columns

patients with psychotic illnesses developed stuttering while being treated with clozapine. The Government's Medicines and Healthcare Products Regulatory Agency (MHRA) is responsible for ensuring that medicines are acceptably safe. It takes action in relation to safety concerns and changes in the balances of risks and benefits. There is no mention by Lyall *et al* of informing the MHRA about the stuttering side-effect. I would like to urge readers of *Psychiatric Bulletin* to report to the MHRA any side-effects, suspected or otherwise, caused by a medicine through the Yellow Card Scheme. This scheme plays an essential role in protecting public health by helping the MHRA to monitor the safety of medicines on the market. Psychiatrists and other healthcare professionals can complete a form online at www.yellowcard.gov.uk, or on a Yellow Card available in the *British National Formulary*, or directly from the MHRA (by telephoning 0800 731 6789). I would also urge readers to encourage patients to report any side-effects. With these reports, we can actively look for signs of potential safety issues requiring further investigation.

Reporting of adverse drug reactions is the professional duty of all healthcare professionals. The continued success of the Yellow Card Scheme depends on the continued support of health professionals and patients in completing Yellow Cards. We encourage Yellow Card reports from patients, but it is also vitally important that we continue to receive reports from psychiatrists and other health professionals.

June Raine Director of Vigilance and Risk Management of Medicines, Medicines and Healthcare Products Regulatory Agency (MHRA), London SW8 5NQ, email: press.office@mhra.gsi.gov.uk

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Work-related stress in psychiatry

I read with admiration Dr Harrison's report on work-related stress (*Psychiatric Bulletin*, October 2006, **30**, 385–387) but I felt a sense of disappointment that we as psychiatrists and the wider medical profession continue to deny our health needs and general fallibility, and that our employers exhibit similar impotence.

Our training focuses our energies on succeeding both academically and later clinically. We are a competitive breed, entering our working life with high personal expectations of our performance on a day-to-day basis. The effect of daily consultation with morbidity and mortality on ourselves has to be addressed somehow. Denial becomes a handy defence mechanism.

As a profession we are more likely to develop alcohol misuse and dependence problems, as well as having a higher suicide rate. Yet how often do the precursors to these go unchecked or unnoticed. Taking time off sick is often accompanied by guilt and a sense of failure. We seem to believe that it shouldn't happen to us.

Currently, our junior doctors are in a heightened state of performance anxiety as Modernising Medical Careers goes live. The usual anxieties related to finding a job are magnified considerably by the number of jobs being applied for. How are we and our employers protecting this vital part of the work force from the inevitable stress-related symptoms that are likely to ensue? When will we start to be honest with ourselves about our susceptibility to illness and look to prevent and manage it? When will our employers?

Amy M. Macaskill Specialist Registrar in General Adult Psychiatry, Royal Cornhill Hospital, 26 Cornhill Road, Aberdeen AB25 2ZH, email: amy.macaskill@nhs.net

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How safe are interview rooms?

Campbell & Fung (*Psychiatric Bulletin*, January 2007, **31**, 10–13) highlighted some important deficiencies in safety of patient interview rooms. We conducted a similar audit of 119 interview rooms in southern Hampshire in 2004, which was a repeat of an earlier study by local trainees in 2000. We were therefore able to look at whether interview room safety had improved and whether newly commissioned facilities had been provided in accordance with the Department of Health's advice regarding the safety of interview rooms (Department of Health, 2004).

Our results were largely similar to Campbell & Fung's but in southern Hampshire 75% of in-patient rooms were not isolated (*v.* 23%), 75% had a functioning panic alarm system (*v.* 0) and 52% had doors that opened outwards (*v.* 6%). Of particular concern was that rooms used in accident and emergency departments to assess acutely disturbed and unknown patients were isolated, had no viewing window, no panic button and were cluttered.

It was reassuring to note that those rooms which had been commissioned in the past 3–4 years demonstrated a higher level of adherence to the standards: 92% had an unimpeded exit, 100% had a functioning alarm and 77% had an internal inspection window. However, 67% remained isolated and 61% were cluttered.

DEPARTMENT OF HEALTH (2004) *Mental Health Policy Implementation Guide – Developing Positive Practice to Support the Safe and Therapeutic Management of Aggression and Violence in Mental Health In-Patient Settings*. Department of Health.

Natasha Rae Specialist Registrar in Forensic Psychiatry, Wessex Forensic Rotation, Ravenswood House Medium Secure Unit, Knowle, Fareham PO17 2NP, email: natasha.rae@hantspt-sw.nhs.uk, **Abigail Hewitt** Specialist Registrar in Adult Psychiatry, St Anne's Hospital, Poole

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BMA guidance on problem gambling

The British Medical Association (BMA) has recently published a document on problem gambling in the UK prior to the Gambling Act 2005 coming fully into force in September. The document focuses on various aspects of problem gambling and particularly emphasises the potential impact on young people (British Medical Association, 2007). Also emphasised is the need for the National Health Service to provide help for those with this problem. Two important areas that the document does not emphasise however, are the impact on the elderly and their carers.

The UK has an ageing population, with 16% of the population currently aged over 65. This is forecast to increase, with the elderly making up 19% of the population by 2021 (projected data from Office of Health Economics, 2002). The elderly can be at risk of problem gambling and are more likely to fall prey to the psychosocial consequences. It is therefore surprising that the BMA document did not make specific mention of this particularly vulnerable group of people.

The government has emphasised the importance of caring for carers (Department of Health, 1999). Carers of those with problem gambling could also suffer psychosocial distress and they require recognition and support. In the UK, where more and more elderly couples have only each other for support, this is particularly important. Again it is surprising that the BMA did not mention this in its recommendations.

BRITISH MEDICAL ASSOCIATION (2007) *Gambling Addiction and its Treatment within the NHS: A Guide for Healthcare Professionals*. BMA.

DEPARTMENT OF HEALTH (1999) *Caring about Carers: A National Strategy for Carers*. Department of Health.

Ishaan Gosai Specialist Registrar, Assertive Outreach Service, Plymouth, email: ishaang@hotmail.co.uk

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Modified 'mooting' should be part of psychiatric training

Naeem *et al* (*Psychiatric Bulletin*, January 2007, **31**, 29–32) describe the incorporation of simulated mental health review tribunal workshops in psychiatric