

training in clinical reasoning, patient safety, human factors, critical thinking, managing uncertainty, cognitive heuristics and biases, test limitations, probability concepts, reliability science and systems thinking. Training focused on the causes and impact of diagnostic error might help providers become more competent in error prevention. Simulations and feedback can be a helpful way to learn.³

Communication skills teaching is a core subject in undergraduate medical education, whereas teaching future doctors about the need to adopt a patient safety-focused approach to the clinical assessment, diagnosis, and management of patients receives surprisingly little attention. Consultation skills teaching should include not only communication skills but also the principles of practices of safer consulting, including risk assessment in clinical decision making, managing diagnostic uncertainty, and safety-netting skills.^{4,5} An online educational programme that covered diagnostic reasoning and how to reduce the risk of diagnostic errors, along with methods of managing diagnostic uncertainty safely, could be developed by the RCGP/SAPC to support both GP teachers and students on their primary care attachments, and has the potential to deliver safer doctors to the workplace.

Paul P Silverston,

Visiting Professor, University of Suffolk; and
Anglia Ruskin University, Cambridge.
Email: paul.silverston@btinternet.com

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Spiritual care is stagnating in general practice

The embedded model suggested is currently functioning in several UK practices and being rolled out into local clusters.¹ These practices have a chaplain fully integrated within their multidisciplinary teams providing spiritual care in line with the biopsychosocial-spiritual model² and modern-maladies approach.³

Research has shown that such chaplaincy provision improves spiritual wellbeing to a similar extent as antidepressants while reducing GP consultation rates.^{4,5} These results justify the place of chaplaincy within our MDTs at this time of workload realignment.

Chaplaincy has also been shown to be responsive to multimorbidity and undifferentiated illness, both of which are core presentations that the expert medical generalist encounters.⁵ Such generalists are ideally placed to refer on to the specialist chaplain within the MDT.

Snowden has developed a patient-reported outcome measure (PROM) to both facilitate spiritual conversations and measure the impact of spiritual interventions.⁶

It is agreed that there is an ongoing need for training but the above evidence suggests the tide is turning on spiritual care and assessing its impact in general practice in the UK.

Gordon W Macdonald,

GP, Regent Gardens Medical Practice,
Kirkintilloch.
Email: gordon.macdonald@nhs.net

Competing interests

Gordon W Macdonald is lead for chaplaincy provision in Regent Gardens Medical Practice.

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The resilient general practice: working as a pack

How true these conclusions are,¹ informed also by Eley *et al*'s study.² The desire to work in a 'supportive team' is a major factor in career choice of younger GPs.³ To provide this in a busy practice requires the recognition that clinicians' informal time together is essential, not a luxury item.

Personal continuity of care has been shown to improve patient outcomes,⁴ and in building mutually trusting relationships between doctor and patient is likely also to offer greater professional satisfaction. (Think cine films versus albums of random snapshots!)

I am minded to ask if the job of a modern commuting, sessional GP, under constant pressure to deal with 'snapshots', and harassed by QOF screen reminders, is as professionally rewarding as it might be.

Only in-practice leadership can create a supportive team, and facilitate personal continuity of care (where appropriate) through a carefully constructed appointment system, difficult though both may be.

Personal and practice resilience are inextricably entwined, requiring shared values, mutual support, and professional satisfaction. Returning either individuals or organisations from the wrong side of the stress-performance curve is extremely difficult: too often GPs on the wrong side of the curve leave their practice ... or the profession.

Vernon H Needham,

Retired GP.
Email: vernonneedham@nhs.net

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Simple techniques for managing dental avulsion in the GP setting

I read the article investigating why patients might consult GPs for dental problems with great interest.¹ I recently organised a teaching session for A&E registrars covering several topics in oral and maxillofacial surgery. A particularly well-received topic was our simple technique for splinting a tooth that

has been avulsed (knocked out of its socket). I believe this would be useful knowledge to share with the *BJGP* readership.

Dental avulsion is a true dental emergency. If such a case presents to a GP, it would be ideal if the tooth is replanted before they are redirected to a dentist. Prompt repositioning and splinting optimises the tooth's prognosis.²

The socket and tooth should be gently irrigated with saline, only handling the tooth by the crown (white part). A temporary splint should then be placed in order to immobilise the tooth while the patient seeks dental treatment.

A popular splinting technique involves the application of tissue glue around the tooth.³ Even simpler methods include adapting Blu-Tack or aluminium foil to the dental arch. Readers interested in learning more about these techniques are directed to a succinct and well-illustrated article by Beech *et al*.⁴

Contraindications to replantation are few, but include: replantation of baby teeth (for example, patients under the age of 6 years) and patients who are immunocompromised or at risk of infective endocarditis (due to the risk of bacteraemia). Finally, the tetanus

status of the child should be checked and managed accordingly.

Hans K Antov,

DCT2 in Oral and Maxillofacial Surgery, Pinderfields Hospital, Wakefield.
Email: hansantov@yahoo.co.uk

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