

What is the experience of providing, receiving and using short-term loan equipment?

Marie Chester

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School of Clinical Sciences
Faculty of Health and Environmental Sciences
AUT University

Primary supervisor: Professor Clare Hocking

Table of Contents

List of Figures	vii
List of Tables.....	vii
Attestation of authorship.....	viii
Acknowledgments.....	ix
Abstract	x
Chapter One: Introduction to the study	1
Introduction	1
<i>Language</i>	2
<i>The voices</i>	2
Background	3
The purpose of the study	5
<i>Definitions</i>	5
The significance of the research question	6
Coming to the philosophy	6
Pre-understandings.....	8
Family influences:.....	9
<i>Professional influences</i>	11
Overview of the thesis	13
<i>Chapter one: Introduction to the study</i>	14
<i>Chapter two: The practice context</i>	14
<i>Chapter three: Literature review</i>	14
<i>Chapter four: Philosophical underpinnings</i>	14
<i>Chapter five: Method</i>	14
<i>Chapters six, seven and eight: Findings</i>	15
<i>Chapter nine: Discussion</i>	15
Chapter Two: The legal, political and social context of occupational therapy practice .	16
Introduction	16
Legislation	17
World Health Organization	20
Neoliberal economic theory.....	21
Accident Compensation Corporation and Ministry of Health differences	24

Ministry of Health	25
District Health Board influences and occupational therapy.....	26
Medical hegemony.....	29
Societal changes.....	29
Occupational therapy.....	31
Conclusion	34
Chapter three: Literature review	35
Introduction	35
Approaching the literature hermeneutically	37
Use and non-use of equipment.....	38
Factors that influence use and non-use of equipment.....	39
Experience of using equipment	46
<i>Ambivalence</i>	47
<i>Lived body</i>	48
<i>Lived relations</i>	49
<i>Lived space</i>	49
<i>Lived time</i>	50
Experience of providing equipment.....	51
Conclusion	53
Chapter four: Philosophical underpinnings	54
Phenomenology	55
Heidegger the person.....	56
Heidegger's phenomenology	58
Gadamer's phenomenology.....	58
van Manen's phenomenology	59
Philosophical notions key to this study.....	60
<i>Being/Dasein</i>	60
<i>Being-in-the-world</i>	60
<i>Leaping ahead</i>	61
<i>Leaping in</i>	61
<i>Ready-to-hand / Unready-to-hand</i>	62

<i>Present-at-hand</i>	62
<i>Technology</i>	62
<i>The 'They'</i>	64
<i>Hermeneutic circle</i>	65
<i>Prejudices, pre-understandings</i>	65
<i>Horizons, fusion of horizons</i>	66
<i>Lived experience</i>	67
Conclusion	68
Chapter five: Method	69
Introduction	69
Approval for the study	70
Recruiting and selecting participants.....	71
<i>Consent, confidentiality and anonymity</i>	73
<i>The study participants</i>	75
<i>Were there enough participants?</i>	78
Collecting the data	78
Working with the data	80
Trustworthiness	83
<i>Balanced integration</i>	84
<i>Openness</i>	85
<i>Concreteness</i>	85
<i>Resonance</i>	86
<i>Actualisation</i>	86
Summary	86
Chapter six: The experience of working in a complex practice context	88
Introduction	88
What is practice?.....	89
Practice enframed	89
<i>Language</i>	90
<i>Material and economic arrangements</i>	93
<i>Social-political arrangements</i>	98

The disadvantages of enframing.....	102
<i>Levelling down and averaging out of patient experience.....</i>	<i>102</i>
<i>Practice dictated by employer's goals.....</i>	<i>103</i>
<i>Occupational therapists as standing reserve</i>	<i>106</i>
The advantages of enframing	106
The 'they'	109
<i>Challenging the 'they'</i>	<i>111</i>
Conclusion	112
Chapter seven: Experience of receiving, using and returning short-term loan equipment	114
Introduction	114
Heidegger on equipment as things	114
Deciding on short-term loan equipment	115
<i>Am I that bad?.....</i>	<i>116</i>
Negotiating equipment	118
Receiving the equipment	121
Using the equipment.....	124
Effect of having equipment in situ on family	129
Returning the equipment.....	130
Conclusion	134
Chapter eight: Getting the equipment right.....	136
Introduction	136
Rapport.....	136
Caring	139
Knowing.....	141
<i>Therapists' knowing</i>	<i>142</i>
<i>Patients' knowing.....</i>	<i>144</i>
Fusion of horizons	145
<i>Limited horizons</i>	<i>150</i>
Thrown into the unknown	154
Conclusion	157

Chapter nine: Discussion.....	158
Introduction	158
Being-in-the-world: Enframed	159
Being-in-the-world: With technology	160
<i>Equipment</i>	160
<i>The system</i>	161
For patients, the system worked when.....	161
<i>Connecting with the occupational therapist</i>	162
<i>The patient themselves</i>	162
<i>The equipment worked for the patient</i>	163
<i>Home, through the eyes of the patient</i>	164
<i>The patients' experiences of the system itself</i>	164
For the occupational therapist, the system worked when... ..	165
<i>The occupational therapist had time to understand patients and their context..</i>	165
<i>The therapist could enable the patient with the 'right' equipment</i>	166
<i>The system was flexible</i>	166
The system did not work when... ..	167
<i>The therapist and patient did not connect</i>	168
<i>The system was inflexible, tightly constrained</i>	169
<i>Occupational therapy practice is restricted by the employer's goals</i>	171
Back to the literature	173
Strengths and limitations of the study.....	174
Implications for practice	175
Implications for research	177
Conclusion	179
References.....	180
Appendices.....	193
Appendix 1: Photos of equipment in situ	193
Appendix 2: Application for ethics approval.....	194
Appendix 3: Locality approval from Counties Manukau Health	195
Appendix 4: Patient participant information sheet and consent form	196
Appendix 5: Occupational therapist participant information sheet and poster	199

Appendix 6: Consent form	203
Appendix 7: interview schedule.....	204
Appendix 8: Interview schedule.....	205
Appendix 9: Crafting a story and initial interpretation.....	206
Appendix 10: Mind map.....	209

List of Figures

Figure 1: The unevenness of influences in health that are congruent with occupational therapy's beliefs and values.....	32
Figure 2: Four inter-related notions on equipment usage, whereby the prominence of each notion can be decided by the potential user.	44
Figure 3: The short-term loan equipment system worked for patients and therapists when openness, confidence and time came together	167
Figure 4: The short-term loan equipment system did not work for patients and therapists when lack of time, an inflexible system and occupational therapy practice dictated by DHB goals came together.....	172
Figure 5: Shower stool with adjustable-height legs.....	193
Figure 6: Over toilet frame with adjustable-height legs.....	193
Figure 7: Rehabilitation chair with adjustable-height legs.	193

List of Tables

Table 1: Characteristics of the patient participant group.....	76
Table 2: Characteristics of the occupational therapist participants.....	77

Attestation of authorship

I hereby declare that this submission is my own work, and that to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgments), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university, or other institution of higher learning.

Signed:.....

Dated:.....

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Abstract

The question at the heart of this thesis is “What is the experience of providing, receiving and using short-term loan equipment?” The study sought to explore the lived experience of occupational therapists and patients with short-term disabilities with short-term loan equipment (assistive devices). While much is known about the use and non-use of such equipment, little is known about the experience of the process of providing, receiving and using the equipment in the New Zealand context. The methodology of hermeneutic phenomenology, informed by the writings of Heidegger [1889-1976], Gadamer [1900-2002] and van Manen [1942-] was selected because of the emphasis on lived experience, and an interpretation of equipment as technology. The term ‘patient’ has been used throughout for those participants who used occupational therapy services because it implies a special duty of care towards the person.

Five occupational therapists and eight adult patients from the acute wards of a busy metropolitan hospital were interviewed. Their experiences of how the equipment came to be chosen, its delivery to their home and how they used it until it was time to return it were explored. Anecdotes from the transcribed interviews became the research text. Dwelling with the texts, referring back to literature and calling on my own experiences with short-term loan equipment gave me the chance to listen to the spoken and unspoken words of the participants. The thesis concludes that patients highly value the short-term loan equipment provided for use at home following discharge from hospital. Nevertheless there are several courses of actions that are possible that will improve the service further. The study findings are presented under two overarching themes: what did work for patients and occupational therapists, and what did not work for patients and therapists. Openness to each other, time to understand each other, and having confidence in each other worked for patients and therapists; whereas a lack of a connection between patient and therapist, an inflexible system, and occupational therapists’ practice dictated by the employer’s goals contributed to the system not working. The thesis finishes with an explanation of the strengths and weaknesses of the study and notes seven implications for occupational therapy practice: 1) taking time to

get to know and understand patients' disability needs; 2) leap ahead and consider patients' potential long-term disability needs while addressing the short-term needs; 3) follow-up after discharge to check that the equipment is meeting the patients' disability needs; 4) use digital technology to see patients' home environment; 5) use the text function on mobile phones as a communication device with patients; 6) improve written and verbal communication with patients while they are on the ward to inform them of the staff who work with them and their roles, contact details, the short-term loan equipment process, and what to do if the equipment does not work for them; 7) protect and preserve expert occupational therapy practice for where it will have the greatest impact for patients.

Chapter One: Introduction to the study

Things exist, and “they impinge on us, intrude on our lives, concern us, in short, are significant to us. In the normal course of our daily lives, things are not indifferently ‘out there in the universe,’ located within some neutral coordinates of space and time. Rather, they are meaningfully present to us. They do not just exist; they make sense, and the sense they make is their ‘being’. Things are present and available. I take note of them, name them, admire them, perhaps possess them. I may also fear and flee them, but even so, I am still involved with them. They still have a place within the world of meaning in which I live.” (Sheehan, 2015, p. 111)

Introduction

Occupational therapists have a long history of working with ‘things’. A key role of their practice is to provide the right ‘thing’ at the right time to enable the person to regain independence. Some of these ‘things’ are referred to as ‘equipment’ or ‘assistive devices’ in this thesis. Equipment is provided via a formalised system. However, little attention has been paid to how ‘things’ (i.e. equipment) impinge, intrude, concern and/or are significant in the everyday lives of patients. Neither does the literature reveal the manner in which occupational therapists are involved with equipment. What place do ‘things’ have in their practice world?

The purpose of creating and providing equipment is to assist people with disabilities to perform their usual daily occupations (Hocking & Wilcock, 1997; Wielandt, McKenna, Tooth, & Strong, 2006). The devices or aids to daily living, are designed to overcome challenges within the physical environmental which impede a person’s ability to perform their usual daily occupations. They are primarily designed for function rather than aesthetics. They are often bulky, take up living space when in use or storage. They may also be imbued with prejudice and stigma. At the same time, they can make the difference between coping at home or not. Little research has been done in New Zealand on short-term loan equipment from either the users’ or the providers’ perspective. The question this study seeks to explore is “What is the experience of providing, receiving and using short-term loan equipment?” In seeking to understand occupational therapists’ and patients’ experiences with equipment, I chose interpretive hermeneutic phenomenology as the methodology to inform this study. I have drawn on Martin

Heidegger [1889-1976], Hans-Georg Gadamer [1900-2002] and Max van Manen [1942-] to guide my learning, understanding and interpretation.

Before I start on the thesis-proper, I would like to clarify the language used and the perspectives that I have taken throughout this project.

Language

Language is the heart of communication and seeking understanding (Gadamer, 2006). We converse, share experiences and express meaning through language, including silence. Meanings expressed in language can be explicit and implicit in that the words chosen, the tone used, and silences can create understanding and misunderstandings. With this in mind, I will explain some of the terminology I use throughout this thesis.

The people who agreed to participate in this study are called participants rather than subjects. All participants are referred to by pseudonyms; some participants suggested the name they wished to be called, and I assigned names to the others. The people who were consumers of occupational therapy services I call 'patients' as I believe that that term connotes a special duty of care within health services. All of the occupational therapist participants in this study were women, and therefore I use the pronouns 'her' or 'she'. Where I have used Maaori words, their English translation (Moorfield, 2011) is provided in footnotes. In addition, I have used the Maaori spelling conventions used by the Tainui iwi (tribe) of the Manukau and Waikato region where this study is situated. In New Zealand, occupational therapists use the term 'equipment' when referring to assistive devices. I use 'equipment' and 'assistive devices' interchangeably throughout this thesis. Finally, I have used New Zealand spelling conventions throughout.

The voices

Each participant's voice is acknowledged through the inclusion of anecdotal quotes in the text, as is customary in phenomenology. To distinguish the participants' voices from mine, I use italicised quotes. Otherwise the interpretations offered in this thesis are mine.

Background

The Counties Manukau area of Auckland, New Zealand, where this study was conducted, is home to more than 500,000 people from over 100 ethnicities, with a large proportion of them non-Western in origin¹. The socio-economic status of people in this district ranges from the wealthiest to the poorest people in New Zealand². With the population being so ethnically diverse, occupational therapists cannot assume that a Western, technological approach is the best way to solve practical, functional problems experienced by people with disabilities in this area. Herein lies a challenge for occupational therapists. Whereas individually tailored solutions are the gold standard for assistive devices, the system that permits equipment to be provided free of charge to patients, is standardised: one rule applies to all.

New Zealand's public health system is funded through general taxation, and therefore there is no direct cost to patients for services. The District Health Board (DHB) that employs the occupational therapists, pays for the rental cost of equipment provided by them to patients on discharge from hospital. With an increasing and aging population, New Zealand public hospitals are busier than ever, and in order to manage the demand for hospital beds, much effort goes into reducing the average length of hospital stay for everyone. In practice, this means that people no longer spend time recuperating in hospital following an operation or a bout of serious illness. It is the role of the occupational therapist to try to determine how, and under what circumstances, the patient will be able to manage when he or she returns home. In doing this, occupational therapists have an integral role to play in facilitating enduring discharges. The provision of equipment for assistance with everyday living by occupational therapists is a taken-for-granted part of their practice. There is a general assumption by therapists that the devices are helpful, and that patients are pleased to have them. The provision of equipment also enables the hospital to achieve its goal of shorter length of hospital stay, so that other patients can be admitted in their place.

¹ Statistics New Zealand 2013 census data

² Statistics New Zealand 2013 census data

An audit of short-term loan equipment for adults discharged from Middlemore Hospital in 2003, found that 86% of the equipment was used at least once in the six weeks after discharge; 14% of the equipment (all of which was low cost) was not used at all. Extrapolated to 2017 figures, Counties Manukau Health occupational therapists spend over \$1,000,000 on short-term loan equipment each year. If 14% of this equipment has been unused, it could mean that up to \$140,000 is wasted. The unused equipment represents a large amount of therapists' time and public health money that is wasted, year on year.

The equipment is provided to people who struggle with using the shower and toilet; getting into and out of the house; getting around inside the house; or getting into and out of bed. The specific purpose of the equipment is to make a task easier and safe; minimise pain and conserve energy while doing the task; and prevent deterioration in the person's condition, or their performance of a task. Examples of such equipment include, but are not limited to, shower stools or chairs; over toilet frames, raised toilet seats; bath boards, bath seats, transfer boards; manual wheelchairs, temporary ramps; perching stools (high stools that one 'perches' on); chair raisers, bed raisers, and bed levers. Equipment can potentially reduce the need for carer's assistance for a person with disability, and can reduce the burden of care for the primary carer (Hoenig, Taylor, & Sloan, 2003; Pettersson, Berndtsson, Appelros, & Ahlstrom, 2005). Appendix one shows a shower stool, an over toilet frame and a rehabilitation chair as used in three of the patient participants' homes.

With the high turnover of patients in the acute wards, occupational therapists typically have no time to provide rehabilitation or undertake a pre-discharge home assessment visit. To overcome their lack of knowledge of the home environment, the therapist will ask the patient and relatives to describe the house and rooms. For example, the size of the toilet, bathroom and bedroom; the width of internal doorways and passageways; the number of steps into and within the house. However, when home assessment visits are done, therapists often find that the actual house is very different to what was described to them (personal communication with therapists). This may explain why

Gitlin, Levine and Geiger (1993) found that hospital-based occupational therapists have among the highest rate of non-used equipment.

The purpose of the study

With 14% of short-term loan equipment being paid for but not used, questions began to gnaw at me: How do the occupational therapists perceive equipment as part of their practice? What helps and hinders their ability to provide equipment? What significance do patients put on short-term loan equipment as part of their recovery? To what extent do patients find the equipment useful or a nuisance? What is the value of short-term loan equipment to patients and/or the DHB?

I settled on the question: “What is the experience of providing, receiving and using short-term loan equipment?” I did not yet understand what the experience of providing, receiving and using short-term loan equipment was for those involved. Until I could understand that, my assumptions about therapists, patients and short-term loan equipment remained unchallenged. The study gave me the opportunity to explore experiences of occupational therapists who provided the equipment, and the patients who used the devices. What were these experiences *really* like? (Heidegger, 1927/1962; van Manen, 1990).

Eight patients and five occupational therapists were interviewed for this study in order to gain insights into both sides of the equipment provision process.

Definitions

“Providing short-term loan equipment” means hiring items of equipment from an independent company (the supplier). Occupational therapists order the equipment through a computer programme linked directly to the supplier, giving specific directions on setting up the equipment in the home (e.g. what height to set up the rehabilitation chair). The supplier delivers the equipment to the patients’ homes, and retrieves it from the same address at the end of the agreed rental period.

“Receiving short-term loan equipment” refers to the patient taking delivery of the equipment from the supplier. It includes how the equipment was set up for the patient’s use.

“Using equipment” refers to what the patient and family/whanau actually did with the equipment.

The significance of the research question

Equipment provision by inpatient occupational therapists is a routine part of their practice. It is so ordinary for them to prescribe equipment, that the experience of providing equipment is hidden. As an occupational therapist, I have made many assumptions about the patients’ need for equipment. Some of these assumptions are based on my and my family’s experiences, and other assumptions are based on what I have read. I also made assumptions about the value of equipment to patients. Increasingly however, I began to question those assumptions, and wanted to hear the therapists and patients tell me of their own experiences.

Personal communication with other occupational therapy leaders in New Zealand confirmed that little is known about equipment provision and usage nationally. Currently, there is no New Zealand research on how a person or other household members experience the equipment, or whether the equipment fulfils expectations of the user or therapist. The aim of this study is to bring to light, through description and interpretation, what it is like for occupational therapists to provide short-term loan equipment, and what it is like for the patient participants who receive and use such equipment. I was also interested to see what similarities and differences there were between occupational therapists’ and patients’ experiences with equipment provision.

Coming to the philosophy

There is a strong emphasis in the New Zealand public health service, and in the international literature, for health practitioners to pay attention to the voice of patients. That is, to understand their disability needs as they see them, and work collaboratively

with them to reach a lasting, practicable solution to their health and disability needs (Hill, 2007; Ministry of Social Development, 2016; L. Smith, 2005). In deciding on the research methodology for this study, I needed to take account of the voices of equipment users and that of the therapists who provide the equipment. I also looked for a methodology that had a strong philosophical fit with my practice philosophy as an occupational therapist.

I selected the hermeneutic phenomenological tradition to guide my study because it is a human science approach that studies people in their real life world, explores their experiences of a phenomenon, and the meanings they attribute to their experiences. Hermeneutic phenomenology is an interpretive methodology that seeks to provide a plausible insight into people's lived experiences (Gadamer, 2004; van Manen, 1990; van Manen & van Manen, 2014). This methodology seeks to reveal that which is concealed, glossed over, taken for granted, hidden, disguised, or understood in a shallow way, with regard to the phenomenon in question (van Manen, 1990).

Gadamer [1900-2002] recognised that a researcher brings her own life experience and prejudices to the encounter with research participants, that she cannot put aside (bracket) as if they do not impact on her current thinking. I was aware that I had years of experience with short-term loan equipment. I wanted to use my pre-understandings along with new learning from occupational therapists and patients to get a deeper appreciation of the phenomenon under study, develop a new and plausible description of their experiences, and perhaps find ways to improve the short-term loan equipment system for patients and therapists. Maybe I could also find out how and under what circumstances people find the equipment useful or not useful. The philosophy of hermeneutic phenomenology is congruent with my personal understandings of people and the world.

Having said that, I quickly became aware that in using this methodology, I would never get to the end, never come to know the whole phenomenon, and my understanding would always be-on-the-way (Smythe, 2011). While doing this research, as is usual with hermeneutic methodology, I was situated within it, and enjoyed being so. While no

definite truth is arrived at, the experience of providing, receiving and using short-term loan equipment is explored to a greater degree and to a greater depth than I had previously contemplated. Heidegger (1927/1962) stretched my thinking and understanding about the meaning of everyday experiences and about the meaning of Being-in-the-world. Gadamer's (2004) notions of horizons, where past, present and future fuse to form one's unique perspective, and language as the basis of understanding, gave me the means to see afresh. Van Manen (1990) added to my understanding of lived experience as being situated in body, time, space and in relationships.

Pre-understandings

Gadamer's (2004) approach in hermeneutics asks that the researcher acknowledge her own 'pre-understandings' of the topic being researched. Pre-understandings are the knowledge, experience, biases and assumptions that the researcher brings to any situation. The first step in interpretive research was for me to know my own reality; how I came to know and to be as I am, my ontology. From the many years I have spent working with short-term loan equipment issues, I have developed my own understandings and prejudices about equipment provision.

Gadamer (2004) describes this as a "horizon", and asserts that a hermeneutic phenomenological researcher should be aware of pre-understandings, so that they can challenge them, use them to help make sense of new information from study participants, and develop a deeper understanding of the phenomenon. Van Manen (1990) says:

If we simply try to forget or ignore what we already 'know' we may find that the presuppositions persistently creep back into our reflections. It is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions, and theories. We try to come to terms with our assumptions, not in order to forget them, but rather to hold them deliberately at bay and even to turn this knowledge against itself, as it were, thereby exposing its shallow or concealing character." (p.47)

Making my pre-understandings explicit allowed me to scrutinise them, compare and contrast them with the participants' information, and helped deepen and expand my

understanding of providing, receiving and using short-term loan equipment. Consequently, the interpretation that results is a fusion of the text and its context, with me and my context (Gadamer, 2004).

Family influences:

I grew up in a large family led by a self-reliant mother. She would attempt to fix things herself before asking for help. When in her 80s she developed osteoarthritis in one hip. It was painful, and affected her balance and stamina in walking. Before she had hip joint replacement surgery, I arranged for a community occupational therapist to visit her and assess her need for short-term loan equipment. Although Mum preferred to have a bath instead of a shower, getting in and out of the bath was now too difficult. The therapist saw that Mum had a small bathroom with a shower over the bath, and provided her with a smooth plastic bath board for Mum to sit on while having a shower. When I next visited Mum, she proudly showed me what she had done. She had replaced the plastic bath board with a piece of wood (5 cms x 10 cms x the width of the bath). This piece of wood was unsanded and rough, and was slippery on the bath ledge. Seeing the pride in her own solution, I decided to make some suggestions to make it safer – put face cloths under the wood to prevent it slipping on the bath ledge, and put a towel on the top to prevent getting splinters in her bottom. She was very happy with that arrangement, and said “You can take the plastic board back for someone else to use.” This taught me that some people prefer to solve their own problems.

The therapist also provided Mum with a kitchen trolley and long-handled reacher. The trolley became a pot plant stand, before I returned it. I found the long handled reacher in Mum’s wardrobe years later when I helped her shift house. I also tried to convince Mum to use a walking stick outdoors to mitigate her risk of falling. She dutifully practised walking up and down stairs and across rough ground with me, then she put the stick in the corner and left it there, never to be disturbed again. Mum frequently declined other offers of equipment, saying, “I haven’t come to that yet.” I suspect that Mum adhered to the philosophy of ‘use it, or lose it’ and wanted to ‘make do’ without

equipment for as long as possible. Perhaps she thought that by using the equipment, she would lose her remaining abilities faster than she would otherwise.

I have three sisters who use a variety of equipment in the course of their daily lives. Sister One is similar to Mum, in that she uses gadgets and equipment sparingly, preferring to use a walking stick instead of a walking frame, even though a frame would give her more support. She shares the perspective that she is not *that* bad. She does use a shower stool and special steps to get into her shower. For her the shower equipment is essential for safety, her walking stick is essential for mobility, but her acceptance of anything else is contingent on whether it will fit into her small apartment. Sisters Two and Three readily adopt gadgets and equipment, and when using these in public find that the general public are considerate and helpful. They have travelled through Europe with their walking frames.

From these observations of my mother and sisters, I have learnt that equipment can be useful if it makes sense to the user and fits with their sense of self (Spencer, 1998; Wielandt et al., 2006). For Mum and Sister One it seems important for them to be able to show that they are still able, and that their sense of *being able* would be diminished if they used mobility aids associated with disability in public. For Sisters Two and Three, the equipment is a pragmatic means to an end for them, and a signal to the public that help might be needed.

My own experience of temporary disability is limited to having surgery on an ankle. I wore a plaster cast, was non-weight bearing for 6 weeks, and used crutches and a kitchen trolley during this time. I remember being frustrated at being slowed up; everything took longer. No matter how padded the handgrips on the crutches, my hands hurt using them. Grocery shopping required standing on one tired leg, juggling crutches and pushing a trolley around a large supermarket. I could not drive while my ankle was in plaster, so had to rely on someone else (usually my elderly mother) for transport. Once home with the groceries, they needed to be put away, and this is when the kitchen trolley was very useful. For me, the crutches and kitchen trolley were a means to an end.

Professional influences

I began my occupational therapy career in 1976, in an era when occupational therapists were in a state of transition from a craft-based practice, into an equipment cottage industry. People often stayed in hospital sometimes for weeks, to recover from their illness, injury or surgery. Equipment items like raised toilet seats, shower stools, bath seats, and chair raisers were made of wood in carpentry workshops in large hospitals. These items of equipment were given to patients to keep, at no cost to them. The range of equipment options was narrow because of lack of availability.

At the same time, the Accident Compensation Corporation (ACC) was in its infancy (ACC Act 1972), and the Disabled Persons' Community Welfare (DPCW) Act (1975) was new. Both of these Acts provided for assistive technology to be funded from the ACC and the Department of Social Welfare (DSW). Along with my peers, I welcomed the opportunity to be able to provide equipment (we called them 'aids' then) that would enable people to continue to do things for themselves.

At that time, the available equipment was limited to inexpensive self-care items, or heavy steel-framed wheelchairs. Most of the equipment, including wheelchairs, was made locally; that is, they were manufactured in the city where I worked, or elsewhere in New Zealand. I recall giving out things such as: elastic shoe laces; long-handled shoe horns; non-slip matting to stop plates & bowls from slipping; bath mats to stop people slipping in the bath; plate guards to assist with one handed eating; wooden boards made by the hospital carpenter to fit across the top of a bath; blocks to go under bed legs to raise the height of the bed; raised toilet seats made of a wooden seat mounted on a metal 'skirt' that sat on top of an existing toilet. Other aids were bottom wipers, urinals (male and female versions), rails, rope ladders attached to the end of the bed to assist a person to sit up in bed, and bed levers which were rails attached at right angles to a wooden platform that sat under the mattress.

We improvised and adapted tasks e.g. velcro adaptation to fasten bras with one hand; peg on the end of a dowel for pulling up pants, socks, stockings; I remember looking for

ways to adapt what the person already had around them to facilitate performance of a task. I learnt to simplify tasks such as rearrange kitchen storage so that the person did not have to reach overhead or bend over unnecessarily. The approach was grounded in finding low cost solutions.

These days, items that cost less than fifty dollars to buy are no longer provided free of charge by the DHB and therapists advise where the items can be purchased from specialty stores. The specialty stores and independent living centres are now the repository for general advice on coping with disability and small assistive devices. The variety of assistive devices available is ever widening, some of which are offered in mainstream stores as labour-saving devices e.g. jar and bottle openers. Clothing has changed as well. For example, bras are now elasticated, and come in a wide range of designs that do not include hooks and eyes. Fabrics are stretchy. Designs for dresses, skirts and trousers often do not have buttons or zips. Shoes are not always lace up. In this way, people with disabilities have a wider choice of clothing than was available 40 years ago.

Over the course of the last 20 years within this DHB, the management of short-term loan equipment changed to a business model that considered it more cost-effective to hire the equipment from an independent supplier. The equipment supplier took responsibility for purchasing a wide range of manufactured items from around New Zealand and internationally, storing, cleaning, delivering to and collecting it all from the patients' homes. With the advent of widespread use of computers and spreadsheets, each item of equipment could be tracked. Occupational therapists in Counties Manukau Health were quick to see the benefits of a wider range of equipment for short-term use by patients. The steady month-on-month increase in equipment hire costs from \$45,000 in 1998 to \$100,000 per month in 2004, resisted repeated attempts to contain it. This provided the catalyst for me, as the Professional Leader, to implement two initiatives. One initiative was a training programme of core knowledge and skills regarding assessing the need for, and prescribing equipment for all occupational therapists working in physical health. Another initiative was the introduction of written criteria for providing each item of equipment, clarifying the circumstances when it could be

provided, and when it should not be provided, e.g. this DHB would not pay rental for long-handled reachers (cost was less than \$50.00), hair washing sinks or stand-alone showers.

Large and expensive items of equipment like temporary ramps, hospital beds, power chairs needed my approval or that of a designated senior therapist. Another initiative from a manager was to appoint an experienced occupational therapist to manage the contract with the supplier, and streamline the occupational therapy processes related to short-term loan equipment. All of these initiatives had the effect of levelling off the month-on-month increasing costs. Without constant vigilance over equipment provision and the speed of retrieval of the equipment, the month-on-month costs started to rise again. It was clear to me that there were other influences at play that I did not understand. Now, through this thesis, I am able to lay out before the reader where my convoluted journey of discovery led me.

Overview of the thesis

My study is about how occupational therapists experienced providing short-term loan equipment, and how patients with short-term disabilities experience receiving and using assistive devices/equipment in their own homes. I began the thesis by writing up what I thought I already knew and understood about the short-term loan equipment system. This was a way to acknowledge my pre-understandings; I could then be aware of how they came with me throughout the research project. I then moved on to the three findings chapters, followed by all the other chapters. I have presented the chapters in an order that I think leads the reader from the beginning of this project to an ending with plausible conclusions. Each chapter can stand by itself, but at the same time, they interconnect. To paraphrase Gadamer's (2004) hermeneutic circle, in order for this thesis to make sense, the whole needs to be considered in terms of its chapters (parts) and the chapters need to be considered in relation to the whole.

Chapter one: Introduction to the study

In this chapter, I set out the context for the study. I explain the purpose and significance of the study, my pre-understandings of the phenomenon of interest, and how I came to select hermeneutic phenomenology as the methodology.

Chapter two: The practice context

This chapter explores the political, legal and social context of occupational therapy in a public hospital in New Zealand, with particular reference to short-term loan equipment. I outline how this context impacts upon occupational therapy practice, both positively and negatively.

Chapter three: Literature review

The literature review explores the literature that is relevant to the study question. Previous research shows that the factors that influence whether a person accepts or rejects the equipment are personal, pragmatic, and often ambivalent.

Chapter four: Philosophical underpinnings

The philosophical basis of the study is outlined in this chapter. The hermeneutic phenomenology of Heidegger, Gadamer and van Manen, and their philosophical notions are explained as they pertain to this study.

Chapter five: Method

In the methods chapter, the research design is explained, giving a step-by-step account of how the research was conducted. It describes the recruitment of participants, how data were collected and interpreted, and provides a framework for establishing the credibility of the finished product.

Chapters six, seven and eight: Findings

The three findings chapters show my interpretation of the experiences of providing, receiving and using short-term loan equipment. The chapters represent the major themes identified during the study.

- Chapter six outlines what it is like for occupational therapists to provide short-term loan equipment in a complex practice environment.
- Chapter seven gives voice to patient participants' experiences of receiving and using the equipment
- Chapter eight presents what works and what does not work for therapists and patient participants regarding the short-term loan equipment system.

Chapter nine: Discussion

The significant findings of this study are brought together and discussed in relation to the literature. Implications for practice, future research suggestions, and the strengths and weaknesses of the study are presented.

Chapter Two: The legal, political and social context of occupational therapy practice

Introduction

While New Zealand is geographically a group of islands at the bottom of the world, we are, nevertheless, culturally and philosophically closely linked with the rest of the 'western' world (Phillips, 2012; Wilson, 2012). Increasingly sophisticated air travel and communications technology have given ready access to the way the rest of the world was thinking, and thus new philosophies about how the world could be better organised. Of particular interest to me is how the new philosophies of health care, monetary and social policies impacted on healthcare in general, and occupational therapy in particular in this country. Cameron and Masterson (1998) wrote about the changing (social) policy context of occupational therapy in Britain as a result of the changes their government was making to the National Health Service (NHS). They made the point that "The way occupational therapy is delivered and the policies that are developed to support this are often driven by factors outside government policy" (p. 558). I suspected a similar effect on occupational therapy in New Zealand.

A large part of the current work of occupational therapists in physical health is related to assessing the need for, and providing necessary equipment to assist people with a disability to get around, remain or return to their home; study full-time; work in full-time employment; or work as a volunteer (Ministry of Health, 2014). Getting a good, workable equipment solution for a person requires the occupational therapist to pay attention to the person's individual circumstances, the occupations that person wishes, needs, and is expected to engage in, and the environment in which the person will perform those occupations. However, the practice of equipment provision is also subject to international trends, legislation and government policy, organisational priorities, changes in society, and consumer expectations. Occupational therapists must assess the person's disability need, meet consumers' expectations, and navigate government policies and funding regimes, and their employer's priorities. These are not always congruent. Consequently, occupational therapists must navigate a maze of intricacies and tensions in the course of their practice when providing equipment. I

believe that these tensions have had a significant impact on the roles and responsibilities of occupational therapists and the services they provide.

In this chapter, I will examine these tensions and what I see as their effects on occupational therapists. I will consider how the World Health Organization (WHO) defines health and occupational therapy's synergy with the WHO's definition of health, and then how these are at odds with the neoliberal economic theory which drives the New Zealand government policies. Then I will highlight how key pieces of legislation and government policies have been both a facilitator and a constraint on the New Zealand public health system and occupational therapists working within it. I will then look at the way the District Health Board enacts government policy. The impact of societal changes on occupational therapists will also be considered. I will follow that with a detailed look at how I think occupational therapists have responded to these influences.

Legislation

Legislation and health policies have had both positive and negative influences on occupational therapy. The welfare state in New Zealand is said to have begun in 1938 with the enactment of the Social Welfare Act (Boston, 1999; Kinney, 2003), which provided for free medical treatment at point of care in hospital among other benefits. For the next 40 years, New Zealanders supported the principle of the welfare state, helped in part by a sufficiently prosperous economy to pay for it (Boston, 1999).

During the 1970s, New Zealand was still solidly a welfare state. Ground-breaking social legislation was passed. The first of these was the Accident Compensation Act ("Accident Compensation Act," 1972) (ACC). The ACC Act was far-reaching in that it introduced a "no fault" entitlement to treatment, covered earners as well as non-earners, and all injuries as a result of an accident, regardless of how or where the injury occurred (as long as it occurred in New Zealand, after 1 April 1974). This was truly a universal approach to accidental injury treatment, rehabilitation and compensation in the tradition of social welfare (St John, 1999). It was funded through levies on petrol, motor vehicle registration and employees. This was the first time in New Zealand that rehabilitation had been mandated for injured people, giving them an entitlement to

rehabilitation. Occupational therapists were well placed to take advantage of the ACC Act to further develop expertise in providing equipment for independence, and housing modifications. They had been gradually developing expertise in wheelchair and seating assessments (Whitcombe-Shingler, 2006), and working with providing a limited range of equipment to assist people to perform their daily activities at home (Helen Lynd³, personal communication, October 2013; Hocking & Wilcock, 1997). ACC only required an application for funding the equipment or housing modification from an occupational therapist; the budget was originally uncapped.

When ACC was enacted, a huge disparity was created between people disabled from an injury caused by an accident, and people who lived with a disability caused by other non-accidental health conditions. ACC clients were entitled to rehabilitation and equipment necessary to return to their normal life as soon as possible, or as near to that as was possible. People with disabilities as a result of developmental disorder, or medical condition (such as stroke, arthritis, cancer), were not entitled to any more than hospital treatment and subsidised GP care (as per the Social Welfare Act, 1938). The government of the day responded with the Disabled Persons' Community Welfare Act, 1975 (DPCW Act). This Act was paid for from general taxation, and introduced 28 days a year respite care for carers of people with disabilities; equipment provision for people living with a disability; housing modifications so that the disabled person could continue to live at home; and sheltered employment for seriously disabled people who could not meet the usual demands of work in an open work market. The DPCW Act (1975) was administered by the Department of Social Welfare, whose budget for equipment and housing modifications was not capped (Emily Gooder⁴, personal communication, 2013). Between the DPCW Act and the ACC Act, occupational therapists had an unspecified and apparently unlimited budget to draw on, and therefore did not have to consider the cost of their interventions for people with disabilities. It could be argued that because occupational therapists did not have to justify their equipment and modification

³ Helen Lynd was one of the original occupational therapists in community services in Auckland, in the mid-1960s.

⁴ Emily Gooder, occupational therapist, was the founding manager for the agency called *Equipment For Independence* who allocated the Ministry of Health funds for equipment.

recommendations, their recommendations may or may not have been good value for money.

The expectations of some clients sometimes went beyond the intended scope of the legislation. I remember assessing a woman who had an underlying condition of osteoarthritis, and a fall had exacerbated the pain in her hips and knees. She requested a *la-z-boy* chair (a comfortably-upholstered recliner) from ACC to help ease her discomfort in sitting. As the occupational therapist, I had to analyse the woman's performance in sitting to stand (she was tall), and compare that with the demands of sitting to stand from a *la-z-boy* chair. My analysis was that the *la-z-boy* chair would only make sitting to stand even more difficult because it would require greater degree of flexion in her hips and knees to get into and out of. I did not proceed with an application on her behalf. On another occasion, a mother asked ACC for a food processor for her disabled son. The young boy was able to eat soft, mashed food, and drink with assistance. The mother requested the food processor so that she could use it to prepare food for the rest of the family as well. I did not proceed with an application on her behalf either. Occasions like these require occupational therapists to be aware that they have a responsibility to work within the law. On other occasions, when I was the Professional Leader for Occupational Therapy, I remember that some therapists were not very discriminating, and 'tried their luck' at requesting equipment even when they knew the person did not meet the eligibility criteria (personal experience of vetting these requests).

Although the ACC Act and the DPCW Act were socialist in their intent, by the 1980s, the support for the welfare state in general started to wane in New Zealand and internationally (Boston, 1999; St John, 1999) and from then on, health and disability legislation has increasingly characterised by capped budgets, managerialism, and narrowed entitlements. The 1980s became a time of significant political change in the delivery of health and disability services in New Zealand.

Throughout the 1980s, New Zealand began to experience a tightening of international monetary policy, made even worse by the 1987 stock exchange collapse, with ensuing

economic retrenchment. The original Accident Compensation Act was amended several times, and each time, the wording became more precise with definitions of 'injury', 'accident' and entitlements. In the 1982 amendment, greater emphasis was given to housing modifications, wheelchairs and other aids of daily living. Return to employment is mentioned, along with vehicle modifications to assist the injured to return to work. Occupational therapists were still able to obtain equipment for clients without prior approval from a case manager. In the meanwhile, the World Health Organization was working towards a global definition of what is health, and what contributes to good health.

World Health Organization

The World Health Organization (WHO) has taken a broad view of health, as evidenced by the Declaration of Alma-Ata (World Health Organization, 1978), Ottawa Charter for Health Promotion (World Health Organization, 1986), and the International Classification of Functioning, Disability & Health (ICF) (World Health Organization, 2001). Each of these documents takes the perspective "that health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity" (Declaration of Alma-Ata, p. 1). The Ottawa Charter of Health Promotion (1986) goes on to say:

To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. (p. 1)

The ICF is a classification system of human health, encompassing body components, activities and participation, and environmental factors; it recognises the huge variation in personal factors which might also impact on health. The eminent occupational therapist, Ann Wilcock, urged occupational therapists to not only embrace these ideals, but promote them within our organisations, and make them the basis for practice (Wilcock, 2006). However, in New Zealand, the ideals have had to compete with the dominant economic theory of the day – neoliberalism.

Neoliberal economic theory

From the 1970s, the belief that governments should provide a 'Welfare State' for their citizens came under increasing criticism around the world. Widespread economic pressures meant that the affordability of a comparatively generous social welfare system (in New Zealand and elsewhere) was widely questioned. When the National party won the 1990 general election, they began a programme of reform based on neoliberal theory which changed New Zealand's social policy direction from a social welfare state, to embracing the ideologies of a capitalist free market, privatisation and deregulation (Boston, 1999).

Neoliberalism, as an economic model or paradigm, rose to prominence in the 1980s. It is simultaneously a group of economic theories and a policy position that embraces the ideology of a self-regulating market (James, 1993; Numerato, Salvatore, & Fattore, 2011; Steger & Roy, 2013; Waitzkin, Yager, & Santos, 2011). The assumptions of neoliberalism are:

- Individual freedom of choice is highly desirable
- an unregulated capitalist market will deliver efficiencies, economic growth, and equitable distribution of services
- benefit for all citizens through removal of price controls, deregulation of business, privatisation of public assets (including hospital and health services), reduction in taxes, freedom of movement for money, goods and services
- market forces will provide a balance between opposing interests
- capping or cutting government spending on social services will provide an impetus for citizens to take greater responsibility for their own health and welfare
- social services can be better provided by private companies using business models; market mechanisms are an efficient means of meeting human needs
- the role of the state should be limited to only what is necessary to define property rights, enforce contracts, and regulate the money supply (Steger & Roy, 2013; Waitzkin et al., 2011).

