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EMPIRICAL STUDIES

Balancing power: Ambulance personnel's lived experience of older persons' participation in care in the presence of municipal care personnel

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Abstract

Background: Patient participation is considered to promote well-being and is, therefore, central in care contexts. Care-dependent older persons living at home constitute a vulnerable population with increased ambulance care needs. Care transfers risk challenging participation in care, a challenge that can be accentuated in situations involving acute illness.

Aim: To illuminate meanings of older persons' participation in ambulance care in the presence of municipal care personnel from the perspective of ambulance personnel.

Method: A phenomenological hermeneutical method was used to analyse transcripts of narrative interviews with 11 ambulance personnel.

Results: The ambulance personnel's lived experience of older persons' participation includes passive and active dimensions and involves a balancing act between an exercise of power that impedes participation and equalisation of power that empowers participation. The main theme 'Balancing dignity in relation to manipulating the body' included the themes *Providing a safe haven* and *Complying with bodily expressions*, which means shouldering responsibility for existential well-being and being guided by reactions. The main theme 'Balancing influence in relation to perceived health risks' included the themes *Agreeing on a common perspective*, *Directing decision-making mandate*, and *Sharing responsibility for well-being*, which means shouldering responsibility for health focusing on risks. Influence is conditional and includes performance requirements for both the older person and municipal care personnel.

Conclusion: Care-dependent older persons' participation in care from the perspective of ambulance personnel means recognising passive and active dimensions involving human dignity, the ability to influence care, and optimising care efforts through collaboration. This study provides a deepened understanding of the balancing of power involved in ambulance care determining participation, where power is equalised or exercised depending on personal engagement, health risks, and

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available care options. The knowledge provided holds the potential to improve ambulance care to benefit older persons in critical life situations.

KEYWORDS

ambulance care, ambulance personnel, home care services, municipal care personnel, older persons, participation in care, phenomenological hermeneutical method

BACKGROUND

Patient participation has long been a key value in care contexts, considered to ensure safe, and qualitative care [1]. Although underpinned by financial incentives, value-based health care increases emphasis on experiences of care including needs, preferences, and goals thus supporting a good life [2, 3]. In Sweden, participation in care is stated in law [4, 5]. However, transferring the concept from vision to execution can be difficult [6, 7]. The World Health Organisation (WHO) has defined participation as a person's involvement in situations in life [8]. The definition has gained critique for being vague [9, 10], and professionals often limit participation to involvement in decision-making [6, 10, 11].

Older persons often view involvement in decision-making as subordinate since clinical decisions might be difficult for a layman [12]. Norwegian research indicates that older persons' participatory ability is related to perceived incapability and not wanting to be a burden [13]. Thus, older persons' participation in care is dependent on the quality of the caring relationship [12, 14] where dignity and individuality are core values [14], honoured by recognising the older person as able and trustworthy [15]. Respectful care positively affects health [16]. However, older persons with poorer health, which is often associated with care dependence, report being treated with respect less often than healthier persons [16].

Older persons living at home assisted by municipal home care services constitute a vulnerable yet growing population in Sweden. Approximately 2.1 million persons in Sweden are aged 65 and older [17], of which about 246,000 (mean age 83.4) utilise municipal home care and 193,000 utilise mobile safety alarms [18]. The population characteristics involving older age and conditions such as physical and cognitive impairments, chronic diseases, polypharmacy and frailty increase the need for ambulance care, and hospital admittance [19–21]. A majority of ambulance assignments in Sweden involve older persons [22, 23], and about 60% of assignments to people's homes involve persons aged 70 or older [22]. Swedish municipalities have no assigned responsibility to provide emergency care, and municipal care personnel face emergencies having insufficient knowledge and support [24]. South Korean research displays how panic might

be experienced when faced with an older person's emergency, in addition to hardship in even recognising acute illness [25].

Ambulance care is a context related to life and death situations where medical skills and reduced prehospital time are crucial [26, 27]. Maintaining a predominant medical focus risks preventing ambulance personnel from adopting a holistic approach, leaving less attention to the ill person's experience [28]. Situations that render persons to call for an ambulance are characterised by an inability to manage the situation and might involve emotional chaos which emphasises a need for relational care [29]. Ambulance personnel's ability to be compassionate and non-judgmental can make patients feel important and worthy of care [30], and respecting the person's uniqueness and vulnerability safeguards dignity [31]. Older persons' dignity is also honoured when supported in making care decisions despite lowered decision-making ability [32]. However, ambulance personnel's decisions on-scene are influenced by the risk of being held liable in case of medical error [33], and the ability to provide qualitative safe care is similarly dependent on the collaboration within the ambulance team [34, 35].

