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## The Role of Parents' Mores on Their Intentions to Enroll Their Children in a School-based Telemedicine Program

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## Accepted Manuscript

### The Role of Parents' Mores on Their Intentions to Enroll Their Children in a School-based Telemedicine Program

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## The Role of Parents' Mores on Their Intentions to Enroll Their Children in a School-based Telemedicine Program

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### Abstract:

Hospitals providing nurse-run school telemedicine programs can improve children's access to healthcare services by delivering such services on school premises. Despite this potential, the enrollment in such programs by parents falls short of expectations because of parents' hesitation to allow their children to receive such telemedicine healthcare services. This study investigates some aspects of the role of parents' perception of contributing to a good cause, i.e., personal mores, on their intentions to enroll their children in such a telemedicine program. Surveying parents about such a new telemedicine service that is being deployed in their school district shows that parents' personal mores are associated with increased intentions over and above its expected time-flexibility advantages. Surprisingly, trust increased intentions was fully mediated by those mores. Practical and theoretical implications are discussed, especially that doing good to others may be another reason why people adopt telemedicine, suggesting another reason beyond the utilitarian, rational, and social processes that are portrayed in previous research.

**Keywords:** School-based Telemedicine, Schwartz's Altruistic Behavior Model, Trust, Information Technology.

[Department statements, if appropriate, will be added by the editors. Teaching cases and panel reports will have a statement, which is also added by the editors.]

[Note: this page has no footnotes.]

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## 1 Introduction

School telemedicine services, namely the provision of medical healthcare through distance technology (Mackert & Whitten, 2007), can enable healthcare organizations to improve children's access to medical care and the delivery of such services. In school settings, telemedicine could act as a first line of treatment, enhancing the quality of care provided by a school nurse and allowing remote physicians to examine ears, throats, and skin, as well as to listen to the student's hearts and lungs through FDA approved telemedicine tools. The physicians can then E-prescribe medications and share reports with the child's primary care provider. School telemedicine can alleviate the number of Emergency Room (ER) visits (Izquierdo et al., 2009; McConnochie et al., 2009; McConnochie et al., 2010; Sanchez et al., 2019), minimize parental work absenteeism and children's school absenteeism (Darzynkiewicz, 2021; Dougé et al., 2019; Lam et al., 2021; Langkamp et al., 2015), and deliver care to children (Bian et al., 2019; Koren, 2020; Lessard & Rn, 2000; Mackert & Whitten, 2007; Tye et al., 2020; Whitten et al., 1998; Young & Ireson, 2003). These could amount to constructive societal changes especially for underserved populations and communities, and address shortages and the lack of access to pediatric services (Wesley, 2020).

Despite these promised benefits, school telemedicine initiatives, such as the one described here where school nurses have direct access to hospital pediatricians, have run into unexpected resistance by parents. A challenge faced by organizations operating such services is parents' hesitation about allowing the application of telemedicine to service their children and the lack of their involvement in such services (MacGeorge et al., 2021). Previous research implies that such unexpected resistance may be due in part to moral and ethical concerns involved in the choice of using school telemedicine, such as data security and confidentiality, informed consent, doctor-patient's relationships (Langarizadeh et al., 2017), inaccurate reporting (Atac et al., 2013), concerns about the quality of the healthcare services provided (Solimini et al., 2021), and possible physician's malpractice and liability (Nittari et al., 2020; Solimini et al., 2021). In this particular case of school telemedicine deployment our preliminary interviews revealed that there was another, unexpected moral issue: concerns that information might be shared with the immigration authorities.

With respect to such ethical and moral standards, the purpose of this study is to examine the possible significance of parents' personal mores in that process. At its core the argument is that apart from the rational and social reasons why people adopt Information and Communications Technology (ICT) — reasons that star in much of the existing research on ICT adoption, starting even as early as TAM (Davis, 1989) and UTAUT (Venkatesh et al., 2003) based on the theory of reasoned action (Fishbein & Ajzen, 1975) — there is also a moral imperative that partly determines ICT adoption. That moral imperative, calls to do good unto others as a behavioral determinant. That is, whether beliefs about what constitutes proper behavior (mores) may result in increased support for this Children's Hospital of Philadelphia (CHOP) school telemedicine initiative. Mores are positive beliefs about doing the right thing as it relates to a broad set of social and moral issues including contributing to the wellbeing of others. Several studies have shown its effectiveness in environmentally relevant behavior (e.g., Han (2014); Kim and Seock (2019); Kim et al. (2022); Minton and Rose (1997); Wan et al. (2012); Wan et al. (2014)).

Parents, as responsible social actors, should be willing to act on behalf of their children, *inter alia*, in accordance with what they believe is the proper thing to do also for the overall good of society based on their personal mores. In this case, those mores are about allowing their children to be enrolled in a school telemedicine program also because that supports the objective of a well-known children's hospital, specifically CHOP, to provide medical services to children through the school nurse. Despite this potential, and possible moral imperative, our preliminary interviews with parents revealed that some parents expressed moral concerns about sharing their child's Personal Health Information (PHI) with the school on account of their immigration status. (That was a real threat. As one of the parents told the coauthor who managed the project for CHOP, a short time prior to this study one of the parents was deported by the U.S. Immigration and Customs Enforcement (ICE) as was one of the students.) We examine this moral aspect based on the model of altruistic behavior of Schwartz (1970, 1977). The assumption is that when parents make a decision based on their moral beliefs, it enhances their willingness to support actions dedicated to their children's wellbeing *also* in view of what is good for society at large. In the model presented, mores are incorporated in addition to subjective norms and beliefs in the trustworthiness of the healthcare organization. Prior research identified trust—as a willingness to rely on organizations based on

their assumed trustworthiness, i.e., their ability, benevolence, and integrity (Mayer et al., 1995)—as a crucial facilitator for implementing school-based health screenings (Nelson & Rajan, 2018).

To the best of our knowledge, the perception of personal mores, as expressed in this study, has not been discussed in past ICT literature, nor in the context of telemedicine programs. A primary contribution of this research is adding personal mores to the telemedicine context, operationalized through the model of altruistic behavior of Schwartz (1970, 1977). Personal mores, more than subjective norms, trust, or time-saving benefits, were associated with parents' intentions to enroll their children in this program. Also adding to theory, we show that trust plays only an indirect role, being fully mediated by personal mores. Practically, while acknowledging that other variables might also be at play, this suggests that parents relied on their mores when allowing their children to enroll in this initiative. This may add another element into addressing the question of why parents do not embrace such initiatives as much as expected.

## 2 Theoretical Framework and Research Hypotheses

Behavioral intentions are antecedents of behavior, indicating how prepared an individual is to complete that behavior (Ajzen, 1991). Ajzen (1991) states that the stronger an individual's intention is to engage in a behavior, the more likely she or he is to perform that behavior. Previous studies have supported this also in the context of ICT-related literature (An et al., 2021; Deng et al., 2018; Razmak & Bélanger, 2018) as well as telemedicine programs (Kamal et al., 2020; Rahman & Hoque, 2018). The following sections discuss some relevant antecedents of parents' behavioral intentions to enroll their children in a new telemedicine service operated by school nurses in their local school district, specifically the CHOP school telemedicine initiative.

### 2.1 Personal Mores

Schwartz (1970, 1977) developed a socio-psychological model of altruistic behavior, stressing a person's moral norms as a core concept that influences behavior. Moral norms are expectations of following one's own moral beliefs (Schwartz, 1977) or concerns about moral obligations (Khan et al., 2019). The concepts of personal norms and moral norms have been interchangeably used in the model of altruistic behavior (Khan et al., 2019). Adapting those definitions to our context to better reflect the preliminary interviews we conducted and to enhance clarity when the terms are used interchangeably in the literature, we named this concept personal mores. According to Schwartz (1968, 1970), literature defining the domain of morality offers three aspects of moral decisions. First, any moral decision resulting in interpersonal action has consequences for others' wellbeing (Schwartz, 1968, 1970). Second, a moral decision is only characterized as such when the decision-maker is deemed a responsible actor – i.e., an individual who has selected an action knowingly while having an alternative option (Schwartz, 1968, 1970). Finally, the action and the individual responsible for it are assessed in terms of its impact on others' wellbeing (Schwartz, 1968, 1970). Building on this understanding, Schwartz (1970) argued that a moral decision is one in which an individual is aware that their actions may have consequences for the wellbeing of others and so takes responsibility for those actions and their consequences. In this respect, he claims that individuals' behavior will correspond to their personal mores whether or not they are aware of it and of their responsibility for the consequence of those actions. As such, individuals initially develop a sense of responsibility, which drives them to form personal obligations towards a specific behavior based on their assessment and awareness of whether it is the proper thing to do for the wellbeing of others. Individuals are then self-persuaded to engage in a certain behavior due to these personal obligations (Kim et al., 2022; Schwartz, 1970).

Several studies have shown personal mores' effectiveness in environmentally relevant behavior, including Han (2014); Kim and Seock (2019); Kim et al. (2022); Minton and Rose (1997); Wan et al. (2012); Wan et al. (2014). Referring to prior literature, Kim and Seock (2019) investigated the role of personal norms on eco-friendly apparel purchase behavior and showed that individuals with strong moral norms purchased eco-friendly apparel as they felt morally obligated to do. Han (2014) emphasized the role of personal norms as a predictor of intentions to attend an environmentally responsible convention. Likewise, Kim et al. (2022) showed how hotel guests' eco-friendly behavioral intentions were influenced by their norms of personal obligations as members of the global community.

