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.

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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 model[2] 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.

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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.

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