

The Senior Psychiatrist Survey I: age and psychiatric practice

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Objective: The aim of this study is to determine the effects of age on the practice, roles, status and attitudes of psychiatrists within the Royal Australian and New Zealand College of Psychiatrists (RANZCP).

Method: A postal survey of Fellows of the RANZCP resident in Australia or New Zealand was conducted. The main outcome measures were: age; location and type of psychiatric practice; hours of work; attitudes towards re-accreditation; changes in work practices over the career; and the perceived benefits and drawbacks of age to psychiatric practice and case selection.

Results: Of 1086 eligible subjects, 629 participated. The mean age of the sample was 52.7 years (SD = 13.5). Those psychiatrists favouring re-accreditation were younger. Psychiatrists practising psychotherapy, forensic psychiatry or general psychiatry; working in psychiatric hospitals and private practice were more likely to be older. Older psychiatrists worked shorter hours. There was largely no association between case selection and age. Psychiatrists reporting increased credibility and respect as a benefit of their current age upon their psychiatric practice were older, as were those identifying fatigue and an inability to keep up to date as a drawback of age. Psychiatrists reporting a lack of credibility and respect were younger, as were those who reported increased enthusiasm and optimism.

Conclusions: Age is associated with benefits and drawbacks to the practice of psychiatry and this may be reflected in the different practice profiles of older and younger psychiatrists.

Key words: age, attitudes, clinical practice, psychiatrist.

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Seniority in psychiatry is akin to sagehood and connotes a mixture of experience, expertise, wisdom and age. A senior psychiatrist need not be an elder, and most older psychiatrists are not regarded as sages

[1]. Little is known about the influence of age and experience on psychiatric practice. The Senior Psychiatrist Survey was undertaken to explore these issues. In Part I (this paper), we shall examine the effects of age on psychiatric practice; in Part II [2] the effects of experience; and in Part III [3] the influence of attitudes towards personal ageing.

Along with the general population, the psychiatric profession is ageing, with approximately one-quarter of Royal Australian and New Zealand College of Psychiatrists (RANZCP) members currently aged 55 years and over, while over 38% of the membership of the American Psychiatric Association (APA) is aged 55 years and over [4]. It has been suggested that professional development for a person in their

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mid-50s to mid-60s may include decisions regarding continued career growth or plateauing and retirement planning. These may be influenced by personal health concerns, adjustments to changing roles in marital and professional life, and the ability to come to terms with life choices [5]. Practice settings of psychiatrists vary with age; older psychiatrists in the APA spend more time in solo office practice and younger psychiatrists in clinics and outpatients facilities [6].

The effects of ageing upon psychiatric practice have not been well studied. In one investigation, older psychiatrists in psychotherapeutic practice reported fewer transference and countertransference difficulties than earlier in their careers and found that fewer patients were seen. Their primary professional concern was to maintain their practice [7]. A survey of 29 psychiatrists who had been in practice 20 years or more (mean age = 55 years) found that 83% agreed that their age and psychiatric experience helped them to empathise with older patients, and 68% agreed that the ageing psychiatrist's practice style may be affected by approaching retirement [8].

Some older psychiatrists have commented on the effects of age on their practice. These include: requirements which demand more time and energy [1]; the reluctance of colleagues to refer patients to a very old therapist [9]; the effects of fatigue and illness on clinical practice [10]; becoming more opinionated with age [11]; and the particular challenges of being an older female psychiatrist [12].

In an earlier publication from this study, we described the work practices and retirement plans of psychiatrists aged 55 years and over [13]. We found that 61% were making retirement plans and about half had reduced their work hours in the previous 5 years. Fatigue (27%) and memory impairment (10%) were reported as age-related changes that were adversely affecting their work capacity. However, the attitudes of psychiatrists of all ages about the professional roles of older psychiatrists are unknown and the extent to which work practices vary with age is also unclear. Such information may assist the College in identifying the needs of its members, may influence the style and content of continuing medical education and may assist in workforce planning.

