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.

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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

opposite side, and the remaining 4 cc distributed around this half of the penile circumference. The skin of the penis is so loose that a single skin puncture with a 1-inch long needle can reach all around. Do not penetrate the fascia, but remain in the very loose subcutaneous layer. One can then grasp the edge of the foreskin with a mosquito clamp to verify anesthesia.

For a newborn, 1 mL of 1 percent lidocaine suffices. After clamping the edge of the foreskin, a blunt probe is used to free its adhesions to the glans. The cup of the Gomco clamp is inserted, then the base of the clamp. The foreskin is pulled through the gap, taking as much mucosa as possible and relatively less skin. Most Gomco clamps do not tighten adequately, but by inserting a scalpel handle under the fulcrum, one can tighten it so that the severed edges are crushed together and do not separate after the clamp is removed. A strip of Vaseline™ gauze then surrounds the severed edge. With adult circumcision, however, it is necessary to suture all around the cut circumference of the foreskin, or it will later separate, retract, and bleed when an erection occurs.

I have found this circumferential nerve block 100 percent effective.

Sam I. Lerman, M.D.
Canton, MI

References

1. Toffler WL, Sinclair AE, White KA. Dorsal penile nerve block during newborn circumcision: underutilization of a proven technique. J Am Board Fam Pract 1990; 3:171-4.

The above letter was referred to the authors of the article in question, who offer the following reply:

To the Editor: Dr. Lerman is clearly "ahead of his time" in reporting his use of local anesthesia with circumcision almost two decades before Kirya and Werthmann first described their technique in 1978.[1] Dr. Lerman's experience calls attention to the need for family physicians to report innovative practice techniques and to avoid keeping their "light under a bushel." His use of this technique in adults is quite appropriate and can avoid the need for spinal or general anesthesia. Dr. Lerman's letter emphasizes the importance of procedural details to enhance the likelihood of achieving effective anesthesia and adds support to our belief that further educational efforts are needed to increase the awareness and appropriate use of a local anesthetic in performing circumcisions in the newborn.[2]

Although a subcutaneous infiltration is one approach to achieving anesthesia of the penis, dorsal penile nerve block achieves the same effect by discretely blocking the dorsal nerves innervating the penis and does not require circumferential infiltration at the base of the penis. A more detailed description of the technique of dorsal penile nerve block is forthcoming.[3]

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Ann Sinclair, M.S.
Keith White, M.D.
Portland, OR

References

1. Kirya C, Werthmann MW Jr. Neonatal circumcision and penile dorsal nerve block – a painless procedure. J Ped 1978; 96:998-1000.
2. Toffler WL, Sinclair AE, White KA. Dorsal penile nerve block during newborn circumcision: underutilization of a proven technique? J Am Board Fam Pract 1990; 3:171-4.
3. Fontaine P, Toffler WL. Dorsal penile nerve block for newborn circumcision. Am Fam Physician (accepted for publication).

Infectious Vaginitis

To the Editor: In his recent review "Diagnosis and Management of Infectious Vaginitis" (J Am Board Fam Pract 1990; 3:195-205), Dr. Quan suggests that "Bacterial Vaginosis" is the most appropriate term for nonspecific vaginitis secondary to bacterial overgrowth. A careful review of the use of the suffix "-osis" would suggest, however, that the most appropriate term for this clinical entity would be "Vaginal Bacteriosis."

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