Interview with PROF CHEE KUAN TSEE

by A/P Daniel Fung, Editorial Board Member

Adjunct Associate Professor Chee Kuan Tsee is currently an Emeritus Consultant with the Institute of Mental Health. Prof Chee received his medical education in Singapore and graduated in 1966. He was one of the team members dealing with the Koro epidemic in 1969. Prof Chee was on a Colombo Plan Fellowship between 1971 and 1972, where he received his Diploma in Psychological Medicine and completed his membership examinations for the Royal College of Psychiatrists in the UK. He has also written *Guide to Psychiatry*, now in its 11th revision, a well-received reference handbook for generations of new trainees, medical officers and other mental health workers. A Senior Consultant since 1988, Prof Chee was recognised with the Public Administration (Silver) Medal in 1996 and awarded the Lee Foundation-NHG Lifetime Achievement Award in 2008. *SMA News* Editorial board member, A/Prof Daniel Fung, caught up with him recently, to delve into the heart and mind of this prominent local psychiatrist.

DF: Psychiatrists always ask about the process of growing up. Can you tell us a little about yourself?

CKT: I spent some time on a farm in Cameron Highlands as a child during the Japanese Occupation. After the war, I attended a Chinese school by chance. During the last year in Chinese High School, it was a turbulent time socially and politically because of communist activities. At that time, students from Chinese schools had to go overseas for their tertiary education or to the newly-established Nanyang University. It was for the first time that a special class was conducted at Beatty Secondary School to prepare Chinese school students in the Higher School Certificate for entry to the then-University of Singapore. It was very competitive and I was really lucky and appreciative to have been given a place in medicine, not because of my results.

As for the family, I truly owe my achievements to my mother and my wife, who is a retired teacher and now a school counsellor. My son is medically qualified but gave up medicine to become an SAF pilot. My daughter is a research scientist with a PhD in Melbourne University. I have been singing in the church choir for the last 50 years and enjoy watching Korean dramas. After my heart attack in 2003, I have been swimming to keep fit.

DF: If you had a chance to live your life all over again, would you have chosen Psychiatry as your specialty and if so, why?

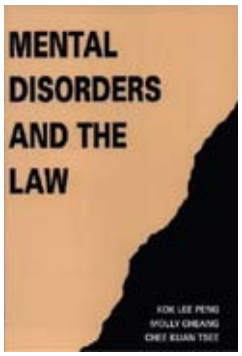
CKT: I think I would probably still choose Psychiatry as my specialty. I have been in the discipline for more than 40 years after all.

Psychiatry embraces all aspects of medicine and on top of that, the psychiatrist has to be interested in and informed about all aspects of life that affect the individual patient. In a nutshell, Psychiatry is holistic and bio-psychosocial in approach. However, this is not to say that other disciplines or subspecialties are not.

In fact, if all of us think and act firstly as doctors and secondly as specialists, we can all be the same in treating our patients as whole persons. I believe that behind every good specialist is a good doctor. Therefore it is useful to remind ourselves constantly that there is inter-relation, interaction and integration (or dissociation) between the individual and his environment, between his body

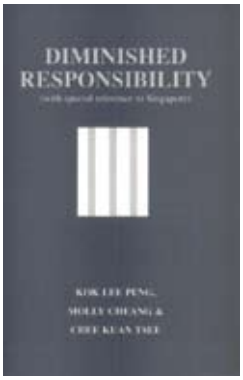
(including brain) and his mind and between his various mental functions such as perception, memory, thinking, feeling and volition.

Unfortunately in order to advance and progress, we have to specialise and sub-specialise. In the process we not only divide the body but also the mind. I am more and more convinced that in all things, we need to have an active balance of the opposite virtues. In our case, it is between being a specialist and a generalist. In life there also needs to be a balance between an individual's rights and freedom as well as social roles and obligations. On the other hand, there are two sides to everything. One man's meat is another man's poison and what is meat today may be poison tomorrow and vice versa.



