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Prescribers' Experiences With Powered Mobility Prescription Among Older Adults

W. Ben Mortenson, BScOT, MSc, PhD,Postdoctoral Fellow, Gerontology Research Centre, Harbour Centre 2800, Simon Fraser
University, 515 West Hastings Street, Vancouver, British Columbia, Canada V6B 5K3**Laura Hurd Clarke, BAH, MSW, PhD, and**

Associate Professor, School of Kinesiology, University of British Columbia, Vancouver

Krista Best, MSc

Doctoral Candidate, School of Rehabilitation Sciences, University of British Columbia, Vancouver

W. Ben Mortenson: bmortens@interchange.ubc.ca

Abstract

Despite the potential benefits of powered mobility, many older adults do not have access to this technology. To date, few studies have explored how prescribers make decisions regarding provision of powered mobility. Therefore, we undertook a qualitative study to develop a better understanding of prescribers' attitudes toward and practices with older adult candidates for powered mobility devices. Our analysis of 10 in-depth interviews identified three main themes: (1) "Deciding who should be entitled" explored how therapists decided who should have access to powered mobility, (2) "power wheelchair negotiation" described the discord between clients and therapists that became apparent during this process, and (3) "practical considerations" revealed how contextual factors shaped the provision of powered mobility. The findings suggest that the ways in which powered mobility is funded, provided, and accommodated should be improved so that more older adults have access to these devices and can use them to their full potential.

MeSH TERMS

attitude of health personnel; decision making; health policy; prescriptions; professional–patient relations; wheelchairs

The use of powered mobility devices such as power wheelchairs and scooters has been associated with increased mobility, enhanced participation in daily activities, decreased pain and discomfort, and improved health-related quality of life (Auger et al., 2008). Despite these benefits, national survey data from the United States have indicated that compared with those ages 18–64, people >65 yr old are more than twice as likely to have a manual wheelchair than a powered mobility device (Kaye, Kang, & LaPlante, 2002). Cost is a prohibitive factor, and many people must rely on government subsidies or insurance plans to afford a powered mobility device. In Canada (acknowledging variation across the provinces), occupational therapists are typically charged with assessing clients' eligibility for funding programs.

Although clinicians have enormous influence over the distribution of powered mobility technology, research on prescribers' attitudes toward and practices with powered mobility prescription is limited. One descriptive study of scooter prescribers in the Netherlands provided insight into how health care professionals struggled to balance their responsibility to recommend devices on the basis of predetermined criteria with their desire to act in what they perceived as their clients' best interests (Jörg, Boeije, & Schrijvers, 2005). Using a multi-method approach that included a variety of stakeholders (Mortenson et al., 2005, 2006), residential care prescribers developed powered mobility safety guidelines, which indicated that prescribers were aware of the benefits of powered mobility use by residents but also wanted to mitigate the potential harm to users and to others in their facilities.

Given the limited research in this area and the low rate of powered mobility provision among this population, we conducted a study to develop a better understanding of prescribers' attitudes toward and practices with older adult candidates for powered mobility devices. Specifically, we wanted to know

- What ideas, attitudes, and beliefs do prescribers have about powered mobility for older adults?
- How do prescribers provide powered mobility to this population?
- How do funding policies and other contextual factors influence the prescription process?

Method

Research Design

We used an ethnographic approach (Hammersley & Atkinson, 2007) to explore prescribers' experiences and to understand how prescribers' norms and values and concomitant contextual factors shaped the powered mobility prescription process. In-depth, semistructured interviews were used as the primary method of data collection. The study was approved by the local university ethics board, and consent was obtained from all participants.

Participants

To be included in the study, participants had to be rehabilitation professionals (either physiotherapists or occupational therapists) who had prescribed powered mobility (either scooters or wheelchairs) in the past 3 yr to clients who were >50 yr old. Participants were recruited through third-party recruiters, who forwarded electronic notices about the study to potential participants or through snowball sampling.

Procedures and Data Collection

The interview guide was developed through an ongoing iterative process, in which sample questions were circulated among the authors and other members of our wheelchair research team (www.canwheel.ca) until no more changes to the format or content were suggested. The guide consisted of four main questions and 22 potential prompts. Sample questions

included “What are your experiences with powered mobility prescription with older adults?” and “How do you decide when someone needs or will benefit from powered mobility?”

