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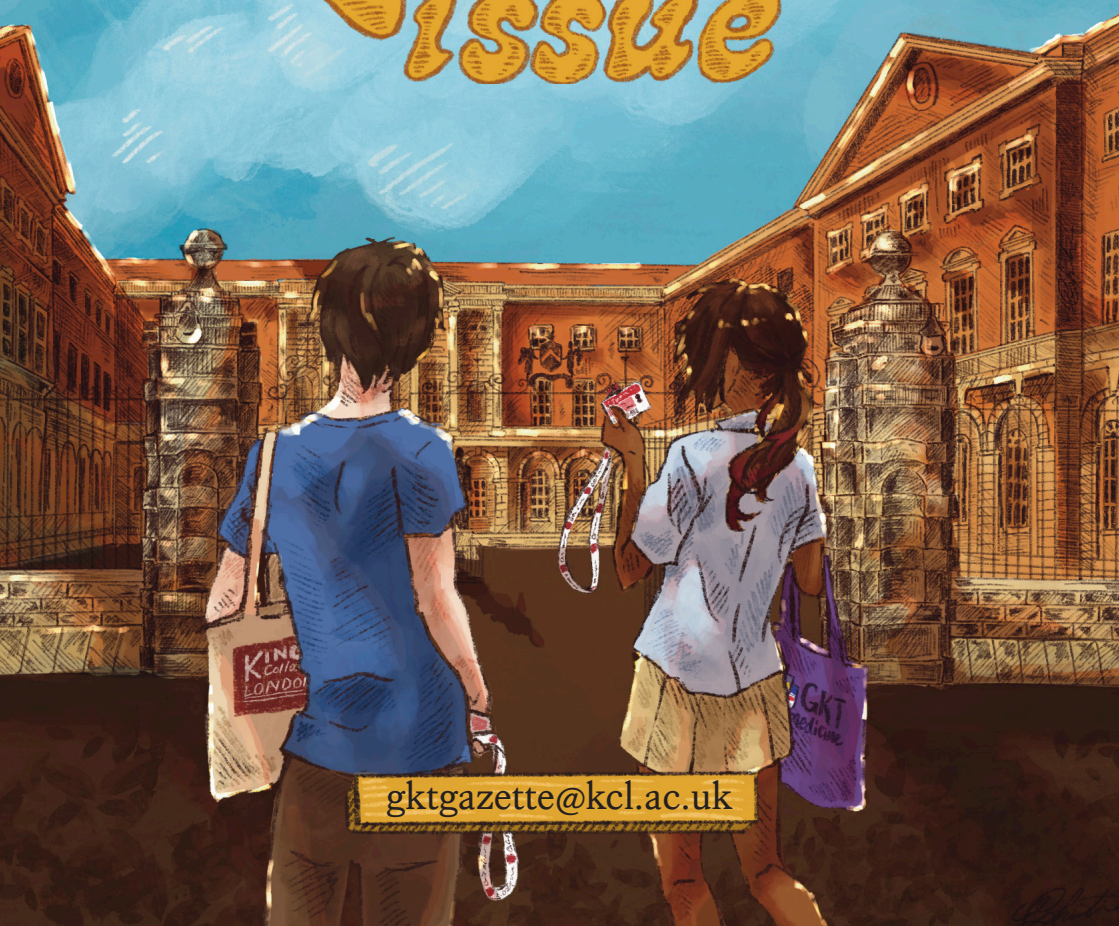
# GKT Gazette

# FRESHERS issue

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# GKT GAZETTE

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# Contents

# Passim: Farewells and New Beginnings

Editor - Morgan Bailey **iBSc in History and Philosophy of Medicine**

Dear readers,

A warm welcome to both newcomers and returners to the pages of the GKT Gazette. Autumn is upon us, which heralds the start of a new academic year. A warm welcome to the new cohort of medics, dentists, nurses, physios, and scientists to the hospitals of Guy's, King's College and St Thomas. You have done well to arrive here and we trust you will have a wonderful time.

For our seasoned readers of students, staff and alumni alike, you may have noticed a change in authorship of our passim. Arnav Umranikar, co-editor since the relaunch of the Gazette for its 150th Anniversary edition back in March of 2023, has officially retired from his role. I thank Arnav for all he has done on behalf of the Gazette and wish him well in his future endeavours.

We also say goodbye to section leads Sami Lewis; our outgoing sports editor, and Ella Burwell; our outgoing layout editor. Both have been on our committee since 2023 and have represented the very best of GKT. They will be sorely missed.

A warm welcome is to our incoming leads, Nayan Perrera of our Sports Section and Sophie Xu Fang of our design team respectively. They are well-deserving of their positions, and I look forward to the work they display across the 24/25 academic year.

Last but not least, welcomes are due for both Noor Amir Khan and Naim Ghantous who will join me as deputy editors of the Gazette. I have no doubt our tri-force will continue the legacy of the Gazette and take it to new heights.

Amongst these changes, this issue marks the beginning of the next volume of the Gazette – volume 134. Looking ahead, we are preparing to mark the 300th Anniversary of the founding of the Hospital to which we call home in 2026, as alluded to in our wonderful cover by Christine Yiu MBBS2. Our back cover is a wonderufl photograph of our medical school by Hasanat Ali MBBS3.

Remaining contemporary, this new generation of the Gazette aims to continue to be the bastion of student voice and advocacy at Mr Guy's hospital, as well as the biggest and best student society in the Borough. We undoubtably are: and the proof is in the pages that follow!

I hope you enjoy this issue of the Gazette. We are always in need of contributions. Please do not hesitate to get in contact through our various channels with your comments or queries.

Dare Quam Accipere.

Yours,

*The Editor*

We welcome submissions from anybody affiliated with GKT to be published in subsequent issues (email us at gktgazette@kcl.ac.uk).

If you are a student and would like to join the Editorial Committee to be involved in crafting future editions, keep an eye out on our Instagram (@thegktgazette) regarding our recruitment rounds.





# Deputies' Digest

Deputy Editors - Noor Amir Khan **MBBS3** and Naim Ghantous **MBBS2**

Dear Readers,

With this current edition of the Gazette, it seems another Fresher's period has swiftly come to pass. Amongst the shifting leaves and waning sunlight, the turn of the season prompts moments of reflection for many - and we are no different. It can be terrifying to look back at our own Fresher's memories and wonder at the pace of change, yet it is a privilege to realise how far we have come.

As we scurried through our first days at campus, little did we know of the Gazette's existence - let alone how much it would shape our university journeys. Interestingly, we have found that our experience writing articles very much forms a microcosm for our expedition so far.

With the world as your oyster, it is exciting to begin writing. Nevertheless, as you navigate the endless possibilities encompassed by a blank page, the prospect of choosing what to write is a seemingly infinite endeavour. Traversing across the plains of novelty, you follow rabbit-holes, find yourself at dead-ends and take leaps of faith. Uncertainty rears its head. In spite of this, however, a stream of ideas begins to ebb and flow, a path clears and eventually, you find your footing.

Whilst this process is not always the exact same for every individual article, the wonderful presence of the Gazette team has been an unwavering constant throughout. It is with this that we thank Arnav Umranikar, Ella Burwell and Sami Lewis for all of their efforts towards creating these unique editions that we love so much.

As for what's coming, we hope to continue providing a safe space for student expression and creativity - as well as prioritising our community (both on and off the page). Please do not hesitate to contact us if you would like to contribute, have any ideas or questions.

It is with this that we bid you adieu.
We hope you enjoy the issue!

Yours sincerely,
*The Deputy Editors*

*If you would like to contact the editor, please email gktgazette@kcl.ac.uk*

# Letters to the Gazette

## Guy's Hospital Car Park

Dear Editor,

As a former Editor of Guy's Gazette (1968) I thought you may like to publish this photo I took when a medical student.
Some of the Consultants, most with private practices in addition to their NHS appointments, were by no means well off!

Emeritus Professor Colin Brown **FRCP**

## The Hume Kendall Educational Trust

Patrick Hume Kendall was a consultant in physical medicine at Guy's Hospital and the Evelina Children's Hospital. He died at the age of 42 and his consultant colleagues set up a trust in 1969 in order to support his children's education. The Hume Kendall Educational Trust continues to support financially the education of the sons and daughters of doctors and dentists. The Trust has supported a number of families who have found themselves in need of assistance for children at school or university, usually because a parent has died or is unable to work.

The Trust is restricted in its charitable purposes to supporting education and is limited to the children of doctors and dentists. The Trustees would be keen to hear of any such need that might be suitable for support. Applications can be made to the Honorary Secretary, Keith Jeremiah (kjeremiah36@hotmail.co.uk) or to the Chairman of the Trustees, Professor John Rees (john.rees@kcl.ac.uk)

John Rees
**Emeritus Professor of Medical Education**
King's College London



*Photo: Guy's Gazette Volume 110 No 2466 - July 1997*




# Features

## Covers and Photos

*All photos are taken by our editorial committee or royalty free stock images unless otherwise stated.*

Our cover is a fantastic illustration by Christine Yue MBBS2. It depicts 2 contemporary first year medical students outside the gates of the courtyard of the original Guy's Hospital, glimpsing at the past; alluding to the upcoming tricentenary (300-years) of Guy's Hospital in 2026.

Our back cover is a wonderful photograph by Hasanat Ali MBBS3 of the Hodgkin Building in bloom.

# Dr Alistair Hunter: A 30-Year Retrospective

Naim Ghantous **MBBS2**

Dr Alistair Hunter is a name known to generations of King's students, a prolific and empathetic teacher of anatomy who culminated his illustrious 30-year tenure at the university in September of 2024. Prior to his final day, Morgan and I had the privilege of sitting down and having a conversation with Dr Hunter, reflecting on his life in and beyond the world of anatomy. I distinctly recall being met with an office empty and bittersweet. All that remained were a handful of gifted textbooks, a monolithic hardback Gray's and of course Dr Hunter himself, an individual of such monumental success that many of us think of him primarily as a product of his achievements. While this is worthy and deserved praise for a champion of his craft, this unconscious chain of thought evades the most critical component: Dr Hunter the *person*.





**Journey to King's**

It is fundamental to reinforce that 30 years is an incredible length of commitment (I have 11 to go before I even see what 30 years looks like), but also that Dr Hunter's period at King's was the product of a lifetime's journey and devotion.

His adult education began in the University of Aberdeen, where he grew up, undertaking a 4-year Physiology course at the institute. However, soon realising his apathy towards the full-time study of physiology, Dr Hunter found his passion in the anatomy module on offer, which spiraled into him being one of four graduates of the Anatomy Honour's Program at the university in the late 1970s. The degree of competition and innovation in Aberdeen was made very clear to us, as Dr Hunter expressed the sheer difficulty of becoming established as a lecturer, researcher or academic in that environment. This was further worsened by his disdain for research in physiology, which seemed to be the prevailing pursuit of the time, as his passion and love remained firmly within anatomy. It was compelling to hear how someone so symbolic of his art was at many times plagued by doubt, which is a feeling I am certain every medical student can connect heavily with. Nevertheless, he was offered a 5-year temporary lectureship at Aberdeen, which was almost unheard of for such a recent graduate. In a time when Dr Hunter was still relatively new to the world of academia, teaching and research, it was immediately evident in the cadence of his voice whenever he spoke about teaching that it was to be a lifelong passion and pursuit. It was not until 1994 that he was offered a teaching position at King's, another 5-year temporary lectureship to cover for the resident anatomy lecturer – Professor Keith Webster - who was on sabbatical at the time. Dr Hunter mentioned Professor Webster repeatedly as an inspiration to his teaching, giving all the anatomy lectures to the medical students, and also Mike Hutchinson who was then the head of the dissection room at the old anatomy department at Guy's. In the beginning of his tenure at King's Dr Hunter's role was far more limited than what we recognise him for today, giving anatomy lectures to the physiotherapy students and serving as a demonstrator in the dissection room. Following Professor Webster's retirement in the early 2000s and Mike Hutchinson's resignation in response to the Guy's and King's merger, Dr Hunter found himself at the helm of anatomy education at the university, preparing and giving every lecture to the medical students and of course spearheading the dissection room. This forms for many the most familiar image of Dr Hunter, yet his experience stretches far beyond teaching.

**Research**

During our discussion, Dr Hunter laid out his fluctuating relationship with research, something he was heavily involved in at several strata and in a myriad of locations prior to him being offered a lectureship at King's in 1994. His work encompassed an eclectic and accomplished range of topics from memory to uveitis to diabetic retinopathy, yet of all the projects that he spoke of, the conversation often circled back to the three years he spent in Milton Keynes at the Open University.

It was here where Dr Hunter, alongside an extensive and multidisciplinary team of anatomists, biochemists and physiologists, investigated how long-term memory gain and loss interrelate with anatomical changes in the brain – more specifically a region called the lobus parolfactorius present in chick brains. He recalled this time fondly, having had opportunities to work with leading experts from across Europe in the harmonious pursuit of a solution to this one memory problem, including neuroscientist Steven Rose. The most specific insight he gave us into his work was through his memories of counting synapses one by one on electron microscope slides, a far-cry from the topographical anatomy savant most of us here know him as today. Unfortunately however, the project lost its funding and could not come to a

natural conclusion, something that Dr Hunter laments still.

The issues of funding, research grants and integrity seemed to persist across the conversation. For instance, in a brief stint with Pfizer working on a drug that could prevent the onset of optic nerve neuropathy in diabetic patients, he found that the compound was not going to have the intended effect, through which the project was dissolved and his grant all but dust. It became clear to me that Dr Hunter's disdain for reliance on grants, corporate permission and ruthless competition was what drove his mentality away from research and fully towards teaching. He confessed that a giant weight had been lifted off him, and I can only imagine the pressure of juggling high-intensity research with a constant need to adhere to what was in demand in the world of scientific research. When King's offered him the lectureship, he could leave that constant instability behind (although the lectureship was only a temporary one still) and begin to focus in on what he truly loved – teaching.

**An Affinity with Technology**

It is perhaps a reductionist assumption that those born before the modern technological golden age collectively failed to adapt to the frankly cataclysmic shift in our world's landscape that it brought. It is one routinely made by younger audiences, yet a rather obvious truth is forgotten: that human change does not usher itself in uncompanioned.

Dr Hunter gave incredible insight into how technology and its uses had changed during his lifetime, and how he himself championed the new toolkits that were on offer. Infact, the Sinclair ZX80, the first computer model made available for mass public purchase in the UK in 19801 (with a whopping 1 kilobyte of memory), saw Dr Hunter as a customer, as he envisioned the value it could bring to his learning and teaching during his time in Aberdeen. He expressed to us quite passionately his interest in computer programming at the time, familiarising himself with several languages, notably Asymetrix Toolbook which he used to craft multiple-choice and written anatomy quizzes for his students in Aberdeen. Unfortunately, Toolbook did not survive the transition from 32-bit hardware to 64-bit machines, but astoundingly, the Dissection Room has retained several 32-bit machines for the sole purpose of keeping Dr Hunter's bespoke quizzes alive and beneficial for the students of tomorrow. The extraordinary heritage of the King's anatomy department is something you can feel as soon as you step into the Dissection Room (or maybe that's just the ten-ton truck of formaldehyde vapour), but the remaining presence of Dr Hunter's programs adds another tangible dimension to it.

It is of no surprise therefore, that Dr Hunter embraced the introduction of the internet and later Microsoft into his teaching and personal life. In King's at the turn of the century lecturers were still using overhead projectors for their presentations, which prompted some frustrated anecdotes about bulbs blowing, power cuts, acetates, cassette slides inexplicably going missing before a 3-hour chest osteology lecture, and a series of other issues that all seem rather archaic now, as Dr Hunter put it. For those of us who were lucky enough to benefit from his last few years of lecturing, it is evident in the detail, personality and fluidity of his presentations that he was not one to struggle with the digital shift. On the contrary, he was quick to call out some of his senior colleagues who were not as affable with the online world and chose rather to laud their electric typewriters than ever dare to own a computer.

As with everything else in his life, Dr Hunter used the meandering realm of technology to enhance his teaching and better the lives of his students. I encourage you to – if you have not had the chance – take a trip up to the Dissection Room, try some of the quizzes and think about the history quite literally at your fingertips.





**The Person, not the Teacher**

Dr Hunter's illustrious 30-year tenure teaching anatomy at King's, and the rich collection of experiences that led him here, weave a strikingly vivid tapestry of a man beyond dedicated to his craft and cause. However, as of his retirement on Friday 27th September 2024, this has all come to a stop. This begs the question, "who is Dr Hunter"? Well, he is someone whose passion and learning reach far past the world of anatomy, as he highlighted so vibrantly when asked about his future.

"My biggest love in life has always been music", were the words he spoke first, as he expressed his pride in building a home recording studio and equipping it with the arsenal of instruments and musical gear he has amassed over his lifetime – including a Fender Stratocaster that found its origins on a backpacking trip through Europe. Both working on original recordings and travelling to see some of his favourite artists (centred around but not limited to progressive rock) were illustrated as clear components of his agenda. I recall clearly a lecture slide from 1st year on the anatomy of the liver, which spoke of alcohol's effects on liver function and appearance, citing Jimi Hendrix, Keith Richards and Jim Morrison as some slightly uncooperative examples. As a musician, it is always exciting to find that someone you revere in other aspects of life shares your passion for the art, so it was thrilling to probe into.

It was made clear that Dr Hunter wields a wide spectrum of interests to shape his plans in retirement, from music to local history to community volunteering. However, throughout the interview one idea seemed to recur as a constant, an elephant in the room persay, and that was whether Dr Hunter had any intention of writing a book on anatomy. While he made it clear that he has not ruled it out, he wants his focus after a lifetime of anatomy to steer in the direction of his love for community, music, volunteering and history. With how much work would have to go into a project of such grand scale, and after 30 years of teaching at King's, it is safe to say that if Hunter's Anatomy is to emerge in the future, it is currently far on the horizon.

*Dr Hunter pictured with Prof. Ajay Shah winning Sustained Excellence Award in 2024*

**A Lapse in Recognition**

In the 30 years since Dr Hunter began working at King's, the medical school has undergone at least 10 changes in Dean, and he has offered his teaching to the medical and dental students, on top of two BSc modules and the physiotherapy classes. That repertoire would retain its magnificence even if you sliced it in half, yet the ludicrous reality is that Dr Hunter will leave King's never being recognised as anything beyond a senior lecturer. He gave us insight into how difficult it was for him to put himself on a pedestal, to be compliant and undertake the formalities required to attain a readership or professorship. His responsibility, and more importantly his passion, was in teaching and he expressed vehemently how student validation and change were his real metrics of success. This attitude is evident in his continuous battle to preserve the Dissection Room, a critical component of our learning as medical students. Thinking retrospectively on first year, I often feel as if I took the value of the dissection room for granted, and Dr Hunter gave us an insight into its struggles with funding and what he felt was intentional,

drawn-out neglect of the resource. Oftentimes he was fighting against the requests of those at the source of the chain of command to refurbish and rejuvenate such an incredible tool, in a national curriculum that is rapidly edging specialised anatomy teaching out of its remit. I think it is more than admirable for someone to believe so strongly in something not solely due to their passion, but the careers and livelihoods of us, the students, and to reinforce that belief for three decades is truly a rare form of dedication. To ask of someone of such commitment to complete a course in pedagogy to prove their worth is absurd, and it was made clear to us that Dr Hunter would much rather direct his efforts into making his teaching of anatomy the best it could be, rather than working towards an arbitrary title. However, an institute which does not make it an absolute priority to reward and recognise such devotion is one whose motives and preferences could be reassessed.

**Quickfire Questions**
**What has been your highlight at King's?**

"Running the advanced anatomy module. So, I was having to learn stuff way above and beyond what I'd ever been exposed to myself before. And, it suddenly made me really begin to understand, more deeply, what the anatomy was about. So, I think as for my personal development running that module really helped me in anatomy."

