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Walter W. Benjamin

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# *Physician or Magician?*

## *The Myths and Realities of Patient Care*

B. F. Fuller and Frank Fuller

McGraw Hill Book Co., New York, N.Y., 1978. 176 pp., \$7.95 (paper).

This is the season to "get physicians." They are now suffering the wrath of the public that earlier was visited upon teachers, clergy and lawyers. "How My Doctor Ruined Me — Physically and Financially" makes good copy as publishers have found out. The medical hero of the hospital TV serial is on the wane and substantial critiques — Carlson's *The End of Medicine*, Illich's *Medical Nemesis*, Klaw's *The Great American Medical Show* — are being heard. Cynicism and disillusionment are gradually replacing sacrifice and altruism in medical biography. For example, whereas William Nolen in *The Making of a Surgeon* saw his training as an essentially heroic adventure, Samuel Shem, M.D. in *The House of God* finds the teaching hospital a mechanism for the systematic distortion of human values. Even a British physician, John S. Bradshaw, in *Doctors on Trial* finds his guild guilty on all counts.

It is with some relief, then, that one turns to Dr. B. F. Fuller's rational and evenhanded analysis of problems in health care. From being a person with long experience in academic medicine (Fuller was professor of internal medicine at the University of Minnesota Medical School and founded and headed the Department of Family Practice) to one who has now returned to private practice, Fuller writes for two audiences. His intent is not only to demystify medicine for the layperson but, more importantly, to reform and recorrect the present practice and delivery of patient care. Thirteen short and readable chapters lay bare the issues. Many deal with philosophical concerns such as "What is Health?", "The Physician's Commodity," and "What Is a Physician?" while others elucidate roles, techniques, and dilemmas. Frank Fuller organized the materials for the book.

The central issue is the profession's inability to control the centrifugal forces let loose by technology since World War II. Both the Flexner Report of 1910 and the 1940's were great watersheds in American medicine: the former increased patient benefit by eliminating proprietary schools, raising standards and increasing professionalization; the latter set into being an exponential growth of the armamentarium which is out of control and in which each new advance brings risk as well as promise. Specialties and sub-specialties multiply, with each carving out its own fiefdom. Each knows more and more about less and less. Centripetal concerns — wholeness, focus, centeredness — are minimized and as a result, the medical "ship of state" has far too much "sail" and too little "anchor."

The philosophical base for medical fragmentation is Cartesian reductionism. Reductionism approaches problem solving by subdivision. Beginning with a mind-body dualism, it moves to organ systems, enzyme systems, cells and even cellular components. The victories won via the Cartesian method are impressive as witnessed by artificial life support systems, coronary artery bypass surgery, organ transplantation and the like. But medical heroics, neglecting the whole for the part, have escalated iatrogenesis and tragedy as symbolized by the case of Karen Ann Quinlan.

Fuller's prescription is to recapture medicine's proper "guidance system" by enhancing the status and numbers of "primary care" physicians. He supports the recommendations of the AMA-commissioned Millis Report of 1966 which affirmed that the central problem in health care was the lost prestige, poor train-

ing programs, and fewer privileges and status for general practitioners vis-a-vis specialists. Conceptually oriented, primary care physicians (internists, family practitioners, pediatricians and obstetrician-gynecologists) are truly specialists in a well-defined area that combines expertise in both basic and behavioral sciences. They are Oslerian oriented "pure physicians" — thinkers rather than doers — and their skills include management, data gathering, interpretation, evaluation, decision-making, therapy, and probability expertise. Primary care "configuration-alism," therefore, should be in complementary parity with the technologists, with the latter restricted to consultation and specialized treatment. Fuller challenges his profession to deliver and the public to demand healers with renaissance interests — those who can read "body language" as well as the spoken word in securing a history; who know communication theory as well as disease theory; who can see the family medical "forest" as well as cells and antibodies.

