emotions and histories imbued in New Mexico's vast landscape. Building on this conceptualisation of

a space that is comprised of a myriad of histories and perspectives, my ethnography explores the ways in which the use of telehealth works to create and alter new and existing spaces.

Guided by Massey, this thesis resituates concepts of space in the discourses around telehealth. Space does not exist solely on the level of governmental and health system imaginaries, as something that can be collapsed with the deployment of new technologies. It also exists as a "simultaneity of stories-so-far" (ibid.). I trace the spaces that make up the daily lives of my informants. I consider who holds the power to alter these spaces, and how these are not the same people as those who navigate spatial shifts on the ground. This thesis attends to the multiple narratives of space in New Mexico's behavioural health system, narratives which illuminate how telehealth has landed and how care has changed.

A particular American space

Social and political life in New Mexico is embedded in multiple spaces and their histories (Garcia 2010; Kosek 2006; Powell 2018). Many of these spaces are intimately involved in the use of telehealth and the ways in which its use in behavioural healthcare is experienced and perceived. To understand the particular spaces that unfold in this ethnography, it is important to consider the wider 'American space' that shapes daily life in New Mexico.

Space and place in the US are particular and specific, and have been studied by many North American ethnographers who have attended to the incredible local diversity across the country (e.g., Basso 1996; Greenhouse 1986; Schmalzbauer 2014; Stewart 1996; 2000; 2007). Influential in this regard is Carol Greenhouse (1986), who traced the ways in which the residents of a small town in Georgia renounced inter-personal conflict and formal law in order to maintain community harmony. She argued that these intricate systems of avoidance "are products of the particular cross-currents that shaped the history of the town, the state, and nation" (1986: 29), particularly in relation to unresolved divisions from the past such as slavery, succession and relations with the Cherokee Indians. In her ethnography, Greenhouse emphasises two questions around the specific history of a place: what is this particular place (Hopewell, Georgia)? And, what is the US as a place?

While many different spaces and places have been explored across the history of the anthropology of the US, rural America did not come into contemporary focus as a site or object of inquiry until the 1980s (Adams 2007). The rural US is often delineated through notions of emptiness and of 'no one

here', fragile communities, places 'left behind' and flyover country[5]; through notions of towns that rely on one industry to stay alive, often based in some form of agriculture. When that industry fails, when plants close—for many and various reasons—people lose their jobs, public school systems shrivel, towns shrink (Hamann & Morgenson 2017). After the 2016 presidential election, discourse around rural America transformed as political interests flooded the rural (Blanchette & LaFlamme 2019); focus turned to understanding this 'urban-rural divide', the intracultural gaps and the regional socio-cultural economic disparities found therein (Hochschild 2016). Consistent in this categorisation of 'the rural' is a detachment from the varied and ever-dynamic dimensions of the families and communities who live there. Despite local heterogeneity across the country, the 'rural' is often conflated with ideas of 'farming' (Green 2012; Hart 1995); the 'rural' is reduced and reified in popular discourses into a singular and homogenous thing. Many anthropologists have worked against these one-dimensional narratives and toward an understanding of the idiosyncratic nature of rural communities (e.g., Adams 1994; Dudley 2002; Fink 1986). Blanchette and LaFlamme (2019) indeed suggest that the ways in which people can 'be rural' are multiple and distinct.

In tracing the use of telehealth in Albuquerque—an ostensibly urban city with a relatively rich landscape of healthcare resources—and in Clovis—a rural city that lacks stable access to healthcare resources—this thesis risks reproducing the same dichotomies anthropologists have worked against. To counteract this, I take seriously the particularity of space. I examine the ways in which space articulates with New Mexican forms of distance, scarcity and marginality. I approach New Mexico more generally as well as Albuquerque and Clovis as multi-valent, distinct and dynamic spaces to uncover the meanings, histories and affect imbued therein (Chapter 4). Through examining the ways in which space reflects particular and local ways of being in the world, I show how the spaces that make up the daily lives of my informants direct their experiences with the New Mexican health system and their use of telehealth.

The space of care

In addition to the understandings that space is constantly created and recreated, that it is an essential and interlinked dimension in everyday life, this thesis also engages with the ways in which space is implicated in and intimately intertwined with care. Processes of care are situated in and unfold through different spatial conditions. Care happens in various and multiple spaces: those associated

[5] This term describes a 'middle America' that residents of East and West coastal states fly over as they travel from one side of the country to the other.

with the domestic, within the community, in formal and institutional settings. Shifts in the space of care influence the ways in which care is performed, perceived and experienced (Buse et al. 2018). Thus, in order to understand the relations and practices of care in the context of telehealth, it is crucial to consider the ways in which this particular form of care is emplaced (Pink 2012).

A primary way in which this dissertation approaches space and care is through the frame of closeness and distance. These are core aspects of relations in healthcare and are crucial for exploring the interface of telehealth—a health infrastructure based on distance and separation—with a health system that has been designed around assumptions of closeness and the in-person encounter. Importantly, closeness and distance can be both helpful and disruptive, ambivalent and multi-valent, as they afford intimacy and safety, as well as separation and isolation (Brown & Marí Sáez 2021; Pink et al. 2014). In the context of the Ebola epidemic in West Africa, clinical practices involving physical closeness, such as delivering a baby, transformed from acts of providing care to dangerous encounters of potential contamination and spreading of disease (Brown & Marí Sáez 2021). In a comparative example, Pink et al. (2014) describe the negotiations of forms of closeness and distance in habitual practices of nurses who care for patients in their homes. Using hand gel and wearing gloves produce forms of distance that allow nurses to safely travel between patient homes, touch wounds and change soiled bed sheets. However, this distance is also inhibitory. One nurse cuts off a fingertip of her glove in order to feel with greater sensitivity a patient's vein when placing a cannula. The glove is used both for safety in its ability to separate and simultaneously, in acting as a barrier, the glove makes providing some forms of care more difficult. This thesis examines the ways in which telehealth also creates new forms of closeness and distance, and what this means for social relations in medicine and the ways in which care is experienced.

Beyond particular conceptual approaches to understanding space and care, medical anthropologists have emplaced the study of care through hospital ethnography (Brown 2012; Livingston 2012; Mol 2002; Street 2014; Wendland 2010; Zaman 2004). Central to this scholarship has been a focus on the complex relationship between hospitals and everyday social space. Street and Coleman (2012) argue that hospitals are "simultaneously bounded and permeable" (2012: 5) spaces, both separate from as well as reflective of and deeply connected to everyday life. Contributing to this understanding, several scholars have found that multiple spatial orderings exist in hospitals, including those beyond the biomedical, such as the domestic (Brown 2012).

In taking the space of care as a field of inquiry, this thesis departs from the work of hospital ethnographers. Telehealth articulates with, imposes on, displaces and creates spaces in care. Its use

works to destabilise assumptions around what comprises biomedical spaces and where care can exist. I argue that with telehealth, the space of care is altered and multiplied. This ethnography illuminates spaces of care that exist outside the virtual space that links doctor and patient via the internet and various screens. Other spaces implicated in telehealth are the rooms in which patients and health workers sit alone with computers, the clinics that work hard to coordinate care over telehealth, the communities that prefer care over telehealth because they do not trust local health services, the long drives that used to be the only way people could receive specialist care. Further, this thesis examines the ripples and implications of these spatial shifts on the ways in which care is experienced and understood.

Conclusion: Telehealth has a space

Brought together, this thesis approaches space as simultaneously open-ended and particular, as influenced by history, and as interfacing with experiences and understandings of care in order to examine the ways in which the use of telehealth shifts space within the New Mexican behavioural health system. The use of telehealth and the spaces involved are dynamic and unending; they reach out into, are defined by and change the experience of the landscape for the people who live there. By producing and reorganising various forms of space, the use of telehealth alters the forms of care that make up daily life. These changes in the spaces of care demand attention. They reveal the ways in which care over telehealth is navigated, how people make sense of health and care in the places they inhabit, and more broadly, where care can be located, and to where it can extend. This thesis looks at how forms of care are refracted through different spaces and materials through the use of telehealth. I consider how care extends beyond the doctor-patient encounter: thinking about both where it extends to, as well as the material world it extends through, as will be discussed in the following section.

Telehealth as infrastructure

Telehealth is not solely an endeavour involving computers, doctor, patient and an internet connection. This thesis illuminates how telehealth is situated in many other materials, both those in the clinic and those that extend into daily life. In this section, I offer an approach to telehealth using the anthropology of infrastructure. I draw on the multiple levels infrastructure can inhabit as a way to conceptualise the material and immaterial implications of telehealth. Finally, I argue that care has a

material infrastructure. The use of telehealth is wrapped up in materials, and often shifts both the materials of care and care itself.

The anthropology of infrastructure

Infrastructures are the material and organisational structures that enable the movement and exchange of matter and relations across space (Larkin 2013). They are defined as the "mundane" (Star 1999: 377) elements of daily life. Infrastructure is both matter itself as well as the relations between other matter, supporting the work of other structures (Star & Bowker 2006). Railroad tracks, roads, water ways and electrical networks, all of which are understood as infrastructures, form conduits and support movement, mobility and communication across disparate places. Infrastructures also extend far beyond their physical functionality: they connect and organise spaces, people and things into networks upon which contemporary social, political and economic worlds come into being (Bear 2007; Chalfin 2010; Collier 2011; Graham & Marvin 1996, 2001; Larkin 2008). Dalakoglou (2010), for example, uses roads as an access point for the ethnographic investigation of social and political life in modern Albania. The specific road Dalakoglou studies connects Southern Albania with its Greek neighbour and is viewed by many of his Albanian informants as an extension of the Greek road system. This perception of Greek expansion into Albanian territory illuminates nationalist tensions and offers insight into the processes of post-socialism and globalisation that are very much present in Albanians' everyday lives.

Importantly, Anthropology enables the exploration of the disparities between the promised effects of infrastructural developments and the ways in which infrastructures are realised on the ground (Scott 1998). This extends, and stands in contrast to, a primary aim of Science and Technology Studies, which often focuses on these gaps on a more proximal scale: at the level of a technology, its immediate surroundings and specific practices, uncovering and exploring 'unintended consequences' (Tenner 1997; Harrison et al. 2007). While there are many overlaps between the two approaches[6], the anthropology of infrastructure departs from the immediate vicinity of a technological system to understand the greater social and political consequences. It approaches technologies first and

[6] In the process of writing this dissertation, the distinctions between the anthropology of infrastructure, approaches in Science and Technology Studies to technology, and the burgeoning field of the anthropology of technology (Bruun et al. 2022) have been both reinforced and muddled. Several questions require attention in this scholarship, namely: why are technology and infrastructure theorised differently? On what scales do technologies exist, and on what scales are they studied? Could the anthropology of infrastructure provide a scalar, rather than a distinct and fundamentally different, perspective on the anthropology of technology? While this thesis does not have the capacity to engage these questions, it remains important to identify the evolving and fertile theoretical ground the intersections of infrastructure and technology offer this thesis.

foremost as components of wider systems of infrastructure: motorcycle taxis that shape and are shaped by social network infrastructures in Hawassa, Ethiopia (Mains & Kinfu 2017); proposed water meters in Mumbai's water system that articulate with local citizenship (Anand 2020); a high-tech landfill as a form of political ordering in Dakar's waste infrastructure (Fredericks 2016); digital data-storage that reproduces former infrastructural patterns in Iceland (Johnson 2019).

In the context of this dissertation—where telehealth has emerged as an integral and interwoven component of the New Mexican health system, the state's history and geography, forms of daily life and relations between communities and the state—it is useful to approach telehealth as part of a larger infrastructural system. Telehealth through the lens of infrastructure enables a view of the 'periphery': the aspects beyond the physical technology itself. This thesis argues that this 'background' (Star & Bowker 2006) infrastructure needs to be more fully considered in studies on telehealth; that the use of telehealth hinges on many components of health, care and everyday life that have thus far been overlooked yet are just as integral to its use as securing a stable internet connection or accessing the correct hardware and software. Importantly, infrastructure is not an ontological entity; it is a perspective. In this thesis, I approach telehealth as infrastructure, rather than telehealth is infrastructure.

This thesis engages with one of the 'actors' that has been neglected in ANT approaches, the wider context. This includes the political climate, ethics, beliefs, emotions and values; the invisible infrastructures of everyday life that surround, shape and are shaped by the use of a particular technology (Krarup & Blok 2011). Further, this thesis considers the consequences of this context: what is included in this context, and how might this alter the understandings and knowledges formed from this work (Huen 2009; Strathern 1980, 1992)? Moving away from an actor-driven network approach to include broader considerations of context and the intangibles that make up everyday life, I describe a meshwork (Ingold 2007, 2011) of contributors to this partial picture of understanding; one that remains open-ended and dynamic, that draws attention to the complex web of the material, relational, spatial and social. Like meshwork, infrastructures do not exist solely to support daily life, they are themselves a part of daily life. They are not only connecting structures, they are themselves integrated and enmeshed in complex ways in the world (Harvey & Knox 2015). Infrastructure as a lens offers a way to approach context, this particular meshwork of care. It offers a complex and porous understanding of the way in which telehealth fits into the wider health system and the lives of people in New Mexico.

Levels of infrastructure

Infrastructures function on many levels concurrently. Levels of telehealth infrastructure include, for example, the very populations telehealth makes accessible as well as the norms and understandings around rurality that make these populations understood as marginal (Farmer 1999). Without populations that are perceived as hard to reach, telehealth has little purpose or direction. In a useful comparative example, Von Schnitzler (2008) illuminates the multiple levels of water supply infrastructure in South Africa. In addition to regulating and delivering water supply, Von Schnitzler argues that individual home water meters also produce an ethics around water usage. The government, in aiming to improve the culture of water waste, employed these meters as tools of governance: extensions of the State that bred particular types of citizens who carefully monitored their water usage. Von Schnitzler describes how these infrastructures become tools of material measurement as well as particular moral infrastructures built into South Africa's water supply system. The meter is defined by a particular understanding of morality and at the same time reproduces this morality in those who use it. Von Schnitzler's ethnography demonstrates that infrastructures are neither neutral nor solely material. They are entangled intimately with forms of governance, social actors and systems of morality.

Levels of infrastructure exist beyond the material and technical; they also exist in the imaginary. Infrastructures are intimately connected to notions of societal progress (Benjamin 2002; Khan 2006), and often represent a channel through which to become modern (Scott 1998; Mitchell 2002). Telehealth has been developed and implemented alongside a vision of a cost-effective health system that is able to provide care to all populations, regardless of varying forms of marginality. How do the imaginaries of these infrastructures and their possibilities influence and define the infrastructures themselves? Mains (2012) found a steadfast public approval of and faith in infrastructural development in Jimma, Ethiopia, even though these projects were accompanied by persistent blackouts. Harvey and Knox (2015) observed a fantastical way of thinking about roads amongst rural populations in Peru, both around the possibilities afforded by roads for social change as well as in the ways roads displaced prior feelings of state abandonment. Along with the dreams and desires surrounding infrastructure, Harvey and Knox also observed a newfound sense of pride in both the self and the state. Even before construction had commenced, road infrastructure in Peru had already created new types of citizens: those who gained a sense of confidence in their government and a willingness to support the initiatives of the State. Further, Harvey and Knox observed a willingness amongst rural populations living near the new road to reorient their lives to accommodate the new

infrastructure. Anand (2011) and Barker (2005) offer similar accounts of appreciative, local adaptations in the context of regional and national infrastructural transformation. While on the political and macroeconomic level of these projects, local populations are often excluded from key decisions and debates, ultimately it is the local populations that both shape and are shaped by infrastructure (Harvey & Knox 2015).

The lens of infrastructure enables an approach to the textures of everyday life through multiple infrastructural levels: the material, physical and mundane as well as the immaterial, such as beliefs, values and the affective, among others. Telehealth is materially embedded in New Mexico's behavioural health system. It is also embedded in practices of mobility, perceptions of the state, understandings of care and where care can exist. This thesis illuminates a rearrangement of material and immaterial infrastructures with the use of telehealth. It argues that alongside and intersecting with this rearrangement is a shift in care.

Materiality of care

Telehealth, as other technologies, involves the confluence of the digital, immaterial and material (Miller 2018). It enables video-consultations between patient and health worker that take place online (digitally). The use of telehealth intersects with, contributes to and alters intangible infrastructures of everyday life in New Mexico: social relationships, emotional connections, individual and collective imaginaries, values and logics around care. There are infinite relations between this immaterial realm and the material, relations as well as the duality that presupposes them that offer their own windows into understanding the human condition (Buchli 2016). However, of the many forms of infrastructural shifts observed and described in this thesis, the most striking ethnographically are the reorganisation of the mundane[7] materialities of care. Care over telehealth is embedded in and inseparable from the material.

Everyday materials—those beyond a particular medical device or technology—make up and mediate practices and relations of care (Maller 2015; Pink et al. 2014). They are comprised of and exude many different meanings (Berg & Bowker 1997; Whyte et al. 2002). By 'material', I refer to physical things: the walls of a clinic, long asphalt concrete highways, the constantly ringing telephones in the understaffed reception office of a community mental healthcare clinic. Material dimensions of care

[7] I draw on Maller's (2015) use of the term mundane to describe everyday materials that are often overlooked, perhaps even invisible to those in whose lives they are embedded, yet which hold great cultural and social significance.

have been examined in medical anthropology through a variety of approaches. Mol et al. (2010), in discussing the centrality of care in everyday life and trying to pin down what care is, consider together care and a form of materiality—technology. "Caring practices", they assert, "include technologies: from thermometers and oxygen masks to laboratory tests and video cameras" (2010: 14). Winance (2010) takes this argument further. Materials are not merely included in caring practices as passive objects; they are also active subjects. Caring in the context of a wheelchair test centre—where people with varying physical mobility issues and their carers are able to test out and adjust wheelchairs to suit their particular lifestyle—is to "take one's time, to 'quibble' over details, to examine together, to test, explore and feel in order to make the right adjustments" (2010: 98). Ultimately, this "tinkering" transforms both the person and the wheelchair. Both are, at the same time, the subject and object of care. To explain this, Winance draws on Callon and Law's (1997) conceptualisation of the collective. Care involves attention to this collective: not only the person who will use the wheelchair, but the chair itself, as well as the carer, and the relationship between the person, their carer and the chair. Winance rejects the often-implicit hierarchy between people and materials in the provision of care. Caring encounters are not simply made up of active people using passive things. Materials are dynamic counterparts in the care they help to produce, structuring and shaping space, transforming and defining what care is and how it is provided (Buse et al. 2018).

A crucial component of the use of telehealth in the New Mexican behavioural health system is the material infrastructure that makes up care. In considering how care is provided and what comprises care, this research attends to the material footprints of telehealth. It finds that the materiality of telehealth includes much more than basic, decentralised forms of technology (screens, microphones, speakers), and that many of the materials implicated in the use of telehealth have thus far been unacknowledged. Importantly, the relations between these materials, people, spaces and practices contribute to the meshwork of care over telehealth. Further, this thesis argues that the use of telehealth involves the reorganisation of these many neglected materialities of care, and through this, care is altered in significant ways.

Conclusion: Telehealth as infrastructure

The health infrastructural landscape of New Mexico is blotchy and incomplete. The state government has attempted to fill gaps in the access to care with telehealth, aiming to enable the traversing of space via new technologies. To appreciate the ways in which telehealth fits into, contributes to and complicates the wider health system, this thesis draws on the anthropology of infrastructure to approach telehealth technology as embedded within, shaped by and shaping larger infrastructural

systems. This thesis explores a form of telehealth that is situated within and connected to the broader landscape in which it is surrounded, including the social, political, economic and geographic. These wider infrastructural systems exist on multiple levels: physical distances, the healthcare workforce and the state's economic resources, as well as beliefs around where healthcare can exist, public feelings of trust in the state and the services it provides, and social relationships—the material and the immaterial. Finally, mundane materials emerge in this thesis as salient expressions of infrastructure and important dimensions of care. Through following particular materials in the process of care, this thesis identifies ways in which care has changed with the use of telehealth.

This thesis

Brought together, the social science scholarship on telehealth and the intersection of three novel theoretical foci—care, space and infrastructure—offer a rich foundation with which to approach this research on telehealth. The balance between care, space and infrastructure is central to behavioural healthcare in New Mexico, and their confluences offer an avenue to inquire about, unpick and trace the ways in which telehealth has landed in this particular place. These three theoretical frames illuminate how the use of telehealth in the New Mexican behavioural health system has become entangled with everyday life. More specifically, through these frames, this thesis argues that telehealth shifts care; telehealth is emplaced and implicated in care beyond the clinic; and telehealth is embedded in and expressed through multiple levels of infrastructure. In the subsequent chapters of this thesis, I delineate and animate these arguments ethnographically.

Overview of chapters

Directly following this literature review is Chapter 3 which describes my methodology, method and navigation of ethics in this research. This chapter offers details into the ways in which I approached this research, how I gained access to different field sites, what data collection and analysis entailed, and the ethical processes and challenges intertwined in each of these aspects.

I then move into the five core ethnographic chapters of this thesis. Chapter 4 focuses on the multivariant landscapes in New Mexico. It sets up important groundwork for the rest of this dissertation by bringing to the forefront the ways in which telehealth and the surrounding social, political, affective and physical landscapes of New Mexico are inextricably intertwined.

Subsequently, Chapter 5 explores how, in these vast distances and drawn-out landscapes, the state health system has relied on individual, physical mobility in its response to space. This form of mobility sits within a larger system that restricts other types of mobility: social and economic. The implementation and use of telehealth aim to address and compensate for these distances. While dependence on mobility is still central to everyday life in New Mexico, this thesis finds that practices of mobility have changed with the use of telehealth, offering newfound access to care to people who otherwise did not have access. Further, this chapter explores the ways in which, through the use of telehealth, mobility itself becomes a form of care.

Chapter 6 looks more closely at the reconfigurations in the spaces and materials implicated in care over telehealth, and how these shifts in turn, lead to changes in care itself. More precisely, this chapter attends to the intersections of space and materiality in specific practices of care that have been overlooked in the employment of telehealth yet are integral to the various forms of care involved in its use. On the level of the health system, and the articulations between system and practice on the ground, Chapter 7 considers how telehealth, a technology based on distance, fits into a health system that is built on specific assumptions of closeness. I argue that whilst telehealth reduces certain kinds of distance, it also produces new gaps in clinical processes as it articulates with a wider health system that is based on implicit, practiced and material infrastructure that spatialises caring relations as 'close' and 'in-person'. I show how these gaps are navigated on the ground by the under resourced healthcare workforce, and in this way, how telehealth reproduces certain forms of inequities.

Chapter 8 both builds on and muddles the perspectives I nurtured in the earlier ethnographic chapters, which illuminate the ambivalence of telehealth in the context of resource scarcity, which focus on the shifts in routine, ongoing behavioural healthcare over telehealth, and which argue that telehealth introduces new forms of care. This chapter offers a counterpoint through its consideration of telehealth in the provision of care at the margins. It moves through three case studies in which the ambivalence in the use of telehealth comes to an inflection point, where a limit is encountered: the boundary between when care over telehealth should happen and when it should not. These cases demonstrate the ways in which this boundary is encountered and negotiated on different registers of care. Ultimately, I consider the meaning of this boundary and the ways in which it reveals fundamental questions about the value of life and resource scarcity.

Chapter 9 is the conclusion of this thesis. It reflects upon the arguments made throughout each individual ethnographic chapter and brings them together to underline the two overarching arguments of this thesis: that telehealth transforms the nature of care and that the use and

implications of telehealth reach far beyond the basic technologies that so often characterise its use. I use this chapter to think through the evolving landscape of telehealth since the start of the COVID-19 pandemic and to consider the boundaries between telehealth and in-person care, and what it means as they become more porous. Lastly, I consider the articulation of telehealth with discourses of 'appropriate care' and call for a rethinking of the standards that guide US healthcare.

Chapter 3: Mapping the Approach to and Unfolding of this Ethnography

In this chapter, I think through the epistemology underlying my conceptualisation and approach to conducting ethnographic fieldwork in New Mexico as well as the realities of ethnography in practice. I reflect on the processes of identifying a field site and gaining access to that site. I consider the ways in which this ethnography included both formal and informal dimensions and how these were often blurred. I also attend to the specific ways in which I managed and analysed empirical material, as well as the reflections that informed the writing process. Ultimately, this chapter grounds the approach to and evolution of the ethnography that sits at the centre of this thesis.

Research conceptualisation and design

This research is first and foremost ethnographic. It aims at what Miller et al. (2016) term 'holistic contextualisation' which involves exploring one thing—the use of telehealth—by exploring the ways in which it is situated in everything else. To address the research questions introduced in the previous chapter, I carried out an inductive and reflexive (Hammersley & Atkinson 2007) ethnography, following the turn in anthropological research over the past few decades toward the spatially and temporally unbounded field (Marcus 1995; Coleman & Collins 2006; Candea 2007; Fortun 2009). While I arrived in New Mexico initially with particular research questions and a vague idea about how I would go about answering them, ultimately, my research in practice was shaped by the people, spaces and things with which I worked. I worked to not solely privilege telehealth, but instead to trace understandings of telehealth through the daily lives of my informants: through the wider health system that they navigate, and through the state's economy, history, geography and forms of mobility, among others. Across my fieldwork, I learned that these many and various dimensions influence the ways that telehealth functions in everyday life.

Seeking to understand the ways in which telehealth intersects with care, the health system and the daily lives of New Mexicans, I was confronted with questions such as: what is and what is not included in these intersections? What informs this research and what does not? Many social scientists of technology have addressed this question through the employment of Latour's Actor Network Theory (2005), a descriptive methodology which traces a network of actors. However, this approach inevitably leads to the following question: what is and what is not an actor? Krarup and Blok (2011) have argued that it is not possible to reduce the world into a map of concrete associations. Rather than ascribing a bounded solidity to daily life in New Mexico or presupposing the capacity of a single ethnography to

enable a comprehensive exploration of care over telehealth, I relinquished the Latourian method and instead followed traces of practices. This enabled a robust understanding into the relational existence between the systems, people, practices and infrastructures on the ground. Instead of aiming to pinpoint how telehealth fit into the wider world around it, I instead attended to how words, actions and practices around telehealth performed particular realities (Strathern 1980, 1992; Law 1994; Escobar 2008; Street & Copeman 2014; Yates-Doerr 2015). Rather than seeking absolute, exact answers to the question of how telehealth has landed in New Mexican behavioural healthcare, I sought to understand the multiple ways telehealth was enacted and came into being. This ethnography is guided neither by an a priori understanding of the important actors, nor by a fixed understanding post analysis. I describe a meshwork (Ingold 2007, 2011) of contributors to this partial picture (Huen 2009) of understanding, one that remains open-ended and dynamic. This partial picture, as I will describe in the subsequent sections, was shaped by the logistics and governance of research as well as by several intersecting temporalities, institutional approaches to research and my own positionality.

My fieldwork lasted from September 2018 to August 2019. During this time, I explored different spaces and practices in which telehealth took form in the New Mexican health system, as well as the complexity and multiplicity of relations between them in three intersecting areas of focus. These areas of focus were guided by my research questions and grounded in different scales of the health system. While the areas of focus detailed below are presented as distinct, they were largely dynamic and overlapping, continually informing each other. Using these areas of focus as a rough organisational framework, I followed particular threads depending on what became relevant during the course of data collection.

The first area of focus involved an ethnographic exploration of 'top level' institutions and processes within New Mexico's health system that interfaced with the use of telehealth. This involved tracing the range of and relations between governmental actors in the behavioural health system and networks of public and private organisations throughout the state that supported the use of telehealth. This contributed to a broad understanding of how and where telehealth fit into the state's health system as well as the unique challenges facing the provision of care in New Mexico more generally.

In the second area of focus, I formed relationships with and became embedded within UNM's Department of Psychiatry in Albuquerque, which provides both ambulatory and emergency behavioural telehealth services to rural populations across the state. Through this area of focus, I formed further understandings of the functioning of and context underlying the use of telehealth in

behavioural healthcare. Spending time with, observing and interviewing telehealth providers as well as telehealth programme coordinators, I fostered an understanding of the provider perspective of telehealth: the practices, frustrations, challenges and rewards involved.

The third area of focus involved what I conceptualised as a counterpoint to the second area of focus: an ethnographic exploration of a rural behavioural health clinic in Clovis, New Mexico that received telehealth services from remote providers. Through this area of focus, I learned about both the experience of patients who receive care from a therapist or psychiatrist over telehealth as well as rural health workers and support workers who live in Clovis and work locally at this clinic. I gained an understanding of what healthcare means for those living in this rural city and how telehealth articulates with this meaning.

Throughout my fieldwork, the interstices of these areas of focus became just as important, just as active and present in my reflections and analyses as the areas of focus themselves. They guided iterative methodological considerations and contributed to my reformulated research questions. Chapter 4, for example, focuses on the drive from Albuquerque to Clovis; what I had first conceptualised as the space 'in-between' sites became fertile ground for understanding the histories, geographies and sociality of New Mexico that together shape the use and experience of telehealth.

Locating telehealth

While the three areas of focus guiding my research were useful in giving structure to a partially amorphous and spontaneous endeavour, they were also problematic as they required me to 'locate' telehealth. Underpinning these areas of focus was an assumption that telehealth existed in specific spaces: on the level of the health system in government buildings and conference rooms, in urban health centres from which telehealth services were provided and in rural clinics where patients received those services. This assumption brings up several questions: are these the only spaces in which telehealth functions? And, are these spaces separate? Adopting Marcus' (1995) term, was this ethnography therefore "multi-sited"?

Multi-sited fieldwork approaches singular field sites as providing only partial perspectives onto particular phenomena that function on much wider scales, beyond the boundaries of one site. In order to understand phenomena comprehensively, ethnographies need to bring together perspectives from multiple sites (Marcus 1995). Cook et al. (2009) argue that multi-sited fieldwork, thus, requires certain conditions, namely, the existence of a "hidden truth" (2009: 47), a universal coherence that articulates

with the different, individual perspectives afforded by the exploration of multiple sites. They assert that understanding a local phenomenon does not necessitate its positioning within a global system, and further, that perhaps such a global system does not exist. In this way, they accept the complexity revealed through the retreat from a presumed unity on an overarching, higher level. For this work, perhaps there is not just one telehealth existing across several spaces, waiting to be perceived from different angles. Instead, taking seriously Cook et al.'s (2009) proposition, perhaps there are multiple telehealths.

As introduced in the previous section, I aimed to understand telehealth through following it in practice, through attending to the specific experiences of its use. I mobilised these experiences to inform my understanding of telehealth rather than trying to pin down a telehealth that exists beyond these experiences. Telehealth and care are emplaced in many different ways. Telehealth alters, extends, augments, detracts, squeezes and stretches the spaces and places of care. There is neither one care nor one telehealth to delimit. And, perhaps "there is no need for us to try and imagine one" (Cook et al. 2009: 69), one particular and bounded space of care and telehealth.

This, however, leads to another question: how does this departure from multi-sited ethnography work in practice? Instead of exploring the same thing from different angles, I researched a multitude of things across different sites. Simultaneously, I also acknowledged that the experiences, perspectives and events from these different sites were shaped by one another in intimate and far-reaching ways. While separate, these phenomena are also interwoven (Cook et al. 2009). To understand these different yet related processes and the ways in which experiences across different sites shape and are shaped by the other, I began my fieldwork approaching three specific sites. Of course, these different sites were not completely distinct. The meshwork of care that emanates through my ethnography shows that these sites are entangled, that the everyday life and the geographies surrounding them are just as important to the use of telehealth as the formal goings on in the health system. When one space introduced me to another, I followed. By travelling between the 'urban' and the 'rural', from one of the sites within which I initially conceived telehealth to be located (Albuquerque) to another of those initially conceived sites (Clovis), I encountered the permeability of telehealth and care in everyday life. It was these unexpected spaces in-between—the physical space separating and connecting these two sites (detailed further in Chapter 4)—as well as the mundane spaces of daily life that led me to explore and understand telehealth as implicated in processes and experiences much broader and extensive than the anticipated urban offices and rural clinics. Ultimately, I traced the unique and diverse practices of telehealth through multiple spaces across the state. For example, and intimately intertwined with one of the main arguments of this thesis, the ethnographic process led

me to focus on spaces that were not virtual; spaces that were not contained within the limits of the telehealth encounter, even spaces that were not considered within 'the clinic'.

Negotiating access

In the previous section, I grappled with the complexities of locating a field. While this iterative process involved both chance and adaptation, it also involved other crucial dimensions: judiciousness and planning. That is, the purposeful formulation of a field that is already known in some capacity through its spaces, networks or relations (Coleman & Collins 2006).

I focused on the use of telehealth services that were already used routinely in care. By the first year of my doctoral programme, I had reviewed a range of literature exploring the introduction of telehealth services (e.g., May et al. 2001; Oudshoorn 2008) that I had formed questions about what the use of telehealth might mean to health workers and patients after it had already been established within a health system. The US, Australia and Norway all had robust telehealth systems in various regions. As an American, and for purposes of language, visa processes and general familiarity with the US health system(s), I chose to focus on telehealth within the US.

I first researched various telehealth programmes across the US and spoke virtually with several regional and national level telehealth professionals including those affiliated with the Centre for Connected Health Policy, the Office for the Advancement of Telehealth and the American Medical Association (AMA). Through these conversations, I was directed toward particular states and programmes that aligned with my research interests. I contacted via email health workers, departmental heads and the administrators of telehealth organisations within in several states that had robust telehealth systems—all in different areas of care and in diverse capacities[8]. As American healthcare is largely state-based, I sought to identify one state within which to situate my research. Two groups in New Mexico, one within the UNM Department of Psychiatry and the other, a non-profit corporation working to promote and facilitate the use of telehealth throughout the state, showed particular interest in my research and offered to support my work in different ways. The group at UNM was immediately responsive, offering their time and resources to help my project, and became the primary reason I chose New Mexico as a field site. They were involved in the provision of telehealth

[8] As I would learn later through my interviews, the particular telehealth programmes in different states are not only dictated by the unique healthcare needs of a state but also by the presence of doctors who are willing to spearhead the use of telehealth in their specific field. In New Mexico, there were both profound disparities in behavioural health services, particularly in rural areas, as well as psychiatrists with the energy, motivation and inroads with the state health system to put together a telehealth programme in behavioural health.

themselves and were happy for my research to both be based within and focus on their department. The head of the non-profit was a retired doctor who used to hold an executive position at the American Telehealth Association, the foremost national organisation working to advance the use of telehealth in healthcare. He was well known and respected in the telehealth arena and had a large network around the state of people interfacing with telehealth across various sectors. Practically, I understood that this support would be vital for my research, and so I decided to base my project in New Mexico, to work closely with these two groups and to largely focus on the provision of care in behavioural health. In this way, behavioural health arose as a secondary source of interest in my research, initially as a way to pursue broader questions around care. Throughout the research process, however, it became an important window through which to understand telehealth as well as the particular daily realities surrounding its use.

Upon arrival in Albuquerque, I was given a desk within the UNM Department of Psychiatry, where for the first few months of my research, I spent nearly every weekday. I worked closely with three advisors, all psychiatrists who were involved in the care of patients over telehealth and research around its use. One of my advisors held an important administrative role in both the department as well as the Behavioural Health Service Division, the state authority for behavioural health and substance abuse. She was known across the state health system and held by many in esteem. This advisor sent an email to the department prior to my arrival as a way to introduce me and the purpose of my work. During my first few weeks, I was welcomed by many people in the department who all referenced this email and expressed interest in my research. The British Bake Off had recently aired on American Netflix and Meghan Markle and Prince Harry had recently married; popular culture and interest in my life in the United Kingdom nurtured connections right away. Over the course of the year, I formed close collegial relationships with many working in the department, including health researchers, psychiatrists, psychologists, social workers, programme managers and administrative staff. I was invited to and participated in the annual departmental 'day out' to an equine therapy centre where we worked through team building activities with horses. I attended the monthly staff meetings and research seminars, twice as the seminar presenter. I waited in the microwave queue to heat up my lunch in the tight office kitchen, often eating with others at the big table in the office's public area. I ran back and forth between my desk and the office of the ethics manager as we worked to prepare, submit and resubmit my ethics application to the Institutional Review Board (IRB). I logged into institutional computers with my institutional ID, printed consent forms from the office printer and organised research records in one of the office's large file cabinets. I woke up early to watch the ascent of hot air balloons at the annual Albuquerque International Balloon Fiesta, a live stream projected onto a big screen in the office's conference room, accompanied by coffee and breakfast burritos. I dressed up

along with others for Halloween, participated in the office holiday cookie exchange and Secret Santa. While everyone knew I was an anthropologist from another university, all of these things, big and small contributed to a sense that I was a part of the department.

The Department of Psychiatry became the urban institution providing telehealth services that I had initially sought to include in my research, while the connections through the telehealth non-profit evolved into the lens through which I was able to approach the regulation of telehealth from the level of the state health system. Knowing that I aimed to include a rural clinic in my research[9], my advisors connected me with several clinics in rural communities that received telehealth services. The department either already provided telehealth services to these sites or showed interest in building relations with them to facilitate potential future programmes, for example, short term placements for psychiatrists training at the medical school to gain experience in a rural clinic (explained further in Chapter 4). My advisers invited me on several site visits to these clinics, introducing me to staff and allowing me to get a sense of whether it might be possible to conduct my research there. Through one of these site visits, in late January 2019, I met the executive director and several administrators of a clinic in Clovis, who all agreed to support my research at their clinic. It was through the relationships I had fostered with the Department of Psychiatry that led me to gain the trust of and access to this clinic.

Because of my unfamiliarity with New Mexico, as well as my previous research and work experience in medical and academic settings, I felt most comfortable approaching the field near the 'top' of the health system. I was unsure where to start in locating and forming relationships with rural clinics in the state that received telehealth services. Concurrently, it was relatively easy to identify people active within the upper levels of the health system and access their contact information via the internet. In this way, it was useful to start with centralised bodies that could then connect me with smaller, peripheral branches of the health system.

Further, language was another dimension of daily life in New Mexico that dictated my access to certain spaces and populations. After English, Spanish is the most common language spoken in New Mexico, with 26.5% of New Mexican residents speaking Spanish at home (Data USA 2019). I did not know

[9] In specifically approaching urban and rural sites, I arbitrarily placed defined boxes around the spaces I considered for my research as well as the spaces with which I ultimately ended up working. The Department of Psychiatry at UNM and the Clovis Clinic, for example, were both distinct and particular, navigating their own unique challenges. However, they were also both ostensibly bounded by their resource availability, population, distance to a big hospital, political climate and economic struggles. Related to these dimensions, the provision of telehealth from Albuquerque and the reception of telehealth in Clovis offered—to an overarching, evolving and ambiguous extent—the 'urban' and 'rural' perspective that I had set out to include in my research.

Spanish well and did not feel comfortable going through the research consent process and interviews in Spanish. Thus, I conducted my research solely with people who spoke English fluently—this often involved people who spoke Spanish as well. This meant, however, that people who did not speak English were not included in the formal interview and observational dimensions of this research. This also meant that the spaces in which I felt most comfortable, the places that I was drawn to and spent the most time, where I met people and hung out, formed relationships, had the strongest grasp on what I was witnessing, and that I could confirm and ask about later, were English speaking spaces.

Ethnography in practice: Interviews, observation and the stuff in between

This ethnographic research was made up of a combination of formal, semi-structured interviews; formal and informal observations; informal conversations with friends, acquaintances and strangers in passing; and broad, undefined participatory engagement in daily life in New Mexico. I followed an emergent design (Garner & Scott 2013), analysing data as soon as I collected it to iteratively inform additional literature reviews, interview questions and spaces in which to situate this research.

In total, I conducted 84 formal interviews. With permissions from informants, interviews and discussions were recorded using a digital recorder. Interviews were informed by a topic guide that I relied on during my first few interviews, however over time, interviews became more fluid. Instead of asking specific predetermined questions, my questions were informed by what had been brought up both earlier in the same interview, as well as in prior interviews with other informants. Interviews stretched between 15 minutes and two hours, the majority lasting for about an hour. 17 of the interviews were with health workers, legislators and executives in state health organisations, government and insurance companies working on health policy and state-level processes interfacing with the use of telehealth. These organisations included the New Mexico Primary Care Association, New Mexico Hospital Association and New Mexico Association for Home and Hospice Care. Across this group, there were four females and 13 males, with an age range from 40 to 70. These interviews contributed to a broad understanding of the ways in which telehealth interfaces with the health system more widely as well as the state-level processes underlying the use of telehealth across the state.

36 interviews were with support staff, health workers and administrators facilitating the direct provision of telehealth services to rural communities across New Mexico. These interviews included 21 females and 15 males, ages ranging from 30 to 70, all of whom worked either with the UNM Department of Psychiatry, the UNM Hospital Psychiatric Emergency Service, UNM Centre for

Telehealth or were remote providers for the Clovis Clinic. These offered insight into the perspectives, experiences and contexts encompassing the direct provision of telehealth services in New Mexican behavioural healthcare. Seven interviews were with health workers, researchers and administrators who did not work directly with telehealth services but whose work interfaced with the use of telehealth in different ways: for example, a researcher with a focus on rural behavioural healthcare, a psychologist running a clinic who was considering introducing the use of telehealth into this clinic, several upper level executives with administration power at UNM Hospital, and a nurse coordinator in an Albuquerque-based behavioural health clinic. These interviews included seven females and no males, ages ranging from 35 to 55, and offered insight into the wider context in which telehealth was situated as well as the ways in which the use of telehealth intersected with various healthcare environments.

12 interviews were with support staff, in-person health workers and administrators at rural clinics—the majority of whom worked at the Clovis Clinic—that receive telehealth services. 10 were female and two were male with ages ranging from 25 to 50. As half of the health workers providing therapy services at the Clovis Clinic were based in Clovis, these interviews offered another perspective on the telehealth system: one from health workers with colleagues who were not physically based in Clovis, and those with alternate insights around how telehealth functioned alongside in-person care at the clinic. Finally, 12 interviews were conducted with patients who received telehealth services at the Clovis Clinic, including seven females and five males, ages ranging from 20 to 65.

With the exception of informants from the Clovis Clinic, interviews took place in sundry spaces. I let each informant decide where to meet depending on what was most comfortable and convenient for them. These places included personal offices, empty conference rooms, over lunch or coffee, in individuals' homes, on a walk, between urgent pages and telephone calls within UNM's psychiatric emergency room, and, for telehealth providers living and working remotely, over Zoom. At the Clovis Clinic, the spaces within which I could conduct interviews was less flexible. All interviews with informants at the Clovis Clinic took place either in the private office of the individual health worker or in a small office at the back of the building that the clinic had reserved for me as a private space from which to work.

The pillars of anthropological research—of living in a place, building moral capital, nurturing relationships and gaining trust—did not happen in the ways I had imagined with the patients I met at the Clovis Clinic. This was due to a confluence of factors: my research design, timing and access as well as a request from the clinic administrators that I not meet patients outside the clinic. This request was

framed by reasons of safety and, while it was not mentioned, considerations of liability. At the time, it was frustrating. 'Patient' is merely categorical, and patients' lives extend far beyond the walls of the clinic. While I asked in interviews about my informants' daily lives outside the clinic, I had difficulty connecting with people beyond their specific perspectives and concerns about their health and care. This inflexibility ultimately offered important insight into legal concerns within the health system as well as relations of trust between individuals and organisations. I also gained glimpses of patients' lives outside the clinic, even from patients who did not formally participate in an interview. These patients told me they did not have time to speak; they had a shift at the Pizza Hut down the road; they had to get home to relieve the babysitter; a family member was picking them up from the clinic at a certain time and that was their only ride home. This fleeting insight into life just beyond the clinic walls informed wider understandings about life in New Mexico. For example, what it meant and what it involved to get to a healthcare appointment, including mobility, time and financial considerations (see Chapter 5). I also had the opportunity to spend time with members of the Clovis community who were not associated with the clinic, in particular two families I stayed with across my visits as well as their friends, lodgers, extended family and social communities in Clovis. This gave me more of a sense of what life in Clovis outside the clinic might be like, however I am aware that the view of the particular lives of patients who receive services at the clinic is limited.

Observations were crucial in this research, enabling me to attend to the gap between how health and care were imagined to happen in theory and the complexities of practices in reality. They enabled me to confirm and triangulate what informants had shared in their interviews and helped me reformulate my interview questions to better resonate with my informants. Observations went beyond healthcare settings, offering perspectives into the ways in which health and care intersected with and were situated within wider aspects of New Mexican everyday life. I conducted observations that informed the exploration of telehealth from a health system perspective in the office of the non-profit corporation that worked to expand the use of telehealth throughout the state. I observed the non-profit's quarterly board meetings as well as several meetings it held with other non-profit organisations in the state seeking partnership and collaboration. As my fieldwork coincided with the 2019 legislative session within the state government, I observed several committee meetings at the State Capitol building—the Santa Fe Roundhouse—during which state senators and representatives made decisions surrounding which proposed bills to vote into law. The specific committee meetings I attended all surrounded the proposed use of telehealth in different and novel forms around the state. At the state capitol, I also attended the Behavioural Health Day at the Legislator, where behavioural health organisations across the state set up tables and posters, gave talks and handed out informational pamphlets with the aim to lobby state representatives for increased support.

At the UNM Department of Psychiatry, I observed and participated in the daily goings-on of the department. I conducted 30 hours of formal observation periods with a telehealth coordinator and a technological support worker, both working full time to facilitate the provision of ambulatory telehealth services between providers based at UNM to several rural clinics across the state. I also conducted 12 hours of observation within the UNM Hospital Psychiatric Emergency Service, which provided emergency psychiatric care in-person to patients in Albuquerque as well as over telehealth to patients in the emergency room at Sandoval Regional Medical Centre (SRMC), a hospital 35 minutes outside Albuquerque that did not have continuous behavioural health staff on site. I did not observe doctor-patient encounters from the provider perspective as I was uncertain about and uncomfortable with navigating the ethics and mechanics of the patient consent process from my position in Albuquerque. As such, I asked health workers in Albuquerque to take me through their own process of getting set up, logging in and going through a mock telehealth session during our interviews.

Across the final five months of my fieldwork, having successfully traipsed the UNM ethics processes—described in the following section—as well as forming relations with, mapping and remapping specifics and practicalities, and gaining access to the Clovis Clinic, I spent six separate weeks in Clovis. I sat at an unused desk along the back wall of the clinic's reception office, across from the reception window where every patient checked in for their appointment. The reception office was the heart of the building, offering me the ability to observe many of the clinic's daily operations. Clinic staff printed all forms and letters from this office, they clocked in and out at the start and end of the day at one of the shared computers, they came to chat, gossip and complain. Clinic staff searched this office for the stapler. They wondered when others might be taking their lunch break and asked about each other's families and weekend plans. In this space, I was privy to many conversations about the use of telehealth, the struggles of a community mental health clinic and life in Clovis, more broadly.

From this position in the office, I was also able to overhear when a patient checked in for a telehealth appointment. Following check-in, I would seek out the patient in the waiting room to introduce myself and my research. I approached everyone who came to the clinic for telehealth appointments except those who arrived during times I was already observing or interviewing a patient. 19 patients, nine of whom also participated in an interview following their appointment, including 15 females and 4 males, consented to the observational component of this research, allowing me to sit in on their appointment. Practically, I had met and spoken with all tele- psychiatrists and therapists online before starting observations. They knew which weeks I would be at the clinic and told me ahead of time if they had any patients coming in that I should not approach regarding my research. As the health workers were

already aware of and had consented to this research, I was able to focus on the patients, giving them information and time as we went through the consent process.

I observed 12 appointments with tele-therapists and seven with tele-psychiatrists. These sessions involved real-time, virtual, face-to-face video-conferencing consultations between therapist or psychiatrist and patient. During these sessions, I took fieldnotes which informed subsequent interviews. In these sessions, providers and patients discussed mental health diagnoses, stressful life situations and plans for further treatment, among other topics. I did not write down any personal information patients shared in their appointments. Instead, my written observations included spatial, material and technical information focusing on the patient and their surroundings. I took note of non-specific questions that therapists and psychiatrists asked as part of their evaluations and how the conversation flowed. I also attended to information about the patients' emotional and physical state: whether they seemed distressed or were restless in their seat. I further included reflections on my own experience in the clinical rooms.