Neoliberal ideology introduced business models to the fields of managing, funding and providing health services from 1991 (Boston, 1999; Gray, 1994; Kendall, 1994; Kinney, 2003). The reforms sought to make efficiencies in health care delivery, and improvements in health for the general population. Kendall (1994) was the Charge Occupational Therapist at one of New Zealand's largest hospitals at the time, and she wrote:

Just as the RHAs⁵ require the CHEs⁶ to be run along business lines, so too does the Auckland Hospital Management Team require service managers to administer their departments as businesses. The role of the occupational therapy manager, a Responsibility Centre Manager, has shifted from theoretical to actual accountability for the total performance of the occupational therapy service. For the author, this role shift necessitated a rapid transition from professional occupational therapist to professional manager. This required assimilation of management skills including the development of key performance indicators both for individual performance and service wide, strategic planning, contracting, zero-budgeting, and performance management. (p. 8)

I was working in another CHE at the same time as Kendall wrote about her experience of these changes in government policy and regulation. Patients were to be charged for outpatient appointments and overnight stays as inpatients. There was a general feeling across the health professionals that I worked with that the ethos in health was changing in a negative way. We wanted the welfare of the patients to be the focus of our attention, not their ability to pay or revenue generation. I remember feeling very relieved when the major unions (the New Zealand Nurses' Association, and the Public Service Association) supported health professionals to not talk to patients about payments or collection of monies. Cashier services were established for this purpose.

While I understood that there was a need to change the way the public health system worked in order to be fit for the challenges of the future, I can remember thinking at the time that the philosophy of neoliberalism assumed too much about people making

⁵ Four Regional Health Authorities ("the funders") were established in 1991 to be the government entities which funded the public health system. These entities were abolished by the New Zealand Health and Disability Act (2000).

⁶ 21 Crown Health Enterprises ("the providers") were established in 1991 across the country to provide the inpatient and community health services. These entities were abolished by the New Zealand Health and Disability Act (2000), and replaced by 21 District Health Boards.

decisions about their health based on their ability to pay. I was also aware of entirely different understandings of health that put the emphasis elsewhere. An understanding of Maaori and Pasifika health beliefs informed me that these cultures see health as having four equally important corners: physical, spiritual, mental, and most importantly, family relationship health (Capstick, Norris, Sopoaga, & Tobata, 2009; Hopkirk & Wilson, 2014). Maaori and Pasifika cultures are notable for their interdependence of people, across generations. For them, strong individualism is an indicator that the individual person may not be completely whole, or well. This interdependence of people and physical, spiritual, mental and family health is at odds with the neoliberal ethos. Occupational therapy's beliefs about health and wellbeing resulting from engagement in occupations, being, becoming and belonging align closely with Maaori and Pasifika health beliefs (Hopkirk & Wilson, 2014; Wilcock & Hocking, 2015). To my mind, neoliberalism takes no account of the rich diversity of people and their capabilities, nor the recognised social determinants of health, such as standard of housing, level of education, level of income, political stability, food supply and so on (World Health Organization, 1978, 1986, 2001). Thus, the neoliberal policies did not sit well with me.

The Health and Disabilities Services Act (1993) was a clear move in the direction of neoliberalism in government, where private sector management practices and managed care were introduced; there was an explicit directive to improve productivity – do more with less and become more efficient and less of a drain on the tax system; all the while, improving the health of the nation. Managed care began in America in the late 1980s and early 1990s as a way of containing costs by reducing administration costs, reducing hospital costs through shorter length of stay, reducing unnecessary treatment costs, and using primary care as a gate-keeper to avoid unnecessary hospital admissions (Christiansen, 1996). The language of healthcare now included *funder, purchaser, provider, consumer/client, responsibility cost centres, contracts*. Contracts included set pricing for medical procedures, and occupational therapy interventions as per the service specifications. The service specifications tried to put a boundary on the range of activities that occupational therapists could do and be paid for. It is not known whether any person missed out on occupational therapy as a result of these changes.

In 1999, a new Labour government enacted the New Zealand Public Health and Disability Act (2000). This was the fourth reform in public health in a decade, and sought to reverse the commercial focus in healthcare. Financial accountability and monitoring of quality of healthcare remained. The Act introduced the Disability Support Services within the Ministry of Health, under which the equipment and housing modifications service (EMS) sits. A national Programme Manager was appointed, and contracts were let to *accessible*⁷ and Enable New Zealand⁸ as funders of equipment and housing modifications. The effect of these reforms meant that occupational therapists still had access to a funding stream through the Ministry of Health (MoH) for equipment and housing modifications when a person's disability is expected to last longer than six months. (Then as now, if the disability is expected to last for less than six months, the DHB is expected to fund the equipment). However, the MoH's budget was now capped, and criteria for eligibility for the funding were specified. The definition of disability as opposed to personal health issues was described. A person disabled by the effects of obesity, diabetes and kidney failure was not eligible for MoH funding for equipment. However, if that same person had a leg amputated because of the compromised circulation due to the same condition, he/she was then eligible. This anomaly continues to frustrate occupational therapists who have to help the person source alternative funding for the equipment if they are not able to afford to pay for it themselves.

Accident Compensation Corporation and Ministry of Health differences

The differences in resources available for people disabled by an accident and those disabled by a medical or developmental condition creates inequities in the disabled population. This inequity is noticed by clients in rehabilitation centres, and causes resentment towards occupational therapists (K. Spence⁹, personal communication). The inequity was also highlighted by research (McAllister, Derrett, Audas, Herbison, & Paul,

⁷ For people with a disability living in the geographical areas of Auckland and Northland, *accessible* funds the provision of hearing aids, equipment, housing alterations and vehicle modifications on behalf of the Ministry of Health.

⁸ For people with a disability living in the rest of New Zealand, Enable New Zealand funds the provision of hearing aids, equipment, housing alterations and vehicle modifications on behalf of the Ministry of Health.

⁹ K Spence was the Section Head Occupational Therapist at the Auckland Spinal Unit when we had this conversation. She is now the Team Leader, Inpatient team, Auckland Spinal Unit.

2013) that was conducted with 118 spinal injured people from the two New Zealand spinal rehabilitation units. McAllister et al found that the people who were eligible for rehabilitation and compensation for their injuries because of an accident had better access to health care, recovered faster, and were more likely to return to work than the people whose spinal injury was not caused by an accident. Under the present ACC legislation¹⁰, ACC clients have a legal entitlement to rehabilitation, equipment, and housing modifications which will enable them to return home to live. There is no capped budget for these things. MoH clients have no such 'entitlement', and there is a capped budget, and restricted range of equipment available. If they meet the MoH's definition of disability for more than six months, they might be eligible for equipment and housing modifications that are 'essential' (i.e. no viable alternative) that will enable them to stay or return to living at their usual home. In practice, people talk to each other about what equipment and services they are getting, and note the disparities. They are not fully informed of the legislation which governs the provision of equipment and housing modifications, and see the therapists as the barrier to getting what they want.

Ministry of Health

In 2000, the then new Labour government published a Health Strategy, and the Disability Strategy; both strategies were updated in 2016 (Minister of Health, 2016; Ministry of Social Development, 2016). These documents were designed to provide policy direction to the Ministry of Health and health and disability providers. The thrust of these documents was equity of access to services; strengthening of primary care; inclusiveness; living well with chronic health conditions and disability; support for people to remain in their own homes; and to participate equally in society. To implement and manage the changes to equipment and housing modifications under these strategies, the Disability Directorate was given the responsibility to manage the funding of essential (i.e. there was no other viable alternative) permanent loan equipment for use at home. The budget was capped.

¹⁰ Accident Rehabilitation & Compensation Amendment Act (1993) (no. 2).

The strategies were congruent with the Declaration of Alma-Ata (1998), the Ottawa Charter (1986), the International Classification of Function (2001), and occupational therapy's philosophy of enabling participation in one's preferred occupations and community, but there were inadequate resources to implement these policy documents. The Disability Directorate was unable to fund anything that was principally to support community participation. No extra staff or money was made available either by the Ministry of Health or the DHBs to achieve the lofty aims. Although the strategies are still part of the MoH's policy direction, there is no mention of their principles in the Counties Manukau DHB's Statement of Intent (CMDHB, 2013) or the Minister of Health's letter to the DHB accepting its annual plan.

District Health Board influences and occupational therapy

At the same time as neoliberal economic theory was being introduced to New Zealand's public health system, a more enduring, and in my mind, a more palatable change was in the form of managerialism. The managerial expectation is to:

- increase productivity (see more patients within the existing staffing level and money)
- increase quality (improve outcomes, reduce number of mistakes)
- reduce waste of resources (time and supplies especially), and
- measure throughput and output (Cameron & Masterson, 1998; Ceci & Purkis, 2011; James, 1993; Numerato et al., 2011; Waitzkin et al., 2011).

District Health Boards (DHBs) have a contractual relationship with the Ministry of Health and the Accident Compensation Corporation (ACC) whereby the DHB agrees to implement government health and disability legislation and policies as agreed to in the annual plan's Statement of Intent (SOI), within a capped budget. Two of the objectives for the DHB (CMDHB, 2013) are to promote effective care or support for those in need of personal health services or disability support; and promote the inclusion and participation in society and independence of people with disabilities. However, the CMDHB 2013/14 Annual Plan and the letter from Minister of Health (Tony Ryall) dated

5 August 2013, indicating his acceptance of the plan, do not mention or allude to disability at all. The emphasis is on integration of primary and secondary care for greater efficiencies; monitoring key quality and safety measures; integrated care for older people, with reference to the dementia pathway; and the expectation that the DHB will deliver on the agreed initiatives, plus keep within budget. Keeping within budget is a huge challenge for the DHB. There are financial implications for the DHB if it does not deliver on the MoH's expectations. Demand for DHB services outstrips the capacity of the staff to provide them. More people are referred for occupational therapy than occupational therapists can see. Staff salaries are the biggest cost for the DHB. While the DHB has reassured us that laying off staff is not their plan, delaying replacing staff is often used to save on staff salaries. This in turn puts pressure on occupational therapists who cover staff vacancies to work towards quick solutions to discharge the client as fast as possible. Quick fixes most often mean equipment solutions.

Occupational therapists in hospital are effected by the District Health Board's managerial imperatives which dictate the time available for interventions, and rewards teams for meeting key performance indicators (KPIs) such as reducing the average length of stay in hospital. Success is seen as increasing productivity with faster throughput of people in hospital. The number of people going through the hospital system and how long that takes, is measured, but the outcome of hospital interventions is not. There are no KPIs about *outcomes*. Although the focus of occupational therapy is to enable people to do their chosen occupations in their natural environments, occupational therapists working in acute wards no longer have the staff and time to conduct visits to a person's home when the therapist suspects the person will struggle after discharge. For inpatient occupational therapists, this means that their scope of practice has been narrowed to safe discharges using equipment, rather than using enabling skills (Townsend & Polatajko, 2007), to give persons the full range of occupational therapy interventions ("rehabilitation"). Burke and Cassidy (1991) put it succinctly when they wrote about the changes brought about by managed care in the American health system:

In the current practice of occupational therapy, we have been forced to shift our allegiance from focussing solely on the person to a more expanded concern that incorporates the needs of our employers to remain financially solvent. This shift has increased our attention to efficient discharges, shortened length of stay... and provision of care in the least costly way. (pp. 173-174)

Not only managerialism and managed care have impacted on how occupational therapists practice in hospitals, but so too have improvements in surgical techniques, pharmaceuticals, and changes in rehabilitation philosophies (Cameron & Masterson, 1998). For example, there is the recognition that a person does not have to stay in hospital until they are well, and that if they recuperate at home they are less likely to experience medication errors, acquire another illness accidentally transmitted to them by staff and other patients, or lose physical and cognitive conditioning due to inactivity. Going home as soon as possible enables them make decisions about themselves and to resume social roles and contacts sooner. This means that for some time now, the grand principles of occupational therapy espoused by our literature and practice models cannot easily be fulfilled in an inpatient setting.

The DHB in which this research has been conducted has taken an approach to manage demand for services and increasing productivity that involves the whole organisation. One key initiative is the 20,000 bed-days project. The project's aim was to give back 20,000 healthy days to the local population, by preventing avoidable admissions to hospital, and expediting discharges from hospital. After years of training ward staff to refer to occupational therapy if a client was likely to have difficulty managing at home, the number of referrals became too great for the number of therapists available to see them. There is now no time to do a home visit with the client prior to discharge, so occupational therapists make a 'best guess' from all the information available, and provide equipment to help the person manage essential self-cares. Neither the therapist nor the person has enough time in hospital to address difficulties the person might encounter with daily routines, or participating in occupations not related to self-care. This is a source of dissatisfaction for therapists in acute hospitals (Craig, Robertson, & Milligan, 2004; Wilding, 2011). So if occupational therapists are to assist the DHB to achieve its triple aim of improving the patients' journey, giving value for money, and

improving population health, they must restrict their practice to supporting people to remain in their own homes, and not expect to assist the person to re-engage in community life. The therapists' access to equipment to support early discharge has become their value to the DHB.

Medical hegemony

The medical model of treating illness and disease to cure or increase comfort, is successful in many conditions. In hospitals, the dominance of the medical perspective (hegemony) is strong (Coombs & Ersser, 2003; Wilding, 2011; Wilding & Whiteford, 2007). The struggle that occupational therapists experience in hospital settings is when a person is medically stable, but not yet recovered enough to manage the demands of living at home. Even if an occupational therapist can argue that the person isn't ready to go home on clinical grounds, this may be interpreted by ward staff as occupational therapists holding up discharge (personal experience, 2013).

Societal changes

Several changes in New Zealand society over the last 40 years have also challenged the delivery of our health and disability services. The rise of consumer rights has empowered them to ask for what they want; and some consumers expect to get what they want.

Today's health care client is often well informed, expects to be privy to health care information and to be part of the decision-making process, understands his or her rights as a consumer, and is dissatisfied with the discrepant information received from health care professional. (Gage, 1995, p. 199)

The internet has made information on equipment accessible to all users. The range of equipment seems only to be limited by what can be sourced nationally and internationally. For some people, this has increased their awareness of what is possible. I have watched a therapist being shown information on a particular car seat that a father has sourced from the internet. He wanted to try it out with his severely disabled daughter. However, the car seat was not available in New Zealand; and no car seat that was available in New Zealand was large enough or supportive enough for the young girl. It is illegal to leave children younger than 14 years at home alone, so the parents had to

take her in the car when they went out. This posed a difficult problem: how could the young girl be safely transported in a car?

The experience of occupational therapists in this DHB is that well educated, and politically active consumers can clearly articulate the level of public service they expect. At the lower end of the socio-economic scale, where people are usually less educated, and less confident in navigating the health system, they are not as demanding. It is often the case that these consumers do not speak English well, have a belief system that is based in Polynesian culture and churches. Their health practices may be based in traditional healing practices. This group of people have worse health outcomes than the well-educated.

Worse health outcomes usually mean low income; low income means they cannot afford to pay for additional equipment. Low income also means lower quality housing or rental accommodation. Housing New Zealand (HNZ) has changed its focus from meeting social housing needs to being a state landlord. Tenants who also have a disability or chronic health condition, no longer receive preferential treatment for approval to make alterations to a house to accommodate their disability or chronic health condition. This puts occupational therapists in a quandary: the disabled person is struggling to access the house with stairs, access the toilet and bathroom that are too small for a walking frame or wheelchair, thus compromising personal hygiene, and putting at risk his/her ability to continue to live in this house. The trouble is, that they cannot afford to live in a privately rented house, which is unlikely to be accessible anyway.

So on the one hand, the Disability Strategy and the Positive Aging Strategy say that the government supports independent living for disabled, and elderly people, on the other hand, another government department has made it more difficult for disabled and elderly people to receive help to do so. The neoliberal beliefs around taking personal responsibility for one's health, that the market will deliver equitable distribution of services, and the private sector is an efficient means of meeting human needs is highly questionable for people with disabilities.

Occupational therapy

New Zealand occupational therapists have adopted international theories about occupation and occupational therapy models as the foundation of their practice, especially occupational science (Wilcock, 2006; Yerxa, 1998), the Model of Human Occupation (Kielhofner, 2002), and the Canadian Model of Occupational Performance and Enablement (Townsend & Polatajko, 2007). These theories and models hold that humans are occupational beings, who can influence their health (positively and negatively) through engaging in occupations of their choice. The belief that humans are occupational beings and need to engage in occupations that have meaning to them, shifted occupational therapists' focus from addressing bodily impairments, to participation in occupations that provide satisfaction and meaning in life despite health or disability challenges, and the environments where the occupations are usually conducted.

Best practice in occupational therapy includes consideration of how the client sees him or herself and ability to act upon the world around them (Kielhofner, 2002; Kielhofner, Hammel, Finlayson, Helfrich, & Taylor, 2004); his or her needs, desires, beliefs and practices, and degree of satisfaction with how they perform chosen occupations (Townsend & Polatajko, 2007; Wilcock & Hocking, 2015). These admirable ideals are challenged on a daily basis for occupational therapists working within the public health system. Whiteford, Klomp and Wright-St Clair (2005) acknowledged the context of practice for occupational therapists when they said:

An individual professional is the product of his or her society and education, practising in a discipline that is governed by currently accepted practice, embedded within a landscape dominated by social, cultural, political and economic influences. It is important that such a systems view is taken in attempting to understand both practice and occupation, because without such an approach, we may be guilty of simply studying the parts, and not the interactions that place them in context. Indeed, we need to understand the complexity that characterises these phenomena. (p. 4)

The occupational therapist must remain focussed on the occupational and disability needs of the person while being ever mindful of the DHB's objectives of giving value for money (in staffing and equipment rental), improving the person's journey, and reducing

the demand for hospital services. In Figure 1, I have attempted to show how I see the unevenness of the powerful influences in health, and whether they are congruent or not with occupational therapy's beliefs and values. In this figure, I show that the WHO's definition of health, significant social legislation in New Zealand, and the New Zealand Health, and Disability Strategies are congruent with occupational therapy's beliefs and values. I think that neoliberal economic theory, the MoH's and CMDHB's Statement of Intent, and medical hegemony are the more powerful forces, but they are not congruent with occupational therapy's beliefs and values. It is akin to an unbalanced seesaw, where the lighter end can get no traction to shift the heavier end.

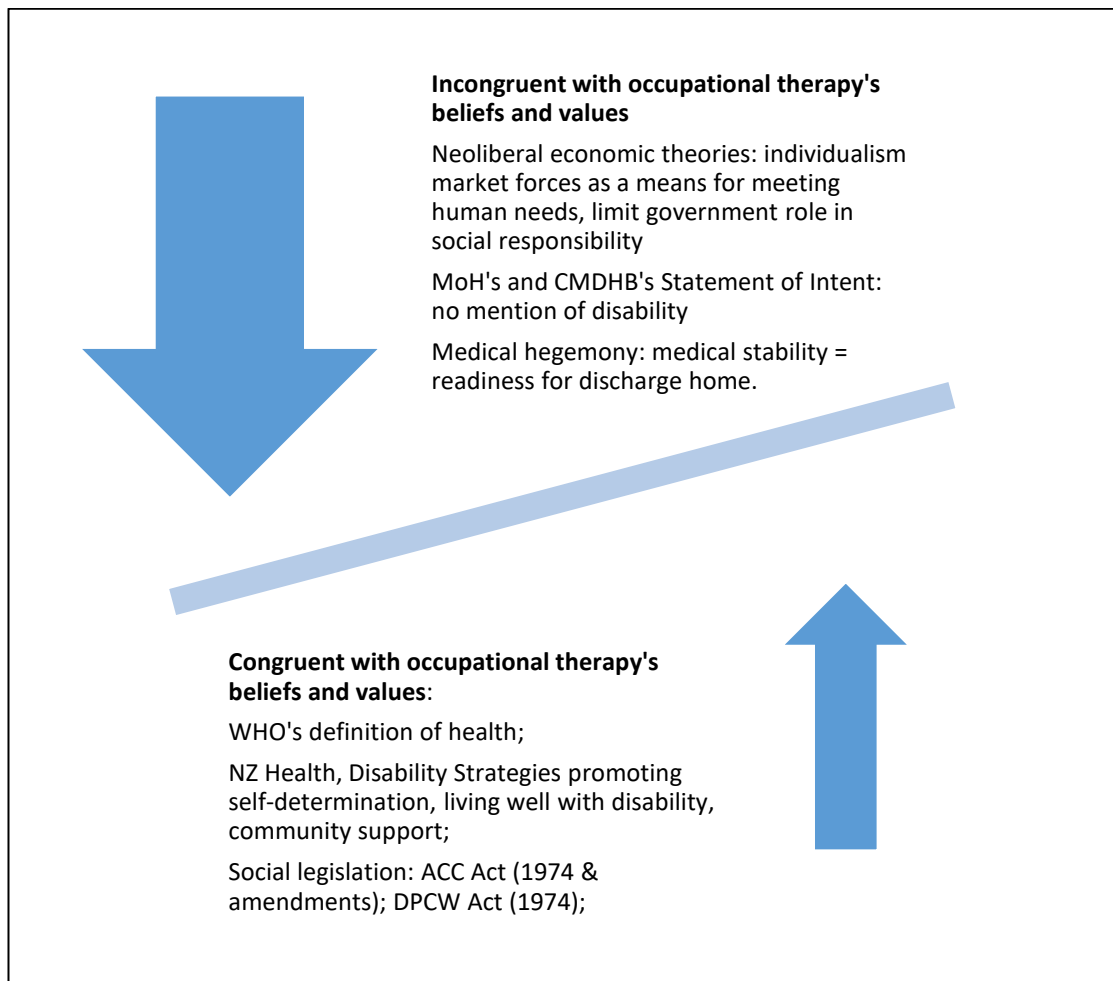


Figure 1: The unevenness of influences in health that are congruent with occupational therapy's beliefs and values

The tensions for occupational therapists lie in being able to reconcile their obligations to the person, their own profession, and to their employer, who is working under a

government that is influenced in turn, by neoliberal theories. I think the perspectives of these successive groups are not synergistic and therefore puts additional stress on occupational therapists who provide short-term loan equipment.

At a personal level, occupational therapists have a number of questions to consider when deciding if short-term loan equipment is necessary to facilitate a successful discharge from hospital. The first consideration is whether this person is ready for discharge home. How will this person manage? That is, will he or she be able to manage physically or cognitively with the demands of being at home? What can the therapist do about it? Can discharge be delayed for further recuperation to take place? How can she advocate for the person to stay in hospital for longer? What will the reaction of ward staff be if she advocates for the person to stay in hospital longer? Can she cope with the pressure that might be put on her to go against her own clinical judgment?

The second consideration for the therapist is what occupational challenges will present themselves at home? Without seeing the person in their own home, what will the environmental and social challenges be? Are this person and family able to solve practical problems that arise? Can the therapist be sure that she has enough information from the person and family to recommend equipment that will fit and be practicable in that setting?

The third consideration for the therapist is what do the person and family expect from her? What have others led the person to believe they will be given by the occupational therapist? Has the doctor, nurse, relative or neighbour told the person that the occupational therapist will give them a hospital bed or ramp or other item of equipment that the therapist must decline because they don't meet the occupational therapy-imposed criteria? Has the person and family had previous experience of their present condition and/or of the equipment, and how can this help with finding the best equipment solution?

The fourth consideration for the therapist is knowing whether the illness or injury is medical or the result of an accident because this will determine the eventual funder of

the equipment (the DHB or ACC or private?), and the processes that must be followed. The funding question is straightforward initially as ACC bulk-funds the DHB for all accident-related treatment up to six weeks following admission. If the person needs the equipment for longer than six weeks, the therapist has to go through the process of notifying ACC to activate their responsibility to continue paying for the equipment.

Providing the best equipment solution for facilitating discharge is based on the occupational therapist being able to ascertain that the person is ready for the occupational challenges of returning home, knowing what challenges might present themselves at home, knowing the person's own understanding of their situation and needs, and knowing what will work for this person, under what circumstances.

Conclusion

This chapter has looked at the political, legal and social contexts of occupational therapy in a public hospital with particular reference to equipment provision by occupational therapists. Providing short-term loan equipment to people to continue to live in their own home after discharge from hospital is done within a complicated and complex system of laws, policies, social/client expectations, the DHB's contracts with the Ministry of Health and ACC, and the profession's expectations of occupational therapists. Occupational therapists have to navigate through these various expectations to find a solution to the person's disability needs that may or may not involve equipment.

Chapter three: Literature review

Introduction

In this chapter, I explore the literature that was significant to my understanding of providing, receiving and using short-term loan equipment. According to Smythe and Spence (2012), a hermeneutic literature review does not simply present knowledge that someone else has written, nor be an all-encompassing summary of the topic; nor is the only purpose to show a gap in the literature. Rather, the key purpose of a hermeneutic literature review is to provoke thinking. Thus it is not my intention to record here all that is known about my phenomenon of interest. Rather, guided by van Manen (1990) and Smythe and Spence (2012), I seek to understand what has been done by others before me, and show how their writings and experiences provoked my thinking.

My motivation for embarking on this study was to find a way to think about short-term loan equipment afresh and expand my horizon (Gadamer, 2004) of the experience of providing, receiving and using short-term loan equipment. Reading and re-reading that literature helped me to make sense of the whole by understanding the detail, and conversely, understand the detail by understanding the whole (Gadamer, 2004). This is what Gadamer refers to as the “hermeneutic circle” (p. 302), although I think of the process more as a hermeneutic spiral. Throughout this study, I returned to what I had already read for deeper understanding of the particular, and sought a wider range of texts from beyond occupational therapy, to expand my understanding of the general. The whole of my growing understanding shed light on the reading of the moment, which in turn fed back into the whole.

I travelled to Europe and Britain recently with two older women with physical disabilities as a result of advanced arthritis. One woman used an electric scooter, and the other used a wheeled walking frame for mobility. Our experience was that other people volunteered their assistance to open doors, carry luggage, or make allowances for our slower mobility. So for us, the electric scooter and walking frame were overt signals that some help might be required, and acted as a prompt for some people to offer help. I

asked these two women about their experience of using their mobility aids in public. Both of them were very clear about the positive contribution the equipment made to their ability to travel, but both admitted that they were initially hesitant to use the devices in public, because of the stigma attached to being disabled. Interestingly, one of the women stated that it was easier to go out in public with the device where she was a stranger. To use the device in her local community would take some courage, at least initially. When I reviewed literature about using equipment, I found that my companions' experiences were shared by many others.

Much is already published about assistive devices/technology or equipment (Dahler, Rasmussen, & Andersen, 2016; Ivanoff, Iwarsson, & Sonn, 2006; Polgar, 2006; Sainty, Lambkin, & Maile, 2009; Wielandt et al., 2006). I searched the literature mainly using online data bases such as CINAHL, Medline, and Ovid using search terms "assistive devices", "assistive equipment", "assistive technology", "disability", "equipment", "experience", "providing assistive devices" and "temporary or short-term disabilities" through the university's and the DHB's libraries, and google scholar. A hand search of occupational therapy, disability and rehabilitation literature was also conducted in the University's and my DHB's libraries. Further searches were conducted of the websites of the New Zealand Ministry of Health and the New Zealand Accident Compensation Corporation, to discover what information they provided for people with disabilities on the equipment that they each fund. Lastly, a search of New Zealand legislation related to disability and public health in New Zealand was also completed. As the study progressed, I became interested in broader concepts that seemed relevant to providing and receiving equipment, such as "establishing rapport", "knowing", "phronesis", "practice architectures and arrangements", and "professionalism". I used the same literature search strategies as above to explore these concepts.

I found that most of the literature related to long-term use and rates of abandonment, although articles on the experience of providing and using equipment are beginning to appear. I have been selective with the literature. I was particularly interested in personal stories related to the experience of providing, receiving and using equipment in general, and short-term loan in particular, and focused my attention on the experience of

occupational therapists who provided the equipment and patients' attitudes towards the devices and using them. I excluded literature which focused on quantifying rates of equipment use and abandonment because the methodology used in these studies did not pay enough attention to the users' or providers' experiences. I was confident that I had discovered all relevant literature when no new information was found relevant to my phenomenon of interest.

Approaching the literature hermeneutically

Gadamer (2004) proposes that understanding is based on what has influenced us from the past. However, from a hermeneutic perspective, exploring texts means more than just going back and exploring past meanings. To every situation we bring our pre-understandings or prejudices that have been shaped by our own life experiences and what we have read, learned or heard within the traditions of our own culture. Thus to reach a hermeneutic understanding, it is essential that the pre-understandings we bring with us are recognised, and accepted as contextual in nature (Roseberry, 1997; Smythe & Spence, 2012). In such a way our understanding of what an author might have meant becomes coloured by our own bias. As Gadamer (2004) says: "the aim of historical consciousness is to know it as a historical phenomenon that can be understood solely in terms of its own time" (p. 301), and at the same time is always incomplete (van Niekerk, 2002). As I read the literature I was unable to put aside what I already knew. I thus recognise the influence of my pre-understandings on both the selection of the literature and my interpretation. I always brought with me my already-there opinions and beliefs and my own experiences with short-term loan equipment. At the same time I was always alert for a sense of an author's opinion being different from my own, and learnt not to take this as 'right' or 'wrong' but rather as simply another view.

My reading of the literature revealed how research about equipment falls roughly into four lines of inquiry: a) the rates of use, decline or abandonment of equipment; b) the reasons for rejecting or abandoning equipment; c) exploring the everyday experience of using equipment; and d) the everyday experience of providing equipment. The literature review I present is an account of the interplay between my pre-understandings and what I read, searched for, dwelt-upon and talked about with others in order to discern what

mattered in relation to my research question. Gadamer is quoted as saying that “...interpretations are only provisional and constantly need to be rectified” (Grondin, 2002, p. 17), and “understanding does not aim at having the final word” (Barthold, 2012, p. 6). With this in mind, I offer this literature review with the understanding that it is my personal interpretation of what others have found before me. Further, it is the reading that provoked my thinking.

Use and non-use of equipment

In chapter one I referred to an audit of the use of short-term loan equipment conducted in my organisation in 2003. This audit found that 14% of equipment provided for short-term use (up to six months) by occupational therapists, were not used at all. Conversely, it means that 86% of all equipment provided to people on discharge for short-term use was used at some time after discharge. In considering what this pre-understanding might indicate for this study, I looked for information about how that rate of non-use of equipment compares with the international literature.

One authoritative source from much the same time is Wielandt and Strong’s (2000) comprehensive review of the literature, published between 1963 and 1996, on the use and non-use of equipment supplied to people on discharge from hospital. The studies Wielandt and Strong found were conducted in America, Australia, Britain, Canada, and South Africa. In these studies there are wide variations in the sample sizes (8 – 502 people), the age range (2.5 years – 93 years), and the clinical diagnoses of the subjects (arthritis, cerebral palsy, orthopaedic conditions, spinal conditions, stroke, visual impairments, and combinations of co-morbidities). The equipment under review also varies greatly and included augmentative communication devices, bath seats, beds, environmental adaptations, over toilet frames, personal alarms, shower stools, tables and wheelchairs, and more. Furthermore, data collection methods include face-to-face interviews, home visits, self-report questionnaires and telephone interviews. The time interval between the equipment being provided and follow up by the respective authors varies meaninglessly (2 weeks - 11 years). Across all these studies, the rate of use of the equipment is between 35% - 100%. While making meaningful comparisons between the

studies is difficult because each study has its own widely varied focus (J. McNaught & Paul, 2015; Sainty et al., 2009), I take from this review the perspective that the rate of use (86%) and non-use (14%) of equipment provided by occupational therapists in my organisation compares favourably with international findings. To me, this indicates that occupational therapists in my organisation 'get it right' most of the time for most of the people.

Some caution needs to be exercised however, in translating overseas research results to a New Zealand setting, where short-term loan equipment is publicly funded, and each DHB organises the equipment differently. For example, my DHB hires all the short-term loan equipment through a supplier that offers a wider range of devices than would be available if we had our own pool of equipment. Whereas other DHBs either have an equipment loan pool, or use a combination of loan pool and rental from a private equipment supplier. Furthermore, my DHB has since put a more robust system in place to track and retrieve equipment which is no longer used, thus reducing unnecessary costs of rental. Unfortunately, the previous audit has not been repeated, so the current rate of use and non-use of equipment prescribed by occupational therapists in my DHB is unknown.

Factors that influence use and non-use of equipment

I have chosen to use the term 'non-use' instead of 'abandonment' because to me, 'abandonment' implies that a person has the equipment in their possession, then chooses to not use it for their own reasons. Whereas 'non-use' can also imply that a person chooses not to have it in the first place, or they might have it, use it for a short time, and then stop using it.

My pre-understandings about the use and non-use of equipment have been influenced by the following, now admittedly dated, literature. The factors that influenced a person's choice of whether to use equipment, or not, were extensively reported (Wielandt & Strong, 2000). The positive factors supporting equipment use included medical diagnosis where the disability was of short duration (e.g. elective orthopaedic surgery); the perceived benefit of the device; a thorough assessment where a home visit

has also been conducted; and where training in the use of the device was perceived to be adequate.

The reasons given by people for non-use of equipment include: change in functional status (Clemson & Martin, 1996; Finlayson & Havixbeck, 1992; Wielandt & Strong, 2000); inadequate training in the use of the equipment (Bynum & Rogers, 1987; Schemm & Gitlin, 1998; Wielandt & Strong, 2000); preferring help from another person (Finlayson & Havixbeck, 1992; Wielandt & Strong, 2000); another method is preferred to do the task (Wielandt & Strong, 2000); the equipment does not fit (Finlayson & Havixbeck, 1992), is not trusted, is considered inadequate, was delivered too late to be of use, or does not meet the person's needs (Mann, Hurren, & Tomita, 1995; Mann, Hurren, Tomita, & Charvat, 1996; Neville-Jan, Pierson, Kielhofner, & Davis, 1993; Parker & Thorslund, 1991; Rogers & Holm, 1992; Schemm & Gitlin, 1998; Wielandt & Strong, 2000). An underlying, unstated theme in many of these studies is that equipment is helpful (Ripat & Woodgate, 2011), and people *should* be using equipment, and that to not do so means that something is wrong either with the equipment, the training on how to use it, or the person. None of these authors suggested that their participants could assess their own risk and accept that risk at home, or that they preferred to solve their own problems. Recall the story about my mother and her bath board.

The detailed study of device use and non-use has not been matched by study into the cultural and social contexts of device use (Hocking, 1999; Kerrigan, 1997; Luborsky, 1993). Socio-cultural perspectives could have an impact on the way that the device is perceived, and that how the patient sees herself or himself may determine whether they use objects which they associate with being sick or disabled (Covington, 1998; Häggbloom-Kronlöf & Sonn, 1999). Covington's story about his preference to not use a white cane despite poor eyesight, illustrates his unwillingness to use something that would publicly label him as being disabled. His sentiments are echoed by the women interviewed by Häggbloom Kronlöf and Sonn (1999). While some of the women discovered that help was forthcoming if they used a walking stick in public, others thought it demeaning to be seen in public with a walking stick. Clearly, people's

perspectives on their use of assistive technology is often different to health professionals' views on the potential usefulness of those devices.

People judge and experience assistive devices from a subjective viewpoint within their social, cultural, and lifetime contexts. Spencer (1998) relates a story of a construction worker, Russell, who became a wheelchair user, and his struggle to come to terms with using the chair. His initial reaction was that it reminded him of how useless he had become, and that it was unfair to his son to have a father who was a 'cripple' (sic). In their review of personal factors that shape individual meanings assigned to assistive technology, Pape, Kim and Weiner (2002) looked at four different groups of people with disabilities, and found that the groups differed in the ways that they perceived equipment. For example, older adults' were more likely to use equipment if it served as an effective strategy for coping with impairments, preserved their self-image, and/or the degree of importance they attached to independence, control and cost savings.

Those with acquired disabilities (neurological, spinal cord injuries, amputations) were found to have the most diverse perceptions. The device might be useful, but it also had to conform with other expectations such as ease of use, time needed to do the activity and whether it helped the user to have a sense of control and/or 'fit in' socially. Another group they looked at was people with congenital disorders (cerebral palsy) who generally viewed equipment as enabling with few limitations. The final group had progressive disorders (cancer, neurological, diabetes). This group of people tended to use equipment to increase their activity participation as the disease progressed. The equipment was also a potent reminder of physical decline arousing feelings of not 'fitting in' socially. Pape et al.'s (2002) contribution to the literature on use and non-use of equipment is important because they have shown how people with disabilities assign the different meaning towards equipment according to their life experiences and the cultures by which they live, and that a need for a device is not the only reason in deciding whether it will be used or not.

Scherer (2017) summed up nicely the reasons why equipment might be used, rejected or abandoned.

*AT [assistive technology] users may be satisfied with the clinic's services, have the necessary funding for the device, received a product that is usable, looks good, functions well and meets all safety standards, and helped them achieve functional gain – but if it is a hassle to use, set-up and maintain, if it doesn't fit with their needs/preferences/lifestyle, if they feel self-conscious using it, insecure with use even though it is safe, if they are socially and physically and emotionally uncomfortable with use, then they are not realising benefit from use and **will not use it**. It is not good use of person and AT. (p. 1) (Emphasis in the original)*

Throughout my literature search, I detected general assumptions that equipment is useful for independence, culturally neutral, and dependency is an undesirable state. These assumptions were also noticed by Ripat and Woodgate (2011) who argue:

Values related to gaining mastery, control, independence and autonomy are generally considered hallmarks of individualist societies. In contrast, members of collectivist societies are more likely to value social relationships, communities, interdependence and a sense of belonging....It may be more important to determine whether the AT assists the individual to live in harmony with, rather than control, their environment. (p. 91)

Ripat and Woodgate (2011) also pay attention to the interdependence of family members and equipment. They note that family members often take on responsibility for setting up, repositioning, maintaining and otherwise taking care of the equipment on behalf of the user. The use of equipment will have an impact on family roles and routines, sometimes with unintended positive and negative consequences. If equipment is provided with a Western concept of independence and the patient's cultural context is dismissed, the equipment may not meet their cultural and/or personal needs. A device that does not fit in with one's cultural values or sense of self, will probably not be used. A point made by Kerrigan (1997) is that the use of an assistive device by a person with a disability is counterproductive if it isolates the individual from desired personal contact.

Limitation in equipment use is borne out in my own experience. Two other elderly relatives of mine prefer to hold on to another person's arm when walking. When I asked them about this separately, they both commented that they felt more secure that way. Recently, I also had cause to seek assistance from another person as we walked from a car park to a concert hall. I held my arm in hers while we walked several hundred metres. It was then I experienced the feeling of warmth, comfort and security of walking with

assistance from someone I loved and trusted. I could not imagine getting the same feelings when using a stick or walking frame. Conversely, I also realised that if my purpose was to independently complete an occupation, then a walking stick would be better suited to the task. This is supported by Hägglom-Kronlof and Sonn (1990) who assert “the use of assistive devices can be influenced by the person concerned, the occupation, the assistive technology and the context in which the occupation is performed” (p. 335).

My new understanding of using or not using equipment is reinforced by Krantz (2012), who wrote about useworthiness, usability, doability and doworthiness as underpinning the use or non-use of devices. Useworthiness concerns what makes the device worth using or not in the mind of the potential user. Useworthiness of a device is rated by the potential user, based on the potential he or she sees for its possibilities. However, Krantz (2012) warns:

A product may be useworthy but rarely usable when difficult to use, but meets a high priority need. On the other hand, that a product is used does not imply that the product is worth using, as the user may have no alternative but to use it. (p. 192)

Pape et al (2002) find that people with acquired disabilities tend not to use devices which diminish the satisfaction of doing an activity, thus supporting Krantz’s (2012) notion of useworthiness.

In Figure 2, I show how I interpret the interaction between doability, doworthiness, usability and useworthiness. I have chosen to represent these notions as four overlapping circles that interact with each other according to the individuals and the devices they relate to. A circle or circles might come forward as a prominent consideration for decisions about equipment, depending on what is important for the potential user.

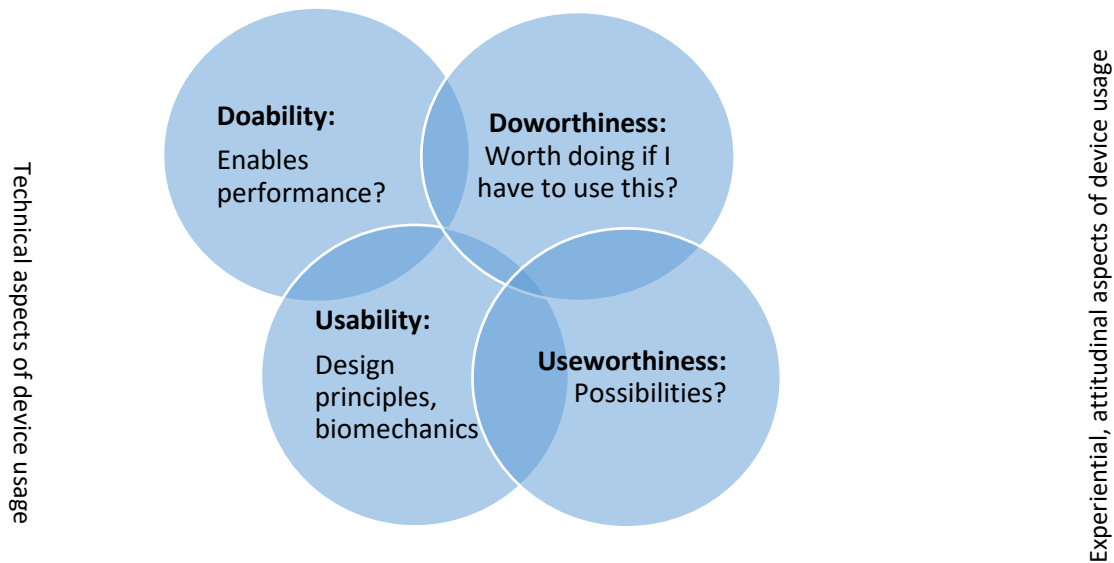


Figure 2: Four inter-related notions on equipment usage, whereby the prominence of each notion can be decided by the potential user.

From an occupational therapy perspective, I think doability and usability are the technical notions that are considered when choosing equipment with patients. For example, does this device have the correct biomechanical and design attributes that are suitable for this patient? Even if it does, will *this* device enable *this* patient to do the task? Furthermore, I wonder if these are the limits of therapists' considerations. I think that useworthiness is generally implied, especially by those who promote training in the use of equipment as a way to increase its usage (Bynum & Rogers, 1987; Finlayson & Havixbeck, 1992; Gitlin & Burgh, 1995; Schemm & Gitlin, 1998; Wielandt & Strong, 2000). Following Polgar's (2006) urging of occupational therapists to delve into the meaning of occupations, I wonder to what extent the doworthiness (or meaning) of a task or occupation is considered by therapists if the patient has to use a device that they do not want, do not like, or find difficult to use, even if the outcome is thought to be highly desirable – but by whom?

