polypharmacy, broadly anticipating the concerns of Lepping & Harborne. Finally, we respectfully suggest that the word polypharmacy be reconsidered, since pharmacy is seldom the originator of the plan!

1 Lepping P, Harbone GC. Polypharmacy: how bad are we really? *Psychiatrist* 2010; **34**: 208–9.

2 Tungaraza TE, Gupta S, Jones J, Poole R, Slegg G. Polypharmacy and high-dose antipsychotic regimes in the community. *Psychiatrist* 2010; **34**: 44–6.

3 National Institute for Health and Clinical Excellence. *Schizophrenia: Core Interventions in the Treatment and Management of Schizophrenia in Primary and Secondary Care (Update) (CG82).* NICE, 2009.

4 Taylor D. Antipsychotic polypharmacy – confusion reigns. *Psychiatrist* 2010; **34**: 41–3.

Chandan Sehgal, Staff Grade Psychiatrist, South West Yorkshire Partnership NHS Foundation Trust, email: chandan.sehgal@swyt.nhs.uk, **Paul A. Hardy**, Pharmacy Services Manager, Fieldhead Hospital, Wakefield.

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Wide of the mark

It would seem that the basis for Christopher Cook's objection to our paper is our perspective on Charles Taylor's theory of the rise of secularity in the modern world.[1] In doing so, he provides a skewed analysis of what we were actually saying. Taylor's work was helpful to us in considering psychiatry's attitude to religion. However, our main aim was to suggest that despite our deeply materialist age a sense of transcendent meaning was of great value to human beings and had never been lost. In this at least Cook seems to agree with us.

We were invited by the Editor to write a response to Harold Koenig's interesting suggestion that psychiatrists might pray with their patients.[2] In doing so, we took the stance that a focus on the practice of praying with patients was distracting attention from the far greater issue of spirituality and meaning in people's lives. Cook appears to think we are against a thoughtful consideration of religion in psychiatry when that was never the case. He has missed our irony completely. One particular peer reviewer of our article had strikingly similar attitudes and forced our commentary through three revisions before they could accept it. The whole unhappy experience has made us worried about the increasing defensiveness of some religious psychiatrists in the College who appear to want to control discourse about psychiatry and religion. This should concern us all.

1 Cook CCH. Spirituality, secularity and religion in psychiatric practice. Commentary on . . . Spirituality and religion in psychiatric practice. *Psychiatrist* 2010; **34**: 193–5.

2 Koenig HG. Religion and mental health: what should psychiatrists do? *Psychiatr Bull* 2008; **32**: 201–3.

Michael King, Professor of Psychiatry, University College London, email: m.king@medsch.ucl.ac.uk, **Gerard Leavey**, Professor in Mental Health and Wellbeing, Northern Ireland Association for Mental Health, and University of Ulster, Belfast.

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Debating common ground and recognising differences

It is good to discover that Michael King, Gerard Leavey and I share more common ground than I had at first perceived based on my reading of their article.[1] Perhaps a part of the problem was that I only saw the abstract after publication and that what I had interpreted as ambivalence towards spirituality in the main body of the article is now set in the context of the clear and positive statement regarding spirituality that the abstract provides.

However, it seems that we do have a different reading of Charles Taylor's *A Secular Age*,[2] and also probably hold different views of exactly what spirituality is. To explore these differences in academic debate seems to me to be a healthy thing, and this is why I was pleased to accept an invitation from the Editor to write a commentary on King & Leavey's article. I would never wish to 'control discourse about psychiatry and religion' but I am glad to participate in a lively and critical debate about a subject that psychiatry has too long ignored and at times even denied.

1 King M, Leavey G. Spirituality and religion in psychiatric practice: why all the fuss? *Psychiatrist* 2010; **34**: 190–3.

2 Taylor C. *A Secular Age*. Harvard University Press (Belknap), 2007.

Christopher C. H. Cook, Professorial Research Fellow, Durham University, email: c.c.h.cook@durham.ac.uk

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Spirituality, secularism and religion

The controversial claim of French philosopher André Comte-Sponville that spirituality is quite compatible with atheism could provide vital insights to continued discussion on the relevance of religion to psychiatry which began in *The Psychiatrist* with the article by Dein *et al*.[1,2]

Handling debates about the existence or otherwise of God can be difficult, unless one is a trained philosopher. Comte-Sponville summarises it best when he tells us that at the age of 18 he wrote: 'If God exists then nothing follows; if God does not exist then nothing follows.' However, a few years later he wrote: 'If God exists everything follows; if God does not exist then everything follows.'

Religious systems depending on God as their pivotal point are in essence only relying on what human beings regard as the relevance of the Divine in human life. Those who have abandoned a belief in God also create what they think are the principles of life without God. They are all human creations.

Today we are surrounded by a variety of religions and ideologies and each of us as individuals makes our own evaluation of life and develops the values by which we live.

Many seem unwilling to take a serious part in any further discussion on the subject and seek only to abide by the law, live on good terms with others and follow the mores of the workplace. Many, like me, see the world as best understood in humanist terms. This means that we start and finish with ourselves. However, this does not prevent us from reaching out to others and beyond to the principles on which life is built.

There was an older humanism that seemed determined to negate all religion and to attempt to rebuild the world on a new atheistic agenda, but there can also be a humanism that seeks to understand the beliefs that are part of human evolution, both individually and collectively, and to reapply them to current needs.

