A number of papers have looked into the readability of information made available on websites[2,3] and in patient information leaflets.[4,5] According to the literature, a Flesch–Kincaid 6th Grade (equivalent to UK reading age of 11–12 years) is the maximum recommended level for public health information,[1] and would be consistent with the average UK reading age quoted as being between 9 and 11 years.[4]

There are, of course, a variety of different readability tests that could be used to examine the readability level of the College information leaflets, including Flesch–Kincaid and Flesch Reading Ease and Simple Measure of Gobbledygook formulae.[2] Whether or not a correlation exists between readability age and the leaflet scores, I would suggest it is pertinent to clarify whether all the College leaflets are written at a readability level consistent with that recommended for public health information.

1 Briscoe M, Briscoe S, Timms P, Ramsay R. Usefulness of reader feedback on the Royal College of Psychiatrists' public information leaflets. *Psychiatrist* 2011; **35**: 175–8.

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3 Fitzsimmons PR, Michael BD, Hulley JL, Scott GO. A readability assessment of online Parkinson's disease information. *J R Coll Physicians Edinb* 2010; **40**: 292–6.

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5 Pothier L, Day R, Harris C, Pothier DD. Readability statistics of patient information leaflets in Speech and Language Therapy Department. *Int J Lang Comm Dis* 2008; **43**: 712–22.

Declaration of interest

M.B. was educational supervisor during L.M.H.'s attachment to the Public Education Editorial Board.

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Surprising discrepancy between high prevalence of suicidality and low BSI scores

I would like to congratulate Meerten *et al*[1] on their excellent paper about MedNet, a service for doctors experiencing psychological problems; and, furthermore, for setting up and running the service in the first instance.

The authors cite that doctors are a vulnerable group with high rates of psychological disorders. This is in keeping with previous work myself and colleagues conducted on junior doctors using the 12-item General Health Questionnaire, albeit at a time when they were undergoing a period of extreme stress (the MTAS fiasco).[2,3] We found that 79% of the sample scored above the cut-off point for psychological distress and 21% for severe distress (i.e. caseness for treatment).[3]

What perplexed me about the paper, however, were the high rates of suicidality in the MedNet sample (nearly half) but the relatively low scores on the Brief Psychiatric Interview. I am not sure that this discrepancy is explained sufficiently in the discussion or, indeed, why the suicidality persisted post-treatment despite the other range of outcome measures used indicating improvement.

I would like to hear more from the authors about their views about this phenomenon.

1 Meerten M, Bland J, Gross SR, Garelick AI. Doctors' experience of a bespoke physician consultation service: cross-sectional investigation. *Psychiatrist* 2011; **35**: 206–12.

2 Whelan P, Jarrett P, Meerten M, Forster K, Bhugra D. MTAS fiasco: lessons for psychiatry. *Psychiatr Bull* 2007; **31**: 425–7.

3 Whelan P, Meerten M, Rao R, Jarrett P, Muthukumaraswamy A, Bughra D. Stress, lies and red tape: the views, success rates and stress levels of the MTAS cohort. *J R Soc Med* 2008; **101**: 313–8.

Declaration of interest

P.W. and M.M. know each other well.

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Psychiatry training and career conundrums – a working mother's perspective

This letter stems from an experience of the numerous problems and choices that a working mother, and a psychiatric trainee, has to face and ones that I hope that many other working mums in psychiatry training will be able to empathise and identify with. Hopefully, it will provide some food for thought and determination to continue a career with a greater conviction.

Having chosen psychiatry as one of my specialty interests as a foundation doctor, I decided to continue my further training in psychiatry, fascinated by the subject, with the work–life balance it offers and the non-resident on-calls at many places as the added attraction. Being a trainee in core psychiatry training seemed to be the right job and the right pace of work I was looking for. But that is when our little one came into our lives and things changed.

Taking time off for maternity leave and coming back to part-time working as a less-than-full-time trainee prolonged the period of training. Specialty training lasts a good number of years and thus extended led me to think about the 'quarter-life crisis'[1] that many trainees in similar circumstances might face. Full-time training helps to achieve training goals earlier but part-time training allows for a more balanced life and more free time for family and children.[2,3] Trainees move in and out of jobs and are committed to training and flexible working.

Indeed, career goals need to be matched to individual circumstances. Many a time I struggled with swapping rotas and arranging for picking up and looking after our child. This made me think time and again whether I should just change my specialty to another interesting basic science or para-clinical subject that will help me avoid the rota headache. There is also the issue of career progression and being an