The Senior Psychiatrist Survey II: experience and psychiatric practice

Brian Draper, Georgina Luscombe, Stephanie Winfield

Objective: The aim of this study is to determine the effects of experience 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: years of psychiatric experience; higher medical qualifications; location and type of psychiatric practice; attitudes about senior psychiatrists and mentorship; changes in work practices over the career; and the perceived benefits and drawbacks of experience on psychiatric practice and case selection.

Results: Of 1086 eligible subjects, 629 participated. Over 96% of respondents, particularly the younger and less experienced, believed that senior psychiatrists have wisdom to offer to junior colleagues. This wisdom principally related to mentorship/supervision. Increased 'respect and tolerance' of patients as a benefit of experience was more likely to be reported by respondents who were more experienced. Respondents more confident about treating younger patients and treating functional psychoses were more likely to be less experienced, as were those reluctant to take on psychotherapy cases. Those respondents reluctant to take on 'dangerous or acting-out patients' were more experienced. The field of psychiatric practice significantly influenced case selection.

Conclusions: Senior psychiatrists have accumulated wisdom through experience that is sought by junior colleagues via mentorship. It is recommended that the RANZCP should specifically address the needs of early career and senior psychiatrists.

Key words: attitudes, clinical practice, experience, mentor, psychiatrist.

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The Senior Psychiatrist Survey was undertaken to examine the effects of age and experience on psychiatric practice. This second paper in the trilogy will investigate the influence of experience on psychiatric practice.

Experience has been defined as the 'active participation in events or activities, leading to the accumulation of knowledge or skill' and 'the process or fact of personally observing, encountering, or undergoing something' [1,2]. The four developmental stages of the professional career (apprentice, competent colleague, mentor and sponsor) are largely based on experiential factors [3]. Although age and experience are inevitably linked, not all older psychiatrists have had the amount of professional experience that is

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commensurate with their age. Some psychiatrists commence training later in their medical career or take breaks from clinical practice.

Experience also has a qualitative aspect. The overall quality of psychiatric training received and the competency of training supervisors plays a crucial role in future practice [4]. Competency in subspecialty fields may require additional qualifications. The experiences obtained through working in different locations, types of practices and fields of practice vary and influence the psychiatrist's style and quality of work.

The harnessing of these experiences to attain wisdom leads to benefits such as earlier recognition of difficult diagnoses, better use of therapy skills, specific expertise in certain cases and avoidance of unnecessary or ineffective interventions [5–7].

The cornerstone of the College training system is the individual supervision of trainees by experienced consultants, a process that includes the elements of education, support and the facilitation of self-examination [4,8]. It may also involve the supervisor being a mentor, 'a wise and trusted counsellor' who grapples with the tasks of being a good, ethical psychiatrist while maintaining a personal life [2,8]. After the Fellowship has been obtained, however, no formal mechanisms exist for the mentorship of early career psychiatrists. The extent to which early career psychiatrists want senior psychiatrists to formally or informally act as mentors is not clear and nor is the role that senior psychiatrists perceive for themselves in this regard.

The aim of this paper is to determine the effects of experience on the practice, roles (including the desirability of mentorship), status and attitudes of psychiatrists of all ages within the Royal Australian and New Zealand College of Psychiatrists (RANZCP). We hypothesised that the structure and content of clinical psychiatric practice is a function of the quantitative and qualitative experiences of the psychiatrist.

Method

The selection of subjects and design of the study are detailed in the first paper of the trilogy [9]. Briefly, a postal survey of all RANZCPFellows aged 40 years and under; every second Fellow by alphabetical listing aged 41–54 years; and all Fellows aged 55 years and over who were resident in Australia and New Zealand was undertaken. The survey questionnaire contained items pertaining to: age; sex; ethnicity; professional qualifications; length, location and field of psychiatric practice; and hours of work.

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 further details be provided in open-ended responses: has your theoretical orientation changed over the course of your career; what, if any, changes have you noted in the type of cases referred to you as you have become older?

The concept of the 'senior psychiatrist' was purposefully not defined, as we recognised that it was related to both the age and experience of the psychiatrist. Experience was measured quantitatively and qualitatively. For a quantitative measure, we calculated the number of years of psychiatric experience since the commencement of psychiatric training. The following qualitative measures were used: RANZCP branch membership; location of practice; field of practice; and possession of a higher medical degree.

The following questions were posed about the senior psychiatrist: 'By virtue of their experience as psychiatrists, what, if any, particular wisdom do you believe that senior psychiatrists have to offer (a) to their junior colleagues, and (b) to society?'. They were also asked whether they believed that the RANZCP should encourage senior Fellows to be mentors to junior Fellows; whether they had had a senior RANZCPFellow as mentor; and whether they had been a mentor to a junior colleague. A mentor was defined as an 'experienced and trusted adviser'.