Municipal care personnel often become involved when older persons need ambulance care. The situations thus become a focal point converging two levels of welfare, carrying inter-professional collaboration, and transitional care. Care transfers involving older persons have been found at risk of communication faults, lack of involvement, diffuse professional responsibilities, and organisational restraints [36], aspects that might be accentuated in acute situations. By exploring the ambulance personnel's lived experience of assignments involving care-dependent older persons, a deepened understanding of participation in ambulance care will emerge with the potential of improving clinical practice to benefit older persons in critical life situations.

Aim

The aim is to illuminate meanings of older persons' participation in ambulance care in the presence of municipal care personnel from the perspective of ambulance personnel.

TABLE 1 Example of the structural analysis process; meaning unit, condensation, subtheme and theme.

Meaning unit	Condensation	Subtheme	Theme
<i>how she thinks she manages to walk. It's a form of participation that she actually gets, "I can decide if I can go with my walker or not" [2]</i>	To provide an opportunity to influence the course of events based on the older person's abilities	Giving choice according to ability	Directing decision-making mandate
<i>But then I know that [ED transportation] is maybe the only solution. Then you can't do anything else. Because I have no more playing cards, to have in front of me and be able to give, but this is it [4]</i>	To lack the opportunity to offer care options other than transportation to the ED		
<i>of course, I play safe too. I'd rather make a decision involving additional efforts, or drive in for an extra check, than sit and be unsure whether, dammit, did I do the right thing [6]</i>	To rather make decisions for the sake of your own safety, and thus not risk making mistakes		
<i>We had good communication, we understood each other. You don't always do that for different reasons. Maybe especially not with someone who is 98 years old, or whatever she was. That we understood each other, and that I could trust that what I said to her, she understood [3]</i>	To understand each other in a trusting dialogue	Trusting decision-making ability	
<i>then we told him just what his situation looked like. (...) And then he was able to, based on that, make the decision himself, in consultation with us. So like, yes, what will be the best here now? And then he himself thought it best to do so, that the medicine came to him. And I hope it turned out well. But we were also very careful, that if there are problems, it can be just half an hour later, then you have to promise to call. (...) and he understands [4]</i>	To provide different care options and let the older person decide which option is best suited, while at the same time providing an agreed plan if the condition deteriorates		
<i>when you're not really a 100 [%] decision-making able, or what's it called, then it's hard. If she had been completely lucid, "I'm definitely not coming along [to the ED]". Then I would have, and if they hadn't had a dementia diagnosis, then I would have said absolutely. We don't carry out compulsory care [6]</i>	To demand full cognitive ability if the older person is to be allowed a decision-making mandate		

METHOD

The analysis follows the phenomenological hermeneutical method developed by Lindseth and Norberg [37, 38]. The method is based on the common motives of phenomenology and hermeneutics to understand lifeworld phenomena through lived experience, where the lifeworld [39] unfolds through hermeneutical interpretation [40]. The essential meaning of lifeworld phenomena is thus revealed by interpreting lifeworld discourse based on lived experience [37]. To elucidate the phenomenon, narratives of situations involving the phenomenon are used. Such narratives are told through human experience, as lived by the narrator. The tripartite analysis involves a movement between understanding the text as a whole and examining its parts to form a deepened understanding. The process involves intentional although controlled

use of the researcher's preunderstanding of the phenomenon [37, 38].

Participants and setting

Swedish ambulance personnel commonly include Registered Nurses (RN), RN specialists (ambulance, anaesthetic, intensive care) and emergency medical technicians (EMT) usually trained as assistant nurses, which are all represented by the participants. The participants were actively working within one ambulance station in a region in the middle of Sweden and included women ($n = 7$) and men ($n = 4$) of various ages (36–51 years), and with varying lengths of work experience (3–22 years). The ambulance services in the medium-sized region provide diurnal prehospital emergency care in rural and urban areas and

include dyadic staffed and single-staffed ambulance vehicles for primary responses.

Data collection

The interviews were conducted by the first author in a secluded room at the ambulance station during or in close connection to work shifts. The interviews were initiated with the main question 'Please tell me about an assignment to an older person where municipal care personnel were present?' Subsequent questions were asked to stimulate the narrative, for clarifying reasons or to encourage reflections about participation in care. To enhance the perspective further, the participants were also asked to narrate a similar situation where participation was challenged. The recorded interviews lasted between 38 and 70 min and were transcribed verbatim.