This study suggests that the concept of mores can be extended to an initiative to provide medical services to school children. That service is provided by the school nurse utilizing a school telemedicine program that is operated by a renowned children's hospital, in this case CHOP. Specifically, it is expected that

parents' personal mores (that their allowing their children to be part of this initiative is the right thing to do on a broad social and moral perspective) will increase their willingness to allow their children to be part of this initiative. That is, parents, as responsible actors, will be influenced not only by what might be good for their children, but also by their mores that their approval of their children taking part in this initiative has a positive impact on the school district and the community at large. The logic parallels that of Schwartz (1970, 1977) that people are motivated also by their mores. In this case, CHOP is a respectable medical institute that is renowned for helping children, and, therefore, by supporting this initiative, parents can be expected to believe that they are playing a role that is consistent with their mores of having a positive impact on the school district and the community at large. The parents' support for this CHOP initiative, by enrolling their children in the initiative, should better enable CHOP to provide better services to all the children in that school district. In other words, the objectives of CHOP, to provide better healthcare to the community through its telemedicine, overlap with their mores, namely that supporting the initiative will provide better healthcare to the community and not only to their children. Consistent with an altruistic behavior model Schwartz (1970, 1977) that claims that people are in part influenced in their behavioral choices by their need to do good to others, it is hypothesized, applying that principle to this context, that personal mores should affect parents' behavioral intentions to enroll their children. Specifically, in this case, those are parents' intentions to enroll their children in a nurse operated CHOP telemedicine system. That leads to the following hypothesis.

**Hypothesis 1: Parents' beliefs that they are behaving morally (mores) by registering their children will increase their intentions to enroll their children in the CHOP school telemedicine program.**

## 2.2 Trust in CHOP

Trust is an enabler of many social interactions, shaping human social structures at large and individuals' behaviors within those structures (Luhmann, 1979; Sztompka, 1999). That is in part because of a fundamental human need to understand the social environment and realize what, why, when, and how others act (Gefen et al., 2003). Understanding the social environments, however, may be overwhelming considering that people as free agents may or may not always be rational or predictable in their behavior (Luhmann, 1979). By trusting, people reduce this overwhelming social complexity by ruling out, or setting aside, some of their concerns about others' undesirable but possible behaviors, thereby simplifying the social world enough to understand the social context and, hence, make informed decisions (Luhmann, 1979). The conceptualization of trust by Mayer et al. (1995) can also lead to a similar conclusion. Mayer et al. (1995) define trust as "the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party" (Mayer et al., 1995, p. 712). Such willingness is based on beliefs about the trustworthiness of the trusted party, namely ability, integrity, and benevolence. Integrity is the trustor's belief that the trustee pursues moral and ethical values. Benevolence is the trustor's belief that the trusted party cares about the trusting party and is motivated to do good by them. Ability is the belief that the trustee possesses a relevant set of skills and competencies (Mayer et al., 1995). Knowing that the other party is trustworthy allows setting aside concerns about the risk involved.

The importance of trust in online settings has been examined in many studies, including Benbasat et al. (2008); Gefen et al. (2003); Lee and Turban (2001); McCole et al. (2010); Srivastava and Teo (2009). Trust is particularly important when ICT users' privacy and security are at risk, including in ICT-based healthcare services (e.g., Akter et al. (2011); Dhagarra et al. (2020); Gao et al. (2016); Guo et al. (2012); Hoque et al. (2017); Liang et al. (2005); Slepchuk et al. (2022)). This is also true in the context of telemedicine programs (e.g., Baudier et al. (2021); Kamal et al. (2020); van Velsen et al. (2017)).

Supporting that understanding, as shown extensively in prior healthcare-related ICT literature, including Archer and Cocosila (2014); Baudier et al. (2021); Deng et al. (2018); Dhagarra et al. (2020); Guo et al. (2012); Hoque et al. (2017); Kamal et al. (2020); Klein (2007); Li et al. (2014), trust is also an antecedent of healthcare-related ICT usage intentions. Consistent with the above, this study too, hypothesizes that trust in CHOP will increase parents' intentions to enroll their children in the telemedicine program operated by the hospital. In this context, parents make a rational decision either by setting aside some of their concerns about unacceptable but possible future behavior by the hospital, per Luhmann (1979), or by assessing the hospital's trustworthiness, per Mayer et al. (1995). Applying the logic of trust as suggested by Mayer et al. (1995), parents who trust the hospital to provide healthcare services through their school telemedicine program do so, in part, based on trusting in the integrity, benevolence, and ability of the

hospital. If parents believe that the hospital does not care, is dishonest, or is unable to provide those healthcare services, then parents may rationally be less inclined to enroll their children in the program.

The same applies to this context. Due to the possible misconceived perceived lack of a comprehensive set of rules and regulations, parents need to trust CHOP by assuming that CHOP behaves with integrity, cares about society and the children it serves, and is capable of doing so. That is especially the case in this context. As we discovered in preliminary discussions with parents, many of those parents are legal or undocumented immigrants and minorities and, as such, had heightened concerns about the integrity of the hospital in protecting their personal data. Specifically, parents were concerned that CHOP might report them to the legal authorities or be forced to do so by legal action. This was a real concern to them, even though the law and hospital bylaws explicitly protect them from such an eventuality. That leads to the following hypothesis.

**Hypothesis 2: Trust in CHOP increases parents' intentions to enroll their children in the CHOP school telemedicine program.**

Apart from its relationship to behavioral intentions to enroll their children, trust in CHOP should theoretically also influence parents' mores as they relate to the telemedicine CHOP initiative. Personal mores is the belief that one's own behavior is morally correct (Schwartz, 1970, 1977). In other words, personal mores differ from trust in that personal mores refer to perceptions about one's own behavior being moral behavior, while trust is about relying on another person based on beliefs that that party is trustworthy (Mayer et al., 1995). Taken together, trust in CHOP should increase parents' beliefs that they are doing the right thing (mores) in supporting the CHOP initiative. That is because the CHOP initiative has the potential of providing much benefit, but it also carries potential risk should CHOP behave in an untrustworthy manner, and so the potential will only be materialized if CHOP is trustworthy. Applying the definition of trustworthiness per Mayer et al. (1995), parents' trust in CHOP means that the parents are willing to rely on CHOP in registering their children to this initiative because they believe CHOP is trustworthy and so will carry out the initiative with integrity, benevolence, and capability. If that is the case, then supporting the CHOP initiative is supporting a moral cause because the CHOP initiative provides unquestionable benefits to the population of children and their parents, but only assuming that CHOP is a trustworthy agent. On the other hand, if there is reason to doubt the trustworthiness of CHOP, then supporting the initiative is of questionable morality because it means exposing people to potential harm related to a suspected lack of integrity, lack of caring, or lack of capability through the CHOP initiative. Questionnaire item wordings support this distinction. Mores, as measured in this study, deal with the belief that supporting this "CHOP initiative is the right and proper thing to do". Trust, on the other hand, is characterized by items such as "Based on my experience with CHOP in the past, I know it is honest". That leads to the next hypothesis.

**Hypothesis 3: Trust in CHOP increases parents' beliefs that they are behaving morally (mores) when enrolling their children in the CHOP school telemedicine program.**

## 2.3 Subjective Norms

Subjective norms can also be an important antecedent of behavioral intentions (Ajzen, 1991; Ajzen & Fishbein, 1980). Subjective norms are an individual's perception of adhering to what they believe important *others* would want them to do. Notice that subjective norms, characterized by items such as "People who are important to me think that I should have my child use a school-based telemedicine service", are about what other people who are important to the subject think, while mores are about what the subject himself or herself believes to be moral behavior (Schwartz, 1970, 1977). As the data analysis will verify, the two are not the same. Subjective norms can shape an individual's perceptions of a particular behavior and determine whether that individual intends to engage in that behavior (Fishbein & Ajzen, 1975). In this context, these beliefs are about whether the parents think that people who are important to them and influence their behavior would approve of their enrolling their children in the school telemedicine program.

It has been well-established in prior healthcare-related ICT research that subjective norms can influence intentions (e.g., Hsiao et al. (2013); Hsu et al. (2016); Kim and Park (2012); Mao and Hovick (2022); Yan and Or (2018, 2019); Zhang et al. (2019)). Subjective norms also play a key role in the context of telemedicine or telehealth programs (e.g., Cimperman et al. (2013); Harst et al. (2019); Huang (2013); Ramírez-Correa et al. (2020); Ramírez-Rivas et al. (2021); Wu et al. (2021)). Continuing that line, it is

hypothesized that also in this context, subjective norms should be an antecedent of parents' behavioral intentions to enroll their children.