While this ethnography involved a combination of formal interviews and observations, as detailed above, I spent most of my time in New Mexico in informal situations. For example, sitting in the Clovis Clinic waiting for patients to arrive for telehealth appointments and speaking with the receptionists offered a rich understanding of how telehealth fit into the workings of the clinic, as well as broader insights into the daily lives, worries and dreams of people who lived and worked in Clovis. At UNM, while I only formally interviewed health and support workers once, I had multiple informal conversations about my research and life more generally with many of them. I had a meeting with one of my advisors every Tuesday morning to discuss my research progress, to catch up with each other and our lives, and to discuss anything going on within the department, the city or the state health system that might be relevant for me to get involved in. Outside of the formal spaces within which I conducted my research, I also participated informally in the seasonal city parades—for Día De Muertas, the Jingle Bell Parade and the parade for Fourth of July. I volunteered at an Albuquerque hospital, dog sat for a health worker at UNM, went to informants' birthday parties and friends' baby showers. Going about my daily life in New Mexico offered further information and context that has framed and guided this ethnography. This included buying groceries, negotiating with my landlord, waiting at traffic lights, going to the urgent care centre, the city library, one of the many drive through restaurants. The observations, conversations, experiences and feelings elicited within these spaces informed my understanding of New Mexico to great extents. The informal dimensions of this ethnography offered more intimate access to the lives of people around me. It was crucial to the ways in which I collected and analysed empirical material, the themes that became most pertinent in informing my findings,

and the ultimate arguments that I make in this thesis. My personal life and my life as an ethnographer collided every day, they were inseparable. This offered an incredibly rich understanding of what it means to carry out a particular daily life.

Because of the particular spaces in which I spent most of my time, formally and informally, I interacted with specific populations of people. In Albuquerque and Santa Fe, nearly all health workers and those working for state-level health organisations, identified as white, Hispanic, Latino or a combination of the three. While I met and included in my research several people who identified as native and American Indian, they made up only a small minority of my informants. In Clovis, 61% of the population identified as white (US Census Bureau 2021). Patients, health workers and community members were mostly white, Hispanic or Latino, however I conducted interviews and observation with several people who identified as black or native.

Doing ethics

I obtained institutional permission from Durham's Anthropology Department in Spring 2018. This iterative process took place across several weeks and involved the submission of an application and supporting forms with topics covering methods, plans for obtaining consent from informants, data safety and storage considerations, and potential implications on informants from taking part in the research. I found this process useful in thinking through not only the ethical landscape of this research but also in imagining how I might conduct this research in practice. I considered questions such as: how would I keep safe identifying information on the ground? How would I maintain my own safety, and who would I contact in the case of various urgent or dangerous events?

I also went through the UNM Health Sciences Centre IRB process for ethical approval. This was necessary for conducting research within UNM and gave my project local credibility. It also helped me think through the particular regulations and systems of governance through which the New Mexican health system functions and the ways in which research articulates with the workings of the health system. I formally started this process as soon as I arrived in Albuquerque, in early September 2018. Completing the application and preparing the required supporting documentation took several weeks. I submitted the application in early October and in early November the application was returned with several requests for modification, specification and additional documentation including signed letters of support from each clinical space within which I proposed to conduct my research. The final application was just over 23000 words, covering topics such as "study procedures", "number of total interventions to be received by each participant" and "study endpoints". Supporting documents

included consent forms for each specific population I planned to involve in my research. While understanding that the boundaries of populations are porous, I prepared three consent forms: for health workers, for patients and for community members. Among others, I also submitted an observation guide, interview topic guides for each population and a specific withdrawal form for anyone who decided to withdraw their participation after consenting to take part. After resubmission in mid-November, I received ethical approval on 21 December 2018. I began formal data collection in early January 2019. I use the term 'formal' here because, while I was not interviewing informants or observing encounters that were explicitly regulated by medical ethics governance—healthcare encounters, for example—I was, nevertheless, living in New Mexico. Going about my daily life and settling into my surroundings, including meeting people, having conversations, going to the bank or an exercise class, making friends, approaching the health system for my own care—all of these components, and many others, shaped the ways in which I carried out the "procedures" of this research that were approved by UNM's IRB.

The process of formally and informally thinking through the ethical considerations in this research involved a great deal of negotiation between anthropologically informed ethnographic methods and ethical regulations in clinical and medical research. The discrepancies between existing ethical models and the intricacies of social research that enable the exploration of the sophistication of everyday life are well documented and debated (e.g., Fassin 2006; Dingwall 2008; Atkinson 2009). Simpson (2011) creates room for a relational ethics by introducing the possibility of an ethics of 'social subject research', extending and complementing the traditional medical research ethics of 'human subjects research'. Particularly in health-related research contexts, ethical review demands a nuanced anticipation of how research will unfold. This stands in contrast to the dynamic and iterative nature of ethnography (Verhallen 2016). In the context of the UNM Health Sciences Centre IRB, for example, I was required to state the specific places in which I would conduct my observations. I was also required to include the duration of time across one period of observation, the number of anticipated periods, location of observation and the specific populations involved. Ascribing specific metrics to my proposed ethnographic research felt contradictory to the methods themselves. To make this research fit into the specific and narrow boxes of the medical ethics application (Lederman 2016), I answered as broadly as possible. Responding to the total number of interventions to be received by each participant, for the observation component of the "intervention", I wrote: "This number is variable. The total number of interventions will be arranged according to the specific participant. Participants consenting to observation will participate in at least one session. The maximum number of sessions per participant will not exceed 50". I chose 50 as a maximum at the time of preparing the application as I had no sense of how many observational "interventions" might be involved with an individual

participant and I wanted to leave myself some flexibility without giving the review board committee any reason to think my research methods were overzealous or excessive. Medical research ethics put forward a certain type of ethical practice that does not leave room for the many granule considerations that present themselves in anthropological research.

The arbitrariness of some aspects of my ethics application was both frustrating and unhelpful. Throughout my fieldwork, analysis and writing, I was confronted several times with the disparity between being compliant with pre-specified ethical regulations and behaving ethically in practice, alongside the nuances of research with people (Bogicevic & Svendsen 2021). What was approved by the ethics board and what I felt was ethical were sometimes two different things. How, then, to be ethical? The many ethical moments throughout the research process necessitate an iterative, recurring consent process, one that reflects and responds to the spontaneity inherent in ethnography. I carried this view of a continuum of ethical moments into the field and further into analysis and writing, acknowledging that at any point in my research, I needed to question and rethink the ethical foundations underpinning this work. At the same time, I still drew on the main tenants of ethics in research including informed consent, confidentiality and minimisation of risk to participants and myself.

Informed consent

Simpson (2011) acknowledges an issue with the isolated and singular informed consent process that is determined a priori by ethical review. It is instead, both a tricky and fluid process. Even though I had outlined distinctly my plan for seeking informed consent from the different populations and communities involved in my research, informed consent in theory—the way which had been described by me, workshopped with my advisors and then approved by the UNM IRB—was almost never realised on the ground in the same way.

For example, for patients at the Clovis Clinic, informed consent for observation happened before their telehealth appointment in the busy waiting room. I only approached patients who showed up early enough for their appointment that we had 10 to 15 minutes to meet each other, for me to explain my research and how they could become involved if they wished. I did my best to explain that I did not work at the clinic, that I was not associated with the clinic and that I would neither share with the clinic whether the patient decided to participate nor any information that they might share with me. However, all participation happened at the clinic. The reception staff knew when I was going to sit in on a patient appointment because I would go back to the therapy or psychiatry offices with the patient

I was observing. The interviews, while happening in a small, private room in the back of the building, were still happening in the clinic. Staff were able to see who was heading back to the room with me.

The interview room was small and freezing as the air conditioning in the building did not function correctly. Half of the building was like the arctic, one staff member walking around with a fleece blanket draped over her shoulders. The other half was left battling the heat, staff trying to keep cool with fans that just circulated the hot air. This room was mainly used as a storage place for extra office furniture. A broken filing cabinet, an empty desk, several mismatched chairs, an unplugged phone, some spare decorations from holidays past. I tried to make the room as welcoming as possible. I first set up the chairs in a corner of the room near each other and by the only window. I realised however, the set up mimicked that of a therapist and patient for in-person therapy. I did not want to sit on the opposite side of the desk, as I did not want the interview to feel intimidating or formal. I landed on using the desk as a makeshift table: sitting on the side of the desk adjacent to where the patient was sitting, separated only by a corner. Still, this set up was not ideal. As many patients had to take off work and coordinate rides to the clinic, the best time to conduct my interviews was when they were already at the clinic, instead of asking them to make the trip back on another day. However, this brought up several ethical issues. We were in the clinic where the patient had just received their therapy or psychiatric services. Several expressed feeling emotional, tender from their session of opening up to their healthcare professional. I reiterated multiple times that I was not associated with the clinic, that I was not a healthcare provider, that speaking to me and answering my questions in the interview would neither harm nor improve their care. However, as per the request of the clinic, I wore a lanyard and ID card. The ID card read VISITOR in black letters across the bottom of the card, though I am not sure how many of the people I interviewed actually looked closely enough to distinguish me as a visitor. Instead, I was aware that they likely saw me sitting in the front office when they checked in, in a space only clinic staff could access. They saw me wearing a lanyard and ID card like all other staff. They saw me in the clinic where they came for their care. They spoke to me in a private office, just as they did with their healthcare professionals. In this way, I paid particular attention to the ways in which I had become, in the eyes of patients, part of the periphery of the health system. All of my interviews with patients happened once, as the coming and going of patients at the clinic was sporadic and I was not at the clinic every week. I am not sure how these patients came to see me, or understood my role, my relationship to the clinic, or my relationship to them. Further, while this research did not offer any connection between participation and increased access to or benefits in care as detailed in previous scholarship, particularly in the context of clinical trials (Joseph & Dohan 2012; Petryna 2009; Timmermans & McKay 2009), I often wondered whether there

was subliminal pressure and coercion for patients to participate as the research took place in the clinic, under the watch of the clinic staff.

As much as I tried to get a sense of patients' lives outside the clinic, our interviews were constrained to this small, freezing room just down the hall from their psychiatrists' and therapists' offices. I am not sure how much of what patients told me was a product of our surroundings. Several patients, particularly those with whom I had just observed in their therapy session, continued with our interview as if it was part of their session, referring back to what they had talked about with their therapist, telling me private information to such extents that I worried they saw me as an extension of their therapist. In these cases, I have chosen not to share the particularities of the life stories that people have shared with me, as the context in which this information was shared was complicated. Even with my attempts to create a boundary between myself and the health workers, between my research and the care that patients received, between the room in which we conducted the interviews and the rest of the clinic building, I felt that my efforts were often unsuccessful. While I am not sharing some of these patients' stories specifically, they have still shaped my thinking about New Mexico, health, care and the ways in which telehealth intersects, shapes and provides unique windows into these aspects of daily life. These stories came through in the way I approached and conducted subsequent interviews and observations, in the ways I have understood the entire body of collected empirical material. They come through in the themes that have been most persistent in analysis and that have informed the core ethnographic findings of my thesis.

Additional aspects of the New Mexican health system and of the particular behavioural health clinic in which I conducted my research influenced the way in which informed consent happened, particularly with patients. At the Clovis Clinic, patients were required to fill out and sign seemingly endless forms and disclosures. This was a reality in many community health clinics which receive the bulk of their funding from governmental grants, for which they are required to closely monitor and measure specifics of the care provided. Health insurance companies also require extensive documentation for billing purposes: clinics need to evidence the treatments and services they have provided in order to receive reimbursement—the primary way in which clinics bring in revenue. Before each therapy session, patients were asked to sign forms confirming that their personal information had remained the same, that their insurance information was up to date, that their current employment status had not changed. Patients would confirm all of these things through signing and signing and signing their name on physical pieces of paper or on a small screen with attached pen that was connected to an electronic documentation system on the reception staff's computers. Following each therapy and psychiatric appointment, patients were asked to return to

the front desk to sign their 'treatment plan'. This treatment plan had to be filled out by each health worker at the end of each appointment. They would go over this quickly with each patient, talking about the next steps for the patient's treatment: whether to continue with therapy, for referral to any particular programmes such as group sessions, housing and community assistance, or psychiatric services. This plan was required by insurance companies to ensure that behavioural health services were being provided correctly and that billing matched up with services provided. After all of this signing, which in theory produced a paper trail in anticipation of unexpected audits, patients seemed to approach my consent form with fatigue and apathy. I took the time to go through each aspect of the consent form: who I was, the aims of the research, what was involved in participation, that they were in no way required to participate, that their care would not be affected either way, that any information they provided would be anonymised and kept confidential, that at any point they could change their mind about participating, among others. While I went through each part slowly and carefully, asking if there were any questions about the research or what might happen with their information, patients would often decide immediately whether they wanted to participate. Those who did not want to be involved said something along the lines of "*this isn't for me, this is not something I want to do*". On the other hand, patients who did participate agreed from the outset, waved through the pages of the consent form looking past what was being asked of them, trying to locate where they needed to sign. In this way, the physical form in which informed consent took place as well as the timing and location of the process might have further muddled for patients the distinction between the care they received and the research I was conducting.

This process was murky and uncertain in other ways. Informed consent, however specific and tailored the processes to the particular context in which they happen, always comes with challenges. Unequal power dynamics are inevitable, despite measures to account for them, as shifts in perception and experience about the research process amongst participants are ongoing (Sleeboom-Faulkner et al. 2017). Relationships formed around a contractual agreement are specific in themselves and influenced patients' decisions to participate as well as the ways in which their participation unfolded. As much as I emphasised to patients that their decision to participate would not influence their care, patients were still worried that their access to health services would be affected. In this way, the informed consent process illuminated aspects of the healthcare context that my informants navigated daily. Healthcare, as I will discuss in all of the following chapters, but particularly in Chapter 5 on mobility in the health system, is something that was fleeting for people in rural New Mexico. Whether existing healthcare services would be accessible in the future was a concern for many of my informants who were patients at the Clovis Clinic. The possibility that access to services may be affected by

participation in this research came up in many conversations with patients, both before the consenting process and during our interviews.

Confidentiality and anonymity

The behavioural health workforce in New Mexico is small and there are continuous staff shortages in behavioural health clinics across the state. In practice, many behavioural health workers in different institutions and organisations know one another, from having trained or worked at the same organisation in the past or through state licensure requirements[10], for example. Behavioural health workers also know each other as well as people working at state health institutions through interfacing with the state and city level governments and lobbying for more resources. Furthermore, Clovis is a small city with a population just over 38000. Many of my informants—both health workers and patients—shared multiple ways in which they experienced Clovis as a small and sometimes suffocating place, where "*everyone knows your business*".

Considering the small, overlapping communities within the behavioural health field in New Mexico as well as with those working and living in Clovis, the confidentiality and anonymity of informants' identities and their protected information—including health information shared by patients in their interviews—was paramount. To mitigate the risks involved with collecting and storing sensitive information, I implemented several data management procedures. I stored all electronic data including audio recordings, photos and typed up fieldnotes on UNM's secure institutional drive through which access is restricted by department and further by specific research project. I accessed this drive through UNM computers as well as through a secure VPN from my personal, password protected laptop. I also stored copies of all electronic research files on a password encrypted external hard drive. I was the sole individual who was granted access to all electronic data files. Hard copies of informants' signed consent forms are stored within a locked cabinet in a locked office in the UNM Department of Psychiatry.

As soon as possible following interviews, I downloaded recordings onto the secure UNM drive and removed them from the recorder. I gave anonymous identification numbers and pseudonyms to

[10] The state of New Mexico requires all social workers early in their career to undergo monthly supervision meetings with an experienced social worker who is trained to carry out supervisory responsibilities. As there are not many social workers with supervisory qualifications in rural parts of the state, supervisions happen oftentimes over telehealth: new social workers in rural areas receive monthly supervisions from supervisors in Albuquerque. I met several social workers in Albuquerque who asked me if I knew specific health workers in rural areas I visited, including Clovis, that they knew through supervisory relations.

everyone participating in this research, both formally and informally. I labelled interview and observation files with the identification numbers and anonymised both transcriptions and fieldnotes. I stored informants' personal information, including name, age, sex and ethnicity as well as contact information for all informants with the exception of patients—whose contact information I did not collect as per request of the clinic—in a password protected file on the UNM drive. In this file, I also stored the key linking each informant with their identification number and pseudonym. Every person we meet throughout this thesis is identified by their pseudonym. I reflected the way in which each informant identified themselves to me in their pseudonym. Dr Garcia and Dr Taylor, for example, introduced themselves with their prefix and surname, while Lucy and Jordan used their first name.

The Clovis Clinic is also a pseudonym for the community mental health centre in Clovis in which I carried out my ethnography. As rural cities in New Mexico are small and without many behavioural health resources, it may be possible for readers to determine which particular clinic is described in this research. I discussed this concern with my supervisors at Durham University, my advisors at UNM and the executive director of the Clovis Clinic, debating whether I should include Clovis directly in this ethnography or if I should instead write about a fictionalised rural city based off of Clovis. Drawing from experiences of other anthropologists of rural areas, we acknowledged that anonymisation practices can be blurry: even following more rigorous processes, people still may be able to piece together informants' identities (Ardener 2012; Kohn 2002). Medical anthropologists of rural New Mexico have approached this quandary differently, some using actual place names while anonymising the specific clinical space in which the research took place (e.g., Garcia 2010) and others anonymising both names of the place and clinics (e.g., Willging et al 2009). Ultimately, we decided to include Clovis as a place in the recounting of this ethnography.

Alongside these considerations sits the respect of the specific realities my informants shared with me. Understanding the unique aspects of my informants' daily lives has been critical to informing the findings of this research, and as best as possible I have respected the stories they shared. However, in some cases, I have changed or omitted individual details about informants in ways that do not influence the arguments I present in order to ensure the anonymity of those who participated in this research.

Analysis

Analysis was an inductive, continuous and exploratory process (Thomas 2006). Themes that were identified in each interview, and ideas borne from observations, were used to inform the focus of

subsequent interviews and observations. Material from participant observation was used to contextualise informants' accounts and, conversely, informants' accounts served to confirm and challenge my initial interpretation of material gathered during observation.

I returned to audio-recordings of interviews multiple times, transcribing in full 12 interviews and partially transcribing the remaining interviews, with particular attention to key themes that arose from data collection and early stages of analysis. I followed up with several informants following their interviews with further questions about information they shared or for clarification of something they said. I typed up handwritten fieldnotes from observations, as well as reflections I jotted down following interviews. I uploaded all transcripts and digitised fieldnotes to NVivo 12 qualitative software for thematic coding.

Upon my return to Durham following fieldwork, I spent the first few weeks writing from memory what felt the most pressing; the material that was most persistent in my thoughts and demanding to be written. The material that was most salient in this way helped me to unfold several key themes that then informed subsequent analysis. Then, from reading, reviewing and discussing emerging themes and empirical material with my supervisors, I developed and re-developed a coding framework in order to index and analyse the data. These themes were linked to previous literature in the field and relevant social theory, as well as from the accounts of informants themselves. Emergent themes were also informed by my own interests.

Position and power

Important for the design and conceptualisation, data collection and analysis of this research is the consideration of the moral dimensions of my work in the field as well as the wider context and positionality from which I interpreted empirical material and moved throughout the field, and the ways these two things ultimately intersect. My positionality and identity influenced the ways in which I connected with my informants and the meanings I drew from my ethnographic material (Schmalzbauer 2013). Furthermore, my positions as an individual and as an anthropologist enabled me to enter, come to know and then leave of my own accord different social worlds and carry out this research.

While the southwest is a generative and important space for American Anthropology, it is also a particular type of laboratory. There are long histories of money from north-eastern institutions funding social science exploration in this space (Cushing 1975, 1976, 1986, 1998; Goldfrank 1927, 1945;

Hinsley & Wilcox 1996; Parsons 1933). This history of the East Coast coming to the West to glean knowledge is even built into popular culture depictions of New Mexico. For example, Robert Redford's (1988) *The Milagro Beanfield War*, a film set in a small town in rural New Mexico features a sociologist from the East Coast studying the culture and religion of the community.

I am American, as were many of my informants, however I am from the northeast of the country where there are distinct histories, social and political climates, modes of transport, financial resources, populations and public imaginaries. Even healthcare is unique from the rest of the US. Massachusetts, the state in which I spent my childhood, adolescence and young adulthood, has one of the most robust health systems in the country. In this way, I thought a lot about how I was contributing to historical cycles of knowledge extraction and colonialism through my research and am still unsure how to portray and reiterate the issues in my research that I aim to critique without simultaneously reproducing them (Mookherjee 2015).

On writing

I wrote this thesis in many places. In Durham, United Kingdom, in Boston, US, in Haifa, Israel. While I grew to feel more and more removed from my field site, I was able to gain an analytical distance that I had not been able to tap into in the field. I would be in the middle of the bustling clinic, in a conversation with an informant or reflecting on an interview, and then I would look up and I would be back in the third-floor postgraduate office in Durham's Dawson Building or back in my bedroom at my mother's house, with my fieldnotes in my hand and a feeling of dislocation. This pull from one world to the next was both disorienting and crucial for my writing process. I revisited New Mexico through fieldnotes and interviews, through photos I took, through catching up with my closest informants. I was transported through other ethnographies, through fiction, reading several novels by New Mexican authors, stories based in New Mexico, to try to understand how the multiple, dynamic and contrasting experiences of this place could be conveyed through words on a page. I also spent a lot of time on Google Maps, "driving" on street view, retracing many of the routes I had travelled across my year of fieldwork. Being back on the road, able to scroll up to look at the gigantic sky, to see the cars around me or the empty road ahead, brought me back, in some form, to New Mexico. I was on highways and in parking lots, passing over the murky Rio Grande and through the shade of the cottonwoods, smelling again the lavender and rosemary that filled the air following the summer afternoon monsoons. Together, these various components allowed me to inhabit a sort of presence and absence that facilitated this writing.

Six months into my writing process was March 2020. As SARS-CoV-2 spread across the globe, the landscape of telehealth changed. This was true for my informants within the particular contexts of my research, as well as in New Mexico, the US and the world more broadly. However, for the vast majority of this dissertation, I draw on empirical findings that precede the COVID-19 pandemic. While this work is informed by social and geographical histories, anthropological work, economic and political contexts that stretch to times well before my arrival in New Mexico, and while I stayed in touch with several informants following my departure from the field, I have enforced a post-fieldwork "bounded field-site" (Candea 2007: 167), a discreet space and temporality for writing and analysis. In the conclusion to this thesis (Chapter 9), I place my research in dialogue with the shifted global terrain.

Throughout this thesis, I have situated myself within the ethnography to remind the reader that I am there, I am the interpreter through which these observations and experiences are filtered. I do my best to present my findings in a way that allows for the messiness of everyday life, to show that nothing is ever straightforward, that patterns can be unpicked, that time and space interact with the present in ways I will never have the ability to disentangle. It is important to recognise here that I have both lost and left behind aspects of my field site with the particular stories I illuminate. This loss comes from a conscious decision on what to include and exclude, as well as from an unconscious way of being in the world. Even without the intention of missing things, the stories I tell are particular because of who I am, what I see and what I knew a piori.

The following chapters are each presented in a unique way. The style of presentation is informed by the ethnographic material that contributed to the specific arguments I make. As the form of empirical material and analysis shifted–arising from formal observation, my own experiences, in depth interviews, stories in the news or an amalgamation of everything– the forms of my thinking and writing also changed. I aim for the different styles of presentation to offer varied perspectives and insights into the particular New Mexico I experienced throughout my time there.

Conclusion

In this chapter, I have described the conceptualisations, design, methods, ethics, analysis, reflections on positionality and experiences of writing that have underpinned this research. I have discussed the emergent and iterative forms this research took on, and the theoretical uncertainties involved in locating telehealth. I have presented the ways in which I gained access to my research sites, the processes through which I conducted this research and the varied and multiple ways in which ethical considerations interfaced with these methods. Importantly, moving forward, research ethics are not

isolated within this methods chapter, they extend into every corner of this thesis—the ways in which this research was designed, carried out and presented. I do this by reflecting on ethical junctures I encountered, considering my own experiences and position in relation to the lives of my informants, and doing my best to relate the complex and heterogenous realities of the people who make up this ethnography. In the next chapter, I explore ethnographically New Mexico's landscape and the ways in which it articulates with the daily lives of my informants, including their experience of health and care.

Chapter 4: "There's Nothing Here": New Mexico's Physical and Affective Landscape

Late in the afternoon on my first full day in Clovis, as the sun bounces in orange light off windows throughout the city, Jodi takes me on a driving tour to show me around. She was the member of staff at the Clovis Clinic tasked with getting me acquainted with the clinic and local area. I climb into her truck, a shiny Ford F-150, parked at the far end of the clinic's parking lot. "This is new; I just traded in my Mustang for it". *Jodi had worked at the clinic for over 10 years and had lived in Clovis and Portales, a smaller town about 20 miles southeast of Clovis, for her entire life. She received a degree in Social Work from Eastern New Mexico University in Portales and completed several internship years during her training at the Clovis Clinic.*

As we drive, Jodi points out important landmarks. "There's Taco Box, the best place to get lunch. You have to try their homemade ranch… There's the best place to get your oil changed. With every oil change, they let you vacuum out your car for free... Here's the new jail. They're building a new one because too many people escaped the old one… Here's the parole office. Drive by here in the early morning and you'll see a line of people outside waiting to check in for their parole". *We turn onto North Main Street, a street with two wide lanes paved with brick. The street is lined by diagonal parking spots on either side, wide sidewalks and the glass doors and windows of store fronts. Several parking spots are filled by cars; I spot both New Mexico and Texas licence plates. Jodi points to a Mission-style theatre that looks like it has been closed for several years.* "There's the old theatre that my uncle used to run". *We drive slowly, perhaps because Jodi is giving me time to see everything, perhaps because at every cross street, the road dips sharply; if we were going any faster, we might bottom out.* "The streets suck. They've needed repaving forever". *The American flag and under it, the New Mexican flag, flap on a flagpole outside the Bank of Clovis. The Gold Rush Pawn Shop advertises* "Jewellery, Guns, Cameras and Tools". *Several store fronts stand empty.* "Here's the library where the 16-year-old shot the librarians and a few others last year. He's recently been tried as an adult… I don't go there anymore".

At the corner of North Main Street and 2nd Street we stop outside the only building on the street with more than three stories. "This is the tallest building in Clovis, Hotel Clovis". *Jodi pauses.* "A girl jumped off it two weeks ago". *My jaw clenches; the weight of a bowling ball starts to form in my chest. At first glance, Hotel Clovis is a landmark of prosperity. It presupposes a time when there were visitors and a place worth visiting. At one time, the hotel's ballroom hosted famous musicians: Louis Armstrong, Glenn Miller and Hank Williams. Most of its business came from the nearby Clovis Depot, as guests and employees from the Santa Fe Railway filled its rooms. Hotel Clovis closed soon after passenger*

service was discontinued on Santa Fe Railway in 1971. Many of its thin rectangular windows, spaced evenly along the sand-coloured brick cladding, have their blinds and curtains drawn shut. In its current, converted form, it houses lower-income families and those in need of assisted living in a series of lofts and apartments, as well as some unoccupied commercial spaces on the ground floor. Still, it is easy to imagine past hotel visitors relaxing inside during the early evening hours before heading out again in search of dinner. Decorative stonework sitting between the ground and first floors harks back to a time when this was one of the nicest places to stay in town. These stone details are also mirrored along the top of the building, drawing the eye upwards. However, with Jodi's words hanging in the air, the building is instantly transformed. It's haunting; enveloped in an affective patination. I no longer wish to observe the stone detailing near the roof for fear of what my imagination might lead me to see. On subsequent trips to Clovis, I avoid driving past this intersection. The building and its past now seep into its immediate surroundings and even further, taking root in my memory. Jodi continues, speaking curtly, in a matter-of-fact way, seeming to do her best to not stir up any related emotions. "Another high school student shot himself earlier in the month. Mental health is getting worse here. More people are killing themselves. Especially teenagers".

As we drive on, Jodi situates our surroundings within a particular history, attaching significant events to specific buildings. North Main Street, once bordered by a movie theatre and bustling store fronts, paved with brick instead of asphalt in a nod toward what was once a wealthier central street, is still lined with some trees, cars of shoppers and stores. However, it is now also lined with these specific memories. There is a heavy feeling of things having been let go, left to crumble over time. "We aren't cared for", *I hear in different ways from several informants.* "The state has abandoned us… and the state itself is abandoned". "There's even less *[resources]* here now, but there wasn't much to begin with". "There's nothing here". *Memories and affect are wound up tightly in this landscape. They become internalised and inseparable from everyday life.*

Introduction

In this chapter, I delineate the physical and affective spaces that make up daily life in New Mexico. I argue that it is necessary to understand this particular New Mexican space because it is inextricably linked with the health and mental health of the population, as well as the healthcare resources accessible to these populations; these physical and affective qualities of space shape the way that telehealth is received and experienced. This landscape forms the foundation for this ethnography of telehealth, a public health intervention designed, in part, to provide health services to the dispersed, underserved populations of the state, considered to be 'hard to reach'.

Over the course of my fieldwork, I experienced the transformation of telehealth in my mind from an isolated technology implemented with the hope of providing care to under-resourced communities into a complex and entangled site of history, culture, geography, economics and politics. In this chapter, I render this transformation visible, foregrounding the particular place and space in which telehealth occurs. It is necessary to attend to and understand the social world and social geography of Clovis, New Mexico in which the Clovis Clinic is situated and in which patients receive care over telehealth for two reasons. First, to situate telehealth in a space of long distances, economic insecurity, highways and parking lots; revealing the complex geographies at play that influence the use of telehealth as well as health of people who live there. Second, to open analytical possibilities for the social and spatial effects of telehealth beyond merely filling a gap in healthcare services. Telehealth simultaneously shapes and is shaped by the space and place in which it is situated. Attending to the relationship between telehealth and its wider surroundings facilitates the investigation of how the use of telehealth influences this place, how telehealth remakes and forges new types of spaces. In this dissertation, I argue that telehealth intersects with daily life in New Mexico in a multitude of ways: from mobility and where care is understood to exist, to the material and spatial relations of care, the novel experiences of distance in processes of providing and receiving care, and the ways in which forms of inequity are understood and addressed. In this chapter, I set up important groundwork for the rest of this dissertation by bringing to the forefront the ways in which telehealth and surrounding social, political, affective and physical landscapes of New Mexico are inextricably intertwined.

In this chapter, I depart from the ways in which telehealth has been primarily approached by social scientists in the past. In previous scholarship, forms of telehealth have been carefully described in contexts intimate to the specific technology, the direct encounter and relations between health workers and patients, as well as the immediate surroundings of those involved (e.g., Greenhalgh et al. 2013; May et al. 2001; Pols 2012). While I attend to these crucial factors of the use and experience of telehealth in other parts of this thesis (Chapters 6, 7 and 8), in this chapter I take a broader perspective in order to trace the ways in which telehealth intersects more widely with daily life in New Mexico. I take telehealth and place together, as entangled relations within a meshwork; arguing that this is an ethnography of place precisely because it is an ethnography of telehealth. Drawing on the work of Garcia (2010), Kosek (2006) and Navaro-Yashin (2009), I argue that telehealth and the spaces in which it is situated are inseparable. The sundry, multiple topographies of space in New Mexico are entangled with the topographies of care, health and the strategies employed to improve healthcare provision. In order to understand the particular instances of telehealth in New Mexico, it is first necessary to

grasp the rhythm, robustness, temperature and landscape that form and shape the daily lives in which telehealth takes place.

Life in New Mexico is dictated by the road. Almost everyone who can afford to buy or lease a car drives. While there are sidewalks and other pedestrian infrastructure in cities and towns across the state—such as crosswalks with adjacent lights that stop traffic at larger intersections—almost no one walks. Seemingly everyone is inside a vehicle. Public transport is minimal, even in Albuquerque, the largest city in the state; most travel necessitates the use of personal vehicles. For many people, daily life in New Mexico involves moving from buildings into cars in adjacent parking lots, onto roads with many lanes, and then back again: into other parking lots and other adjacent buildings. The design of urban and rural life is set up for cars to manoeuvre, not people. This quality is reflected in many cities, designed with the underlying presumption that most of the population will move around by car (Sudjic 2007).

I spent a lot of time during my fieldwork in my car, driving from one place to another. Approaching the road as an important field site (Stack 1974), this chapter takes the form of a road trip. Mobile methods have been used to illuminate everyday mobilities, access to public services and interactions with the local environment together as a means through which to better understand lived experiences (Carpiano 2009; Porter et al. 2010; Evans & Jones 2011; Finlay & Bowman 2017). I employed them not only as a way to connect with my informants about the long roads and geography of the state, but also to unravel how the journey to receive healthcare might be imbricated with healthcare experiences themselves. I focus on my own experience of driving from Albuquerque, where I lived, to Clovis, where the Clovis Clinic was based. I begin the chapter with a broad picture of the New Mexican landscape as well as the histories, memories and precarities imbued therein. I situate telehealth in place and time, within a vast landscape of highways, parking lots and emptiness. I trace the ways in which this particular landscape intersects with, shapes and becomes implicated in the health and care of the population. I argue that the landscape shapes the health and healthcare of New Mexicans in two different ways. First, is in regard to the physical distance between communities, healthcare professionals and resources. New Mexico is poor and vast. The state struggles to populate rural areas with healthcare professionals and many rural communities operate on "*barebones resources*". Residents in these areas often have to travel hours to see a specialist doctor. Seeking out healthcare can involve taking a full day off work, sometimes taking the kids out of school, and driving long distances to a place with better resources. Some people who have family in Albuquerque, the largest city in the state, stay overnight with family members. Others have to pay for a hotel room if the trip to the city and back is too much for one day. Many people I met in Clovis, a small city on the eastern

border of the state, go to Amarillo or Lubbock, two cities in Western Texas, for their specialist care. Figure 4.1 depicts Clovis in relation to these larger cities. As many New Mexicans do not have the time, financial resources or health to make these trips to receive healthcare, many go without sufficient care. Chronic conditions are often left undiagnosed or undertreated. Mental health conditions are often not cared for proactively through therapy and medicines. Instead, many are addressed reactively at the point of emergency.

Second, New Mexican geography is implicated in experiences of health through the memories, affect and complex histories that permeate the landscape. Feelings of institutional and state abandonment, historical and present struggles with colonialism, economic hardship and the loss of life are materially present amongst communities in New Mexico: in buildings, local landmarks, billboards and street names. Both aspects of the landscape, the physical and the affective, influence the health and mental health of the population and create the context in which telehealth functions.

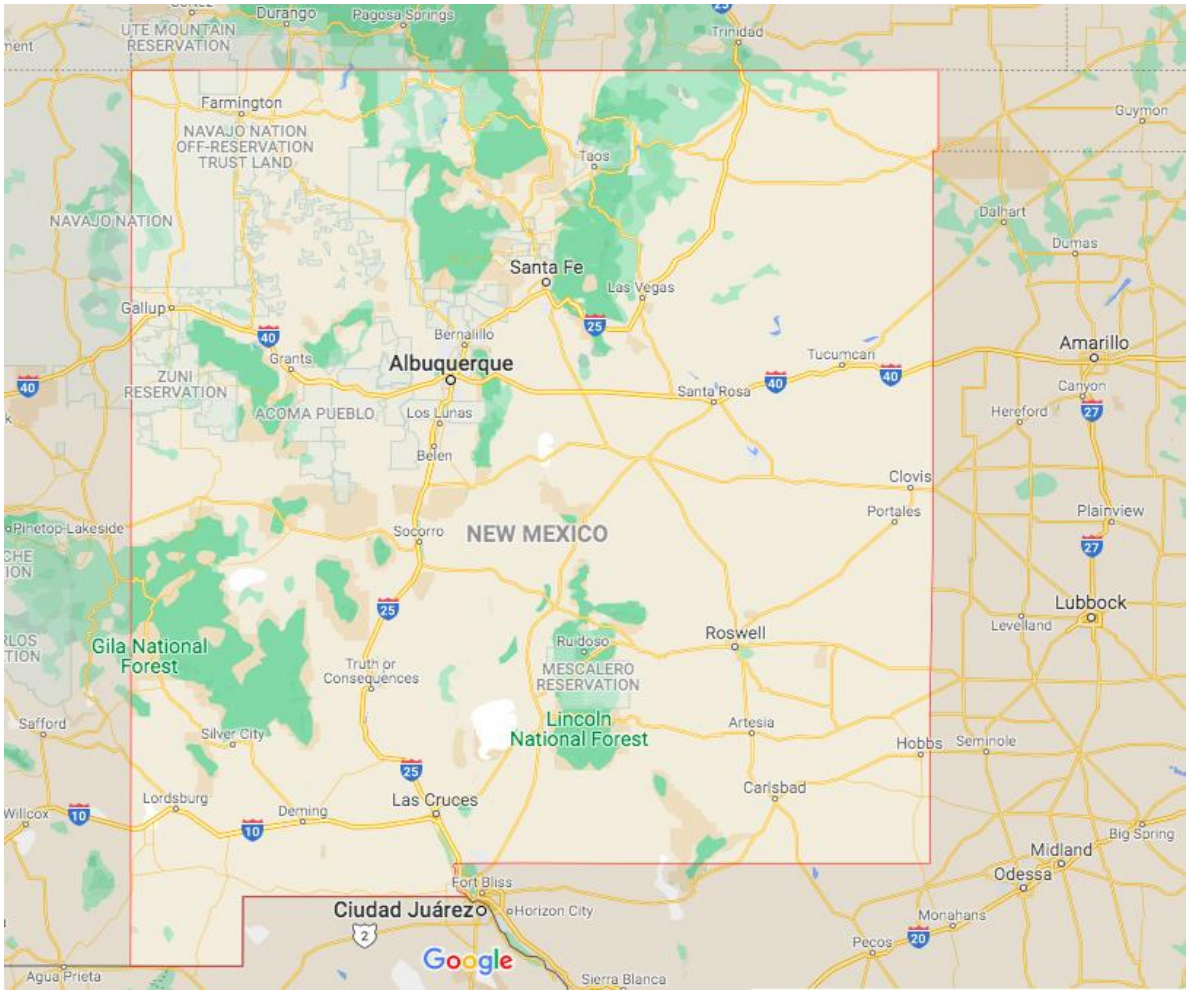

Figure 4. 1 A map of New Mexico and its peripheries. Clovis sits on the eastern border of New Mexico, three and a half hours driving from Albuquerque and one and a half hours driving from both Amarillo and Lubbock in Texas, the neighbouring state (Google Maps 2022).

The particularity of New Mexican space

Space in New Mexico is particular in many ways. In terms of physical geography, the state borders Mexico in the south. Southern highways are lined with passport controls, drivers are pulled over at unexpected points to confirm the legal status of everyone in their vehicle. The state's eastern border is with West Texas. This part of the state is politically conservative and has an active oil industry, particularly in the south-eastern cities: Rosewell, Carlsbad and Hobbs. New Mexico also borders Arizona and Colorado, on the West and North, respectively. Land here, as well as in other regions of the state, exists in a patchwork of ownership, across both space and time. Land belongs to American Indian reservations and pueblos, to the Federal Government (e.g., Los Alamos National Laboratory), to land grant[11] holders and their ancestors. In the state, mountains cut through deserts and high plains. Elsewhere, mountains surge up through forests of piñon, juniper and fir; valleys are bisected by rivers and cottonwood groves. The state not only covers vast horizontal distances—nearly 315000 square kilometres—but also a range of altitudes: from Red Bluff reservoir at 866 metres above sea level to Wheeler Peak, standing over 4000 metres tall.

Figure 4. 1 (left) **The New Mexican state flag** (Star Spangled Flags 2021). **Figure 4. 2** (centre) **A New Mexican license plate from a passenger car** (Johnston 2011). **Figure 4. 3** (right) **A New Mexican state road marker** (Stronglight 2013). The Zia Sun in the centre of each image is a symbol initially representing the Zia people who are indigenous to New Mexico. More recently, it has come to represent Puebloan peoples and New Mexican culture more broadly. Among several meanings, the sun's rays point in the four directions of a compass and represent the four seasons of each year (Saez 2018).

[11] Land grants in New Mexico were allocated to communities and individuals by the Spanish and Mexican governments from the late 1500s to the mid 1800s as a means of encouraging Hispano settlement on lands considered to be "frontier". Many of the land grants were built into settlements and ranchos for rearing livestock. Following the Mexican-American War (1846-1848), land grants were incorporated into the US. In the majority of cases, the property rights of the resident Hispano population were withdrawn; land was either declared to be within the public domain, sold to the federal or state government or dispossessed, as families could not pay for the taxes applied to the land. In present-day New Mexico, there are few land grants still under the ownership of the heirs of the original settlers. However, controversy, tension and bitterness over how land grants had and had not been recognised and respected over the past 150 years continues to persist in New Mexico and inform the ways in which the land is understood.

The particularity of New Mexico, and the loyalty of many of its residents to the state itself refracts through many aspects of daily life. The New Mexican State Flag is displayed seemingly everywhere (see Figures 4.2 - 4.4). During my weekly grocery runs, I would pass under a giant flag hanging above the entrance of the local Walmart. The flag's red Zia Sun stamps license plates, tattoos, storefronts, town welcome signs, t-shirts. I received restaurant recommendations from several informants who told me I must go to specific places for 'real New Mexican food', the places that have the best red and green chile. They helped me avoid businesses that advertise themselves as serving authentic New Mexican food, but in actuality, serve the lesser Tex-Mex or Mexican cuisines. The roadrunner is the state bird; several of which spent time in my backyard and scuttled down my street. Just before Christmas, I baked biscochitos—the state cookie—with Claudia, an informant and friend. Claudia told me that these cookies are made in the hundreds for important family occasions such as weddings. "We call them bizcochos in Las Cruces", where she's from, the second largest city in the state, sitting just 65 kilometres north of the southern border. In this statement, Claudia revealed a regional particularity within the state. Many people I met in Albuquerque watch the news on KOB-TV or KRQE-TV, NBC and CNN affiliates respectively, both of which are transmitted from Albuquerque. In Clovis, on the other hand, as it sits closer to cities in West Texas than Albuquerque, people watch news broadcasted from Amarillo and Lubbock, Texas. Some of the most popular radio stations among Albuquerque residents are The Peak (Albuquerque's Music Variety), The Q Radio (out of Albuquerque), KRST Country Albuquerque. In Clovis, the range of radio stations include broadcasts from within Clovis and several from Portales, a small city 20 miles to the southwest. Media in New Mexico, as in the US more broadly, is incredibly localised. The people seen on TV or heard on the radio are based in New Mexico and speak to specific New Mexican audiences.

Emerging from this research is an emic understanding of spatial particularity: a New Mexico that was both experienced and described as significant and distinct by my informants; a distinctness that also radiated from the space around me. New Mexico encompasses particular and multiple types of living in the world; daily lives that differ vastly from the lives of those living in other states and regions in the US. This thesis takes seriously this particularity, approaching New Mexico more generally, Albuquerque, and Clovis as multi-valent, distinct and dynamic spaces. When initially conceptualising this work, I approached New Mexico as an entry point for the study of telehealth. Through analysis and reflection, I have realised that the inverse emanates just as strongly from this work: telehealth was an entry point for understanding a particular New Mexico.

A road trip through New Mexico's physical and affective landscape

In this section, I describe how the particular daily lives of my informants became intelligible through experiences of the land: through many hours on the road, back and forth between rural[12] and urban areas, across cities, towns and small villages. Understandings of telehealth and its use in rural behavioural healthcare became visible to me in new ways as I spent time navigating New Mexico's vast geography, aligning myself with the tempo of daily life, feeling the hot sun on my head and finding myself in constant search of shade. I learned to see the tensions that are built into the New Mexican landscape. On one side is the incredible beauty of this 'Land of Enchantment'[13]—a geography that is praised for the hugeness of its sky and the open and empty land stretching for miles beneath. On the other are the everyday realities of life here: scarce resources made even more scarce as they are stretched thin over huge swathes of land, of addiction, dispossession, colonial[14] rule and oppression, violence, ill health, cultural and historical pain. New Mexico's landscape and the struggles of everyday life are inextricably linked; they shape and are shaped by one another (Garcia 2010). In her ethnography of heroin addiction in the Rio Grande Valley of North Central New Mexico, Garcia (2010) traces the relations between the physical landscape, drug addiction and despair. She emphasizes the connection between physical spaces in New Mexico and the affective consequences on the people who live there, using the contours of the landscape to unpick the nature of heroin addiction. Similarly, Kosek (2006), in his investigation of the political life of two New Mexican forests, delves into the connection between forest politics and the many connecting and intersecting histories that influence and are influenced by the forest. He argues that it is impossible to understand forest politics in isolation, without the interwoven cultural and political histories that have formed the landscapes and people who live there. In this section, I follow in Garcia and Kosek's analytical and descriptive footsteps, attending to the work that a landscape does in order to convey the reality of daily life in the New Mexico I came to know. I use descriptions of the road, of rural villages lacking resources, of places that

[12] While I use the term 'rural' to describe Clovis and the particularities of daily life there, I want to flag that this term is my own. My informants in Clovis hardly ever used the term themselves. "*What is it like to live in a rural city?*", I naively asked patients and health workers in my first few interviews at the Clovis Clinic. I was met with silence and stares that said "*what do you mean what is it like? This* is *it*". Instead, my informants described their small city as being in the middle of nowhere; they situated Clovis and its absence of resources in comparison to the abundance of resources in the nearest big cities; they expressed their frustration with being overlooked by the state because they were so far away from Santa Fe—the state capital where decisions were made about state-wide resource allocation.

[13] 'Land of Enchantment', officially adopted as New Mexico's state nickname in 1999, projects a particular imagery of the state, focusing on its diverse and natural beauty.

[14] The United States can be understood as both a site of postcolonial history as well as of a colonial present. While Spanish, English, Dutch and French settlers colonised North America from the late 1400s to the mid-1700s, land from indigenous populations is still being dispossessed and federal laws are structured by persisting systems of colonialism (Glenn 2015; Wolfe 2006).

conjure violent and oppressive pasts to provide a spatial framework with which to understand the many interlocking landscapes that formed the foundation for my research on telehealth. Ultimately, I am not using the landscape as a lens to understand the context in which this research took place. I am arguing that the landscape is the context; it is inseparable from the lives of those that inhabit it.

My first trip to Clovis was in late January 2019 with a small team from the Department of Psychiatry at UNM. It was a scouting trip for a potential new placement clinic for the rural arm of the psychiatry residency programme. As I had been in search of a rural clinic that offered telehealth to its patients in which to conduct my research, I was invited to join the two psychiatrists and psychiatric resident for a brief overnight trip to Clovis. The clinic we planned to visit—the Clovis Clinic—was one of the best rural community mental health clinics in the state, one of the psychiatrists told me. The director of the clinic was very active at the state level, always trying new ways to get money and resources for the clinic.

Setting up rural placements for psychiatrists in the residency programme, as well as for residents in other programmes, is a strategy alongside telehealth in New Mexico to establish longer term, sustainable provision of specialized healthcare to rural areas. This strategy involves organising placements for residents—doctors in their internship years of training—to spend time in and form connections with rural communities. Evidence shows that doctors who have strong connections with a rural community are more likely to work in that community following their training (McGrail & O'Sullivan 2021; Noya et al. 2021). UNM Medical School, currently the only medical school in the state, employs this strategy of community building, as well as others—such as accepting only local New Mexico applicants into their programme—to combat disparities in the healthcare workforce in rural areas.

However, while it is more likely for a doctor to continue their practice in either the place they have trained or the place they grew up, less people from rural areas go to medical school. Many doctors are also in debt from the student loans that enabled their medical training. There are more economically competitive jobs in urban and suburban areas, attracting doctors to these positions as they will be better suited to pay off their debt with a higher salary. Further, many rural areas do not have good resources for education or healthcare. Doctors I speak to in Albuquerque say there is not much to do in rural areas; that Albuquerque has a lot more restaurants, movie theatres and resources for themselves and their families. There also are not good training opportunities in rural areas. As there are not as many doctors and not as many people, it is hard for health workers, especially

specialists, to treat enough cases in their speciality in a rural area, to keep up their practice, continue learning and to advance their career.

