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Independent Articles

The Ethical Justifiability of Patient Restraint in Hospitals: Moving to a Public Health Ethics Approach

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Abstract

The use of restraint in hospital settings is divisive, and internationally there are calls for its elimination. However, this is at odds with the experience of many hospital staff, who consider restraint, at times, a "necessary evil". In this paper, we explore the definition of restraint and potential ethical justifications for its use. We argue that the current ethical literature employs two definitions of restraint — outcome-oriented and intent-oriented — neither of which successfully captures all ethically relevant features of the practice. We propose a new conceptualization of restraint which centers on the number of individuals impacted by an act of patient restraint — a continuum between therapeutic restraint and public-safety restraint. Understood in this way, neither the principlist nor human rights frameworks that dominate the current literature are appropriate for assessing the ethical legitimacy of restraint. We suggest that, given the similarities between restraint and public health interventions, the use of public health ethics principles to consider the ethical justifiability of restraint in hospitals is a potentially productive way forward in this controversial area.

Keywords: public health ethics; restraint; bioethics; clinical ethics

Introduction

Restraint is sometimes used in hospital settings to facilitate the treatment of agitated patients, to prevent self-harm, and to protect staff and other patients.[1] Though used to avoid injury and decrease agitation,[2] restraint may cause physical and psychological harm to the restrained patient and staff involved.[3] Consequently, restraint is often perceived by staff as a "necessary evil."[4] Impacting and infringing the interests and rights of patients — their dignity and autonomy — its use is ethically controversial[5] and divisive.[6]

Restraint is defined as a "measure[] limiting a person in his or her freedom."[7] It is used internationally[8] and across a variety of hospital settings including psychiatric, geriatric, emergency, and intensive care.[9] In the hospital context, overt restraint is administered using one of three "types" of medium — physical, chemical, or mechanical (see Table 1). Restraint rates, and the medium used, vary widely between countries,[10] hospitals, and individual wards within hospitals.[11]

Precise estimates of the prevalence of restraint, particularly outside psychiatric settings, are difficult to obtain.[12] However, recent international research reports prevalence in psychiatric settings between 3.8% and 20% of patients.[13] In Australia, only physical and mechanical restraint rates in acute specialized mental health services are currently reported.[14] Recent national data in this setting indicates that in 2022–23, the physical restraint rate was 10 events per 1000 bed days and the mechanical restraint rate was 1 event per 1000 bed days.[15] Data concerning the use of restraint in other hospital settings (i.e., emergency departments and intensive care) is not centrally collected or reported. However, studies suggest that restraint is regularly used in Australian intensive care units[16] and emergency departments, where it is estimated that the rate is 3.3 events per 1000 presentations.[17] It is difficult to accurately assess where Australia sits among other similar (i.e., high-income) countries internationally due to differences in definition and reporting requirements, as well as in the methods used to collect and report data.[18]

The purpose of restraint and the methods employed also vary considerably within and between hospitals.[19] For example, in intensive care restraint is often used to prevent therapy interruption or self-harm[20] — patients may be mechanically restrained (e.g. using [soft] wrist restraints) to prevent them from removing uncomfortable medical equipment.[21] In psychiatric settings, chemical, physical, and (rarely) mechanical restraints may be used to manage "challenging [patient] behaviors,"[22] including high-risk and/or dangerous behavior.[23] The most common indications for restraint in emergency settings are violence, psychosis, and behaviors related to acute brain trauma.[24] In this setting, patients are generally chemically restrained.[25] Restraint is also reported to be implemented in response to staff shortages[26] and poor ward administration and management.[27]

The effectiveness of restraint is contested.[28] It is reported that, appropriately managed, restraint can be used safely and achieve positive results,[29] allowing hospital staff to provide necessary care and restore health.[30] Its use, however — particularly in psychiatric settings — is associated with both direct and indirect physical and psychological adverse outcomes for the patient,[31] their caregivers,[32] and staff involved.[33] Hospital staff, particularly nurses, also regularly

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Table 1. Definitions of restraint mediums

MEDIUM	DEFINITION
Physical	Direct use of bodily force, e.g., where a staff member holds a patient down
Mechanical	Use of a device, e.g., handcuffs
Chemical	Use of a pharmacochemical drug, e.g., the antipsychotic medication Droperidol

experience feeling "shame," "guilt,"[34] and internal conflict about the use of restraint. This is often referred to as moral distress.[35] The risk of adverse outcomes increases when restraints are applied without appropriate oversight.[36] There is overwhelming consensus that, particularly outside mental health care settings, restraint is under or poorly regulated,[37] and otherwise that its use "should be minimize[d]"[38] or eliminated.[39] However, despite these risks to patients and themselves, staff — particularly in managing patients with challenging behaviors — report "significant fear[s]"[40] about the potential elimination of the practice.[41]

The use of restraint in hospital settings runs counter to international law,[42] its use perceived by some as a violation of the right to liberty and security, the right to be free from violence and abuse, the right to integrity of the person, and the right to privacy[43] — all rights protected at international law.[44] Its use in mental health care settings is particularly condemned, with the United Nations Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment calling for an "absolute ban"[45] on the practice, declaring its use to be akin to torture and a breach of human rights.[46] Calls for the elimination of restraint in healthcare settings are gaining momentum internationally.[47] This sentiment is reflected in Australia, including in the state of Victoria. For example, one of the key recommendations of the 2021 Royal Commission into Victoria's Mental Health System (Royal Commission) was that the Victorian Government "act immediately to [end] the use of … restraint."[48]

Largely the purview of state regulation in Australia, restraint is the subject of disparate legislative arrangements. Commencing in September 2023, Victoria's *Mental Health and Wellbeing Act 2022* (MHWA) is the most recent Australian legislation defining and regulating restraint — including, for the first time, chemical restraint — in hospital settings. Part 3.7 of the MHWA regulates the use of restraint, and confines its use to circumstances where it is *necessary* to

1. prevent imminent and serious harm to the person or other persons; or
2. in the case of bodily restraint, to administer treatment or medical treatment to the person.

