I have been writing this column for 20 years. I used to worry that the well would run dry and that I would run out of material. I soon realized that ethics cuts across almost all aspects of our lives as child and adolescent psychiatrists, and it is our awareness of our ethical principles that allows us to maintain our professional integrity. My initial interest in ethics stemmed from the numerous boundary issues that arose while practicing in a small town and living in close proximity to my patients and their families. These issues might involve running into patients at the dump, potentially embarrassing locker room encounters at the YMCA, my children wanting to carpool or play with my patients, and patients or their parents joining boards upon which I sat. In addition, the question of whether it is ever appropriate to treat two members of the same family would arise. When I first started my private practice in midcoast Maine in 1986, I was the only child and adolescent psychiatrist in private practice in the northern half of the state. I used to be concerned that turning down referrals would turn off the faucet of referrals. I would feel bad when my inability to see a patient would necessitate miles of travel for the family to find another child and adolescent psychiatrist. I was often asked to see the children of medical staff or acquaintances and had to determine when these relationships were Too Close for Comfort (1998) and would preclude my taking on a therapeutic role. Yet another challenge was the art of “double bookkeeping,” i.e., trying to remember what I’d heard from whom and whether it was discussable. I would often hear things about patients or their families from other patients or friends and sometimes would hear about my sons, who had a different last name, from patients who were unaware that they were my children. I once slipped and chided one son about not studying for an exam he had the next day. He looked puzzled and wondered how I knew about the exam and then I realized I had heard this during therapy with one of his classmates. Years later, during my staff orientation at Maine State Prison, I was taught the valuable adage “nothing in nothing out.” This meant that you did not share information about your life outside of the prison with inmates and what inmates told you stayed in the prison. It was also intended to deter gifts or contraband from going in and out of the prison and becoming a medium of exchange. Nothing in and Nothing Out (1997) has served me well in my practice as a reminder of the importance of boundaries and confidentiality and remaining focused on the patient.

The teaching of ethics is now mandated in training, yet sexual and non-sexual boundary violations continue to be a serious problem for our profession. This
continues to amaze me considering the volumes written on this topic and how damaging boundary violations can be for the patient, the psychiatrist, and the image of psychiatry. I suspect there is now less emphasis on transference and countertransference in training and that this may contribute to mutual acting out. Unfortunately, there are still some psychiatrists who feel they are above rules and ethical guidelines and do not consider the consequences of not keeping the patient’s interest foremost.

Our well-crafted codes of ethics (AACAP, AMA, and APA) have served to guide us through many difficult and new situations, including evolving systems of healthcare delivery and communications technology. Beginning in 1993, I took on managed care in many of my columns. In 1994, I raised the question of whether managed care was compatible with AACAP’s Principles of Practice. This led to a task force, which I chaired, in which we crafted Annot
tions to AACAP Ethical Code with Special Reference to Evolving Health Care Delivery and Reimbursement Systems (1995). Subsequent columns addressed limits of confidentiality under managed care and managed medication. In Silent Grief (1998), I lamented the demise of the practice of psychiatry as many of us knew it and our frustration, feelings of helplessness, and loss of autonomy under managed care. Our ethical codes have also helped us negotiate problems of confidentiality that came with the arrival of the internet, Confidentiality of Electronic Communication (1997), and cell phones, Tyranny of the Cell Phone (2006).

In 2002, I first explored conflicts of interest with drug companies, What Have Your Drug Reps Done for You Lately? In 2005, I discussed conflicts of interest in consulting with the investment industry, an increasingly worrisome practice. I also sat on the AACAP Corporate Contributions Policy Committee that generated the AACAP Guidelines for Commercial Support of Educational Activities (1998). It has been reassuring to see AACAP take a firm stand on the limits of drug company support to our organization. Currently, revenues from pharmaceutical companies constitute about 11 percent of all AACAP revenues. Professional organizations are finally demanding more transparency, severing speaker ties with drug companies, and further limiting the role of pharmaceutical companies in medical education. Yet, pharmaceutical companies continue to woo us with wine and food at meetings.

This column has provided me with the opportunity to address pressing social issues that impact on the wellbeing of children and their families, such as poverty, global warming, same sex marriage, gun control, and juveniles and the death penalty. I have always welcomed reader feedback on my columns, but it has been scarce. I did receive a few vociferous comments when I took a position on the disposition of 6-year-old Elian Gonzales, Out of the Sea and into the Swamp (2000), suggesting he might be better off with his Cuban father. One reader felt I had no right to express my personal opinion in an AACAP column, but then that is one of the privileges of being a columnist.

Although my well of ethical issues has not yet run dry, I am retiring my Ethics column. Retirement has distanced me from clinical ethical issues, other than the two ethics committees (Maine Association of Psychiatric Physicians, and the American Academy of Psychiatry and Law) upon which I sit. Given the confidential nature of the cases and issues we review, they do not lend themselves readily to ethics columns. I continue to write but in new venues. I recently published a volume of my poetry entitled Poems on Loss, Hope and Healing and edited The Original Maine Shrimp Cookbook*. The latter is a collaborative effort of The Island Institute, Midcoast Fishermen's Association and The First Universalist Church of Rockland that seeks to promote sustainable fishing, Maine shrimp, and buying locally. And so, I pass the ethics mantle on to the next generation with the hope that ethics will maintain a strong presence in AACAP News.

*Both books are available from the author (arcticpoppy1@gmail.com).

Dr. Schetky is retired from clinical practice, but continues to teach at Maine Medical Center in Portland in the Division of Child and Adolescent Psychiatry.

To discuss ethical issues in child and adolescent psychiatry with your colleagues, attend the following sessions at AACAP’s 56th Annual Meeting—Symposium 3: Contemporary Ethical Issues in Child and Adolescent Psychiatry; Workshop 6: Ethical Challenges in Conducting Child and Adolescent Psychotherapy; and Clinical Consultation Breakfast 9: Ethical Issues in Child and Adolescent Psychiatry.