DF: What are some of the significant moments of your career as a psychiatrist?

CKT: The significant moments in my career as a psychiatrist started with my studies in the UK on a Colombo Plan Fellowship in 1971, for the Diploma in Psychological Medicine. We did not have our own postgraduate training and qualification then. When I was due to return in 1972, I successfully sat for the membership examinations of the newly-established Royal College of Psychiatrists. It was a gratifying bonus. You can say that the Royal College of Psychiatrists was also lagging behind the other Royal Colleges like our own MMed (Psychiatry) in the early 80s. In 1980 I became the Inaugural President of the Singapore Psychiatric Association and a Founding Council Member of the ASEAN Federation for Psychiatry and Mental Health in the following year. Then there was the sensational murder trial of Adrian



Lim and his collaborators in 1983. Adrian Lim was portrayed as a powerful medium dabbling in religious rituals and had killed two children. There were three accused, each with their own legal counsels and defence psychiatrists. I was the only expert witness for the prosecution. It was a very stressful period but the outcome had been ego-boosting and a relief. Another satisfaction was co-authoring two books: *Diminished Responsibility* and *Mental Disorders and Law* with Dr Kok Lee Peng (NUS/NUH) and Dr Molly Cheang, a law professor in the 1990s.

DF: What are your views on the roles of the psychiatrist in Singapore in relation to practising psychotherapy versus biological psychiatry?

CKT: There has been perennial controversy or debate on the dichotomy between "nature and nurture" or "brain and mind". Personally I do not find too much conflict in the proponents for physical or psychological hypotheses of psychopathology and treatment. Bearing in mind what I have said earlier regarding inter-relation, interaction and integration/dissociation, it cannot be an issue of absolutes, one or the other.

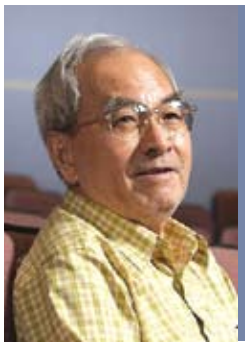
I subscribe to the neuro-psychological model of memory and reflex, or the complex formation of neural circuits and circuitry. In that sense it is more biological. The psychopharmacological approach to treatment is to restore normal neurotransmission. The rationale is to augment what is deficient and to dampen what is excessive through the use of drugs that are agonists or antagonists in the system concerned. On the other hand, psychotherapy in its broadest sense aims to effect a change in the morbid pattern of neural circuitry. This is achieved through strategic and systematic verbal, behavioural or experiential input to re-channel or bypass prevailing faulty circuits or to open up/create new desirable circuits. In both cases compliance and effort are required. However, psychotherapy is akin to downloading some software to a person with the therapist's own belief, experience and cultural background. It should therefore be carefully evaluated just like drugs used in biological psychiatry. Having said this, the practice of Psychiatry is also influenced by the stage of development of a society and the affluence of its people. The aetiological concepts of diseases have been evolutionary. We start with supernatural/superstitious belief, then physical/environmental explanation, then biological/genetic causes, then psychological/social factors and then perhaps moral/spiritual issues such as the recent financial disaster.

It is interesting to note that despite the World Health Organisation (WHO) and other authoritative predictions of depression escalating to become the second most prevalent health problem globally, our suicide rate has stayed below 10 per 100,000 last year. The Samaritans of Singapore stated that their education programme and support to the community had helped. Our own suicidalogist, Dr Chia Boon Hock, gave credit to the government for what it has done for the country and its people through economic policies and environmental management. I feel that psychiatrists cannot claim too much by diagnosing more depression cases and prescribing more antidepressants.

DF: What are the qualities that make an ideal psychiatrist?