Medical education became fragmented after World War II with the gradual displacement of faculty who were recruited from the outstanding community clinicians by research faculty who came directly from graduate ranks. Medical perceptions and service became distorted because these people had never served in the medical "trenches" and were subjected to the "publish or perish" dogma. Medical wholism and balance were lost. Today, many physicians have little understanding or sympathy for illness outside the "medical model." Ignorance of behavioral science, especially medical sociology, makes them misunderstand the "sick role" in our culture and they become insecure when faced with functional illness or the "psychiatric model."

Moreover, the function of the modern physician has become so complex that confusion reigns as to "what is a physician." There are over 100 specialty areas in medicine today with 11 in the field of internal medicine alone. Fuller asks, then, where should a patient with stomach pain go — to the general surgeon, the gastroenterologist, the vascular surgeon, the gynecologist, the urologist, the endocrinologist, the cardiologist, the immunologist, the psychiatrist, the hematologist, the colon-rectal surgeon, or the primary physician? Other medical mazes, however useful for the profession, which apply to chest pain, back pain and headache serve only to confuse the public. Primary care specialists or conceptually oriented physicians can be educated to a high degree of skill and knowledge in the same time as it takes for a technologically oriented physician. The greater utilization and status of the former will enhance the effectiveness of the latter. There are other bonuses as well: continuing patient/family contact, reduction of high cost technology usage and a more intellectually and emotionally satisfying form of medical practice.

Fuller cogently explains difficult concepts such as sensitivity, specificity and the normal and predictive range and value of testing. The meaning of false negatives and false positives, alpha and beta error, and the value and limitation of multiphasic screening is discussed. There are no quickie solutions to the dilemma we face, however, for more paramedical professionals and computers cannot give us a quick fix. Only by giving commensurate authority and status to the primary physician, seeing them somewhat analogous to the captain of a ship or the chief executive officer of a corporation, can the profession deliver quality care at reasonable cost.

There are insightful one-liners scattered throughout the book. Maslow's "If the only tool you have is a hammer, everything you see looks like a nail," should remind all technologists of the myopia engendered by their specialty, whether their "hammer" be a scalpel, cardiac catheter, laser, tranquilizer or E.C.T. Norman Cousins's remark, "There were other tests, some of which seemed to me to be more an assertion of the clinical capability of the hospital than of concern for the well-being of the patient," reminds Fuller that "should" must replace "can" in the aphorism: "Everything has been done for you."

In spite of my general acceptance of the theses of the work, there are three points of critique I would like to make.

1. Fuller believes that to the degree that a conscientious physician is on top of medical data, moral ambiguity is minimal. It is the reviewer's position, however, that ethical ambiguity is proportional to the growth of the armamentarium. The greater the alternatives of intervention, the greater the possibility of ambiguity and iatrogenesis. Like many physicians he faults moralists for not helping on difficult decisions ("Although ethicists are working diligently to develop and teach approaches to the resolution of difficult moral dilemmas, satisfactory methods are not yet available"). In point of fact, ethicists can seldom help on a "hard decision." Perhaps their value is to sensitize physicians to get within, under and above a problem; to teach ethical methodologies and cause medical decision-makers to be more reflective and consistent than to react intuitively or from prejudice. Even when the medical data is clear on such issues as *in vitro* fertilization, care of terminally ill, abortion, amniocentesis, etc., physicians will differ in judgment. They do so not only because the medical "facts" are in dispute, but also because they come from differing values, philosophical commitments, religious loyalties and the like.

2. While an increase in numbers and status of primary physician "conceptualists" may slow down the escalating high cost medical technology, one wonders in the long run how effective they would be. Jacques Ellul observes that when "technique enters into every area of life, it ceases to be external to man and becomes his very substance. It is no longer face to face with man but is integrated within him, and it progressively absorbs him." Moreover, Hans Jonas reminds us that technology is a "restless phenomenon" with a Faustian soul that drives us nonrationally to infinite novelty. New technologies may suggest and even impose new ends, never before conceived, simply by offering their feasibility. Who before our time ever wished to have the Boston Philharmonic Orchestra in his living room, drink coffee in a plastic cup, have artificial insemination, be frozen and revived in the 25th century, or see a clone of himself walking around? Ends first accidentally generated by technological intervention have become necessities of life. Just beyond the medical horizon is the totally artificial implantable heart and the artificial pancreas.