For me, a walking stick is useworthy if I have no other way of walking the distance to get where I wanted to. Usability refers to a device having satisfactory mechanical properties. For me, the walking stick needs to be light and adjustable to a comfortable height that encourages a natural arm swing when walking. Better still if the stick is collapsible so

that it can fit folded in my handbag. Doability refers to the possibility of being able to perform and even increase the number of activities that are possible, as a result of using the device. For me, that means I could walk where, as far as, and as often as I desire. Doworthiness refers to the worth of doing the activity as judged by the individual. For me being able to walk from the car park to the concert hall is indeed worth doing, but given a choice, I prefer to use the arm of my companion to help me.

A recent study by Gramstad, Storli and Hamran (2014) took a fresh look at the experience of equipment provision and use. They explored the experiences of older Norwegian equipment users throughout the intervention process of assessment of need, selection of equipment, training in the use of the equipment, and follow-up at home. The researchers found non-use of equipment, in part, was associated with unmet expectations, fear, and a sense of being abandoned by the system. Managing at home with the equipment was associated with receiving satisfactory training and guidance to use it. However, the experience of being left alone without help when needed, was a contributing factor to not using the equipment.

Moreover, the researchers find that interactions between patients and occupational therapists are also undermined by unspoken expectations of each other. For example, patients expect the therapist to make follow-up phone calls, while therapists expect the patient to call if something needs to be changed. Even when patients had information on who to contact when help is needed, some are reluctant to do so for fear that they will be seen to be complaining, ungrateful, pushy, and therefore not get the service they needed. In these cases, the participants struggle on without using the equipment. To me, the notion of unmet expectations of patients and therapists struck a chord. It set me thinking about: How clear are the expectations around short-term loan equipment between the therapists and patients in this DHB? How do they each talk about these? How do therapists know with assurance that the patients and their carers know what is expected of them in relation to the equipment? How do the therapists know what the patients' expectations of them are? It seems so clear to me that there might be a number of unspoken expectations between therapists and patients/carers that could

lead to misunderstandings, which then impact negatively on the experience of providing, receiving and using short-term loan equipment.

Federici and Borsci (2016) also explore the experience of the intervention process of providing equipment. Their focus is on the relationship between the management of providing equipment and non-use of the equipment in four centres in Umbria, Italy, where equipment is provided. They find that the two centres which strove for efficiency in service delivery in terms of minimisation of time and cost of the service, have the higher rate of non-use of equipment (24.34%) than the centres that aim for effectiveness in service delivery (12.08%). The authors conclude that the centres which strive for effectiveness in service delivery are experienced by their participants as less problematic, and with low 'economic leakage' (Federici & Borsci, 2016, p. 28) from unused equipment, compared to the centres that aim for efficiency. My own DHB aims for efficiency and effectiveness in providing short-term loan equipment, and to find the best trade off possible between fiscal constraints such as minimisation of time and costs, and effectiveness of the service in terms of the quality of the service and the equipment provided to the patient.

From all the above studies on the use and non-use of equipment it is evident that this is a challenging topic for study (Dahler et al., 2016). While earlier research on the use and non-use of equipment focuses on the rates of non-use as an outcome measure, these studies were published during the time of neo-liberal macro-economics, when efficiency of services and capping or cutting government spending on social services was of high priority for governments and the organisations they funded (I will cover this in more detail in a later chapter), so perhaps it is not surprising that the economics of providing equipment that was then not used became important at that time. Also, the research into using and not using equipment has, I think, provided a basis for the next section of this literature review – the experience of using equipment, which now I turn to.

Experience of using equipment

There is now a strong emphasis in the New Zealand public health service (Ministry of Health, 1994, 2014) and in the international literature for health practitioners to pay

attention to the voice of patients to understand their disability needs as they see them, and work collaboratively with them to reach a lasting, practicable solution to their health and disability needs (Johnston, Currie, Drynan, Stainton, & Jongbloed, 2014; Krantz, 2012; H. McNaught, Jones, Immins, & Wainwright, 2016; Ministry of Health, 2014; Pettersson, Appelros, & Ahlstrom, 2007; Pettersson et al., 2005; Polgar, 2006; Ripat & Woodgate, 2011; Scherer, 2017; T. Smith et al., 2016; Vadiiee, 2012; van Manen, 1990). In other words, health practitioners are urged to take notice of the experience and knowledge of people with disabilities.

Experiencing is a personally significant, dynamic stream of processing that can be directly referred to and felt by the individual in his or her body (Gendlin, 1962). It is 'felt' but is not necessarily known consciously. My personal experience of knowing when something is right for me, is when I feel a calmness, comfort and/or a lightening of spirit. Sharma (2011) built on Gendlin's work and described the felt sense as being "experienced in the body...It cannot be forced to arrive; it comes to us just as other bodily experiences do, such as hunger and sleep" (p. 183). Van Manen (1990) uses the term *life world* to say that it is through the *lived body, lived space, lived relations and lived time* (p. 103) that we meet and interact in the world, and unwittingly, we both reveal something about ourselves and conceal something too. It is this sort of experiential perspective that I sought to find in the literature. I found that ambivalence was the predominant feeling towards using equipment, and ambivalence ran through lived body, lived relations, lived space and lived time experiences (van Manen, 1990).

Ambivalence

For me, the most striking experiences of users of equipment is ambivalence towards the devices (Dahler et al., 2016; Gramstad et al., 2014; Häggblom-Kronlöf & Sonn, 1999; Kylberg, Lofqvist, Phillips, & Iwarsson, 2013; Nordstrom, Naslund, & Ekenberg, 2013; Pettersson et al., 2007). The mixed feelings relate to having to accept the need for assistance of some sort in the first place, and the possibilities and practicalities of using the devices. A device can be experienced as useful, prompt feelings of relief and safety, enhance privacy, enable a person to do chosen activities and not feel like a burden on

others. The same device can also be cumbersome, heavy or uncomfortable to use such as when a doorway or shopping aisle is too narrow to readily accommodate the device, or when it reduces desired social interaction. Ambivalence shows up as feelings of a 'love-hate relationship' (Pettersson et al., 2007), or feelings of 'pleasant-unpleasant, safe-unsafe, respect-afraid, or do not mind-embarrassing' (Kylberg et al., 2013, p. 403). Now I will look in more detail at the ambivalence experienced when using equipment under the headings of lived body, lived relations, lived space and lived relations.

Lived body

There is a widely held assumption that the things people have, use and consume are an expression of who they are, and what they think about themselves (Hocking, 2000; Pettersson et al., 2007). Equipment is no exception. It is experienced as having advantages in offering possibilities, and disadvantages and restrictions in the situations where they are used (Pettersson et al., 2007; Pettersson et al., 2005). The devices compensate for an impairment and facilitate achievement of some activities. In replacing or supporting aspects of bodily function, devices can give a sense of security, save energy (Hägglom-Kronlöf & Sonn, 1999), and give people confidence to go about their community (Skymne, Dahlin-Ivanoff, & Claesson, 2012). However, the opposite can also be true. Having to use the equipment draws the users' and others' attention to body parts wearing out.

Personal feelings can be intensified depending on where the equipment is to be used. For one woman (Hägglom-Kronlöf & Sonn, 1999), the thought of having a free standing commode in her bedroom is too awful to contemplate, despite any advantages it had. Incorporating the devices into people's lives involves adjustments, usually to create new habits or routines, such as sitting on a rehabilitation chair at a table for meals and when watching television. The use of devices can also facilitate a return to old habits, such as using a stool in the shower and be able to shower oneself, or use crutches to walk outside in order to smoke a cigarette. For some people, the equipment becomes an extension of themselves in order for them to be able to do what is necessary and

desirable to continue to live at home (Pettersson et al., 2005). For example long-handled tongs become an extension of one's reach.

Lived relations

Lived relations with the equipment can be like being friends with the device, or seeing it as a necessity, even a necessary evil (Hägglom-Kronlöf & Sonn, 1999; Pettersson et al., 2007). For some people the equipment imposes an identity on them that they do not feel comfortable with (Pettersson et al., 2005; Skymne et al., 2012). The experience of lived relations with other people is more complicated. Experiences range from feeling conspicuous in public, assuming that others see them as different, judge them negatively and as being a burden to others, through to experiencing consideration, kindness and encouragement (Hägglom-Kronlöf & Sonn, 1999; Kylberg et al., 2013; Skymne et al., 2012).

In terms of lived relations and using assistive devices, it is common for people to find the best device is a spouse or another person (Finlayson & Havixbeck, 1992; Pettersson et al., 2007; Wielandt & Strong, 2000). However, the role of the spouse or other person often changes to include fetching, cleaning or moving the device into place (Pettersson et al., 2007; Pettersson et al., 2005).

Lived space

While the environment poses challenges to people with impairments, I think the impairment also restricts what a person can do in an environment due to fatigue, pain, limited range of movement, impaired sight and so on. The equipment can enable a person to do what she or he would otherwise not be able to do, that is of course, subject to the usability, useworthiness, doability and doworthiness of the equipment as interpreted by the user.

Assistive devices can both restrict and extend lived space, both indoors and outdoors, taking up space when in use and in storage (Dahler et al., 2016). This becomes a problem for those who live in small and/or cluttered homes, and may necessitate rearrangement

of furniture, even replacing some furniture with the equipment. Other adjustments to the use of indoor space is when other family members use the equipment too because it is more convenient to leave it situ, than to remove and then replace it (Pettersson et al., 2007). Others talked of the equipment initially getting in the way (unready-to-hand) and being intrusive, but then it faded into the background and became part of what they did (ready-to-hand) (Pettersson et al., 2005). In a later chapter, I look at Heidegger's (1927/1962) notions of present-to-hand and ready-to-hand in more depth.

Mobility equipment can extend the outdoor lived space, but can also be the source of some trepidation. While mobility devices enable a person to walk or travel, there are places in the community where equipment can get stuck e.g. on and off public transport if no help was forthcoming: uneven surfaces (road works, potholes, cobblestones), high kerbs, sloping footpaths, heavy doors, and weather conditions all need to be navigated. It is common for authors to discuss equipment restricting places to go owing to inaccessible environments (Dahler et al., 2016; Kylberg et al., 2013; Pettersson et al., 2005).

Lived time

Lived time is also experienced in different ways. Having a sense of control over one's own time, is highly prized (Kylberg et al., 2013; Pettersson et al., 2007; Pettersson et al., 2005). People with short-term disabilities come to a time when they no longer need the equipment – a clear signal that they have recovered. Long-term equipment users and their families are reported to be cognisant of past, present and future (Dahler et al., 2016; Kylberg et al., 2013; Pettersson et al., 2005). Thoughts of the past relate to what they used to be like, or how their own parents struggled without equipment that is available now. Thoughts of the present are about managing the day-to-day demands of life such as the devices being in situ and correctly positioned when needed. For spouses or carers, lived time relates to the amount of time spent helping the disabled person. Thoughts of the future relate to future prospects: Will the disability get worse? Will I/they be able to cope? It is likely that these same issues relate to lived time for patients and carers with temporary disabilities.

While many people experience equipment as enabling activities to be done faster, others experience extra time being spent when a device was cumbersome, the device was essential to complete the task but is difficult, complicated or impractical to use (Hägglom-Kronlöf & Sonn, 1999; Pettersson et al., 2007).

In my experience of travelling with two women with disabilities who use mobility devices, I saw the ambivalence often. The gratitude of having a travel scooter or walking frame, coupled with the frustration of having to pick them up and carry both devices up and down stairs, over kerbs, onto public transport. I also saw how going to the toilet can show the lived body, the lived relation to others, lived space and lived time (van Manen, 1990) come together in one occupation. There were concerns about whether there is a toilet nearby, getting there in time, was the toilet roomy enough for the person and their equipment, will she be able to sit on and stand up from the toilet by herself? On another level, one of the women altered the time she took her diuretic medication so that needing to use the toilet was reduced while she was out and about.

Experience of providing equipment

I could only find three articles which looked specifically at the experience of providing equipment, and all of them were about assessing the need for long-term use of electric scooters (Jorg, Boeije, & Schrijvers, 2005; Maywald & Stanley, 2015; Mortenson, Clarke, & Best, 2013). One article related to occupational therapists only, another involved occupational therapists and physiotherapists, while the third involved occupational therapists and social workers as needs assessors.

The studies were done in Australia, Canada and the Netherlands where, like New Zealand, there are state, provincial or government funded equipment services for people with disabilities. I found it interesting that their findings were similar. In all the studies there is the expectation for therapists to adhere to their profession's expectations of client-centredness and occupational needs, and simultaneously apply funding agencies' criteria, while also being mindful about possible litigation should the user injure themselves or others while using the scooter. The contradiction in expectations is not lost on the prescribing therapists. Novice therapists and those new

to prescribing electric scooters take their assessment role seriously but tend to follow the prescription criteria closely.

Experienced therapists on the other hand, use their discretion regarding eligibility and learn to word applications to fit the funders' criteria. Discretion, however, revealed the prescriber's values, albeit unconsciously. Jorg et al (2005) discovered that prescribers make judgements about whether a person 'deserved' or did not 'deserve' a scooter, depending on the prescriber's view of the person. In order to strengthen the application, prescribers omit information provided to the funders or create extra criteria to strengthen the application – usually in favour of the clients they think deserve the scooter. I have observed similar practices in my own organisation, where occupational therapists have been selective with the information included in equipment applications. For example, the diagnosis of morbid obesity is not considered a disability by the Ministry of Health criteria, so therapists applying for long-term loan equipment have downplayed the patient's weight, and emphasised their shortness of breath, arthritis, diabetes and risk of leg amputation and so forth.

Another interesting point all the studies make is that discourse around risk pervades the therapists' thinking. Novice therapists in particular, share their concerns around fear of injury to the user or others and any litigation that might follow – 'a cover-your-back' strategy. This fear is used as a reason to not support a funding application for a scooter. More experienced prescribers are less likely to assume personal responsibility for the risk of injury from using the scooter. Perhaps they have more confidence in their communication with, assessment and understanding of the people they work with.

In summary, therapists' experiences of providing equipment, as recorded in the limited literature on the subject, is having to strike a workable balance between the role conflicts of adhering to professional standards and to institutional requirements, which are at odds with each other. Therapists try to overcome this conflict by invoking their personal values, restricting information shared with the funder, and manipulating criteria to suit their view of the user.

Conclusion

Occupational therapists have the institutional power (Mortenson et al., 2013) to make decisions about who gets what equipment. Occupational therapy philosophy expects therapists to be mindful of each person's occupational needs; personal, environment and social context; personal preferences; and each person's capability to make their own choices and create their own meaning in relation to using equipment. Prescribing assistive devices for short-term or long-term use is deceptively complicated, but has the potential to make a world of difference to the user.

Where does this literature review leave me in my quest to understand the experience of providing, receiving and using short-term loan equipment? It shows that the experiences of using assistive devices goes beyond acceptance of the utility of the equipment (Dahler et al., 2016). Variations exist in experiences of device use according to personal preferences and attitudes, where users reveal ambivalent positive and negative feelings: pleasant-unpleasant, safe-unsafe, respect-afraid, do not mind-embarrassing feelings in relation to using equipment (Kylberg et al., 2013; Pettersson et al., 2005). Having learnt more about overseas equipment users' experiences, I still want to understand how Counties-Manukau users and therapists experience the New Zealand equipment system.

Chapter four: Philosophical underpinnings

Acknowledging the philosophical basis of a study is recommended by Koch (1996) as a way of establishing the rigour of a methodology. The methodology chosen for this study is hermeneutic phenomenology. 'Hermeneutics' is the art of understanding texts (Gadamer, 2004). 'Phenomenology' is a methodological concept (Heidegger, 1927/1962, p. 50) inquiring into what makes the experience what it is, as opposed to what is studied (Adams & van Manen, 2017; Heidegger, 1927/1962). Brought together in research, hermeneutic phenomenology is concerned with *interpreting* (Heidegger, 1927/62) the lived meaning of an experience (van Manen, 1990). In this chapter, I describe how the philosophical notions of Heidegger, Gadamer and van Manen in particular, influenced my thinking and guided this study. I show the interconnectedness between the philosophy of hermeneutic phenomenology, the methodology and the method used. The aim is not to provide a summary of all their work, but to illustrate how some of their key notions have influenced my thinking and learning during this study.

The choice of hermeneutic phenomenology for my study was influenced by my background as an occupational therapist. Occupational therapy has a strong bias towards phenomenology (Borell, Nygard, Asaba, & Gustavsson, 2012; Clarke, 2009; Cronin-Davis, Butler, & Mayers, 2009; Kelly, 1996; Turpin, 2007). As a profession, it is concerned about the lived body, lived space, lived time, and living with others (Radomski, 1995; Robeiro Gruhl, 2005; Townsend, 1997; van Manen, 1990) and holds that a person's sense of self is created through engagement with their environment (Hammell, 2013; Townsend & Polatajko, 2007; Wilcock & Hocking, 2015; Winfield, 2003). Furthermore, hermeneutic phenomenology recognises my experience in, and knowledge of, the provision of short-term loan equipment and the questions I have about the practice of providing the equipment. It allows a focus on both the stories of experience, and the opinions that participants have about challenges and successes related to the provision, receipt and use of short-term loan equipment (Barthold, 2012; Finlay, 1999; Malpas, 2014; van Manen, 1990).

Phenomenology

Phenomenology is first and foremost a philosophical discipline (van Manen, 2014). Van Manen explains that “phenomenology is more a method of questioning than answering, realising that insights come to us in that mode of musing, reflective questioning, and being obsessed with sources and meanings of lived meaning” (p. 27). Further, “phenomenology is, in some sense, always descriptive and interpretive, linguistic and hermeneutic” (van Manen & van Manen, 2014, p. 610). In other words, phenomenology is a way of being curious about aspects of everyday life and relations, and dwelling on what is read, seen and heard in order to describe and interpret the not-so-obvious, the covered-over or taken-for-granted (van Manen, 2014). Being curious in this way, the phenomenon of interest can then “show itself as itself” (Heidegger, 1927/1962; van Manen, 2014).

Edmund Husserl [1859-1939] is considered to be the father of phenomenology. While he began his academic career as a mathematician, he became critical of the positivist sciences and urged others to reflect on everyday existence, particularly how consciousness is directed towards intentional action (Woodruff Smith, 2013). Furthermore, he drew attention to the experience of things and phenomena, and explored how language, habits, beliefs, values, social practices and institutions shape the way we interpret the world (Heidegger, 1927/1962; van Manen, 2014). To avoid interpretations clouded by assumptions, Husserl proposed that personal biases and preconceptions be ‘bracketed’ and put aside, so that phenomena could show themselves as themselves. For Husserl, this was the basis of ensuring validity and rigour of interpretation (Woodruff Smith, 2013). The practice of bracketing did not come easily to me, as I was aware of frequently drawing on past experience and knowledge to help me understand and interpret new and/or complex situations. I came to this study with an already-there-understanding (Smythe & Spence, 2012) of the purpose of short-term loan equipment and the system for providing it. At the same time, I was aware that there was much that I did not know, and to some extent, I was ignorant of what I did not know (Sellman, 2012). Knowing is always in development (Bonis, 2009; Regan, 2012; Shotter & Tsoukas, 2014). Heidegger (1927/1962) argued that pre-understandings are part of

one's past, and one's past is "something which already goes ahead of it" (p. 41). I felt drawn to the writings of Heidegger, Gadamer and van Manen because they acknowledged that personal pre-understandings cannot be readily put aside, they are part of who we are now. I will now move on to give a brief background of each of these phenomenologists in turn, and describe their influence on this study.

Heidegger the person

Heidegger was probably the most important philosopher and one of the greatest thinkers of the twentieth century (Badiou & Cassin, 2016; Wisnewski, 2012). However his membership of the Nazi party has polarised the opinions of modern philosophers, and caused some of them to reject his work outright (Karademir, 2013; Wisnewski, 2012). For example, Fuchs (2015) argues that it is time to abandon Heidegger in the light of the revelations in the *Black Notebooks* because of the similarities between some of his writings and that of National Socialism. It is beyond the scope of this thesis to examine the arguments for and against Heidegger in this matter. As I grappled with understanding his work, and in the light of this controversy, I wanted to understand the life and times of Heidegger, and how, if at all, his philosophy was tainted by Nazi ideology. I came to this already knowing something about the rise of Nazism and its role in World War Two. I already knew that membership of the Nazi party was required for certain positions, and that people joined the party for many and varied reasons, sometimes related to their own survival. Their membership did not necessarily mean that they were also guilty of the hateful and heinous crimes committed under the name of Nazism.

Heidegger [1889-1976] was born in the southern German town of Messkirch into a Roman Catholic family. He gained his doctorate in 1913, and became Husserl's assistant in Freiburg in 1918, remaining there until 1923 (Wisnewski, 2012). From 1923 until 1927 Heidegger lectured at Marburg University, then returned to Freiburg to be Husserl's successor as the Chair of Non-Catholic Philosophy at Freiburg University in 1927. In the same year, he published *Being and Time* which has had a profound influence on the study of philosophy ever since (Wisnewski, 2012). Heidegger joined the Nazi party in

1933, about the same time he became the rector at Freiburg. At that time in Germany, a person had to be a member of the Nazi party to hold such high office; there is no evidence that he was anything other than a minor party member. He held the rectorship for 10 months, until he stepped down from it in 1934. However, he retained his party membership until 1946 (Wisnewski, 2012). In the meanwhile, his professional reputation continued to grow and he remained at Freiburg until 1946, when he was required to undergo 'de-nazification' by the victorious Allies before he could teach again.

Heidegger was born at a time of monumental change in Germany. In 1871 German states were unified for the first time, and a time of massive industrial upheaval began. The rapid industrialisation of Germany interrupted the traditional agricultural way of life. Large factories replaced farms and encouraged the migration of country people to work in the growing towns and cities. Heidegger believed that people were becoming alienated from their traditional communities, common roots, language and nature (Karademir, 2013). According to Karademir, Heidegger lamented the development of industrialisation, technology, and the drift to towns. But even more so, he decried how "beings are objectified, calculated, stocked, organised, and prepared for further manipulation" (Karademir, 2013, p. 107) thus ending the way of life he cherished. This reminds me of his writings on *enframing* in the *Question Concerning Technology* (Heidegger, 1977). In the early years of National Socialism, Heidegger thought that this movement was the only one that could restore Germany to his ideal Germany of the past (Karademir, 2013). For all his naïveté about eschewing technology and urbanisation, Heidegger was also critical of National Socialism in the late 1930s, regarding what he called "the will to power" (Karademir, 2013, p. 116) and authoritarianism. With his criticisms and later works, Heidegger made himself unpopular with Nazi hierarchy which resulted in his writings not being published (Wisnewski, 2012).

I looked for indications of hidden National Socialism ideologies, such as anti-Semitism, racism, and German superiority, in the philosophical notions of Heidegger that I found useful. I did not recognise any of the above ideologies in Heidegger's work. Instead, I found reading Heidegger enlightening, providing explanations of ordinary things in my

existence that brought them to clearer understanding. So, although Heidegger associated himself with National Socialism and the Nazi party, I am convinced by Wisniewski (2012) and Karademir (2013) that his contributions to philosophy are original and extensive. I am therefore comfortable with being influenced by his philosophical notions, and now will show how they have informed this study.

Heidegger's phenomenology

Heidegger (1927/1962) explained that the term 'phenomenology' is the science of the "Being of entities" (p. 61), letting them be seen as they show themselves. The word 'phenomenon' is derived from Greek and originally meant "to show itself". Heidegger used the word to mean something, an entity, "that shows itself in itself" (Heidegger, 1927/1962, p. 51), and indicates a characteristic way in which something can be encountered. However, Heidegger warns, an entity can show itself in many ways, and even "show itself as something which in itself it is *not*" (1927/1962, p. 51). It can look like something, give the appearance of being something but on closer exploration it is not that at all (semblance). The entity may be connected to, and indicate the presence of the phenomenon, but it is not the phenomenon itself. In this way, the phenomenon, although announced, remains undisclosed, covered over. It may be that the phenomenon is so common in everyday life that it is taken-for-granted, and unnoticed. It is the challenge of phenomenology to uncover phenomena, and let them be seen as themselves. A phenomenologist seeks to describe and interpret the experiences of people who have lived them in their everyday lives.

In this thesis I have drawn heavily on Heidegger's (1927/1962) notions of 'being' (Dasein) and 'being-in-the-world'. I now want to turn to his student Gadamer, who agrees with Heidegger that understanding is "the original form of the realisation of Dasein, which is being-in-the-world" (Gadamer, 2004, p. 260).

Gadamer's phenomenology

Hans-Georg Gadamer [1900-2002] was a student of Heidegger, and became another important thinker of the twentieth century (Binding & Tapp, 2008; Malpas, 2014). He

expands on Heidegger's work through asking "how is understanding possible?", and asserting the primacy of language as the medium for understanding (Malpas, 2014). Gadamer explains that all understanding is linguistic in character: the process of reaching an understanding between people, and the process of understanding as such are embedded in language (Gadamer, 2006). He is also renowned for his development of philosophical hermeneutics, where language, dialogue and our own historical situatedness come together in understanding (Malpas, 2014).

Furthermore, he proposes that understanding has three different features: intellectual grasp, practical know-how and agreement (Gadamer, 2004; Grondin, 2002). As I progressed through this study, I came to recognise how occupational therapists understood their role in regard to short-term loan equipment. They demonstrated an intellectual grasp of the models of practice and the rules and expectations of them in regard to providing short-term loan equipment. When they were able to connect with patients in a meaningful way, they were able to come to an agreement with them over their disability needs and identify appropriate assistive devices. Thus, through knowledge and agreement with patients, therapists revealed their practical know-how with assistive devices.

Gadamer's work is significant because of his proposal that understanding is achieved through dialogue and conversation, especially in being genuinely open to the to and fro of debate, and question and answer. Being open to what others say means being prepared to see and hear things from their perspective and allow them to influence your own understanding. This was a timely reminder for me; for in allowing new understandings to arise, it was necessary for me to be aware of my own prejudices or pre-understandings around short-term loan equipment.

van Manen's phenomenology

Max van Manen [1942-], a teacher, was strongly influenced by German philosophers, including Heidegger and Gadamer, and became renowned for phenomenology of pedagogy (van Manen, 1990). Van Manen's contribution to phenomenology, for the purposes of this thesis, is in the phenomenon of 'lived experience'. The emphasis on

understanding ‘lived experience’ means that I as the researcher was directed towards exploring a recognisable human experience (the phenomenon of the experience of providing, receiving and using short-term loan equipment) as it was lived through, uncovering the meaning of the experience for the participants. I expected the lived experience to be different to how I conceptualised, theorised, or reflected on it (van Manen & van Manen, 2014).

I will now bring Heidegger’s, Gadamer’s and van Manen’s philosophical notions together and explain how I have used them in this thesis.

Philosophical notions key to this study

Being/Dasein

The question “What *is* being,” and his attempt to explain it, is one of Heidegger’s great contributions to philosophy (Dreyfus, 2001). Simplistically, Dasein means being-there (from German *Da* for ‘there’, and *Sein* for ‘being’), and can be thought of in terms of a way of being that is characteristic of human beings, individually or collectively (Dreyfus, 2001). For Heidegger (1927/1962), even asking the question “What *is* being” shows a way of ‘being’. “Everything we talk about, everything we have in view, everything towards which we comport ourselves in any way, is ‘being’; what we are is ‘being’, and so is how we are” (p. 26). According to Heidegger, we humans are distinctive because of the way we “always find ourselves amidst particular objects and items of equipment, engaging in particular occupations and goals, all of which make up a particular situation” (Wrathall, 2005, p. 11). In this study, ‘being’ was evident in the way the participants talked about their professional and domestic lives in relation to short-term loan equipment: what they expected and did with each other and the equipment, along with their comfort and discomfort with the process of providing, receiving and using short-term loan equipment.

Being-in-the-world

Dasein, as a mode of being for humans, is inextricably intertwined in the world (van der Hoorn & Whitty, 2015). *Being-in-the-world* cannot be thought of as just the physical

body; rather it relates to considering the whole human being and its existence within a worldly context, including hopes, courage, anxiety, joys and experiences (Overgaard, 2004). Dasein is not fixed; it is a complex outcome of the decisions made, the practices partaken in, the skills, habits and attitudes it fosters, and the rest of the world it finds itself in (Wrathall, 2005). Being-in-the-world refers to the relationship that Dasein has with other people and objects in the same location at the same time. In this study, the Being-in-the-world focused on the everydayness of living with a temporary disability, being together with others in hospital, and being at home with objects as equipment in the bathroom, toilet and living areas. In deciding upon my research question, my philosophical approach and interpretation, I wanted to explore *how* the participants experienced being-in-the-world with short-term loan equipment. In other words, how they comported themselves towards the equipment and the system that enabled it to be provided.

Leaping ahead

‘Leaping ahead’ is a mode of being-with-one-another where the one and the other together devote themselves to address a common issue – with considerateness and patience, the one thinks ahead to possibilities and deliberately gives space to the other to exercise responsibility and autonomy over their care (Heidegger, 1927/1962). The effect of leaping ahead is that both the one and the other the other retain their own independence.

Leaping in

‘Leaping in’ is a mode of being-with-one-another when one takes away care from the other by taking a position of dominance over the other, who then takes a step back. When the matter is over, the other can then decide whether to pick up where the one left off, or leave it be. This mode of ‘being’ can take responsibility and autonomy of decision-making away from the other, encouraging the other to be dominated and dependent (Heidegger, 1927/1962).

Ready-to-hand / Unready-to-hand

Ready-to-hand is the kind of 'being' which equipment possesses (Heidegger, 1927/1962, p. 98). In its readiness-to-hand, equipment reveals its usability; the user encounters the already 'in order to' that belongs to it. In other words, the equipment is not *just* an object, but is a means for doing something. In this study, the assistive devices revealed their readiness-to-hand when the desired enabling effect became taken for granted in everyday use, and thus became concealed from view insofar as they functioned effectively (Harman, 2010; Heidegger, 1927/1962). For example, the raised toilet seat was quickly forgotten after a day of use. It simply became how the toilet was. When something is unavailable or unusable in some way, it becomes unready-to-hand, and moves into being present-at-hand, but does not necessarily lose all of its readiness. For example, when the equipment first arrives in a person's home and is unfamiliar, it may be un-ready-to-hand. When an object is defective it announces itself as obtrusive because it does not function properly. How does the raised toilet seat fit on the toilet? Do my feet reach the floor? How come it feels unsteady or unsafe? In being un-ready-to-hand the person struggles to integrate such equipment into their everyday life.

Present-at-hand

An object is present-at-hand when Dasein is explicitly and consciously aware of it. In this study assistive devices were present-at-hand when, for example, the therapist discussed a 'raised toilet seat' with the client in the ward. It was something in their 'thinking'.

Technology

In his essay *The Question Concerning Technology* Heidegger (1977) discusses his understanding of technology as a means to an end and as human activity, especially in the putting of technology to work. He states "the manufacture and utilisation of equipment, tools, and machines, the manufactured things themselves, and the needs and ends they serve, all belong to what technology is" (p. 288). However, he also warns that technology is never neutral since it makes us blind to its 'essence' - *what it is* to users.

Thinking about the essence of equipment as technology led me to Heidegger's (1971) 'the thingness of the thing' (p. 167), which in this study is short-term loan equipment. To paraphrase Heidegger's thingness of the jug (1971), an over toilet frame is a thing for assisting someone to get on and off the toilet easily. The thing can be described as a white powder-coated metal frame with arms and a horizontal plastic toilet seat. A splash guard is mounted under the seat. The height of the seat is adjustable (480mm to 620mm) by lengthening or shortening the legs. It weighs 3.5 kilograms and is designed to support someone up to 110 kilograms in weight. The higher than usual seat on an over toilet frame reduces the biomechanical stress on a person's hips, knees and quadriceps muscles thus making it easier to move from standing to sitting to standing when using the toilet. The thing we call an over toilet frame stands alone, self-supporting and is placed over the existing toilet. The existing toilet is lower and does not usually have anything to hold on to, to assist with standing to sit and vice versa. The existing toilet is still useable by people who have strong enough leg muscles, good enough balance reactions, and enough pain-free range of movement in their hips and knees to use it without a problem.

When an over toilet frame is in situ over an existing toilet, the over toilet frame in its form, is set before and against (Heidegger, 1971, p. 167) the person who is about to use the toilet. The toilet user must make a choice between using the over toilet frame, or not. To use the over toilet frame is a reminder of the current disability, and it is not the usual way. But to not use the equipment could make the activity a painful experience. In making the choice to not use it, the over toilet frame has to be lifted off the toilet, and moved out of the way, then perhaps put back for future use. But this description does not get to the heart of the essence of the over toilet frame. The thingness of the over toilet frame is found in the using of it: does it have the desired effect for the user? Is it comfortable? Does it make using the toilet easier? Does it feel safe? Is it cold? Does the splash guard give adequate protection? What does the equipment *mean* to the user? The patients' use of equipment in this study will be explored in a later chapter.

I was already aware through literature and conversations that assistive devices were useful and not useful, used and not used, loaded with stigma about disability and aging, and at the same time, fully accepted.

During the study, I came to understand how the 'enframing' of systems was also a form of technology. For the purpose of this study, enframing (Heidegger, 1977, p. 301) refers to the interconnecting workplace structures that impact on occupational therapists providing short-term loan equipment. The interconnecting systems are set up specifically to make equipment provision possible, at no cost to the patient. Enframing arranges by bringing otherwise independent systems into operational order, that permits occupational therapists to provide public health system-funded short-term loan equipment, and creates boundaries and expectations for occupational therapists providing short-term loan equipment. Enframing is set up by people with some authority on the matter. They might never meet the end user. The technology of "enframing is a kind of setting-in-order" (Heidegger, 1977, p. 296). The setting-in-order of the enframed short-term loan equipment system in turn, *sets upon* occupational therapists to become equipment providers in *standing reserve* (Heidegger, 1977, p. 298): to be on call, ready to provide equipment when necessary to facilitate early hospital discharge, and so help the hospital achieve reduced average length of stay statistics. Heidegger's key message in this paper is that we must be ever mindful of the danger that technology will enframe us in such a way that what it means to be human gets lost. It is, he argues, by being mindful of this danger that we are gifted with the potential to take care of the things that matter most to us as people. This research opens the 'enframing' by the systems of short-term-loan equipment to enable any danger to be revealed.

The 'They'

Who are 'they'? Heidegger (1927/62) says "The 'who' are not this one, not that one, not oneself, not some people, and not the sum of them all. The 'who' is the neuter, *the 'they'*" (p. 127). Being part of the 'they' dissolves one's own Dasein into being indistinguishable from others. In their inconspicuousness and unidentifiability, lies the

dominance of the 'they' (p. 127). The existential characteristic of the 'they' is averageness of what has value and what does not, what should be granted recognition and what should not, and what should be ventured and what cannot be done. In this study, the 'they' included a combined sense of expectation arising from the mix of the Ministry of Health, Accident Compensation Corporation, District Health Board, and managers.

Hermeneutic circle

The work of hermeneutics is, according to Gadamer (2004), to understand the whole in terms of its parts and details, and the parts and details in terms of the whole. In other words, there is a circular relationship between the whole and the parts, wherein the whole determines the parts and the parts determine the whole. True understanding comes from the parts harmonising within the whole. In terms of this study, an example of a hermeneutic circle showed itself in a shower stool (for example) as an assistive device which belongs to the larger group of assistive devices available, alongside occupational therapists who provide them and patients as users of the device, and the enframed system that permits and funds the devices to be given to patients. At the same time, the experience of providing and using the shower stool was individually personal and subjective. Full understanding of the phenomenon of experience with the shower stool could only be attained through dialogue with the users via their interview transcripts (text), and going back and forth between the (subjective) text and the (objective, enframed) short-term loan equipment system (Gadamer, 2004). It also involved going back to the literature to read others' accounts of providing and using equipment. To me, the circular relationship was more like a spiral, as the circle was never closed, but deepened and widened with each interaction.

Prejudices, pre-understandings

Prejudice for Gadamer means a judgment that is reached before all the features that determine a situation have been fully examined (Gadamer, 2004). The pre-judgment does not necessarily mean an incorrect conclusion; prejudices can have legitimacy, a positive or a negative significance, and can open us up to what is to be understood

(Malpas, 2014). Gadamer identifies two sources of prejudice as “authority” and “over-hastiness” (p. 289), where over-hastiness relates to over-reliance on one’s own reason, and the reference to authority means not using one’s own reasoning at all. In chapter one, I outlined my pre-understandings of disability and short-term loan equipment, and my role in managing the demand and cost of the equipment to the DHB. I was part of the authoritative the ‘they’ when I wrote the criteria for providing short-term loan equipment. In this thesis, I have interpreted over-hastiness as being too quick to rely on one’s own reasoning alone, instead of including other sources of understanding such as patients’ knowledge of themselves and their experiences.

The important thing for me to remember was to slow down my thinking, be aware of my own prejudices, and be open to the voices in the text so that the text could show itself in its own reality against my own pre-understandings. In this thesis, I prefer to use the term ‘pre-understandings’ because it does not have the connotation of negativity that ‘prejudices’ does.

Horizons, fusion of horizons

Gadamer (2004) describes a horizon as “the range of vision that includes everything that can be seen from a particular vantage point” (p. 313). The range of vision (horizon) includes the past in what lies behind us in the form of tradition (one’s background knowledge and the impetus for the inquiry), and history; the present in what is around us, our present culture and society; and the future in what is before us and yet to come (Barthold, 2012). Gadamer uses the term ‘historical consciousness’ (2004, p. 313) to describe being aware of the past in its own terms and context as opposed to the interpreter’s present criteria and prejudices. A horizon is not a self-contained site that can be entered or left at will; rather, it is a situatedness from which one understands one’s world (Barthold, 2012).

A fusion of horizons occurs when differences are acknowledged, and in the process of understanding each other, one’s own horizon shifts and changes in light of what is learnt from the other; neither original horizon remains the same (Barthold, 2012; Gadamer,

2004). What is more, “by fusing their horizons of understanding, participants in a dialogue reveal the topic to be different, more expansive, more thoroughly uncovered than either participant might have previously understood the topic to be” (Binding & Tapp, 2008, p. 122).

In this study, each participant brought their own horizon to the encounter with me, in person at their interview and through their text. I believe that occupational therapists strive to achieve a fusion of horizons with patients when they try to understand the patients’ disability needs, home environment and their expectations on returning home with equipment.

Lived experience

Gadamer (2004) describes experience (*Erlebnis*) as being retained in memory. The memory has a lasting meaning for the person who had the experience. It is not so much what is thought about, but what is lived through. In saying this, van Manen (2014) describes lived experience as something that happens upon us, and can be understood as “an act of consciousness in appropriating the meaning of some aspect of the world” (p. 40). Exploring lived experience is the primary concern of phenomenological research, and aims to provide plausible descriptions and interpretations of the meanings of phenomena in people’s lives.

The phenomenon explored in this study was the experience of providing, receiving and using short-term loan equipment. The meaning of the participants’ experiences with short-term loan equipment could well be hidden in experiences of anxiety, illness, pain, surgery, hospital systems, risk management and the stigma of disability. Exploring the experience of a phenomenon often reveals a cluster of experiences rather than a single, integrated experience (Adams & van Manen, 2017). The challenge for me was to look beyond the obvious, taken-for-granted, everyday descriptions of the participants’ experiences, and reveal what was already ‘there’.

Conclusion

In this chapter, I have presented the phenomenologists and their philosophical notions that underpin this study and why I thought they were appropriate. In doing so, I have come to understand how van Manen's work built on and expanded Gadamer's ideas, which in turn were influenced by Heidegger's work. Each of these have informed my thinking and writing in ways I could not have predicted at the outset of this research. I paid particular attention to Heidegger, and in doing so, I explained how after close examination I could put aside his membership of the Nazi Party, and use his phenomenology purposefully in this study. As each of these phenomenologists have published extensively, I could not use all of their works in this thesis. Therefore, I have selected the notions that had a direct bearing on my study. In particular, I have drawn on Heidegger's *Dasein/Being*, *Being-in-the-world*, and 'the they' as ways of acting and being present in the world. *Present-at-hand*, *readiness-to-hand*, and technology expanded my understanding of assistive devices and how they are more than just items of equipment. Gadamer's hermeneutic circle provided me with an understanding of a way of making sense of the process of hermeneutic inquiry. Prejudices/pre-understandings, horizons and fusion of horizons helped me to see the relationships between the past, the present and what is yet to happen, but can be anticipated. The concept of lived experience, as described by van Manen, provided the core phenomenon on which this study is founded.

Chapter five: Method

Introduction

In this chapter on the method of my study, I am reminded of the convoluted path I have taken to get thus far. From the beginning, I was aware that the choice of methodology was interdependent on the question. I wanted to explore something around short-term loan equipment, but was not sure what the question should be. I knew I wanted to uncover the experiences of a routine part of practice for occupational therapists, and explore the value of short-term loan equipment to patients. The provision of short-term loan equipment had been a dominant feature of my life as the Professional Leader for Occupational Therapy, and I was aware that research within New Zealand into providing short-term loan equipment was only beginning to emerge. I considered a number of possible lines of inquiry. With the DHB's commitment to their Triple Aim of improving the patient journey, improving population health and value for money in mind, I asked myself what is the link between the patient journey with short-term loan equipment and the quality of service provided by occupational therapists? Further, what value for money does the provision of short-term loan equipment have for the DHB (and therefore the taxpayer) and patients? As I pondered these questions, I became convinced that I needed to understand first of all, patients' and therapists' experience of providing, receiving and using short-term loan equipment. I wondered what might be revealed if I lay their experiences next to each other to see how they corresponded. I also wanted this inquiry to be useful to occupational therapists; and if appropriate, give guidance on how to adjust their practice to better meet the needs of patients.