It was not until about a month later that I formally started fieldwork in Clovis, returning there on my own in early March to spend a week at the Clovis Clinic, getting to know the different employees and exploring the ways in which I might conduct my research there. I leave home around 7:30 in the morning, hoping that an early start will get me to Clovis by midday, giving me the afternoon at the clinic. The night before was cold, as are many nights in the high desert. I sit in the car for a few minutes with the heat blasting, waiting for the ice on the windshield to melt. The sky is mostly clear, with some haziness on the horizon. Two hot air balloons float silently above, unaffected by the early morning jostling of the city below. I pull off my street onto University Boulevard and drive about a mile north toward Route 40. I stop at the Circle K gas station on the corner of University and Indian School Road to fill up before the long drive ahead. Gasoline is cheap; there is an oil boom in the south-eastern part of the state. The state government has more money to spend this year, over $1 billion. The underfunded, under resourced sectors are all vying for extra funding this year.

With a full tank and a hot, weak coffee from the small gas station shop, I pull back into the morning traffic and soon merge onto Interstate-40 East, heading towards the Sandias and into the rising sun. The drive is just over three and a half hours, without stops. It takes me south east, towards a place that feels and looks much more like the west Texas plains. This first stretch from Albuquerque to Santa Rosa on “the big I” is the longest, nearly two hours. After getting out of Albuquerque and passing through the Sandia Mountains, the road becomes straight and mostly flat, with a few rolling hills. There are two lanes driving in each direction, separated in the middle by a grassy median strip, and bordered by dirt and grass on the outside. Every so often on the median, there is a white wooden cross, covered in flowers, staked into the ground (see Figure 4.5). In late summer, this ground bursts into thousands of wild sunflowers.

Figure 4. 4 A handmade, painted white cross and a smaller wooden cross. Located on West 21st Street, one of the main roads in Clovis, New Mexico. These roadside memorials, *descansos*, are resurrected in memory of people who were killed in motor vehicle accidents. They dot the roads and highways throughout the state. *Photo by author.*

There are ranches on this part of the drive: wide open fields, black cows, heads down, nibbling grass. I listen to the news on the car radio until Edgewood or Moriarty, 30 to 40 miles outside Albuquerque, before it becomes too fuzzy to understand. Halfway to Santa Rosa is Clines Corners Travel Welcome Centre, a huge, multi-room shop for New Mexican souvenirs. Leading up to Clines Corners, in both directions, is a visual siege on the road-focused driver. Lining the highway are 20 to 30 billboards, spaced every 400 metres or so, advertising everything that an I-40 traveller can find at their "world famous" travel centre. "Route 66 Souvenirs"; "Fireworks!"; "Indian Pottery" that is "Worth stopping for". According to one billboard, this travel centre has the largest roadside restrooms in the state of New Mexico. Even after passing Clines Corners, there are a few follow up billboards, "Come back soon!" and "Travel Safely".

There are fewer cars on this road than 18-wheeler trucks. Most have nondescript, large white trailers, and are usually driving in the outside lane. Once in Santa Rosa, I exit off of I-40 and head south on

Route 48, a two-lane highway. I get stuck behind big, slow trucks that are hard to pass; rolling hills make it difficult to see if there is another vehicle coming in the opposite direction. Other cars slowly build up behind me and the trucks, forming a caravan. I pass one or two ranches, a few numbered dirt roads, telephone poles running alongside the road, several signs that have a slash through a martini glass and a car key to communicate no drinking and driving, some shrubs and the big sky. Otherwise, there is almost nothing here (Figure 4.6). This route takes me 44 miles south east to Fort Sumner, a village of just over 1300 people. Named after a military fort that was active in this area in the 1860s, Fort Sumner initially operated as an internment camp with the purpose of "Americanising" Mescalero Apache and Navajo Indian tribes.

Figure 4. 5 Route 48 as seen through the windshield. Taken on the drive from Albuquerque to Clovis, New Mexico. Uninhabited land, except for the road and the string of telephone poles, as far as the eye can see. *Photo by author.*

New Mexico's complex histories radiate from the land. The landscape is a palimpsest of the past; histories of multiple groups of people lay scattered throughout the state in place names, statues and land grant signs. Even the names by which some American Indian pueblos identify themselves hark back to a time when they were colonised by the Spanish, marking the land's complex history and present-day tensions. In 2005 Ohkay Owingey pueblo relinquished the name given to them by Spanish

conquistadores back in the 17th century (San Juan), returning to their traditional name. Kewa Pueblo also reinstated their traditional name, renouncing 'Santo Domingo' in 2010. New Mexico's colonial history permeates the landscape in other places as well. Indian School Road in Albuquerque is one example. It has become so much a part of my morning commute to the University's campus that I often forget the history from which the name of the road originates: boarding schools—the forced residential and educational process to assimilate young American Indians—from the late 19th to mid-20th century. Statues depicting Don Juan de Oñate, a Spanish conquistador known for ordering the massacre of the Acoma Pueblo Indians in 1599, stand in town centres across the state, including the touristy Old Town Plaza in Albuquerque. As New Mexico's population is composed of Hispanics, Latinos and Native Americans, among other ethnic groups, these statues are present day reminders of New Mexico's complex and contentious pasts. While they stand as a beacon for some, whose histories have been reinforced by his actions, Oñate's statues stand as a dark and offensive reminder to others, whose ancestors were killed, enslaved and colonised by this same man. Like Edensor's (2001) "hauntings", these landmarks muddle the distinctions between history and present; they comprise a tangle of temporalities and evoke unsettled collective and conflicting memories. The New Mexican landscape is not only defined by its vastness, the open expanses and resources spread thin. It is also steeped with a history of colonisation, racism, dispossession, violence and turmoil. Land in New Mexico is still contentious. Nearly 35% of state land is owned and managed by the federal government. The state is used for natural resource extraction to support the national, rather than state, economy. New Mexico is the site of nuclear testing, national laboratories and national forests. Histories and memories, colonialism and expropriation have been worked into the landscape.

Before arriving in New Mexico for my fieldwork, I met with a British doctoral student from another university who had recently returned from her own fieldwork in New Mexico. During our conversation, she mentioned offhandedly that, in relation to conducting research in New Mexico, she was glad she was British. Alluding to the histories of oppression and colonial rule of American Indian communities and land by white Americans, she shared that her experience might have been different as a white American. For a while after this I tried to conceive of ways to conduct my research without making it about American Indians or Native health. However, I quickly learned that studying health in New Mexico is partly studying Native health. Studying New Mexico is studying American Indians, their history and their present. It is not possible to parse these histories from the landscape, from the physical and affective geographies of New Mexico, as they are permanently intertwined within each other. Even without an explicit focus on the lives of American Indians, the tensions imbued in the land are inescapable, boiling under the surface of everyday life.

Another example of histories of violence persisting in everyday life comes from the experience of a researcher at UNM whose work involved setting up pilot projects in several American Indian pueblos with the aim of bolstering local healthcare resources. One of the pueblos had wavering trust in the research team. In the researcher's words, "*it was hard to get community buy-in*" for the research project. The relationship between the community and research team was severed when the research team sent donated packages of food to the pueblo without realizing that the food had expired. This had severely offended members of the community. One community member expressed, "*anything that you're going to throw out, just give to the natives*". At another point during the process of setting up the project, another community member told the research team, "*we are not your test monkeys here*". With neither community support nor support from tribal leadership—a complex process necessary for external initiatives to gain traction in the pueblo, though for which I cannot claim any ground in understanding—the project sat at a standstill until its funding ran out. The histories of violence, oppression and colonisation on this land sit intimately alongside present-day turmoil, scare resources, underfunded health systems and small, short-term grants working to fill giant, long-standing gaps.

Arriving in Fort Sumner, a town en route to Clovis, I drive under a bridge that supports a huge train heading west. The train pulls big container boxes, one after another after another, extending for what seems like miles in both directions. I pass a homemade wooden sign that reads "Sadie's Restaurant – Right at Intersection then go 2 Block's". There are buildings labelled 'barber shop' and 'windmill supply shop'; with dark windows, they always look closed. There are a few other buildings with windows and doors blocked off with taped up newspaper. The "Fort Sumner Community Development Corp." has its curtains drawn shut and a tilted "closed" sign hanging on the door. There is a peeling mural of several cowboys rounding up cattle with their horses. Cortese Feed and Supply sits next to a small water tower and a closed down bowling alley, "Bowl-o-Matic Lanes". I come to a small intersection where Route 84 meets Route 60 and I take a left to head east on 60. Another hour or so of driving behind big trucks and trying to pass them. By this part of the drive, the land has flattened out and I can see if cars are coming from longer distances, making passing a bit easier.

Accompanying me on this drive are several long trains on the railroad that I drove under as I entered Fort Sumner (Figure 4.7). The tracks follow Route 60 from Fort Sumner to Clovis, and beyond into Texas. Clovis' origins lay in the history of this railway. Originally built as the Santa Fe Railway—officially known as the Atchison, Topeka and Santa Fe Railway—the town was established in 1906 as a division point for the Railway's first transcontinental railway system. A settlement built up over a few years and in 1909, Clovis was incorporated—it became a self-governing municipality. Passenger trains used

to operate on regular schedules through Clovis. The *California Special* ran between Houston, Texas and Clovis, with a through connection to California via *The San Francisco Chief*, a line running between Chicago and San Francisco. The *Cavern Line* ran between Clovis and Carlsbad, New Mexico, and also offered connections to other trains travelling between Chicago and California. However, in 1971, the Santa Fe Railway ceased all passenger train operations. Currently, the BNSF Railway (created from a merger between Burlington Northern Inc. and Santa Fe Pacific Corporation), one of the country's largest freight transportation companies, maintains heavy traffic through Clovis with over one hundred freight trains arriving and leaving daily. A huge train yard sits just south of the tracks near the outskirts of the city. The trains can be heard from all across town, especially those that throttle through Clovis without stopping. Standing on 1st Street, just north of the tracks, the trains passing through can be so loud, it feels as if they might crash into the entire city.

Figure 4. 6 A mile long freight train running alongside Route 60. Taken between Fort Sumner and Clovis, New Mexico. *Photo by author.*

Between Fort Sumner and Clovis, I drive past a few tiny villages along Route 60. Each town sits perched next to an out-of-service grain mill and elevator, which sit seemingly on top of the railroad tracks,

perhaps to receive or give away products when the mill was in use. The giant freight trains roar past these villages carrying supplies and resources to urban populations elsewhere. These trains pass quickly, their resources are present but fleeting, taking up space in these villages for just the short time that it takes for the train to speed through. The trains and their tracks remind me of the electrical transmission lines in Powell's ethnography (2018) that run high above the Navajo reservation in north-western New Mexico, bypassing the small houses and trailers below, many of which do not have electricity. "*Albuquerque gets all the resources*", I hear at different points from several informants. A few days earlier when talking about the cold winter weather, Sandra, an employee at the University, told me about a big power outage that happened a few years back, across the entire central corridor of the state. "*Energy from generators were used to get power back up and running in Albuquerque, but some rural towns up north didn't get power back for an entire week. A few people froze to death*". Resources and care for urban populations at the expense of rural populations was a persistent theme during my time in New Mexico.

The villages I pass on Route 60 are Taiban, Tolar, Melrose and St Vrain. Each village has several streets and a small assembly of single-storey houses. Melrose, which seems to be the largest, has an Allsup's Gas Station and convenience store along the highway. Harriet, one of the patients I met at the Clovis Clinic, lives in Melrose and used to work at this Allsup's. "*It's the only place hiring in town*". Harriet, along with a few others I met at the clinic who live in Melrose, have to drive the 25 miles to Clovis in order to receive telehealth services at the clinic. Clovis is the closest city and the closest place with any behavioural health resources. The drive is even longer for people who live in Ft Sumner: 60 miles to get to the clinic to speak with a behavioural health professional over telehealth.

Figure 4. 7 Another windshield view on the drive from Albuquerque to Clovis, New Mexico. This photo was taken just before arriving in Clovis. An administrator at the Clovis Clinic joked that the land is so flat there, you can see a dog run away for two weeks. *Photo by author.*

I know I have almost reached Clovis when I am instructed by a road sign to 'reduce speed ahead' (Figure 4.8). The wide-open fields that had lined the highway outside of the city become wide-open fields demarcated by barbed wire fences. Neighbourhoods pop up on both sides of the road, populated by several water towers, playgrounds and streets of houses that all look the same, built for military families. A road sign tells me that the next exit is for 'Cannon Air Force Base Main Entrance'. Cannon Air Force Base, established in 1942 and sitting several miles south west of Clovis, has an important role in both the city's identity and economy. In 2005, the base was almost shuttered during a Base Realignment and Closures (BRAC) commission. Since the end of the Cold War, there had been five BRAC commissions, led by the federal government, to reorganize and consolidate military installations across the US. The 2005 commission brought Cannon Air Force Base under intense scrutiny; significant reductions and even closure of the base became a tangible possibility. Clovis community members speak proudly about how the base was spared, in part due to local and state-level lobbying efforts—"*Operation Keep Cannon*"—and how it has since become home to a "*special*

ops unit". The base's role in the local economy and Clovis' economic dependence on the base creates an atmosphere of precarity. "*It would've been disastrous for the local economy. I would've lost my job. Many people would've lost their job*", shares a local realtor, referring to the possibility of the base closing in 2005. "*Many of the families moving to Clovis move here for the military*". The Cannon Air Force Base is made up of 4500 active-duty service members, 5600 family members and 3500 retirees. The base also employs about 1500 civilians. Together, there are over 15000 people associated with the base locally, equal to roughly 40% of Clovis' 38700 population.

On the radio, I am now in range to listen to K-Love, a Christian radio station which broadcasts out of local stations across the US. When I tune in, the announcers are asking listeners to become leaders in their community by pledging $50 a month to the radio station. One listener calls in to pledge and shares that she loves giving money every month; she thinks her donations are worth every penny because her kids listen to the radio station and their faith grows because of it. Christian faith is a particularly large part of everyday life in Clovis. "*Clovis is the last notch on the Bible Belt*" said a New Mexican author who had become familiar with Clovis through conducting research for an upcoming novel. I drive by 'The Firing Pin', a gun shooting range between the Air Force Base and Clovis. There is Sandia Baptist Church and Clovis Fun Centre, with a chipped white and blue painted castle that stands over an empty mini-golf course. Two trains, moving goods in opposite directions, pass one another on the train tracks. A motorhome park and some single-storey houses stand in the space that is filled mostly by open fields and the occasional cow or sheep. Several old cars sit next to a rusted chain link fence, unused for years perhaps, weeds growing up and through their hoods.

I turn left off of Route 60 onto an old paved road to drive north into the city. The entire city sits within 57 square kilometres, hovering to the north and south of Route 60 and the train tracks. The main roads of the city lay in a grid, travelling from east to west and north to south. Within the larger grid of the main roads are neighbourhoods made up of less trafficked roads. Neighbourhood streets mostly follow a grid pattern except for a few of the newer, wealthier neighbourhoods whose street layouts model classic American suburbia, with several curved streets and a handful of cul-de-sacs. In the wealthier neighbourhoods, houses have 3, 4 or sometimes 5 car garages. The streets are wide, sometimes lined with sidewalks. The houses sit low, single storey and are mostly brick. These neighbourhoods sit in the north east of the city, situated diagonally opposite the city from the poorest neighbourhoods, in the south west. The poorer neighbourhoods have sun-bleached houses with chipping paint. Some have boarded up windows. I am told by employees at the clinic that families are still living in these houses, they are just unable to pay for window repairs. 20.6% of the population in

Clovis lives below the poverty line. This is higher than the 16.8% of New Mexicans and 11.4% of Americans living in poverty (US Census Bureau 2021).

I pass a few big fields lined by centre pivot and linear irrigation systems, and then take a right onto W 21st street, one of Clovis' main streets. The radio hosts chatter about the "*high plains*", "*plateau*", and "*diet plans*". Heading in any direction, the city quickly turns into farmland. The air is heavy with the smell of manure. It is a largely agriculturally based community, home to irrigated farms and ranches, live-stock auction and cattle feeding facilities. There is peanut and cotton farming, as well as cattle ranching for meat and dairy production. In 2005, the Southwest Cheese Company Plant started its operations in Clovis. It is the largest cheddar cheese producer in North America, and processes milk from local dairies. Alongside the Cannon Air Force Base, the "*Cheese Plant"*, as locals call it, is one of the largest employers in Clovis.

Driving east along W 21st street, I spot Plains Regional Medical Centre, the only hospital in the county. I see small billboards, supported by tall, metal poles along the side of the road, advertising the businesses that sit adjacent. The street is lined by a collection of siloed health services, interspersed with local businesses and churches. There is an Allsup's Gas Station, a Non-emergency Care Clinic, Community Home Care, Steven Haynes MD PA, Medical Cannabis Centre, Albert Kwan MD Clovis Surgery Centre, Hazen Chiropractic Centre, Kids Childcare Centre, Soapy Springs Car Wash, Accolade Home Care, Church of Christ, Trinity Lutheran Church, Jayashree Sinha MD, Genesis Healthcare and Rehabilitation Centre, and Trinity United Methodist Church. This strip of medical centres and businesses is a metaphor for the health and social care systems in New Mexico: one that is often dispersed and dysfunctional; one that requires individuals to navigate disparate options to receive care.

Several businesses have cars parked outside, while others look closed, with dark windows and deserted parking lots (Figure 4.9). This geography of shut-down shops, buildings, businesses and clinics makes up everyday life for the residents of Clovis. I hear from many informants about businesses that have closed, doctors that have left town, initiatives that have been swallowed up by this flat, grassy land. "*Over there used to be a movie theatre, but it closed*". "*My favourite Mexican restaurant was on North Prince Street and 8th, but it closed*". "*We used to have a psychiatrist in Clovis, but he retired years ago*".

Figure 4. 8 The empty parking lot of a shut-down Family Practice clinic. West 21st Street in Clovis, New Mexico. *Photo by author.*

Different forms of loss are built into the landscape. Financial loss is reflected through pay-day loans and 'cash for cars' shops, closed down businesses, empty store fronts, cars and houses left to decay in the hot sun. The loss of health and healthcare is manifest in closed down clinics and billboards advertising lawyers for people who have experienced accidents, personal injury and medical malpractice. "Hurt? Call Bert" billboards glower at highway drivers across the state. The landscape renders loss and neglect visible; the absent state in Clovis sits heavy on the community's shoulders. Gaps in the health and social care systems are many and diverse. The patients and staff I meet at the Clovis Clinic and in Albuquerque work with and across many different domains of state care. There are legal and penal systems, governmental and welfare systems, the Children Youth & Families Department (CYFD). This larger institutional apparatus structures many of the lives of patients and healthcare professionals that I meet. I hear often about people "*falling through the cracks*", getting caught between particular institutional gaps. The lack of care in New Mexico is revealed in part by the ways in which New Mexicans get stuck, lost or abandoned in various institutional arrangements. How

do New Mexicans navigate these different care offerings? What does this geography of a run-down health system mean for people's understandings and perceptions of health and care?

Distrust in the local health system

In Clovis, this particular geography has contributed to a general distrust in both the quality of local care provision as well as the intentions behind the work of local health workers. Many of my informants shared negative experiences of their own or from someone they knew regarding healthcare received either at the Clovis Clinic, the local hospital or the several primary care clinics around the city. Clovis community members shared stories of negligence; of not being turned in their hospital beds during long hospital stays and developing bed sores; of incorrect diagnoses; of doctors who did not listen. "*We get international docs, we get locum docs from Albuquerque only for a few months who don't get to know the community*", explained Tracy, one of the receptionists at the Clovis Clinic. Tracy's experience of international and locum doctors in Clovis reflects the many initiatives in New Mexico and across the rural US that aim to attract doctors to underserved and under-resourced areas[15]. Many rural areas rely on temporary trainee and contract doctors who come from elsewhere, to hold up their healthcare facilities.

It is the norm for many Clovis residents to move from doctor to doctor, starting over relationships as previous doctors moved away. Many doctors who work locally do not understand the idiosyncrasies of the community because they are not from there and they do not stay long enough to become more familiar. I am told by several health workers in Albuquerque that as healthcare positions in rural areas are not as competitive, sometimes less competitive candidates take up those positions. "*I'm not saying that rural physicians aren't good doctors. But that usually, if a physician is competitive, they will likely be recruited by better healthcare institutions, most likely in an urban area*", explained Dr

[15] For example, many immigrant doctors use a National Interest Waiver (NIW) which allows highly skilled professionals to petition for employment-based permanent residence in the US. Among other requirements, doctors under an NIW must practice full-time for at least three years in an area that is federally designated to have a shortage of healthcare professionals or at a healthcare facility under the U.S. Department of Veterans Affairs.

Additional systems are set up to bring doctors to rural communities for the short term such as the National Health Service Corps which funds the education and training of primary care doctors in exchange for at least one year of service in a federally designated health worker shortage area. After their time is served, many doctors leave, returning to areas with more opportunity and better pay. This trope of the trainee doctor in a rural community has been reified by popular media, for example in 'Northern Exposure' (Brand & Falsey 1990), a comedy-drama television series that aired on CBS in the early to mid 90s. The series followed Dr Joel Fleischman, a young doctor from New York City, as he moved to a small, remote village in Alaska to repay his medical education scholarship with four years of medical service.

Barón, a psychiatrist based in Albuquerque. These generalisations of American medicine precipitate into the lives of my informants through their own experiences of the health system in Clovis. Experiences of building up relationships with doctors followed soon after by their doctors' departures have contributed to the culture of distrust in the local health system.

Ashley, a support worker at the Clovis Clinic, told me about a specific experience involving her son's care:

> "*I took* [my son] *to his primary care doctor who said he was fine, he's diabetic and has low blood sugar, and sent him home. I took him home and he just wasn't right. It didn't seem like the other times when he had low blood sugar, he was still sick. So I took him to the* [emergency room] *and the* [emergency room] *doctor said that he didn't know how the primary care doctor didn't catch my son having real bad pneumonia*."

Negative experiences of the local health system among populations that have, historically, been disproportionately disadvantaged, overlooked and systematically repressed led to particular forms of distrust in the local health system. This distrust also extends from the unexpected and immediate withdrawal of behavioural healthcare resources following the 2013 fraud allegations detailed in Chapter 1 and sits alongside forms of distrust in the government and government run agencies: child and family services and home support services, for example, especially when these agencies are represented by local professionals.

Rebéca, an older woman who had received several services from the Clovis Clinic over the past few years, told me about a particularly distressing experience she had with a healthcare coordinator who had been assigned to her. This coordinator was supposed to spend two hours at her home helping her make healthcare appointments and ensuring she had access to all the services she needed. Instead, after 30 minutes, the coordinator asked Rebéca to sign a reimbursement form confirming she had received two hours of help. Rebéca was furious and refused to sign. "*I don't want someone to get paid for work they didn't do*", she said in her interview. She continued,

> "*these coordinators, they're not helpful like they say that they are. The coordinator that coordinates the things, she helps me with my appointments, you know if I have problems with my Medicaid, she steps in, things like that. Well, everything that she said she is capable of doing and would do for me, she has done nothing. Not one single thing, but one appointment that she*

made for me. Why do I want somebody to sit there with me making money while they're not doing nothing for me?"

The distrust Rebéca felt toward this health worker is situated within a local health system that does not have much money and is lacking resources. In this landscape, these feelings of distrust were experienced by many of my informants who were concerned that health workers and organisations were taking advantage of them in the attempt to bring in more money to the clinic or agency for which they worked. In the subsequent section, I consider how these forms of loss, dysfunction, resource scarcity and distrust that are built into and have grown from the landscape bear on the health and mental health of the population.

New Mexico's landscape of care and absence of care

Yael Navaro-Yashin's (2009) ethnography of Turkish-Cypriots in Northern Cyprus offers a helpful frame for understanding the ways in which the affect of places and things in everyday life can come to bear on the people who live within and amongst them. Following 1974, when Turkish troops invaded Northern Cyprus, thousands of Greek- and Turkish-Cypriots became refugees. Turkish-Cypriots who lived in the south moved to the north, while Greek-Cypriots who lived in the north moved south. Both left behind their homes, belongings and property, and found themselves making new homes in spaces that had just been evacuated by the displaced other, "the enemy". Navaro-Yashin asks how it feels for Turkish-Cypriots to be surrounded by and live amongst the objects and homes left behind by the Greek-Cypriots who used to inhabit these spaces. Observing her informants referring to the materials and land as "Greek property", she describes a "spatial and material melancholia" (ibid., 1). The spaces and objects that make up everyday lives evoke the Greek-Cypriots who at one time had occupied those same spaces, who had used the same objects in their own daily routines. Navaro-Yashin takes seriously the feelings her informants project onto these homes and belongings, as well as the affect the objects and spaces exude themselves. Her work evokes important questions for this research: what is it like to live in a place where community landmarks have become the sites of a shooting and suicide? Where Hotel Clovis, its past and demise along with the ruination of the Clovis economy, all wrap together, relating in new ways, leaving an affective residue on those who pass by as they move down North Main Street? To extend Navaro-Yashin's work further, I ask: what work do these affective spaces do? Thinking back to the geography of loss I described in the previous section—the landscape of closed down clinics, of billboards anticipating accidents and misfortune, of cars left to rust and windows left broken because there is not enough money to pay for repairs—how do these spaces,

and the affect they exude, intertwine with the health and mental health of the community? How do these spaces influence perceptions of health and care?

Navaro-Yashin furthers her project, asking: "what is the role of the outer environment in engendering subjective feeling?" (ibid., 4). In other words, how does the atmosphere of a particular space—an empty parking lot of what used to be a doctor's office—influence the way people understand themselves and their communities? How does it influence the ways people live their daily lives? And what values, priorities, understandings and ways of life are generated as a result? Ultimately, Navaro-Yashin argues that ruins and the people who live around and amongst them transmit affect relationally. Affect neither comes solely from the people who live amongst ruins, projecting affect onto them; nor does affect seep from ruins alone. Affect works hand in hand with subjectivity. In this research, I posit how this intertwined coupling, this intimate dialogue between affect and subjectivity, bear on the mental health of those who live in these particular, affective spaces. What bearing does this coupling have on understandings and perceptions of health and care? A further question not addressed by Navaro-Yashin, yet important to this research, is that of agency: whether people have a choice in being surrounded by these affective spaces. Do people have the agency to change their environment by moving, for example? What does it mean to live in a place where memory and affect are distributed throughout the landscape, to be surrounded by abject things that exude melancholy, and not be able to leave? How does choice and mobility come to play in this relational construction of affect and subjectivity? This question will be considered in the subsequent chapter (Chapter 5) on mobility in New Mexico.

Several days after the driving tour with Jodi—detailed in the opening vignette of this chapter—Mike, a gregarious man in his mid-60s, tells me about the library shooter. I met Mike and his wife, Johanna, through a local website that connects people looking for short-term sublets with people who have spare rooms for rent in their homes. I stayed with them during my first few weeklong visits to Clovis and grew close with them. We would cook dinner together in the evenings and watch the newest episode of The Resident, a medical drama on TV. That specific night, we were playing cards at Java Loft, a coffee shop in a building called the Master's Centre. "*There used to be a bookstore in here, too*" Mike tells me, "*but it closed*". The coffee shop is busy. There are a few students, perhaps from Clovis Community College, working on their laptops. A group of ten women, sitting around a large circular table, hold their weekly Bible study. As Mike deals the first hand, he tells me quietly that the biggest problem facing the country right now is how boys are growing up. "*Boys don't have enough support*". He speaks from his experience of leading 'Life-Skills' classes at a local Christian-based charity. He tells me that the teenager who shot and killed people at the library used to attend some of the classes he

teaches. Classes, he explains, are for people struggling with different types of things. Some are for those struggling in school, others are for people on parole or who have been in trouble with the law. There are a few for people with anger issues, students who act out in school, and those who have been convicted of domestic violence in the past. The classes, he tells me, are part of a process to help people make amends and learn to heal. "*I knew that kid was really struggling from things going on at home and at school… there was a lot of bullying*". Tears form in Mike's eyes as he looks down at the cards clutched tightly in his hands. He tells me he wishes he could have been there at the library when the teenager had arrived with the gun. "*Maybe I would have been able to talk him down*".

On the days and weeks following the driving tour, I notice purple t-shirts worn by people around town. In white lettering they read "Clovis Strong"[16]. The 't' in the 'strong' is designed to look like a Christian cross. I learn these were made in the fall of 2017, soon after the library shooting. While these t-shirts signal community and religious support following the local tragedy, they are also a reminder of the general lack of overarching, state support in Clovis. The justice system cannot contain prisoners, the health system is struggling to keep the local youth alive. State neglect in these ways is replaced in Clovis by the presence of other bodies. "*There's a church on every corner*", one of my informants tells me. There are dozens of charities, many of them founded in some Christian denomination, trying to fill the gaps left by the state. The lack of state care has been mapped onto the city.

Garcia (2010) observes similar systems of redistributed care in her ethnography of heroin addiction in North Central New Mexico. In the absence of institutional and governmental care, families and communities step up to support addicts, especially in the context of detoxification clinics. These "informal acts of care" (Garcia 2010: 33) are distinct from institutional processes of care and are reflected on many different levels of everyday life in Clovis: for example, the lack of government attention, resource provision and healthcare infrastructure. These gaps are filled by churches, charities—many of which are run by churches—and relationships from within the community. At the Clovis Clinic, which is constantly understaffed and underfunded, phones ringing incessantly with patients trying to make appointments in the over-booked clinic schedule, gaps are filled by friendship and food. "*Who wants something from Sonic*?", shouts one of the support staff on her way out of the clinic, on a quick snack run to the nearby fast-food chain. A sign-up sheet sits partially filled in by the staff mailboxes: "Fourth of July Potluck". The staff vending machine has been dismantled so people can pay $0.50 into an old coffee tin when they have the change, rather than needing exact change

[16] The phrase "Clovis Strong" is a variation of "Boston Strong", a slogan created following the Boston Marathon Bombings in April 2013. The "Strong" slogan has been used by other cities across the US that were also affected by tragedies, such as mass shootings, as an expression of community togetherness.

every time they want a cold drink. While the reception office is always buzzing with phone calls, the mutters from conversations with patients at the front desk window and the fax machine, the support staff keep the radio on. It is Ronda's turn to pick the music; she turns on "Footloose" by Kenny Loggins. "*It's 80s day!*", which then turns into 80s week. Whether it is an afternoon fast-food treat or the ability to pick the office music for the day, these small acts of care between members of staff within the clinic seem to substitute, at least partially, for the care that is missing from institutional, governmental and state levels. As particular levels of care decrease, others increase—not necessarily in the attempt to confront entire needs that are left unaddressed, but to bring forms of joy, comfort and support into everyday life.

I often feel like I am given special treatment at the clinic, particularly from the executive director, as I am associated with UNM. He was immediately supportive of my plan to conduct research at the clinic. He explained this when we first met, saying "[the clinic] *has a lot to gain*". At that time, there were no psychiatrists in Clovis. The clinic received psychiatric services over telehealth from three psychiatric professionals: a nurse psychiatrist and two medical doctors. Creating stronger networks with the largest hospital in the state, UNM Hospital, through supporting research on telehealth could benefit the clinic. In addition, the clinic employs several other strategies to address the significant community need and lack of resources: the 'Open Access Scheduling Model'[17], experiments in 'Value-Based Care'[18], the prioritization of medical billing[19], and countless pilot projects that are often listed off in a slew of bewildering acronyms[20]. These strategies make visible the lack of state care and the financial desperation that the clinic constantly navigates. The pilot projects, for example, bring in resources and

[17] The Open Accessing Scheduling Model, which had been employed at the Clovis Clinic a year or so before I first arrived, involves scheduling patients for appointments within a day or two of when they call in to request an appointment, as opposed to someday further in the future. The aim of this model is to make care more accessible to patients who are in urgent need and reduce the possibility of no-shows (Lesaca 2017). However, this system requires returning patients to call each week to make an appointment with their long-term provider. Nearly all the patients I spoke to expressed frustration and sometimes exhaustion with the effort involved to see their provider, sharing that they often could not get booked in for an appointment.

[18] Value-Based Care is a model of healthcare provision in which the amount clinics and health workers are paid for the services they deliver is based on the health outcomes of their patients (Porter 2009; Teisberg et al 2020). This model focuses on preventative care practices which, in theory, lower the cost of healthcare through decreases in superfluous procedures and testing as well as the use of ineffective medicines.

[19] Health workers at the Clovis Clinic were instructed by the clinic's executive team to complete all medical billing forms for patients by the end of each appointment. While this often meant that health workers were rushed and distracted at the end of patient visits, it enabled the clinic to receive reimbursement for the health services provided as quickly as possible. In the landscape of resource scarcity and financial uncertainty for rural clinics, this strategy offered the most fiscally secure approach to continue paying employees and providing services to the community.

[20] During the time I spent at the clinic, these pilot projects included: Early Childhood Home Visiting (ECHV), Multi-System Therapy (MST), Youth Assertive Community Treatment (ACT) and Comprehensive Community Support Services (CCSS).

staff for the clinic without cost. Most projects are temporary, with funding to run for several years or less. I hear clinic staff mixing up the acronyms of new pilot projects with those of projects that have recently ended. "*I have a call for you from the director of PAS, or PAC, PCT? Oh whatever it's called*", says one member of support staff to another. These projects fluctuate in and out of the clinic, bringing in extra resources for a finite amount of time, before withdrawing at the end of the grant. There are several offices at the back of the clinic that are allocated to the pilot project of the moment, their occupants as fleeting as the resources that each project provides.

This clinic is not the only behavioural health resource in Clovis. There are several other clinics and charities that offer similar and sometimes overlapping services. All the clinics are underfunded and understaffed, wrestling with long waiting lists and a persistent shortage of resources. Instead of working together to provide care to the residents of Clovis and surrounding villages, these clinics are in direct competition with each other for the scarce resources provided by the state government. Clinics can only keep their doors open if they have enough revenue coming in. Most clinic revenue comes from seeing patients, providing services and then billing insurance companies for the services provided in order to get reimbursed. Even in the context of precarious and uncertain resources, clinics are still vying to ensure that patients come to them for services, instead of one of their competitors. The local charity where Mike—whom we met above playing cards at Java Loft—works provides several behavioural health services including in-person therapy. "*You're with the competition*", he tells me when he learns the name of the clinic at which I am conducting my research. From his perspective, the Clovis Clinic steals his charity's patients. He explains that while the charity has a few part-time therapists, it does not have the resources to offer as many services as the Clovis Clinic, for example group classes for people experiencing addiction and substance abuse. The therapists at the charity refer their patients to the Clovis Clinic's group classes for an extra dimension of support. For the past few years, however, the Clovis Clinic has required all patients taking part in group classes to see a therapist at their clinic. As a patient's insurance will only help to cover the cost of one therapist, patients in the past have left their therapist at the charity to see a therapist at the Clovis Clinic, in order to continue with group therapy. Even though the Clovis Clinic is overrun with patients and struggles to book every patient an appointment, it still relies on the resources that come along with continually registering new patients and placing them on the case loads of their therapists. The disbanded local health system in which these clinics function is precarious and does not allow for collaboration, even though clinics' and charities' missions to provide behavioural health services to Clovis and surrounding communities are aligned.

In the previous sections, I delineated the physical and affective landscapes of New Mexico. I have shown how these landscapes are implicated in the health and mental health of the people who live there. In the following section, I explain why understanding these geographies and their influence on health is necessary for understanding my work on the use of telehealth.

An ethnography of telehealth and of place

The use of telehealth in the New Mexican behavioural health system cannot be disconnected from the broader context in which it exists. The distance between places and open spaces, the scarce resources, the local histories and ongoing forms of structural violence that are dispersed across and embedded in this vast land come together to define the way the health system works. These dimensions inform the ways specific clinics and hospitals function, and the ways in which individuals and communities understand health and care. Both the physical and affective geographies come together to define the health of communities in New Mexico as well as the ways in which they receive healthcare.

By making this strong connection apparent, between the landscape—its physical vastness as well as the emotions, memories and histories imbued therein—and the ways in which the population perceives and experiences health and care, I am setting the foundation for arguments I make later in my thesis: that telehealth shapes and is shaped by the sociality and physicality of a place. Telehealth is inextricably linked to the landscape and everyday life in New Mexico. The use of telehealth influences more than merely the specific route of healthcare provision. At the Clovis Clinic, telehealth is bound up with many aspects of life: geography, local politics, state and national politics. Telehealth changes the ways in which people experience the landscape; it influences the ways people view their health and understand care. In subsequent chapters, I argue that telehealth influences what distance and mobility mean in healthcare, what it means to live far away from most healthcare resources and what it means to receive care 'locally'; that telehealth changes people's experiences of closeness and distance in care; that telehealth reconfigures care. Focusing on the specific intricacies of telehealth in this small, Eastern New Mexican city enables a stronger understanding of how telehealth is constituted in a particular location and how it comes to shape the distinct forms of health and care for the particular people with whom it encounters.

An overarching argument of this dissertation is that telehealth reconfigures care in different ways. It changes the way patients view their health and their access to care. It shifts the ways in which health professionals understand and experience their work. The consequences, challenges, outcomes and

benefits of telehealth are much wider than enabling the provision of healthcare services to rural populations. Telehealth marks a change from the way things used to be, the way healthcare used to be provided. While I focus on the particularities of this small clinic in this small city along a long railroad, hours away from any urban area, overlooked by state and national governments, the experiences of telehealth at the Clovis Clinic help to show how telehealth, in a more general sense, influences daily life; how it is part of a much larger change in who we are and how we view our health and our care. Understanding the particular context around telehealth is important as it is implicated in the distinct daily lives that surround it. In this chapter and those that follow, I show that experiences of telehealth are not universal; they are in fact very particular. Understanding the particular context in which telehealth functions and how it is inseparable from the landscape, history and memories that surround it will enable an understanding of the implications of telehealth in this context. Then, in focusing on this particular phenomenon in this specific place, I will unravel aspects that could be more universally applied: findings from this ethnography of telehealth and of place that convey much larger shifts in ideas about health and care on a larger scale.

Conclusion

In this chapter, I have traced the material remnants, the histories that linger, the ongoing work of elimination and silencing of specific populations, and the weight of memory in New Mexican everyday life. I have focused on these physical and affective dimensions with a view of opening up new opportunities to explore how the use of telehealth influences and is influenced by this specific and particular world. This chapter took the form of a road trip because mobilities are integral to everyday life in New Mexico. In the next chapter, Chapter 5, I take mobility as a lens to understand how the landscape of and economic precarity in New Mexico articulate with the use of telehealth.

Chapter 5: Everyday Mobilities in New Mexico and the Experience of Care over Telehealth

During my time in New Mexico, I volunteered at The Ronald McDonald Family Room at Presbyterian Medical Centre, one of the largest hospitals in the state. The Family Room was funded by the Ronald McDonald Charities to provide resources and comfort for families who travel to Albuquerque from far away for their child's care; families who need a place to stay because travelling home at the end of each day is not an option.

The Family Room was located on the sixth floor of the main hospital building in the centre of Albuquerque, down the hall from the Newborn and Paediatric Intensive Care Units. In this room, there was a carpeted seating area with several comfy couches, stacks of magazines sitting atop wooden side tables, a radio playing calming classical music (Figure 5.1). The main light sources were from windows that stretched across the room's eastern wall, and various shaded table and ceiling lamps, which offered relief from the harsh fluorescence that lighted the rest of the hospital. There was a wooden table and several dining chairs next to a small kitchen area with a microwave for families to heat up food. There was a snack bar, coffee machine and refrigerator filled with cold drinks, cheese sticks and pieces of fruit. There was also a bathroom with a shower that families could use, laundry facilities, internet access and computers, as well as four small bedrooms that could be booked for naps during the day or overnight stays. In this room, I wore an oversized turquoise smock over black trousers, the required volunteer uniform. From behind a desk near the entrance to the room, I welcomed families, introduced them to the various facilities available and made sure they felt comfortable and had everything they needed. I kept the snack bar stocked, wiped down the eating and cooking areas after use, offered single-use soaps and shampoos to parents who wanted to use the shower, and laundry detergent and dryer sheets to those using the laundry room. The family room faced east, looking out over the large hospital parking lot, helicopter pad, and further, to the Sandia mountains that overlook the city. It was a comfortable space, designed to feel separate from the bustle and cold sterility of the wards just down the hall.

Figure 5. 1 The lounge area of the Ronald McDonald Family Room at Presbyterian Medical Centre in Albuquerque, New Mexico. *Photo by author.*

Many of the parents and families I met during my weekly Thursday evening shifts had travelled to Albuquerque from far corners of the state for their child's care. I stood up against the windows one evening next to Emilia[21], a mother from Tularosa, a small town in southern New Mexico. Together we watched a helicopter land outside on the helipad (Figure 5.2). Hospital transport staff were at the ready to move the patient, transported from elsewhere, onto a hospital cot and into the emergency room. Over the noise of the slow-motion helicopter landing, Emilia recounted her own experience of arriving at the hospital the week before, on a helicopter just like this one. She had had a complicated pregnancy and needed an emergency caesarean section. Her new daughter was healthy, thankfully, but needed to be observed for several days before she could be sent home. Emilia's husband and two older children had yet to meet their new family member. They were planning to make the three-hour car journey to pick both of them up in several days and take them back home.

[21] Emilia is not a real person. As I did not formally involve anyone from the Family Room in my research, I am not sharing information specific to an individual. However, I met many mothers with similar experiences to the story I describe here—all of whom influenced my understanding about life in New Mexico, and whose lives ultimately shaped the arguments I make in this chapter.

Figure 5. 2 A helicopter transporting a patient from another part of the state landing on the hospital's helipad, the low whir of the turning blades still audible. Photo taken from the Ronald McDonald Family Room at Presbyterian Medical Centre in Albuquerque, New Mexico. *Photo by author.*

Emilia's experience, of having to travel far from home for healthcare, of having to stay at a distance from family, is common in New Mexico. This chapter illustrates how daily life in New Mexico, including access to healthcare, requires certain forms of mobility and how the use of telehealth alters this mobility.

Introduction

I wrote about driving in the previous chapter because cars are central to life, mobility and the ability to access healthcare in New Mexico. When I first arrived in New Mexico, I had not adjusted to the particular culture of driving and was disoriented. Most people were hidden from view by car windows tinted black for privacy and shade. Unable to see drivers and their passengers, I had no idea who shared the space around me. To find out who they were, I started spending time at the Coronado Centre, an indoor shopping mall just off Route 40 in the centre of the city. The mall was cool from air

conditioning and bustling with people, especially on a Saturday afternoon. Families walked up and down the long, open atrium that ran down the centre of the building, pushing kids in strollers, stopping at the food court for lunch, looking into the windows of stores. Apart from a few spaces across the city—UNM campus, the eight blocks of the Downtown strip, the small parks that dotted my neighbourhood, the winding paths of the Sandia foothills, and the odd person either waiting at a bus stop or standing on the concrete medians at large intersections asking for change—this mall was the only place in Albuquerque where I saw people walking around as a form of mobility.

My first few weeks in Albuquerque, I had been inclined to walk whenever I had somewhere to go. However, spending more time surrounded by so many people who drive, and navigating much larger distances within and beyond the city, driving quickly became the principal way I moved about in my daily life. Another major factor in my transition to driving was my own perception of safety. As I was often the only person on the sidewalk navigating the sea of cars that made up many roads and intersections in central Albuquerque, I attracted unwanted attention. People in cars would honk, sometimes yelling out expletives or pick-up lines. I felt much safer in my car; I could lock the doors and blend into the streams of drivers moving about the city. Rather abruptly, my conception of getting from place to place and of my own ability to move changed. As did several of my behaviours that I had not previously associated with the way in which I moved. I started attending to different aspects of a journey. Instead of considering whether I had comfortable walking shoes or a hat to shade me from the sun, I was now occupied with how much petrol was in the tank of my car, whether it might be easy to find a parking spot at my destination, if it might be rush hour and whether I should avoid the highway.

With a car, I experienced the city in a different way. My daily routines changed. I started to consider how much this particular culture of mobility came to define the lives of my informants. How do people get around without a car? How do people navigate life in a place where everything is so spread out? How do the specific forms of New Mexican mobility influence the ways people understand themselves, their health and their experiences of care? In a state where healthcare resources are scarce, especially in rural areas, and where telehealth technologies are implemented with the hope of reducing the disparity in access to care, do telehealth initiatives intersect with experiences of mobility? It was through my own new and alternate mobilities that I encountered this theme initially. My own embodied daily practices had changed; my own routines and daily movements helped me reflect on this particular reality. Across the year I spent in New Mexico, I found this theme reverberating through many aspects of my informants' daily lives.

Scholars of mobility have conceptualised it in broad ways. It includes the global movement of people, objects and information, as well as movement on the local level, that is, movement that makes up practices of daily life (Hannam et al. 2006). Mobility studies attends to how these different forms of mobility structure people's lives. As a window through which to understand society (Urry 2007), it tries to unpack the meanings that different mobility practices hold. By doing so, mobility studies attend to the many and inequitable ways different networks are formed locally, translocally and globally. Further, mobility is tightly intertwined with interpersonal relations through hierarchies, power and privilege (Adey 2006; Salazar & Schiller 2014); mobility studies chart the ways in which mobilities reciprocally create and are created by social inequalities (Manderscheid 2009).

As defined by Salazar (2016), mobility is a "complex assemblage of movement, imaginaries and experience—[it] is not only an object of study but also an analytical lens" (ibid., 2). I use mobility as a concept to make my informants experiences, perceptions, values and understandings around health and care legible. I focus specifically on the mobilities of everyday life, of populations that are mobile within their own region through forms of necessity, as compared to populations that cross borders as forms of migration or tourism. These everyday mobilities, "the changes and breaks in the daily rhythms, routines and actions are not merely matter-of-fact, they imprint on the way we construct meaning in our everyday life" (Freudendal-Pedersen 2009: 5). Mobilities came into and had bearing on my informants' lives in multiple and intersecting ways: mobility in relation to health, accessing healthcare services and care, as well as desired and imagined mobility.

Mobility, health and healthcare have been shown to intersect in many ways. Under the anthropological gaze in particular, these intersections have been observed in global pharmaceuticals, international and local responses to disasters, medical tourism and studies on access to care. Vindrola-Padros et al. (2018) focus on the connections between the movement of patients, health workers and emerging and differing forms of healthcare services. They argue that there is a reciprocal relationship between healthcare and mobility: on one hand, health systems and policies shape forms of mobility, and at the same time, forms of mobility shape health systems and policies. In this chapter, I show how individual mobilities hold together the largely dispersed and disconnected New Mexican health system.

Mobility scholars also contend that caring practices are changing as patients, healthcare professionals and medical technologies become differently mobile (Vindrola-Padros et al. 2018). In this chapter, I evidence the ways in which telehealth muddles the conventional flows associated with receiving care. With telehealth, rural patients are no longer constrained to either receiving care from providers locally

or from providers hours away. In Clovis, patients attended the Clovis Clinic to receive care at a distance—from a specialist over a computer screen who lived and worked elsewhere. In this way, I argue that the use of telehealth shifts the mobility required to receive care.

Scholarship on mobility and care has placed particular emphasis on mobility as a path through which to receive care. Gamarel et al. (2021), for example, detail the ways in which American transgender young adults migrate within the US to places with trans-inclusive healthcare resources. Harvey (2011) describes how informal forms of "mobile medicine" in Guatemala among the Maya population are understood as unregulated components of the public health system that offer alternative ways through which to receive care. Mobility in these instances is a way to access health services and is sometimes a necessary route to receive care. Moving forward with these explorations of the interrelations between mobility and care, this chapter opens up considerations of mobility as a form of care itself, rather than mobility as a facilitator of care.

