Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a quarterly journal where continuity of comment and redress is difficult to achieve. When the redress appears 3 months after the comment, 6 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

One Family of Generalists

To the Editor: The essays in the recently published Supplement entitled "Medical Education: Time for Change" are eloquent, timely, and contain much food for thought by all of us who are concerned with the future of medical education and with family medicine's role therein. My copy of this special issue will go on the shelf beside the Millis and GPEP reports, *The Task of Medicine*, and some other landmark publications of recent decades.

It was illuminating to read Dr. John Benson's essay advocating the merging of family practice and general internal medicine under the auspices of an "American Board of Physicians," alongside Dr. Edmund Pellegrino's commentary, which documents the remarkably constant failure of the medical education system to sustain rational and needed reforms during the past half century. Some questions came to mind: Would the two primary care disciplines be stronger together than they are separately, or would family practice become co-opted and lost as a consequence of being amalgamated with the numerically superior, academically entrenched specialty of internal medicine? Would the distinctive, politically unencumbered, rational approach our discipline has brought to "uncommonly good care of common problems" persist, or would it be overshadowed by the other specialty's focus on the esoteric?

One "litmus test" worth checking is the setting in which ambulatory care is taught to residents. When internal medicine either adopts our time-tested model family practice center, with its emphasis on comprehensive, continuing care of patients and families, or else creates another model of equal quality, I will find it easier to believe that the best interests of patients needing primary health care services will be best served by a merger of family practice and general internal medicine.

Robert D. Gillette, M.D.
Youngstown, OH

To the Editor: I was dismayed to read the disparaging remarks regarding osteopathic physicians made by Drs. Brucker and Benson in the April-June Supplement of the *JABFP*. Dr. Benson's comments linking osteopathic medicine with "sun-dried tomatoes and fundamentalist religion," and separating osteopaths from physicians as "other professionals," were especially offensive.

I am proud of osteopathic medicine's tradition of training general physicians. I am also proud of my training in family medicine and being a Diplomate of the ABFP. As the allopathic community struggles to develop new models for educating general physicians, there is much that could be learned from our traditions. At least, stop the jokes and name calling.

Gust Stringos, D.O.
Skowhegan, ME

To the Editor: I feel the need to comment on Dr. John A. Benson, Jr.'s presentation at the 20th Anniversary Symposium on Medical Education that was published in the Supplement to Volume III.

I have listened now for several years to various proposals of merger and collaboration between the American Board of Family Practice and the American Board of Internal Medicine, some of which included the American Academy of Pediatrics to create a "generic generalist." Although I am certain that Dr. Benson and the others who share his views are fully aware of the issues, I can't help but believe that they simply don't understand what it is that a family physician does. Perhaps they hope by constantly repeating that "Family doctors and general internists basically do the same thing," this in fact will become true. It is not true at this time.

While both family physicians and general internists include the care of adults in their practices, the two specialties diverge from that point. Philosophically, while internists have sought to become "curious and scholarly," family physicians prefer to take a practical approach to health care. This has branded us as "nonscientific," and as Dr. Benson points out, the amount of original research coming out of family medicine departments is relatively low; however, in terms of cost effectiveness and patient satisfaction, I believe that we are in fact number one.

The rhetoric about family practice being appropriate for "rural and isolated" areas is also only a partial truth. Suburban areas and cities as well as rural areas can and do benefit from the comprehensive care provided by family physicians. While some of us have been "driven" from the operating room and the delivery room, many family physicians continue to provide obstetrical care and other surgical services in nonrural locations.

When general internists express the desire to care for newborns and children, provide gynecologic care, and include orthopedics in their practice, they will have become closer to being "basically like family physicians." If they can shed their scholarly desires they will have come even closer. At that point, they might consider becoming family physicians rather than attempting to create a new specialty.

The suggestion that because family medicine residents receive much of their internal medicine training from internists is supportive for a consolidation of our specialties is silly. We receive surgical training from surgeons and pediatric training from pediatricians, but no one has

suggested our consolidation with either of these specialties. In fact while we receive a large portion of training from a variety of other specialists, the overriding influence in the training of a family medicine resident is from family physicians. Dr. Benson's assertion that we have, "wisely confined training to panels of families in model practices" tells me that he has not visited very many family medicine clinics or health centers. Although some are somewhat sheltered, a large number provide sorely needed health services in areas of need both in rural and urban settings. They treat "all-comers" with all types of complaints and problems. Often, they treat patients that no one else wants.

