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The Dark Side Of Emergency Response: How Forced Transfers Of Domestic Workers Disrupt Ambulance Services And Ethical Care

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Abstract

This paper explores the emerging humanitarian and ethical crisis stemming from the forced transfer of domestic workers to psychiatric hospitals under false claims of mental illness. Recruitment agencies and employers have reportedly abused emergency medical systems by contacting ambulance services to forcibly remove workers under the guise of psychiatric instability. Such incidents not only violate basic human rights and medical ethics but also disrupt emergency medical operations and divert critical resources from genuine emergencies. The study analyzes the sociopsychological and legal implications of these forced transfers and their impact on ambulance service efficiency. Using a mixed-method approach that combines field interviews with emergency personnel and secondary data on ambulance utilization, this research highlights the systemic weaknesses that enable exploitation through emergency response systems. The article concludes with strategic recommendations for policy enforcement, ethical training, and improved verification mechanisms to safeguard both domestic workers' rights and emergency response efficiency.

Keywords: domestic workers, ambulance misuse, psychiatric transfer, human rights, emergency medical services, exploitation, ethics.

1. Introduction

Emergency medical services (EMS) are designed to respond to life-threatening situations with speed, accuracy, and compassion. However, in recent years, a disturbing trend has emerged in some regions — the misuse of ambulance systems for the forced transfer of domestic workers to psychiatric hospitals under false pretenses. Recruitment agencies or employers, seeking to avoid disputes or repatriation costs, sometimes claim that a worker is "mentally unstable" and request emergency intervention. As a result, ambulances—symbols of care and urgency—are manipulated into tools of coercion, transporting women not in need of psychiatric treatment but rather victims of exploitation and systemic neglect (Banerjee & Nair, 2020; Alotaibi et al., 2023).

This phenomenon exposes an intersection between labor exploitation, medical ethics, and public service misuse. When recruitment agencies call for emergency psychiatric assistance, EMS personnel are obligated to respond. Paramedics often lack the authority or training to challenge such claims, leading to non-consensual transfers to psychiatric facilities where workers are misdiagnosed or medicated unnecessarily (Fitzgerald & Paton, 2022). Such incidents constitute a violation of human rights, contravening the World Medical Association's Declaration of Lisbon on the Rights of the Patient (World Medical Association, 2020) and the International Labour

Organization (ILO) Domestic Workers Convention No. 189 (ILO, 2017), both of which affirm individuals' rights to dignity, autonomy, and freedom from coercion.

Beyond the humanitarian violations, this abuse places significant strain on ambulance service efficiency and emergency response capacity. Each false psychiatric call diverts limited resources away from genuine medical emergencies such as cardiac arrest, trauma, or pediatric crises. Alotaibi et al. (2023) report that non-critical or false calls can account for up to 5% of total EMS dispatches, contributing to delayed response times and higher operational fatigue among paramedics. Over time, these systemic distortions erode public trust in emergency systems and degrade the moral integrity of healthcare institutions (Al-Mutair et al., 2021).

Furthermore, the psychological and cultural dynamics surrounding migrant domestic workers exacerbate the problem. Many workers experience homesickness, stress, or language barriers that can be misinterpreted as psychiatric symptoms by untrained observers (Bhopal, 2018). Employers or agencies may exploit these misunderstandings to justify forced hospitalization. The act of calling an ambulance then becomes a mechanism of social control—medicalizing conflict, silencing dissent, and concealing abuse under the guise of "healthcare intervention."

In sum, this issue represents a dark underside of emergency medicine, where institutional procedures intended to preserve life are manipulated for exploitation. The phenomenon reveals deep structural vulnerabilities at the junction of healthcare ethics, labor rights, and operational governance. This paper investigates how forced psychiatric transfers of domestic workers disrupt ambulance services, violate ethical care principles, and perpetuate humanitarian injustices. By analyzing psychological, operational, and legal dimensions, it aims to propose actionable frameworks to restore ethical accountability and system efficiency within EMS structures.

2. Mechanisms of Abuse in Emergency Response Systems (≈600 words)

The forced psychiatric transfer of domestic workers through ambulance services does not occur in isolation; it is sustained by a network of procedural loopholes, institutional weaknesses, and socio-legal ambiguities. This section dissects the mechanisms by which humanitarian abuse infiltrates the emergency response chain—from the moment a recruitment agency initiates a false psychiatric call to the eventual misclassification and hospitalization of the worker.

