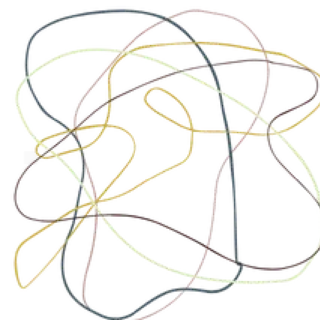
Humanities in Psychiatry

Reflections from Medical Students, Residents and the Medical Faculty



by Humanities in Psychiatry
Core Team 2025

‘Weaving student reflections on humanities in psychiatry, this book highlights the essential role of the arts and humanities in enriching psychiatric care. It offers personal insights into how the humanities cultivate empathy, sensitivity and a deeper understanding of patients’ experiences. It is an inspiring guide to develop holistic and compassionate attitudes among students and trainees.’

Dr Dujeepa D. Samarasekera, Senior Director, Centre for Medical Education (CENMED), Yoo Loo Lin School of Medicine, NUS

‘I would like to extend my congratulations to Prof Sim Kang and his team on the publication of this compendium of reflections on Humanities in Psychiatry, and more importantly, on bringing this conversation to the foreground for all of us. Your work beautifully reminds us that medicine is an art, as so beautifully described by Osler. This collection will undoubtedly inspire deeper connections between humanity and healing.’

Dr Faith Chia, Associate Professor, Cluster Education Director (Pre-Professional Education), National Healthcare Group and Assistant Dean (Curriculum Lead), Lee Kong Chian School of Medicine, NTU

‘“Humanities in Psychiatry” is a compelling read for medical students and healthcare professionals, especially in a high-paced, efficiency-driven healthcare system. It delves into the intersection of art, empathy, and human connection, offering reflections on patient-centered care amidst technological advancements. With relatable narratives from Singapore’s medical practitioners and students, it challenges readers to balance the rigor of clinical practice with the humanity essential to patient care. Perfect for those seeking to reconnect with the heart of medicine.’

Dr Lau Tang Ching, Professor and Group Director, Education Office, NUHS and Vice Dean (Education), Yong Loo Lin School of Medicine, NUS

‘This thoughtful initiative bridges the often-overlooked gap between clinical practice and human experience in psychiatry. In weaving together literature, reflections and medical practice, a valuable framework is offered for developing both professional competence and emotional intelligence. A timely reminder that the art of healing extends far beyond scientific knowledge – it lives in the stories we share and the connections we forge. Congratulations to the team for putting this altogether!’

Dr Michelle Jong, Associate Professor and Group Chief Education Officer, National Healthcare Group

‘This book admirably underscores the critical need for integrating stress management, social media awareness, and spirituality into medical education to humanize medicine and restore its social fabric. In an era where medical practice risks becoming overly focused on biology, the authors’ effort to reintroduce these dimensions offers a refreshing perspective. Stress reminds us of the emotional toll medicine exacts, social media its pervasive influence on doctor-patient interactions, and spirituality its role in offering solace and meaning. By targeting medical students and doctors, the authors take a bold step toward reclaiming the humanistic core of our profession. As Avedis Donabedian once reflected, “The secret of quality is love,” a reminder that compassion and understanding are as essential as clinical precision in the art of healing.’

Dr Daniel Fung, Associate Professor and Chief Executive Officer,
Institute of Mental Health

‘In a world marked by much complexity, the words of the late poet Maya Angelou assure us that “The human heart is so delicate and sensitive that it always needs some tangible encouragement to prevent it from faltering in its labor. The human heart is so robust, so tough, that once encouraged it beats its rhythm with a loud unswerving insistency.”

The “Humanities in Psychiatry” collection is indeed a heartfelt labour of love that reflects deeply individualised, yet universally recognised challenges and triumphs from across the continuum of health professions education, penned by colleagues who delicately consider emotions, uncover assumptions and explore perspectives to better understand why we do what we do, to improve our sense of self, and to bolster resilience for the next time and the time after that. There are fewer powerful forces than opportunities for deliberate, guided reflection in a supportive community of mentors and role-models to enable meaning-making and by extension, to deepen our commitment to the profession and to shape our professional identity. Kudos to all who exemplify this ideal and inspire us with the unswerving insistency of their hearts.’

Dr Shiva Sarraf-Yazdi, Associate Professor and Vice Dean,
Education, Duke-NUS

Contents

Foreword....5

Preface....6

On reading this anthology....7

Will humanistic medicine survive the technological age?....8

How do we teach empathy?....15

How do we sit with the anxiety?....22

Why are we able to help our patients?....27

What lies beneath depression?....31

Who are our patients behind their labels?....35

When does life resume, when it is held in illness?....40

How does it feel to be well and alive?....43

Acknowledgements....46

Foreword

In an era marked by rapid advancements in medical science and technology, the importance of the humanities in the field of psychiatry cannot be overstated. "Humanities in Psychiatry" is a testament to the profound impact that literature, art, and reflective practice can have on our understanding of the human experience, particularly in the realm of mental health.

This collection emerges from the necessity to reconnect with the essence of what it means to be a healthcare professional in psychiatry. Borne out of the challenges posed by the COVID-19 pandemic, these sessions aimed to reclaim the person in medicine, fostering a community of learners who are committed to listening, reflecting, and sharing. Through the lens of the humanities, the writers have sought to slow down and engage with the stories that shape our patients' lives, allowing us to connect more deeply with their experiences.

As you delve into this compendium, you will find a rich tapestry of readings and reflections that not only serve as a resource for personal contemplation but also inspire others to initiate similar dialogues within their own practices. It is our hope that this book will encourage a renewed passion for the art of healing and remind us all of the profound reasons we entered this noble profession.

Happy reading!

Dr Swapna Verma
Associate Professor and Chairman, Medical Board
Institute of Mental Health

Preface

> "The practice of medicine is an art, not a trade; a calling, not a business;
> a calling in which your heart will be exercised equally with your head."
> Sir William Osler (1849-1919)

The idea of starting this series of "Humanities in Psychiatry" (HIP) sessions was borne out of necessity and the unusual circumstances of the COVID-19 pandemic in 2021 when we were experiencing an increased pace of clinical work and amount of virtual meetings, yet also greater physical distancing and isolation. Humanities are academic disciplines that study aspects of human society and culture and include art and literature. Thus our aims are simply that through our encounters with the humanities as a community of learners and practice, we may firstly, reclaim the person in medicine and psychiatry; secondly, slow down, listen to the story, which helps us listen better to our patients; thirdly, connect with the people in the story and let them speak to us, which helps us to connect better to our patients; fourthly, reflect and share in a safe space, admit our own limitations as such stories often ground us and allow us to find our true selves amongst a community of practice; and fifthly, remind us of the reason and passion regarding why we entered medicine and psychiatry in the first place, which is to help others. This process can build inner personal and interpersonal resources during our lifelong journey of learning and caring, which can, in turn, reduce burnout.