After consent was obtained, participants were asked to provide demographic information about their professional history and clientele. The third author (Krista Best) interviewed each participant in a location of his or her choice and provided each with \$25 as thanks for their participation. Interviews lasted between 45 and 85 min (mean = 67 min). After each interview, reflections were recorded about the content and interaction between participants and researchers, and information about the interview setting was recorded.

Analysis

Best transcribed interviews verbatim. All transcripts were entered into Atlas-ti analytic software (Muhr, 1999). By repeatedly reading the data, we collaboratively developed inductive ideas and interpretations about recurring, converging, and contradictory patterns, along with illustrative examples (Hammersley & Atkinson, 2007). Twenty-nine codes within and across participants were developed through this iterative process, including concepts such as accidents, assessment, activity participation, independence, and safety. These codes were amalgamated into subthemes and then into main themes to encapsulate the findings. Any disagreements among the study authors were discussed until consensus was achieved. We made counts to document variability among participants. In this way, we developed an understanding of prescribers’ common experiences and attitudes about older adults as candidates for powered mobility and also developed a sense of the variation among them.

As described next, we used a variety of trustworthiness strategies to ensure the credibility of the findings. Over the course of the study, Best used postinterview debriefing sessions with the research team members to discuss alternative approaches and interpretations. Reflective commentaries that were shared with the team were used to document the effectiveness of the interviews, initial impressions of each data collection session, areas requiring investigation in subsequent interviews, and emerging themes. As a form of member checking, participants were given an initial report summarizing the study’s findings and were invited to provide feedback; however, no comments were received.

Results

As described in Table 1, our sample of Canadian occupational therapists included 1 man and 9 women. The participants ranged in age from 25 to 60 yr old (mean age = 43 yr) and had an average of 19 yr clinical experience and 13 yr experience with powered mobility prescription. Their clinical settings included acute care, rehabilitation, community-based care, and long-term residential care. Their ages and years of experiences were rounded to increase their anonymity.

Our analysis revealed three interrelated themes: (1) “Deciding who should be entitled” described how prescribers tried to balance potential benefits and perceived risks, (2) “power wheelchair negotiations” illustrated the tensions that therapists experienced during the prescription process, and (3) “practical considerations” emphasized the importance of contextual factors.

Deciding Who Should Be Entitled

Prescribers went through a complex process to determine who they thought should be allowed to use powered mobility, which involved weighing various pros and cons to powered mobility use. All of the prescribers viewed powered mobility as an invaluable means of improving mobility, enabling independence, facilitating social engagement, and ameliorating or protecting their clients' physical health. For example, Barbara indicated, "I see power mobility as giving the person some control over their mobility and what they're doing and how they're doing it." The freedom gained through power mobility use, which enabled clients to participate in various occupations, could have an immediate life-altering effect on users, as Cynthia explained:

All of a sudden, they're coming out to the [local shopping center] and buying their own groceries, or they're able to go to their son's for dinner because now they can get out of the [facility] on their own and drive the power wheelchair to the bus [or] taxi. They're not just having people come to them.

Moreover, 9 of 10 prescribers noted that the specific capabilities of power wheelchairs, such as the tilt-in-space feature, which allows the entire seat to tilt backward without changing (reclining) the back angle, were essential for repositioning (to ensure users remained correctly positioned in their wheelchairs over the course the day) and prevention of skin breakdown, which might lead to pressure sores.

However, despite the potential advantages, prescribers also conveyed a variety of concerns about powered mobility, including safety issues related to users' physical, visual, and cognitive abilities; lack of confidence; and risks for physical deconditioning. Safety was the most prominent of the prescribers' concerns because they all identified serious accidents that had occurred with powered mobility use, resulting in injury to the user or to others. In the most extreme example, Lesley indicated that she knew a client who "went to the bank, [and] he backed up and he couldn't stop, and his chair went off the curb and he died." Julie revealed how these concerns made her feel paternalistic: "I'm always worried they're going to run over somebody or hit something or have an accident, because people do . . . and I've got to get protective of them." The perceived need to be protective of their clients was underscored by the commonly (although not universally) held assumption that age-related declines were natural and inevitable, as articulated by Karen, who stated,

Talking stereotypically, as [people] age they are prone to more cognitive issues such as dementia, and that's the biggest concern for me, and then the eyesight as well. [It] stereotypically can get worse as we get older. . . . [If an] older adult is more frail, then they're at higher risk if something does happen.

