Haavi Morreim’s provocative title and, more importantly, her probing analysis of the legal and ethical challenges to physicians as a result primarily of changes in health-care financing in the United States, raise several important questions [1]. What is required to understand current changes in health-care services and delivery? How do these changes affect the legal standards of care relevant to medical malpractice? What impact do economic changes in the health-care system have on the ethical standards regulating the physician-patient relationship? Morreim offers plausible but incomplete answers to these questions. After critiquing them, I will take her conclusions as a point of departure for an exploration of additional implications for bioethicists, physicians, and patients. In particular, I will offer some suggestions about the education of patients and physicians as “intellectual crossdressers.”

I. UNDERSTANDING MEDICAL PRACTICE

The complexity of medical practice is not, as Morreim points out, reducible to principles or formulas. Much more than many other human interactions, medical practice includes scientific complexity as well as uncertainty, psychodynamics and power relationships, barriers to communication about injury, illness, and especially death. Legal regulations, professional standards, and fiscal limitations result in changes, if not chaos, in health-care financing. Legal and ethical issues must be analyzed in the context of these multiple factors, thus making the field of bioethics inherently interdisciplinary. Bioethicists must know how to find their way among several professions—medicine, law, ethics, and economics. But bioethicists must also know the factual details of current policies and practices.
II. MEDICAL MALPRACTICE STANDARDS

Morreim’s thesis about medical malpractice standards is that continuing economic and organizational changes in health-care delivery undermine the stability of prevailing practices in medicine. This, in turn, makes it difficult, if not impossible, to define legal standards to determine whether a particular course of conduct by physicians falls short of acceptable practice. “Ultimately it will be evident,” Morreim writes, “that there is virtually no such thing as prevailing practice anymore, and the judiciary needs to look elsewhere for medical standards.”

She goes on to show how standards of care are shaped by “varying economic perspectives and agendas” for the organization and delivery of health care. She distinguishes nine “standards,” ranging from the lavish artesian standard of providing any potentially beneficial treatment regardless of cost through more circumscribed standards based on managed care, corporate, government, subspecialty, group practice, malpractice insurers, patients’ expectations, or individual clinicians’ ad hoc standards. The multiplicity of standards results in decreasing control over the economic resources available to physicians in establishing practice patterns. Her proposal is that physicians can only reasonably be held legally accountable for their professional knowledge and expertise within the limits of the resources available to them. Others—insurers, managed-care organizations, businesses, or other payers—should be held accountable for allocation of resources.

Morreim’s proposal would provide welcome legal relief for physicians who feel beleaguered by the tumultuous changes in the economics of health-care delivery. The elegance of her proposal lies in its sharp distinction between professional expertise and resource issues. But is this bifurcation of responsibility realistic? It sounds plausible in theory, but it becomes problematic in practice when Morreim turns her attention to ethical challenges for physicians.

III. ETHICAL CHALLENGES TO THE PHYSICIAN-PATIENT RELATIONSHIP

Occasionally, but rarely, patients and physicians stand in a simple dyadic relationship. A patient consults a physician for diagnosis and treatment. A physician makes a recommendation and is paid a cash fee for services. More often the patient and physician interact in the context of polyadic relationships with families, other health professionals, health-care institutions, third-party payers, government regulators, professional organizations, researchers, and