During the HIP sessions, we used the close reading drill to help us hone our sensitivity to the nature and details of the writings. I never imagined that my chance attendance of a short narrative medicine course in New York some years ago before the COVID-19 pandemic would actually lend the tools to be adopted for these sessions. We started first with our psychiatry residents and I am most thankful to the core faculty, chief residents, year reps and all residents that have supported these efforts all these years. This was then extended to the medical undergraduates in 2022. As a rough estimate, to date, we have had around 35 HIP sessions with participation of over 350 medical undergraduates and psychiatry residents. In this compendium, we have collated some of the readings that were used in our sessions. It is hoped that they would serve as a useful resource for personal reading, contemplation, as well as for others who may be spurred to start similar sessions within their own settings. In addition, we have included some personal reflections of past participants for our deeper mulling. Kudos to the energy and dynamism of Lincoln, Sachi and team for putting this together. Happy reading!

Dr Sim Kang
Associate Professor and Assistant Chairman, Medical Board (Education)
Institute of Mental Health

On reading this anthology

Thank you for giving our work your time. Sachi and I are Final Year Medical School Students from NUS, and are part of the Medical Humanities Collective (we call it medhums), a student-doctor group spanning the medical schools, hospitals and clusters that aims to bring to life the world adjunct to medicine. We're thankful to have had the opportunity to put the thoughts and feelings of the students who rotated through Psychiatry and the Doctors who make up its practice into an anthology. Here's a quick word on how it goes:

Each chapter is tied to a particular text read by students or doctors. A brief synopsis written by us will be provided at the start, along with relevant excerpts from the source text. There will be reflection prompts at the end of the synopsis, with a link and QR code to the official source. Please note that some of these sources are hidden behind journal paywalls, and we encourage readers to make use of their institution's library-access methods (such as the NUS Library proxy bookmark) to access the sources via institution. Despite these limitations, we hope we have retained the essence of the texts, in our writings and illustrations.

To see more of what we do at the collective, check out our instagram! We also have a telegram channel that you can access from our link in bio.

Lincoln and Sachi
medhumscollective

Chapter 1:
Will Humanistic Medicine survive the technological age?

The Great Technological Divide

George Gubernikoff

The Great Technological Divide

George Gubernikoff, JAMA Cardiology, September 2020

Discussed 15th October 2021

In this article, Dr George Gubernikoff addresses the encroachment of technology in medicine, questioning if and how the core tenets of humanistic care can endure in an increasingly digitalised field. He likens modern technology to the forbidden fruit, tempting yet divisive, and warns of a future where reliance on data and algorithms could overshadow the personal connections that form the foundation of compassionate medicine.

He observes that physicians' focus in consultations have shifted from engaging the patient to engaging the computer screens, with much of their time now devoted to data entry. As he describes, "Hours spent entering information in required fields leave little time to enter a patient's room and engage in conversation", highlighting the growing dissonance familiar to the modern physician.

> "Are we at the precipice where this pact with technology disrupts the patient-physician relationship?"

Drawing upon the Renaissance, Gubernikoff points to four "areas of significance that speak clearly and bring meaning to the physician-patient relationship", that may aid in the revival of the lost art of the physician:

(1) rhetoric/debate
(2) study of the humanities
(3) appreciation of a unique human experience
(4) the individual in society

Of the 3rd point, he reminds us:

> "[...] A rational approach in medicine provides for a balance between science and humanism. Scientific approaches embrace technology in an attempt to cure complex disease, ease suffering, and prolong life. **This approach in medical care** with its focus on therapeutics to prolong life **can at times fail to recognize that the human experience is fragile, flawed, and ultimately fleeting.**"

He also references Renaissance artworks, like Titian's The Three Ages of Man and Michelangelo's The Creation of Adam, as symbols of the union between intellect and compassion, suggesting that a physician's role is both scientific and deeply humane. This balance, he argues, is at risk if technology continues to monopolise clinical interactions.

> "[...] The Three Ages of Man reflects the sequence of life from the vulnerable child, to the mature adult, and ultimately the contemplative aging individual all set in the background of nature. Humanism acknowledged emotional expressions of joy, strength, weariness, and acceptance of the finite nature of life. Humanism asks the individual to question a virtuous life well lived and perceive the plight of others with understanding, mercy, benevolence, and compassion."

Finally, the article challenges us to consider whether medicine, under technological transformation, can still uphold the humanitas of classical humanism—a term encompassing kindness, compassion, and moral integrity. Can a system designed to "diagnose and treat" also serve to comfort and understand? Gubernikoff leaves the question open, urging doctors to guard against a future where technology disrupts the patient-physician relationship rather than supporting it.

Prompts for Reflection

- What is humanistic medicine to you?
- How have technological advancements changed your approach to patient care?
- Can humanistic medicine go hand in hand with global technological advancements?
- How do you think the tension between efficient vs humanistic medicine play out in Psychiatry?

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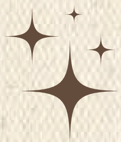
Reflections

Technology is a potent tool. From a practical point of view, it has revolutionised the way physicians care for patients – by screening for previously undetectable ailments, allowing for greater accuracy in diagnostication and prognostication, and reducing time to treatment, amongst other previously unfathomable benefits. This paper posits that the automation of (much of) clinical care has made the patient experience equally mechanical – in both the figurative and literal senses. We treat the signs, symptoms, graphical abnormalities of disease, but not the humans behind them. Perhaps what is most important in utilising this tool is to realise that tools make it easy to take the convenient way out (copy-pasting EMR notes without clerking the patient in person etc.), and that it is a personal choice whether to actually do so.

Flora Xu, Student



Our very first task with a patient in year 1 of medical school was to "hold a conversation for 10 minutes about anything". Every patient history we take thereafter is run through a fine-tooth comb, tucked neatly into 9 pressurised boxes.

5 years later, this perfect performance is quickly forgotten and we are slaves to an electronic universe. Our fingers glide effortlessly in muscle memory typing "Heart sounds S1S2 heard lungs clear abdomen SNT" without a second thought.

Need to admit a patient? Click through a maze of a dozen forms first.
Start a new medication? Override 3 computer generated warnings.
Perform a quick investigation? The computer will tell you if their ECG is normal, or if the eGFR is within normal range.

Years later I wonder if I will ever think to myself -
"I treated the patient through the bars of a screen and keyboard prison.
I can't even remember their name"

Anonymous, Student

Monotony and Stereotypes

In the interface between clinical consults and EMR, the EMR can rear its head and take precedence. There are times where I have to focus on crossing to the next item on screen. Whilst I focus on this task, I may lose track of the person across from me, who feels anxious, depressed, lost, concerned or angry.