One of the ways in which mobility precipitates as a form of care in this ethnography is in the imaginary, in the possibility of moving and of receiving care. The potential to move, by both social and spatial means, has been termed motility (Leivestad 2016). Motility came under the social science gaze through the search for concepts to address the gap between mobility and immobility. As described by Leivestad (2016), motility is a "sociocultural exploration of how mobilities are constructed, experienced, and imagined" (ibid., 143).

In my research, I spent time with policy makers and healthcare visionaries at the forefront of New Mexico's telehealth agenda. Telehealth was imagined not only by these people, but by many doctors, patients and families as a potential solution to the many challenges and inequities within the state's health system. The thought was that if rural health clinics could get set up with computers, cameras and speakers, if they could get connected to strong enough internet and clinics could get enough 'buy in' from the administrative and healthcare staff, then telehealth could be used all over the state in the provision of care. Access to specialist care would no longer necessitate physical movement across vast spaces. Access to care would no longer rely on the particular infrastructures that enable that movement: time, a reliable vehicle, money for petrol and the ability to drive. In-person care could be virtually reproduced over telehealth. In this chapter, I consider how these imaginaries of mobility afforded by telehealth are realised on the ground. I ague that, through novel forms of motility, telehealth offers new possibilities of care.

Brought together, I present three arguments in this chapter. First, that access to healthcare in New Mexico requires individual mobility. Second, the use of telehealth shifts this mobility; by connecting patients and their carers across space in new ways, telehealth opens up new forms of mobility that hold the health system together. Third, that mobility is not just a requirement for care; mobility is itself a form of care. Mobility is wrapped up and intertwined in the way people experience and receive care in three ways: (1) through enabling rural communities access to specialist services, (2) through imaginaries of the possibility of care, and (3) through feelings of being seen and cared for by the State. These arguments contribute to the broader assertions of this thesis, that telehealth changes the nature of care and that care over telehealth extends beyond the screen.

To evidence these arguments, I draw on several interviews as well as observations and informal conversations I had in healthcare spaces. The ideas and experiences behind and woven through this chapter, however, are informed primarily by an amalgamation of the practices of mobility that constitute daily life in New Mexico beyond the clinic. These practices slowly accumulated into ethnographic practices themselves. While I had not initially set out to study mobility, forms of mobility became inseparable from this ethnography of telehealth; mobility as a lens formed across my fieldwork as a crucial way through which to understand New Mexican life. The people we come across in this chapter are mobile, they come in and go out. I pass some by, sometimes offering only quick glimpses into their lives; others, I stay with a bit longer. I attend to many different, often miniscule practices that ended up not being miniscule at all. Practices that defined life for myself and my informants as well as the ways in which the health system works, the ways in which beliefs and values around care are shaped, and the ways in which telehealth landed in this particular place.

The subsequent sections bring into ethnographic relief the ways in which mobility is an integral and inseparable component of care in New Mexico, and how telehealth shifts these mobilities and in turn, shifts care. In the next section, *Forms of mobility in New Mexico*, I explore the unique circumstances that encompass New Mexican mobility: car clubs, drive-throughs, car loans and loan repayment schemes, experiences of immobility, the cost of petrol, the socialities intertwined with the ability to move. This section grounds one of the arguments of this chapter—that access to healthcare in New Mexico requires particular forms of mobility—in the larger cultural context surrounding mobility in New Mexico. The subsequent section, *Healthcare as something that is not here* develops the understanding of the piecemeal New Mexican health system that I introduced in Chapter 4. Receiving care requires travel between different nodes in a largely disconnected and obscure network. I show that care is experienced as temporary and fleeting, and that New Mexicans feel that they do not have agency in this uncertain and unstable healthcare environment. The section on *Desired Mobility*

focuses on narratives of feeling stuck, financial immobility and the desire for better education, healthcare, safety and employment. I illuminate how the forms of mobility that are imagined as possible shape experiences and perceptions of the health system and care. In *Patient experiences of telehealth and mobility*, I present several patient perspectives of the ways in which telehealth has altered care in the form of new mobilities. The section *Mobility reproduces beliefs about where good care exists* focuses on several implications of these new mobilities: patient trust in the health system, experiences of stable clinical relationships and feelings of being cared for by the state. Finally, in the conclusion, I consider how these newfound mobilities contribute to a form of care that is fundamentally shifted in nature, and what this means for the New Mexican health system.

Forms of mobility in New Mexico

Mobilities are cultural, and as such, are central to the structure of people's lives (Jensen 2009a; Jensen 2009b; Salazar 2010; Vannini 2009, 2010). It is important to understand the dominant mobility cultures in New Mexico in order to understand the implications on daily life, the types of mobilities available to New Mexicans, as well as the ways in which people in New Mexico receive healthcare. Extending the discussions I introduced in Chapter 4, this section engages with the pervasive culture of transport via personal vehicles in the state, as well the sparse public transport systems.

People's reliance on private vehicles and the inaccessibility of functioning public transit systems are found in many corners of the US and are recognised as core aspects of American culture (Miller 2001). Yet, the spaces through which people move, the resources available which both hinder and necessitate such movement that I describe in this chapter, are in fact, very particular to New Mexico. A wider form of American culture, the car, is refracted through an extremely localised way of living, and is understood and experienced as a distinct local culture (Bright 1998). Mustangs, for example, are one of the most common types of car on the road, their engines revving at stop lights. Pickup trucks are also common. Some are so large they have four wheels on the back axel and take up the space of an entire lane. The car culture in New Mexico goes beyond a basic mode of transportation. There is also a facet of this culture involved in the repair and customisation of old automobiles. At the New Mexico State Fair and parades throughout the year, people drive vintage, classic cars that they have restored themselves, sporting "Built-not-Bought" bumper stickers. Every Sunday from 6pm on Route 66 between 1st and 8th streets in Albuquerque, the local car clubs gather. Driving back and forth for hours, they play music loudly and show off their low-riders, hydraulic systems and under-glow LED systems that radiate rainbow lights from the bellies of their cars. People living nearby bring camping

chairs and blankets to watch the weekly entertainment. Drivers from outside the city, who are not aware of this Sunday tradition, get stuck unknowingly in this slow-moving parade of cars.

Fast food chains found in strip malls on nearly every road have drive-through windows for their many customers who prefer the convenience of picking up food for the road, rather than sitting down inside the restaurant for a meal. In Clovis, the Coffee Depot is recommended to me by several employees at the clinic. The business is a spruced up shed in the middle of a large parking lot. It is drive-up only; there are two lanes, one on either side of the shed. Looking out onto each lane is a window where the one, sometimes two baristas lean out to take their customers' orders as they sit in their cars, engines idling. Lines build up on either side. The baristas have come up with a good system: they take the order, prepare the order and take the payment from one car, while following close behind with the order for the car in the opposite lane. This keeps the lines moving quickly. Most mornings, as I drive by on my way to the clinic, lines of four or five cars on either side sit, waiting for their turn to order. This particular culture of driving and mobility in New Mexico permeates and shapes many aspects of daily life.

Cars are imperative for the conduct of many aspects of life in New Mexico. Along with rent, many people I meet are also making large monthly payments for a car they have on loan. Loaning a car is an option for someone who might not have enough money to buy one. I often hear about people saving to buy a car or saving for a car payment. Signs advertising 'car loans' are omnipresent on the roads. The car culture contributes to the geography of economic struggle in New Mexico. Many neighbourhoods have pawn shops and stores that will 'buy any car'. Many cars on the road have dents, broken windows or scratched paint; drivers get into accidents though do not have enough money to pay for repairs. On the radio, the location and details of car crashes are reported often. In the morning, shattered glass glimmers on main thoroughfares, waiting to be cleaned up from an accident the night before. Loan advertisements come on between songs on the radio offering to help people with their credit card debt, or to give 'cash for cars'. Julio, a patient at the Clovis Clinic, shared that he is doing school part time so he can keep his job and work toward paying off his car. Julio's physical mobility, his ability to move around, is a priority and involves postponing the social mobility he hopes to gain by completing a degree. Elena, another patient, shared how she was not able to finish high school. Her car kept breaking down, making it difficult for her to attend classes and ultimately leading her to drop out of school. While cars can enable multiple types of mobility in New Mexico, their absence and inhibitory costs can often contribute to forms of immobility.

At a Mental Health First Aid training in a neighbourhood in the south-western part of Albuquerque, I met Maria. She was born in Albuquerque and had lived there her entire life. At the time of the training, Maria had been experiencing homelessness and had never owned a car. In our brief encounter, I mentioned offhandedly that I had been conducting several interviews in the north-eastern part of the city. Maria told me that she had heard that part of Albuquerque was nice but that she had never been there. Without a car, she was unable to move very far even within Albuquerque; there was no easy way to travel from her neighbourhood to one across the city. Her reality of having lived her entire life in Albuquerque but never having the opportunity to visit the far side of the city makes visible the particular mobilities that are enabled in the city, and those that are not.

May, a patient at the Clovis Clinic, told me that she used to see a doctor in Portales, a small town 20 miles southwest of Clovis, for her primary care but the trips got too expensive with all the driving back and forth. When we spoke, she was still trying to find primary care services in Clovis. Being able to afford a car and petrol in New Mexico not only enables people to receive healthcare services that otherwise might not be accessible, but it also contributes to their sociality and familial relations. Marjorie, an older woman who received telehealth services at the Clovis Clinic, told me proudly that she was a great grandmother, as she waited for her appointment. She did not have the chance to see her great grand babies often, though, she shared. They lived in Portales and she could not afford petrol to make the trip to visit them. Many patients I met at the clinic did not have time after their appointment for an interview because they were either getting picked up by a family member who had been told to arrive at a specific time, or they themselves had to leave from their appointment to go pick up someone else. In the context of navigating daily life on low-income or sometimes in poverty, car sharing with family and friends was an important form of kinship and exchange.

As for public transportation, Albuquerque and some of the other larger cities in the state had bus systems. I was told by my landlord, neighbours, contacts at the University, friends and informants to avoid the buses at all costs; "*they are unsafe and unreliable*". I had embedded myself within a community of practice who avoided riding the bus and perceived that particular mode of transportation as dangerous and unsatisfactory. In combination with this advice and the ways in which I had felt unsafe as a pedestrian, I never rode the bus throughout the year I lived in Albuquerque. My inexperience with the public transport system is a limitation in understanding the lived experience of New Mexicans who rely on buses to navigate the city and highlights how positioned mobilities are.

There are some longer haul buses traveling between Albuquerque and Santa Fe, New Mexico's state capital, as well as to larger cities in neighbouring states like Phoenix, El Paso and Oklahoma City. There

is also a railroad system throughout the state. Besides the occasional Amtrak trains that have routes connecting Albuquerque with Colorado, Texas and Arizona, the Rail Runner—named after New Mexico's state bird, the Road Runner—offers a service that runs several times a day between Albuquerque and Santa Fe. The train takes 40 minutes longer than the hour it takes to drive between these cities, and it drops passengers off about half a mile away from the central Santa Fe plaza. While the train station in Albuquerque is connected to bus routes running through the city, enabling someone to reach the train and travel to Santa Fe without a car, many of the stations on the north-south route drop passengers off in places without any further public transport infrastructure. Kewa Station, for example, about halfway between Albuquerque and Santa Fe, is 2.5 miles away from the closest community, Kewa Pueblo. With no buses or further public transport, anyone traveling to or from Kewa Pueblo via train either requires a ride in a personal vehicle, or the time and health to walk the 50 minutes along Indian Service Route 88, a two-lane highway without sidewalks which connects the station to the Pueblo. The Rail Runner's Kewa Station is an example of how public transport systems in New Mexico are not designed to be fully public. Transport on these systems requires facilitation from private transport; public transportation in New Mexico relies on individual forms of mobility.

With the limited connectivity of public transportation infrastructure throughout the state, how do people move if they do not have a car or money for petrol? As expressed above, some people depend on family members and close friends for rides, structuring their days and their lives around the schedule and mobility of others. Others depend on low-income support transport: the Sun Van in Albuquerque and the Clovis Area Transport System (CATS) in Clovis, for example. While these systems offer free rides to people who fall in a particular income bracket to healthcare appointments and to the grocery store, they require advance booking. As multiple individuals may book a ride on the same day, riders often need to wait for their compatriots to be picked up and dropped off before they arrive at their stop. These systems, while free in terms of monetary expenditure, require the time, energy, planning and patience of those who use their services.

Carlos, a patient at the Clovis Clinic, comes up to the front desk after his teletherapy appointment. He asks Amber, the office manager, to make a phone call. Amber picks up the phone, dials and soon says into the receiver, "*This is Amber from* [the Clovis Clinic]. *Carlos is ready to be picked up*". Carlos thanks Amber and retreats into the waiting room, finding an empty seat by the window. I ask Amber if there is a ride service for patients. Amber explains that Carlos is able to get rides to and from his appointments through his health insurance, Medicaid. "*As long as they're healthcare appointments*", Amber emphasises. Half an hour later, Carlos is still sitting by the window in the waiting room. He

returns to Amber at the front desk wanting to know when his ride will be here. Amber picks up the phone to call the ride service again. She hangs up and explains to Carlos that the driver who was initially going to pick him up is now making a much longer drive to pick up a patient in Tucumcari, an hour and a half away. The service is going to send a different driver to transport Carlos. Carlos expresses frustration, he had not expected to have to wait so long. It is unclear to me why there was a miscommunication regarding the first driver and why they were now headed out of Clovis, rather than coming to pick up Carlos. I do not ask about it, however, as the office is busy; Amber is already making another phone call and a line of patients is starting to form at the front desk. After another 20 minutes, Carlos' ride still has not arrived. He comes back up to the front desk to ask for Amber to call the ride service again; it has been nearly an hour since his appointment ended. Without access to a car or a ride from relatives, Carlos relies on the publicly provided health insurance for rides to his appointments. I am not sure how much longer Carlos had to wait before his ride came—if it ever arrived. I went to observe another patient's appointment and after the hour of this appointment, Carlos was no longer at the clinic.

The cultural dependence on cars and individual mobility in New Mexico offers important context to the inequities and forms of mobility that shape the way people are able to move throughout their daily lives. This culture shapes the way the health system has been designed and it structures the ways in which people access healthcare on a daily basis. In the next section, I attend to the meanings and understandings New Mexicans attach to this culture of mobility as they engage with the health system.

Healthcare as something that is not here

In New Mexico, healthcare is often associated with leaving home; with being away from family; having to take time off work and take the kids out of school; with traveling and moving. For my informants in Clovis, healthcare was often something that was not local, that did not happen 'here', that was not received 'here'. Many people in Clovis travel to Amarillo or Lubbock, cities in western Texas, for specialist care. These cities are both 90 minutes away, which means travelling there and back in one day is possible. Albuquerque, on the other hand, the closest place in New Mexico that offers many specialist services, is three and a half hours away. This is far enough that it often necessitates an overnight stay. People in Clovis travelling to the larger cities in Texas for care usually try to make a day out of it. They invite friends to come along, they go to a restaurant that does not have a chain in Clovis, they go to Costco and Target for their bulk shopping, they might see a movie at one of the big cinemas. Steve, a middle-aged man who travels to Lubbock every three months to meet with his cardiologist, tells me he has made the mistake of scheduling these appointments early in the morning. Even though

the Texas border is only 10 miles east of Clovis, the state of Texas is in a different time zone: one hour ahead of New Mexico. Steve explains how several times he has made an appointment at 8am to see the cardiologist. "*That's 7am in New Mexico. And the drive is an hour and a half. And I like giving myself some extra time just in case I run into traffic. So I've had to wake up at 4:30 in the morning*", he shares. "*Now I always book my appointments for early afternoon*".

Shirley-Ann, an older woman whom I meet while she waits for her appointment at the Clovis Clinic, tells me she goes to Lubbock to see a cardiologist three or four times a year. As she can no longer drive, her daughter takes off work to take her to these appointments. Luckily, her daughter has recently started a new job as a home health nurse and her schedule is fairly flexible. She chose this job so she could have more flexibility to take care of Shirley-Ann. Another patient at the Clovis Clinic, Ruby, has just moved back to Clovis after spending four months in Albuquerque living with her daughter. She had cancer and needed both chemo- and radiation therapy. Although Clovis has a small radiation oncology department in the local hospital, Ruby had no way to get to the daily appointments. She relocated to her daughter's house in Albuquerque for the duration of her treatment so she could have some extra help and get a ride every day to the oncology centre there. "*I'm glad to be back in Clovis*", Ruby tells me. Albuquerque was lonely, as her daughter was often working and she was far away from her community and Clovis friends. Individuals and families in New Mexico have created their own forms of mobility and sociality in order to gain access to the otherwise inaccessible speciality healthcare services.

Many people I meet in Clovis refer to the area as a place without a lot of resources, particularly in comparison to somewhere else where more resources exist. "*There aren't as many mental health facilitators out west* (in New Mexico) *as back east*", expresses Carly, a woman originally from New Jersey, as she waits for her tele-psychiatry appointment. "*Medical care isn't as great here. There aren't as many doctors out here. We travel to Lubbock a lot for specialty care*". Carly tells me she wants to go back to the East Coast where her family is and where there is better healthcare. She is in Clovis because her husband is in the military. They moved their family "*out here*" a year ago. Another woman I meet at the clinic, Jan, tells me she has been seeing the clinic's psychiatrist "*over the screen*" for six years now and that she has grown used to it. Jan used to see a psychiatrist in-person when she lived in California, where she is from, "*but here*, [in Clovis], *[care] is over the screen*". Kathy, another woman I speak with while she waits for her tele-psychiatry appointment, tells me that the psychiatrist is the only doctor she sees "*over the TV*". However, Kathy shares, all her other doctors are in different places: "*I have to go here and here and here and here*", referring to the many different locations she needs to move between in order to receive care. Kathy tells me how in Colorado, where she is from and where

she hopes to move back to soon, she was able to see all her doctors in the same place. "*I'll also be able to see a psychiatrist in-person*", she mentions as she imagines her life in Colorado. Not only do other places have more healthcare providers, health systems elsewhere are imagined by my informants in New Mexico to be more comprehensive. Instead of piecemeal care cobbled together by individual patients, involving travel between multiple locations and meetings with virtual doctors, places outside of New Mexico are imagined to have care all in one place as well as stronger systems dictating how patients should navigate that care.

The perception that good healthcare did not exist locally extended to those living in the better-resourced, larger cities in the state. During my first few weeks in New Mexico, I meet with Frank, an older man who had worked nearly 40 years in the communication industry and was looking forward to retirement. Frank praises Albuquerque for its sunny climate and warm days, even in the winter. "*It'll snow in the mountains overnight, so I'll go skiing in the morning. By afternoon, once everything heats up down here in the valley, it's perfect weather for playing golf*". I wonder out loud why more Americans do not consider Albuquerque when thinking about retirement. The temperate weather and opportunity for outdoor activities often attracts older populations towards other warmer locales around the country: Florida, California and Texas, for example. "*The state can't support retirement communities, there's not enough healthcare here*", Frank explains. Several other informants living in Albuquerque had stories of their own or from close friends of having to travel elsewhere for care. A professor at UNM told me about his recent heart surgery at the Mayo Clinic in Minnesota. One of the University's telehealth programme coordinators had been in Florida the year before for a minor surgery. A close friend shared how a young member of her church had fallen extremely ill after suffering a brain aneurism and had been sent to Colorado for surgery and subsequently to Illinois for long-term recovery. In fact, this church member's whole family moved to Illinois to be closer to extended family and long-term care resources. When I asked why this church member would not seek rehabilitation services in New Mexico my friend responded, "*we don't have much around here*".

Healthcare as something that is not 'here' was reinforced by the nearly constant sound of helicopters overhead in central Albuquerque, transporting patients from rural hospitals to the three biggest and best resourced hospitals in the state, all sitting within one square mile of one another in Albuquerque. For patients like Emilia, whom we met in the opening vignette of this chapter, helicopter transfers were the only way to access specialist emergency care. These transfers come at incredible expense—each costing upwards of $30000 (FAIR Health 2021)—nearly all of which is shifted onto the patient to pay. Many patients cannot afford this cost and do not pay, leaving the state health system to foot the bill. For a system already struggling financially and unable to provide care to much of its population,

these costs are incredibly prohibitive. While in New Mexico, I met with several nascent telehealth programmes working to set up telehealth in emergency rooms in rural hospitals—for behavioural health emergencies as well as neurological (Whetten et al. 2018) and paediatric (Cotton et al. 2020) emergencies—as cost saving and resource allocation initiatives. These programmes aimed to triage patients with input from specialists based in Albuquerque, enabling more informed decisions about who requires an emergency helicopter transfer and who can be monitored in their local, rural emergency room.

Further, healthcare was not 'here' in New Mexico in the form of expectations. Several of my informants expressed surprise and even reverence for doctors who had come either to Clovis from another part of New Mexico, or to New Mexico from out of state. "*We are blessed to have them in New Mexico*" shared an administrator at the New Mexico Primary Care Association, referring to several specialist physicians who had recently come from out of state to provide care in New Mexico. Many New Mexicans I met felt thankful to have a doctor in their community, or to have an expert working within a certain state-level organisation. "I*t's a miracle we have him. We haven't had a psychiatrist in years*", said Carol, a patient at the Clovis Clinic referring to Dr Sánchez, the psychiatrist she sees over telehealth. Carol expressed worry about how she will get her prescriptions if Dr Sánchez decides to end his work with the clinic. She mentioned that she often tells Dr Sánchez, "*I hope you never leave*". Carol's concern is not unfounded: many rural residents, including those in Clovis, have long struggled to find stable, accessible and long-term specialist care. Many rural residents have experienced a doctor leaving; often this has been experienced more than once; for some, it is a recurring experience, happening every few years. Although patients are often staying in the same place, their care is frequently uprooted.

Professionals were often described as returning "*back east to be with family*" – a phrase I heard multiple times. Danielle, a woman in her 40s receiving therapy services at the Clovis Clinic, told me she used to go to Salud Clinic in Clovis for her primary care, but she was currently trying to change clinics. She was tired of Salud Clinic; "*the doctors there are leaving all the time*". It often felt to me that my informants did not believe that New Mexico deserved such highly skilled professionals, or perhaps, it was that they were not used to highly skilled professionals being in or staying in the state. These expectations of the fleeting temporality of healthcare professionals also point to a lack of agency that patients and even health workers experienced around whether these providers will stay. It is out of patients' control if a provider chooses to leave; and if a provider chooses to stay, then it is a fortunate and uncommon experience. Alongside these experiences of impermanence and insufficiency in the health system, my informants shared dreams of wanting to leave to somewhere

with better infrastructure. These desired mobilities, which I explore in the next section, contribute to the culture of mobility in New Mexico and frame perceptions and beliefs around the state health system.

Desired Mobility

Another way mobility crept into the lives of my informants was in the form of desired mobility. "*Nothing is here. I want to leave. By all measures* [New Mexico]*'s not doing well*", Joyce, a patient at the Clovis Clinic told me, reflecting the sentiment of many people I met in New Mexico. New Mexico is one of the poorest states in the country. The state struggles in terms of other national rankings, as well. It ranks 49th out of 50 states for education, which measures both attainment in higher education as well as enrolment, standardised test scores and graduation rates from preschool to 12th grade (high school) in public school systems. Crime and violence are often mentioned as reasons my informants want to leave; New Mexico currently has the third highest rate of property crime in the country (Statista 2021).

Joyce is in her sixties. She tells me she is originally from Dallas where her whole family still lives. She came to New Mexico on a scholarship to New Mexico Tech a long time ago. I tell her I have heard New Mexico is called the Land of Entrapment. "*That's exactly what I was going to say*", she responds. The phrase is a play on the official state nickname, Land of Enchantment, and alludes to the state's high rate of poverty and lack of economic mobility. She tells me about her good friend from the Dominican Republic who came to New Mexico and used to say the same thing, "*you get stuck here*". This friend, she tells me, was ultimately able to leave to California.

Many people I met in New Mexico have dreams of leaving but do not have the means to do so. Even though the cost of living in New Mexico is less than many other states, the average income is also less. Saving enough money to move and live in another state is difficult, often impossible, leaving many people 'stuck' in the state. I met several people who were caught in cycles of debt, seeking out high interest pay-day loans in order to pay back their credit card bills or other types of debt. In Clovis, patients, employees at the clinic and members of the community talk about one day leaving either to Albuquerque or to Amarillo and Lubbock in Texas. In Albuquerque, I hear about dreams of leaving to Colorado or California. I hear stories about the people who have been able to 'get out' from those who have not. A good friend, originally from Israel, joked that after five years of living in Albuquerque she had become fully local to New Mexico as she now hopes to one day move to Denver, Colorado.

In the Clovis Clinic reception office, between checking in patients, answering phone calls, making paper copies and scheduling new appointments, there was also the constant chatter amongst the support staff. When I arrived one morning, the staff were discussing whether one of the in-person therapists had returned from her holiday in Las Vegas, Nevada. "*Is Kristen still on vacation?*" Tracy asked the room. Renae spun around in her chair, turning away from her computer screen. "*Maybe she won a lot of money in Vegas and she's not coming back*". Amber, the office manager, shut down the gossip: "*nah, we would've heard about it by now*". The three of them chuckle and return to their work. While this short conversation was held in jest between friendly co-workers, it offers a glimpse into a much larger aspect of my informants' psyche, of their daily life, goals and dreams. It alludes to a general, shared understanding that if it was financially possible, by some fluke of good fortune, people would choose to leave.

Leanne, a social worker at the Clovis Clinic told me that she was from the East Coast. She could not wait to get out of the small town she grew up in over 20 years ago, and as soon as she graduated from high school, she headed West. Arbitrarily, she ended up in Portales, taking classes at Eastern New Mexico University. At the time, moving across the country, away from her family and town to this place called 'New Mexico' had seemed exciting. However, after graduation, she had difficulty finding a job anywhere other than in the local area. She had been working in Clovis as a social worker for the past 15 years. She still had some student debt that she was working to pay off. She would have really liked to leave Clovis, she told me, but she was not able to financially. The only way she would be able to afford to go back to the East Coast is if she was to move back in with her parents, and that was not something she was willing to do. Her job in Clovis did not allow her to save enough money to move and start life somewhere else, without relying heavily on her family. She felt trapped there and was frustrated; she had not anticipated experiencing this form of immobility when she made the decision to come when she was 18.

Clarita had not lived in Clovis long when we met before her tele-therapy appointment. Her long, dark hair was held back in a low ponytail. She walked slowly, with a limp. She told me she was coming to the Clovis Clinic so she could get a prescription for suboxone, a medicine used to treat adults who are addicted to opioids. "*To help me get off drugs*", she explained. She and her husband moved to Clovis from Roswell with their daughter to take care of her father-in-law several months ago. "*God threw us a curve ball*" she said, explaining that soon after they moved to Clovis, her father-in-law passed away. Clarita told me she did not like Clovis. "*It looks like it's shrinking. Everything's shutting down. It's depressing as fuck*". She said, "*I'm stuck here with my husband and daughter, we don't have enough money to move back*". She told me how she did not have any friends in Clovis. Her best friend was

back in Roswell. This friend's son had just passed away from an overdose, though she had not been able to visit her friend as the trip back to Roswell was too expensive. "*I'm here with freaking shit nothing. All my family's back in Roswell. Money's tight. It's hard when you live pay check to pay check. I just looked in my wallet and found a dollar. How did that get there? Why didn't they leave a $20? A $100?*". She asked this as a joke, about an imaginary person who left a bill in her wallet. However, she was not laughing. She had not been working because of her health. She had arthritis and told me that "*everything*", all types of movement, made it worse. She used to do food preparation at Carls' Jr in Roswell but she could not anymore as there was not a chain in Clovis. Clarita was restless and angry. She wanted to move her family back to Roswell, back to the larger support system and stronger relations that she had there, but she did not have the financial resources to do so.

In addition to looking for greater economic opportunity, safety and better state support in education and healthcare, people in Clovis also desired the mobility to leave in order to make a "*fresh start*" somewhere else. Jason slouched in one of the black, faux leather chairs in the waiting room of the Clovis Clinic. He had arrived several minutes early for his appointment with Dr Sánchez, one of the clinic's three tele-psychiatrists. He was busy on his phone, scrolling through a long list of names and photos. The photos were portraits of different people taken from the shoulders up, all dressed in orange and all against the same grey background. I asked what he was looking at. He told me he was checking the local arrest list to see if anyone in his family had been arrested. Every day, the local Clovis paper publishes the jail log for the county jail. The jail log lists the full name, date of birth, race and sex of everyone who was arrested in the past 24 hours, along with their arrest photo and the reasons for which they were arrested. Members of Jason's family were arrested often. When this happens, he would go to the prison to "*put money in their books*". "*Their accounts*" he explained, when he saw that I did not understand, "*so they can make phone calls and get things from the commissary*". Jason told me he often goes to prison, too.

For people who had been in trouble with the law, Clovis felt especially small. "*Everybody knows your business, and everybody knows it pretty quickly*", shared Laura, another patient at the clinic. "*There isn't any way to get away from people sometimes*", she continued, "*when you're trying to start over, you made a mistake, you're getting out of jail or prison, trying to have a new life, people are still there, they still remember your past, they are still there to judge you*". It is difficult to find a job and otherwise make connections in the community when everyone knows your name, what you look like and the ways in which you have broken the law. The reality of being stuck, wanting to leave and not being able to financially, played an active role in the daily lives of many of my informants. Desires for a different present and for futures that may not unfold framed the lives of many of my informants. These desires

and the forms of mobility with which they were intertwined, were also shaped by the local health system and scarcity of accessible resources. In the next section, I present narratives of two patients at the Clovis Clinic who received telehealth services and who experienced altered mobility.

Patient experiences of telehealth and mobility

The health system in New Mexico depends largely on the movement of individual patients and families in order to function. Individuals form the bridges between the largely stationary nodes of the health system. Doctors can even be considered stationary as their time is so expensive. As travel costs are not included in billable services for insurance companies, it is not economically feasible for healthcare institutions to pay doctors to travel to see a handful of patients, when they could see a full panel of patients instead by staying in one place.

It is this individual-dependent mobility that connects health facilities, that makes up and holds together the health system. This partially helps to explain the effect of telehealth on the New Mexican health system: telehealth affords new mobilities. With telehealth, my informants in Clovis were able to see behavioural health professionals in their local clinic instead of driving multiple hours to Texas or Albuquerque. As telehealth enables patients and carers to cross space in new ways, it alters the mobilities that are typically required to receive care. What does the altered mobility afforded by telehealth mean for people in New Mexico and their experiences of the health system?

Joyce, one of the patients at the Clovis Clinic who we met earlier in this chapter, cannot drive anymore. Her eyesight, she tells me, has deteriorated since the chemo treatments she received for cancer a few years back. Joyce moves very slowly. She walks with an aluminium cane that branches into four small legs at the bottom. She wears big, gold bamboo hoop earrings and sunglasses. I never see her eyes.

I ask how she gets around town. She tells me the CATS bus is one option for doing her shopping, but that she does not like it because there was not much room onboard for her shopping bags. She says, "*you have to still fit into the same small seat with everything on your lap and by your feet for the ride home*". Her daughter, sister and niece are all back in Dallas, Texas. Her brother used to be there too, but he died. With no family around, she sometimes asks a friend to drive her to the shop so she can get groceries. Her friend drops her off, and then she calls her friend once she is done to get a ride back home. This reminds me of the young man I walked by on my way out of the local Walmart the night before. He was sitting cross legged on the ground, next to the Redbox DVD rental, with a few silvery

plastic bags bulging with food. Perhaps he too was waiting for a ride. Joyce tells me she does not ask others for rides often, though, as she does not like when people say 'no'.

She tells me she watches TV every day. She is up every morning for the morning news. When we speak, it is late morning. She is looking forward to getting home for the 12pm news, "*I hope to get back in time to see it*". She also watches the evening news, both at 5pm and just before bed. "*CNN is better than the movies*". The news is perhaps her only way to see the world. Stuck at home most of the time, without an easy way to get most places, Joyce's TV transports the world to her living room.

I ask Joyce about her sessions with Dr Sánchez, the tele-psychiatrist at the Clovis Clinic. She tells me, "*he always asks how I'm doing and if I need my medicines changed*". She tells me that at first, she did not like talking "*to the TV*" but it had since grown on her. She says, "*we haven't had a doctor in years since Dr Ortiz left*". Since Joyce cannot drive and does not have any family close by, if Dr Sanchez were to leave, she may no longer be able to access psychiatric care.

Luis, another patient at the Clovis Clinic, leans forward in one of the clinic's waiting room chairs, forearms resting on his knees. His hands are shaking. "*Tremors*", he explains. Luis tells me how he sees the psychiatrist "*over the TV"* and that if he could not see him over the TV, he would have to drive to Amarillo every month to see someone there. He tells me that he does not like the drive to Amarillo because then he has the whole car ride there to think. He meets with the doctors, and then has the whole car ride back to think more. He prefers coming to the clinic in Clovis to see the doctor over the TV. He does have to go to Amarillo for other doctors' appointments, like the doctor who helps with his tremors. "*Sometimes they're really bad*", he tells me, referring to his tremors, "*so bad*" he says, "*we wouldn't be having this conversation*". I ask him how he can drive to his appointments in Amarillo when his tremors are so bad. The trip is 100 miles or so. "*Very carefully*", he tells me.

For Joyce and Luis, being able to see a psychiatrist locally enables them to receive specialist behavioural healthcare that they otherwise might not have access to. Telehealth at the Clovis Clinic has altered care in the form of new mobilities. In the next section, I present the ways in which mobility has contributed to shifts in the experiences, feelings and beliefs associated with accessing that care.

Mobility reproduces beliefs about where good care exists

While most of the in-person therapists and support staff working at the Clovis Clinic and living in the surrounding area felt economically trapped and unable to leave, the mobility of doctors in rural areas

like Clovis was different. As presented in Chapter 4, many of the doctors based in Clovis were there temporarily. Most often, doctors were not there because they had connections with the community, but rather were there out of obligation, providing service as part of a visa programme or in exchange for scholarships received to attend medical school. Not only was healthcare something that people in Clovis had to leave their community to receive, when it was present locally, it frequently involved health workers who did not understand, or did not work there long enough to understand, the community's needs. People living in Clovis felt a lot of distrust in the local health system: specialised and 'good' healthcare is not here, in Clovis, many of my informants shared. Further, the healthcare that is 'here' is neither good nor permanent. This distrust in the health system and beliefs around where good care exists intersect with the mobilities of everyday life in New Mexico. The shifted mobilities in the context of telehealth contribute to the fermentation of this distrust and the reproduction of the belief that good care comes from far away.

Arturo, a chatty, older man I interviewed following his appointment with a tele-therapist at the Clovis Clinic shared, "[the therapists over telehealth] *aren't here. I trust them more. They are good at what they do because they aren't here*". I asked him to explain his thinking. "[The telehealth workers] *are people from the bigger cities*", he continued.

> "*They are more qualified because maybe they have more experience because the city's bigger and they see more* [patients] *and they have more schooling in what they do to bring them to where they are… Whereas* [the in-person health workers] *in this little rinky-dink place, I don't know where they had their schooling here, I don't know… the psychiatrist and the two therapists I see* [over telehealth]*, they're all from bigger places and that makes to me a big difference because they come with a lot of experience and so if anybody tries to take them from me I promise I'll stop getting help. Really, I'll stop getting help. I'm not going to get help from nobody here. Not nobody in this place*"

Arturo also shared a related belief, that health workers over telehealth had better intentions than those in-person in Clovis:

> "*it's a plus to have someone over the TV because they're really there to help… Albuquerque is so swamped with a whole lot more people than a little place like this. Could you imagine how many patients they have there? That they still took off the time to help the people here over the TV that don't have the benefit of having good doctors here, like the people who live in Albuquerque or California or other places like that. All I know is what helps a small little town like this is*

therapists and doctors that come from a bigger city… The people who are here [in-person] *are not caring, they're here for the pay check"*

Arturo's understanding was that health workers over telehealth knew there were disparities in the access to care in Clovis and they took time from their busy schedules in Albuquerque to provide care to the Clovis Clinic. Arturo also believed that the local health workers were not there for the same reasons; instead, they provided services to the clinic for their own benefit.

Finally, Arturo expressed two sentiments shared by many of the patients at the clinic. First was gratitude for receiving telehealth services and for having access to health workers who were based elsewhere. Second was the fear that telehealth services would be taken away. "*Whoever's responsible* [for] *letting us have that privilege of seeing people over the TV who have more experience, I'm just so grateful. It has really helped me a lot. I'm serious when I say I look forward to coming to see them. I feel a lot better when I leave from here… Are they going to take the TVs away or something?*"

Telehealth afforded doctors from other places the ability to be mobile in new ways, to provide care to patients in Clovis from a distance. This supported the shared understanding among many patients at the clinic that care over telehealth was better than in-person care because it meant that the health workers providing their care were from elsewhere; they were neither from Clovis nor embedded in the local health system. However, while the tele-psychiatrists had never been based in Clovis, all of the tele-therapists working at the clinic had previously worked there in-person. They all did their training in Clovis and had continued to work with the Clovis Clinic even after moving away. The tele-therapists even made explicit references to their connection to Clovis during their patient appointments. Yet, the idea that good healthcare came from elsewhere and that telehealth allowed access to this better care was a steadfast belief among many of my informants. "*You could go anywhere here in Clovis and ask anybody 'ok well how do you feel about seeing a doctor here or a doctor in Albuquerque'*", said Rebéca, a patient at the clinic. "*I bet you $100 they're going to say they'd rather see a doctor in Albuquerque*".

Another dimension of the shifted mobility that contributed to patient preferences for health workers over telehealth is the relative permanency and stability of that particular form of clinical relationship. Several patients at the clinic had been seeing the same tele-therapist and tele-psychiatrist at the Clovis Clinic for years. These health workers were not swept up in the constant influx and efflux of doctors into and out of rural areas that often leaves patients without care. They were neither perceived nor experienced by patients as temporary. With telehealth, these health workers could live in their

preferred community with the quality of life and desired resources for themselves and their families, while also providing long term care to underserved populations, like those in Clovis.

Being seen by health workers over telehealth also meant to several patients that they were seen by the state, that they were recognised as deserving of better care. This sits in contrast to the feelings of state abandonment discussed in Chapter 4. Telehealth, in this way, became what Street (2014) terms an "intense site of visibility work" (ibid., 13-14). The changes in mobilities involved with the use of telehealth as well as the shifts in care can also be understood, from the perspective of patients in Clovis, as shifts in visibility: rural communities are being seen by both health workers in other places and by the state. In this way, telehealth enables the provision of both healthcare and the sense of being cared for.

The use of telehealth changes the mobility of doctors, enabling doctors from far away to provide consistent and continuous care to patients in rural areas. For patients in Clovis, care from health workers over telehealth is distinct from those in-person: it is not implicated in the structures of corruption believed to underlie the local health system, it is neither temporary nor at risk of suddenly disappearing. Through this shift in mobility, the use of telehealth has led to stable, longer term care arrangements and it has reinforced beliefs among patients around where good care exists. Care is elsewhere, in larger cities, where doctors are better because of their access to better education and training. These beliefs among patients influence the ways in which they approach the health system, receive care, think about their health, as well as understand themselves as part of a wider state that has historically overlooked rural communities.

Conclusion

Telehealth is not an isolated technology incorporated into an isolated health system. The use of telehealth unfolds within and shapes the meshwork (Ingold 2007, 2011) of everyday life in New Mexico, including the health system, health and care of the population. The material world, the landscape and geographies of everyday life are not things with which we interact, "but the ground upon which the possibility of interaction is based" (ibid., 2011: 93). Through this incorporation in the meshwork, telehealth has changed the possibilities for how relations and connections between people, spaces and institutions exist and evolve. This chapter has focused on these changes in the meshwork through the lens of mobility.

Mobility is built into the culture, the landscape, the imaginations of daily life, as well as the dreams and hopes of New Mexicans. Individuals are often responsible for physically navigating the dispersed health system in order to access care. In this chapter, I attend to the interface between these mobilities and the use of telehealth, and ultimately make room for explorations of mobility as a component of care.

I argue that telehealth shifts everyday mobilities within the New Mexican health system and that, through these shifts, the use of telehealth affords new possibilities for both care and for health. This happens through access to care in practice as well as experiences of care in the imagination. For example, some worries of patients at the Clovis Clinic around finances, getting medicines and being able to see a doctor were quelled—or, cared for—by the use of telehealth. These newfound mobilities—and motilities (Leivestad 2016)—made accessible imaginations of care that were, with the use of telehealth, possible. Mobility also fostered feelings of state care: patients at the Clovis Clinic did not feel completely abandoned by the health system; they no longer had to travel great distances to be acknowledged and seen. In this way, mobility encompasses another form of care: care as visibility to the state. In these ways—access to care on the ground, care through the imagination and care from the state—mobility itself emerges as a component of care. It is partially through these newfound mobilities that the health system cares for and cares about rural patients.

Alongside the mobilities directly implicated in accessing care, the mundane mobilities that make up everyday life also change with the use of telehealth. For example, the trips to see and stay with family or the day trips to the big city with friends. There are also the people who want to be increasingly mobile; those who want to move around and who desire to leave. Instead of enabling people to have more economic mobility to move elsewhere or improving the existing care in the geographically marginal and underserved areas of the state, telehealth addresses a symptom of the health system. In her monograph, Self-Devouring Growth, Livingston (2019) attends to the practices of "[pouring] money and hopes into technologies to solve our problems whose roots lie much farther". Are telehealth technologies and the new mobilities—as well as motilities—afforded by them just further contributors to this "self-devouring growth"? Looking forward, it is important to consider the types of new spaces and social relations that are generated, and those that are inhibited, through the use of telehealth and the altered mobilities through which people receive healthcare.

Finally, one promise of telehealth is to transform space by enabling access to care across distance. However, as I will show in future chapters, the imaginaries of reproducing in-person care virtually are not completely realised because the care provided over telehealth is different in nature. In the frame

of motility, there is a divorce between the health system's imagination and the reality of the altered mobility afforded by telehealth; these new mobilities do not enable access to existing forms of care, but rather to new forms of care. Importantly, this altered mobility does not happen in a vacuum. The use of telehealth has reconfigured other aspects of the health system as well, including care itself. In the following chapter, Chapter 6, I explore the intersections of the spaces and materials implicated in care and the ways in which these shift with the use of telehealth.

Chapter 6: Telehealth Shifts the Space and Materiality of Care

When I first arrived at the Clovis Clinic, staff always pointed me toward the 'IT guy', Adam. Adam also always sought me out during every visit. Knowing that I was researching the use of telehealth at the clinic, he saw me as a compatriot of sorts; someone who was also interested in and curious about 'tech stuff'. He printed out articles for me about the use of telehealth in different settings. He always invited me into his office under the premise of learning more about how my project was progressing, though we rarely discussed my work. His office was cramped and windowless. It was accessed through a larger office off one of the main hallways in the clinic. It felt like a storage closet, tucked away from the waiting room, front desk and clinical rooms. His office was stuffed from the floor to ceiling with unused computers, screens and wires, with a small space carved out for his desk, chair and another chair in which I sat. There were other items in the office, too, adding to the mountains of gadgets, like two crockpots that Adam would whip out for the annual Fourth of July cookout for all clinic staff. His desk was covered in stress balls, paperwork, sometimes a half-eaten sandwich. On my first visit, Adam took me down the hall to another cramped closet, where 'the internet' was stored. All the connections for the broadband and telephone wires were in there. My eyes glazed over as Adam explained how everything worked. He let me hold a small strip of fibre optic wire, a nearly microscopic glass fibre wrapped in colourful rubber. To me, it looked like a mess of wires and blinking lights. To Adam, this was telehealth.

*While Adam was responsible for everything telehealth related, he was also responsible for the electronic health record, the telephone system, "*everything computers*" he told me. He explained to how the system works: a software system they had been using since 2015 downloaded onto the clinic's hardware that looks and functions a lot like a HIPAA[22] compliant Skype. On the system's interface, there is a list of all users: Adam and all of the clinic's telehealth and front desk staff. Users communicate with each other through a chat function or a video call. The internet that supports this system at the clinic is fibre optic, which is ideal; "*[*the telehealth system*] is always crystal clear*", Adam tells me proudly. Though there are still connectivity issues, he says, which are almost always due to the tele-*

[22] The Health Insurance and Portability and Accountability Act (HIPAA) is a federal law in the United States that prohibits health workers and healthcare institutions from disclosing protected health information without a patient's consent. The HIPAA guidelines on telehealth specify that any electronic system used for the communication of protected health information must: 1) be accessible only by authorised users. Authorised users include health workers who have completed HIPAA compliance training and have appropriate grounds for accessing the protected health information. 2) Enable secure communication. Unsecure communication channels include email, SMS and Skype. And 3) Monitor communications in order to prevent breaches. This includes having mechanisms in place to remotely delete communications if necessary (HIPAA Guidelines on Telemedicine 2022).

*therapists' and psychiatrists' home internet. Part of Adam's role is to make sure the staff who use the system are able to maintain strong digital connections during their patient visits, and to troubleshoot when there are issues. "*Most things can be fixed by turning them off and on again*", he admitted. Adam also led the staff training on the telehealth system: getting them set up with laptops, speakers and microphones, accounts on the software, setting up mock appointments for staff to practice using the system during a patient encounter.*

Whenever I was in his office, I felt desperate to leave; partially because of the slight claustrophobia I experienced with objects looming over me on all sides, exacerbated by the broken computer chair I was offered to sit in, rising just two feet off the ground and swivelling in such a precarious way that if I were to lean too far in any direction, I'd be in danger of falling off completely. My desperation to leave primarily, however, was because when I was in there, I felt like I was missing out—missing out on observing and chatting with the support staff in the front office, observing interactions between therapists and patients, asking patients if they would be interested in participating in my research. To me, all the interesting stuff—the spaces, materials, practices and relations of telehealth—was out there, in the public and functioning spaces of the clinic. To the clinic staff and Adam, my focus of interest was contained within the IT sphere, located in this small, overfilled office, in the computers, in the ether where online communication happened, where telehealth was perceived to exist. While initially rejecting this—squirming out of any possible situation that might lead to me sitting in that low chair, often for over an hour, politely saying things that might hint at my desire to leave—I later came to appreciate this particular divorce. Many of my informants understood telehealth as something solely in the tech realm, even though they were themselves involved in the use of telehealth on the ground, embedded relationally in spaces and materials in ways that were beyond the 'technological'.

What I had initially wanted to move away from, what I had assumed would not be part of my work on telehealth—the 'technical'—was, in reality, a crucial element in understanding how many of my informants experienced and perceived telehealth. I juxtapose these understandings with another vignette, whereby I present the complexity of the use of telehealth, showing how its use extends far beyond the technical aspects central to my informants' conceptions above. In presenting these two ethnographic accounts, I wonder how to grapple with both the complexities of telehealth beyond the technical, and the ways in which telehealth is viewed largely as its technical components.

Sandra and I sat at the large table of an empty meeting room within the UNM Health Sciences campus, where she worked in healthcare research. We had met through her colleagues at the University. A few years back, Sandra worked as a peer support worker in a small northern New Mexican town at a peer-run, drop-in centre for people struggling with substance abuse. During this time, the drop-in centre offered telehealth appointments with substance abuse counsellors as part of a pilot project. I asked Sandra to participate in an interview to learn more about her experience with telehealth at the centre.

*This pilot project was formed following the closure of many behavioural health providers across the state from 2013-2015. According to Sandra, this closure devastated the small town. Some clinics only had one staff member with the credentials to prescribe suboxone treatment—a prescription medicine used to treat opioid addiction. The primary general practice clinic for the town only had one behavioural healthcare provider. Sandra explained how, in her view, "*there have never been enough providers. Even before 2013, people just couldn't get help. In this town*, [the closure of services]* was really, really bad. All behavioural health people just went poof*". The nearby hospital was overrun with patients. Sandra tried multiple times to get one particular client from the drop-in centre scheduled for an appointment at the hospital, but there were no appointments available. This person was not able to get help and soon after died by suicide.*

The drop-in centre included a reception area and a large room where group sessions and meetings were held. As there was no other space, a small partitioning screen was set up in one corner of the large room, concealing a small desk and computer, offering clients some form of privacy for their telehealth appointments. Since the telehealth room was shared with the large meeting room, telehealth appointments had to be scheduled around functions in the room. For example, as there was a support group meeting every day at 12pm, telehealth appointments often had to be scheduled in the morning.