Fears for their clients' safety were amplified by a lack of time to provide adequate training because of the competing demands of their jobs. Julie opined, "We don't have the time to be going back over and over [things related to powered mobility driving]." Lack of time for training may have contributed to perceptions among 9 of the 10 prescribers that older adults, in particular, lacked confidence using powered mobility. As Julie indicated, "[Older adults are] often nervous around traffic lights, and going up and down the curb cuts They're concerned about going too fast, they're concerned about hitting somebody, and . . . they're

worried about maintenance.” Given this impression, the therapists tried to provide simpler devices and technological solutions whenever possible to facilitate ease of use and to decrease stress on clients.

Prescribers were divided about the potential for deconditioning that might occur with powered mobility use. Three prescribers subscribed to the use-it-or-lose-it perspective; they made statements similar to those of Cynthia, who asserted, “We don’t want to take away their independence with standing and [make] them use a ceiling lift, just so they can use the power wheelchair, because then physically, they’re declining more.” For Julie, using powered mobility was “almost giving in to the disease [so] I feel strongly that people have to try other means of mobility, before, because this is kind of the last resort in my mind.” However, 4 therapists emphasized using powered mobility to enable users’ participation without concerns about deconditioning. Arguing that the ability to be socially engaged was essential and being pragmatic about the likelihood of physical declines in later life, this latter group of prescribers echoed the perspective of Rebecca, who felt that concerns about deconditioning had softened over time:

I remember when I graduated, people would be very reluctant at giving power chairs, because they would be afraid the person would lose strength. So the [manual] chair was used as a personal training gym. . . . Now it’s becoming a functional tool.

Before allowing clients to trial a power wheelchair for the first time, 9 of the prescribers explained how they would screen for potential problems that could affect a person’s driving ability. Barbara said,

I really like to screen people first. I like to do some sort of cognitive screening to know that they can make decisions and they’re safe in making those decisions. I like to do visual screening, I like to look at hearing, I like to look at all those factors first before I even introduce the discussion of a power chair with someone who’s elderly.

Four prescribers emphasized the need to proceed to an in-chair assessment regardless of these findings because, as Julie put it, “Sometimes people that you’d think couldn’t manage will really surprise you, and in fact, they do very, very well.”

Power Wheelchair Negotiations

Just as they experienced tensions weighing the pros and cons of powered mobility, prescribers often reported conflict between their own preferences and those of their clients. For example, 7 participants described problem situations in which their clients did not agree with their recommended solutions. The situations included disagreements about the type of features the chair should have, whether a scooter or power wheelchair was more appropriate, and whether a client should have powered mobility at all. Julie provided a detailed narrative about the latter type of disagreement:

[There] was a ministry client [eligible for government funding, who] wanted a scooter. He said it would save his life because he needed to go bowling every week, but it was getting harder and harder for him to walk because he couldn’t breathe

very well. . . . So I got him a four-wheeled walker from our office because he had never tried one. He didn't want to use the walker; he wanted to proceed with power . . . but I had concerns around his vision. So I had to do a thorough assessment to really see if he was safe. Meanwhile, the man went down to the local supplier with his Visa card and bought a scooter. So he's out there driving around, probably, to me, [in a way that is] quite unsafe.

Thus, despite the prescriber's doubts about the legitimacy of the client's need and concerns about his safety, the client was able to obtain a scooter.

Frequently, it was the clients who wanted powered mobility and the therapists who were reluctant, but sometimes it was the converse. Ellie noted that "even if I think a power wheelchair or scooter would be good, [some clients] don't want to be seen in one because it makes them look more disabled." Likewise, Andrea reported,

I've seen people who had a powered [wheelchair, but] they left it at their cottage so nobody on their street would know they were using power. I would say this is an example of a person who really was not ready to accept it and got it.

Although they were generally sympathetic to their clients' concerns, many prescribers articulated competing concerns related to safety and function over time, as described by Barbara:

I think the visibility of the chair is a big [issue]. And I know that there are flags that people can buy and stick up. You battle between wanting to have a chair that doesn't look like a great big bulky thing, for body image, or, you know, what you feel you look like as a person, but something that is very visible to other people so . . . they can see it.

