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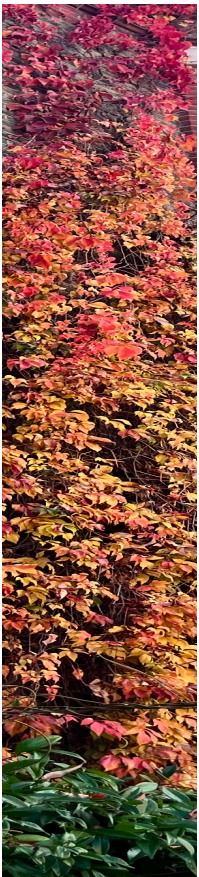
GKT GAZETTE



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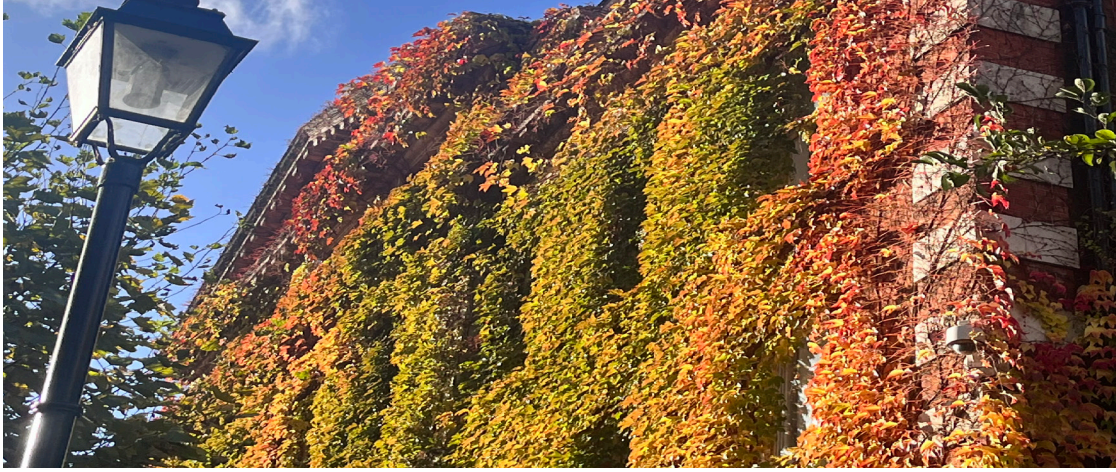
Email: gktgazette@kcl.ac.uk
Instagram: @thegktgazette
Website: kcl.ac.uk/lsm/gazette

GKT Gazette,
Room 3.7, Henriette Raphael House,
Guy's Campus, London,
SE1 1UL



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Passim September 26

Editor - Zaynah Khan, **MBBS4**

Human connection is central to healthcare, and community plays a huge role in this. By virtue of studying at GKT, we are automatically part of a wonderful community, spanning over 300 years! As we enter this new academic year, or perhaps as you are beginning your journey here at GKT, we can celebrate the rich history and incredible alumni we share this space with, whilst holding space for the wonderful peers we have and the future of healthcare that we're working towards.

This issue reflects our strengths- our incredible history, milestones and achievements, as well as highlighting the innovative ways that we are currently building upon the landscape of healthcare at GKT and beyond - concurrently, immortalising history while shaping the future of healthcare. How exciting is that?! GKT is made up of such inspiring individuals, but our collective voice makes us stronger. The GKT Gazette is a great medium to combine and amplify our voices.

The GKT Gazette has always been my home here in medicine and being the Arts and Culture Editor for the past 3 years has helped me explore so many avenues. Now, as I re-enter medical school after 2 'side quest' years out - intercalating at Imperial in a BSc in Humanities, Philosophy and Law, followed by a sabbatical year working as the Editorial Scholar at the BMJ, running BMJ Student - I feel both a sense of excitement and nervousness. I hope that curating these issues can help keep me grounded. I am honoured to be your Editor, and to work on co-creating these issues with you - I hope that they can bring you joy and catharsis too!

I'd like to thank Morgan Bailey, our outgoing Editor-in-Chief, for his innovative and memorable work leading the GKT Gazette for the past 3 years!

Spearheaded by our previous Editor, Arnav Umranikar, we commemorated 300 years of Guy's hospital, by creating the G300 book. Thank you to Arnav, Morgan, and all the GKT Gazette committee members and contributors to this momentous book.

Thank you to our outgoing editors who have graduated in the Class of 2026 - Dr. Sammer Atta (Science and Research), Dr. Jing Yuan Chan (Dental Corner), Dr. Nana Ossei (Sports) for all their input and involvement in creating these issues over the past few years.

Welcome to new editorial committee members and new GKT students, and, of course, welcome back to everybody else! We're honoured to co-create and spotlight our GKT highlights together, and we welcome all of your contributions.