The aim of this paper is to determine the effects of age on the practice, roles, status and attitudes of psychiatrists within the RANZCP. We hypothesised that the structure and content of clinical psychiatric practice changes with the age of the psychiatrist.

Method

A survey of Fellows of the RANZCP was undertaken after approval by the RANZCP Board of Research and the University of New South Wales Ethics Committee. The sample, resident in Australia or New Zealand, included all Fellows aged 40 years and under; every second Fellow by alphabetical listing aged 41–54 years; and all Fellows aged 55 years and over. This resulted in approximately equal numbers in the sampling frame in each of the three age groups.

To maintain confidentiality, only broad demographic data about the sample (sex, RANZCP branch membership and the number of Fellows who were classified by the RANZCP as being 'retired' or 'active') were supplied to the investigators. The 'retired' list included three groups of Fellows: those aged 65 years and over who had been Fellows for 30 years or more; those who had notified the RANZCP that they had retired from practice (defined as working two sessions per week or less); and Honorary Fellows. The surveys were mailed by the RANZCP in August 1995 with a reminder letter being sent a month later.

Subjects were instructed to complete as many items as they wished. The survey questionnaire contained items pertaining to: age; sex; ethnicity; professional qualifications; length, location and types of clinical practice; hours of work; and re-accreditation.

To examine the shifts in psychiatric practice that may occur over the course of a career, the Fellows were asked the following questions, each of which requested that additional details be provided in open-ended responses: have you noticed any changes in the attitudes of colleagues or patients towards you as you have grown older; what, if any, changes have you noted in the type of cases referred to you as you have become older?

Fellows in 'active' practice were asked to comment on the benefits and drawbacks of their current age to their clinical practice and the types of cases they would be confident about seeing or would be reluctant to take on. In addition, further comments were encouraged from all respondents.

The data were analysed using the SPSS statistical package (SPSS Inc., Chicago, IL, USA). Categorical variables were analysed using Chi-squared analysis (with Yates' continuity correction for all 2×2 analyses) and continuous variables by independent sample Student's *t*-tests, using separate- and pooled-variance tests as appropriate. In analysing the data, age was

treated as a continuous variable when examining for age effects.

Open-ended responses were categorised into broad groupings post hoc by consensus between two of the investigators (SW and BD). Analyses of broad groupings of open-ended responses were only performed when a minimum of 4% of eligible subjects had made such a response. Non-response, 'don't know' and 'can't distinguish age and experience' responses were excluded from analyses, thus the sample size varies from question to question. All analyses were two-tailed, and alpha was set at 0.05 except where multiple comparisons necessitated adjustment using the Bonferroni correction.

Results

Of the 1086 RANZCP psychiatrists who were surveyed, responses were received from 629 (57.9%). One subject was excluded due to receiving an 'active' survey while actually being retired. Of the 628 remaining, 460 were males (73.2%), while 571 respondents (90.9%) were still working in psychiatric practice, of whom 20 were on the nominal 'retired' list.

Ages ranged from 31 to 87 years (mean age = 52.7 years, SD = 13.5). Five hundred and twenty-eight (84.3%; N = 626) were married or in de facto relationships, 46 (7.3%) separated or divorced, 31 (5.0%) single and 21 (3.3%) widowed. Ninety-five (15.2%; N = 621) were from a non-English-speaking background. The respondents were from the following RANZCP branches: New South Wales, 194 (31.2%; N = 620); Victoria, 153 (24.7%); Queensland, 83 (13.4%); South Australia, 69 (11.1%); New Zealand, 54 (8.7%); West Australia, 46 (7.4%); Tasmania, 13 (2.1%) and the Australian Capital Territory, 9 (1.5%). Respondents and non-respondents did not significantly differ in terms of RANZCP branch, or the proportion on the 'active' or 'retired' lists. However, there was a significantly higher response from female psychiatrists ($\chi^2 = 8.83$, $df = 1$, $p < 0.05$) and older psychiatrists (60% of those 55 years and over, 62% of 41–54-year-olds and 50.3% of those < 41 years; $\chi^2 = 10.67$, $df = 2$, $p < 0.01$).