**Hypothesis 4: Subjective norms supporting the CHOP initiative increase parents' intentions to enroll their children in the CHOP school telemedicine program.**

Subjective norms should also play a role in influencing parents' mores. Applying the theory (Ajzen, 1991; Ajzen & Fishbein, 1980), in this context too, parents may consult with those whose opinions they value, thus building and verifying their own understanding of their own mores about what constitutes moral behavior. This is especially the case with these subjects. As we noticed on multiple preliminary occasions, some parents participated in school events with friends or other family members, suggesting that they were interested in the opinions of those others too. While subjective norms are beliefs that important others will approve a behavior (Fishbein & Ajzen, 1975), personal norms (i.e., personal mores),<sup>1</sup> capture the individual's perception of what is morally correct as rooted in that individual's self-concept (Davies et al., 2002). In other words, subjective norms differ from personal norms in that personal norms refer to an individual's norms, while subjective norms are the individual's perception about the norms held by those who are important to that individual (Fishbein & Ajzen, 1975; Niemiec et al., 2020). This distinction could also be seen in terms of the effect of the consequences of an individual's action. For instance, violating subjective norms may lead to sanctions from important others, while violating personal norms may result in punishment from the individual himself or herself in terms of a bad sense of morality (Kerr, 1995). Thereby, it is also possible to establish personal norms which do not comply with those of important others (Manstead, 1999). Applying this logic to this context, parents' beliefs about what is morally correct should be influenced by what they think important others believe to be moral. That is, each parent's beliefs that their support for this CHOP initiative should benefit community healthcare and the school district, i.e., their mores, could be the internalization of their perceptions of what they believe important others think they should do. Supporting this conjunction, research shows that subjective norms can affect personal norms (Golob et al., 2019; Liu et al., 2020; Liu et al., 2017; Park & Ha, 2014; Rezaei et al., 2019; Schwartz, 1977). The next hypothesis tests that.

**Hypothesis 5: Subjective norms supporting the CHOP initiative increase parents' beliefs that they are behaving morally (mores) when enrolling their children in the CHOP school telemedicine program.**

## 2.4 Time-Flexibility

In addition, the model includes the explicit benefit CHOP intended for this service: increased time-flexibility. Telemedicine can allow individuals to save time and money (Becevic et al., 2015; Dirnberger & Waisbren, 2020; Maurice et al., 2020; McConnochie et al., 2005), minimize geographical and transportation barriers (Pollard et al., 2017), reduce health disparities (Cohen et al., 2012; Pollard et al., 2017), and eventually allow individuals better access to medical healthcare and improve their health and wellbeing (refer to list of citations about the benefits provided by school telemedicine in the Introduction). Time-flexibility possibilities are based on the belief that enrolling in a school telemedicine program allows parents more time-flexibility or prevents scheduling issues at work, which is explained by the expectancy-value model of Ajzen and Fishbein (1977). According to this model, an individual's behavior is influenced by the expectations or beliefs that an individual holds about the potential outcomes of performing that behavior (Ajzen & Fishbein, 1977). These expectations or beliefs represent the individuals' assessment of the probabilities of the specific outcome of that behavior. That potential outcome can be either positive or negative (Ajzen, 1991). According to this theory, an individual anticipates the outcome of her or his behavior before performing it. This expected outcome can then influence the engagement in that particular behavior.

Based on that logic, this study argues that an apparent and plausible reason why parents enroll their children in such a service is that they expect school telemedicine to allow them more time-flexibility, and in doing so also potentially prevent scheduling issues at work. Research supports the relationship between expectancy and intentions (Hardeman, Kinmonth, et al., 2011; Hardeman, Michie, et al., 2011; Shah et al., 2021; Wei & Lu, 2014). The next hypothesis tests this.

<sup>1</sup> As said above, adapting the definition of personal norms to our context to better reflect the preliminary interviews we conducted and to improve clarity when the terms are used interchangeably in the literature, we named this concept personal mores.



**Hypothesis 6: Time-flexibility provided by school telemedicine increases parents' intentions to enroll their children in the CHOP school telemedicine program.**

A key aspect of morality is about helping other people by one's own actions, or at least not causing them unnecessary harm. Applying that concept to the current CHOP initiative, it would be a moral act by an individual parent to support the initiative (mores) if indeed doing so might help other parents too to benefit from the expected time-flexibility created by the initiative, or at least that doing so will not cause them unnecessary harm. Notice that this is about helping others while Hypothesis 6 was about self-interest. However, that helping others holds true only providing that indeed the CHOP initiative enables parents to enjoy more time-flexibility. Specifically, the more potential benefit there is from more time-flexibility, the stronger the moral imperative to be part of the initiative and through it to help other parents too. That is, individual parents will feel it is more "the right and proper thing to do", the more time-flexibility is expected from the initiative. And, conversely, if there is little expected time-flexibility benefit to the school district population of parents, then the lower the moral imperative to assist in the initiative should be.

**Hypothesis 7: Time-flexibility provided by school telemedicine increases parents' beliefs that they are behaving morally (mores) when enrolling their children in the CHOP school telemedicine program.**

The time-flexibility aspect is added to show that mores, trust, and subjective norms play their hypothesized role even when this rational explicit benefit is considered. The research model is shown in Figure 1.

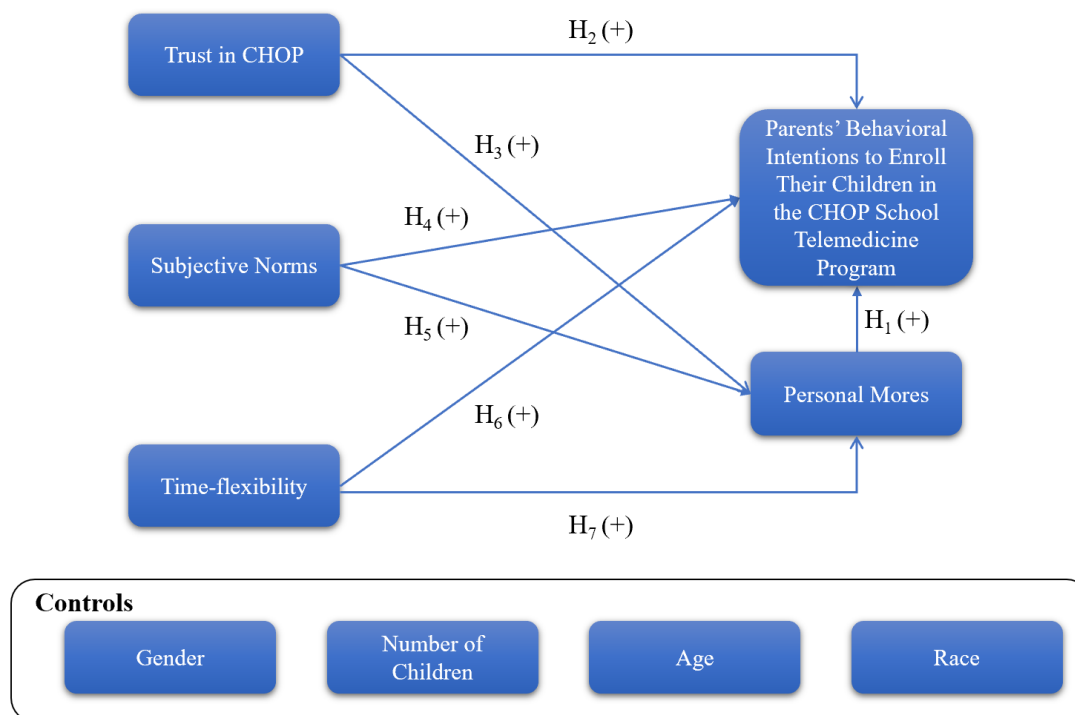


Figure 1. Research Model

### 3 Methodology

#### 3.1 Research Context

CHOP started a project that enables school nurses to connect to their pediatricians online so they can provide better medical services to children with low-acuity issues, e.g., cold, abdominal pain, and headache, on school premises through embedded telemedicine services. CHOP personnel can then e-prescribe medications, provide visit reports to CHOP and non-CHOP primary care physicians, and enable

parents to get those medications when real-time communication is not required. CHOP was curious to know why despite its school telemedicine's promised benefits, enrolling in such a service fell short of expectations.

### 3.2 Data Collection and Procedure

The data were collected through a survey. The survey was offered in either English or Spanish. The survey was provided also in Spanish because there are many undocumented immigrants from Latin America living in the targeted area. The Spanish version was validated by Norristown Area School District and personnel in the pediatric institution. After receiving the necessary legal and Institutional Review Board (IRB) approval, online invitations were sent to participants' email addresses describing the purpose of the study and the importance of parents' participation. The survey was anonymous. Participation was voluntary. The only criterion for inclusion in the survey was that the participants must be parents of children in grades K-12 who attended school in the Philadelphia area or Norristown school districts. The school district insisted on sending out the surveys so that they could ensure the contact information stayed confidential and they could control the number of times the communication was sent out. The invitations to participate were sent out over the summer recess, which may have impacted response rates. 403 responses were obtained. The district indicated that there are currently 7,611 students enrolled. Response rate was calculated as the ratio of completed returned surveys to the total number of qualified reporting units (Hulland et al., 2018). Based on the timing of the survey and feedback from the school district about their typical response rates, the 5.3% response rate exceeded their expectations.

