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Editor's choice

As a GP trainee I recently attended the 2014 London GP Trainee Conference. Prominent in the programme were the Excellence Awards. I marvelled at the achievements of some of my colleagues: dazzling research projects, numerous publications, and successful large-scale public health campaigns overseas.

But some of us wondered about the true nature of excellence in general practice. Should we really be celebrating these outstanding successes with Excellence Awards? Is it possible that they may come at the expense of true proficiency at the Royal College curriculum? Perhaps it is the humbler trainees who concentrate on core general practice, who may be more on track to meet the needs of their patients.

As a doctor my CV may never match those of the award winners, but as a patient I know which type of GP I might prefer to see.

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Skin cancer excision performance in Scottish primary and secondary care

I agree with the authors view that a secondary care specialist, supported by a multidisciplinary team within the hospital, will excise skin cancers with a greater degree of skill than the average GP.¹ This seems obvious. What is much less clear, however, is whether this incremental technical quality, achieved at considerable cost, is truly clinically meaningful. This is the key issue to be addressed if the debate reinvigorated by this article is ever to move forward.

The authors raise several valid methodological issues with our own previously published and related work. They are right to do so. Our work is flawed and provides no definitive answers. Unfortunately, however, they have not themselves improved on our approach and their results offer no new insights. Particularly, it appears that pathology reports were audited without blinding as to the source (primary or secondary care). This compounds the flaw of nearly all earlier work except our own 'anomalous' results. The potential for partial auditors to favour their own in this type of analysis is too important a source of bias to ignore. Additionally, the decision to compare 1 month of secondary care data with a year of primary care data is not properly justified and seems idiosyncratic. The shorter period of observation for secondary care in the study may further bias the results in favour of secondary care operators. Furthermore, they have made no allowance for different levels of experience among GP excisers.

These data are unconvincing and I do not believe they take us any further forward. As we have repeatedly stated, a prospective randomised trial is needed. Only then will we have the high quality evidence on which to base future guidelines and the best models of care for patients.

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1. Haw WY, Rakvit P, Fraser SJ, *et al.* Skin cancer excision performance in Scottish Primary and Secondary Care. *Br J Gen Pract* 2014; DOI: 10.3399/bjgp14X680929.

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GPs' skin cancer excisions

I am a GP with a special interest in skin cancer, and have been excising basal cell carcinomas (BCCs) in the community within the Oxfordshire Community Dermatology

Service since 2010. My incomplete excision rate over this 4-year period is 1.7%, as is that of the GP colleague who works with me. Approximately half of the lesions we excise are on the head and neck. There are other GPs with surgical aptitude who would love to work in our service but are unable to undergo the costly (to themselves and their practices) training and accreditation process required by the National Institute of Health and Care Excellence guidelines. How can they demonstrate competence through audit data, when they are not allowed to perform the procedures in the first place? Rather than using this study¹ as evidence to implement a similar guideline in Scotland, I would encourage commissioners there to engage with GPs with surgical aptitude, get them trained to a suitable standard (in conjunction with their local dermatologist and skin cancer multidisciplinary team) and encourage their colleagues without such aptitude to refer the patients with low-risk BCCs to them.

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Authors' response

We value the contribution from our GP colleagues in medical and surgical dermatology, and are keen to support safe, high standard, evidence-based patient care. We accept that further studies on skin cancer excision are needed. If practical experience or adherence to management guidelines correlates with excision results, we will have an evidence base to develop primary care management in Scotland and perhaps stimulate reassessment of National Institute of Health and Care Excellence guidance.

In terms of bias, the pathology reports are factual, and reported by pathologists,