[...] I remember a patient with a likely borderline intelligence and multiple medical issues who would play with candles at night and stay out by himself. In the midst of trying to understand all his medical issues, I did not notice his younger brother who was crying out of concern for his brother's situation. [...] Technology can be a bane and boon, we need to be careful about the monotony and stereotypes, cut and paste work that lures us inwards away from our patients.

Anonymous, Faculty

Today facilitated a discussion that ought to not simply rest within the confines of this zoom call. A conversation which fundamentally boils down to the crux of who we are and what we are pursuing this dream of Medicine for. Outcomes vs people, older vs less old, we are the generation who grew up with desktop computers and now hand-sized computers from which we enter into every single social interaction of our lives. Technology is so deeply permeated into our lives that this discussion is next-to-impossible; we simply do not know of life without technology. The "patient interaction" this author speaks of is entirely alien to us, we cannot possibly understand why any patient would want to see a doctor who does not take down his impressions and diagnoses - our impression of a "Good doctor" hinges upon our use of the technology we have been told is our friend. To be honest, perhaps we never really will understand the richness of medicine Dr Gubernikoff alludes to. And perhaps part of the story of growing up is that we never will. That the Rubicon he speaks of with a certain nuanced warning is a fluid, dynamic force we will always continue to traverse. That most importantly, we will only catch glimpses of the past through the stories we learn from our mentors. And perhaps we too, one day, will share our own glimpses of the technology we now have, as an archaic reminiscence of the time we once knew.

Ashiley, Student

The Singaporean ah ma might not appreciate Michelangelo's genius in the Sistine Chapel, but certainly the gaze of compassion, the sense of being heard, the reassurance in an unfamiliar place. I have no experience being a junior doctor working till the wee hours of the night, but one of the privileges of medical school is the privilege of time - that we have the space and the capacity to listen. Perhaps something even more is the privilege of helplessness - in the inability to help our patients medically, all we can do is to use our ears, our words, our time. As we gain the power to do more physically for our patients, I hope that we also remember this human touch and this power that we all possess - no matter which level of medical expertise - to be humans.

Anonymous, Student

I agree with the author that medicine these days relies heavily on technology - detailed electronic patient records eg medication reconciliation/past medical history, investigations etc - relying less so on "art" of medicine like obtaining a detailed history, doing a thorough physical examination to obtain a diagnosis - especially in specialities where there are significant technological advances eg cardiology. But is it for the worse? The practise of "art" points to a more subjective assessment, one that can be argued against, one that may rely more on experience and even hunches or emotions, but with technology, medicine has become more "objective" - can one argue against the presence of a valve defect on an echocardiogram versus a murmur heard by one doctor but not another?

Anonymous, Resident

Deattachment and Reattachment

I feel a sense of detachment when I am typing onto the computer after a long list of patients in the clinic. It feel surreal when I disconnect from the 4th Zoom meeting that seems to go nowhere and half the time are about unrelated matters. I am reminded about the need to ground myself just like how a patient with dissociation needs to do so to gain a sense of reality. How we need to refocus on why we do what we do. And not just do just like an automaton. We need to harness [technology] to help us better journey along with the patient.

Perhaps better than the question of whether is technology a bane or boon, is to ask regularly have I detached or reattached myself to the person in front of me during a consult when all seems to go as required by routine.

Anonymous, Faculty

However, in the process of using technology we must be careful not to let the convenience of technology be an excuse for spending less time and effort on the patient, and spending even more time on just technology itself. i think the human experience is too complex and full of nuances to ever be understood fully by technology, and only humans have the ability to navigate these complexities. what many patients want is to know that they are not alone in their struggles, and only with interactions with humans can they be able to feel this way. with technology it's easy to see patients as "just another case", so i think it's important to always see the patient as a person, and not a case. i think its also breeds the defensive medicine culture where everything needs to be documented, and there are pros and cons to this which we need to manage and balance.

Anonymous, Student

Chapter 2:
How do we teach empathy?

Medicine’s Uncanny Valley

Caleb Gardner

Medicine's Uncanny Valley: The Problem of Standardising Empathy

Caleb Gardner, Lancet Volume 386, Issue 9998, September 2015
Discussed 28th July 2023

"A month after my father died of heart failure in a cardiac intensive-care unit in my hometown, I flew back to Baltimore to finish my final year of medical school. Although I was apprehensive about returning to the hospital, I knew that the full schedule would be a welcome distraction. Still, I was surprised how easily I fell back into the old routine of attending morning rounds, admitting patients, writing progress notes, and presenting cases to the head physician..."

In Medicine's Uncanny Valley, Caleb Gardner presents a reflective critique on the challenges of teaching empathy within the rigid frameworks of medical education. He narrates his own experience following his father's death, observing the nuanced difference between genuine human connection and a scripted, impersonal empathy. The "rote phrases" and checklist-driven empathy of one doctor made him feel profoundly disturbed and disconnected from his father's care. "The only thing worse than not having [empathy] is being insincere about it," he writes, likening the artificial empathy to the uncanny valley in robotics—a place where something almost human, but not quite, triggers discomfort and alienation.

"The doctor on duty during the week my father spent in the cardiac intensive-care unit was young, focused, and energetic. In the few brief conversations we had she used many phrases that I recognised from medical school. But her approach couldn't hide the fact that she would have rather been looking at the screen of her smart phone than talking to me or my mother; if anything, the rote phrases she used emphasised it. At one point she awkwardly nudged a box of tissues in our direction, although neither one of us was crying."

Gardner's experience with his father's cardiologist, on the other hand, offers an inspiring counterpoint. This doctor, who did not rely on formulaic language or protocols, took time to listen deeply and reflect on his relationship with the patient.

This encounter, simple yet deeply personal, is where Gardner finds a model of genuine empathy. He recognises that empathy in medicine is about more than following a communication guide—it's about fostering a shared humanity and presence in the face of life's most challenging moments.

> "I understood the situation, I said, but I wanted him to explain it to me one last time. He told me, instead, to explain it to him, and he listened as I struggled to make sense of things. When I finished, he told me about the first time he met my father and how much he had grown to admire and care about him over the years, and finally how he knew that what was happening was the best thing for his patient and his friend. As he spoke, unhurried and affectionately, I realised what it means to be a good doctor."

Reflecting on his journey, Gardner argues that while certain expressions or phrases may support compassionate communication, true empathy is cultivated through personal experience and understanding rather than standardized tools. He suggests medical education should encourage students to seek varied experiences and embrace their own humanity. "Real damage is done," he concludes, "when medical training inadvertently facilitates the substitution of scripted empathy for the real thing".