Fellows in 'active'practice were asked to comment on the benefits and drawbacks of their experience on their current 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 statistics remain as in the previous paper except that 'years of experience' was treated as a continuous variable, whereas branch, location, field of practice and possession of a higher medical degree were all categorical variables. The data were analysed using the SPSS statistical package (SPSS Inc., Chicago, IL, USA).

Results

Details of age, sex, marital status and branch membership are contained in the first paper [9]. Briefly, there were 629 respondents (response rate 57.8%), of whom 571 were still working in psychiatric practice and 58 were retired. The working psychiatrists

included 551 on the RANZCP 'active' list and 20 on the nominal 'retired' list.

The mean years of psychiatric experience since the commencement of training was 22.5 years (range = 4–60 years, SD = 11.0, N = 614), which was strongly correlated with age ($r = 0.88$, $N = 609$, $p < 0.001$). Membership of the RANZCP (or its predecessor, the Australasian Association of Psychiatrists) had been held for at least 20 years by 236 respondents (40.0%; N = 590), for 10–19 years by 142 (24.1%), and for less than 10 years by 212 (35.9%). In addition to RANZCP Fellowship, 182 respondents held the Diploma of Psychological Medicine, 135 were Members or Fellows of the Royal College of Psychiatrists, 65 had higher medical degrees and 55 were members of other medical colleges. They also held a wide range of other psychiatric, medical and non-medical qualifications. 'Substantial breaks' in psychiatric practice had been taken by 122 respondents (19.6%; N = 623), with the main reasons being maternity leave (n = 43; 18.9% of female respondents), extended travel/ recreation (29) and other medical work (18).

Senior psychiatrists

The majority of respondents believed that senior psychiatrists have 'wisdom' to offer to their junior colleagues (n = 548; 96.1%, N = 570). The most frequent types of wisdom related to 'mentorship/supervision' (286, 50.2%), 'life experience' (116, 20.4%), 'acceptance of personal limits/fallibility' (71, 12.5%), 'treatment and management techniques' (61, 10.7%), 'psychiatric theory and services' (63, 11.1%), 'historical perspective' (54, 9.5%), 'leadership' (49, 8.6%) and 'awareness of personal needs' (44, 7.7%).

Respondents who stated that senior psychiatrists offered 'mentorship/supervision' were more likely to be younger ($p < 0.001$) and less experienced ($p < 0.001$). This category covered both mentorship and supervision as responses did not distinguish between the two concepts. Community psychiatrists and family/child/adolescent psychiatrists in particular believed that senior psychiatrists offered wisdom on 'treatment and management techniques' ($p < 0.001$).

Some typical comments included: seniors provide

> …experience of previous fashions in diagnosis and therapy, to temper unbridled enthusiasm (41-year-old male)

and junior colleagues need a senior colleague

> to share past traumatic experiences and provide a model of survival (70-year-old male).

Contrary views were also put:

> Working requires developing maturity, vision, forward thinking, progress—that is not what most older psychiatrists actually offer—demoralised, cynical, negative—but it is what they should offer (43-year-old female)

and

> Most of my experience with senior colleagues is their restricting juniors by way of old boys club (41-year-old male).

Fewer respondents believed that senior psychiatrists have 'wisdom' to offer to society (n = 400, 82.0%, N = 488). The most frequent types of wisdom related to 'mental health education' (171, 35.0%), 'insights/commentary on social issues' (107, 21.9%) and 'tolerance' (37, 7.6%). While those respondents who stated that senior psychiatrists offered wisdom about 'mental health education' were younger ($p < 0.001$) and less experienced ($p < 0.001$), those psychiatrists who contended that they had no advice to offer were more experienced ($p < 0.005$).

A typical comment was:

> I think with experience it is important for senior Fellows to lobby State and Federal governments re the needs of the psychiatrically ill, their families and their carers (50-year-old female).

Some very tart remarks were received:

> I've no reason to think an old and wise psychiatrist would be any more benefit to society than an old and wise plumber or brickie (38-year-old male)

and

> too many older psychiatrists seem to believe they have a political role to sort out society's ills (70-year-old male).

Some believed psychiatrists did have a special role to play: for example,

> I think experienced psychiatrists do develop a sense of personal and societal dynamics which might be more strongly expressed by the profession (53-year-old male).

But other respondents expressed doubt about the reception of such advice:

> when I have attempted to give advice, e.g. on par-

liamentary subcommittee, no notice was taken (64-year-old female).

