A Psychiatric Powwow

Psychiatry is one of the least popular specialties in Medicine due to several reasons. Firstly, psychiatrists have to deal with a difficult population of patients who are strongly stigmatised by society. They are also among the lowest paid of medical specialties, and the training is relatively long and arduous. We ask several senior members of this specialty to shed light on their work and give some opinions on matters of interest to doctors at large.

SMA: First, let us introduce our panel.

Dr Ang Yong Guan – AYG: Even before I entered medical school, I was already showing interest in Psychiatry. I remembered when I was disrupted from national service in 1974 to pursue my medical studies, one of the four secondhand books I bought at a Bras Basah bookshop was a book titled *Psychiatry Today* by Dr David Stafford-Clark. 38 years later, I still have this old book sitting on a shelf behind me in my clinic at Paragon.

When I signed on with the Singapore Armed Forces (SAF) in 1980, I was thrilled to be given an overseas scholarship to do postgraduate Psychiatry at the University of Edinburgh. Before I left for Edinburgh in October 1983, I did two years of Psychiatry at Woodbridge Hospital (WH) and six months of Medicine at Tan Tock Seng Hospital.

After returning to Singapore in 1986, I immersed myself totally in military Psychiatry, both the clinical and operational aspects. I built on what my predecessors had done. I ran a psychiatric ward at Alexandra Hospital and spent most of my time attending to soldiers with psychological problems. I was also actively promoting mental health amongst the soldiers, emphasising on resilience-building. I started a series of workshops known as Building Resilience and Achieving Vitality and Effectiveness in life or BRAVE, and organised regular talks on wellness and stress management for SAF soldiers.

Prof Chee Kuan Tsee – CKT: I have been in Psychiatry since 1967. As part of the training requirement, I did one year in Internal Medicine and Neurology under Dr Gwee Ah Leng and Dr Fred Jeyaretnam in the Medical Unit 3, Singapore General Hospital. They were great mentors and physicians by personal examples. After that, I spent about 20 months at the Institute of Psychiatry, London from 1971 to 1972 on a Colombo Plan Fellowship and worked as a general psychiatrist when I returned.

Dr Tan Chue Tin – TCT: I am trained as a psychiatrist, but I will also always be a family doctor. I believe in a holistic approach that factors in the personal, family, work and social domains of my patient, and include them in my treatment plans. My special interests are Forensic Psychiatry, managing mood disorders, counseling and psychotherapy. Of course, assessment and pharmacological support for patients are very essential, but appropriate contextual and support psychotherapy has to be factored in, in order to bring about hope for patients and therapeutic involvement of their families.

A/Prof Wong Kim Eng – WKE: I graduated from the then University of Singapore in 1973, and at 64, I am now a re-employed retiree. I have been the Clinical Director of the National Addictions Management Service since completing a stint as the Chairman of the Medical Board, Institute of Mental Health (IMH). I am an adult general psychiatrist with an Addiction Psychiatry subspecialty interest. I am now a grandmother of three.

SMA: Mental illness is rather stigmatising but do you think that psychiatrists are stigmatised too?

AYG: When the *Straits Times* senior correspondent Radha Basu interviewed me for a full page article in 2009, I said, "Seeing a psychiatrist should be as readily accepted as seeing a doctor for fever. It's slowly happening in many countries in the West. So why not here? We cannot help the mentally ill without fighting stigma."

Psychiatrists are indirectly stigmatised too because many patients do not publicly acknowledge their treating psychiatrists, for fear of letting others know that they have mental illnesses. Many proudly tell others their cardiologists, obstetricians, ophthalmologists, etc, but not their psychiatrists. One patient of mine overcame his panic attacks with agrophobia and was looking good but when asked how he became so well, he would say exercise, diet and positive thinking without mentioning his psychiatric treatment. I hope the situation will change in the future, when having a mental illness is just like having a physical illness and there is nothing to be embarrassed about or ashamed of.

SMA: Can you share some of the myths of being a psychiatrist? What do your medical colleagues from other disciplines think of psychiatrists?

WKE: When I was a young medical officer, my then boss told me that his medical colleagues from other disciplines opined that he was the only "normal" psychiatrist they knew. That spoke volumes about what our medical

colleagues thought of psychiatrists back then. Presently though, I don't think that this misperception is prevalent.

