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Providing Life-Saving Care under Restraint: Nurses' Experiences of Nasogastric Tube Feeding in Severe Anorexia Nervosa

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Abstract

Anorexia nervosa is a serious psychiatric condition with profound physical and mental effects. It frequently leads to hospital admission, and in extreme situations, patients may undergo involuntary treatment. One of the most demanding nursing responsibilities when caring for these individuals is performing nasogastric tube feeding while the patient is physically restrained. It is essential to identify and respond to the distinctive practical and ethical difficulties that nurses encounter when supporting adults with severe anorexia nervosa. The purpose of this study was to develop a richer insight into how registered nurses experience the process of administering nasogastric tube feeding under restraint to hospitalized patients suffering from severe anorexia nervosa. This study followed a naturalistic approach. Data from narrative interviews were examined through reflexive thematic analysis. Twelve registered nurses took part; they were recruited from an inpatient unit specializing in adult eating disorders at a psychiatric hospital in Norway.

Three core themes emerged: delivering high-quality nursing care throughout coercive treatment; experiencing ethical unease regarding nasogastric tube feeding under restraint once the patient's body mass index is no longer immediately life-threatening; and feeling worried about including staff from a different ward in the nasogastric tube feeding under restraint procedure. Nurses view nasogastric tube feeding under restraint as an essential component of life-saving care for patients with severe anorexia nervosa. Nevertheless, it raises significant ethical questions, particularly when the patient's body mass index reaches a level of immediate danger. The findings highlight the vulnerability of nurses themselves as well as the complex challenges and moral dilemmas involved in providing nursing care during nasogastric tube feeding under restraint.

Keywords: Anorexia nervosa, Coercion, Ethics, Involuntary treatment, Nasogastric feeding, Nursing

Introduction

Anorexia nervosa (AN) is a multifaceted mental illness that produces serious physical and psychological harm, markedly impairing quality of life. The disorder commonly causes extreme malnutrition along with numerous related medical problems. It carries a high mortality rate, with affected individuals facing a risk of death that is five or more times greater than in the general population [1].

The most serious form of AN constitutes a medical emergency that can endanger life and typically demands hospitalization. Patients in the most critical state may need treatment involving physical restraint to protect them and support recovery. Such intervention is usually employed to avoid self-harm and to handle the intricate medical issues arising from the illness. The symptoms pose a complex challenge for healthcare providers due to the interactions among psychological, physiological, and

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sociocultural factors [2–4]. Even though progress has been made in psychological therapies and medication, some people with AN struggle to participate in voluntary treatment. They may lack the drive to recover or may deny that they require any intervention [5].

When patients are unable or unwilling to accept voluntary care, compulsory interventions such as nasogastric tube feeding under restraint (referred to from now on as NGT-FR) are sometimes required to manage life-threatening malnutrition and its effects.

NGT-FR is a vital, life-saving measure in situations of severe malnutrition caused by AN. At the same time, the psychological consequences of using force on the relationship between nurses, clinicians, and patients deserve close attention. A recent meta-synthesis suggests that manual physical restraint is distressing for nurses and other staff, yet it remains essential because preserving life must take priority [3]. In another recent study, nurses reported that they did not believe physical restraint necessarily harms the therapeutic relationship, provided there is strong team support [6]. A qualitative investigation focusing on nursing assistants involved in NGT-FR found that they frequently suffered emotional strain, physical fatigue, bodily harm, and aggressive encounters linked to performing manual restraint [7]. These results offer valuable insight into how healthcare workers perceive the use of physical restraint. NGT-FR also raises important legal and ethical issues regarding patient vulnerability, autonomy, personal integrity, and the risk of harm [4, 8–10]. In AN, where patients' awareness of their condition is often limited, nurses face the difficult task of balancing respect for the individual's vulnerability and autonomy while preventing the serious harm or death that can result from extreme malnutrition [10, 11]. The use of NGT-FR as a form of compulsory treatment prompts nurses to debate the appropriate boundaries of medical care and the moral consequences of disregarding a patient's wishes [10, 12-15]. Given the anticipated rise in cases of AN and its persistently high mortality rate, it is vital to examine the difficulties nurses confront when caring for adults affected by this potentially fatal disorder [1].