Gardner ends his reflection with T S Eliot's poem "Little Gidding", a reminder that "it is often out of confusion, uncertainty, and sometimes loss, that our clearest thoughts and most meaningful experiences arise."

> **Every phrase and every sentence is an end and a beginning,**
> **Every poem an epitaph. And any action**
> **Is a step to the block, to the fire, down the sea's throat**
> **Or to an illegible stone: and that is where we start.**

Read the original PDF via the QR code, or access it online via https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(15)00161-0/fulltext

Prompts for Reflection

- How far can standardised assessments of empathy take us?
- Is empathy an inherent trait, or a trainable skill?
- In our society, how do you think patients wish for us to express empathy to them?

Further reading

- Is AI more empathetic than your doctor? Nathan Gray, Los Angeles Times

Reflections

What does it mean to be a good doctor? Is it knowing about every possible condition, treatment and answer? Perhaps. Or is it being dedicated and fully committed to spending your time, effort and energy on every single one of your patients? Maybe. Or is it maybe that your patient should feel heard, seen and understood. In a culture where results are paramount and deliverables need to be met, patients may seem like just another case to clear, another checkbox to tick. But put yourself in their shoes, at your lowest point and feeling your worst. You come across a doctor, who's seen 15 patients and is going through the consultation hurriedly and barely listens to what you say as he runs through his "template". How would you feel?

Anonymous, Student

[...] On one hand, there is a need for medical schools to streamline and standardise teaching of empathy using a fixed formula. [...] On the other hand, empathy comes from the heart, and by confining it to a mnemonic, you remove the authenticity of empathy.

Anonymous, Student

Presence and Professionalism

Being present can be challenging, and effortful. It may not be entirely accurate to say that "As long as you are physically present, you are in business". Our mind is constantly active, delinquent, and prone to wander. Only when we rein it in can we be present, in the here and now. The patient can sense and smell when we are here in body but absent in spirit.

Perhaps we should not try so hard and over-pressure ourselves to be always present 100% of the time. That shows our humanity as we balance our sense of professionalism with the presence to serve and help the patient in front of us.

Anonymous, Faculty

How important it is to be reminded of the importance of empathy and building a sincere human connection. That frameworks and scripts for empathy is a means to the end of connecting with the patient and that we often confuse the means as the end.

Anonymous, Student

Rushed but not hurried

I am struck by the importance of presence and posture as seen in the example of the article's cardiologist. What he said, left unsaid, and did; his waiting for the author to convey his understanding about the withdrawal of supportive care for his dying father, reminds me of when dad passed on in the hospital 6 years ago.

A junior doctor came in and first conveyed that he needed to do an ECG to check on dad before drawing the curtains. He was rushing amid many duties but also seemed not to be in a hurry, as he explained to us in a personal way about Dad's condition and also asked whether we had any questions before he proceeded.

Anonymous, Faculty

It was comforting to realise that we don't have to fully relate to patients. As long as we are genuine and making a conscious effort to understand them, it is enough and appreciated.

Anonymous, Student

We, as humans, are fundamentally flawed. Hence there is no 'perfection' in empathy as it is a reflection of our human state - we can only strive to listen intently & understand what the other person is trying to convey. sometimes that is all that is needed to be done

Anonymous, Student

Empathy is a value that stems from the heart. The uncanny valley illustrates that inauthentic human likeness defeats the purpose of attempting to replicate human empathy when the user is not putting in effort or is unable to show it.

Empathy does not have to be perfect, does not have to involve finding the right words and phrases. Rather it is expressing our emotions and doing our best to genuinely relate to the patient's circumstances.

Anonymous, Student

I think this session reminded me of the art of medicine, and the entire reason of me wanting to pursue a career in medicine. More than just learning about conditions, I wanted to make a difference in patients' lives as well as help others. It's so easy to become jaded after going through the many years of medical school and focusing on the theory rather than the heart behind executing these things.

Empathy is not something that is good to have, but rather something that is necessary to have, and should be the core of patient care. We see so many doctors who treat patients as problems they need to solve and I feel that it makes us less human.

If only we held on to the reasons why we started, instead of conforming to the culture and expectations of the current system on what medical care is like. Sometimes patient-centred care is more of what the patient desires and what he/she views as good for them after given the medical information (e.g. smoking because it relieves stress) rather than doing what we deem is theoretically right (e.g. making the patient cut smoking entirely), because a patient is human, and someone with their own beliefs and views, that they may end up being depressed in a seemingly 'better' life.

Ultimately, the quality of life is relative to the patient and their experience, and I wish we could just realise the weight this problem of empathy and how much it would change the quality of care we provide if we could learn to become more empathetic.

Anonymous, Student

Being able to empathise with people based on shared experience is easy, but being able to set aside time in the midst of a busy schedule and truly try to understand and be with the person is what makes empathy hard and precious. Showing empathy not only helps to strenghten relationships but also encourage patients to share more and hence, empathising with patients shouldnt be viewed as a lack of time. But indeed there are so many factors that prevent us from doing so despite how earnestly we want to form such bonds. Pragmatic factors like the lack of time, productivity, amount of loaded tasks, make it hard to strike a balance. Therefore, minimising time spent on empathy is the first thing that someone would naturally turn towards. Both structural changes as well as a change in attitude should go hand in hand to solve such an issue.

Anonymous, Student

I think the session gave me an opportunity to slow down and crystallise an overview of the thoughts I have about empathy as a whole. Part of the beauty about doing a seminar style discussion on the humanities is discovering that there is no perfect answer, that there are always multiple facets to a problem like the many sides of a diamond, and that there is no perfect method. Rather, how do we better the problems as a system and a whole?

Anonymous, Student

Writer Milan Kundera observed that a doctor is “someone who consents to spend his life involved with human bodies and all they entail. That basic consent (and not talent or skill) enables him to enter the dissecting room during the first year of medical school and persevere for the requisite number of years.” But I believe that barely any of us had truly understood a life involved in the fear, weakness & love of our patients when we consigned our futures. This does not mean we were deceived, however, and therefore the only way to honour our fait accompli is to spend the time we owe with our patients and their emotions.

Anonymous, Student

Chapter 3:
How do we sit with the anxiety?

Calming the Storm

Jesse John Goitia Jr.

Calming the Storm

Jesse John Goitia Jr, JAMA Volume 324 Number 13, October 2020

Discussed 7th June 2022

In **Calming the Storm**, Dr Jesse John Goitia Jr. recounts his journey through medical training, marked by his personal experience with anxiety - he describes a time when he was "convinced that [he] was dying," laying awake at night plagued by the fear that he had an undiagnosed illness despite a series of negative tests and consults. This fear eventually led him to a primary care physician who helped him understand the mind-body connection.