Analysis

All interview transcripts were read repeatedly by the first author which allowed a naïve understanding to develop that captured the sense of the text [37, 38] and what participation in care is about from the perspective of ambulance personnel. The naïve understanding was formulated in collaboration with author five. Thereon, a thematic structural analysis commenced. Text units indicating ambulance personnel's lived experience of older persons' participation were identified, the meanings condensed (Table 1), and stratified into subthemes, themes and main themes (Table 2). Throughout the process, the developing themes were compared with the naïve understanding to validate their consonance, and the 'whole' could thus be explained by the text parts. Finally, the results were further elaborated on and synthesised in relation to theoretical perspectives in a comprehensive understanding. All authors reviewed, discussed and challenged the results to reach a consensus.

Ethical considerations

The study was conducted in accordance with the Declaration of Helsinki [41] and approved by the Swedish Ethical Review Authority (Dnr: 2019-02027). Access to ambulance personnel was granted by the operations manager of the ambulance services in the region. Information regarding the aim, the confidential handling of data and voluntariness were provided verbally and in writing on several occasions. Ambulance personnel accepting to participate signed informed consent.

TABLE 2 Results of the structural analysis.

Main themes	Themes	Subthemes
Balancing human dignity in relation to manipulating the body	Providing a safe haven	Respectfully connecting with the person Sheltering the vulnerable person
	Complying with bodily expressions	Understanding the ill body Providing an opportunity to resist
Balancing influence in relation to perceived health risks	Agreeing on a common perspective	Seeking information to comprehend Fusing different perspectives
		Giving choice according to ability Trusting decision-making ability
	Directing decision-making mandate	Appreciating helping efforts Joining forces with a common goal

RESULTS

Henceforth, municipal care personnel will be referred to as MCPs.

Naïve understanding

Older persons' participation in care from the perspective of ambulance personnel is a balancing act between an exercise of power and an equalisation of power, where balance empowers participation in care. The balancing act is governed by an overall responsibility to save the older person's life, where saving a life also means restoring and preserving human dignity. Participation includes dimensions involving the older person's home, life, and body, the experience and competence of all involved, and their opportunity to influence care. The dimensions include coexisting paradoxes that involve a tension between the equalisation of power that promotes participation and the exercise of power that impedes participation. Examples of paradoxes that need balancing are being a guest while barging in, respecting privacy while needing quick access to the body, respectful listening while assessing the

information and respecting choice while following mandatory guidelines. In short, being caring while disciplined.

The realisation of participation depends on how well the balancing act is performed and is affected by the severity of the acute illness, guidelines, available care options, own engagement and subjective perception of the older person's and MCPs' abilities. A well-executed balancing act can be understood as collaborating with everyone present, to provide the older person with the best possible care. In the position of uniformed leaders, one's professional superiority is balanced against the inferiority of others by recognising them as valuable persons needed to find the best option of care. Participation means encountering the older person as an equal human being with unique needs and abilities, which include the MCPs as representatives of the person and the person's life. Participation means inclusion, safety, trust, consensus, preserved dignity and well-being for all involved, while lack of participation means exclusion, coercion, distrust and violation of human dignity.

Structural analysis

The analysis resulted in two main themes, *Balancing human dignity in relation to manipulating the body*, and *Balancing influence in relation to perceived health risks* (Table 2). The former involves passive dimensions of participation related to the older person's dignity, in respecting and sheltering the unique person. The latter involves active dimensions of participation which include performance requirements for both the older person and MCPs to gain influence.

Balancing human dignity in relation to manipulating the body means shouldering responsibility for the older person's existential well-being without demanding anything in return. The responsibility is sparked by an engagement to provide the best care possible, which reaches beyond the acute situation. The responsibility is fulfilled by attentiveness toward suffering and vulnerability. Participation in care is passive, manifested as a respectful inclusion of the older person.

Providing a safe haven is providing relief, and comfort in a threatening situation. A human connection aiming to convey trust and safety is established through calm, and respectful entrance, eye- and physical contact and communication at an equal level. Suffering is recognised and accepted in the form in which it presents itself without judging, and a sheltering stance is adopted to assure well-being which holds a promise of keeping the person safe. Time is taken to identify both acute and existential needs, and the older person is given time to prepare for new life conditions. Attentiveness to the older person's experience,

wishes, and needs guides how to fulfil expectations of care, and how to provide a solution that alleviates suffering in both the short and long term. The identified suffering brings advocacy, and the acquired knowledge is used to impact future care measures that benefit the older person and prevent further suffering. The safe haven also extends to the older person's spouse since ambulance care can be perceived as dramatic and thus requires trustful assurance that the situation is under control. A focus on efficiency and time-saving measures counteract the ability to provide a safe haven. Working efficiently, such as when connecting with MCPs rather than the older person due to perceived communicative or functional inability, or when the older person is perceived as stalling, risks turning care into a time-saving execution where the older person is neglected and excluded.

