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Scientific Contribution

The balancing act: psychiatrists' experience of moral distress

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Abstract. Experiences of moral distress encountered in psychiatric practice were explored in a hermeneutic phenomenological study. Moral distress is the state experienced when moral choices and actions are thwarted by constraints. Psychiatrists describe struggling 'to do the right thing' for individual patients within a societal system that places unrealistic demands on psychiatric expertise. Certainty on the part of the psychiatrist is an expectation when judgments of dangerousness and/or the need for coercive treatments are made. This assumption, however, ignores the uncertainty and complexity of reality. Society entrusts psychiatrists to care for and treat those among its most vulnerable members: persons deemed to have a severely diminished capacity for autonomy due to a mental disorder. Simultaneously, psychiatrists are held accountable by society for the protection of the public. Moral distress arose for psychiatrists in their efforts to fulfill both roles. They described an 'outsider/insider' status and the ways in which they attempted to cope with moral distress.

Key words: autonomy, ethics, moral distress, psychiatry, relational responsibility

In her novel *Regeneration*, Pat Barker (1991) explores the real life relationship between the poet Siegfried Sassoon and his psychiatrist, Dr. W.H.R. Rivers.[1] In 1917, Sassoon came under the care of Dr. Rivers at the military psychiatric hospital, Craiglockhart in Edinburgh. A decorated soldier, Sassoon had, while on leave from the Western Front, written *A Soldier's Declaration* in which he denounced the war and the terrible deaths of the trenches. This public challenge to the way in which the war was being conducted put him at risk for a charge of treason. As a means for avoiding that charge for which execution could be the penalty, Sassoon was persuaded to go before the Medical Board. The Board decided that Sassoon be treated for a psychiatric disorder, neurosis. Rivers was assigned to treat an unrepentant Sassoon for his protest. Rivers, as a psychiatrist at Craiglockhart, was attempting to treat and heal soldiers whose young bodies and minds had been damaged by the horrors of war. He was expected to do this as quickly as possible so that his patients could return to combat and face those horrors once again. This social expectation sat uneasily with his professional values.

> Rivers was aware, as a constant background to his work, of a conflict between his belief that the war must be fought to a finish, for the sake of the succeeding generations, and his horror that such events as those which had led to Burns' [his patient] breakdown should be allowed to continue. (Baker, 1991, p. 47)

Despite such conflict, Rivers did what was expected of him: "it certainly didn't rest with him to decide whether it continued or not" (Barker, 1991, p. 47). There is a cost to this compliance. Rivers collapses at one point with symptoms similar to those of his shell-shocked patients.

There is a type of distress – moral distress – that can arise for psychiatrists due to the competing demands of society and the best interests of individual patients. Moral distress is the term, attributed to the philosopher Andrew Jameton (1984), used to distinguish moral dilemmas (situations where one is deciding 'what is the right thing to do?'), from situations where one has decided the right thing to do but is thwarted by constraints. Moral distress arises when one must act in a way that contradicts one's personal beliefs and values;

it is individuals' response to their own perception that they have failed to act ethically. The constraints to ethical action may be external ones, such as a lack of resources, or internal ones, such as a lack of moral courage.

Rivers' need to balance societal demands with ethical responsibility to a patient was situated in wartime, but this balancing act is evident in contemporary, everyday, civilian psychiatric practice. In an interdisciplinary study of the moral distress of mental health professionals, it was the experience of the competing demands of fidelity to both the public and to patients that characterized psychiatrists' moral distress. In this paper we describe their experiences, including their attempts to resolve and/or live with moral distress.