> "She helped me realize how powerful the mind can be and how stress can manifest as physical symptoms."

Dr Goitia's narrative echoes the common human experience of anxiety as he reflects on moments in his life where he felt paralyzed by uncertainty and fear. Despite the universality of anxiety, he writes that healthcare providers often struggle to offer patients the listening ear they desperately need. He shares his experience of "burning through numerous primary care doctors, whom [he] quickly labeled as uncaring idiots," highlighting **disconnection as a barrier to patient care**.

His experiences have shaped his own approach to patient care as a cardiology fellow, where he frequently encounters patients with similar fears about an undiagnosed illness, stating that -

> "the specter of sudden death can create anxiety in anyone and can lead a person to attribute even the slightest and most brief palpitation to being a symptom of life-threatening illness."

In the wake of the COVID-19 pandemic, he notes that while the immediate crisis may have subsided, the anxiety it generated lingers. "The uncertainty around transmission, symptoms, testing accuracy [...] all add to this growing distress," suggesting that the fear of sudden health threats continues to affect both patients and providers.

Quoting Dr Faith Fitzgerald who had previously written about how curiosity "converts strangers...into people we can empathize with," Dr Goitia urges clinicians to engage deeply with patients' experiences:

> "We need to be curious about our patients as people, not simply as patients."

Through his reflections, Dr Goitia underscores the importance of nurturing curiosity and compassion in healthcare, advocating for a shift towards patient-centred care.

Prompts for Reflection

- Have you personally experienced moments/periods of anxiety in your life? If so, how did you cope?
- We know that patients all want a listening ear. What do you really think stops us from providing them with what they need?
- Consider our current position, now that the pandemic has abated. Has the anxiety it's wrought still persisted?

Read the free full text via QR code or at:
https://jamanetwork.com/journals/jama/fullarticle/2771257

Reflections

Reflecting on my own life, there have definitely been brief periods of time where I've had perhaps similar existential dread and despair, and I cannot imagine how tiring it must be to have similar feelings for a prolonged period of time, sometimes for one's whole life. Sometimes I wonder how one would go about finding their purpose or sense of meaning in their life; and if I happened to find mine out of sheer luck. I cannot imagine how tiring it must be to just live for the sake of living. The fatigue must be overwhelming and it makes me feel helpless in alleviating that fatigue. How do we help those who have not found their reason to live, and in the same vein - is it possible to never find it yet live happily?

Anonymous, Student

Yesterday at NAMS* clinic, our first patient had been abusing heroin for many years, and had a recent relapse. He used his appointment card to sweep the dust on the table, in a strangely familiar way that seemed like he was sweeping his drugs into a line so that he could sniff it down. I thought that that might have been a habit of his, borne out of the years he had spent chasing the dragon. Observations like these may be subtle, but [...] can help us have a better idea of the patient.

Anonymous, Student

*National Addiction Management Service

I feel that Psychiatry is one of a few specialties (like Internal Medicine) where you really see all the social issues come together to be a major precipitating or perpetuating factor of the problem. The public can give up on mentally ill patients, but the therapists should not. But we really need the public's help, as social issues are almost entirely out of our control. Although I understand that some social issues like divorce, and poverty are also out of the public's control, there are so many more compensatory measures or choices that would be protective factors of mental illness.

Anonymous, Student

Reflections

[...] And I guess here lies the danger of losing sight of the very thing that drew me to medicine — having the personal connection with patients: providing a listening ear, being able to be there for them in what may be their toughest moments as they receive a new diagnosis alone, without any family or friend by their side.

Time after time as patients I've met poured out their hearts to me, I'm reminded that these are precious humans beyond the diseases they have, and that it is a huge privilege to be able to be trusted to hear their life story. At the end of the day, whenever I look back at my different postings, what I remember is not the signs I picked up. But instead, what I remember so vividly is the few individuals who have been so vulnerable, shedding tears as they shared with me their innermost worries and anxieties.

Anonymous, Student

When caring for patients, perhaps the most important thing that we can give them is our time and our understanding. This allows us to peer into their lives, comfort them, and work together on a plan to help them in a way that is most beneficial to them.

Ethan, Student

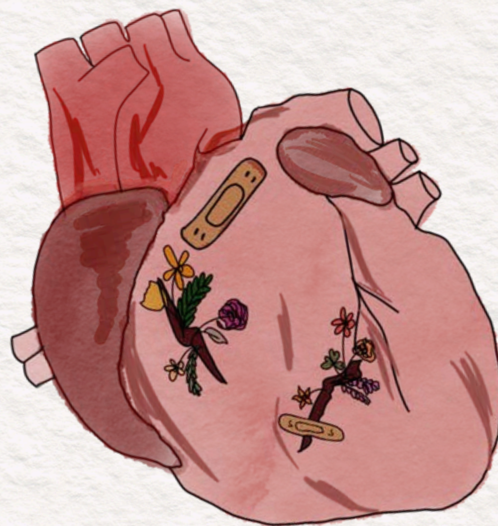
I like to spend my days in peace. Sure, I really enjoy getting to know my friends, acquaintances and patients better - an abundant source from which my laughter, tears and frustration originate from - but there are days when it becomes too much. Friends with broken hearts, patients with broken spirits, and myself with a brain wrung dry; it enshrouds my mind with a noisy fog. How can I remain curious? Where does that emotional stamina come from? Sometimes I wonder if I'm fit for this line of work, or if I'm the odd one out.

Anonymous, Student

Chapter 4:
Why are we able to help our patients?

The Wounded Healer

Joe Colletti



The Wounded Healer, Commentary

Joe Colletti, April 2015

Discussed 5th April 2022

In his **commentary on The Wounded Healer**, Joe Colletti delves into Henri J. M. Nouwen's exploration of the intersection between personal wounds and the ability to heal others. Colletti emphasizes Nouwen's central idea that everyone carries wounds - whether from experiences of alienation, loss, or trauma - and that **these wounds can become sources of strength rather than shame.**

Colletti reflects on Nouwen's description of the minister as a "wounded person" who seeks to serve others while grappling with their own pain. This duality is critical; understanding one's own wounds allows for a deeper empathy towards others who are suffering. He highlights the universal nature of human suffering by reiterating Nouwen's question:

"What are our wounds?"

He also considers how experiences like divorce, death, and illness shape our understanding of woundedness, connecting this to the idea that these experiences, while deeply painful, can foster resilience and enable individuals to become effective healers.

Colletti further illustrates Nouwen's belief that a community thrives when individuals share their wounds, as this **openness fosters connections and healing**.