Complying with bodily expressions is adapting the manipulation of the older person's body by being attentive to reactions. The illness is understood through deliberate touch, using one's senses, and medical devices and by asking medically focused questions. The main focus is the older person's body, vital parameters, and appearance. Trust and safety are conveyed through professional, and respectful manipulation, requiring attentiveness toward the older person's ability or inability, to respond. Information about the acute procedures is given to create a sense of control over what is to come, and thus provide an opportunity for the older person to verbally or bodily resist. An older person's pliant body conveys a silent consent to proceed, a given right to manipulate the body and thus a responsibility to keep the body alive. The rapid need to medically assess and understand the status of the older person's body implies a temporary need to disregard other persons present, such as MCPs, spouse or relatives. Severe, time-sensitive conditions allow for coercing manipulation of the body, as preventing death is the main objective. If the right to the older person's body is taken rather than given and manipulation is guided by medical procedures, the older person is at risk of being objectified and 'managed'.

Balancing influence in relation to perceived health risks means shouldering responsibility for the older person's health focusing on risks, which impacts the older person's ability to decide and make decisions for themselves. Providing an opportunity for influence relates to performance requirements, and the older person must demonstrate flawless cognitive ability, and functional ability, and truly understand the consequences of their decisions. The requirements also apply to MCPs, who are given greater opportunity to influence, and actively participate in the situation the more engaged, able and knowledgeable they are. The requirements make participation in ambulance care conditional, and the opportunity for influence

is only given if requirements are met. Participation in care is active, manifested as activity requirements for the older person and MCPs in their role as the older person's representative.

Agreeing on a common perspective is searching for, and fusing available information regarding the older person's status, life situation, and needs into a common horizon of understanding, which guides how to provide appropriate care. If the older person is unable to account for their situation, MCPs and the appearance of the home become important sources of information. Finding a perspective all can agree to, involves acknowledging the experience and needs of both the older person and MCPs and complementing their perspectives with their own professional expertise. When perspectives differ, negotiation is sometimes required to reach a common horizon. Difficulties in finding a common perspective, such as when MCPs are unable to provide information or refuse to accept the clinical assessment, aggravate the ability to provide appropriate care which might lead to conflict. In conflict situations, finding a common perspective is not a matter of negotiation, rather one wins or loses by choice in recognition of the older person's exposed position. A common perspective is also required within the ambulance team, which supports practices that benefit the older person. Giving preference to the own perspective underpinned by superior medical knowledge, or the categorical 'truth' displayed on medical devices, means questioning the perspectives of others which risks diminishing the experience of both the older person and MCPs.

Directing decision-making mandate is assuring safe decisions to control health risks. Decision-making is governed in relation to the older person's perceived cognitive ability, expectations of care, medical liability, mandatory guidelines, and available care options. Allowing the older person mandate to influence important decisions of care, such as to remain at home or be transported to hospital, is dependent on trust in cognitive ability. Perceived limited cognitive ability, limits trust which in turn limits the older person's self-determination. Medical liability requires that no uncertainties exist not to jeopardise health, and assessments that the older person is not able to make a well-informed decision means that decision-making power is assumed or exercised in collaboration with MCPs. Giving the older person authority, and thus an opportunity to deviate from guidelines requires the older person to demonstrate a comprehensive understanding of the consequences, and health risks the decision brings. Decision-making is also about giving the older person mandate to influence care measures occurring in the home based on their bodily experience, such as choosing pain medication or walking to the ambulance instead of being transported on a stretcher. Directing the decision-making mandate

also means taking a recommendatory stance that benefits the older person when decision-making power is surrendered in favour of professional expertise, and defending the older person's right to self-determination in conflict situations. Assuming decision-making power is sometimes necessary due to time-sensitive conditions, the older person's inability to understand the severity of the illness, guidelines, or lack of care options, and requires sensitivity to the amount of coercion involved. Refusing the older person's self-determination, such as when giving precedence to own safety and thus not risk being held liable, risk subjecting the older person to coercive care.