The survey began with demographics and proceeded to 7-point Likert scales anchored at "extremely unlikely" and "extremely likely" for all the items in the Time-flexibility (TF) scale, and "strongly disagree" and "strongly agree" for all the items in the Behavioral Intentions to enroll their children (BI), Personal Mores (PM), Trust in CHOP (TRC), and Subjective Norms (SN) scales. To verify attention, the anchoring of PM, SN, and BI were reverse coded so that they were anchored at "strongly agree" (1) to "strongly disagree" (7) rather than "strongly disagree" to "strongly agree". Prior to the data analysis, those items were transformed to the same "strongly disagree" to "strongly agree" anchors as all the other items. That is, all the scales as analyzed assign lower scores to disagreement and higher scores to agreement. Survey items and their standardized loadings are shown in Table A1 in Appendix A, and their cross loadings in Table A2 (and Table A3 for all the data) in the same Appendix. The study adapted previously validated scales for all the constructs except PM. BI items were adapted from Ajzen (1991), SN from Mathieson (1991), TF from Knabe (2012), and TRC from Gefen et al. (2003). Gefen et al. (2003) combined the three trustworthiness dimensions and trust into a single construct. That is common in many studies on ICT adoption because it is statistically difficult to distinguish between trustworthiness and trust (Benbasat et al., 2010; Gefen et al., 2005; Warkentin et al., 2018).

The preparation of the PM scale began with identifying the characteristics of the construct and obtaining a representative description of those characteristics (Sartori, 1984). Next, the constructs' conceptual domain was specified as suggested by MacKenzie et al. (2011) by determining the subject of the construct application (person) and the characteristics the construct reflects (positive feeling of doing the right thing). We then created a set of items that captured that conceptual domain based on preliminary interviews with a large number of parents in the school district and verified their theoretical application to this construct by comparing the items to the literature, including Barrett et al. (2004); Cialdini et al. (1999); Davies et al. (2002); Klöckner and Ohms (2009); Schwartz (1970, 1977). The set of items was validated through data analysis techniques described in the Data Analysis section.

The preliminary phase of this research encompassed extensive onsite fieldwork with parents in their educational settings, specifically within the Philadelphia or Norristown school districts. A series of back-to-school events were organized by CHOP and attended by one of the coauthors as its project leader. These events served as an opportunity for actively engaging with parents and school administrators, facilitating an exchange of information about the CHOP initiative, and allowing the coauthor to personally interact with and learn from the parents. Through conducting preliminary informal chats, designed to encourage open and unguarded discussions, with parents and observing their responses and behaviors during these events, invaluable insights were gathered. These insights played an important role in informing and shaping the research approach, which is also reflected throughout the study. This knowledge, gathered from the pre-study discussions and observations, informed the deliberate selection of research constructs, ensuring that the research objective is closely aligned with the parents' experiences and perspectives, thus enhancing the external validity of the research. These preliminary interviews shed light on potential

avenues for improving the implementation of school telemedicine, particularly by addressing parents' trust and moral concerns regarding the sharing of their child's PHI with the school. Additionally, the benefits of time-flexibility offered by school telemedicine emerged as an important aspect of interest during these pre-study discussions. Notably, on multiple preliminary occasions, some parents attended school events with friends or other family members, suggesting an interest in seeking the perspectives of important others when making decisions.

### 3.3 Control Variables

Demographics including number of children, age, race, and gender of parents were added as controls in the analysis. From a dataset consisting of 229 responses, the distribution of the respondents' age groups were 2.20% Gen Z (18-25), 4.41% Gen Y2 (26-30), 32.60% Gen Y3 (31-40), 57.27% Gen X (41-55), and 3.52% baby boomers. 69.43% were Caucasian, 21.83% African American, 1.31% Asian, 0.87% Hawaiian, and 6.55% others. 11.40% were Hispanic and 88.60% Non-Hispanic. The race variable was registered as 1 for the majority group and 0 for the minorities. Race was included because research shows that African Americans may have a lower level of trust in healthcare (Kennedy et al., 2007). 90.83% of the participants were female (coded as 2) and 9.17% were male (coded as 1). Research is ambivalent about gender differences in the context of telemedicine, with some (e.g., Luo et al. (2021)) claiming it is significant and others not (e.g., Annapragada et al. (2021); Wesley (2020)). In the school setting, the "mom" is often listed as the primary caregiver, and this is likely why the respondents in this study were mostly women. 51.53% of the respondents had one child registered in the school district, 34.06% had two, 11.35% three, 1.31% four, and 1.75% had five.

### 3.4 Data Analysis

Of a total of 403 responses, only 229 responses with complete data were included in the analysis. Age ( $F = .31$ ,  $p$ -value = .58), ethnicity ( $F = .06$ ,  $p$ -value = .81), race ( $F = .14$ ,  $p$ -value = .97), and zip-code ( $F = 1.06$ ,  $p$ -value = .38) did not identify those who started the survey but did not complete it, however those who did complete the survey were predicted ( $F = 7.58$ ,  $p$ -value < .001,  $R^2 = .62$ ) by how many children the parent had enrolled ( $\beta = -.43$ ,  $t = -15.99$ ,  $p$ -value < .001) and if the first child was male ( $\beta = -.10$ ,  $t = -2.37$ ,  $p$ -value = .02), but not the age of the first child ( $\beta = .01$ ,  $t = 1.20$ ,  $p$ -value = .23). Those results suggest that the fewer children the parent had enrolled predict whether the parent will skip questions in the questionnaire. That is, there is more interest in completing the questionnaire, after starting it, among those who might most benefit from the new nurse-run telemedicine system. To test the idea that convenience is the main story, as we inferred CHOP originally thought too, we ran additional analysis regressing the number of children the respondent has on parents' behavioral intentions to enroll their children. The results show that the prediction is insignificant ( $F = 3.59$ ,  $p$ -value = .059,  $R^2 = .02$ ,  $\beta = .21$ ).

Non-response bias was examined using the Armstrong and Overton (1977) method, showing an insignificant difference in a generalized linear model (GLM) analysis between the first half and the second half of responses according to when the survey was completed ( $F = .52$ ,  $p$ -value = .759,  $R^2 = .01$ ) as it relates to time-flexibility ( $t = -.32$ ,  $p$ -value = .747), parents' behavioral intentions to enroll their children ( $t = .91$ ,  $p$ -value = .364), personal mores ( $t = -.45$ ,  $p$ -value = .651), trust in CHOP ( $t = .62$ ,  $p$ -value = .533), and subjective norms ( $t = -1.22$ ,  $p$ -value = .225).

Descriptive statistics, Cronbach's alpha (CA), Composite Reliability (CR), and Average Variance Extracted (AVE) are shown in Table 1. Correlations are shown in Table 2. (And, respectively, in Tables A4 and A5 in Appendix A for all the data). Standardized loadings exceeded the threshold value of .70. The convergent and discriminant validity of the scales was validated through confirmatory factor analysis run in Mplus. Common Method Variance (CMV) was tested based on Podsakoff et al. (2003) through a Harman's single factor test and by showing that when all the measurement items in the model except demographics were modeled as a single construct the fit indices were unacceptable ( $\chi^2_{119} = 2147.171$ ,  $p$ -value < .001, RMSEA = .259, CFI = .421, TLI = .339, SRMR = .200). In contrast, without considering only one construct, the model indicated acceptable and better fit indices ( $\chi^2_{109} = 257.919$ ,  $p$ -value < .001, RMSEA = .073, CFI = .958, TLI = .947, SRMR = .037). In all the analyses presented next, all the measurements had the same anchors of 1 being low or strongly disagree and 7 being high or strongly agree. This includes PM, SN, and BI that were transformed to be on this scale prior to the analyses.

**Table 1. Descriptive Statistics, Reliability and AVE**

Items	Mean	Std.	CR.	CA.	AVE.
BI	5.30	1.40	.918	.908	.788
SN	4.64	1.36	.982	.981	.964
PM	5.85	1.12	.928	.920	.765
TRC	5.67	1.42	.946	.946	.748
TF	4.96	1.64	.703	.714	.543
Race	0.69	0.46	---	---	---
Age	42.78	8.27	---	---	---
Gender	1.91	0.29	---	---	---
Number of Children	1.68	0.86	---	---	---

**Table 2. Correlations**

Items	BI	SN	PM	TRC	TF	Race	Age	Gender	Number of Children
BI	.888								
SN	.539***	.982							
PM	.664***	.487***	.875						
TRC	.199**	.155*	.220**	.865					
TF	.521***	.447***	.420***	.162*	.737				
Race	-.055	.049	.152*	-.104	.019	---			
Age	-.184**	-.151*	-.088	.003	-.039	.127*	---		
Gender	.077	.051	.113	.017	.061	.052	-.234***	---	
Number of Children	.123	.147*	.103	.055	-.007	.015	-.088	-.084	---

Note. The square roots of AVE values were presented on the diagonal, and correlations were presented off diagonal. (Significant level: \* p-value < .05, \*\* p-value < .01, \*\*\* p-value < .001)

The research model was analyzed with covariance-based structural equation modeling (CBSEM) with a Maximum Likelihood estimation using Mplus version 7.4 (Muthén & Muthén, 2010). The resulting model fit indices are acceptable:  $\chi^2_{163} = 321.711$ , p-value < .001, RMSEA = .065, CFI = .949, TLI = .937, SRMR = .066 (Gefen et al., 2011). The results support all the hypotheses except H<sub>2</sub>. Parents' personal mores increased behavioral intentions to enroll their children in school telemedicine ( $\beta = .504$ , p-value < .001), supporting H<sub>1</sub>. Trust in CHOP increased personal mores ( $\beta = .167$ , p-value = .016), supporting H<sub>3</sub>, but did not increase parents' behavioral intentions to enroll their children ( $\beta = -.002$ , p-value = .966), not supporting H<sub>2</sub>. Subjective norms increased parents' behavioral intentions to enroll their children ( $\beta = .158$ , p-value = .018) and personal mores, ( $\beta = .274$ , p-value < .001), supporting both H<sub>4</sub> and H<sub>5</sub>. Time-flexibility increased parents' behavioral intentions to enroll their children ( $\beta = .267$ , p-value < .001) and personal mores, ( $\beta = .337$ , p-value < .001), supporting both H<sub>6</sub> and H<sub>7</sub>, respectively. As to the control variables,<sup>2</sup>

