distinction between religious practice and spiritual belief, about which Speck has written at length.[3] What my survey revealed, is that too many doctors seem to fail to make any such distinction. My purpose in writing of 'some people who claim to be not religious', was to point out that those patients who do not obviously practise religion may still have spiritual or religious needs which need to be met. These are the people whom King and Speck refer to as possessing spiritual belief while not necessarily involving themselves in religious practice. They are also the people who may not be receiving care, because too many doctors are unaware of their real need and therefore to whom they might best be referred.

What makes this situation of concern is the recognition that the proportion of the population with religious or spiritual problems is probably a large one (although it must be acknowledged that many would not articulate their problems in this way)[4,5] and that research in the USA has revealed that patients often go to a doctor with trivial symptoms when really looking for reassurance, guidance, or even confession.[6] The question then arises as to the doctor's ability to respond to these religious problems. Shriver has pointed out that many doctors are 'making life and death decisions from the religious stance of a 14 year old', that being the age at which formal religious education ceases for most people, whereas education in other areas, particularly science, continues through at least another decade.[7] This is disconcerting given the priestly role which many patients are evidently according their doctor these days.[8]

My hope is that the debate over meeting spiritual needs will achieve a higher profile in both the education of medical practitioners and the provision of medical care. While this fails to be the case, it will be to the detriment of good patient care.

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Psychiatrists in primary care

Sir,

In their interesting paper on psychiatrists in primary care (September *Journal,* p.369) Brown and Tower describe patterns of existing links between psychiatrists and general practitioners in primary care settings. We would like to report a particular form of linkage which we have found to be of value over the last 15 years. Once a month the partners as a group meet over lunch with a consultant psychiatrist to discuss the nature and management of patients who are giving rise to concern. Some patients are the difficult, demanding and dependent patients we all know so well, but others are of clinical interest, or have raised particular questions of management for the practice.

The focus of discussion is as much on the interaction between the general practitioner and patients, or between the general practitioner and the specialist to whom the patient has been referred, as on the presenting pathology. The value of this regular linkage is not just the development of a relationship between the consultant psychiatrist and individual partners and trainees, but between the psychiatrist and the partnership as a whole, and between all the partners. The discussions have allowed the emergence of a group consensus both on what is possible and what is desirable within the practice. Trust has grown up over the years, and partners are able to speak openly of their anxieties, doubts, and uncertainty over how best to respond to these patients.

Although the discussion often focuses on patients with manifest psychiatric, or at least psychological/emotional content in their presentation, the reason for discussion of a particular patient is as often the internal conflict or difficulty the patient causes the general practitioner, as the nature of the presenting pathology. As a result, the benefits of this linkage have extended beyond the management of a set group of patients, to all troubled and troubling patients who call on the general practitioners for help.

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Fatal methaemoglobinaemia in a dental nurse

Sir,

I read this case report (November *Journal,* p.470) with sadness. As Dr Gowans points out, nitrites are substances of abuse that can result in severe poisoning and death. They are also standard antidotes for cyanide poisoning and are, therefore, commonly found in university and commercial chemistry departments. Since 1 October 1989 it has been required by law that before any process involving a hazardous material is undertaken an employer must assess the process with the aim of reducing the risk to employees. Part of the assessment is the correct storage of materials and how to clear up spillages. In addition, the employer must provide information, instruction and training to staff about hazardous materials. These regulations are known as the control of substances hazardous to health (COSHH) regulations and they specifically mention that all substances marked with the skull and crossbones and other hazard labels should be assessed. Every dental surgery in the country using sodium nitrite tablets should be aware of their toxicity and should be able to show the factory inspectorate that they have informed and trained their staff appropriately. Likewise all general practitioners should have looked at their activities in a similar way.

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Hazards of chlorine to asthmatic patients

Sir,

The discussion of the aetiology and management of asthma is a regular feature in the *Journal.* Contrary to the prevalent assumption that swimming is beneficial, a review of my asthmatic patients who swim suggests that in certain individuals, exposure to the irritant fumes of chlorine in the swimming pool contributes to their bronchospasm. This association would be logical in view of the recent developments elucidating the inflammatory pathology of asthma and wartime experience of the toxic effects of chlorine on airway endothelium. Regarding the continuity of the respiratory tract, how many of our chronic wheezy, catarrhal and deaf patients could be exacerbating their condition with a weekly swim in increasingly undiluted bleach?

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