Where restraint is used pursuant to the MHWA, the Chief Psychiatrist must be notified.[49] Reflecting the recommendations of the Royal Commission,[50] an express objective of the MHWA is: "[t]he reduction in the use of … restraint with the aim of eliminating its use within 10 years" (s.12(c)(ix)). This objective ignores the challenges evidenced in the experiences of hospital staff who feel compelled, at times, to restrain patients to facilitate treatment and otherwise protect themselves and others.[51] Anecdotally, Victorian hospital staff are concerned about the implications of the MHWA for staff and patient safety, and ultimately the quality of care provided.[52]

Given the level of international concern expressed about the use of restraint in hospital settings — both from a clinical perspective (i.e., its likelihood to cause harm) and a moral or ethical perspective (i.e., tension between the competing interests of the patient and others) — it is unsurprising that there is a substantial body of literature investigating the where, when, and how of restraint in hospital settings.[53] This literature addresses practical or descriptive questions about the practice, including its prevalence[54] and impact on patients and staff,[55] in a variety of settings. There is a particularly rich body of literature describing the use and regulation of restraint in psychiatric, senior care, and disability settings.[56] However, there have been few systematic attempts to examine the conceptual and normative dimensions of the practice, particularly in general hospital settings.[57] Instead, the ethics literature tends to consider the practice in specific contexts, predominantly psychiatric and geriatric settings.[58]

The tension between an elimination policy and the perception held by many hospital staff of restraint as a "necessary evil"[59] necessitates consideration of the underlying ethics of patient restraint in hospitals. In responding to this gap, this paper addresses the following questions from an ethical perspective:

1. What is restraint?
2. How is restraint best conceptualized for ethical analysis? Specifically, what type of ethical framework should be used in practice to evaluate potential instances of restraint in hospitals?

Our argument is in three parts. In the first, we consider the definition of restraint. We argue that current definitions in the ethics literature are not fit for purpose and suggest that restraint is more usefully conceptualized as a continuum between therapeutic restraint and public-safety restraint. In the second part, we explore the dominant ethical frameworks used to understand restraint in the current literature: human rights and principlism. We argue that, due to their exclusively individualistic foci, neither of these frameworks provides a satisfactory approach to addressing the ethical tensions posed by restraint. In the third part, we suggest that an ethical approach grounded in public health ethics (PHE) may better address these tensions. We suggest that, in certain contexts, the intent and impact of an act of restraint are similar to the intent and impact of a public health intervention (PHI). Given this similarity, and that a PHE framework provides scope to consider third-parties' interests while safeguarding the interests of individuals, this framework provides a better approach to considering the ethical justifiability of restraint.

Critical Interpretive Review

As a starting point for defining restraint and exploring the ethical justification for its use in hospital settings, we conducted a critical interpretive review (CIR) of the existing ethical literature on the use of restraint in hospital settings. A CIR is a literature review method specific to the discipline of bioethics designed to generate new ideas and theories about ethical justifiability through critical engagement with existing literature.[60]

Search Strategy

We identified literature on the ethics of using restraint in hospitals by searching titles, abstracts, and keywords in SCOPUS and MEDLINE Ovid in March 2024. We conducted an additional search using Philosopher's Index in April 2024, to identify and capture any philosophical literature not referenced in the other databases. We selected these databases with the assistance of a research librarian,

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to facilitate a comprehensive search of biomedical and philosophical/ethical journals. The search terms are listed in Table 2 and aimed to capture literature at the intersection of ethics, restraint, and hospital care.

We selected these terms after initial searches demonstrated their effectiveness at identifying relevant literature. Other search terms we trialled included "immobilization" and "sedation," but these were discarded given their tendency to exclusively identify literature considering the use of restraint in contexts outside the scope of our research. We also searched the reference lists of included publications.

Inclusion Criteria

Though primarily interested in the use of restraint in general hospital settings, we did not exclude literature exclusively considering its use in psychiatric settings given the overlap of relevant normative considerations between these settings. For similar reasons, we did not exclude literature addressing specific patient populations. We did, however, exclude literature which concerned the restraint of patients also criminally detained given the overlay of the custodial setting.

To answer our research questions, it was essential that publications use ethical concepts as a tool in their analysis. For example, several qualitative research studies of the experience of nurses administering restraint in hospital settings[61] were excluded. Though these publications provided a rich description of the moral experience of nurses administering restraint, they otherwise did not engage with the question of whether the practice was itself ethically justified. For this reason, literature exclusively considering the legal aspects of restraint was also excluded — for example, literature which presented a comparative legal analysis of domestic and international legislation.[62]

Screening involved two stages. First, Author 1 screened titles and abstracts against the inclusion and exclusion criteria (see Table 3). Author 1 then reviewed the full text of any publications that she had initially been unsure about; any remaining uncertainties were resolved through discussion with Author 2. Consistent with the CIR method, quality assessment was reserved for the analysis stage, forming part of the critical analysis and interpretation of the arguments — which included "judgements and interpretations of [their] credibility and contribution."[63] A PRISMA diagram[64] describing the search process is at Figure 1.

Our review identified 38 relevant publications from a range of ethical (n=16) and clinical (n=22) sources. Of these, sixteen were published or considered restraint in North America, twelve in the United Kingdom, four in continental Europe, four in Australia, and two in China. The earliest article was published in 1986,[65] however the majority were published post-2010. Particularly interesting were the authors' professional backgrounds, with all but two publications[66] including at least one author with a clinical background and/or role; of these the majority were nursing. Details of the 38 publications are included in a supplementary file.