CKT: I am not sure whether there is an ideal psychiatrist. In some ways it is context-bound. I would put it this way: I learn most of my Psychiatry from my patients. I think the first requisite is communication. We can only be "in business" when the patient talks, as one

of my tutors in the UK put it. If possible, we need to speak the same language. We need to ensure that the patient understands what we ask and conversely we need to understand their answers too. Mental symptoms, unlike physical ones, are more difficult to describe and express. To be able to complain, the patient would have to be familiar with the strange psychopathology terms or language used to describe the symptoms. The psychiatrist needs to be curious, patient and probing to clarify and verify the complaints because he is his own laboratory. We must avoid "rubbishing" what the patient says and make presumptions that cannot be proved or disproved.



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DF: Stigma is an often-used term in mental illness, how do you think being a psychiatrist is stigmatising?

CKT: Stigma is not confined to mental illness alone. But it was certainly true that staff, including psychiatrists in the old Woodbridge Hospital were laughed at or joked about. Even families of the staff were unhappy. Very few doctors would apply to join Psychiatry as a first choice. To me, the heart of stigma is not knowing how to relate to the other person for whatever reason. Education about stigma is important and familiarity with the condition helps to breed understanding and acceptance.

DF: You won the Lee Foundation-NHG Lifetime Achievement Award, what does that mean to you?

CKT: Compared to other more illustrious colleagues winning academic, professional and service awards, I consider my personal achievements rather negligible. So the Lifetime Achievement Award must be in recognition of my work in Psychiatry and mental health. Of course, I feel honoured.

DF: Any thoughts for the next generation of Psychiatry wannabes?

CKT: My thoughts on the future generation of Psychiatry wannabes are the shared concerns of the other subspecialties. People are talking about the Generation X in commitment, performance and lifestyle. I think we need more respected mentors and role models than courses and coaxing. It is said that we reap what we sow, or we are what we eat. In many ways, we are also who we are, depending on what we have been downloaded with, like software to hardware. In the past, our teachers and mentors "downloaded" on us their experience, values, wisdom, humanity and relationships, the nobility of the profession and the importance of care, concern and compassion for the patient. Nowadays we "download" on our students and juniors with the so-called evidence-based knowledge and information, scales and measurements and in the economic language of clinical entrepreneurs and the industry, cost-effective management, technology and skill, productivity, medical tourism and so on. There is already such inbred downloading in our profession, and I suspect in all areas outside medicine as well. Everything including education and sports are equalised and converted into a common currency of market value and revenue. There is no more altruism so to speak.

DF: Also, one additional question which is now a hot topic amongst some doctors – the issue of becoming a gun for hire in Psychiatry, do you think that is a rising trend and how we can nip it in the bud?

CKT: I think there are three possible positions taken by psychiatrists in forensic work. The first is who the court would consider to be the appropriate one to give a professional and yet neutral expert's opinion. In other words, the psychiatrist would give the same opinion or conclusion based on his clinical assessment of the accused to whoever that asks for it.

But in the adversarial system of our court, sometimes if not often, the psychiatrist unintentionally or unconsciously plays the role of advocate for the offender or accused. He may do so from his vocational training and ethical pledge of doing no harm and wanting to help the "suffering". There is some conflict or difficulty in separating the roles of a doctor and the impartial witness. In other words, the psychiatrist sees himself as a doctor and the accused as a patient. So, not every psychiatrist is suitable to do forensic work. Otherwise, he may indeed do so as "hired" by the defence to explore for advantages and loopholes, but not necessarily distorting facts or telling lies. This is done within the boundary of the adversarial system allowed. There may be a genuine erring or bias towards the benefit for the offender who does suffer from a disorder. There is also confusion between a diagnosis *per se* and explainable psychopathology as a plea for mitigation. For example, just because there is a strong causal link between psychopathology and an offence in a depressed person does not mean that every diagnosis of depression should qualify to be exonerated. One problem with Psychiatry is that of using subjective report as evidence. It is not good for our professional image.

DF: Thank you for your time, Prof Chee. SMA