Quoting Nouwen's writing,

"a wounded healer's primary task is not to take away the pain, but to deepen it to a level where it can be shared,"

Colletti reinforces the idea that empathy and shared experience are vital in the healing process.

Additionally, Colletti draws on the imagery from St. John of the Cross's Spiritual Canticle, which symbolizes the mutual recognition of suffering in relationships. He concludes that embracing our vulnerabilities and acknowledging our shared wounds can transform both our lives and those of others, making us all potential wounded healers.

Overall, Colletti's commentary serves as a thoughtful reflection on Nouwen's insights, urging readers to **embrace their woundedness as a pathway to deeper empathy and connection** in their roles as caregivers and healers.

Prompts for Reflection

- The writer draws upon religious concepts to describe the spiritual realities of helping others. Would you consider yourself a wounded healer? If so, why?
- Do you believe that there is a role for the Wounded Healer in medicine?
- How would you feel if your Doctor or Psychiatrist or Psychologist identified with the role of the Wounded Healer?

Read the full review via the QR code or:
https://www.joecolletti.com/the-wounded-healer-in-the-spirit-of-henri-nouwen/

Reflections

You said nobody understands you
You've been through so many doctors
You've tried so many medications
You've answered so many of the same questions
You've lost hope with treatment
You think I can't help because I haven't gone through the things you have
And it's true
I haven't lived the same life as you
Because everyone is different
But then again, we are also the same
Because
I've suffered before
I know what pain feels like
I know what it means to try and struggle and try again only to fail over and over
And eventually stop striving
Not because I accept the outcome
But because I've found meaning in the process
And I wish the same for you
So I won't stop you from this bitterness, anger, rage, hopelessness
But I will choose to stay with you in this process
With the hope that we shall surrender to
Meaning and recovery
Growth and maturity
Victories amidst miseries
Together

Dr Ang Ren Xuan, Faculty

I am a wounded healer. And I will continue to be wounded. It will result in scars and it will show. But it will show that I am human. And that will tell others that I am just like anyone else. And hopefully it will bring people together. Just like in moments of joy, wounds can help bring us closer. We share a common pain. And that is living in this world. But it shouldn't be taken up by one person. It is shared and processed together. And that is when the wounds start to get better. And the resulting scars become a symbol of healing that comes not only from myself, but from others who have shared the pain. I thank all the patients, as their wounds are a reminder that I also have wounds. I am a wounded healer. And I will continue to be wounded.

Anonymous, Resident

Chapter 5:
What lies beneath depression?

The Other Side of Silence

Linda Gask

The Other Side of Silence, Conclusion

Linda Gask, Published August 2015

Discussed 3rd October 2021

Gask reflects on her lifelong struggle with depression in the **conclusion of The Other Side of Silence**, describing it as a deeply complex and personal illness. Through multiple depression relapses for over two decades, Gask has come to understand the condition as far more than a simple set of symptoms listed in clinical manuals.

She describes depression as a spectrum of experiences, highlighting the importance of acknowledging the unique personal history behind each person's depression and pointing out that it often results from a combination of factors such as vulnerability, grief, trauma, fear, loneliness, and unresolved emotional wounds.

> "Depression is related to all of these factors,
> and at the same time is also none of them."

While she acknowledges the role of biological factors in depression—such as genetic predisposition and brain chemistry—Gask questions the idea of reducing depression to mere biology. Instead, she states that **depression is a complex interplay of biological, psychological, and social factors.**

Gask understands depression as a deeply personal and isolating experience, one that affects a person's sense of self and purpose. Yet, she holds onto the belief that recovery is possible - through connecting with others and seeking help when needed, which she recognises as a sign of strength rather than weakness.

> "To be able to have a frank, open and meaningful conversation with another person is, as Bob Hobson (a psychotherapist who supervised my therapy in my early career) said in his book Forms of Feeling, **crucial in enabling us to explore, learn and modify how we deal with our difficulties**, especially those concerned with our significant relationships."

As she reflects on her own path to healing, she shares the importance of a combination of therapy, medication and self-care routines. While not religious herself, Gask also shares how some may find strength in their faith while on their journey towards recovery.

> **“I am beginning to learn the need to nourish my own soul in order to prevent relapse, rather than simply mend it when it is broken.”**

In the final paragraphs, Gask expresses a sense of hope and acceptance; she concludes by stating that despite her struggles with depression, she has made progress in both her personal and professional life, and will continue to take the necessary steps to maintain a balanced and fulfilling life. While depression may be a lifelong struggle for many, the author suggests that with the right support, self-compassion, and understanding, **it is possible to find ways to lead a fulfilling life.**

Prompts for Reflection

- If you had to choose, which of the proposed mechanisms for depression do you agree with more? Why does it matter?
- The “self”, the body and the mind. How can we be sure of who we are?
- What patterns do you notice in your thinking when it comes to dealing with personal challenges? Have you noticed similar patterns in patients with psychiatric diagnoses?

Find full text via QR or at: https://lindagask.com/the-other-side-of-silence/

Reflections

I think [this article] really encapsulates why I chose psychiatry in the first place. Psychiatry is really a complex field with so many different interesting things I can learn from. The patients are indeed the true teachers in psychiatry. Noting that each patient is different, each patient has their own life story to share, each patient has something to offer. Also like to thank everyone else for the sharing. Really opens up my mind and makes me more excited to kick start my psych training after my medical rotations. Lastly, it's important to understand self care and the importance of taking care of ourselves while treating our patients. As we are doctors and psychiatrists to be, but we are also humans with our ups and downs.

Anonymous, Resident

Be in the present

We often live in the future and past and not in the present. It is true in our consults and own personal experiences. Anxious about clearing the next few names on our clinic list, ward reviews, presentations, exams, etc even now as I sit in this discussion. The present will soon be in the past and is ephemeral if not experienced, captured with patients. Perhaps the pain and suffering of the patient can be lessened or halved when it is heard and shared in the present. Perhaps the joy that the patient had can fill him with greater gratitude as we do not take things for granted in the now.

Chomp Chomp, Faculty

Thinking that we know

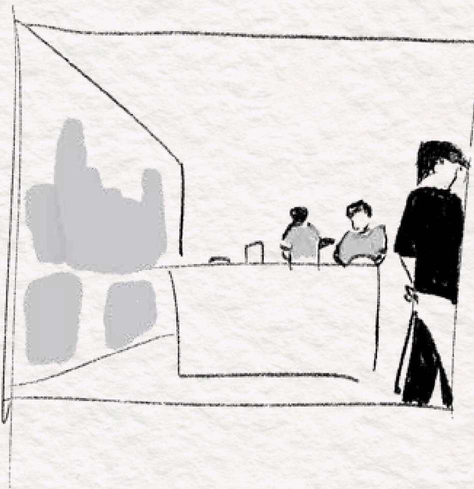
Thinking that we know everything about the condition and patient's experiences, takes us furthest from the truth; we only become more ignorant. We come with presumptions, presuppositions about what underlies the clinical symptoms, yet we do not know until the patient validates what they are going through and issues underlying them. It could be past trauma or failures, recent tension with a loved one, or disappointments like a recent promotion that wasn't such a big deal after all.

