inaccurate; OP92 includes an implicit critique of the entire system and the clinical environments it creates, as can be seen in the passages I have quoted.

It is disappointing that Cox & Gray declare no conflict of interest in their editorial. Four years ago, in a letter to this journal,[3] they supported a call by Robert Higgo and myself[4] for the College to establish a working party on psychiatry and religion. Their declaration of interest in that letter was as follows: 'John Cox is a Christian from the Methodist Tradition. Alison Gray was recently ordained Deacon in the Church of England', and their affiliation was stated as 'Centre for Faith Science and Values in Healthcare, University of Gloucestershire'.

Cox & Gray's religious faith may well help them to adhere to their own moral standards. They have every right to understand things that go wrong in the world in terms of morality and religious faith. These are personal matters. The suggestion that the Royal College of Psychiatrists should take such a position is wholly inappropriate and wrong. The College has important institutional roles concerning ethics and proper professional behaviour, which are part of its overall *raison d'être*: to maintain and improve standards of care for patients. These roles would be utterly compromised by dabbling in morality and religion. If the College were to take a position on individual morality informed by religious thinking, we would enter a morass of schism and conflict. This would do nothing to protect patients.

Three years ago, concern was raised that the ostensibly anodyne College position paper *Recommendations for Psychiatrists on Spirituality and Religion* would be taken as permission to breach professional boundaries with respect to religion.[5] The vast majority of psychiatrists successfully avoid inappropriate interdigitation of faith, belief and professional practice. It will not be just the atheists who will find Cox & Gray's editorial worrying.

**Declaration of interest:** I am an atheist.

1 Royal College of Psychiatrists. *Driving Quality Implementation in the Context of the Francis Report* (OP92). Royal College of Psychiatrists, 2013.

2 Cox J, Gray A. The College reply to Francis misses the big question: a commentary on OP92. *Psychiatr Bull* 2014; **38**:152–3.

3 Cox J, Gray A. Proposed College working party on psychiatry and religion. *Psychiatrist* 2011; **35**: 118.

4 Poole R, Higgo R. Psychiatry, religion and spirituality: a way forward. *Psychiatrist* 2010; **34**: 452–3.

5 Poole R. Praying with patients: belief, faith and boundary conditions. Author's reply. *Br J Psychiatry* 2011; **199**: 518.

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**Authors' reply:** We welcome the opportunity to reply to Professor Poole's stimulating and challenging commentary on our editorial which, even if misunderstood, has clearly succeeded in alerting the readership to the pressing managerial and moral challenges for the NHS in the aftermath of the Francis report.

The College, in its 6-month update of its report, has a further chance to unravel the complex contributing circumstances in Mid Staffordshire, and to consider not confining its recommendations to mental health services alone. The failure to put patients first and the neglect of basic quality of care standards could be replicated elsewhere.[1] The task is not confined to applied scientists, but involves values as well as the personal ethics of members. Therefore, in appearing to belittle the contribution of moral philosophers, comparative religion experts and even patient groups to the consideration of the roots of compassion and to the conceptual underpinning of patient-centred care, Prof. Poole is out of kilter with much local and international work in this field.[2]

We would wish also to counter his suspicion that the source of our dissatisfaction with OP92 was linked to a secret Christian plot to impose our religious values on others of a different faith or none. That was far from our intent – as a detailed, unblinkered reading of the editorial would confirm. Moreover, our earlier disclosures of interest were as cited, but have been repeated without first checking neither their current accuracy, nor the precise context in which those declarations were appropriate. For the interest of readers, J.C. remains a lay member of a Methodist Church in Cheltenham, A.G. is now an associate priest in the Church of England, and the Centre for the study of Faith, Science and Values at the University of Gloucestershire closed last year.

Rex Haigh, on the other hand, is correct to have identified our implicit awareness that the values of the therapeutic community, the understandings of the need for healthy environments respectful of the person – and the grasp of group processes – have each conditioned our search for solutions to the current NHS impasse. The excellent work undertaken by the College's Centre for Quality Improvement (CCQI) was referred to in our editorial and in the College response. It is much to be hoped that the CCQI will increasingly be more integrated with the other College structures, so that its impact on routine medical work in acute hospital care (such as intensive care, a gastrointestinal cancer service or a primary care community unit) can be facilitated. The lack of uptake of the CCQI's projects in the NHS (other than the Quality Network for Perinatal Mental Health Services, which is conspicuously successful)[3] is, in the context of the Francis recommendations, a cause for much concern and may be symptomatic of the current malaise.

We thank both correspondents for prolonging this timely and important debate. We conclude by declaring an interest in the hope that the College, in tandem with other national organisations, will seek for a majority opinion about the nature of these key structural issues in the NHS – including the fitness for purpose of the competitive business model – and also facilitate a greater understanding of the conceptual (biological, philosophical, ethical, humanistic and religious) underpinning of the nature of health, the process of healing and the primacy of the person.

**Declaration of interest:** A.G. is a Non-Stipendiary Associate Priest in the Church of England.

1 Dewhurst NG, Jones MC, Wilson JA. Time to refocus the NHS on quality and dignity of patient care: RCPE response to Mid Staffordshire. *J R Coll Physicians Edinb* 2013; **43**; 3–6.

2 Miles A, Mezzich JK. Person-centered medicine: advancing methods, promoting implementation. *Int J Pers Centered Med* 2011; **3**: 423–5.

3 Solomon S, Thomson P. *The Quality Network for Perinatal Mental health Services*. College Centre for Quality Improvement, 2010.

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