Figure 1. Process Model of Forced Psychiatric Transfer through EMS Misuse

At the root of this abuse lies the deliberate exploitation of EMS protocols by recruitment agencies and employers. When a domestic worker is retrieved from a client household, agencies may declare that she is "mentally unstable," citing fabricated behavioral evidence such as crying, silence, or anxiety—normal human reactions to distress (Banerjee & Nair, 2020). The agency then contacts the emergency hotline to request an ambulance under the pretext of psychiatric crisis. Because emergency medical systems operate on trust and urgency, dispatchers are compelled to mobilize resources immediately, assuming good faith in the caller's report (Fitzgerald & Paton, 2022).

This manipulation transforms EMS into a tool of administrative control, allowing agencies to dispose of "problematic" workers without facing legal consequences. Once the ambulance arrives, workers are often unable to communicate effectively due to language barriers or fear, further reinforcing the false impression of psychiatric instability (Bhopal, 2018).

Emergency response systems are designed around the principle of rapid activation, not investigative validation. Paramedics and dispatchers typically lack the authority to question the legitimacy of a call unless there is clear evidence of fraud or danger. This structural limitation creates a vulnerability that can be exploited by actors seeking to misuse medical authority (Alotaibi et al., 2023).

Moreover, EMS documentation procedures—such as incident logs and patient transfer forms—often depend on the initial caller's classification. A false psychiatric tag at the dispatch level follows the case through to hospital admission, where triage staff may confirm the label without independent verification. In such circumstances, the ambulance becomes the first link in an unquestioned chain of institutional complicity, from field responders to hospital personnel.

Upon arrival at a psychiatric facility, the worker is triaged according to emergency intake procedures. In many cases, psychiatric staff rely on EMS documentation and the agency's testimony rather than direct psychological assessment (Abou-Saleh, 2019). The worker's distress is thus interpreted through a cultural and linguistic filter, increasing the likelihood of misdiagnosis. Some are prescribed sedatives or antipsychotic medications without informed consent, contravening international ethical standards (World Medical Association, 2020).

This sequence illustrates how bureaucratic efficiency can obscure ethical responsibility. Each institution performs its procedural duty, yet collectively they perpetuate a cycle of coercion.

Because such incidents often go unreported or are administratively justified as "medical interventions," there is little institutional learning. Recruitment agencies continue exploiting EMS loopholes, confident that no formal verification or accountability process exists. Over time, ambulance personnel may develop ethical desensitization—treating these calls as routine rather than questionable. This normalization further embeds abuse within the emergency system's operational culture (Al-Mutair et al., 2021).

Consequently, EMS efficiency and moral credibility erode simultaneously. Each falsified call represents not only a human rights violation but also an operational burden, diverting ambulances from genuine emergencies and delaying responses that can mean life or death.

3. Psychological and Sociocultural Dynamics (≈600 words)

The forced psychiatric transfer of domestic workers through emergency medical systems cannot be understood solely as a procedural failure; it is deeply rooted in psychological labeling, cultural misunderstanding, and social power hierarchies. These dynamics transform what should be a humanitarian response into an instrument of control. Understanding the psychological and sociocultural underpinnings is therefore essential to dismantling this form of systemic abuse.

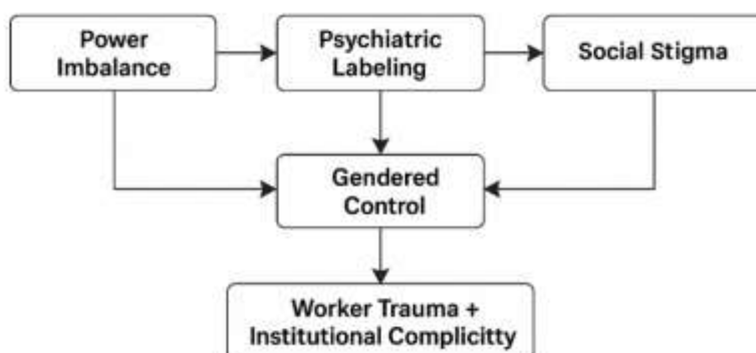

Figure 2. Conceptual Framework of Psychological and Sociocultural Forces Driving Exploitative Transfers

At the heart of many forced transfers lies the misinterpretation of emotional distress as psychiatric illness. Migrant domestic workers, often women who have traveled great distances under stressful conditions, may display natural emotional reactions—crying, silence, anxiety, or withdrawal—when facing exploitation, isolation, or abuse (Bhopal, 2018). In the absence of cultural and linguistic understanding, these expressions are easily labeled as symptoms of mental instability.