The process of getting set up with the telehealth system and scheduling an appointment with a counsellor was complicated. Clients first had to make an initial appointment to come into the centre to register on an online portal. Following registration, clients could then schedule a second appointment at the centre to speak with a counsellor over telehealth. The initial registration process involved answering questions online. Many clients did not have computers at home, so Sandra would often sit with them at the centre's computer station, helping them go through the process to get set up to receive services.

However, the online registration comprised only a fragment of what this process involved for each client. In order to schedule this initial appointment, clients had to call in. Many clients did not own phones. Some had 'Obama phones', the popularised name of the Lifeline Assistance program— free phones given to people receiving assistance from specific state and federal aid programmes. These phones hardly worked, unfortunately, as at the time there was little cell phone reception in this part of the state. Once an appointment was scheduled, clients also had to figure out transportation to the drop-in centre. Although the centre was just off the main street in town, many clients did not have cars and were only able to come to the centre when they were able to get a ride from family or friends.

After scheduling an appointment, getting to the centre and completing the registration process, clients could schedule an appointment with a counsellor. This appointment would almost always be on a different day as the large room with the desk and computer would be in use in the afternoon. To receive counselling and suboxone treatment, clients were also required to give a urine sample before their appointment, which could be collected and read at the lab down the street. Sandra explained how clients would need to schedule a lab appointment earlier in the morning on the same day as their counselling appointment so their counsellor would have access to their lab results. Clients then had to get a ride to the lab, give a urine sample, wait for the processing, and then walk down the street to the centre for their appointment.

*Outside of these complicating factors, Sandra mentioned a number of times how much a client "*had to really want treatment*". Among the Hispanic and American Indian communities living around this town in particular, there was stigma around mental health. It was often not acceptable to share mental health issues outside of the family. Further, drug use is often inter-generational within families. Sandra explained that if family members from older generations did not believe in getting help, seeking help could mean leaving the family. Sandra also observed that for many people in this town, drug addiction co-occurred with other mental health issues. Many people grew up with trauma from some history of abuse.*

Sandra's position at the walk-in centre involved facilitating the telehealth pilot project. This entailed a vast coordination of efforts, timing and planning, navigating the particular challenges of an underfunded and under-resourced health system and the complexities of bringing together people, materials, spaces and technologies in a way that might lead to some form of care.

Introduction

Sandra's experience of the telehealth pilot project stands in stark contrast to the ways in which telehealth is approached and understood by staff like Adam at the Clovis Clinic. Her experience was particularly striking to me as it offered a complex account of the assemblage in and around what care involves and what care can be. In her case, care involved computer skills, telephone reception and a ride into town. It required an empty meeting room, a nearby lab, a supportive family, a client who was both motivated to receive treatment and was well enough to make their appointments. Not to mention the technology, stable internet connection, available counsellors and software to foster the digital connection.

While the technical aspects of telehealth are necessary for its use—maintaining certain levels of internet connection between both parties, troubleshooting connection mid-session, navigating updates and interfaces with other systems like electronic health records—this chapter describes the spaces and materialities of telehealth that are integral in the care that is provided. It focuses on the ways in which telehealth extends beyond its technical infrastructure. Sandra's experience demonstrates how telehealth is implicated in much wider and complex processes than an isolated video call. Telehealth involves an intricate web of relations between people, materials and spaces that extend much farther than the basic technologies involved in telehealth and the conventional spaces in which care is thought to happen. In this chapter, I argue that it is these components of telehealth—particularly the 'mundane' materials and spaces, and the ways in which they shift and articulate—that have both been largely unconsidered in the planning and implementations of telehealth initiatives and yet are crucial to and irreducible from the care provided.

In doing so, I explore the reconfigurations in the spaces and materials implicated in care over telehealth, and how these shifts in turn, lead to changes in care itself. More precisely, I attend to the intersections of space and materiality in specific practices of care that are integral to the various forms of care involved in the practice of telehealth. The spaces, materials, protocols and structures used in healthcare are as necessary for the production of care as the people who use, follow and operate within them. Drawing on ontological orientations and collapsing the distinction between the spaces and materials of care and care itself, I engage with space and materiality not only as part of care, but space and materiality as care in order to argue that materials and the spaces in which they function are forms of care in and of themselves.

A material and spatial ontology of care

This chapter's ontological approach to space, materiality and care in the use of telehealth in the New Mexican behavioural health system is informed by recent and ongoing debates in material culture. Anthropological interest in the material gained traction and form through humanist inclinations: materiality as a lens through which to understand the social and cultural world, to ultimately explore what it means to be human. Humanist approaches rely on the distinction between the human and non-human to examine the reciprocal influence of materials on people, and people on materials (e.g., Miller 2005), engaging with things through the application, employment and refinement of existing lenses in order to interpret, superimpose or extract meaning.

'Posthumanist' (Henare et al. 2007) approaches, conversely, contend that objects are social not just because of the sociality people extend onto them through association; they are social in their own capacity, "actant[s] in [their] own right" (Latour 1996b: 239) with their own ontology. This rejection of the often-implicit hierarchy between people and objects is useful for studying the provision of care, as caring encounters are not simply made up of active people using passive things. Rather, materials are dynamic counterparts in the care they help to produce: structuring and shaping space, transforming and defining what care is and how it is provided (Winance 2010). Through applications of this approach—such as, Latour's Actor Network Theory—the consideration of objects as determinants of the social world alongside human actors becomes, instead, a consideration of a material-human hybrid. The thing, then, is diluted; ultimately irreducible from the ontology of the network (Henare et al. 2007).

The aim of the process is what Holbraad (2017) later came to label 'post posthumanist': to understand things as they are, as intrinsically laden with meaning. This approach relies on the acknowledgement that existing concepts are inadequate; that anthropology should not seek to order a familiar reality in new ways but rather to witness the creation of new realities, worlds and things. This is delineated through Holbraad's ethnography of diviners in Cuba who draw their power from a particular powder:

> "One must accept that when someone tells us, say, that powder is power, the anthropological problem cannot be that of accounting for why he might think that about powder (explaining, interpreting, placing his statement into context), but rather that if that really is the case, then we just do not know what powder he is talking about. This is an ontological problem through and through. For its answer is patently not to be found by searching 'in the world'—maybe in Cuba?—for some special powerful powder. The world in which powder is power is not an uncharted (and preposterous!) region of our own. It is a different world, in which what we take

> to be powder is actually power, or, more to the point, a third element which will remain ineffably paradoxical for as long as we insist on glossing it with our own default concepts—neither 'powder' nor 'power' but, somehow, both, or better still, the same thing" (Henare et al. 2007: 12).

To access this world, where the concept of powder as power and powder itself are the same, Henare et al. (2007) call for us to think through things. Instead of applying familiar concepts to the unfamiliar instance of powder as power, the authors redirect anthropological attention: "the unfamiliarity of the instance [is] an occasion to transform the concepts".

In this chapter, I draw upon similar ontological footing. Instead of encountering spaces and materials in the process of care and understanding them as contributors to care, I engage with these spaces and things as forms of care themselves if, in specific ethnographic instances, that is what they come to be. And further, I ask, what do these spaces-and-things-as-care mean in the context of telehealth in New Mexico's behavioural health system?

To approach these questions, I draw on empirical material from interviews with health workers: those living and working in Albuquerque, providing care over telehealth to behavioural health clinics in rural parts of the State, and interviews with therapists at the Clovis Clinic—both those who work there in-person and those who work there remotely, over telehealth. I also draw on observations from the Clovis Clinic: patient appointments with their tele- behavioural health providers, the waiting room and offices of both tele- and in-person therapists. The ethnographic instances in this chapter offer a window into the "nitty-gritty of the material practices" (van Hout et al 2015: 1215) involved in telehealth. Ultimately, this chapter argues that the mundane materials and the spaces they inhabit are forms of care themselves. Many of the materials and spaces that have come alive in the processes of this research and are presented through the ethnographic sections of this chapter, have been unacknowledged in the use of telehealth. As these spaces and materials are forms of care themselves, this chapter argues that in the transition to telehealth, care has not only been shifted, but dimensions of care have been left behind, overlooked and transformed into something new with new possibilities and challenges for relations and processes of care. The diminishing and expansion of care offered through telehealth is the focus of the next section.

The diminishing and expansion of care through telehealth

The nature of space and materials as care are described through the empirical material presented in the subsections below. I first explore the multiple ways in which space and materiality influenced encounters of care over telehealth, noting the multiple ways in which both forms of care shift with the use of these technologies. Then, through the lenses of these particular spaces and materiality as forms of care, I detail the emerging challenges and opportunities for care over telehealth.

Space as care

Although many of the tele-healthcare providers I met discussed their work over telehealth as fruitful and gratifying, there was often a sense that something about being in-person was not replicated over telehealth. When I spoke with Jordan, a tele-psychologist who works out of Albuquerque, she had been recently invited to visit one of the rural clinics she cares for over telehealth. Jordan explained, "[The clinic] *wants us to come visit them and they're going to pay for it all. So we're going to go out that way… there's like a community centre or building and they're gonna do an open house and some meal or something,* [so we can] *meet everyone* (clinic administrators and patients)". Jordan had been caring for patients in this community for three years. She had been told by the director of behavioural health at the clinic that "*a lot of the patients enjoy coming to work with us through telehealth and* [the telehealth programme] *grew really fast, so they wanted us to go there in-person so that we can meet them in-person, our patients, to give that extra level of you know,* being there*,* [show] *that we care,* [that] *we want to understand* [them and their community] *and all that stuff*". Jordan explained that even individual patients sometimes ask if she will be able to visit them: "*I've actually had patients say, 'can you come?' I had an adolescent say, 'can you come to my house, can you come visit us?' And I was like,*" she said while chuckling, "'*I can't just take off!' So they are interested in meeting the actual person*". For the patients at this rural clinic, a certain form of care comes through sharing physical space, such as within a community centre, and sharing a meal. Care arises through the effort made to travel to a community; from feeling understood, individually and as a member of a particular community, an understanding that is borne from shared physical space.

Eileen, a psychiatrist at UNM Hospital, rotated through several correctional facilities during her psychiatric training. While the use of telepsychiatry is common in these contexts and had been part of her clinical training programme—as prisons in New Mexico and other states are often located away from cities, in places that are hard to get to—she initially sought to provide care in-person, from within these facilities to gain both educational and clinical perspectives. Eileen explained,

> "*Part of the experience of treating incarcerated or detained individuals is understanding and experiencing a tiny, tiny bit of what* [your patients] *are living, which you just don't get through a video and being in a different place. Going to the facility, having to go through security, interacting with the corrections officers on a daily basis or however often you're there providing care, understanding what* [your patients] *are going through on a day-to-day basis to get to their appointments, to get their medication… the experience is crucial to understanding the difficult systems that they are navigating*"

She recalled one prison in particular:

> "*It's challenging to just to get to.* [It] *is 30 miles or so outside of* [the closest major city] *however depending on what side of the city you're coming from, it's going to take you at least an hour, an hour and a half to get there. It's much more accessible by car, it's harder to get to by public transport. Then you're thinking about the task of* [your patients] *having any visitors, for people to come and see them, how challenging that is*".

Eileen described the imposing physical architecture of the prison: "*…it's a fortress. It's just got huge, huge, huge doors… I mean it looks like it's from the movies… so the experience of coming to work is not an inviting one*". She detailed the restrictive prison environment that she entered every day: "*…you can't have gum, you can't have newspapers, you can't have Chapstick. You can't have anything that inmates might want, that you might think is not that big of a deal…and that's before you've even gotten in*". Imagining the experience of being an incarcerated individual gave her pause and made her think more critically about the conditions and systems within which her patients lived. This included being stripped of any belongings, being ushered through multiple locked doors, having a sense of being trapped, and knowing that family members may not visit often because the facility is too difficult to get to. "*It helps you understand truly how difficult it is to be in that environment and get what you need in that environment, and how people in that environment determine what their priorities are*".

Eileen explained that having a nuanced understanding of the spaces in which her patients live is crucial for providing clinical care: "*I may be providing* [my patient] *with a medication but if I don't understand all of the other context for how they got to that point, or what their other needs are, or how they're determining what their needs are, then the care is just not as good and not as complete.*" Experiencing the environment and sharing at least some of the space that comprises a patient's daily life influences

the way Eileen understood her patients' situations and subsequently, the ways in which she cared for these individuals.

Life within the criminal justice system is particular and distinct from the civilian lives that make up the bulk of this ethnography. However, Eileen's example highlights the importance of understanding the physical and relational environment in which someone lives for the process of their care. In her account, Eileen described the importance of proximity to a particular material space, rather than to the patients themselves. Proximity in this form enabled the physical spaces and materiality of the lived environment to inform her interactions with patients; it allowed for a particular form of participation in her patients' lives. This idea of understanding the physical space someone inhabits becomes important when thinking about telehealth, as often healthcare providers who provide care over telehealth do not share a physical environment with their patients. How do providers, then, get a sense of the context of their patients' lives? How does the absence of shared space, and perhaps the absence of a nuanced contextual understanding, influence care?

Jordan and Eileen's examples above illuminate how the sharing of physical space and the materialities that make up that space as well as understanding the context in which a patient lives, not only inform care but become forms of care. Both behavioural healthcare providers talked about making an effort to visit their patients in-person, to relate and care through shared physical space. This effort is a form of care, particularly when patients live in isolated places—whether in a rural village or a prison—and do not often have healthcare professionals come to them. Receiving an in-person visit from a health worker could mean a lot to an individual, a community or a prisoner. It could make them feel seen and visible in ways different to those they may experience with telehealth. Brought together, these examples illustrate both space as a form of care, as well as care as forms of space: shared space, the crossing of space.

Shared space can influence the way in which a healthcare provider understands their patients' daily lives and needs. In my work, I found that an understanding of and familiarity to a place can be gleaned by being in-person, and then can later be tapped over telehealth. This was the case for the tele-therapists who provided care to patients at the Clovis Clinic, who all at one point before working over telehealth had worked as in-person therapists at the clinic. The tele-therapists were all "military spouses", married to someone who worked for the Cannon Air Force Base, located just southwest of Clovis city limits. While living in Clovis, they found work at the clinic and cared for patients in-person. When their spouses were ultimately reassigned to another base, as often happens in the military, the

therapists were able to continue their contracts as well as their caseloads with the clinic by working remotely over telehealth.

Having lived in Clovis, for many years in some cases, the tele-therapists all had a strong understanding of the experience of living there. They knew what the main streets were, which intersections had the worst traffic, where the grocery store was, which Mexican restaurant was best, what it was like to have to walk 10 blocks. They knew about the wind in the spring, and the dry, dry weather.

Lizzie, one of the tele-therapists at the Clovis Clinic, relates to and cares for her patients through shared space:

> "*That is kind of how I try to relate to* [my patients] *so they know that hey, I'm not just some person behind a screen in Montana trying to talk to you about little old Clovis, not knowing the stressors that happen in that town, what it's known for, the struggles that you might be experiencing… I know it, I lived there. I know what street you're talking about. I know that's not a good neighbourhood, it's never been a good neighbourhood. That's definitely something that helps me relate to them*".

For the tele-therapists, familiarity to Clovis was helpful not only in relating to their patients, but also to their colleagues. The tele-therapists still have some of the same colleagues they used to have while they were working at the clinic in-person. Avery, another tele-therapist, pointed out how

> "*some of the people that I worked with before are still working at* [the clinic]*, just maybe in a different department. Have you met Holly? So Holly was in grad school to become a counsellor while I was* [clinic] *director. Now she's* [clinic] *director. And let's see, Jess that you've met, she was a therapist when I was a therapist. So we were pretty close there. And then Greg's been there forever*".

Avery's familiarity with in-person health workers at the clinic was helpful for her work in several ways. For example, she felt comfortable asking for help when navigating administrative processes within the clinic because she had established relationships with some of the clinic's staff. If she had a clinical question, she had trusted colleagues to approach for help. Even continuing to foster forms of collegiality at a distance was facilitated by the in-person relationships she had formed earlier on. In the next chapter, Chapter 7, I offer a counterpoint to Avery's experience: challenges faced by health

workers who provide care over telehealth in the context of having neither been physically to the clinic to which they provide care nor met any of their colleagues in-person.

Sharing the same physical space also affords a relationality and elasticity to an interaction. It provides carers and patients a richness of encounter. Relations can be defined and redefined depending on where someone is sitting, whether someone is moving and the position that a health worker intentionally assumes in relation to their patient. Shared space can impart a multidimensionality onto an interaction. Shared space allows the possibility of fluid relations, of shifting: a healthcare provider can change the direction and focus of an appointment by changing the space around and between themselves and their patient.

Holly, an in-person therapist at the Clovis Clinic, explains how she moves within her office during a patient session. Sitting behind her desk along one wall of her office, she says "i*n the beginning of my sessions, I'll try to get at least a portion of my note done and update things on my computer* [from my desk] *but other than that I sit over here and engage with* [my patients]*".* She motions across the room to a comfy chair placed at an angle to another, matching comfy chair, separated from the other by a small side table. "[This is] *so* [my patients] *know what I'm doing... I want to make them feel like I'm not behind a desk, I'm not limited in my connection or rapport with them*". Holly is able to distinguish distinct phases of her sessions by where she places herself in space, in relation to her patients. She will be behind her desk, typing at her computer for part of the session, and then emerge to take a seat adjacent to her patients in the comfy chair, allowing them time to unfurl. Holly uses the space in her office to communicate to her patients when she has their full attention and when they can open up. Care, here, is not just mechanical or diagnostic. It hinges and depends on spatial relations (Pols 2012: 49; van Hout et al 2015: 1214-5).

Space is part of the relation and the relating. This can happen as well when care is at a distance, however the processes through which it happens are different. Aaron, a psychiatrist in Albuquerque who provides family therapy over telehealth asks his patients to move the camera sideways, and up and down so he can see every family member as they speak. Jordan, a psychologist in Albuquerque, often requests that her patients move back from camera so she has a better view of their whole body. She also shared how one time, as a patient was leaving his session, he turned around and walked back toward the camera, arms open, to express how grateful he was for her help. She was able to feel his appreciation through his movement toward the camera. In these ways, shifts in space over telehealth can happen and can influence an interaction as well as the relations between provider and patient.

Materiality as care

Alongside the spatial shifts in the provision of care described above, material reconfigurations in the use of telehealth were equally salient in this ethnography. While some materialities were accentuated—through attention in staff training and daily work processes, as well as in allocation of financial resources—others were completely overlooked. A focus on the materials that are neglected in the use of telehealth yet ever critical to its use in processes of care, offers an opportunity to question and unsettle habitual understandings of what care is and in which things it exists (Puig de la Bellacasa 2011).

As demonstrated in the opening vignette, a particular technology-facing materiality of telehealth was emphasised again and again by my informants. I was constantly directed to the IT guy, Adam. The training health workers received consisted solely of how to navigate the technical aspects of telehealth. The materials deemed relevant for the use of telehealth consisted of computer screens, microphones, speakers and fibre optic wires. However, the presence of these specific materials of care did not always lead to care provision (Street 2014). I heard from several health workers in Albuquerque involved in telehealth programmes providing care to rural communities in the state, about clinics that had received these 'materials of telehealth', in some cases cutting-edge technologies in the telehealth realm: touch screens with built in cameras, microphones and speakers. And yet, in some of these clinics, the technologies were sitting unused in storage closets, sometimes still in the boxes in which they came. Similar to Sandra's experience recounted at the beginning of this chapter, the presence of the basic technologies required for telehealth was not enough to make care happen. In these cases, there was not enough staff to coordinate care in-person and over telehealth; the internet connection was not good enough, or there was a lack of private spaces in which telehealth sessions could take place. "*We don't want to have the telehealth in the broom closet*", a programme manager at a rural clinic told me. Materiality requires relationality; "devices only function in relation to other things—the power supply, the internet, managers—and their users" (Pols 2012: 121). However, there are further materialities of care lacking in the relations of telehealth that are not as immediately apparent. Their lack can have profound implications for the quality of care.

The absence of material connection and opportunities for relationality was a salient discussion point among many telehealth providers. A prescribing psychologist, Tom, who up until the past year had practiced in-person for his entire career, expressed it as follows:

> "*There are days, they've come up recently, where I've had these thoughts along the lines of you know, man, I used to cook. Wherever I've been, I've always been a person who will bring like pulled pork and put it in a crockpot and bring it for my staff. Or I would just you know, when I was* [at my previous job]*, there were a couple of times where the exec staff made breakfast burritos for everybody and that kind of stuff. I miss that*."

Tom now works full time from a small, soundproofed office in his basement caring for patients at several different rural clinics. His only company is Bess, a small white dog who sleeps all day just beyond the view of the camera. Tom misses the connection fostered through sharing a favourite recipe with his colleagues. Sharing food was a way in which he showed appreciation to his staff. It offered him the opportunity to interact with his staff in an informal and collegial way. It also revealed another dimension of himself to the people with whom he worked.

Similarly, Amanda, a tele-therapist at the Clovis Clinic, reflected on gifts she had received from patients during our interview over Zoom: "*I have not received gifts from* [patients] *over* [telehealth] *however I did receive some during my time* [in-person]. *They were mostly from children and adolescents, all crafts that were made by a* [patient] *in their home or during session, and I kept them in my office so they could see them when they came in*." Amanda displayed the material gifts she received from her patients in her office, creating an opportunity for connection, showing her patients that she appreciated them, just as her patients were able to share their appreciation for her by presenting her with a gift. The opportunity for gift giving is missing over telehealth, as there is no possibility for shared physical substance across the digital connection.

Avery, a tele-therapist at the Clovis Clinic, mentioned in her interview how, when she worked in-person, she would leave a small pitcher filled with water and an empty glass on the table next to the chair in which her patients usually sat. She would pay attention to whether her patients felt comfortable helping themselves to the water, if they were open or not to receiving a glass of water as a form of care. In her work over telehealth, she is unable to draw on this particular physical and material cue to gauge her patients' experience of the therapeutic encounter. It is the everyday materials—those beyond a particular medical device or technology, like a pitcher of water and a glass—that make up, inform and mediate practices and relations of care (Maller 2015; Pink et al. 2014). It is also these "mundane" materials that have been left behind in the transition from in-person care to telehealth.

Lucy, a psychiatric nurse practitioner who works with children and adolescents over telehealth, reminisced about her time providing in-person services: "*I miss it in-person because you get so much more richness in the encounter. I have a basket, or I had one, full of toys, fiddlers, fiddly things that kids like to fiddle with because they'll talk to you more. I also have a sand tray that children played with. I could get more out of them*". Lucy describes how she used to relate to her patients through different objects, how toys or sand would mediate her interaction them. Her digital interactions with patients have shifted; not only in the ways in which she is able to relate to her patients, but also in the way she is able to care.

Thus, the way in which healthcare professionals interact with their colleagues and patients over telehealth has changed from their in-person practices. This can be partly attributed to no longer sharing the same physical space but also to no longer being able to share material things. Through materials, forms of relationality and care come into being. In the examples above, care is in part made up of pulled pork, breakfast burritos, crafty gifts, toys and sand. Care still exists in their absence. However, it is an altered form of care.

Materiality as an integral yet shifted, and in some cases discarded component of care over telehealth was illuminated not only through my interviews with care providers, but also through observation of caring interactions; through being physically present in the private clinical rooms with patients as they received therapy or psychiatric care over telehealth. Being among the materials of care, I was struck by how much of the material substance of caring encounters had been neglected in the transition from in-person to telehealth. The components of care that had been forgotten left material traces.

Each therapist at the Clovis Clinic, both those in-person and those over telehealth, had their own physical office. This afforded a form of consistency for the patients, as each appointment with their therapist happened in the same office. This also facilitated the work of the clinic's in-person support staff. At the beginning of each day, a member of support staff would set up the computer in each tele-therapist's office by connecting to the correct tele-therapist via the telehealth software. At the top of each hour, when patient appointments started, the support staff would bring new patients receiving therapy over telehealth into the correct office for their appointment. Veteran patients were told that they could head to the relevant office on their own, as they already knew their way. The offices of the tele-therapists felt distinct to the offices inhabited by the in-person therapists. The offices of in-person therapists were unique, each decorated and maintained differently; each with its own, considered set-up of chairs, tables and other objects to facilitate therapeutic encounters. Holly, a therapist who played basketball, set up a small plastic basketball hoop over her office door. Judy's office was taken

over by a giant bookshelf filled with knick-knacks, her desk covered by stacks and stacks of administrative work and coffee mugs. Shannon's office was set up with low lighting, a furry rug underfoot and an aroma therapy diffuser which emitted small puffs of lavender-scented mist.

The offices of the tele-therapists, conversely, were sparse. Each had a desk with computer and desk chair, where patients sat. Random and often generic decorations awkwardly dotted the walls, as if placed there merely for the sake of filling an empty wall. A large canvas of the Seattle Skyline hung arbitrarily in Lizzie's office. In her interview, she admitted casually and with a small laugh that she was not sure why it was displayed in her room, having never been to that city. Several white stickers with affirmations written in curvy, black text were affixed to the wall behind the computer in Sydney's office: "I am brave", "I take care of myself", "Obstacles help me to learn and grow". Amanda's office walls displayed several pieces of abstractly painted metal, looking unsurprisingly similar to the painted metal pieces hung in the halls and front office of the clinic. All telehealth offices had several, worn armchairs pushed up against bare walls. One office had a dusty bookshelf, sparsely filled with a box of LEGO and several empty plastic magazine holders. Lizzie's office was large enough to become the informal storage room for unused or broken kitchen appliances: two microwaves and a coffee maker had been stacked on top of an otherwise unused desk in one corner of the room. A clock on the wall of Amanda's office was perpetually stuck at 4:15, either having gone unnoticed, or without anyone to claim responsibility to replace the batteries. For several hours one day, a used tissue lay in the middle of Sydney's office floor, presumably belonging to an earlier patient. The support staff were always pressed for time and rarely came into the telehealth offices with patients unless they had been alerted to a small technical issue such as a disruption in the connection, or a camera that needed to be readjusted. As no physical staff occupied the telehealth offices, and no member of staff was tasked with their upkeep during the day, the tissue had stayed untouched on the floor through several patient appointments. On another occasion, the tissue box in Amanda's office, which was placed next to the computer for patients to use, sat empty for a whole week. A staleness often hung in the air as there was no one to intentionally keep the office doors open between patient sessions to invite in fresh air. Curiously, two of the tele-therapy offices had large, healthy plants which always struck me as odd as otherwise these rooms exuded feelings of barrenness. "*Who waters these?*" I wondered multiple times in my fieldnotes. In these offices, the absence of a physical therapist was felt strongly through these particular material details, in both their absence and their presence.

Other physical aspects of care left an impression on me as I observed therapy and psychiatry encounters over telehealth. There were the frequent bouncing legs of a nervous patient under the desk upon which the computer sat. There was the computer screen reflected in several of the

therapists' glasses; a constant and intimate reminder that they too were not looking directly at a person, but first and foremost, a screen. There were the folds of the grey curtain that hung behind Lizzie to block a wider view of her home from the camera, offering an illusion of privacy to her patients. There was also the recalcitrant cat who constantly jumped up on Amanda's desk, obscuring her face and the screen. Sydney's messy living room contained a baby rocker, exercise equipment and tall plastic shelves storing cleaning products and dog food. Lizzie's collared t-shirt with the Clovis Clinic name and logo, connected her materially, from her own separate space, to the clinic.

The materiality of care over telehealth was ambivalent. From my perception, the cold and vacant rooms in which patients sat alone at the clinic felt devoid of a physical human care giver[23]. However, some patients welcomed the emptiness of the telehealth offices. "*It's a little less personal to talk to someone over the screen, but I like it that way*", said Brian, a patient at the clinic, as he waited for his tele-therapy appointment. "*I'm retired from the military and have PTSD*", he continued, "*I prefer to be in isolation. It's helpful when they* (the health workers) [a]*re over the computer*". During interviews with patients, some mentioned enjoying glimpses of their therapists' lives at home. However, sometimes the presence of the tele-health workers' domestic environments was unpleasant, even off-putting. Dr Shellito, for example, one of the Clovis Clinic's two tele-psychiatrists, shared her screen with a large ceiling fan turning above her head. The gum she chewed throughout several of her appointments was distracting, as was the steady droll of a male news reporter speaking from a TV somewhere nearby. Morgan, one of Dr Shellito's new patients, told me as she was leaving her first appointment "*I didn't like it. I could hear the TV in the background, I felt like I was in someone's house. It felt really impersonal*".

The materiality of care over telehealth was shifted, in multiple and diverse ways. The shifts did not simply detract from or enhance care; such a binary is too simplistic. From my interviews and observations, I found that different people experienced and perceived the use of telehealth differently. There are infinite ways in which a telehealth encounter can unfold, in which it might intersect with ideas of 'good care'. Instead of addressing these ideas specifically, I offer a starting point through

[23] This sentiment of absence and cold vacancy was my own. Very few patients commented on the inadequacies of the specific care they received over telehealth. Owens and Batchelor (1996) argue that several assumptions are made around how patients evaluate their own experiences of health services. For example, patients might not hold many expectations about the care they receive, and thus might not be able to form an evaluation. This may be relevant for the patients receiving psychiatric services at the Clovis Clinic, as it was often the first time they had access to a psychiatrist locally. Further, patients might fear that in sharing negative perspectives about services, their care could be taken away. It is important to mention, however, that some patients did express feelings of dissatisfaction in their care, however these feelings were more generalised: regarding the state health system as well as existing local services such as the availability of 'good' primary care providers and the infamous emergency service at the small regional hospital in Clovis.

which to approach further conversations around the application and use of telehealth in care: the materials that make up care change with the use of telehealth and alongside this material reordering comes a shift in the nature of care that is provided.

Many of the relations of telehealth and the dimensions of its care are materially emplaced. In this ethnography, it was the mundane materialities of everyday life with which telehealth articulated—rather than the physical technologies often associated with the use of telehealth—that spoke the loudest; whose absence or presence reverberated throughout encounters of care. It was these materialities that had not been given attention in the implementation and practice of telehealth, yet that were wound up tightly with this new form of care.

Shifted spaces and materiality: the challenges of care diminished?

The shifts in the space and materials of care introduced challenges in patient care, as well as in the personal lives of health workers. For example, providing care over telehealth left some clinicians without a sense of physical and material orientation. Tom, the prescribing psychologist introduced above, described the challenge of not having a strong grasp on the physical surroundings of a clinic beyond the view of the camera.

> "*If it's in a clinic that I've never been to* [in-person] *before, I don't know how to tell people to get to the pharmacy. I don't know how to tell people where the front desk is to make another appointment. I don't know how to tell people how to get to the lab… If I was working with someone face-to-face,* [I'd say]*, 'well you know where the lab is right?' And they'd go 'no I don't know where that is'. And I'd go 'Ok, come on I'll walk you down there. I gotta get out of my chair for a while anyways.' I don't have that, and I can't talk them through it. Other than to say, I know I've been told* [the pharmacy's] *downstairs but that's the best I can tell you… And it also means things like, I have no clue about waiting time, right? So, if you're working* [in-person] *and you walk past the pharmacy you know some days there's nobody in there and other days you know there's 4000 people in there waiting. It's nice to be able to say, 'you could pick up your medication this afternoon, but I know you're going to be waiting a long time'… Those kinds of things are odd for me to not know. To not be able to advise my patients that way*".

For Tom, an understanding of and knowledge about a clinical space offers the opportunity to better understand the physical context surrounding his patients during their appointments. He cares through the use and understanding of space when he is in-person and is unable to do so in the same ways over

telehealth. He lacks an understanding of space, and therefore is unable to tap the spatial dimension of care.

Lucy, the psychiatric nurse practitioner, also draws on understandings of space to better understand the context in which her patients go about their daily lives: both within the clinic as well as beyond.

> "*When I was working* [in-person] *in Albuquerque and I'd ask where* [my patients] *live in the city here, I'd know where that is. I could have a feel for what their home might be like… I don't have that at all* [at the community I provide telehealth to]*. That's one of the things that bothers me* [about working over telehealth] *is I don't even know where the room I'm seeing people is, where that is in association to where the front desk is, where they've come in, do they wait* [in a waiting room]*?*"

Like Tom, Lucy is also aware of and uncomfortable with not having a sense of the layout of the clinic to which she provides telehealth services, or what her patients see or do before they get to her office. Having never been in-person at the clinic where she provides care, Lucy is not able to use information and feelings about space as a way to gain clinical knowledge, as a form of understanding and connection with her patients. Further, her unfamiliarity with the local space of the community inhibits her understanding of the home life of her patients. She is unable to employ her knowledge of the area—as she used to with her patients in Albuquerque, in the city she lives in and knows well. In this way, the care Lucy provides over telehealth is altered and, she feels, somewhat diminished.

Shifted spaces and materiality: the opportunities of care enhanced?

Alongside the challenges of not sharing space and materials, many of the telehealth providers I interviewed shared ways in which the physical and material distance between themselves and their patients afforded new caring opportunities. "*There's an interesting thing about providing services through* [telehealth] *that in some ways I think people are more open*" mentioned Aaron, an Albuquerque-based psychiatrist who had previous experience of working in-person in a rural community.

> "*People* [in the rural community] *are so concerned about whether or not you're going to run into them at the local store, and whether or not you know their uncle. And, in fact, they know that you know their uncle. And even though I know I'm never going to tell their uncle a damn thing about the fact that this person showed up in my clinic today, they don't know that… In*

some ways, having this layer of separation provides people with a freedom to talk about things that perhaps they wouldn't if I were sitting in that same community with them".

Aaron and his patients experience telehealth as a "layer of separation" which, in the case of behavioural health services in a small, rural community, can be useful in the provision of care because of its distancing qualities. Distance, in this form—this shift in shared physical space—offers comfort to patients who are concerned about confidentiality.

Amanda, a tele-therapist at the Clovis Clinic, shared a similar experience: "*I have a* [patient] *right now that's in the military who recently started counselling with someone on* [the Air Force] *base. A lot of her fear with opening up to that person was the fact that she was concerned that it was going to get back to somebody on base and impact her job. So she held back a lot*". This patient had told Amanda that she felt more of a connection with her over telehealth than she did when she was seeing the in-person therapist on base. "[My patient] *was able to share more information* [with me] *than she was able to tell anyone else. She said, 'I don't know what it is, but there's just something about you not being in the room that makes me feel like I can open up more and say things that I wouldn't normally say'*". The particular spatial relations of telehealth, between Amanda and her patient, offer the opportunity for this patient to disclose information she would have otherwise kept to herself, if speaking with someone who was part of her community and shared the same physical space.

Jordan, one of the tele-psychologists we met above, said that new forms of physical distance between herself and her patients over telehealth offered not only feelings of confidentiality, but also feelings of starting off with a "*clean slate*". She explained,

> "*Because I'm not right there, I'm not their neighbour, I'm not involved in local politics, I'm not dating their father or whatever you know?* [My patients] *say they're not judged prematurely before they come in* [for therapy] *… I remember I did a summer internship in grad school back home* [in the community where I grew up] *which is super tiny. And I had such a hard time because you know, some of the kids that would come* [in for therapy]*, I knew their father or their mother in high school. So it was like, oh I know that family. And so it's not fair, you know, for the kids.* [Telehealth] *gives someone that clean slate to work off of. They're not stuck with some label of their family. So, yeah,* [my patients] *kinda like that*."

The physical space afforded by telehealth offers Jordan's patients a form of freedom from the social and political situation in which they are surrounded. It enables them to approach and be welcomed

into the therapeutic encounter. It gives them agency to define their therapeutic work, without the concern that they may be seen through the lens of their particular social history within their community.

The physical distance involved in care over telehealth also opens up opportunities for health workers outside of the clinic. Jordan shared how working in-person in a small, rural community in her previous employment had limited her social life.

> "*Everybody knows everybody* [in that community] *which made being a provider and a community member difficult. You don't want to form friendly relationships with anyone who could become a patient. It gets pretty isolating. And there's not much of a choice you know, since you're the only provider there. You really have to separate yourself from the community in that way because you can't interact with them except on a professional basis*".

By providing care over telehealth, the spaces in which Jordan works and lives are separate. She is no longer confined solely to the role of a behavioural healthcare provider in a small community. The shift in shared space through her work over telehealth affords her more freedom in her personal life.
Physical distance can also offer health workers security. Lizzie, a tele-therapist at the Clovis Clinic shared during her interview the uneasiness she used to experience when she lived and worked in the same place.

> "*I remember those days, I couldn't go anywhere without running into* [a patient] *I was currently seeing, saw in the past, or might be seeing the future. There was always that concern there. It triggers some anxiousness. People react differently in public, you're just unsure… Clovis being such a small town, how do I know that someone doesn't already know where I live? Like if I have a disgruntled* [patient]*, they could very easily go to the county clerk and find out my address and they can just show up* [at my home]*. Which has happened to other* [providers at the clinic]*. In a small town, that reality becomes a lot more probable when they can very easily follow you home, walk you to the car; that's just more of a possibility*".

When she lived in Clovis, Lizzie was always aware and uneasy about potentially coming across a patient outside of the clinic. Living in Montana now and caring for patients over telehealth, she no longer has these concerns. As a behavioural health provider, she feels safer.

Lucy, the psychiatric nurse practitioner introduced above, uses the physical distance between her and her patients as a way to connect. "*I always introduce myself and tell* [my patients] *I'm here in Albuquerque, at* [UNM]*",* she explained. "*Some of* [my patients] *have friends or family here and they're always quite curious. The weather's always something fun to talk about because it's very different up there* (in the north of the state) *than it is over here. So that's something we chat about*". Not occupying the same physical space as her patients creates room for curiosities. Lucy is able to engage her patients through their physical distance, through their particular spatial circumstances.

In interviews, I often asked health workers if they felt a disconnect with their patients because they do not live in the same place. "*If anything, they're more intrigued*" responded Lizzie,

> "*I have a guy I'll see tomorrow morning, he's a hoot. He used to live in Montana and he's a huge Grizzlies' fan, and that's how we connect. He's always asking about the weather in Montana.* [Patients] *are like 'what's the weather been like by you?' It might be a cliché that as a starting question people ask about the weather but sometimes people just want to know about the fishing or the mountains. So I'd just say that it's just a topic of conversation sometimes.*"

In some cases, as Lizzie has experienced, shared space and materiality helps to create a form of familiarity. This familiarity is not necessarily fostered through physical space and materials that are, themselves, shared, but rather the idea that space and materials *can be* shared. Not occupying the same space and the materials therein brings space into the conversation. It transforms space and materiality into a conversation topic, into something that is curious and not taken for granted, into something people use to connect. Not sharing the same space offers a point of connection between health worker and patient. If a patient asked an in-person provider about where they live, the question would have a different meaning. The question would not be an opportunity for connection, but rather a point of discomfort; it could potentially engender feelings of danger. For Lucy and Lizzie, space and shared space become something different. The absence of shared space affords a form of spatial familiarity and relationality that is not possible when health worker and patient share physical space. Health workers can share more personal information with their patients because of the physical distance that separates them, not despite of it.

Finally, telehealth offers opportunities for some patients for clinical reasons. Amanda, a tele-therapist at the Clovis Clinic, explained in psychological terms why telehealth might be the preferred mode of care for some patients: "[for] *people who have extreme anxiety or paranoia,* [though] *it depends on the paranoia, like PTSD and stuff like that,* [patients] *feel safe* [with telehealth] *because they don't*

have anybody in the room with them. They feel like ok, I'm by myself, I have this safe space, you know, my anxiety is not getting to me". For patients who experience specific kinds of mental ill health, receiving care in a secure physical space in which they are alone offers feelings of safety and ease, perhaps creating a more comfortable environment in which to participate in the therapeutic encounter.

The opportunities for care described here were afforded by the spatial and material shifts implicated in the use of telehealth in behavioural healthcare. Care is flexible and relational. As such, the opportunities for care are diverse and overlapping. In these examples, telehealth offers forms of privacy, freedom, safety and connection for and between health workers and patients.

Discussion

In this chapter we have seen care over telehealth as embedded in, inseparable from and refracted through spaces and materials. Telehealth reconfigures the space and materiality of care, and in doing so, telehealth reconfigures care. The spaces and things that make up in-person care encounters are, in a telehealth encounter, often missing, rearranged or forced to function in an alternative manner or through a different process. While telehealth involves a digitally mediated connection between provider and patient, it also requires much more, both spatially and materially. There are the components of telehealth that are more often recognised as part of this form of care: two private spaces, two computers, speakers, microphones, people to help set up the connection, available health workers, patients who can access the clinic, a human health worker and a human patient. Yet, there are also spaces and materials that have been overlooked: spatial relations formed when two people are together in the same physical space, the knowledge that comes from being in a particular space, the safety afforded by being at a distance, gifts that can be given and received, a single tissue and stale air.

Grappling with multiple ontologies

The body of this chapter has offered empirical examples that extend this idea of space and materials as care. Care is embedded in and produced by things, as well as the spatial relations these things have to each other, people, processes and other spaces in the world. Telehealth creates new assemblages of both existing and novel spaces and materiality with ambivalent effects: care is shifted in both diminishing and expansive ways.

These shifting forms of care are complex—more than merely identifying a private space, plugging in a computer and connecting it to the internet—and required ongoing "redefinition and contest" (Muller 2004: 60). The shifting spaces and materials made visible both the constant evolution and complex ontological realities of care. Spaces and materials are part of a larger picture of care, a unique picture that unfolds in this particular behavioural health system.

I contend that telehealth extends the space and materials of care far beyond the conceived space of the digital connection and the materiality of the basic technologies involved. Telehealth is reconstituted in every implementation, shaping and shaped by the specific setting, reconfiguring and reconfigured by the particular spaces and materials, both those present and absent. The entanglements of telehealth and care are continually redrawn. The assembling of things, people, technology, relations and spaces around the clinic "[produce] a story that could not have been anticipated prior to the gathering (of all these things)" (Henare et al. 2007: 22).

Mundane spaces and materials as frames for understanding care

I further argue that while the spaces and materials of care in the use of telehealth extend, change and come into being in multiple ways beyond the spaces and materials conceived together as making up "telehealth", many of the spaces and materials of care are, crucially, unacknowledged. With telehealth, much attention is paid to the digital connection between doctor and patient. In practice, attention is directed toward stable internet, making sure the doctor appears over the screen to the patient in a particular fashion. Training involves how to log in to the software used for telehealth calls. Set up involves making sure the volume is loud enough for the patient, the connection is strong enough so audio and visual components are not choppy. Much attention has been placed on creating and maintaining this connection between two places. However, beyond allocating a private room on each end for patient and doctor, rarely any attention has been paid to the spaces and materials that are being connected—or distanced—via telehealth, those that surround the patient and the doctor, those that implicate other health workers and the organisation of the clinic. This ethnography illuminates the spaces and materials of care that exist outside the digital space that links doctor and patient via the internet, outside the basic technologies of various screens, microphones and speakers. It demands that, in the consideration of care—how it is conceived, provided and received—it is necessary pay attention to these overlooked, "mundane" components of telehealth (see Dalakoglou and Harvey's 2012 study of roads in development studies).

In focusing on the spaces and materials that are connected, as well as those involved in the connection, it is important to consider the work practices and routines with which they articulate. Pols (2012), for example, explores the ways in which telecare devices fit or do not fit into processes of care.

> "Existing practices are full of 'memories'; these routines have served their purpose for some time and are kept alive by many actors and devices in their particular alignments. Participants rearrange old practices to make new devices work. This is hard as the people who have to work with the device do not perceive the need for it in the first place and require instruction to become aware of its potential usefulness. Even when they are convinced that the technology has some good use; it is hard to change practices and tame devices in work routines. Working routines are material, embodied and relational" (ibid., 12)

Similarly, telehealth in the Clovis Clinic has been squeezed into old routines. There are some aspects that have been considered in this squeezing: billing procedures, technical set up and patient check-in. Yet, there are many aspects that have not been considered. Aspects that are part of the processes of care yet have been overlooked. Importantly, these aspects—and the spaces, materials and practices in which they are enmeshed—make visible forms of care that perhaps were not visible before the transition to telehealth. Through their shifts, absences and novel presences, they reveal what makes up in-person care; aspects of in-person care that had not been (formally) considered care at all. In other words, these spaces and materials make up the frame (Gombrich 1984; Miller 2005) through which we can understand care—both over telehealth and in-person.

In his approach to studying the material, Miller (2005) builds on the work of art historian Gombrich (1984), who attends to the frame which encases a piece of art. When the frame aligns with, matches or suits the art therein, it becomes invisible. Miller extends this understanding to objects, asserting that their importance radiates not from their physical presence, but rather from our lack of awareness of their presence. "The less we are aware of them", Miller (2005) contends, "the more powerfully they can determine our expectations by setting the scene and ensuring normative behaviour, without being open to challenge" (ibid., 5). In Euro-American health systems, we come to expect certain things in settings we think of as 'medical' such as a clinic building, a waiting room, a reception desk, computers, examination rooms, doctors and nurses. Telehealth frames care in a new way, through the use of new spaces and materials as well as the reconfigured use of those that are familiar. The spaces and materiality of care are rendered visible when the frame of telehealth, a novel mode through which care is provided, does not quite fit the processes, materials and systems built for traditional care. Bowker and Star (2008) write about this in their work on infrastructure: only when things break

down—i.e., when the frame does not match, when the technology does not fit—does infrastructure become visible.

Miller (2005) further argues that in order to understand who we are and from where we have come, we need to look in "a material", and, I would argue spatial, "mirror" (ibid., 8). By this he means that through examining the spaces and things that make up our daily lives, that we have created and embedded therein, we can come to see ourselves. In the creation of new spaces and things, we are shifted and altered. His argument conjures the work of Ian Hacking (1986). As we make and come to know things—or categories, as in the work of Hacking—we are simultaneously and reciprocally made and categorised. It is not until the spaces, materials or categories come into being that certain forms of humanity, too, come into being. As care is provided over telehealth, patients and doctors become those who are seen and those who see at a distance; those who sit alone in rooms and look at screens in order to receive and provide care. Taken together, the spaces and materials that come into play, fall out of use or are taken up differently in the doing of telehealth make up not only new forms of care, but also new types of people.

Conclusion

In this chapter, I have offered specific, grounded observations and narratives concerning spaces and materialities of care as exemplars of wider issues in the use of telehealth. With telehealth, spaces and materials intersect in new ways, implicating the relations, processes and meanings of care. Acknowledging space and materiality as a form of care brings to the forefront the many crucial components of healthcare provision that have been shifted, unattended to and left behind in the transition to telehealth. Care, here, is understood in wholly new terms vis-à-vis the relations created in the juxtapositions of various spaces and artefacts. Care over telehealth in the New Mexican behavioural health system is not recreated and reconfigured, it is reconceived; it transforms and evolves.

These multiple spaces and materials are experienced in multiple ways, as different people interact with the technology, the spaces and materials around themselves differently. Ultimately what I want to put forth is that the use of telehealth extends the space and materials of care beyond the virtual interface, that there are far more spaces and things to consider in care over telehealth. This has several implications, particularly as telehealth becomes more pervasive in health systems globally. For example, how does telehealth fit into health systems that are designed and underpinned by existing

and perhaps more singular understandings of the spaces implicated in care? The next chapter, Chapter 7, addresses this question through the frame of closeness and distance in care.

Chapter 7: Telehealth Creates New Forms of Distance in Care

"*It feels like I'm wearing gloves*"

- Dr Taylor, a psychiatrist in Albuquerque, reflecting on providing care over telehealth

Introduction

In this chapter, I argue that telehealth creates new forms of distance in care. Distance is a core, spatial aspect of relations in healthcare. It can both support and trouble practices of care, as it nurtures connection and trust as well as detachment and separation (Brown & Marí Sáez 2021; Pink et al. 2014). Conceptualisations of distance have been integral to biomedical practice. For example, there is a necessary distance that health workers must cultivate in order to separate themselves relationally from their patients. Too much proximity, in the form of intimacy, can be detrimental to the provision of care (Good & Good 1993).

