

Correspondence

Re: Expert Consensus Statement on Proficiency Standards for Dermoscopy Education in Primary Care

To the Editor: The article “Expert Consensus Statement on Proficiency Standards for Dermoscopy Education in Primary Care” (*J Am Board Fam Med* 2023;36:25–38)¹ raises more questions than it answers. Only 14 family physicians who are regular users of dermoscopy for early skin cancer detection were part of this expert consensus panel (representing 0.000014% of ABFM diplomates), yet the authors suggest that the dermatoscope could become part of the physician’s toolbox alongside the ophthalmoscope, otoscope, and stethoscope. As with other instrumental skills such as dilated funduscopic examination and cardiac auscultation—proficiency in which by many accounts is declining among medical students and physicians,^{2–4} maintenance of skill requires frequent application. A better comparison to the acquisition of dermoscopy skills would be to colonoscopy, colonoscopy, and endoscopy, which a subset of family physicians has chosen to make a regular part of their practice.

Despite the expert panel’s implicit goal of increasing the use of dermoscopy by family physicians and the panel’s stated goal for dermoscopy training initiatives—namely, “to decrease patient morbidity and mortality from skin cancer, especially in regions without convenient access to dermatology specialists”—the panel dodges the question of whether teledermatology with a dermatologist (or “teledermoscopy,” to coin a phrase) could better address geographical disparities in early skin cancer detection. Further, the panel inadvertently suggests that the key to early diagnosis of skin cancer with dermoscopy in underserved areas might not be family physicians but rather “advanced practice practitioners,” such as physician assistants and nurse practitioners. This would be analogous to the roles of allied health professionals like emergency medical technicians and nurse anesthetists.

Although dermoscopy was introduced more than 25 years ago, its most promising use has been in the diagnosis of melanoma. Rather than compile a lengthy list of skin conditions (many of which are uncommon) that dermoscopy can help diagnose, the panel would have better served family physicians by providing a list of skin conditions that we should be able recognize by means of a history, physical examination, and inspection with a hand lens and a good light. For that matter, the recommendations by an expert panel of the most useful textbooks and websites would also be helpful.

Would not a greater emphasis in family medicine residency education—and by the ABFM—in better history-taking and mastery of the diagnosis of common dermatologic conditions be preferable to advanced training in dermoscopy?

Addendum: I would be remiss in not expressing disappointment that a paper with 35 authors does not clarify the contribution of each author. It is further puzzling that the lead author is the only non-physician among the group.

And who is to say that, given the rapid advances in artificial intelligence, there will not soon be an electronic scanning dermatoscope that will print out a diagnosis, much as our EKG machines now do, albeit imperfectly?

Although dermoscopy can be an asset in the early detection of melanoma, its addition to the primary care toolbox is far from proven. Family physicians should not be made to feel a fear of losing out for not incorporating dermoscopy into their practice.

Alan Blum, MD

Professor and Endowed Chair in Family Medicine
From the University of Alabama School of Medicine
Tuscaloosa, AL
ablum@ua.edu

To see this article online, please go to: <http://jabfm.org/content/36/4/695.full>.

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Response: Re: Expert Consensus Statement on Proficiency Standards for Dermoscopy Education in Primary Care

To the Editor: We agree with Dr. Blum that mastery level dermoscopy training is most appropriate for family physicians who wish to make dermatology a focus of their clinical practice. We also agree with the American Academy of family physicians, which has published recommendations that *all* Family Medicine residents receive dermoscopy training during residency.¹ Thus, our work² aimed to provide a guide for foundational dermoscopy training. Our panel included 14 family physicians, including both those who focus on dermatology and family physicians who practice the full spectrum of primary care without a skin focus. Although Dr. Blum has concerns that our inclusion of 14 family physicians is insufficient to generate a robust and meaningful consensus statement, we wish to share that we approached numerous physicians and found the 14 family physicians who committed to our project to be highly engaged and willing to rigorously reflect the practice of themselves and their peers.

Our inclusion of advanced practice practitioners (APPs) such as physician assistants and nurse practitioners

was in no way inadvertent, but a reflection of the current diversity of practitioners caring for patients, particularly in underserved areas. If we deliberately exclude APPs in our skin cancer education and prevention efforts, we do not reflect the “real world” care environment.

Dr. Blum suggests that we deliberately dodged the question of whether teledermatology could better reduce geographic disparities in skin cancer detection. We intentionally did not include that topic as teledermatology and asynchronous electronic visits (eVisits or eConsults) are well established in dermatology and many of these programs now include dermoscopy (teledermoscopy)^{3–5}. Furthermore, there are now published guidelines for the use of dermoscopy in telemedicine.⁶

Teledermoscopy not only allows for improved visualization of skin tumors, but also serves as a potential telementoring opportunity for primary care physicians aiming to improve their dermoscopy skills. These virtual platforms allow for the transfer of knowledge to patients and create a collaborative learning environment that benefits patients and physicians. We have both participated in telementoring efforts with family physician colleagues^{7,8} who wish to move beyond a list of common dermatologic diagnoses and add dermoscopy to their clinical practice. As medical educators and melanoma prevention researchers, we appreciate the value in consensus-driven agreement on which dermoscopic diagnoses are most appropriate when teaching foundational skin cancer detection skills with our primary care colleagues.

Lastly, it is not the family physician who will be losing out if the dermatoscope is not in their clinical toolbox—the patient with a concerning skin growth who took time off from work to see his Family Physician is the 1 who misses out on timely care. Dermoscopy is not a tool exclusively used by dermatologists.⁹ Physicians are lifelong learners, and we must evolve and embrace technology—dermoscopy—that aids our physical examination skills, improves skin cancer detection, and reduces unnecessary biopsies.¹⁰

With respect,

Elizabeth V. Seiverling, MD
and Kelly C. Nelson, MD

From the Department of Dermatology, Tufts Medical Center, Boston, MA (EVS); Department of Dermatology, The University of Texas MD Anderson Cancer Center Houston, TX (KCN)
KCNelson1@mdanderson.org

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Programs Can Improve the Diversity Workforce in Family Medicine

To the Editor: We were pleased to read the article entitled “People, Not Programs: Improving Diversity in the Family Medicine Workforce,” by Schiel et al,¹ which describes the factors that influence URiM medical students to choose family medicine residencies.

As women of color in academic Family Medicine, we are inspired by the increase in URiM students choosing Family Medicine as a career. However, we are requesting that the authors cast a wider net to explore and define the specific factors concerning racial concordance within mentoring that could account for these gains over the last few years. Exposure to URiM faculty in assigned clerkships or community preceptorships seemed to be a determining factor for URiM students choosing Family Medicine as a speciality. However, we believe that there are variables aside from identity alone that are not accounted for in the outcomes.

In addition, it is important to identify and investigate factors outside of identity alone that could have accounted for this trend.² Several other studies indicate that factors such as gender concordant professional relationships have been noted to have a positive effect on outcomes.³ It is imperative for the continued growth of Family Medicine that researchers correctly identify and link all associated factors that may be at play. Survey hesitancy and social desirability were listed as potential reasons for limitations to this study. An equally great limitation is the low numbers of minority clerkship directors nationwide, which limits how many URiM directors can respond.

As we focus on increasing the Family Medicine physician workforce, we should also focus on why only 14.8% of medical