Norwegian legislation

Over the past few years, Norwegian political policies and laws have strongly prioritized reducing coercive practices and strengthening patient self-determination. Every official coercive action – including compulsory hospital admission, forced tube feeding, or mandatory medication – requires solid legal grounding. The conditions that must be met for formal coercive treatment include: 1) all alternative treatment approaches have already been attempted without success; 2) the presence of a serious mental disorder; 3) the patient has been judged incapable of giving consent; 4) there exists a risk of harm to the patient's own life or to the lives of others, the likelihood of recovery or major progress is markedly reduced, or the patient's state is expected to worsen (§ 3–3). When the patient's life or the lives of others are in danger, consent is not needed. The Supreme Court has established that eating disorders can legally be regarded as a serious mental illness (RT. 2015, p. 913). For severe anorexia nervosa, the coercive measures most often applied are the introduction and continuation of compulsory treatment (§ 3–3) together with the provision of nutrition without patient agreement (§ 4-4b) [8, 9]. Applying coercion at the point of admission, therefore, triggers both legal and ethical issues.

The study aimed to gain a richer understanding of how registered nurses experience NGT-FR during the care of hospitalized patients with severe AN.

Materials and Methods

Design

The study was guided by a naturalistic approach [15]. In keeping with Braun and Clarke's outlook and building on Gough and Madill's characterization of qualitative research as an inherently creative, reflective, and personal process, we treat the researcher's own subjectivity as a valuable resource rather than a hindrance to knowledge creation [16, 17]. We hold that meaning is shaped by context, the researcher's standpoint, and the particular circumstances involved. To explore the personal accounts of nurses who have encountered the challenges of NGT-FR in hospitalized patients with severe AN, we used reflexive thematic analysis. Our review of the narrative interviews followed a naturalistic, inductive, and purely data-driven method. This kept the analysis closely tied to the data, free of prior theoretical models or frameworks [18].

Setting

This research looks at nurses' experiences with the most critically ill AN patients who are receiving treatment under coercion. It took place on an inpatient unit that delivers continuous 24-hour care for adults with severe eating disorders within a Norwegian psychiatric hospital.

There is still no single agreed-upon definition of severe AN [19]. The ward applied the diagnostic standards for severe AN set out in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V): body mass index (BMI) < 15; purposeful limitation of calorie intake causing major weight loss; strong fear of becoming heavier; and distorted perception of one's body (that is, seeing oneself as extremely overweight even when weight is normal or low). Furthermore, the mental effects of extreme underweight status seriously reduce the patient's ability to consent.

The ward has eight beds and roughly fourteen nursing posts, supplemented by other treatment personnel. The patients included both those admitted voluntarily and those under compulsory care. Most patients were female, primarily between the ages of eighteen and twenty-five, although some were in their thirties or forties. Hospital stays ranged from just a few weeks to a full year.

Recruitment and characteristics of participants

The study was introduced to staff during a meeting, and interested nurses reached out to the first author. The group of participating nurses included 10 women and 2 men, aged 38 to 70 years. Their experience on the inpatient ward ranged from 2 to 19 years. Seven held specialist training in psychiatric nursing or mental health, while the rest specialized in areas such as intensive care, diabetes, leadership, pediatrics, or public health. Every participant also brought considerable prior experience working with a wide range of patients in both physical and mental healthcare environments.

Data collection

After the participating nurses provided informed consent, the first author conducted the interviews at the hospital in 2022, following a prepared interview guide **(Table 1)**. The interviews lasted an average of 54 minutes. All of them were recorded and then transcribed exactly as spoken.

