Recruitment and retention in Old Age Psychiatry – an online survey of trainees’ attitudes and experiences

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BACKGROUND
Recruitment and retention are important issues in any medical speciality. Arising from a Royal College of Psychiatry Faculty of Old Age Psychiatry strategy meeting considering these issues, a survey of trainees’ opinions relevant to recruitment and retention in this specialty was planned and carried out. The survey’s focus on trainees was on the assumption that this group would have the most up-to-date knowledge of pertinent issues. The objective of the survey was to describe current attitudes in order to inform Faculty policy in this area.

METHODS
This survey of Old Age Psychiatry trainees was carried out over a one month period during August 2012. An online survey site (www.surveymonkey.com) was used for administration of the questionnaire and collation of responses. Trainees were contacted about the survey and encouraged to participate, both through emails from the Faculty and via the trainees’ social network group.

The survey comprised the following eight questions with open fields for narrative responses:

1. Have a think back to when you started thinking about Old Age Psychiatry as a career. What do you think were the key things that attracted you to this specialty?
2. Was there anything about the specialty that nearly put you off considering it, at that early stage?
3. Were there any obstacles in your way in obtaining training in Old Age Psychiatry?
4. Once you'd started training in Old Age Psychiatry, what do you think have been the most important factors in encouraging you to continue?
5. Has there been anything since starting Old Age Psychiatry training which has made you think about discontinuing this (e.g. switching to another specialty)?
6. Overall, what factors do you think are most important for encouraging recruitment to Old Age Psychiatry?
7. Overall, what factors do you think are most important for ensuring that people continue in Old Age Psychiatry?
8. Thanks very much indeed for completing the survey. Do you have anything further to add that you think might be useful?

In addition, respondents were asked to provide information on their gender and stage of training (pre-MRCPsych, post-MRCPsych trainee, and consultant). No identifying information was collected.

Initial thematic analysis of the text data was carried out independently by the authors, considering each question as a separate heading and grouping responses under what were felt to be the most appropriate sub-headings. This was followed by a meeting to achieve a consensus on the most appropriate way of collating and describing the responses. Themes described below are ordered according to their salience (descending order) and descriptions are followed by examples of quotations which most typified the responses. Themes tended to become saturated and repeat themselves in later questions, and descriptions accordingly are briefer.

RESULTS
In total there were 38 responders, 26 female (68%) and 12 male, 37 of whom were post-MRCPsych trainees (and one a new consultant).

Question 1. Have a think back to when you started thinking about Old Age Psychiatry as a career. What do you think were the key things that attracted you to this specialty?
Responses to this question could be grouped under the following themes/ headings:

Patients (and families)
The majority of responders stated enjoyment and interest in working with older people as attractions for this speciality - this was expressed in around 50% of the responses and was linked to high job satisfaction.

“Enjoyed seeing older patients. The mix of organic and functional conditions. The complexity of patients seen. The medicine that is involved in working with older people with mental health problems and the interface between physical and mental health conditions. An inspiring consultant who I worked with.”

Other descriptive terms applied to the patient population included: “respectful and appreciative”, “lovely population”, “stoicism”, “thankfulness”, “interesting”, “life experience”, “nicer” [compared to younger age groups]. In response to this question about attractions of Old
Age Psychiatry, there were also descriptions of the patient population as “undervalued”, and “needing advocacy”.

Intellectual stimulation
47% mentioned the overlap with and retention of medical skills, and the task of dealing with physical health complications and co-morbidities as attractions of Old Age Psychiatry.

“Working with the elderly, the complex interaction between mental health and physical needs.”

“The huge variety of clinical presentations, holistic multi-disciplinary approach, less about risk more about people, ethics & law (capacity etc.) and the medical aspect.”

Other interests included the opportunities to experience neuropsychiatry and liaison work.

Positive comparisons with working age Psychiatry
Several responses made explicit positive comparisons between Old Age Psychiatry and Working Age Psychiatry including the following: “less chaotic”, “nicer patients”, “less PD” [personality disorder], “less borderline PD”, “less alcohol and drug misuse”, “less pressurised”, “less MHA” (Mental Health Act work).

Positive aspects of the work
Examples of positive aspects of Old Age Psychiatry included: “work/life balance”, job security and perceptions of an expanding need (ageing populations, increasing dementia prevalence, new treatments for dementia).

Supportive clinicians
Several respondents cited positive views of clinicians in the specialty as an attraction: “nice consultants”, “excellent trainer”, “inspiring consultant”.

Other responses
Other responses included: “holistic approach”, “multidisciplinary”, “family work”, “less about risk, more about people”.