When asked whether the RANZCP should be involved in the re-accreditation of psychiatrists, 474 (76.9%; N = 616) responded 'Yes', 52 (8.4%) responded 'No', and 90 (14.6%) responded 'Don't know', those psychiatrists favouring re-accreditation being younger ($p < 0.001$). This did not vary with RANZCP branch, field of practice or location of practice.

Information about current work practices was only obtained from the 551 respondents who were on the 'active' RANZCP list. The principal field of psychiatric practice significantly varied with age as displayed in Table 1.

The 'active' list psychiatrists' principal work locations were private practice (n = 304; 55.8%, N = 545), followed by general hospitals (n = 99, 18.2%), psychiatric hospitals (n = 58, 10.6%), community health centres (n = 40, 7.3%), universities (n = 31, 5.7%) and other settings (n = 13, 2.4%). This varied significantly with age, those psychiatrists who worked in 'other', often administrative, locations (mean age = 53.1 years), psychiatric hospitals (51.8 years) and private practice (51.3 years) were older, while psychiatrists who worked in general hospitals (44.1 years) and community health centres (48.3 years) were younger ($p < 0.001$).

On average, the 'active' list psychiatrists were working 45.0 h per week (range = 3–94 h, N = 543) including 4 h per week at home. Younger psychiatrists worked significantly longer hours ($p < 0.001$). Such workloads may adversely affect lifestyle, as noted by a 40-year-old male:

I wanted to be a medical specialist but now find myself trapped into mortgages, school fees, long hours of work. I have lots of responsibility but little true power.

These hours often extend into mid-career as indicated by a 51-year-old female:

Table 1. Effects of age on principal field of psychiatric practice (N = 543)

Field of practice	n†	%	Mean age (years)*
Psychotherapy	81	14.8	51.0
General psychiatry	297	54.4	50.9
Forensic	17	3.1	50.8
Other‡	15	2.7	49.7
Family, child and adolescent	51	9.3	49.3
Administration	14	2.6	47.7
Psychogeriatrics	25	4.6	45.9
Community	22	4.0	44.0
Consultation-liaison	19	3.5	43.6
Research	5	0.9	40.8

* $p < 0.05$. †n = 3 subjects provided information on field, but not on current age, n = 5 did not provide information on field. ‡Includes neuropsychiatry, transcultural psychiatry, drug and alcohol.

I guess I'm not old enough yet for age to impact except I would like to work 50h and not 60 h a week.

In the previous 5 years, 213 respondents (39.1%; N = 545) had reduced their work hours, the main reasons being a change of lifestyle/development of other interests (n = 71; 35.9%, N = 198), burnout/fatigue (41, 20.7%), career change (35, 17.7%), parenthood (33, 16.7%), age (16, 8.1%), semi-retirement (16, 8.1%) and ill health (14, 7.0%). A typical comment from a 56-year-old female:

I have significantly reduced my workload in the last 2 years. I have a Diploma of Fine Arts (and) oil paint. I've always needed a strong balance of activities and work in my life...

A 63-year-old female noted that:

...the practice of psychiatry is emotionally draining... (there is a) need for increasing leisure time to survive when older.

Changes in psychiatric practice over the career

Changes of attitudes of patients or colleagues towards them as they had grown older were reported by 281 respondents (51.5%, N = 546), while 215 (39.4%) responded 'no' and 50 (9.2%) 'don't know'. Psychiatrists who responded 'yes' were older, and those who responded 'don't know' were younger ($p < 0.05$).