From each paper, Author 1 extracted

1. the definition of restraint used;
2. criteria and guidance for its use; and
3. the ethical framework utilized.

Both authors synthesized these findings and considered the arguments of each publication — both in isolation and in the context of the entire body of literature — identifying any consistencies, inconsistencies, and omissions. This process facilitated the critical analysis and assessment of the literature,[67] which grounded the subsequent consideration of — and answers to — our research questions.

Table 3. Screening Criteria

	INCLUSION CRITERIA	EXCLUSION CRITERIA
Language	English	All others
Time	1970–current to capture literature published post the International Covenant on Civil and Political Rights and the Convention on the Rights of Persons with Disabilities	
Type of publication	Journal publications (all types including responses, letters to the editor, etc.) Book chapters	"Grey" literature
Content	Includes explicitly ethical consideration of the use of restraint in hospital settings	Exclusively descriptive and/or legal consideration of the application and use of restraint
Type of restraint	Overt forms of restraint, including but not limited to chemical, physical, and mechanical	Exclusive discussion of "covert" restraint, i.e., seclusion.
Setting	Hospitals	"Residential" settings (including aged-care facilities, forensic facilities, hospice care, and palliative contexts), schools, and dental settings

Table 2. Search Terms

DATABASE	SEARCH TERMS
SCOPUS	*(TITLE-ABS-KEY (ethic* OR bioethic*) AND TITLE-ABS-KEY (restrain* OR {restrictive intervention* OR {restrictive practice*) AND TITLE-ABS-KEY (patient OR patients OR inpatient OR inpatients OR hospital OR hospitals)) AND (LIMIT TO (LANGUAGE, "english") AND (PUBYEAR > 1969 AND PUBYEAR < 2025)*
Medline(Ovid)	*((Ethics/ OR Ethics, Nursing/ or Ethics/ or Ethics, Medical/ or Ethics, Clinical/ OR Bioethics/ OR (ethic* or bioethic*).mp.) AND (Restraint, Physical/ OR (restraint adj4 patient*).mp. OR (restraint adj4 inpatient*).mp. OR {restrictive intervention*.mp.} OR {restrictive practice*.mp.})) LIMIT TO (english language and yr="1970 -Current")*
Philosopher's Index	*(ethic* OR bioethics*) AND (restrain* OR "restrictive intervention" OR "restrictive practice") AND (patient OR patients)*

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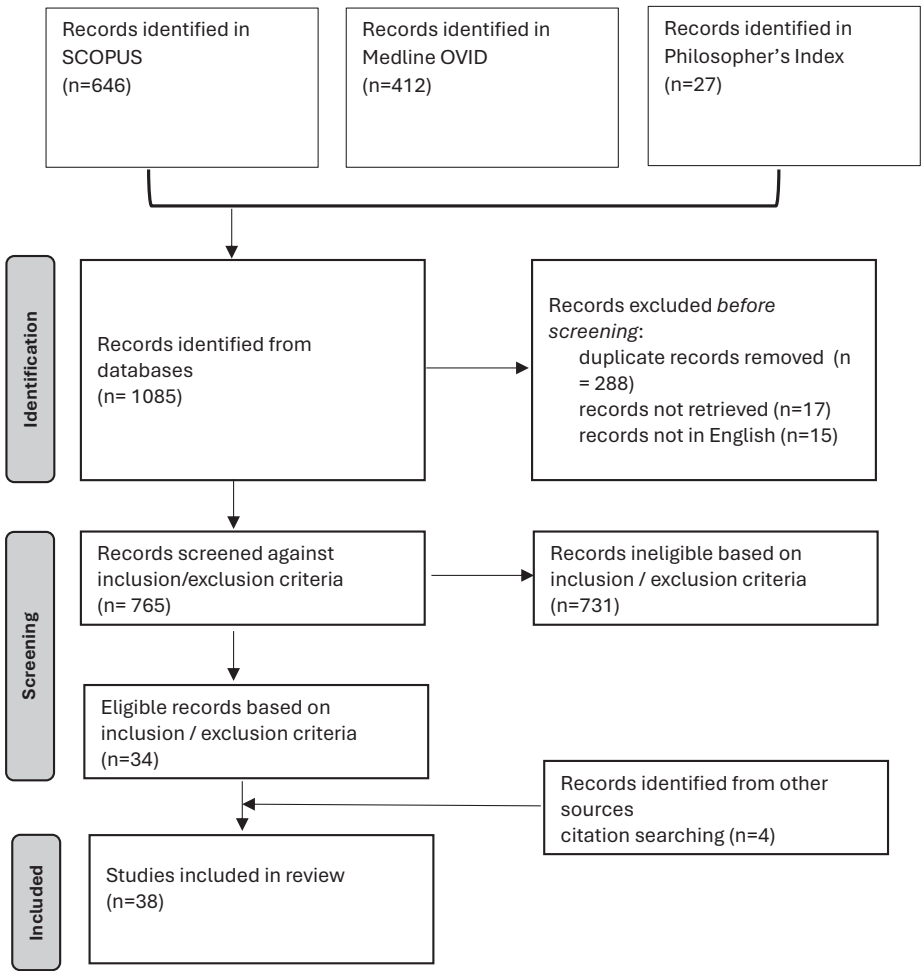

Figure 1. Prisma Diagram.

Part I: Defining Restraint

Our searches identified several publications which provide an explicit definition of restraint.[68] However, the majority rely on a common understanding of the term and only define the types of restraint as outlined in Table 1. Publications are predominately concerned with the application of either

1. physical and mechanical restraint; or
2. physical, mechanical, *and* chemical restraint.

