words, a very real cause for concern. The same may, however, also apply to their experience in day-to-day psychiatric practice. With so called functionalisation, clinical teams and their members may be dealing with an increasingly narrow range, if any at all, of patients, most of whom might have the same diagnosis. This is not to deny the need and requirement for individual care pathways and treatment plans, but it may severely limit learning opportunities. Of no less concern, and possibly even more so as it may eventually effect early interest in and recruitment to our specialty, is the influence that these changes in service organisation have had on undergraduate medical students' experience of psychiatry.

The development of functional teams, the separation of in-patient care from community care, and the increasing specialisation within psychiatry mean that the clinical experience offered in undergraduate placements may not be providing either the depth or breadth of experience required to assure that students see common conditions, follow through the course of a single episode from inception to recovery, and understand the range of abnormal phenomena in psychiatry and the treatment options that are available. Most medical schools offer 6 weeks of placement in psychiatry within the 5-year course. This exposure is likely to be the only formal training in psychiatry for most doctors training in the UK.

The problems in specialist training highlighted by Waddell & Crawford extend beyond mere reduction in the number and frequency of assessments, to experience of presentation and management of anxiety-related disorders, obsessive–compulsive disorder and eating disorders, and will soon include assessment of memory disorders, most of which have been ceded to nurses or psychologists. These trends and changes will ultimately affect the clinical skills of future psychiatrists and recruitment to psychiatry from among UK medical graduates.

1 Waddell, Crawford C. Junior doctors are performing fewer emergency assessments – a cause for concern. *Psychiatrist* 2010; **34**: 268–70.

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Readability – writing letters to patients in plain English

One in six people in the UK struggle with literacy.[1] The Leitch Review found that more than five million adults lack functional literacy, the level needed to get by in life and at work.[2] This is particularly important as approximately 70% of adults with a self-reported mental health problem are either functionally illiterate or marginally literate. Furthermore, adults with mental illness who are literate read three to five grade levels below that expected by their level of education.[3]

The involvement of patients, carers and the public in health decision-making is at the heart of the modernisation of the National Health Service (NHS). Hence, in the good practice guideline, *Copying Letters to Patients*,[4] the Department of Health stressed the importance of using 'plain English' when sending copies of letters between healthcare professionals to patients.

We conducted an audit to assess whether clinicians were sending copies of letters to patients written in plain English. The secondary outcome was to see the differences between letters from doctors and nurses.

We used the Simple Measure of Gobbledygook (SMOG) to check for use of plain English. This measure of 'readability' estimates the years of education needed to completely understand a piece of writing. It is the outcome of research commissioned by the National Institute of Adult Continuing Education.

The data were collected retrospectively in April–May 2010 from letters sent by clinicians working in older people mental health services, 2gether NHS Foundation Trust.

We found that only 59% of letters in the sample were copied to patients. The average SMOG readability index was 17.2, with little difference between doctors and nurses. The sentence length varied, with a few examples of sentences with more than 40 words. Also, passive sentences and noun and adjectives in large clusters were frequently used.

The SMOG value of 14 corresponds to GCSE levels A–C, and to Adult Literacy Standard level 2. The SMOG values for editorials of the commonly read tabloids *The Sun* and *The Daily Express* are less than 14 and 16 respectively.[5]

It was painful to note that not a single letter in the audit sample had a SMOG value of 14 or less. This may mean that many of our patients may not be able to understand our letters.

We suggest that all letters sent by clinicians should be copied to patients unless there is a valid reason documented in notes not to do so. We should ponder on the layout and presentation of the letter, avoid long sentences, passive sense, and polysyllabic words.

1 Department for Education and Skills. *Skills for Life: The National Strategy for Improving Adult Literacy and Numeracy Skills*. Department for Education and Skills, 2003.

2 Leitch S. *Leitch Review of Skills: Prosperity for All in the Global Economy – World Class Skills*: 61. HMSO, 2006.

3 Christensen RC, Grace GD. The prevalence of low literacy in an indigent psychiatric population. *Psychiatr Serv* 1999; **50**: 262–3.

4 Department of Health. *Copying Letters to Patients: Good Practice Guidelines*. Department of Health, 2003.

5 National Institute of Adult Continuing Education. *Readability: How to Produce Clear Written Materials for a Range of Readers*. NIACE, 2009.

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CORRECTION

When to use DoLS? A further complication. *The Psychiatrist* 2010; **34**: 356. The 55-year-old lady described was the appellant and not the defendant. The publishers apologise for their error, and for any embarrassment caused to Dr Zigmond.

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