Once I confirmed the study question of 'What is the experience of providing, receiving and using short-term loan equipment?' the appropriate methodology and study method became more evident. The question guided me towards a hermeneutic phenomenological approach. As someone new to research, phenomenology and hermeneutics, I had a lot to learn. Like many others new to phenomenological research, I was daunted by the philosophical foundations of such research. It took a considerable

amount of time devoted to reading, writing, deliberation, reflection and coaching to find my phenomenological voice.

In selecting the appropriate methodology for this study, I deliberated over the research question, my motivation for the study, and a method that fitted with my way of thinking. Hermeneutic phenomenology fitted because it was the most appropriate way to tell the stories of the providers and users of short-term loan equipment, it allowed me to investigate the providers' and users' experience of an integral aspect of occupational therapy, and it allowed me to pay attention to my knowledge and experience of short-term loan equipment throughout my career (Gadamer, 2004).

Approval for the study

Approval for the study (Appendix 2) was gained from the Auckland University of Technology Ethics Committee in October 2014 to recruit up to eight patient/whaanau participants and up to eight occupational therapists who could speak fluent conversational English, and give an account of their experiences in providing, receiving and using short-term loan equipment. I also sought approval from Counties Manukau Health (Appendix 3) to conduct the research with patients from that region, and occupational therapists employed there. As a Pakeha¹¹ researcher, I was aware of the need to consult with Maaori¹² under the Treaty of Waitangi¹³. Although my research was mainstream, I wanted to include Maaori participants, as they represent an important group of consumers of health care. Therefore I sought advice from the Maaori Research Advisory Officer at Counties Manukau Health. In particular, I wanted to follow culturally sensitive ways of recruiting potential Maaori participants, while also heeding good research practices. I also wanted to include some Pacific people, as they are another important group of consumers. To that end, I consulted with the Pacific

¹¹ The term *Pakeha* refers to a non-Maaori New Zealander. This term was originally used to describe European colonisers in the 19th century, and now is often used to describe 'Caucasian' people who identify as New Zealanders.

¹² The term *Maaori* refers to the people who inhabited New Zealand before the arrival of Europeans.

¹³ The Treaty of Waitangi was signed between Maaori (the indigenous people of New Zealand) and the English colonisers in February 1840. The Treaty is considered the founding document of New Zealand, underpinning political, social and health activities in contemporary New Zealand.

Research Advisory Officer. Consultation with these two research cultural advisors resulted in recruiting potential participants in the manner described below.

Recruiting and selecting participants

I was originally given ethics approval to interview up to eight patients and eight occupational therapists. When I started interviewing and interpreting transcripts, it was not clear if that number was going to be enough to find sufficient richness of participant stories. I sought and gained an amendment to my original ethics application for approval to interview up to 20 participants.

The inclusion criteria for the patient group were that they had been discharged from hospital within the past 12 months with assistive equipment provided by an occupational therapist to assist them with activities of daily living at home on a short-term basis; They needed to be able to talk about their experience of negotiating with an occupational therapist over their need for, and using, short-term loan equipment at home, and therefore needed to be in speaking conversational English. Exclusion criteria for the patient group included not being able to speak conversational English well, and being re-admitted to hospital within the period of using the equipment.

The inclusion criteria for occupational therapists were that they spoke English fluently and worked in a large metropolitan hospital and provided short-term loan equipment as part of their everyday practice. Fluency in English is a requirement for employment as an occupational therapist in New Zealand. Exclusion criteria included therapists who primarily provided long-term solutions to people with long-term conditions, and occupational therapists with whom the researcher had a direct supervisory relationship.

After interviewing eight adult patients and five occupational therapists, I had 168 pages of data, and I was beginning to hear familiar stories from the participants. In order to do justice to the participants' stories within the timeframe of the DHSc, it was decided with my supervisors that I had enough data to work with. Recruitment of participants was spread over the course of 12-16 months, allowing time to have the interviews transcribed, and time to dwell with the data before interviewing the next person. Initial

contact with potential participants was done in several ways, to address different cultural preferences. For potential Maaori participants, occupational therapists initiated the contact in hospital, giving the patients a formal Patient Information Sheet explaining the research focus, their role in it, assuring their confidentiality, and the researcher's contact details. The information sheet included a section for the written consent of the patient saying that the patient gave permission for the therapist to give me their contact details, so that I could contact them regarding the research (Appendix 4). This section also had the patients' 'sticky label' attached on which their contact details were recorded. I then contacted the patient after discharge to discuss the research further, and if they were still willing, arrange an interview time and venue. This approach fitted with *Te Ara Tika's* (Hudson, Milne, Reynolds, Russell, & Smith, n.d.) minimum standards for mainstream research where Maaori participate, and the concept of *kanohi ki te kanohi* (face to face approach). For potential non-Maaori/non-Pacific participants, I followed the same process as for Maaori participants, as in my experience if I got the process right for Maaori, then it was often the right thing to do for other people as well.

For potential Pacific participants, the plan I made with the Pacific Research Advisor was for the occupational therapist to initiate the contact in hospital. If the person was interested in participating, they would be asked to tick the box indicating that their name could be passed on to me and the Pacific Research Advisor. The Pacific Research Advisor would then initiate contact with Pacific people, and introduce me to interested patients and their family/fanau¹⁴. However, at the time of data gathering, I could not re-establish contact with the Pacific Research Advisor, so this avenue of recruitment was not open to me.

The patient participants were contacted at their home address at least six weeks after discharge from hospital, and for the most part, after their short-term loan equipment had been returned. I liaised with the occupational therapists in the hospital when I was

¹⁴ 'Fanau' is the Pacific spelling of whaanau, and has the same meaning.

ready to interview another patient. The request to participate was only given to patients who met the criteria.

Occupational therapists working in the acute wards were invited to participate because they provided most of the short-term equipment. Their invitation was in the form of a poster and hand-outs in the therapists' shared office. See Appendix 5 for a copy of the therapists' information sheet and poster. The poster contained the details of the study, and my contact details. Also, I spoke to the therapists at a general staff meeting to introduce the research and left consent forms for volunteers. Snowballing was also used, where participants were asked to pass an invitation on to any colleagues she thought might value being part of the research. This approach addressed the potential risk of coercion of the therapists.

Consent, confidentiality and anonymity

In designing the data collection methods, I was aware of my duty to seek informed consent (Appendix 6) and maintain confidentiality and anonymity of the participants. I was also mindful of my obligations under the Treaty of Waitangi to uphold the principles of *partnership, participation, and protection*. As I see it, these obligations are not mutually exclusive; I see that these principles apply when working with all people in health and research.

Partnership: Partnership implies collaboration, working together towards a common goal. I conducted a practice interview with a relative of mine who had experience of using short-term loan equipment, and asked her to make suggestions for questions in the 'real' interviews. While she made no suggestions regarding questions to ask my participants, she talked of her naiveté about her abilities after her first hip replacement, and was grateful that the occupational therapist insisted on providing her with an over toilet frame, shower chair, bed lever, and kitchen stool on discharge from hospital. When she had her second hip replacement surgery, she knew what to expect of her own abilities and limitations, and could negotiate with the occupational therapist about her equipment needs. As I proceeded with the formal interviews I found my interview with

each participant was slightly different to previous ones, due to the different experiences of the participants, and the points raised by the previous participants that were able to be explored further in remaining interviews. Thus the participants helped inform me of what the important issues were around receiving and using short-term loan equipment.

Partnership with the occupational therapists relates to refining the research question. I played with ideas around the therapist-patient interactions at the time that equipment was being considered, and the effect on therapists and patients when the Ministry of Health's new "prioritisation tool" was introduced nationally. I was mindful that I wanted a research product that was of interest to other occupational therapists. With that in mind, I deliberately talked to older occupational therapists who were greatly experienced with providing equipment, and asked them what question they thought needed to be answered. Gradually, our conversations refined my thinking to 'what is the experience of providing, receiving and using short-term loan equipment?'

Participation: Participation implies togetherness in decision-making, planning and development (in this case, of data collection). The experience of receiving and using the short-term loan equipment is not confined to an individual, but is a shared experience, albeit experienced differently. When working with all patient participants, I needed to remember that respect for the family/whānau was important. They were included in the interview if that was their wish. The principle of mutual benefit meant that the honour and dignity of the participant had to be enhanced as a result of engaging in this research. I tried hard to ensure that participants felt as though they had equal status with the researcher. The interviews with patient participants were conducted in their home, therefore I was a guest in their home. This meant that I needed to pay attention to social niceties of the participant such as: bring a food voucher or other koha¹⁵, take shoes off at the door, pay attention to seating arrangements, and who is the spokesperson of the household and so on.

¹⁵ Māori for gift, offering, especially one maintaining social relationships, and has connotations of reciprocity.

Each participant was given an envelope with a greeting card thanking them for their time and stories, telling them how much their participation was appreciated by me and a \$30.00 supermarket voucher. However, in a study of this nature, there is inherently a difference in how each party benefits from their participation. As the researcher, I probably benefited the most from hearing and studying their narratives to complete the degree of DHSc. The participants received the koha as a benefit, and perhaps some satisfaction from telling their narrative to help me, or to help other patients in the future.

Protection: Protection involves maintaining the participants' confidentiality, anonymity, dignity, values and practices. I was very aware that I had a duty to actively protect all participants from harm, coercion and deceit. It was important to respect their privacy and differences, especially in regards to their language, taonga¹⁶, culture, opinions, values, and ways of working/acting in the world. This meant that I had to protect their identities. On meeting each participant in person, I reiterated the purpose of the study, sought their consent to participate again, asked them to sign the consent form, and talked about what pseudonym they would like me to call them in the interviews, transcripts and in writing the descriptions in this thesis.

The study participants

The participants were five occupational therapists and seven patients and one daughter of a patient who had experience of using short-term loan equipment within the previous 12 months. Aligning with the DHB practice of involving extended family members as they wish to be involved, I made the decision that the consumers of occupational therapy services (i.e. patients), included both the person admitted to hospital and close family members who shared the illness experience, and were involved in the receipt, use and disposal of assistive devices.

In Table 1, I have listed the pseudonyms, ethnicity, age brackets, hospital procedures undergone, and the equipment the patient participants received on discharge from

¹⁶ Taonga in Maaori culture relates to a treasured thing, which might be tangible or intangible.

hospital. It is noteworthy that all the patient participants had surgical procedures, and that none were older than 70 years.

Initially, I wondered whether talking about private ablutions would be culturally inappropriate for the two Maaori patients. There was potential for me, in ignorance, to blunder through questions of a private nature that could have violated their cultural norms of *tapu* and *noa*. Broadly speaking, *tapu* and *noa* are key concepts of risk and safety that underpin and balance many Maaori practices (Health Quality & Safety Commission, 2011; Medical Council of New Zealand, 2008). *Tapu* relates to restrictions and prohibitions that protect well-being, dignity and sacredness from violation. Breaking *tapu* is considered a serious breach of cultural sensitivity and likely to interfere with developing trust. *Noa* on the other hand, is about freedom of mind and spirit that comes through being acknowledged, restored and made good again, or activities that reduce the effect of *tapu*. I sought advice from the Maaori Cultural Advisor. Her advice was to spend time getting to know the Maaori participant through being prepared to talk about myself and letting them ask questions of me, before starting the interview; this was good advice.

Table 1: Characteristics of the patient participant group

Pseudonym	Ethnicity	Age bracket	Hospital procedure	Equipment received
Annie	Maaori	51-60	Hip joint replacement	Over toilet frame Rehabilitation chair Shower stool Crutches
Cathy, daughter of a patient (deceased)	NZ European	51-60	Mother had hip joint replacement	Crutches Over toilet frame Rehabilitation chair Shower stool
Elizabeth	Maaori	51-60	Knee replacement	Crutches Over toilet frame Shower stool
Helen	NZ European	51-60	Spinal surgery	Crutches Long-handle reacher Over toilet frame Rehabilitation chair Shower stool

Moir	Immigrant to New Zealand	61-70	Spinal surgery	Crutches Over toilet frame Rehabilitation chair Shower stool
Nelle	NZ European	61-70	Spinal surgery	Crutches Over toilet frame Shower stool
Ron	NZ European	41-50	Hip replacement	Crutches Over toilet frame Rehabilitation chair Shower stool
Scorpio	NZ European	61-70	Hip replacement	Crutches Long-handle reacher Over toilet frame Rehabilitation chair Shower stool

I could see the participants relaxing in front of me and becoming more talkative, as we warmed to each other, and the topic of their experience of receiving and using short-term loan equipment. Thereafter, the two Maaori women revealed a willingness to talk about how they privately managed showering and toileting, with and without their equipment. Data from the Maaori participants did not reveal any specific Maaori interpretation regarding their experience of receiving and using short-term loan equipment.

The pseudonyms of the occupational therapists and their ethnicity are listed in Table 2. All therapists were female, reflecting the preponderance of women in the profession of occupational therapy, with four of them having six or seven years' experience since graduation.

Table 2: Characteristics of the occupational therapist participants

Pseudonym	Ethnicity	Gender
Carol	NZ European	Female
Jenny	NZ European	Female
Kay	NZ European	Female
Lucy	Migrant to New Zealand	Female

Nina	Migrant to New Zealand	Female
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Were there enough participants?

I enjoyed interviewing the participants and listening to their narratives. At the same time, I was mindful of the quality and large amount of data I was collecting from participants, and needed to be able to give each story its due respect and time. In research of this nature, the focus of data collection is on the richness of the narrative rather than the number of participants (Prion & Adamson, 2014). Following discussion with my supervisors after interviewing participant number 13, the decision was made that I had sufficient data on the phenomenon in question. Data collection stopped at that point.

Collecting the data

I planned to collect data through semi-structured, in-depth interviews. I developed two interview guides, one for patients (see Appendix 7) and one for therapists (Appendix 8), based on my pre-understandings of the interview question, and on recommendations from the literature (Minichiello, Aroni, Timewell, & Alexander, 1999; van Manen, 2014). The guides contained broad, open-ended questions as a prompt for me prior to each interview. I reviewed the relevant guide just before meeting each participant, then put it aside and engaged in conversation with the participants; sometimes following their lead, and at other times bringing their dialogue back to their experiences around short-term loan equipment.

I met all patient participants in their own home, at their request. The patient participants (two of whom were joined by their spouses) were interviewed about their experiences of receiving and using short-term loan equipment. Their experiences covered their time in hospital; their interactions with an occupational therapist; going home on discharge and resuming their domestic activities with a temporary disability; perhaps using the

equipment, perhaps not, and their reasons for doing so; and what it was like for them to return the equipment.

For occupational therapy participants, I was interested in their experience of providing the equipment in the same organisation as I worked in. In order to facilitate their participation, I gave them the option of time and venue for the interview, away from their usual work place. Three of them opted to be interviewed in an office in the hospital at the end of their working day. One therapist chose to meet in a mutually convenient café, and another asked to meet in her home. The occupational therapy participants were asked what it was like for them to be an occupational therapist in an acute hospital; what was it like to talk to patients about showering and toileting; who decides what equipment the patient will be given; what they take account of when deciding that a patient needs equipment; what they do if a patient declines equipment; and how they know that the equipment worked for the patient.

Each interview was audio recorded with the participants' prior consent. Interviews were 45 to 90 minutes each, and were conducted at approximately one month intervals. Each was transcribed, read and re-read over for meaning, before doing the next interview. I kept a written journal of my pre-suppositions, reflections, insights, ideas throughout the research journey. The journal became part of my own horizon which I used as the starting point for interpreting the research question from my own perspective and that of the participants.

The experience of receiving and using the short-term loan equipment is not confined to an individual, but is a shared experience (albeit experienced differently) for all those people living in the same household, or helping the person use the equipment (Dahler et al., 2016; Pettersson et al., 2005). For this reason, when Cathy and the spouses of two patient participants joined the interviews, with the full agreement of the participant, I listened to what they said too. Cathy's story was slightly different to the two spouses, in that she was also talking on her (now deceased) mother's behalf. Cathy's story was also important because it illustrated lack of joined up care, forcing her to rely on her own resources to get what her mother needed.

The recordings and the transcripts were stored securely in my home during data collection and analysis, and thereafter at AUT. Only the transcriber and I heard the recordings in their raw state. Consent forms were stored separately in another location from the data.

Working with the data

Hermeneutic phenomenology is a methodological approach that is not bound by specific rules on how to handle the data (Crowther, Ironside, Spence, & Smythe, 2017). Like other beginning researchers, I found the actual doing of the research and writing it up posed a number of challenges. Initially I was somewhat overawed and puzzled by the lack of step-by-step method. First, I looked at every sentence or cluster of sentences looking for something that revealed something about the experience being described. This produced a lot of data that became distracting and overwhelming. I moved on to a selective reading approach (van Manen, 2014) where I read and re-read the text trying to be open to statements and phrases that seemed particularly revealing about the experience. I kept asking myself “What *results* am I looking for?” Gradually, I realised that this question created a block or barrier to being open to what the data had to say. My supervisors’ words “let the text do the talking” needed to be repeated often, as I grappled with the unfamiliar nature of this research methodology. Eventually, I came to understand that the nature of this kind of research was personal in that I was part of this study. I wrote about my pre-understandings of short-term loan equipment to make them explicit, and used them as part of the narrative and interpretation in an attempt to make sense of what the participants told me.

My role as the researcher was to accept the participants’ stories as their construction of their reality, and describe and interpret how the texts came alive for me (Regan, 2012). My understanding of each text developed as I moved between recognising consistency between my pre-understandings and new perspectives from the participants. I read through each interview transcript several times, trying to ‘see’ or ‘hear’ the usually glossed over narratives of the participants. As van Manen (1990) said, the problem was not that I knew too little about the subject, but that I knew so much. This potentially

predisposed me to interpret the phenomenon before I had truly understood the participants' narratives.

My deliberations lead to me in a spiral of learning through repeated readings of transcripts, trying to understand participants' specific words and paragraphs; the participants' work and life contexts; the purpose of the study; and the literature. Gadamer (2004) called this way of working the *hermeneutic circle*. I spent much time dwelling on the data, reflecting on how it fitted, or fused, with what I already knew (Gadamer, 2004), and what others have said in personal communications and the literature (Koch, 1996). All of this new information led me to expanding my understandings (Regan, 2012). To me the hermeneutic circle was more like a spiral, because with each reading and deliberation, my understanding of the phenomenon became broader and deeper.

There were times when I became so buried in the data and writing that I did not know where my interpretation was heading – there seemed to be so much information and so many possibilities. The key to acceptance of the participants' perspectives was to slow down – allow time to think beyond the obvious, being attentive to the uniqueness of each participant's experience, exploring tensions as I saw them. A big challenge for me was to write about the participants' experiences paying attention to, and accepting the tension between the known and unknown aspects of their experiences (Caelli, 2001).

I kept returning to the purpose of the study, asking myself: Did the question have enough depth? What was I seeing in the data? What was I not seeing in the data? What was the 'void'? (Heidegger, 1971/1975). Just when I thought I had made a breakthrough with interpretation, it was common for things to become confused and unclear again. I kept a learning journal where I wrote about my experiences doing the research, and of my emerging understandings, insights, thoughts and questions. Each time I met with my supervisors we would discuss these, and so my understanding of the phenomenon has also been influenced through these discussions.

Through crafting stories from the transcripts (Caelli, 2001; Crowther et al., 2017; van Manen, 1990), I started to make sense of the mass of information that each participant shared. I was able to draw out narratives from transcripts, using the participants' own words (Crowther et al., 2017). In crafting the stories, I removed duplications, amended grammar, and brought together their stories into readable narratives so that the stories could stand on their own. In Appendix 9, I give an example of how I took an excerpt from Helen's transcript, crafted it into a story and made my first tentative interpretation.

When interpreting the stories, I looked for the way in which each person told their story, seeking and exploring insights, as opposed to looking for the most commonly told stories of experiences (de Witt & Ploeg, 2006). Sometimes important words leapt up from the page; at other times I sat and dwelt with the text and waited to 'hear' what the *fundamental nature* of this experience was (van Manen, 1990). Sometimes the analysis and interpretation came easily; at other times it seemed excruciatingly slow and forced. With the help of my supervisors, I gradually learnt to trust the understandings that 'came' (Smythe, MacCulloch, & Charmley, 2009), and little by little the significant themes (van Manen, 1990) became apparent. The themes were not those which were said repeatedly, but were features of experience that I thought were significant and evoked further thinking (Smythe, Ironside, Sims, Swenson, & Spence, 2007). As the features that described an aspect of the lived experience emerged, I gave them titles. Where the experiences were common I grouped them together into themes that I thought were related to the essential experience of providing, receiving or using short-term loan equipment (van Manen, 1990). To test the themes, I discussed them with colleagues, my supervisors, and other people who live with disabilities.

I used mind maps to identify what seemed to matter to the participants, then to see which themes clustered together and how they inter-related with each other. I have provided an example of a mind map in Appendix 10. In this way, the study's findings were grouped into three findings chapters: the experience of working in a complex practice context; the experience of receiving and using short-term loan equipment; and getting 'it' right.

Hermeneutic interpretation is always incomplete, unfinished (Geanellos, 1998; Malpas, 2014) because of the nature of the people involved and their different traditions and history, their present culture and society, and their expectations of the future (Barthold, 2012). In hermeneutic phenomenology, there is no single “truth”, but “multiple, constructed realities ungoverned by any natural laws” (Koch, 1999, p. 25). The analysis and interpretation that I offer is done in the full knowledge that I am seeing the world of short-term loan equipment from my historically affected consciousness (Gadamer, 2004) which is fused with what I have learnt from my participants and the literature.

Trustworthiness

Trustworthiness of results in hermeneutic phenomenological research, as in all research, is important. Much has been written over the last 25 years regarding how trustworthiness is measured in qualitative research (Anderson, 2017; Annells, 1999; de Witt & Ploeg, 2006; Fossey, Harvey, McDermott, & Davidson, 2002; Koch, 1996; Pereira, 2012; Rocco, 2010; Rolfe, 2006; Sandelowski, 1993). The “fluid set of guiding principles of hermeneutics” (Regan, 2012, p. 291) seemed so subjective that I wondered how they could be rigorous, and therefore trustworthy. In searching for a framework with which to demonstrate the trustworthiness of this study, I returned to the literature for guidance. Several frameworks were considered (Annells, 1999; de Witt & Ploeg, 2006; Fossey et al., 2002; Rocco, 2010). Annells’ (1999) criteria of an understandable and appreciative product, an understandable process of inquiry, a useful product, and an appropriate inquiry approach has been popular in nursing qualitative research. These criteria are general in that they can be applied to qualitative and quantitative inquiry. A much more specific framework of trustworthiness was proposed by Fossey et al (2002). Their criteria were divided into methodological rigour (congruence, responsiveness to social contact, appropriateness, adequacy, transparency) and interpretive rigour (authenticity, coherence, reciprocity, typicality, permeability). While comprehensive, there is a danger of a researcher paying so much attention to ensuring rigour under these criteria, that she loses sight of the art of the interpretation (de Witt & Ploeg, 2006).

The same criticism can be levelled at Rocco's (2010) eight criteria for qualitative studies which include: 1) a well-articulated problem; 2) in the relevant literature; 3) method, data collection tools, and steps to ensure rigour are adequately described and grounded in relevant literature; 4) adequate explanation of sampling strategies and sample description; 5) data analysis process described in detail and limitations reported; 6) findings include categories with definitions, sufficient data from sufficient participants to support the category; 7) meaningful discussion of the significance and implications of the study; and 8) attention to organisation, use of headings, succinctness, editing and formatting.

Like Fossey (2002), de Witt and Ploeg's (2006) framework also splits up research process rigour and study findings rigour. They use the term 'expressions' of rigour, rather than 'criteria', arguing that the research report 'expresses' its trustworthiness insofar as it is rigorous and systematic, and uses reason to persuade the reader in a practical sense, as opposed to demonstrating process and outcomes (p. 223). I chose this framework to evaluate my study against because De Witt and Ploeg (2006) align their framework with the work of van Manen (1997) and argue that it is specific to phenomenological inquiry. Their expressions of rigour include balanced integration, openness, concreteness, resonance, and actualisation. I will now go on to explain how each of these are expressed in my research.

Balanced integration

Balanced integration occurs when three characteristics are present: 1) clearly articulated philosophical theme and how it fits with the research topic and researcher; 2) in-depth interweaving of philosophical notions within the study methods and findings; 3) a balance between the study participants' voices and the philosophical interpretation. In this study, balanced integration is evident in the way that I have explained how the hermeneutic phenomenology is appropriate for my study question. I then make my pre-understandings of the topic explicit so that the reader can see my biases and fore-knowledge, and make their own judgement on my findings and the extent to which the findings are an outcome of interweaving the participants' voices

with the philosophical concepts of Heidegger (1927/1962, 1971/1975, 1977), Gadamer (Gadamer, 2004; Malpas, 2014; Regan, 2012) and van Manen (1990, 2014) in particular.

Openness

Openness refers to the extent that the process of the study and the decisions made throughout are open to scrutiny. From the outset, I have been open to my pre-understandings of short-term loan equipment, and the experiences of close relatives with disabilities who use equipment. I have shown how I am embedded within the study, and how my understandings evolved through being influenced by the participants. In each chapter, I have shown how I have made decisions, how my understanding of the phenomenon widened and deepened as I worked with the data, and how I came to my conclusions.

Balanced integration and openness relate to the rigour of the process of this study. I will now move on to the concreteness and resonance expressions of trustworthiness, which de Witt and Ploeg (2006) refer to as rigour of research outcomes.

Concreteness

Concreteness in a study is evident when it is written in such a way that a reader can put herself or himself in the context being described, and link what is being read with her or his own experience. Other authors have referred to 'contextuality' (Madison, 1988, cited in de Witt & Ploeg, 2006) or 'lived throughness' (van Manen, 1997) to describe this aspect of trustworthiness. The study elicited examples of participants' and my own experiences of short term loan equipment within a complex practice environment. The stories that have been told show how the complex practice environment has been enabling and constraining for occupational therapists and patients. In telling these stories, I have tried to assist the reader to understand the 'lived experience' (van Manen, 1990) of providing, receiving and using short-term loan equipment.

Resonance

Resonance refers to the 'felt sense' (Gendlin, 1962) or 'epiphany' (van Manen, 1997) that the reader experiences upon reading the study findings (de Witt & Ploeg, 2006). It occurs when the reader feels their understanding as something quite moving, and maybe accompanied by self-understanding. When I have talked to individuals with disabilities and with occupational therapists about my study, their animated responses to my learnings about their experiences gave me confidence that I was sharing something that resonated with them. In some cases, the resonance was with their own experiences. On other occasions, the information I shared seemed to be a revelation to them that they immediately understood and could see possibilities for. I found this heartening.

Actualisation

Actualisation relates to the future application of the findings (de Witt & Ploeg, 2006). Phenomenological interpretation does not end with a study – interpreters of studies bring their own context and pre-understandings to the text and will come to their own conclusions (Geanellos, 1998; Koch, 1996, 1999). In the discussion chapter, I make some recommendations that I believe will apply some of these findings in practical ways within my DHB. While my findings are relevant to my DHB in New Zealand, these findings might be a catalyst for further study by therapists elsewhere who want to look at their own system of providing equipment and the experiences of the people involved.

Summary

In this chapter I have given an account of my journey through researching the experience of providing, receiving and using short-term loan equipment. I have described how the question came to be, the recruitment of the participants, how their stories were crafted into meaningful accounts of their experiences, and how I worked with the data to make sense of their experiences. Participants' anonymity, dignity and autonomy were protected through applying the notions of participation, partnership and protection. To demonstrate the trustworthiness of this study, I have used de Witt and Ploeg's (2006) framework, which is situated in the interpretive paradigm of phenomenology.

The participants' experiences in this study gave rich information for this study. The journey through this research was one of going back and forth between the data, literature, personal communications and my own pre-understandings. Often I strayed from the research question, and was brought back it with the help of my supervisors, personal reflection and testing of ideas. This chapter lays the foundation for the rest of the thesis, in that the reader will know how and why the research was conducted as it was. I hope it heightens the reader's anticipation of the three findings chapters.

Chapter six: The experience of working in a complex practice context

Introduction

In chapter two, I described the complex practice context for occupational therapists who provide short-term loan equipment to patients being discharged from hospital. In this findings chapter I explore the experience of occupational therapists working in a complex practice context, namely, the acute wards of a major metropolitan hospital and a hospice, that “[en]frame” (Heidegger, 1977, p. 307) their practice. Some insight into to experience of working in such a complex context can be gained from claims that occupational therapists have to balance the assistance they can provide with the constraints on their practice, to achieve best practice and the desired outcomes (Townsend & Polatajko, 2007). Cribb and Gewirtz (2015) were more explicit in summarising the dilemmas of people working in health and social care as a balancing act involving competing standpoints and opinions i.e. not only being a traditional ‘autonomous expert’, being responsive to service users and accountable to managers and professional bodies, but also being expected to manage ever-increasing workloads. Somehow, the occupational therapists in the present study managed to find their way through the competing demands of the government’s strategic intent, their employer’s goals, their profession’s expectations, and the patients’ disability wants, needs and expectations. One aim of this study was to understand how the occupational therapist participants experienced finding their way through those demands, expectations, enablers and constraints, to provide short-term loan equipment.

This chapter begins with an exploration of the concept of practice and how it is enframed, as it relates to the occupational therapists in my study. Second, I will use Heidegger’s notion of the ‘they’ to explore the therapists’ account of how the power and authority that others wield, influence their day-to-day practice. Third, I will propose what I think are the key elements of the occupational therapist participants’ experiences of providing short-term loan equipment.

What is practice?

The word *practice* comes from Medieval Latin *practicāre* to practise, from Greek *praktikē* for practical science, practical work, and from *prattein* to do, act (Collins, 2016). However, a dictionary definition of practice is inadequate to describe the enactment of occupational therapy practice. Higgs (2012) tried to capture the complexity of professional practice when she described it so:

Practice (particularly professional practice) is based on specific intentions and values, is often grounded in assumptions rather than conscious decisions, is constructed by individuals and groups, is situated and situational, and is constantly evolving. Characterised by complexity, uncertainty, and diversity, practice includes technical, practical, relational, and communicative aspects. It is essentially 'fuzzy,' dynamic, and indeterminate, and achieves excellence through improvisation and invention. Practice occurs within social contexts, is framed by each professional's experience and theoretical framework and is negotiated between people; practice is realised and created by seeking to both make sense of and influence a particular context. (p. 76)

In her definition, Higgs (2012) notes that practice is characterised by making decisions in ambiguous, complicated and social situations. Moreover, it is more than technical and practical skills; it involves communication and relationships, in order to make sense of a situation and effect a positive outcome. I suggest that for occupational therapists, the practice of providing short-term loan equipment also involves making assumptions about a patient's future state, in an unseen environment, with incomplete information available.

Practice enframed

Higgs' (2012) description of professional practice above is silent on the effect of the workplace structures that in this study, impact on occupational therapists who work within interconnecting systems. In the case of short-term loan equipment, the interconnecting systems are set up specifically to make equipment provision possible, at no cost to the patient. Heidegger (1977) refers to systems as enframing. According to Harman (2010), "the enframing arranges. It pulls everything together into orderability. It heaps up everything that is present into orderability and is thereby the assembly of this heaping up" (p. 22). I think of the system that permits occupational

therapists to provide public health system-funded short-term loan equipment, and directs their actions towards this end, as enframing. There is a non-visible, orderly, interconnected and monitored grid-work of arrangements that facilitate, and simultaneously constrain, what equipment occupational therapists can provide through public health funding. The enframing creates boundaries and expectations for occupational therapists working in the region of short-term loan equipment. 'Region' is a notion that Heidegger (1927/1962) described as the place where the context of things, which have form and direction, can be encountered spatially. Heidegger specifically referred to the use of equipment in regions where the equipment is situated where it will be used. Arisaka (1996) took the notion of regions further when she said "the places we live and work...all have different regions which organise our activities and contextualise 'equipment'...Regions determine where things belong...Our activities, in turn, are defined by regions" (pp. 37-38).

The regions in this study are the hospital and hospice, and their purpose of treating people for health conditions that cannot be adequately treated at home. The hospice service has a philosophy of dying well (Totara Hospice, 2014), and the occupational therapist helps the hospice to achieve this aim, by providing equipment to enable the person to stay at home for as long as possible. With this arrangement, the Hospice is part of the enframed, interconnected system. In the region of a hospital, making space for new patients waiting to be admitted to a ward is a very high priority, and therapists direct their actions towards facilitating discharges. Now I shall look more closely at the factors that enframe and influence occupational therapy practice.

Language

Gadamer (2004) asserts that "language is the medium in which substantive understanding and agreement take place between two people" (p. 402). It is through language that we communicate occupational therapy. However, the language has not always been consistent or clear. To remedy this, during the late 1970s and throughout the 1980s, the American Association of Occupational Therapists (1979, 1989) advocated for the development and use of uniform terminology for occupational therapy. In

Canada, it was recognised that language can be used to organise power, and “...define the boundaries of power by articulating a domain of concern and scope of practice....The spoken and written text expresses both the perspective and authority of a profession” (Townsend, 1998, p. 46). The scope and authority of the profession in New Zealand is defined by The Occupational Therapy Board of New Zealand (OTBNZ) as:

*Occupational therapists are registered health professionals, who use processes of **enabling occupation** to optimise human activity and participation in all **life domains** across the lifespan, and thus promote the health and well-being of individuals, groups, and communities. These **life domains** include: learning and applying knowledge; general tasks and demands; communication; mobility; self-care; domestic life; interpersonal interaction and relationships; major life areas; and community, social and civic life. **Enabling occupation** incorporates the application of knowledge, principles, methods and procedures related to understanding, predicting, ameliorating or influencing peoples' participation in occupations within these life domains. Such practice is evidence-based, undertaken in accordance with the Occupational Therapy Board's prescribed Competencies and Code of Ethics, and within the individual therapist's area and level of expertise. (Occupational Therapy Board of New Zealand, 2004)*

Notably, the bold type is in the original document. Specific terms such as ‘enabling occupations’ have replaced terminology such as ‘facilitating function’ or ‘remedial’ of my training days. There has been a shift from doing to and for the patient, to identifying opportunities that enhance the client’s chance of success. The use of the word client is consistent with the business approach of managerialism in healthcare. The OTBNZ definition of the occupational therapy scope of practice above describes the legitimate domain of concern for occupational therapists, but not how they should go about doing their work. While the scope is aspirational, it is blind to the systems of government funding and DHB and supplier systems that enframe, direct and reduce the scope and manner of occupational therapists’ practice.

The *Occupational Therapy Code of Ethics (2015a)* and the *Competencies for Practice as an Occupational Therapist (2015b)* outline the specific actions and capabilities that occupational therapists must demonstrate. For example, competency 1.11 states:

You choose and use a range of strategies, including: helping clients to adapt, modifying their environments, developing their skills, and teaching them

processes for learning. You consult, advocate, and coach. (Occupational Therapy Board of New Zealand, 2015b)

An occupational therapist then, is the person who exercises the knowledge, skills and judgements required to practice the art, profession and occupation of occupational therapy. There is nothing in the scope of practice or the competency document that addresses the experience of working within the scope or demonstrating competence. Also, there is no acknowledgment that choices are enframed within a system, and the help that can be provided is directed down specific channels. Even so, each therapist I interviewed was proud to be an occupational therapist. I think that the way the occupational therapists interpreted occupational therapy as defined by authoritative voices (Occupational Therapy Board of New Zealand, 2004, 2015b; Townsend & Polatajko, 2007), gave the therapists their place to stand, a sense of how to comport themselves in their work environment. Also, I think it would be a mistake to consider that language used in practice is limited to verbal language. I suggest that symbols are part of the language too, especially the symbolism associated with equipment. Carol gave an example of how she understood what equipment symbolised for a patient, and changed her language accordingly.

Because in some regards, people see equipment as a sign that they're unwell and they're sick and they just don't want to see it, they don't want it in their home, and so then it's a whole different conversation you have with the person about, "It's not about disabling you. It's actually about enabling you, and this is why I'm giving you this equipment." (Carol)

In this example, Carol recognised that her patient ascribed a negative meaning to the equipment, seeing it as a potent reminder of being ill and being *disabled*. Through re-wording her saying to “It’s actually about enabling you”, Carol has tried to turn a negative perception into a positive one.

The language of occupational therapy practice both constrains practice to the stated scope of practice, and enables practice by giving occupational therapists the authority and legitimacy to practice within this unique scope. In other words, only a registered occupational therapist is given authority and professional legitimacy to do the work of occupational therapy in New Zealand.

Material and economic arrangements

The material and economic arrangements for occupational therapists providing short-term loan equipment are about the doing of practice, the technology, and the economic realities of practice. In the doing of practice, equipment is the physical technology of occupational therapy. It is the most concrete, observable aspect of occupational therapy practice in an acute hospital. Equipment in this study includes mechanical tools or gadgets especially designed to help people with disabilities to do what they need and want to do. The specific purpose of the equipment is to make a task easy and safe to perform; minimise pain and conserve energy while doing the task; and prevent deterioration in the person's condition, or their performance of the task (J. McNaught & Paul, 2015; Sainty et al., 2009).

Technology is not only a means to an end, but also human activity (Heidegger, 1977).

The two definitions of technology belong together. For to posit ends and procure and utilise the means to them is a human activity. The manufacture and utilisation of equipment, tools, and machines, the manufactured and used things themselves, and the needs and ends they serve, all belong to what technology is. The whole complex of these contrivances is technology.
(p. 288)

Here, I interpret Heidegger's definition of technology to encompass the physical items of equipment (including how they came to be ready and waiting for use) and the process that occupational therapists go through to assess a patient's disability need, talk with the patient about equipment, select the appropriate item/s, arrange for them to be delivered to the patient's home, the documentation that records the transactions, and the system of retrieving the equipment when it is no longer needed. The material and economic enframing begin at the national level with the Accident Compensation Act ("Accident Compensation Act," 1972) (and subsequent amendments), and the New Zealand Public Health and Disability Act ("New Zealand Public Health and Disability Act," 2000) (NZPH&D Act). These Acts recognise that people with disabilities may need material assistance in the form of equipment to assist with daily living (among other things), and economic assistance to pay for equipment. I consider these Acts to be enablers. Their intent was for social good (Barnes & Harris, 2011; Ministry of Health,

2014; St John, 1999). The ACC Act (and amendments) gave occupational therapists access to funding for equipment for people disabled, either temporarily or permanently, as a result of an accident. In contrast, the NZPH&D Act established the Disability Support Services within the Ministry of Health, for people with disabilities as a result of a medical condition. The NZPH&D Act gave occupational therapists access to a funding stream through the Ministry of Health for permanent loan equipment and housing modifications. However, the Act specifically excludes short-term loan equipment, delegating responsibility for funding all short-term loan equipment to the DHBs.

These Acts are then put into practice within the region of the DHB. As previously described, within my DHB, short-term loan equipment is hired from a company which has a contract with the DHB to make available the equipment as requested by an occupational therapist, deliver it to the patient's home, and retrieve it when it is no longer needed. This arrangement enables patients to return home while they live with a temporary disability. At this level, the material and economic arrangements show themselves as dual funding streams (ACC and Ministry of Health) with their own processes and levels of entitlement, which occupational therapists are required to follow when providing equipment. Carol described her experience of this dual funding, plus a third funding stream associated with a private hospital.

I can tell you about the spinal man that I've just had who needed private hospital care and a wheelchair. I checked with the private hospital what they needed to provide under their contracts, then what we could provide. Then I went through the wheelchair criteria, arranged a power wheelchair for trial, which was unsuitable, contacted the rental company to arrange a replacement. Then I needed to talk with the Equipment Clinician, and then finding after I had done all this and I felt like I'd met the wheelchair criteria that actually I couldn't provide the equipment anymore because of cost to the patient. And then having to go back and say to the patient, "I'm really sorry, we can't actually give you this equipment." And then it's just that frustration with knowing that this is a spinal patient, who's a spinal patient due to progression of his cancer. Yet if he had been in a car accident, because he'd got behind the wheel after consuming 12 beers, he'd be under ACC and would have everything. And that's really difficult, and it's actually really difficult to then explain to the family, because you don't really-- I mean the answer is financial and how do you then have that conversation with the family who, for them, this is so important, so integral. (Carol)

ACC bulk-funds DHBs for treatment and rehabilitation for people with injuries as a result of accident for up to six weeks following the acute presentation of the injury. Therefore, the DHB pays for ACC patients' equipment for up to six weeks, and then the occupational therapists must apply to ACC to transfer any ongoing costs of equipment rental after the expiry of six weeks. According to the NZPH&D Act, short-term loan equipment, that is, equipment required for less than six months, is funded by each DHB. In Carol's example, the patient came under the MOH, and the DHB's wheelchair criteria excluded renting power chairs. The time taken by Carol to go through this procedure would have been several hours over the course of a couple of days. No wonder she was frustrated. She was frustrated with the time taken to arrange a suitable power chair and convince the DHB to pay the rental, and with the more restricted funding available to him than if his disability was covered by ACC.

Arrangements for funding short-term equipment for palliative patients is also a challenge for Kay whose patients have severe activity limitations and not long to live.

One of the difficult conversations I often have with people is around rails and housing modifications, which of course aren't provided on short term. I find myself getting quite smart about offering equipment alternatives, and explaining the difference between long term funding for disability related modifications, and short term funding for a palliative care service. I think that in a way, it's quite easy to fall back on that I work for hospice, because people know that they're under a palliative care service, so I can say, unfortunately I can't-- it's not because of you and your diagnosis that I can't get you Ministry of Health funding. It's actually because I work for a palliative care service, and therefore I'm not able to apply for long term funding because of the service. I'm not just saying no, I'm saying, "This is a builder that I can recommend who does a lot of disability modification work, who's very responsive, and will work with you, if you're willing to fund. He understands concepts of design, and space, and dimensions, and equipment and stuff like that, and can help you if you want to modify your bathroom, for example, or understands about rails and can do that." Or I can say, "This is a private rental that you could access in the community. (Kay)

In this instance, there is a tacit understanding that the patient will not live long enough to qualify for MoH funds to pay for items of a permanent nature. To avoid saying 'No, because you will likely die before you are eligible for MoH funding' Kay tactfully steers the explanation towards her being a Hospice employee, and as such she is unable to apply for MoH funding. Did Kay find it too hard to be honest to her patients about their

prognosis as the reason why they would not be eligible for MoH funding of rails and housing modifications? Even if Kay worked for the DHB and not the hospice, the patient's prognosis would still have to be taken into account when establishing eligibility for MoH funding. In other words, will the patient live longer than six months after the application is made to the MoH? To offset any disappointment as a result of not getting what they want, Kay suggests that the patient and family can pay privately. It is unknown how many hospice patients take up the latter option.