<sup>2</sup> The subjects could choose whether to take the survey in English or in Spanish, but as only 18 of the total (~4%) chose to answer in Spanish, it was impossible to compare the variables of interest by chosen language too. Instead, language-culture differences were assessed indirectly through zip-code, considering that immigrants often tend to congregate in the same neighborhood. Adding the zip-code to the model as a set of dummy variables, resulted in essentially the same results: personal mores increased parents' behavioral intentions to enroll their children ( $\beta = .502$ , p-value < .001), subjective norms increased personal mores ( $\beta = .251$ , p-value = .002) and parents' behavioral intentions to enroll their children ( $\beta = .162$ , p-value = .014), trust in CHOP increased personal mores

race affected both parents' behavioral intentions to enroll their children ( $\beta = -.155$ ,  $p$ -value = .003)<sup>3</sup> and personal mores ( $\beta = .165$ ,  $p$ -value = .009). The number of children registered in the school district affected subjective norms ( $\beta = .141$ ,  $p$ -value = .019).  $R^2$  was 61% for parents' behavioral intentions to enroll their children and 36% for personal mores.<sup>4</sup> Running a saturated model as a standard robustness test as suggested by Bollen (1989) did not significantly improve the model.<sup>5</sup> The results of the analysis are shown in Figure 2<sup>6</sup>.

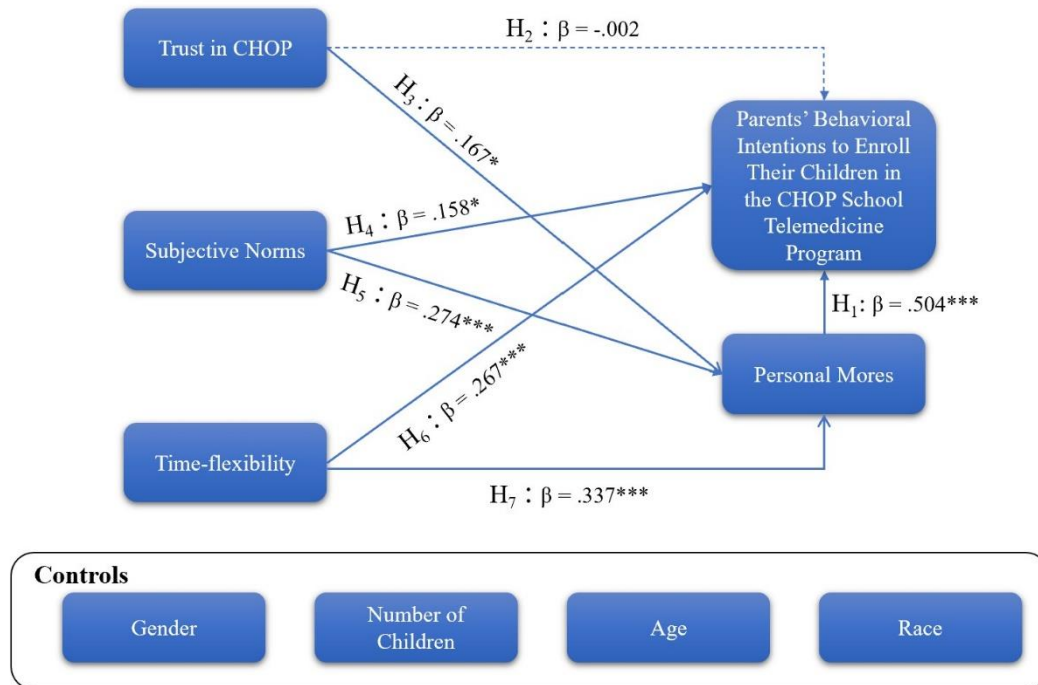
( $\beta = .183$ ,  $p$ -value = .008) but not parents' behavioral intentions to enroll their children ( $\beta = -.009$ ,  $p$ -value = .881), and time-flexibility increased personal mores ( $\beta = .338$ ,  $p$ -value < .001) and parents' behavioral intentions to enroll their children ( $\beta = .265$ ,  $p$ -value < .001). Consequently, zip-codes were removed from the subsequent analyses.

<sup>3</sup> The inconsistency observed between an insignificant correlation of race and behavioral intentions to enroll their children in Table 2, and the results obtained from Mplus was addressed in a post-hoc analysis, showing that subjective norms is important among Caucasians only. In contrast, minorities cared about mores. Technically, there is no multicollinearity, as shown in low VIF values in an equivalent linear regression that replicated the Mplus analysis. The VIF values for subjective norms, personal mores, trust in CHOP, time-flexibility, race, age, gender, and children were 1.51, 1.56, 1.10, 1.36, 1.12, 1.15, 1.14, and 1.10, respectively.

<sup>4</sup> We also ran the data with pair-wise deletion rather than the default listwise deletion of observations, so that more data could be included in the analyses. Additionally, to further validate the results of the analysis, the model was rerun replacing missing values with their means, including 349 surveys in the analysis. The results were practically the same as in the primary analysis. Parents' personal mores increased behavioral intentions to enroll their children ( $\beta = .495$ ,  $p$ -value < .001). Trust in CHOP increased personal mores ( $\beta = .197$ ,  $p$ -value = .003), but did not increase parents' behavioral intentions to enroll their children ( $\beta = .025$ ,  $p$ -value = .652). Subjective norms increased parents' behavioral intentions to enroll their children ( $\beta = .143$ ,  $p$ -value = .030) and personal mores ( $\beta = .294$ ,  $p$ -value < .001), and time-flexibility increased both parents' behavioral intentions to enroll their children ( $\beta = .294$ ,  $p$ -value < .001) and personal mores ( $\beta = .329$ ,  $p$ -value < .001). In the second technique, we ran a Bayesian analysis that included 254 datapoints. Here too, parents' personal mores increased behavioral intentions to enroll their children ( $\beta = .503$ ,  $p$ -value < .001). Trust in CHOP increased personal mores ( $\beta = .199$ ,  $p$ -value = .011), but did not increase parents' behavioral intentions to enroll their children ( $\beta = -.008$ ,  $p$ -value = .885). Subjective norms increased parents' behavioral intentions to enroll their children ( $\beta = .138$ ,  $p$ -value = .039) and personal mores ( $\beta = .305$ ,  $p$ -value < .001), and time-flexibility increased both parents' behavioral intentions to enroll their children ( $\beta = .297$ ,  $p$ -value < .001) and personal mores ( $\beta = .329$ ,  $p$ -value < .001).

<sup>5</sup> The saturated model  $X^2_{159}$  was 320.615, and so the change in  $X^2_4$  at 1.096 is insignificant, indicating that adding those paths does not significantly improve the model. Indeed, none of the added paths is significant: Time-flexibility is not influenced by Age ( $\beta = -.034$ ,  $p$ -value = .679), by Gender ( $\beta = .062$ ,  $p$ -value = .446), by Race ( $\beta = .027$ ,  $p$ -value = .733), or by the Number of Children ( $\beta = -.007$ ,  $p$ -value = .930).

<sup>6</sup> The pattern of significant paths and their signs remains the same even after removing the insignificant paths from the demographic variables. Parents' personal mores increased behavioral intentions to enroll their children ( $\beta = .513$ ,  $p$ -value < .001). Trust in CHOP increased personal mores ( $\beta = .165$ ,  $p$ -value = .016), but did not increase parents' behavioral intentions to enroll their children ( $\beta = .001$ ,  $p$ -value = .992). Subjective norms increased parents' behavioral intentions to enroll their children ( $\beta = .183$ ,  $p$ -value = .004) and personal mores ( $\beta = .301$ ,  $p$ -value < .001). Time-flexibility increased both parents' behavioral intentions to enroll their children ( $\beta = .256$ ,  $p$ -value < .001) and personal mores ( $\beta = .316$ ,  $p$ -value < .001). Race affected both parents' behavioral intentions to enroll their children ( $\beta = -.148$ ,  $p$ -value = .003) and personal mores ( $\beta = .165$ ,  $p$ -value = .007). The number of children registered in the school district affected subjective norms ( $\beta = .138$ ,  $p$ -value = .018).  $\chi^2_{141} = 296.984$ ,  $p$ -value < .001, RMSEA = .068, CFI = .952, TLI = .942, SRMR = .066.