Question 2. Was there anything about the specialty that nearly put you off considering it, at that early stage?
Of the respondents, 13% reported no off-putting factors. The following themes were identified where responses were given:

Concerns about functionalisation and the decline of the speciality:
In response to this question, 21% of total responders reported concerns about the speciality being split to provide organic services only. This was exemplified by the following responses:

“I was worried that I would be dealing purely with dementia and little else”

“Restructuring of services with emphasis on functional model i.e. separate in-patient vs. out-patient consultant and then further division into Organic vs. Functional teams. Proposals of handing over the functional elderly to general adult consultants to save money. It is heart breaking to see lack of empathy for the patients while developing such policies”

“The way that new funding / service lines appeared to make it purely focus on dementia care”

“worry that there would be a possible lack of jobs in future, slow burnout….”

“Concerns about the future of the speciality”

Challenges of dementia care:
Concerns under this heading included the volume of work and changes in services, in particular lack of social care. Responses included:

“Ageing population. There is already almost an unmanageable amount of workload that existing consultants and the teams were struggling to cope with. I wondered how the system and I would cope when I become a consultant.”

“Problems with funding social care so frustrating when trying to move patients on.”

“volume of dementia work”

Training issues:
Of the respondents, 18% were also concerned about training which included both comments about a lack of structure and comments about it being too rigorous. There were also concerns about the level of medical care involved.

“Lack of training structure. Under funding.”

“I think the portfolio can be too rigorous and labour intensive”
“Doing the job as an SHO you end up feeling like a GP unqualified for your role which can be pretty uninspiring but having some community experience can show a different view.”

“The amount of medicine involved, which I am not so confident about”

**Reputation:**
In response to this question, the view of the speciality from others and negative images of the speciality were exemplified in the following responses:

“Negative responses from friends and relatives both medical and non-medical.”

“At the beginning of my training in psychiatry there was no strong message about potential interesting aspects and I perceived it as slightly monotonous.”

“Not considered to be glamorous like Forensics.”

**Question 3. Were there any obstacles in your way in obtaining training in Old Age Psychiatry?**
Over 65% reported no problems. Responses where given included negative attitudes from colleagues and problems with application/interview process, job shortages, difficulties with dual training, and liaison accreditation.

“negative attitudes by other psychiatrists”

“Problem with liaison accreditation and time to gain breadth of experience.”

“Less number of higher training numbers in the area where I was doing core training. I was ready to move though to stay in old age psychiatry.”

**Question 4. Once you'd started training in Old Age Psychiatry, what do you think have been the most important factors in encouraging you to continue?**

The most common factors, cited by over 30% of responders were the encouragement received from supervisors and colleagues, the feeling of making a difference through clinical practice and working with the patient group as well as general comments around satisfaction, enjoyment and finding the job challenging.
“Supportive, available, easy-to-talk to supervisors who both set good examples and allow exposure to difficult/complex cases and situations arising from them in a very well-supported environment with practical supervision and discussion, which helps allay anxiety about encountering such situations as a consultant.”

“Good job satisfaction due to appreciative patients and their families. Good TPD (Training Programme Director) and colleagues.”

“I enjoy the clinical work. I have been able to work with some inspirational people.”

“My Patients and the fact that I can try to make a difference in their lives and future elderly patients. Possible opportunity to develop the services according to personal vision.”

Other reasons cited included service development opportunities, time for undergraduate teaching, good community mental health teams, multi-disciplinary teams, availability and acceptability of part-time training, perceived expansion of the specialty, and home visits.

**Question 5. Has there been anything since starting Old Age Psychiatry training which has made you think about discontinuing this (e.g. switching to another specialty)?**

The majority of responders had thought of discontinuing the speciality due to concerns over future resources, functionalisation, lack of opportunities for experience, and clinical issues. Around 30% of responders reported no thoughts of discontinuing the speciality; 15% of responders were specifically concerned about the future of the speciality.

“Concern about lack of consultant jobs in the short term have made me consider whether dual-training in old age and general adult psychiatry would be advantageous, especially with the current drive for functional illness to be treated by general adult psychiatry well beyond 65 years.”

“I am keen on psychotherapy and there hasn’t been as much of an opportunity to further my skills in this during my old age posts as opposed to general adult posts. Also, the move towards ageless services is an issue and I have wondered if I would have chosen old age psychiatry if I could have my choice over again.”

“I am concerned about the changes to services that may lessen the role of old age psychiatrist and have considered dual training.”
“Too many cuts to services beds closed and people being placed due to lack of services. Worried about the future of old age psychiatry.”

Other comments cited administration processes, paperwork, “terrible IT”, an example of a specific poor (under-supported) post, lack of private work, and the lack of experience in certain areas in training such as liaison work.

**Question 6. Overall, what factors do you think are most important for encouraging recruitment to Old Age Psychiatry?**

Over 25% of responders wrote that increased awareness of the speciality and early exposure, either in medical school or foundation training, would encourage recruitment to Old Age Psychiatry.