Included in the material and economic arrangements are the equipment manufacturers, importers, and the equipment rental company that is contracted by the DHB. The manufacturers and rental company are positioned in what Heidegger (1977) calls 'standing reserve' (p. 298). He describes standing reserve as "Everywhere everything is ordered to stand by, to be immediately on hand, indeed, and to stand there just so that it may be on call for a further ordering" (p. 298). This is exactly how the equipment manufacturers and rental company show themselves; the manufacturers create equipment to be available for purchase, and the rental company waits until a therapist sends an electronic equipment request, then it performs what it is contracted to do.

In Kay's case, as an occupational therapist with the hospice and not a DHB employee, she did not automatically have the same access to short-term loan equipment as her DHB colleagues. However, she was in a unique position where all her patients were also under the care of DHB Specialists. She had to make a case to the DHB's equipment team for approval to be included in the DHB arrangements for short-term loan equipment.

I had to put forward a case that I would be responsible and accountable if they were to open the doors so that hospice could have access to the current existing rental equipment. That involved a few meetings - meetings with me and meetings without me - and fortunately, at the end of the day I was given the green light that I could have the same kind of rights as the DHB occupational therapists, and the same access to the rental equipment as them, on the basis that it was for the patients, not for the service, and that as long as the patients were within the DHB catchment area and eligible for DHB services then there was no reason why they couldn't be eligible for equipment. So that was a huge coup. (Kay)

For Kay, working in a complex practice environment meant that sometimes she had to challenge the way things were arranged, so that she could provide an equitable service

for her patients. In this case, the arrangements were extended to include an organisation that had traditionally been left out, because there had been no occupational therapist available to advocate on their behalf.

In my role as Professional Leader, I was part of the enframing when I reminded the therapists that clinical decisions are resource decisions, and reminded managers that resource decisions are also clinical decisions. In other words, the amount of rental equipment provided had a material cost to the DHB, and that a restricted budget for equipment meant that therapists had to curtail what they could provide. Being curtailed is thus an inescapable aspect of occupational therapists' experience of equipment provision in the current context. Jenny is a therapist who recognised the clinical versus resource dilemma and discussed the implications with her manager.

I'm actually very directive with these people, partly because I found that if they say, "Oh no, no, no I won't need this. I'll be okay," then a couple of weeks later, they're coming back saying, "Oh, I can't manage. I can't cope." So, [my manager] and I have talked about it in terms of therapist time and cost. It's actually cheaper for us to put in equipment at the beginning and say, "This is what you're likely to need; if you don't need it, send it back," than it is to later go and visit them, and reassess them, and put in the equipment. (Jenny)

Jenny's experience told her that the clinical need was still present even if the patient did not recognise it at the time, and waiting for the patient to experience the need for equipment was a costlier option in terms of therapist's time. So Jenny changed her practice to providing equipment anyway, and encouraging the patient to return it when it was no longer needed. The orderability of the material and economic enframing of short-term loan equipment set up the context for Jenny's discussion with her manager. As a consequence, Jenny demonstrated what Heidegger (1927/1962) calls 'leaping in' (p. 158). 'Leaping in' is demonstrated when Jenny becomes directive with patients, and makes the decision to provide equipment that she thinks will help the patient. The patient is expected to step aside from the decision-making about *what* equipment they will receive. When the equipment is delivered to his/her home, the patient can then decide to use the equipment at his/her disposal or not. The danger of 'leaping in' is that the patient can be dominated, even tacitly, by the therapist, whose main concern is to make the equipment 'present-at-hand' for the patient at the lowest cost to the DHB.

'Present-at-hand' is a term used by Heidegger (1927/1962) to explain the conscious awareness or existence of an entity. The entity in this example is short-term loan equipment. Being present-at-hand means that the equipment is 'encounterable' (p. 81) by the patient, who can then decide whether to use it or not.

Social-political arrangements

In this study, the occupational therapist participants talked of how the organisational rules impacted on their practice. Carol is a therapist who feels the pressure to conform to the expectations of her manager:

Essentially it comes down to resources: we as therapists; the number of therapists we have; the demand we have on our service; the demand we have on beds; and getting people out of the hospital. Therefore, if we've only got six therapists with 60 people to see, who need shower stools and toilets seats and this kind of stuff, it's about moving them on. That's just the message we get: this is how you prioritise the P1s who are discharging today, who have this identified functional need and physical capacity. (Carol)

Carol knows what is expected of her by her manager, the ward staff and her employer: to facilitate discharges from hospital, by providing short-term loan equipment (e.g. shower stools and toilet seats) for people who need them and who have been prioritised as P1 (being the top priority) for discharge. She has accepted that facilitating fast discharges is part of her responsibility, and part of what she is paid to do.

The rules of the organisation, for the purpose of this thesis, include my previous work on the equipment prescription criteria. The equipment prescription criteria define what equipment can be provided free of charge to the patient, and under what circumstances. They are the rules that therapists are expected to follow when considering equipment. When I started in the position of Professional Leader of Occupational Therapy in 1998, the cost of hiring equipment was \$45,000 per month. The cost steadily increased over the years to over \$100,000.00 per month in the mid-2000s. The budget-holding manager was not happy. So it became my duty to set limits on equipment options, and ensure that occupational therapists were clear about their options and responsibilities in relation to short-term loan equipment. I saw my duties around short-term loan equipment as making it clear to therapists, and the DHB as funders, what equipment

could be provided by therapists under what conditions. My role required me to write prescription criteria for equipment that could be regularly provided, and for equipment that was occasionally requested, but was expensive to hire. Certain equipment was allowed to be hired by therapists without question. Some equipment could be hired if approval was given by me or a delegated senior therapist. Others were not to be hired at all.

The purpose of the criteria was to help control spending on equipment that was increasing year on year. In other words, I was actively setting up a system designed to ration resources; I was an active participant in enframing practice. My concern was directed towards making the low cost/low risk equipment available to as many people as possible, and I hoped to do this by excluding what I considered non-essential items, and restricting access to expensive equipment such as power chairs, temporary ramps, and ceiling hoists. Before therapists could provide these items, they had to request approval to hire by completing a form, giving their reasons why this 'non-catalogue' equipment was essential for a patient to return home. Each month, the rental company provided the DHB with a spreadsheet of equipment transactions. The spreadsheets were monitored for the types of equipment provided, costs and timeliness of retrieval.

The social-political arrangements are also where the "web of human relationships" (Arendt, cited in Metroshilova, 2015, p. 37) plays a part in practice. In the web of human relationships, individuals are who they are in themselves, as well as part of a social group. What is more, the relationship does not just exist in the present, but the present is influenced by what has gone before – relationships formed, decisions made, actions taken (Motroshilova, 2015). An example of a web of human relationships is provided by Kay:

"A" connected me with "B", and "B" and I had conversations before we actually met. "B" invited me to meet her admin team, and then I did the training. I've maintained that good relationship, and I continue to work at it. Every day back and forth, I'm having emails with the admin staff at the equipment team. If I've got a question or I'm not sure, I'll email them. They might email "B", and she might get back to me. It's great, and we're working cooperatively very strongly. "B" encouraged me to visit [the equipment supplier], and I visited there, so I could actually clap eyes on the warehouse

and see how they operate, and get a sense of what happens at their end of the process. That was really, really helpful. (Kay)

Kay works as an occupational therapist in a hospice and, as part of establishing access to the DHB equipment processes, she needed to find out how the system worked, who the key people to know were, and what her responsibilities were. Understanding how the enframing of short-term loan equipment worked made Kay's subsequent experience of it positive. In other words, the social-political arrangements are based on Being-in-the-world-with-others (Heidegger, 1927/1962). Here is where the 'they' (Heidegger, 1927/1962) functions. I will explore the influence of the 'they' later in this chapter.

Kay provides another example of the web of human relationships when it is time for the equipment to be collected from the patient's home following the patient's death, an emotionally sensitive time.

When people pass away [there are] different scenarios about family and collection, some want it now, immediately. Others don't want any disruption while the funeral's going on, or the tangi or whatever. In some cases people go away, they might take the body to the [Pacific] Islands, or they might take it down country to the marae or whatever. So there's actually quite a lot of negotiating that goes on with collection. If I get a patient ringing me up and giving me an ear bashing because something hasn't been collected, I explain that they [the rental company] do their very best for delivery, and sometimes it's understandable if collection doesn't happen quite so quickly, because they're actually delivering not only to Counties Manukau but all over Auckland, all three DHBs, and I say, "They're a very huge operation and they're doing their best." Then I might assure them and say, "Please be assured you're not going to be charged for this or anything, nor is the DHB being charged for this. If you could bear with us," kind of thing. (Kay)

Collection of equipment is not straight forward, when families have different reactions and practices related to the dead person. I wonder if the families where the equipment was open to public view in the house are the ones who want the equipment collected immediately. It is understandable to me if the families who had to share the same space where equipment was used or stored wanted the equipment collected as soon as possible. What was displaced by the equipment being in situ? What sense of normality does the collection of the equipment facilitate? Here, Kay is trying to be sensitive, realistic and responsive to the family's needs. She has to navigate through a very sensitive situation, and keep everyone calm. Kay uses "us" to demonstrate that she is

part of the retrieval system, and at this moment, she associates herself with the equipment supplier and is part of the 'They'.

Another example of the social-political arrangements impacting on an occupational therapist's practice was provided by Jenny. She has learnt that not everything can be planned for.

I don't enjoy the pressures when things [surgery lists] change quickly. Yesterday was very frustrating because I took some time off work on Friday. I made sure when I left on Friday everything was done for Monday and some preparation for Tuesday, but Monday is also joint education day. So, I had to run up to the Joint Ed clinic and make sure that everything was organised for the people on Tuesday. And in the middle of all that, they kept changing the surgery lists. So then the person that you've got everything [i.e. equipment] organised for, is now on hold and there's somebody else in the picture.
(Jenny)

She enjoys the work when it goes according to plan, but when plans have to change at short notice she must adapt quickly. Surgery may be cancelled for a patient because of their unwellness at that time, and another person takes their place in the next day's or week's surgery list. Jenny has no control over the changes and experiences them as disruptive and unsatisfying. She is 'thrown' (Heidegger, 1927/1962) into disarray, and must rethink and reorganize herself so that the new patient is taken care of, and receives their short-term loan equipment in a timely manner.

I think of the short-term loan equipment system as being enframed because the government agencies (and by extension, the occupational therapist participants of this study, employed in a public hospital) are brought into order together, through legislation, government and DHB contracts, DHB equipment prescription criteria, and the occupational therapy profession's standards of practice. The enframing provides pre-existing structures or arrangements, by which occupational therapists can provide short-term loan equipment at no direct cost to the patient. I used my organisational authority to create a new, restricting process that further enframed occupational therapists' practice, and to monitor the provision of short-term loan equipment.

Now that I have looked at the arrangements that enframe the provision of short-term loan equipment, I want to move on to the advantages and disadvantages that accrue from such enframing, and the occupational therapists' experience of working in this system.

The disadvantages of enframing

Levelling down and averaging out of patient experience

Heidegger (1977) warns that enframing has the potential to be a danger where it can be responsible for "levelling down of all possibilities of Being" (p. 165). In order to meet their obligations to all people with disabilities across the region, I see that the enframed agencies have averaged or 'levelled down' the needs of the people. This levelling down of disability needs means that the system of providing short-term loan equipment is insensitive to individual differences in each patient's circumstances. The individual experience of disability "gets passed off as something familiar" (Heidegger, 1927/62, p. 165) and therefore not owned by individuals. The effect of the equipment prescription criteria was that I contributed to averaging out and levelling down disability experiences (Heidegger, 1927/1962, p. 165). Individual experiences of disability were not my primary concern when writing the criteria. While I developed the criteria in conjunction with frontline therapists, the use of the criteria was non-negotiable.

A good example of averaging out the needs of patients occurs in elective surgery, where the patients are usually well medically, cognitively alert, and recovery from surgery is relatively predictable.

I believe that in the first two weeks after they go home everybody needs virtually everything, but it's debatable if they need it for the whole six weeks.
(Jenny)

Here, Jenny has recognised the potential activity limitations for people following hip or knee surgery. The activity limitations are caused by pain and the need to protect the surgical incisions heal. So in Jenny's reasoning, everyone needs the equipment she has outlined, to a greater or lesser degree.

At times they'll ask me for rather odd things, and I remind them that this is the essential equipment. So, I expect them to sit in one chair not two, or I won't raise the sofa or another chair and give them a rehab chair as well.
(Jenny)

Jenny is mindful of the criteria for providing short-term loan equipment, by explaining that she can only provide equipment that (she decides) is essential in order for the patient to be discharged from hospital. She is direct about her expectations that the patient should use the one (raised, rehab) chair for the duration of the recovery. In this way, Jenny is acting as a 'gate-keeper' for the DHB, and minimizing non-essential equipment rental costs. Here, she has a dilemma: does she conform to the expectations of the DHB, or does she follow her professional (occupational therapy) beliefs of client-centredness and enablement? Either way, Jenny is expected to do the impossible and please both parties all the time. In this case, Jenny has chosen to please the DHB.

Not only are patients' experiences levelled out, but so are the therapists'. Carol is a therapist who experienced the equipment prescription criteria as annoying and time consuming, and not recognising her ability to reason clinically to a high level.

Sometimes processes are just incredibly frustrating and time consuming. It can be difficult when you need to still discuss with [the equipment clinician] for more complex things. It's one of those difficult things to understand why the processes need to be there, and they need to be there to aid your clinical reasoning; junior staff need the processes to be. (Carol)

Although Carol recognised the intent of the criteria (aiding clinical reasoning), for her the processes also represented frustration and a lot of time to go through the process. She is enframed in a process which takes no account of her expertise as an experienced occupational therapist. Carol's experience as a therapist takes her expertise beyond the basic level of clinical reasoning of the equipment prescription criteria, but she is brought back to the general rules that are in place for everyone to follow.

Practice dictated by employer's goals

A second danger is that the practice of occupational therapists can be dictated by the DHB's goal of reducing the average length of stay in hospital, or feeling restricted by the material and economic arrangements of the workplace. The feeling of "being hemmed

in” (King, 1964, p. 81) was experienced by Carol in a couple of ways. In the first instance, she recognised the limitations imposed, their rationale and effect:

I feel a lot of the time we're bound by policies and procedures and resources and funding and money, which kind of restricts us a little bit. I know that we have a limited pool, and I'm often very open with families as well, and open with staff members. I'd love them to sit down in their shower and have a stool, but I acknowledge that there is a very small money pool to serve a large population of people who will benefit from it, and therefore we need to look at where it's necessary. (Carol)

In this instance, Carol acknowledged an irresolvable fact of practice: that there is not enough money available to pay for all the equipment that could meet the disability needs of everyone she worked with, so some patients had to go without. Her words “kind of restricts us a little bit” is a type of understatement common in New Zealand vernacular, when the speaker really means the opposite. In reality, the policies and procedures around equipment provision are designed to restrict what therapists can offer patients, because of the cost of unfettered availability. For example, at one time therapists were able to provide temporary ramps to give wheelchair access into and out of a house. When I realised that the cost of temporary ramps in one month was \$45,000 and increasing month on month, I decided that the cost was unsustainable, so I restricted the availability of temporary ramps to a) adults who had a leg amputated due to poor circulation as a result of diabetes, because hopping on the remaining leg would compromise the health of that leg; and b) to children under 14 years using a wheelchair temporarily, because it is illegal to leave children under 14 alone at home without reasonable supervision, so any time a caregiver left home, he/she would have to take the child with them. Containing costs and meeting all patients’ disability needs is not possible and remains an unresolvable dilemma for therapists.

Another danger of practice being hemmed in by the employer’s goals is that other enabling interventions are not given time (in the acute wards in this study), and slip into disuse. Carol’s second experience of feeling hemmed in was when she noticed the shift to a narrowing of concern required when she began working in the acute physical wards.

I was thinking a lot about one of the things that I have struggled with working here, coming from a mental health background, is around when you identify concerns in our initial assessments, where you're around people's mood, motivation [including] mild anxiety issues, and how they're spending their time, their leisure All those patients would be prioritized as a P3 [priority 3 in an acute hospital]. Very rarely do we ever get to see P3s because we're constantly, I feel like, running a reactive service, as opposed to a proactive service. (Carol)

Carol's observation is consistent with what I've noticed in discussion with other therapists over time, and that is: the enframing of equipment provision is so strong that inpatient therapists are expected to provide equipment. In Heidegger's (1977) words, they are 'set upon' (p. 296) by their hospital colleagues to provide short-term loan equipment to such a degree, that they 'forget' about how they might enable patients in other ways. Heidegger uses the phrase 'set upon' to mean making something produce or yield something (1977, p. 296) in order to further something else. In this case, the setting upon of occupational therapists to provide equipment is to achieve the DHB's goal of reducing patients' average length of stay in hospital. Here lies a danger of the therapists losing their 'discretionary space' (Kohlen, 2015, p. 166) where their actions are informed by patients' disability and occupational needs.

I remember when the equipment prescription criteria were first implemented, I had many questions for therapists seeking the approval process for non-standard rental items. My common questions were "What is the essential need? What other options have you considered? What is the risk of not having it, and what is the likelihood of that happening?" To begin with, I thought the therapists were not specific enough with their answers, but I had no doubt about their compassion for the patient. On these occasions, I applied the handbrake to their equipment provision practices, which some resented (personal observation). Over time, the therapists came to provide specific answers, and I came to understand the complexities of expectations they faced from patients and ward staff. The danger here is that when the DHB's goals and the technology of providing equipment become the driving force behind practice, the individualism of practice can get lost.

Occupational therapists as standing reserve

A third danger of enframing is that occupational therapists will be reduced to the status of standing reserve (Heidegger, 1977). Being reduced to the status of standing reserve, to Heidegger, means being on standby, waiting to be called upon to do as asked. For me, such a situation could reveal occupational therapists as only coming into consideration and value as a team member on acute wards when equipment is required to discharge patients. If therapists were to be so subordinated to the orderability of equipment provision, their other practice skills will be ignored by their colleagues and may even atrophy within the therapist. I can remember a conversation with an experienced therapist about enabling occupations when she stated that she did not know how to do this anymore. Her comment pulled me up sharp. I remember thinking “Is this how we have allowed our practice to be narrowed in this hospital?”

The advantages of enframing

The enframing of practice can simultaneously be a saving power, a positive force (Heidegger, 1977). As described earlier, the ACC Act and the NZPH&D Act make provision for publically funded equipment, thereby making it available at no cost to the patient, regardless of their circumstances. The DHB has systems in place to manage the contract with the equipment rental company and pay for all rented equipment. The equipment prescription criteria provide a structure for therapists to decide how equipment is essential for the patient to return home. The prescription criteria are a tool to help spread the budget to the greatest number of patients for whom short-term loan equipment is essential for safe discharge from hospital. Having a system for providing short-term loan equipment available to all patients who need it, free of charge to them, means that having the equipment in ‘standing reserve’ is not dependent on ability to pay. The introduction of the prescription criteria was received positively by some therapists who were relieved to have something to refer back to as an authority.

Lucy is a therapist who used the equipment prescription criteria to justify her decisions on occasions.

If the patient can shower standing up safely, well, the shower stool is not an essential need. His balance is good enough to shower. So that helps to depersonalize [the decision]; so that it's not me, but it's actually, that's just how it is. The criteria are there and you either fit the criteria or you don't.
(Lucy)

In Lucy's opinion, the patient either fitted the criteria (therefore could be given a shower stool) or he did not. From her assessment, the patient could stand for long enough to shower himself on the ward, and therefore did not need the shower stool. However, others (Glendinning & Newbronner, 2008; Trappes-Lomax & Hawton, 2012; Tuntland, Aaslund, Espehaug, Forland, & Kyeken, 2015) have found that when assessing a person, there is a challenge to distinguish between the person's performance and their actual capacity to perform. It does not follow that because a person has the capacity to do a task to a certain standard, that in fact they will do so. The challenge is intensified when the context of the assessment is taken into account. What a person can do in hospital with facilities set up for people with disabilities, may be very different to what a person can, or will, do at home.

Lucy could have looked at other possibilities of that patient's 'being'. For example, how tired was the man after showering standing up, did he feel safe standing in the shower? Lucy took "...a little internal manager along with [her] into [her] practice environment, making micro-assessments of the cost consequences and efficiency of [her] practice..." (Fitzgerald, 2012, p. 50). Taking the internal manager with her helped Lucy to separate out the individual person from the decision-making process. In other words, she was forced to take utilitarian action (Butler, 2012) that was more in line with the needs of the system than that of the patients. Nina is another therapist who experienced being enframed by protocol and criteria as positive.

Have I had an occasion when the patient wanted something and I didn't think they needed it? Yeah. Yeah. Hospital beds often and lazy-boy chairs. But there are criteria and an eligibility that you can print out and say, "It's not me. This is what you have to do," or, "This is where you have to be at to be eligible to meet the criteria for this piece of equipment that you're after. They accept that there are rules and laws and you give them other alternatives. You provide them with information about where they can get one if they still wish to acquire one themselves. I need the criteria to be able to back me up. I can't just say, "I don't think you need a bed. You're okay." Or, "Here's your bed. You're welcome." It's not always black and white, but the majority of it

is. Do you meet the criteria, yes or no? So I feel like it's my backup. If someone does decide that I've made the wrong decision, I can say, "No, I didn't. This is what I have to follow." If they do need something, but they don't meet the criteria, then there are ways to apply for funding and I don't have to say yes or no. I can apply for it, but I don't call the shots in this case. (Nina)

Nina's experience of the equipment prescription criteria is that the criteria give her some support in her clinical reasoning, especially when she is not going to provide an item of equipment; for her it is a positive aspect of working in an enframed system. But she does not stop there. She is alert to other ways of helping the patient get what they want, while at the same time make it clear that her actions are not personal decisions. Also, she uses the criteria to explain her actions if her decision-making about equipment is questioned. Using the criteria as a basis for practice seems to give Nina some confidence in her ability to navigate her way through the short-term loan equipment system.

Carol's experience of working with patients with a life-limiting medical condition is that short-term loan equipment enables them to go home, rather than end their days in hospital.

If that person wants to go home and families think it's just not even possible because of all the challenges they have. But working with them and looking at what is possible, like hoists and hospital beds and all this kind of stuff, it enables that person to be where they want to be, to think about living their life, what remainder of it they can, within their chosen environment. (Carol)

For Carol's patient, it is the material-economic arrangements that are enabling. They enable people to go home because there is a system that takes care of the provision of equipment they need, at no direct cost to them. The short-term loan equipment arrangements give occupational therapists the resources to be practical problem solvers. This is an aspect of practice that Jenny enjoys:

I think probably all my life I've been a problem-solver, so this is a natural extension of that. It sort of fits with, "Oh, so how are we going to solve that problem?" What could you do to get round this issue? (Jenny)

The biggest saving power (Heidegger, 1977, p. 310) of the enframing, I believe, is the occupational therapist who knowingly and intentionally takes the time to consider the patient's individual circumstances: their goals, social situation, abilities, and needs.

When an occupational therapist remembers her shared humanity with patients and individualises each patient as a unique occupational being (Wilcock & Hocking, 2015), with their own way of being in the world (Heidegger, 1927/1962; Wilcock, 1999), the danger of averaging or levelling down of the patient's personal experience of disability is averted.

For all its advantages and disadvantages, the enframed short-term loan equipment arrangements are what they are, and individual therapists are bound by them. They are part of the power of it, the 'they'.

The 'they'

Heidegger (1927/62) described the 'they' as Being-with-one-another in such a way that one's own Dasein dissolves "...completely into the kind of Being of 'the Others', in such a way, indeed, that the Others, as distinguishable and explicit, vanish more and more" (p. 164). As part of the 'they', one's own individualism fades and becomes indistinct from the Others. The 'they' make the rules, grant approval, and exert their authority to influence what is seen as normal, right and proper. Heidegger goes on to say:

The 'they' has its own way in which to be...Being-with-one-another concerns itself as such with averageness which is an existential characteristic of the 'they'...Thus the 'they' maintains itself factually in the averageness of that which belongs to it, of that which it regards as valid and that which it does not, and of that to which it grants success and that to which it denies it. In this averageness with which it prescribes what can and may be ventured, it keeps watch over everything exceptional that thrusts itself to the fore. (pp. 164-165)

'They', in their averageness, can be the faceless people in the background that make decisions that affect many individuals. I was also one of the 'they', who became indistinguishable from the 'others' who used our positional authority to set limits on what equipment therapists could and could not provide. In carrying out my duties, my Dasein merged with the 'others' (Heidegger, 1927/1962, pp. 154-155) who created regulations, budgets and other managerial tools to control spending on short-term loan equipment. Heidegger (1927/1962) says "In this inconspicuousness and unascertainability, the real dictatorship of the 'they' is unfolded" (p. 164). In other

words, in my position amongst others in authority, and implementing the equipment prescription criteria, people with disabilities were treated as if their needs were similar; their needs had been *averaged* or *levelled down* (p. 165), or made impersonal (Dreyfus, 1995; Heidegger, 1927/1962). I did not have to meet patients on a daily basis to explain why I made the rules I did. I was faceless to them. Therapists also became indistinguishable from each other and the organisation, when patients forgot their names, and referred to their service as 'the hospital'; the therapists became part of the 'they' from the patients' perspective.

For Nina the dictatorship reveals itself in two ways. On the one hand, she recognises the power that she can wield, and tries to mitigate it.

I always sit with them and level with them and just say, "This is what I think, but it's your right to say no. And if you still want to decline, then that's your right and I respect that." I understand that power struggle and I try to avoid that. I try not to tell them what they need. I try to ask them, "What do you think you'll need? What do you think you'll struggle with?" And then if they don't mention anything that I feel they'll struggle with, I mention it. You know, you try to give them that slight feeling of power even though in my experience, they don't really get that at the hospital. It can be a bit weird because they're the vulnerable patient and you're almost trying to force something on them. (Nina)

Nina tries to draw on the patient's experience of life to assist with identifying new challenges at home, and uses her own knowledge and experience to prompt them if necessary. On the other hand, Nina recognises the influence the 'they' has in monitoring her professional standards, in the form of documentation audit, peer review, professional supervision.

That's why we have to document that we recommended this for fall prevention and injury prevention, to reduce those risks. That's what you'll need at home. That's what we normally provide in this sort of scenario. And if you decline that, then you're at risk of falling or of something happening. And if it's not documented, then it may come back: "Why didn't you assess this person? Why didn't you provide with this? That that's what they need. That's what the research shows". You have to cover yourself. Even if they probably don't need anything, there's still that risk of having a really bad day. (Nina)

Nina is very conscious of the potential for her practice to be scrutinised by someone else, who could ask questions about her decisions. To cover her professional self, she uses documentation in the patient's clinical files to explain her actions. The second dictatorship is shown by her wanting to avert any risk of falling at home, to the point that she tells the patient that the equipment is essential, even if they do not recognise that they need it. She is afraid of being found negligent because of the off-chance that the patient might be injured if they declined equipment. In these two quotes from Nina, I think she reveals her defensive stance and her attempts at providing a personalised service, while remaining focused on the patient's disability needs. The metaphor of navigating a straight and narrow path through risky territory comes to mind. It is as if Nina has to ensure that all entrances and exits on this path have to be opened and closed in turn, to ensure that nothing escapes her attention along the path, and she can only then be satisfied that she has done the right thing.

Challenging the 'they'

Although the therapists are part of the enframed arrangements for short-term loan equipment, they also challenged it. Earlier in this chapter, Carol described her experience of multiple funding streams for equipment, not all of which were available to her patient with a spinal cord disease. She believed so strongly in her role as an advocate for the patient that she challenged the decision to not approve payment for the rental of a power chair. Instead, she chose to emphasise the man's wish to engage in important occupations that would bring a sense of closure to him, his business and his workers.

I said to the Equipment Clinician: "Look, I understand that this is a huge cost." I gave the reasons why this is important for the patient; that it wasn't just about sitting out in a private hospital; this is about this person and enabling him to do what he needs to do in the limited time that he has left. He needs to go to his business, to tidy his affairs, and they want to give him a farewell; he can't do this in a care-chair. So it's having that information, justifying and negotiating. And the outcome was I was able to give him a rental power chair for a month. I think you can do that when you've got grounds, because I think a lot of our role is also about being advocate, and in some cases, fighting for a patient. Because you get to know the patient, you get to know their family. And the people making decisions about equipment, they don't know the patient, they don't know the family; they don't know the impact of their

decision. So it's about you advocating for the family and putting that forward and deciding this is why this is necessary. (Carol)

In challenging the power of the 'they', Carol demonstrated commitment to occupational justice (Hammell & Iwama, 2012) for the man who was dying. She recognised how 'they' were so distant from the patient's reality that their decision was wrong for him. She acknowledged the cost for the DHB, but even more so, acknowledged the issue of occupational justice for the man. Carol was fully aware that she had access to the resources that could help the man arrange his business and personal affairs before he died, and felt a strong professional obligation to do what she could to overturn the decision. So, she stood her ground against the 'they'. Lucy is another therapist who stood her ground against a different power: that of the hospital doctor. When a doctor questioned why a patient was still in hospital, she spoke up.

The patient is cured or whatever, but she can't mobilise and that's not sustainable. I think it's just a matter of being assertive as much as possible and be confident in your role, presenting a good analysis as well, and a good plan; and presenting the actual risk involved with the discharge that would go against our recommendations as well. (Lucy)

For Lucy to be able to stand her ground and speak up against the powerful 'they', she has drawn on her knowledge of occupational analysis (Fidler & Velde, 1999) and planning for goal achievement to give her the courage to speak up. To not speak up against a hasty discharge, Lucy would have been complicit in a potentially unsustainable discharge of a vulnerable patient.

Conclusion

Throughout this chapter, I have tried to convey occupational therapy practice in my study as being influenced by certain arrangements that have enframed the provision of short-term loan equipment, and how occupational therapists have experienced this enframing. I looked at the different arrangements that I thought were pertinent to the provision of equipment and found that the enframing both constrains *and* enables practice. To some extent, the enframing, as it stands, may protect therapists from the avalanche of demand that they could not meet. The occupational therapy participants in this study have evolved their practice in response to their experiences of the

enframed, interconnected systems and the webs of human interaction they met along the way. More especially, I like the way that Higgs (2012) recognised how the individualities of each practice context shapes practice in that region.

For each practitioner, not only is his or her evolving practice knowledge and capabilities a result of experience and context, but each practice action or episode is influenced by and, optimally, shaped to suit the particular practice. Professional practice is linked inexorably with the contexts of what Certeau (2002) calls “practised places” of everyday life; these places exhibit a rich interconnectedness of cultural texts, institutions, knowledges, and practices.
(p. 76)

In applying Higgs’ (2012) understanding of how practice is shaped to occupational therapy, I see that occupational therapy practice is shaped by the therapists’ understanding of their role as an occupational therapist, the type of medical or disability condition the patients have, the knowledge that is appropriate to those conditions, the policies and priorities that enframe that work area, and the way the staff work together in that work area. Moreover, I think that all this knowledge gives the therapists in this study a place to stand firm in their professional opinion, a confidence to know that they are doing the right thing in their opinion. I suggest that Lucy and Carol could challenge the ‘they’ because they both knew well that their role as an occupational therapist is to enable people to engage safely in the occupations of their choice, despite their disability (Townsend & Polatajko, 2007; Wilcock & Hocking, 2015). Lucy and Carol experienced situations of facing up to any perceived risk, and took on the responsibility for client-centred interventions that were true to their professional beliefs (Edwards-Groves & Grootenboer, 2015). They had to work with the irresolvable dilemma of providing an effective service to the client and providing an efficient service to meet the DHB’s goals (Federici & Borsci, 2016). I found that an enframed system for short-term loan equipment is necessary in order to keep within a budget, but that there also needs to be enough flexibility in the system for occupational therapists to address the uniqueness of individual people.

Chapter seven: Experience of receiving, using and returning short-term loan equipment

Introduction

This second findings chapter explores and interprets the patient participants' experiences of receiving, using and returning the items of equipment provided by occupational therapists. To explore these experiences, I will start by giving a brief overview of Heidegger's description of equipment as being present-at-hand and un/ready-to-hand (Heidegger, 1927/1962). Second, I will explore how decisions were made about what equipment would be provided, paying special attention to whether they felt as though their particular disability needs were met. Third, I will look at the patient participants' experience of receiving the equipment in their home. This will be followed by exploring the experience of using the equipment, and the effects of having the equipment on family members. Finally, I will describe how the process of returning the equipment worked from the patients' perspective.

Heidegger on equipment as things

Up to this point, I have discussed the users' experience of equipment and note that the equipment is not value-neutral. Rather, their experiences are characterised by a sliding back and forth between positive and negative feeling towards the devices, depending on the physical environment and social situations the users encounter in their day. To me this emphasises the need for occupational therapists to remember that they not only prescribe equipment for the person but that person's physical environment and social contexts (Skymne et al., 2012).

Heidegger made a significant contribution to the philosophical understanding of equipment as things in *Being and Time* (1927/1962). He observed that people's dealings with things are not so much being conscious of the things themselves, but in taking the things for granted in everyday use. He developed the notions of equipment entities as being present-at-hand (p. 105) and ready-to-hand (p. 98). Being present-at-hand is that

mode of being where the thing is explicit in conscious human perception. The object is obvious (through sight, touch, sound, smell, and/or taste) to an observer. An object also becomes present-at-hand when the thing is not working effectively (broken or not usable for some reason; what Heidegger calls unready-to-hand), or is not familiar, and so is obtrusive in consciousness. The mode of being ready-to-hand is when a thing is available and used without conscious effort; it is just 'there' and works as the user wants it to. While it is working, the thing withdraws from consciousness; it is ready for use without the user having to think about it. Harman (2010) goes further and states that these modes of being are not exclusive; there is an interplay between them.

Present-at-hand and ready-to-hand are not two different types of entities. Instead, all entities oscillate between these two modes: the cryptic withdrawal of readiness-to-hand and the explicit accessibility of presence-at-hand.... Objects can withdraw into their hidden underground action, or they can become objects of explicit awareness. In fact, they do both simultaneously: the hammer is faintly felt even when we invisibly use it, and something withdraws in objects even when we explicitly stare at them.
(Harman, 2010, p. 19)

The participants in my study revealed in their accounts that these modes of being in relation to things applies to the use of short-term loan equipment. The notions of present-at-hand and ready-to-hand resonated with their experiences. However, before gaining experience in using equipment, the would-be user first has to be prepared to accept the equipment in its present-at-hand-form, and it is this idea that I turn to now.

Deciding on short-term loan equipment

Coming into this research I was aware of the range of attitudes towards equipment by people with disabilities through my family members, international literature (Covington, 1998; Hocking, 1999; Kylberg et al., 2013; Nordstrom et al., 2013) and general media. In the present study, the patient participants' attitudes toward equipment reflected the findings of others in the literature, ranging from resistance, ambivalence, acceptance, and wishing they had more or had it sooner. My research participants' attitudes were also shaped by a range of influences, including health professionals, friends and family.

Am I that bad?

One person needed surgery to relieve back pain and an intermittent loss of muscle power in one of her legs which lead to several falls and subsequent lacerations and bruising. She explained:

If I walked over uneven ground I would often fall, and then sometimes I would walk and the leg wouldn't respond. Going up and down stairs, I frequently fell and I just couldn't trust it, because I never knew when it was going to give way. One of the times I fell had been at a person's house and there was a step from their front door, just before their front gate, and my leg gave way going down that step. I ended up falling into their wrought iron gate. I was bruised from head to toe [chuckles]. I looked like I'd been in a fight. When I first saw the surgeon, he said "I don't think you're bad enough to have a walking trolley." And I thought, "No, I don't believe I was bad enough. Old ladies use those [walking trolley]." (Helen)

The embarrassment of falling and injuring herself in public was ever-present in Helen's mind, but this was less significant for her than using an item that has conspicuous connotations of disability. Helen's resistance towards using a walking aid (the public display of a disability, being aged) precluded her from experiencing any benefits that such an aid could give her. Helen accepted the risk of falling and the likelihood of being injured, in preference to being seen in public using a walking aid of any description which would indicate that she was disabled, even temporarily. For her, the walking aid was so preloaded with stigma, that she could not see the usefulness of it to give her confidence to walk without falling over, and avoiding injury. Helen's response to the surgeon's comment on using a walking aid shows her attitude being shaped by the surgeon. She did not question the surgeon's assessment of her mobility. She accepted as correct his opinion of her mobility as not being "bad enough", and the possible interim solutions to prevent her falling and injuring herself. Helen gave over the decision to have or not to have a walking aid to the surgeon, as someone who knows best (Heidegger, 1927/1962) even though the surgeon has only mentioned the 'worst-case' solution – a "trolley". Other, less supportive and less stigmatising aids are readily available e.g. a simple walking stick. Furthermore, when asked why she did not use a walking aid, Helen replied:

Why didn't I use a walking aid? Pride. I've got a bit too much of my mother in me I suppose [chuckles], and I will beat this. (Helen)

Helen was also influenced by her mother as an example of how to be when facing adversity. Her *Dasein*, or *Being-in-the-world*, and sense of self, precluded allowing certain objects to become present-at-hand. She saw herself as being determined and capable of meeting the challenge of an unreliable leg while simultaneously looking non-disabled. Helen's attitude towards a walking aid is in stark contrast to the way she accepted the over toilet frame, shower stool and rehabilitation chair.

I had been up to the toilet and realised that the seats there in the hospital were higher than they were at home. I found that I could use them far better. I'd seen other people with the shower stool and the toilet seat, so I already knew the benefits of them. (Helen)

Having experienced using a higher toilet in hospital, and seeing that the people she knows use a shower stool and raised toilet seat in their homes, Helen realised how they can be useful. She trusted her own experience, and was quick to see how the equipment could work for her. She envisaged herself using it at home, where it quickly came ready-to-hand. The equipment didn't hold any stigma for her. Could it be that the over toilet frame, shower stool and rehabilitation chair were acceptable for private use inside her own home, whereas a walking aid used outside the house is public recognition of a disability? Helen could accept this equipment for use in the private domain of her home, but not use a walking aid in public, which in her mind was a sign of disability rather than assisting her body in a ready-to-hand, taken-for-granted manner.

Annie is another patient participant who thought that the equipment did not match her image of herself, but she changed her mind after she used it in hospital.

I played netball until I was in my 40s and always walked and ran, gardened. When I looked at it [the equipment] I thought: "Really? Do I really need it [chuckles]? I'm too young for this equipment. I don't need it. This is me, the way I look, I don't need that stuff," until I got to hospital and saw how disabled I'd become through having that hip operation. It wasn't until then that I realised that the only way I could sit was on something like what I was given. I didn't realise how much better it was for me sitting on a chair like this, and a raised cushion on my couch. But I was so grateful for having this equipment in the meantime. I've gotten over it [her reticence about the chair] because it is so comfortable. It's the only way I feel good. (Annie)

There is some disbelief in Annie's reaction to seeing the over toilet frame, shower stool and rehabilitation chair recommended for her before she had her surgery. Her sense of self as an active woman was challenged. The sight of the equipment suggested to her that she had aged. In her mind she was still young; too young to need such things. Her perception of the equipment changed dramatically when she experienced the limitations of her disability after surgery. The effect of being able to sit down and stand up again comfortably through using the equipment when she needed it was a revelation to her.

For Helen and Annie, their initial reaction to some of the equipment was to retreat from the prospect of including that equipment in their lives because it *showed or indicated* (Heidegger, 1927/1962, p. 106) that they were disabled (for now), and inevitably aging, and somehow they are not as capable as they wanted others to regard them. The change in Helen's and Annie's attitudes towards equipment came through their seeing and feeling the difference it could make for them. This is when they understood that the equipment had "the character of 'in-order-to', its own definite serviceability" (Heidegger, 1927/1962, p. 109), and experienced the essence of the equipment as an enabler. It is notable that both Helen and Annie were first-time equipment users, and their attitudes towards equipment that they associated with disability did not allow the equipment to be part of who they are, their *Dasein*, and therefore the equipment was initially prevented from becoming seen as something that could become ready-to-hand in their everyday world.

Negotiating equipment

The process of providing equipment is routine for the occupational therapist. In this routineness, there is the potential for therapists to act towards patients in such a manner that the therapists are insensitive to the differences between patients; where all patients in a particular category are treated as if they have the same disability challenges and equipment needs. Patients' individuality can get glossed over as if they are already well known. Heidegger (1927/62) called this 'levelling down' of the possibilities of Being (p. 165) as described in the previous chapter. Consequently, as I

interviewed each patient participant I was interested to hear whether they felt their individual circumstances had been taken into account; had they been given a say in what equipment might be useful to them. Nelle described her experience of deciding on the equipment as a conversation about what might help her.

I'm not sure necessarily who decided. Obviously it must have been the occupational therapist, but that's all quite hazy. Whoever I talked to just talked to me about what might help, and so it was almost a questioning thing. "Do you think a bed support might be helpful?" So essentially it was my choice. "Yes, yes, I do think that would be helpful. Yes, I certainly do need a chair, a stool in the shower." So maybe it was a collaborative thing. (Nelle)

Although Nelle could not remember the profession of the person who discussed equipment with her, she could remember aspects of the conversation and that she was asked her opinion on what would be useful for her. In her concern for Nelle, the therapist demonstrated an aspect of being-with-one-another through one of the positive modes of solicitude: *leaping ahead* (Heidegger, 1927/1962, p. 158). It seems, through her questions, the therapist helped Nelle think ahead to being at home and where she might have difficulty managing. Also, by offering a range of equipment, Nelle was given options of things that she could decide to take or leave.

Helen also experienced being part of the decision-making.