Mentorship

Mentorship had been received by 294 respondents (48.1%, N = 611), with recipients more likely to be younger ($p < 0.001$) and less experienced ($p < 0.001$). Two hundred and ninety-seven respondents had been mentors (50.3%, N = 590), especially the more experienced ($p < 0.01$), the older respondents ($p < 0.05$) and those working in universities ($p < 0.005$). The majority of respondents, particularly the younger ($p < 0.005$) and less experienced ($p < 0.001$), stated that the College should encourage mentorship by senior psychiatrists (n = 450; 73.9%, N = 609), with 43 (7.1%) disagreeing and 116 (19.0%) being unsure. The most frequent comments about mentorship were that it was 'an underutilised model' (n = 125; 36.9%, N = 339), that it 'should be up to the individual, not forced'(77, 22.7%), and that 'ability rather than age is more important in choosing mentors' (35, 10.3%). There were no significant effects with branch, location, field of practice or higher medical degree.

Some characteristic remarks included:

> As a fairly junior consultant I would highly value being able to work with a senior colleague. Unfortunately, this is not the case and I feel stressed by the lack of support (35-year-old female)

and

> the mentorship/supervision I have formally arranged and received since obtaining my FRANZCP has been by far the greatest teaching/training I have received since beginning training (36-year-old female).

There were a number of comments for and against the College organising a formal mentor system. A 42-year-old male was of the view that

> …the relationship between senior fellows and junior fellows should be developed naturally without interference from 'introduction agencies',

but a 68-year-old female reported rather poignantly

> at the height of my career…I had offered services or sought opportunities as a mentor…. There were no openings. In short I had usefulness which was not encouraged within the profession.

Current work practices

The following analyses, based on information about current work practices, was obtained from the 551 working respondents who were on the 'active' RANZCP list. There were significant relationships between years of experience and College branch (Queensland least experienced, ACT most experienced, $p < 0.05$), location of practice (general hospital least experienced, 'other'most experienced, $p < 0.01$) and field of practice (consultation–liaison least experienced, forensic most experienced, $p < 0.05$).

*Table 1. Benefits of current experience on work as a psychiatrist? (N = 454)**

Benefit	N (%)	Mean years of experience: Response given	Mean years of experience: Response not given	t	Statistics df†	p‡
Increased confidence and competence	228 (50.2)	22.5	20.7	–1.82	427.12	0.070
Wider, more balanced life perspective	68 (15.0)	20.6	21.8	0.88	443	0.378
More realistic expectations, more able to limit set	40 (8.8)	23.5	21.4	–1.23	443	0.219
Better able to communicate with patients of own age, life stage	36 (7.9)	25.6	21.3	–2.41	443	0.016
Increased credibility and respect from patients and peers	29 (6.4)	23.8	21.4	–1.22	443	0.223
More respectful and tolerant of patients	22 (4.8)	26.9	21.3	–3.14	24.56	**0.004**

*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 = 0.05/6 = 0.0083; those p levels significant after correction are indicated in bold.

*Table 2. Drawbacks of current experience on work as a psychiatrist (N = 405)**

Drawback	N (%)	Mean years of experience Response given	Response not given	t	Statistics df†	p‡
No drawback	164 (40.5)	23.8	20.1	–3.63	354.13	**0.000**
Increased cynicism, burnout	50 (12.3)	23.7	21.3	–1.51	392	0.133
Insecurity, lack of competence	32 (7.9)	10.4	22.6	10.13	46.44	**0.000**
Difficulty in keeping up to date with knowledge, new perspectives	22 (5.4)	28.1	21.2	–3.06	392	**0.002**
Less enthusiastic, pessimistic, cautious with patients	19 (4.7)	19.8	21.7	1.04	21.49	0.309
More selective in taking cases	19 (4.7)	19.7	21.7	0.84	392	0.402

*n = 137 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 = 0.05/6 = 0.0083; those p levels significant after correction are indicated in bold.