The moral distress research project

Moral distress is a relatively new concept and, to date, research on it remains primarily within nursing. In a 2004 review of the literature, Hanna found that of 35 studies of moral distress, 34 concerned nurses. The few interdisciplinary studies do indicate, however, that moral distress occurs in various clinical and health professional groups (Austin et al., 2005; Kälvemark et al., 2004; Kim, 2004; Løvseth et al., 2005; Sporrong et al., 2005; Sporrong et al., 2006). In our Canadian study, *Mental Health Practitioners' Experience of Moral Distress*,[2] we used hermeneutic phenomenology to explore, through one-to-one interviews, the lived experience of moral distress of psychiatrists, nurses, psychologists, and social workers. Phenomenological research attempts to uncover the phenomenon of interest through a rich, evocative description rather than create a theory or explanation. A description of mental health practitioners' moral distress can allow for a greater understanding of it, enabling practitioners to recognize moral distress and to be better able to address it. We aimed, in this study, to identify care situations which give rise to moral distress, to describe how practitioners' address and attempt to resolve ethical issues within their practice, and to identify both environmental supports and obstacles to ethical practice. [See Austin et al. (2005) for a more detailed account of the research method.] It is the moral distress of psychiatrists that is addressed in this paper, although our understanding of the phenomenon is informed by the broader research.

A definition of moral distress

Jameton (1993) identifies two kinds of moral distress: initial and reactive. "Initial distress involves the feelings of frustration, anger, and anxiety people experience when faced with institutional obstacles and conflict with others about values" (p. 544). Should the initial distress fail to be resolved, reactive distress may result. Based on the literature, Nathaniel (2002) further defines moral distress as:

> ...the pain or anguish affecting the mind, body or relationships in response to a situation in which the person is aware of a moral problem, acknowledges moral responsibility, and makes a moral judgment about the correct action; yet, as a result of real or perceived constraints, participates in perceived moral wrongdoing (*¶5*).

Perception is a key component of moral distress: one person may feel distressed at the process or outcome of a particular practice situation, while a colleague may be distressed if things were otherwise. Not only does one's perception of correct moral action determine whether one experiences moral distress from a given outcome, so too does one's perception of what constitutes an ethical issue. What one individual may perceive as an ethical issue, another may not. Yet a lack of moral distress is rarely indicative of an environment free of ethical issues; rather, such an environment likely points to a dulling of ethical sensitivity.

Within mental healthcare, the constraints that frustrate desired moral action vary. In our study nurses described moral distress arising, in part, from a lack of power and control over the resources necessary for them to fulfill their role obligations. At times, they felt unable to answer the call of their patients and as if they were abandoning those entrusted to their care (Austin et al., 2003). Psychologists, in turn, articulated a range of moral distress responses resulting from institutional and inter-institutional demands that seemed incongruent to them fulfilling their roles as psychologists according to their Code of Ethics (Austin et al., 2005). Social workers described bending rules, using professional connections, and calling in favors in an effort to make the system work in the best interests of patients. Psychiatrists' moral distress seems to lie in the nature of the role itself.

The balancing act

As a professional, a psychiatrist has an accord with the public regarding the trustworthy provision of specific expertise. This expertise is regulated and credentialed by the profession. There is a covenant of fidelity to the public good and the professional is held accountable by his or her peers. Society gives great authority to the expertise of psychiatrists and, in turn, holds comparable expectations of the discipline. In writing about the power of psychiatry, Robitscher (1980) identifies the psychiatrist as the most powerful non-government decision-maker and the only professional who, on the basis of expert assessment, can take persons' freedom from them. There is, however, little recognition that an assessment of a person's state of mind and the risk for harm to self or others is a complex process or that absolute certainty about it is not genuinely possible. Despite the inherent difficulties, failure on the part of a psychiatrist to identify and act on a risk to public safety would be seen as a betrayal of the public trust. It was in these societal expectations and obligations of their profession that our psychiatrist participants' experiences of moral distress were situated.

Dr. Stratfford

One of our participants, whom we will call Dr. Stratfford, described an experience related to enacting his societally mandated power with a patient.[3] A patient was referred to Dr. Stratfford by his family physician when the patient developed paranoid delusions following surgery. This otherwise very highly functioning gentleman began to suspect that his neighbors were spying on him, making disrespectful gestures, denigrating him in their comments, and putting intimate pictures of him on the internet, pictures that they had taken through the walls of his house. A complete organic workup ruled out disorders other than a primary psychiatric illness. Dr. Stratfford described his patient:

> *He couldn't really be considered a danger to himself or to others... He was initially accepting of treatment and he had trials of two or three different anti-psychotic medications, none of which were of any benefit. So we were in a situation with a fellow who was chronically delusional. These delusions would wax and wane over time but would never go away all together.*