Table 1. Interview guide. From: Nurses' experience of nasogastric tube feeding under restraint for Anorexia Nervosa in a psychiatric hospital

Interview guide
Could you please describe some of your experiences as a nurse caring for patients with a severe eating disorder?
Can you explain situations in which you believe you delivered high-quality nursing care, as specifically as possible?
Please recount a situation in which you encountered an ethical dilemma.
What are your views regarding the use of coercion?
What aspects of working with this patient group do you find challenging?

Data analysis

All researchers thoroughly and repeatedly examined the full set of interviews, working both individually and together. It quickly became clear that a large number of participants shared intense emotional and very personal accounts related to carrying out NGT-FR with patients who had severe AN. The topic clearly carried great weight for them, which led us to investigate it more deeply in the later stages of analysis. We pulled out the most relevant sections from each interview and coded the material at the surface level to build an early sense of emerging themes. By comparing the codes across all interviews, we identified deeper underlying meanings that helped shape the main themes. The ultimate interpretation of these meanings came from a thorough, overall examination of the complete interview material [18].

Findings

A narrative about nursing and NGT feeding under restraint

The patients who remain most vivid in memory are those who must be physically held down because they actively resist. On our ward, we bring in staff from a different unit to take charge of restraining these patients. We only proceed with inserting the tube once every other option has been offered and refused. We then keep them still, insert the tube, and deliver the feed through it. We choose to involve unfamiliar staff for this task, even though we realize it can feel especially distressing for patients — often young women with difficult histories — because we believe deeply that we are the ones who will remain with them around the clock. We are the ones who will continue caring for them long after this invasive episode ends. I cannot imagine any medical procedure more intrusive than forcing a tube into someone's nose and feeding them against their will.

I have sometimes wondered whether it would be better if I personally carried out the restraint, then stayed with the patient afterward to ask how the experience had been for her and what exactly had happened. She would know that she had been fed and that the physical holding had been limited to what I judged necessary. I would have held her

head securely but not roughly in the crook of my arm. Because she recognized me, she might not have fought as hard. One person would hold one of her hands, another would hold the other, and a third person would be present while I carefully guided the tube downward.

What strikes me most is how many different roles a psychiatric nurse must adopt in a unit like this. In the lead-up to mealtimes, I am the one who discusses the food with the patients, negotiates what they will eat, and agrees on a plan. During the meal itself, I sit with them and provide support. If the meal still fails, we may offer a replacement or move to tube feeding. At that point, I act as a kind of monitor, reminding them: "You know what will happen if you don't eat. I don't want you to end up being force-fed. I only want what is best for you, and I believe eating by yourself is the better path." That supportive, collaborative role before and during the meal feels completely different from the moment we decide to use the tube. Then I must shift into a firmer stance. I do not become harsh or upset, but there is no longer room for gentle conversation. The message becomes clear: we have exhausted every possibility. I then contact the doctor to obtain authorization for the procedure so we can complete the feeding. Only after that do we proceed to insert the tube.

Some nurses believe you have to get on with it and stop prolonging the struggle. For me, however, it feels natural to keep offering chances even while standing there holding the patient and the tube, gently saying: "You can still drink this nutritional supplement if you choose to." At times, I am aware that I may be extending the process longer than necessary, giving every last opportunity. This creates an inner conflict because I know how frightening the intervention is. During the actual insertion, I focus on performing my nursing duties and following the correct procedure as carefully as possible. In most cases, the technical part goes smoothly.

Once the feeding is finished, I must return to care for the very same patient I helped restrain and tube-feed. I often question whether it is truly best for me to be involved at every step — planning the meal, supervising it, deciding on tube feeding, inserting the tube, and then providing aftercare — or whether a different approach would be kinder. My strong belief is that I offer the highest quality of care by staying present throughout the entire process. The patient knows I have not overlooked anything and that nothing happened without my awareness. I was there, and I carried it out.