Four papers identify other types of restraint. Priesz and Priesz (2019) refer to, but largely dismiss, the notion that removing access to technology may constitute restraint, and Behrman and Dunn (2010) briefly discuss the use of "environmental" restraints (e.g., bedrails to prevent patients from leaving their beds). By contrast, Gallagher (2011) and Roper et al. (2020) propose broad definitions; for example, Roper et al. suggest that restraint is any act "that restricts a person's agency."[69] The literature rarely considers physical and mechanical restraint separately, unless ranking "restrictiveness."[70]

We interpret the literature as positing two essentially different definitions of restraint. One group of publications defines restraint by result and includes only physical and mechanical restraint. The second group of publications defines restraint by the practitioner's intention and includes chemical methods alongside physical and mechanical methods. These differences are presented in Figure 2.

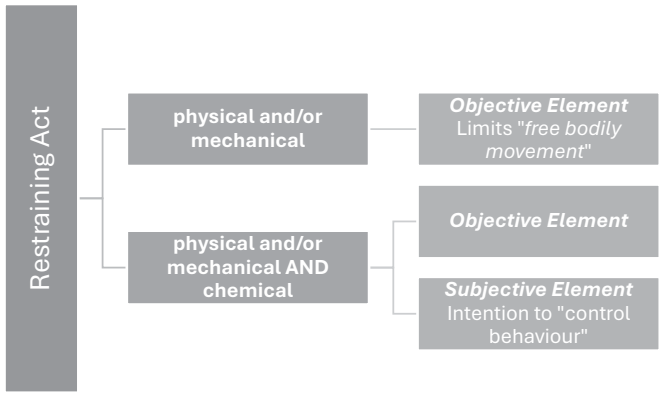

Figure 2. Definitions of Restraint.

Physical and Mechanical Restraint: Defining Restraint by the Result

Most of the literature considers only physical and mechanical restraint. Proposing a result-oriented definition of restraint, these papers are concerned with the effect of an act on the individual's free movement of their limbs. The act, the application of the device and/or bodily-force, must "prevent … free bodily movement,"[71]

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"limit[ing] freedom."[72] The potential use of medication/sedation to restrain is not considered. The reason for this silence is unclear, though it may reflect the assumption, alluded to in the older literature,[73] that sedation is an ethically permissible precursor to restraint. This understanding reflects the historical regulation of restraint in Australia that has not previously regulated the use of sedating medications as a precursor to, or instead of, physical and/or mechanical restraint.[74]

Physical, Mechanical, AND Chemical Restraint: Defining Restraint by the Intention

By contrast, the more recent and smaller body of literature considering physical, mechanical, *and* chemical restraint adds a subjective element to the result-oriented definition.[75] In these articles, applying a medium constitutes restraint where it

1. deprives the individual of a relevant "freedom,"[76] specifically "bodily"[77] or "mental state"[78]; and
2. is applied "intentionally"[79] to "control behavior and restrict … freedom of movement."[80]

It is the "intent, not mechanism [that] determines whether movement restriction is considered restraint."[81] The MHWA adopts this definition, and similarly distinguishes using medication to restrain from using it exclusively[82] or predominately[83] to "treat a medical condition."[84] Though alluded to by Bray (2015), the inherent difficulty in defining restraint by reference to the restrainer's subjective intent is not clearly articulated or resolved.

Problems with These Definitions of Restraint

Our research identified two definitions of restraint in the literature: a result-oriented definition, and an intent-oriented definition. However, in our view, neither definition draws out all ethically relevant features of the act sufficiently to assist in assessing the ethical justifiability of the breadth of freedom-limiting acts (FLAs) that occur in hospital settings. For example, an FLA to prevent a patient in intensive care from self-extubating is different in an ethically important way from the same FLA to placate an aggressive patient experiencing a psychiatric emergency on a busy ward. In the first, the FLA is solely intended to benefit the patient; in the second, the intended benefit is shared between the patient, the staff, and other patients on the ward. Yet, the result-oriented definition cannot distinguish between them. Tied to the objective effect of the FLA, using the result-oriented definition, these acts are ethically equivalent.

The intent-oriented definition is also problematic for two reasons. First, it requires the impossible: the objective determination of subjective intent. A third party cannot unequivocally or reliably discern the *intention* of another. In practice, this definition relies on proxy measures of intent, for example the "off-label" use of medication. This is unsatisfactory, given that the distinction between treatment and restraint — particularly in patients presenting with mental health conditions — is often fine and potentially arbitrary. For example, the administration of an antipsychotic to a medically unstable patient with anorexia and comorbid anxiety before commencing nasogastric feeds may have multiple motives, including to facilitate necessary treatment (e.g., nutritional stabilization), and/or to treat the comorbidity. Whether this is an instance of restraint or treatment is unclear when applying the intent-oriented definition. The complexity exposed by this example is compounded where the patient, or their medical condition, is unknown to the prospective restrainer, and an FLA intended to control behavior may ultimately treat an unknown, underlying medical condition.

Second, even if it were possible to accurately identify the restrainer's intent, this definition remains insufficient for the purpose of assessing ethical justifiability. Knowing the restrainer's intent does not necessarily differentiate between the examples described above of the FLA in the intensive care unit and the one on the ward. In fact, it is likely that both FLAs were intended to control the patient's behavior. Even if "intent" does differentiate between these examples, we consider this difference insufficient to warrant either regulating or understanding them differently. It does not capture all ethically relevant differences.

