Regarding "DERM: A Four-Step Dermatology Education Digital Tool Kit for Nondermatologists"

TO THE EDITOR:

Giesey et al identified the challenge of teaching dermatology in family medicine residencies and proposed a solution with a dermatology education tool kit.[1] Our family medicine program is also looking for ways to improve dermatology education, and we plan to implement some of the evaluated toolkit's components. The toolkit, however, is not generalizable, because it includes resources that may not be realistic for some programs to implement.

The DERM toolkit includes four tools for resident education: the LearnDerm lessons and quizzes, the Birdwatching List, VisualDx mobile app, and a core curriculum created by the American Academy of Dermatology (AAD). The LearnDerm lessons and the AAD curriculum are online lessons that are free and easily accessible. However, VisualDx is not universally available for practitioners and has a substantial subscription cost. For other programs to find an alternative tool, the author needs to give a better description of what VisualDx added to the learning experience. Another component of the toolkit, called the Birdwatching List, appears to be a tool in a curriculum created by another group. Giesey et al do not break down the components of the Birdwatching List or explain how it was incorporated. These omissions make it difficult for other programs to use this tool. In addition, the Birdwatching List seems like a labor intensive step for learners, with low promise of practical utility; a small homemade catalog of diagnoses can hardly compete with professionally developed databases and the multitude of dermatology information available in textbooks and online.

The work of Dr Giesey and colleagues addresses a common and important knowledge gap in many family medicine residencies. Our program will definitely be using some of the suggestions and resources as we tackle this same issue in our program. Given that the article does not provide comprehensive details on the components of the toolkit, however, we will not be able to fully implement it. Authors publishing curriculum designs could help other educators by giving more details on how to implement the curriculum, and by suggesting alternative resources for the tools that are not available universally.

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Distinguishing Ethical From Moral Duties in Medical Practice

TO THE EDITOR:

Thank you for having the courage to address the limitations of the commonly accepted approach to modern medical ethics.[1,2] Drs Tunzi and Ventres' recommendation to evaluate a given situation using several analytic methods is compelling. Both articles address the overlap between the ethical, moral, and legal perspectives to a problem, but stop short of defining what distinguishes them. Such a distinction is important because although in an idealized homogenous society the three would be identical,[3] in a society rich in diversity they are often in conflict. Absent a clear distinction, a practitioner runs the risk of providing a moral solution to an ethical problem, or relying on a legal solution that may not be ethical.

Moral obligations may be shared by groups within a community,[4] but are at their core personal and subjective—an internal belief system.[3] Moral violations may have social ramifications, but absent direct overlap with legal and ethical obligations, will not inherently have personal or professional consequences.

Legal obligations come from an external political authority.[3,4] Various stakeholders may or may not agree on a given law or its interpretation, and laws may be in direct conflict with moral obligations. Violations of the legal system may have direct personal and professional consequences regardless of the "rightness" of an action taken.

Ethical obligations also come from an external source, but they are obligations that we voluntarily take, often as a predicate to membership in a particular society.[3] Applied ethics in particular set standards of conduct for individuals and groups.[4] Violations of an ethical system may have direct personal and professional consequences. Unless there is direct overlap with legal obligations, penalties are typically limited to exclusion from a group (which, when that group is "those able to practice medicine" can be a potent consequence).

With these distinctions, we might consider that the duties to which Dr Saultz refers—to balance the interests of patients with societal interests, duties that flow from core concepts—are ethical duties, not moral duties. This is important because while an individual physician may take moral objection to a particular tenet of commonly accepted family medicine practice, they must still adhere to the ethical code of family medicine or face exclusion from that group. This perspective further allows us to maintain Drs Tunzi and Ventres' ethical humility, and recognize that an appropriate ethical code for us may not apply to other cultures.

Thank you again for confronting and developing this important topic.

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Reply to "Distinguishing Ethical From Moral Duties in Medical Practice"

TO THE EDITOR,
We greatly appreciate Dr Lennon's thoughtful comments and careful reading of our paper. We agree that in diverse societies such as ours, people's values and morality, larger issues of professional ethics, and the law of the community are sometimes in conflict. How we address this reality in our work as family physicians is what we conceptualize as family medicine ethics.