The initial treatment approach had to be reassessed when the patient began writing to the Justice Minister, the Mayor and other government officials about his persecution. He began to hint that he had some thoughts about harming others in retaliation. In relating a specific incident about someone bumping into him at a store, the patient told Dr. Stratfford that if he had had a hammer in his hand he would have hit back and that if it happened again, he was going to defend himself. Dr. Stratfford had to decide how to act: should he continue to follow this patient on an outpatient basis or, as he put it, *Was there enough evidence that he was dangerous to others* [for him] *to be certified and brought into hospital? And if we were to do that, would medications benefit him?* They had not benefited him to date. Dr. Stratfford sums up his situation as having:

> *a patient who's functioning, who was impaired because of delusions. And not being able to offer him, not being able to put into place, adequate treatment so that he would improve and there would be a resolution of his symptoms.*

Being unable to help his patient medically is what Dr. Stratfford finds particularly difficult: *You know, usually we would see our patients improve over time and that certainly wasn't happening with him...You want to help. It is not a good feeling when you cannot.*

Unable to genuinely help him medically, what is Dr. Stratfford's responsibility? He says:

> *Here is a fellow—he's living in the community, he's functioning well in many ways. Do we put him through the process of certifying him and bringing him into the hospital, possibly having to get a treatment order to impose treatment? The end result might be that he may not respond to treatment any way. I couldn't be 100% sure that admission to the hospital would benefit this guy in the long run, in fact, it may do more harm in some ways. He'd been very independent. Imposing admission to the hospital on him, I didn't feel quite right about that either. So it was balancing his rights with the rights of others and the protection of others.*

Dr. Stratfford chooses to *take a chance*. That his patient might misinterpret somebody's actions and possibly retaliate is a responsibility that he now carries. He remains exquisitely aware that, as he puts it: *I mean, if you were a neighbor of this guy you may not feel comfortable with what is going on, but this is something that you can't* [as a physician] *do anything about*. And that:

> *There are cases of course, where something does happen and the reality is that many physicians do*

get put on the spot and they think, in retrospect, ''Why didn't I do something, why didn't I?'' It's not really fair considering the circumstances.

Although there is little medically Dr. Stratfford can offer, he remains responsible for more than his patient's welfare and that seems unfair. He has little control of the situation except to use the power bestowed by the state to hospitalize persons against their will, if it is necessary. He must decide if and when it is necessary. Although Dr. Stratfford relies on his medical knowledge and experience in making his decision not to hospitalize, he recognizes that this decision can be – as its alternative, to hospitalize, can be – perceived as moral wrongdoing.

Dr. Gauthier

Another psychiatrist participant, we've called him Dr. Gauthier, described his experience with a patient who was:

A gentleman in his 40s who had suffered from a paranoid psychosis for many years who was living on his own on an acreage. His neighbors were concerned because he would sometimes holler at them. Like many persons who live in the country he had guns on the property. Eventually the police were called because of some hollering and he was brought into the hospital. He believed that he was the victim of persecution by many people and had a right to do whatever he could to protect himself when threatened, including using a gun if necessary. He will not take treatment.

Dr. Gauthier described how difficult it is to authorize the forced treatment of someone when you are not really sure it is going to be doing much good, particularly in terms of decreasing dangerousness. Delusional disorders, for instance, do not respond consistently well to treatment with antipsychotic medication.

But you don't want to be the one that sends him out and then, many weeks and months or even years later, he does something. If you're lucky 99 times out of a hundred... not much would happen but, in the one case out of a hundred, it's the sort of person that would wipe out the neighbors' family.