The Importance of Context: A Continuum of Restraint

The outcome- and intent-oriented definitions both miss the ethical significance of the context in which the FLA occurs. Considered within its context, it becomes apparent that the key feature differentiating the examples above is the number of people impacted by the FLA. For example, while the consequences of an FLA (e.g., wrist restraints) to prevent a patient in intensive care from self-extubating are largely confined to the patient, the consequences of a similar act to control the behavior of an agitated patient experiencing a psychiatric emergency on a busy ward are potentially spread across many individuals, including proximate patients and staff. These examples demonstrate that FLAs can be understood as occurring along a continuum. At one end of the continuum are FLAs which only impact the patient. We refer to these as "therapeutic restraint." At the other end are FLAs which impact many people's interests. This describes the ward scenario, where a patient's behavior, without intervention, endangers the safety of many. We refer to these instances as "public- safety restraint" (see Figure 3). There is no specific point of demarcation on the continuum between these two types of restraint. Instead, FLAs are understood to be more or less like an act of "therapeutic restraint" or "public-safety" restraint depending on the circumstance/context in which they occur.

When considering an FLA, the applicant's intent and/or its outcome is less relevant to the question of its ethical justifiability than its impact on the (ethically relevant) interests of those affected by its application. Conceptualizing restraint as occurring along a continuum redirects attention to this (ethically) critical feature, thus facilitating the subsequent ethical analysis.

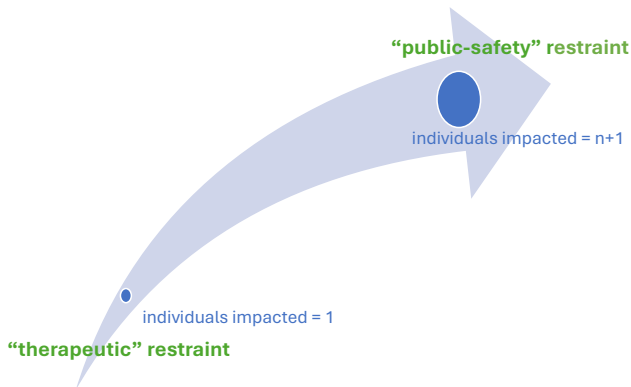

Figure 3. Restraint as a Continuum.

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We argue that, from an ethical perspective, a critical feature of a restraining act is the number of individuals impacted, and thus the current definitions of restraint are inadequate because they fail to consider the ethical relevance of the number of individuals impacted by the act (i.e., its potential public impact). With this understanding, we propose that such acts are better understood as acts occurring along a continuum, from acts which impact the interests of a single individual (e.g., the patient restrained in ICU — "therapeutic restraint") to those that impact the interests of many (e.g., the use of restraint in a busy ward — "public-safety" restraint). Conceptualizing the act in this way allows for a (gradual) change in the focus of the ethical analysis — that is, the weight different ethical principles are afforded when considering the ethicality of the act.

Part II: Frameworks in the Existing Literature — Principlism vs. Human Rights

Kotalik argues that "every discourse about health care has not only a scientific but also a moral dimension."[85] This latter dimension identifies whether, and if so when, the use of restraint is ethically justified in hospital settings. As analytical tools, ethical frameworks facilitate this inquiry, highlighting the ethically relevant values and principles for consideration and the appropriate way of approaching the issue.[86] There are many frameworks used to assist in resolving ethical challenges — their particular principles, values, and priorities determined by the context of the issue.[87] For example, many of the principles and values of ethical frameworks used in clinical medicine are like those deployed in public health contexts. However, differences in social scale, goals, and the nature and number of interests between the settings require the ethical priorities to differ. While the interests of the individual are prominent in both public health and clinical ethics frameworks, they are afforded primacy in the latter. By contrast, in a public health context individuals' interests are balanced against the health of the public.[88]

The use of ethical frameworks to guide decision-making is a particular feature of clinical medicine. The dominant framework is Beauchamp and Childress' four principles of biomedical ethics or principlism.[89] A principlist analysis involves considering an issue from the perspective of four principles derived in part from "the obligations and virtues of health professionals"[90] — beneficence, non-maleficence, autonomy, and justice (see Table 4). Having a *prima facie* nature, a principle can be "justifiably overridden"[91] by another. Where conflicting, the decision-maker must balance the respective weights of the competing interests.[92] Theoretically, no principle is supreme, and thus the ultimate prioritization is an exercise of discretion.[93]

Emerging out of political liberalism, another ethical framework used in health contexts is human rights. Historically used in legal and political contexts,[94] the human rights framework (HRF) proceeds from the ethical principle that individuals have an inherent value, or "dignity."[95] This value entitles all individuals to a collection of "universal, [and] inalienable"[96] rights and freedoms, many of which are now codified in international law (see Table 5).[97] Rights-based approaches are increasingly a feature of health policy and legislation,[98] and have been a core feature of mental health policy in Australia since the early 1990s.[99] Placing the "person" at the center of the analysis, the HRF considers the ethicality of an act or policy by reference to its interaction with these fundamental (absolute[100]) rights.[101] Where an act is demonstrated to limit or infringe a human right, it is unethical.[102]

Justifying the Use of Restraint

Framing the Arguments

Several ethical frameworks are prominent in the literature. Of the publications considered, the majority (n=28) were written by health practitioners/academics and use Beauchamp and Childress' (2001) four principles approach to frame their ethical analysis of restraint. By contrast, publications which use the HRF are predominately written by legal academics,[103] which is perhaps reflective of the increasing influence of human rights discourse in health policy. The remaining literature draws upon values from specific professional-ethics frameworks[104] and high-level normative theories.[105] Three articles responding to Crutchfield and Redinger (2024) rely on the notion of basic (negative) liberty[106] — "what is required to live the life of a free person."[107] The choice of ethical framework is significant, determining the ethically relevant interests — and consequently, whether restraint can be ethically justified.

