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,

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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

school applicants are URiM despite being 34.1% of the population.[4,5] To increase the number of URiM Family Medicine physicians we should support or create pathway programs that support and recruit URiM individuals into medical school.

Keeping in mind that education is not equitable in the United States, longitudinal pathway programs can close the gaps and increase opportunities for URiM students to learn about health care careers.[6] Pathway programs allow schools to target barriers that are otherwise not addressed by the educational system. Having a combination of URiM faculty and pathway programs increases the prospect that we will see an increase in URiM individuals in Family Medicine and have a workforce that reflects the communities we serve.

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Re: Local Economic Inequality and the Primary Care Physician Workforce in North Carolina

To the Editor: We were pleased to read the article entitled "Local Economic Inequality and the Primary Care Physician Workforce in North Carolina" by Nenow et al, which describes the association between county-level economic inequality and the primary care physician (PCP) workforce in North Carolina.[1] We appreciate the relationship between socioeconomic factors and access to primary care. We found it particularly useful to learn that where there was more economic inequality, there were fewer PCPs, specifically family physicians. We suggest a more drastic measure, which is to prepare more underrepresented in medicine (URiM) family physicians to work in areas of greater income inequality.

The article recognizes that the high-income inequality in black, indigenous and people of color (BIPOC) households is a result of the historic racism in North Carolina. This effect is not limited to North Carolina, and it is notable to mention that there are states and territories that have high income inequality, with the top being Puerto Rico, District of Columbia, and New York.

According to the American Medical Association, BIPOC patients who receive care from URiM providers have better outcomes.[2] Although there has been an increase in the number of URiM applicants who are being accepted into medical school, the same increase is not being noted in URiM who practice primary care.[3] Although there are efforts being made to increase primary care physicians with repayment of student loans, the programs would have a greater impact if there were tracks specifically for URiM physicians. The programming should include incentives that attract high quality URiM physicians including guaranteed initial salary, secured employment position for the partner of the URiM physician, reimbursement for primary and secondary education for dependent children, as well as recognition of the difficulties that URiM physicians can have in communities that have a history of historic racism.

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