**What is your favourite body part?**

"It's like, you know, who are your favourite children? It's an impossible question to answer. I do love it all. I love chest. Head and neck is a more difficult area and it's something that I've never been asked to teach you. So, it's the one thing which I've never kept up with, as well as I should have, kept up with it."

**What is your least favourite body part?**

"Back. It's difficult to dissect, it's full of things, so many individual little bits that you don't really need to know, and I hate it for that because for me, the majority of anatomy, you really do need to know it. I think it's probably my least favourite area."





**What will you miss most about King's?**

"The students, I love, you know. I just love teaching and it's that kind of light bulb moment. I was teaching in the DR [dissection room] earlier on this morning and the first-year students were coming in and you're getting them to think. What layers has skin got, why do we call it those things, and it's that kind of realisation of how the words, the language of anatomy is so important. And you suddenly see the students saying, 'that's why it's subcutaneous, that's why it's a cutaneous nerve, and it's almost like you've triggered a whole series of things that they can hang a memory onto, and I'll remember that now."

**What will you miss least about King's?**

"I hate admin. I hate committee organisations. I hate structured, curricular change, all these people coming in telling me, oh we don't need anatomy anymore, just you know, it just makes my blood boil."

**Conclusions and Farewell**

Last year, I and a cohort of anxious 18-somethings took our first steps into the terrifying and brilliant world of medicine, and we were the last to experience directly the tutelage of Dr Alistair Hunter. His dedication and his warmth brought the impossibly giant, cosmic world of anatomy down to earth, whether that was in the Greenwood or in the Dissection Room. He is the sole reason I associate the sternum with a dagger, or the grooves of the heart with a crown, and I distinctly recall how stirred we all were at his final lecture. The Greenwood Theatre packed far more than it had been accustomed to over the past months with exhausted students, exam day looming, coming together to recognise and celebrate a great teacher. I think that has immeasurable value.

On behalf of all GKT, we wish you a happy retirement.

# Dr Hunter's Impact on the Demonstrators of The Alcock Society

*For more information on the Alcock Society head to thealcocksociety.com*

Dr Alistair Hunter's commitment and contribution to anatomy and education at King's College London cannot be overstated. He possessed a level of dedication to his craft that is a quality seen in individuals of his generation and is now perhaps more elusive in today's modern world. He shared a similar pledge to one of his predecessors, the eminent physician and anatomist William Harvey 1578-1657, who professed '..to learn and to teach anatomy not from books but from dissections, not from tenets of Philosophers but from the fabric of Nature.' I say similar here with some irony, because books were part of his teaching. In fact, there were no better resources that the ones he had created himself for his students. Perhaps their future publication will be a retirement project of his and a gift to future students of anatomy.

Spending a year in the dissection lab under his tutelage, teaching medical student and dentists, was one of the best educations I have received. It gave me an appreciation for the value of dissection as a tool to understand the body, and to develop my craft as an educator. It has given me a sound foundation in understanding the anatomy of the human body, and an opportunity to combine what I learnt in the dissection room and to apply it to the living in the operating room. Lastly, it helped me recognise the meaning in what another eminent anatomist who shares his surname once said (John Hunter 1728-1793). 'Surgical skill is not born; it is honed through years of dedicated practice and unwavering commitment.'

I wish him a long and happy retirement.

Mr Iolo Thomas-Jones **BSc.(hons), MBChB, PG Cert (Clin Ed.) MRCS**
Core Surgical Trainee
Aspiring plastic surgeon
Anatomy Demonstrator KCL 2022-2023

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Dr. Hunter's enthusiasm and passion for anatomy are truly unparalleled. One of my most cherished memories as an anatomy demonstrator was the moment we discovered a Splenunculi during dissection. Dr. Hunter was just as excited as I was, instantly diving into research to provide me with further insights. His ability to break down intricate topics, like embryology, and make them accessible has profoundly shaped my love for anatomy, not just as a science, but as an art. I'm deeply grateful for his invaluable contribution to my career—working alongside him was instrumental in helping me complete my MRCS exams and pursue my ambitions of becoming a plastic surgeon.

Dr Zainub Bazeer

## GKT MSA Blues and Shields Success in 23/24

Congratulations to Naim Ghantous (left), Arnav Umranikar (centre), Zaynah Khan (right), Ella Burwell, Sami Lewis, Jade Bruce, Noor Amir Khan, Morgan Bailey for winning for the contributions to the Gazette at the prestigious awards ceremony. Each have made fantastic contributions to the GKT community and their awards were very much earnt!


# Portsmouth Branch Campus Medical Degree: In Conversation with Professor Russell Hearn

Jade Bruce **MBBS5**


In early September, I visited Portsmouth to nose around the brand-new University of Portsmouth medical degree branch campus and to speak with Prof Russell Hearn, the newly appointed programme director. Tucked away on a side street just a five-minute walk from the train station, the single-building campus would be innocuous if not for the branding emblazoned on the windows that reads: 'King's College London Medicine in partnership with University of Portsmouth'.

On the 13th of September the Portsmouth branch of KCL Medical School (known in London as GKT) formally opened, though doors unofficially opened to 54 students three weeks prior. Students had spent the previous weeks completing their 'crash course' in clinical skills and anatomy – also in place for the graduate entry medicine programme in London.
The first cohort, comprised solely of graduate-entry students, will follow an identical curriculum to the four-year Graduate Entry Medicine programme at GKT, which mirrors the undergraduate curriculum, bypassing the first year and augmented by the three-week introductory module. The Portsmouth students will sit the same exams as London students and will be ranked alongside them.

Upon graduation, Portsmouth students will be awarded an MBBS from KCL. However, The University of Portsmouth aims to become an independent medical school in 2028. Prof Hearn shared that 'Portsmouth University has had a long-standing desire to have a medical school.' A GP himself, Prof Hearn is keen to highlight that 'the area really needs doctors particularly in primary care'. Indeed, Portsmouth is one of England's worst regions for GP provision, with fewer than 40 per 100,000 patients.
But it's no easy feat setting up a brand-new medical school. There are complex processes to become GMC accredited and significant logistical considerations. To overcome these, the branch-campus model has become an increasingly popular approach for setting up new medical schools. For example, the University of Lincoln partnered with the University of Nottingham to open a medical school in 2018, and Imperial College is launching a branch medicine degree at the University of Cumbria next year. The partnership between KCL and The University of Portsmouth provides the 'scaffolding them to have their own fully approved GMC course.'

Initially, the course offered in Portsmouth will be based on the GKT curriculum but will likely evolve as Portsmouth gains independence. In the long term, the aim is for students who train in the region to remain after graduation, thereby increasing the number of local doctors and potentially improving health outcomes and reducing inequalities. While some regions successfully retain graduates, predicting graduate retention in Portsmouth remains uncertain.

Currently, there are no focused incentives for graduates to continue working in Portsmouth, and so retention will largely depend upon their affinity to the community and area. With students coming from across the UK, and with the new preference-informed application process for foundation placements, it's difficult to predict if students will continue to work in Portsmouth upon graduation.

Students may still plan to relocate to London in the future, especially as the inaugural cohort initially applied to study at the London campus. During the application process, students were asked if they would be willing to study at the Portsmouth campus, should they receive an offer to study there. Although studying in Portsmouth may differ from their original vision of studying in London, Prof Hearn notes, 'they have all the same feelings as students starting at any new medical school... They're experiencing the excitement of beginning their journey into clinical medicine.' So far, the feedback has been overwhelmingly positive, with students really enjoying the course.'

According to Prof Hearn, in subsequent years students will apply specifically to study Graduate Entry Medicine at the Portsmouth Campus with 'contextualised' assessment of their UCAS applications. This means students local to Portsmouth may be granted an interview based upon their connection to the area, caring responsibilities or widening participation characteristics when their UKCAT score may be slightly lower.

Students will primarily be placed in one trust, Portsmouth Hospitals University NHS Trust, and in primary care practices throughout the Portsmouth area. Certainly, a different experience from studying medicine in London, which



Prof Hearn accurately reflects as 'lots and lots of hospitals, you bounce around hospitals, trusts and your travel might be quite significant.'

A Portsmouth student I spoke with mentioned that it doesn't feel like there is distance between teachers and students, noting that staff are responsive in real-time to feedback. Prof Hearn reinforces that they can be 'very dynamic in responding to feedback', which will be crucial to overcome teething problems and adapt effectively as the branch campus inevitably expands and evolves.

Looking ahead to the future of the medical school, Prof Hearn anticipates a cohort of 67 students next year, with numbers expected to grow over time. As demand increases, some London students may be concerned about the potential impact on their education, after all Prof Hearn is a key educator at GKT. However, he emphasised that they're 'trying to ensure parity of experience' and 'that all students get access to the same resources.'

Portsmouth students will have the opportunity to join KCL societies and sports teams, as well as access all the facilities available to King's students, in addition to those at the University of Portsmouth. As it stands, the same cannot be said for GKT students in London. While there may not be utility in going, those based in SE1 will not be able to visit the Portsmouth branch.

The London and Portsmouth campuses will remain mostly distinct, with the Portsmouth campus not taking any staff from GKT, besides Prof Hearn whose role has been backfilled by a new post. Prof Hearn highlights 'the benefits of learning between two institutions,' noting Portsmouth's expertise in various fields, including extreme environments, physiology, and sports and exercise and the future possibilities for London based students.

I suspect Prof Hearn has got a few tricks up his sleeve... I ask him if there are any exciting future plans... He points out that 'there's no reason to wait until the day that you've got doctor in front of your name' to help patients. He outlines possible plans for student-run clinics for flu Jabs, smoking cessation and phlebotomy services – an opportunity for both students and the local community.

Prof Hearn is eager for students to be as involved as possible, which will be unsurprising for the many GKT students who know Prof Hearn as the primary care lead and a medical education enthusiast. Ultimately, Prof Hearn is most excited 'to see how the students take advantage of the opportunities and what they manage to achieve.'

Here at GKT, the new campus raises important questions about our identity and the relationship between GKT and the Portsmouth branch. It seems likely that the Portsmouth branch will become increasingly separate from GKT as it gains autonomy. However, in the meantime students have raised concerns about equity between the two campuses.

Given GKT's ongoing struggle to accommodate the growing student population, we must question the fairness of opening a brand-new branch with additional buildings and resources.

Moreover, if students in Portsmouth benefit from more clinical contact time due to a smaller cohort, is it equitable to rank them against London students, who often face competition for clinical experiences?

As the Portsmouth branch campus evolves, it will be crucial to balance its growing autonomy with the need for equity in resources and experiences. The intention to train doctors who can meet local healthcare needs is clear, but how the relationship with GKT develops will shape the future of both campuses. Watching this transition unfold will be intriguing, as the potential impact on medical education and local health outcomes in Portsmouth becomes clearer.

Thank you to Prof Hearn for taking time out of a busy schedule to speak to The GKT Gazette

*Have thoughts on the new Portsmouth branch? Write in to the Gazette!*

# Our Medical Leadership Does Not Listen

Morgan Bailey **iBSc in History and Philosophy of Medicine**

***The King's Fund report into the Royal College of Physicians' failures at governance highlight a systemic issue. What can we do about it?***

Here at the Gazette, myself and others have been following the developments surrounding both physician and anaesthesia associates (PAs and AAs) closely. And whilst we did cover part of this story in April 2024 edition (kcl.ac.uk/lsm/gazette), much has now come to light.

As of writing, it is September 2024. The King's Fund, an independent health-focused think-tank, have just published a damning report into the widespread failures of governance within the Royal College of Physicians (RCP) in relation to its handling of the issues raised surrounding the issues of expansion and regulation of the medically associate professions (MAPS). The full report, at a lengthy 47-pages, describes the failure in leadership leading up to and during the time period surrounding the 3rd Emergency General Meeting (EGM) in the College's 500-year history, which had been called by fellows following their concerns regarding the decisions leading up to regulation of MAPS.

The proposed regulatory order, titled "The Anaesthesia Associates and Physician Associates Order 2024", had passed and ascended into law on the 13th of March 2024. Its purpose was to give the General Medical Council (GMC) the powers and responsibility of regulating medical associated professionals; thus making the GMC a multi-professional regulator for the first time in its 166-year history. The same day the order passed, the RCP tabled its 5 motions at the EGM – with all 5 passing - against the Government's plans for regulation and expansion of MAPS. The EGM had originally been called in late 2023 but had faced countless delays by the leadership within the College. The King's Fund report found that these delays had been unnecessary. As a direct consequence of these delays, the resulting change in the College's stance on MAPS subsequently could have no impact on the Government's decision to expand and regulate these associates as the order had already come into force. Both the RCP President and Registrar at the time, Dr Sarah Clarke and Prof Cathryn Edwards respectively, resigned in response to backlash from members and fellows of the College.

The report, summarised succinctly on the King's Fund website, is undoubtably a wound to the already weakened RCP. Various other failures were also noted, such as a "pervasive lack of trust", "decision-making processes are unclear", "lack of due process in the survey of members", "organisational bias", "poor behaviours across the College... (including) shouting and the use of intimidatory language". I will leave the rest at your perusal.





Normatively these are not the standards one would come to expect from the College overseeing training and standards of care across the medical specialities in hospitals.
And as trainee and trained medical professionals many of us will know – albeit anecdotally here – that these issues of unaccountability, lack of transparency and the very British idea of "managed decline" remain pervasive across the National Health Service. One cannot buy fish and ships without seeing the name "Lucy Letby", "NHS" or the words "Infected blood scandal" doused in salt and vinegar every other week.
Recently the broadsheets had exposed the Great Ormond Street Hospital for Children as ordering an enquiry into some 721 orthopaedic operations conducted by an individual surgeon in response to a confidential report the Trust had commissioned in 2022. The report, conducted by the Royal College of Surgeons (RCS), was investigating into the issues within the department from which the surgeon operated. According to the Guardian, children had suffered "severe harm" under the surgeon, with complaints from parents being "brushed under the carpet". Disappointingly, the information had to be leaked to the press to reach the court of public opinion.

Whilst that scandal continues to unfold, it is clear to me that there are too many instances where leaders at all levels in the medical field are unaccountable – both to us, as subordinate members of the profession, and to our patients. Even when leaders are supposedly held accountable, it seems to be rare for heads to roll. The problem is so notorious, in fact, that in the run up to the General Election this year, Labour Health Secretary, Wes Streeting had vowed that Managers who silence whistleblowers "will never work in NHS again". Clearly this rampant unaccountability is being noticed.

The RCP and the Royal College of Anaesthetists have both voted in favour of a pause on recruitment of associate professionals. The Royal College of General Practitioners voted to reject the idea that the GMC regulate the associate professions. Various other parties and individuals have voiced opposition to the expansion of the profession and its regulation, either in part or as a whole. Despite the difficult pretences leading up to the ultimate conclusion that these trusted and elected Colleges have taken, the final hand has been drawn: the recruitment of associate professions should be paused and the strategy re-thought.

Though to the surprise of no one - the alarm bells have failed to ring atop Westminster's ivory tower. The Department for Health and Social Care, various Trusts across NHS England, and the GMC remain blinkered and are steamrolling ahead with the introduction of GMC regulation for December 2024 and are continuing with the original plan of mass expansion of MAPS.

Meanwhile, the associate professions are still unregulated, have no national scope, and each associate will remain dependent upon a GMC-registered primary medical degree-holding medical practitioner – previously known as a doctor – making them dependent upon the consultants whom they are supposed to supplement. The effectiveness, safety and cost-benefit analysis of the associate practitioners are yet to be systematically assessed. The individuals entering the associate professions could potentially be facing unemployment, should this so-called scandal continue to draw out.

Though, whilst we continue through these trials and tribulations, I would like to suggest that there is light at the end of the tunnel.

With the recent resident (formally junior) and consultant doctor strikes, the GP collective action, and the RCP's former president Dr Sarah Clarke and the GMC's Professor Colin Melville "stepping down" from their roles, we as a collective have demonstrated that the status

quo can be changed and leadership challenged. With the advent of social media, and anonymous communities thriving on applications such as Reddit and X (formally Twitter), the new generation of doctors has demonstrated it will no longer be dictated by the previously-prevailing "stiff-upper lip" attitude, which has arguably caused enough damage and destruction to the profession and to our patients already.

I propose that we aspire to transpose this lesson of challenging status quos to all aspects of life. In my opinion, both leadership and authority are done best by consent, such that the leaders we install are not only those most fit for the job, but also those that represent the values we as a collective want our institutions and society to reflect – both signs of a functioning meritocratic democracy.

Detouring through history, let us remind ourselves that we are bestowed the title "doctor" by our patients; an ancient tradition tracing its origin to Hippocrates. The title is value-laden and denotes social standing and importance. We stand out to others and are respected. And yet we are perpetually accountable to those who bestow us our title and unto the title itself. Our right to use the title is tied directly to our registration and "license to practice" with the GMC, and for one to be stripped of their license is to metaphysically strip one of their title – thus holding one to account for their misgivings.

This tradition seems to conveniently avoid the self-selected, self-installed leaders of the institutions that are running our health service. Why are we not asking the question – "who put you in charge?"

Let us rekindle a value of democratic duty to


*'Beauty is truth, truth beauty,—that is all*
*Ye know on earth, and all ye need to know.'*
*Ode on a Grecian Urn by John Keats (1819)*

challenge the unchallenged, supporting those who raise concerns, give voice to the voiceless, and to strive for the best to represent us at the highest echelons of our society.

We must always remember that our actions of today shape the society of tomorrow.

.... And I for one want a world in which my "doctors appointment" is delivered by a medically-qualified doctor.

*Do you agree or disagree? Please send your thoughts to gktgazette@kcl.ac.uk*





# GKT Graduate Dr Lucy Seddon wins prestigious University of London Award

*Some parts of this article were originally published at london.ac.uk/news-events*

This year, one of our very-own GKT graduates, Dr Lucy Seddon, claimed top honours in the University of London Gold Medal and Betuel Prize competition, being awarded the Betuel Prize. The awards, which have been running since 1903, recognise excellence in medical and dental education, with the Gold Medal, and a £500 prize, given to the winner and the Betuel Prize, and a £200 prize, to the runner-up in each field.

The competition involves a rigorous face-to-face examination by a panel of external examiners, testing candidates' knowledge across various areas of medicine. For MBBS students, these areas include General Medicine, Surgery, Obstetrics and Gynaecology, Clinical Pharmacology, Emergency Medicine and Psychiatry.

We caught up with Dr Seddon, who said: *"I'm thrilled to have been awarded the Betuel Prize in the University of London Gold Award viva. This achievement represents six years of dedication and hard work, supported by the unwavering love, care, and encouragement of my parents and close friends. I am deeply grateful to King's College for the opportunity to study at such a prestigious university in the heart of London."*

Congratulations to Dr Seddon on her achievement and best of luck to starting your foundation year!

# Finding Success in a World where You Feel Average

Ruby Ramsay **MBBS2**

Our education system is based upon grades and expectations. The better the grades you get, the more 'intelligent' you are. The harder you work, the more successful you are bound to bewill be. The more extensive your extracurriculars are, the better your financial prospects. The more instruments you play, the more impressive your CV is. It all sounds silly when written out, doesn't it? Performative and empty. But when you are in it, it can feel very real. Doesn't it all sound so silly when written out? So performative, so empty. But when you are in this system; it doesn't feel very silly at all. It feels very real indeed.

Soon enough we are spiralling into subconsciously basing, at least part of, our value on our achievements. Soon enough, we spiral into basing our self-esteem on our achievements, subconsciously or otherwise. According to John Atkinson's Expectancy Value Theory, we are more likely to pursue an activity if we expect to do well, and when we value that activity. More generally, it suggests our motivation is determined by how much value we place upon the outcome, and how likely we are to achieve that outcome. If we are already good at maths, and we recognise that we need to continue studying maths to pursue an 'academic' degree, this may encourage us to work harder to become better. And furthermore, as Jeff Haden wrote in his book 'The Motivation Myth'; success leads to motivation, which leads to further success. A lovely, virtuous cycle is formed. In addition, your natural aptitude to maths may itself encourage you to become better. Ultimately, we as humans like to be good at things, and get better at those things.

