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.

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