CKT: On one hand, people believe that we can read their minds, but on the other hand, they also think we are woolly. Actually, although every individual is unique as social human beings, there are patterns of thinking and behaviour which are common and recurrent. However, some psychiatrists or psychological-minded persons may explain or interpret too much with insufficient factual evidence. In the early days, not only psychiatrists, but all staff working in WH, were stigmatised.

TCT: Many people think that a psychiatrist can read minds and have answers to all forms of behaviour. I have encountered, in social contexts, questions like: "Doc, please tell me what I am thinking?" or "Why is my wife nagging all night?" Another common misperception is that we see only mad persons and usually hopelessly incurable cases. This is untrue as we often see cases of social, relational or situational issues, such as relationship problems that lead to depression or mood issues, as well as problems like esteem issues and poor self confidence, which often have favourable outcomes.

Medical colleagues in disciplines with frequent psychological aetiologies or aftermaths, like Neurology and Oncology for example, are most aware of what psychiatrists do. Understandably, medical colleagues with the least understanding come from specialties unconnected with patient care and relationships.

AYG: Some people are still not clear about the difference between a psychologist and psychiatrist. One of the myths is that we are like psychologists and therefore, only deal with psychological issues, without realising that we are medical doctors first and are trained to exclude medical causations of psychiatric disorders.

As for our medical colleagues, they are divided into two camps. One camp thinks that we are dabbling in an inexact science, and hence, there is hardly any objective evidence to fall back on. The other camp is more inclined to think that the body and mind cannot be separated. They believe that many medical disorders are associated with underlying psychological issues and hence, a psychiatrist's input is often invaluable.

SMA: What would it take for you to go into private practice?

CKT: To go into private practice, one needs to have some entrepreneurial spirit. Of course, there are also push and pull factors. I am basically an "institutionalised" person who avoids change and risk taking. There have been attractive offers but I do enjoy my work and the opportunity to teach, train and research in WH and IMH.

WKE: It is a fact that all public sector doctors would think about going into private practice at various points in their career. I have remained in public service beyond my official retirement because I am contented with the work environment in the broadest sense. For most people, it is the interplay of push and pull factors at various stages of their career that determine whether they stay or leave the public sector.

TCT: I left for private practice a long time ago! When I left WH, it was partly due to financial reasons but mainly for the chance to do private Psychiatry and to be able to see patients from the start to the finish – meaning to clerk and take a fresh history, and follow up personally till their discharge. Over the years, I have built up a clientele of patients who recommend their family and friends to me, and also multigenerational patients from the same family.

AYG: When I retired from SAF in 2003, I had already served 23 years, 17 years of which I was a practising military psychiatrist. At the age of 48, I wanted to see how I could contribute in the private sector. After nine years, I have built up a fulfilling and enjoyable practice at Paragon Medical. It is very difficult to persuade me to go back to public sector now, considering that 23 of my prime years have been spent there. However, I do not mind playing whatever role I am called upon to take on in the public sector. For instance, I am a member of the IMH Board of Visitors and IMH Medifund Committee.

SMA: The Singapore Mental Health Study looked at the treatment gap of 50% to 90% across a variety of mental health disorders. Do you think we need more psychiatrists? If so, how many more and why?

WKE: A visiting US psychiatrist recently told me that he spends two hours on each patient; his jaw dropped when he learnt that we spend 40 minutes on a new patient and much less time on a repeat patient.

If we are to change the way we work, we would certainly need to have more psychiatrists, but we would have to balance against the cost recovery factor that public hospitals do have to contend with. Presently, we have about three psychiatrists per 100,000 people, which is way below what other first world countries have, but definitely an improvement from what we had a few years ago.

CKT: The number of psychiatrists needed, like all other resources, depends on the standard and quality of care we aim for besides political implications. When there are underdevelopment and limited resources available, a "one size fits all" basic solution would be the norm. When standard and quality of care is raised, more personnel and

resources are needed for more personalised treatment. In a developed and consumer society, there is a tendency to medicalise existential human imperfections and sufferings, which leads to increasing demands for services. There has to be a cut-off point somewhere.

AYG: Yes, we certainly need more psychiatrists to narrow the treatment gaps.

In 2009, there were only about 120 practising psychiatrists here, about 2.6 per 100,000 people (based on a population of 4.6 million). It is a low ratio compared to other developed countries like the United States (13.7), Britain (11) and Australia (14). In order to bring this figure (2.6 per 100,000) to that of Britain (11 per 100,000), we need to have about 500 psychiatrists. Currently, we have about 160 psychiatrists, with a shortfall of 340 psychiatrists. If we train 20 psychiatrists a year, it will take us another 15 years to reach the UK rate.