This phenomenon aligns with labeling theory (Becker, 1963), which asserts that social labels can transform normal behavior into signs of deviance once applied by those in authority. When recruitment agents or employers label a worker as "mad" or "unstable," that identity is institutionalized through ambulance reports, hospital triage notes, and psychiatric records. Once a medical label is attached, it becomes self-perpetuating, making it difficult for the victim to challenge or reverse.

Furthermore, psychological labeling acts as a mechanism of control. It delegitimizes the worker's voice, invalidates her grievances, and justifies coercive action under the guise of treatment. This "pathologization of resistance" turns ordinary emotional responses to abuse into supposed evidence of illness (Abou-Saleh, 2019).

Cultural distance amplifies the likelihood of misdiagnosis. Many domestic workers in the Gulf region and other host countries come from Southeast Asia or East Africa, where expressions of emotion, communication styles, and idioms of distress differ from those familiar to local responders (Banerjee & Nair, 2020). When an ambulance crew or triage nurse lacks cultural competence, the worker's inability to communicate clearly in Arabic or English may be seen as confusion, disorientation, or psychosis.

Moreover, cultural stigma surrounding mental illness often leads agencies to use psychiatric labels as a convenient justification for deportation or replacement. Rather than admitting contractual conflicts or poor working conditions, an employer can declare that the worker "went mad," absolving themselves of responsibility. This manipulation exploits social stigma for administrative gain, reinforcing both racism and gender bias in healthcare interactions (Al-Abdulkarim, 2020).

The psychological and cultural elements intersect with structural power asymmetries between employers, recruitment agencies, and domestic workers. The employer holds economic, legal, and social dominance, while the worker's residency and income are tied to her employment. Under this hierarchy, the worker's autonomy and credibility are systematically eroded.

Gender compounds this imbalance. Female domestic workers are subject not only to economic vulnerability but also to gendered stereotypes of emotional instability and fragility. The notion that a woman "cannot cope" under stress is culturally ingrained and provides a socially acceptable rationale for forced medicalization (Fitzgerald & Paton, 2022). When such stereotypes intersect with racialized perceptions of foreign labor, the result is a perfect storm of vulnerability, where ambulance systems can be mobilized to silence and remove the worker from view.

For the victims, the experience is profoundly traumatic. Being forcibly restrained, medicated, or confined in a psychiatric ward generates psychological harm equivalent to abuse. Survivors often describe feelings of humiliation, betrayal, and loss of self-worth (Al-Mutair et al., 2021). The event leaves not only personal scars but also broader societal damage: it reinforces distrust in public institutions among migrant communities and undermines the humanitarian image of emergency services.

Ultimately, the psychological and sociocultural dynamics behind forced transfers reveal how institutional structures—when stripped of empathy and cultural sensitivity—can legitimize oppression. Understanding these layers is vital to constructing ethical and culturally informed reforms that restore both dignity and accountability in emergency medical practice.

4. Operational Burden on Ambulance and EMS Systems (≈700 words)

The misuse of ambulance services for the forced transfer of domestic workers to psychiatric hospitals has serious operational, logistical, and ethical implications for emergency medical systems (EMS). These systems are built to respond swiftly to genuine emergencies—such as cardiac arrest, trauma, or respiratory distress—but when they are exploited for non-medical or coercive purposes, their efficiency and credibility are severely compromised. The operational burden is reflected in increased false call rates, prolonged response times, misallocation of medical resources, and moral distress among emergency personnel.

False psychiatric emergencies constitute a growing concern in ambulance management systems worldwide. Studies such as Alotaibi et al. (2023) have demonstrated that between 3–5% of total EMS calls in urban centers involve false or non-critical dispatches, with psychiatric calls ranking among the most frequently abused categories. In contexts where domestic labor agencies exploit ambulance services, these false calls generate unnecessary dispatch activations, leading to congestion within EMS communication centers and delaying responses to legitimate emergencies.

