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EMPIRICAL STUDIES

Entrusting life to professionals: A phenomenological hermeneutical study of older persons' participation in prehospital emergency care involving municipal home care and ambulance services

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Abstract

Background: Participation in care is considered to promote safe and qualitative care. Care-dependent older persons ageing in place have increased emergency care needs, which initiate inter-organisational collaboration involving municipal home care and ambulance services. Previous research concludes that uncertainties exist regarding what participation in care means in clinical practice, which necessitates the need to illuminate the phenomenon for older persons in critical life situations.

Aim: This study aimed to illuminate meanings of participation in prehospital emergency care from the perspective of care-dependent older persons experiencing acute illness at home.

Design: This study has a qualitative design with a lifeworld approach.

Method: A phenomenological hermeneutical method was used to analyse transcribed telephone interviews with eleven care-dependent persons aged 70–93 years.

Results: Care-dependent older persons' participation in prehospital emergency care means 'Entrusting life to professional caregivers' when being in helpless solitude and existentially unsafe, which emphasises a deepened interpersonal dependence. Meanings of participation in care from the perspective of older persons involve *Being reassured in togetherness*, *Being pliant in trust of emergency expertise*, *Being enabled through the agency of professional caregivers*, and *Encountering readiness in the emergency care chain*.

Conclusion: Care-dependent older persons' participation in prehospital emergency care is existential and involves interpersonal dependence. Togetherness brings reassurance, safety and opportunity for emotional rest while accessing the professional caregivers' power, competence and abilities which provide opportunities for existence and movement towards well-being and continued living.

Implications for practice: Prehospital emergency care from the perspective of care-dependent older persons transcends organisational boundaries and includes the municipal mobile safety alarm service. The involved municipal and regional organisations need to provide support by implementing lifeworld-led care models and care alternatives that enable professionals to recognise the existential dimension of participation in care.

KEYWORDS

ambulance services, home care services, mobile safety alarm, older persons, participation in care, phenomenological hermeneutical method, prehospital emergency care

BACKGROUND

Participation in care is a globally used concept that denotes the involvement of persons in need of care in care situations [1]. From a welfare perspective, participation in care is promoted as part of value-based health care which combines personal values with sound welfare finances to support a good life [2, 3]. The World Health Organization defines participation as persons' involvement in situations in their lives [4]. The broad definition makes clinical execution complex, and participation in care tends to end up as information-giving enhancing compliance [5] or partaking in decision-making [6, 7]. Participation in care favours safe and qualitative care for persons in need of care, given that both the caregiver and the cared-for person share a common understanding of what participation in care means and how it is to be enacted [8].

Older persons are encouraged to remain living at home as part of a sustainable 'ageing in place' strategy that promotes well-being and autonomy [9, 10]. Canadian research identifies service and support as greatly important when ageing in place, characterised by interpersonal relations, being safe in one's home, and coordinated care activities [11]. In Sweden, ageing in place is facilitated by the municipalities that provide services aligned with everyday care needs. However, home care service dependence is known to predict emergency care needs and emergency department (ED) conveyance [12]. Emergency care is the responsibility of the regional emergency medical service (EMS) and is provided by the ambulance services. Acute illness thus involves municipal and regional collaboration and transitional care [13].

European research on health and social care displays that older persons often ascribe relational aspects to the concept of participation in care, where being recognised as a unique person with a life history and interpersonal sharing is emphasised [14]. Older persons' views on home care display that 'feeling involved' requires caregivers to adopt a holistic perspective that includes consideration of the life situation which, in harmony with unhurried social interaction, facilitates trust and safety [15]. Swedish EMS research depicts the care experience as surrendering in dependence [16], which emphasises the presence of power and the acutely ill person's inferior position. Older persons with lowered decision-making ability also risk paternalistic ambulance care, which emphasises the ethical obligation to make decisions in the older person's best interest [17]. In situations involving older persons' acute illness, municipal care personnel are found to take on the role of the older person's representative in contact with EMS [13]. The involvement of both municipal and regional caregivers in emergencies can, however, both disturb and promote caring efforts [13, 17].