Humans like to be good at things. John Atkinsons expectancy value theory postulates that we are more likely to purse an activity if we expect to do well and when we value that activity. It suggests our motivation is determined by how much value we place upon the outcome, and how likely we are to achieve the outcome. In a school environment this was quite straight forward. You are good at maths, you need maths to do an 'academic' degree, you try harder at maths, become better. But this is probably familiar to many of you reading this. If we're honest with ourselves, we are probably used to being seen as cleverer than the average person, whether that may be absolutely true or not. But as we enter medical school, everybody has experienced this, perhaps all their lives.

We should remember that being average in this collective, should be seen as an achievement in and of itself, not a seed of insecurity to germinate into self-doubt. What is success anyway? Who decides who is successful, and who isn't? Is it based on an exam performance, how we are perceived, or simply a feeling? Perhaps, it is a measure of passion and hard work, discipline, and diligence? Or, what if it is something we self-define? If so, could success be found in small wins; finishing a book, or doing the fabled, or simply trying your best?

In our post-industrial society, this latter form of success does not feel good enough when someone always seems to do better. The Oxford English Dictionary plainly defines success as the achievement of a goal. So why do many of us struggle to feel successful when meeting our goals? Why do we always seem to want to surpass them further?

Within a higher education environment, the definition of success has been manipulated into something greater than ourselves. To be successful has extended from meeting a goal, to encompassing an often-unattainable feat. The idea of success has become intertwined with a feeling, elevated, and twisted out of recognition. Success has become akin to perfection. Something abstract and out of reach. The world is hard, and we have learned to be hard on ourselves.

As Jeff Haden said in his book 'the motivation myth' success leads to motivation which leads to success. Let's be honest, we are used to being seen as cleaver. We are used to being 'above average'. But now that we are surrounded by the above average, being average in this collective should be seen as an achievement in itself, not a seed of self-doubt.

What is success anyway? Who decides who is successful and who isn't. Is it based of an exam? is it based on a feeling? is based on how we are perceived? Perhaps it is a measure of passion and hard work, maybe disciple and diligence. Or maybe success is something we self-define. Could success be found in the small wins, in finishing that book, in doing the fabled trying your best. In our post-industrial society this often does not feel enough when someone always seems to do better. The oxford english dictionary plainly defines success as the achievement of a goal. So why do many of us struggle to feel successful when meeting our goals, why do we desire to always surpass them? Within a higher education environment, the definition of success has been manipulated into something greater. To be successful has extended from meeting a goal to encompassing an often-unattainable feat. The idea of success has become intertwined with a feeling, elevated and twisted out of recognition. Success has become akin to perfection. Something abstract and out of reach. The world is hard, and we have learned to be hard on ourselves.

The GMC 'Outcomes for Ggraduates 2018' focuses more than ever on the need to be self-compassionate as a doctor. The need for junior doctors to demonstrate an awareness for 'self-care' and 'maintain [ing] their own physical and mental health' is laid out clearly as a professionaln expectation. We have sped from a society where struggling is seen as a weakness, to one in which we are encouraged to be open about it.

Perhaps this can be jarring and uncomfortable at times, but it has been brought about by an incredibly societal shift, based on empathy, and understanding. We must continue to support, encourage, and engage with this new norm, and the feelings underpinning it.

Success is truly everywhere. Why do we not congratulate ourselves when completing small, but nonetheless imperative, tasks? They may not be the most grandiose parts of our life, but perhaps we should.

To feel success in a world where you are average, you must find it and cherish it. It can be found in everything; completing a lecture, finishing that flash card set, and making time in your day for those you care about. These are successes. Notice them, because doing so might just make you a bit more motivated, and that might just lead to more success.

*References available on request at gktgazette@kcl.ac.uk*

# News from the Medical Students' Association President 24-25

Shahnaz Hussein **GKTMSA President 24-25**

Hey hey GKT. My name is Shahnaz and I'm the President of the MSA for 24/25. I want to start by saying a massive congratulations to you all for getting into the finest medical school in the country! Here's to never having to do the dreaded UKCAT again, stressing from messages on the student room, and getting jump scared from UCAS emails. You've all worked immensely hard to get to where you are, and we can't wait for you to begin your medical journey.

Starting university can be a daunting experience, but fear not as the MSA have your back, whether you're a medic or not. From events, to education and welfare, the MSA is here to support you throughout your entire journey so don't be afraid to reach out! No question is too silly - especially as we're all going through this journey and want to help where we can.

Although the degree may initially seem like a long time, with a lot of your non medic friends graduating before you, it will definitely fly by and you'll be in your cap and gown before you know it (by Vivien Westwood of course). Use your time to meet new people and use every opportunity to the fullest! Try that new sport (even if you're crazy unathletic like myself), go to that event (you may meet your new best friend), and join that society. King's has it all!

It was so lovely seeing everyone at our freshers events over the last few weeks, and we hope to continue seeing you at our events throughout the year. We have a very exciting line up of events for the autumn term, so make sure you keep updated on our Instagram/newsletter so you don't miss out! Some events include:

- Start of our GKTeach Series
  - o GKTeach is the MSA's teaching platform, created to celebrate and amplify the inspiring teaching taking place within the student community at GKT. Its aim is to provide an opportunity for medical students at GKT to teach to a larger audience, from 1st year, to finals, and even OSCE's – we run sessions for it all!
- Merch Drop
  - o Dress up from head to toe in shields with our first redbird merch drop of the year from 27th October to 3rd November
- Cultural Day
  - o Try food from cultures across the word on our cultural day on Guys campus!
- Fashion Show
  - o Travel the world through fashion with our fashion show at greenwood lecture theatre! More information to come soon!

And many many more!!

Remember - our inboxes are always open for queries, or even just chat (msa@kcl.ac.uk or shahnaz.hussain@kcl.ac.uk).

**From me and my amazing committee, we wish you an unforgettable first year and a future here at GKT that's brighter than a surgical light.**

MSA Love,
Miss Pres,
Shahnaz Hussain






*The Conservation Room of the old Dental School in Guy's at around the turn of the century*

# Dental Corner

*Photo: UMDS Volume 101 No 2369, 31st of January 1987*

# King's College London Dental Alumni Association - Alumni Weekend 2024

*Originally published in the British Dental Journal (https://doi.org/10.1038/s41415-024-7690-3)*

*In March 2024, the King's Dental Alumni Association held its annual Alumni Weekend. This year it consisted of two days of lectures and social activities to bring together alumni of the current and former schools, including Guy's Hospital Dental School, King's College Hospital Dental School, the Royal Dental Hospital Dental School and the United Medical & Dental Schools, as well as King's College London.*

*The annual event provides an important opportunity to meet with former members of staff and students, as well as show-casing high calibre presentations in clinical dentistry from both internal and external speakers. The 2024 event included the Hygienists' and Therapists' Meeting, the Staff & Alumni Reception and Annual Dinner, and the Clinical Open Day, tours of the clinical teaching facilities, and the Dental Alumni Association's Annual General Meeting.*

*Charlie Spedding, KCLDAA President introduced a theme for all speakers at the event, which was "Managing Expectations".*

*Straumann/YITI were the main sponsors, and their Friday morning session was well attended in the newly refurbished Function Room in the Guy's Hospital Tower.*

*"We were privileged to enjoy lectures on Managing Expectations from their three speakers: Charlotte Stillwell on Successful Removeable Partial Denture Design Principles; Sami Stagnell on an Update on Guided Bone Regeneration; and Robert Abraham on A Career in implantology -Live Interview. The delegates found these lectures very informative and were interested to hear what YITI can offer."*

*"We were also grateful to Align, BDA, DB Orthodontics, Haleon and Wesleyan for their sponsorship."*

*Clinical Day lectures took place on Friday afternoon in the Robens Suite and Saturday morning in the Tower Lecture Theatre. Clinical Day was opened by Charlie Spedding KCLDAA President and Professor Michael Escudier, Executive Dean of the Faculty of Dentistry, Oral & Craniofacial Sciences at King's College London.*

*The Friday lectures were given by Mark Sayers, Shreeti Patel and John Costello on Managing Expectations in Orthodontics and the Dento-legal field. Lectures on the Saturday were: Managing Expectations in Facial Cosmetic vs Reconstructive Surgery Patients by Tim Blackburn, the Rod Cawson lecture. Trish Berko presented Managing expectations: Increasing Awareness of Body Dysmorphia Disorder to Ensure Optimal Dental Care. The Walter Herbert Lecture was presented by Kavit Shah – Managing Expectations in the Restoration of Structurally Compromised teeth.*

*The Hygienists' and Therapists' Specialist Section Meeting ran parallel in the afternoon in the Gordon Museum at King's. Ellie Heidari spoke on Minimum Intervention Oral Healthcare for People with Dental anxiety; Tara Taheri spoke on Applying Psychological Strategies for better Oral Health Outcomes; Tanika Gohil was unable to attend to give her Update in Paediatric Dentistry and so Linda Perry from Haleon kindly stepped in at last minute, with a talk on Xerostomia.*





*KCL-Dental-1050: Professor Gallagher receives the Alumnus of the Year award, (L-R) Jen Turner, Professor Jenny Gallagher and Charlie Spedding, KCLDAA President*

*Professor Michael Escudier, Executive Dean at the Faculty of Dentistry, Oral & Craniofacial Sciences at King's College London said:*

*"It was wonderful to see the high level of engagement amongst the alumni who obviously thoroughly enjoyed the presentations as well as the chance to catch up with friends and colleagues."*

*The Staff and Alumni Drinks' Reception and Annual Dental Dinner returned to the Hilton Tower Bridge Hotel. Alex Groves and Rae Daher from the Alumni Office expertly ensured the evening was a success. 155 guests attended and Tomos Lavery (KCL 2014) and Ben Smith entertained with beautiful choral numbers.*

*A highlight of the event is the presentation of the Dentistry Alumni Awards. Established in 2006, awards are presented for Alumnus of the Year and Distinguished Service Awards. These recognise exceptional service both within and outside the Faulty of Dentistry, Oral & Craniofacial Sciences.*

*Alumnus of the year was presented to Professor Jennifer Gallagher and Distinguished Alumnus was awarded to Dr David Radford who was unable to attend in person.*

*The organisers would like to thank all who participated and attended this successful event and look to welcoming everyone back for the 2025 event to be held on Friday 7th and Saturday 8th March. This weekend will be a combined meeting welcoming the Hygienists and Dental Therapists with the theme Beyond the Smile and the Alumni Dental Dinner on the Friday 7th March once again at the Hilton London Tower Bridge.*


*Alumni-dinner-photo: Eddie Crouch 40th year reunion at the Alumni Weekend*

# KCLDAA Weekend 2024

Jing Yuan Chan **BDS4**

*Earlier in March this year, I was very kindly sponsored by Professor Stephen Challacombe, who sits on the Gazette Board of Trustees, to attend the KCL Dental Alumni Association (KCLDAA) Weekend 2024 on behalf of the GKT Gazette. This year's Alumni Weekend centred on the theme of "Managing Expectations" and, as per tradition, comprised a two-day programme held on the first weekend in March.*

**Friday 1st March: Straumann YITI Session, Clinical Open Day, and Hygienists' and Therapists' Specialist Section Meeting**

*The morning started off with the Young ITI Session courtesy of Straumann, the main sponsor for the weekend. This session featured speakers Charlotte Stilwell, Sami Stagnell, and Robert Abraham, who shared their thoughts on managing expectations in the context of partial denture design, guided bone regeneration, and when considering a career in the field of implantology respectively.*

*This was followed by the highly anticipated Clinical Day, where attendees (including those streaming remotely) were warmly welcomed by Charlie Spedding, President of KCLDAA, alongside Executive Dean Professor Michael Escudier. Guests enjoyed lectures from Mark Sayers (KCH Clinical Director) on "An Orthodontic Perspective"; Shreeti Patel (BDA Dento-legal Advisor) on "Consent and Communication"; and John Costello (Specialist Orthodontist) on "Are We Consenting Our Patients to the Full Capabilities of Orthodontic Aligners?". Running parallel to the evening lectures was the Hygienists' and Therapists' Specialist Section Meeting which was held in the Gordon Museum, and welcomed speakers Ellie Heidari, Tara Taheri, and Linda Perry (in lieu of Tanika Gohil, who was unable to attend).*

*Because I had a timetabled clinical session on this day, I was unfortunately unable to attend these talks in person, and therefore opted to retrospectively access the livestream which was made available until April.*

**Friday 1st March: Staff and Alumni Drinks Reception**

*Dinner was then hosted at the prestigious Hilton Tower Bridge Hotel, where we saw an impressive turnout of approximately 160 guests— it was extremely heartwarming to see that some alumni had even travelled from abroad to reunite with colleagues. I was joined by members of my cohort, who represented the Dental Society in managing attendance for the night; we had all been hard at work preparing for exams throughout the month, so having this opportunity to socialise with familiar faces and recent graduates felt like even more of a treat!*

*The excellent three-course meal was perfectly paired with lovely choral duets performed by King's very own Tomos Lavery, and Ben Smith. The highly awaited Alumni awards were then presented jointly by Charlie Spedding and KCLDAA Secretary Jennifer Turner, recognising Professor Jennifer Gallagher as Alumnus of the Year, and Dr David Radford as Distinguished Alumnus. The raffle draw was led by Professor Frances Hughes, Past President of KCLDAA.*

**Saturday 2nd March: Clinical Open Day, KCLDAA AGM, and Innovations in Dentistry and Dental Education Workshops**

*The morning started with rainy weather but high spirits in the Floor 30 Tower Lecture Theatre of Guy's Hospital, where both in-person and online attendees were welcomed back by Charlie Spedding and Professor Escudier.*

*The Rod Cawson Lecture was delivered first by KCL alumnus Professor Tim Blackburn, Consultant maxillofacial/facial plastic surgeon, who shared his experience in Managing Expectations in Facial Cosmetic vs Reconstructive Surgery Patients. Professor Blackburn highlighted the importance of managing expectations of both patients and colleagues throughout the patient journey, and I especially enjoyed the anecdotal aspect of his talk: for me, the most memorable clinical example was a glossectomy with an anterolateral thigh flap performed for an elderly patient. It was even more inspiring to see the post-operative video interview for this patient, which really showcased the patient's confidence that had been restored alongside function.*

*Following a riveting Q&A session, the spotlight was handed to Dr Patricia Berko, Clinical Psychologist in Orofacial pain, who discussed Increasing Awareness of Body Dysmorphia Disorder to Ensure Optimal Dental Care. I believe that this discussion is highly necessary in an age where we see countless examples of social media being used deceptively for the purpose of adhering to contemporary beauty standards.*

*After a refreshment break and the KCLDAA Annual General Meeting, in which Dr Jonathan Turner was announced to commence his term as KCLDAA President in March of 2025, the Clinical Open Day continued in the afternoon with the Walter Herbert Lecture, featuring prosthodontist and KCL alumnus Dr Kavit Shah who discussed Managing Expectations in the Restoration of Structurally Compromised Teeth. Being in BDS3, I found Dr Shah's talk highly relevant to this stage of my course, as we were just starting to learn about the many ways that missing and badly broken-down teeth can be restored. The presentation also touched upon the theoretical side of restorative dentistry, including micromechanical retention and wettability in adhesion– something I appreciated, especially as exams were right around the corner!*

*Professor Escudier then hosted the Dean's Lunch for a final round of networking and socialising, and the day ended with a tour of the Haptics Suite led by Dr Melanie Nasseripour and Dr Turner.*

*I would like to thank Professor Challacombe again for his generosity, and I look forward to the next alumni weekend in March 2025!*

# University of London BDS awards 2024

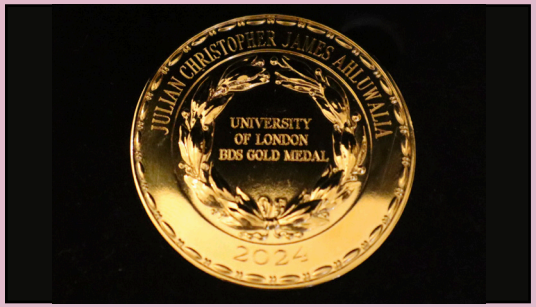
Jing Yuan Chan **BDS4**

Each year, London's medical and dental schools nominate their top-performing final-year students to compete for the prestigious University of London Gold Medals. Since its inception in 1903 for medicine, and later expanding to include dentistry, the competition has recognised exceptional students, including the famed Alexander Fleming, discoverer of penicillin, who won the medal in 1908. The recipient of the Gold Medal receives a medal struck by the Royal Mint, alongside a £500 prize, while the runner-up is awarded the Betuel Prize and £200.

The competition is a rigorous, face-to-face examination, led by a panel of expert external examiners from across the UK. For dental students, the viva encompasses key areas such as Restorative Dentistry, Orthodontics, Oral and Maxillofacial Surgery, and Dental Public Health. Medical students face equally challenging topics, including General Medicine, Surgery, Obstetrics and Gynaecology, Clinical Pharmacology, Emergency Medicine, and Psychiatry.

This year, the BDS Gold Medal returned to King's, with **Dr Julian Ahluwalia** emerging as the 2024 recipient. Reflecting on the award, Dr Ahluwalia shared his thoughts.

Dr Ahluwalia, who previously qualified in medicine from King's (2013–2019), is now eager to embark on the next chapter of his career. He aspires to pursue a future in Oral and Maxillofacial Surgery as he begins his surgical training.




*I am deeply humbled to have been awarded this year's University of London Gold Medal. Competing alongside such accomplished candidates was a true honour. The examination process was both challenging and exhilarating, pushing the boundaries of our knowledge and critical thinking. I am immensely grateful to the dedicated university and NHS staff at King's College London – this award is a testament to their unwavering commitment to excellence in teaching. I also extend my heartfelt thanks to my family and colleagues for their continuous support throughout my studies. Lastly, I offer my warmest congratulations to my fellow dental graduates.*





## BDS Betuel Prize winner

Dr Xii Cin Lim (Jessica)
**King's College London**

I was sitting in a café in Paris, basking in the sun and enjoying my last long summer holiday, when the email came. "UoL Gold Medal viva – Reporting Instructions for Candidates 1st July 2024", the subject line read. Turns out, I was one of the top scorers at King's for finals, and had been selected for a viva covering orthodontics, oral and maxillofacial surgery, dental public health and restorative dentistry against fellow King's top scorers and Bart's nominees. It's in 10 days time and I don't remember anything! I thought, panicked. Worth going just for the attendance certificate, I thought to myself.

The 6 of us who were nominated hurriedly put together a few revision sessions. Prof Jones, Dr Ghuman, Dr Moore and Dr Austin gave us a session too, which we were all very grateful for.

On the day of the viva, I arrived at UCL at my designated time. The restorative and orthodontics stations were both case based discussions, the DPH one was on survey and research design, OMFS was trigeminal neuralgia. The viva felt very much like getting questioned by a consultant on clinic, so it was hard to gauge how I'd done - every answer had led to more questions being asked!

The email came that same afternoon – huge shock - I had won the Betuel Prize!

Overall it was a really good learning experience, but the greatest lesson I learned from this was to trust myself. I had drilled my ankis religiously everyday in the months before finals and the knowledge was definitely still in there when I got put on the spot. So, if you get called to go to the UoL gold medal viva, I'd say well done and don't worry, you've definitely still got it!

Photos by Dr Julian Ahluwalia and Dr Xin Cin Lim (Jessica)

# The London Anatomy Office Service of Thanksgiving

Morgan Bailey **iBSc in History and Philosophy of Medicine**

The London Anatomy Office, headquartered in the Hodgkin Building on Guy's, organises bodily donation on behalf of the 8 medical schools within and surrounding London. They are also responsible for hosting the annual Service of Thanksgiving, which on the 17th day of May in the year of 2024, was hosted by academics and students from within GKT.