(Significant level: \* p-value < .05, \*\* p-value < .01, \*\*\* p-value < .001)

Figure 2. Model Results

### 3.5 Post-hoc Analyses

The preceding analysis revealed an insignificant effect of trust in the hospital on parents' intentions to enroll their children in the school telemedicine program. This section further investigates this. The mediation analysis was conducted in Mplus following the same procedure outlined by Baron and Kenny (1986) for linear regression, with added controls for the demographic effects. In the first step of the analysis, personal mores was regressed on trust ( $\beta = .255$ , p-value < .001), showing that trust significantly affects personal mores. In the second step, parents' behavioral intentions to enroll their children was regressed on trust ( $\beta = .178$ , p-value = .020), showing that trust also affects parents' behavioral intentions to enroll their children. In the third step, parents' behavioral intentions to enroll their children was regressed on both personal mores and trust, showing that personal mores is significantly associated with parents' behavioral intentions to enroll their children ( $\beta = .715$ , p-value < .001), but trust does not affect parents' behavioral intentions to enroll their children ( $\beta = .020$ , p-value = .748). A Sobel test (Sobel, 1982) confirmed that personal mores significantly mediates the relationship between trust and intentions (Test-statistic = 3.09, Std. Error = .046, p-value = .002). To further validate the mediation role of personal mores, a bootstrap using 5,000 samples was run on the research model displayed in Figure 1. The analysis showed no direct effect of trust on parents' behavioral intentions to enroll their children ( $\gamma = -.002$ , p-value = .971) but showed an indirect effect through personal mores ( $\gamma = .084$ , p-value = .019, 95% confidence interval = [.029, .148]), confirming that trust increased parents' behavioral intentions to enroll their children fully mediated by personal mores.

The next analysis regressed personal mores on subjective norms ( $\beta = .469$  p-value < .001), parents' behavioral intentions to enroll their children on subjective norms ( $\beta = .533$ , p-value < .001), and parents' behavioral intentions to enroll their children on both personal mores ( $\beta = .628$ , p-value < .001) and subjective norms ( $\beta = .300$ , p-value < .001). The results showed that both subjective norms and personal mores influence parents' behavioral intentions to enroll their children. The Sobel test (Sobel, 1982) confirmed that personal mores mediates the effect of subjective norms on intentions (Test-statistic = 5.12, Std. Error = .046, p-value < .001). Likewise, a bootstrapping analysis indicated that both the direct effect of subjective norms on parents' behavioral intentions to enroll their children ( $\gamma = .158$ , p-value = .046) and the indirect effect of subjective norms on parents' behavioral intentions to enroll their children through

personal mores ( $\gamma = .138$ ,  $p$ -value = .004, 95% confidence interval = [.058, .215]) are significant, suggesting that personal mores partially mediates the effect of subjective norms on parents' behavioral intentions to enroll their children.

In the next post-hoc analysis, personal mores were regressed on time-flexibility ( $\beta = .490$ ,  $p$ -value < .001), parents' behavioral intentions to enroll their children was regressed on time-flexibility ( $\beta = .596$ ,  $p$ -value < .001), and parents' behavioral intentions to enroll their children was regressed on both personal mores ( $\beta = .648$ ,  $p$ -value < .001) and time-flexibility ( $\beta = .331$ ,  $p$ -value < .001). The results indicated that time-flexibility and personal mores both have significant effects on intentions to enroll their children. A Sobel test (Sobel, 1982) confirmed the mediating role of personal mores between time-flexibility and parents' behavioral intentions to enroll their children (Test-statistic = 3.92, Std. Error = .054,  $p$ -value < .001). Additionally, a bootstrap analysis showed that both the direct effect of time-flexibility on parents' intentions to enroll their children ( $\gamma = .267$ ,  $p$ -value = .006) and its indirect effect ( $\gamma = .170$ ,  $p$ -value < .001, 95% confidence interval = [.086, .261]) are significant. These findings suggest that personal mores partially mediates the effect of time-flexibility on parents' behavioral intentions to enroll their children.

The discrepancy evident between the non-significant correlation of race and parents' behavioral intentions to enroll their children in Table 2 and the findings derived from the Mplus analysis, necessitated further investigation. The analysis was performed separately for the majority group, i.e., Caucasians, and minority groups, i.e., African American, Asian, Hawaiian, and others. The results of the two analyses, each performed by running a bootstrap using 5,000 subsamples, revealed distinct patterns. For the minority groups, personal mores is the only predictor influencing behavioral intentions to enroll their children ( $\beta = 1.060$ ,  $p$ -value = .031). On the other hand, among the majority group, personal mores ( $\beta = .420$ ,  $p$ -value < .001), subjective norms ( $\beta = .242$ ,  $p$ -value = .017), and time flexibility ( $\beta = .305$ ,  $p$ -value = .007) significantly increased parents' behavioral intentions to enroll their children. Interestingly, the analysis shows that subjective norms affects behavioral intentions only among the majority group. We caution that the dataset is small and the context very specific. However, if it holds true that subjective norms are a predictor of behavioral intentions only among the majority stratum of the population, the implications could be far reaching from a theory of planned behavior perspective (Ajzen, 1991) and the theory of reason action (Fishbein & Ajzen, 1975) upon which it is based, especially as much research has shown the importance of subjective norms on ICT adoption intentions too (e.g., Hsiao et al. (2013); Hsu et al. (2016); Kim and Park (2012); Mao and Hovick (2022); Yan and Or (2018, 2019); Zhang et al. (2019)). That mores may be more important and even replace subjective norms is an intriguing thought, especially as it provides an alternative reason why subjective norms are important: people do adopt ICT and other behavior not just because others who are important to them think they should, but maybe rather because people internalize those norms as their own mores. Additional research is clearly needed, but the thought is provoking.

## 4 Discussion

### 4.1 Summary of the Analysis

This study examined potential antecedents of parents' intentions to enroll their children in a school telemedicine program. The literature highlights the importance of parents' consent in allowing their children to use school telemedicine and the difficulty in obtaining such consent as a barrier to increased children's access to medical services (e.g., Cook et al. (2002); Narum (2016); Reynolds and Maughan (2015); Shih and Portnoy (2018)). The study examined another aspect of this issue. Namely, parents' personal mores as an antecedent of their intentions to enroll their children in a school telemedicine initiative, highlighting the need to consider moral antecedents too. The role of mores was supported by the data, which has not been addressed by prior literature. Unexpectedly, the study found no direct effect of trust in CHOP on parents' intentions to register their children to the initiative. Adding a possible new aspect to trust theory, parents' personal mores fully mediated the effect of trust in CHOP on behavioral intentions to enroll their children. As hypothesized, expected time-flexibility increased parents' personal mores and intentions, and intentions and personal mores were increased by subjective norms favoring the new initiative. As the analysis shows, there was an element of convenience, i.e., time-flexibility, involved in the parents' decisions, as was in part how CHOP initially planned to convince the parents to enroll their children. What is interesting is that there was more than just convenience involved.

## 4.2 Theoretical Implications

Previous research on ICT adoption centered on rational, social influence, and utilitarian reasons why people adopt an ICT. Prominent among that research are some of the most cited theories in MIS (e.g., TAM (Davis, 1989) and UTAUT (Venkatesh et al., 2003)). Much of that research is based on the theory of reasoned action (Fishbein & Ajzen, 1975), which, as its name implies, deals with rational, social influence, and utilitarian reasons that impact behavioral intentions. Undeniably, based on previous research and this one too, that is the case. But, as this study shows, people are also guided by morality in their behavior. A key reason parents chose to adopt the CHOP telemedicine system was because they believed that it “is the right and proper thing to do” and that it will benefit the community. That is to say, parents supporting children’s healthcare enhancements may show their dedication to ensure other children receive the equivalent healthcare and services access as they would want for their own children. It acknowledges that children’s healthcare accessibility goes beyond parents’ concern; it is a shared responsibility. Thus, parents may expect that the improvement in healthcare access through school telemedicine can bring about positive benefits for their children and also for other children and their parents. Thereby, they may identify moral values that align with their sense of what is right while also placing trust in those implementing the ICT. As the study shows, parents believe enrolling their children in CHOP’s telemedicine is morally right because they also trust CHOP. Adding mores thus adds a new dimension to the study of ICT adoption.

One of the primary contributions of this study is accordingly adding and supporting the hypothesis of personal mores as a new ICT adoption antecedent. In the present study ICT is a school telemedicine system. To the best of our knowledge, personal mores have not been part of previous ICT-related literature. The data support the hypothesis that as parents’ positive beliefs that they are doing the right thing from a broad social and moral perspective, i.e., their personal mores, increases, so too do these parents’ intentions to support such a telemedicine initiative. Seen through the lenses of the altruistic model proposed by Schwartz (1970, 1977), these beliefs can also be interpreted as an altruistic behavior that is influenced by the need to do good to others, over and above the rational and social influence antecedents proposed by previous research on ICT adoption. This is supported by the analysis that shows that parents’ intentions to enroll their children in this CHOP initiative is increased by their belief that they are doing the right thing for society. That these mores are increased by the parents’ trust in CHOP, adds new aspects to both Schwartz (1970, 1977) and trust theory. This personal mores antecedent is independent of the rational path that CHOP initially thought as being a primary reason why parents might adopt their initiative, namely that it is a rational choice that saves time. Indeed, the observed significant correlation between the perception of time-saving through school telemedicine and personal mores serves to reinforce the fundamental concept underlying this research, i.e., motivation to do good for others. In the context of our study, doing good for others can partly be achieved through the school nurse providing CHOP-consulted medical services on the school premises, rather than have parents go through the time-consuming process of taking their child to hospital. Accordingly, if parents expect that having a school telemedicine system will save them and other parents the occasional time-consuming need to take their children to hospital then, we hypothesized, many parents may view supporting its implementation as corresponding to their mores of doing good for others. Conversely, if school telemedicine does not save parents time, it very likely will not be considered beneficial in helping others, and, thus, there may be no discernible moral reason to support it.