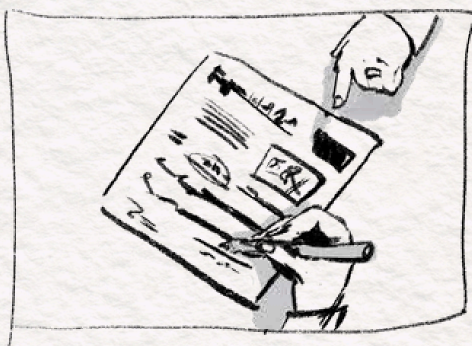
Chomp Chomp, Faculty

Chapter 6:
Who are our patients behind their labels?

Vaccinated, but Not Protected

Lindsay Ryan





Vaccinated, but not Protected:
Living Immunocompromised during the Pandemic

Lindsay Ryan, JAMA 2021

Discussed 3rd September 2021

In **Vaccinated but Not Protected,** Dr Linsay Ryan invites us into the life of an immunocompromised physician navigating the uncertainties of the COVID-19 pandemic. While many celebrate the protection offered by vaccines, Ryan's experience challenges this narrative, prompting readers to consider; what does it mean to be "vaccinated" when that protection is not guaranteed?

> "[My students] practice again and again, and I'm proud of them: They're getting skilled at delivering the key messages. 'These vaccines are so much better than the flu shot," they say. 'They're almost entirely effective at preventing hospitalisation and death.' What they say holds true for most people - but not for me."

She paints a vivid picture of the isolation she endures as she watches her friends return to their pre-pandemic activities—traveling, dining out, gathering mask-free—while her own world remains restricted. She wonders, as her peers enjoy these new freedoms, "As their freedom expands, mine will shrink." How does it feel, she asks implicitly, to be left behind in a race toward normalcy that you cannot safely join?

She shares a moment of deep discomfort reading a comment online that reduced immunocompromised individuals like her to potential "vectors of infection," stripped of humanity. This label, she suggests, reveals a painful truth:

> It never occurred to me that someone might write about me as a potential 'vector,' not as a human being."

"[...] A few months into the pandemic, one of my mentors told me that the situation reminded her of the early days of HV. 'All the language is about risk,' she said, 'with all the stigma of whether certain people are risky.'"

The stigma alluded to in the language of infection control may be subtly hidden in the rest of medical language; in our diagnoses and descriptions:

rensics history" "Poorly Controlled T2DM, noncompliant to meds" "Patient denies

rawal" "16 year old primigravida" "The pancreatitis in bed 17" "Indonesian nation

ality trait" "ADL-dependent, max assist" "5 year old, social admission" "Condoms r

mpulsive Disorder "19 year old NSF, acute stress reaction" "Employer demands

To what extent do labels shape our patients?
To what extent do those labels shape our response?

Dr Ryan's story is a call to pause and reflect on what it means to truly see a patient; their fears, limitations and narratives.

Prompts for Reflection

- The author's position makes it difficult for her to accept the choices of others, despite knowing that not all of them have any other choice. How do you feel when you see patients make decisions you do not agree with?
- Think about the language of Pandemics and Infection Control. Are there any similarities with the language we use in Psychiatry?

Read full text via QR or at: https://jamanetwork.com/journals/jama/fullarticle/2781012

Reflections

I felt that the central theme of the article was freedom. At the start of the article, it was how Dr Lindsay's freedom was curtailed by the disease which brought her debilitating pain. This pain was then relieved by her monoclonal antibody infusions, warriors that knocked the hardworking overdriven B cells into remission. Yet with the pandemic, the freedom that she won through the antibody infusion became the very reason her freedom is taken away yet again. I thought it to be quite a cruel twist of fate, to have one's freedom so intertwined with one's mortality. To have one means to lose the other. To live means to give up her freedom. I could feel how the lack of freedom creeped up on her, chipping away her self worth, identity when she no longer has the freedom to choose and to take up work opportunities offered to her. In relation to the current psych posting then, it reaffirms what patients at IMH have shared - the pandemic being so long and drawn out, has inevitably taken a toll on all of us, exacerbating our present illnesses, putting a strain on our mental health, causing our past demons to relapse.

Anonymous, Student

Every patient tells a story. [...] it is easy to be blinded by the numbers and figures that speak of vaccination progress, total infections, total deaths, and etc, to get caught up in the big picture. Yet each individual has a story that we must not forget to hear and listen to, to approach each patient as an individual and not as a number. As healthcare workers, as we see patient after patient, the workload builds up, and it feels almost necessary to detach a little more emotion as we go along. To be desensitised in order to continue to function. How important it is however for us to remember that for the patient how harrowing their current medical experience might be; to remember that even as we comfort by normalising, we do not minimise their distress. We empathise. We must also remember to reflect on each patient, to process and not repress our emotions, less we become a machine more than a physician.
Someone who fixes but does not heal.

Anonymous, Student

When is your next patient?

In our care for patients we are often overwhelmed. Which means I am less present for the person sitting in front of me, which means I am listening less, more distracted, less aware of the reasons that have brought the patient here.

I wonder what my patient feels? Does he feel like he is being treated as another number or name on the list, a case to be gotten rid of expeditiously so that the doctor have time for whatever things they have to be busy with? “Do you know that I did not even want to come to see you in the first place, that it was because my parents dragged me here, or that a friend had encouraged me, or that something happened a few weeks ago? Will you want to know? When is your next patient?”

Chomp Chomp, Faculty

Ryan’s piece sheds a light on the selfishness, or perhaps more generously, the unawareness of man as we toil through this protracted pandemic. A narrow-mindedness makes us to put labels on others, quick to condemn them for choices that at a glance appear to be “incorrect”. Yet there is a whole wealth of information about these people and what guides the choices that they make that we do not have access to. As Ryan enlightens, “for many, the barriers to vaccination are structural”.

In our local context, as well-educated physicians well-versed in the ways of science, we too may, often, find ourselves judging those who refuse to be vaccinated, the majority of whom belong to the older generation. But is it because some are too sick to have the vaccine? Or are they fearful of contracting the virus when they leave their homes? Or maybe they simply don’t believe in modern-day science. Regardless of the reason, we cannot deny that we have had the privilege of affording a good education, and most of us are able-bodied, healthy individuals and therefore hold unwavering faith in these vaccines and their potency. The majority of the older generation might not be in possession of most of these. Who are we, then, to lord over them and criticise them for choices that we will not be able to understand, having walked a different path? As members of the healthcare community, our role should be to guide them as best as we can - sans condemnation.