Sharing responsibility for well-being is joining forces with MCPs to generate a care alternative that better meets the older person's preference. Helping efforts displayed by MCPs are appreciated and recognised as promoting the older person's well-being. With a common goal in focus, structuring a previously unstructured collaboration takes place where responsibility for well-being can be shared with MCPs, in respect of the older person's human agency. Collaboration requires openness to suggestions, and trust in the MCPs' ability to complement care, and constitute a resource that expands the older person's possibilities. Through collaborative negotiation in respect of organisational opportunities and barriers, an adapted care alternative can be created to accommodate the older person when existing options are inappropriate. However, such collaboration is subject to requirements. MCPs are required to be engaged, knowledgeable and take initiative with the older person's best interest in mind, as well as respecting superior levels of education and competence. Time-sensitive conditions also limit collaborative opportunities. In such situations, MCPs are required to step back and assume a background position. If MCPs are perceived as lacking knowledge, time, abilities, or interest in the older person's well-being, they are barred from collaboration, which risks fragmenting care and depriving the older person of optimised care.

Quotations illustrating each theme are presented in Table 3.

DISCUSSION

Comprehensive understanding and reflections

Ambulance personnel's lived experience of older persons' participation in ambulance care in the presence of MCPs involves passive, and active dimensions relating to human dignity and opportunities for influence. The balancing act involves a display of professional power, where the power is either equalised or exercised. Equalisation

TABLE 3 Quotations corresponding to each theme illustrating ambulance personnel's lived experience of care-dependent older persons' participation in care in the presence of municipal care personnel.

Themes	Quotations
Providing a safe haven	<i>this human contact is a bit [pause] whatever you say, it shows something, if you have contact between two hands, like, that I put my hand on yours and show I'm here now, I'm at hand, I see you (...) hopefully [I] will make the patient feel like this is someone who means well [2]</i>
Complying with bodily expressions	<i>he didn't say anything. But he was compliant, we were allowed to examine him. So he, somewhere I still got the feeling that he understood that he was going to receive care [11]</i>
Agreeing on a common perspective	<i>This person had been alerted to the patient, due to the respiratory problems, and perceived the problems as very serious, and called an ambulance. So we head out as priority 2 initially, and this home care personnel thinks that the patient has gotten worse and calls up again, so then we go the last bit as priority 1 (...) and it's very hard for her as well, to see this and face this, and the frustration when we don't come fast enough [5]</i>
Directing decision-making mandate	<i>TIA [transient ischemic attack] patients should be conveyed to the emergency department, according to our chief ambulance physician, and our guidelines, and such. But she was completely clear in her head and it went really well talking to her, and she was so clear about what she wanted (...) it had felt good to leave her at home [3]</i>
Sharing responsibility for well-being	<i>she [MCP] was already one step ahead, that she had intended to call and inform the daughter after we had gone, and immediately started packing the patient's bags, and also asked if the patient needs to go to the bathroom before we leave (...) which we might not even think of [10]</i>

of power means using and sharing power to promote the existential well-being of the older person, characterised by personal engagement and a widened focus on saving a dignified life. The exercise of power means assuming

power, characterised by efficiency and control, limiting the focus to saving a life, and eliminating health risks. Due to the balancing of power, which includes providing care in uniform, the following reasoning will address the passive and active dimensions of older persons' participation in care from the perspectives of humanised care informed by a person's lifeworld [42], and (military) discipline as a mechanism of power to gain control and efficiency [43].

Providing dignifying or objectifying togetherness

The passive dimensions of participation found in this study, *Providing a safe haven* and *Complying with bodily expressions*, mean recognition of both existential and bodily suffering, in line with a humanising care practice [42]. Human dignity is preserved through the respectful entrance into the older person's lifeworld, in recognition of the human being, the acute experience and the life conditions involving assisting MCPs. The passive dimensions of participation emphasise togetherness displayed by the respectful inclusion of the older person in the situation, which is based on the responsibility to support a dignified life. Togetherness is fundamental to a humanised care practice and generates the empathy needed to grasp another person's unique suffering [42, 44]. The metaphorical safe haven can be viewed as a place where the older person can rest and find peace, which promotes well-being [45].

Lacking the ability, or willingness to acknowledge the passive dimensions of participation risks objectifying the older person, thus supporting an exercise of power. Objectifying a human into a manageable body is according to Foucault [43] a means to assume control, and promote efficiency. The medical responsibility implying saving biological life is objectifying by nature and allows for the managing of the body rather than providing humanising care [42]. The body becomes an object that can be analysed, controlled and rectified, which in turn reacts, and obeys. An objectifying approach risks forcing the older person to surrender to the commands, and manipulation of ambulance personnel, to be recognised as a well-behaved patient [42]. According to Foucault [43], the efficient approach also entails communicating with persons of use, which correlates with the ambulance personnel at times establishing communication with knowledgeable MCPs rather than the impaired older person. Favouring efficiency thus risks both excluding and objectifying the older person.