The majority of respondents, particularly those who were younger ($p < 0.05$), reported no changes in

the type of cases referred to them over their career (n = 250; 53.1%, N = 471). When changes were reported, the most frequent were 'more difficult/complicated cases' (n = 63, 13.4%), more 'neurotic/psychological therapy patients' (30, 6.4%), more older patients (28, 5.9%), fewer younger patients (26, 5.5%), more 'VIP/special patients' (25, 5.3%), and more second opinions (22, 4.7%), although 61 (13.0%) reported that any changes were related to changes in their type of psychiatric practice. Respondents who reported seeing more older patients were more likely to be older themselves ($p < 0.05$). There were no other significant differences in the types of cases referred that related to the age of the respondents.

Benefits and drawbacks of age upon psychiatric practice

The perceived benefits of age upon psychiatric practice vary across the age range (see Table 2). Respondents who reported that age was associated with increased credibility and respect from patients and peers were more likely to be older. As one 64-year-old male wrote:

Patients regard you as the 'wise old man'. Perhaps too as more trustworthy concerning your motives.

There may be other issues as indicated by an 83-year-old male:

Age brings closer the threat of death so attitudes of respect are always tinged with fear.

Table 2. Benefits of current age upon work as a psychiatrist (N = 464)*

Benefit	n (%)	Mean age		t	Statistics df	p [‡]
		Response given	Response not given			
Better able to communicate with patients of own age/life stage	99 (21.3)	46.3	51.3	3.80	459	0.000
Wider, more balanced life perspective	97 (20.9)	51.6	49.9	-1.49	188.1	0.139
Increased credibility and respect from patients and peers	87 (18.8)	53.6	49.5	-2.92	459	0.004
Age of no benefit	75 (16.2)	53.1	49.7	-2.26	459	0.024
Increased confidence and competence	45 (9.7)	54.0	49.9	-2.22	459	0.027
More respect, tolerance of patients, and humility	35 (7.5)	56.5	49.8	-4.00	43.5	0.000
More enthusiastic, optimistic	32 (6.9)	36.1	51.3	14.51	59.2	0.000

*n = 66 left question blank. [†]Degrees of freedom vary because of unequal or separate variance t-test employed if Levene's test for equality of variances revealed significant inequality. [‡]Bonferroni corrected p-value = 0.05/7 = 0.007; those p levels significant after correction are indicated in bold.

In turn, respondents who believed that age brought them more respect and tolerance of patients were also more likely to be older. A 66-year-old male commented:

Reaching an age at which one is forced to face one's own approaching death has an effect which, if you are balanced personally, enhances your relationship with severely ill and suicidal patients.

In contrast, respondents with longer clinical experience were more likely to state that their age was of no benefit to psychiatric practice ($p < 0.005$). This ambivalence about the benefits of age and experience is alluded to by a 66-year-old male:

Many people clearly want a father figure and age is a plus but just as many people are not looking for a father figure and see age as a generation gap.

Respondents who reported that due to their age they were better able to communicate with patients of their own age or life stage were more likely to be younger, as were those who mentioned enthusiasm or optimism.

Drawbacks to psychiatric practice related to age are found in Table 3. Those who reported problems with their physical and mental health, fatigue, coping difficulties and problems in keeping up to date were more likely to be older. As noted by a 61-year-old male:

I seem to be expected to be everywhere and function as well as I could 20 years ago, which is getting less easy and I am enjoying work less.

These changes may affect competence as suggested by an 86-year-old male:

(We should) accept that the College has a responsibility for the health state of the members as well enough to continue working.

Some drawbacks may relate to practice characteristics, as one 72-year-old male noted:

...fewer referrals due to death and retirement of referring sources.

Respondents who reported more negative attitudes from patients and a lack of credibility/respect from patients and peers were more likely to be younger. A 31-year-old female commented:

Babyboomers...vilify the younger generation for shunning their materialistic achievement orientated values. Discrimination is occurring at both ends of the age spectrum for professionals.