Dr. Gauthier and his colleague commit the patient to hospital. His patient *hates it, and is very, very upset*, feeling that this is part of the same conspiracy that's threatened him for years. He is both angry and tearful. Dr. Gauthier explained how it *played out*:

He is a big guy... so you end up getting four or five people to hold him down to give him an injection of antipsychotic medication. And so it's a case where you ask yourself whether what you're doing is right. And even now I'm not sure that it was right. What happened was that I treated him for a few weeks with antipsychotic medication, without much being changed. We went to court and got his gun license taken away and got his guns removed, which reduced the level of concern a little bit. Then he went back, no doubt, [*upon discharge*] *to discontinue his medication and, no doubt, carry on as before.*

Dr. Gauthier describes acting to prevent a relatively rare but potentially dangerous situation as a *balancing act*. He is distressed in this situation because he feels that, in the balance, he is harming his patient. He said:

First of all there's the 'do no harm' principle. Well, that goes out of the window immediately because you're putting the guy through quite a bit of harm by forcing medication on him. You hope that this is balanced against the greater good. Maybe it's the greater good for him in the long run too, and if his delusions are treated then he may be more at peace with life and with himself. But really it was for the greater good of society...

So you're balancing, recognizing that you're doing him harm against the possibilities [that he might harm others].

A crucial aspect to the balancing act is the inherent uncertainty: physicians cannot predict with absolute certainty what is going to happen. As one of our participants said: *In psychiatry we know we're limited.* The role society has assigned psychiatrists, however, does not seem to permit the acknowledgement of such limitation.

There is a great moral responsibility that is assigned and assumed. This responsibility can be interpreted in surprising ways. A psychiatrist related an illustrative situation:

I sat there stunned as a parent described his son's verbalizations over the last 72 hours in regard to his repeated assertion that he was going to kill his ex-girlfriend. The father talked about trying to get an appointment at the clinic with me and being somewhat dumbfounded as to what action to take in the interim. His wife backed up that they were worried about their son and what he might do and were looking for some guidance. When I asked about the seriousness of the threats, both parents

expressed doubt that their son would reach to such measures but felt that in the back of their minds that something bad still could happen. When I asked if they had thoughts about calling the police or warning the girl, the response was unanimous. "That's your job," expressed the father, "we did our part by getting him here."

From this family's perspective, the psychiatrist is the medical expert and it is with him that the ultimate responsibility lies. This is not an uncommon assumption.

The role of double agent

According to Veatch (1997), an American ethicist, one of the most deeply rooted systems Western societies use to make sense of the world is the medical model. It is the predominate means of shaping our actions and attitudes toward human deviance. Illness, Veatch says, is a socially assigned category, a deviance from the norm that has biological and/or social causes. The sick are put under the authority of the medical profession, which has jurisdiction over labeling an illness. Physicians, as the experts, are expected to control and correct behavior placed within the medical model. That this is an unrealistic expectation does not mitigate its power. Bloche (2005) argues that physicians are increasingly facing pressures to use clinical expertise for social purposes or on behalf of third parties, and that the ethical conflicts created by such social expectations are not being adequately addressed.

Psychiatrists, certainly, are placed in the situation of competing responsibilities as agents for their patients and for their society. The double agent role of the psychiatrist has been discussed since the 1970s (Strasburger et al., 1997). It has been termed the most difficult ethical dilemma confronting psychiatrists (Grunberg, 2002). Societal demands can threaten the moral grounding of medicine as a trustworthy profession with primary obligations to the best interests of individual patients. Grunberg has pointed out that tragic consequences have resulted when societal demands persuade psychiatrists to abandon the basic Hippocratic ethical principles of beneficence and non-maleficence to individual patients. He gives as examples the extermination of the mentally ill in Nazi Germany, the involuntary hospitalization of political dissenters in the former Soviet Union, and the involvement of American psychiatrists in executing the death penalty. The concerns about the double agent role, however, have done little to change the day-to-day demands on the psychiatrist.

Artificial personhood

Being an agent for society makes psychiatrists, what the philosopher Hobbes in 1651 termed 'artificial persons' (p. 120). Hobbes coined the term to explain how governments act in the name of citizens. Where a person acts in his own name, an 'artificial person' acts in the name of someone else. Actions, in a sense, become agent-less. Wolgast (1992), in exploring the moral hazards of professions, argues that responsibility can lose coherence for 'artificial persons.' Based on a theatrical metaphor, role and person are separated. Personal character and morality are viewed as discrete from the morality of the role, a stance that diminishes a coherent understanding of individual responsibility. Action in a professional role can be morally different from what it would be if the role was not there. Like an actor, a professional does things within a role that they would not do otherwise. This should be morally troubling and seems to be so for the psychiatrists in our study. How does one keep one's sense of responsibility as a fully integrated person if professional responsibility is detached from one's personal sense of morality?