Alternatively, perhaps the best approach would be to step back completely, or to have staff from another unit handle the entire restraint while I leave the room during the procedure. These thoughts occupy me often. I consider this one of the most distressing actions I perform on a young woman, and it affects me every single time. At the same time, I recognize that using the tube and delivering forced nutrition is still an act of care. Providing essential nourishment is care, even when it represents the greatest restriction of the patient's freedom.

Yet this same care leaves me wondering why I feel such a powerful need to return to the patient's room wearing a different "hat." I am convinced she understands that I mean her no harm. She knows I do not want to see her suffer or cause her pain. I usually ask: "Is it all right with you that I am here now? I realize we were just in a situation where I fed you against your will." She may reply that it is okay. I then sit down, but not too close. As a male nurse, I remain mindful to maintain an appropriate distance and avoid any physical comforting, such as hugging. Instead, I offer what I think of as cognitive support—a kind of emotional presence—and say: "I care about what just happened, and I hope you will let me know if there is anything I could have handled differently." This debriefing with the patient feels important, perhaps partly for my own sake as well. These are matters I feel strongly about; it is how I would wish to be treated if the roles were reversed (Thomas).

We developed three main themes: providing high-quality nursing care during coercive treatment; ethical concerns about continuing NGT-FR when the patient's BMI is not immediately life-threatening; and concerns about involving personnel from another ward in the NGT-FR procedure.

Providing good nursing care during coercive treatment

In patients suffering from severe AN who have reached a critical stage where their lives are in danger, NGT-FR must be carried out according to medical evaluation and existing legal requirements.

Some of these patients appear to resist care itself. It is not only the care we offer that fails, but also their own ability to look after themselves that breaks down completely (Rosie).

Faced with these difficult and complex situations, nurses acknowledge that the best form of care is sometimes compulsory when it becomes necessary (Beatrice). Gina expressed it this way:

The compulsory care we provide should be of such high quality that, when it ends, the patients themselves choose to stay in the unit voluntarily…… The use of coercion combined with nursing care should be so good that we would feel comfortable placing our own daughters in the same situation (Gina).

Nevertheless, nurses also acknowledged that inserting a tube while the patient is physically restrained constitutes the most intrusive type of coercion.

While aiming to create a collaborative and supportive atmosphere, nurses wanted NGT-FR to be performed in a way that still encouraged patients to take an active part, where possible. Even under compulsory treatment, respecting patient autonomy remained extremely important, though this was difficult given patients' intense fears about food and eating.

When patients are too unwell to eat independently, it is still vital to honor their autonomy to the extent possible. At the same time, it is an act of care and respect for their lives to step in and ensure they receive the nutrition they urgently need (Lilly).

NGT-FR was usually introduced through a gradual, step-by-step approach that prioritized voluntary cooperation. Nurses made genuine and repeated attempts to secure the patient's willing participation and called in additional staff only when every other option had been fully exhausted. Thea described the process as follows:

First, we ask them, then we encourage them repeatedly. We keep trying and trying again. If that still does not work, we will talk with them about how they feel and whether we should go ahead with the tube. Usually, two people are involved, with one assisting… And if the situation does not improve, we then have to bring in staff from another ward to help (Thea).

Despite the need for NGT-FR, nurses considered it essential to maintain a careful balance between empathy and firm encouragement. They believed in continuing to motivate patients even when initial resistance was strong. Rather than seeing NGT-FR only as a restrictive intervention, they viewed it as an opportunity to give patients some sense of control within the overall care plan. As Gina put it: For patients, being offered even small choices during compulsory treatment is very important. It represents a form of high-quality compulsory care.