Some prescribers conceded that scooters were less visibly disabling, but they further expressed worries about their clients' changing physical needs and ability to move to power wheelchairs at a later date. Barbara explained,

Moving from a scooter to a power chair is not an easy transition [so I would prefer them] to go into a power chair right away, if someone has a deteriorating disease. . . . I think they think they look more able if they're in a scooter than if they're in a power chair, [but] I want a chair that allows me to be able to change things.

In this regard, there was a disjunction between the clients' current preferences and the prescribers' perceptions of their future needs.

One of the most difficult, if not traumatic, issues that prescribers grappled with had to do with the handling of drivers they deemed would be or had become unsafe. Rebecca described her experiences of taking powered mobility devices away from clients in this way: "It's putting them [in] jail. It's horrible. You take their life away." In this way, the power that prescribers had over the allocation and utilization of powered mobility created a profound sense of burden. Consequently, prescribers sometimes tried to prevent clients from obtaining powered mobility in the first place as a form of risk management as well as to avoid future emotional distress for both the client and the prescriber. For example, Julie relayed the

following story: “We just knew that if he had a scooter he would hurt somebody. And every year he came, and every year we set up handyDART [adapted public transportation] . . . and all the things that we thought we could do instead of [giving him a scooter].”

Practical Considerations

Prescribers had many practical considerations to navigate as they negotiated workload responsibilities, funding limitations, and accessibility issues. Government funding was a source of frustration for all of the prescribers. Barbara explained,

If people [in the province of British Columbia] are [ministry clients] before they’re 65, [the government] will fund stuff, but if they are over 65 when they first have needs, the [government] often will not fund [powered mobility]. It’s just the funding rules, and [the government] thinks there are other resources for people over 65, which is a fallacy.

Moreover, government funding was usually not available for anyone living in residential care, as Cynthia indicated: “Even with [individuals] younger than 65 in extended care, you need to fully justify why we cannot accommodate to their needs.”

In addition to these age restrictions, government funding was available only for those clients who had a disability, whose income fell below a certain threshold, and for whom powered mobility was proven to be medically necessary. Karen explained the policy in this way:

There’s a big differentiation between what’s medically necessary and what’s for quality of life. Things that are medically necessary are so that they can get from their bed to the kitchen to eat dinner. What’s more of a quality of life concern is whether they can access the computer. Whether they really need power mobility for mobility [inside] or if it’s only for outdoor mobility, they might consider “only outdoor mobility” more of a quality of life issue. So, again it depends on the funder where those lines are drawn. If you’re seeking government funding, [medically necessary is] life threatening only. A client who would benefit from getting around using power mobility might still only get funding for a manual chair, because they’re still alive if they can get up into a chair—even if they can’t move the chair.

Consequently, prescribers struggled with their desire to be client centered and to not let the client down while also working within the confines of government policies and regulations. This struggle created difficult tensions for the prescribers, as articulated by Ellie:

I try to be as client-centered as possible [when applying for funding], and if I know it’s going to make a difference in their life, but at the same time you can’t lie either. So it’s trying to find that balance.

That said, those with more experience became savvy about how to navigate the funding rules for the benefit of their clients. Karen stated,

You learn what the funders consider to be a quality of life issue versus a medical necessity issue versus a functional issue which you might be able to [make a case for funding] if you argue it the right way.

Specifically, Karen would not ask for a cushion to improve comfort but rather would request “a good seat so the client is not susceptible to pressure wounds,” thereby making the intervention medically necessary.

Time restrictions, however, limited the participants’ ability to obtain funding for devices, because they made it difficult for therapists to write compelling letters to funding agencies, as noted by Lesley, who stated, “The [occupational therapist’s] role is primarily to identify what is the equipment they need, [but] it’s not our responsibility to find the money. We can give them some suggestions, but we just don’t have the time to be knocking on all the doors.” The competing demands of clients and funding agencies were discouraging for some therapists, as Julie revealed:

It falls upon us to justify [funding for powered mobility] all the time. And it’s hard because we’re in the middle, because we see the client, we see their need. We have to try and translate that, what we see, into a description, so that the person in [the government bureaucracy] reading it can understand why it’s important. And sometimes it’s very clear and sometimes it’s not very clear.

Moreover, government agencies did not always follow prescribers’ recommendations. Thus, even as gatekeepers, prescribers were not omnipotent.

