Koenig's proposals. These were that a spiritual history should be taken from all patients, even where the patient is resistant to this; that patients' healthy spiritual or religious beliefs should be supported and unhealthy beliefs should be challenged; and that under some circumstances it is appropriate to pray with patients. Although we fully accept that it is sometimes appropriate to explore spiritual or religious issues with patients, we remain seriously concerned that these more controversial practices breach fundamental professional boundaries. Furthermore, the College appears to be lending tacit support for them.[4]

Although our letter[3] has been referenced in a number of publications by members of the SPSIG Executive Committee (e.g. their recent book),[5] our concerns over boundary violations remain unanswered. Indeed, Larry Culliford[6] has rather exacerbated our concerns by suggesting that boundary breaches might a good thing; that this might have spiritual benefits for clinicians; and that boundaries are in any case illusory.

The General Medical Council position on these matters is clear. Their supplementary guidance on personal beliefs[7] states:

> You should not normally discuss your personal beliefs with patients unless those beliefs are directly relevant to the patient's care. You must not impose your beliefs on patients, or cause distress by the inappropriate or insensitive expression of religious, political or other beliefs or views. Equally, you must not put pressure on patients to discuss or justify their beliefs (or the absence of them).

In our opinion, it is obvious that Koenig's contentious recommendations are not compatible with this guidance. Although Dein *et al*[1] acknowledge the risk of boundary breaches, and advocate extreme caution in praying with patients, they do not reject the practice. Indeed, it is implicitly left to the individual clinician to decide whether to pray or not. We can think of no example of a permissible practice in one-to-one clinical interviewing that is acknowledged to be hazardous to patients to this extent. We cannot understand why SPSIG does not simply state that prayer with patients in clinical settings is unacceptable. We feel that it would be helpful if they explained.

Declaration of interest

The authors have a range of personal convictions, including atheist, Buddhist, Methodist, Roman Catholic and non-denominational faith.

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

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

3 Poole R, Higgo R, Strong G, Kennedy G, Ruben S, Barnes R, et al. Religion, psychiatry and professional boundaries. *Psychiatr Bull* 2008; **32**: 356–7.

4 Hollins S. Understanding religious beliefs is our business. Invited commentary on . . . Religion and mental health. *Psychiatr Bull* 2008; **32**: 204.

5 Cook C, Powell A, Sims A (eds). *Spirituality and Psychiatry*. RCPsych Publications, 2009.

6 Culliford L. Psychiatrists and the role of religion in mental health. *Psychiatr Bull* 2008; **32**: 395–6. doi: 10.1192/pb.32.10.395c

7 General Medical Council. *Personal Beliefs and Medical Practice – Guidance for Doctors*. GMC, 2008.

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Correction

Controlled comparison of two crisis resolution and home treatment teams. *Psychiatrist* 2010; **34**: 50–4. The title of this paper should read: A controlled comparison of the introduction of a crisis resolution and home treatment team.

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