*Table 3. Cases interested/confident to take on because of experience as a psychiatrist (N = 405)**

Types of cases	N (%)	Mean years of experience Response given	Response not given	t	Statistics df	p†
Experience irrelevant to case selection	86 (21.2)	20.4	21.3	0.71	395	0.478
Mood disorders	53 (31.1)	20.4	21.2	0.58	395	0.562
Stress and anxiety	41 (10.1)	22.8	20.9	–1.11	395	0.268
Functional psychoses	39 (9.6)	15.1	21.8	4.06	395	**0.000**
Complicated cases	37 (9.1)	24.2	20.8	–1.94	395	0.053
Personality disorders	33 (8.1)	19.4	21.3	1.01	395	0.312
Younger patients	29 (7.2)	15.7	21.5	3.08	395	**0.002**
Older patients	28 (6.9)	18.5	21.3	1.42	395	0.156
Marital, family cases	28 (6.9)	22.0	21.1	–0.48	395	0.628
Cases requiring psychotherapy	27 (6.7)	21.1	21.1	0.00	395	0.997
Medicolegal cases	25 (6.2)	24.5	20.9	–1.70	395	0.091
Victims of abuse and neglect	16 (4.0)	18.9	21.2	0.89	395	0.373

*n = 142 left question blank. †Bonferroni corrected p-value = 0.05/12 = 0.0042; those p levels significant after correction are indicated in bold.

Theoretical orientation

When asked whether their theoretical orientation had altered over their career, 270 (50.2%; N = 538) said 'yes'. These were significantly older psychiatrists with more years of psychiatric experience ($p < 0.05$). Forensic psychiatrists and psychotherapists were more likely to have altered their theoretical orientation and psychogeriatricians were least likely ($p < 0.05$). Those in private practice were also more likely to have experienced a change in theoretical orientation and those in community health the least likely ($p < 0.01$). The most frequent changes in theoretical orientation reported were 'more psychodynamic' (n = 65; 24.6%, N = 264), 'more eclectic' (54, 20.5%), 'more behavioural' (43, 16.3%), 'less psychodynamic' (40, 15.2%), 'more biological' (32, 12.1%) and 'less biological' (20, 7.6%). The only theoretical change that significantly varied with age or experience was 'less biological' which was reported mainly by less experienced psychiatrists ($p < 0.001$). Psychotherapists reported that

*Table 4. Cases reluctant to take on because of experience as a psychiatrist (N = 430)**

Types of cases	N (%)	Mean years of experience: Response given	Mean years of experience: Response not given	t	Statistics df†	p‡
Personality disorders	106 (24.7)	20.9	20.9	–0.05	419	0.958
None, experience irrelevant	77 (17.9)	21.5	20.8	–0.52	419	0.605
Younger patients	77 (17.9)	19.8	21.1	1.05	419	0.296
Medicolegal cases	61 (14.2)	21.0	20.9	–0.04	419	0.965
Drug and alcohol	51 (11.9)	23.7	20.5	–2.25	67.57	0.028
Eating disorders	33 (7.7)	16.7	21.3	2.47	419	0.014
Cases requiring psychotherapy	31 (7.2)	13.8	21.5	4.66	37.01	**0.000**
Long-term, chronic patients	29 (6.7)	17.2	21.2	2.03	419	0.043
Older patients	25 (5.8)	16.2	21.2	2.36	419	0.019
Dangerous or acting out patients	23 (5.3)	27.0	20.6	–2.86	419	**0.004**
Functional psychoses	19 (4.4)	27.0	20.6	–3.87	22.09	**0.001**
Complicated cases	17 (4.0)	17.2	21.0	1.50	419	0.135

*n = 117 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 = 0.05/12 = 0.0042; those p levels significant after correction are indicated in bold.

their orientation had become more psychodynamic ($p < 0.001$) and administrators and psychogeriatricians more biological ($p < 0.001$).

Benefits and drawbacks of experience on psychiatric practice

Increased confidence and competence, reported by over 50% of the respondents, was the main benefit of experience on psychiatric practice (see Table 1). The only type of benefit reported which varied significantly with the psychiatrists' length of experience was increased respect and tolerance of patients ($p < 0.005$). A 61-year-old male commented:

> As one gets older there is hopefully a recall of a wealth of experience with which to accept, relate and help the patient.

Most frequently, experience was felt to have no drawbacks on psychiatric practice and this was more likely to be reported by respondents with more years of clinical practice ($p < 0.001$; see Table 2). Those respondents who observed that their experience contributed to difficulties in keeping up to date with knowledge were likely to be more experienced ($p < 0.005$). Respondents who remarked that their lack of experience contributed to feelings of insecurity and lack of competence in their psychiatric practice were more likely to be less experienced ($p < 0.001$).

Respondents working in administration and as community psychiatrists ($p < 0.005$) and those based in universities, community health centres and psychiatric hospitals believed their experience contributed to cynicism and burnout ($p < 0.005$).