Family physicians as well as the patients we treat would lose a lot if we were forced to become "basically like internists." The world needs internists just as it needs physicians of all specialties. That does not mean that family physicians should stop providing the breadth of practice we are trained for, including obstetrics, surgery, and pediatrics, simply because general internists have become unhappy with their lot.

Family physicians are continually being challenged when requesting hospital privileges. This is partly because our specialty includes aspects of patient care traditionally considered to be within the turf of other specialties. Although overlap exists between other areas, it seems that only family physicians are singled out for close scrutiny of their competence. Our efforts should be to maintain our own identity as a specialty as well as our scope of practice so that our colleagues will recognize what we are in fact qualified to do. Becoming chameleons will certainly backfire. Let us expend our energy toward eliminating discrimination against family physicians both in hospital credentials and in recognition by government and third-party payors so that we can effectively provide the comprehensive care that is included in the scope of practice of family medicine.

Maury J. Greenberg, M.D.
Stony Brook, NY

The above letters were referred to the author of the article in question, who offers the following reply:

To the Editor: Dr. Gillette's questions beg for answers, which today must be only speculations. I believe that the two practice specialties are coming closer and that it is time for each side to discard stereotypes of the other. Neither attracts enough students to train to serve the best interests of the public. Neither practice is the same as it was 20 years ago; family practice features more internal medicine, and internal medicine more work in the ambulatory care setting, prevention, and care for adolescents. The two Boards formed a constructive and powerful link in setting a single standard for training and certification in Geriatric Medicine. That mutual respect and admiration continue as we embark together on recognizing competence in Sports Medicine. Dr. Gillette, I count the impact of the ABFP as substantial and rational curricular reform, the legacy of a remarkable man. My rubric, the American Board of Physicians, delineates an evolutionary step that may well be politically unworkable. The results of outcomes research will be the next evolutionary step in guiding the training and practice of the general physician.

I apologize for any unintended offense taken by osteopathic physicians. My point was and is that a single standard for a single general physician made sense in California about 25 years ago, a model for the organization of primary care today. That Californians had such foresight belies their reputation for flakiness. Dr. Stringos would be pleased to know that osteopathic physicians trained in allopathic residencies have done quite well in recent years on ABIM's Certifying Examinations in Internal Medicine.

I disagree strongly with Dr. Greenberg that any physician should be regarded as neither curious, scholarly, nor concerned with a practical approach to health care. All professionals apply the scientific method and should be skeptical and prepared to adapt to the new biology. Family physicians get more training in internal medicine than in any other discipline. I do understand the need for a broadly trained general physician. I don't believe either internists or family physicians are trained for or interested in the care of the very sick newborn, but internists today are being trained to provide continuing, comprehensive care in the areas of office gynecology, orthopaedics, dermatology, and behavioral medicine. The philosophies and skills taught to residents in the two specialties are far less divergent than he thinks.

An unlimited breadth of practice skills regularly applied is clearly impossible and not needed in those nonrural areas where a variety of specialists, managed care systems, or teaching hospitals are available. Modern transportation, allied health professionals, preventive medicine, and improved communications reduce the numbers of general physicians needed in rural areas (not the need for them there). I agree with Dr. Greenberg that urban areas and large managed care systems need good general physicians for primary, secondary, and tertiary care, not simply triage and offering reassurance through the course of self-limited illnesses.

The question is not either/or but how to deliver the best physician possible for the most people. I don't believe we have found the answer yet.

John A. Benson, Jr., M.D.
President
American Board of Internal Medicine

Dorsal Penile Nerve Block

To the Editor: It is good that you printed an article[1] on use of local anesthesia for newborn circumcision. I have used it for more than 30 years for both newborn and adult circumcisions. For 100 percent effectiveness, in addition to dorsal nerve block, one must use circumferential infiltration at the base of the penis. For an adult, a 10-cc syringe of 1 percent lidocaine with a 1-inch long, 27-gauge needle is used. Initially, 2 cc is injected subcutaneously on the dorsum near the base, then the needle is turned laterally and advanced subcutaneously around to the ventral side. As the needle is withdrawn, 4 cc is injected. Without coming out of the skin, it is turned to the