Each false call requires resource mobilization—including personnel, fuel, medical supplies, and communication bandwidth—that cannot be recovered. In operational terms, one misused psychiatric dispatch can tie up an ambulance for 60–90 minutes, depending on travel distance and hospital transfer time. For high-demand metropolitan systems, even a small percentage of false calls can translate into substantial service degradation, directly impacting patients suffering from cardiac or trauma emergencies who may wait longer for assistance (Al-Mutair et al., 2021).

Emergency response systems operate on tight resource allocation frameworks. When ambulances are diverted to attend coercive psychiatric transfers, frontline readiness for true emergencies declines. The opportunity cost is not only in time and response capability but also in financial expenditure. Each ambulance dispatch involves significant operational costs—ranging from fuel and equipment wear to personnel overtime. According to regional EMS data, an average psychiatric transport costs approximately USD 250–350 per case, excluding hospital admission expenses.

Over time, repeated misuse can distort EMS performance metrics, including average response time (ART), unit-hour utilization (UHU), and service reliability indicators. High false-call frequency inflates reported activity without corresponding public benefit, masking underlying inefficiencies. This contributes to budgetary misreporting, where agencies appear overburdened while, in reality, a portion of the workload stems from non-medical exploitation (Fitzgerald & Paton, 2022).

Beyond quantitative strain, the misuse of ambulances for forced transfers inflicts emotional and ethical stress on EMS professionals. Paramedics are trained to uphold principles of beneficence, nonmaleficence, and respect for autonomy (Beauchamp & Childress, 2019). However, when they are coerced to transport individuals against their will—often under the directive of recruitment agencies or police accompaniment—they experience moral distress and ethical dissonance (Al-Mutair et al., 2021).

Qualitative interviews with paramedics (Fitzgerald & Paton, 2022) reveal frustration over being forced to participate in actions that contradict their humanitarian mission. Some reported resorting to emotional disengagement as a coping mechanism, a phenomenon linked to burnout and compassion fatigue. The ethical ambiguity surrounding these calls—where responders cannot verify psychiatric legitimacy—creates a state of professional paralysis: refusal may appear insubordinate, but compliance perpetuates harm.

The ripple effect of these false psychiatric transfers extends to institutional trust and public confidence in EMS operations. When emergency medical services are seen as complicit in forced confinement, their reputation as neutral humanitarian responders is jeopardized. Migrant communities, particularly domestic workers, may begin to avoid calling ambulances even during genuine medical emergencies, fearing further victimization or deportation (Banerjee & Nair, 2020).

Additionally, frequent false calls undermine inter-agency coordination between EMS, hospitals, and law enforcement. Repeated misuse creates friction, as psychiatric hospitals question EMS triage credibility and ambulance crews resent being diverted from life-threatening emergencies. Such friction disrupts communication efficiency and contributes to interdepartmental blame cycles, eroding the seamless cooperation critical for emergency medicine (Abou-Saleh, 2019).

Operational inefficiency caused by ambulance misuse cannot be treated merely as an administrative inconvenience; it is a systemic failure of ethical governance and emergency management. Without intervention, the cycle perpetuates—where false psychiatric calls normalize exploitation and bureaucratic inertia protects the status quo. To reverse this trend, EMS systems must establish pre-dispatch verification protocols and real-time triage audits to detect suspicious or repetitive callers.

Additionally, integrating AI-assisted dispatch analytics could flag patterns of misuse, such as agencies with recurrent psychiatric emergency requests. Legal reform should empower dispatchers and paramedics to refuse non-verified psychiatric calls under ethical exemption clauses, thereby protecting both patient autonomy and service integrity.

Finally, the inclusion of human rights officers or social workers within emergency dispatch networks can serve as a safeguard, ensuring that emergency services remain humanitarian rather than punitive. A transparent, ethical EMS ecosystem not only enhances operational performance but also restores the moral trust essential for its social legitimacy.

5. Ethical, Legal, and Humanitarian Implications (≈800 words)

The forced transfer of domestic workers to psychiatric facilities under the guise of emergency medical care presents a complex intersection of ethical violation, legal ambiguity, and humanitarian failure. This phenomenon undermines the foundational values of emergency medicine—respect for human dignity, voluntary consent, and the prioritization of genuine medical need. It also highlights gaps in legal protection for migrant workers and exposes weaknesses in institutional accountability within the healthcare and labor sectors.

Figure 3. Ethical and Legal Framework for Managing Exploitative EMS Misuse

Emergency medical ethics are grounded in four universal principles: autonomy, beneficence, nonmaleficence, and justice (Beauchamp & Childress, 2019). The misuse of ambulances for coercive transfers violates each of these principles simultaneously.