Human Rights: Protecting the Person

Three publications[108] use an HRF, focusing on the experience of restraint by marginalized and/or vulnerable cohorts: children,[109] the mentally ill,[110] and the disabled.[111] Drawing upon the language and values of international rights instruments, particularly the United Nations Convention on the Rights of Persons with Disabilities (CRPD),[112] the primary ethical concern of these publications is the basic, inviolable "human rights and freedoms"[113] of "the person."[114] The importance of "personhood" is evidenced by the

Table 4. Definitions of the Four Principles of Biomedical Ethics

PRINCIPLE	DEFINITION
beneficence	The obligation to provide benefits and to balance risks against benefits. Whether this is a general obligation (owed to the world-at-large) or a specific obligation (owed to a specific individual because of an existing relationship, e.g., parent-child, doctor-patient) is context dependent
non-maleficence	The general obligation to avoid causing harm
justice	The obligation to equitably distribute risks and benefits
autonomy	The obligation to respect the decision-making of autonomous individuals

Adapted from Beauchamp and Childress (2001) and Beauchamp (2003).

Table 5. Examples of Human Rights

HUMAN RIGHTS	SOURCE/S
Right to life, liberty, and security	UDHR, ICCPR
Self-determination	ICCPR
Non-discrimination	UDHR, CRPD, ICCPR
Participation	UDHR, CRPD
Autonomy	UDHR, CRPD
Equality of opportunity	CRPD
Respect for the inherent dignity of the individual	CRPD, ICCPR

UDHR — Universal Declaration of Human Rights; ICCPR — International Covenant of Civil and Political Rights; CRPD — Convention on the Rights of Persons with Disabilities

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decision to exclusively use the term "person." While papers applying other frameworks refer to the restrained individual by their situation (e.g., the principlist literature refers to the restrained individual as a "patient") those applying the HRF only ever refer to the "person." The person's rights — including their right to "freedom of movement,"[115] "to make [their] own decisions,"[116] and "respect for [their] inherent dignity"[117] — operate as "essential limit[s] for all human action … [and] must be protected in all circumstances."[118]

Concluding that restraint limits these rights, it necessarily follows that restraint violates human rights "whatever terminology is used,"[119] "irrespective of questions of 'justification,'"[120] and is unethical. From this conclusion, an elimination — as opposed to "reduction" — policy is preferred by Roper and colleagues (2020), who argue that "'reducing' is not enough"[121] given restraint "may be crushing to a person's sense of self, their dignity and self-respect."[122] The other publications are more equivocal, suggesting longer-term solutions culminating in elimination. This correlation replicates the findings of Chieze et al. (2021). Their research similarly identified the "elimination position" as a minority opinion, justified because restraint is perceived as "violat[ing] fundamental rights."[123]

Principlism: (Peeking) Beyond the Patient

Applying (expressly or implicitly) the principles of biomedical ethics, the majority of the literature concludes, somewhat pragmatically,[124] that using restraint in "exceptional"[125] circumstances can be ethically justified — restraint being at times "unavoidable" or "necessary" to ensure therapeutic values are met.[126] This results in a preference for the "reduction," not elimination, of restraint. This preference is enabled by the *prima facie* nature of the principles.[127] In contrast to the absolute rights of the HRF, the principlist frame allows authors, when faced with conflicting principles, to "strike a balance."[128]

However, the principles are not equally weighted. Regardless of place of publication,[129] primacy or "sanctity"[130] is granted to the principle of autonomy — "the ability … to make decisions free from … controlling interference by others."[131] The other principles, particularly justice, "giving others their due,… fairness, and equit [y],"[132] receive markedly less attention. The primacy of autonomy correlates with the general movement in clinical practice away from medical paternalism (i.e. "doctor knows best"), itself reflective of the broader sociocultural recognition of the value of self-determination.[133] This approach firmly places the individual's personal preferences at the core of the ethical analysis.

In evaluating the ethics of restraint, two conflicts emerge. The first, a conflict between patient autonomy and "best interests"[134] (beneficence/non-maleficence), appears most frequently in publications considering restraint in intensive care settings. This conflict is resolved by considering the "relative weights"[135] of the harm to be minimized, the patient's risk to themselves, and the "burdens, risks and harms of the violation."[136] The second, identified in psychiatric and emergency settings, is a conflict between the interests of "an individual patient versus [those] of others (staff and other patients)"[137] — a "dialectic between individual autonomy and collective safety."[138]

Unlike the HRF, which holds that "restraint must be considered from the perspective of people who have experienced [it]"[139] and does not consider[140] the interests of others, principlism provides moral scope for considering "third-party" interests.[141] However, this scope is limited by principlism's allegiance to the "fiduciary duty to care and advocate for … individual patients."[142]

Justified (Barely)

In both conflicts, ethical restraint requires an "imminent"[143] or "immediate"[144] risk of harm to the patient or "others." The identity of the "others" lacks consensus. Most authors agree that the safety of other patients and the "therapeutic milieu"[145] are relevant.[146] Less common is the recognition of a broader "public welfare" interest.[147] Staff safety is generally considered ethically relevant,[148] though some suggest this is an accepted risk.[149] There is similar ambiguity regarding using restraint to mitigate against the impact of staffing shortages.[150] Ultimately, however, the authors agree that it is "the *patient's* best interests [which] should be of prime concern"[151] (emphasis added).

Though uncomfortable in doing so, much of the principlist literature conceives of (very) limited circumstances where restraint is ethically justified. Some also suggest criteria for its use, intended either to "safeguard[]"[152] the patient,[153] or guide or support staff in managing its administration.[154] The criteria proposed can be broadly categorized as requiring respect for the patient, proportionate application, and safe systems (see Table 6).

Problems with the Ethical Frameworks in the Literature

Once the ethical importance of the context in which the FLA occurs, and the (ethical) significance of its potential magnitude, are highlighted, the deficiencies for the task at hand of the preferred "person"- and "patient"-centric frameworks prominent in the literature are exposed.