Participation in care is a practice that care organisations are not sufficiently prepared for [1], and collaborative care involving municipal and regional organisations is urged as a research priority [18]. This study provides knowledge that supports organisational development and collaborative care in marginal situations to accommodate older persons' preferences for participation in care when experiencing acute illness at home. The current lack of understanding of what participation in prehospital emergency care means for care-dependent older persons affects professional caregivers' ability to enact participation in care in such a way that promotes the older persons' safety and well-being. Failure to enact participation in care thus risks subjecting older persons to defaulted emergency care and intensified suffering. Highlighting the concept from the perspective of acutely ill older persons enables the involved care organisations to support clinical care practices that recognise a comprehensive understanding of the concept. In this way, qualitative and safe emergency care embracing the older person's perspective can be provided starting in the older persons' homes.

AIM

To illuminate meanings of participation in prehospital emergency care from the perspective of care-dependent older persons experiencing acute illness at home.

METHODS

The study had a qualitative lifeworld approach. The analysis adhered to the phenomenological hermeneutical method by Lindseth and Norberg [19, 20], which combines phenomenological [21] and hermeneutical [22] ontology and epistemology in their joint effort of providing an understanding of lifeworld phenomena through lived experience. The tripartite analysis serves to disclose meanings by hermeneutical interpretation of interview texts and includes moving between whole and parts, understanding and explanation [22]. The analysis includes articulating a first naïve understanding portraying the sensed essential meaning and interpreted whole, followed by a structural analysis close to the text involving condensing and explaining meanings that disclose variations and nuances. In the last part of the analysis, the meanings are further elaborated and reflected upon by using theory as a reflexive lens and thereby forming a comprehensive understanding.

Participants and setting

The participants were recruited with the aid of appointed personnel in a home care organisation in a municipality in the middle of Sweden, who distributed information letters by post to purposively selected persons aged 70 or older with recent experiences in prehospital emergency care. The age cutoff was determined in dialogue with the municipality and considered to best target the group of interest. Further criteria for inclusion involved verbal ability, in addition to understanding and providing informed consent. The participants ($n = 11$) comprised women ($n = 5$) and men ($n = 6$) of varying ages (70–93), with different amounts of home care utilisation, and different living statuses, as shown in Table 1. The acute illnesses prompting the need for prehospital emergency care embraced conditions such as bleeding, dizziness, fatigue, heart conditions, pain, respiratory conditions and trauma. The emergency responses were initiated by the older persons activating their mobile safety alarm in all situations but one, in which the alarm was out of reach and the older person had to await the arrival of personnel. Swedish municipal care personnel include both assistant nurses (upper secondary school level education) and personnel without formal care training. The prehospital emergency care chain commonly includes the emergency medical communication centres (112) and the ambulance services and denotes advanced care often provided by specialist-educated registered nurses (RNs) out of the hospital [23].

Data collection

The interviews were conducted between March 2020–January 2022 by the first author. Due to the SARS-CoV-2 virus in December 2019 causing the Coronavirus disease 2019 (COVID-19) and the participants being at high risk for severe illness, all interviews were conducted by telephone. The participants received a preparatory telephone call from the first author which, apart from planning and providing an opportunity for questions, served to establish a familiar connection and rapport [24] thus facilitating the upcoming interview. The interview was conducted in privacy on both parts and initiated with the one main question 'Please tell me about a situation when you needed ambulance care?'. Follow-up

TABLE 1 Participant characteristics. The presented names are fictitious for confidentiality.

Participant	Age (years)	Home care service	Mobile safety alarm	Living status	Interview duration (min)
Helen	89		x	Living alone	22
Bill	86		x	Living with partner	55
Sam	93	x	x	Living alone	45
Elsa	70	x	x	Living alone	17
Margret	79	x	x	Living alone	59
John	73		x	Living alone	27
Hanna	92	x	x	Living alone	89
Eric	81		x	Living with grandson	44
Jack	86		x	Living alone	60
David	79	x	x	Living alone	120
Mary	82	x	x	Living alone	42

TABLE 2 Example of the structural analysis process and theme development.