Nurses emphasized the importance of balancing empathy with clear resolve. Some highlighted the value of warm and understanding interactions, while others stressed the need for assertiveness when compulsory measures were required. Several nurses pointed out that the most effective approach combined both elements. Mia explained this balance in the following way:

On the ward, we are reminded to be cautious about becoming too warm and affectionate during tube-feeding, as it can create a longing for extra empathy and might lead the patient to stop trying to eat, preferring instead to be fully force-fed to receive that attention. You need to remain warm and understanding, but you also have to stay firm. Finding this balance is what makes the treatment most effective (Mia).

Moving between the roles of helper and someone exerting control over the patient was often described as a dilemma (Beatrice). When NGT-FR did take place, it was generally conducted in private. This approach helped protect patient confidentiality and reduced distress for both the patient undergoing the procedure and other patients on the ward. Keeping the door closed prevented the situation from turning into a public event.

Having ethical concerns about NGT-FR when the patient reaches a BMI that is not immediately life-threatening

Nurses gave considerable thought to the ethical aspects of continuing NGT-FR, particularly once a patient's BMI had risen to a level that was no longer immediately life-threatening. At that point, some nurses began to question whether it was right to keep using the procedure. They raised these concerns during ward meetings and expressed doubts about the care they were being asked to provide.

I find it difficult as a nurse to insert a tube when the patient's BMI is fifteen or even sixteen, especially when the decision has been made that they should mostly be eating on their own or taking supplements if solid food feels too overwhelming … yet we are still using tube feeding for those with a relatively high BMI who continue to refuse food. It feels really hard! …. (Rosie).

…If the situation is no longer life-threatening and we are still performing tube feeding, then I cannot see how this can be considered good treatment. In my view, it simply is not (Luke).

Evelyn described how she sometimes found NGT-FR so ethically troubling that she chose to step away from it entirely. She would either remove herself from the patient's care team or openly refuse to carry out the doctor's order for NGT-FR.

We currently have a patient whose BMI has become quite high, and I believe the continued use of NGT-FR has crossed an ethical line. I have raised this several times in

team meetings, saying that I do not think what we are doing is acceptable. The last time she was admitted, I stated that I would refuse to participate, no matter what the ward manager said. I stood my ground because I could no longer justify our actions (Evelyn).

Having concerns about involving personnel from another ward in the NGT-FR procedure

Nurses often felt conflicted about who should actually carry out the NGT-FR procedure. Ward routine required that whenever tube feeding under restraint became necessary, staff from a separate unit were summoned to manage the physical holding. At the same time, the regular nurse focused on placing the tube and delivering the feed.

If a patient fails to complete their meal, they are first offered a nutritional drink. Should they decline that, too, an official decision is recorded. We then phone the other ward, and two physically strong male colleagues arrive to securely hold the patient down while we proceed with inserting the feeding tube (Luke).

Particular scenarios created noticeable unease among the nurses, especially when patients fought back vigorously and refused to cooperate. Several nurses challenged the standard approach of bringing in outsiders to restrain the patient. They wondered whether it would be kinder for the regular nursing team to handle the entire process themselves, especially since unfamiliar staff might retraumatize patients who had previously suffered abuse. …I have often considered that it would be preferable for me to do the restraining personally… (Thomas).

By contrast, some nurses regarded tube insertion and feeding as necessary and natural components of comprehensive care for the most critically ill patients. As a result, they reported almost no moral unease about using restraint, viewing the whole intervention as genuinely life-preserving.

Personally, as a nurse, I experience no inner turmoil in these situations. When the patient can no longer manage on their own, we must step in. I am grateful that our ward works closely with the neighboring unit and that communication flows well between us. Their staff is well trained to handle difficult patient behaviors, so I can focus entirely on correctly placing the tube and managing nutrition, confident that experienced hands are overseeing the patient's safety and comfort (Rosie).

Nevertheless, several participants voiced worries about the impact on the nurse–patient relationship. They pointed out that inserting a tube is far more than a mechanical task — it is also a relational act. They stressed the importance of developing a strong therapeutic alliance with the patient. Some felt that allowing unknown staff to perform the physical restraint could seriously damage the possibility of building a deep and enduring bond. Nancy shared a specific case in which she was asked to insert a tube for a patient she had never met. Because of that first encounter, a trusting relationship never formed, even though the patient returned to the ward multiple times afterward.