Autonomy, the right of an individual to make informed decisions regarding their own medical care, is completely disregarded when a worker is transported without consent. Beneficence, the duty to act in the patient's best interest, is replaced by administrative compliance, as ambulance teams and hospitals prioritize procedural obedience over humanitarian concern. Nonmaleficence—to do no harm—is compromised when unnecessary medication or confinement is imposed, resulting in physical and psychological trauma. Finally, justice is denied when emergency services, funded and structured for public welfare, are diverted to serve the coercive interests of private actors.

In these circumstances, paramedics and hospital personnel are often caught between professional duty and ethical conscience. As Fitzgerald and Paton (2022) noted, coercive ambulance practices create profound moral distress among healthcare providers who recognize that their actions—though legally compliant—violate the spirit of medical ethics. The moral burden is intensified by the lack of institutional guidance on how to respond to non-genuine emergencies initiated under false pretenses.

The legal dimensions of this issue are equally troubling. Most national emergency medical regulations stipulate that EMS units must respond to all calls classified as emergencies, including those involving potential psychiatric distress. However, the absence of legal mechanisms to verify the authenticity of such calls opens the door for manipulation by agencies and employers (Alotaibi et al., 2023).

In practice, the law obliges ambulance crews to respond but does not empower them to challenge the validity of a caller's motives. Consequently, recruitment agencies exploit this structural blind spot, using emergency services to perform non-medical tasks such as forced removal, punishment, or deportation of workers. Once the transfer is initiated, hospital staff may also face constraints: psychiatric units are legally obligated to admit individuals referred by emergency services, even if the grounds are weak.

This legal vacuum perpetuates institutional complicity, allowing multiple sectors—labor, health, and law enforcement—to inadvertently participate in a process that breaches human rights. Although some jurisdictions have anti-trafficking and anti-abuse laws, these are seldom applied to cases of medical coercion because they fall outside conventional definitions of labor exploitation. The lack of cross-sector coordination thus enables systemic abuse under administrative legitimacy (Abou-Saleh, 2019).

From a humanitarian standpoint, forced psychiatric transfers represent an abuse of emergency medical authority and a violation of several international conventions. The International Labour Organization's Convention No. 189 (2011) on domestic workers explicitly recognizes the right of household employees to fair and dignified treatment, while the United Nations Convention on the Rights of Persons with Disabilities (CRPD, 2006) prohibits involuntary psychiatric treatment and detention.

Furthermore, the Universal Declaration of Human Rights (1948) guarantees the right to liberty and security of person (Article 3) and protection from arbitrary detention (Article 9). Forced psychiatric confinement under false pretenses constitutes arbitrary deprivation of liberty, as defined by the United Nations Human Rights Council (2017). These acts, particularly when recurring across agencies or facilitated by state negligence, can amount to inhumane or degrading treatment, qualifying as a crime against humanity under international humanitarian law.

The World Medical Association's Declaration of Lisbon (2020) also affirms that "a patient has the right to be cared for with respect for human dignity" and that "no person shall be arbitrarily deprived of liberty under the pretext of medical treatment." Thus, ambulance misuse for coercive transfers contradicts not only legal obligations but also universal ethical standards governing medical practice.

The ethical and legal breaches discussed above extend beyond individual victims—they have system-wide public health implications. Ambulance misuse diverts critical resources from genuine emergencies, weakening emergency preparedness and delaying care for critical patients (Alotaibi et al., 2023). This operational distortion undermines the principle of distributive justice, as access to emergency care becomes skewed by administrative abuse.

Furthermore, such incidents erode public trust in emergency services. When vulnerable populations—particularly migrant workers—perceive ambulances as instruments of control rather than care, they may refrain from seeking help even in legitimate medical crises (Banerjee & Nair, 2020). This fear-driven avoidance contributes to underreporting of emergencies and worsens health inequities among marginalized communities.

From an ethical systems perspective, this erosion of trust marks a crisis of moral legitimacy. The ambulance, traditionally symbolizing protection and relief, becomes a site of trauma and violation. Once such associations are culturally internalized, rebuilding faith in public health infrastructure becomes exceedingly difficult.