Meaning unit	Condensation	Subtheme	Theme
I completely trusted them. Because I heard, heard partly what they said, how they solved their problem and [pause] I trusted them fully. (Helen, 89)	To be able to completely trust the professionals' competence when listening to their conversation and problem-solving	Sensing the competence of professionals	Being pliant in trust of emergency expertise
Because they are experts (…) *you can tell they know what they're doing, and can. And that you quickly get the medical help you need* (Eric, 81)	To sense the competent behaviour of professionals when rapidly getting medical needs met		
They were fantastic ones too, they worked so very effectively together the two who were here, there was a male and a female. They put tubes and test devices most everywhere on the body to see how it was going. (Jack, 86)	To meet fantastic and team-playing personnel who find out the state of the body through detailed examinations		
Inserting a needle and such, that is devilry I think (…) *it has to be allowed, if it must, if they must have it. And that, if one lays [in the hospital] for a long time it might get, kind of infected sort of. But it's worse when they move on out, perhaps move to the outer side of the arm to get [vascular] access*. (Sam, 93)	To allow painful interventions if the professionals think it is necessary, despite the knowledge that infections can arise	Allowing forced bodily manipulation	
And then the ambulance men would, then they would get me up [on the stretcher]. Whether it was them, or the others [MCPs], I don't remember, it was either one of them. And I said, no I can't do it! I know I screamed, but "oh yes it's going really well, just leave it to us. And relax". It's really hard to just think now I'm just going to relax, now they get to take over the responsibility here. You keep on thinking, ahh now I'll fall again! (Margret, 79)	To relinquish bodily responsibility and thereby be obliged to rely on the assurance of the ambulance personnel that everything will be fine		
And [the professionals] stuffed some things [up the nose] (…) *But it just resulted in me getting it [bleeding] down my throat instead. So it didn't stop anything anyway*. (John, 73)	To be subjected to a bodily intervention in which material is inserted into the nose without it helping		

questions were asked to stimulate narratives of lived experience, for probing or clarifying reasons. To further stimulate reflections regarding participation in care, questions such as 'How did you experience participation in this situation?' were asked. All follow-up questions were formulated in relation to the unique narrative and lived experience of each participant. The length of the interviews was adapted according to the preference of the participants and lasted between 17 and 120 min. Most interviews assumed the character of an everyday conversation. The recorded interviews were transcribed verbatim for text analysis.

Analysis

The transcripts were repeatedly read by the first author which allowed the overall sense of the text to be grasped and a naïve understanding of older persons' participation in care was articulated [20]. Thereon an examination of the text parts in search for meanings commenced. Text indicating meanings of participation was identified, and the meanings were condensed. The condensations were differentiated based on their similarities and differences and assembled in groups, which were abstracted into subthemes and themes (Table 2). During the theme

development, the naïve understanding was used as a background enabling the parts to explain what was previously understood as a whole. Lastly, the meanings of participation were reflected upon in relation to the lifeworld, the body of knowledge developed by existential philosophers such as Husserl [21], Merleau-Ponty [25] and Heidegger [26] and incorporated into caring science to highlight the existential view of human experience in contexts of care [27–29].

Ethical considerations

Approval to conduct the study was obtained by the Swedish Ethical Review Authority (Dnr: 2019–02027). All participants were approached by post to ensure voluntariness and prevent external influence. The invitational letter contained information about the research purpose, researcher credentials and affiliation, how data were to be handled and confidentiality guaranteed, and that participation could be terminated at any time without consequence for care. Persons accepting to participate signed and returned informed consent by post along with contact information after which contact by telephone was established by the first author. Further information was provided along with the opportunity for the older person to ask questions and become familiar with the researcher. Before interview initiation, the participants were informed of the researcher's secluded whereabouts and that privacy was guaranteed. Narrating about a critical life situation requiring ambulance care risks subjecting the participant to traumatic memory recall. If negative reactions were to be identified during the interview, guidance to professional support would be offered. No negative reactions were identified, nor did the participants express any need for further support.