Relying on such mores in making a decision, as discussed by Schwartz (1970, 1977), may not be a new theoretical context overall, as it has been applied in the environmental literature (e.g., Han (2014); Kim and Seock (2019); Kim et al. (2022)). However, applying that hypothesis to parents’ decisions to enroll their children in a school telemedicine initiative is new and ties it into ICT adoption literature too. This new application of the theory may explain parents’ hesitation, adding a new theoretical understanding of processes involved in ICT adoption. The reasons why mores may encourage parents in this context may be partly explained based on the altruistic model of Schwartz (1970, 1977). Schwartz (1970) indicated that individuals develop a sense of responsibility toward a behavior. That responsibility then leads them to form personal obligations toward that behavior based on their awareness that this behavior of theirs is the proper thing to do. And, importantly, it is the right thing to do also based on the presumption that this behavior is the right thing to do for others’ wellbeing too. Adding beyond that obvious application of Schwartz (1970, 1977) to this context is that the belief in those mores is highly correlated with trust in CHOP. Plainly put, mores are important as behavioral antecedents, but, as the data analysis shows, how strong those mores are also depends on the trust that the parents have in the agent performing that activity. That is, the belief that participating in this CHOP initiative is the right thing to do depends on



whether the agent carrying out this activity is a trusted agent. If CHOP were not trusted, then parents' mores as they relate to this behavior would have been compromised because the outcome of that behavior depends on the agent performing it. Mores do not operate in a vacuum. Mores are related to the agents carrying them out. And this brings trust theory into the picture. Indeed, also in Agency theory (Eisenhardt, 1989) the nature of the relationship between the principal and the agent is crucial and is partly based on trust the principal has in the agent performing the behavior, as shown also in other ICT contexts (e.g., Dong et al. (2022); Gefen and Carmel (2013); Gefen et al. (2008); Henrich (2020); Kim and Kim (2018); Pavlou et al. (2007)).

Including that aspect of trust as it relates to mores suggests a possible new avenue of how trust operates. To clarify the importance of this indirect effect, consider how trust is often conceptualized. According to Luhmann (1979) and subsequent research based on his conceptualization (e.g., Gefen et al. (2003)), trust is important because people have a need to understand the social environment – an environment that is too complicated to understand because all people are in essence free agents who may not always even be predictable. That makes rationally assessing the social context overwhelming. By trusting in others, or, as Gefen and Carmel (2013) put it, setting aside concerns that the trusted party may behave in undesirable manners, people allow themselves to reduce the otherwise overwhelming social complexities. Such trust is crucial especially if people are unsure whether the authorities will properly regulate the behavior of those others (Fukuyama, 1995; Pavlou & Gefen, 2004). The preliminary interviews suggested that such concern was an issue among many of the parents. Applying this conceptualization, research often related trust to increasing the perceived value of the interaction with others, and hence to ICT adoption (e.g., Chandra et al. (2010); Gefen et al. (2003); Gu et al. (2016); Wang and Benbasat (2016); Xin et al. (2015)). That that trust may operate through an increased sense of doing the right thing for others, mores, adds a new aspect to this conceptualization. It is not only about understanding the social context. It is also about assuming that that social context is morally acceptable.

Interestingly in this regard, the effect of trust on parents' behavioral intentions to enroll their children is fully mediated by mores. This adds another possibly important implication. Trust, in theory and past research, is important also because, by trusting, people rule out possible behaviors by others and thereby reduce the extent of social complexity to more manageable levels (Gefen et al., 2003; Luhmann, 1979). However, the mediation suggests that, at least in this context, that reduction of social complexity is also important because of the moral aspect it is correlated to. In other words, it is to the extent that the parents trust CHOP to be an honest, caring, and capable agent, that these parents believe they are doing the right thing for society by enrolling their children in the CHOP initiative. This is very rational. The good to society that their enrolling their children delivers is brought about precisely because CHOP is trustworthy. Had CHOP not been trustworthy then there would be little reason to believe that any good might come to society by their enrolling their children in this initiative. Viewed in this light, trust increases the value of the mores, but it is the mores that predict behavioral intentions to enroll their children. More specifically, trust is important in this process because it is aligned with a context that matches parents' moral beliefs of what is right and what they want to do. That is, parents believe that enrolling their children in CHOP's telemedicine is morally correct because they trust CHOP.

### 4.3 Practical Implications

The results suggest that alongside convincing parents of the benefits of school telemedicine, as revealed through the effect of its time-flexibility possibilities on intentions, CHOP and other healthcare organizations operating such services might also need to know how to incorporate parents' mores and the reasons behind them. One way of doing so, in line with the model of altruistic behavior, as suggested by applying the ideas in Schwartz (1970, 1977), might be through increasing parents' awareness of the consequences of their actions for others' health and wellbeing. Taking advantage of those mores might also be increased by convincing those involved that the agent, CHOP in this case, is trustworthy. As the analysis shows, parents' trust in CHOP correlates with their associating positive mores to supporting the CHOP initiative. One way of doing so suggested by the wording in the questionnaire might be through convincing parents that the hospital is able, honest, and caring to provide services to their children, consistent with Mayer et al. (1995). Indeed, the CHOP team engaged with the school administration, parents, and community groups, including by attending back-to-school nights, advertising through the school, and making themselves available to answer questions.

Those preliminary discussions with parents provided valuable insights that shaped the approach of this study. The pre-study discussions revealed that the possibility of having their PHI and immigration status

shared by the hospital with the authorities may have undermined parents' trust in CHOP. Alleviating those fears could be an initial step towards increasing parents' acceptance of school telemedicine. Furthermore, the outcomes of the post-hoc analysis indicate that personal mores have a significant positive impact on the behavioral intentions of both majority and minority groups to enroll their children in the CHOP school telemedicine program. Considering this, school telemedicine providers can adopt another strategic approach, on account of the indirect effect of trust in CHOP through mores on parents' intentions to enroll their children. This approach involves tapping into the common cultural element that may resonate with parents from diverse backgrounds. This approach aligns with the shared values of contributing to the health and wellbeing of the larger community and may potentially transcend cultural boundaries. Highlighting how the program benefits the broader community allows providers to underscore the positive impact of parental involvement on collective health outcomes.

Additionally, it was observed that subjective norms only influence behavioral intentions among the majority group, but not among minorities. In light of this cultural diversity, it might be advisable to have both minority parents and majority parents serve as promoters of a new ICT, rather than an outsider at CHOP. It would perhaps be more believable if messages about time-flexibility and mores came from such parents. Moreover, having an insider, in this case, it would be another parent in the same school district, as the promoter of the system could also indirectly reduce the us-versus-them boundary and play better to the mores of the parent decision-makers.

Another implication is that improved implementation of school telemedicine systems may be achieved by reaching out to parents about the legally enforced protection of PHI (including that hospitals do not and are legally prevented from sharing PHI with authorities) and the time-flexibility benefits the system provides. As also noted by previous research, managing the success of an IT implementation project is not just about the technology but is also about knowing what motivates its users – in the case of a school setting in the US, the mores of benefiting the community of parents is one such motivator.

#### 4.4 Limitations

The research model was analyzed as it applies to CHOP. Future studies may wish to examine how the model applies to other healthcare organizations across the country as well as to non-urban settings. The context studied was parents registering their children to the CHOP initiative as a preliminary step toward acquiring services from CHOP doctors through telemedicine. As such, trust was measured as it relates to CHOP itself rather than to the subsequent telemedicine service or the doctors providing it after the children are registered. That is, we measured trust in the initial step in the process. However, there is more to trust in this context than only that aspect. Undeniably, trust in the accuracy of diagnosis through a telemedicine visit and, by extension, also trust in the concordance between a telemedicine diagnosis and an in-person visit is of crucial importance (Demaerschalk et al., 2022). Future research may wish to examine trust also as it relates to those and other aspects in the subsequent steps in the process such as in the accuracy of telemedicine. Measuring trust in a context where it directly reflects outcomes of significant importance to individuals, in this case, their children, can be challenging. Extrapolating from the fear of authorities expressed in the interviews, it may be that respondents hesitated to declare low levels of trust in authorities or institutions, fearing potential retribution. In such a sensitive context, there is a need for careful consideration of the potential biases that can impact the measurement of trust. To mitigate this limitation, an alternative approach could be to assess trust indirectly by asking about trust-related topics rather than trust itself. This approach may provide a more nuanced understanding of trust, as respondents may feel more comfortable expressing their opinions without fear of potential consequences. This approach of assessing trust-related topics rather than trust itself may shed light on why the effect of trust was found to be mediated in this study.

Another topic that should be mentioned when comparing this study to others is that the dependent variable of interest is parents' intention to permit the use of a nurse-based telemedicine system for their children. It is not about the parents' intended use of an ICT themselves, as in much previous research on trust and ICT. That permission may also depend on the delicate need to provide multilingual services by the nurse. The data provided only 4% of respondents in Spanish, and so assessing that segment of the population who might prefer Spanish requires additional research.

