The threat of 'small' subspecialties being assimilated by the generalist type of liaison services is a reality. However, the question remains – is this the best way forward? Mental health trusts have already benefited from a number of diversifications of services.[6] The rapidly changing demographics in the UK population – with the older population doubling by 2050 from 10 to 19 millions[7] and the expected 80% increase in people with moderate or severe dementia in the following 15 years[8] – argues for urgent diversification of the health services to meet older people's health requirements, including their mental health. In this respect, it would be counterproductive to rely on liaison services catering for a single commodity. The steady growth of LSOA demand provides further support that this is the area for diversification of not only the psychology medicine portfolio, but also mental health services in general.

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We have read with interest the editorial by Sharpe.[1] Recognition of liaison psychiatry as valuable to patients, general hospitals and commissioners has been a long time coming.

We agree that the crisis of identity in psychiatry may have indeed resulted from the many decades of isolation from the rest of medicine. As such, there may be a temptation to redefine psychiatry based on the path of least resistance which is one left by the 'compassion' vacuum highlighted by the Francis inquiries.[2] Psychiatry does indeed 'retain strengths in humane social and psychological care',[1] although it has much to learn from the involvement of patients in the design of care[3,4] and often struggles with the interface between physical and mental healthcare itself.

There is indeed a need to 'enhance the patient's experience of medical care' and for medicine to move away from purely 'disease-focused medical care'.[1] However, we differ on the opinion that liaison psychiatry or psychological medicine 'aims to put these skills back into medical care'.[1] We may be at risk of medicalising the distress that is prevalent in healthcare settings.[5] Healthcare professionals have a duty to improve the experience of people they care for and to respond to their distress in a humane and compassionate manner.[6,7] From our experience of delivering training and support in general hospital settings, there are many barriers to liaison psychiatry being able to achieve this kind of change, not least the sheer scale of the task. This may actually be a strength of the current trend of psychiatric superspecialisation occurring in general hospital settings – more psychiatrists advocating and modelling change.

In the article, an excellent point is made that the current approaches to commissioning liaison psychiatry may be less than ideal.[1] It is unlikely that teaching from another specialty, let alone another organisation, will address these issues to a satisfactory extent or in a timely manner. We could avoid the temptation of calling for more training. Instead, perhaps each specialty and organisation could take seriously the responsibility of creating the right culture and putting patients first.

Indeed, it may be that lessons can be learned from psychiatry, but we have many lessons to learn ourselves. The key to medicine rediscovering its humanity may be more likely to lie in re-engaging with its patients and carers than looking to another medical specialty.

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Given my interest in liaison psychiatry, I could feel the passion in Sharpe's[1] piece, which he has extended to include the proposed future of psychiatry as a discipline. However, even though he has mentioned patient safety in passing, I would like to urge a wider debate on the fact repeatedly highlighted by several publications of the National Confidential Enquiry into Suicide and Homicide by People with Mental illness. In its last publication, it again highlighted that 72% of those who die by suicide (between 2001 and 2011), had no contact with mental health services in the year before their death. Given the massive variation in funding of mental health services across the country and some viewing it as a Cinderella service, I feel mental health providers and advocates have failed to grasp the nettle in terms of attempting to reach out to that group of individuals who 'successfully' take their own life. We are aware that a majority of those individuals could be diagnosed within F43.0 (Reaction to severe stress, and adjustment disorders) of the ICD-10.[3] Yet we fail to invest in services and concentrate efforts on a narrow remit to severe mental illness. With the 2007 amended Mental Health Act 1983 in England and Wales, we have successfully replaced the erstwhile four categories with a single category of mental disorder. Along with it, we have replaced 'treatability' and 'care' tests with appropriate treatment tests. Yet we do not seem to adequately invest and respond to the above-mentioned category, costing

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