RESULTS

Henceforth, all involved personnel will be referred to as professional caregivers or professionals unless there is a need for professional clarification, thus allowing the phenomenon of participation in care to be the focus.

Naïve understanding

Participation in care for older persons experiencing acute illness at home involving municipal home care and ambulance services means entrusting life to professional caregivers when incapacitated due to acute illness. The meaning of participation is in relation to the experienced suffering involving existential insecurity and life stagnation, which can be understood as being in helpless solitude and stuck in time and space. Participation means the ability to breach the deadlock by activating the mobile safety alarm, which constitutes a lifeline in the ever presence of death and ensures human contact. The arrival of professionals means access to their power, competence and abilities, thereby extending capacity and chance for survival while being in a powerless state. Entrusting life to professional caregivers is a forced activity and involves handing over control and decision-making in the trust of emergency expertise and thus complying with directives and bodily manipulation without questioning procedures. Being together with genuinely interested professionals conveying an honest intention to help provides existential reassurance and enables rest. Through the efforts of professionals, opportunities for existence are provided that enable movement towards well-being.

Thematic structural analysis

The analysis resulted in the main theme 'Entrusting life to professional caregivers', which included the themes *Being reassured in togetherness*, *Being pliant in trust of emergency expertise*, *Being enabled through the agency of professional caregivers*, and *Encountering readiness in the emergency care chain*. An overview of the results is presented in Table 3.

Being reassured in togetherness means having someone coming to the rescue, and in the presence of professional caregivers be relieved, and recognised. The mobile safety alarm constitutes a secured lifeline and a possibility of being heard and found when in an existentially unsafe situation that cannot be managed in solitude. The lifeline ensures prompt response by loyal and resourceful professionals when incapacitated due to acute illness involving feelings of anxiety, helplessness, indignity, insecurity and mortal fear. The presence of committed, unhurried and genuinely interested professionals who instinctively assume responsibility provides security, peace and opportunity for emotional rest and means having someone alongside who safeguards. Defaulted safeguarding, such as when not having the illness taken seriously, risks creating feelings of being abandoned and existentially unsafe:

> kind of like, well here's 'one' now again (...) then that question pops up, despite everything, [the ambulance personnel] ask this if I wanted to go [to the ED] or not. And then I must decide if I *want* to go in or not, it wasn't a question of this [illness] actually being

TABLE 3 Results of the thematic structural analysis.

Main theme	Themes	Subthemes
Entrusting life to professional caregivers	Being reassured in togetherness	Having a secured lifeline in case of acute illness
		Being relieved in the presence of professionals
		Being recognised in a social context
	Being pliant in trust of emergency expertise	Sensing the competence of professionals
		Allowing forced bodily manipulation
	Being enabled through the agency of professional caregivers	Recognising own abilities and constraints
		Accessing the abilities of professionals
	Encountering readiness in the emergency care chain	Accessing continuous and coordinated care
		Having to accept the conditions of the care chain

> something that we *have* to go with. It's a little reassurance, anyway, when they almost force you to go.
>
> (David, 79)

Togetherness also includes social coexistence and means being recognised by the professionals as equal and competent person sharing common life references. Coexistence involves connecting on a personal level, where friendliness, curiosity and a cheerful mood serve as bonding agents. Coexisting includes taking on situational challenges together, which means being included in reasoning and problem-solving as part of the team.