Objectification also involves controlling time and pace, displayed in the result as taking over tasks or hurrying the older person up. Ambulance care follows an established

routine constituted by different phases that forwards the process, forcing the involved persons to adapt. Foucault [43] means that routine merges body and time, and when time enters the body, so does the control of power. Effective ambulance care practice is a precondition for saving lives in high acuity situations, but when practised in low acuity situations, an efficient approach instead risks objectifying the older person which increases suffering [46].

Trusting or distrusting abilities

The active dimensions of participation, *Agreeing on a common perspective*, *Directing decision-making mandate*, and *Sharing responsibility for well-being*, hold opportunities for human agency, influence and adapted care. The active dimensions mean recognising the abilities of both the older person and MCPs, which emphasise trust. From the perspective of humanising care, agency implies freedom of choice which is closely connected to human dignity [42]. The results display that a 'truthful' picture delineating the situation needs to be established to provide the appropriate care response, which includes assessing the abilities of both the older person and MCPs, such as cognitive functioning and competence. However, searching for the older person's lived experience and personal values promotes recognition of vulnerability, and the effort of trying to understand vulnerability often surpasses accurate medical knowledge [44]. Todres, Galvin and Dahlberg [44] point out that the effort of trying to understand requires professionals to be open, reflective and accept having limited knowledge. Our results indicate that there is little tolerance for uncertainty. From a power perspective, intolerance risks producing questioning rather than asking questions which risks turning the search for precise knowledge into an interrogation.

The results display a great reliance on medical measurements, and the 'truth' displayed on medical devices. Foucault [43] argues that technical devices that enable inspection and make the person fully transparent, are indisputable tools of power. The medical devices used by ambulance personnel thus become tools of power that cannot be questioned by the older person or MCPs, capable of passing judgement on whether the older person is ill or not and whether the MCPs' decision to call an ambulance was correct. A person's lived experience, knowledge and values impact the sense of self, and the ambulance personnel's interpretations and constructions of reality risk compromising the older person's self-worth [42].

The result indicating conflict when a common perspective cannot be negotiated emphasise distrust, in line with Foucault's [43] reasoning of discipline as a distrustful power. Behaviour is monitored and assessed to encourage

wanted behaviour and discourage faulty behaviour. MCPs who are perceived as lacking sufficient knowledge might be disregarded and left out as correcting sanctions. MCPs opposing ambulance personnel's assessments might face sanctions by conflict. Previous research describes how MCPs in recognition of the older person's vulnerable state act as representatives, and how they express frustration and anger when ambulance personnel display ignorance or disinterest [24]. Foucault [43] states that power and resistance always coexist. Thus, conflict situations signal an exercise of power.

This study displays that the ability of older persons and MCPs to influence care relates to performance requirements. Discipline is a power that ranks persons in relation to competence which impacts their opportunity to influence [43]. The results indicate that older persons are given a higher rank, and thus decision-making mandate, if judged 'clear and lucid'. If judged unable to understand, decision-making mandate is redirected to more 'able' and thus higher ranked personnel. Dispossessing self-determination risks producing coercive care, restricting the older person's freedom of choice and compromising dignity [44]. MCPs recognised as engaged, and interested in the older person's well-being are more likely to be allowed to partake in the situation. MCPs perceived as acting for the benefit of the older person are essential in the effort of providing appropriate care when the older persons are unable to speak for themselves. The opportunity to collaborate and share responsibility is also crucial for allowing oneself to deviate from guidelines. Thus, MCPs constitute an expanded ability of the older person, and a possibility to create a solution based on 'what is at hand'.

The ability of older persons to make decisions about care is also dependent on the existing emergency care organisation. Available care options are often designed for high acuity conditions, and ambulance personnel are bound by mandatory medically focused guidelines. Thus, organisational shortcomings render the ambulance personnel powerless in having no suitable care options to offer the older person. Such organisationally induced powerlessness turns into an exercise of power, and coercion in contact with the older person. The older person is, however, encouraged to influence care measures taking place in the home which is less dependent on cognitive ability, and more focused on bodily experience. Such encouragement implies a possibility of freedom within limits [42]. Decision-making can also be surrendered by the older person, in trust of professional expertise. Such surrendering of decision-making requires that decisions are made in the older person's best interest since being authorised is a sign of trust that suffering will be alleviated [47].