Another inevitable limitation is related to demographics, i.e., race and gender. Most of the participants were female and Caucasians, although this is the reality in this population. Future research may also wish to explore different demographic variables, including income. Furthermore, some parents may have been

unable to participate in the survey due to low digital literacy, which may be viewed as another unavoidable limitation.

## 5 Conclusion

School telemedicine services have the potential to improve children's access to medical care on school premises; however, those services can only be obtained if parents allow the school to serve their children through school telemedicine. CHOP faced such challenges. Including personal mores as positive beliefs about doing the right thing in a broad social and moral perspective might add new insight into understanding how to approach and address this issue. The data and its analysis indeed show that personal mores are important, even to the extent that they mediate the importance of trust. A key takeaway is that behavioral intentions to adopt an ICT are based not only on rational, social influence, and utilitarian reasons, but also on moral considerations of doing good unto others.

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## Appendix A:

**Table A1. Measurement Items and Their Standardized Loadings**

Items	Wording	Loadings
<b>Parents' Behavioral Intentions to Enroll Their Children</b>		
<b>BI_1</b>	If my child has access to a telemedicine service, I intend to have him/her utilize it.	.784 (.030)
<b>BI_2</b>	If my child has access to a telemedicine service, I would allow my child to use it.	Dropped
<b>BI_3</b>	I plan to enroll my child in the telemedicine service to see how it works.	.960 (.013)
<b>BI_4</b>	It is likely that my child will use the telemedicine service in the near future.	.894 (.018)
<b>Subjective Norms</b>		
<b>SN_1</b>	People who influence my behavior think I should have my child use a school-based telemedicine service.	Dropped
<b>SN_2</b>	People who are important to me think that I should have my child use a school-based telemedicine service.	.975 (.014)
<b>SN_3</b>	People whose opinions I value think I should have my child use a school-based telemedicine service.	.986 (.014)
<b>SN_4</b>	In general, I want to do what people who are important to me want me to do.	Dropped
<b>Personal Mores</b>		
<b>PM_1</b>	My supporting this CHOP initiative is the right and proper thing to do.	.817 (.027)
<b>PM_2</b>	My supporting this CHOP initiative will benefit community healthcare.	.912 (.016)
<b>PM_3</b>	My supporting this CHOP initiative is good for the school district.	.928 (.015)
<b>PM_4</b>	My supporting this CHOP initiative will enable better healthcare in Norristown.	.781 (.030)
<b>Trust in CHOP</b>		
<b>TRC_1</b>	Based on my experience with CHOP in the past, I know it is honest.	.949 (.010)
<b>TRC_2</b>	Based on my experience with CHOP in the past, I know it cares about patients.	.938 (.011)
<b>TRC_3</b>	Based on my experience with CHOP in the past, I know it is not opportunistic.	.763 (.033)
<b>TRC_4</b>	Based on my experience with CHOP in the past, I know it is predictable.	.735 (.036)
<b>TRC_5</b>	Based on my experience with CHOP in the past, I know it knows its patients.	.926 (.013)
<b>TRC_6</b>	CHOP has nothing to gain by being dishonest in its interactions with me.	.838 (.025)
<b>TRC_7</b>	CHOP has nothing to gain by not caring about me.	Dropped
<b>TRC_8</b>	CHOP has nothing to gain by not being knowledgeable when helping me.	Dropped
<b>Time-flexibility</b>		
<b>TF_1</b>	Enrolling in or having my child use school Telehealth program in the next 12 months would allow more flexibility with my time.	.752 (.054)
<b>TF_2</b>	More flexibility with my time is...	Dropped
<b>TF_3</b>	Enrolling in or having my child use a school Telehealth program in the next 12 months could prevent scheduling issues at work.	.739 (.054)
<b>TF_4</b>	To me preventing scheduling at work is ....	Dropped

All the loadings are significant at p-level < .001. Because of the low item loading, high significant cross-loading, and solving negative covariance issues, item SN\_4, TF\_2, TF\_4, TRH\_7, TRH\_8, BI\_2, and SN\_1 were dropped.

**Table A2. Measurement Items and Their Cross Loadings with 229 Observations**

Exploratory Factor Analysis (Oblimin Rotation)					
	Factor1	Factor2	Factor3	Factor4	Factor5
<b>BI_1</b>	-.02823	.14026	<b>.71233</b>	.05706	.12477
<b>BI_3</b>	-.02105	.08341	<b>.84001</b>	.08150	.05948
<b>BI_4</b>	.09095	.03157	<b>.87713</b>	.03446	.00001
<b>SN_2</b>	-.00250	-.00154	.01353	<b>.98271</b>	.01261
<b>SN_3</b>	.00459	.01877	.01336	<b>.98561</b>	-.02510
<b>PM_1</b>	-.03098	<b>.72758</b>	.19517	.08286	-.05955
<b>PM_2</b>	.01157	<b>.87829</b>	.12373	-.01757	-.03305
<b>PM_3</b>	.00572	<b>.83776</b>	.16875	-.01112	.02542
<b>PM_4</b>	.06616	<b>.87712</b>	-.16560	.07760	.11880
<b>TRC_1</b>	<b>.92415</b>	.09962	.02174	-.03826	-.08031
<b>TRC_2</b>	<b>.92597</b>	.02808	.03209	-.04051	-.06993
<b>TRC_3</b>	<b>.83700</b>	.07108	-.00147	-.07578	-.00223
<b>TRC_4</b>	<b>.81756</b>	-.06035	-.06103	.02696	.18499
<b>TRC_5</b>	<b>.92162</b>	-.05959	.05415	.09065	-.07779
<b>TRC_6</b>	<b>.88545</b>	-.04184	-.01390	.05740	.04785
<b>TF_1</b>	-.02042	.21545	-.08470	.04799	<b>.83079</b>
<b>TF_3</b>	.03831	-.13157	.25605	.02018	<b>.80268</b>

**Table A3. Measurement Items and Their Cross Loadings with All the 403 Observations**

Exploratory Factor Analysis (Oblimin Rotation)					
	Factor1	Factor2	Factor3	Factor4	Factor5
<b>BI_1</b>	-.01566	.15396	<b>.71567</b>	.05019	.10820
<b>BI_3</b>	-.01290	.07695	<b>.84072</b>	.08371	.04663
<b>BI_4</b>	.08780	.03493	<b>.87251</b>	.02782	.00328
<b>SN_2</b>	.00018	-.00321	.01874	<b>.98146</b>	.00770
<b>SN_3</b>	.00252	.03337	.00501	<b>.98255</b>	-.02524
<b>PM_1</b>	-.02228	<b>.75645</b>	.17042	.07167	-.04741
<b>PM_2</b>	.01935	<b>.88854</b>	.10859	-.02064	-.02086
<b>PM_3</b>	-.00219	<b>.84298</b>	.15575	.00031	.02082
<b>PM_4</b>	.06451	<b>.86231</b>	-.15173	.08386	.11730
<b>TRC_1</b>	<b>.92066</b>	.09562	.00573	-.02156	-.05974
<b>TRC_2</b>	<b>.92529</b>	.03818	.01351	-.02525	-.05113
<b>TRC_3</b>	<b>.84231</b>	.05714	.01253	-.10006	-.02540
<b>TRC_4</b>	<b>.82708</b>	-.06961	-.06063	.05133	.14797
<b>TRC_5</b>	<b>.91644</b>	-.04865	.05804	.07121	-.05413
<b>TRC_6</b>	<b>.88931</b>	-.03937	.00403	.04775	.04082
<b>TF_1</b>	-.00596	.19171	-.09452	.01600	<b>.85431</b>
<b>TF_3</b>	.02989	-.13286	.27108	.03837	<b>.77099</b>

**Table A4. Descriptive Statistics, Reliability and AVE with All the 403 Observations**

Items	Mean	Std.	CR.	CA.	AVE.
<b>BI</b>	5.33	1.42	.918	.913	.788
<b>SN</b>	4.64	1.40	.982	.982	.964
<b>PM</b>	5.84	1.17	.928	.926	.765
<b>TRC</b>	5.64	1.45	.946	.948	.748
<b>TF</b>	4.98	1.62	.703	.703	.543
<b>Race</b>	0.68	0.47	---	---	---
<b>Age</b>	41.90	8.28	---	---	---
<b>Gender</b>	1.89	0.32	---	---	---
<b>Number of Children</b>	1.69	0.86	---	---	---

**Table A5. Correlations with All the 403 Observations**

Items	BI	SN	PM	TRC	TF	Race	Age	Gender	Number of Children
<b>BI</b>	.888								
<b>SN</b>	.562***	.982							
<b>PM</b>	.680***	.519***	.875						
<b>TRC</b>	.264***	.208**	.285***	.865					
<b>TF</b>	.541***	.473***	.443***	.198**	.737				
<b>Race</b>	-.040	.068	.155*	-.087	.018	---			
<b>Age</b>	-.191**	-.149*	-.069	.009	-.054	.141*	---		
<b>Gender</b>	.114	.117	.141*	.092	.082	.040	-.168**	---	
<b>Number of Children</b>	.118	.126*	.060	.059	.002	-.051	-.110*	-.025	---

Note. The square roots of AVE values were presented on the diagonal, and correlations were presented off diagonal. (Significant level: \* p-value < .05, \*\* p-value < .01, \*\*\* p-value < .001)

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