The new great interest in the spirituality of patients is to be welcomed but there is a risk that it will become just another part of service provision without fully regarding its complexity.

Nevertheless, to see conviction – and it does not necessarily need to be religious conviction – as part and parcel of someone's life is important. It can form a crucial part of how they evaluate themselves and their world and it is hard to see how one can support them without taking it into account.

Thus a person's personal conviction system is part of their personal history and identity. When George Kelly[3] developed the personal construct theory he demonstrated that everyone has a personal template by which they evaluate life. If we seek to understand and respect this, we discover that we will need also to look at our own understanding because we in turn evaluate others on the basis of our own templates.

Historically, people seem to have regarded psychological processes as coming from the world outside themselves. Mental illness could be 'the work of devils' and even sexual feelings were sometimes perceived as some form of karma that entered people. Today, we have reached the opposite extreme and see that ethics, politics, law and finally religion were not delivered to us by some external agency but were created by ourselves.

With this in mind we can explore the spiritual pilgrimage of our patients with them without imposing on them preconceptions of our own. It is an interesting journey because everyone's pilgrimage is different, and without knowing their story you will not understand where they are in the present, nor what will be the next step in their future.

Those who study religious and ideological traditions will find nuggets of great wisdom in all of them and this understanding is enhanced the more one knows the cultural and historical background in which they originated. We are all on a learning curve but I hope that it will not be long before there are consultants who have a vivid knowledge of religion and ideology from a psychological perspective and who will enhance our ability to understand the individual patients in our care more completely.

The more one tries to understand the depths of other people, the more one deepens one's own understanding and this may help alleviate that hidden isolation, loneliness and even despair that comes from never being properly listened to, or at any rate to find someone who at least tries to understand.

1 Comte-Sponville A. *The Little Book of Atheist Spirituality* (transl N Huston). Penguin, 2007.

2 Dein S, Cook CCH, Powell A, Eagger S. Religion, spirituality and mental health. *Psychiatrist* 2010; **34**: 63–4.

3 Kelly GA. *The Psychology of Personal Constructs*. Norton, 1955.

John Edmondson, Consultant in Child and Adolescent Psychiatry, Lincolnshire, email: john.edmondson5@btopenworld.com

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When to use DoLS? A further complication

Shah & Heginbotham[1] describe a number of issues relating to the Deprivation of Liberty Safeguards (DoLS) of the Mental Capacity Act. A recent court case[2] appears to complicate matters further. The defendant was a 55-year-old lady with 'a significant impairment in intellectual functioning as a consequence of a learning disability' who developed an endometrial adenocarcinoma. She required major surgery if her life was to be saved. It was agreed that she lacked the capacity to make decisions about her healthcare and treatment.

She also suffered from hospital and needle phobias. Attempts to explain the need for surgery to her had failed and on occasions she refused to attend hospital for treatment (even when she had initially agreed).

The judge agreed the defendant could be sedated to ensure that she attended hospital for the operation and did not 'leave it prematurely after the operation had taken place'. She would 'be given analgesic medication which would have a sedative effect on her, thereby rendering it unlikely that she would be able to abscond. However, it might be necessary to use force as a last resort to ensure that she returned to her hospital bed'.

The judge then said 'In my judgment . . . it will be necessary to detain [the defendant] in hospital during the period of post-operative recovery. After mature consideration, the Official Solicitor, on [the defendant's] behalf, came to the view that it was not necessary to invoke the Deprivation of Liberty Provisions under Schedule 1 of the Act. I agree with that analysis. If it is in [the defendant's] interests (as it plainly is) to have the operation, it is plainly in her interests to recover appropriately from it'.

Given that it was planned, if necessary, to use sedation and/or force to prevent this patient leaving hospital, she was clearly to be deprived of her liberty. The court determined that because the patient lacked capacity and it was in her best interest (two necessary criteria for the use of DoLS), the DoLS were unnecessary.

Other articles in *The Psychiatrist*[1,2,4] discuss the problems surrounding the definition of deprivation of liberty and the interface between the DoLS provisions of the Mental Capacity Act and the Mental Health Act. It now seems there is a further difficulty in determining whether the DoLS provisions are needed even if there is clear deprivation of liberty.

1 Shah A, Heginbotham C. Newly introduced deprivation of liberty safeguards: anomalies and concerns. *Psychiatrist* 2010; **34**: 243–5.

2 *DH NHS Foundation Trust v. PS (by her litigation friend the Official Solicitor)* [2010] All ER (D) 275 (May).

3 Selmes T, Robinson J, Mills E, Branton T, Barlow J. Prevalence of deprivation of liberty: a survey of in-patient services. *Psychiatrist* 2010; **34**: 221–5.

4 Cairns R, Richardson G, Hotopf M. Deprivation of liberty: Mental Capacity Act safeguards versus the Mental Health Act. *Psychiatrist* 2010; **34**: 246–7.

Tony S. Zigmond, Psychiatrist, Royal College of Psychiatrists' lead on mental health legislation, Leeds, email: azigmond@doctors.org.uk

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Doctors are not adhering to General Medical Council prescribing guidelines

In light of recent media coverage of the General Medical Council (GMC) suspension of Adam Osborne,[1] we became interested in the issue of doctors prescribing to non-patients: friends, family and self. The GMC recommends that doctors do not self-prescribe or prescribe to family and friends, except in an emergency.[2]

We audited prescribing practices among doctors working in London to determine whether GMC guidelines are being followed. We composed a 13-question online questionnaire