The service took place in St George's Cathedral in Southwark. The sky was clear and the weather fair as families streamed and sunk into the pews lining the cobbled floor.

At precisely 11 o'clock, the academic and clerical procession began. Names notable to us at GKT were Dr Tanya Shaw, Dr Alistair Hunter, Jim Craig and Rev'd Ellen Clark-King, all headed by Dr David Parry; upon his shoulders rested the organisation of the event.

Words were spoken by Dr David Parry and the clergy of St George's Cathedral Father Joseph Donkor, followed with hymns sung by the Chorus of King's College. Student reflections were given by myself and Arnav, followed by a clerical address given by the Dean of Guy's Chapel Jim Craig.

Following the service, it was heartwarming to speak to the loved ones of the departed, to hear their anecdotes and to share their grief. It was reassuring that, whilst the sadness was palpable, much-needed closure had been given to many of the families during the service.

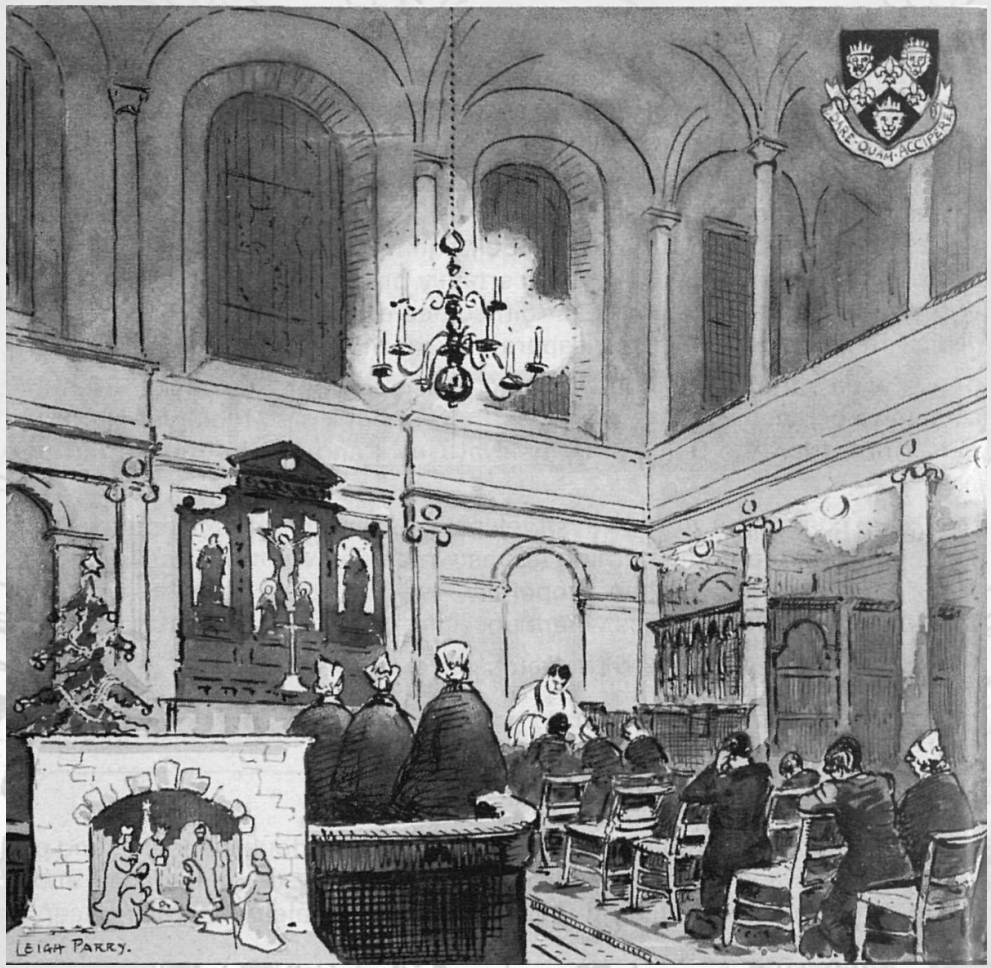
Thanks to Dr David Parry and Kim Piper of the London Anatomy Office for their incredible organisational feat, and to Dr Parry for inviting us to the address.

Finally, thank you to the departed who bestowed an anatomical education upon us; for without whom we would not be here to give the address.

*From left to right: Prof. Malcolm Logan, Dr Alistair Hunter, Mark Bradshaw, Nicola Stanbridge, Mr Vishy Mahadevan PhD FRCS, Douglas MacGregor, Dr David Parry, Dr Tanya Shaw, Morgan Bailey, Arnav Umranikar*



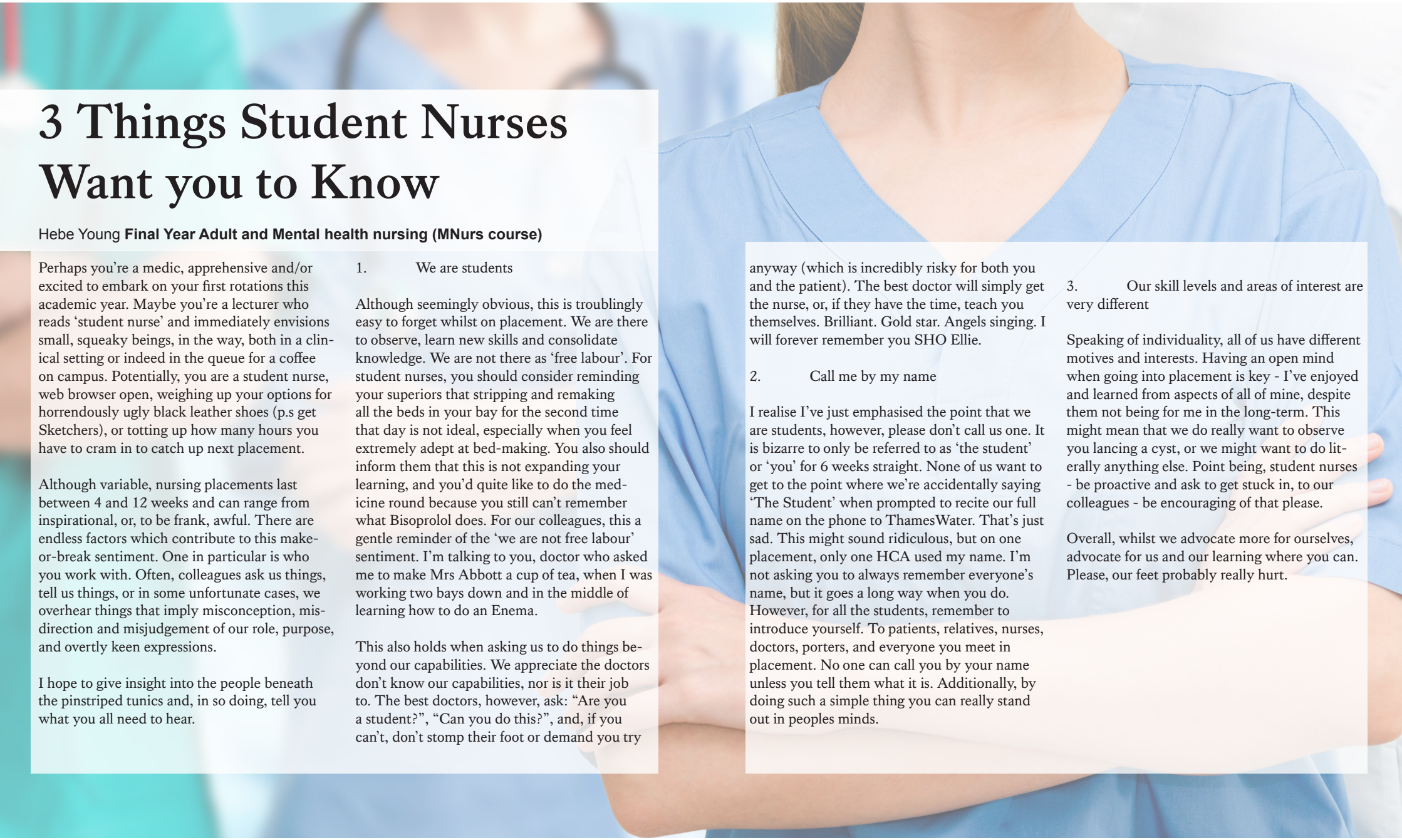





# Nursing Corner

*Image taken from UMDS (Guy's) Gazette, Vol. 97, No. 2333, 28th May 1983*
*'A Few Memories of Guy's 1921-1929' by Edith M Trick*

NURSING CORNER



# 3 Things Student Nurses Want you to Know

Hebe Young **Final Year Adult and Mental health nursing (MNurs course)**

Perhaps you're a medic, apprehensive and/or excited to embark on your first rotations this academic year. Maybe you're a lecturer who reads 'student nurse' and immediately envisions small, squeaky beings, in the way, both in a clinical setting or indeed in the queue for a coffee on campus. Potentially, you are a student nurse, web browser open, weighing up your options for horrendously ugly black leather shoes (p.s get Sketchers), or totting up how many hours you have to cram in to catch up next placement.

Although variable, nursing placements last between 4 and 12 weeks and can range from inspirational, or, to be frank, awful. There are endless factors which contribute to this make-or-break sentiment. One in particular is who you work with. Often, colleagues ask us things, tell us things, or in some unfortunate cases, we overhear things that imply misconception, misdirection and misjudgement of our role, purpose, and overtly keen expressions.

I hope to give insight into the people beneath the pinstriped tunics and, in so doing, tell you what you all need to hear.

1. We are students

Although seemingly obvious, this is troublingly easy to forget whilst on placement. We are there to observe, learn new skills and consolidate knowledge. We are not there as 'free labour'. For student nurses, you should consider reminding your superiors that stripping and remaking all the beds in your bay for the second time that day is not ideal, especially when you feel extremely adept at bed-making. You also should inform them that this is not expanding your learning, and you'd quite like to do the medicine round because you still can't remember what Bisoprolol does. For our colleagues, this a gentle reminder of the 'we are not free labour' sentiment. I'm talking to you, doctor who asked me to make Mrs Abbott a cup of tea, when I was working two bays down and in the middle of learning how to do an Enema.

This also holds when asking us to do things beyond our capabilities. We appreciate the doctors don't know our capabilities, nor is it their job to. The best doctors, however, ask: "Are you a student?", "Can you do this?", and, if you can't, don't stomp their foot or demand you try anyway (which is incredibly risky for both you and the patient). The best doctor will simply get the nurse, or, if they have the time, teach you themselves. Brilliant. Gold star. Angels singing. I will forever remember you SHO Ellie.

2. Call me by my name

I realise I've just emphasised the point that we are students, however, please don't call us one. It is bizarre to only be referred to as 'the student' or 'you' for 6 weeks straight. None of us want to get to the point where we're accidentally saying 'The Student' when prompted to recite our full name on the phone to ThamesWater. That's just sad. This might sound ridiculous, but on one placement, only one HCA used my name. I'm not asking you to always remember everyone's name, but it goes a long way when you do. However, for all the students, remember to introduce yourself. To patients, relatives, nurses, doctors, porters, and everyone you meet in placement. No one can call you by your name unless you tell them what it is. Additionally, by doing such a simple thing you can really stand out in peoples minds.

3. Our skill levels and areas of interest are very different

Speaking of individuality, all of us have different motives and interests. Having an open mind when going into placement is key - I've enjoyed and learned from aspects of all of mine, despite them not being for me in the long-term. This might mean that we do really want to observe you lancing a cyst, or we might want to do literally anything else. Point being, student nurses - be proactive and ask to get stuck in, to our colleagues - be encouraging of that please.

Overall, whilst we advocate more for ourselves, advocate for us and our learning where you can. Please, our feet probably really hurt.

# Online Friends Shop

***Via the Friends pages of the Guy's & St Thomas' Website***

***guysandstthomas.nhs.uk/get-involved/friends-guys-and-st-thomas***

*We can deliver to your home (postal charges apply) or you can collect from the Shop at St Thomas'*
*All hospital memorabilia available - Tankards, Tumblers, Gin glasses, Hip Flasks, Cufflinks, Ties, Tie Slides, Lapel Badges, Compact Mirrors, Trinket Boxes, Pens, Letter Openers, Bottle Stoppers, Key Rings, Bookmarks, Card Holders, Mugs, Pictures, Books, Cards, T-Towels, Aprons, Bags.*





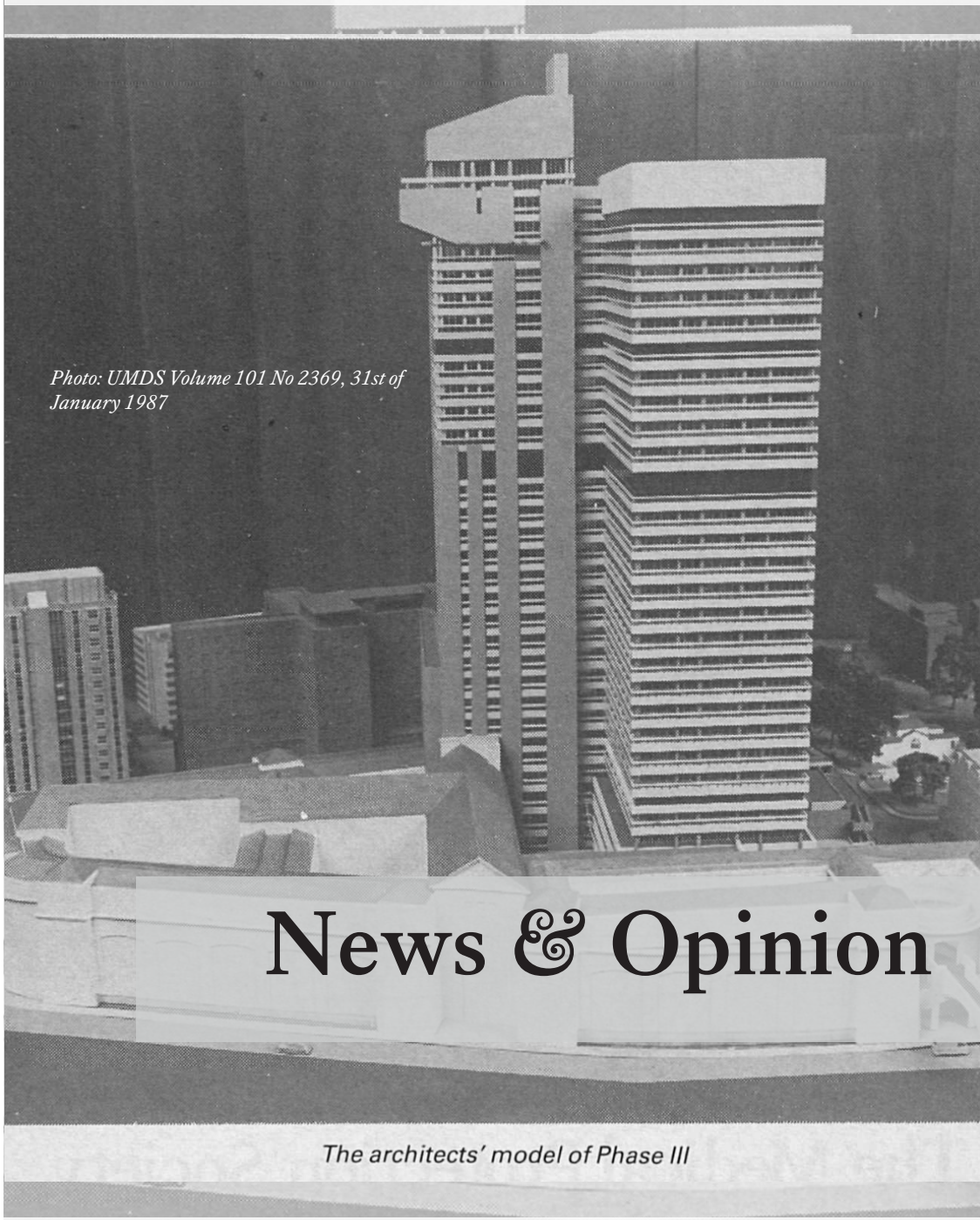


*Photo: UMDS Volume 101 No 2369, 31st of January 1987*

# News & Opinion

*The architects' model of Phase III*

# Should medic influencers promote Natural Cycles?

Charlotte Mulcahy **MBBS5**

Natural Cycles is a birth control app founded by Swedish physicist Elina Scherwitzl. The app was designed by Scherwitzl when she decided to have her first child and wanted to track her fertility. It now has over 3 million registered users and 40,000 reviews on The App Store. Before signing up to the app, it asks you to fill in a survey to try and assess if, based on your current cycles, you would be an appropriate user of the app. Then it offers a subscription service from £10 a month (not including an official thermometer). The app uses data you input on your basal body temperature and an algorithm to tell the user if it is a green day (they are not fertile) or a red day (they should use protection). The overall premise is that the app uses the hormone driven changes in body temperature to determine the user's fertility.

Natural Cycles has funded multiple studies which show the effectiveness of the app compared to traditional methods – claiming it is 93% effective, the same percentage as the contraceptive pill. However, Scherwitzl appears as a co-author on nearly all published studies on this specific app, meaning the data does not come without bias. The NHS patient information websites do mention similar methods, terming them 'fertility awareness', but do not officially recommend using apps or similar methods. NICE also reviews some of the evidence for this app but does not include it in any specific guidelines so far.

The app is controversial... The Guardian published an article in 2018 commenting on backlash received by users who fell pregnant after using the app for contraception. Users shared their stories of how they felt the app was not clear on the real risk of pregnancy. The Swedish Medical Products Agency completed a review on the product and determined pregnancies were in fact in line with the product's failure rate, but that they needed to clarify the risk.

Although the effectiveness of natural cycles is ambiguous, several medic influencers, this meaning healthcare professionals with social media presences, have promoted the app. A quick search on YouTube shows Natalie Crawford MD (176,000 subscribers), Kendra Tolbet (76,000 subscribers), Dr Jennifer Lincoln (1.11 million subscribers) and Dr Nellah (76,000 subscribers) endorsing and the explaining the Natural Cycles app. Dr Faye Bate (219,000 subscribers) also uploaded a video endorsing the app but this is now deleted.

But is it ethical for doctors to promote the app? Firstly, there is the question of freedom of speech. None of these videos were paid sponsorships in which Natural Cycles paid the influencers to talk about the app. They were simply women sharing their contraceptive experience and expressing their preference. Despite being healthcare professionals, they also have every right to share any details of their life that they wish.

However, they remain healthcare professionals. Is it right that they effectively advertise a product which is not approved to be prescribed on the NHS? There is a grey area about whether doctors should be held to the same professional responsibility in their personal life. The influencers have a wide audience of unknown viewers consuming their content, so the effects of using social media to recommend a product like Natural Cycles is not the same as simply recommending it to a friend. Doctors are trusted by patients and it's important that, although speaking 'off the record' and not as a doctor, medic influencers are not exploiting that trust.

It begs the questions of 1) what power social media influencers have, 2) what power medical professionals have, and notably 3) what happens when these are combined?

YouTube recently introduced the YouTube Health programme designed to prevent the spread of misinformation and to ensure viewers that any medical advice is provided by a professional. However, YouTube Health does not regulate their content or evidence base so is not necessarily stopping medical malpractice online. There is also a wider question about why these apps are so popular. What does it say about the current contraceptive options available that non-hormonal and app-based methods are popular not just with medics, but also patients?

To date, the evidence for Natural Cycles is not strong enough to support medics to recommend the app to NHS patients. So, the question remains should medics be allowed to promote Natural cycles on their social media?

