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Coercion in the ambulance setting

SHORT REPORT

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BACKGROUND

Patients who resist medical assistance can undo the safety straps on the ambulance stretcher. Ambulance personnel have been known to make use of blankets, bandages and Velcro straps to restrain patients in transit. This study aims to establish how often this type of coercion is used.

MATERIAL AND METHOD

In 2021, approximately 400 ambulance service personnel in the county of Innlandet were invited by email to take part in an online survey about the use of coercion vis-à-vis patients who resist medical assistance.

RESULTS

We received 85 responses, and 62 respondents (72.9 %) stated that they had used coercion. Of these, 38 (44.7 %) had restrained the arms/legs of patients using blankets, bandages or Velcro straps in order to keep them safe while in transit. A total of 36 respondents (42.4 %) had observed other personnel travelling in an ambulance without a fastened seatbelt in order to maintain patient safety during transit.

INTERPRETATION

The results clearly show that ambulance personnel regularly use coercion when patients who resist their help are transported by ambulance. There is a need to discuss how such ambulance services can be provided in a safe, secure and caring way.

Main findings

The majority of the ambulance personnel had applied coercion in order to maintain patient safety during transit.

A large proportion of the respondents had experienced situations when personnel would unfasten their own seatbelt in order to maintain patient safety during transit.

According to the Norwegian Health Care Act, coercion and force are defined as 'interventions resisted by the service user, or that are of such an intrusive nature that they, irrespective of resistance, must be considered to involve coercion or force' (1). In this study, coercion is defined as the use of physical force. The principle of legality suggests that the state cannot intervene against citizens unless a specific statutory basis is present (2). In the health service, coercion is used to secure the safe provision of services to patients who do not have the capacity to consent, and to prevent injury to patients or staff (3–7). Norwegian welfare legislation includes several provisions that sanction coercion, but applying these in a pre-hospital setting has never been extensively addressed in legal preparatory works and in research literature. There are many grey areas in clinical practice, and the guidance issued by the Norwegian Directorate of Health with respect to the use of coercion highlights a need to apply clinical discretion (8, 9).

Transport by ambulance involves several special circumstances with respect to the use of coercion:

- Patients can be physically acting out while in transit in situations that do not allow the ambulance to stop and/or the door to be opened.
- Individuals who undo their safety straps can represent a threat to themselves and others in the same compartment.
- The ambulance callout will frequently have been booked by a third party with whom the ambulance personnel have had no personal contact.
- Ambulance personnel have no access to the patient's medical records.
- Ambulances are not kitted out with equipment that prevents patients from undoing their own safety straps in transit while lying on a stretcher.

From personal experience, we know that ambulance personnel in some instances use coercion in order to prevent patients from travelling unsecured in an ambulance setting if they resist medical assistance. The objective of this study was to investigate the extent to which coercion is being used in ambulance settings. We also wish to highlight challenges that ambulance personnel encounter when dealing with patients who resist their help, and discuss traffic safety issues and the legal framework that applies with respect to ambulance services.

Material and method

In the period June-August 2021, the approximately 400 employees who work for the ambulance service in the county of Innlandet were invited by email to read an information circular and to complete an online questionnaire with questions about the number of times they personally had applied coercion, or had observed ambulance personnel or other staff travelling without a seatbelt in order to ensure the safety of a patient in transit (table 1). Participation was voluntary and anonymous.

Table 1

Answers to three questions submitted by ambulance personnel in the county of Innlandet (n = 85). On how many callouts since the turn of the year have you: 1) … had to use coercion to maintain patient safety during transit? For example, this might involve fastening the patient's safety straps if the patient is trying to undo them, or restraining the patient's arms and/or legs without their consent. 2) … restrained/secured the patient's arms and/or legs with blankets/bandages/Velcro straps etc. to make sure the patient would be safe in the ambulance setting? 3) … observed that ambulance personnel/police officers/others have travelled without a fastened seat belt in order to keep the patient still while in transit?

	Never	1–3 times	4–6 times	> 7 times
Question 1, n (%)	23 (27)	48 (56)	12 (14)	2 (2)
Question 2, n (%)	48 (57)	33 (39)	3 (4)	1 (1)
Question 3, n (%)	36 (42)	38 (45)	8 (9)	3 (4)

The Norwegian Centre for Research Data (NSD) considered the data to be anonymous (ref. no. 775741). The Regional Committees for Medical and Health Research Ethics (REK) for South-East C deemed that the study's objective fell outside the remit of the Health Research Act (submission assessment ref. no. 270172). Responses were analysed by means of descriptive statistics and were presented as absolute numbers (n) and percentages (%).

Results

We received 85 responses, which equals a response rate of 21 per cent. A total of 62 respondents (72.9 %) had used coercion to maintain a patient's safety while in transit, 38 respondents (44.7 %) had restrained a patient's arms and/or legs with blankets, bandages or Velcro straps. A total of 49 respondents (57.6 %) had observed ambulance personnel travelling without a fastened seatbelt in order to keep a patient safe while in transit.

Discussion

The results suggest that coercion is frequently applied in ambulance settings. This matches the findings of a Polish study, where 75 % of paramedics had applied coercion in the form of restraint (10). Patients may well feel the negative consequences of coercion more acutely than the healthcare personnel (11). Although coercion is applied in order to reduce the risk of injury to patients and staff (9, 11), earlier research has shown that there is no rise in injuries when the rate of coercion falls (12). However, there is no research available that covers a prehospital setting and that discusses traffic safety issues and other prehospital circumstances. Our findings show that ambulance personnel are at risk when travelling in an ambulance without a fastened seatbelt because they consider this to be necessary to keep the patient safe. Considering the obligation to ensure safety in the workplace, it is troubling that patients and personnel routinely travel in the patient compartment of an ambulance without a fastened seatbelt (13). Moreover, patients and staff, like other occupants of motorised vehicles, are obliged to wear a seatbelt while travelling in road traffic (14). Wearing a seatbelt reduces the risk of being killed or injured in a road traffic accident by up to 60 % (15).

It is the coordinator at the Emergency Medical Communication Centre (AMK) who allocates ambulance personnel to callouts requested by a third party. According to Norwegian legislation on the rights of patients and service users, healthcare personnel who provide health care, are personally responsible for making healthcare decisions when patients refuse treatment (3). However, when the callout has been requested by a third party and the ambulance personnel have no access to the patient's medical records or any other documentation, we have found from experience that ambulance personnel often do not have the information they need about future plans for healthcare provision to be able to determine whether coercion may be warranted.

This study was conducted on a non-random sample of ambulance personnel within a limited geographic area. The findings cannot be generalised because the response rate is low. Ambulance personnel who responded to the same callout may well have reported the same incident, which may have caused the rate of coercion to be over-estimated. Even if the exact rate of coercion applied within the ambulance service is difficult to quantify, the study verifies that coercion does occur. Assessing whether this type of coercion is warranted under current legislation requires discretion and expert knowledge on the many relevant laws beyond the scope of healthcare legislation. There is a need to review our interpretation of the complex legislation, and to consider the equipment available in our ambulances as well as the structural framework, so that patients who refuse health care can be transported in a manner that is safe for patients as well as ambulance service personnel.

The article has been peer-reviewed.

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