Being pliant in trust of emergency expertise means complying with directives and authorising access to the body in trust of professional 'craftsmanship' (Mary, 82) involving advanced medical and experiential knowledge and technical skills. In the trust of competence, and being in 'safe hands', the responsibility for one's life and ill body is transferred to professionals. Authorising access to the body means allowing forced medical and sometimes painful procedures since the end in the form of well-being and bodily 'normalisation' justifies unpleasant means. Transferring bodily responsibility also means accepting compromised dignity, in trusting the honest intention to help:

> the next time I woke up I was heading down the elevator, and into the ambulance. And then he'd [the ambulance personnel] put a splint on the wrist, and well, I was lying there all wet [urine] and so, and bloody, and all. Then I got in [to the ED] anyway. But that guy, or two guys it was, they did really well.
>
> (Hanna, 92)

Although complying with directives and manipulation, the professionals' commitment and intentions behind actions are continuously interpreted. A crucial aspect that enhances the feeling of being in 'safe hands' is having the illness taken seriously by calm and genuinely interested professionals able to convey a sincere intention to understand, and unrestrictedly share concerns in open and honest reasoning. The commitment of professionals also includes their collaborative behaviour and shared consensus.

Being enabled through the agency of professional caregivers means being provided with means and opportunities to bring about change when the acutely ill body restrains life itself. Responsibility for existence is taken as far as possible, which means doing what you can on your own. Own abilities including knowledge, bodily ability, possibilities and constraints are scrutinised to assess the magnitude of the professional help needed while also considering a responsible use of welfare resources. Through the efforts of able, resourceful, powerful, and collaborating professionals, stagnation caused by acute illness can be breached which enables movement towards well-being. Efforts include advisory and practical help, representation, advocacy and access to medical resources and higher care levels, accepted in a silent or verbal agreement. Communication breakdowns due to language difficulties or the professionals' inability to identify and understand needs prevent movement towards well-being, and instead fuel stagnation and further suffering:

> in the end, I had to tell him [mobile safety alarm operator], I don't give a damn what you say, call for an ambulance! Then I couldn't manage to talk anymore, I shouted. You can't manage that when you're lying down, when you're in pain, so you're ooh! It was really horrible.
>
> (Margret, 79)

Own abilities, such as bodily ability and knowledge, also include social networks consisting of partners, close

relatives and friends who can act as representatives. The social network serves as collateral if professionals fail to accommodate needs. If all human agency is out of reach, trust in divine intervention may be the final option.

Encountering readiness in the emergency care chain means that the responsibility for one's life is transferred between and shouldered by all professionals involved in the presupposed emergency care chain to ensure survival and well-being, the first link being the municipal mobile safety alarm service and the last being ED care. Readiness means having every chain link prepared and ready to respond through coordinated collaboration. Readiness means encountering prepared, committed and competent professionals throughout the care chain who maintain the feeling of being reassured, enabled and on the move towards well-being:

> All these contexts that I've had to deal with, the healthcare system, on this ambulance, and at the hospital, and the [mobile safety] alarm service, and the home care and everything, that they are committed people and friendly people who know their job, whom you gain confidence in at once. And that feels very comforting.
>
> (Jack, 86)

Lack of readiness instead brings feelings of being an object in transit, a 'package' (David, 79) that gets unpacked when someone finds the time. The conditions of the care chain must simply be accepted, which means being grateful for the care that exists, that is provided at a reasonable cost. Accepting the conditions means understanding that others may need to be prioritised in the large volume of patients. Being of less priority means having to wait for care both at home and in the ED, being denied hospital admission in favour of other patients, or being discharged before fully recovering which increases the risk of rapid reentrance in the emergency care chain. Acceptance also involves adapting life to the conditions of the mobile safety alarm which only functions indoors. Leaving home may thus pose a threat to life, by not being able to access rapid emergency care response.