3. While Dr. Fuller feels confident that the professions' "in house" restructuring of medical care will solve our medical problems, I submit that just as education is too important to be left to the teachers, our medical dilemmas are too important to be left to the guild. Financially, our health care system is close to collapse. We need the expertise of economists, political scientists, statisticians and others to bring costs under control before the medical "commons" is gone. We may have to set a maximum of 10% for our G.N.P. for health care and then triage that in terms of cost effectiveness. Fuller does not consider other cost containment strategies — H.M.O.'s, increasing physician competition, regionalization, government regulation, holistic medical centers, mandatory second opinions, etc. — because they are beyond the scope of his thesis.

In spite of these caveats, I believe Fuller's thesis is sound and timely. He is neither shrill nor anti-technology. He wants to stop "doctor shopping" and help people get to the right place and have their questions and health needs sympathetically dealt with. While Fuller does not compare our medical delivery system with other countries, our medical profligacy (like our energy consumption) is a shame. The United Kingdom, for example, with one-third our population, has 60,000 physicians, half of whom are in family medicine (there a non-specialty) while in the United States *only* 30,000 of our 400,000 physicians are family specialists. Minnesota with one of the best family specialty programs in the nation is only barely replacing "conceptualist" physicians who leave practice through death, disability and retirement. A recent study by the Robert Wood Johnson Founda-

tion found many technologically oriented physicians practicing poor family medicine at exorbitant cost. In the case of a young woman going to a gynecologist, the report stated, "most attention was paid to the pelvis, some to the breasts and little to the rest." Put these and other facts together with the confession of a nationally renowned gastroenterologist that he spent only 15% of his time treating patients concerning his subspecialty, and one must admit Fuller is on target.

It is my hope that *Physician or Magician* gets a wide hearing, not only within the lay audience but, more importantly, among medical educators and the profession.

— Walter W. Benjamin, Ph.D.  
Chairman, Department of Religion  
Hamline University

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## ***Making Medical Choices: Who Is Responsible***

Jane J. Stein

*Houghton Mifflin Co., Boston, 1968. xix + 270 pp., \$10.95.*

This clearly written book is a journalistic presentation of many of the problems and issues that are involved in the field of bioethics. There are four parts to this book: birth, life, death, and ethics-keeping. The format of each section is to present the basic issues involved by using cases and stories which have been called to public attention either through newspapers or medical literature. The use of these cases helps to concretize and clarify the many problems, issues, and dilemmas inherent in both discussions and resolutions of bioethical questions.

Those who have been involved in bioethical discussions for any length of time will not find this a useful book. The purpose of the book is neither to provide a framework for analysis nor to give specific ethical analysis of the various cases which are discussed. In fact, the back sheet of the cover emphasizes that Ms. Stein does not answer the question she raises; rather she sketches the context in which these questions must be answered.

On the other hand, for those who are interested in questions of bioethics or who want to receive a good introduction to the questions of the field, this will be an excellent volume. The style is informal, but a great deal of information is presented in a very clear and compelling fashion. The use of cases helps to intensify the life and death issues which are often faced, and Ms. Stein also includes a great deal of background material on various problems. As such, the book presents an excellent overview of basic problems, questions, and discussions which are involved in bioethics. The book includes a set of notes which refers the interested reader to a variety of excellent sources giving further clarification and development to the issues raised in the book.

Ms. Stein presents much complicated material in a very clear and realistic fashion and has done an excellent service for those individuals interested in learning about the different debates being carried on in bioethics. It is an excellent contribution to the field.

— Thomas A. Shannon  
Department of Psychiatry  
University of Massachusetts Medical School