faith and join me as a fellow God-less person, where will the guidance come from?

It appears that the inequality of power in the doctor–patient relationship has been forgotten in the heat of this debate. God help me and my fellow confused brethren. It looks like we have been hit for six at this boundary.

Declaration of interest

S.P.S is a member of the Royal College of Psychiatrists' Special Committee for Professional Practice and Ethics and a past member of the College's Ethics Committee.

1 Poole R/Cook CCH. Praying with a patient constitutes a breach of professional boundaries in psychiatric practice (debate). *Br J Psychiatry* 2011; **199**: 94–8.

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doi: 10.1192/bjp.199.6.516a

The debate between Professors Poole and Cook[1] appears to ignore the fact that spirituality, transcendency and individual religious beliefs expressed in prayer are historically and culturally bound to the social institution of organised religion: the first estate. Neither author acknowledges how the sociology of religion and its place in our society affects whether prayer should be shared between doctor and patient. The Christian religion has been firmly bound to the functioning of organised Western society for well over a thousand years. Consideration of the spiritual needs of patients has been part of holistic care models for decades and is present in the delivery of individualised care plans in most mental health services. However, prayer in day-to-day life does not have an individual identity that is divorced from structured religion. There is a potent social boundary here and it should not be crossed, for sociocultural reasons as well as individual professional ethics.

Poole focuses on the individual boundaries that are appropriate in the doctor–patient relationship, but we have social boundaries based on our religious history that have resulted in our modern social institutions having a broad secular base. When in the UK in 2011, religious assassination of police officers occurs within 'the single-faith Christian tradition', when football managers receive bullets in the post because of their particular Christian tradition, when the UK still has regions where religion is more about the fire in the belly and less about the angst between the ears, less 'happy clappy' and more 'happy slappy', it seems a little naive of Cook to view prayer as a therapeutic tool that can exclude the history of Christianity in this country and the challenges this may pose.

Cook's arguments emphasise the individual's connection to the Divine through prayer and the potential benefits this may bring. Historically, this is the argument of the 'dissenter', the evangelical Protestant tradition which is a rich faith that can deliver spiritual fulfilment, as can all the branches of the Christian church that exist in the UK today. But again historically, prayer is not just about an individual's spiritual needs and fulfilment. For St Augustine and St Patrick and onwards, it is also a tool of the missionary for conversion. The form of words used, the rituals and the rites of prayer have an uncomfortable history of conflict and even the unstructured prayer within a nonconformist 'free church' comes with a history of struggle.

Within my own psychiatric service, I am happy to say that we can allow everyone the freedom to pray and express their religion as they wish, a right that has emerged from the religious history of the British Isles. I am fortunate in having a specialised team of professionals with decades of training and expertise in meeting and fulfilling the spirituality of our service users. I turn to their wisdom and guidance often when prayer and religious needs present with mental health problems. We call them the hospital chaplains. I don't pray with the patients. They don't give depot injections. It works.

1 Poole R/Cook CCH. Praying with a patient constitutes a breach of professional boundaries in psychiatric practice (debate). *Br J Psychiatry* 2011; **199**: 94–8.

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doi: 10.1192/bjp.199.6.517

Author's reply: I am grateful to Dr Davies for highlighting the importance of faith and belief in psychiatry. Atheism, materialism and biological determinism are as much belief systems as are religions. Because of a mismatch between systems of belief, it will often be inappropriate for clinicians to pray with patients. But what about prayer in contexts where faith and belief are shared? In faith-based organisations, in faith communities and in other contexts where doctor and patient are brought together knowing that they share the same belief system, 'praying with a patient' takes on a different connotation. The psychiatrist who prays with a patient in such contexts should still be able to justify their reasons for thinking that this would be helpful, and their reasons for expecting that it would do no harm, but I do not see why it should automatically be excluded.

Pace Dr Haley, I do not view prayer as a therapeutic tool that 'can exclude the history of Christianity in this country and the challenges this may pose'. In some parts of the UK, sectarianism is such that differences between some 'Christian' groups are greater than those between people from completely different faith traditions. Naive attempts to pray across these divides, in the clinical context, are ill advised. Haley describes my view of prayer as a means of 'the individual's connection to the Divine'. I limited prayer to being defined as 'conversation with God' only because this appeared to be the understanding of prayer that was causing concern. This approach to prayer is not associated preferentially with the Protestant or dissenting tradition, and is encountered in the writings of Catholic saints such as Ignatius Loyola and Teresa of Avila. The writings of Ignatius and Teresa, among others, now unite many Christians from different spiritual traditions (e.g. Catholic and Protestant).

The idea that spiritual and pharmacological treatments are analogous, and that they should be dealt with in completely separate departments, may have some attraction to Dr Haley. However, I am frequently approached by service users who find this kind of fragmentation of their care to be unhelpful and unacceptable. We do not accept separation of the psychological from other aspects of well-being. Similarly, I do not see why prayer should be excluded.

A position statement on spirituality and religion in psychiatry has recently been published by the College.[1] Although this statement does not explicitly address Dr Sarkar's concerns about praying with patients, it provides guidance that should be very helpful in avoiding breaches of professional boundaries in clinical practice. I think that the situations in which praying with a patient represents as serious a breach of professional boundaries as preaching to a patient will usually be because they are just that – preaching (albeit under the pretext of prayer). I find this just