They - I'm sure it was a physio, it might have been an OT, I don't know, I can't remember – asked me about how many stairs I had at home and what else did I have at home. They asked me about what equipment I wanted at home. They suggested the chair. I suggested the toilet seat and the shower. (Helen)

Helen also experienced being part of the decision-making about what equipment she would have as collaborative and personalised. Arnason (2000) describes the type of reciprocal, respectful interaction that Helen and Nelle engaged in with their therapists as the *dialogic relation* whereby the “focus is on the relationship between the two partners engaging in a shared deliberation resulting in a joint decision which is based on mutual trust” (p. 17). The therapist in each case demonstrated through their questions an openness to not knowing (Gadamer, 2004) what equipment would be helpful for Nelle and Helen.

When I asked Moira how it was decided what equipment she would have, she replied:

I can't remember now. I think they just thought I would need a toilet seat, and a seat for the shower, and a high seat for sitting. (Moira)

In Moira's case, it seems that her therapist was employing a different mode of relating, that of prematurely understanding the other (Arnason, 2000, p. 19). In this mode of relating, the therapist *leaps in* (Heidegger, 1927/1962, p. 158) and decides, based on her own professional knowledge and experience, what the patient needs, without fully understanding the individual. In healthcare, *leaping in* has the effect of the health professional dominating the decision-making about what is right for the patient. The patient is relegated to the person being "done to", and their role is to tacitly comply with the health professional, until such time that the patient can regain their autonomy over decision-making.

In chapter six I discussed Heidegger's notion of the 'they', and several patient participants referred to 'they' when talking about equipment provision. Although it is standard practice for staff to introduce themselves to patients when they first meet, this is not enough to assist the patient to recall who they are, as separate from each other. 'Leveling down' in health care goes both ways. In calling staff 'they', to Moira, Nelle and Helen, the staff have lost their individuality, and are seen as indistinct from each other.

Moira silently and implicitly gave authority to others to decide what she needed, just as Helen did with the surgeon. In each case, it did not seem to matter who talked to them about their need for equipment. Helen has a sister who is an occupational therapist, and I expected that she would have been alert to an occupational therapist introducing herself. Yet she too did not remember who spoke to her about equipment needs.

Conversely, therapists might stand out from the 'they' when there is true negotiation between therapists and patients. While in hospital, Scorpio used an over-bed table which he and his wife thought would be useful at home. He described their interaction with their therapist regarding the possibility of supplying one.

We did have one question, and that was for an over-bed table, like they have in the hospital. [The therapist] came in and spoke to us about it. She didn't think that we'd need one anyway. "Wait till you get home and just see. If you were confined to the bed for a long time it would probably be a good idea". But I knew I wasn't going to be, so we didn't bother in the end. She also told us we could buy one - a cheap one - from a warehouse. But they [the hospital] don't provide them themselves outside the hospital. Well, that's what we were told anyway. We didn't need it, which was alright. (Scorpio)

This is a good example of therapists having to consider a patient's request for equipment which was deemed by policy (in this instance, written by me) to be 'not essential' for returning home, regardless of how useful it might appear to the patient. In this instance, the therapist needed to consider Scorpio's request, and sensitively bring him and his wife to the understanding that the table was not necessary, without saying a definite "No, I'm not going to give you one because you don't need it, and the DHB doesn't pay for it." Having this discussion with the therapist brought the over-bed table back to being present-at-hand, where its role in his rehabilitation could be reappraised, and a mutual understanding was reached that the over-bed table was not needed. The therapist lead the conversation delicately around the criteria for making the over-bed table unavailable to them, and Scorpio and his wife were satisfied with the outcome. In this instance, I was the person who decided that an over bed table was not going to be provided, with no specific person or context to underpin that decision. There was also an assumption that not providing the over bed table had an additional, albeit unspoken, benefit of encouraging people to resume their usual daily routines as soon as possible i.e. not use their bedroom as the default environment while they recovered.

Receiving the equipment

The human activity involved in the process of identifying equipment need, arranging the delivery and pick-up of the equipment is also an example of what Heidegger (1977) refers to as technology. As part of the technology of equipment provision, occupational therapists are required to give patients a green (the 'green form') A4 size, one-page document detailing what equipment they have been provided with, the name of the supplying company, instructions on how the equipment will be picked up, and a contact name and phone number. Sometimes the technology, or process, went smoothly and the patient was well aware of what was to happen.

Before I left hospital, they said that the equipment would be delivered. I think it was delivered a couple of days after that. How did that equipment get set-up? Who put it in place? I think we did it ourselves. I'm sure we did. Yeah, I think the person that just delivered it-- was a delivery person. So, it was quite simple. It was all ready just to go, and new. I have a feeling that the person that delivered it did it [set up the over toilet frame] for the toilet. You know how the toilet frame could move a bit, up and down? If I remember right, I think he did it. (Moir)

Moir was not called on to interact with her equipment as technology that could be handled, adjusted and placed in situ. Whoever put it in place did so in such a way that Moira experienced that event as being straightforward, and the equipment was ready to use immediately. Perhaps the transition of the equipment from present-at-hand to ready-to-hand was facilitated by it being positioned at the right height and in the right places in her home. For Moira, the equipment had the semblance (Heidegger, 1927/1962, p. 51) of being new. However, it is just as likely to have already been used by another person, and subsequently been thoroughly cleaned before being provided to Moira. Either way, Moira believed it was new, and therefore of an acceptable standard for her. Did her belief about its newness help it become ready-to-hand for her?

In Scorpio's case, he and his wife could remember being told that the equipment would be delivered, and the delivery occurred before Scorpio was discharged from hospital. Having Mrs Scorpio present at the times when the equipment was being discussed probably added a memory 'back stop'. What Scorpio couldn't remember, his wife could fill in. The equipment was delivered in a timely manner so that it was present-at-hand immediately Scorpio arrived home from hospital. A smooth delivery process seems to facilitate the equipment quickly becoming ready-to-hand at home for Moira and Scorpio, because they did not need to put some other strategy/equipment of their own in place in the interim that they would then have needed to unlearn or remove, if they switched to the hired equipment.

Getting the equipment in the first place did not always go well, as Cathy, daughter of a patient (Mrs C) and a registered health professional, explains.

I guess the hardest thing about our experience was actually getting the equipment. Although we were told my mother required crutches, toilet seats,

et cetera, actually getting them was difficult because it was on a Sunday that we brought Mum home. Nobody seemed to know where or how or why we were supposed to get the equipment, and initially we went home without it and borrowed it from someone else. We received the equipment a couple of days later. I guess going home on Sunday may have influenced that. I think probably they thought she would go home on the Monday, Tuesday, but she wanted to go home and there was no reason that we couldn't take her home.
(Cathy)

Cathy's experience as a health professional informed her of the existence of short-term loan equipment for people following hip surgery. With this foreknowledge, she expected equipment to be ready, but it was not available at the time she took her mother home. It is not clear who said that her mother would need the equipment, but on that Sunday, the equipment not available, it was unready-to-hand (Heidegger, 1927/1962). As Cathy made enquiries about its whereabouts, she stumbled upon a system of care that was not joined up; relevant information was not reliably passed on or accessed, and the process did not work for her. At this stage, the equipment was very much present-at-hand in her consciousness, but not in the physical realm where it could be taken and used. Cathy talks of "they" as in '...I think they probably thought she would go home on Monday, Tuesday...' I didn't think to ask who 'they' were; I assume she is referring to the occupational therapist and other ward staff. In this case, 'they' controlled the equipment Mrs C needed, which was not available to her on discharge. To add to the confusion, Cathy was unaware of the 'green form'.

Well, they told us they didn't have the forms for us to take. Well, when we picked the stuff up from Pukekohe (hospital), we didn't sign anything. We just collected it and dropped it back, so [chuckles] I'm not sure what forms we were supposed to or not to have done. (Cathy)

The process of providing Mrs C with her equipment clearly did not work as it should have done. Cathy and the ward staff on duty that day, would have known that Mrs C's clinical record would be the most obvious place for information to be recorded. However, Cathy's statement that "no-body seemed to know where or how or why we were supposed to get it" implies that there was either no record of an occupational therapist's assessment and plan, or the ward staff did not refer to the clinical record to find the answer. This case led me to thinking that the technology of providing equipment needs a hitherto concealed factor in order to succeed: patients' involvement with planning

their discharge. I suggest that Mrs C's departure from hospital was not planned in a joined-up way with ward staff, so that the many steps of equipment provision were not completed when Mrs C was personally ready to go home.

Elizabeth also experienced confusion and lack of mutual understanding; she was left unsure of what to do, or what was expected of her. She has a vague memory of talking to someone over the phone and of attending the pre-operation 'joint camp'.

I think what I got is what I got because I had talked to someone over the phone. She may have asked, but in saying that, I think the questions she asked lead me to think to myself, "Well, she knows what we need." I think more to the point there, is she didn't ask about the toilet—or whether the seat was right for the toilet, whether we got to look at some toilet or whether you were just sent a toilet. My daughter and I weren't aware that we had to stay back afterwards and talk about things that you may need when you go home.
(Elizabeth)

In Elizabeth's case, the system was unclear. She remembered talking to someone over the phone about equipment but she was confused over what was expected of her regarding what equipment she needed, what to do if the equipment didn't fit, or she no longer used it.

Using the equipment

Each patient participant was disabled in a way that was not usual for them. In Heidegger's (1927/1962) words, they were 'thrown' or delivered-over (p. 174) to their present situation. To be 'thrown' is to be where they are, the starting point where they just happen to be, and now must deal with that situation, with all its circumstances and concerns (Withy, 2011). The experience of being 'thrown' into using equipment while recuperating from their temporary disability was positive for some and a challenge for others. Despite her initial hesitation to accept that she might need equipment following her surgery, Annie described how she got used to using the rehabilitation chair.

Well it's a lot easier than getting out of the other chairs. And it's just become a habit to me now. Sometimes I forget, and people come in and I automatically go and sit on whatever chair I can find. As soon as I sit on one of those chairs, ordinary chairs, all of a sudden I say, "This isn't right. I don't

feel right," and then I can't sit for too long in an ordinary chair. I just get myself up again and move around to come to this chair. (Annie)

Sometimes Annie reverted to her old habits when she had visitors and she sat on one of her own chairs without thinking. At this point the ordinary chair was ready-to-hand. Immediately she noticed that the chair was not right, that once-familiar chair became uncomfortable and present-at-hand. Then Annie remembered the rehabilitation chair – it became present-to-hand because she thought about it explicitly, but once she sat on it, felt comfortable and forgot about sitting on it while she talked to her visitor, the rehabilitation chair returned to being ready-to-hand. The rehabilitation chair then gets sat in without thought-through choice. The body simply goes to that chair. The experience of the equipment being enabling was shared by Moira:

Oh, it made a lot of difference. I could never have managed without it I don't think, especially in the toilet and the shower. The shower stool was a blessing really. I think it was more you felt more secure getting up and down. There wasn't that fear that you're going to fall off. They were quite functional, and comfortable. They were convenient; very convenient; I didn't feel any discomfort. I felt more independent, and didn't have to rely on people. I couldn't have done without any of them to be quite honest. (Moira)

Moira was short in stature, and still she experienced the benefits of having sitting surfaces higher than her usual home furniture. She appreciated the assistance and security offered by using the shower stool and the over-toilet frame, as they took away her fear of falling. For Moira, the essence of the equipment was as an enabler; she was able to manage on her own, and retain her privacy and independence, in comfort. The equipment meant more than being able to go home; for Moira, each item enabled her to do what she wanted to do at home, independently.

Helen's experience of using her equipment was of giving confidence.

The shower-- going into the shower, that gave me confidence. Especially the first couple of nights I was at home, I would sit on the stool and I was able to wash myself. I was even able to wash my feet because I could put my feet up on the wall and just feel my feet there. The over toilet frame meant I could control sitting down more easily. The getting up wasn't a problem, because I was used to putting one foot in front of the other and pushing myself up with my legs, but the getting down, I was scared I was going to flop. So, I could

hold it and lower myself down without flopping. That was very, very helpful.
(Helen)

Helen describes her use of the over toilet frame, shower stool and rehabilitation chair in terms of their utility and comfort. She saw the equipment as a means to maintain personal comfort and safety during showering, drying herself, avoiding loss of control of movement (flopping or falling) during these occupations. I suggest that Helen's own body became present-to-hand. She showed an in-depth awareness of her body during showering and the acts of lowering herself to, and raising herself from, the toilet. In the shower, she refers to sitting on the shower stool, putting her feet on the shower wall, and feeling her feet there as she washed them. Being able to feel her feet against the shower wall seemed to give her some pleasure and stability, and contributed to her sense of confidence of being able to shower by herself. The over toilet frame had its utility in supporting Helen to control her descent on to the toilet seat. She was afraid of losing control of the movement and 'flopping'; I presume that landing hard on the toilet seat was jarring and painful for her, so she was relieved to be able to avoid that. Her own toilet was unready-to-hand as it was too low for her, and she risked hurting herself if she lost control. The over toilet frame was ready-to-hand as she got on and off the toilet, and her body was present-at-hand as she consciously sought to control its movements.

For another patient participant, being 'thrown' into temporary disability and needing to use an over toilet frame was daunting. When Ron was asked what it was like to use the equipment for the first time, he replied:

[Pause, umm, pretty umm]. How would you describe it? Demoralising in some ways. Just the simple fact that you couldn't do it for yourself. To think that you have to go to the toilet on something with arms on it, and you're not actually sitting on a proper toilet is.... I think you get comfortable and personal when you're stuck in your house. And when you've got to go and change that to be able to live a normal day in your life, it really is something that takes a while to get your head around. (Ron)

"It takes a while to get the head around" implies the Ron was 'thrown' into a situation that was not familiar to him, and it was somewhat off-putting. The over toilet frame was present-at-hand whenever he needed to use it because he consciously thought about it.

It was an interruption to his usual independence. For Ron, using the over toilet frame revealed his vulnerability, the need for him to pay particular attention to protect his healing hip during this activity; thus his body also became present-at-hand during that occupation. Having used the equipment when he was recuperating, Ron overcame his resistance to it, and now is ready to use it if the need arises again. Ron also experienced mixed feelings towards the rehabilitation chair:

It's great to sit in but after a while it's just that little bit, not enough padding on the bottom of it-- You sort of get a bit of a dull sensation after a while. I think it's [the rehab chair] a lot more comfortable for a short period of time, it's not something you want to sit in for eight hours of the day. Like I say, for me it was great because I had a fold-up table that I could push away from me to get out of the chair or I could pull back towards me if I wanted to eat or have a cup of coffee. (Ron)

Ron experienced the rehab chair was comfortable to use for short periods. After a while, the foam seat no longer provided a cushioning effect, and the effect was a dull numbness, indicating that the normal volume of blood supply and nerves to Ron's bottom and back of thighs are under abnormally high pressure. Because the seat was designed for the 'average' patient, it is not surprising that at some point it became uncomfortable for Ron, because of his stocky stature. At this point, the rehabilitation chair moves from ready-to-hand to present-at-hand. With Ron being able to shift his weight at will and normal sensation, he was able to relieve that pressure, thus avoiding a pressure injury. Ron mostly used his rehabilitation chair while sitting in the lounge watching television with a fold up table in front of him (Appendix 1). Ron gave me verbal permission to use his photo. This arrangement worked well for him because he could move the table back and forth to fit his needs. This means he didn't have to move the heavier rehabilitation chair to fit the table. The height of the rehabilitation chair is adjustable, but the rest of the chair is not. Ron also received a shower stool, which put him off-kilter when he first used it.

I don't really know why [the shower stool] has to have a slope on it, to the front. Maybe it's easier for people that have had hip joints [surgery] to get down there. But I would think that it'd probably be easier if it was flat rather than sloped. And the thing with it being sloped, if you've got, say, your shower gel on the floor, you reach down to pick it up, then there is the tendency to want to go forward-- Yeah the first couple of times it was a bit scary. (Ron)

The shower stool is designed with the front edge slightly lower (10-20 millimetres) than the rear edge of the stool. Ron felt the difference in height and felt it as discomforting and insecure. The forward sloping seat gave him the sensation of being propelled further forward when he reached down to pick something up off the floor. The shower stool was very much present-at-hand for Ron; he was concerned for his safety when he used it. Instead of providing comfort and security, the shower stool caused alarm. To add to Ron's distrust of the shower stool, somehow a leg of his shower stool was lengthened without him realising it, rendering it unstable.

On one occasion I got in the shower and one leg was actually longer than the other three. And I thought, what's going on here? And then I realised that someone had actually grabbed the leg and pulled the leg, so it slid out the first slot and then clicked in. (Ron)

Someone, unfamiliar with the equipment, inadvertently lengthened one of the legs of Ron's shower stool, thus making it unstable for him to sit on. The way he told the story in his matter-of-fact way gave me the impression he was not perturbed about it, so much as recognizing that others can and do interfere with the equipment, and that he needed to be alert to that. To adjust the leg on the stool needs pressure on two buttons simultaneously to release the stopping action of the buttons, and allow the inner tube to move up or down within the outer tube. In doing this, the stool was changed into an object that was unstable, and it immediately became present-at-hand, drawing Ron's attention to the change in the stool. For Ron, the shower stool provided occasions of instability and insecurity as opposed to the intended purpose of security.

For Elizabeth, the over toilet frame she received did not provide the security she sought.

It didn't sit in the toilet properly and I couldn't sit on it properly, and I didn't use it that much. I had to use it but then I found it hard to use anyway. I had to lift the seat up to fit over the toilet and that seat didn't fit around the thing itself. It came out halfway out of the bowl. Yeah, it was too small for me and I had to elevate it, lift it up to sit in the toilet, which I couldn't use it properly. I didn't know how to use it properly. There was nothing to grab on to, to sit on my toilet, so I had to use that [the over toilet frame]. I think it was the wrong seat. (Elizabeth)

Elizabeth was left to work out how to position the over toilet frame herself, but she did not know how to. To protect her sore knee, she needed something to help her get on and off the toilet, so she was thrown into a situation, for the time being, of using equipment unfit for purpose, i.e. unready-to-hand. Consequently, the over toilet frame became present-at-hand each time she had to use it. However, this situation revealed Elizabeth's problem solving skills in another way.

When I stopped using it [the over toilet frame] in the toilet, I used it for a walker. It was good to have because I could move around, sit on it, and could adjust the feet on them. Other than that, I didn't use it that much to go to the toilet. I ended up getting me some handrails, towel rails, and I had them put on both sides of the toilet so I could get up and down because I didn't have any handrails. (Elizabeth)

Elizabeth tried the over toilet frame as it was intended to be used, but when that didn't work for her, she used it as she thought best fitted her needs. Using the over toilet frame as a walking aid revealed two things: a) her problem-solving ability to turn the toilet frame into a walking frame; and b) the utility of the frame had meant that she saw the practicality of not restricting its use to just in the toilet, but something to use in all regions of the house. She further demonstrates how people use their own initiative in organising for handrails to be installed, thereby providing long term security. Elizabeth's experience of the ill-fitting over toilet frame reveals the focus of the therapists to be on solving short-term disability needs expeditiously, rather than considering an individual's longer term needs, which might take longer to solve.

Effect of having equipment in situ on family

By its very nature, short-term loan equipment takes up space in the rooms where it is situated. Its sturdy construction can make it heavy and or awkward to move, and might have impacted on how other people living in the same house experienced the equipment. For some, having the equipment in situ gave peace of mind to relatives. Scorpio's wife revealed great concern for her husband's safety, and having the equipment in place allowed her to think that any risk was mitigated enough for her to let him do the activity by himself. However, she was not sufficiently reassured to allow him to move from a safe place when she was not at home.

Because of her training as a health professional, Cathy recognised that there was a risk that her mother could dislocate her hip if she was not careful. Having the equipment in place meant that she could relax somewhat, knowing that some risks had been addressed and that her mother could retain some of her independence and autonomy.

Oh, that independence with toileting, and just being able to get up and make herself a cup of tea or if she wanted something. Oh, peace of mind. Peace of mind. Knowing that she wasn't going to dislocate her hip [chuckles], knowing her chances of that. Just the fact that she was safe, I think for me, was important. I think for the rest of the family, it was about safety but it was also about the fact that she gained a little bit of independence back. It just meant really someone had to be around in case she needed us, more than being there initially because (Cathy's emphasis) she needed us to do it for her. She wasn't totally dependent on us. An independent lady for so many years; it was hard, I think, for her to give up some of that independence. (Cathy)

The equipment also altered the way the family could be with their mother. They could be present in their mother's house should she need them, rather than be there in order to help mother perform the activities. Cathy recognised how the equipment enabled her mother to do important activities on her own like going to the toilet, and making a cup of tea. Perhaps Mrs C also enjoyed doing these activities in her own time, and in private. Cathy thought the rest of the family shared her concern for their mother's safety, but they were also aware that a sense of independence was an important part of her mother's recovery and getting back to her old self.

Returning the equipment

Deciding when it was time for the equipment to be returned happened in planned and unplanned ways. For some patient participants, the process of returning the equipment occurred very smoothly. Scorpio and his wife experienced the 'auto collect' system of a pre-arranged date for equipment pick-up. In Scorpio's case, the phone call from the equipment rental company was the catalyst for returning the equipment that was no longer needed, and therefore ready to be returned; but other equipment was still useful and Scorpio wanted it to remain ready-to-hand. In negotiating the equipment pick-up, both parties demonstrated respect for the other and their roles in the technology of equipment provision. At the equipment pick-up point in the short-term loan equipment process, there is flexibility; the patient can decide which item/s to return, and which

item/s to retain for the next while. Moira's experience of returning the equipment also went according to plan:

When they delivered the equipment, they said "Now you can have it as long as you like, but as soon as you feel that you don't need it just give us a ring." So that's what I did. I just gave them a ring. I think he asked would there be somebody home on a certain date, and we said, "Yeah." And he just came up. Wasn't long after I'd rung; it was quite quick. Did I miss it at all? No. Not really [chuckles]. It just came that I didn't need them anymore. (Moira)

The 'they' that Moira refers to is the equipment supplier's courier driver who delivered the equipment to Moira's home. She experienced the delivery and pick-up as efficient, whereby she had the equipment ready-at-hand when she needed it, and it was taken away when she no longer needed it. It had transitioned from ready-to-hand to present-at-hand; it was serving no purpose, and was now 'in the way'. Moira decided when she no longer needed the equipment, and she initiated the phone contact with the equipment supplier when it was time for it to go.

I was intrigued to hear from several patients that they did not know or remember how the pick-up process was to happen in their case. When asked if they had been given the green document by an occupational therapist, the usual reply was something like:

Possibly in the first package of stuff that came. But I haven't opened that in months. (Ron)

Ron recalled that he had been given written information at some time, but had not referred to it since then. He didn't recall the content of the 'package of stuff' specifically. The package and the information it contained was not of high importance to him at the time he received it, and it subsequently became invisible and unready-to-hand for him. The loss of awareness of the green page of information probably contributed to the equipment pick-up being experienced as unplanned, and could easily have resulted in waste of time for the people involved.

I was not aware that I was contacted. I came home one day and it wasn't there, and I sat on the toilet. "Oh, there's something missing." The arms were missing and I thought, "Oh, yes." I looked for the shower seat and that was gone. I wasn't aware they were coming then. I read the green sheet when I got it, but it didn't necessarily compute what was going on. It didn't upset

me. Fortunately, somebody was at home who could give them the equipment. I used the toilet seat and shower seat right up until they were collected. I was quite sad when they went, but I knew that I only had them for a certain time. If anything it might have been helpful if they had phoned and said: "Will somebody be at home?" But then again, they might have phoned, and the message hasn't been passed on to me, so that's highly probable. (Helen)

The collection of equipment from Helen's house was unplanned from her perspective. She was out of the house when the supplier came to pick it up. She acknowledges that the supplier might have rung her house, and someone else in the household answered the phone call, but did not pass the message on to her. So even when the equipment rental company follows the correct process of equipment retrieval, the process can fall down at the patient's end. The over toilet frame became so ordinary and ready-at-hand, that when it was taken, Helen didn't visually notice its absence, she felt its absence when she used the toilet, supporting Gendlin's (1962) assertion of 'felt' experience. She had completely assimilated the over toilet frame and shower stool into her showering, drying and toileting routines right up to the time they were taken away. She had not finished with them of her own accord. Helen accepted the over toilet frame and shower stool to the degree that she was sorry when they were taken back. At the end of Helen's interview, when the voice recorder was turned off, Helen went to see if she did have the green document, and found it among the other papers that she received in hospital, but had not looked at since her discharge. She then remembered reading the green document regarding the equipment when she first received it, but the information became lost to memory after that, and unready-to-hand.

Nelle's experience of the equipment pick-up was of it being 'hit and miss': unplanned and a surprise.

The guy who arrived to pick it up, he knocked on the door and obviously it took me a little while to get to the door to answer. I think if I had been out or being even slower, I may well have missed him. I didn't get a phone call beforehand. It was completely hit and miss. This guy was very accommodating. He gave me the impression that if I had still felt that I needed it, then I could have said so. He was just particularly pleasant and chatty. (Nelle)

Nelle did not remember anything about a conversation with an occupational therapist discussing equipment pick-up or the green document, nor did she receive a phone call from the equipment supplier prior to the driver arriving to pick-up the equipment. So she was unprepared for the driver's arrival. Her slowness of movement due to arthritis meant that she took a long time to answer the door, and there was a risk that the driver could have given up waiting and driven off without her equipment. Because Nelle was not aware of being given any written information regarding her equipment, she would not have known about a pre-arranged pick-up date, or how to contact the supplier when she had finished with the equipment. That raises the question of how and when the equipment would have been returned to the supplier, and when the DHB would have stopped paying for it. On the positive side, the driver was personable, and he and she engaged in a mutual conversation that gave Nelle the impression that she could have continued to use the equipment if she wanted to. The driver's respectful, pleasant and chatty demeanour towards her seems to have influenced Nelle's acceptance of the 'hit and miss' nature of the pick-up.

For Mrs C, when it came time to return the equipment, Cathy remembers there was a sense of relief:

She was quite happy to see it go because I think to her it meant that she was okay again. It was like, "Okay, I've finished with it [laughter]. It's been, it's done, and now I can get back to being normal." (Cathy)

As Cathy noted in her earlier account of her mother's use of equipment, that she was aware that her mother 'felt' the conspicuousness of the equipment, and the return of it meant that that chapter in her life was now over. She was 'normal' again and could resume her usual identity as an independent woman. I wonder if Cathy also experienced a sense of relief now that her mother could do without the equipment, because it would also mean that her life could go back to being concerned about her mother as 'Mum' and her mother could now retreat from being 'a mother as patient'.

From an occupational therapist's perspective, the retrieval of equipment from a patient's house can require tact and explanation, to maintain good working

relationships with family/whaanau and the supplier. This is especially poignant when the patient has recently died, and a family member wants the equipment gone. Kay described her experience of interacting with some relatives of patients who have recently died.

When people pass away [there are] different scenarios about family and collection, some want it gone immediately. Others don't want any disruption while the funeral's going on, or the tangi or whatever. In some cases, people go away, they might take the body to the [Pacific] Islands, or they might take it down country to the marae or whatever. So there's actually quite a lot of negotiating that goes on with collection. Occasionally the person will ring up and say, "I've been waiting a week and it still hasn't been collected." If I get a patient ringing me up and giving me an ear bashing because something hasn't been collected, I explain that they [the rental company] do their very best for delivery, and sometimes it's understandable if collection doesn't happen quite so quickly. Then I might assure them and say, "Please be assured you're not going to be charged for this or anything, nor is the DHB being charged for this. If you could bear with us," kind of thing. (Kay)

Kay recognises how families react differently, and carry out their own plans during the bereavement period. Every so often, she experiences a relative's frustration regarding equipment pick-up. Her description of relatives "giving me an ear bashing" implies that they were forceful in their opinions about the slowness of equipment pick-up. For them, the need for the equipment no longer exists, and it has become present-at-hand: the presence of the equipment could be taking up precious space; be an eyesore; a reminder of unhappy memories that the relative wants rid of; or continuing to displace other objects that the relative wants to restore to their original place. Here, Kay is being an advocate for the equipment supplier, explaining why the equipment hasn't been picked up yet. Kay uses "us" to demonstrate that she is part of the retrieval system, and at this moment, she associates herself with the equipment supplier. Her tactfulness has the effect of maintaining the reputation of her employing organisation as caring and respectful, as was the rental company, which has the monopoly on short-term loan equipment supply to the DHBs in Auckland.

Conclusion

One of the aims of this study was to understand how patient participants experienced receiving, using and returning short-term loan equipment. Although the process of

deciding on, delivering and returning short-term loan equipment has been planned in detail from the DHB's perspective, and gives a semblance (Heidegger, 1927/1962, p. 51) of order and predictability, in practice and despite good intentions, smooth operation of the process is not guaranteed. While occupational therapists give written information on the equipment provided and pick-up instructions for the patients' future reference, the information is 'lost' rather quickly among the other papers received upon discharge and the resumption of life at home. The information was no longer 'there', and was lost to consciousness to the extent that it might never have existed.

The use and non-use of equipment for this group of patients is consistent with similar findings in the literature (Wielandt et al., 2006). In using the equipment, the most common experience was of a feeling of enablement and confidence that they would not hurt themselves while they performed activities independently. Having the equipment in situ also had a positive effect on some family members, through reducing their anxiety about their family member attempting to perform activities by themselves. My participants stopped using their equipment for one or more of four reasons: a) they had recovered sufficiently to not need it any longer, b) it was uncomfortable, c) the equipment did not fit the space where it was to be used, or d) the courier arrived to pick it up. In the last case, the decision to stop using the equipment was given over to the courier driver, who was acting in accordance with the instructions they received from the original order for the equipment from the occupational therapists. In other words, the equipment retrieval process had averaged out the patients' disability needs. Although the courier driver was reported to be personable and helpful, people like Nelle felt obliged to relinquish the equipment and manage without it.

I contend that the essence of the equipment was that it gave the patient participants a sense of independence from having to rely on other people. For the family, they experienced freedom from having to be present to help, rather they could be available in case help was needed.

Chapter eight: Getting the equipment right

Introduction

In the last two findings chapters, I discussed the occupational therapists' experience of providing short-term loan equipment, and the experience of patient participants in receiving, using and returning the short-term loan equipment provided to them on discharge from hospital. Equipment provision by inpatient occupational therapists is a routine part of their practice. It is so ordinary for them to prescribe equipment that their experience of doing so is glossed over and taken for granted. On the other hand, for patients, receiving and using this equipment is another facet of a major disruption to their life. It is not routine or ordinary, and they are usually expected by occupational therapists to accept and accommodate the equipment in their life for six weeks or more. This chapter explores the nature of the work that occupational therapists and patient participants did to get the right equipment solution. I have identified several key themes: rapport building, caring, knowing, and fusion of horizons. I propose that by using a combination of these themes, the occupational therapists and patient participants in this study, for the most-part, got the equipment 'right'. I will start with *rapport* because I think it is key to establishing the initial relationship between therapist and patient. Then I will look at *caring* as an important part of establishing rapport and trust between the therapist and patient. From there I will look at *knowing* as a basis of decision-making. I think that rapport, caring and knowing set the context for *fusion of horizons* and thence getting the equipment right.

Rapport

It is common to hear health professionals talk of 'establishing rapport' with patients when they first meet (Tickle-Degnan & Rosenthal, 1990).

I think we work much more closely with the families than other professions do. I think we get much more involved because we're coming in from a different aspect - about function - and so instantly gain rapport with patients.
(Carol)

Carol believes that by centring her interactions with patients on what they actually want to do, she gains rapport with them that her colleagues don't achieve. But what does she mean by rapport? Tickle-Degnen and Rosenthal (1990) propose that rapport is a social relationship between individuals, and that they may experience it when they 'click' or feel that the 'chemistry' between them is right (p. 286). They go on to say that individuals experiencing a high degree of rapport become joined together through mutual positive attention on what the other is saying or doing. Hendrick (1990) added to Tickle-Degnen and Rosenthal's definition of rapport, calling it a "magical meshing" (p. 314), and "...when everything clicks, everything seems suspended in time, and everything for that moment is perfect" (p. 315).

However, these authors also refer to rapport being developed over time. If that is so, how does a therapist develop rapport with patients in hospital that they might only see once or twice? In commenting on Tickle-Degnen and Rosenthal's (1990) work on rapport, Altman (1990) adds that the display of rapport may vary according to the context: professional and nonprofessional relationships, work and social settings, and participants act in ways that they think are appropriate in the setting they are in. Furthermore, he asserts that the physical environment creates the cues for behaviour. A hospital is an environment in which fleeting and short-term social relationships occur between people, who in turn, use a wide range of behaviours to manage those social interactions. In hospital, the cues for behaviour may be found in what Parsons (cited in Mottram, 2010) described as the social expectations of the sick role (p. 141). According to Parsons, patients are expected to cooperate with medical help, and are expected to want to get better. The expectation of behaving in a certain manner in a particular place is consistent with Heidegger's (1927/1962) notion of regions, or spaces where things are and action occurs. Conversely, health practitioners are expected to act in the best interests of the patient, act with honesty and integrity. Why then, is establishing rapport important? Leach (2005a) states that establishing a positive relationship leads to positive patient outcomes, possibly because of satisfaction with the care received and increased treatment compliance.

Writing about establishing therapeutic relationships or rapport in a New Zealand health setting would not be complete without considering the therapist's obligations under the Treaty of Waitangi¹⁷ to recognise and use Maaori ways of establishing relationships when working with Maaori: *whakawhanaungatanga*. Whakawhanaungatanga (pronounced fahkah-fahno-nah-tahnga) is the act of establishing connections with another person through sharing information about yourself, especially who you are and where you are from (Moorfield, 2011). Sharing information about yourself creates an opportunity for the other person to seek commonalities between you (personal communication, Brian Emery,¹⁸ 2000). Mooney (2012) supports this stance and reports that using whakawhanaungatanga approach enhances the likelihood that Maaori patients will engage with the health professional because the patient then has some information on which to decide whether the health professional is caring, trustworthy, knowledgeable and dependable (in particular, being sensitive to Maaori protocols and respect for others). Using this approach to establishing a relationship shows the Maaori patient that the therapist cares about them as an individual before steering the conversation to the therapist's object of concern (personal communication, Hineroa Hakiaha¹⁹ August 2016).

In my experience, establishing rapport in this manner also works for people from other cultures. If I extrapolate these expectations to the patient-occupational therapist relationship and the development of rapport, perhaps for Carol, 'rapport' is her paying attention to the 'being' (Heidegger, 1927/1962) of her patients, and in return, she experiences respect, attentive listening, cooperation and an ease of communication with her patients, as they both behave according to social expectations of staff and patients in hospital. However, I suggest that there is more to rapport than these behaviours. I think these behaviours provide the foundation for a successful interaction, and the relationship is enhanced by the therapist giving the impression that she cares

¹⁷ The Treaty of Waitangi was signed between Maaori and English colonisers in February 1840. The Treaty is considered the founding document of New Zealand, underpinning political, social and health activities in contemporary New Zealand.

¹⁸ Maaori elder (Kaumaatua), Counties Manukau Health

¹⁹ Maaori Cultural Advisor and Registered Nurse, Counties Manukau Health

about the person who is the patient, she is trustworthy, knowledgeable and dependable. How does a therapist give these impressions?

Caring

According to Wright-St Clair (2001), caring is seen as the basis of establishing therapeutic or meaningful relationships. She talks of 'phenomenological knowing in caring' (p. 192) and this form of knowing is concerned with engaging with a person in mutual cooperation to understand who the patient is and what his or her needs are. We are reminded by Landes (2015) that practice "is not an isolated skill-set, but a complex art comprising an indefinite set of skills, attitudes, and perceptions" (pp. 271-272). He further states that professional practice involves being caring and responsive and requires "a sense of tact guided by the weight of experience and responsibility" (p. 276).

Caring, reaching out towards others, wanting to be helpful, and satisfaction in doing so, were recurring themes described by occupational therapists. Lucy became an occupational therapist to help people. She describes the intent of her work being:

To help people be independent and achieve what they want to achieve. I love working with people and I like helping people. I like to feel useful as well, which is why I come to work, and feeling like I can make a difference. (Lucy)

For Lucy, being an occupational therapist means being helpful, making life easier for others, understanding what they want to achieve, and helping them to do so. In helping people and making a difference for them, she is reaching towards others, feeling a call to help (van Manen, 2014). Working as an occupational therapist serves her dual purposes of helping people, and giving her a chance to feel useful. Jenny's story of wanting to help and enjoying being helpful is similar:

I think it's important to be part of the patient journey. Our paths cross for a brief moment at that point in their lives, and at the brief time that our paths cross I need to be looking after that person and trying to do the best for that person. I quite enjoy that. (Jenny)

For Jenny, there is a sense of professional responsibility towards people as patients when she meets them. She thinks she must 'look after' them and do the best work for

them. In experiencing the call to reach out towards another in order to do the best for them, Jenny has demonstrated what Levinas called “being addressed by the otherness of the other” (van Manen, 2014, p. 115), and Jenny cannot help but feel responsible towards patients. While therapists talked about wanting to help and do the right thing by the patient, I wondered if the patients experienced their interaction with therapists in that way. Ron has a rare bone disease which retards bone healing, and he appreciated the individual attention he received.

My surgery was a total right hip replacement, and the first time the equipment was discussed was at an afternoon of meet and greet where some of the staff members talked through what you would be required to have at home to carry on your normal day-to-day activities when you were released from hospital. It was very good because the lady that ran it..... realised that I was different than the other people that were out there having their little talk. So she pulled myself and my wife aside and took us into another room to explain that because of my bone structure and what I was having done, it may be little bit harder to use the equipment than the normal person that was getting it done. Which was very nice, the simple fact that she picked up on the fact that I have a rare bone disease and that my usage of the equipment might have been slightly different than somebody else. Obviously she could see that there may have been a different way of recuperating than a person [that has normal] bone structure. (Ron)

Ron experienced the care and attention to his individual needs that Jenny said she wanted to give each of her patients. When the therapist demonstrated to Ron that she understood his condition, and had the foresight to give individual attention to him, he appreciated the individual attention. He understood his own condition and what that meant for him. He appreciated that the therapist recognised his needs as different to the usual patients undergoing a total hip replacement. When I asked Ron about his experience of using the equipment, he replied:

It's been great. It really has been. And like I say, I didn't really know what to expect but now that I've used the equipment and I had to go and have the other one done, I'd be quite happy to have the same stuff back. (Ron)

Scorpio had a similar experience of personalised service.

When we had a query while I was still in the hospital, [the therapist] came to us and sorted out what he thought he might need, so we weren't alone. And we had a phone number to ring at any time. It was very personal. The

equipment that was provided did meet my needs-- so I could function as normally as possible. Taylor-made to the individual. (Scorpio)

For Mr and Mrs Scorpio, the personal attention they received from the occupational therapist felt precisely tailored to their needs, and also gave them the impression that they could ask for help if they needed it. Both Ron and Scorpio experienced the therapists as caring about them individually.

For Ron and Scorpio, the occupational therapist had leapt ahead (Heidegger, 1927/1962) of them, and thought about how they would manage in the near future. I suggest that by leaping ahead, therapists are able to give patients a sense that the therapist understands their needs. Understanding their needs, implies that the therapist knows something about their condition and its impact on doing things. But what is 'to know'? I now turn to exploring what it means to know.

Knowing

Heidegger (1927/62) argued that "Knowing is a mode of Dasein founded upon Being-in-the-world" (p. 90). In other words, knowing is a way of being alongside other entities; a way of directing oneself towards someone or something intentionally; interpreting and making sense of what already is. To me, this sounds like an intellectual knowing. Also on an intellectual level, Aristotle is credited with distinguishing three different ways of knowing: *episteme*, *techne*, and *phronesis* (Kinsella, 2012). *Episteme* is thought of as theoretical knowledge; knowledge that can be proven, and learnt by anyone interested enough to do so (Gadamer, 2004). *Techne* is thought of as the practical, craft-like skill, applied to a particular task or field of endeavour (Gadamer, 2004; Heidegger, 1977). *Phronesis* is less easy to define. Kinsella and Pitman (2012) called it a 'slippery concept' (p. 2), and I found that each author had a slightly different interpretation of how *phronesis* revealed itself in practice. It is generally thought of as practical wisdom (Kinsella & Pitman, 2012; Landes, 2015; Sellman, 2012). Higgs (2012) helpfully suggests that practice knowledge is the sum of all knowledge used in practice, gained from professional practice experience and personal experience; and that *episteme*, *techne* and *phronesis* "dance together" (p. 77). There is general agreement that *phronesis* involves deliberate thought and judgment for 'good' and therefore is virtuous (Kinsella

& Pitman, 2012; Landes, 2015; Sellman, 2012); is experienced, as opposed to known as fact (Higgs, 2012; Shotter & Tsoukas, 2014); involves being able to discern the salient points of a situation in order to carry out prudent action (Shotter & Tsoukas, 2014); assists the professional practitioner to find their way through the messy, complex and variable context of practice (Higgs, 2012); and is characterised by the practitioner knowing more than they can say, and usually knowing more than they realise they know (Sellman, 2012). But as Meyer (1998) and Sellman (2012) point out, knowing comes with experience, and is never finished, one never knows it all. Occupational therapists bring all of their knowing through episteme, techne, phronesis, and life experience to the therapist-patient relationship.

Therapists' knowing

Turning now to the occupational therapist participants in my study, they showed their knowing in various ways. Jenny revealed her knowing of potential practical difficulties following elective hip replacement by drawing on her occupational therapy domains of concern, particularly self-care activities (Townsend & Polatajko, 2007).

