learning about the physiology of the liver.

The roots of our need for detachment and equanimity go back to Sir William Osler, but the pendulum has swung too far, and the need for retention of millions of data bits overwhelms our souls. Although excessive emotion is destructive and counter-productive, we must not suppress our passion—but control it. The best physician both *feels* with the patient and prescribes *for* the patient at the same time. To do one without the other is inadequate care. As medical educators our task is clear.

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Nonclinical Use of Medical Skills: Beneficence Lost?

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The first time that I was asked to probe a rectum to search for sequestered drugs remains fresh in my memory. The correctional lieutenant, commander of the watch, seemed more menacing than the convict suspect as I attempted to explain my refusal to participate. "Yes, I am employed by the prison, but I am a physician. My profession's code of ethics prevails."[1-2]

It may have been the first demand to apply my medical skills to a body-cavity search but the issue of nonclinical use of medical skills was not new to me. The incident took place at San Quentin Prison, site of California's gas chamber. State regulations call for doctors to pronounce cessation of vital signs during executions. Before accepting a position at the prison, I sought assurance that I would not be expected to work in the death chamber in the event of an execution.

The ethical principle in these examples is beneficence. We physicians use our special skills for the good of our patients.

It could be argued that there are times when our skills must be applied for the good of the community. Retrieval of sequestered drugs, for example, might benefit the prison community by preventing access to harmful substances, needle sharing and accumulation of debts. However, Jonsen et al argue that competing ethical responsibilities must be prioritized and the patient's medical interests receive greater weight than public good.[3]

Beneficence is grounded in a fundamental medical premise: The patient must trust the physician.[4] The physician's skills signify life or death, health or illness; violation of the trust disrupts the patient-doctor relationship. The physician loses the opportunity to intervene and help the patient with his or her substance abuse, the opportunity for a potentially more sustained benefit than a one-time interruption of drug trafficking.

Doctors' involvement in executions might seem a clear-cut misuse of clinical skills. However, it was not until 1980 that the American Medical Association resolved that physicians should not participate in executions.[6] Most states that execute have statutory or regulatory requirements for physicians to be present.[7] Even after the AMA pronouncement, some physicians have argued there is a role for doctors at executions because the death penalty is legal.[8]

Determination of competence to be executed is still controversial. The AMA awaits action by the American Psychiatric Association on whether it is prohibited participation in executions. In 1986, the United States Supreme Court decided that it is cruel and unusual punishment to execute condemned people who, because of mental illness, do not understand their wrongdoing or the consequences of the penalty.[9] (Prior to 1986, this was also customary law.) Psychiatrists are asked to render opinions on measures of competency, opinions that can contribute to the killing of the person whom they examined.[10]

One argument that favors psychiatrist involvement in competency-to-be-executed assessments (and other judicially mandated evaluations) is that forensic medicine is a bona fide field of specialty in which doctors do not have patients. Forensic psychiatrists and others serve important legal functions and work as objective experts for the courts and other quasi-legal entities. Beneficence is not an issue.[11]

Could this be a slippery slope?

What then about demands for application of medical skills in the interest of the military, a prison, or an industry?[12-13] The primary mission of these institutions is defense and war, detention and punishment, or manufacturing and production, not medical care of soldiers, prisoners, or workers. These institutional missions could easily corrupt professional values if doctors readily used their skills to serve military, prison, or industrial purposes.

Other demands for physicians' clinical skills are more insidious. Some may arise from the adversarial nature of the legal system. There is a tendency to cast many societal decisions as polar, an individual's needs against the public good. The medi-

cal profession is sought to render opinions about an individual's needs. Disability assessments are an example. We are also involved in welfare decisions, child placements, insurance eligibility and other situations in which we apply our skills for purposes other than to care for the patient.[12]

It is true that our assessment may help the individual, such as a truly needy patient who receives disability benefits. But it is also possible that we may contribute to a decision not to render benefits. Such a decision can be quite disruptive of the doctor-patient relationship. The risk arises because these are nonclinical uses of medical skills—beneficence lost.

The contemporary transformation of the delivery of medical care could further erode the principle of beneficence as a premier ethical premise of the medical profession. More and more, physicians are finding themselves in institutional relationships. In contrast to the prison or military or industrial physician, the institutions do not seem to be at cross-purposes with our professional mission. They are institutions, such as health maintenance organizations and other managed-care entities, whose purpose is to organize health care for patients. Problems will arise because institutions serve groups. Physicians care for individuals. The principle of beneficence is more important than ever as a guide to our practice of medicine.

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Consent for Children as Organ Donors

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The use of children as organ donors has been a source of legal and ethical concern since transplantation became generally available.

Introduction

The number of diseases in children successfully treated by bone marrow and solid organ transplantation continually increases. The availability of a histo-compatible minor sibling as a donor has raised ethical and legal issues since transplantation became available. Organ donation represents a significant risk to one child (the donor) while the benefit accrues to a second child (the recipient). Parents who decide for both children must deal with this conflict.

St Francis Medical Center has devised a consent procedure that attempts to avoid parental conflict of interest, recognizes the emerging competency of the child donor, and provides a measure of protection for the donor.

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Sophie's Choice

In *Sophie's Choice,*[1] a mother was forced to decide which of her two children would be killed in a Nazi concentration camp. Early commentators portrayed parental consent for their child's organ donation similarly, refusing to acknowledge that organ donors benefited from the donation:

> [T]he parents should not be allowed to deprive a child of one of his vital organs without his consent or his intelligent comprehension...[I]t is considered almost impossible to support the view that parents should be allowed to consent to the removal of organs from minor children. Actually, legislation should be passed to prohibit children under a certain age from acting as donors.[2]

The Supreme Court of the United States in a different context has stated that while parents may be free to become martyrs themselves, it does not follow that they are free, in identical circumstances, to make martyrs of their children before they have reached the age of full and legal discretion when they can make that choice for themselves.[3]

Parents are given broad authority to enter into contracts for their children and to consent to medical treatment. Since organ donation is not medical treatment, however, consent should not extend to procedures such as organ donation where the benefit accrues to one child while the risk is borne by a second. Does the decision presented to the parents differ from Sophie's choice only in degree and not in kind?