The effects of age on case selection

Case selection was significantly influenced by the age of the psychiatrist, although most respondents believed age was irrelevant (Table 4). A representative comment from a 35-year-old female:

*Table 3. Drawbacks of current age upon work as a psychiatrist (N = 458)**

Drawback	n (%)	Mean age		t	Statistics df†	p‡
		Response given	Response not given			
None, age is irrelevant	157 (34.3)	50.3	51.5	1.12	363.9	0.264
Fatigue, lack of energy or motivation	87 (19.0)	57.0	49.7	-5.93	147.8	0.000
Negative patient attitudes, concern about psychiatrist's age	70 (15.3)	45.9	52.0	3.53	87.5	0.001
Less able to cope with work demands	38 (8.3)	56.2	50.6	-2.98	45.5	0.005
Difficulty in keeping up to date with knowledge	31 (6.8)	59.9	50.4	-6.12	40.5	0.000
Impaired memory or mental capacity of psychiatrist	23 (5.0)	62.6	50.5	-7.93	29.7	0.000
Impaired physical health of psychiatrist	20 (4.4)	59.6	50.7	-3.30	453	0.001
Lack of credibility and respect from patients and peers	20 (4.4)	35.4	51.8	14.91	34.2	0.000
Less enthusiastic, and more pessimistic and cautious with patients	19 (4.1)	53.3	51.0	-1.18	21.7	0.251

*n = 87 left question blank. †Degrees of freedom vary because unequal or separate variance t-test employed if Levene's test for equality of variances revealed significant inequality. ‡Bonferroni corrected p-value = 0.05/9 = 0.006; those p levels significant after correction are indicated in bold.

Table 4. Effects of age upon case selection

Types of cases	n (%)	Mean age		t	Statistics df†	p‡
		Response given	Response not given			
Interested in/confident to take on (N = 371)*						
None, age irrelevant	192 (51.8)	49.5	54.3	3.92	368	0.000
Older patients	39 (10.5)	57.3	51.1	-3.62	52.5	0.001
Younger patients	24 (6.5)	44.7	52.3	3.02	368	0.003
Mood disorders	22 (5.9)	58.0	51.4	-2.53	368	0.012
Marital, family cases	18 (4.9)	50.8	51.8	0.36	368	0.717
Depends on gender of patient	15 (4.0)	43.6	52.1	4.00	16.9	0.001
Stress and anxiety	15 (4.0)	60.9	51.4	-3.03	368	0.003
Reluctant to take on (N = 419)†						
None, age irrelevant	198 (47.3)	46.7	55.7	8.35	416	0.000
Younger patients	72 (17.2)	55.8	50.6	-3.81	116.8	0.000
Personality disorders	45 (10.7)	55.0	51.0	-2.13	416	0.034
Long-term, chronic patients	39 (9.3)	61.5	50.4	-6.46	49.2	0.000
Violent/dangerous or acting out patients	27 (6.4)	57.1	51.1	-3.40	33.2	0.002
Medicolegal cases	17 (4.1)	58.6	51.1	-2.55	416	0.011

*Interested in/confident to take on: n = 172 left question blank. †Reluctant to take on: n = 126 left question blank. ‡Degrees of freedom vary because unequal or separate variance t-test employed if Levene's test for equality of variances revealed significant inequality. §Bonferroni corrected p-value = 0.05/7 = 0.007 for interested/confident and 0.05/6 = 0.008; those p levels significant after correction are indicated in bold.

My confidence/interest in taking on patients is affected more by whether I believe I can work with the patient.

Those respondents more confident and interested in taking on older patients were themselves older, as were those reluctant to take on 'younger' patients, 'long-term or chronic' patients, or 'violent, dangerous or acting out' patients.

In contrast, those more confident and interested in taking on younger patients were younger. Respondents who were more likely to be influenced by the gender of the patient were mostly younger females ($\chi^2 = 26.91$, $df = 1$, $p < 0.000$). As pointed out by a 31-year-old female:

As well as age and experience, gender affects cases we do/don't take on.