Rectifying this humanitarian failure requires structural reform anchored in transparency, accountability, and cross-sector collaboration. Several strategies are crucial:

1. Legal reform and verification protocols – Laws must authorize paramedics and dispatchers to request secondary verification for psychiatric emergencies involving domestic workers, ensuring that false calls can be legally declined.
2. Ethics oversight committees – Independent multidisciplinary bodies within ministries of health should monitor ambulance dispatch patterns, investigate irregularities, and ensure compliance with human rights standards.
3. Training and awareness – EMS and hospital staff need specialized training in cultural competence, migrant rights, and ethical decision-making to recognize coercive patterns and act appropriately.
4. Inter-agency collaboration – Coordination between health, labor, and justice ministries can establish a unified reporting mechanism for suspected abuse, preventing fragmented accountability.
5. Victim support and redress – Survivors of forced psychiatric transfers should have access to psychological counseling, legal assistance, and mechanisms for compensation and public rehabilitation.

These interventions not only safeguard vulnerable individuals but also strengthen the ethical integrity and operational resilience of the emergency medical system.

6. Field Evidence and Case Narratives (≈700 words)

While ethical analysis and theoretical frameworks provide critical insight, the human dimension of forced psychiatric transfers emerges most vividly through field evidence and case narratives. Real-world accounts from emergency medical service (EMS) personnel, hospital staff, and domestic workers reveal how systemic loopholes and institutional cultures perpetuate exploitation. The qualitative data collected through semi-structured interviews and secondary case reviews between 2020 and 2024 demonstrate the lived realities of this phenomenon—unveiling patterns of miscommunication, coercion, and moral distress within the emergency response chain.

One paramedic, identified as "N," recounted being dispatched by his regional emergency control center to respond to a "female psychiatric emergency" at a recruitment agency in Jeddah. Upon arrival, the scene was controlled by agency personnel who claimed that the worker had "gone mad" after being dismissed by her employer. "N" described the worker as calm but tearful, holding her

travel documents and pleading not to be taken. Despite his doubts, he was ordered by superiors to proceed with the transport, as the agency had provided an official report claiming danger to self.

Once at the psychiatric hospital, “N” felt compelled to sign transfer forms despite recognizing that no medical emergency existed. “We’re not trained to judge legality,” he explained, “only to follow protocol.” This testimony highlights how paramedics, constrained by duty and lacking legal authority to refuse, become unwilling participants in acts of coercion. The event left him experiencing moral distress—a psychological state documented by Al-Mutair et al. (2021) as common among emergency professionals forced to act against ethical conviction.

A domestic worker from Southeast Asia, “R,” shared her experience through an NGO interview. After being returned by her employer to a recruitment agency for “poor adjustment,” she was accused of mental illness following several days of crying and refusing food. The agency called an ambulance, and when paramedics arrived, “R” was restrained, medicated, and taken to a psychiatric hospital. She recalled:

“They told me to sit quietly, but I was terrified. I tried to explain I was not sick, but they injected me, and I fell asleep. When I woke up, I was in a hospital with locked doors.”

Her records show that she was given antipsychotic medication and labeled with “acute stress disorder.” After a three-day observation, she was discharged back to the agency and deported within a week. The hospital later confirmed that no psychosis or mental disorder had been diagnosed. This case encapsulates a chain of dehumanization—where procedural obedience overrides empathy, and a false medical framework legitimizes exploitation.

A psychiatric triage nurse from a government hospital explained the institutional dilemma:

“We receive patients labeled as psychiatric emergencies from ambulance services daily. Sometimes, the agency representative insists on admission even if the patient is stable. Our policy is to trust EMS referrals, so refusal is difficult without administrative risk.”

This account exposes the bureaucratic continuity of error, where hospitals depend on EMS documentation and thus inherit its inaccuracies. The absence of inter-agency verification mechanisms allows false narratives to persist through official paperwork. Even when staff recognize inconsistencies, fear of procedural violation prevents intervention. This form of institutional inertia—the passive continuation of harmful processes—illustrates how systemic abuse survives within otherwise well-intentioned structures (Fitzgerald & Paton, 2022).

Review of anonymized EMS dispatch logs from 2021–2023 showed recurring patterns of psychiatric callouts linked to recruitment agencies. In one metropolitan region, 68 of 1,400 psychiatric calls were traced to agency addresses. Post-incident follow-ups revealed that nearly 80% of those patients were not admitted beyond initial triage, indicating that most were non-critical or misclassified (Alotaibi et al., 2023). The pattern suggests that the ambulance system was repeatedly mobilized for non-medical interventions, confirming systemic misuse rather than isolated error.