Human Rights: … but Not All Humans

Neither the HRF nor principlism provide sufficient scope to evaluate the legitimacy of FLAs in the variety of contexts in which they are used in hospital settings. Comprised of inviolable rights and freedoms,[155] as applied in the literature,[156] the HRF sites "the person" — their "rights" — at the center of the analysis.[157] This approach excludes consideration of others' ethically relevant interests — the inviolable rights of other individuals impacted by the conduct prompting the FLA and/or its application. Evaluated exclusively from the person's perspective, the objective finding that an FLA limits or infringes an otherwise inviolable right to, for example, "bodily integrity"[158] necessitates the conclusion that the FLA is unethical. This is regardless of its potential to enhance others' interests. As applied, the HRF does not provide any guidance or scope to balance the infringement of the individual's inviolable rights against its potential to enhance and/or preserve the otherwise inviolable rights of proximate patients or staff.

Principlism: The Pull of the Patient

Compared to the HRF, principlism is better-suited to analyzing the ethical justification of restraint in hospital settings for two reasons. First, because the principles — beneficence, non-maleficence, and particularly justice[159] — explicitly recognize the potential ethical importance of the interests of individuals beyond the patient. Second, because the principles, considered *prima facie* — "binding until meeting conflict with another"[160] — can, when conflicting, be prioritized one over the other.[161] At least theoretically, "no pre-eminent principle exists in biomedical ethics,"[162] and the conflict is determined wholly by the circumstances in which it occurs.[163]

However, with its biomedical origins,[164] principlism has an implicit fidelity to the "special"[165] fiduciary relationship between

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Table 6. Criteria for Ethical Restraint

Purpose of criteria	Ethical consideration	Ethical requirements
Patient protection	Respect for the patient	Obtain informed consent from the patient or their surrogate (28, 57, 65, 68, 83, 86, 89, 92) Ongoing consultation with the patient or their surrogate (17, 55, 68, 82, 94) All reasonable steps must be taken to maintain the patient's privacy and dignity (28, 47, 49, 68, 89, 93, 95) Only use where the application is medically appropriate (57, 65, 68, 83, 86) During and after restraint, must ensure the patient is supported and receives necessary and appropriate care (33, 55, 59, 68, 83, 88, 89, 92, 93) Complaints procedure (55) Transparent evaluation process (49)
	Proportionality	Should only be used as a last resort (33, 47, 82, 84, 88, 89, 94, 97, 98) Least restrictive for the least amount of time necessary (47, 55, 57, 65, 68, 86, 92, 93, 95, 96, 98) Proportionate to the level of risk (33, 90, 94) Only use when likely to be effective (49, 88)
Practical guidance	Safe systems	Use of checklists to prompt staff to consider all ethically relevant issues and to enable staff to manage restraint in a legally defensible manner (33, 54, 82, 90, 92) Institutional policies that clearly define the indication, duration, patient observation, documentation, and the review of the procedure (54, 59, 64, 89, 95, 98) Planning (17, 84, 86) Evidence-based policies (64, 95) Broad (interprofessional) consultation prior to and during implementation (17, 59, 86, 90, 98) Regular review of policies (17, 64) Ongoing education and training of staff (17, 33, 47, 55, 64, 84, 88, 89, 92, 95, 98) Staff support, including debriefing (33, 47, 64, 99) Incidents of restraint must be documented in clinical records and audited (33, 47, 54, 55, 65, 93–95)

the doctor and patient.[166] In practice, particularly when applied in a Western medical setting,[167] this translates to an emphasis on the interests of the patient — (specific) beneficence, non-maleficence, and increasingly[168] their autonomy.[169] The principles of justice, and general beneficence and non-maleficence to the extent they incorporate the interests of others,[170] sit at the periphery, identified but rarely explored.[171] The centrality of the doctor-patient dyad, and this preference, is reflected in our results. Few articles interrogate in detail the ethical justifiability of an FLA by reference to its impact on justice.[172] The principlist literature otherwise universally begins its ethical consideration from the patient's perspective. When considered, the interests of others are an adjunct — noted, but not explored.

It is unsurprising that principlism, given its origins, is well-suited to assessing the ethical justifiability of therapeutic restraint, a classic clinical ethics question. In this context, as intended,[173] a principlist analysis "aid[s] deliberation by making [all] relevant values explicit."[174] However, its application is challenged by public safety restraint.[175] When starting the analysis from the patient's perspective, it is unclear why and how to "take others into account"[176] — principlism does not provide the necessary tools or safeguards to manage the fundamentally different roles of the actors, the type of power exerted, and its impact where there is a public component. This is particularly so when an FLA is of questionable benefit to the patient. The implicit understanding of the pre-eminence of the patient's interests makes the decision to preference the interests of others uncomfortable and potentially untenable. This is particularly because principlism does not otherwise provide a means of "checking" this use of power. This discomfort is evident in the literature. The circumstances required to permit the restraint of an individual for the benefit of others must be most grave,[177] and even then, there must be some benefit derived by the patient from the act (e.g., an ultimate restoration of autonomy).[178]

Part III: The Potential of Public Health Ethics

Conceptualizing restraint as occurring along a continuum exposes the difficulties in "reconciling ethical principles across different social scales"[179] — doctor-patient versus hospital.[180] While applying the principlist framework aids ethical deliberation about therapeutic restraint events, its utility diminishes as we move along the continuum, the "public" component grows, and (potentially) any therapeutic benefit derived by the patient diminishes. What then are the appropriate values and principles to consider?

Public-safety restraint shares many conceptual similarities with public health interventions (PHIs) such as isolation in the setting of infectious disease. Though occurring on different scales, at the most rudimentary level, both public-safety restraint and PHIs like isolation involve the exercise of institutional power to compel behavior-change primarily for the benefit of others. Isolation involves the state or a health authority compelling the behavior of individuals known to pose a public health risk with the expected benefit of preserving or promoting public health.[181] Its implementation is recognized to have consequences for core values — including autonomy, equality, and justice[182] — and causes many of the same ethical tensions observed when considering public-safety restraint.