DISCUSSION

The following discussion constitutes the comprehensive understanding and final part of the analysis. The meanings of participation in care and its impact on well-being will be reflected upon in relation to caring science theory emphasising an existential view of well-being [27], where well-being can be experienced despite illness [30]. The acute suffering characterised by 'being stuck in time and space' sets the scene for the care encounter and gives the phenomenon of participation in care an existential purpose and direction for well-being. The core meaning of participation when acutely ill is the movement towards the well-being and continued living, and manifests in being released from stagnation and powerless solitude through situational change. It is the movement that promotes well-being as it creates new possibilities for existence [29], and the existential possibilities involve all elements of the lifeworld; time, space, body, mood and others [30].

Being in togetherness

Participation as being in togetherness, in being seen, recognised and therefore able to share the situation and suffering with professional caregivers is fundamental when experiencing acute illness, portrayed as a precondition for survival which emphasises a vulnerable interpersonal dependence. The mobile safety alarm guarantees togetherness in always having someone close, thus enabling making oneself heard and known to the world when the body becomes unmanageable and the home a place of obstacles and boundaries or even a death trap. Togetherness brings a chance for being released from potentially lethal confinement. From an existential view, acute illness can be described as 'homelessness' characterised by unfamiliarity [30]. The responding professionals can therefore be understood as becoming environmental anchors who temporarily represent familiarity, and 'at homeness' in providing rescue which brings a sense of belonging, security and well-being [27].

Togetherness also means opportunity for rest while the responsibility for life is transferred to professionals until well enough to cope on one's own again. The ability to transfer responsibility thus means having a safeguarding representative in the power of creating opportunities for continued living. From a caring science perspective, rest means peace, stillness and acceptance and is an expression of well-being [29].

Togetherness also involves a social dimension with a focus on what unites persons living in a common world although the relationship is forced. According to Holopainen et al. [31], togetherness brings a sense of communion, a connectedness that makes coexistence meaningful. Togetherness is a social activity, and socialising is an important aspect in relation to older persons' well-being and life satisfaction [32].

Being in trust

Participation as being in trust of the professional caregivers' emergency expertise and sincere intention to help emphasises the professionals pronounced power position. Being acutely ill means exposing oneself in a vulnerable, and powerless state. Great confidence, therefore, lies in the professionals' competence to recognise this vulnerability and assume responsibility for life accordingly. If a trusting relationship is experienced, the own body can be 'let go', which allows distancing from embodied suffering [33]. Within the tradition of nursing, the power imbalance existing between the professional and patient risks producing paternalistic care that compromises well-being [34]. To prevent paternalism, autonomy and self-determination are promoted by empowering the patient which involves a transfer of power that 'allows the patient to take control and thereby responsibility for his/her own life', thus enabling 'the patient to utilize his/her own power resource' [35]. However, when acutely ill and incapacitated, empowerment takes on a different shape. The professionals become the resource of power, authorised to take control and responsibility for life. The professionals are to exercise their power as authorised representatives, and empowerment in this context is to be understood as authorised representation. Authorised representation emphasises the ethical dimension of the caring relationship. According to the reasoning of Rundqvist [36], awarding authority is a sign of trust and involves an agreement on the professionals' part to honour that trust by managing and preserving life, and alleviating suffering. Honouring trust is, however, a choice, and involves choosing to act for the benefit of the patient [36]. The power asymmetry emphasises a humanising care practice, characterised by compassion, dignity and mutuality [37].

Being in continuity

Participation as being in continuity and encountering readiness in the emergency care chain discloses the older persons' extended perspective of prehospital emergency care, which apart from the current organisational EMS perspective (112, ambulance response) also includes the municipal mobile safety alarm service and ED care. The extended perspective emphasises the importance of continuous movement along the chain to maintain well-being. To be 'put on hold', such as when subjected to long waiting times in the unfamiliar environment of the ED confined to a bed (at best), allows stagnation and suffering to resurface. Only this time stagnation and suffering are caused by care, and therefore always constitute a violation of dignity in diminishing human value [38]. It is well-documented that older persons risk long waiting times at the ED [39, 40], and ED care additionally involves risk for missed diagnoses [41] and defaulted care [42], along with increased risk for pressure ulcer development [43] and delirium onset [44]. Older persons provided with choice are known to prefer hospital avoidance [45]. However, research also indicates that being left at home increases the risk of worsening conditions and even death [46]. Thus, participation in care must also be addressed from a welfare perspective, in providing a safe emergency care chain.