A gentleman came in; he had a stiff hip; he was not able to sit in a chair easily. I talked with him about his supports at home, and about the home environment, and about his coping skills, what he was going to do to manage after his surgery. We went through in detail what he was going to do, how he was going to get dressed, how he was going to have a shower, what soap he was going to use, how he could sit on the toilet, how not to twist around. How he could lie on the bed, how he could turn over in bed, how he could get up from the bed, I think we needed to raise the height of his bed. What chair he was going to sit in, how he was going to manage during the day when his wife was out to work, how he was not allowed to drive, and how to get in and out of the car, what he needed to do to be able to have a cup of tea at home. (Jenny)

Jenny was thinking ahead to the activities that she anticipated this gentleman would have difficulty doing at home after surgery, when he needed to be mindful about protecting his hip during the initial recovery phase. By using her knowledge of hip replacement surgery, activity and movement analyses Jenny predicted the practical problems that this gentleman might face at home. By asking him questions about these everyday activities she implied that he should think about them, and avoid hip

movements that might put his hip under unnecessary strain, and therefore delaying recovery, or risking re-dislocation. Some of the activities mentioned by Jenny are usually done automatically, without conscious planning, for example, sitting to stand, lying and rolling over in bed, what soap he was going to use in the shower, twisting on the toilet. Through alluding to the possibility that these activities might pose a challenge, Jenny has brought them to the gentleman's attention – made them present-at-hand - for him to consider special precautions to protect his hip following surgery. This is especially appropriate if the man has not experienced a hip joint replacement before. Jenny goes on to show how her knowing points the way to her providing what she thinks is the right equipment:

With your chair, you tell me it's a struggle?" "Oh yes, it's very difficult to get in and out." "Right, so I will provide you with a rehab chair because I want you sitting in a chair with your knees lower than your hips and your feet on the floor." And for most people, they don't have a chair at home that will allow them to sit in that position. [This position] allows the muscles around the hips to relax so that they're not painful, they're not working all the time. When they get up, the person's got more energy to manage. It also means that they're half-way to standing. Therefore, it's easier for them to get up from the chair. So I'll probably start talking to them about observing hip precautions, so while I'm doing that I need to provide a [rehabilitation] chair.
(Jenny)

It does read as though Jenny was doing all the thinking, and suggesting possibilities. However, Jenny's understanding of the practical difficulties following this surgery has built up over several years. She talks as though she understands that the patient is struggling with the standing to sitting and vice versa. At this point Jenny calls upon her surgical, musculo-skeletal and biomechanical knowledge, to demonstrate her authority in hip precautions and how she applies it to patients following hip and knee replacement surgery. She explains why she recommends a rehabilitation chair with a high seat. In explaining her reasons she is giving the patient an account of her reasoning; that is, giving enough information to convince the patient of the benefits to him/her of using the rehabilitation chair. The expectation is that the patient will see the benefit of the equipment, accept it and use it. Moreover, Jenny watches out for other clues to tell her more about the patient in front of her.

One of the things that I look very carefully at, is the person's handwriting. So if you've got a person who's got good handwriting, and they're up playing golf and doing activities, then I know that they're pretty much okay. But when the person's got very shaky handwriting, and they're telling me that it's difficult to do very much, that gives me an indication they've got more problems. They're very likely to have other issues beyond handwriting; it might be muscle strength; it might just be age. It just tells me to watch what's going on. (Jenny)

I think Jenny's ability to look ahead at potential difficulties her patients might experience by observing performance of non-surgery related activities is the hallmark of an occupational therapist who is using her theoretical and practical knowing of aging and how performance of activities can be affected by impairment.

Patients' knowing

However, the patient participants in my study revealed their experiences of using equipment through talking about their bodily experiences such as comfort and discomfort; painful and pain-free movement; a sense of security and of feeling unsafe. For example, Ron felt unsafe when he felt the shower stool sloping forward; Helen felt secure in the shower when she used the shower stool; Moira felt safe using her over toilet frame and rehabilitation chair; and Elizabeth felt unsafe using her ill-fitting over toilet frame in her toilet, but she felt safe using the same piece of equipment as a walking frame. Merleau-Ponty (1948/2004) and Gendlin (1962) proposed that we know ourselves, others and things through our bodily interaction with the world, rather than through intellectual endeavour. Scorpio exemplified this when he described his rehabilitation chair as "quite cumbersome, and it's not all that comfortable. And it's very sticky in summer". His view is supported by Gendlin (1962) who asserts that the world moves in, on, and around us through our own actions with it, and that knowing from this experience is complex, personal and has many aspects to it.

Nicolini (2011) takes a different view when he writes about practice as the site of knowing. He argues that a health professional's knowing "is always a practical accomplishment and practice is where knowledgeability manifests itself, and agency becomes possible" (p. 602). I interpret this to mean that knowing is revealed through one's actions, and through those actions, one is able to make things happen. Nicolini

goes on to say that knowing is “the totality of everyday practices ordered in space and time” (p. 605). In this article, his emphasis is on the telehealth nurse’s knowing what they need to do when, with whom, with what, in what order, and how it fits with what other health practitioners are doing at that time. Little attention is paid to knowing patients, the patients’ knowing of themselves, or how patients might contribute to the nurses’ knowing. I suggest that it is their personal knowing that the patient participants bring to their relationship with occupational therapists. As Jenny noted earlier, the therapist and the patient come together briefly in hospital, and neither knows anything about the other when they first meet. How do the two differently lived worlds of occupational therapists and patient come together? Perhaps “Being-in the same world” (Heidegger, 1927/1962, p. 64) and showing understanding of each other is the precursor to a what Gadamer (2004) calls *fusion of horizons*.

Fusion of horizons

What is a horizon? Gadamer (2004) talked of horizon as “the range of vision that includes everything that can be seen from a particular vantage point” (p. 313). He goes on to argue that “we must always already have a horizon in order to be able to transpose ourselves into a situation” (p. 315). Gadamer is saying that we all have our own range of vision or perspective that we bring with us into life situations. He also writes of horizons consisting of consciousness of the past as well as the present. Occupational therapists and patients thus always already have their own horizons when they meet in hospital. What then, do the patients and occupational therapists bring to the concerned inquiry? The patients bring to the relationship their *Being* (Heidegger, 1927/1962), their knowledge of themselves through their past and present bodily experiences, plans and wishes for the future.

Everything we talk about, everything we have in view, everything towards which we comport ourselves in any way, is being; what we are is being, and so is how we are. Being lies in the fact that something is, and in its Being as it is (p. 26).

My understanding of Heidegger’s (1927/62) concept of *Being* is that he writes mostly from the perspective of an individual, but an individual who is part of, resides alongside,

and is familiar with his or her world, which is always a world with others (even in their absence). Patients are considered the expert on themselves (Vadiee, 2012), and it is this knowledge that they bring to the patient-therapist relationship. I suggest that one's *Being* also consists of their horizon as described by Gadamer (2004).

Occupational therapists bring to the practice situation their own past experiences of life; their experiences as an occupational therapist and understandings of how impairments might affect a patient's performance of common occupations at home; their own knowledge of equipment and its potential to be helpful or a hindrance; and the expectations of the occupational therapy profession and the DHB. From this vantage point, occupational therapists have their own *horizons*. When a therapist demonstrates a willingness to understand a patient's perspective and merge it with her own, she expands her own horizon in what Gadamer (2004) calls a "*fusion of horizons*" (p. 317). The therapist has the opportunity to place herself in a patient's shoes, so to speak, in order to begin to understand "the indissoluble individuality of the other person" (Gadamer, 2004, p. 315) and reach some degree of mutual understanding (Arnason, 2000, p. 18) of what is important for them with regards to going home to resume their life with a temporary disability. The purpose of having a shared understanding of the patient's perspective of themselves is not to just describe or interpret the patient's horizon, but to *apply* that knowledge (Gadamer, 2004, p. 318) towards a successful outcome for the patient.

Other theorists have also written about the coming together of understandings. Van Manen (1990) proposes the notion of *Lived Other* (pp. 104-105) where people share interpersonal space; they come together in some bodily way and develop a relationship through conversation, and in doing so, transcend themselves. In hospital, both the patient and therapist put aside their differences, and together they focus on the purpose of their coming together and planning a common goal: discharge home. They come together in the world of practice, each with their own understanding of how that world is. However, for the occupational therapist to be truly helpful to patients, she has to also understand their world. Now I turn to Gendlin, cited in Sharma (2011), to offer an

explanation of how a therapist can understand the lived experience of patients with disabilities. Gendlin argues that:

We are able to understand the other individual, despite differences in personal history and culture, when we approach the interaction with an attitude of eager interest. This attitude includes openness towards the possibility of widening our own experiencing to find new, shared symbols to express the [situation], thus crossing our lived meanings. Crossing enables the creation of something meaningful that was not there initially in either person. (Sharma, 2011, p. 187)

Gendlin asserts that past and present circumstances and influences constantly cross each other in our thinking. I suggest that when therapists and patients share their thoughts in concerned inquiry, a crossing of understanding occurs, and these crossings point toward the next step, and thus new and expanded meaning can be attained. To me, this is how Gadamer's (2004, p. 317) *fusion of horizons* occurs. As a result, each person in the encounter has learnt something from the other that "involves rising to a higher universality that overcomes not only our own particularity but also that of the other" (Gadamer, 2004, p. 316).

The therapist cannot know what the 'being' of a patient is in advance of meeting them. In order to demonstrate an openness to the others' experience, and begin the process of crossing or fusing the horizons, the therapist must ask questions. Heidegger (1927/1962) said of questioning:

Every inquiry is seeking. Every seeking gets guided beforehand by what is sought. Inquiry is a cognizant seeking for an entity both with regard to the fact that it is and with regard to its Being as it is. (p. 24)

Occupational therapists ask questions to deliberately seek information on what they cannot know beforehand: what the patient's home environment is like, how the patient managed at home before being in hospital, and how the patient thinks they will manage everyday activities like getting in out of the shower, on and off the toilet, making meals, doing the laundry when they go home again. In Helen's case, her therapist asked her:

Who's at home with you? How will you do things? Who's going to do the washing? Who will be cooking for you? I was quite proud to say I don't do it [chuckles]. Had I not had that family support, it would've been a very

necessary question because, if I was going home to be by myself - and they did ask - or if I had people at home who weren't domesticated, it could have been very, very difficult. (Helen)

Helen understood the purpose of the questions was to ensure that necessary services could be put in situ. The therapist was concerned about Helen's ability to perform the occupations of running a household, such as laundry and making meals, which are typically done by the woman of the house. In Helen's case, other members of the household took responsibility for regularly cooking meals and doing the laundry, and she expected that they would continue to do these occupations. Through the act of asking specific questions of Helen, the therapist sought to understand Helen's previous and present level of occupational performance, her knowledge of herself and her home situation, and expectations for the near future. In doing this, the therapist is seeking to understand Helen's *horizon* (Gadamer, 2004, p. 317): her view of herself and how she thinks she will manage when she gets home, from her vantage point.

Nonetheless, talking about private matters like getting on and off the toilet and in and out of the shower are not an everyday topic of conversation between adults.

I remember when I first started here I felt like a complete wally²⁰ saying to someone, "How do you get on and off the toilet?" but after a couple of times I realised that actually a lot of people are just so relieved to be asked that. I link it in with how they function on the ward. I might start with the chairs and lead into that. So give them a reason of why I'm asking about this. And I say, for example, "A lot of my patients before had said they really struggled to get off the toilets. The toilets are very low. Are you using the rails on the toilet when you get off?" and I talk to them about how they're functioning in the ward environment with the equipment, and you translate that to home and what home looks like. (Carol)

Once Carol got over feeling conspicuously awkward in asking about getting on and off the toilet, she developed a way of incorporating questions so that they appeared less intrusive. In asking patients how they managed to get on and off the toilet, Carol learnt that people were thankful that the subject had been raised. In this respect, Carol had opened the conversation up to allow for patients to express their lived experience of

²⁰ In New Zealand vernacular, to feel like a "wally" is to feel conspicuously silly and awkward.

toileting. From asking such questions, the next step was revealed to Carol: inquire further, and if necessary provide equipment to address any difficulty.

How did the patient participants experience such questioning? Nelle was someone who found it comforting to think that someone had thought about how she was going to manage getting on and off the toilet:

Quite comfortable and, yeah, probably reassuring. I had really struggled prior to the operation with getting on and off the toilet. So it was a relief to know that there would be a toilet chair. (Nelle)

Nelle's experience of being asked about the private matter of toileting was of finding a positive solution to an activity that she found challenging. Others also experienced therapists' questions about their activities at home as positive: "One of the things was that the hospital staff are very good at is identifying your needs through questions" (Moira), and this was echoed by Scorpio: "I don't think there was anything that wasn't covered in some way." From the questions asked, and the answers elicited, therapists and patients could together think through in dialogical relation (Arnason, 2000), potential practical difficulties at home and make some predictions about what equipment the patients might need.

Could it be that by leaping ahead and concernfully asking questions about the personal and private activities (that in polite society might otherwise be unmentionable), occupational therapists reveal their Being-with Others (Heidegger, 1927/1962, p. 161), being on their side as it were, and show their understanding of practical difficulties at home? Maybe, this revealing "helps the Other to become transparent to himself (sic) *in* his care and to become *free for it*" (Heidegger, 1927/1962, p. 159). And maybe it is this revealing that allows patients as 'others' to relax with and trust the therapist, thus making it easier for the two of them to find common ground, allow their horizons to merge. As Arnason (2000) says "Thus the partners meet, so to speak, in the subject matter and the criterion of a successful dialogue is that they achieve a common judgement or a consensus concerning it" (p. 21).

If I am correct in saying that occupational therapists seek to understand patients as 'beings' with their own horizons in order to apply that understanding to seek appropriate equipment solutions, then what happens when the practice context does not support therapists to spend time getting to know the patient well?

Limited horizons

Working in a busy hospital ward has its frustrations for occupational therapists. All of them experienced a dynamic tension between the ideals of occupational therapy practice and the limitations placed on practice by the hospital environment. Occupational therapists value being able to see the environments in which patients live in order to be able to recommend the best equipment solution (Townsend & Polatajko, 2007). However, the pressure of work on acute wards means that home visits are not practicable because of the time they take. The implications of not being able to see or picture the home environment is that therapists have to make educated guesses based on incomplete information provided by the patient and family/whaanau.

That's the trickiest part in Acute because we actually don't see the environment. It makes it harder for us to recommend equipment, and to make sure it works for their setting, because we don't actually see the house. Which is the biggest problem, I think. (Lucy)

Lucy laments that she is unable to see a patient's home, and this is a significant hindrance to her being able to ensure that the equipment she has provided actually will work for the patient in their environment. Getting the equipment right for Lucy is hampered by having to work blind in regards to the environment where it is to be used. Jenny faces this blindness as well. She works with people undergoing elective joint replacement surgery, and is mindful of the hip precautions recommended for these patients. To help fill the information gap, Jenny asks her patients to fill in a form.

They fill out a home assessment form. If people are telling me they have difficulty rolling over in bed, and hang onto the headboard, or the hubby, or the bedside cabinet, or the mattress, or the dog, then it's better for us to give them a bed lever so that they can manage that, and that action makes them independent. (Jenny)

Jenny is unique among my therapist participants in that her patients' hospital admissions are planned, and she is able to interview them before their surgery. She is able to seek written information from the patient because of the contact she has with them before they are admitted to hospital. The home assessment form she refers to has diagrams of a toilet and shower, and room for measurements to be recorded. Jenny is also unique in that elective hip and knee replacement surgery is comparatively routine, with general precautions to assist healing. This makes it possible for Jenny to predict likely difficulties at home. She deals with any uncertainty by being directive.

I now put in equipment at the beginning and say, "This is what you're likely to need; if you don't need it, send it back". I would expect to give hip patients a rehab chair to sit in, a shower stool and an over-toilet frame. Knee surgery patients will have a toilet-surround frame and a shower stool. They may also have bed raisers, a bed lever, possibly a second shower stool if they're needing to stand in the kitchen. (Jenny)

Here Jenny is leaping in and leaping ahead at the same time. She's taking control of what equipment the patient will be provided with, because she can see the possibilities of difficulties, and the possibility of equipment as an enabler of independence. This is also an example of the difference between the thrown trajectories between the patient with limited experience of life after surgery, and the therapist with years of experience in practice.

For Carol, who works with terminally ill patients, not knowing more about a person as a *Being* at home was the significant gap.

Without seeing the home environment and how the person is in their home - you never really have all the information. From the hospital, you don't meet all the family, and you don't really get an idea about who the person is outside of an acute end patient setting. I don't actually know who that person is as a being and how they want to interact with the world. I think of some of our patients who for whatever reason, be it kind of a cultural norm, they're happy to be looked after and to be cared for. They don't want to be independent in self-cares because they get the support at home, that's part of their being, that's a part of how it fits in their culture or for some people how they feel love and acceptance and are supported by their family. All of these things that are happening in their world and support that [B]eing, as opposed to us just saying, "They need to be independent. I'm going to give them a shower-stool, they would be fine." But then you might be taking away

a whole support-structure and then you're taking away a social element.
(Carol)

Carol is showing her understanding of people as occupational beings (Wilcock & Hocking, 2015), who have preferred ways of living their lives. She is alert to the possibility that by leaping in (Heidegger, 1927/1962, p. 158) and providing equipment, she might be interfering with valued family practices. When I asked Nina how she knew that she had enough information to be able to decide on what equipment to provide, her reply was much more prosaic:

I know that I don't have enough information when I have more questions. If someone's like, "Oh, it's just a bath. You know, a shower over a bath." I'm like, "Okay, well, is there a wall and a ledge, or is there just a wall? And what else is in the bathroom and where is the basin?" You know, like, "Give me more than shower over a bath," because that just gives me the bath scenario, you know. So I just have to keep asking questions until I can paint the room out. (Nina)

Nina's concern in this passage is to find out exactly what the fittings in the bathroom are like. Knowing these details will inform Nina of what equipment is most likely to fit where it needs to go. However, she asks the patient to recall details that are so familiar to them but are no longer visible to them. So she uses prompt questions to help create a picture of the room, so she can visualise where things are sited. In following this line of reasoning, Nina is also concerned about possibilities of not getting the equipment right (poor fit, unusable) and therefore putting the equipment in the realm of present-at-hand, rather than ready-to-hand and used.

Lucy and Carol allude to making decisions about which equipment to provide with incomplete information about the patient, the family, the home. Carol goes on to explain how she tries to expand her limited horizon.

Before I go see any patient, I usually talk to the nurse and read the notes and find out exactly what they're requiring assistance with. I get family to double-check equipment already at home. Do they have lips on their bath? You do assessments on the ward, find out how if they're using equipment on the ward. Are they just using it because it's there, or are they using it because they need it? Sometimes people just use it because it is there, and so I observe them getting off the toilet without using any of the rails. I'm obviously identifying their occupational concerns, looking at the performance

components, and then looking at whether any of those performance components are changeable. I talk a lot with the doctors as well. Is the patient going to get better, or are they likely to get worse? And then looking at my different intervention options. I don't think you have a hundred per cent of the information, but you just pull everything together and do the best that you can. (Carol)

Carol uses a range of sources from observation of the patient doing activities, information from family members, documentation in the patient's clinical file, nurses and doctors to gauge a patient's capability and likely difficulties, given their illness. While all this is appropriate data gathering, it is time-consuming. Getting family involved in the gathering of information on the details of baths, toilets, and showers can take more than 24 hours. The therapist is reliant on a third party to give her the information, remember the details, or visit the house to take note of the details for the first time, such as: does the bath have a level rim or a lip? What is the position of the toilet outlet pipe – back, left or right? What size and shape is the shower? Does it have a lip – how high? How much room is there in the toilet, bathroom? How does Carol know who the best family member is to get this information? How does she make contact with them? Relying on catching family members when they visit the patient and talking to them then, is somewhat hit-and-miss.

Talking to them over the phone is more direct and faster, but may be difficult to 'show' them what you mean. So working with family members doesn't guarantee more accurate or faster information gathering. Thus Carol is still in the position of having to make decisions or recommendations without fully knowing the home situation. Carol talks about gleaning information from doctors about the patient's condition – what the immediate prognosis is; can an improvement be expected in the short- to medium-term? She considers to what extent performance components (physical, cognitive and psychosocial aspects of moving, thinking, engaging with others) impact on the person, and what, if any of them, could improve or deteriorate, and how will this affect the person's ability to do for themselves. Through observation of a patient getting on and off the toilet on the ward, Carol can see if they use the ward equipment, and if it is essential for them to be able to get on and off, or is it 'desirable' i.e. used because it is there. In Heidegger's terms, is the equipment *ready-to-hand* or *present-at-hand*? In

Counties Manukau Health's terms, is the equipment essential or desirable? This is occupational therapy clinical reasoning at its most fundamental (Robertson & Griffiths, 2012).

People come into hospital with the expectation of being treated or cured of their ailments. They do not come with the dimensions of their bedrooms, toilets, bathrooms, the front door access, and the furniture/fittings in them etc. When asked about these by an occupational therapist, the patient and family give incomplete information, based on their memory of their unconscious use of these spaces. This is an example of being thrown in the unknown.

Thrown into the unknown

When occupational therapists and patient come together at the site of practice, they are together thrown into, or delivered over to, a new situation (Heidegger, 1927/1962). However, the trajectory of the thrownness is not equal for therapist and patient. For patients, the thrownness may be from a number of things, for example: an operation or treatment received which they have not experienced before; being dependent, even temporarily; or feeling trepidation about the future. Annie had her first hip replacement and commented on her reaction following the surgery:

[When I] saw how disabled I'd become through having that operation, I thought, "Am I going to be able to walk?" That's the first thing that gets in your mind. You've got to start walking all over again. (Annie)

Annie's reaction to her impaired mobility after surgery reveals her uncertainty and nervousness about being able to walk again. "Gets in your mind" implies that she mused about it often. She had been thrown or delivered into a situation that was, for now, an earlier stage of human development – learning to walk again. For Annie, this was a leap into the unknown. Ron observed thrownness, not so much in himself, but in others who attended the same hospital meeting as he did.

As far as the experience went, it was possibly something that wasn't new to me because I've been in and out of hospitals most of my life. When I looked around the room and saw the variety of people that were having their hip done, I thought it must have been quite daunting to some of them. Especially

the people that were from Islam states or Arabs states that didn't speak any English. They had to have family there to interpret for them. A lot of people couldn't get their head around the fact that they were going to get operated on and wouldn't be able to look after themselves for six weeks. They had to have some sort of home care. (Ron)

Ron sensed that a number of his fellow meeting participants had difficulty understanding, or coming to terms with, what would happen during and after their surgery. How much more difficult it must be for the non-English speakers to make sense of where they have been delivered over to? Withy (2011) understands thrownness as a starting point, where we are located at this moment, and “from which we have to start and with which we must deal” (p.62).

For occupational therapists, the thrownness is related to meeting a new patient, a new Being to get to know, with their own horizon or experience and perspective of their world. A key difference between patients' and therapists' thrownness is, I think, most patients will experience their particular thrownness a small number of times in their life. On the other hand, therapists will have their experience of working with large numbers of people with similar disabilities, and they have a whole enframed equipment system at their disposal. The newness of each therapist's thrownness is with each new patient as a unique Being, the therapist cannot assume that what worked for someone else, will also work for the new person in front of them. The therapists in this study were blind to 'their patients' home environment and how the patients usually managed at home. To fill this information gap, therapists developed their own way of eliciting the missing information they wanted. Kay said:

You don't imagine that everybody lives in a brand new purpose-built house. I can quite often now almost imagine what the house is like from the address. You can pretty much guess which ones are Housing New Zealand's and which ones aren't. I often don't get a lot of time to get to know people, but I've developed a very good way of assessment by remote control, if you like. I know the questions to ask - the practical ones like: "Does your toilet have a side pipe? Are there other people in the family who're going to be using the toilet?" But also, questions about what they do during the day, just to try and visualise the environment. And not just the environment, but how people are operating in that environment on part of a normal routine. (Kay)

Kay seeks different types of information related to the patient managing at home. She knows that where a house is situated will give clues as to its design. Housing New Zealand houses²¹ have small bathrooms, toilets and bedrooms, and can pose challenges around space for equipment. The practical questions about the physical layout of the toilet will assist Kay with finding the right equipment to suit all toilet users in the house. Her queries about the person's daily routines gives Kay more information about the person's present capabilities. According to Heidegger (1927/1962) interpretation of information is about working out possibilities (pp. 188-189). I suggest that patients' thrownness is a catalyst for the occupational therapist to join them in a quest for possibilities, towards something possible (Heidegger, 1927/1962, p. 305). Kay works with terminally ill people at the end of their life. Like Jenny and her patients with hip replacement surgery, Kay has more experience of people dying from cancer and their practical needs than the individuals with cancer themselves. Her experience leads her to think about the possibilities of barriers to continuing to do for oneself, and the possibilities of equipment that could overcome the identified or potential barriers.

I hear myself saying to patients, "Better to have it and not be using it than need it and not have it." Sometimes I'll do it with something like a shower stool. The patient might say "I'm all right, I can stand up in the shower," etc. I say, "Okay. If you don't use it in the shower, how about positioning it outside the shower so you can sit on it when you're drying yourself, or why don't you position it at the vanity so you don't have to stand up when you're doing your teeth?" or having a shave, or putting your makeup on, or whatever, knowing full well that sooner or later it's going to be used in the shower. Or I'll say, "It's such a useful piece of equipment. It doesn't have to be used in the shower. Why don't you use it as a bus stop between the lounge and the bedroom? Just pop it in the corner and if you're walking between the lounge and the bedroom, and you suddenly need to sit down, you've got somewhere to sit down. Or pop it on the landing of the stairs so you can have a rest halfway up (Kay).

Here, Kay is using her experience to pre-empt some of the difficulties that she predicts her patients will face at home. She knows the equipment could mean the difference between coping and not coping at home. She has broken each activity into stages where the patient might need rest during the activity, and once rested, they might be able to

²¹ Housing New Zealand is a government agency whose role is to provide and manage social housing for people in the very low socio-economic category. They usually have three bedrooms, one lounge room, a combined kitchen and dining area, one small bathroom, one toilet, and laundry facilities. They are often clustered together in neighbourhoods

continue the activity to completion. In this case, the positioning of a shower stool in different places when the patient needs to sit and rest, reveals the possibilities of the shower stool as a flexible item of equipment as the patient decides to use it, thus it can be ready-to-hand when they need it.

Conclusion

The occupational therapists in this study gave a lot of consideration to getting any necessary equipment right for the patient, but each therapist used different clinical reasoning to come to a decision about 'what is right'. Carol approached her patients with the belief that each person is an individual *Being* in their own right, so any equipment solution needed to be specific to their needs. In order to understand the patient's specific needs for equipment, Carol liked to understand the patient in the context of their physical disability as well as her/his cultural beliefs and values. On the other hand, Jenny believed she was doing the right thing by patients if she provided an almost pre-determined set of equipment for patients undergoing elective joint replacement surgery, based on her knowledge of surgical procedures and bio-mechanics. Kay paid attention to her patients' daily routines, and broke activities into stages where rest stops could be arranged as the patient tired. In addition to their clinical reasoning, the therapists also paid attention to caring for patients, and this was noticed by patients as individualised care. Therapists and patients demonstrated their knowing at the site of practice, although in different ways: the patients through bodily experiences; and the therapists through their theoretical knowledge (episteme), organisational and technical knowledge and skills (techne), but more importantly I think, through their practice know-how (phronesis). When therapists were able to take the time to glean specific relevant information from their clients, and link that with their own practice wisdom, the equipment was more likely to be 'right'.

Chapter nine: Discussion

Introduction

In this study, I sought to understand, describe and interpret the experience of providing, receiving and using short-term loan equipment by interviewing occupational therapists and patients. Conducting the study has been a very privileged and interesting occupation for me. It took me into the heart of the occupational therapist participants' practice, and into the privacy of the patient participants' personal lives. My beliefs about short-term loan equipment were, in turn, affirmed and challenged. Not only that, I have learnt how occupational therapy practice is shaped by influences that are beyond the therapists' control, but through which they must navigate to reach the goal of providing the 'right' equipment for each patient. I have learnt that patients bring their own unique way of knowing to the therapist-patient encounter that only they could know. Now I have reached the position of being able to see from whence I have come, and to which I can go with what I have learnt from this study. Heidegger (1927/1962) describes this way of Being as coming to a 'clearing' (p. 171). To explain what a clearing is, he used the metaphor of the open space in a forest where there is a big enough gap in the canopy of trees to let light reach the ground. At this point, it is possible to see before, behind, left and right as possible directions to travel. "Only for an entity which is existentially cleared in this way does that which is present-at-hand become accessible in the light or hidden in the dark" (p. 171).

In this chapter, I will use Heidegger's (1927/1962) notions of Being-in-the-world to interpret the experiences of the occupational therapists and patients with short-term loan equipment. To shed further light on the experiences of providing, receiving and using short-term loan equipment, I will relate the findings of this study with what I found in the literature. I will finish off with consideration of the strengths and weaknesses of the study, and practical recommendations for therapists and the DHB that I believe will enhance the experience of providing, receiving and using short-term loan equipment.

Being-in-the-world: Enframed

"Being-in-the-world" (Heidegger, 1927/1962) is interpreted by Overgaard (2004) as a mode of 'being' for humans of "being situated in the midst of the world, in the midst of what there is" (p. 121). It is more than being bodily present. Being-in-the-world implies a wholeness to the human being that cannot be divided into component parts, and includes mood, hope, courage, and sensing (p. 122). The participants in this study came to be alongside each other, individually, each with their own way of 'being', in the world of practice. In this study, the world of practice was in a large hospital and hospice, with all the arrangements created in that world to provide the services they were originally set up to provide. The world of practice for occupational therapists providing short-term loan equipment revealed itself as an enframed (Heidegger, 1977) system: an invisible, interconnected grid-work of arrangements that facilitated and constrained the provision of short-term loan equipment. Enframing is specifically designed to prefigure particular kinds of practice (Ronneman & Kemmis, 2016). In this study, much of the enframing was set up by authorities (the 'They') in the health system, and led to the therapists feeling constrained and hemmed in (King, 1964). Therapists developed strategies to cope with the demands of their work.

Patients entered this enframing when they sought medical assistance for their ailments which resulted in short-term disabilities. For most patients, needing rehabilitation was a new experience, and occurred in a world that was unfamiliar to them. They too were constrained by what the short-term loan equipment system could offer them in the range of equipment. With my manager's hat on, I was complicit with the constraints when I introduced the equipment prescription criteria and therapists' training programme for prescribing equipment. The criteria and training became the means for achieving control over the equipment rental budget (Kohlen, 2015). The capped budget meant that the therapists' and patients' choices of equipment were limited to what I deemed to be essential for use at home.

Conversely, patients were also enabled by the same system. The ACC Act ("Accident Compensation Act," 1972) (and amendments over the years) and the NZPH&D Act

("New Zealand Public Health and Disability Act," 2000) were social in their intent and application. These Acts provide material assistance to people with disabilities in numerous ways that were unavailable to them before their enactment. These Acts are consistent with occupational therapy's philosophy of assisting people to continue to live their lives as part of their society. The short-term loan equipment system made it possible for the patients to be discharged home with equipment that was designed to assist them in occupations that may otherwise have been painful and insecure. The short-term loan equipment was valued by the patients. Annie's, Moira's, Nelle's and Ron's stories attest to this enablement, each of them saying that they could not have managed without the equipment.

The 'short-term' nature of the loaned equipment implies that there will be a transition from 'needing' to 'not needing' in the near future. The therapist fully expects the equipment to be returned when it is no longer needed. The change in need comes about through healing and recovery, or because of the patient's death. Either way, the therapist usually does not have anything more to do with the patient once she or he is discharged from hospital. The equipment administration team takes on the oversight of equipment retrieval at the end of the expected loan period.

Being-in-the-world: With technology

Equipment

For some patients, the equipment brought into explicit awareness connotations of old age and infirmity that initially put them off wanting to use it. The equipment represented something that was not the image they had of themselves, nor the image they wanted to show publically. The belief that equipment was for old and infirm 'others' was especially notable in the patient participants who were first-time-users. Those who had previous experience with the equipment recalled its helpfulness, and were prepared to use it again, even predicting their own needs. For most participants, however, it was a pragmatic short-term solution that they were pleased to have available because it enabled them to retain some independence in their daily routine. They could do what

they needed to, when they wanted to do it, without relying on assistance from someone else. The instrumental technology (Heidegger, 1977) was the means to an end.

The system

In chapter four I described how the human activities and socio-political arrangements of providing short-term loan are considered by Heidegger (1977) to be an example of technology (p. 288). The system as technology has been enframed, as previously described, to create some order (Royeen, 2003) in an otherwise fragmented, non-linear, complex system (Creek, Ilott, Cook, & Munday, 2005; Kannampallil, Schauer, Cohen, & Patel, 2011; Lambert, Harrison, & Watson, 2007). The equipment prescription criteria I wrote were designed to create some order and consistency of equipment provision within my DHB. The criteria had a constraining effect on what therapists could and could not provide. Therapists such as Nina and Lucy experienced the restrictions positively; having the criteria in place gave them authority to not provide short-term loan equipment if they thought the patient did not need it. In contrast, Carol thought the restrictions did not recognise her skill as a therapist nor her patients' occupational needs. To remedy this situation, she took the role of patient advocate to challenge the criteria when she thought the patient was being disadvantaged.

The system of providing short-term loan equipment works some of the time, and does not work at other times. I now turn to explore what makes the system work or not work for occupational therapists and patients.

For patients, the system worked when...

For the patient participants in this study, the system of receiving, using and returning short-term loan equipment worked well when several positive actions came together. I will group these positive actions into *connecting with the therapist, the patient themselves, the equipment worked for the patient, home through the eyes of the patient, and the patients' experiences of the system itself*.

Connecting with the occupational therapist

Patients liked it when the therapist displayed a mood of openness and concernfulness towards them as an individual. According to Crisp (2015), mood “refers to a state of being that occurs below the threshold of consciousness, and which precedes and influences consciousness” (p. 164). Patients experienced the therapist as having a mood of openness when she respected their opinions, experiences, strengths and their own particular disability needs. Concernfulness was experienced when the therapist asked about potential difficulties at home following discharge. In other words, the therapist did not average out their disability needs, but took a special interest in them as an individual. Patients also liked it when the therapist, through her questions to them, demonstrated that she understood how their condition might impact on the activities they needed to do at home. Moira and Helen remembered that the therapist asked questions about getting into and out of the house, and how they would manage the domestic tasks. Ron was impressed when special attention was given to him because of his bone disease and its likely impact on healing following surgery. The mood of openness seems to have helped to create rapport (Cribb & Gewirtz, 2005; Leach, 2005b; Tickle-Degnan & Rosenthal, 1990) and trust (Flores & Solomon, 1998) in the therapist.

The patient themselves

The system worked well for patients when they believed they were well-informed, and events happened as planned. In particular, explanations about what they were likely to experience on discharge from hospital, and what the process was for equipment delivery and retrieval were appreciated. Recall Mrs Scorpio and Moira talked matter-of-factly about the equipment delivery and retrieval process happening as the therapist said it would. Scorpio was even able to return some items and retain others for a little longer. When events happened as planned, they contributed to establishing patients’ ‘confidence in’ (Rotenstreich, 1972) the therapist and the system. Rotenstreich commented:

There is in confidence, either warranted or not, as aspect of an opinion: that the person can or should be trusted, or that things will turn out satisfactorily,

or that the response relied upon will be forthcoming, or that the expectation will indeed be fulfilled. (p. 348)

For patients, the system worked when they had confidence that the therapist was respectful towards them, she worked on their behalf, and knew how the system worked. In other words, the system worked for patients when they experienced rapport with their therapist, and the system's activities played out as expected.

The equipment worked for the patient

The system worked for patients when, together with therapists, the potential difficulties were identified or became present-at-hand (Heidegger, 1927/1962), and they helped to select the equipment. Recall that Nelle and Helen described how their conversations with therapists embraced their self-determination (Arnason, 2000). In these conversations, both parties met in a mood of openness to each other, and reached a consensus over the equipment. Nelle and Helen were able to decide (from a limited range of items) which equipment was likely to be useful to them.

The system worked for patients when the equipment was delivered in a timely manner so that it was ready-to-hand (Heidegger, 1927/1962) immediately they arrived home from hospital. A smooth delivery process seems to facilitate the equipment quickly becoming ready-to-hand at home, saving from patients having to put some other strategy/equipment of their own in place in the interim that they would then have to unlearn or remove, if they switched to the hired equipment. Perhaps the most vulnerable period is in transition from the support of the hospital to a home not-yet-ready to receive their disabled body. If the equipment is not 'there' and correctly installed in terms of height, stability and positioning, the person and their carer/s are left to flounder. Having the equipment 'ready' is thus vital to supportive care.

Equipment was successful for patients when it fitted where it was to be used, felt secure and afforded independence for the user and other family members. Moira and Helen relished the independence they experienced. Mrs Scorpio and Cathy were relieved to think that their husband and mother respectively were safe in the shower. Thus there

was both a physical support and a mood of being supported afforded by the right equipment in place.

Home, through the eyes of the patient

For patients, the system worked when they were able to return to the familiar environment of their own home, and could have confidence that they would manage there because of the equipment. Moira and Annie talked of their pleasure in being able to manage independently in the shower and toilet respectively because the equipment was right for them. While it is unlikely that people would choose to clutter their homes with such equipment, in this rehabilitation phase of their health experience it was the equipment that enabled them to be at home. In their at-homeness, the equipment receded to the background, became ready-to-hand, and for that time was part of their at-home experience.

The patients' experiences of the system itself

Having the short-term loan equipment in standing reserve (Heidegger, 1977) was appreciated by all the patients. Annie, Elizabeth, Helen, Moira, Ron, and Scorpio all valued having the equipment available to them when they needed it. When I asked Helen about her memories of the equipment, she said:

I am really grateful for having the equipment readily available for me and the efficiency of it being there a couple hours after I was discharged. That is something that I'm really grateful for because that was very, very helpful (Helen).

The system also worked well for those patients who remembered the information about returning the equipment when it was no longer required. They either contacted the equipment supplier, or the supplier contacted them in a timely manner to arrange the pick-up. The system worked well for the patients when the right equipment was delivered and picked-up in a timely manner.

For the occupational therapist, the system worked when...

For the occupational therapists in this study, the system of providing short-term loan equipment worked well when they had time to connect with patients, could enable the patient with the right equipment, could get a clear view of the patient's home, and when the system was flexible.

The occupational therapist had time to understand patients and their context

Therapists like Jenny, Kay, Nina and Carol were most satisfied when they were able to spend enough time with patients in order to understand them as individual people, their living contexts and reach a consensus about equipment. Recall that Jenny enjoyed being a part of the patient's journey, and trying to do her best for them. Doing her best for them involved being able to solve problems related to occupational challenges at home, and provide short-term loan equipment and other strategies for patients to protect their joints during the recovery stage. For Kay, having time to create a web of relationships with patients and colleagues in the DHB and equipment supplier was integral to her being able to do a good job. Carol liked to understand patients as 'beings', with their own worldview and preferred ways of doing activities, and to have the time to trial equipment that would meet a patient's disability and occupational needs. Nina liked to take time to give patients a sense of control over the choice of equipment they would get. These therapists took the necessary time to establish rapport (Cribb & Gewirtz, 2005; Leach, 2005b; Tickle-Degnan & Rosenthal, 1990) with patients and colleagues. Their mood of openness towards patients facilitated the fusion of horizons with patients, where each came to understand the possibilities and constraints of getting the equipment right for the patient and their situation.

The system also worked for therapists when patients were able to talk about themselves and their home environment. Nina talked of continuing to ask questions until she could picture where the walls and fittings were so she could 'paint the room out' and see what their bathroom or toilet looked like in detail: whether the bath has a lip around the top of it, how big the shower is, how high the step is into the shower, or where the toilet outlet pipe sits. These details helped Nina to select the right equipment i.e. the

equipment would fit and be secure where it was to be used. Perhaps in this age of smart phones, there are easy ways of therapists being able to view photographs of particular aspects of patients' homes that may enable them to 'see' with more clarity.

Kay liked to ask about the patient's daily routine, how they spent time during the day, who else lived in the house and therefore needed to be considered, and specifically about bathroom and toilet fittings. When patients and therapists came to the encounter with a mood of openness, openness to possibilities (Heidegger, 1927/1962) ensued. Openness to possibilities allowed patients to consider how recommended equipment could be useful to them. In other words, the system worked for therapists when they experienced rapport with patients.

The therapist could enable the patient with the 'right' equipment

The system worked for therapists when they were able to get the right equipment for the patient. Recall that Carol expressed satisfaction at being able to provide equipment that did not interfere with her patients' cultural needs, and to her palliative care patients that could enable them to go home before they died. Lucy gained satisfaction with enabling her patients to do activities at home easily:

We come with the possibility of them actually functioning a bit easier at home, and having the tools for it as well. Quite often they'll be waiting for [the occupational therapist], and they'll be anxious about how they'll manage at home, so they're glad to know that there's something available for them. So it's nice to have that role of making their lives a bit easier. (Lucy)

A raised toilet seat, for example, is never just a piece of equipment. For the therapist it is the piece of equipment (Heidegger, 1971) 'this' patient needs. For the patient, it becomes 'my' toilet seat. When it works well, it is soon fades into the background, forgotten. The patient uses the toilet in a manner of normality, not thinking about the seat that makes this possible.

The system was flexible

The system worked for therapists when they were able to provide equipment they anticipated would meet the patient's disability needs. More than this though, the

system worked for them when it was flexible enough so they could provide equipment that enabled occupations beyond showering, toileting and getting into and out of bed. Carol's story about her patient with cancer of the spine wanting to set his business right before he died, is testament to this.

In summary, the system of providing receiving and using short-term loan equipment worked well for patients and therapists when three elements came together, as shown in Figure 3: a) *mood of openness* to each other and to possibilities; b) *confidence* in each other as doing their best to solve a practical problem and in the equipment as being useful, safe to use, and ready-to-hand when needed; and when the system was flexible; and c) there was *time* to establish rapport and understanding, and to solve the problems identified.

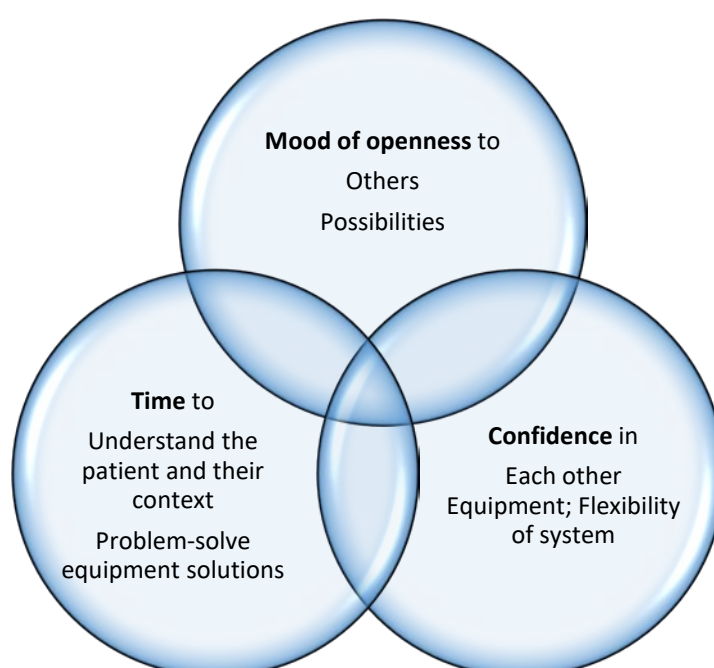


Figure 3: The short-term loan equipment system worked for patients and therapists when openness, confidence and time came together

The system did not work when...