References available on request at gktgazette@kcl.ac.uk

# Too many medical memoirs?

Charlotte Mulcahy **MBBS5**

Ask any medical student what they included in their UCAS personal statement and they will list off an impressive bunch of accolades and achievements. They will then state 'oh, and I also wrote about reading [insert a popular medical memoir here]'. However, when you ask medics what they like to read for leisure, those who find time in their busy schedule to read will likely proclaim 'well I don't like to read about medicine in my free time!'

In the last few years, medical memoirs and similar non-fiction books have become increasingly popular, particularly following the runaway success of Adam Kay's *This is Going to Hurt*. But who is reading them? Why are they so popular? And importantly, is their popularity good for the profession and public alike?

Early on during medical school we are taught to reflect... reflect on what we are taught, on our experiences, on our patient interactions and so on. Much of this formal reflection is done in the written form for our portfolios (maybe against our will). But also, anyone who has been stuck in a group of medics will know that we love to talk about our experiences on placement in depth, reflecting verbally.

Perhaps, it makes sense that many medics decide to turn their experiences and reflections into books after years of working in hospitals. Afterall, most of us will be patients during our lifetime and will interact with health services. It's natural to be interested in what goes on behind the scenes. Moreover, a gory or comical story has universal appeal, even if it is at the expense of another's ill health.

Other than comic relief, many memoirs seek to teach readers something the writer has learnt throughout their career. Memoirs range from Atul Gawande[1] and Kathryn Maddix's[2] frank conversations about death and dying, to Phil Whittaker[3] and Penelope Campling's[4] explanations of current NHS practice, to Alistair Santhouse[5] and Suzanne O'Sullivan's[6] books considering the connection between mind and body. The authors of these memoirs share their expert knowledge of specific topics with a lay audience, which can have a real impact.

Patients having greater understanding of the NHS, their bodies and their treatment can only have good consequences and enable more informed consent. Furthermore, it helps to demystify the inner workings of the NHS, something which causes much frustration, but few fully understand. These books can contribute to public health education and reassure or inform patients about a variety of conditions, including their own.

However, some memoirs have come under fire due to their critical depiction of the profession. *This is Going to Hurt*, shares the experiences of a junior doctor who ultimately leaves the NHS, so it's perhaps inevitable that the NHS is portrayed negatively. In some memoirs such as Rachel Clarke's *Your Life in My Hands*, she writes almost exclusively of her miserable and difficult time in the NHS and how much it needs to change, without any sort of positive conclusion. Some writers also expose their own bad behaviour, as Henry Marsh writes about his own, somewhat abusive, behaviour of his juniors in *Do No Harm* with very little insight or


apology. Perhaps it's not role-model behaviour to demonstrate to future consultants.

Some memoirs swing the other way and portray idealised and God complex-like figures of themselves. David Nott in *War Doctor* details his many journeys across the world, often ignoring official advice to put himself in near-death situations, so he could save the many lives of citizens living in a warzone. To be fair to Nott, he also discusses his regrets and times where he was not able to save everyone, but readers would be forgiven in thinking this memoir was a self-absorbent advertisement for *Médecins Sans Frontières*. Rahul Jandial falls into a similar trap as his memoir Life Lessons from a *Brain Surgeon*, although well-meaning, essentially turns into a story about how much cleverer he is than his colleagues.

That being said, many of the stories are inspiring and well-written, including Paul Kalanithi's *When Breath Becomes Air* – a memoir of his experience as doctor and patient as he writes about his experience with lung cancer. This book is a favourite of medical students due to its beautiful writing and emotional ending.

Amanda Brown's Prison Doctor and Richard Shepherd's *Unnatural Causes* also shine a spotlight on some of the lesser understood and more alternative pathways in medicine (namely a prison GP and a forensic pathologist respectively). Well-written memoirs have the potential to appeal to wider audiences and provide deeper insight than a slideshow presentation or a stand a careers fair.

Finally, there is one other big issue when it comes to medical memoirs: confidentiality. Medical memoirs often teeter between fiction and non-fiction, raising the question of how to maintain confidentiality when publishing patient stories for the world to see. Although patients may give consent for their stories (or embellished versions) to be included in a memoir, if that book reaches high levels of commercial success, it begs the question of whether patients consented to their stories being that well known.

Some topics are also trickier to write about. In Gwen Adshead's *The Devil You Know*[7], she explicitly details the crimes and psychotherapy sessions of patients she met while working in psychiatric prisons. Sue Black also toes the line in *All That Remains* where she discusses her work as a forensic anthropologist and describes not only the remains that she works with, but how they died.

Medical memoirs are here to stay as bookstores fill up shelves of the latest publications by doctors. However, aspiring writers need to take care. Their memoirs need to ensure that: they look impressive but not arrogant, patients' stories are interesting but confidential, and they portray the job in a positive but honest light... certainly no easy feat!

[1]Atul Gawande – Being Mortal
[2]Kathryn Maddix – With the End in Mind
[3]Phil Whittaker – What is a Doctor?
[4]Penelope Campling – Don't Turn Away
[5]Alistair Santhouse – Head First
[6]Suzanne O'Sullivan – It's All In Your Head
[7]Gwen Adshead & Eileen Horne – The Devil You Know

# The Tipping Point: Mpox in the Democratic Republic of Congo

Noor Amir Khan **MBBS3**

Mpox has been caught in a spider's web: tangled between epidemics, global health inequalities and stigmatisation, its emergence has left a surge of misinformation in its wake. Public perceptions are snagged and skewed, compromising patient outcomes across the world. Nevertheless, through exploring this cat's cradle, perhaps we can learn to amend it.

## What is Mpox?

In brief, Mpox is caused by the monkeypox virus (MPXV) and transmitted through close contact with individuals, animals or inanimate objects that are contaminated. (World Health Organization, 2024). MPXV has two strains: clade I and clade II. Each of these possesses two subtypes - for example clade IIa and clade IIb. (World Health Organization, 2024)

Whilst clade IIb drove global outbreaks in 2022, clade I has recently emerged. This causes characteristic skin rashes and lesions as well as constitutional symptoms (such as fever, lethargy, swollen lymph nodes, aches and pains across the body). These can progress to more severe complications and possible death. (World Health Organization, 2024)

Clade I, with its epicentre in the Democratic Republic of Congo (DRC), was declared a 'public health emergency of international concern' in August 2024. (World Health Organization, 2024) It has now spread to neighbouring countries (Burundi, Rwanda and Uganda) and broken international waters (Sweden). (European Centre for Disease Prevention and Control, 2024)

## Mpox in the DRC

In a country marred by a history of conflict, colonialism and political uncertainty, it is tragically understandable that Mpox pressurises an already fragmented system. (BBC News, 2019).

With clade I having infected over 19,000 people in the region, tensions run high as contradictory narratives regarding the emergence of the virus intersect with inaccessibility to reliable information. (European Centre for Disease Prevention and Control, 2024) Some believe that Mpox has been fabricated by pharmaceutical companies for financial gain via vaccines, while others worry it has been constructed by foreign powers to weaken African populations – and approximately 44% of the populace have never heard of the condition at all. With less than half of the public owning a mobile phone and communities residing in rural landscapes, conspiracy theories prevail in both physical and online spaces. This lack of access to accurate medical advice hinders the implementation of preventative behaviours, inevitably leading to increased transmissions. (Lay, 2024)

The mutated virus' presentation also adds fuel to the fire. Whilst individuals may discriminate, the virus does not: clade I can infect anyone, regardless of their sexual orientation or activity. This, unfortunately, opposes the medical and social contexts Mpox is associated with in the DRC. The surfacing of lesions has classically been viewed in a negative light by the Congolese as conclusions of 'sex work and spousal infidelity' are often drawn. (Baraniuk, 2024)

Equally, with the clade II outbreak initially being associated with men who have sex with men (MSM) and people within the LGBTQ+ community, many have experienced an added dimension of discrimination and stigma. (World Health Organization, 2024) This can prevent individuals from seeking help for fear of condemnation and societal exclusion, leaving them vulnerable to a poorer prognosis. (Acharya et al., 2024)

Despite the prevalence of misinformation and stigma complicating patient outcomes, an estimated 75% would be open to receiving a vaccine. (Lay, 2024) Nevertheless, this courageous openness in an environment of institutional mistrust is tainted by problems of vaccine inequity. Indeed, Japan, Canada and the US have hoarded millions of vaccines whilst supply in the DRC does not reach the demands imposed on its healthcare system. (Ahmed, 2024) It has, consequently, been argued that the Global North plays the role of a reverse Robin Hood: it ignores the needs of developing countries in epidemics, stockpiles resources, imposes travel bans when its borders are at risk and provides 'performative charity' in place of 'authentic solidarity'. With evidence of this pattern in previous waves of HIV/AIDS, Covid-19 and Mpox in 2022, will this cycle ever be broken? (Ifedayo Mo Adetifa and Pai, 2024)

## Solutions

At present, 'community action cells' have been created. These cells train trusted members of the general public, such as teachers, frontline workers and those holding positions of responsibility, to convey accurate medical information in local areas. By taking the time to embrace, consider and respond to the nuances of each individual's thought process, this personalised approach has the potential to create lasting change. (Lay, 2024) Additionally, Gavi (a vaccine alliance group) has utilised the First Response Fund to supply vaccines for immediate use in countries struggling with the virus. They also hope to build a stockpile for future emergency outbreaks. (Ahmed, 2024)

Whilst these are steps in the right direction, more manufacturers need to be involved in the production of vaccines and costs should be lowered to ease their acquisition. Equally, public campaigns and contact tracing measures require enhancement to overcome communication difficulties and stigmas within the region. (Ifedayo Mo Adetifa and Pai, 2024)

To pave the way for a better future, national and international responses must be strengthened. At its root, this involves guiding the transition of developing countries to a more independent healthcare model, one that empowers the DRC to attain autonomous health security whilst maintaining global relationships. (Ifedayo Mo Adetifa and Pai, 2024)

Ultimately, the Democratic Republic of Congo is held at a tipping-point. With a history of poor health literacy, vaccine inequity and clashing social contexts, it balances on a fulcrum via trickling charity aid and local narrative changes. Yet, through promoting autonomy and a more considerate, egalitarian global response, perhaps it is finally on the precipice of change.

*References available on request at gktgazette@kcl.ac.uk*

# GKT School of Medical Education Faculty Update

Dr Sam Thenabadu **GKT MBBS Programme Director**

The faculty were excited to welcome all our returning students back to the school of Medicine in August and September, but particularly to welcome our newest cohort of Stage 1 students of which some will be our first graduates of the 2030s.

With the important task of preparing the healthcare teams of the next decade, we have worked hard to ensure our course is contemporary, whilst maintaining the high standards and traditions of core medicine, that have been taught at GKT for hundreds of years.

Within the School, we are now starting to implement the curriculum refresh. The stage 1 curriculum has been streamlined and now includes a new reading week in the first semester and the introduction of a two week 'Transition to Clinical Practice' block following the second exam period to better prepare students for the clinical world. We have also rolled out 'small group Wednesdays' in stage 2 and clinical tutor groups to bring core topics based around the new Medical Licensing Assessment to life whilst also building a sense of academic community as students study side by side on campus rather than online. Much of the early success of these sessions is down to the hard work of our seven new medical education fellows (4 of whom are are own GKT alumni). We hope this will become a well trodden path and one day many of you will return to teach with us as fellows too. In Stage 3 we put a strong focus on immersing into the clinical environment but have developed revision resources for PTs and OSCEs for clinical sites to utilise to better support consolidation of knowledge and preparation for exams.

This year will see an increased emphasis on projects with more choice for SSCs and SPMs and more attention to supporting careers throughout the course. The culmination in a summer projects conference, an upgrade from our already fantastic existing QIP conference, will allow even more project opportunities to present locally and to use this as a launchpad to present and publish more widely.

Student experience remains a huge focus and the student voice a key priority. The range of fora and drop ins for students to meet faculty formally or informally continues to grow, and initiatives like the student experience virtual suggestions box, will hopefully make connecting and collaborating even more easy. Multiple informal visits are planned to our partner sites so that students meet central faculty on a regular basis. Combining these with social events is a priority and undertaking activities like student / faculty beach clean ups in Margate are just one of many initiatives on the horizon to strengthen our GKT community.

We continue to strive to have a fair and equitable course for all our students and to embrace our diversity, something that can only make us stronger. We begin another year of reverse Mentoring with students from ACMS and the LGBTQ+ societies mentoring senior facility about their lived experiences. We will also highlight key events such as world mental health day, black history month and key events from the religious calendars of all the six major religions. Celebrating and understanding these important events with members of our community remains key.

The NHS continues to be under huge stress but the desire from our inter professional team to teach students remains steadfast. We urge you to be part of this wonderful NHS team in any way you can and to enjoy every moment. The journey is long and not always easy, but when you undertake a vocation like medicine the difference you will make to patients will always be worth it.

Have a wonderful year ahead and please never hesitate to reach out to the senior faculty when needed,

Sam

*Medical School Deans throughout history, 1st floor Hodgkin Building (Medical School Building)*

# Medical School: the Commitment with Covert costs

Ama Owusu-Manu **MBBS2**

When we think of the word 'cost,' our minds often turn to finances and anything of monetary value. However, 'cost' can also refer to any resource expended in pursuit of a goal. In this broader sense, cost becomes synonymous with sacrifice.


A hidden sacrifice is one that goes unnoticed, lurking beneath the surface of our awareness. Medical school is generally perceived as the domain of driven, goal-oriented individuals. However, in the pursuit of the significant goal of becoming a doctor, there is a cost that extends far beyond tuition fees and supplementary course expenses. Today, I want to focus on an often-overlooked cost: the time, emotional expenditure and countless memorable moments that must be sacrificed in the singular quest to become a physician.

From the application process to the completion of the program, medical students often find themselves torn between two vital spheres: academia and personal relationships. Some may have to put aside promising business ventures that simply cannot flourish alongside the demands of medical school. Humans can be multi-faceted beings with multiple talents and medical students are no exception. Promising athletes, musicians and instrumentalists are required to most likely forsake their first love for another demanding passion. Juggling between multiple pursuits is not an impossible mission but will prove to be very difficult.

Our familial and social connections are fundamental to our humanity. As social beings, we need interaction and the influence of our communities to shape who we are. Missing significant events involving loved ones leaves a void that no number of pictures or videos can truly fill. Having to skip yet another birthday celebration because of an impending OSCE is a difficult hurdle, but it is one that must be overcome.

The medical student is exposed to multiple life-altering situations that can be classified as traumatic and heart-breaking. The emotional burden carried from the placement site to the classroom to the bedroom can often be overlooked but does leave a psychological imprint in the long run. There is a definite emotional expenditure made by medical students as they tarry through the process of becoming a physician. Nonetheless, these encounters facilitate the production of an excellent medical practitioner.

As a medical student, you constantly find yourself weighing the odds. But when you step back and consider the bigger picture, it becomes clear that the price paid is justified by the ultimate reward: becoming a doctor. As doctors, we are afforded the opportunity to transform lives and enhance the well-being of every person we encounter throughout our careers. Transformation is progressive and there is an overt beauty in observing the amelioration of our patient's health which, as doctors, will be our paramount duty.






*Photo: Guy's Gazette Volume 110 No 2462 January 1997*


*The Operating Theatre*

# A visit to the Old Operating Theatre

Victoria Chu **MBBS2**

If you've ever headed towards London Bridge from Guy's campus on foot, you'll have passed Europe's oldest surviving operating theatre. Tucked away at the top of St Thomas' Church on St Thomas' Road, the entrance is right next to the Amazing Grace Restaurant. I wandered in one Sunday afternoon out of curiosity and trekked up the 52 narrow wooden stairs to discover a time capsule of medicine before modern times, intertwined with GKT's very own history.

St Thomas' opened as a teaching hospital in the 18th century, and the theatre was built following this, originally attached to the third floor of the women's wards. However, it closed in 1862 when St Thomas' Hospital relocated to where it is today in Lambeth, and was only rediscovered in 1957, opening as a museum to the public five years later. As you first step in, you're greeted by the wooden interior of the Garett; jars of herbs, ointments and balms line the shelves, demonstrating how they were once incorporated into healing by the apothecary for medicinal remedies. Wandering around the room, you'll find anatomical models and skeletons that aided teaching dating back to the Victorian era. The displays give detailed accounts of the history of pharmacy, midwifery, amputations and surgery, as well as the uses of the instruments and objects shown such as syringes, forceps, shears, prosthetics, leeches, plague masks and many more.

Heading deeper into the attic, you will find the semicircular theatre itself in the corner, where surgeons would operate on female patients in front of spectators. The skylight brings in natural light to spotlight the operating table, a simple wooden design with a removable headrest and extending footplate. It wasn't until the introduction and teaching of antiseptics that hospitals would swap the use of wooden equipment for metal instead. The theatre itself never performed antiseptic surgery, and in an age where unwashed blades and reused bandages were used, it's no wonder that patient mortality rates were so high, if not due to the failed operation, then from an infection incurred from the unhygienic standards of the wards. Anaesthesia also wasn't utilised until the mid-19th century in the form of ether and chloroform, so you can imagine before then patients on the operating table would have to endure painstakingly agonising procedures fully conscious. Frances Burney, a patient who underwent a mastectomy in 1811 wrote in her journal of the 'scream that lasted unintermittedly during the whole time of the incision ... so excruciating was the agony'. While thankful that medical practice is sanitary and adept now, these accounts prompted me to think of those today in countries with limited access to safe and hygienic healthcare, where accepting or denying a procedure poses an equally grave risk to patients either way. Such examples include the war in Gaza currently, where children have wounds in their heads needing to be stitched, patients needing amputations, and those with serious burns, all done without anaesthesia.

*The Herb Garret*
*Photos taken January 2024*

On the walls outside of the theatre, there are displays of renowned surgeons of the past affiliated with GKT such as national treasure poet John Keats, James Miranda Barry, a woman who lived their life as a man to be accepted as a university student and to pursue a surgical career, and John Flint South, a renowned London born surgeon. The theatre would host over 140 students watching the operation from the barriers, and South himself recounts what it was like to be a Guy's student in his memorial: 'After our operations were over, the students rushed down two flights of stairs and across the street to Guy's...', maybe this was their equivalent to grabbing a Pret with your friends after 9 am dissections. Reading these biographies also highlighted to me that despite having a long way to go, we have come so far in terms of the array of individuals from diverse backgrounds treating, researching and practising in the field of medicine.

So if you ever have a spare hour between lectures, tutorials or practicals and you need a break from the hectic buzz of London life, I highly encourage a visit to the museum for inspiration and time to yourself. It is a gentle yet affirming reminder of those who dedicated their lives and bodies to the advancement of medicine, as well as honouring the individuals in our lives who dedicate teaching and passing on their knowledge to us today as the next generation of healthcare professionals.

*Concession fare grants a £6 entry for all students with their ID and is open every Thursday-Sunday from 10.30 am until 5 pm.*

*References available on request at gktgazette@kcl.ac.uk*

# The GKT Gazette Committee ZinE

Dear Readers,

We are pleased to present the GKT Gazette's first-ever Committee Zine*! Pour over its pages: spanning life's big questions to politics and AI through drawings, poetry and more!

The pieces featured within the following zine were created by our Committee. In preparation for this, we designed prompts based on topics that piqued our interest within the Fresher's 2023 issue of the GKT Gazette. If you flick to the end, you can see which questions inspired the final works!

We understand that, as students at GKT, it can be difficult to spend time writing articles or on artistic endeavours; many of us are limited by perfectionism, others by time. Our motivation was, therefore, to create a safe space for students to take full ownership of the creative process - not for an achievement or grade but the opportunity to share a little corner of one's world, unique experiences or stories.

Ultimately, being able to hold this tactile, physical culmination of everyone's efforts has been so personally gratifying and something we will all treasure forever!