Apart from the movement itself, being 'passed on' in the care chain also requires that togetherness and trust are maintained by all professionals in every chain link to promote a sense of belonging as the scenery changes. The professional being the familiar and secure anchor needs to transfer the shouldered responsibility and anchoring role to the next professional in line to counteract feelings of simply being 'dropped off', or even 'displaced'. Being welcomed promotes feeling existentially 'at home' and safe, thus promoting well-being in allowing suffering to be endured [30].

Methodological considerations

Considerations have been made to enhance trustworthiness and ensure research quality [47]. Information letters were sent to 93 persons of which eleven accepted participation. Stated reasons for declining participation included memory loss, nursing home admittance, hearing loss, weakness and participation in other research projects. The objective of phenomenological studies is to disclose variation [48] and the participants represent variation, being women and men of various ages with various living statuses utilising different services and having unique lived experiences of more or less acute illnesses.

Telephone interviews are associated with poor data due to often short interviews and absent body language [49]. The mean length of the interviews was 53 min, which can be considered equivalent to face-to-face interviews. The shorter interviews also provided valuable lived experience, although they were not as elaborate as the longer interviews. When researching sensitive topics, such as traumatic events, the telephone also provides anonymity which might ease narrating [24]. However, the absence of body language is a considerable limitation when conducting phenomenological research where the 'lived body' is essential. Having to rely exclusively on verbal information,

cues and requests means that bodily conveyed reactions might have been missed which could have influenced the interview and subsequently the following analysis. During the interview, the participants were not directed to talk only about the acute situation although being the starting point. Most interviews therefore developed into genial everyday conversations facilitating trust between researcher and participant [24]. Due to telephone distortion, hoarseness or accent, some words were not audible in the recordings and therefore lost in transcription. However, the gaps did not compromise understanding. Most participants also narrated multiple ambulance care episodes, which enriched their lived experiences.

The method includes an intentional but controlled use of the researcher's preunderstanding of the phenomenon [20], which means using preunderstanding as a guide in spotting the phenomenon while keeping an open mind for new understandings based on what the text discloses. After each interview, researcher–participant interaction was reflected on, as well as preunderstanding. To prevent researcher bias, such as a judging attitude, the analysis and results were reviewed, questioned and discussed by all authors to reach a consensus.

CONCLUSION

This study illuminated meanings of participation in prehospital emergency care from the perspective of care-dependent older persons experiencing acute illness at home.

Participation means entrusting life to professional caregivers when existentially unsafe in helpless solitude and involves authorised representation in the trust of emergency expertise. Togetherness brings reassurance, safety and opportunity for emotional rest while accessing the professionals' power, competence and abilities which provide opportunities for existence and movement towards well-being and continued living. The results of this study implicate that the current organisational perspective on prehospital emergency care needs to extend to include the municipal mobile safety alarm service. A comprehensive view involving the entire emergency care chain is needed to prevent care fragmentation for older persons in critical life situations where interpersonal dependence is deepened. In addition, the involved municipal and regional organisations need to provide support, e.g. by implementing lifeworld-led care models that enable professionals to recognise the existential dimension of participation in care. Future research should focus on the implementation of lifeworld-led care models in the prehospital emergency care context that support professionals in adopting a caring approach that involves seeing the patient as an equal and competent person as a starting point for care.

AUTHOR CONTRIBUTIONS

All the authors were involved in the study design. The first author conducted all interviews. Data was analysed by the first author in collaboration with all authors. The first author drafted the manuscript, which was reviewed, revised and accepted in its final version by all authors.

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CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest.

DATA AVAILABILITY STATEMENT

The data supporting the results of this study are not publicly available due to ethical restrictions.

ETHICS STATEMENT

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

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