The effects of experience on case selection

A wide range of effects of experience on case selection were reported (see Tables 3,4), although it was most frequently remarked that experience was not relevant. Respondents who observed that they had confidence/interest in taking on younger patients and patients with functional psychoses were less experienced ($p < 0.001$). Irrespective of their level of experience, respondents were reluctant to take on patients with personality disorders. Respondents who reported that due to their experience they were reluctant to take on dangerous or acting out patients ($p < 0.005$) and patients with functional psychoses ($p < 0.005$) were more experienced. Those respondents who were reluctant to take on cases requiring psychotherapy were less experienced ($p < 0.001$).

Field of psychiatric practice had a significant effect on case selection. Forensic psychiatrists felt more confidence/interest in managing medicolegal cases ($p < 0.001$), psychotherapists in treating personality disorders ($p < 0.001$) and community psychiatrists in treating victims of abuse/neglect ($p < 0.005$). Psychogeriatricians were more interested in treating

older patients ($p < 0.001$) and family, child and adolescent psychiatrists, younger patients ($p < 0.001$).

Location of practice and holding a higher medical degree did not significantly affect case selection. However, there was a significant association between branch and belief that experience was relevant to case selection ($p < 0.001$), New Zealanders being most likely to believe experience was irrelevant (46%), and South Australians the most likely to believe it was relevant (91%).

When questioned about changes in the types of cases referred over their career, one significant effect of experience was that forensic psychiatrists and administrators were more likely to see 'more difficult/complicated cases' ($p < 0.001$). Apart from psychiatrists who saw more older patients being more experienced ($p < 0.001$), there were no other significant differences in the types of cases referred that related to the experience of the respondents.

Discussion

In this exploratory study, we have examined the effects of experience on psychiatric practice from quantitative and qualitative perspectives. Most of the significant findings related to the length of psychiatric experience rather than the measures of qualitative experience. These qualitative measures were likely to have been insensitive in many respects; for example, they were unable to judge the quality of training received by the respondents. More sensitive measures of qualitative experience, perhaps obtained through interviews and focus groups, may have provided different findings.

Despite the close relationship between the psychiatrist's age and length of experience, significant differences were noted with regards to their effects on psychiatric practice. The various types of experience measured had a more notable influence on case selection than the psychiatrist's age. Some of these effects related to subspecialty interests, but others reflected the type and amount of training received. This was particularly noticeable with less experienced psychiatrists who were confident about treating functional psychoses but not psychotherapy cases, which is hardly surprising given the limited range of cases seen by trainees these days.

The results concerning change of theoretical orientation by psychiatrists suggest quite a degree of flux within the College, without a clear move towards or away from any single theoretical stance. The extent to which these changes are a function or rejection, or disillusionment with, a previous stance or are a matter of emphasis, perhaps as a result of moving into a subspecialty area, cannot be dissected from the present study. It has been suggested that with experience, allegiance to a specific theoretical orientation becomes less intense [10], and this has been supported in this survey.

It did not appear that psychiatrists who saw more difficult cases were more experienced. Is it that cases start to feel less difficult with experience, or are seniors and juniors alike being referred a mix of easy and difficult cases haphazardly? This finding is interesting in view of the results on the question of mentoring. Are early career psychiatrists struggling with complex cases for lack of a culture of mentorship? But it is not clear from the responses whether more supervision, that involves education and clinical advice, is desired in addition to mentorship. Possibly peer review groups developed through the Maintenance of Practice Standards Program may offer this form of supervision.

Yet, the belief that the senior psychiatrist has more to offer than clinical facts is striking. Juniors look to their seniors for perspective, emotional support and reassurances in difficult times. They also look to them as role models in developing a well-balanced and satisfying lifestyle. There seems to be a desire for more mentoring of the early career psychiatrist by the senior, a relationship not fostered by the College. The preponderance of comments, however, suggested that a voluntary rather than a formal scheme would be favoured. Intergenerational links between psychiatrists ought to be encouraged within the College. In the United States, the APA Committee on the Senior Psychiatrist has proposed a mentoring program in affiliation with the APA Committee of Early Career Psychiatrists [11]. Unlike the APA, the College does not have any specific bodies that are charged with the responsibility of overseeing the needs of Fellows at either end of their career. Perhaps the establishment of similar committees could be the starting point of addressing these issues.

Our respondents were rather modest about the psychiatrist's role in the larger social arena, largely preferring to limit psychiatrists to commenting on their area of professional expertise. Still, various comments indicated that psychiatrists were involved in a broad range of social activities including parole boards, government committees, guardianship boards and non-government organisations. Clearly, our experiences as psychiatrists are valued by

society, although some of our respondents expressed concern that we may take ourselves too seriously.

In conclusion, we have found that experience has a range of effects on psychiatric practice. Early career psychiatrists seek to glean the benefits of this experience from senior psychiatrists through mentorship, but may require some assistance in developing contacts.

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