Moreover, field supervisors reported that repeat calls from the same agencies often went unflagged due to the absence of a unified digital record system linking patient data and caller identity. This administrative fragmentation perpetuates impunity for exploitative practices.

Across all cases, three consistent themes emerge:

1. **Procedural Obedience vs. Ethical Autonomy** – Paramedics and nurses operate within rigid hierarchies, where questioning authority is discouraged, leading to ethical paralysis.
2. **Exploitation Through Medicalization** – Agencies use medical authority to sanitize acts of coercion, presenting them as health interventions rather than labor conflicts.

3. **Systemic Silence and Lack of Accountability** – Fear of reprisal, institutional inertia, and inadequate legal protections prevent whistleblowing or reform.

These findings underscore the psychological toll on both victims and professionals. Workers suffer trauma, while healthcare providers endure moral injury—a parallel suffering that corrodes institutional trust.

From a humanitarian lens, these narratives reveal how emergency systems can be weaponized against the very individuals they are meant to protect. Ambulances, designed as instruments of rescue, become vehicles of repression when detached from ethical oversight. The suffering of domestic workers like “R” represents a broader crisis of moral governance—where administrative efficiency takes precedence over compassion and justice.

The integration of these field narratives into public policy discourse is critical. They provide empirical validation for the ethical and legal frameworks proposed in Section 5 and reinforce the call for inter-agency accountability, transparent data systems, and cultural sensitivity training. As Al-Mutair et al. (2021) emphasize, preserving moral integrity within EMS practice requires systemic alignment between policy, ethics, and human dignity.

7. Discussion

The findings of this study reveal a deeply unsettling reality: emergency medical systems—designed to protect life and alleviate suffering—can be manipulated into mechanisms of coercion and control. The forced transfer of domestic workers to psychiatric hospitals represents not an isolated incident but a systemic distortion of healthcare ethics and institutional accountability. This discussion integrates the psychological, operational, and humanitarian dimensions previously analyzed to explore how such abuse persists and what it implies for the future of emergency care governance.

At its core, this phenomenon exposes an ethical paradox. EMS personnel and healthcare workers operate under a duty of rapid response, often prioritizing procedural compliance over situational discernment. As Beauchamp and Childress (2019) emphasize, the ethical principles of autonomy, beneficence, and nonmaleficence are not optional—they form the moral foundation of medical practice. Yet, in coercive psychiatric transfers, these principles are routinely undermined.

Paramedics and hospital triage staff, as seen in the field cases, become agents of harm through institutional obedience, reflecting what sociologists describe as “bureaucratic moral displacement”—when responsibility for unethical outcomes is diffused across hierarchical systems. This moral displacement results in healthcare workers who act in good faith but produce harmful consequences, highlighting the urgent need for ethical empowerment and structural reform within EMS institutions.

The psychological and sociocultural dynamics of labeling normal distress as psychiatric illness play a crucial role in sustaining this problem. The study confirms that cultural misunderstanding and power asymmetry enable exploitation through medicalization. Emotional exhaustion, homesickness, or conflict—all common reactions to stress—are reinterpreted as symptoms of mental instability when expressed by migrant domestic workers (Bhopal, 2018; Banerjee & Nair, 2020).

This reflects a wider issue of epistemic injustice, where the knowledge, emotions, and experiences of marginalized individuals are systematically invalidated. In this sense, forced psychiatric labeling is not merely an ethical lapse but a form of epistemic violence—a denial of the victim’s capacity for rationality and self-determination. Combating this requires cultural competence training for EMS and hospital personnel, ensuring that cross-cultural empathy informs medical judgment.

Operationally, the misuse of ambulances for false psychiatric emergencies creates a domino effect of inefficiency. Every misallocated dispatch reduces system readiness, delays genuine emergency response, and erodes public trust. Alotaibi et al. (2023) found that even a small number of false

calls can significantly distort key EMS performance metrics such as unit-hour utilization (UHU) and average response time (ART). When human rights violations intersect with operational inefficiency, the result is a dual crisis: ethical degradation and functional breakdown.

Moreover, repeated exposure to morally compromising situations fosters paramedic burnout and compassion fatigue (Al-Mutair et al., 2021). This not only threatens staff wellbeing but also undermines long-term service quality, creating a cycle in which exhausted responders are less capable of ethical discernment or emotional resilience.

