acceptance of citizen responders entering private apartments and safety for both first responders and patients.

Method Retrospective analysis of the data from the smartphone-based dispatch system for citizen responder „KATRET-TER” and prehospital outcome data from the Berlin EMS including all OHCA-alarms to which a citizen responder was alerted in the period from 28.09.2020 and 28.02.2021.

Results citizen responders were activated to suspected OHCA 4614 times, of these 2305 (=50%) were located in private apartments. Citizen responders arrived on scene at residential locations 1053 times (=45,7%) and prior to EMS in 628 cases (27,3%). There was a significant difference in confirmed OHCA and CPR-attempts between the residential setting (38,9%) and calls in public spaces (14,5%). In 11 cases (1%) citizen responders were not granted access to the private apartment. During the observation period there were no reports of any legal or ethical problems.

Conclusion Sending citizens responders to these calls is safe and even necessary, as most of the OHCA occurred in private apartments. Also the absolute number and the ratio of suspected to confirmed OHCA is higher in the residential setting than in public.

Conflict of interest None declared.

Funding None declared.

Quality improvement and organization

Background Voluntary and informed consent is a fundamental principle of healthcare provision. However, health care laws in some countries allow for exceptions from the consent requirement when patients are not competent to consent or pose a danger to themselves or others. In these cases, the use of coercion may be an alternative to voluntary health care. Ambulance personnel are confronted with patients who need healthcare but refuse it and/or refuse to cooperate. To what extent coercion is used by ambulance personnel in these situations or what constitutes coercion in a pre-hospital setting has not previously been explored. This study therefore examines (i) ambulance personnel’s perceptions of coercion, (ii) their experience of the use of coercion, (iii) situations in which they have used coercion, and (iv) forms of coercion they have used.

Method We conducted focus group interviews with a group of ambulance personnel from a large Norwegian ambulance service. Digital recordings of the interviews were transcribed verbatim and the transcripts were analysed using Systemic Text Condensation.

Results Informants primarily interpreted and described coercion as the use of physical force. Other types of coercion as persuasion, pragmatic force, pharmacological coercion and securing during transport were described.

Conclusion The different methods of force/coercion are mainly used in situations where the ambulance personnel consider that healthcare is necessary but the patients refuses. The findings indicate that adherence to emergency law, a duty to help, the welfare of the patient and insecurity or fear promote the use of coercion among ambulance personnel. Insecurity and fear seem to be rooted in: 1) an experienced contradiction between the ambulance service’s guidelines and the legislation, 2) fear of breaching guidelines and leaving patients behind because of lack of support from management, and 3) fear of charges of misconduct. The difficulty of applying the law in real-life situations and assessing competence is also a contributory factor.

Conflict of interest None declared.

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