I found myself walking straight into the room to insert the tube, connect the pump, and begin the feeding without any prior introduction. The problem was that I had not been properly presented to the patient. I was there to complete a task. I sensed that this initial meeting spoiled something important… It matters a great deal to prepare for that first contact and to approach the patient with greater respect (Nancy).

Following tube insertion, nurses frequently observed that patients became filled with remorse and often wept uncontrollably. Those who had taken part in the restraint then had to switch roles and provide emotional support. This responsibility proved especially draining, as they had themselves contributed to the coercive act.

In the aftermath, the patient is commonly overcome by distress, crying intensely, and emotionally disintegrating. You remain with her for up to an hour, trying to soothe her and help her regain steady breathing and composure. It feels strangely like the person who carried out the forced procedure is now the one comforting the victim (Luke).

Results and Discussion

The objective of this study was to obtain a more profound insight into how nurses experience nasogastric tube feeding under restraint (NGT-FR) among hospitalized patients suffering from severe anorexia nervosa (AN). Three central themes emerged: delivering high-quality nursing care throughout coercive treatment; experiencing ethical dilemmas regarding NGT-FR once the patient's BMI is no longer immediately life-threatening; and feeling uneasy about involving staff from a different ward in the NGT-FR process.

This investigation centers on nurses' encounters with the most critical cases of AN, where numerous patients depend on NGT-FR to stay alive. The intervention plays a vital role for those unable to fulfill their nutritional requirements because of the extreme nature of their

illness. Administering NGT-FR can be a life-saving measure that ensures patients receive the nutrients they need for recovery and sustained health. Nonetheless, NGT-FR is likely the most intrusive type of coercion imposed on patients and generates numerous ethical and legal challenges for nurses [4, 8–10]. The biomedical principles of beneficence, non-maleficence, and autonomy appear especially pertinent to this topic [20]. Beneficence involves the obligation to act in the best interests of others; non-maleficence means the duty to prevent harm; and autonomy concerns respecting a person's ability to govern themselves and make their own decisions [20]. In our region, the principle of patient autonomy has become increasingly central in healthcare ethics and clinical choices. However, when dealing with severe, life-endangering conditions such as AN in patients lacking the capacity to consent, it becomes essential to evaluate whether the patient's life is at risk. Although the majority of these patients lack decision-making capacity, nurses worked hard to preserve as much of the patients' autonomy as feasible while performing NGT-FR. Under these conditions, the principles of beneficence and non-maleficence must outweigh autonomy [20].

Rendtorff and Kemp present the principles of dignity, integrity, and vulnerability as fundamental elements in healthcare [21, 22]. According to Rendtorff, dignity "expresses the intrinsic worth and equality of all human beings and expresses the moral responsibility of the human person" [23]. This concept is especially relevant when caring for individuals with life-threatening AN, underscoring the necessity of treating them with respect and compassion. Nurses must strive to protect patients' dignity even while carrying out NGT-FR. In the present study, nurses expressed concern about allowing patients to make decisions to the greatest extent possible before, during, and after the procedure. They also put considerable effort into encouraging patient participation to preserve their dignity. Integrity demands that human life remain intact and its wholeness be maintained, particularly in the face of illness and fragility [21, 23]. Vulnerability, which is closely connected to integrity, highlights the natural susceptibility of the human condition, and addressing it is crucial in healthcare environments like the one examined here: "Medicine's action directly concerns bodily vulnerability; the human person, however, is both object body and lived body" [23]. Therefore, NGT-FR must be performed with great care, acknowledging and honoring the patient's vulnerability while promoting their overall welfare.

