I. INTRODUCTION

When I first started doing bioethics in the clinical setting, I was struck by the moral importance of factual complexity. It’s all very well to study principles in their purity, I thought, but solving real moral problems in medicine requires us to attend to political clashes and turf battles, emotional attachments and personality conflicts, communication glitches, legal threats both real and fictional, practical obstacles, fiscal limitations, and a host of other details that constitute the actual and often highly complex substance of a moral problem ([46] [44]). Solving these problems requires something more than purely philosophical contemplation.

Our moral lives are comprised, not of terrible hypotheticals from which there is no escape, but of complex situations whose constituent elements are often amenable to considerable alteration. And our moral aim should be, not to make dramatic choices which honor one value at a terrible sacrifice to some competing value, but to create a resolution which honors all important values maximally … to be as thoughtful, even inventive, as possible…. The philosopher may be right in thinking that sometimes we must make terrible priority choices between important values. But with a bit of ingenuity, such occasions can be far rarer than we are inclined to think ([46], p. 49).

Nowhere is this need to appreciate details and to negotiate with practicalities more true than the area in which I’ve done much of my writing over the past several years: the intersection of medicine, law, economics, and ethics. As outlined below, economic relationships in medicine have, in the past few years, posed moral and legal challenges that have become so complicated and so fast-changing, it is difficult to keep pace. We cannot even understand, let alone re-
solve, these challenges without crossing disciplinary lines freely and comfortably. Those who work in this area of bioethics must be “intellectual cross-dressers,” as comfortable talking about “exclusive provider organizations” and “stare decisis” as they are about beneficence and autonomy.

This article will explore this claim by focusing particularly on one area: the standard of care that physicians owe their patients. On one level it is a legal issue concerning the kind of care that physicians must deliver, lest they be found negligent and thereby civilly liable for any injuries their substandard conduct causes. As I will argue, the traditional appeal to customary or prevailing practice is profoundly challenged by a variety of powerful economic factors pressuring physicians to change their practices. Because many of these pressures point in opposing directions, there is far less consensus about appropriate practice and, therefore, is not clear on what bases the law’s standard should now be set.

On another level are moral questions concerning the level of care that physicians owe their patients. Traditional moral expectations of virtually unlimited resources and unstinting loyalty are impugned by newer realities, as it is no longer possible for physicians to produce resources with just a signature. If “ought” implies “can,” it may now be unfair to expect physicians to commandeer resources belonging to third parties who refuse to furnish them, or to expect physicians to place their own well-being endlessly in jeopardy in that quest. Reappraising physicians’ duties raises anew the question what it means for the physician to be a fiduciary of the patient, and how far the duties of advocacy should be pressed.

I will not attempt definitive analyses here. Rather, the purpose of this essay is much simpler: to show that any acceptable answers must be intensely interdisciplinary. Good ethics and good law begin with good facts. Only when the full complexity of the situation is appreciated can plausible resolutions be constructed. Otherwise we will badly miss the mark.

II. THE NEW, THICKER ALPHABET SOUP

A bit of alphabet soup will highlight some of the economic changes. A decade ago we learned about DRGs (diagnosis related groups), PPSs (prospective payment systems), HMOs (health maintenance organizations) and their variants, the IPAs (independent practice associations). These new arrangements emerged from the realization that traditional FFS (fee-for-service) reimbursement had the economically perverse incentive of encouraging providers to maximize the number of services they provided and to “unbundle” their care into as many