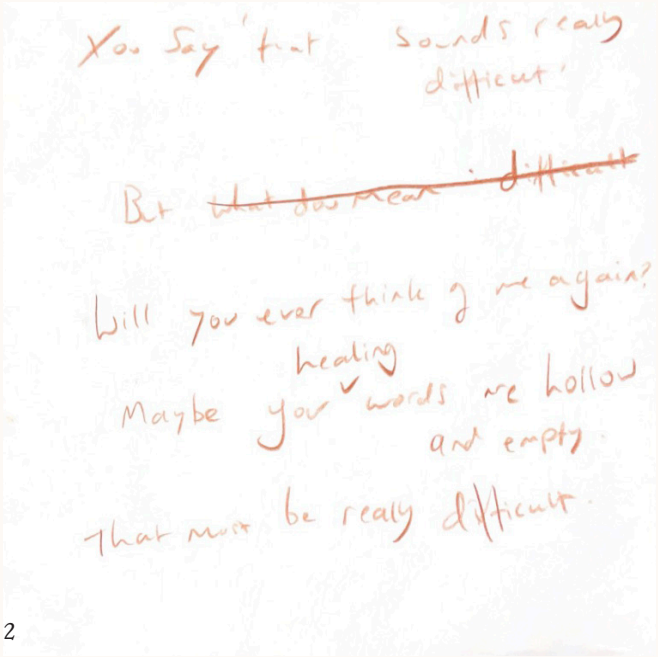
As we bid you adieu, following our Zine we have included an excerpt of Zaynah's personal reflections from our very first Zine Event.

Best Wishes,
Noor Amir Khan,
Zaynah Khan,
& (last but not least!) Ruby Ramsay :)

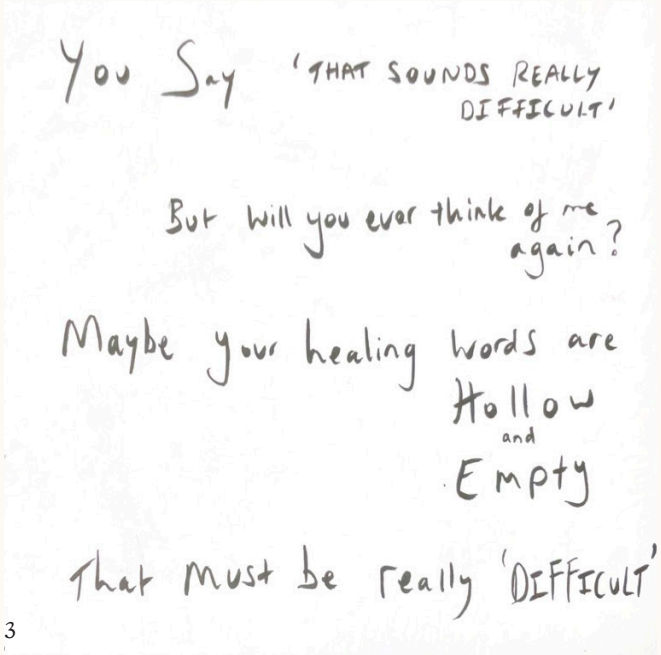
*Zines are independently made mini magaZINES, often produced in small batches for little-no profit. They have no set medium, topic or rules, but are a spring-board for spreading ideas.







You say 'that sounds really difficult'
But ~~that you mean · difficult~~
Will you ever think of me again?
healing
Maybe your words are hollow
and empty
That must be really difficult

2


You Say 'THAT SOUNDS REALLY DIFFICULT'
But will you ever think of me again?
Maybe your healing words are
Hollow
and
Empty
That must be really 'DIFFICULT'

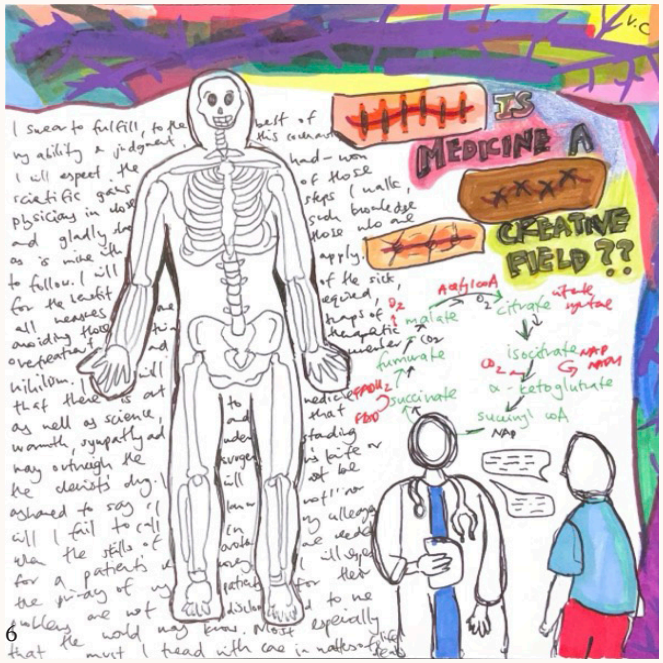
3


IS THE DEVIL IN THE DETAIL?
JB

4


MED
#hello

5


IS
MEDICINE A
CREATIVE
FIELD ??

6

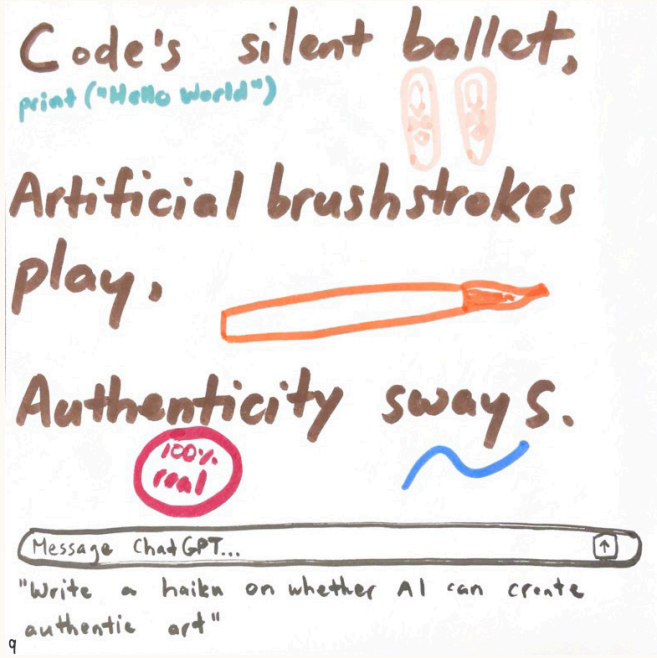

Why?
Why?
Why?
Does healthcare focus too much on cure as opposed to prevention?

7

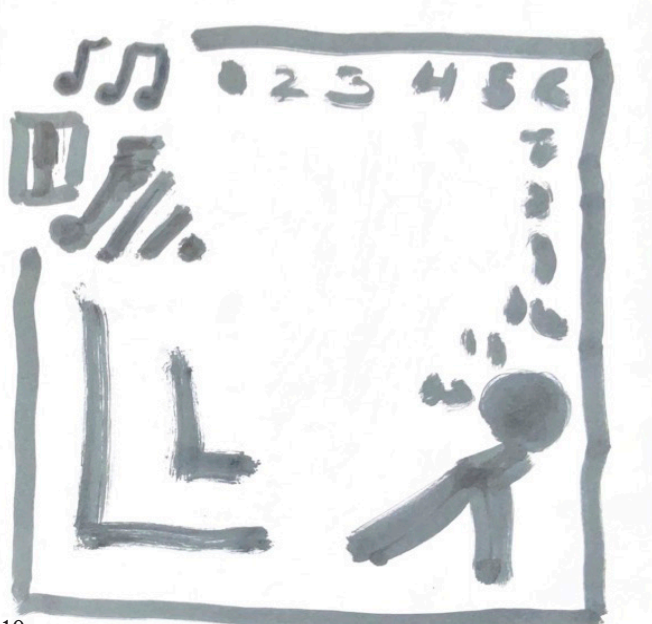



Created by DALL-E

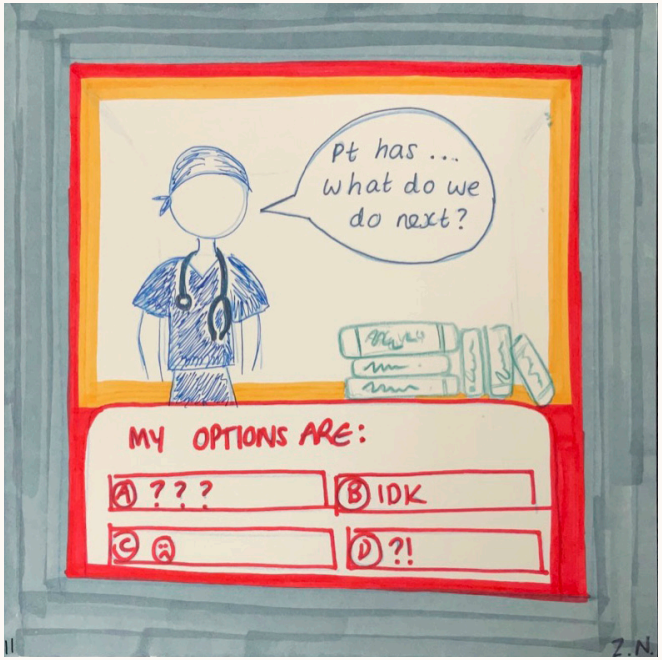
8


Code's silent ballet,
print("Hello World")
Artificial brushstrokes play,
Authenticity sways.
100% real
Message ChatGPT...
"Write a haiku on whether AI can create authentic art"

9

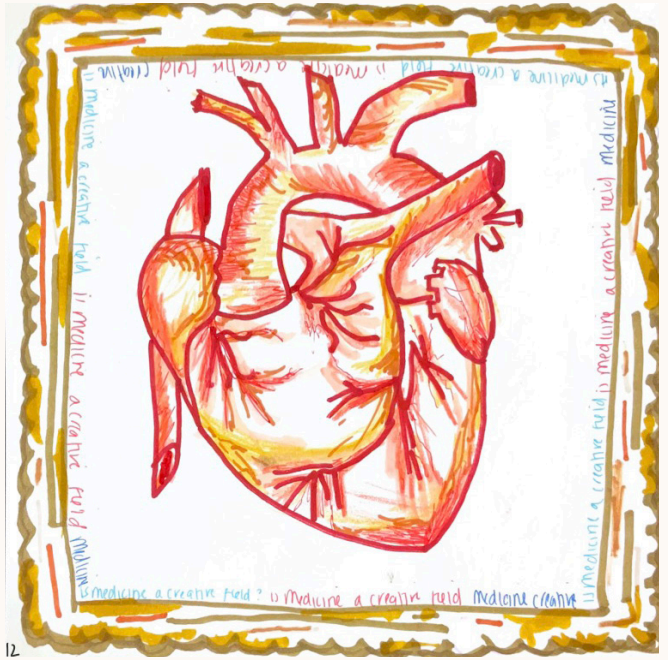

1 2 3 4 5 6

10

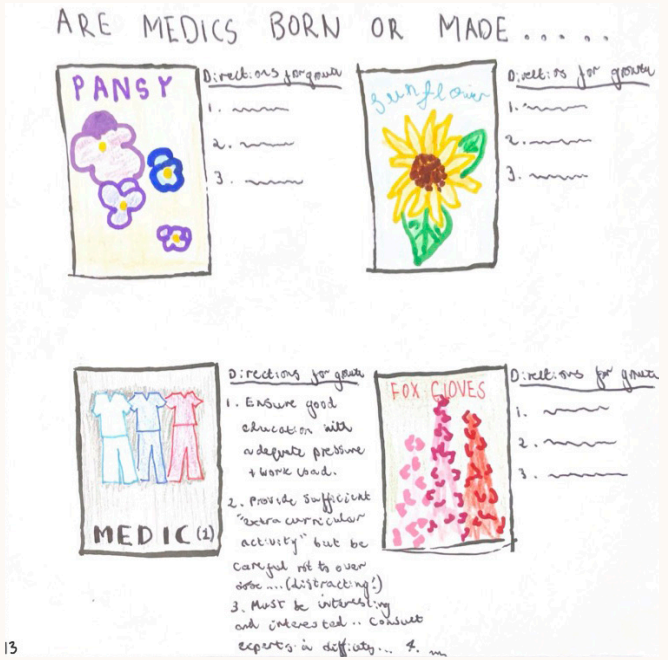

Pt has ... what do we do next?
MY OPTIONS ARE:
A ? ? ?
B IDK
C @
D ?!
Z.N.

11

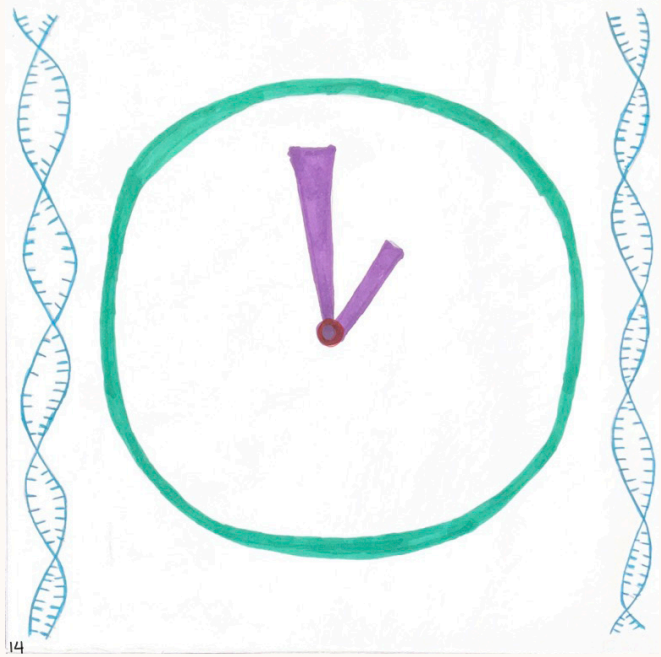



is medicine a creative field ? is medicine a creative field medicine creative

12


ARE MEDICS BORN OR MADE . . . . .
PANSY
Directions for growth
1.
2.
3.
Careful over
Directions for growth
1.
2.
3.
MEDIC (1)
Directions for growth
1. Ensure good education with adequate pressure + work load.
2. Provide sufficient "extra curricular activity" but be careful not to over doso ... (distracting!)
3. Must be interesting and interested .. Consult experts in difficulty...
FOX GLOVES
Directions for growth
1.
2.
3.

13



14


15

ARTS & CULTURE

# CONTRIBUTORS :

1: DO OUR BODIES HAVE A 'PERFECT' DESIGN? - SOPHIA XU FANG

2-4: IN LIFE IS IT BETTER TO FOCUS ON THE BIGGER PICTURE-OR IS THE DEVIL IN THE DETAILS?
- JADE BRUCE

5: ARE MEDICS BORN OR MADE?
- SAMMER ATTA

6: IS MEDICINE A CREATIVE FIELD?
- VICTORIA CHU

7: DOES HEALTHCARE FOCUS TOO MUCH ON CURE AS OPPOSED TO PREVENTION?
- ERATO MARKANTONI

8: WHAT ARE THE WORRIES HEALTHCARE PROFESSIONALS HAVE ABOUT AI & ITS IMPLICATIONS ON HEALTHCARE?
- NANA OSSEI

9: CAN AI CREATE AUTHENTIC ART?
- MICHAEL ROONEY

10: HOW DOES MUSIC AFFECT YOU/HEALTH?
- ARNAV UMRANIKAR

11: HOW WELL DOES TEXTBOOK MEDICINE PREPARE US FOR CLINICAL SETTINGS?
- ZOHRA NOORI

12: IS MEDICINE A CREATIVE FIELD?
- RUBY RAMSAY

13: ARE MEDICS BORN OR MADE?
- ELLA BURWELL

14: IS THERE VALIDITY TO THE TICKING OF THE BIOLOGICAL CLOCK?
- TRIXICA KAPDEE

15: HOW DO YOU FEEL ABOUT THE NHS?
- MORGAN BAILEY

★ COMPILED BY : NOOR AMIR KHAN, RUBY RAMSAY & ZAYNAH KHAN ★

GKT GAZETTE ZINE© + COVER CREATED BY NOOR A·K

# The Art of Connection: A Reflection on the Zine Event

Zaynah Khan **iBSc in Humanities, Philosophy and Law**

To me, the joy, success and significance of the zine event was the formation of connection. In a previous article of mine from our Fresher's Edition, I wrote about the immense power of art in uniting us, reflecting on a quote by John Green:

***'The art and its viewer or reader make meaning together in a collaboration that transcends time and space."***

The zine event encapsulated this sentiment and really embodied this connection between Editors and Readers of the GKT Gazette - both of whom play an equally important role.

It's certainly interesting to see the variety and vastness in our different sections and articles. But there was something special in the process of dissecting the articles to identify themes and create prompts for the event, and in handing over the baton to our Readers, or Zine Creators, to reconstruct them and translate them into a new artistic format.

The depth and layers of concepts unfolding when making the prompts, from even a single paragraph from an article, is a testament both to the craft and authorship of the editors, as well as to the engagement, reflection, and creativity of our Readers. The fact that we were able to create so many prompts from a single closing paragraph or statement from the articles astounds me!

This is OUR magazine, together, and in being able to solidify this connection beyond readership alone is wonderful and a testament to the joy of art!

It was so heart-warming for me to see the confidence, comfort, and creativity bloom as the event went on. Some people started apprehensively, (falsely) stating "but, I'm not creative or artistic." Yet, as the event progressed and their ideas came to life, they were fully immersed and transported - I was in a room of artists!

To consume media, connect with, and translate it into your own art is a form of magic!

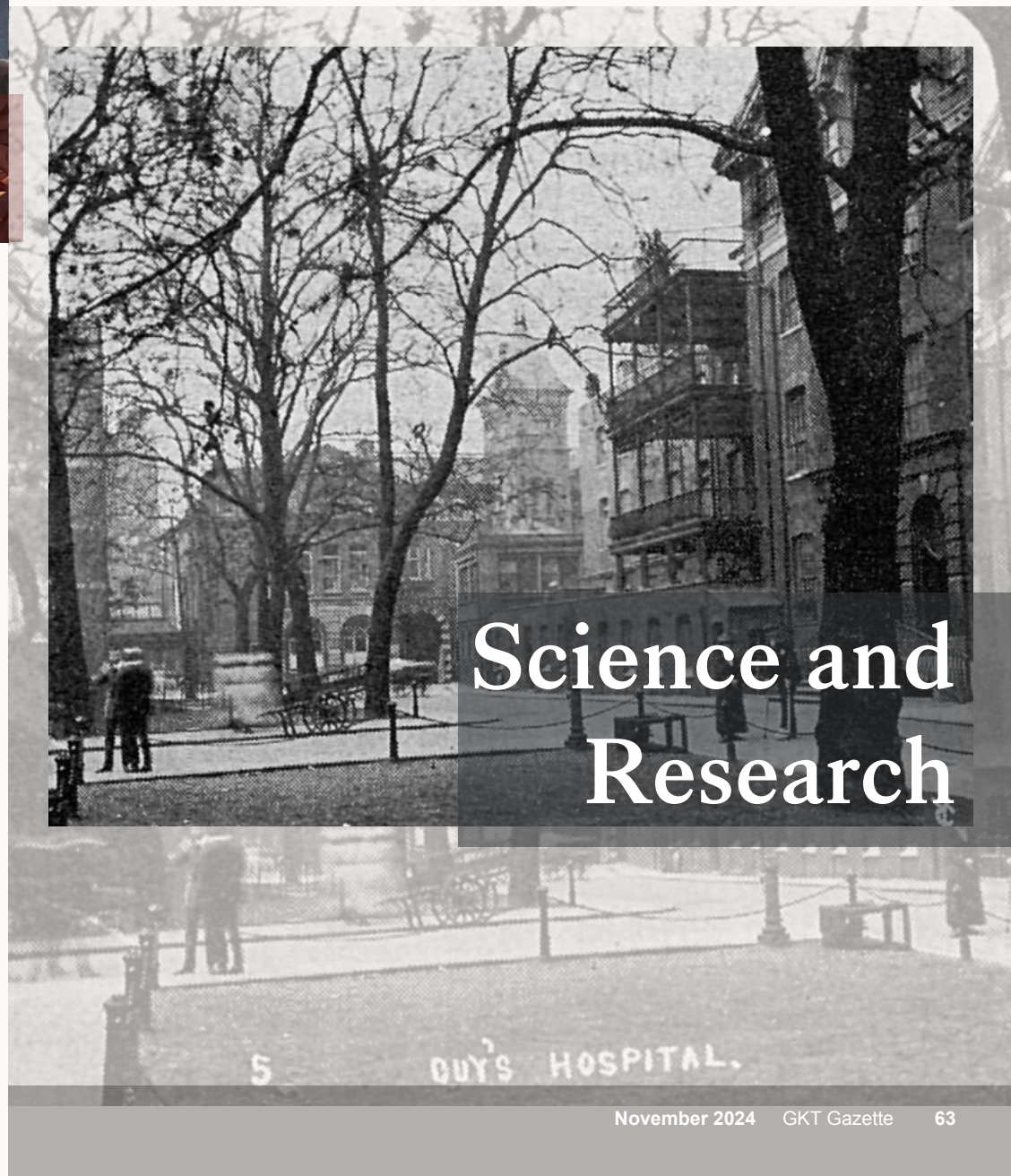
It was such an incredible joy to hear the number of people asking for the date of "the next zine event", and earnestly requesting that it become a tradition we continue alongside our future editions.