In our opinion, ethics always involves action and behavior, in addition to thoughts and beliefs. As we wrote in our paper, family medicine ethics means answering the question: "What, all things considered, should happen in this situation?—at every clinical encounter over the course of the patient-doctor relationship." We believe that applying the steps outlined in our approach—identifying issues and stakeholders, gathering data, and performing analyses from a variety of perspectives—can help determine which of these "all things" are most important in a particular case and lead to the most appropriate actions and behaviors in the complex situations we face in real life.

We again thank Dr Lennon for his letter and encourage him to think and write more on these topics. We encourage others to reflect and respond on family medicine ethics as well.

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Primary Physician or Primary Care Physician?

TO THE EDITOR:
Belatedly reading the September 2018 issue, I was struck by two articles, clearly related and hopefully published in the same issue for that reason. First is the Eugene C. Rich, MD article "The Physician Workforce and Counting What Counts in Primary Care."[1] The second is a narrative essay by William Hoffman.[2]

Dr Rich starts by correctly quoting the Millis Commission report on graduate medical education of 1966 which concluded on pages 36 and 37 that there was need for educating and training a new type of physician which they called a "*primary physician*" not a *primary care physician* (italics mine).[3]

Charles Odegaard, PhD, president of the University of Washington and a scholarly historian, was a member of that Commission. I had the great honor to serve on the faculty of the UW School of Medicine starting in 1970 as the founding chair of the Department of

Family Medicine. Based on Dr Odegaard's experience with the Commission, he took a personal interest in what I was doing. Whenever he was in the Health Sciences Building he would stop in my office to catch up with what was happening. A major concern of his was the developing tendency to use the term primary care physician. He would point out that primary care was one of three labels applied to levels or locations in the organization of medical care (primary, secondary, and tertiary); often meaning ambulatory/outpatient, community hospital, and highly specialized hospital. *Primary physician* instead describes a relationship between patient and physician, which relationship is active at all levels or locations.

The article by Dr Rich correctly attributes to the Millis Commission the name they chose to describe the new type of doctor needed: primary physician. However, in the next paragraph, and throughout the rest of the paper he reverts to the term Dr Odegaard disliked. I have often thought over the years that this confusion is central to many of the conflicts and issues that arise, and so it seems with this article.

In 1980, then President Emeritus Odegaard addressed an audience of family physicians in a continuing education course.[4] I have a copy of that address (never published) in which he discussed these issues at length, including other titles they considered: general practitioner, personal physician, first contact physician, family physician, comprehensive care physician; settling finally on *primary physician.* He also shared a bit of history about what they did next. Believing that the Board of Internal Medicine might be interested in providing certification for this primary physician, they invited influential leaders to a meeting. The conclusion was:

> After extended discussion with them, the Commission members became convinced that there was lacking in internal medicine at that time the necessary interest or zeal to lead toward an alternative for a general internal medicine suitable for the primary physician's role; the drive toward specialization and superspecialism within internal medicine was obviously still very dominant.

The narrative essay by William Hoffman gives substance to the Millis Commission recommendation. Hoffman describes his experience as a medical student on a family medicine rotation in rural Minnesota. The patient described was 88 years old and had multiple strokes. Her family physician doctor had cared for her for 40 years since he first entered practice after residency. Hoffman says "Dr Bob showed me that patients in a well supported rural hospital might have access to something that those in an urban medical center do not." The student was involved with his mentor in hospital care, hospice care at home, and a final home visit as the patient had chosen dying with her family and friends around her. He concludes with: "Embodying the duality of medicine as both a science and an art, Dr Bob employed evidence-based science while never overlooking the therapeutic value of a simple home visit."

I am convinced that Dr Bob was the *primary physician* President Odegaard and the Millis Commission had in mind. He had completed a family medicine residency in 1977, eleven years after the Commission report.

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STFM President, 1978-1979

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