Finally, prescribers expressed concerns about the practicalities of using power wheelchairs in their clients’ home and community environments. Powered mobility devices can only be used in accessible environments and require special accommodations to allow them to be transported. Stephen stressed how stairs could be a costly issue:

There’s ramping options for a short amount of stairs, but other than that we’re talking major renovations—porch lifts, elevators—and often that’s a barrier. If you can’t have a client get in and out of their house with a power mobility device, then they’re not going to get one. And I’ve had that happen a couple of times. That’s their house, and some aren’t prepared to move. That’s a pretty big barrier.

For those considering discharge back into the community from residential care, Cynthia indicated that powered mobility was actually a deterrent because “it really restricts the environments that you can access.” Moreover, transporting power wheelchairs from one environment to another was frequently problematic because it necessitated access to adapted vehicles, which represented an additional, prohibitive cost that was not covered under existing government programs.

Discussion

In this article, we have examined how prescribers perceived older adults as candidates for power wheelchairs and negotiated the competing demands of governmental funding policies, scarce resources of time and money, clients’ wishes and changing physical capabilities, and their own assumptions about the benefits, risks, and appropriateness of powered mobility in later life. For organizational purposes, we have structured the discussion on the basis of the study themes.

Deciding Who Should Be Entitled

As gatekeepers for powered mobility, prescribers were expected to adhere to governmental policies, professional standards, and best practices. To determine suitability, prescribers frequently relied on informal and formal assessments of various client attributes, including cognition, vision, hearing, and perception—tests that may have reinforced their expert knowledge but, as some prescribers noted, may also have lacked predictive validity (Mortenson et al., 2005, 2006). Given cognitive and workload demands, prescribers may have used age-based heuristics—that is, problem-solving shortcuts—to help them to make provision decisions quickly and efficiently. These heuristics, however, can be a source of bias (Cioffi, 1997) and, in this case, may have restricted access to older clients in particular.

Despite their authority, prescribers often expressed a sense of unease and powerlessness because they were unable to fully meet their clients' needs through adequate provision of technology, training, funding support, or a safe and accessible environment, and they, too, were subject to the demands and limits of the existing health care and funding systems. Caught between their responsibility to comply with government funding requirements and their desire to act in a client-centered manner (Canadian Association of Occupational Therapists, 2007), prescribers were faced with the unenviable task of denying some individuals access to the technology despite their own sense that it was suitable, if not essential, while also feeling compelled to complete requests for powered mobility for clients whom they felt were not appropriate. That said, some prescribers learned to use the language of institutionalized policy to their clients' benefit, and those (admittedly few) individuals who had sufficient resources bypassed prescribers and simply purchased their power wheelchairs directly.

Power Wheelchair Negotiations

Powered mobility prescription entailed the negotiation of competing and sometimes intersecting ideas and beliefs pertaining to independence, autonomy, and accessibility, which further contributed to prescribers' sense that they were caught in the middle. On one hand, prescribers were motivated to provide powered mobility to facilitate their clients' independence and occupational performance. On the other hand, for some prescribers independent mobility using a power wheelchair was less preferred than independent mobility using a walker or manual wheelchair. In this regard, those who used powered mobility were seen as less autonomous, given their reliance on a powered device, perhaps because powered mobility use was considered a greater departure from "ablebodiedness" than manual wheelchair use and served to render the user more visibly disabled (Mortenson et al., 2005). Moreover, some prescribers also had fears about the potential for deconditioning that might further reduce their clients' independence, thereby rendering them even more powerless and subject to societal discrimination and segregation. Similarly, in light of funding and accessibility issues and attitudinal barriers (McClain, Medrano, Marcum, & Schukar, 2000), some prescribers might have avoided powered mobility provision because it ultimately represented a third-class form of mobility relative to manual wheelchair use and ambulation.

Within the prescription process, mobility was viewed as a privilege that must be earned rather than as a fundamental right. Powered mobility provision was thus entrenched within an individual model of disability (Oliver, 1990), which diminishes governmental and societal responsibility for providing these devices and ensuring physical accessibility. Given the intimate relationship between users and their wheelchairs, inappropriate mobility devices may cause discomfort or pain and contribute to overuse injuries (Chow & Levy, 2011). Such occurrences could not only disrupt the wheelchair adoption and adaptation process but also prevent users from experiencing the sense of unencumbered mobility that many people without disabilities take for granted, which could over time lead to increased stigma (Papadimitriou, 2008) and disability (Chow & Levy, 2011).