Several things contributed to the failure of the system to deliver an effective service to patients and their family/whanau. Especially noticeable were: the therapist and patient

did not connect with each other, the system was inflexible and tightly constrained, and the occupational therapist's practice was dominated by the goals of the organisation.

The therapist and patient did not connect

The system of providing short-term loan equipment did not work for patients when the therapist was experienced as being remote or unavailable, as in Elizabeth's and Cathy's cases. For Elizabeth, a middle-aged Maaori woman, the therapist was remote. Elizabeth had vague memories of having a phone conversation about equipment that she would need after her operation, but did not recall any other meaningful interaction with a therapist. In an earlier chapter, I referred to *whakawhanaungatanga* as the way of establishing rapport with other people, as being culturally appropriate for Maaori. In Elizabeth's case, I wonder how much attention the therapist paid to the culturally appropriate method of getting to know her, developing rapport, before 'getting down to business'. Perhaps this omission by the therapist contributed to Elizabeth's lack of connection with the system.

Recall that Cathy's mother (Mrs C) left hospital on a Sunday, and the staff on duty that day did not know what arrangements, if any, had been made for Mrs C's equipment. For Cathy, the therapist was absent. She had no interactions with a therapist before taking her mother home. It seems that Mrs C's discharge was not planned in a joined-up way. It was through Cathy's determination and problem solving that Mrs C received any equipment after she arrived home. There can be no understanding of each other when there is no connection between people.

The system did not work for patients when they or their family did not understand how the system worked, or they did not know what to do. Unclear and unspoken expectations between therapists and patients showed a gap in communication which contributed to the system not working for Elizabeth and Cathy. This is consistent with Gramstad et al's (2014) finding that unspoken expectations were a source of dissatisfaction with equipment provision. Lack of follow-up post discharge meant that

Elizabeth's and Cathy's predicaments were not identified and addressed by occupational therapists.

Without rapport and openness, there was the danger of the patient becoming a diagnosis, and the equipment supplied on the basis of expected or average need, or not receiving a service at all. While this approach likely worked in some situations, it afforded no room for uniqueness, for complex health needs, for cultural considerations, or for helping the patient understand how and when to use the equipment. Possibilities for individualised care in such an approach, disappear into standardised equipment allocation. The more care becomes standardised, the easier it is to delegate to non-registered health workers such as Assistants. This is a call for occupational therapists to consider afresh the skill base and practice wisdom they bring to the patient encounter and short-term loan provision, and to decide when it is, and is not, appropriate to delegate the provision of short-term loan equipment.

The system was inflexible, tightly constrained

As described in an earlier chapter, constraints were deliberately introduced to the short-term loan equipment system, in order to control the equipment budget. Recollect Carol's frustrations with being hemmed in by policies, procedures, and a tight budget for equipment. Nina experienced frustration with having to curtail her practice in order to fit in with the expectations of the acute wards:

When you first start, you just want to give the patient everything and you want to make everything okay because you sympathise so much. But then you talk to the senior therapist and they tell the new ones, "Just say no. If they don't need, they don't need it." But at the same time, you start and you just want to be the OT that you imagine at university and solve everyone's problems with everything, but you can't always. So it is conflicting, isn't it?
(Nina)

A tightly constrained, inflexible system does not allow occupational therapists to visit patients' homes. When occupational therapists are not able to see the patients' home environment, they must make educated guesses from incomplete information about what equipment could work for the patient. Unless the patient alerted the therapist about problems with the equipment, therapists had no way of assessing the

effectiveness of equipment within the patient's home. It may or may not be at the right height, or not fitted. It may have to be shared with other family members who find that uncomfortable, removed it and did not re-install it. It may be an embarrassment when a visitor asks to use the toilet. The toilet seat may become a walker when the patient realises that its wide base of support provides stability, and it is light enough to pick up and place in front of her. The therapists' role ended with their initiation of delivery of specified pieces of equipment, and consequently, they did not become involved in decisions about the appropriateness of the timing of the equipment 'going back' after a set period.

For some patients, the 'auto collection' happened out of the blue. One day, the delivery man arrived to take the equipment away. Standing at the door, the patient had no sense of knowing how well they would manage without it. Their response to the suggestion that they could keep it longer was likely informed by a variety of factors. They may not have really known how easy it would be to use the toilet without the raised seat. Yet, in the moment, they needed to make a decision. Some people had the confidence to ask for an extension (the information on how to do so is given to the patient on a 'green sheet' before discharge). When an extension is requested, the prescribing therapist makes contact with the patient. However, I suspect that many people do not have the confidence or information on how to ask for extra time. Equipment is taken away without the occupational therapist having any opportunity to give input. It may be that an aging person has got to a stage where such a seat would be helpful as a permanent fixture in their home. The system affords little, or no, opportunity for this to happen. It is the same for all short-term loan equipment. It is given for the short-term and is gone within a short term. The constrained system does not have enough flexibility for therapists to spend time to routinely follow-up patients after discharge, to check on patients' continuing disability needs. I am left with the question of whether this limit to their practice 'works' in the best interests of their own professional integrity and the effective rehabilitation or recovery of the patient.

Occupational therapy practice is restricted by the employer's goals

The occupational therapists in this study experienced having their practice restricted by the drive to facilitate rapid discharges from acute wards to achieve the DHB's goal of reducing patients' average length of stay in hospital. Therapists experienced a need to take a utilitarian approach to their work in order to comply with the 'discharge as soon as possible' discourse of the organization. Jenny and her manager reasoned that it was more cost efficient to provide equipment prospectively for all people recovering from elective hip and knee surgery, than to provide equipment after the patient identified a need at home after discharge. These patients received a standardised equipment intervention. Their disability needs were averaged among all people receiving similar surgery, with a loss of patient individuality. Having said that, I believe Jenny's and her manager's intention was to balance efficiency with effectiveness (Federici & Borsci, 2016; Kohlen, 2015). When there is an emphasis on discharge, I think there is also a loss of patient individuality. Recall how Carol felt hemmed in by the equipment criteria and her manager's expectations to concentrate on her patients' equipment needs rather than their mood level, anxiety, daily routines and other things that contribute to a sense of wellbeing.

I have depicted the issues related to the system not working, as I see them, as three unconnected circles in Figure 4.

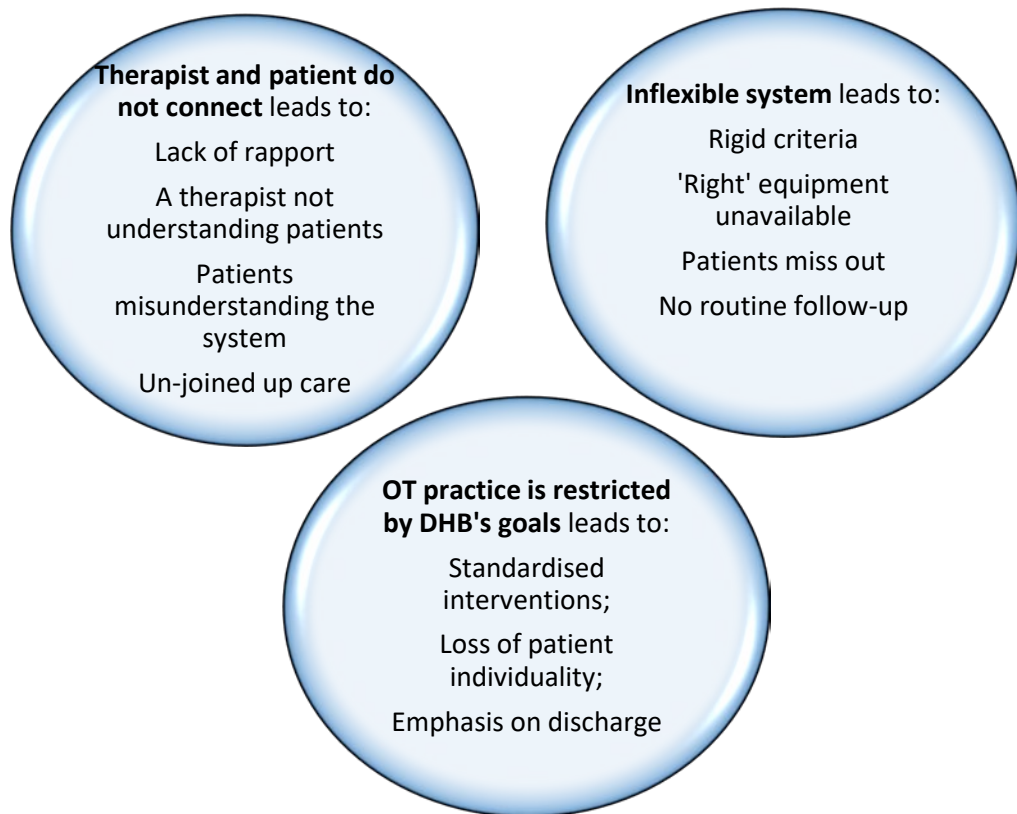


Figure 4: The short-term loan equipment system did not work for patients and therapists when lack of time, an inflexible system and occupational therapy practice dictated by DHB goals came together.

For the most part, the weeks of rehabilitation go smoothly, out of the gaze of the health service. It is taken for granted that regaining bodily strength and decreasing discomfort simply happens. It usually does happen, but at different rates and time for each person. I think this is the 'void' (Heidegger, 1971) that assistive devices fill; that is, the space where patients struggle with their recovery. The system is geared towards the 'average'. The biggest gap in the equipment system is the lack of attention paid by occupational therapists to what happens when it is time for the equipment to be returned. While the equipment system 'gives', it also 'takes away'. At this time, the averaging out of patients' experiences is most evident. There is little oversight of patients' ongoing disability needs once the initial loan period ends. The findings of my study support and are supported by other studies, which I turn my attention to next.

Back to the literature

Throughout my study, I repeatedly returned to the literature to assist me to understand and interpret the participants' experiences of providing, receiving and using short-term loan equipment. Engaging with the texts and literature has been a privilege; listening to and reading the participants' stories, and reading others' accounts of their experiences has extended my understanding of providing, receiving and using short-term loan equipment in ways that I did not anticipate at the beginning. The purpose of this section is to bring together the findings of this study and relevant literature.

In an earlier chapter, I described the enframing of the short-term loan equipment system as being somewhere between a complicated and relatively complex system (Creek, 2009; Creek et al., 2005; Kannampallil et al., 2011; Lambert et al., 2007; Royeen, 2003). The actual process of providing the equipment is, in Kannampallil et al's (2011) terms, complicated in that there are many components, the process is lineal with some interrelatedness between these components. In other words, the process can be mapped out, predicted and described, with some predictability; with "each person interacting with the system in a limited manner for their specific role-based tasks" (p. 945). It is also a complex system in that the people involved act in ways that are consistent with who they are in all their individuality, leading to sometimes unpredictable responses (Paley & Eva, 2011).

To non-occupational therapists, providing short-term loan equipment can appear to be a straightforward task. Sometimes it is easy and routine. However, the complicated and complex nature of the practice context in this study is revealed in the large number of elements that interact in non-linear ways: the individuality and unpredictability of patients and their environments; the individuality and practice behaviours of therapists; the expectations of the DHB; the OTBNZ; and managers of occupational therapy.

The experience of providing short-term loan equipment in this study has parallels in overseas studies. It is common for occupational therapists working in hospitals to feel that their scope of practice is restricted by the employing agency's policies, procedures and funding arrangements (Jorg et al., 2005; Maywald & Stanley, 2015; Mortenson et

al., 2013). I used the model of practice architectures (Kemmis, Wilkinson, Edwards-Groves, & Hardy, 2014) to explain how practice is enframed for occupational therapists in this DHB. In order to provide the right equipment to address patients' disability and occupational needs, occupational therapists were required to demonstrate an ability to navigate competing demands (Maywald & Stanley, 2015; Murray, Turpin, Edwards, & Jones, 2015). They must constantly weigh up time spent with clients and enabling interventions with achieving the DHB's goals of rapid discharge.

Strengths and limitations of the study

Previous studies have investigated the experience of therapists or patients related to providing or using permanent equipment. The strength of this study is that it sought to understand the experience of providing, receiving and using short-term loan equipment from both the patients' and occupational therapists' perspectives. This means that an aspect of 'experience' was explored from the beginning of the process of providing short-term loan equipment to the point that the equipment was returned to the equipment supplier. This study is unique in that respect.

The research approach selected inevitably set limits to what would be included. Two participants identified as Maaori. Due to my language being limited to English, the participants were limited to those who could speak conversational English. This excluded people who were not fluent in English, but whose experiences of the phenomenon could well have given me different insights. I had intended interviewing Pasifika people, but this did not happen because I was unsuccessful in making contact with the Pacific Health Advisor at the time of recruiting participants. There were no participants from Asian countries. With their strong cultural emphasis on family interdependence, Asian and Pasifika participants could have added another dimension to my understandings.

A second limitation of this study is the narrow range of ages of the patient participants, and the fact that they all had undergone surgical procedures. Although the invitation to participate in this study was open to medical patients too, it transpired that no medical patients were recruited by occupational therapy staff from those wards.

A third limitation is that I had recently been the Professional Leader for these occupational therapists, although at the time of interviewing, I was no longer in that position. However, I cannot know how the therapist participants' stories were influenced by the relationship.

Implications for practice

This study has revealed the complexity and complicatedness of providing short-term loan equipment. I see several implications for occupational therapy practice in acute hospital services. The *first* implication for practice, and I think the most important, is 'taking time'. In striving for an efficient system that improves the patient journey, provides value for money and improves the population health, there is a danger that individual patient's disability needs can be glossed over and taken for granted. In this study, the system worked when therapists took the time to get to know individual patients, teach them how to use and adjust the equipment to fit, and where necessary, challenged the decisions of the 'they'. I suggest that therapists need to ensure that they protect the time necessary to practice *whakawhanaungatanga* (establishing relationships, connections and rapport) with patients so that they can really understand the patients' hopes, dreams and disability needs.

The *second* implication for practice is that occupational therapists should leap ahead and pay deliberate attention to the potential ongoing disability needs of each patient at the time of negotiating short-term loan equipment. To wait for the patient to notify the therapist of any difficulty contributes to covering over a need. In an earlier chapter, I described how Helen gave over the decision of whether she was bad enough to warrant using a walking aid to the surgeon. More of giving over of decision-making is evident when the courier arrives to pick up equipment at the end of the loan period. The patient may or not be ready to give up the equipment, but in that moment when the courier driver is standing there in front of her, Nelle gave over to the driver the decision to take the equipment away. When Helen's equipment was picked up in her absence, she also let that decision stand, even though she would have liked to retain the shower stool and over toilet frame for longer. The absence of occupational therapy input at this stage of

their recovery could mean that patients continue to struggle unnecessarily. On the other hand, it could also be the impetus for them to rediscover that they can manage without equipment.

The *third* implication for practice is the need for follow-up after discharge to check if the equipment is having the desired effect, or if there is a long-term need for equipment. Remember Elizabeth's experience of the over toilet frame not fitting the toilet. I wonder how often this occurs, thus making the equipment unsafe and useless.

The *fourth* implication for practice is using digital technology to 'see' into patients' homes. Therapists talked of being able, or not, to picture the patient's home. There is an opportunity now to ask the patient or family members to take digital photos or videos of specific areas of the house, and send the photos to the therapist via email or other format.

The *fifth* implication for practice involves using mobile phone texting to communicate with each other. Patient participants in this study were cognitively able to describe their experiences to me, and create solutions to the challenges they faced at home. Even then, they sometimes forgot about the written information they were given in hospital by an occupational therapist. What then, of the patients who are cognitively compromised, and unable to remember information given to them, or solve problems they face at home? Therapists or the equipment supplier company could use mobile phone texts to communicate with patients and their family e.g. to follow-up after discharge, or to remind them when the equipment is due for collection and ask if they are ready for it to be picked up, or did they wish to keep the equipment for longer. I'm hopeful this option will become even more routine as the older generation of patients become digitally literate and experienced.

The *sixth* implication for practice relates to patients knowing who the people are who work with them, and therefore who to ask when things do not work out as expected once they get home. An opportunity exists to provide patients with a booklet giving this information on admission to the ward. The patient and family would then have time to

read it and ask questions before discharge. Information on their equipment could be included in the booklet when the equipment is negotiated with the patient. Furthermore, information on Independent Living Centres within the city, where they can buy their own equipment for long-term use, can be given at the same time. The information, together with a concerned conversation, might lessen the likelihood of the written information being forgotten or lost among other discharge papers.

Occupational therapists have the expertise to transform lives (Wilcock & Hocking, 2015) as the patient participants in this study have described. Currently, skilled and experienced occupational therapists can confidently uphold their expertise on providing short-term loan equipment because at some previous point in their practice they have visited patients in their homes. They have seen the variability of people, house designs and fittings, and how people cope and create their own ways of doing things that work for them in their own environment. Newer graduates may not have experienced such home visits, for they are no longer standard practice. I worry about the effect of practice constraints that now prevent occupational therapists from conducting home visits, and the lost opportunities for learning much more about the lived experiences of patients in their own homes. I think the *seventh* implication for practice is that there is a danger that occupational therapy will become narrowed to assessment, discharge planning and supervision of Assistants (Cameron & Masterson, 1998), rather than the enactment practice of skilled enablement. Within such a narrow context, decisions are made on the basis of a levelled down or averaged out perspective rather than through their own and the patients' lived experiences. The challenge is for occupational therapists to protect and preserve their expert practice for situations where it can add value.

Implications for research

As this study progressed, several ideas for further research emerged. The ubiquity of smart phones gives families and therapists opportunities to share photos of the patient's home readily. Occupational therapy could investigate the efficacy of using digital photos and videos for seeing home environment of patients while they are still in hospital. The therapist could ask family members to take specific photos or videos, supported by

instructions on specifics such as access into the house, the lip around the bath, the shower itself, where the toilet is in relation to walls, where the toilet out-flow pipe is situated, and relevant measurements related to the toilet, bathroom, and any steps into and within the house. An action research study could work towards designing guidelines for such practice initiatives.

Another focus for research is to investigate the agreement in equipment prescription between occupational therapists and occupational therapy assistants for patients undergoing routine hip and knee replacement surgery. Patients who are otherwise well and cognitively able but who need hip or knee replacement surgery, may have predictable equipment needs. It is possible to train assistants to recognise potential occupational performance issues in these patients, and provide equipment accordingly (personal observation). If it is found that trained assistants have similar outcomes to occupational therapists providing equipment for this group of patients, then assistants could work in this area under supervision of occupational therapists, thus freeing a more expensive and scarcer resource for the more complicated areas of practice. Again, action research could draw together co-participants to work on such a proposal.

There is a movement in health in New Zealand to partner with users of health services to co-design new systems so that the new system is better suited to users' needs. Occupational therapy could invite equipment users to assist with redesigning the short-term loan equipment process. The following questions are the ones I thought about, and service users will have their own questions. What do patients and their families think will make the system work better for them? How could equipment provision for patients being discharged at weekends be made secure? How can patients and their families know about equipment options, such as the range of products? Which ones can be funded by the DHB, or what could they buy themselves? How to arrange to keep the equipment for longer or permanently? This again lends itself to action research.

It would be useful to extend this hermeneutic phenomenological study to interview people more specifically about their experience following the short-term loan equipment being taken away. Such a study would seek to recruit people likely to be in a

transition phase of their independence e.g. aging, chronic health issues. It would seek to reveal the need to be open to the possibility of ongoing need for equipment, and consider ways this could be initiated.

The results of this study are particular to the group of people I interviewed. The findings cannot be generalised to the diverse ethnic and migrant populations of this district. Research into how Asian and Pasifika peoples' experiences of receiving and using short-term loan equipment is required. Such research will probably need language support from speakers of the participants' preferred language.

Conclusion

The nature of hermeneutic phenomenology means that I brought my pre-understandings with me into the questions I asked participants and my interpretation of their stories. My pre-understandings included: short-term loan equipment is helpful to people recovering from short-term disability; providing short-term loan equipment is a large part of acute therapists' practice; providing written information to patients on equipment collection and therapists' contact details was an efficient way of giving this information. As I near the end of this study, I now understand that my original understandings were not necessarily right or wrong; however, I now see that the experiences of providing, receiving and using short-term loan equipment are multifarious, ranging from rejection to ambivalence to enthusiastic, and were tied in with feelings of frustration with their disability. It became clear to me that there is no such thing as one way that suits everyone, but there are possibilities to modify practice to enhance therapists' ability to provide the 'right' equipment. In doing so, perhaps the patients will also benefit by receiving equipment that meets their disability needs, and then the DHB will spend less money on abandoned equipment. The challenge for occupational therapists is to preserve their skill in 'getting it right'.

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Appendices

Appendix 1: Photos of equipment in situ



Figure 6: Over toilet frame with adjustable-height legs.



Figure 5: Shower stool with adjustable-height legs.



Figure 7: Rehabilitation chair with adjustable-height legs.

Appendix 2: Application for ethics approval



AUTEC
SECRETARIAT

28 October 2014

Clare Hocking
Faculty of Health and Environmental Sciences

Dear Clare

Re Ethics Application: **14/331 What is the experience of providing, receiving and using short-term loan equipment (STLE)?**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 20 October 2017.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 20 October 2017;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 20 October 2017 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Marie Chester mcwchester@xtra.co.nz

Appendix 3: Locality approval from Counties Manukau Health



03 February 2015

Dear Marie

Thank you for the information you supplied to the Counties Manukau Health Research Office regarding your research proposal:

Research Registration Number: **2004**

Ethics Reference Number: **14/331**

Research Project Title: **What is the experience of providing, receiving and using short-term loan equipment?**

I am pleased to inform you that the CMH Research Committee and Director of Hospital Services have approved this research with you as the CMH Co-ordinating Investigator.

Your study is approved until 16th June 2017.

Amendments:

- All amendments to your study must be submitted to the Research Office for review.
- Any substantial amendment (as defined in the *Standard Operating Procedures for HDECs*, May 2012) must also be submitted to the Ethics Committee for approval.

All external reporting requirements must be adhered to.

Please note that failure to submit amendments and external reports may result in the withdrawal of Ethical and CMH Organisational approval.

We wish you well in your project. Please inform the Research Office when you have completed your study (including when a study is terminated early) and provide us with a brief final report (1-2 pages) which we will disseminate locally.

Yours sincerely

Dr Shamshad Karatela

Research Advisor

Counties Manukau Health Under delegated authority from CMH Research Committee and Director of Hospital Services

Appendix 4: Patient participant information sheet and consent form



Date Information Sheet Produced: 15 July 2014

Project Title

What is the experience of providing, receiving and using short-term loan equipment?

An Invitation

Hello, Kia ora, Talofa, Malo e Malei. An Occupational Therapist or Occupational Therapy Assistant is giving you this information on my behalf. My name is Marie Chester and I am an experienced occupational therapist, based at Middlemore Hospital.

I am inviting you to take part in a study that I am doing on the experience of occupational therapists who provide short-term loan equipment, and **the experience of people receiving and using the equipment when they are discharged from hospital.**

Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason, and it won't affect the care you receive. If you do want to take part now, but change your mind later, you can pull out of the study at any time.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why I am doing the study, what you will be asked to do, what the benefits and risks to you might be, and what would happen after the study ends. I will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with other people, such as family, whaanau, friends, or healthcare providers. Feel free to do this.

If you would like to take part in this study, please sign the Consent Form on the last page of this document, and give it to one of the staff at the end of this session. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep. This document is four (4) pages long, including the Consent Form. I will contact you again in three or four weeks to check if you still want to participate, and if you do, we'll agree on a time and place for the interview.

What is the purpose of this research?

In occupational therapy, we are very interested in making sure that our service at Middlemore Hospital is the best it can be. As someone who has recently been in hospital

and provided with short-term loan equipment when you went home, your experience of receiving and using the equipment is of great interest to us, so that we can make improvements where necessary in our equipment service. I plan to present the findings of this research to the Occupational Therapy New Zealand conference in 2017. I also plan to submit an article for publication in the New Zealand Journal of Occupational Therapy in 2017.

How was I identified and why am I being invited to participate in this research?

You are about to undergo elective surgery, and will probably need some equipment to use when you go home to help with your recovery.

What will happen in this research?

Participation in this research will involve

1. The interview with me that will last about 1 hour, in your own home, or somewhere else if you prefer. The interview will be about what it is like for you to receive and use the equipment at home. The interview will be audio-recorded, then typed up and used, along with all the other interviews, to describe and interpret the experiences of people who received and used short-term loan equipment.
2. I might ask you if I can take a photo of your equipment where you use it. The photo will only be used to show how people position the equipment to suit their own needs.

What are the discomforts and risks?

Because the research involves you talking about your experience of receiving and using short-term loan equipment, any risk to you is unlikely. I would like to ask you some questions about how you manage your everyday tasks, such as getting into and out of the shower or your bed; or on and off the toilet; or walking and carrying things; and whether the equipment was helpful or not. Also, I would like to hear about your experience of having the equipment delivered and picked up.

How will these discomforts and risks be alleviated?

You will not have to tell me anything you do not want to.

What are the benefits?

This information that you and other participants give me will be used to make improvements to the occupational therapy equipment service. This research will also form the basis of my thesis for a Doctor of Health Science degree through the Auckland University of Technology (AUT).

How will my privacy be protected?

Your privacy will be protected in several ways. Only I as the interviewer will know your real name; you will be asked to suggest a false name for yourself so that you cannot be identified by anyone else. The person who types up the interview recording will hear our conversation. The typed document will use your false name. This recorded interview and the typed document will be saved in a secure location for up to six (6) years after the interview,

according to AUT's policy and protocols. The information will not be used by anyone else, for any other purpose.

What are the costs of participating in this research?

The only cost to you will be about two (2) hours of your time over two interviews, several weeks' apart.

What opportunity do I have to consider this invitation?

I will contact you in three to four weeks after your surgery.

How do I agree to participate in this research?

If you choose to participate in this research, you will be asked to sign a consent form. You can do this by filling in the consent form attached to this information sheet, and give it to one of the staff at this information session.

Will I receive feedback on the results of this research?

Yes, I will send you a summary of the findings of this research when I have analysed all the information.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Clare Hocking*, at clare.hocking@aut.ac.nz work phone number: 09 921 9162.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEK, *Kate O'Connor*, ethics@aut.ac.nz , 921 9999 ext 6038.

Who do I contact for further information about this research?

Marie Chester, primary researcher, marie.chester@middlemore.co.nz or 021 582 805

Researcher Contact Details:

Marie Chester, primary researcher, marie.chester@middlemore.co.nz or 021 582 805

Project Supervisor Contact Details:

Clare Hocking, at clare.hocking@aut.ac.nz work phone number: 09 921 9162.

Approved by the Auckland University of Technology Ethics Committee on 28 October, AUTEK Reference number 14/331

I give my permission for my name to be passed on to Marie Chester for her research. I understand that Marie or a Cultural Advisor will contact me in about 2 weeks.

My name:

If patient agrees, affix their sticky label here

Signature:

Date:

Appendix 5: Occupational therapist participant information sheet and poster



Date Information Sheet Produced: 22 August 2014

Project Title

What is the experience of providing, receiving and using short-term loan equipment?

An Invitation

Kia ora. My name is Marie Chester and I am a Doctor of Health Science student at AUT.

You are invited to take part in a study that I am doing on on **the experience of occupational therapists who provide short-term loan equipment (STLE)**, and the experience of patients receiving and using the equipment when they are discharged from hospital. Whether or not you take part is your choice. If you don't want to take part, you don't have to give a reason, and it won't disadvantage you in any way. If you do want to take part now, but change your mind later, you can pull out of the study at any time up to the point of data analysis.

This Participant Information Sheet will help you decide if you'd like to take part. It sets out why I am doing the study, what your participation would involve, what the benefits and risks to you might be, and what would happen after the study ends. I will go through this information with you and answer any questions you may have. You do not have to decide today whether or not you will participate in this study. Before you decide you may want to talk about the study with others, such as your colleagues. Feel free to do this.

If you agree to take part in this study, you will be asked to sign the Consent Form on the last page of this document. You will be given a copy of both the Participant Information Sheet and the Consent Form to keep. This document is five (5) pages long, including the Consent Form. Please make sure you have read and understood all the pages.

What is the purpose of this research?

In occupational therapy, we are very interested in making sure that our service at Middlemore Hospital is the best it can be. As an inpatient occupational therapist who routinely provides short-term loan equipment to adults with temporary disabilities, your **experience of providing** this equipment is of great interest to me. I plan to present the findings of this research to the Occupational Therapy New Zealand conference in 2017, and the Assistive Technology Association New Zealand conference in 2016. I also plan to submit an article for publication in the New Zealand Journal of Occupational Therapy in 2017.

How was I identified and why am I being invited to participate in this research?

As an occupational therapist working in Middlemore Hospital, you are therefore known to the occupational therapy staff group. You are being invited to participate in this research because of your experience of providing patients with STLE, to assist with patients' recovery at home.

What will happen in this research?

Participation in this research will involve one interview with me that will last about 1 hour, in a mutually agreeable venue. The interview will be audio-recorded, then be typed up and

used, along with all the other interviews, to describe and interpret the experiences of occupational therapists who provided STLE, and patients who received and used the equipment.

What are the discomforts and risks?

Because the research involves you talking about your experience of providing short-term loan equipment, any risk to you is unlikely. I would like to ask you some questions about what does being able to provide STLE mean to you? What do you think about, or take into account, when deciding on providing STLE? What do you like/not like about providing STLE?

How will these discomforts and risks be alleviated?

You will not have to tell me anything you don't want to.

What are the benefits?

The information that you and other participants give me will be used to describe and interpret the experience of STLE for occupational therapists and patients. It might be able to inform improvements to the occupational therapy equipment service. This research will also form the basis of my thesis for a Doctor of Health Science degree through the Auckland University of Technology (AUT).

How will my privacy be protected?

Your privacy will be protected in several ways. Only I as the interviewer will know your real name; I will then give you a false name so that you can't be identified by anyone else. The person who types up the interview recording will hear our conversation. The typed document will use your false name. This recorded interview and the typed document will be saved in a secure location for up to seven (7) years after the interview, according to AUT's policy and protocols. The information will not be used by anyone else, for any other purpose. Another way your privacy can be protected is by conducting the interview in a venue of your choice, away from the general staff thoroughfare.

What are the costs of participating in this research?

The only cost to you will be about one (1) hour of your time.

What opportunity do I have to consider this invitation?

I will contact you about two (2) weeks after you have indicated your interest in participating in this research.

How do I agree to participate in this research?

If you choose to participate in this research, you will need to sign a consent form. You can do this by filling in the consent form attached to this information sheet, and post it to me via the hospital internal mail.

Will I receive feedback on the results of this research?

Yes, I will send you a summary of the findings of this research when I have analysed all the information.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, *Clare Hocking*, at clare.hocking@aut.ac.nz work phone number: 09 921 9162.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTECH, Kate O'Connor, ethics@aut.ac.nz , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Marie Chester, primary researcher, marie.chester@middlemore.co.nz or 021 582 805

Researcher Contact Details:

Marie Chester, primary researcher, marie.chester@middlemore.co.nz or 021 582 805

Project Supervisor Contact Details:

Clare Hocking, at clare.hocking@aut.ac.nz work phone number: 09 921 9162.

Approved by the Auckland University of Technology Ethics Committee on 28 October 2014 AUTECH Reference number 14/331

WOULD YOU LIKE TO PARTICIPATE IN OCCUPATIONAL THERAPY RESEARCH?



<http://products.disabled-world.com/product.php?id=38131>

Occupational therapists routinely provide short-term loan equipment to assist recovery after discharge from hospital.

As an occupational therapist, I want to understand and describe:

What is the experience of providing, receiving and using short-term loan equipment?

To understand the experiences of occupational therapists, I'd like to interview you. Are you interested in sharing your experiences with me in an individual interview? If yes, please contact me. My details are in the pink box at right.

What is it like for patients to receive and use short-term loan equipment?

What is it like for occupational therapists to provide short-term loan equipment?

1-hour individual interviews with up to 8 occupational therapists, & up to 8 patients

Marie's contact details are:

Learning & Development
level 3
Esme Green Building

Marie.chester@middlemore.co.nz

Ph: 276 0044 ext 7281
Mob: 021 582 805

Appendix 6: Consent form



Project title: *What is the experience of providing, receiving and using short-term loan equipment?*

Project Supervisor: *Professor Clare Hocking, and Professor Liz Smythe*

Researcher: *Marie Chester*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 15 July 2014.
- ☐ I have had an opportunity to ask questions and to have them answered.
- ☐ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ☐ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to a photo of the equipment being taken for the purpose of showing where I use it. Yes ☐ No ☐
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (please tick one): Yes ☐ No ☐

Participant's signature:.....

Participant's name:.....

Participant's contact details (if appropriate):

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on 28 October 2014 AUTECH Reference number 14/331 Note: The Participant should retain a copy of this form.

Appendix 7: interview schedule

Patients

You have [specific health or disability condition]. What is your experience of living with your this condition?

Prompt questions could include:

- Does it stop you from doing anything that you want to do?

How was it decided that you needed short-term loan equipment when you left hospital?

Prompt questions could include:

- Have you had any experience of using this equipment before?

Occupational therapists typically ask patients about how they will manage their everyday activities when they get home from hospital. What was it like for you to talk to the therapist about these things?

Prompt questions could include:

- If the therapist asked you about showering, dressing, toileting, making meals or drinks at home, what was that conversation like for you?

How well do you think the occupational therapist understood you and your situation or needs regarding how you do things at home?

Prompt questions could include:

- How did she show that she understood you?

What thoughts or memories does this equipment bring back for you?

Prompt questions could include:

- What did you expect the equipment would do for you?
- What actually happened with the equipment?
- In your experience, is there anything that could/should be changed with the equipment, and the way you got it?

What do you think are the most important things to consider when deciding if equipment is the right solution?

Prompt questions could include:

- What should occupational therapists, or anyone else for that matter, take into account when considering giving patients equipment?

How can people like you be more involved in decisions around providing equipment?

Prompt questions could include:

- How providing equipment be made better, more efficient?

Appendix 8: Interview schedule

Occupational therapists

Occupational therapists typically ask patients about how they will manage their everyday activities when they get home from hospital. What was it like for you to talk to the patient about these things?

Prompt questions could include:

- When you ask the patient about showering, dressing, toileting, making meals or drinks at home, what is that conversation like for you?

What is your experience of talking to patients about their need for STLE to do everyday activities when they're discharged from hospital?

Prompt questions could include:

- What happens in you when a patient doesn't want, or is hesitant to accept the equipment?
- What happens in you when a patient knows what they want, but you disagree with them?

What do you think about when deciding whether a patient needs STLE or not when they leave hospital?

Prompt questions could include:

- Have **you** had any experience of using this equipment before?
- What do you expect the equipment to do for the patient at home?
- What is it like for you when you provide equipment to patients?
- What's it like for you to not provide equipment to patients?

As an occupational therapist working with hospital inpatients, what is your experience of getting to know the patient well enough to know what they might need at home after discharge?

Prompt questions could include:

- How do you know that you've got all the information you need to make a decision about equipment?

What thoughts or memories does this equipment bring back for you?

Prompt questions could include:

- In your experience, is there anything that could/should be changed with the equipment, and the way patients get it?

What do you think are the most important things to consider when deciding if equipment is the right solution for a patient?

Prompt questions could include:

- In your experience, what should be taken into account when considering giving patients equipment?

How can patients be more involved in decisions around providing equipment?

Prompt questions could include:

- How can providing equipment be made better, more efficient?

Appendix 9: Crafting a story and initial interpretation

Helen's story

*If I walked over uneven ground I **would often fall**, and then sometimes I would walk and the leg wouldn't respond. Going up and down stairs, I frequently fell and I just **couldn't trust it**, because you never knew when it was going to give way. Sometimes I'd get up and then actually I would walk with that leg being straight, because it just wasn't responding.*

One of the times I fell had been at a person's house and there was a step from their front door, just before their front gate, and my leg gave way going down that step. I ended up falling into their wrought iron gate. I was bruised from head to toe [chuckles]. I looked like I'd been in a fight, and to the point that the woman's house actually wanted to call an ambulance.

*Well once I gathered up **my pride** [chuckles] and got over that - I was embarrassed. Then having bruises around here and up there (indicates from legs to her face), I was embarrassed because it did look like I'd been in a fight. So it made me very unsure of going up and down stairs.*

*I consulted a surgeon who said, "I don't think you're bad enough to have a walking trolley." And I thought, "No, I don't believe I was bad enough." Old ladies use those (walking sticks). Pride. I've got to bit too much of my mother in me [chuckles] I suppose, and **I will beat this**.*

*The physios came on Saturday and gave me exercises to do. On Sunday, they came back and got me out of bed. Then on the Monday they came, it might have been an OT, I don't know, I can't remember, and then they [**the 'they'**, Heidegger, 1927/62] got me walking down the corridor, and then walking up some stairs. They ask me: Who will be at home with you? How will you do things? Who will do the washing [laundry]? Who will be cooking for you? How many stairs I had at home and what else did I have at home. They asked me about what equipment I wanted at home. I suggested the toilet seat and the shower because by that stage I had been up to the toilet and realised that the seats in the hospital were higher than they were at home. I found that I could **use them far better**. I'd seen other people with the shower stool and the toilet seat, so I already knew the benefits of them.*

I was discharged from the hospital around about midday on the Tuesday. When I got home I lay on my sofa and it (the equipment) arrived while I was asleep. They put the toilet seat on and put the shower stool in, so it was there when I woke up.

*The shower stool, that gave me **confidence** especially for the first couple of nights I was at home. I would sit on the stool and I was able to wash myself. I was even able to wash my feet because I could put my feet up on the wall and just feel my feet there. With the toilet seat, it meant I could control sitting down more easily, and getting up. The getting up wasn't a problem, because I was used to putting one foot in front of the other and pushing myself up with my legs, but the getting down... **I was scared I was going to***

***flop.** So, I could hold it and lower myself down without flopping [**felt sense**]. That was very very helpful.*

*I didn't use the rehab chair as much because for sitting long periods, it was **uncomfortable** [**felt sense**] even though I put a sheep skin on it. I found I could sit in my lounge suite and be more **comfortable**, or lie on my lounge suite. Just after I got out of hospital, I went out to dinner to a person's house and their lounge suite was quite low, and I hadn't taken the chair, and I was quite uncomfortable. So, I learnt next time, you take it with you, which I did. I did that a couple of times, and that worked well, because I was **comfortable** enough for that evening but, at home, I was more **comfortable** in the lounge chairs.*

*I came home one day and sat on the toilet. "Oh, there's something missing." [**felt sense**]. The arms were missing. I looked around into the shower and the seat was gone. Then when I went out into the lounge and found the chair was still there, I thought, if it could have been the other way around, it would've been better. I wasn't **aware** they were coming now, and I read the green sheet [information sheet given to patients by occupational therapists when they are provided with short-term loan equipment] but it didn't necessarily compute what was going on.*

*I remember thinking how lucky I was to be in a situation where I had that **equipment readily available** for me a couple hours after I was discharged. That is something that I'm really grateful for because that was very, very helpful.*

Brief summary of Helen's story

Helen revealed how public and private use of equipment was different for her. Her acceptance of the privately used equipment was influenced by having seen how other people benefitted from using it, and feeling the benefit using the same equipment in hospital. However, she did not accept the publically used equipment like walking aids.

Helen described her felt sense when using the over toilet frame, shower stool and rehabilitation chair following back surgery. The shower stool gave her confidence in the shower to wash herself, especially her feet. The over toilet frame was "very, very helpful" in avoiding "flopping" on to the toilet; she felt the security. The rehab chair did not feel comfortable and was only used as a backup chair to take to others' homes if Helen had doubts about the available chairs. The rehab chair was the least useful of all three items of equipment.

She was taken aback when the “auto collect” function of the short-term loan equipment system was actioned. She realised that she had overlooked the information on the green form that the hospital occupational therapist had given her before discharge from hospital.

Moving to interpretation

Helen revealed the difference between her public and private self, and acceptance of devices that could help her. Her public self did not want to draw attention to her disability. The embarrassment of falling in public did not outweigh the stigma she associated with using a walking aid. Conversely, her private self was comfortable to use equipment that was also designed to prevent falling, but in private. Others did not get to see her using it. Perhaps the shower stool and over toilet frame represented a temporary situation, whereas a walking aid gave her a sense of aging in a way that did not fit with her sense of self.

Internal meaning structures for Helen

Confidence: to do an activity that otherwise would present known challenges i.e. untrustworthy muscle action in her leg leading to impaired balance; back pain; high risk of falling causing more pain and further injuring herself.

A willingness to try the activity with some expectation of successful completion without pain (immediately, or delayed), loss of balance.

Felt sense: Helen ‘felt’ through her body senses: pain, instability in her leg, comfort and security,

Independence: Being able to do things her way, by herself. Associated with pride and dignity in being self-reliant, maintain physical fitness and flexibility – Dasein? (Heidegger, 1962)

The ‘they’: the surgeon, physiotherapist, occupational therapist, nurses were all part of the system, without names, and whose roles blurred into each other. In the case of the surgeon, she remembered her meeting with him, but ‘gave over’ to him the assessment that she was not ‘bad enough’ to use a walking aid, despite physical injury from falling.

Appendix 10: Mind map

Here I have attempted to show how what seems to matter to patients and therapists were often interlinked, but also different. For me, when patients were part of the decision-making process around equipment, there were several connections to what mattered to occupational therapists. It is notable that the patients' point about what to do if something goes wrong with the equipment or system has no direct connection with what matters to occupational therapists.