I'd like to thank Noor for her innovative idea and wonderful zines and Ruby for all her efforts - both of whom it was a pleasure to work with to create this event. I feel radiant that it worked out like it did.

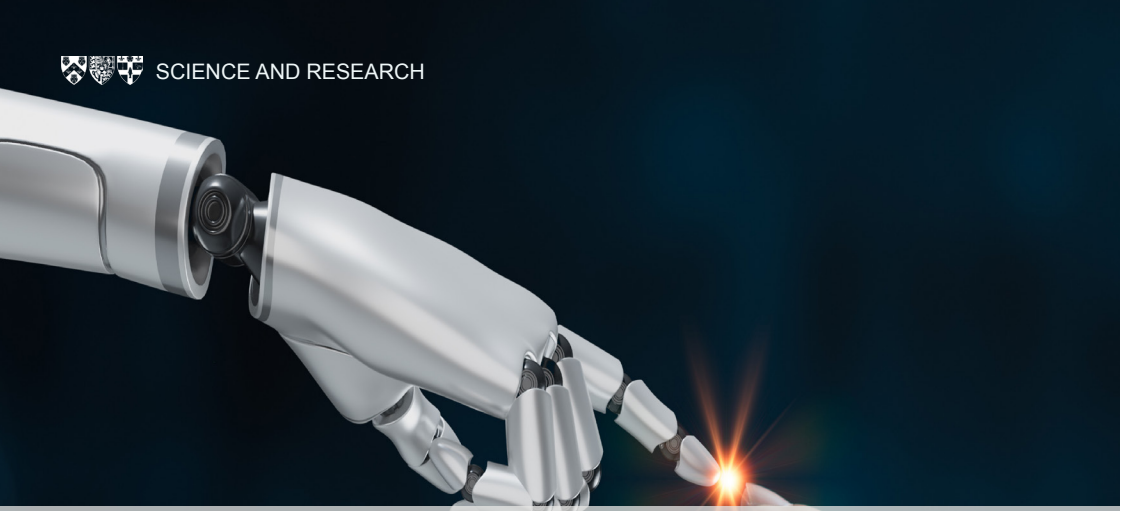
I look forward to creating future zine events in which we can continue to collaborate in a way that transcends time and space!



*Photo: UMDS Gazette, Volume 95 No 2313 - 27th of June 1981*




# Science and Research



# The Bionic Arm's Race: Fact or fiction?

Laura Snell **MBBS2**

Steve Austin, astronaut, 1974. A man barely alive, and definitely short of limbs. "We can rebuild him. We have the technology. We can make him better than he was. Better, stronger, faster." (The Six Million Dollar Man, 1974-78) Thus was the 'Six Million Dollar Man' created. Today, 1970s TV science fiction meets 2020s science fact. Bionic arms have evolved from claw-like constructs to anatomically accurate, multi-grip variations on the human hand. Does the reality match the hype?

Around 5200 people have an upper limb amputation in the UK each year (Brack R, 2020). A further one in every two thousand live births are born with a limb difference and may benefit from an artificial limb in the future (Anon., n.d.) , meaning that developments in the functionality of prosthetic arms can help many people.

While prosthetic legs are reasonably functional, the creation of a prosthetic arm has proven to be a much longer and more complex challenge. The dexterity of the finger is to blame. The first prosthetic hand was created as long ago as 1504, for German knight Götz von Berlichingen after he lost his arm in battle (Puiu, 2022). It was made of iron and had two hinges at the top of the palm to move its fingers for him to hold a sword. However, progress in prosthetic development after this early breakthrough was slow.

Until recently, prosthetic arms had a limited range of motion and were difficult to control. They relied on myoelectric signals from remnant muscles which can be deliberately produced by the user through the contraction of their remaining muscles (Bello & Min, 2023) . After amputation, insufficient muscles remain to enable complete control of the prosthetic, meaning that while prosthetics could assist in gross motor tasks, they lacked the sensitivity to assist with fine motor ones and their scope was limited (Bello & Min, 2023). This is especially true in cases of above-elbow (transhumeral) amputations.

To start with, prosthetics were the only option for those with an amputated hand. They had some functionality, however required the user to look at them as they were reaching for objects and lacked the intuitive nature than non-amputees have with their own arms. That's where bionics come in. As they are controlled by computers or microprocessors rather than electrical signals from remaining muscles, they allow the user to reach for things without looking and take less effort to control.

The first bionic arm was fitted to patient Campbell Aird at the Princess Margaret Rose Hospital in 1998. It was a ground-breaking move in many ways. At just 1.8kg in weight, it was the first implant to have a powered shoulder, elbow, wrist and fingers and was controlled using electronic micro-sensors. Aird had lost his arm to muscular cancer in 1982. Using his bionic arm, he went on to win 14 clay pigeon shooting trophies and windsurfed across the English Channel demonstrating the remarkable impact bionic implants can have on the lives of their users.

In the time since, research has continued into improving bionic arms. A breakthrough came in 2023 when researchers at Sweden' Center for Bionics and Pain Research (CBPR) developed a new bionic hand that allows for control of each finger. A technique called neuromuscular reconstruction, which involves rewiring the remaining nerves to control different muscles, supports moving individual fingers (Bello & Min, 2023). The arm can therefore perform tasks such as typing on a keyboard, piano playing and sports involving fine hand-eye coordination. This new technology uses an artificial intelligence algorithm to record each patient's preferred movements so it can carry them out more efficiently. The design also includes an improved attachment function. Previously, prosthetic limbs were attached using an uncomfortable and unstable socket. In the new design, a titanium implant would be placed within the residual bone. Not only would this be more comfortable, but it would promote fluidity of movement. Professor Ortiz Catalan, the CBPR's founding director, claims his team's research "opens up the possibility of creating bionic hands that are as functional as natural hands" (Bello & Min, 2023). The new bionic arm has already been tested on a 52-year-old transhumeral amputee, Tonney, with great success (Bello & Min, 2023).

This fusion of technology, physics and medical research could revolutionise the quality of life of those who are missing an arm. With over three million people living with an arm amputation, the market for functional, affordable bionic arms will continue to grow. A technological revolution is at hand.

Nevertheless, doubts remain over its practicality. Bionic arm user Britt Young challenges the bionic technology arm's race in stark terms. She argues that "it's time to ask who prostheses are really for, and what we hope they will actually accomplish. Each new multi-grasping bionic hand tends to be more sophisticated but also more expensive than the last (Young, 2022)." Yet research concludes much simpler and far less expensive prosthetic devices can perform many tasks equally well.

Technological change is here. The bionic arm's race will become ever more sophisticated. But how far will it change the average amputee's life. Time alone will tell.

*References available on request at gktgazette@kcl.ac.uk*

# The Lingering Footprints of COVID-19: COVID Toes

Olivia Barry **MBBS2**

As the medical community continues to unravel the complexities associated with Long COVID, cutaneous manifestations have emerged as a significant yet sometimes overlooked indicator of the syndrome. Among these, podal dermatological manifestations such as chilblain mimicking lesions, erythema and vascular changes are frequently observed. This article provides an overview of these cutaneous expressions, examining their presentation, underlying mechanisms and clinical implications. Recognising these signs in the feet can aid in early diagnosis and management of Long COVID, highlighting need for increased awareness among healthcare providers.

As we move further from the initial waves of the COVID-19 pandemic, it's becoming increasingly clear that the virus has left more than a fleeting mark on our bodies. While we may have focused on respiratory symptoms, it's the hidden, often subtle aftereffects, like the skin on our feet, that remind us just how pervasive the disease is. We are living in an era where Long COVID, also known as post-acute sequelae of SARS-CoV-2 infection (PASC) with all its mysteries, continues to emerge. But among the more striking signs of this phenomenon are the podiatric manifestations — the so-called "COVID toes".

With much attention being given to respiratory, cardiovascular, and neurological sequelae, it is fascinating to think of the quiet march of the illness from our chests to our feet. The burning question now isn't about how to produce a vaccine at an exponential rate, or how to save lives, but what deeper damage Long COVID can inflict on us. In this piece, I explore the curious cases of COVID toes - what they are, why they matter, and how they fit into the broader puzzle in the wake of this dystopic disease.

## Cutaneous Manifestations: What are COVID Toes?

"COVID toes" refer to chilblain-like lesions, erythema (redness), and other vascular changes that are appearing in people recovering from COVID-19, sometimes long after the initial infection. These symptoms may seem trivial at first, but they offer us a glimpse into what's happening beneath the surface, within our blood vessels and immune systems (Figure 1). These





*Figure 1: Photo capturing cutaneous manifestations associated with COVID toes (Curry, 2021)*

symptoms can serve as early indicators of ongoing vascular and immune system involvement, potentially aiding in diagnosis and management of this complex syndrome.

In fact, the prevalence of these dermatological signs is surprisingly significant. Research has shown that anywhere from 14.3% to 72% of patients experiencing Long COVID report some form of foot-related symptoms. It may seem strange that the viral infection which put the world into lockdown leaves its mark on our feet, but it's testament to the virus's ability to affect even the most remote parts of our bodies.

## Pathophysiology

The pathophysiology, or "how and why", behind cutaneous manifestations of Long COVID potentially involves complex interactions between the immune system, vascular endothelium, and persistent viral particles. There's ongoing debate within the medical community about the exact causes of these manifestations, with one prevailing hypothesis being direct cell injury caused by ACE2 (angiotensin converting enzyme 2) replication within cells, particularly the cells which line our blood vessels. When this happens, it triggers an intensive immune response, including activation of alveolar macrophages (clean-up crew of the lungs), initiation of the lectin complement cascade (intruder alarm of the body), and release of proinflammatory alarmins (smoke signals pointing out the location of distress). Alveolar macrophage activation leads to release of pro-inflammatory cytokines such as IL-6, TNF- , and interferons, causing what's known as a "cytokine storm", which is in essence an overreaction of your immune system leading to even more damage than the intruder was causing in the first place. This contributes to widespread endothelial inflammation and microvascular dysfunction, or blood vessel irritation and small vessel problems (Naeem, Rai and Pierre, 2022).

Additionally, the lectin complement cascade can be activated by viral particles. When this pathway is triggered, mannose-binding lectin (MBL, the spies who recognise intruders) and related serine proteases (MASPs, the knuckle dusters of the immune system) work together to produce complement proteins. This boosts the inflammatory response and helps form small blood clots, especially in the distal extremities, where reduced blood flow and cooler temperatures can worsen these microvascular issues (Lim et al., 2022).

Another theory suggests autonomic dysfunction rather than direct viral injury or inflammato-

ry processes. The autonomic nervous system (ANS), which regulates the automatic functions such as heart rate, blood pressure, and circulation, can be significantly impacted by prolonged viral stress. This dysfunction may lead to disruptions in the normal regulation of blood flow to extremities. One critical aspect of this is imbalance between sympathetic and parasympathetic branches of the ANS. Enhanced sympathetic activity, driven by chronic stress or residual viral effects, can cause excessive vasoconstriction in peripheral vessels, leading to reduced blood flow and oxygen delivery to the feet. Additionally, autonomic dysfunction can impair thermoregulation, as the ANS controls dilation and constriction of blood vessels in response to temperature changes (Mallick et al., 2023).

Both theories underscore a critical point: what we observe on the skin often represents just the tip of the iceberg. These foot symptoms may signal that there is something deeper occurring within the body, potentially offering valuable insights into the broader mechanisms of Long COVID. This mimics the concept of the atopic triad, where a seemingly simple history of eczema can lead to a prompt asthma diagnosis. Such connections highlight the importance of recognizing how skin conditions can serve as indicators of underlying health issues, facilitating earlier and more comprehensive care for patients.

## Clinical Implications and Reflections

A case I found particularly compelling involved a 73-year-old patient who presented with what doctors referred to as “violaceous purpura” on his foot — a dark, purplish discoloration (Gumbita et al., 2022). Blood tests indicated a significant inflammatory response, with elevated levels of markers like C-reactive protein (CRP) and D-dimer, which are typically linked to severe inflammation and clotting issues. This patient’s blood work suggested that the cause was likely systemic inflammation rather than a localized issue with circulation or the autonomic nervous system.

In terms of clinical findings, the absence of deep vein thrombosis (DVT) on ultrasound, despite the markedly elevated D-dimer, suggests a systemic prothrombotic and inflammatory state rather than a blood clot, furthering my conviction that acroischaemia induced by COVID-19 is induced by the inflammatory state and not dysautonomia.  What stands out to me about this case was the focus on his discoloured feet leading to the uncovering of serious elevations in some of his bloodwork. His feet were, quite literally, the red flag.

## Conclusion

The dermatological manifestations of Long COVID, particularly those affecting the feet, represent a significant but often under-recognized aspect of this complex syndrome. The underlying pathophysiology likely involves a multifactorial process, including immune system activation, endothelial inflammation, and possibly autonomic dysfunction. As we continue to uncover the many layers of Long COVID, it’s important to remember that every symptom, no matter how small or seemingly insignificant, could be telling us something valuable about the disease’s long-term effects. COVID toes might not seem like the most urgent symptom, but they highlight a larger conversation we need to be having about how COVID-19 affects our bodies in ways we are only beginning to understand.

Will we look back in 100 years and still be piecing together the effects of COVID-19? It’s likely. But by paying attention to the subtle signs, like the discoloration of a toe, we may start to get a clearer picture of this complicated syndrome. COVID toes remind us that while we might be done with the virus, the virus isn’t quite done with us yet. And as students, clinicians, researchers and everyday individuals, we’re still learning how to listen to what our bodies are trying to say.

*References available on request at gktgazette@kcl.ac.uk*





# A Past Pact for our Survival

## Nature’s Great Trade-Off

Sammer Atta **MBBS4**

Many of us are prepared to join the frontline to combat the various long-term medical conditions that cause such immense suffering to our patients, and traditionally, disease has been perceived as one of the greatest adversaries to humanity. However, I invite you to explore the contentious argument that perhaps the very same medical conditions that we serve to fight were once crucial allies for our evolutionary survival.

Let us begin by exploring one of the most notorious chronic conditions: Type 1 Diabetes. First documented in the Ebers Papyrus, an ancient Egyptian medical text from 1550 BC, let us appreciate the resilience of the condition; having endured thousands of years of evolutionary pressures. How can such a “detriment” receive grace at the merciless hands of mother nature?

Its notably high prevalence in Northern Europe gives us a hint of potential evolutionary benefits, and in fact, it is through animal models that we can begin to appreciate the “advantage” it offers. Type 1 Diabetes leads to elevated blood glucose levels due to insufficient insulin production, and it is thought that the resultant sugar-rich bodily fluids imitate a miraculous invention of the modern day: nature’s very own antifreeze!

You’d likely be mauled by a bear long before experiencing the chronic effects of the condition in cruel ancient times, and conditions such as diabetes offered an amiable trade of short–term cryoprotective benefits at the expense of long–term detriments for early humans. In today’s world, with longer life expectancies, diabetes poses substantial chronic health risks which overshadow the immediate advantages it offers.

Just as Type 1 Diabetes may have offered an advantage in colder climates, other chronic conditions have likely served similar protective roles under different environmental pressures: cystic fibrosis giving resistance to Salmonella typhi, and even haemochromatosis protecting against iron-reliant intracellular pathogens!

But what evidence is there to confirm that medical conditions can indeed provide an inherent advantage under certain environmental pressures? A modern-day example would be individuals who are heterozygotes for the sickle-cell gene, as they are less likely to die from malaria – this has been strongly supported through several clinical studies in Africa: it is thought that misshapen red blood cells create a hostile environment for the malarial pathogen.

In the complex landscape of medicine, pinpointing a clear evolutionary advantage for every chronic condition is extremely difficult; as not every condition fits neatly into this framework and the historical and genetic factors at play may be more complex than we might realise. However, with this article I aim to bring you a new perspective – rather than viewing chronic conditions through the lens of the modern challenges they bring, we can consider them as relics of our evolutionary past.

While some individuals with chronic conditions may perceive themselves as societal burdens or bearers of a generational curse, I once again invite you to view this from another angle. That they wield the tools that once helped our ancestors thrive through challenging times; that they hold within them the genetic adaptations that contributed to the fight against the volatile early earth: true veterans of the human race.

# The Legacy of the Human Genome Project

Nahian Ahmed **Intercalating**

With over a decade of international collaborative research culminating in the first sequence of the human genome, the Human Genome Project (HGP) is heralded as one of the greatest scientific accomplishments. The project began in 1990 with the hopes of advancing the genetic field by identifying the genes in both rare and common diseases, however during the launch of the programme and the milestone achievements along the way, the rhetoric surrounding the project was one of sensationalism and hyperbole. Predictions ranged from completely individualised therapies for common ailments to breeding 'designer babies' being the new norm. However, scientists at the forefront of this effort had more measured albeit ambitious goals, for example, clinical geneticists desired a greater understanding of the molecular basis of inherited disease, whilst other specialists focused on the relevance of genetics to common ailments such as cardiovascular disease.

The HGP involved researchers from 20 separate universities and research centres across three continents facilitating global scientific collaboration by leveraging the value of big data and reference maps. This subverted the norms of scientific research in this era, which mainly consisted of small-scale collaborations rather than large-scale data sharing of prepublication data. Setting a precedent in the biomedical community, this provided a platform for future international consortia to collaborate. One notable project was the 1000 Genome Project in 2007, the largest distributed data collection and analysis project ever in the biological field at the time. This built on the foundations of the HGP to create a catalogue of human genetic variation using the whole-genome sequence of 2504 anonymous healthy volunteers from 26 different populations from Africa, East Asia, Europe, South Asia and the Americas. This project was a milestone in the benefits of "consortium-based science" including broader representation of human genetic variation, particularly with improved coverage of South Asian and African populations as well as insight into the history and demography of our ancestor populations.