Achieving participation in care requires ambulance personnel to shoulder responsibility for preserving

human dignity, recognising abilities and establishing collaborative care for the benefit of the older person. Time, commitment, and trust are crucial elements needed for recognising and honouring the passive and active dimensions of older persons' participation in ambulance care.

METHODOLOGICAL CONSIDERATIONS

Trustworthiness was considered throughout the process to enhance quality [48]. The data material included 11 interviews which fulfil phenomenological research requirements [49], the focus being on variation and not quantity [50]. The strategically selected sample included variations regarding age, sex, educational level, profession and work experience, and the interviews were all considered rich in lived experience of the phenomenon.

The method used for analysis is in itself rigorous due to the explicit ontological, and epistemological foundation which merges elements of both understanding and explaining in a tripartite analysis [37]. The method's deliberate use of preunderstanding, such as acquired knowledge about the phenomenon from previous research in other contexts and own professional experience, requires awareness and openness on the researcher's part since understanding is always at risk of being coloured by a judging attitude. Preunderstanding thus guided 'what to look for' but remaining 'open to the text' allowed new understanding to be disclosed. Combining understanding and explaining also favour elucidating possible researcher bias as the structural analysis discerns biased understanding in its closeness to the text [40]. In addition, the interpretation was challenged in discussions between all authors. Although not generalizable [37], this study provides results that can be recognised and useful in similar contexts both nationally and internationally.

CONCLUSION AND IMPLICATIONS

Care-dependent older persons' participation in ambulance care from the perspective of ambulance personnel means recognising passive and active dimensions involving human dignity, the ability to influence care, and optimising care efforts through collaborative care. The passive dimensions emphasise togetherness and require shouldering responsibility for existential well-being. The active dimensions emphasise trust and involve conditional influence. The present study provides a deepened understanding of the balancing of power involved in ambulance care determining participation, where power is equalised or exercised depending on personal engagement, health

risks and available care options. The results call for further research attention to care-dependent older persons' experiences of participation in ambulance care. Improving ambulance care to benefit care-dependent older persons requires recognising ambulance personnel's needs for individual and organisational support in providing humanised care that promotes participation in care.

AUTHOR CONTRIBUTIONS

All authors were involved in the study design. Anna Hjalmarsson collected and analysed data under the supervision of Gunnel Östlund and Mats Holmberg. Anna Hjalmarsson drafted the manuscript, which was revised and approved by all authors.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available upon reasonable request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICAL APPROVAL

The study was approved by the Swedish Ethical Review Authority (Dnr: 2019-02027).

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QUESTIONNAIRE PE2(25) Part 1 of 2

Balancing power: Ambulance personnel's lived experience of older persons' participation in care in the presence of municipal care personnel

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Background

Question 1: Patient participation in medical care is considered to promote well-being.

- A: TRUE
- B: FALSE

Question 2: Care-dependent older persons living at home constitute a _____ population with increased ambulance care needs?

- A: Difficult
- B: Vulnerable
- C: Unpleasant
- D: Easy

Question 3: Older persons' participation in care is dependent on the quality of the caring relationship where which ONE of the following is a core value?

- A: Courage
- B: Creativity
- C: Dignity and individuality
- D: Passion

Question 4: Older persons with poorer health and who are often dependent on others for care, report being treated with respect _____ healthier persons?

- A: Similarly to
- B: Less often than
- C: More often than

Question 5: Older patients often have which of the following which increase the need for ambulance care and hospital admittance? Select all THREE correct options.

- A: High levels of suspicion
- B: Physical and cognitive impairments
- C: Chronic diseases and polypharmacy
- D: Frailty

Results

Naïve understanding

Question 6: Older persons' participation in care from the perspective of ambulance personnel is a balancing act between which of the following?

- A: Exercise of power
- B: Equalisation of power
- C: Perception of power

Question 7: A well-executed balancing act can be understood as collaborating (working together) with everyone present, to provide the older person with the best possible care.

- A: TRUE
- B: FALSE

Question 8: Examples of paradoxes that need balancing are which of the following?

- A: Being a guest while barging in
- B: Respecting privacy while needing quick access to the patient
- C: Respectful listening while assessing the information
- D: Respecting choice while following mandatory guidelines

Question 9: Participation means which THREE of the following?

- A: Inclusion
- B: Coercion through knowledge
- C: Safety
- D: Trust

Structural analysis

Question 10: Providing a safe haven is also to establish a human connection aiming to convey trust and safety by?