“Increased awareness of the speciality. As a medical student I had a 5 day placement in a total of 8 weeks psychiatry, but more awareness and exposure in both pre-clinical and clinical years (maybe with clubs and societies as the rest of psychiatry are starting to do) may improve understanding of and reduce the stigma of our speciality.”

The breadth and depth of the specialty and training experience was mentioned by 18%, including comments that marketing the wealth of experiences and variety of cases the speciality had to offer were important.

“Show people how varied, interesting and thoughtful it is, how much innovation there is, and that there are jobs.”

Role models and ambassadors as well as reassurance about the survival of the speciality (in relation to job shortages, disappearance of the specialty or its becoming dementia-only) were also mentioned:

“Clear guidance from the College that Old Age will exist in twenty years and drive that older people with functional illness should have Older People’s Mental Health consultant care specialists in treating older people. Clear message from College that Older People’s Mental Health will not become dementology.”

“Discouraging some myths about limited consultant posts and in future this branch might disappear.”

“Positive role models, growing and developing specialty, importance of good medical skills.”

**Question 7. Overall, what factors do you think are most important for ensuring that people continue in Old Age Psychiatry?**
In general, similar themes were evident here to those present for Q6 responses. Of those who responded, 21% cited their supervisor as a source of continued encouragement in the speciality. Opportunities to be involved in service development, varied interests and research were also factors stated. Responders also mentioned reassurance regarding the survival of the speciality and flexibility in training programmes as factors.

“Good educational programmes and varied training opportunities including good mix of liaison/inpatient and community.”

**Question 8.** Thanks very much indeed for completing the survey. Do you have anything further to add that you think might be useful?

A few further statements were made:

a) Other specialties (e.g. GPs) not understanding enough about the role of Old Age Psychiatry
b) A request for dedicated Neurology exposure
c) Not enough old age specific issues in training (too generic)
d) On call cover requirements being too broad.
e) A question about whether information is being collected by the College on the long term impact of MTAS (Medical Training Application Service).

**CONCLUSIONS**
To our knowledge, it has been quite some time since Old Age Psychiatry trainees were formally surveyed on recruitment and retention issues, if this has ever been previously attempted. The ability to administer the questionnaire online, in combination with the Faculty’s email list and an active online social network community rendered sampling and data collection much more achievable than would have been the case in the days of postal surveys. The number of responses would be considered relatively low for a quantitative survey; however, there was evidence of thematic saturation even with the relatively brief statements elicited, and the authors feel that important new themes would be unlikely to have emerged in a larger sample. Clearly the responders will have been preferentially those trainees who felt that they had a point they wanted to make; however, the wording deliberately sought both positive and negative considerations which sought to minimise such response bias, so that relevant themes could be identified with respect to both facilitators and obstacles for recruitment and retention. It should also be borne in mind that all respondents were those who had successfully been recruited for and retained in Old Age Psychiatry at the time of the survey, and no attempt was made to take information from trainees who had left the specialty – although logistically challenging, this would be a useful extension to this work, as would a survey of more
undecided samples such as medical students or recently qualified medical graduates.

In terms of broad conclusions, there are clearly a number of positive aspects of Old Age Psychiatry as a specialty which need to be both retained and/or advertised including the attractive nature of the job as it currently stands, experiences of positive role models and supportive colleagues, and the intellectual stimulation to be derived from the specialty. Working with older people was also a strong positive (particularly, for many respondents, when compared to Working Age Psychiatry). Some features are both a positive and negative, such as the need for medical knowledge – although this was more often seen as positive, and the negative experiences tended to be in conjunction with training posts which may have excessively focused on provision of medical care by the trainee at the expense of a broader experience.

The most salient negative feature was a concern about the future of Old Age Psychiatry as a specialty – understandably viewed as particularly important by a sample who have recently committed themselves to this career. Although dementia was viewed as a positive feature of the specialty in terms of its fascination as a disorder, an exclusive focus on dementia care was seen as negative by respondents citing this. More generic issues around service cuts and job insecurity were also clearly concerns. Negative stereotyping of Old Age Psychiatry was mentioned, although the nature of the respondents (i.e. trainees who had all committed themselves to the specialty) might have lowered its prominence.

If a trainees’ survey has ever been carried out in the past, we feel that the survey here was justified as an update. Certain issues were raised which are likely to be new ones – in particular, the very evident concerns about functionalisation and threats to the specialty. The report which this paper summarises is being considered by the Faculty Executive at the time of writing in terms of its implications and is anticipated to be salient in developing policy to promote recruitment and retention to Old Age Psychiatry, and it would be interesting to see the extent to which the opinions cited are subject to change in the future.

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