I draw on ethnographic findings from a place where conventional forms of care have not worked. The New Mexican health system has struggled for a long time to provide care to its residents in rural areas, where specialist healthcare providers often times do not exist and where people have to drive hours to see a doctor. Telehealth is a practice of connectedness: it offers a closeness in relation to the complete absence of certain types of care before. However, in the attempt to foster closeness, the use of telehealth produces new forms of distance. This distance leads to new gaps in clinical processes as it articulates with a wider health system that is based on implicit, practiced and material infrastructure that spatialises caring relations as 'close' and 'in-person'. In the US, health systems and care practices are, typically, local and in-person. Telehealth challenges assumptions in the US health system around the forms of space implicated in care provision by mobilising new forms of distance in the processes of care.

To reiterate points made earlier in the thesis, telehealth is not a straightforward addition to a health system. It is not a technology merely tacked on to support an existing mode of care. Rather, it serves to alter the ways in which the system functions and shape the nature of care provided (Oudshoorn 2009; Pols 2012). In enabling new forms of closeness, telehealth reciprocally embeds new forms of distance in the relations and practices of care (Cartwright 2000). The shifts in the relations and processes of care reveal gaps between how telehealth is imagined by the state health system to provide care and the ways in which things happen in practice. Telehealth is imagined to enable care across distance, to create forms of closeness between health workers and patients far away. It is

situated within a discourse that valorises the crossing of geographical distance, improved access to care for remote populations and the cost effectiveness of this endeavour. Yet, in reality, the use of telehealth implicates new forms of space that do not align with conventional practices in the health system. In this chapter, I complicate the ways in which telehealth has become embedded in the New Mexican health system and problematise ideas of distance in healthcare.

Importantly, distance in healthcare does not solely articulate with forms of social intimacy and physical distance between patient and healthcare provider. Taking distance as my ethnographic object, I argue that forms of distance introduced in the use of telehealth reconfigure the ways in which health workers produce clinical knowledge as well as how they relate through and around healthcare encounters. These forms of distance influence clinical workflows and the ways in which both quotidian and emergency protocols are carried out, ultimately impacting the nature of the healthcare provided. In this way, distance produces boundaries around what is known and what types of care are possible, leading to broader questions about care that this thesis addresses more generally.

To expand on and explore these arguments, I draw on interviews with health workers in Albuquerque who provided care via telehealth to rural communities across the state. I also draw on observations of clinical encounters at the Clovis Clinic, as well as interviews with health workers there: both those working in-person and those working at a distance via telehealth. Focusing on the perspective of health workers, I draw out the ways in which this particular reorganisation of space influences clinical skills, the roles and responsibilities of health workers and the relations between them. I argue that the distance implicated in the use of telehealth creates gaps in care that individual health workers see as their own responsibility to fill. From this, I ponder questions about equity and care: as the health system prioritises one form of care—through increasing access to specialist services in rural communities—it neglects another—care and consideration for the healthcare workforce as they navigate shifts in distance on the ground.

Telehealth shaping distance

Telehealth is implicated in a number of reorganisations of distance. These intertwine with changes in clinical practice and sociality. In this section, I consider the implications of these shifts for the production of clinical knowledge and employment of clinical techniques, health worker roles and responsibilities, processes of care and relations between local and remote health workers.

Distance changes what is knowable in a clinical encounter

Telehealth involves new formulations and mediations of care. Care practices that have conventionally happened in-person, guided by assumptions of closeness as well as the sensory modalities that closeness enables—e.g., touch and smell—are shifted in the context of this newfound distance. The training of health workers, including the knowledge that is understood as important for clinical evaluations as well as the clinical skills health workers are required to master and employ in order to provide healthcare, is designed on the assumption that care happens in-person; that health workers are able to use their senses in ways specific to being in-person to evaluate, diagnose, treat, monitor and care for their patients (e.g., Prentice 2012; Rice 2008). These changes in sensory modalities in the use of telehealth influence clinical experience and the production of medical knowledge (Lupton & Maslen 2017). While I focus on the senses and related clinical knowledge and practices that are absent in the use of telehealth, Oudshoorn (2009) points to the importance of also attending to the forms of clinical information that telehealth makes accessible. Care across telehealth involves the gathering and triangulation of multiple sources of information: visual and auditory sources as well as textual sources such as electronic health records. In her analysis, however, Oudshoorn overlooks other sources of information that are not incorporated in the exchange between in-person care and care over telehealth. Many health workers I spoke to discussed senses that were missing over telehealth: smells, gut-feelings, the ability to "*get a sense of the room*", the touch from shaking someone's hand, having an idea of what was outside the clinical room, who is outside the room and, in some cases, who is in the room. Dr Taylor, a tele-psychiatrist, described her experience of telehealth by saying "*it feels like I'm wearing gloves*", as she was not able to sense situations as adeptly as compared to when she was in-person. Telehealth changes what is knowable in a clinical encounter; it shapes forms of knowledge production which are mediated by proximity and distance.

A lot happens outside the small box which delimits the tele-health worker's view of their patient and their patient's surroundings. Amanda, the tele-therapist we met in the opening vignette of this thesis, reflected after her session with Bonnie,

> "*I know I'm missing a lot. I'm limited to a very small square of space… Especially as most of my clients* [have] *substance abuse* [issues]*, there have been several times where I've been like 'man did that person smell of alcohol? I couldn't really see their eyes, were they glazed over?' It's kinda hard to tell, you know?*"

Amanda's experience of caring for her patients from a distance involves navigating the absence of clinical information that she might otherwise draw on in-person: the smell of a patient and acute visual cues such as glazed over eyes, which are difficult to identify with the limited precision of the visual image captured through telehealth. The use of telehealth here involves a production of limits around what is knowable. Mapped onto a computer screen is a bounded view of a person, of their current reality. Telehealth involves the carving of space, the cutting out of a fuller picture.

However, although her view is narrow, Amanda does attend to specific aspects of her patients in order to discern how they are doing:

> "*I'm paying attention to eye contact, if they're restless, if they're fidgety… And then of course, the usual stuff, are they on time, do they look frazzled or anxious, sometimes I can tell when someone is shaking, sometimes I can't... Hygiene is another thing. I may not be able to smell or see in-person if someone is having difficulty maintaining their hygiene, but I can probably have a good idea looking at somebody, do they look dishevelled, do they look like they have clean clothes on today, is their hair brushed. And then go from there. But a lot of it is just a deduction of what I can see*."

In the absence of other sensory modes of gathering information, Amanda draws heavily on the visual information available in order to understand more comprehensively her patients and their states of health and illness.

However, Lucy, a psychiatric nurse practitioner, explained that even how a patient presents over telehealth can be misleading: "*I can look at* [my patient's] *grooming and they look like they're well groomed, and then staff will come in later with their air freshener because* [the patient] *hadn't taken a shower. They combed their hair but I can't tell*". These examples offer a sense of the challenges involved in caring situations where certain sensory information is unavailable to health workers over telehealth. Clinical understandings may be askew because of information that goes missing across the telehealth interface.

Lucy also spoke more specifically about being at a distance from the children and adolescents she cares for now over telehealth, in comparison to those with whom she used to work in-person:

> "*I would go down* [the hall] *and get them in the clinic. I watched where they were sitting next to their parent, whether or not they were right next to them or, if they're little, if they're on their* [parent's] *lap. You can just tell so much from seeing somebody when they don't know they're*

> *being observed. I miss that…. I don't get any of that* [over telehealth]. *Nine times out of ten, the children* [I see over telehealth] *are pretty connected to whomever brings them in* [for their appointment]. *I haven't detected enormous amounts of hostility... Maybe 'cause by the time they come into my office they're kind of prepared and guarded about who they are*".

By not being able to move around the clinic, to see patients in settings other than in front of the computer screen, Lucy misses information that could be otherwise helpful for the care she provides. She is unable to understand how her patients experience the clinic more broadly and how they relate to the person accompanying them. In the absence of particular sensory interactions, forms of clinical information upon which health workers rely are inaccessible (Mort et al. 2003).

The clinical encounter over telehealth is defined by the location and purview of the computer screen and camera. Lucy described a clinical situation in which her physical absence changed her ability to engage with patients:

> "*One day, I'm sitting there and nobody's coming in, nobody's coming in, nobody's coming in. And I finally call* [the clinic front desk over the phone] *and I say, 'what's going on? I've been sitting here, are my patients not here?'* [The receptionist responds] *'Oh no, the door locked when that last patient left.* [The clinic coordinator] *went to* [run errands] *and he had the key in his pocket so we can't open that door until he gets back'. And I said, 'can you call maintenance? Tell them to come in and unlock that door'. A patient of mine had to wait like 40 minutes to come in and see me because nobody could unlock the door*".

Lucy's physical absence rendered her powerless against the hard material of the locked door. Being at a distance, she was locked inside her own office, over a screen. She was unable to operate through touch and movement in space—both a form of physical agency. This agency is crucial to—and included in—her understanding of clinical care: the ability to solve problems that are not strictly 'clinical' but still essential to enabling clinical work. This mishap resulted in a lengthy delay, requiring her next patient to wait and backing up the rest of her clinical schedule that day.

Some clinical techniques—particularly those that rely on senses, such as touch, smell and sometimes vision and hearing—are underpinned by assumptions of closeness between the health worker, the patient and the physical space in which care conventionally happens. The use of silence as a clinical technique is another example. In behavioural healthcare, silence can take on multiple forms with varying meanings. Health workers might intentionally employ silence as a tool to offer space and time

to their patients to more deeply explore their own thoughts and feelings without interruption or input from the health worker (Knol et al. 2020). "*In in-person care, the patient is in front of you and you can see exactly what the patient is doing*", explained Dr Diaz, a psychiatrist at UNM Hospital. "*Over telehealth*" he continued, "*they might be doing something else, like looking at their phone, rather than being influenced by the silence*". Dr Diaz pointed to the uncertainty in his practice over telehealth around the use and effectiveness of silence. I observed this uncertainty during tele-therapy sessions with patients at the Clovis Clinic. There were several cases when a therapist over telehealth may have attempted to use silence, yet it was interpreted by the patient as a brief glitch in the internet connection. As an observer who was aware of the use of silence in the therapeutic encounter, I was also unsure when the presence of silence was due to a conscious effort by the therapist and when it was a result of a frozen video or lapse in the audio.

In the examples above, the ways that the physical distances introduced by the use of telehealth influence clinical knowledge and practices of health workers had not been considered. The senses are central to providing care (Gardner & Williams 2015; Goodwin 2010; Grosjean et al. 2020). Distance and the production of a bounded image of a patient's mental health restricts the important ways that health workers use and depend on their senses and physical agency for clinical work. The senses and techniques described are employed clinically to inform care; their absence illuminates how telehealth does not always align with the workings of a health system that presumes certain forms of closeness between health worker and patient. Through the deficiency of some sensory modalities and health workers' inability to practice certain clinical techniques, distance in the healthcare encounter limits what is knowable.

Distance disrupts clinical temporalities, roles and responsibilities

Telehealth also presented challenges for health workers as the distance involved in this form of care put temporal limits on the clinical encounter. This led to the offloading of responsibilities for the sensorial work described above onto in-person members of the clinical team. It also disrupted roles and responsibilities in the clinic that are conventionally underpinned by expectations of closeness and raised questions of accountability. Moreover, this disruption happened in different ways depending on the specific clinical setting.

In community behavioural healthcare, the use of telehealth redistributes certain roles and responsibilities from tele-health workers to those who are in-person. At the Clovis Clinic, the period of time between when a patient checks in for their appointment and when their appointment begins

offers a rich example of these reconfigurations. At the top of each hour, in-person therapists met their patients in the waiting room to bring them back to their office for their session together. Tele-therapists relied on the support staff working in the reception office to either bring their patients back for the appointment or, for patients who had been coming in for tele-therapy services for a while, shoo them toward the therapy offices when their tele-therapist was ready. Unable to participate physically in this interaction, tele-therapists could not perceive and interpret potentially relevant information about their patients upon which in-person therapists often draw (as discussed in similar situations in the sub-section above). This information includes, for example, whether a patient carries the smell of alcohol or a cigarette smoked just before their appointment, how their gait is while they walk from waiting room to clinical room, whether they were accompanied by anyone to the clinic and by whom they were accompanied, how they dealt with the busy waiting room, how they respond to small talk before their session formally begins. All of these are clinical indicators that offer insight into how a person is feeling on a particular day, whether they are comfortable coming in for therapy and how they behave around others. Behavioural health workers might attend to and draw from these details to inform their understanding of and clinical decisions around a patient.

With the use of telehealth, the responsibility of tuning into these details was shifted onto the support workers who were in-person. This redistribution of responsibilities was informal—each tele-therapist navigated it in their own way; in some cases, not navigating it at all. Lizzie, the tele-therapist who took the most proactive approach to this redistribution, asked the reception staff to inform her if a patient who had come in for an appointment was "*not their usual self… if they have a bad smell or are unfocused or agitated*". Amber, who worked at the front desk, confirmed Lizzie's request. She would message Lizzie via the telehealth software to let her know when patients seemed "*off*" during check-in. However, Amber admitted that her main goal at the top of each hour was to get everyone checked-in on time and into their appointments. She was often overwhelmed by the volume of patients checking in, especially those coming in at the last minute. She was not always aware of, or paying attention to, the demeanour of each patient.

Moreover, Amber and the other receptionists were not clinically trained as behavioural health workers. While they may have been able to sense if something was askew with a patient at check-in, they were not formally prepared to identify what factors about a patient's behaviour were clinically relevant and, importantly, they were not responsible for the patient's care. The types of information that tele-therapists missed through their inability to walk to the waiting room—"*stuck to the desk*", as described by Lizzie—are not replaced by the observations support staff sometimes make and, less frequently, pass along.

The time between a patient checking-in and the start of their appointment had been left out of the forms of care that were explicitly translated over telehealth. The ways in which telehealth in New Mexico had been imagined and the ways in which it had been deployed in the Clovis Clinic did not account for several important aspects of distance that were intimately intertwined with the provision of remote behavioural healthcare. Only some forms of care had been recognised as necessary to translate across distance. Other forms, like the ability of a health worker to meet their patient in the waiting room before the appointment starts, were left behind. In this case, the use of telehealth offers an alternative view of care, as compared to the care dyad which involves the relationship between an individual providing care and an individual receiving care as described, for example, by Aulino (2019), Buch (2013) and Mol (2008). In Clovis, care is dispersed beyond the health worker and patient. Care over telehealth also happened in the margins of the doctor-patient encounter, along the peripheries: in the clinic waiting room and the hallway leading to the therapy offices. It is these margins and peripheries that were not considered in the design and implementation of telehealth. It is these margins where the gaps between in-person and virtual care became most apparent.

In the example above, tele-health workers' responsibilities were disbursed in novel ways across support workers who were physically based in the clinic. A contrasting example is in the context of emergency psychiatric care. Psychiatrists at UNM Hospital in Albuquerque cared for patients in-person in the emergency department there. For their in-person care, psychiatrists relied heavily on a team-based approach (see also Chapter 8). Alongside their patient evaluation, interns, nurses, security personnel and medical technicians all gleaned and contributed collateral information about patients to inform care decisions. These psychiatrists also evaluated patients over telehealth in the emergency room at Sandoval Regional Medical Centre, a rural hospital that had no full-time behavioural health staff. Over telehealth, the clinical team was not translated across distance. There were rarely health workers who had been trained in behavioural health at the rural hospital emergency room upon whose clinical observations and insights the tele-psychiatrist could draw. The psychiatrist role was altered in these situations: from a part of a wider team working together to form a clinical decision, to an independent health worker evaluating a patient largely on their own. By making distance an intrinsic part of the clinical encounter, telehealth changes the nature of clinical work and the relationships that are central to that role.

In this consideration of roles and responsibilities, particularly in the US healthcare context, comes the question of liability[24]: who is legally held responsible for the care of a patient? How do the general principles that underpin medical liability in the US align with care at a distance, with care that involves redistributed responsibility? These questions are relevant for multiple healthcare contexts in which telehealth is used; in this ethnography they were most apparent within the psychiatric emergency setting.

The role of psychiatrists in emergency care—both in-person and over telehealth—is to assess whether a patient is at risk to themselves or someone else, and thus, whether they are safe to leave the hospital. "*We're just doing a consultation*", explained Dr Martinez, one of the psychiatrists on-call for emergency telehealth evaluations. "*We, as psychiatrists, are not the primary responsible person* [for the patient]*, it's the emergency room doctor* (at the rural hospital) *who's the primary responsible person*". He continued, starting to muddle what had seemed in his earlier declaration to be a clear distinction: "*something that I think is not very clear is the culture of who's responsibility is to do what. My view is that* [the patient] *is the* [emergency room] *doctor's responsibility; that I make a recommendation as a consulting physician".*

Dr Martinez offered an example of an emergency telehealth encounter to detail his confusion around clinical roles and responsibilities:

> "*Say* [the patient] *has a diagnosis of alcoholism; I say he should be referred to* [Alcoholics Anonymous] *and to local counselling. His suicide attempt, his overdose* (the reason for which he is in the emergency room) *was an impulsive attempt and was not lethal. He is telling me in many ways that he does not want to kill himself, he is describing how he's future oriented and he has plans. And I recommend that* [the emergency room doctor] *talk to the* [patient's] *family and make sure he's with someone today and that's it. Now, I don't know to what extent the emergency room doctor is going to be able to do that… Who is liable? What's the extent of the liability of someone, a specialist* (referring to himself), *who does a video interview in an emergency situation if the person is discharged and later it was judged that the* [care] *plan* [for the patient] *was suboptimal... It's very uncomfortable*"

[24] The US health system is structured by systems of liability as a way to support cultures of patient safety. Lawsuits in this area arise when a patient has suffered preventable injury in the course of treatment (termed medical malpractice). An integral aspect of this form of litigation is determining who was responsible for the patient's care when negligence and/or injury occurred (AMA 2022).

Dr Martinez expressed his discomfort in the uncertainty surrounding his role, responsibilities and liability in emergency telehealth encounters. Is he the doctor responsible for the clinical decisions made about a patient? Is he a consultant, offering guidance to the emergency room doctor who then is responsible for decisions around patient care? Is he some form of both? Does his recommendation—based on a remote evaluation—to the in-person emergency room doctor legally tether him to the outcome of the patient? Malpractice liability for telehealth providers is a complex and evolving landscape. There still exists great uncertainty and heterogeneity across laws governing liability in the use of telehealth (e.g., Fogel & Kvedar 2019). This aspect of the health system had been missed in the transition from in-person to remote care. Incorporating telehealth into the meshwork of the New Mexican behavioural health system introduced new gaps. In this instance, it is the novel reconfigurations of roles and responsibilities—made possible through the use of telehealth—that had not been negotiated on a system level. Instead, individual physicians were left to clinically, practically and emotionally manage the complex terrain of novel distributions of space in care and the resulting uncertainties in responsibility and liability over telehealth.

With telehealth, temporalities, roles and responsibilities in the processes of care were shifted in different and sometimes contradictory ways. Remote health workers at the Clovis Clinic had to rely on their in-person colleagues for practices they would otherwise do themselves. In emergency care, tele-psychiatrists who, in-person, rely on others to inform their care were not able to do so at a distance. While health worker roles and responsibilities were reconfigured in inverse ways in these examples, both illuminate how telehealth troubles the ways in which healthcare is designed and implemented in a health system underpinned by assumptions of closeness.

Gaps in processes of care

While telehealth addressed some challenges facing the New Mexican state health system—limited health workforce, great distances and remote populations—the distance upon which this form of care relies has also introduced new gaps that required on-the-ground navigation in order for care to be provided. These gaps emerged in a range of ambulatory healthcare situations: (1) crisis procedures, (2) pivotal moments in patient encounters and (3) everyday care processes. The gaps within each of these three situations are detailed below.

Lizzie, one of the tele-therapists at the Clovis Clinic, discussed her frustration around managing patients who were "*in crisis*" from a distance. New patients who came into the Clovis Clinic without a scheduled appointment, "*walk-ins*", as well as returning patients about whom therapists had

expressed explicit concern, were asked by the reception staff to fill out the Patient Health Questionnaire-9. This was a standardised questionnaire used in the US health system to "[assess] depression severity and response to treatment" (Löwe et al. 2004: 1194). It included a series of questions asking patients how often they had experienced different symptoms of depression, including how often they had "*thoughts that you would be better off dead or hurting yourself in some way*". If a patient answered that they had these types of thoughts almost every day in the past week, they were immediately deemed as "*in crisis*" and were scheduled to see the next available therapist at the clinic—either in-person or over telehealth. The therapist then took the patient through a crisis evaluation which assessed their particular risks and determined whether they needed to be hospitalised.

Sometimes, a patient would only be identified as "in crisis" once they were already in session with their therapist. Lizzie explained how this situation unfolded over telehealth: "*when I'm talking to someone who I feel is in crisis, I definitely give the* [reception] *staff a little message* [over the telehealth system] *to say that the person I'm seeing is in crisis* [and to] *either cancel my next appointment or stand by because I may need* [them] *to call 911 for me*." In the US, 911 is the emergency telephone number which anyone can call from any telephone in an emergency. 911 calls are routed to a local public safety answering point where information is quickly obtained through a sequence of questions in order to determine which responders need to be dispatched to which location. Since Lizzie is based in Montana, a call to 911 would be routed to an answering point in Montana that has information about the local resources there. When she is in a telehealth session with a patient who is at risk to themselves, Lizzie needed to request that the reception staff, who are physically based in Clovis, call 911. This offers another example of how health systems are built to be local, to be carried out in-person, and how telehealth disrupts this design.

Lizzie continued,

> "…*when I figure out that* [the patient] *need*[s] *to be hospitalised, I have a crisis assessment that I fill out on the computer and once I've gathered enough information to make that decision, I speak with* [the patient] *and let them know: 'This is what I'm determining to be in your best interest, this is the process of what's going to happen'. If they're in agreement, obviously it's a lot easier. Sometimes they're not and at that point I just try to keep them comfortable and keep them in front of me, saying 'stay on the line with me', and also messaging reception until I know that law enforcement has shown up... It can get pretty hairy at times… if* [the receptionists are]

busy and they're not seeing that I'm [messaging] *them, I have to send multiple messages and push the fact that 'hey I need you to* [call 911]'".

Once 911 is called, Lizzie then sends her crisis assessment to reception so they can print it out and hand it to law enforcement—generally the responders for crises—who then pass it along to the doctors at the local hospital who will be looking after the patient there. When law enforcement arrives, the reception staff meet the patient in the therapy room, walk the patient down the hall, through the waiting room, out of the clinic building and to the ambulance so they can be transported to the hospital. The tele-therapist is not able to do anything beyond the screen.

This process can be stressful. There are multiple avenues of communication for the therapist to keep active, including engaging a patient over a screen who is having thoughts of hurting themselves and may not want to be taken to the hospital. However, Lizzie mentioned that the staff at the clinic were slowly improving their processes for managing crises.

"[Reception staff] *are trying to get better… it's just a matter of managing so many different things at the same time. They're definitely more aware of when they take someone back to me that they already know is* [in] *crisis, somebody who has answered on one of the questionnaires that they're having thoughts of hurting themselves… then they're on alert. Like 'ok, I know I just gave her a crisis, I've got to sit by and watch or wait for that response'*".

Importantly—as I discuss later in this chapter—the novel gaps in crisis procedures, which are enmeshed with the use of telehealth, are navigated informally by therapists and reception staff.

Gaps were also apparent in non-emergent yet still critical points in processes of care. I observed several therapy sessions with Sydney, a tele-therapist at the Clovis Clinic, whose internet connection was the choppiest of the three tele-therapists. She lived in a rural area in another state that was only serviced by one internet provider, so she was not able to change providers for better service. Her first session with Bianca, a Hispanic woman in her 40s seeking therapy for the first time, was particularly choppy. Sydney's movement on screen was disjointed; her video and audio were sometimes in sync, sometimes the video froze while the audio flowed smoothly. Bianca did not seem to mind; she became increasingly chatty as the session went on. 20 minutes into the session, once they had built up some rapport, once enough details and pleasantries had been shared between them, Sydney asked Bianca why she was seeking therapy. Bianca's voice seemed to catch a bit as she started to answer. Halfway through her response, she was interrupted by Sydney who said she could not hear anything Bianca

had said and asked her to repeat it. For me, this interruption was particularly startling as Bianca had started to disclose some harrowing details from her daily life. Bianca started again to tentatively share what, up until this point, seemed to be the most difficult topic for her to discuss. Again, Sydney interrupted. The audio was still not working. "*I'm going to hang up and call back to see if that helps. A box will pop up, click on the green answer button*". Sydney disappeared from the screen. Bianca turned back in her chair toward me, giving a shrug with her shoulders and arms. Even though at the start of the session I had asked her to ignore my presence as best as possible, I was her only physical companion in the room and she did not know how to respond to the fairly sudden disappearance of her therapist. After a few moments—only about 5 seconds— Sydney called back via the telehealth software and Bianca answered. The audio was working again, "*it must have been some sort of glitch*" said Sydney, apologetically. For a third time, Sydney repeated her question, and for the third time, Bianca began to share her reason for seeking therapy.

Bianca expressed several positive thoughts following her session with Sydney and, besides the brief moment of confusion, was seemingly unphased by the technical failure. However, this sort of disconnection was a big concern for many of the telehealth workers with whom I interacted. The UNM Department of Psychiatry held monthly "Provider Support Sessions" for behavioural health workers who provided care to rural communities via telehealth. These hybrid sessions—taking place in one of the University's conference rooms set up with a large projector screen and camera to include those calling in remotely via Zoom—offered health workers a safe space for counsel, advice and sharing frustrations among colleagues. Sergio, a psychiatrist who was in the process of completing the paperwork necessary to start providing telehealth services for the first time, shared that one of his main concerns about this form of care was "*building up a rapport and safe space with a patient, and then losing it when the* [technical] *connection is lost*". "*What do we do*", he asked his colleagues, "*if we're at a pivotal moment in the session, the patient has just admitted something that we've been working up to for a long time, and then the screen freezes?*" Several of the other health workers nodded—this was a concern for many of them, even those who were experienced telehealth providers. Dr Bernard, another psychiatrist who had been providing care via telehealth for over a year, agreed: "*you spend a lot of time working up to the point where a patient feels comfortable confiding incredibly personal and often very difficult information. Perhaps they don't even know yet what they are going to share, but through the therapeutic process together, they are able to reach this point*." What happens, then? How do health workers navigate a simultaneous technological and emotional disconnection? The participants in this session shared individual, yet similar approaches to managing failures with the technology. Jordan, a clinical psychologist, shared that she tells each of her patients during their first appointment: "[if there are technical issues], *stay at the computer. Don't leave, don't*

go home. I'll try to call you [on the telehealth system]. *If that doesn't work, I will get the IT guy to help. If that doesn't work, we will finish the session on the phone. Just stay there until I talk to you again*".

Jordan's approach focused on re-establishing the virtual connection and ensuring that her patient would wait until they could connect again so they were not left on their own in, what could be, an emotionally liminal and fragile state. Her approach, however, did not address the progress that may have been lost in the therapeutic process, the patient's sense of safety that may have been deflated, or the emotional rapport that may have dropped off alongside the video and audio connection.

After his colleagues shared their advice, Sergio responded to the discussion pensively, "*we need to think about the technology clinically. Not just technologically*". Here, he drew attention to the need to create processes that ensure the important tenants of care are still upheld by the telehealth process. Moreover, this statement revealed that telehealth creates gaps in clinical processes *and* that individual health workers see themselves as responsible for navigating these gaps in order to provide 'good' care.

The implementation and use of telehealth and the physical distances implicated therein also involved novel gaps in everyday care processes, such as prescriptions. Lucy, the psychiatric nurse practitioner we have met several times before, explained how the prescribing process works in the context of the care she provides via telehealth. "*I do* [prescriptions] *by email. I can email, or,* [submit them] *on the* [rural clinic's] *medical record system. The ones I can't do* [online] *are stimulants or anything that's a controlled substance, I have to have a physician* (in the rural community where she provides care over telehealth) *do a hard copy*".

Lucy continued, explaining the challenges of finding a local physician to write and submit hard copies of her controlled substance prescriptions, "*nobody told me how to do it, this is a thing I had to develop myself… one of the docs there finally said why don't you just put a co-signer on the end of your* [patient's] *note that will alert me to the fact that you've written a stimulant script, and I'll do that… that took probably two and a half years to figure out*". After two and a half years, Lucy figured out a way to prescribe certain medicines for her patients from a distance. She spent a long time trying to manage and organise her clinical care and the processes of the rural clinic more broadly from a distance, in a place where there were no pre-existing processes for telehealth, and where she lacked the physical knowledge of the clinic and community, including familiarity with the other health workers in the area. Telehealth services were situated in a wider health system that did not always

accommodate distance; or at least, were not initially designed to accommodate distance. In this way, the distance upon which telehealth functions produced gaps in the clinical process.

Another prescribing physician, Dr Shellito, who provides psychiatric care via telehealth to the Clovis Clinic, formed a different strategy to the challenge of prescribing patients controlled substances from a distance. The diversity of approaches to clinical processes shows the individual and non-standardised nature of navigating the use of telehealth in behavioural healthcare. Dr Shellito detailed her belaboured process of writing a physical "*script*"—a small piece of paper ripped from a pad of prescription papers, containing her name, practice information and signature along with her patients' name, birthdate and necessary medicines to be received. Following the workday, she overnighted all of her prescriptions via Fed-Ex to the clinic to be picked up by her patients and then brought to the pharmacy in exchange for their prescribed medicines. This meant that patients who were prescribed controlled substances had to attend the clinic on two separate days: once to meet with Dr Shellito over telehealth, and again to pick up and fill their prescription. This process was particularly challenging for patients living outside of Clovis. A handful of patients at the clinic lived in Fort Sumner, the small town of 1300 residents 60 miles to the west of Clovis that I drove through in Chapter 4. As the Clovis Clinic was the closest health centre with access to behavioural health professionals, these patients had to travel nearly two hours round trip on two different days, paying for petrol and often times taking off work, in order to receive services and their medicine.

The use of telehealth and the distances implicated therein sat in tension with several existing care practices such as crisis procedures, technical failures and the prescription of controlled substances—all designed with the assumption that care happens within a certain proximity. Health workers and patients navigated these gaps and tensions themselves to enable the provision of care. This navigation involved extra work, the expenditure of time and money, forming new processes and creating novel channels of communication and trust.

Navigating relations with local clinical teams from a distance

Involving these new forms of distance in healthcare altered ways of relating among health workers, particularly those based locally at rural clinics with those working remotely over telehealth. There were several dimensions to the ways in which these relations were influenced by the novel involvements of distance in the provision of care: the ability for telehealth workers to function with a limited understanding of the organizational reality of the remote clinic; and the care and collegiality

experienced by behavioural health professionals over telehealth. Importantly, both dimensions influenced patient care.

At the Clovis Clinic, there were substantial organisational and administrative shifts throughout the spring of 2019. These started in March when, on the Monday of my first full week at the clinic, the executive director of the clinic announced that he was resigning and would be leaving the clinic by the end of the week. During each subsequent visit, I noticed changes. ID tags were now required to be worn by everyone, including me, a "*VISITOR*". The clinic's hours were extended in increments, lengthening by the week. In late March, during my second week-long visit, the first member of the reception team was expected to arrive by 7:30am, 15 minutes earlier than the 7:45am arrival that had been in place long before my visits began. By the end of April, the clinic's hours had been further extended: the first receptionist was expected to arrive by 7am. An interim executive director was named and had assumed the position. The director of human resources was let go along with a few of the clinical staff. There was a new receptionist undergoing training each time I visited. The clinic was now open on Saturdays; a list for volunteers lay untouched in the reception office, waiting for clinical staff and receptionists to sign up for shifts over the next few weekends.

With all of the administrative and organisational changes, health workers over telehealth sometimes felt out of the loop. There were changes nearly every week, many of which were not communicated to the tele-therapists. Lizzie, one of the tele-therapists explained,

> "*sometimes we get kind of like left… I don't want to say left behind, but forgotten about, when certain things with* [the clinic] *are going on… there are certain things that get translated to all the other therapists that are there face-to-face but it takes a while to get us,* [tele-therapists]. *And so that's kind of difficult because it's like wait, I haven't heard anything like this, when did this happen? When did we start doing this? And so, we're kind of the last people to know what's going on. So that can be frustrating*".

Even in the fortnightly staff meetings held on Friday afternoons for all clinic staff (executive, administrative, clinical and support), the tele-therapists struggle not only to relate and collaborate with their colleagues, but even to hear what others are saying and follow along with the conversation. Lizzie continued, "*I think maybe the biggest struggle right now is… when it comes down to like staff meetings, whenever they pull* [all of the tele-therapists] *up on the same call, it's really hard to hear* [everyone in the staff meeting*] … Sometimes the calls will drop and it's kind of hard to like interact with them or connect with them*". While Lizzie was employed full-time by the Clovis Clinic, she felt

dislocated and detached from the organisation. These examples invoke questions such as, what does it mean to be a part of a local care team? When is a health worker considered local? What practices cultivate and reinforce this condition of being local? And what happens when these practices no longer exist, or exist only in part? How much distancing does being at a distance involve? And what are the implications of this distancing?

Health workers in Albuquerque who provided care to rural communities over telehealth also experienced challenges in navigating relations with rural clinical teams. For example, it can take time for clinicians over telehealth to get a sense of how the local health system works in the community to which they provide care. Lucy, the psychiatric nurse practitioner, felt lost in her interactions with the local health system, specifically regarding patient referrals.

> "*There doesn't seem to be any real procedure or policy* [in the community]. *Like here,* [at a hospital in Albuquerque], *if you had a kiddo discharged* [from the hospital], *they had to be followed up within a week. That's just the way it is. It's never like that* [in the rural community], *that I can tell. Because I get kids that have been out of the hospital for months and then they find me! And by now they're off of all their meds! Because nobody's refilled them. How did that happen? I don't know if they don't know about me, some of the clinicians. I don't know if they don't think I would see that* [patient] *on an emergency basis. I don't know!* … [Patients] *get referred through a consultation to behavioural health for psychiatric med evaluations. And sometimes it's the therapist… I can't get this figured out either. There're some therapists that work in the school that I think are employed by* [the health system] *and there are some therapists that work at the hospital but I don't know... I haven't figured out what the system is*".

In our interview, Lucy was actively trying to get a grasp on how the local system worked in the community in which she provides care. She was unable to discern how her patients ended up coming to see her, which protocols she needed to follow and which local healthcare professionals she needed to liaise with in order to give her patients the best care. Her distance from the local clinical team and from local clinical processes not only influenced her experience of providing care, it also had implications on the care she was able to provide. Telehealth, here, created another gap in the provision of care: the unintentional exclusion of remote health workers from the local health system.

Lucy continued to share her experience of feeling as if she were not fully part of the local care team:

"*I get on* [to the telehealth system] *sometimes and they don't get on. I've learned to call* [on the telephone] *and say 'what's going on?' cause if they're not right on immediately when I get on then it's unlikely they will* [get on]. *One morning I called on the telephone and this guy goes, 'oh we have clinic today?' I go, 'yes we have clinic'… I think the staff don't have an investment in me or the* [telehealth] *clinic per se.* [One of the local physicians in that community] *did say that at one point, he goes 'I just think that they're not accepting responsibility for the clinic, I just don't think they see it as real 'cause you're not here*'".

Lucy's 'clinic'[25] was spread across space and time. Once a week, patients in this rural community would come into the local clinic for psychiatric care. The health workers present there would coordinate the processes of that care: checking patients in, bringing them back to the private office where a computer was connected via video call to Lucy, who sat in her own private office in Albuquerque. Since Lucy was not physically present to hold her clinic, the local staff may not have recognised the clinic as tangible and concrete. Lucy shared several experiences of local staff members forgetting that she was holding a clinic, even though she had been working with this community for over four years, holding clinics consistently on the same days every month.

Lucy's experience illuminates the ways in which telehealth addresses an issue in the larger New Mexican health system: the paucity of access rural residents have to behavioural healthcare services. However, it also reveals how access is only one component of the challenges a rural health system faces. The standard of care procedures Lucy was used to following in Albuquerque—e.g., following up with a child who had recently been discharged from hospital—did not exist in this rural community because there were not enough local resources to uphold these procedures. Lucy's virtual connection to this community was not sufficient to address the many challenges this community faced more broadly. The use of telehealth is intertwined with aspects of daily life that extend much farther than the clinic.

Lucy further detailed the difficulty she experienced in creating connections with healthcare professionals within the local community.

"*I make every effort when I meet somebody that I feel like I can connect to, to get something done for the patient. Like I've got Jen, a nurse case manager and she's just amazing. But I never*

[25] Telehealth challenges the conventional understanding of 'the clinic'. In this example, the clinic is not only the physical location where patients go for healthcare appointments. It is also a term that denotes the time a health worker allocates to caring for a particular group of patients in a specific location. This clinic exists across multiple spaces and requires particular forms of connection and coordination.

ever met her until January. She's been there for years… it's kinda hard to sift through all the people I'm connecting with and trying to find these jewels, these people who'll just go the extra mile for the patient … It feels like you're going in blind when you're not able to go to the place to see it, meet people".

As Lucy had not had the chance to visit the clinic in-person, to get a sense of who works there, who holds which positions and where in the clinical hierarchy someone might fall, in combination with the clinic's high staff turnover, she has struggled to connect and collaborate with local health workers toward better patient care.

Dr Walsh, a tele-psychiatrist at the Clovis Clinic, also expressed frustration about the difficulties in forming relations with the local care team and the ways in which these difficulties influenced his provision of care. Dr Walsh generally worked with Beverly, an in-person nurse who supports his work. Beverley was the first health worker psychiatric patients encountered at their appointments. With each patient, she went through several questions about their well-being and collected physiological information through physical examination: weight, blood pressure and heart rate, all of which could be influenced by psychiatric medicines and could be indicators of whether a medicine has been safely administered. "*The one thing I really have noticed*", shared Dr Walsh, "*is that you really have to be able to trust the staff that's at the site where the patient is. Because, since I can't do a physical assessment, I have to trust the assessment skills of the nurse that is bringing in the patient*". Dr Walsh had never met Beverley in-person. He had not had the opportunity to observe how Beverley took blood pressure readings, or how she asked the introductory questions that then informed his clinical assessment. Dr Walsh's clinical care not only depended on his own expertise and judgement, but also on Beverley's clinical skills. This example highlights the uncertainty surrounding tele-health worker reliance on local staff and the importance of strong, trusting relations between remote and local health workers.

Jordan, a clinical psychologist who provided care from Albuquerque to several rural clinics, described how her communication with the local team at one of the clinics was influenced by telehealth: "*I think they're afraid to come in*[to the telehealth office] *and be on camera. Like, if they have to come talk to you, they'd rather just email you or call you and they're just sitting in the room across from you, they could just like walk in and talk to you… they're just not comfortable, I guess*". Even though the local support staff could easily speak with Jordan over the telehealth interface, they avoided this. Instead, they emailed her or called her over the phone. This slightly circuitous mode of communication influenced her patient care. "*I really need the* [staff] *there to tell me sometimes what's going on in the*

community, so I get an idea of like, I get a lot of kids there that are triggered by something… [the staff] *just send* [the patient] *in*[to my office] *and then I got to ask the* [patient] *like 'what's the deal there?'*." Jordan explained that at the other clinics she cares for over telehealth, the staff were more receptive to her and the modality through which she was present in the office. She learned from the staff about the community, about local events that may have influenced the mental health of her patients. However, at this particular clinic, the staff's discomfort with being on camera changed the way in which communication happened. Jordan felt less informed about the goings-on in that particular community, and therefore had a limited understanding of her patients.

To counteract experiences of disconnection from rural clinics, health workers described strategies and techniques they used to decrease the distance between themselves and the local support staff. This strategising generally happened on an individual level; health workers put in more time and energy in their workday toward understanding local processes and familiarising themselves with clinicians and resources local to each clinic. Jordan, for example, shared:

> "*It takes more work and effort on my part… so I work with* [a small, rural community] *over telehealth. But I used to live there, so it's so much easier because I know what's over there, where to go, what services* [are there]*… I know the police station is just across the street from the clinic. I know that if we need help with a patient who needs to be brought to the hospital, for example, that the police are just there, they will arrive shortly. In other communities I work for, I don't have a sense how long it might take police to arrive, if they're coming from across town, or even if they're based in another community. I haven't been there. I don't know everything that's offered, I don't know the case managers over there, anything, so I have to maybe work a little harder and call them, talk to them*."

A provider's familiarity with the community and support systems local to the clinic in which they work are important aspects of in-person care that have not been considered in the transition to telehealth. The qualities, scales and forms of closeness and distance upon which the health system relies are upended in certain ways; disrupted with the use of telehealth. They can no longer be taken for granted; they need to be attended to, understood and navigated in order to facilitate the use of telehealth in this particular New Mexican health system, as well as the wider American health system.

The presence of distance, inherent in the use of telehealth, also influenced the forms of care telehealth workers received, both from the wider clinic and their colleagues. Tiffany, a tele-therapist who had recently moved from Clovis to California, experienced an absence of care from the Clovis

Clinic and her colleagues during an incredibly distressing period. Tiffany was a military spouse and when her husband was transferred to a base in California, her family moved there. She had been working as an in-person therapist at the Clovis Clinic for a couple years and had decided to continue her therapy work with the clinic over telehealth following her family's move. In her interview over Skype, she described how, on the day she moved to California, one of her patients died by suicide. "*It was the hardest experience I've ever had in my career thus far*", she reflected. "*I haven't been doing* [therapy] *very long but, in the two and a half years that I had been doing this, that was the most difficult thing I've ever had to deal with*". Tiffany explained how she had seen her patient in-person the week before her move, a 16-year-old who had said that she was doing well and that she was feeling happier.

"*What was even more difficult was being so far away, I don't think I got the support that I needed… I couldn't focus on anything else because I was always focused on the fact that this had happened to my* [patient]. *And because I was so far away… I don't want to say* [my colleagues and bosses] *forgot about me, I don't think that they even realized how much it had impacted me*". Tiffany explained that she reached out several times for help and after about three months, told the upper management at the clinic "*I can't do this anymore if you guys aren't gonna help me with this, there's no way. I was just kind of over it. I had lost confidence as a therapist during that time. I used to cry about it all the time, I felt like I was grieving a* [patient] *as if she was a family member*".

Tiffany continued,

> "*you spend a lot of time by yourself* [when practicing over telehealth]. *Whereas I used to like be in an office and interact with other therapists, I'm* [now] *at my house all day, it's isolating… Because of* [my patient's death] *and not really feeling like I got the support I needed, I just felt like maybe it was time for me to move on and do something else. So I got a job here in* [California] *and I won't even be working directly with* [patients] *anymore*".

The traumatic experience of her patient's death in combination with her new lifestyle as a tele-therapist—working every day at a distance from her colleagues and physical, professional support structures—led to Tiffany's ultimate decision to leave clinical practice for the time being.

The systems, operations and modes of support for health workers that had been built up around practices in the Clovis Clinic—being seen every day, interacting with colleagues, having people be able to see physically if someone is struggling—were neither designed nor redesigned to work at a distance.

The ways in which health workers are cared for, how they are seen and considered are dimensions of telehealth that have been lost in the move from in-person care to virtual. The use of telehealth has implications for many aspects of care including those that are on the 'periphery' of the virtual encounter and beyond the doctor-patient relationship, such as the "intersubjectivities" (Strong 2020) of care between health workers.

Shifting care relations, distance and isolation between health workers were also present in more quotidian circumstances. Amanda, a tele-therapist at the Clovis Clinic, explained,

> "*regardless of how much* [my in-person colleagues] *try, I still kind of feel like I am left out of things that happen just day to day. You know, because I'm not there physically. Like you know, you pass by somebody, you say 'how's it going',* [they say] *'oh I got engaged!' Or 'Oh, I'm having a baby'… It's not anything that can change, or that is done on purpose, but it's just that little bit of disconnect there… And then um, employee get-togethers, like the Christmas party every year… I've missed it twice now and yeah it would be nice to go and experience that in-person, just kind of have that connection*".

Working over telehealth, Amanda was not able to participate as much in the daily lives of her colleagues, in the undirected, spontaneous connections that may happen when running into someone in the hall, going out for lunch or enjoying an employee holiday party.

Lucy described similar experiences of isolation: "*I can hear people talking* [outside of the telehealth office]. *I'm like 'hello! Hello! Is anybody there?' And then maybe somebody will come in*[to the office] *or maybe they don't. They like to laugh and talk out there all the time*". In-person, Lucy may have heard colleagues laughing outside her office and gone to the hallway to see what was going on. Over telehealth, she is moored to the screen, distanced from opportunities to relate with the local care team. This isolation also influences the way in which she provides care: "*the thing I do miss* [from working in-person] *is that I used to maintain a connection with the* [patient]*'s therapist*. *I was treating in a team kind of function. And I feel like I'm now more of a solo practitioner, and I don't like that*." Practicing over telehealth, Lucy had not been able to form connections with the other health workers involved in her patients' care. She no longer felt like she was practicing as part of a clinical team.

At a distance, telehealth workers navigated relational shifts with their colleagues and the wider clinics to which they provided care. These shifts precipitated from experiences and perceptions of being part of the local care team, having a grasp on local health system processes, the ability to become familiar

and form relations with those in-person upon whom telehealth workers relied. These shifts came alongside changes in the forms of care available for telehealth workers, in terms of both collegial and institutional support. The novel distances implicated in the health system through the use of telehealth did not align with the conventional, expected and persisting forms of relationality between health workers.

Who carries the weight of the gaps implicated in this newfound distance?

Who navigates the gaps and misalignments between telehealth and existing care processes? In other words, who is responsible for 'making telehealth happen', for navigating the transformations in the provision of healthcare on the ground? At the Clovis Clinic, it was the in-person therapists and support workers who carried the weight of multiple gaps in care, both in day-to-day responsibilities as well as in crisis situations.

In interviews with the in-person therapists at the Clovis Clinic, I gained further insight into how the reliance of telehealth workers on in-person staff unfolded on a daily basis at the clinic. Holly was an in-person therapist who was often vocal about her frustrations and discontent around the reliance of telehealth workers on those who were in-person: "*there are times where it's frustrating because* [the tele-therapists] *don't have the same responsibilities as some of the in-person people…* [one of the tele-therapists] *gets off at 4pm because she doesn't live in the state and there's a time change for her*". Holly explained how the regular schedule for clinical staff runs from 8am – 5pm Monday through Friday. The hours for each in-person therapist, however, are adjusted one day a week to 9am—6pm to enable to clinic to stay open later and give patients the opportunity to make appointments in the evening. "[Tele-]*therapists don't have to do that*".

Holly continued, "*then we have other expectations…* [the clinic] *has a contract with the* [local] *hospital to go do the mental health evaluations for the suicidal, homicidal, whoever they determine needs an assessment*". Holly explained that these evaluations are the responsibility of the therapists at the clinic. "*There's four of us* (in-person therapists) *on rotation who take on a week every month. So during the week we work 8am—5pm* [at the clinic] *and then the on-call therapist takes calls* [from the hospital] *until 11 at night"*. Hospital calls are received through a clinic-owned smart phone. The on-call therapist is expected to be available to come in-person to the hospital; "*obviously* [tele-therapists] *can't do that*".

"*Some other menial things* [that tele-therapists don't do] *would be like phone calls… the amount of voicemails we get, the amount of phone calls we have to return…* [The tele-therapists] *never have to deal with those calls. If a* [patient] *has any issues or they need to tell* [the tele-therapists] *something, they go through me or the* [reception] *staff to get that message to* [them]". I asked why therapists receive so many phone calls, and why this places an extra burden on the in-person clinical staff. Holly expanded,

> "*Let's just say like one of your* [patients] *is involved with probation. If the juvenile or adult probation officer wants to follow up about something or inform you of something or ask you something, we have a responsibility to do that.* [Also] *CYFD* (Children, Youth and Family Department) *or even family members complaining about our scheduling system or medication issues… just a whole gambit of things… We also have to run support groups,* [tele-therapists] *can't do that*".