- A: Taking control of the situation and focusing on efficiency and time-saving measures
- B: Calm and respectful entrance
- C: Eye- and physical contact
- D: Communication at an equal level

Question 11: The illness is understood through which of the following? Select all THREE correct options.

- A: Deliberate touch and using one's senses
- B: Thinking for yourself
- C: Using medical devices
- D: By asking medically focused questions

Question 12: Trust and safety are conveyed through professional and respectful manipulation, requiring attentiveness toward the older person's ability or inability to respond.

- A: TRUE
- B: FALSE

Question 13: *Agreeing on a common perspective* which guides how to provide appropriate care, is searching for and fusing (putting together) available information about the older person's

- A: Status
- B: Life situation
- C: Needs
- D: Medical aid status

Question 14: With reference to the decision-making mandate, which **ONE** of the following is most important in terms of the older person?

- A: Cognitive ability
- B: Available care options
- C: Perceived relationship with family members
- D: Expectations of care

Question 15: Assuming (taking) decision-making power by ambulance personnel is sometimes necessary due to all of the following, **EXCEPT**

- A: Time-sensitive conditions
- B: The older person's inability to understand the severity of the illness
- C: Lack of care options
- D: If the older person is able to account for their situation

THE END

QUESTIONNAIRE PE2(25) Part 2 of 2

Balancing power: Ambulance personnel's lived experience of older persons' participation in care in the presence of municipal care personnel

INSTRUCTIONS

- Read through the article and answer the multiple-choice questions provided below.
- **Some questions may have more than one correct answer;** in which case you must mark **all** the correct answers.

Question 1: Giving the older person authority (to make his/her own decisions) , and thus an opportunity to deviate from guidelines, requires the older person to _____?

- A: Listen
- B: Demonstrate a comprehensive understanding of the consequences, and health risks the decision brings
- C: Demonstrate the ability to walk
- D: Be accompanied by a family member

Discussion

Providing dignifying or objectifying togetherness

Question 2: Objectifying a person (only seeing the person as an object and not as a human being) into a "manageable" body, is according to Foucault a means to assume control and promote efficiency. Is it then **TRUE** that an objectifying approach risks forcing the older person to surrender to the commands and manipulation of ambulance personnel to be recognised as a well-behaved patient?

- A: YES
- B: NO

Question 3: Objectification also involves and , appearing as taking over tasks or hurrying the older person up?

- A: Controlling time / devices
- B: Controlling pace / managing triage
- C: Controlling time / pace

Trusting or distrusting abilities

Question 4: The _____ used by ambulance personnel are tools of power that cannot be questioned as to whether the older person is ill or not?

- A: Questionnaires
- B: Uniforms
- C: Medical devices

Question 5: Is it **TRUE** or **FALSE** that the ability of older persons to make decisions about care is never dependent on the existing emergency care organisation?

- A: YES
- B: NO

Question 6: Older patients are often in a vulnerable state and express _____ when ambulance personnel display ignorance or disinterest?

- A: Fear and helplessness
- B: Submissiveness
- C: Frustration and anger

Question 7: Older persons are given a higher rank, and thus decision-making mandate, if judged _____?

- A: Unable to understand
- B: Able to see without glasses
- C: Able to hear
- D: Clear and lucid

Question 8: Decision-making can also be surrendered by the older person in trust of professional expertise. Such surrendering of decision-making requires that decisions are made in the older person's best interest since being authorised is a sign of _____ that suffering will be alleviated?

- A: Mistrust
- B: Respect
- C: Trust
- D: Helplessness

Question 9: Which of the following THREE are crucial elements needed for recognising and honouring the passive and active dimensions of older persons' participation in ambulance care? Select three correct options.

- A: Time
- B: Speed
- C: Commitment
- D: Trust

Conclusion and implications

Question 10: Care-dependent older persons' participation in ambulance care from the perspective of ambulance personnel means?

- A:** Focusing on passive dimensions
- B:** Recognising passive and active dimensions
- C:** Maintaining power

THE END



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ANSWER SHEET

PE2(25)

Balancing power: Ambulance personnel's lived experience of older persons' participation in care in the presence of municipal care personnel

*Time spent on activity		hour					min																	
PART 1												PART 2												
	A	B	C	D	E		A	B	C	D	E		A	B	C	D	E		A	B	C	D	E	
1						8						1						6						
2						9						2						7						
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4						11						4						9						
5						12						5						10						
6						13																		
7						14																		
						15																		

How relevant was the content of this activity to your scope of practice?			
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