SMA: Psychiatry is not a popular specialty so how can we increase interest in it?

TCT: I think Psychiatry is increasing in popularity, and its popularity certainly has increased since the time that I was trained. Perhaps, a way to raise interest in Psychiatry would be to raise awareness of it in medical school, by exposing students not mainly to institutionalised Psychiatry and psychiatric inpatients in public hospitals, but also to community Psychiatry, private Psychiatry, GPs with special interest in Psychiatry, and established private clinical psychologists and psychotherapists.

WKE: Apart from the intrinsic interest in Psychiatry that some future psychiatrists would have, young doctors sitting on the fence could be nudged to specialise in Psychiatry through incentives like better training, competitive remuneration, improved career prospects and so forth. Psychiatry does not have the glamour element that is inherent in other medical disciplines.

CKT: My impression is that Psychiatry will become more popular. The evolution and hierarchy of aetiological concepts of diseases move from supernatural and superstitious, to physical and environmental, to biological and organic, to psychological and social, and moral and spiritual direction. The lifespan of psychiatric practice is much longer than procedural Medicine and can be rewarding.

AYG: Psychiatry is not a popular choice mainly because the potential for making lots of money is not there and it is still regarded as an inexact science. We need to appeal to the higher values and ideals associated with being a psychiatrist, and focus on the body-mind interaction seen in so many disorders. We need to actively identify


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A/Prof Wong Kim Eng

young doctors who are psychologically-minded and show interests in the psychodynamics of their patients' illness and lives, and motivate them to take up Psychiatry as a specialty.

SMA: Currently, a third of psychiatrists are in private practice. What are your thoughts on this?

WKE: Many of us believe there is a maldistribution of psychiatrists in Singapore, principally because human nature propels people to places perceived as being more attractive, in terms of image, workload, remuneration and so forth.

CKT: The brain drain from the public sector to private sector is not peculiar to Psychiatry. I have spoken to a number of psychiatric colleagues in private practice and discover that they seem quite satisfied with their own niche and express no regret. It shows there is a demand for them for whatever reason there is.

TCT: I find it satisfying and rewarding to be able to have such a personal involvement throughout the process of treatment, and to empower the family in the therapeutic process too. This is something I find the most rewarding about private practice. The nature of public sector work to date would not allow the same level of individualisation of treatment plans which I consider to be important in my work.

AYG: It is too parochial to see the issue as a public versus private divide. As long as all the local psychiatrists are practising locally, it does not matter whether they are working in the public or private sectors.

Firstly, regardless of whether we are in public or private sectors, we are all serving Singaporeans who will have a choice of the kind of psychiatric services they want, depending on their need for privacy, special services and their ability to pay. Secondly, we should collectively see ourselves as promoting Singapore as a medical hub of the region attracting foreigners to our shore for psychiatric treatment. Thirdly, the private and public psychiatrists should work closely and seamlessly together so that there is exchange of information and notes for the betterment of the patients.

SMA: In view of the recent controversies on overcharging, what is a reasonable fee for psychiatrists to charge?

WKE: This is a complex issue that should factor in, amongst numerous other factors, the considerable time spent on each patient relative to other medical disciplines.

CKT: In enterprise, people subscribe to market forces. But I always view the medical profession as a vocation, although the bread and butter issue is important. We talk about "doing no harm" to our patients, meaning no harm to the "body and mind". But we should also be conscious about doing no harm to their "pocket". In Psychiatry, our overhead expenses are different. We are our own laboratory and part of the therapeutic milieu. Our work is time-based and our overhead expenses are not quite the same. The new cases and psychotherapy take up much time while the long term follow-up of stable cases do not. So I rather like the idea of "ethical limit". Perhaps a certain number of dollars per hour to yield a reasonable income could be attained. I believe all doctors do give pro bono treatment to those who cannot afford it.

AYG: Fees must not be shrouded in secrecy. Although the SMA has done away with the Guideline on Fees, my clinic still displays the fees chargeable according to the time taken. Charging according to time taken seems to be the most appropriate. Depending on experience and seniority, a psychiatrist can charge, say, from $250 to $400 an hour in his clinic.

SMA: Psychiatrists are often team leaders in mental health practice. Should this change and what are the roles of clinical psychologists and advanced practice nurses?