Dr. Gauthier notes:

As doctors we don't like to think of ourselves particularly as agents of society... most of us feel strongly that we're in this game to improve the lot of the individual. When in medical school you didn't see yourself as a social agent. It was about "What is the best 'good' for this patient?"

Although they qualify as 'artificial persons' acting for society, the psychiatrists in our study are struggling to come to terms with their genuine selves in the role.

Dr. Gauthier, for instance, has another patient, a young man with schizophrenia, who is being subtly and not so subtly coerced into living in a particular way. This happens with a lot of patients, Dr. Gauthier says, as he describes the situation with this unhappy fellow:

You know, you are more or less telling him, "This is the way it's going to be" and in his group home he is given his medication 4 times a day and he is

told his doctor says he has to take it. So, yes, he has the freedom to say, ''No!'' but if he were to say ''no'' he has to leave the group home and he has no money and the [Public] Trustee is not going to give him any money because he'd just spend it on gas and glue. So he has many years of being coerced and he is kind of trapped in this situation and he objects to it, he doesn't like it, he says he's always angry and he's ''going back to the good ol' days.'' The other option would be just to say ''Ok, off you go,'' and he would use solvents and he'd be more psychotic and he might get into more trouble as a result of his psychosis...

This is a clinical decision, Dr Gauthier says, but

It's a moral decision as well. [We're] *attempting to make decisions for this guy, his illness prevents him from making sensible decisions for himself. And so I am not really sure which would be the best route to take... of what's right for this individual.*

Psychiatrizing

Edwards (1997), the editor of the *Ethics of Psychiatry*, in an introduction to a chapter by Veatch on the nature and problems of the medical model, claims the medical model as an 'ethicomedical model,' given that it has had an ethical dimension since its inception (p. 102). Veatch (1997) describes the World Health Organization's definition of health and the fact that it encompasses total well-being, making physicians the experts for failure of well-being and, as he ironically puts it, for ''marriage, poverty and, unanswered prayers'' (p. 123).

A participant in our study situated his moral distress in the question: *What is Psychiatry?* He used the term, *psychiatrizing* and said:

I had a case recently of an elderly 80 something woman in acute care... for the last month or two and it was very clear that this woman has essentially prepared herself psychologically to die. She's basically tired of living. She has had dreams about joining her husband who's been gone for twenty years... She's had some medical problems and has recently found out that she has a malignancy in her pancreas...She may not have that much more time to live. We were asked to see her about depression. She's in a state of relative refusal of treatment, partly because in her own mind she's had enough. She wants to end her life. She wants to go home and end her life.

Although the family and the psychiatrist are comfortable with her decision – *I think it's a relatively appropriate decision* – the other physicians involved are insisting *that we have to do something*. The expectation is that psychiatry will intervene and treat her so that she will make a different decision.

Sometimes I think it may be more in the best interest of the patient and even the family system not to do anything at all... I'm not willing to necessarily give this woman who's in the final stages of her life ECT, to certify her, to make her psychiatric, to force treatment upon her.

This physician is unwilling to use his power as a psychiatrist to make a person 'psychiatric' so that others, uncomfortable about her decision to accept death, can remove her right to that decision. His situation is not unlike that of Dr. Rivers in relation to Sassoon. When a person's stance on an important life and death issue challenges the position of others within society (usually powerful others), psychiatry can be used to discredit or defeat that stance. The pressures on psychiatrists to enact prevailing social values are strong, and they seem to be increasing.

