1. A Filipino waiter of 38, with three children from a previous marriage to support in his own country, had married an English girl ten years his junior a year before, when he was comparatively fit. Secondarily to hyperuricaemia, he developed progressive, irreversible renal failure, began vomiting and losing weight, and was admitted for the formation of a fistula and to start regular haemodialysis. This implied curtailment of his earning capacity, and he had become impotent: his wife's expectations of a comfortable home and children were unlikely to be realised. He began to improve physically when dialysis was started, his plasma urea going down from 25 to 15 mmol per litre, and he was put on the waiting list for transplant. There was a possibility that his sister would donate a kidney. The patient was friendly, somewhat ingratiating, and apart from some initial insomnia, had no complaints. One morning after his third dialysis he refused to eat his breakfast, and lay with his eyes closed, speaking without moving his lips. He said he would die that night, and to inform his wife. He then stopped all communication, lay mute, motionless, flaccid and unresponsive to painful or other stimulae, neither eating, drinking, nor taking medication. He was catheterised once but passed no urine spontaneously for thirty-six hours. Breathing was almost imperceptible. At this stage, a psychiatric opinion was requested.

Neurological examination, haematological profile and blood chemistry gave no lead, but his pulse rate was 100, increasing to 120 when his wife was mentioned. Without evidence of an organic cause, and no earlier depressive symptomatology, a provisional diagnosis of hysterical stupor was made, and amylobarbitone given through his nasogastric tube. He was incontinent of a large quantity of urine, asked if he was in heaven, and then fell asleep. When he woke up he appeared to be his former cheerful self, eating, speaking and moving normally, and with a memory 'like a dream' for the period of inaccessibility. He continued well, put on weight and went home smiling. There had been no further news from his sister when he returned a month later with a mild infection at the shunt site, and a dramatic tremor in his leg. The latter could be abolished by reassurance, and he was put on a small dose of diazepam. He demanded attention for his tremor, but remained smiling, and persistently denied any other problem. He killed himself by cutting his shunt.

2. An Irishman of 39, working as a clerk, had chronic renal failure due to glomerulonephritis, and the time had come when haemodialysis was necessary. He had two depressive episodes, treated as an outpatient, ten and five years previously, and had decided against the responsibility of marriage because of his nerves. He lived alone but hoped to move in with his brother's family. One day he was unexpectedly irritable with the nursing staff and during his brother's visit became akinetic and mute. Physically he was improving. After 48 hours with no change, he was given intravenous amylobarbitone, and began to talk, move and eat. He claimed to remember nothing of the last two days and did not recognize his brother. After a night's sleep with a hypnotic, his memory returned completely, and he could recall much of what had been said when he was stuporose. He became again a popular joker in the ward, appeared to accept that he could not live with his brother, and progressed well. On the morning he was due for discharge, he had a cardiac arrest and died.

Both men had recently started haemodialysis, a situation of helpless dependency frequently associated with depression, anxiety and suicidal ideation, especially in those over 35 (Kaplan De-Nour, 1979). Possibly their chronically raised blood urea made them more vulnerable to a hysterical reaction of this type. The lesson to be learned from the first case in particular is not to underestimate a patient's capacity for prolonged dissociation from feelings of despair. Symptomatic recovery may be a snare, and hysterical stupor a rehearsal for death.

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THE NURSE'S CLINICAL ROLE

DEAR SIR,

The development of a nurse therapist training scheme described by Dr Bird, Professor Marks and Mr Lindley (*Journal*, October 1979, **135**, 321–9) has a significance extending far beyond behavioural psychotherapy and clinical psychiatry and it is important that it receives the widest possible debate. Professor Marks' impressive pioneering work clearly supports an expansion of the clinical role of the nurse and, by implication, forces other professions to define their particular area of competence more clearly. The two groups most affected by the advent of the nurse therapist in behavioural psychotherapy are obviously clinical psychologists and psychiatrists. Some of the implications for psychologists are mentioned in the paper and no doubt will be discussed by members of that profession. As for psychiatrists, a reappraisal of our sphere of special skills is long overdue; it is a misuse of training if psychiatrists are

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