One major mission of the Human Genome Project was to facilitate personalised medicine as a standard practice where treatments are tailored based on a patient's specific genetic information. CRISPR/Cas9 is a gene-editing technology that brings this goal one step closer to reality. This gene-editing technology involves a guide RNA molecule with a complementary sequence to a desired gene and a Cas9 enzyme acting as 'molecular scissors' causing a double-break in the DNA, allowing edits to be made to the genome. The implications for this technology are far-reaching, with great potential to treat genetic disorders caused by single gene mutations such as cystic fibrosis. The world's first CRISPR therapy has been approved in the US and EU this year which aims to cure sickle cell disease and prevent patients suffering from severe Vado-occlusive crises, which are painful inflammatory attacks that can require hospitalisation. By targeting stem cells using CRISPR/Cas9 technology to edit the genome to reproduce foetal haemoglobin, addressing the mutation in the haemoglobin of sickle cell patients which causes abnormal red blood cells. However, there are several challenges with this sort of technology including ensuring that gene editing occurs in the correct cell as unintentional edits of the genome can have unpredictable consequences (including malignancies). Further, current potential therapeutic applications of CRISPR/Cas9 are aimed at changing DNA which is not part of egg and sperm cells (somatic cells). But, there remains the potential to edit such germ-line cells to prevent genetic conditions. However, editing the germ line is permanent as such mutations would be inherited by future offspring, proposing a practical and ethical scenario the scientific community continues to grapple with today.

Ultimately, the HGP represents a seminal project in a rapidly evolving field which has the potential to offer personalised treatment and earlier diagnoses to improve patient care. Despite the sensationalised rhetoric around the project goals, the HGP succeeded in fostering global scientific collaboration and mapping the human genome, paving the way for further revolutionary initiatives like the 1000 Genome Project. Twelve years have passed since the publication of the landmark paper showing CRISPR/Cas9 as a gene-editing tool, and the potential for various clinical applications continues to increase. It is paramount that further developments in this field are not clouded by the hyperbole surrounding the HGP, and that challenges such as safety, accuracy and ethical implications are at the forefront of progression. As the boundaries of genomic medicine advance from the first genome being sequenced to developing novel treatments with CRISPR/Cas9, the question remains whether clinicians should indeed edit the germ line, knowing the risk of permanently passing changes down all future generations.

# The Bar of Soap That Could Cure Cancer

Shriya Karlapudi **MBBS2**

When we think of cancer treatment, we think of bottles and bottles of expensive medication, long visits to the hospital and gruelling side-effects. Now, would you believe me if I told you that the cure for cancer could be sitting on your bathroom shelf?

Heman Bekele, recently named TIME magazine's 'Kid of the Year', aims to achieve just that. The 15-year-old from Fairfax County, Virginia, is currently working on a bar of soap that has the potential to fight skin cancer. This discovery has the potential to revolutionize the way we treat skin cancer. It could put an end to the fatigue, nausea, vomiting and hair loss faced by millions of skin cancer patients worldwide who are being treated with chemotherapy, radiotherapy or immunotherapy.

The soap is made of a compound called imiquimod which helps re-activate dendritic cells which were previously killed by the cancer. In essence, the soap allows the body to regain its cancer-fighting ability. It is prescribed for superficial basal cell carcinomas and has shown potential in treating other forms of skin cancer. This drug is currently used as a cream as part of a broader cancer treatment plan which could cost upwards of $40,000. Bekele's bar of soap, on the other hand, is a LOT cheaper, with a cost of just 50 cents!

This, however, leads to an important question: How is the soap going to be of any use if the drug is ultimately going to be washed away?

Bekele found that, rather than simply mixing the drug into a bar of soap, he would need to combine the soap with a lipid-based nanoparticle which would remain on the skin even when the soap was washed off. This works in a similar way to how the fragrance of soap lingers on. This innovation will allow everyone, irrespective of socioeconomic class, to have affordable access to skin cancer treatment. Think construction workers who work in the hot sun with little to no sun protection. Or agriculturers and gardeners who might not be able to afford it.

Bekele now continues to work on this idea in the laboratories of Johns Hopkins in Baltimore, with the aim of getting FDA certification for the use of this soap.

I personally wonder what would happen if people started regularly using this bar of soap. Would it be able to prevent us from getting skin cancer in the first place? Could it be a replacement for the other measures we take against sun damage? Imagine if we no longer need expensive sunscreens and could just shower with this bar of soap! Better yet, if we found a way to incorporate sun protection within the same bar.

Currently, the typical course of imiquimod cream ranges from 2-16 weeks, depending on the condition being treated. We are yet to know the side-effects of using imiquimod daily for several years. Moreover, would the soap be as effective as the cream, considering the cream is much more concentrated? Would we also be able to use this soap on sensitive areas like the face and scalp?

There are several questions about this soap that are yet to be answered. But for now, what we do know is that scientists like Bekele from around the world are coming up with different innovations that will change the way in which medicine is practiced. The cure for cancer isn't as far as we think it is.





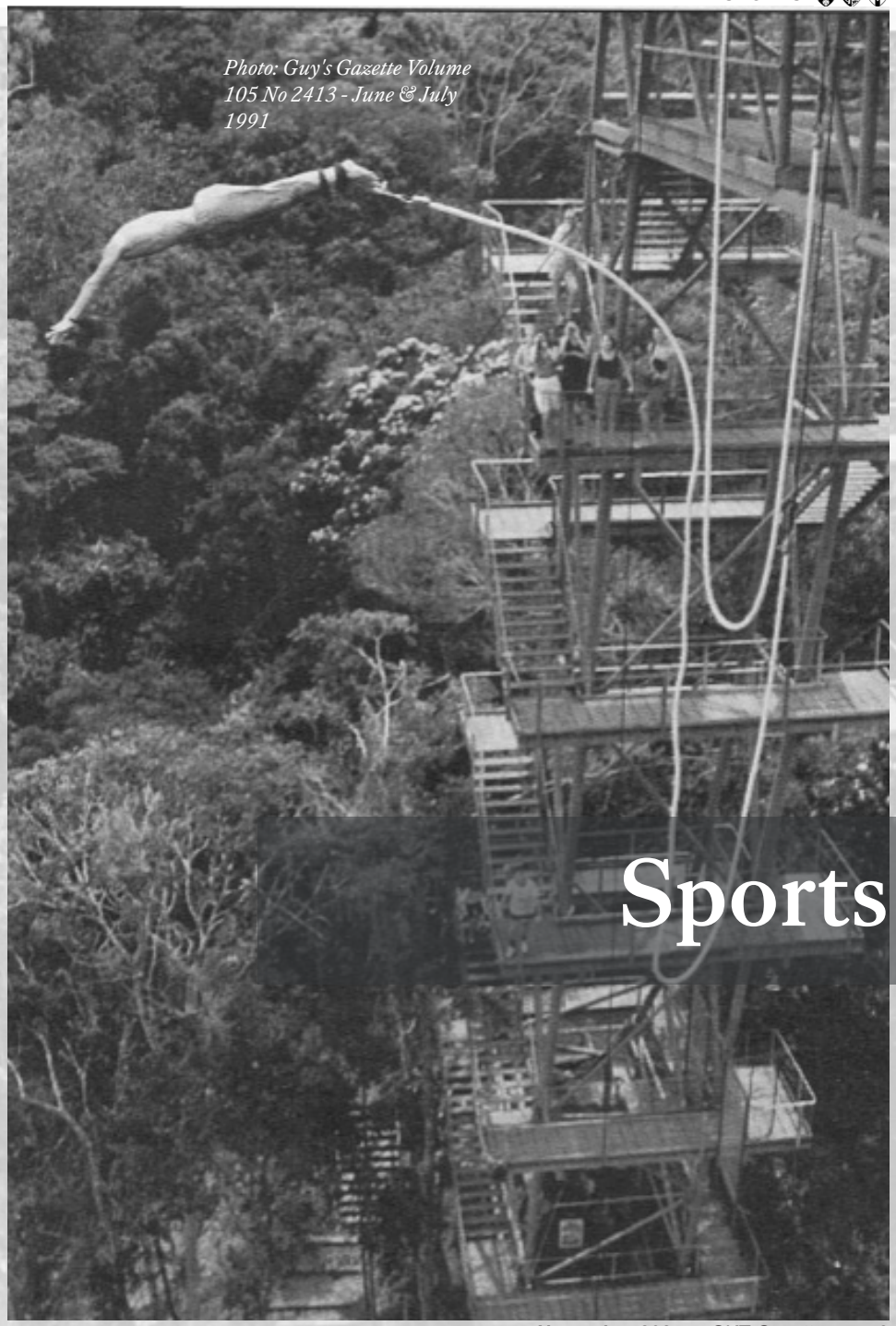


*Photo: Guy's Gazette Volume 105 No 2413 - June & July 1991*

# Sports

# King's Sports Hall of Fame 2024

Nayan Perera **MBBS2**

*From left to right: Professor Stephen Challacombe, Professor Michael Gleeson, Dame Katherine Granger*

In May, the King's Sports Hall of Fame induction event again took place and proved to be another well-received celebration of the sporting achievements of the King's College London community, both past and present. This event, organised by the KCL Alumni Association and King's Sport and Wellness, involved the induction of a set of athletes which included those from the current King's student community and alumni reaching back to the 19th century.

The evening was hosted by Dame Katherine Grainger, KCL alumna and an Olympic Gold Medal winner in 2012 along with a host of other achievements. A bright reception, filled with excited chatter amongst current students and staff as well as many King's alumni, was followed by an awards presentation which celebrated the breadth and quality of achievements by members of the King's community. Twelve athletes, present and past, were given awards for Significant Playing Achievement. These individuals are listed here:

| | | |
|---|---|---|
| Paul Bennett, Rower<br>MSc Mathematics<br>(2012) | Jayne Ludlow,<br>Football player<br>BSc Physiotherapy<br>(2002) | Alan Yates, Water<br>Polo player<br>Cardiac surgeon<br>(first joined Guy's<br>Hospital in 1964) |
| Frances Houghton,<br>Rower<br>BA Hispanic Studies<br>(2003) | Edward 'T eddy'<br>Morgan, Rugby<br>player<br>Medicine at Guy's<br>(1902) | David Eustace<br>Blake, Cricket player<br>Dentistry at Guy's |
| Laviai Nielsen, 400m<br>Sprinter<br>BA Geography<br>(2018) | David James<br>MacMyn, Rugby<br>player<br>Medicine at Guy's<br>(1928) | Anthony S.F .<br>Butcher, Rower<br>Medicine at Guy's<br>(1950) |
| Theo Dan, Rugby<br>player<br>Philosophy, Politics<br>and Economics<br>(2025) | John Phillips Jones,<br>Rugby player<br>Medicine at Guy's<br>(1924) | Herbert Liddell<br>Cortis, Cyclist<br>Medicine at Guy's |

*Note: All information in the above table (including names, sports, subjects and dates) was presented by King's Sports Hall of Fame. The dates that are not included were not provided. See https://www.kcl.ac.uk/sport/performance/alumni-athletes for more information on the prize-winners.*





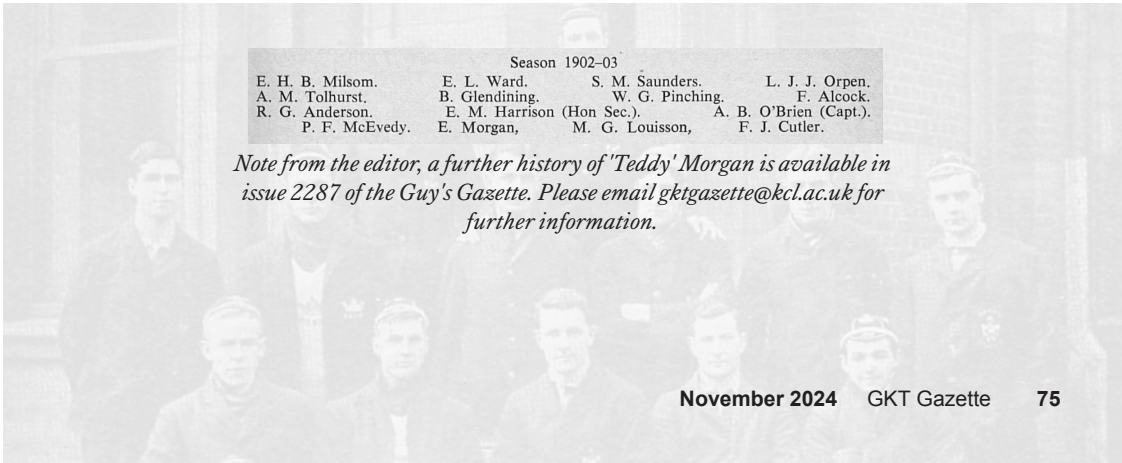
*Photo of Edward 'Teddy' Morgan. Taken from the Guy's Gazette,, Vol. 92, No. 2287, 1978. See below for teamsheet.*

During the event, Dame Katherine Grainger mentioned that many friendships and connections from the past appeared to still be present today. This seemed apparent as the atmosphere throughout the evening was one of enthusiasm and conversation.

The award for Commitment T o Sport was presented to Professor Michael Gleeson. This celebrated his love of rowing which extended from his university days at Guy's and throughout his presidency of Guy's Hospital Boat Club and the KCL Boat Club formed after two mergers. Professor Gleeson's numerous achievements, both in rowing and in surgery, were illustrated throughout this award presentation which also involved the engaging recollections of friends.

King's College London Boat Club and Guy's Hospital Boat Club were given the Sporting Clubs award. This recognised the club's role in its sport and in developing rowers who have achieved national and international prominence. The club has a strong history in the sport, which stretches back to the 1840s and prior - through KCLBC's former constituent clubs, and has been the starting point for novice rowers as well as a part of the rowing careers of Olympians.

T owards the end of the event, Professor Stephen Challacombe spoke about the importance and relevance of the history of sporting achievement and it was clear that this evening showed the great history in sports that members of the King's community have created and are now commemorating.




*Note from the editor, a further history of 'Teddy' Morgan is available in issue 2287 of the Guy's Gazette. Please email gktgazette@kcl.ac.uk for further information.*


# KCL Tennis win British Universities & Colleges Sport Club of the Year 2023/24

*Game, Set, Match, KCL Tennis: Rounding off their most successful year in style at the British Universities & Colleges Awards.*

David Nana **Intercalating**

Just days after Wimbledon, tennis took centre stage once again. This time it was at the prestigious British Universities and Colleges Sport (BUCS) Awards at the University of Warwick. KCL Tennis made history by being named BUCS Club of the Y ear 23/24 - the first time any club at King's College London has won this award - celebrating them as club of the year not just within tennis but across all university sports in the UK. BUCS is the governing body for higher education sport in the UK, with the goal of enriching the student experience through sport. As such, this achievement is no easy feat for KCL Tennis and is a testament to their efforts this year in boosting participation, inclusion, personal development, competitive performance and partnerships, which has allowed more students than ever to enjoy their university experience through tennis. This arrives on the back of their most successful year in club history, winning a hat-trick of awards at the recent KCLSU Awards:

KCLSU Club of the Year
KCLSU President of the Year (Jonathon Dawes)
KCLSU Honorary Life Membership (Dr. Benjamin Zuckerman).





Dr. Benjamin Zuckerman, former KCL Tennis President and current internal medicine trainee rotating through the Intensive Care Unit at Guy's and St Thomas', shared his thoughts: "The awards that KCL Tennis have won this year has made myself as an alumni and former committee member incredibly proud. To win the BUCS awards is something I never thought we would have been capble of considering the facilities and funding we have available compared to other universities. But most importantly what I've found fantastic about the society currently is just how well integrated everyone is, and it's something I felt first-hand at V arsity this year, which I had the absolute pleasure to be part of. It's lovely to see both students from KCL and GKT continuing to mix together to form a really diverse and inclusive society."

Unlike other sports at King's which have two separate clubs for GKT and KCL, tennis at King's is governed under one umbrella. It has enjoyed its most successful year with membership increasing by 65% to 341, becoming the largest sports society at King's, and raising £17,500 in sponsorship to expand and enhance existing activities. To support the additional membership, KCL Tennis added 2 new competitive teams to BUCS and LUSL this year, including a first ever GKT BUCS team, and was able to single-handedly facilitate the cost of these teams through club funds with no Students' Union support. Additionally, they collaborated with King's Sport to revamp their recreational BeActive tennis programme, which has allowed an additional 180 students to take part in tennis sessions throughout the year at a low cost. And for the first time ever, BeActive included staff tennis and LGBTQ+ sessions. This was facilitated by their flagship A.C.E. (Activate, Champion, Empower) Leadership Academy which raised £9440 in sponsorship to successfully empower and fully fund 32 students through their LTA Level 1 coaching qualification free of charge. In line with their strategic commitment to engaging more women and girls to enjoy their university experience through tennis, 66% of places on Level 1 (24) were allocated to women, with 10 of these women identifying as BAME. This innovative programme has enriched the student experience by creating a homegrown workforce of student coaches who have gone on to deliver the BeActive programme, work at the Queen's Club Foundation community programme, and volunteer on their widening participation project with Greenhouse Sport which delivers tennis to London's most deprived children.

KCL Tennis Alumna Cynthia Shen, who graduated from the IoPPN last year and was offered a place onto the A.C.E. Leadership Academy, described it as a "life-changing experience and I'm forever grateful to KCL Tennis for this opportunity... it has provided me with the skills and confidence to make relevant and meaningful on court adaptations to make a difference to people's lives and has opened up the opportunity for me to work as a tennis coach for SEND children as I look to pursue a PhD in Clinical Psychology".

Tennis have also been active in creating more opportunities for competition at all levels, from a highly competitive sold-out London Varsity fixture at Lee V alley Tennis Centre to the introduction of their first ever GKT X RUMS V arsity at the prestigious Queen's Club. Additional collaborative events allowed for friendly fixtures against other London institutions outside of the LUSL format including fully formed self-run intermural programmes with their 'Box Leagues' and 'Play Y our Way to Wimbledon' tournament. This has ultimately resulted in an ever-improving relationship with tennis' national governing body, the LTA, as well as better results on the court which saw KCL as the only UK institution to send two delegates to the GB Universities Students development camp, a bespoke opportunity for the best university tennis players to train at the National Tennis Centre for two days alongside the world's best tennis coaches.

Incoming 4th year medic Ali Hassan, who has boasted wins over the likes of Wimbledon Champion Carlos Alcaraz in his junior days before deciding to study medicine at King's, was one of 13 students across the UK accepted into the prestigious GB Universities Development Camp and described it as "an absolute privilege and a glimpse into what it takes to build a professional tennis player/coach".

In addition to increasing capacity, KCL Tennis made an exceptional effort to ensure tennis at King's is truly inclusive by design, championing students by delivering outstanding continuous professional development opportunities focused on working with underrepresented groups. These included a women's only INSPIRE masterclass with LTA President Sandi Procter, which touched on her lived experience as the second-ever female President; a disability tennis workshop and VI tennis session with disability tennis expert Mark Bullock to raise awareness and encourage inclusive practices amongst the student body; an organised trip to the Surbiton Trophy, providing 16 students leaders with free centre court tickets to watch Andy Murray followed by leadership talks with LTA Councillors; an International Women's History Month networking and panel events with sector leaders and special guests including former British Number 1, Sam Smith and Women's Tennis Association Founder, Ingrid Bentzer.

2023/24 has been a year of firsts for KCL Tennis. Reflecting on the season, President Jonathon Dawes shared his thoughts: "At KCL Tennis, we are delighted to have been named 23/24 BUCS Club of the Year. 23/24 has been the most successful year in our club history across all key metrics and I am confident that we will use this award as a springboard for growth next year".

While the 2023/24 season has drawn to a close, exciting plans are already underway to make 2024/25 bigger and better and incoming President Ann Maria Muuli, who will be entering her 3rd year of medicine at King's, looks forward to the challenge ahead: "I am excited to build on the legacy we have established at KCL Tennis this year, to foster new partnerships, and to engage more deeply with our alumni network and other universities."

We are incredibly grateful to all our sponsors and alumni who have supported us in reaching the top this year and achieving our mission of allowing more students enjoy their university experience through tennis. We are always looking to engage current GKT students and alumni interested in tennis, so if you are a student or alumni at looking to get involved with tennis at King's, or curious about how you can support us, please do not hesitate to email david.nana@kcl.ac.uk (23/24 Vice President).





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