Braut maintains that an individual's autonomy fluctuates over the course of life, influenced by factors such as age and illness [24]. Even though autonomy changes, human dignity and integrity stay consistent. This implies, for instance, that when people cannot make independent choices, they still deserve to have their physical and psychological boundaries respected. **Figure 1** illustrates how autonomy and vulnerability may fluctuate during a person's lifetime. When patients experience high levels of vulnerability, healthcare staff face increased responsibility to protect their autonomy and integrity [24].

Figure 1 How autonomy and vulnerability can vary in a person's life according to Braut [24]. From: Nurses' experience of nasogastric tube feeding under restraint for Anorexia Nervosa in a psychiatric hospital

The circle on the left could symbolize a patient with AN who requires NGT-FR, displaying a low level of autonomy and a high level of vulnerability, yet possessing the same degree of integrity as the circle on the right (which depicts a healthy individual with a high level of autonomy). Patients with AN who need NGT-FR

rank among the most vulnerable people [25]. When autonomy is minimal, these patients become even more fragile and reliant on others to uphold their dignity. While autonomy holds significance, beneficence, non-maleficence, dignity, integrity, and vulnerability may be equally crucial when examining this matter.

In severe AN, NGT-FR is occasionally indispensable and can be lifesaving. Certain nurses regarded the insertion of the tube as a fundamental component of delivering excellent nursing care to critically ill patients. They reported no moral distress in applying the restraint, viewing the measure as life-saving and consistent with existing laws. This finding aligns with a meta-synthesis of research on nurses and caregiving staff, which found that handling physical restraints is distressing yet often unavoidable [3]. The majority of those in the meta-synthesis [3] voiced worries about their relationships with patients. It stressed that placing a feeding tube is not solely a technical procedure but also a relational activity. In a separate study, nurses reported that physical restraint did not appear to undermine the therapeutic relationship, although team support proved essential [6]. Nurses in the current study constantly balanced non-maleficence and beneficence. To achieve this balance, they sought to protect patients' autonomy by encouraging active involvement, adopting a gradual approach that prioritized voluntary cooperation, and offering patients options for how the mandatory procedure would be carried out. A study exploring patients' perspectives on good coercion [9] emphasized the value of preserving patient autonomy before and during coercive interventions, maintaining transparent communication, fostering shared understanding of the reasons for coercion, building secure and reliable relationships, and treating the patient as a whole person. These elements match the findings of Tan *et al*., who discovered that patients considered compulsory treatment and coercion acceptable when their condition was life-threatening [25]. Ultimately, what proved most important was not the limitation of freedom or choice itself, but the quality of the relationship with mental health professionals. Effective nursing care during NGT-FR involves skilfully combining empathy, motivation, and firmness. Nurses in our study portrayed the challenge of moving between the roles of supporter and authority figure as a difficult balancing act. This observation is consistent with earlier research that highlights the need to safeguard dignity and acknowledge vulnerability in patients' lives [26-28].

The nurses recounted instances in which they considered NGT-FR to be unnecessary and ethically questionable. They worried about the strictness of protocols and guidelines, the need for more personalized approaches, and the value of professional judgment when performing NGT-FR. Many contemplated the moral difficulties surrounding tube feeding, particularly when a patient's BMI had improved to a point where it was no longer immediately life-threatening. When coercion is viewed as both required and morally acceptable, NGT-FR appears essential for preserving life. However, once patients achieve a higher BMI and are nearing hospital discharge, this justification no longer applies. At that stage, nurses may conclude that continuing NGT-FR conflicts with the principle of beneficence [20] and that treatment under restraint causes more harm than benefit. The continued use of coercive decisions, even after the immediate life-threatening phase has passed, often stems from the fact that some patients with low BMI still lack the cognitive ability or mental capacity to provide consent [28, 29]. If granted full autonomy, these patients might stop eating, leading to rapid weight loss and a return to a critical state. In such cases, all previous efforts and resources would be lost. Therefore, coercive interventions remain consistent with Norwegian legislation ("an assessed incapacity of the patient to consent") [8, 9] and are ethically defensible for completing the full course of treatment. Nevertheless, this practice has prompted some nurses to withdraw from such duties due to ethical reservations.