As I introduced earlier in this chapter, when a patient came into the Clovis Clinic with acute thoughts of hurting themselves or someone else, they were deemed to be in 'crisis' and would immediately see whichever therapist had an opening in their schedule or who was able to cancel an upcoming patient appointment. Sometimes, the available therapist was over telehealth. Holly described how she was often asked to get involved in these situations:

> "*A lot of the times, I'll get called in on* [the session between the patient in crisis and tele-therapist] … [The tele-therapist] *can't get a good feel on the* [patient]*… they'll say 'well I can't tell if this person is really going to leave here and be ok, can you come give me a second opinion'… in the last month that's happened like three or four times where the* [patient] *was presenting as high risk, potentially they were on some sort of substance, and with the* [tele-therapist] *and the* [patient] *not being in the same room,* [the tele-therapist] *couldn't all the way tell if the symptoms were due to drugs or alcohol. So I went in there and I was trying to assess if the person was intoxicated and if they were intoxicated, could they leave by themselves or you know, that whole thing* (get law enforcement and the hospital involved) *… You can sometimes smell* [if they're intoxicated]; *you can sometimes hear if they're slurring their words differently. Like, I guess the* [tele-]*therapist couldn't really tell if there was a lot of slurring and if* [the patient] *just wasn't acting his normal self. And so that's a barrier at times*."

Holly explained a situation when a tele-therapist may be redirected from their usual case load to attend to a patient in crisis. These clinical circumstances sometimes required additional assistance

from an in-person therapist to inform the ultimate decision about whether a patient was safe to go home or if they needed to be admitted to the local hospital. Calling in another therapist for a second opinion takes the time of two of the clinic's seven therapists. This can be especially disruptive if both therapists were initially scheduled to see other patients, and perhaps both patients had to be cancelled or rescheduled because of the crisis.

The disparity between what in-person and tele- therapists were able to do and tasked with doing was particularly pronounced at the Clovis Clinic as all tele-therapists had previously provided care at the clinic in-person. The tele-therapists had transitioned to remote services when their spouses in the military were assigned to bases elsewhere. While the tele-therapists were still employed by the clinic and continued to see many of the same patients from when they were in-person, some of their previous responsibilities, as delineated above, were shifted and dispersed between the remaining in-person therapists. The in-person therapists were disgruntled by these reconfigurations in responsibilities, as they were caught in the fluctuation of staff changes from in-person to remote therapists and were expected to absorb these extra tasks into their own workload with no reciprocal decrease in responsibilities elsewhere. However, while in-person therapists had to pick up the work that tele-therapists were no longer able to complete themselves and had to navigate nearly unmanageable patient caseloads, they still expressed gratitude for the tele-therapists. At the end of the day, at least there were more health workers contributing to the care of the people in this community.

The shifts in distance in the use of telehealth implicate multiple levels of the health system. However, a large portion of the responsibility in navigating these shifts landed on the already overworked and under resourced healthcare workforce on the ground[26]. In many healthcare contexts, responsibilities have been devolved from the State onto local communities and community health workers (e.g., Cooper 2015). Perhaps the allocation of responsibility in the context of telehealth was due to limited conceptualisations of distance in healthcare and concurrently, of what the health system needs. Distance is conceptualised in a distinct and narrow way that offers a sort of legitimisation for the employment and utilisation of telehealth: the distance between health workers and patients is the issue, and telehealth enables a solution through allowing healthcare to be provided across that

[26] At the Clovis Clinic, all of the support staff and six of the seven therapists (both those working in-person and over telehealth) were women. Not only was the burden of navigating the gaps in the use of telehealth shifted onto people at the bottom of the healthcare hierarchy, most of these people were women. The implications for gendered practice and equity in care, particularly regarding how women often work at the intersection of governmental health policies and daily practice in communities, have been discussed elsewhere (Roalkvam 2014; Uzwiak & Curran 2016).

distance. This conception of distance neglects other forms of health infrastructure implicated in the use of telehealth. Most notably, the healthcare workforce and their navigation of the gaps between conventional spaces in the health system, and the new clinical and social spaces that are implicated in the use of telehealth.

Discussion

This chapter is about the intersections of distance and care. It is about health practitioners: what they can know and how they can relate to each other. It is about how the clinic is redefined, how the production of distance in the use of telehealth changes the nature of care and the nature of the clinic. I argue that telehealth implicates novel registers of distance that do not align with the conventional understandings and orderings of space upon which the American health system relies. I bring attention to how the spatial and technical restructuring of healthcare provision in New Mexico through the use of telehealth altered the production of clinical knowledge, daily practices, temporalities of care and collegial relations. I explore how telehealth comes to bear on health workers: both their ability to provide patient care, their relations with colleagues and forms of care they themselves receive. Finally, I try to make sense of the ambiguous nature of responsibility in the use of telehealth: who is expected to make telehealth 'work'? How does this happen, and at what cost?

This chapter contributes to the body of work in the anthropology of health systems (Closser et al. 2021) that illuminate the ways in which health workers negotiate tensions between their own standards of care, the resources available and wider health system expectations (Kienzler 2020; Strong 2020). The forms of distance introduced through the use of telehealth altered the clinical skills upon which health workers could draw. These shifts in space contributed to reconfigurations in clinical roles and responsibilities as well as relations between remote and local health workers. They created gaps in processes of care. These new forms of distance in care provision are navigated largely by the healthcare workforce, a critical infrastructural component of the New Mexican behavioural health system that is already stretched thin, already operating within a paucity of time and resources. This has consequences in terms of inequities in healthcare and how that care is delivered. Having explored the intersections of distance and care in this chapter, I now raise new ideas around multiple forms of inequities and care, respectively.

Forms of in/equity

I have shown how health and support workers navigated extended workloads in order to illuminate how inequities in the health system are perpetuated via telehealth. While discourse over the past two decades around the potential cost effectiveness of telehealth has focused, at least partially, on the delegation of tasks from doctors to less expensive actors in the health system (e.g., Cartwright 2000; van Montfort & van der Helm 2006), the delegation has not been formalised in practice. In the absence of formalisation, the burden of addressing gaps in care falls onto health workers who must relate, collaborate and care in new ways. Are the health workers carrying the weight of making telehealth 'fit' the outliers in the health system (Krieger 1994)? Unlike assemblages which, in Latour's (2005) terms, involve equal actors within a flat ontology, in this case, not all 'actors' within the health system are equal. There are people who are considered peripheral—or perhaps are not considered at all—even though they are critical to the functioning of the health system. While the aim of telehealth programmes is to make the access to care more equitable, telehealth in these examples increased inequity among the healthcare workforce, particularly those who were already over worked and under resourced. Is the use of telehealth in this context another example of the perpetual paradox within which American healthcare is situated: brimming with medical 'breakthroughs', yet catering to populations vastly unprepared to afford (and provide) these same services (Rosenberg 2007)?

Importantly, I bring up questions about what type of equity is addressed by the implementation and use of telehealth. Although policies have been created with the hope of improving access to care, there is a lack of understanding of what life is like on the level of the clinic; how these policies are actually happening on the ground (Justice 1986). In the New Mexican behavioural health system, those on the level of the government (policy makers, insurance companies, the Behavioural Health Services Division, telehealth advocacy groups) have legally negotiated the processes that enable care via telehealth to take place, including creating systems whereby health providers and clinics receive reimbursement from insurance providers for the provision of telehealth services[27]. However, the ways in which practices around the use of telehealth happened were informal and ad hoc. They fell within the remit of an individual health worker, in collaboration between health workers or within the clinic at an organisational level. Health workers who were already struggling to provide sufficient care were tasked with also making telehealth 'work' within the particular social, political and financial topologies of their specific clinics (Sullivan 2012), with making care more equitable through their own effort and

[27] US Healthcare is structured by medical billing processes (Rosenberg 2002). An initial and crucial step to enabling the provision of care via telehealth in New Mexico involved legal agreement from insurance companies to reimburse health workers for their work over telehealth at the same rate as their work in-person.

time. Who are the proponents of these technologies, these new forms of distance to be crossed and navigated, and who, in practice, navigates them? Which distances are not considered in the implementation and use of these technologies? In which ways is the ordering of space through the use of telehealth a particular mode of state power (Mueggler 2001; Sullivan 2012) and a reproduction of existing power structures?

These questions are resonant with those of Willging (2005) who traced how the restructuring of New Mexico's public health system (Medicaid) unfolded on the level of clinics, health workers and patients. She argued that in the attempt to deliver better services, the state health system instead placed more pressure and hardship on health workers, patients and their families. Willging points to the ways in which systems underlying healthcare provision in New Mexico are dictated from the top down, through the state government as well as several levels of private organisations. In order for patients to receive care and for clinics to keep their doors open, health workers and families—those with the least agency in the hierarchical health system—were required to navigate multiple forms of diverted responsibility. Further, increased pressure, minimal support and financial precarity can hinder attempts from health workers and clinics that challenge these underlying systems of power (Wagner 2005).

The responsibility added to health workers' workloads reveals systemic inequities and brings up questions about the forms of inequities that telehealth is intended to address and what forms it ignores. The consideration of equity further implicates questions about the forms of care that these particular shifts in space enable, and the forms of care they restrict.

Forms of care

Assumptions about the forms of distance implicated in the health system have led to a paucity of understanding around how telehealth works on the ground. We have seen situations in which health providers work in compromising clinical, relational and emotional situations in order to continue providing care alongside and through telehealth. Care in these situations is dictated by several different and sometimes conflicting logics (White et al. 2012). One form of logic revolves around the access to care via the technologically enabled crossing of geographical distance. This logic, however, does not accommodate other forms of space and related processes of care that are created through the use of telehealth. I have outlined how these distinct logics of care and the distances implicated therein interact on the ground and what they come to mean for those who navigate them every day. I draw attention to the forms of care that are enacted, and the forms that are disregarded.

Importantly, these logics reflect state-level beliefs around what care is—or at least, which form of care should be prioritised. Care over telehealth exists far beyond the computer screen: it involves multifaceted configurations of distance and lopsided systems of power.

In this chapter, I delineate the gaps between the implementation of telehealth and its employment and use; gaps specifically related to forms of distance. I argue that the people with the least power in the health system are those who are made responsible for filling these gaps, for aligning a technology based on distance with a health system underpinned by assumptions of closeness.

Care can be contradictory: imagined as something positive and promoting of health, yet in practice is detrimental, even harmful and violent (Stevenson 2012, 2014). The use of telehealth increases access of specialist care to patients who otherwise would not be able to receive these services locally. Simultaneously, telehealth puts new strain on health workers who are already struggling to keep up with the demands of the health system. While one form of care, for patients, is in some ways helpful given the state's goal of increasing access, another form of care, that for the under resourced, over worked health workers has been, in some ways, disregarded. In Willging's (2005) research as well as this ethnography, the provision of care, the challenges therein and the experiences of health workers and patients are intertwined with much wider processes than those within the clinic. The use of telehealth involves many more complex processes and navigations than what happens in private rooms in front of a computer screen. Care extends beyond the physical technology of telehealth.

Murphy (2015), in unsettling assumptions about how practices of care unfold, who is cared for and who is left behind, asks: "where does care begin and end"? (ibid., 721). In this chapter, I have approached two related, yet distinct questions: what forms of care are prioritised, and which forms of care are excluded? In other words, where does the attention given to care end? What is left out? Through the lens of distance, I have traced where care trails off, the forms of care that thus far have not been included in research into the implications of the shift to telehealth.

Conclusion

As I write this chapter, nearly two years into the COVID-19 pandemic, a very different context around the use of telehealth has developed. These technologies can still be seen as offering a solution to distance, to be articulating with space in new ways, albeit in a different form: shared physical space. Telehealth is no longer used merely to cross great spans of distance, to make healthcare accessible to the geographically marginalised. Telehealth is now employed more similarly to the gloves described

by Pink et al. (2014) or the personal protective equipment used in the Ebola epidemic (Brown & Marí Sáez 2021): as a way to prevent the spread of disease, as a response to the risks of sharing the same physical space. Telehealth makes visible the different ways in which the US health system has been spatially ordered. As the distances upon which care over telehealth change, so must our attention to the shifting forms of care that might be considered and those that might not.

In the next chapter (Chapter 8), I approach equity and care through a different lens. I focus on examples of the use of telehealth located at an inflection point; at a limit between where care over telehealth should happen and where it should not. Through these cases, I offer a glimpse into wider ethical debates around these technologies: around whom telehealth is for and in which circumstances; around who decides that care can happen over telehealth and what underpins those decisions.

Chapter 8: Telehealth Introduces Novel Boundaries within Care

Introduction: An emerging boundary

*In February 2019, the state of New Mexico went through a two-month legislative session. These sessions happen at the beginning of every other year. Law makers in the state discuss whether proposed bills should be brought into law. During this session, several bills mentioned telehealth, one of which was particularly divisive. Named the Elizabeth Whitefield End of Life Options Act, this bill would have made it possible for a person who had been given 6 months or less to live to be prescribed life-ending medicines—a process in New Mexico termed both 'death with dignity' and 'medical aid in dying'. According to the bill, for a doctor to prescribe these medicines, a complete psychological assessment first needed to be undertaken to determine that the patient had sound mental capacity, as they would be making the decision to end their own life. Originally, this bill stated that the psychological assessment could happen either in-person or via telehealth. However, early on in the legislative process, the bill was amended to remove the telehealth option. Bills are often amended in the early phases of the process if they are seen to include anything that might obstruct the bill from passing into law. One of the law makers sponsoring this bill explained in a brief conversation, as we walked briskly from her office to the house chambers, that the option to complete the psychological assessment over telehealth was removed because the bill was already divisive amongst other law makers and the public, and telehealth was "*not mainstream enough*". The option of receiving a psychological assessment over telehealth was removed from the bill as telehealth was not understood enough by the public or lawmakers. It was felt by those sponsoring the bill that its inclusion could thus weaken the bill and hurt its opportunity to be made into law*[28].

This ethnographic encounter shows that telehealth is still too new, or rather "not mainstream enough" to be used for something that is considered highly sensitive like death with dignity. While telehealth is approved by the state of New Mexico for routine and emergency behavioural health encounters,

[28] This bill was ultimately passed into law two years later in the February 2021 legislative session, having "died" in the 2019 session. Telehealth was never added back to the bill and is currently not mentioned in the law. A colleague who is a lawyer working in medical law explained that leaving telehealth out of the wording of the law offers a loophole: while telehealth is not explicitly allowed in this form of end-of-life care, it is also not explicitly prohibited. In this way, the lawmakers have opened up the law to interpretation, potentially permitting the use of telehealth in practice. However, what is most interesting and crucial for the purposes of this research is that telehealth was explicitly removed because it was "too new", too different from in-person care and not understood well enough as providing acceptable care.

what about this encounter makes telehealth conditional? What is it about care that at some point we need it in-person? How should this boundary be negotiated?

On 9 March 2019, a debate instigated by the media brought attention to this same boundary within care. "Doctor told California man he was dying via robot video-call" (CBS News 2019), read an online newspaper headline that was forwarded to my email by Dr Taylor, a psychiatrist at UNM. Her message accompanying this headline referred to a discussion we had several weeks prior regarding the removal of telehealth from the Death with Dignity Bill: "[this] made me think of the conversation that I was having with you: how telehealth is considered mainstream and 'usual healthcare' except in situations where it is not...*".*

A 78 year old man, Ernest Quintana, had been in the Intensive Care Unit of a California hospital when he was told by a doctor over telehealth that he only had a few days to live. "If you're coming to tell us normal news, that's fine, but if you're coming to tell us there's no lung left and we want to put you on a morphine drip until you die, it should be done by a human being and not a machine*", his daughter was quoted as saying (CBS News 2019). The hospital's response to this encounter was ambivalent. On the one hand, CBS News reported, "hospital officials said the technology doesn't replace in-person conversations with the patient and loved ones". On the other hand, "the robot technology has done wonders for patients and their families, some of whom are too far away for in-person visits".*

Telehealth is seen in many ways as a solution to gaps in access to healthcare. Much of the rhetoric around telehealth creates an image of care that is as warm and intimate as care in-person. That is, however, until certain situations cross the line. *Headlines from other media outlets reported similar shock to the use of telehealth in the delivery of this delicate, clinical information: "Man told he's going to die by doctor on video-link robot" read BBC News (2019); "California man learns he's dying via 'robot' that video conferenced his doctor" announced NBC News (2019); "A doctor in California appeared via video link to tell a patient he was going to die. The man's family is upset" reported CNN Health (Andone & Moshtaghian 2019). In this particular situation, a doctor providing care over telehealth was transformed in the public eye into an inhumane "robot-video". Why was a line crossed here?*

The example of Ernest Quintana offers another look at this boundary: between the standards that state it is clinically approved and acceptable for a doctor to give news to their patient over telehealth on one side, and on the other: the feeling that irks people, that shouts that something is amiss, that

there is something visceral and unsettling about the way in which this encounter has played out. When is telehealth inappropriate in the provision of care? This example reflects the sentiment, the unease and the rejection of telehealth that was displayed during the New Mexican legislative session. It is at the extremes of care, at the margins, when suddenly in-person care is not only preferred but commanded. Telehealth does have limitations. But why are the limitations attended to in these particular situations? Why does a boundary emerge here?

In New Mexico, many of the health workers I interviewed who were proponents of telehealth evidenced their support for these technologies with an explanation along the lines of: "*telehealth upholds the same standards of care as in-person care*". This belief involves the idea that standards of care from in-person care can be extended to include care over telehealth across multiple medical domains. It is supported by the medical literature around telehealth (e.g., Batsis et al. 2019; Bongaerts et al. 2021; Butler Tobah et al. 2019; Donelan et al. 2019; Holstead & Robinson 2020) and has not only been absorbed by individual health workers but by health systems as well as state and national governments. Why, then, do situations exist where telehealth is rejected as a form of care?

As I have shown in previous chapters, the use of telehealth alters care in multiple ways. It shifts the mobilities implicated in receiving care and navigating the health system, the materials and spaces which define doctor-patient encounters, and the ways in which distance articulates with practices of care and the work of healthcare providers. All are defining components in the provision of care in New Mexico, and all are transformed with the use of telehealth. A recurring theme entangled within and amongst these changes in care is that of ambivalence. Many of my informants acknowledged that care via telehealth is altered and many expressed the belief that, if it was possible, providing and receiving in-person care is best. However, alongside this belief existed the acknowledgement that the provision of in-person care to everyone in the state is not possible and that care over telehealth is better than no care at all. "*In-person care is best* but *there's so much need*" was a phrase I heard over and over. There was this daily grappling with and acknowledgement that care over telehealth is different. And yet, telehealth enabled care to be provided when otherwise some people would be receiving no care at all.

This chapter addresses the few cases where this ambivalence, this back and forth, this weighing of altered care versus no care, became cemented into a firmer line between when care over telehealth should happen and when it should not. This chapter dives into and unpicks encounters which illustrate the establishment of this boundary and the negotiations therein. In the following section, I first demonstrate the ways in which anthropology has worked toward a better understanding of care

through explorations of how it is defined in relation to other social domains, to practices that are defined in contrast to or as intersecting with care. I then turn my attention to scholarship that investigates how different forms of care sit in relation to one another. This literature forms a foundation through which to approach different understandings and practices of care.

Delimiting care

As demonstrated in Chapter 2, the notion of care in anthropology is multiple and ever-expanding. With its roots in feminist philosophy, the concept of care has now come to encompass empirical categories observed in the world as well as analytical approaches to that world (Puig de la Bellacasa 2011). Care can be described as both action and outcome. It circumscribes the social, economic, affective, emotional and political. Care can be embodied and practiced by actors across different sectors, locations and temporalities (Alber & Drotbohm 2015).

Several theorists of care have endeavoured to define the amorphous and dynamic nature of care, homing in on how care is socially constituted, how care can be conceptualised, perceived and experienced in different ways. Many have framed care in relation to other domains of social life, tracing their distinctions and interactions. Tronto (1993) describes the problematic ways in which things that are classified as care get separated from the political and the economic. Mol (2008) focuses on the points of congruency and those of divergence between care and choice. Others have paid particular attention to the differentiation between care and work (Brown 2012; Duffy 2011); and more recently, the relationships between care work and domestic labour (Brown 2020). Cooper (2017) rethinks the intersections of care and neoliberalism in her ethnography of mental health courts in California, US. Carsten (2000) brings into question the ways in which caring practices comprise kinship. Moreover, care has been assessed in relation to forms of reciprocity (Haberlein 2015), control (Muusse et al. 2022), power (Robinson 2011) and violence (Feldman & Ticktin 2010; Mulla 2014; Stevenson 2014; Ticktin 2011).

Ultimately these authors contribute to an increasing “fuzziness” (Alber & Drotbohm 2015) of what care is. Within the scholarship that works to grapple with the evasive nature of care, there are also considerations of the relations between different forms of care itself. Hyde (2017) explores “clashes in care” at a residential addiction rehabilitation facility in rural China. This facility conceptualises illegal drug use in two different ways: (1) a component of societal and health problems and (2) an infringement of morality and China’s self-image. Hyde argues that these two notions of addiction lead to contradictory forms and logics of care: a westernised, individualistic approach focused on

psychology, and a collectivist model of care centred around China's view to nurture a socialist state. Through this work, Hyde questions what it means to care in the context of heterogenous models of therapy that are underlined by different histories, politics and motivations. Comparatively, Strong (2020) offers a muddled distinction between "fierce care" and "abusive care" on a maternity ward in Tanzania. Nurses strike and yell at labouring mothers to encourage them through the delivery of their baby with the hope that the birth will happen quickly and without complications. These efforts can be understood, Strong argues, as both care and abuse; the boundaries distinguishing them as one or the other are porous, flexible and dependent on the particular situation. Russell (1999) opens up for examination the politicisation of Depo-Provera contraception in the US. He illustrates how the legalisation of this drug encompasses two competing notions of care: care as birth and overpopulation control, as well as care and concern about potential side-effects. Finally, Garcia's (2010) ethnography of heroin addiction in the Rio Grande Valley of New Mexico unsettles assumptions around what care can be, as she describes a mother giving heroin to her opioid-addicted daughter. Does this count as care?

The notion of boundaries has been central to thinking about care: from considerations of what is and is not care to how care differs from or enables other orientations. Boundaries bring attention to the complexities of care, the ways in which care crosses institutional and personal settings, the ways in which it ricochets through the social and cultural contexts that make up daily life. This literature offers a frame through which to understand how and why the boundary that comes up in this ethnography emerges in the way that it does.

In this chapter, I explore this boundary ethnographically through three encounters—including the two vignettes presented above. All three examples help us to look at the same problem: the boundary arising within care over telehealth, and the associated implications. The first two cases provided a distal perspective, occurring on a level removed from the delivery of healthcare: the account of legislative action and the debate instigated by the media. These accounts focus on arguments about where the boundary within care should be positioned: when should telehealth be used to provide care? The third account, which makes up the body of this chapter, occurs on the ground, in the trenches of the provision of behavioural healthcare in the UNM Hospital Psychiatric Emergency Service. In this account, telehealth is already used to provide care, but doctors are not comfortable with it. This example shows how the boundary of appropriate care provision is negotiated in practice. Brought together, the three accounts not only enliven this boundary, but they show how this boundary is negotiated across different magnitudes of care. Ultimately, this chapter finds that boundaries are both critical analytical components in the study of care as well as inherent components

of the nature of care itself, as it is enacted on the ground. The chapter ends with a discussion of what these particular boundaries mean, and further, what they come to reveal: about healthcare in New Mexico, about injustices in the health system, and more broadly, about the ways in which technologies intersect with our lives.

The Psychiatric Emergency Service

I present in the following two sections the experiences of three psychiatrists who cover shifts in the Psychiatric Emergency Service at the UNM Hospital, Drs Garcia, Martinez and Williams. I first show how care happens in this particular emergency setting, and how particular processes have been set up to address the uncertainties in care in this chaotic, dynamic, fast paced clinical space. This account offers an understanding of emergency care in-person. It juxtaposes the subsequent section in which I describe how emergency psychiatric care is provided over telehealth and how the provision of this virtual care dismantles many of the processes that facilitate in-person care (van Hout 2015). The lived experience of these doctors involves negotiating a boundary: between the institutional policies that require them to provide care over telehealth in emergency situations, and their deep feelings of discomfort around their responsibility to do so.

It was a cold, windy March morning. The sky was grey, and the air had a piercing wetness to it, as if it might snow later on. I had made plans with Dr Garcia, a psychiatrist at UNM Hospital, to meet at the corner of Stanford Drive NE and Marble Ave, on the Northern edge of the UNM campus. Dr Garcia walked up to me brisky, griping a fleece jacket close to her body over turquoise scrubs. We barely introduced ourselves before making our way back toward the Psychiatric Emergency Service. Dr Garcia walked quickly, I was nearly running to keep up. As we crossed the parking lot, she mentioned over her shoulder that we would go in the back way. However, when we arrived at the locked chain link fence door that led down a small concrete paved alley to the back door of the emergency service office, we ran into several people in a scuffle. One, who I later learned was Mary, a woman in psychiatric distress, was screaming, wrestling with two police officers who were attempting to calm her down. "*She's cool, she knows all her meds*" shouted one of the officers to someone on the inside of the office. The person in the office responded, "*we're getting something to calm her down*". Dr Garcia peeled back from the fence, explaining that we would instead go in the front way. "*Two doctors were hurt on Monday*" is the reason she gives for our change in course. She is already several steps ahead of me, I do not have time to ask for further explanation.

We wove through the front entrance, into a waiting room with several cream-coloured chairs and tall leafy plants; then down several hallways, sturdy with concrete block walls, painted a different shade of cream, lit overhead with a fuzzy fluorescence. Dr Garcia swiped the key card attached to her scrubs by a retractable string to let us through multiple locked doors. We entered the main office through a cramped corridor, a desk pushed up on either side, one with a computer set up with two screens and a keyboard. Dr Garcia pushed a desk chair that had been jutting out into the corridor closer to one of the desks so we could walk past. We continued through quickly into the main office space. Dr Garcia told me she needed to answer a page, fill out some paperwork and then she would be able to speak with me. I sat down at a desk next to Dr Garcia, where she was already furiously typing, to gather my bearings and wait. The main room of the office was lined with workstations along three walls. One of these had been taken over by a communal snack area. A plastic container of grocery-store cupcakes sat open and half empty next to a pile of small candy bars and several napkins. A shelf running the full length of one of the walls hung heavy with books and binders, several feet above the workstations. A radio played loudly in the background. The only windows in the office looked out onto the narrow, concrete alley of the back entrance, where we had just seen Mary and the police officers several moments before. I later learned that patients who are brought in via the backdoor have an acute safety concern, with either intention to harm themselves or others. I introduced myself to two older women sitting at workstations by the windows. Sandy and Maureen are both psychiatric nurses. Sandy asked if I was a medical student and I explained that I was a graduate student doing research on the telehealth system. Neither she nor Maureen knew what I was talking about. They told me to help myself to any of the snacks and then returned to their computer screens.

Several minutes later, Dean, a mental health technician, entered the room from a door in the corner of the office where Dr Garcia and I were sitting. He was tall, muscular, in his 20s, wearing green scrubs and bright red sneakers that squeaked as he moved across the laminate floor. He announced to the office that he took the blood pressure of Mary, the patient who was just admitted. He continued to debrief the office: talking about reading her urine test to see if she was on any drugs, sharing the exact expletives Mary had just shouted at him. Sandy and Maureen had both turned around from their desks for this update. Dr Garcia was still typing, staring at her screen, but was also listening to Dean. With her back turned to the office, she asked for more information about what happened. How had the police come across Mary? Had she been in the emergency room before? Dean answered while plopping down into one of the workstation chairs and cracking open a tall black can with a jagged green 'M'– Monster Energy. The conversation then changed tack almost simultaneously. "*Where do you park on campus?*" Dean asked the room, before relaying his struggle finding a parking spot that morning. The conversation continued, over the music blaring from the radio: details of another patient

who had just come in, weekend plans, friendly jokes about Dr Garcia's new haircut, "*you look like Cyndi Lauper*"; debates on which sandwich Maureen should get from the hospital café for lunch, "*the Monte Cristo is by far the best*". During this time, phones were ringing, everyone was in and out of the conversation, typing on and off at their computers. Dean played a YouTube video from his phone, volume on loud.

BANG. I jumped. Mary was banging on the door Dean had come through several minutes prior. Sitting closest to the door and not knowing at the time that it was locked, I felt exposed and scared. Dr Garcia turned away from her screen toward the rest of the office and gestured at an intercom system set up next to the door, instructing Dean: "*tell the patient to sit in the chair in her room before we come out to help her*". I heard Dean's voice, muffled, from speakers on the other side of the door. Dr Garcia then addressed the room. "*I feel too vulnerable opening the door into the patient hallway. When something unsafe happens, like a patient banging on the door and the door being opened, that puts us all at risk. We really need to check on the camera to see what's happening in the hallway*". I noticed a small security TV near the door, showing a black and white corridor. Dr Garcia would tell me later that it is her job to pull everyone together, to lead the unit by making sure everyone is safe and making safe decisions.

Yasmin, a psychiatric resident, arrived through the back entrance. She set her stuff down at the workstation next to me and greeted Dr Garcia. Dr Garcia explained the situation earlier with Mary and the police. She told her the medicines Mary had been put on and how she had just been banging on the door. They speak about another patient who walked in front of a car earlier this morning. "*I think it's adjustment disorder*", said Yasmin. "*Depending on how it evolves over time*", replied Dr Garcia, "*Lets watch it*". Yasmin then greeted Dean, who repeated some of the expletives Mary had directed at him earlier, seeming to admire their creativity rather than taking them personally. They discussed what happened during Yasmin's previous shift. Two patients were fighting, and Yasmin was spat on with saliva and blood. "*It was an intense 10 minutes*", they told me. I was unable to hide my surprise, having not realised the constant risk encountered in the emergency room. Dean responded, telling me that he had been in this job for 6 months. "*Every day is different; every hour is different. I love it*". This environment could be unsafe, and I realised then how helpful it was to have someone physically strong, like Dean, on the clinical team.

Sandy packed up her bag to leave, her shift was over. Dr Garcia ran over to give her a hug. They quickly compared socks, pulling up the legs of their scrubs. Sandy had tall black socks with a pattern she described as "*Día de Muertas*". Apparently, she had been deciding between these ones and her

unicorn socks. Dr Garcia's socks were decorated with Van Gogh's Starry Night. The light-heartedness of their interaction juxtaposed the seriousness and high intensity of their work, the yelling and expletives coming from patients in distress on the other side of the office door. The intensity of the environment was diffused, or perhaps expertly managed, through the matter-of-fact way the clinical team discussed patients, through their shared jokes and attention directed elsewhere, toward socks and YouTube videos. "*Camaraderie is really important in this role*", Dr Garcia explained during a quiet moment. The Psychiatric Emergency Service (PES) followed a team-based approach. "*Everyone's input is helpful, you need the help and support of the PES team, it's not just the psychiatrist deciding* [on the course of action for a patient]", explained Dr Garcia. "Y*ou get the nurses' impressions, the residents' impressions. Maybe they know the patient, and that helps you feel more confident in your decision making*". This reflected the movement and conversation I observed in the office following Mary's admission: updates from whomever had interacted with her most recently, discussion regarding what further information was required to inform a clinical decision. While everyone in the office seemed to have their own work to complete, they were all in coordination. There was a constant ebb and flow of information as the clinical staff came together in the centre of the office, and then as they moved apart toward their individual workstations.

After half an hour of constant phone calls, typing, running back and forth between the office and the patient hallway, Dr Garcia had a chance to speak with me. She apologised for how long it took her to set some time aside, "*time is very challenging in PES. I'm the only attending-- there's very little downtime*". However, even with all of the commotion, movement and flux I had just observed, Dr Garcia told me that the morning had been relatively slow. "*We're usually all running around a lot more*". Dr Garcia told me that she had been in her position for several years. She also worked on the psychiatric in-patient wards and had two days a week set aside for administrative work. "*I only work 80% FTE, I can't imagine what full time would be like*", she told me. It is a sentiment shared by many behavioural health workers in New Mexico—there is a lot of need, a meagre behavioural health workforce and not enough time.

Dr Garcia explained how the emergency service works. The psychiatric hospital had 40 in-patient beds, while in the emergency room, there were 6 "*beds*". These beds were actually large armchairs that could lean back into flat, bed-like surfaces. Each chair sat in the middle of an otherwise empty room, and each room was along the patient hallway, accessed through the locked door on which Mary had been banging. The chairs were not inviting. Their blue, plasticky surface looked as if it was chosen for its ability to be easily cleaned, not for its comfort. A chair in one room was set up with fabric restraints along the armrests. The walls were constructed out of the same thick concrete blocks as the rest of

the building. The lights were low. Mary was curled up in the chair in her room, hiding herself from view under a white bed sheet. A security guard sat at the far end of the hallway, next to another locked door that led out into another hallway. Working within the emergency service at any one time was an attending (lead doctor), two psychiatric nurses, a behavioural health technician, one or two residents, and several security officers. "*We have much more staff working here than we did when I started*" Dr Garcia explains, "*but the flow has also increased, the flow of patients*". Here, Dr Garcia was referring to the increased influx of patients following the 2013 scandal and the closure of the majority of behavioural health clinics across the state.

The emergency service received many people who were intoxicated in some way; people who were suicidal or homicidal. Sometime people came to the service because they were not sure where else to go. Dr Garcia told me about a teenage boy who had had an outburst earlier this morning and his father did not know what to do, so he brought him in here. Some people admit themselves; others are brought in by the police. "*Primarily, when you get evaluated in PES, we're thinking about risk*", Dr Garcia explained.

> "*There are a couple of different trajectories* [for a patient]*: One is that there's too much concern about risk and someone's ability to be safe and so they need to stay in hospital for a little while… The other avenue is that there may be some concern for risk, but there's not so much of a concern that we feel like they need to stay in the hospital right now and so we send them home and then the idea is to figure out what other supports we can put in place to help them be at home*".

To make this determination, regarding whether a person needs to be admitted to the hospital or can be discharged to return home, Dr Garcia and her colleagues conducted emergency behavioural health evaluations. These evaluations, which I also heard referred to as psychiatric interviews, involved going through a series of questions with a patient.

> "*We ask about their background, their personal history, what happened today that led to them coming to the emergency room or being brought to the emergency room, what has happened in their life in general in the last several weeks, any changes, any past psychiatric history, any history of substance use, any treatment for any kind of psychiatric history… It's the evaluation of dangerousness: dangerousness to the self or to others. That's really what we're evaluating. And the potential relationship between this risk of violence with evidence of a psychiatric illness*".

What Dr Garcia shared with me reminded me of a conversation I had with one of her psychiatric colleagues, Dr Martinez, several days before. In explaining how psychiatry worked, Dr Martinez said: "*Psychiatry is a part of medicine that is really 99% dependent on the ability to interview the patient. The information that we extract is from interviewing the patient. Not from laying hands on the patient or getting blood tests or x-rays*".

Drs Garcia and Martinez both work several shifts a month as the attending doctor in the emergency service. Both shared how, in an emergency situation, the ability to interview a patient over time is crucial to their ability to assess dangerousness. "*Because of the nature of an emergency mental health crisis*", Dr Martinez explains, "*the evaluation takes place in chunks rather than just one sit down, 'ok, I've got my evaluation, now I'm done and this is the disposition* [of the patient]". The clinical team gleaned a lot of information about the patient by observing their affect, reactions and movements over time. This intermittent temporality of the emergency clinical encounter was especially important if a patient was agitated, disorganised or uncooperative with the clinical staff – all of which, both doctors told me, are common for a patient in a psychiatric emergency situation. Dr Martinez offered further detail about how his interaction with a patient might unfold:

> "*the nurse sees* [the patient] *first and the doctor might come in briefly while they're first being brought in just to check on them medically and getting a sense for what they're like at that time… And then we go back* [to the office], *look at the chart a little bit more and then come back out and start talking to them. But if you have someone who doesn't want to be there, then you might start talking to them a little bit but if they get kinda worked up or they're starting to be really anxious or agitated, you're gonna give them some space. Maybe you're gonna go call someone for collateral information or talk to a family member out in the lobby*".

The team often relied on collateral information from other people in a patient's life. If someone brought the patient in, then a nurse or the doctor would speak with that person out in the waiting room. They might call the patient's partner, parents or siblings to ask for further context about the patient's situation.

> "*Then you're gonna come back in when they've had some space. Maybe they've taken something to help them calm down a little bit, maybe you're gonna talk to them further. Maybe they open up more. Or initially they say 'I don't want you to call my girlfriend who called the police, I'm not gonna give you the phone number'. So you wait. And that takes a bit* [of time]. *Ultimately trying to determine across these chunks what's the final safety disposition*".

Both doctors described how they depended on the information-gathering and patient assessment of their colleagues in the emergency service to make a clinical decision about the patient. "[Initially], *the nurses get the basis for all of the things that I'm going to go into more detail about*", explained Dr Garcia.

> "*They ask about past psych history, they ask about family psych history, they ask about medications, they ask about clinical treatment, they ask about medical problems, allergies, all of those things… then they relay all of that information* [to me]. *Often times, they're getting some collateral information as well, if I have a real concern about safety or collateral information, then I'll try and get some also but they're gathering a lot of the information. And then the resident or attending or [nurse] is just getting more details about that information.*"

The use of time, space and teamwork were employed strategically to gather information from patients, particularly when a patient was "*uncooperative*". "*Some patients don't wanna talk. For all sorts of reasons*", said Dr Martinez. "*A person's paranoid. They're hearing voices telling them don't trust this guy* [the doctor]. *Another person may not wanna talk because they overdosed and they're saying 'ahh, now they're gonna put me in the hospital, I don't wanna go in the hospital, I'm just gonna sorta look down and deny everything'*". These two examples are very common, Dr Martinez told me. Alongside the strategies discussed above, psychiatrists in the emergency service also drew on interview techniques to further glean information from a patient. Dr Martinez continued, "*Being able to implement the skills you have learned as a clinician to* elicit *and* coax *and make the person comfortable in many, many different ways and try different things on the spot just as you see that the person is shutting down* [or] *the person is making a gesture like they don't want to talk*" (interviewee added his own emphasis). The interviewing skills employed by a psychiatrist in an emergency situation are dynamic, changing depending on the behaviour and receptiveness of a patient. These skills were nuanced, they involved a strong grasp on the situation and an ability to adapt the approach if the patient does not feel comfortable.

It was imperative to gather this information—through interviewing, collecting collateral information, observation across time and space, interactions with different healthcare professionals—because the ultimate clinical decision, whether to admit someone, often against their will, or discharge them from hospital when there was a potential danger, was the most consequential determination in psychiatry. "*Is there enough risk of potential imminent harm and is this most likely related to mental illness that the best procedure is to take away* [a patient's] *rights by putting the person in the hospital against*

their will? Or do we let them go and we miss something, and they end up killing themselves or killing someone else?" Dr Martinez explained the two grave options with which he often grapples. He offered the example of a patient he had seen on a recent shift:

> "*This person took a bunch of pills. He was drunk and had a fight with his girlfriend. I found out he has a drinking problem; he gets depressed sometimes and thinks about suicide. But he took the pills in front of* [his girlfriend]. *So he didn't hide, and she called the police. When I talked to him, he said he'd been depressed and hadn't had a job and wasn't sure his life was worth living, that he's had enough. But that he didn't mean to kill himself, that he didn't want to kill himself—he's minimising everything—and that he wants to live. And I have to decide, well, where will this person go? The girlfriend is saying she doesn't want him back at home. I'm thinking, well, it doesn't sound like he had a well-planned, serious suicide attempt but this guy is still at risk for suicide and the next time he could kill himself. And where is he gonna go? I haven't been able to reach any of the other relatives he's told me about where he might go and stay, so what do I do? There's all this other information that has potentially grave consequences. I need to be able to get the best possible information from the person. It's not just I put them in* [the hospital] *or not. But what can I* provide*, what kind of security blanket is there gonna be there to make me feel comfortable that this person's gonna be safe? Tonight, tomorrow, for the next several days.*"

Admitting a patient to the hospital involved a range of kaleidoscopic considerations. "*We have very few beds. Very, very limited bed space* [on the inpatient ward]" explained Dr Martinez, "*so there's always this balance… so we are not in the position where whenever I have any doubt I admit. In theory we could do that. But in practice we can't*". Space and resources within the psychiatric hospital were a factor that the psychiatrists in the emergency service needed to consider with every admission. This further consideration underlined the importance of obtaining as much pertinent information as possible in order to make an informed decision about a patient's trajectory, either into hospital or back home. "*The other thing is we can't really predict violence with certitude*", explained Dr Martinez, exposing the vulnerability of his position and the gravity of the decision he has to make with every patient in the emergency service.

Admission involved moving a patient from one locked area—the patient hallway in the emergency service—to another locked area—the inpatient psychiatric ward. "*If I decide the patient needs to be admitted to the hospital, I try to persuade them to come voluntarily, to sign the* [consent for admission] *papers voluntarily*", explained Dr Martinez. If the patient agreed to the admission, the process could unfold smoothly. However, "*if they don't sign the papers voluntarily, then I admit them involuntarily.*

Most times, even if they don't wanna come in, they will not get agitated and start screaming and kicking. Sometimes they do." Along with signing the necessary paperwork, each admission involved recording the patient's medical history, taking another physical exam, writing medication orders and speaking to the nurses on the in-patient ward. If a patient was admitted involuntarily, the emergency doctor also needs to petition a commitment hearing: a process to bring representatives from the district attorney to the court. The patient is then moved, usually walked, accompanied by at least one member of staff, to the back of the building and onto the in-patient ward.

Patients who are admitted usually spend from three days to three weeks on the in-patient ward. If the patient has been admitted involuntarily, they are only initially required to stay in hospital for seven days. Within these seven days, a commitment hearing is scheduled and held within the psychiatric hospital (SAMHSA 2019). The hearings are formal legal proceedings. They involve a judge or someone who can act in a judicial capacity who presides over the hearing, a scribe who documents and two attorneys—one for the patient who has met with the patient during their in-patient time before the hearing, and another representing the district attorney's office. The doctor who admitted the patient testifies, as well as the patient, any witnesses, such as family members, and an independent behavioural health professional of the patient's choosing. The ultimate outcome of the hearing is a decision made by the presiding judge: will the patient with symptoms of serious mental illness be confined in the psychiatric hospital for up to 30 days or be discharged and receive outpatient psychiatric treatment. "*This process happens for every patient who is involuntarily admitted*", confirmed Dr Martinez. The decision to admit a patient involved not only taking away a person's rights immediately in the short term but also a consideration of resources: whether there were enough beds for the number of patients coming in, if there was a strong enough case to undergo the entire process of court proceedings.

Telehealth in the Psychiatric Emergency Service

In the preceding section, I detailed the processes and practices in place that enable the emergency psychiatric team to provide care in often challenging and uncertain circumstances. I spent time and space on this description to illuminate the juxtaposition between in-person care and care over telehealth, which I will now move on to present. The use of telehealth in emergency psychiatric care alters the ways in which doctors obtain relevant diagnostics, the team dynamics of care, and the comfort and confidence doctors have in clinical decision making. This section makes visible a boundary within care, introduced by the use of telehealth, that psychiatrists in the emergency service navigate daily: the boundary between when care over telehealth is appropriate, and when it is not.

At the top of the hour, another resident arrived for the beginning of her shift. There were no longer enough desks in the main office space for everyone, so Dr Garcia and I moved out of the main room, into the tight corridor through which we first entered the office. There were two desks, each pushed up against opposing walls. Dr Garcia took a seat at the desk with two computer screens and logged in automatically, opening the electronic medical record system. "*This is the telemed desk*" she explained, gesturing at the entire hardware set up. A pair of padded headphones affixed with a microphone straddled the unused monitor next to a small mounted webcam.

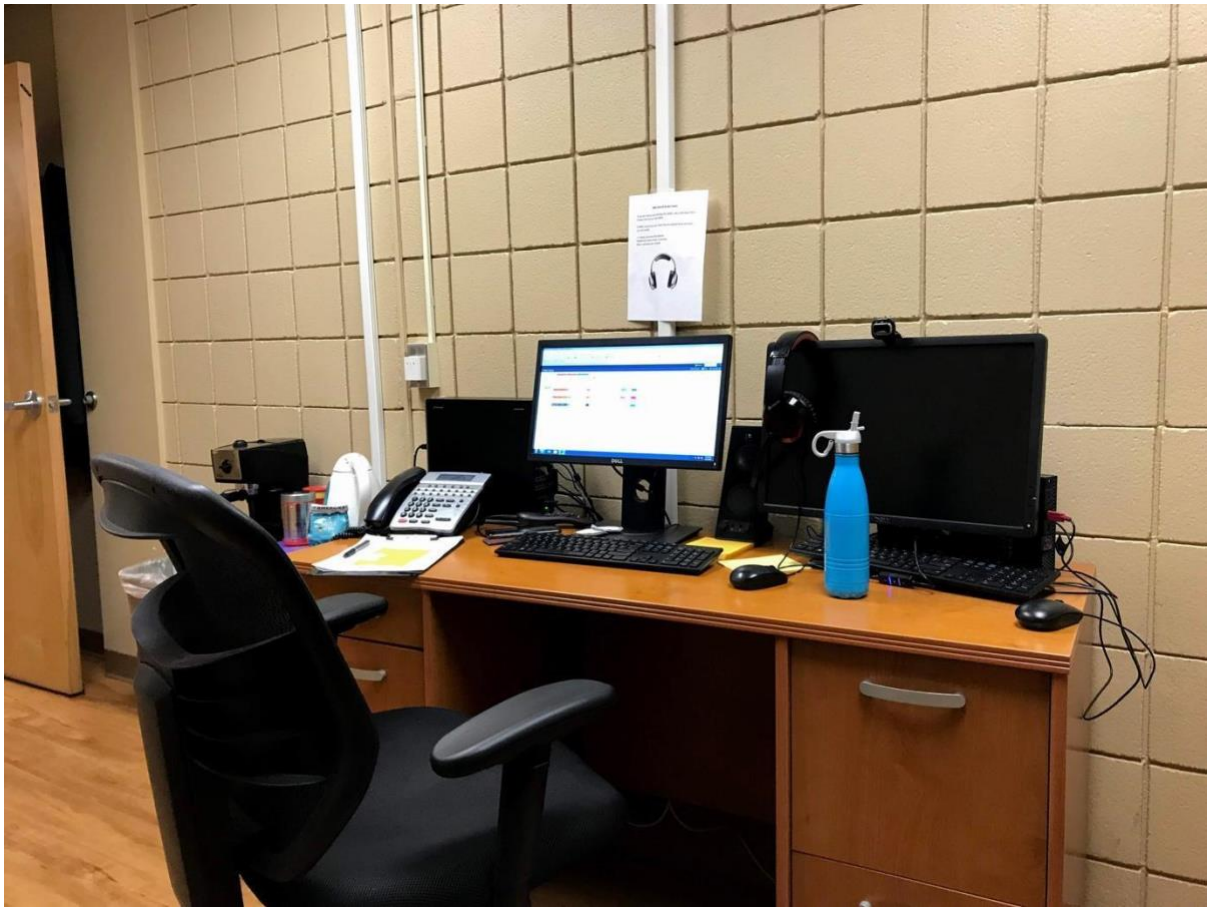

Figure 8. 1 The "*telemed desk*" in the Psychiatric Emergency Service. *Photo by author.*

There was a telephone, stapler and post-it notes strewn about. A small laminated sign was taped above the monitors explaining how to turn on and sign-in to the telehealth system. It was quieter there, as we were around a corner from the bustling office, except when people entered or exited the office through the door at the end of the corridor, which led out to one of the main arteries of the building. There was a lot of traffic. Each time someone walked past, Dr Garcia scooted her chair closer

to the desk to make more space for the movement passing behind her. Until then, all telehealth systems I had seen were set up in private spaces. Even systems in cramped offices with other people working nearby were at least enclosed, separated by a door and accompanied by noise cancelling devices to protect private conversations. Having a stable, undistracting background was one of the shared rules among most telehealth providers: to help create a sense of privacy for telehealth patients. This space was different. Anyone calling in via video would have been able to see the flow of people squeezing behind Dr Garcia. Perhaps this is just emergency medicine, I wondered: faster paced, less time and space for private encounters. "*They will renovate this one*", Dr Garcia told me, reading my face as I took in the telehealth set up. "*We will have a more private room for telepsych. Right now it's a main thoroughfare*".