TCT: I think this is already changing, and necessarily so for good quality of care. Psychiatry is very much a multidisciplinary team (MDT) specialty and a combined effort from the MDT, with each member of the team playing an important role. The role of clinical psychologists, counsellors and specialist nurses are vital to treatment, especially in longer term management. For example, assessment, diagnosis and anxiolytics from a psychiatrist are beneficial in treating the acute phase of anxiety attacks or phobias, and thereafter, cognitive behavioural therapy with systemic desensitisation by a clinical psychologist or counsellor is effective in treating the source of anxiety and maintaining healthy functioning. I have met patients with chronic mental illness, such as chronic schizophrenia, who have told me that psychiatric nurses or counsellors have helped them the most, because of illness education, and practical advice on day-to-day coping, such as medication reminders and recommendations of day centres, such as those run by the Singapore Association for Mental Health, which greatly improved their quality of life.

WKE: There are certainly areas where other mental health professionals could take the lead and we should deploy this route more often in view of our chronic shortage of psychiatrists.

CKT: If we accept that medical disease could have physical and mental symptoms, and mental disorders could have mental and physical complaints, then it makes sense that the psychiatrist should continue as team leaders in mental health practice. However, some problems are completely or mainly that of nursing, economic, psychological or social natures. Then, it is natural to delegate the management to the most appropriate member of the team to lead. The psychiatrist is not unlike the captain of the football team. It depends on where the ball is and who is in the best position to receive it.

AYG: Yes, this should change. Psychiatrists should no longer use the hierarchical model of leadership in mental health practice. They should flatten the pyramid and see all members of the MDT as co-workers, and that anyone in the team is potentially capable of being a leader or co-leader. The only difference between the psychiatrist and the rest in the team is his prescribing power. Aside from this special role, he should see himself as equal to others in the team. Clinical psychologists and advanced practice nurses have certainly a big part to play in the management of the mentally ill. The key to who is suitable to be a leader should not be based on specialty, but rather, on competence.

SMA: What are your thoughts on prescribing privileges for psychologists and nurses?

TCT: Psychopharmacology is a part of Pharmacology and psychotropic drugs, just like any other, have systemic effects, side effects and interactions with other drugs. In the course of medical training, doctors are trained in Anatomy, Physiology and Pharmacology, in order to prescribe medication and understand, prevent or treat the above. I strongly feel that prescribing is the role of doctors for this reason, to ensure patient safety as well as to protect other allied healthcare professionals in their work.

WKE: Crucial to the prescribing privilege for non-doctors is adequate training to know what to prescribe. I am comfortable with our previous practice of nurse practitioners prescribing the same repeat medications for stable patients referred to them by doctors.

CKT: The question surfaces probably because of the shortage of doctors and the enlarging clinical roles of psychologists and nurses. I am in favour of restricted prescription privileges for clinical nurses. They are more medically trained and experienced. They are certainly more qualified than the so-called "barefoot doctor". Perhaps we could allow certain classes of drugs within certain dosage ranges for certain diagnoses of mental disorders.

AYG: They should not be given these privileges unless they are well trained in Pharmacology.

SMA: What does work-life balance mean for a psychiatrist?

WKE: As it is for other professionals – to have sufficient time to spend with the family and indulge in non-work activities.

TCT: No more than what is universally meant for any person; at best, we are perhaps more aware of the need for such balance and proactively seek to maintain it, rather than allow events to upset it.

CKT: Psychiatric work or management can be mentally taxing and emotionally draining. In general, when we talk about work-life balance, we have in mind the amount of workload and the quality of lifestyle in a cause and effect manner. As a psychiatrist, we should ask about the level of stress one can cope and the quality of lifestyle one desires or expects (for oneself and family). It is an active balance, not a passive equilibrium. Everything has a price.

AYG: Work is only a part of one's life. The ideal job is one which you look forward to everyday and it is a challenge, not a chore. For a passionate psychiatrist, going to work is a joy and is almost akin to pursing a hobby in your clinic. For him, his job is not a job, but a calling to make a difference in someone's life. For many who are not in such an idealistic situation, they need to find time outside their work to de-stress and rejuvenate. Have a hobby outside of work. Do regular exercises to keep fit. Maintain a healthy lifestyle, and an active family and social life. Finally, it is important that we are mindful of the symptoms of job burnout and nip them in the buds before they get worse.

So there you have it – four senior psychiatrists who have been there, done that with a mind of their own. The rest of this month's issue of *SMA News* expands some of the ideas discussed and we hope that you will have a better understanding of psychiatrists and their relationship with the rest of the medical fraternity. SMA