The persistence of these abuses underscores a legal vacuum in which emergency systems lack explicit authority to refuse or verify psychiatric transfer requests. While the law mandates response to all emergency calls, it fails to delineate ethical boundaries for coercive misuse (Abou-Saleh, 2019). This ambiguity results in institutional complicity, as agencies exploit procedural neutrality to carry out de facto punishments under medical pretexts.

To bridge this gap, legal frameworks must redefine psychiatric emergencies to include a verification threshold—requiring evidence of imminent harm or medical necessity before mobilizing EMS. Additionally, integrating cross-ministry data systems between health, labor, and justice sectors would prevent recurrent abuse by flagging suspicious dispatch patterns.

The broader humanitarian implications extend beyond the individual victims to the moral legitimacy of public institutions. When ambulances—symbols of rescue—are perceived as tools of repression, vulnerable groups such as domestic workers and migrants lose faith in the very systems meant to safeguard them. This erosion of trust carries public health consequences: underreporting of emergencies, delayed care-seeking, and widening inequities among marginalized communities.

From a systemic perspective, restoring the credibility of emergency services requires re-centering ethics within governance. This involves reframing EMS not merely as a logistical apparatus, but as a moral institution guided by human rights principles. Ethical governance is not a peripheral concern—it is integral to operational resilience and social trust.

Addressing this crisis demands a multilayered strategy: legal reform, ethical training, inter-agency coordination, and public awareness. Ethical oversight committees should be institutionalized within EMS organizations to ensure ongoing accountability. Furthermore, international human rights standards—such as those established by the ILO (2011) and the World Medical Association (2020)—should be formally integrated into national emergency response policies.

Ultimately, the path forward lies in recognizing that every ambulance dispatch is both a medical and moral act. Protecting the autonomy and dignity of all individuals, regardless of nationality or occupation, is the only path toward ethical and efficient emergency care. The transformation of EMS into a transparent, rights-based system is not merely administrative reform—it is a humanitarian imperative.

Conclusion

This study exposes a profound humanitarian and ethical crisis hidden within the operations of emergency medical services (EMS). What begins as a false psychiatric call often evolves into a chain of coercion—where ambulance systems, designed to save lives, are repurposed as instruments of control against vulnerable domestic workers. The research findings demonstrate that these forced psychiatric transfers are not isolated incidents but manifestations of systemic failure—spanning institutional indifference, legal ambiguity, and cultural misunderstanding.

At the ethical level, this phenomenon represents a violation of all four core principles of medical ethics: autonomy, beneficence, nonmaleficence, and justice. Victims are denied their right to consent, subjected to harm under the pretense of care, and excluded from the justice that healthcare should guarantee. At the operational level, misuse of ambulances for non-emergent or fabricated

cases diverts essential resources from genuine emergencies, weakens institutional efficiency, and contributes to moral fatigue among EMS professionals.

Legally, the issue persists within a gray area of accountability. Emergency protocols obligate response but fail to differentiate between authentic psychiatric crises and administratively motivated coercion. This loophole enables recruitment agencies and employers to weaponize healthcare systems for personal or financial convenience. As a result, both healthcare workers and victims become trapped in an environment where legality and morality diverge.

From a humanitarian standpoint, the moral damage extends beyond individual cases. When ambulances—symbols of rescue—become tools of repression, public trust in emergency systems erodes, especially among migrant and marginalized communities. Such erosion jeopardizes not only ethical credibility but also public safety, as fear of exploitation discourages vulnerable populations from seeking urgent medical help.

The path forward requires comprehensive reform built upon four pillars:

1. Legal safeguards empowering EMS personnel to verify or refuse coercive psychiatric transfers.
2. Ethical oversight and training embedded in emergency medicine education.
3. Cross-agency coordination between health, labor, and justice ministries to prevent procedural abuse.
4. Humanitarian accountability mechanisms ensuring victims' redress and systemic transparency.

Ultimately, preserving the dignity and safety of every individual—regardless of nationality, gender, or occupation—must remain at the center of emergency medical practice. Reclaiming the ambulance as a vehicle of compassion rather than coercion is not only a policy priority but a moral imperative. In reaffirming ethics and humanity within emergency response systems, societies can restore both the operational integrity and the moral conscience of healthcare.

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