The telehealth system in the psychiatric emergency room was set up with the aim of providing psychiatric consultations to patients in the emergency room at Sandoval Regional Medical Centre. "*SRMC*", it was called, was a hospital within the UNM Health System. It was located in the neighbouring county, Sandoval, a 35-minute drive north west from Albuquerque. While the emergency room at SRMC had some daytime, weekday psychiatric support, it did not have a full-time behavioural health professional on staff. The telehealth service enabled consultations between the attending psychiatrist at the UNM Psychiatric Emergency Service and patients in the emergency room at SRMC who required behavioural health evaluation when psychiatric support was not available locally. "*Only the attending, the doctor in charge of each shift can use the telemed system. Residents don't use it, they don't observe. It's not used for training purposes*", explained Dr Garcia. When I asked if she received any training prior to using the system she responded, "*no training, we're just given a log-in, log-out code*".

In preparing for my periods of observation in the Psychiatric Emergency Service, I had been unsure how to navigate the emergency telehealth encounters. Ethically, I felt uneasy about the prospect of including a patient who was experiencing a psychiatric emergency in my research. Practically, attendings in the emergency service received on average one or two telehealth consultation requests a month. They were sporadic and variable, making it difficult to anticipate when an encounter might happen. Considering these factors, I asked Dr Garcia to talk me through the process of an emergency telehealth encounter instead of attempting to observe one while it happened.

Dr Garcia's eyes darted between me and the lit up, vibrating pager secured to her hip. Through these constant interruptions, she took me through the process of conducting an emergency psychiatric evaluation over telehealth: a dance of multiple phone calls, moments of free time, information

gathering and a virtual patient interview. A doctor or nurse from the SRMC emergency room would call the Psychiatric Emergency Service to petition a video evaluation of a patient there. One of the psychiatric nurses usually answered the call. If it is particularly busy in the emergency service, Dr Garcia asks the psychiatric nurse to communicate this to SRMC, letting them know that she will be back in touch as soon as she can. "*You have to prioritise the in-person patients* [in the emergency service] *because we're the only people managing them. At SRMC they have their emergency room doctors and physicians* [managing patients there]". When there is enough time—that is, when she has a break in the chaotic flow of in-person patient care—Dr Garcia would look up the SRMC patient on the electronic medical records to get some background information. As SRMC was within the UNM Health Network, they used the same electronic medical record system, enabling Dr Garcia to access the medical records of patients there. "T*he access to the medical records of the patient is key. If you don't have access to their records, then the quality of care is going to be variable. I think part of telemedicine that is essential is that you have access to the records right then*". From the medical records, Dr Garcia is able to see who brought the patient to the emergency room in Sandoval, whether they have been to that emergency room before and how many times, whether they have been to the UNM psychiatric service before, any lab tests that had already been run: the amount of alcohol in the patient's blood, any drugs in the patient's urine.

When she is able to find another break in the constant flow of the emergency service, she would call back the referring clinician from SRMC over the phone, "*to make sure I understand their clinical question, what they need help with*". She would then accept the patient for a telehealth evaluation and ask the SRMC clinician to set up the telehealth technology. Dr Garcia was not sure what the set up in SRMC looked like but she guessed they have a computer screen on some sort of cart that could be wheeled to the end of the patient's hospital gurney. This screen displayed a live image of her to the patient and was set up with a camera so she had a view of the patient from her end. "*They will set it up in the patient's cubicle. I'll log into the computer at the telemed desk. I put the headphones on, click on the telemed software, a screen pops up and the patient is there in the window. It's all through the computer monitor*". Dr Garcia would then speak with the patient via the telehealth set up. She was not sure if the SRMC staff stay for the encounter or if she speaks with the patient privately—she cannot see anyone else on the screen. She starts the encounter by explaining to the patient that she is a psychiatrist at UNM in Albuquerque, though she expects the doctor or nurse at SRMC would have already explained this to the patient. She then interviews them, asking about their medical history, family and social history, if they are taking any psychiatric medicines, about their drug use.

After the interaction, Dr Garcia makes a clinical decision: whether the patient is safe enough to be discharged or if the patient needs to be admitted to the hospital for further observation and care. She enters this decision into the shared electronic medical records and calls back the referring clinician at SRMC via telephone to tell them her decision. "*These patients often mention self-harm, suicidal thoughts. It takes a lot of clinical skills to determine if they're a danger to themselves or someone else. There's just so many things you want to take into account. I think this is why only attendings do* [the telehealth evaluations], *so you can have a good sense of situations, you feel confident that there's not a lot of dangerousness*". "*However*", she shared "*if you start worrying more, like this is sounding dangerous or worrisome, it can often be better to see* [the patient] *in-person*".

In a situation where she is uncomfortable making a decision about the patient's condition over telehealth and unsure which route to take regarding discharge or admission, Dr Garcia would request that the patient is transferred to the UNM psychiatric service to evaluate them in-person. A patient transfer involved two admission processes: the initial admission of the patient to the emergency room in Sandoval and the subsequent admission at UNM. The transfer also required a 35-minute ambulance ride between the two hospitals. These processes were expensive: financially for the patient who may be responsible for their cost as well as in terms of the use of scarce resources. A transfer further involved giving up one of the six beds to the incoming patient in the already limited space of the Psychiatric Emergency Service. If the patient is coming in for an evaluation of suicidality, the emergency service would observe them for several hours, sometimes through the night. This meant that, for a significant amount of time, one fewer bed was available to patients from Albuquerque coming into the emergency room.

"*We need to weigh the options, to discuss whether a patient really needs a bed*", Dr Garcia explained. I got the sense that she did not feel at ease with the telehealth process, especially regarding her responsibility to make important decisions about a patient's potentially suicidal condition and the use of scarce resources. "*What do you think about [*the system]? ", I asked her. "*It's awkward*", she responded.

> "*I can't do everything I'd do clinically in-person with a patient, even if the technology was improved. It's hard to get a gestalt view of the patient through telehealth, to really assess their disposition… In-person I observe a patient over time, I see how a patient deals with the frustrations of staying in hospital. Irritation can build up over time and this is a clinical indicator. With telehealth, I usually am only able to see the patient once, in a bulk session, trying to get all of the information from the patient at one time*".

Dr Garcia expressed frustration with the shift in temporality of the patient encounter over telehealth. It was less flexible, more restricted than in-person encounters. This change in temporality, from incremental clinical moments that accumulate over time to one longer encounter, partially obscured her view of the patient. It changed the information she was able to glean from the patient, and the availability of particular types of clinical knowledge.

Further, it was difficult to obtain collateral information when evaluating patients via telehealth. "*Talking to the family is a really important part of the clinical assessment*" explained Dr Garcia, "*but it's awkward to call family while on telemed, I'm never sure how to coordinate my actions. If I was in-person, I might sit outside the patient room with the family and ask a few questions separately to try to get a better understanding of the patient's clinical situation. But on telehealth, do I ask the family to leave the room and call them via phone? Who sets up that call?*". Dr Martinez, in his interview, also admitted uncertainty in navigating the gathering of collateral information over telehealth: "*You don't talk to the family. I mean, I haven't*".

Dr Williams, another psychiatrist who covered several shifts a month as the attending in the Psychiatric Emergency Service, also shared several reflections on the ability to gather collateral information for patients at SRMC.

> "*The harder parts of the* [telehealth] *model is getting collateral information from other people, family members. Generally, in PES, the nurses will help with that or the residents… It just depends on the complexity of the patient. Like, more straightforward patients, I feel more comfortable doing an interview. But if I feel like we need to gather a lot of collateral information to really know what's going on or a patient who's really difficult to interview and not very cooperative, then it's much better to see them in-person.*"

Telehealth in emergency psychiatry introduced a different model of care, rendering unavailable several clinical facilities attending psychiatrists use in-person. With the design of the telehealth system between the two hospitals, the team approach that was indispensable in in-person care was not recreated over telehealth.

Telehealth evaluations posed another challenge as they took the attendings out of the rhythm of the emergency service, both physically and in terms of attention. They were something attendings do alone, around the corner from the main office space in the cramped corridor, away from the rest of

their team. Dr Garcia reported that telehealth sessions took 30-45 minutes of her time. "*It pulls me out of what's going on in my emergency room. I have immediate responsibility for patients here, I'm only consulting patients at SRMC. I need to make sure patients and staff are safe here, I need to pay close attention to ensure this environment is safe. Telemed takes me away from that*". The way in which the telehealth system was implemented into the existing workings of the emergency service was not ideal. It placed pressure on the attending to put her immediate responsibility aside to provide care to a patient elsewhere[29]. Dr Williams shared a similar perspective: "*It's a very busy setting in PES and you as the attending have to see everyone who's coming in. So if you're getting really involved in* [a telehealth evaluation] *that takes a long period of time… I mean the telehealth isn't the only thing that's happening, right? PES is also busy*".

Further, the set-up of the telehealth system, with the screen and camera located at the end of the patient's hospital gurney obscured some of the finer clinical details that Dr Garcia usually looked for with a patient in-person. Referring to the position of the webcam and screen which are placed at the end of the hospital gurney, Dr Garcia shared, "*It's really hard to distinguish slight movements when the patient is 5 feet away or so from the camera… Small eye movements can indicate hallucinations. Small mouth movements can be signs that people are on particular psych drugs. Even how a patient shakes your hand* [can be a clinical indicator]". While we spoke, Dr Garcia wafted her arms slightly in front of her midsection, her palms facing toward her and the back of her hands facing out, as if she was trying to open her arms wider but was restricted, as if she was trying to reach out to something but could not open her arms wide enough. She continued, "*it's not a complete view of the patient. Telemed is different. I feel different when I'm practicing telemed. I'm not sure how to explain*". She held her hands near her stomach. "*It's a gut feeling... I will have a feeling about a patient by even just walking into the room. I don't get that over telemed*". Many other health workers shared their experiences of a similar feeling, that telehealth was somehow different from in-person care, but the difference was difficult to articulate. "*I feel like you just get so much more of a sense of a person when you're there with them*", shared Dr Williams. Similarly, Dr Martinez said, "*it's subtle… the nature of the interaction that you have as a psychiatrist with a patient involves much more than just the actual content of the speech[30]… the vividness of the interaction is not there. The vividness of the interaction…*

[29] Refer to Chapter 7 for further discussion on how telehealth, a technology based on distance, is slotted into a health system based on assumptions of closeness. This has led to gaps in the processes of care, many of which are filled in by people on the ground such as attendings in the emergency service who are left feeling uncomfortable and unsure about how to balance their time between in-person care and care over telehealth.

[30] This insight complicates research involving content and speech analyses—quantifying and qualifying different words spoken and topics brought up during in-person doctor-patient encounters as compared to telehealth encounters—as a means to understand the forms and quality of care provided and received over telehealth (Agha et al. 2009; Hammersley et al. 2019; McKinstry et al. 2010; Miller 2011). This type of research relies on

is not the same." The difference between telehealth and in-person care often manifested as a particular feeling. Pols (2012) observed similar sentiments in her interviews with health workers who used telecare devices to monitor patients at home. She located their experiences in what one of her informants described as "fingerspitzengefühl" (ibid., 49), a "gut feeling" that was missing from care over a webcam. This difference between in-person care and care over telehealth escaped conventional metrics (Adams 2016). The feeling of sharing physical space with a patient and the use of that feeling to gain clinical comprehension was an aspect of in-person care that did not exist, at least in the same way or magnitude, in care over telehealth.

Dr Martinez also shared several difficulties he experienced in emergency telehealth evaluations.

> "*On the screen I see typically the patient lying on a stretcher, which is not great. The stretcher might have been lifted some but they're not in chairs, they're on stretchers. The thing is, they can lay down if they don't want to talk, they can be more avoidant of tough questions. That's a disadvantage in principle because if you're going to do an interview, to assess someone for example for suicidality, you wanna be sitting… So that's an issue. That's why we never interview patients when they're on beds* [during in-person encounters]. *You wanna have a place where you have two chairs, hopefully very similar so that you can engage the person as directly as possible*".

"*With a patient sitting in a chair*", Dr Martinez explained, "*that helps me look at them in the eye, on the same level*". "*Not like this*", he said while he stood up in order to look down at me, turning his head sideways to recreate for me what a patient might look like laying down on their hospital gurney, from the perspective of the telehealth camera. Further exacerbating the evaluation was the emergency room environment. "*There are tubes and IVs and noise. It's not a setting where we typically do psychiatric interviews*" he lamented.

All of these aforementioned components influenced the information psychiatrists were able to glean during a patient interview in order to make a clinical decision. "*There are factors that limit whether that information is gonna be good enough, reliable enough, valid enough*", continued Dr Martinez. "*How long you interview the patient, how well you interact with the patient, to what extent you get the patient to trust you, to what extent the patient wants to talk to you, to what extent they have an*

scales of analysis for measuring and interpreting how telehealth 'works' as well as understandings of what care is and what good care might mean, that are different to this thesis' focus on care as it is lived in-practice. This insight also challenges an assumption observed throughout this research: that behavioural healthcare can happen easily over telehealth as it relies on speech alone.

accent, to what extent you have an accent, your cultural biases, their cultural biases… it's not just language that you get, speech, but you get all this other information, non-verbal information". Dr Martinez said this slowly, purposefully enunciating his words. "*When you're checking if someone is doing well, even if you're not thinking about it, you pick up on things. How do they smell, what's their colour, what's their posture, how's their eye contact. That is very hard to extract from just a flat screen interview*". Dr Martinez offered insight into some of the components that come together to form a different feeling over telehealth. Several seemingly small details that psychiatrists may not have been able to attend to consciously, accumulated in a big way in emergency psychiatric care. The absence of these details, as experienced in telehealth evaluations, led at least partially to feelings of doubt in the ability to assess a patient's disposition.

This doubt was fed by the gravity of the decisions for which these psychiatrists were responsible. "*It is the most important determination that we make in psychiatry*", expressed Dr Martinez.

> "*To make that determination with significant limitations in developing an interaction with the person that is empathetic, professional, humane, and that allows us to detect subtle hints in the patient's behaviour, in the patient's gestures, in the patient's interaction with me... I mean, being limited, like I believe I am, to get the best possible interaction, to get the best possible information to make this most tremendous* [decision]*… that has huge implications. That's what makes me uncomfortable about it. I still do it!*"

These telehealth encounters and the relationships formed through them were delicate. Dr Martinez described how difficult it could be to cultivate this rapport across video, to navigate the subtleties of the non-verbal connection with a patient whom he does not know well, and whose medical history and social background were neither familiar nor apparent. "*The balance of the quality of the interaction with the risk is suboptimal*", he said; the risk of the clinical encounter was too great for the diminished quality of the interaction. The majority of cases in the psychiatric emergency room were vague, and the decision around whether a patient should be admitted or discharged was unclear. However, he shared later on in his interview, "*in a setting where the risk is much less, the quality of the interaction isn't as pivotal*". Here, Dr Martinez referred to a minority of cases in emergency psychiatry where the determination of risk for a patient was straightforward and where the use of telehealth could be helpful.

> *"There are patients who are extremely cooperative. They tell you the whole story and their story is consistent with what I heard from the emergency room doctor. They might say, 'I tried to kill*

myself, I don't want to live any more. I planned this, I looked for all the pills that were in the room, I waited for my spouse to leave and then I locked the door and started drinking. I didn't call the ambulance, it was by chance that my spouse just happened to come back and find me'. That's a no brainer. If a patient is like that, most likely a tele-interview is gonna be very helpful, just as helpful as interviewing in-person, in order to make the right decision which is this person needs to be in the hospital. It's so obvious what needs to happen."

In the minority of cases where the clinical decision was clear, like the patient described here who needed to be admitted to hospital, telehealth was a useful option for emergency diagnosis and care. Telehealth in these circumstances was also useful for the wider health system. It offered the Sandoval emergency team behavioural health expertise via telehealth consultation and, importantly, removed the need to transfer a patient to UNM. "*Telemed could be really helpful in non-crisis care*", considered Dr Garcia. "*I can see how consistent care over telehealth is helpful*", she said, referring to the long-term care provided to rural communities, "*but not in this* [emergency] *situation*". During our interviews, Drs Garcia and Martinez both tried to make sense of when it is necessary to be in-person in a psychiatric encounter and when it might be useful to provide psychiatric care via telehealth. In doing so, they were attempting to negotiate, grapple with and solidify this boundary within care.

This boundary within care was shaped by the particular context in which it had formed: a context of vast distances and incredible need. Despite the murkiness of providing care, the discomfort, the great risks and consequential decisions, the need for behavioural healthcare in any form was so great that it outweighed the discomfort. Everyone I interviewed regarding the use of telehealth in the emergency service agreed that with the levels of health resource scarcity in the state, telehealth was helpful in some capacity. "*I feel it's a lot easier to do things in-person. But to be practical, I'm glad when we can* [see people over telehealth]*"*, concluded Dr Garcia at the end of her interview. *"I think the best care is in-person",* shared Dr Williams, *"but you can do a lot of good care with telepsychiatry for people who wouldn't get care otherwise". "We are the only emergency room in the state that has a psychiatrist on site 24-7"*, said Dr Martinez, *"so I perfectly understand the push to do video and provide that service for rural emergency room doctors and for patients."* The way in which the wider state health system had approached this need and paucity of resources—employing telehealth in emergency psychiatric care—was what placed these psychiatrists in the position of crossing a boundary within care: providing care that they felt uncomfortable providing, that they felt was neither appropriate nor well suited for telehealth, yet ultimately, that they felt was necessary.

Conclusion

Care is dynamic, a shape shifter, involving in different situations the ability to both harm and nurture (Lovell & Rhodes 2014; Strong 2020). It is made up of and enacted through a multiplicity of different and varying components, similar to the multifarious nature of Mol's (2002) atherosclerosis. It is a meshwork (Ingold 2007, 2011) of instances, materials, practices and relations that are all added up together. This chapter extends from and articulates with arguments posed earlier in this thesis, namely that telehealth does not replicate in-person care; rather, it shifts care. I show that the use of telehealth reconfigures the meshwork of care, and how, through this reconfiguration, a novel boundary within care emerges. The boundary inhabits the space between where telehealth is good enough to provide care and where it is not; where the difference between care in-person and over telehealth is perceived as too vast, where the ability to be in-person is both urgent and necessary. This boundary becomes visible in the negotiations of daily practice and the points of tensions that underlie them. As in the work of Hyde (2017), Strong (2020), Russell (1999) and Garcia (2010), the boundaries within care are socially and culturally situated. I show in this chapter how the particular context of the New Mexican behavioural health system frames and defines this boundary, and how in specific situations, the limits of care over telehealth are understood and enacted differently.

This boundary within care is encountered in three examples, situated within different registers of care and negotiated both at a distance and on the ground. The Elizabeth Whitefield End of Life Act on the level of policy, and the reporting of Ernest Quintana's hospital care in the media illustrate the positioning of this boundary within care. In the Psychiatric Emergency Service, this boundary has already been formalised; care is taking place over telehealth. However, the implications of the formalisation of this boundary are negotiated everyday by health workers and their individual experiences of risk, comfort and responsibility. The psychiatrists within the emergency service feel deeply uncomfortable making clinical decisions over telehealth because the situation is often both ambiguous and severe. They decide whether to see a patient in-person, via hospital transfer, which requires an acute balancing of limited resources; whether to take away a person's rights if they refuse to be admitted to hospital; and whether to conduct a second admission, to take up beds and potentially put in process legal proceedings. These psychiatrists, as other behavioural health workers (see Chapter 7), carry the weight of systemic gaps in the health system through their daily provision of emergency telehealth as well as their negotiation of the boundaries therein.

In this chapter, I have approached the boundaries within care as ethnographic objects themselves. I paid attention to how the boundaries were drawn, what they came to mean, and what type of work

they did. The boundaries in this ethnography unfolded on the ground. Their existence did not precede practice; instead, they were formed through practices of care. This focus on boundaries offered the ability to explore the contradictions inherent in this malleable notion of care. This boundary also acted as an analytical lens. It was helpful not only for understanding practices of care, but also for understanding the wider social worlds that encompass forms of care. In this way, boundaries take on two forms: (1) a critical analytical approach in the study of care and (2) a fundamental component of care itself.

The descriptive focus on the ways in which this boundary is negotiated is also helpful for understanding how care works in complex systems and how different forms of care, such as care over telehealth, articulate with these systems. This chapter forms the framework for future explorations of this boundary as telehealth is increasingly embedded in national and international health systems. It draws attention to questions such as, how will future shifts in this boundary be negotiated? When is care over telehealth 'good enough' and when is it not? How does 'good enough' care intersect with resource scarcity? Perhaps 'good enough' care is merely a function of what is 'mainstream enough', what sufficiently fits into a particular cultural milieu and what aligns with what we can imagine as 'care'. Importantly, in New Mexico at the time of my fieldwork, care over telehealth was only provided to certain populations: people who were geographically marginalised, often living in poverty and just scraping by. This leads us to ask a crucial question about equity in care: for whom is this form of care 'good enough'? These questions offer a wealth to consider around how boundaries in care are drawn, the processes through which they are formalised, by whom, under what conditions and how they might change over time.

As the use of telehealth extends beyond the singular doctor-patient encounter to the clinic, health system and beyond, several social scientists have raised questions about equity. Sinha (2000) considers how power relations in medicine might change as rural and geographically marginalised populations receive telehealth-mediated care from health workers who are generally based in urban hospitals. For these patient populations, the options to receive healthcare are limited: either involving long distance drives and the related logistic and economic considerations, or accessing telehealth services at their local clinic. Cartwright (2000) also questions how power dynamics might shift with this new mode of providing healthcare. She outlines the ways in which information is shared and relations are formed across distance. While power is always implicit in medical encounters, telehealth introduces new forms of power disparities, connecting people and places with different degrees of healthcare resources and medical knowledge. More recently, Greene (2022) investigates whether the use of "digital medicine", including telehealth, in the US health system has facilitated more equitable

care. He examines communication systems in the provision of medical care from the late 19th century to the present in order to map the persisting and evolving ethical and social dilemmas arising from "medicine at a distance". He suggests that, with reference to the use of telehealth during the COVID-19 pandemic, care becomes more equitable in some healthcare situations, while the inverse occurs in others, as some health disparities are exacerbated. With telehealth and the new forms of care which emanate from its use, new understandings of what care is, the standards that regulate that care, as well as the ethics and critical approaches to health inequity require rethinking.

These contemplations and findings redirect our attention toward the ways in which the use of telehealth intersects with much wider processes in the US health system. The standards that define what 'good care' is are constantly renegotiated: by law makers, health workers and the public. While the use of telehealth aims to address gaps in care on a system level, it also reproduces power inequities and brings into relief fundamental questions about humanity, the value of life and resource scarcity on the ground. Through taking a closer look at the negotiations of this particular boundary within care, I have rendered visible some of the broader societal issues implicated in the use of telehealth.

Chapter 9: Telehealth: Moving Forward

In this thesis, I have explored the nuanced perspectives on and experiences of the use of telehealth. I did not set out to determine whether telehealth 'works', as this question means many things and has infinite answers. Instead, I have offered a window into the ambiguous realities of telehealth on the ground and in practice, and the ways in which they are intertwined with daily life in New Mexico. In doing so, I have presented two overarching arguments that bring together the findings from each individual chapter. The first is that telehealth shifts the nature of care. Second, that telehealth extends beyond the physical technologies that so often characterise its use.

In this conclusion, I map the ways in which these overarching arguments are informed by and intersect with the arguments presented across this ethnography. I then consider the findings of this thesis in light of the COVID-19 pandemic and the fundamental changes in the landscape of telehealth. Finally, I think through the implications of telehealth as a new form of care in the context of the standards governing conventional and 'appropriate' care.

Shifting and extending care

In this thesis, I argue that telehealth changes the nature of care. This is not a new argument; it has been asserted by multiple scholars of telehealth reaching back to the beginning of the 21st century. However, in this thesis I have attended to the particular and multiple ways in which care over telehealth is shifted: through practices and cultures of mobility; with the formation and reconfiguration of spaces and materials; in forms of distance and assumptions of closeness; in the reproduction of inequities; through the navigation and formalisation of novel boundaries of when care should be provided. This thesis considers the particular realities these shifts perform as well as their implications for care more broadly.

In Chapter 5, I traced the ways in which forms of mobility made up and defined everyday life in New Mexico. This includes the ways in which people interact with the health system as well as how they experience the intersections of space and care. In making a form of specialist care accessible to rural communities, telehealth alters these mobilities. Receiving care via telehealth neither requires long drives to clinics in other places, nor the individual infrastructures required to make those drives possible. In shifting mobilities, telehealth transforms the spaces and nature of care. It changes the ways in which rural residents access care, their imaginaries of the possibility of care, and their feelings of state presence and absence. It changes the ways in which people live within and experience the

landscape and the resource scarcity in rural areas (Chapter 4). These shifts have implications for the ways in which health systems work. They influence the ways in which care can be provided and received, who within health systems are responsible for being mobile in order for care to happen, and what access to care comes to mean.

Alongside intersecting forms of space, telehealth is also material. In Chapter 6, I showed how the material dimensions of telehealth articulate with the material infrastructures of care, altering the nature of care in the process. The materials of care that are problematically missed in the transition from in-person care to care over telehealth include the heavy bag that Bonnie, in the opening vignette of this thesis, dragged into the telehealth room. They include the drawings a therapist used to receive from her patients, the pulled pork and breakfast burritos at the staff potlucks, the knock on a colleague's door following a difficult patient appointment, the smell of alcohol on a patient's breath, the hot air sitting heavy on summer days in Clovis. These are the materials that—in articulation with relations, practices and spaces—make up the meshwork of care that echoes throughout this thesis, and they are the materials that are shifted in the use of telehealth. This thesis argues that through this reorganisation of the materiality of care, telehealth alters care.

The use of telehealth further transforms the distance implicated in caring relations. As I describe in Chapter 7, in aiming to diminish health disparities among rural communities, telehealth has been implemented to reduce the distance between patients and specialist health workers. However, in this process, telehealth comes up against assumptions, ideas and practices that underlie the wider health system, and are based on being physically close. In this way, the use of telehealth creates gaps in the meshwork of care: between the new forms of distance involved in healthcare encounters and existing practices based on assumptions of closeness. These gaps are navigated in formal and informal ways and involve the reconfiguring of responsibilities of health workers who interface with these processes. Support workers and in-person health workers at the Clovis Clinic were expected to pick up responsibilities that telehealth workers were unable to do from a distance. In this way, telehealth contributes to changes in healthcare roles. The use of telehealth thus poses questions to health systems around how the boundary between health professions is configured and how it unfolds in practice. This also leads to practical considerations around professional development, roles and relations, as well as questions around inequity in the health system. While telehealth aims to address disparities in access to care, it reproduces inequity in the provision of care: increasing the workload of health and support workers on the ground who, due to scarce resources and limited state support, already struggle with making care happen (see also Chapter 8).

The second overarching argument I make in this thesis is that telehealth extends beyond the screen—beyond the basic technologies and the direct doctor-patient encounter. Telehealth extends into the rooms in which patients sit alone, surrounded by dusty and unused objects. It extends out into the hallways of the clinic, the waiting room, the window of the front desk. It extends out of the clinic doors into the parking lots, roads and gas stations. Its use articulates with the ways in which people in Clovis understand the city in which they live, the ways in which they perceive their relations to the state, and where they understand good healthcare to exist. It intersects with the paucity of resources, of doctors who come and go, of the one psychiatrist who retired years ago and whose position was never refilled. The use of telehealth is implicated in the long drives to bigger cities, the amount of time people take off work to receive care far away, even the mere possibility of receiving healthcare. As described in Chapter 4, the use of telehealth touches the unique sorrows and challenges Clovis residents face, the decaying infrastructure, the fear of further tragedies, the histories of violence and colonisation imbued in the landscape. Telehealth shapes all of these factors that make up everyday life. It sits intimately alongside them, offering the residents in Clovis a form of care, a way of being seen, a pause in their worries about when they might next be able to get their medicines.

Approaching telehealth through the lens of infrastructure enabled the consideration of these crucial contexts into which telehealth extends. Contexts that situate telehealth are often shunted unknowingly into the background. Through this ethnography, I have found that the use of telehealth is implicated in and influenced by many components of everyday life, this context. The use of telehealth has become entangled with multiple infrastructural levels within the health system: patients and their cars; health workers, their workloads, and the support they receive; clinics that struggle to keep their doors open; a behavioural health system that faces workforce shortages and resource scarcity. Seeping out of the clinic, the use of telehealth shapes and is shaped by the social, political, affective and physical landscapes of New Mexico. In order to understand the ways in which telehealth has landed in a particular place, it is necessary to attend to these wider dimensions of everyday life.

While the provision of care over telehealth involves internet-based, virtual connections and is understood to conquer space, I have found that telehealth is profoundly and intimately enmeshed in multiple forms of space: physical spaces, imaginations and experiences of space. In this way, the spaces of telehealth require consideration in our understandings and practices of care, in the implementation and use of these technologies, as well as in the formalisation of the clinic and the spatial demarcation of the clinical encounter. The multiple spaces of telehealth illuminate the ways in which care extends beyond the clinic. This forces us to consider where care exists, and further, how

the spaces in which care is conventionally located are not singular, isolated or distinct from the wider spaces and contexts in which they are encompassed. This illuminates challenges for hospital ethnography, for conceptualising the hospital, the clinic and other spaces in which care is understood to exist. It asks us to consider what increasingly porous spaces mean for understanding medicine and healthcare, and how the further exploration of telehealth might offer insights into the emerging spaces of care in the future.

In addition to conceptualisations and understandings of space, my assertion that telehealth is not solely virtual also extends discussions of the material and the immaterial. I have shown that the 'virtual' and the 'material' are not distinct. The boundaries between these are interwoven to the extent that perhaps it is unhelpful to approach the virtual as a unique condition. The virtual exists in the physical world as much as the physical world exists and functions in the virtual. This thesis finds that telehealth is situated in the materials and spaces of everyday life to a degree that had neither been appreciated nor reflected in the design of telehealth programmes, policies or practices of care. I ask, then, to consider new ways to think about the virtual and the physical together, or perhaps as one. In collapsing the distinction, we are attending to the ways in which these internet-based technologies and their effects sit among us, not only as computers and screens, but as palpable things, in our bodies, emotions and feelings, in our cars and long drives, in our communities and relations.

Finally, these two overarching arguments intersect in many ways. As the use of telehealth articulates with and seeps into everyday life in New Mexico, understandings around and experiences of care, in its widest sense, change. Care, from the direct doctor-patient encounter to feelings of being seen by the state, is altered by the use of telehealth. Understandings of what care is and where it exists shift and reflect back onto wider experiences of daily life for New Mexicans. Care no longer involves a long drive, expensive gas payments, the logistics of finding a child minder or trading shifts at work. Care over telehealth means a lot more than speaking with a doctor or therapist over the screen.

Reciprocally, the histories, landscapes, socialities, spaces and materials unique to New Mexico shape the use of telehealth and the practices of care. We are forced to consider the granular ways in which the use of telehealth in a specific place is fluid and particular, and how this leads to the existence of multiple telehealths. The surrounding contexts and worlds, the use of telehealth and the forms of care involved are tightly bound and therefore cannot be understood in isolation. For example, the mobility of individual patients and their families—across town to the general practitioner or across the state for specialist care—is necessary for the functioning of the New Mexican health system. Telehealth has entered this meshwork of movement, money, time, health and care, altering the mobilities required

in order for some forms of care to be provided and received. In this way, the use of telehealth also alters the ways in which components of the health system are connected, the ways in which distance takes on different forms, the ways in which healthcare spaces and health workers are changed. Through this articulation with things wider than the basic technologies, through seeping out of the clinic, telehealth shapes and shifts care.

Telehealth neither replicates nor opposes conventional, in-person care. Instead, telehealth reformulates care. It transforms spaces, materials, practices, relations, values, beliefs and experiences. It does so not within the confines of a particular doctor-patient encounter, nor within the walls of a clinic. This reformulation occurs well beyond the physical technologies of the screen, speaker, microphone and fibre optic internet cables. It happens amongst the social and political histories underlying daily life, the mundane mobilities and materials, the consequential decisions of the psychiatric emergency room, the long highways and the state legislature. Care as a lens has enabled me to hold these seemingly disparate dimensions together, to understand that they are connected, overlapping and intimately involved in the use of these technologies.

In consideration of COVID-19

Several months following the end of my fieldwork, the COVID-19 virus started to spread across the globe. On 11 March 2020, the World Health Organisation declared the viral outbreak a pandemic. School systems closed, international border crossings were frozen, planes grounded, entire countries retreated into lockdown and isolation. Millions lost their jobs, national economies faced recessions, world leaders became ill, infections and deaths across the world increased.

In the US, following increasing rates of unemployment (Jackson et al 2021), upwards of 5 million Americans lost their health insurance (Banthin et al 2020), compounding the 70 million Americans who were either uninsured or underinsured before the pandemic (Collins et al 2019). Ethnic and racial health disparities were heightened (Mackey et al 2021; Mude et al 2021). With the unexpected and profound increase in need for acute health services alongside the related decrease in patients seeking routine services, financial precarities left some hospitals, providers and general practices in tenuous positions, particularly those in rural areas that were already vulnerable (Blumenthal et al 2020). Health workers carried increasingly heavy loads, leading to burn out and mental ill health (Leo et al 2021). Population-wide mental health rates worsened alongside the recession and rates of unemployment, through shifts in routines, isolation and experiences of ill health amongst loved ones, as well as increased challenges for people already experiencing mental ill health and substance abuse problems

(Czeisler 2020). Further, in March 2020, services for paediatric mental health decreased by over 40% due to pandemic related restrictions (Leeb et al 2020).

The pandemic illuminated the viability, necessity and utility of telehealth, enabling in many cases what was described as safe and efficient care (e.g., Hakim et al 2020; Oesterle et al 2020). In a matter of weeks, state governments, health workers and patients took up the use of telehealth as a means through which to continue the provision of healthcare services during the pandemic. This included changes in telehealth policies—some long term, others temporary—across all 50 states (Pistor & Enlund 2020). Nationally, an emergency authorisation was put into place requiring the equal billing of telehealth and in-person appointments. This was a short-term measure that circumvented the long fraught debates and policy work within state health systems, including New Mexico's, to require insurers to reimburse telehealth services at the same rate as in-person services. Further examples of the increased use of telehealth during the pandemic include the expansion of eligibility for telehealth services from only patients in rural areas to all patients covered by the federal Medicare system. HIPAA policies around privacy and security of video-conferencing technologies were loosened, allowing health workers to connect with patients via any non-public facing video or audio technology such as Apple FaceTime, Google Hangouts video, Zoom and Skype (Office for Civil Rights 2020). Health workers could provide care to new patients via telehealth, whereas previously, telehealth appointments could only be held with established patients. A number of states authorised short term medical licenses to health workers licensed to work in other states, facilitating the provision of care via telehealth to residents in one state from a health worker in another (Centre for Connected Health Policy 2021). States also supported increased access to behavioural health services, for example, expanding the types of doctor-patient encounters that are covered by insurers to include audio-only telephone-based appointments. This shift in health policy was particularly helpful for patients who did not have access to a device with video technology.

While the status of telehealth in the American health system post-COVID is still uncertain, several federally proposed bills point to continued governmental support for telehealth. The Infrastructure Investment and Jobs Act was passed into law on 15 November 2021, including $65 billion for the extension and adoption of broadband coverage across the country and promising to bring high-speed internet to remote and underserved areas. The Telehealth Modernisation Act, introduced to the US Senate in February 2021, proposed to make permanent some of the pandemic-driven changes expanding telehealth coverage within Medicare (Scott et al 2021). And in April 2022, three US senators proposed bi-partisan legislation, the Medicaid Ensuring Necessary Telehealth is Available Long-term (MENTAL) Health for Kids and Underserved Act, which would increase guidance to states about how

to expand tele-behavioural health resources and integrate them within the existing health systems (Thune et al 2022).

As the landscape of telehealth has radically changed since the conception of and ethnographic fieldwork underlying this project, where can we situate the findings and arguments made in this thesis? Importantly, I did not continue collecting empirical material during the pandemic. While the boundaries of the field are increasingly blurred (van den Scott 2018), maintaining firm temporal and spatial boundaries for my fieldwork was essential to the analysis, findings and arguments presented in this thesis (Candea 2007). Instead, I approached the writing of this thesis as a way to tell a particular story and to form a foundation for thinking about telehealth theoretically, with a view of guiding both anthropological scholarship as well as policy, practice and further research into this burgeoning field of clinical practice and novel formulations of daily life. The shifts in care and the ways in which care extends beyond the screen with the use of telehealth—through spaces, materials, mobilities, relations and forms of trust—as put forward by this thesis, offer crucial considerations for the future use and integration of telehealth.

Through this ethnography, I provide a nuanced understanding of the use of telehealth before the pandemic. Coming in from the ground level of the use of telehealth, this research presents a point of comparison. It opens up streams of questioning into how the use, experience, politics and realities of telehealth have changed, and how they might continue to evolve. Importantly the space of these findings is not constrained by ties to an interest group. Empirical knowledge formation in this descriptive work depicts as best as possible what is happening on the ground and underlines what is at stake as these emerging technologies become more routinised in care. While these technologies initially promised to remove barriers of time and space in access to care and to overcome the social geography that 'produces' these barriers, some health disparities were exacerbated by the use of telehealth during the pandemic. Inequities in access to services were accentuated across medical fields for older adults and non-white populations (Aziz et al 2021) as well as those whose first language is not English, those with low-income and patients receiving Medicaid (Gmunder et al 2021; Qian et al 2022). The widening of disparities leads us to questions about the limits of these technologies and how to conceptualise these limits and understand them. At what point is telehealth no longer appropriate for care at the level of the health system? When are these limits reached and who is negotiating them (see Chapter 8)? How do these limits articulate with the technological optimism flooding the health system (e.g., Zarei 2021) and commercial sector (e.g., Jercich 2021)? Further, with the increased use of telehealth, it is necessary to consider how different groups are affected. This

thesis brings attention to the healthcare workforce and the inequities exacerbated among health workers on the ground.

This thesis sets up further questions to pursue, forming a space of traction for future research in this arena, particularly around ideas of care. As care over telehealth is different, where does the continued and embedded use of telehealth lead healthcare more generally? Does care over telehealth simply become 'care'? How will the sectors, fields, academic departments, patient waiting rooms, pharmacies, all of the infinite components that come together to form some sort of system—how do these shift? Will the understanding of what is a 'standard of care' change? And what about the understandings of what and who a doctor is, what and who provides care? This thesis also offers empirical insight into areas where important data has not yet been captured, particularly as health policy decisions during states of emergency were made with the immediate health of the public in mind, rather than the long-term implications of these technologies. In this way, understandings from the routinised use of telehealth in a less acute climate offer important insights as the use of telehealth persists. This will be helpful as the use of telehealth becomes naturalised, embedded in the imaginations and practices that make up the US health system. This thesis brings attention to the meaning of the changes in care, to the spaces, materials, practices and relations beyond the immediate technologies that are intricately implicated in the use of telehealth and that have thus far been neglected in the conceptualisations and deployments of these technologies.

The boundaries of telehealth

As mentioned in the introductory chapter of this thesis, conceptions and understandings around telehealth and related technologies–those that make up telecare, telemedicine, teletherapy–relate to distinct categories of technologies in various types of care. The telehealth systems described in this dissertation involved virtual encounters between certain health workers—psychiatrists and therapists—and patients. These encounters generally entailed two participants separated by some amount of distance, ideally sitting in their own, private rooms with computers set up with a microphone, speaker and stable internet connection to allow secure video-consultations. However, when some part of this encounter failed, sessions would continue over telephone. Sometimes an in-person health worker would be called into the room to aid the interaction (see Chapter 7). The boundaries of what 'telehealth' included in this ethnography are not fixed. Virtual consultations were always structured and supported by multiple actors and actions, for example communication between health and support workers over the electronic health records system at the Clovis Clinic.

These reflections mirror existing scholarship on the use of information and communication technologies in healthcare. Pols (2012) for example, presents telecare devices that connect elderly people in their homes to nurses in a clinic or telecommunication setting. The form of connection afforded by these technologies involves the transmission of certain physical information (blood pressure, weight) that patients measure in their homes and subsequently send to the nurses via the telecare device for review. This form of "care at a distance" (Pols 2012) is termed telecare. However, the telecare Pols describes is also porous. If patient measurements show a great enough deviation from what is understood as normal, nurses may get in touch with patients over the telephone to ask certain follow up questions. The patient may even be asked to come to the clinic or hospital for a physical examination. It is unclear in these situations where telecare ends and where in-person care starts.

In this ethnography, telehealth and in-person care were connected by themes of materiality, space, mobility, health and care, and ultimately both offered perspectives onto behavioural healthcare in New Mexico. My research has explored them in concert. The presences and absences of their physical infrastructures are intertwined; the implications of both forms of care are increasingly inseparable. Together they compose the landscape of healthcare and daily life in New Mexico. As the use of telehealth becomes normalised in health systems globally, the boundaries between telehealth and in-person care may become less sturdy. What happens as telehealth and in-person care melt together?

Final contemplations: Appropriate care

Throughout this thesis' discussions on shifts in care and the extension of telehealth beyond the screen, I have grappled with a persistent question: as telehealth is a different form of care, what does this mean not only for the practices of care, but for the standards and ethics governing that care? Those that define and regulate conventional medicine and care cannot be simply extended onto telehealth. However, the New Mexican health system, in their use of telehealth to provide behavioural healthcare to the state's rural populations, as well as the American health system, in their increasing use of telehealth in the wake of the pandemic, have applied "universal" (Tsing 2005) understandings and standards of medical practice to this new form of care.

Standards of care in the US health system outline the responsibilities of medical professionals and the conduct in which they are lawfully required to provide care (Cooke et al 2017). Importantly, these standards are essential for the protection of patients; adherence and nonadherence to these standards demarcate the boundary between care and malpractice. In 2013, the AMA released a list of

10 standards to guide medical practice over telemedicine, one of which stated: “Telemedicine services should support equitable and enhanced access to clinically appropriate healthcare” (AMA 2013: 2). In 2017, the AMA released a Telemedicine Policy stating that “telemedicine services should be covered and paid for [by medical insurance providers] if they abide by the following principles” which include: “the standards and scope of telemedicine services [are] consistent with related in-person services” (AMA 2017: 3). In both of these statements, the AMA presents their expectation that telehealth services align with the expectations and quality of in-person care, collapsing the distinction between telehealth and conventional care.

One of my informants, a “*telehealth visionary*” as deemed by several people working at the level of the state health system, told me early on in my fieldwork that one day he hopes “*telemedicine will be seen as medicine*”. Similarly, Krupinski and Bernard (2014) reflected in their paper on the Standards and Guidelines in Telemedicine and Telehealth that “ideally, there should not be separate guidelines for providing healthcare services in the traditional manner *versus* telemedicine” (2014: 89). Fields (2020) stated that “telemedicine is simply another way to practice medicine” (2020: 416) and that “the same ethical, conflict of interest, and personal health information protection obligations exist for practicing telemedicine as practicing in-person medicine” (ibid., 409). The American Academy of Family Physicians (AAFP) released a statement in 2021 in support of “the use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care”. Further they state, “the appropriateness of telemedicine should be dictated by the standard of care” (AAFP 2021). Others have offered suggestions for how to get telehealth to the point where it is a “standard of care” (Lokken et al 2020). But, which care is this? This application of in-person standards to care over telehealth is performative in some ways, opening up the possibility for the appropriate practice of telehealth to be governed by existing medical standards. It also neglects the idiosyncratic nature of care over telehealth.

Some have considered standards of care and recommendations for medical practice that are specific to telehealth in specific fields of medicine, for example, Zon et al (2021) in medical oncology. However, these are far and few between and largely involve superimposing the standards of in-person care on top of care over telehealth. As I have shown throughout this dissertation, telehealth has its own specificity; it articulates with the spatial, material and immaterial dimensions of everyday life in ways particular to New Mexico and care in the New Mexican health system. It is further necessary to attend to the unique dynamics encountered with telehealth in order to understand the ways in which regulations and policies within the state health system—as well as education, training and support for the healthcare workforce—need to shift alongside the changes in care. As this new form of care is

further established in health systems globally, we need to consider new definitions for, standards underlying and ethics guiding appropriate care over telehealth.

These novel standards are ontologically different than the organisational and technical shifts to current telehealth practice that might be able to address challenges in the use of telehealth. In Chapter 8, for example, Dr Garcia shared her uncertainty in how to coordinate the gathering of collateral information about a patient from their families, while at a distance and working over telehealth. "*Talking to the family is a really important part of the clinical assessment*", she explained, "*but it's awkward to call the family while on telemed. I'm never sure how to coordinate my actions… do we call them over the phone? Who sets up this call?*". This awkwardness points not only to a discomfort in using the system but also to something that could be remedied, perhaps with better systemic and organisational support for the telehealth programme. Several of the physiatrists working in the emergency service shared that they would feel more comfortable with their telehealth evaluations if there was a behavioural health worker present at the remote hospital. As the behavioural health team was so important for diagnosis and treatment, particularly regarding the temporality of the evaluation, having someone who could check in on the patient across multiple time points and offer their informed, in-person perspective to the psychiatrist could transform the way in which the telehealth emergency service worked. It could offer the psychiatrists in Albuquerque more local support and give them more certainty around these consequential decisions. In some cases, organisational and technical changes could improve the use of telehealth.

However, not everything is technical. Many aspects of medicine and care are nebulous. Some exist within mundane materials and spaces, within public imaginations, mobilities, landscapes and relations. Others exist within experience and instinct, in gut feelings. It is not possible to fully translate in-person care across the screen. The appropriateness of care does not solely function on the ground within organisational structures and technologies. It is part of a wider value system reflecting what is understood as good care and involves the structuring of standards and ethics accordingly; appropriate care over telehealth requires rethinking. In this way, the translation of telehealth into in-person care should not be the goal. For telehealth, we need new understandings. We need to reimagine appropriateness and this needs to be reflected through new forms of training, medical relations, communication and healthcare organisation, alongside ethics and standards.

This is not a simple task, as care over telehealth takes on different forms and has varied implications. In Chapter 7, for example, telehealth changes the practice of outpatient care at the Clovis Clinic inversely to the ways in which telehealth changes care in the psychiatric emergency room. In

outpatient care, more of the clinical team is relied upon to make a patient encounter happen, as compared to in-person. In emergency care, care is less dispersed: less of the clinical team is able to contribute over telehealth than in-person. These are two particular examples that show how the dispersal of care can be altered in contrasting ways with the use of telehealth. The implications of telehealth are diverse, shifting with different contexts. In this ethnography, I have attended to several of these contexts, and have contributed to the messiness, the entropic nature of the transition to telehealth. In this way, we need to attend carefully to this new form of care, to better understand the particular ways in which care is transformed, the practices, people and relations implicated in this transformation, and how to move forward into a world that has become more digitised, that relies currently and may rely more on these technologies in the future.

So, where does this leave us? Is telehealth partially a plaster bandage placed over the access to care deficit in New Mexico, further marginalising health workers on the ground and employed in practice without a comprehensive understanding of the underlying ethics and standards? Yes. Is telehealth an option for communities to gain access to health services and to feel cared for by the state in the absence of resources, in the fear of a pandemic and the risk of spreading disease? Yes. Both are true and both need to be taken seriously. Telehealth, while premised on distance and functioning in a context that involves greater distances than in-person care, also enables closeness. Tensions exist, contradictions are present around every corner. The ambivalence of telehealth needs more attention; shifted standards of care, shifted relations and shifted practices require consideration. There is a great deal of negotiating to do. This is the lacuna of knowledge looking forward. For this new form of care, we need new standards, ethics, conceptualisations of what appropriate care looks like, and understandings of the immaterial as well as material and spatial potential of care.

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