undertaking tasks which can be performed just as competently by other professionals whose training is shorter and less costly. The content of psychiatric training ought to be assessed with this in mind. We need to determine what other aspects of psychiatric practice can be carried out by non-medical professionals and which tasks require a medical degree. The results would almost certainly lead to a diminished role for psychiatrists but the specialty might be healthier and more viable as a result.

If the nurse's responsibilities are to expand, some lessons can be learned from the United States where the career role of nurse clinician is well established. One area which is of particular significance for psychiatry concerns the detection and management of emotional complications in the physically ill, a facet of what has come to be known as liaison psychiatry.

The liaison nurse clinician undertakes special training, leading to a master's degree, after a basic nursing course and the scope of nursing in this field has recently been described (Bilodeau and O'Connor, 1978; Beraducci *et al*, 1979). Such an expansion of the nurse's sphere of influence offers the prospect of improved psychological care for the physically ill. Indeed, if the psychological needs of patients in general hospital wards are to be met it might be more realistic to establish a career structure for liaison nurse clinicians rather than to expect an increase in the numbers of psychiatrists available for liaison work. However, if this is done the particular contributions of nurses and psychiatrists will have to be defined, within certain limits, so that unnecessary overlap is avoided.

This is another area where the specially-trained nurse could extend the traditional boundaries of nursing responsibility. The establishment of a career structure for the liaison nurse should be given serious consideration by nursing and medical authorities in the United Kingdom.

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DEAR SIR,

Professor Marks and his colleagues are to be congratulated upon their most recent paper (*Journal*, October 1979, **135**, 321–9) on nurse therapists in psychiatry, and also upon the careful planning and evaluation evident in this project. They make a number of important points. It may seem churlish then to express irritation at their implicit but persistent suggestion that the nurse's clinical role is extendable only in the direction of behaviour therapy. I have written elsewhere of this matter and of my different experience at the Ross Day Hospital (Morrice, 1974, etc.). Here let me make but two points.

(1) To insist, as the authors do, that the expanded role and greater autonomy of the nurse are 'new' and 'unusual' is to deny the practice over many years of well-known therapeutic communities like Henderson Hospital, the Cassel, Dingleton, and Fort Logan. In such settings the multidisciplinary team has demonstrated its basic purpose in enabling paramedical staff to broaden their clinical roles and responsibilities in an atmosphere which seeks to encourage new learning for all. So it happens that the performance of the nurse in therapy with groups, couples, and families is seen to match that of more prestigious professionals.

(2) Fostering a nursing elite, trained and confined to behaviour therapy (with all its undoubted advantages), may lead to neglect of the urgent need for many more nurses to be trained, led, and supervised in a broad psychodynamic treatment approach. My belief is that, if even a small percentage of nurses, in and out of hospital, were to make more conscious and skilful use of the opportunities presented in their day-by-day relationships with patients, a transformation would occur in many situations that are still too often bleak, inactive, and merely custodial.

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THE VALIDITY OF NATIONAL SUICIDE RATES

DEAR SIR,

Douglas (1967) argued that official suicide rates were inaccurate since different coroners and medical examiners have different criteria for categorising deaths. In support of this, Brooke (1974) presented