Anonymous, Student

Chapter 7:
When does life resume, when it is held in illness?

Life is for the Well

Rachel Naomi Remen

Life is for the Well: Kitchen Table Wisdom

Rachel Naomi Remen, published 2000

Discussed 7th December 2021

In this **excerpt from Kitchen Table Wisdom**, Remen shares the story of a patient with Chronic Fatigue Syndrome who initially believed that she could only fully live life once she was symptom-free. She had spent years obsessively tracking her health, seeking perfect wellness in order to participate in life's joys. But she eventually came to the realisation:

it wasn't her illness that was preventing her from living fully, but rather the meaning she had attached to it.

She learned to embrace life with her illness – accepting that while she might need to modify her plans or pace, it did not mean she could not participate in life at all.

Instead of chasing an elusive state of perfect health, she now focuses on simple, natural ways to care for her body and consults doctors only for pressing concerns. She discovered that by letting go of the need for certainty and perfection, she could accomplish more than she had previously imagined.

Her new motto became "Anything worth doing is worth doing half-assed," reflecting her shift in perspective — acknowledging that **life can be meaningful and fulfilling, even when lived imperfectly; even in the presence of illness**, if we only adjust the meaning we assign to our circumstances.

Prompts for Reflection

- Remember your patients. Were there things they could not do (or things they thought they could not do) because of their conditions?
- The pursuit of a perfect life prevents one from living their life. Have you felt this to be true of your life?
- In Psychiatry, what constitutes a "recovery" or "cure?"

Find the full book via the QR code, or here: *Kitchen Table Wisdom*

Reflections

I question how much we really can accept the final line of anything worth doing is worth doing half assed. Will it be worth doing if it will be half assed? At the same time I realise, this person in the story sometimes it pays to focus less on the outcome and more on the journey And sometimes in undertaking that journey we find the acceptance from others that we can then learn to give to ourselves.

Anonymous, Resident

A "phased reopening" to a "new normal". During this COVID-19 pandemic, how do I accept the imperfections of the learning I'm receiving, the work I am doing, the relationships I'm keeping? How do I balance the pressure I put on myself to keep pushing the boundaries of my comfort zone, yet stop feeling guilty that I do need to take steps back as I need more rest and personal time during a season such as this? In the 'hammer and dance' of my own life, I hope to find answers that I can share with my patients, for mental illness is a pandemic like any other.

Dr Ian Matthias Ng, Resident

Moving in uncertainty

We are brought up to want a certain timetable everyday; tuition, music lessons, dance classes, meeting for fun only after homework and exams, making best use of time during school holidays working on projects, or learning a new skill. None of the above are bad but we are used to being dependent on some sense of certainty of what is happening next almost as though we are in control of each and every situation and time slot.

Life is often not like that, as some patients would share with us. A retired teacher was hoping for his wife to retire then go away for a long holiday to travel around the world. But his wife came down with cancer and she passed on within a few months leaving him empty and downcast. Another patient wanted to be completely free of his chronic anxiety before he feels well just like the lady in this chapter.

Can we move on with life even if unsure, and even if the future looks unpredictable, or even bleak? Did they not say that there will always be light after darkness, peace after the thunderstorm and that all things will come to pass?

Anonymous, Faculty

Chapter 8:
How does it feel to be well and alive?

Tulips

Sylvia Plath

Tulips

Sylvia Plath, 1961

Discussed 7th June 2022

Sylvia Plath's poem "Tulips" was written in 1961 and first published in 1965 as part of her collection *Ariel*. One of Plath's most well-known works, it captures a moment of intense emotional and psychological turmoil, narrated from the perspective of a speaker who is recovering in a hospital.

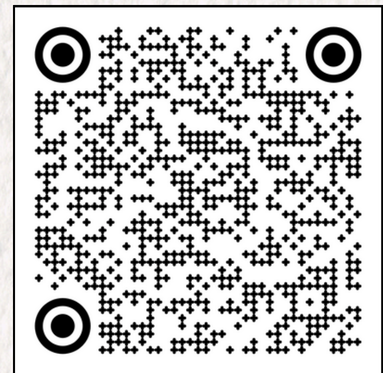
"The tulips are too bright in this world. / They hurt me."

The narrator speaks of feeling overwhelmed and disconnected from her environment, particularly in relation to the tulips brought to her. The flowers, vivid and bright, symbolise the external world's demands, which the speaker wishes to escape; she longs for silence and numbness, desiring to withdraw from life and its emotional intensity. The tulips, while beautiful, represent something she cannot ignore - her internal struggle between wanting peace and being pulled back into life.

This poem explores themes of isolation, the tension between life and death, and the challenge of maintaining one's sense of self in the face of overwhelming external pressures.

Prompts for Reflection

- What do you think is happening to the person in this poem?
- What do you think is the author's attitude towards health and the medical system? Does it differ at the start and at the end of the poem?
- What does the idea of being ill mean to you? How do you feel about the vulnerability of the body?



Read the poem via the QR code or via https://www.poetryfoundation.org/poems/49013/tulips-56d22ab68fdd0

Further Reading

- https://owlcation.com/humanities/Analysis-of-Poem-Tulips-by-Sylvia-Plath

'"Tulips," written in 1961, is a free-verse poem that deals with Sylvia Plath's state of being whilst in hospital for an appendectomy. She initially named it "Sickroom Tulips in Hospital" but later shortened the title.

A subtle tension is introduced from the opening line, perhaps reflecting the poet's emotional uncertainty and fear—just weeks earlier, she suffered a miscarriage—and this theme is carried on to the end.'

- https://medium.com/@thekenlemarchand/the-beauty-in-sorrow-an-analysis-of-tulips-by-sylvia-plath-23e65e8a228f

Reflections

Tulips. I usually think of a sweet scene of a field of tulips. Tulips of all different colours and varieties, a beautiful lively sight. In this poem, the writer expresses a different reaction to them -- a sign of life eating away at her like a savage animal. The refuge of the thought of death and nothingness can in fact be freeing. Caught up in the hustle and bustle of life -- getting laundry done, feeding my cat, studying for the never-ending barrage of examinations, sometimes I understand how it feels - just want to escape all these in death.

Anonymous, Resident

Tulips
Bloom anew
At the dawn of spring
Shrivel in the heat
The summer brings
Fall to the ground
As autumn sinks
Shudder in the cold
At winter's brink

Did you manage
To catch a whiff?
Or will you wait
For the coming spring
As Tulips
Bloom anew
A cycle renewed
As with all things

Dr Arvind, Chief Resident

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