In the United Kingdom, a plan in the late 1990s to change the Mental Health Act to allow for the preventive detention of persons with a new category of mental disorder, dangerous severe personality disorder (DSPD), was proposed by the government (McMillan, 2003). Protecting the public is a clear objective of the plan, in addition to providing services that might enhance an individual's reintegration into society. The plan was strongly opposed, with critics arguing that most British psychiatrists do not believe such individuals currently can be treated effectively and that this measure is based on assessment of risk (dangerousness prediction) that can only be fallible (Griffith et al., 2004). Despite opposition from groups such as the Royal College of Psychiatrists [''It is not the psychiatrist's role to be an agent of social control,'' wrote the Chair of the College's Public Policy Committee to the Minister of State (Shooter, 2001)], the amendments proposed in November, 2006 would remove the ''treatability'' criteria for involuntary commitment. Such a change in the legislation does not augur well for the psychiatrists' ability to refuse, or even to define, their role in social control. The United States may be moving in a similar direction (Appelbaum, 2005). In 1997, a Supreme Court decision, seen by many as an overt attempt to use psychiatry as a means to keep

dangerous persons away from the public, endorsed the use of civil commitment to continue the confinement of sexual offenders finished serving their time when there was the possibility that proposed treatment could produce reliable change. Maier (1999), an American psychiatrist concerned about such an 'abuse' of psychiatry asks: "How is it that we have been co-opted into participating in this transparent process?" (p. 295).

This is an important question, and psychiatrists are right to be wary. As Adshead (1996) notes in a consideration of ethics in psychiatric research and practice, it was not so long ago (60 years) that psychiatry supported the eugenics program of National Socialism. This program, framed as a public health measure, resulted in the killing of over 200,000 patients (Dudley and Gale, 2002). This is an extreme example of the use of psychiatry for social purposes, but it does underscore the need for cautiousness on the part of medicine. The current American "war on terror," for instance, is having an impact on the demands made on medical personnel, creating new debates regarding the use of psychiatric expertise in intelligence interrogations and the control of detainees at Guantanamo Bay (Arboleda-Flórez, 2006).

In *Regeneration*, Barker imagines River's realization of his lack of control over how his work, and that of other psychiatrists, is used by a society at war.

> He'd found himself wondering once or twice recently what possible meaning the restoration of mental health could have in relation to his work. Normally a cure implies that the patient will no longer engage in behaviour that is clearly self-destructive. But in present circumstances, recovery meant the resumption of activities that were not merely self-destructive but positively suicidal. But then in a war nobody is a free agent. He and Yealland [another psychiatrist] were both *locked in,* every bit as much as their patients were (Barker, 1991, p. 238).

Autonomy of psychiatrists

Physicians, as healers in our society, are seen as being very autonomous. Psychiatrists, however, can feel not only socially and legally constrained by their role, but pressured to act in ways that are inconsistent with their own estimation of medical knowledge, skills and responsibilities. In trying to uphold their professional obligations to society, psychiatrists are placed in intolerable and morally distressing situations.

MacDonald (2002), a Canadian ethicist, believes that we need to recognize that individual professionals do not have the freedom to act on their own conscience. It needs to be understood that the professional's power flows from the social structures and relationships in which the professional practices. If the moral distress of psychiatrists is to be alleviated, it would seem that an acknowledgement of the contextual complexity of the role must occur. Professionals act, not only according to the standards of their profession but "in the face of countervailing pressures from institutional authorities, disagreement with members of other professions, or inappropriate demand on the part of patients or clients or, more generally, the public"(MacDonald, 2002, p. 284). The false notion of the autonomous professional acting without internal and/or external constraints needs to be replaced by relational understanding that can facilitate a more honest and realistic dialogue about role responsibilities.

Psychiatrists in our study attempted to cope with moral distress by trying to open a dialogue with others. There was, however, an 'outsider/insider' aspect to this dialogue. For instance, discussions with the hospital lawyer were not seen as helpful.

> *Well, the hospital lawyers, their client is the hospital so they're going to give you advice to reduce the likelihood of the hospital getting sued and it's always interesting to know what you should do, if that was your goal. But that goal isn't the same if you are a clinician.*

Not only was the lawyer an outsider, but so was the ethics committee. As one psychiatrist put it:

> *The ethical panel is not quickly responsive, usually it takes quite a while for them to get together. And maybe some people wonder about the competence of the ethical panel. There's usually one or two people that know about ethics but the rest are kind of the token representatives that come from wherever it is that they come... a whole bunch of clinical people. There's a whole bunch of people; it's a waste of everybody's time. ... And they do just come in and argue the pros and the cons of the clinical aspects.* [Staff members wonder]: *"Are these people really going to help or are they going to be creating more problems?"*

There was, however, a different kind of discussion that was seen as helpful, supportive, and real. It was a discussion within the team about the realities of the psychiatrist's orders. One psychiatrist

described a weekly team discussion that involved: *bringing in the non-professional staff, such as the folks that come to the unit to clean or the folks that were involved in serving food because they would sometimes find themselves in difficult situations*. It was an opportunity for people to raise the concerns they had. The psychiatrist described this dialogue as a way of coping by *making it true*.