Practical Considerations

Because of the expense, powered mobility was available only to those who were wealthy enough to afford it or those who were impoverished, disabled, and young enough to qualify for government funding. Assigned the institutional power to make fiscal and moral judgments, prescribers were expected to allow only safe drivers to have access to these devices. Yet conceptualizations of safety were themselves underscored by assumptions about later life as a time of inevitable decline and decay. Combined with workload demands and fears of being held legally responsible, some prescribers exhibited paternalistic thinking that discouraged them from allowing their clients to take risks that the clients themselves might have perceived as reasonable. Consequently, our findings illuminate how institutional policies and practices might cause some individuals to be underserved (Bowling, 1999) and others to be strictly controlled because of their age.

Ultimately, the health care system seems to be set up to curb rather than to facilitate access to powered mobility and to make this outcome seem natural and inevitable. Thus, government funding for powered mobility is only provided to a very small set of younger individuals. This age-related criterion represents an overt form of ageism that openly denies older individuals access to these devices. Moreover, prescribers' workloads limit their ability to seek out alternative funding sources or provide more intensive training for clients who are not immediately successful using these devices. In this system, lack of confidence in using the device becomes understood as a characteristic of the individual rather than as a symptom of inadequate training.

To address the tensions identified by prescribers, changes should be made to allow better access to these devices and reduce barriers to their use. Such changes not only would involve amending funding policies but also would include changes in the way in which training is provided and accessibility is facilitated and, most important, how powered mobility use is conceptualized. A rights-based approach that considers mobility something to which everyone is entitled rather than a discretionary privilege could be adopted. This approach could involve using the court system to establish precedent-setting cases to allow users to access appropriate mobility devices (see, e.g., Users First, 2012). These changes would allow more older adults to have access to these devices and permit them to be used to their full potential as a mainstream form of mobility that would facilitate their societal inclusion, occupational engagement, and quality of life.

Limitations and Future Research

When considering this study's findings, we should emphasize that they reflect the perspectives of a limited number of participants from a Canadian context who volunteered to participate in this research. This interpretation of the data is ours, and others may see the findings in different ways. Although different funding models exist in different jurisdictions, in terms of transferability, government funding for these devices is tightly controlled in many other countries, including the United Kingdom (Frank, Ward, Orwell, McCullagh, & Belcher, 2000) and the United States (Centers for Medicare and Medicaid Services, 2006), and prescribers in these settings may experience similar tensions.

To develop a better understanding of the provision process, future research could use ethnographic studies that include interviews coupled with observations of the interactions between prescribers and their clients. Policy-oriented research could examine the different outcomes experienced with different funding models.

Implications for Occupational Therapy Practice

The results of this study have the following implications for occupational therapy practice:

- Prescribers need to attend to the heuristics they use to ensure that older adults are not excluded from consideration for powered mobility.
- Professional organizations should lobby for changes in how funding is provided for devices, training, and follow-up and how accessibility is facilitated.
- Mobility should be considered as a basic right rather than as a privilege.

Conclusion

In this study, we have explored the tensions that powered mobility prescribers experience as they attempt to balance the demands of clients, the requirements of funding agencies, and the responsibilities they perceive as health care professionals. The findings suggest that changes should be made to the ways in which these devices are funded, training is provided, and powered mobility is conceptualized as a form of mobility.

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Table 1

Description of Participants

Pseudonym	Sex	Age	Type of Clinical Experience	Experience, Yr	Power Wheelchair Experience With Older Adults, Yr
Karen	F	25	Acute care hospital, rehabilitation center	5	5
Debra	F	30	Acute care hospital, community-home care	5	5
Ellie	F	30	Acute care hospital, community-home care, rehabilitation center	5	5
Cynthia	F	30	Acute care hospital, community-home care, residential center	10	5
Stephen	M	35	Acute, community-home care, rehabilitation center, residential center	10	10
Barbara	F	60	Acute care hospital, community-home care, rehabilitation center, residential center	30	10
Julie	F	60	Community-home care, acute, rehabilitation center	35	10
Andrea	F	45	Community-home care	20	20
Lesley	F	60	Rehabilitation center	40	25
Rebecca	F	50	Residential center	30	30

Note. F = Female, M = Male.