While we did not specifically ask about career satisfaction, some were obviously enjoying themselves; for example, one 47-year-old female commented:

(Psychiatry) has been a great intellectual and social 'home' for me,

and a 71-year-old male reported:

Growing old in such an exciting vocation is a great privilege and enormous fun (most of the time).

Others were less complimentary; for example, a 45-year-old male wrote:

I find that psychiatry can be a greedy and demanding mistress.

Discussion

In this survey, we have found that age influences many aspects of the psychiatrist's career. There are significant differences in the clinical practices of older and younger psychiatrists which are likely to be due to a mixture of age, experience and the cohort effect.

The basic practice profiles of older and younger psychiatrists differ. Psychiatrists principally practicing psychotherapy, general psychiatry or forensic psychiatry and those located in psychiatric hospitals and private practice were more likely to be older. In contrast, psychiatrists practising one of the newer subspecialties (community, consultation/liaison or psychogeriatrics) and located in general hospitals or community health centres were more likely to be younger. These differences reflect the changes that have occurred in psychiatric practice over the last 30 years with public psychiatry moving from the psychiatric hospitals into general hospitals and community centres.

Age was noted to influence many aspects of clinical practice. Psychiatrists who regarded that their age assisted them in treating patients of their own age and contributed to their enthusiasm and optimism were more likely to be younger. Similarly, psychiatrists who perceived that negative patient attitudes and lack of credibility and respect from peers were the main drawbacks were also more likely to be younger. Gender issues were more frequently mentioned, particularly by females. This will be further explored in Part III of this trilogy [3].

Older psychiatrists worked fewer hours, having reduced their hours mainly for lifestyle reasons, burnout or fatigue. They were more selective in the cases they took on. Ageing also had some benefits, principally increased credibility and respect from patients and peers and a greater tolerance and respect of patients. Drawbacks of old age included fatigue and lack of motivation, difficulties in coping with work demands, difficulties in keeping up to date and impaired mental and physical health.

However, none of the views expressed in this survey is as bitter as those expressed by Freud at the age of 65: '...My capacity for interest is soon exhausted; that is to say, it turns away so willingly from the present in other directions. Something in me rebels against the compulsion to go on earning money which is never enough, and to continue with the same psychological devices that for 30 years have kept me upright in the face of my contempt for people and the detestable world....'[14].

It is not possible to ascertain whether these drawbacks to clinical practice were affecting some older psychiatrists' competence to practice. Over 75% of respondents, particularly younger ones, believed that the RANZCP should be involved in the re-accreditation of Fellows, a higher proportion than reported in a smaller RANZCP survey undertaken in 1994 [15]. Some respondents commented that the College should monitor the competence of psychiatrists. It has been suggested that there is a need for a program to evaluate the mental competence and provide support and therapy for impaired physicians identified in peer assessment processes [16]. Although not designed for the purpose, the Maintenance of Practice Standards program (MOPS) may identify potentially impaired psychiatrists in the RANZCP during practice visits, but there is no mechanism to link these psychiatrists to a remedial program. This seems a major weakness of the program and should be changed.

There does not appear to be any formal body or

process within the RANZCP to assist older psychiatrists in planning their retirement. The APA Council on Ageing has established a Committee on the Senior Psychiatrist to respond to issues relevant to older APA members including alterations of practice patterns and styles associated with ageing, pre-retirement planning, retirement and post-retirement activities [17]. This may be an approach that could be considered by the College.

Although there was an adequate response, the results of this survey have to be interpreted with some caution. The test-retest reliability of the survey questionnaire was not established. Some potential biases in the respondents may be reflected in the higher response rate from females and older psychiatrists. In the analysis of the open-ended questions, lack of a response cannot be interpreted as a negative response, so age comparisons simply indicate the influence of age on making the response. Further, some of the issues raised by the respondents could have been explored in more depth through face-to-face interviews or focus groups with a representative subsample.

In conclusion, age is associated with benefits and drawbacks to the practice of psychiatry and this may be reflected in the different practice profiles of older and younger psychiatrists.

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