If we return to **Figure 1**, the circle on the left could symbolize a patient requiring NGT-FR, characterized by low autonomy and high vulnerability, and therefore dependent on nurses to safeguard her integrity. The circle on the right could depict a patient who no longer relies on NGT-FR, showing greater autonomy while remaining vulnerable. Alternatively, it might represent the nurse herself, who is also vulnerable and in need of protecting both her human and professional integrity. Even though NGT-FR is often essential and life-saving, our results suggest that nurses found it demanding and stressful to take responsibility for coercion, acting simultaneously as both "helper and executioner". They experienced the treatment as potentially infringing upon the patients' vulnerability and integrity [26, 30]. Nurses themselves are vulnerable, and assuming the role of "executor" can also threaten their own integrity. This observation corresponds with the findings of Kodua *et al*.'s study on nursing assistants, which reported that they encountered

emotional distress, physical fatigue, pressure, and a heavy sense of responsibility in connection with NGT-FR [7].

Our final finding concerns the issue of involving staff from another ward in the NGT-FR procedure. Once the decision has been made that NGT-FR is required, the question arises whether it is better to call in additional nurses from a different ward to help restrain the patient, or whether this approach might be viewed as even more traumatic for the patients, particularly those with a background of abuse. The nurses did not reach an agreement on this matter. In the introductory narrative, Nurse Thomas reflects on whether comprehensive care, which includes NGT-FR, can be considered optimal for the patient when the same nurse remains involved throughout the process and also participates in holding the patient. Other nurses emphasized the importance of building a solid relationship and creating an alliance with the patient, arguing that involvement in restraining the patient might hinder the development of a meaningful and enduring therapeutic bond. The participants found it frustrating to occupy the dual position of "helper and executioner". This aligns with the results reported by Bommen *et al*. [30]. Additional research involving both nurses and patients with AN is needed to determine whether it is more beneficial for the patient and the therapeutic relationship to have unfamiliar staff perform the restraint during NGT-FR.

Study limitations

The sample consisted mainly of female nurses with extensive professional experience in a single ward, which may have influenced the interview findings. Including a broader range of participants, such as more male nurses, less experienced staff, and nurses working in other hospitals, might have enriched the results with greater variety and depth. The study was carried out by authors who are all registered nurses with varied clinical backgrounds, although none had direct experience in this particular area. Nevertheless, the interviewer brought substantial research expertise with the relevant patient population. This combination of professional identities links clinical practice and research, but it also creates difficulties for nurses and warrants further consideration [31]. While the lack of specific clinical experience in AN among all authors might be regarded as a weakness, it can equally be seen as an advantage, since it encouraged a more open and inquisitive perspective. This allowed the interviewer to pose questions that an insider might have taken for granted. The data-driven method and ongoing reflexivity applied throughout the research process helped to address these potential limitations [16, 17]. The research team held regular discussions during the analysis phase to remain conscious of any preconceived ideas, and all authors participated fully in every stage of the study.

Conclusion

Our study shows that nurses regard NGT-FR as an integral element of life-saving care for patients with severe AN. Under Norwegian law, all forms of coercion, including NGT-FR, must have a sound legal basis. Nevertheless, NGT-FR continues to provoke ethical questions, particularly when a patient's BMI is no longer at a life-threatening level. Nurses also express concern about which personnel should carry out the restraint. Our findings highlight that nurses themselves are vulnerable, and that providing nursing care during NGT-FR is both demanding and ethically complex.

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Ethics Statement: The Norwegian Data Protection Services (SIKT) for research approved the study (Reference no. 947253), rendering it exempt from Ethical Committee approval. Participants provided informed consent, and the data material is pseudo-anonymized and treated confidentially.

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