Because of these ethical tensions, PHIs, like isolation, are increasingly the subject of ethical interrogation to ensure that an appropriate balance between "individual freedom and community-wellbeing"[183] is achieved. Although there is no settled framework or approach,[184] several principles feature prominently in the PHE literature (see Table 7). Sharing many similar principles and values with clinical ethics frameworks, a PHE approach distinguishes itself by incorporating and emphasizing communitarian values.[185] Combined, PHE principles are sensitive to the larger social scale of public health and PHIs, and the need to balance individual freedom and community well-being.[186] Specifically, in emphasizing principles of good governance, transparency, and accountability, PHE approaches draw out the relevance of using compulsive public power for the benefit of third-parties to the ethical analysis. These principles operate as safeguards and accommodate the need to balance the interests of individuals with the common good.

The potential "public" implications of public-safety restraint applied in a hospital setting warrants a more balanced consideration of, on the one-hand, the individual's interests, and on the other, the others' interests, than afforded by principlism. However,

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Table 7. Principles of Public Health Ethics

PRINCIPLES	DEFINITION
Evidence of likely effectiveness	A PHI must be justified by reasonable evidence ("sound data" (110 p.1778)) of its effectiveness to achieve the legitimate goal (71).
Least restrictive / harmful	A PHI must be "necessary to realise the [legitimate] public health goal" (102 p.173). Where "2 options exist … we are required, ethically, to choose the approach that poses fewer risks" (110 p.1780) and "involves the least restrictions of liberty" (71 p.2).
Proportionate	The "probable public health benefits outweigh … (any) negative features and effects" (102 p.173).
Equitable	A PHI must provide for a "fair distribution of benefits and burdens" (110 p.1780).
Procedurally fair and publicly justified	The development and implementation of PHIs must take account of democratic governance processes at all stages, and decision-making must be transparent (111), subject to oversight, and capable of review and revision (71, 112).
Reciprocity	Where burdens are imposed, "there is an obligation on a social entity … to assist the individual … in the discharge of their ethical duties" (111 p.102).
Solidarity	A "relational," "constitutive concept" (113 p.2) which sees the "distribution of health … as being of joint and common concern" (72 p.77).

this necessary dilution of the emphasis on individual autonomy, and the consequent potential to curtail an individual's interests for the benefit of others, requires mechanisms to ensure this power is exercised appropriately. PHE principles provide these mechanisms, combining the individual or patient-focused principles of principlism (including autonomy) with community or public-oriented principles (i.e., democratic governance). However, if the ethicality of therapeutic restraint is aptly assessed using a principlist framework, the question becomes: at what point along the continuum ought we transition from a principlist to PHE analysis?

We suggest there is no specific "tipping point," and that PHE principles are applicable at all points along the continuum, albeit with different weighting. Ethical frameworks are not algorithms to be applied didactically to deduce a correct result. Instead, they are tools. Frameworks are intended to direct the decision-maker's attention to relevant values, and encourage deliberation and specification based on the particular circumstances.[187] The advantage of applying a PHE framework in this context lies in its inclusion of principles that direct attention to the interests of the individual (i.e., those principles that are common to both PHE and principlism), and principles that direct attention to the interests of the community. On this basis, we argue that an application of PHE principles is appropriate regardless of where an FLA falls on the continuum — all that changes is the relative weight afforded to the different principles. For example, when applied to an FLA at the therapeutic-restraint end of the continuum, the principles which accommodate the "public component" of public-safety restraint (i.e., that the FLA is publicly justified) are less relevant, and thus carry less weight in the ethical deliberation. As we move along the continuum towards the public-safety restraint end, the relevance of — and weight afforded to — those uniquely PHE principles increases. The PHE framework is able to recognize and account for the "public" aspect of some FLAs in hospital settings, while at the same time ensuring that the interests of the individual patient involved are also taken into account.

Conclusion

At a hospital level, the key practical question is how to ensure that any and all use of restraint is ethical. Public health ethics principles may provide the necessary tools for this task. Applying a public health ethics lens to the issue both shifts the focus and widens the frame of ethical consideration. Rather than zooming in on the patient and the FLA, a PHE approach, with its emphasis on principles of "good governance,"[188] suggests that the ethical justifiability of the act is partly determined by the broader systems within which it occurs. The precise form that these systems should take is beyond the scope of this paper. We would, however, recommend that further research be carried out in concert with a broad range of involved stakeholders — including hospital staff, patients, and caregiverrs — directed at developing administrative systems and hospital policies and procedures that operate at an institutional level to minimize the use of restraint and otherwise safeguard the interests of all involved. Cultural attitudes towards the use of coercive public power and the role of medicine are likely significant in shaping attitudes towards the use of restraint in hospitals, and the relative weight afforded the ethical principles concerned. Future research that incorporates a broader range of cultural perspectives would provide a more holistic overview of the ethically relevant issues, and is warranted given the level of international concern.[189]

Our research is a unique contribution to the field, providing a novel perspective on how to understand and define restraint that highlights the relevance of "social scale" when considering whether, and when, its use in hospital settings can be ethically justified. We have identified that the current definitions do not incorporate all ethically relevant features of restraint in hospital settings. Specifically, the definitions do not capture the potential "public component" of restraint — the ability of its use to impact the ethically relevant interests of multiple individuals. This feature of restraint explains why the current preferred person- and patient-centric ethical frameworks — human rights and principlism — are problematic. Instead, this understanding supports the application of the principles of PHE to ground the future development of policies, practices, and procedures for the ethical application of restraint in hospital settings.

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