Making it true: what does it mean? It is a workman's term: "to give a right form to; to make exactly straight, square, level, or the like"(Thatcher and McQueen, 1984, p. 898). For this psychiatrist, team dialogue made the situation seem more square – "fair, just, honest" (Thatcher and McQueen, 1984, p. 813). This seems to be a good example of enacting relational autonomy.

It seems to constitute, as well, an enactment of a related concept, *relational responsibility*. In this approach to responsibility, recently described by McNamee and Gergen (1999), the possibility of the independently responsible person is called into question, shifting the locus of responsibility and distributing accountability and blame in a more meaningful way. Tomm (1999), a Canadian psychiatrist, supports using relational responsibility in defining the psychiatrist's role. He defines responsibility as "living consistently within an awareness of whether one likes or dislikes the consequences of one's own actions" (p. 131). Dialogue with others informs this awareness and can contribute to each professional's attempt to be more realistically responsible.

Bloche (2005) offers some first steps for dealing with the conflict of clinical loyalties and the social use of medicine. He suggests that there must be honest acknowledgement of the contradiction between physicians' fidelity to patients and fidelity to society, and recognition that there will never be one sure way to resolve the conflicts incurred by this contradiction. Current paradigms proffered as ways to address the conflict such as "undivided commitment to patient well-being," the "dismissal of patient welfare as ethically irrelevant" in certain situations, and "reliance on consent" to justify actions are evaluated by Bloche as not genuinely addressing the moral problems involved (p. 269). He argues that, if a more modest approach to the ethics of role conflict is taken, that of ongoing case-by-case mediation, the tension created by the public and professional expectations of medicine can be more sensitively and realistically understood and responded to.

Walker (1997), a philosopher, writes of 'geographies of responsibility.' She argues that moral responsibility is part of social and political practice. "In contexts of medical care, it is professions, institutions, and in more indirect ways communities and societies that set these norms" (Walker, 1997, p. 40). Walker believes that we must recognize that where responsibility is placed is actually a choice, a decision. In regard to psychiatry, it is one that we may need to change.

Conclusion

The forensic psychiatrist Paul Appelbaum (1997) says that "Psychiatrists' increasing sensitivity to the opposing demands of their different roles is a positive development for the profession" (p. 446). In exploring psychiatrists' experience of moral distress, it became apparent to our research team that these opposing demands need to be reframed in a more relational way and that the concepts of autonomy and responsibility should be revisited. Dialogue needs to be opened so that society's unrealistic demands on the individual psychiatrist and on the profession as a whole can be acknowledged and addressed.

Dr. Rivers never attempted to change Sassoon's perspective on the war but he did support his decision to return to active service, a decision based on a desire to share the danger and suffering of his men. Rivers continued to use his skill to lessen the suffering of his soldier patients. And to watch those healed return, like Sassoon, to the trenches. *Regeneration* ends with:

> It was Sassoon's decision to abandon the protest, not his [Rivers]. But that didn't work. He knew the extent of his own influence.
>
> He went on sitting by the window as dawn grew over the Heath, and felt that he was having to appeal against conviction in a courtroom where he himself had been both judge and jury (Barker, 1991, p. 239).

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Notes

1. The novel has been adapted as a film by Giles Mackinnon, renamed *Behind the Lines* for its release in the USA.

2. The project was funded by the Social Sciences and Humanities Research Council of Canada and received ethical approval from the Health Research Ethics Board of the University of Alberta, Canada.
3. Throughout this text we have put psychiatrists' words in italics. The quotations are not strictly verbatim, however, as we have omitted redundant phrases and expressions such as "you know."

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