Your Editor,

Zaynah Khan (BSc Hons.), MBBS4

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 Editor - Naim Ghantous, **Intercalating**

Dear Readers,

Once again, summer is fading, yet in its place comes a hopeful autumn, and with it sees nigh-on 650 of the country's brightest medical and dental students flooding the courtyards of campus for the first time. This edition of the Gazette is dedicated, first and foremost, to those joining our magnificent community here at GKT this September. Within this issue, you will find moments of challenge, comfort, wisdom, and community, for all those at GKT, spearheaded by our indelibly talented unit of editors, writers, and designers. I sincerely hope that somewhere amongst these pages you can find a home.

For those brilliant individuals who have worked hard to join us this September, I implore you to go and sink your teeth deep into anything and everything life at GKT will offer you. Play the sport you wanted to try, join the society, make friends with new and exciting people, wipe your slate completely clean for all I care and immerse yourself unapologetically within this new world at your fingertips. You will certainly make mistakes, yet through it all, will gain truly invaluable knowledge about yourself and who you are.

Nowadays stepping foot on Guy's makes me feel, in a warmly manner, awfully archaic, with every glance across campus attached to a rich well of memories and personnel from a myriad of stages within my life. As a Fresher, I distinctly recall how daunting yet exhilarating it all was, and it was the decisions that I had made then as an eighteen-year-old that had unknowingly blossomed into the cornerstones of my life as it stands now.

On a more personal note, I am thrilled to be reprising my role as Deputy Editor-In-Chief of the Gazette, and after a positively manic summer of hopping between London, Shanghai, the Algarve and Beirut, I'll be taking myself away from GKT for my intercalated year to pursue an MPhil at the University of Cambridge.

As always, we would like to thank the wonderful team here at the Gazette for their unwavering diligence and compassion, and for making sure that GKT voices are heard.

Please do not hesitate to contact us if you would like to contribute to the journal, or whether you have any ideas or questions.

I hope you enjoy this issue!

Naim Ghantous - MBBS, Intercalating

Notes from the Outgoing Editor

Morgan Bailey **MBBS5**

After many years of being involved in the Gazette, I am very glad to be able to pass the baton into the safe hands of Zaynah Khan and Naim Ghantous, our new Editor in-chief and Deputy Editor in-chief respectively, along with their marvellous team of leads and deputies, whose names and photographs are shown on the back pages. I have no doubt they will take the Gazette to new heights.

The Gazette in its infancy was a pipe dream between friends, wanting to revive a forgotten magazine that claimed to be the oldest hospital journal in the world. Many years later the project grew; the team grew exponentially, and between us we produced 7 Gazettes and 1 fully-fledged book. We celebrated our own 150th anniversary in March of 2023 and then the Guy's 300th anniversary in May of 2026. We continued to re-connect with alumni who were thought to have lost touch with their alma mater. We honoured those from our community who had sadly passed. We reported on the ongoings of the school, filling the void of student voice left by others. We revived an interest in our history by unlocking the complete archives of the Guy's Gazette from 1873 to 1999. Going forward this work will continue, and from 2026 onwards we will have much-needed representation within the KCLSU.

I have been around long enough (or perhaps, for too long) such that I have welcomed freshers into the team; seen team members graduate into scientists, doctors and dentists; and seen previous contributors and staff committee members of the Gazette pass away. Despite the constant ebb and flow of change, students and staff associated with our hospitals have continued to come together to create our high-quality journal. I doubt our founders in 1872 could ever have envisaged the sprouting of our vibrant community of friends and colleagues, bound together only by writing on paper, but united in the belief that it is better to give than to receive (dare quam accipere). Long may it continue to grow.

Yours,
Morgan. Outgoing Editor of the GKT Gazette 2022-2026 (Volumes 133, 134 and co-lead of 'Guy's Hospital: 300 Years').
Morgan.bailey@kcl.ac.uk

Letters to the Gazette

Want to contact the Editor? Have a short-form reply to any of the articles in this issue? Want your opinion heard? Get in touch to contribute to our letters section.

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

The King's Letter to the Guy's 300th Dinner

BUCKINGHAM PALACE

23rd April, 2026

Dear Dr. Dixon,

I have been asked to thank you for your kind message informing The King of Guy's Hospital's 300th Anniversary which is being marked on 8th May, 2026.

This has been shown to His Majesty, and I now have pleasure in enclosing his reply.

Yours sincerely,

pp.

James Dawson
Private Secretary's Office

Dr. Michael Dixon L.V.O., O.B.E.

BUCKINGHAM PALACE

Dr. Michael Dixon L.V.O., O.B.E.,
Head of the Royal Medical Household

Please convey my warmest congratulations to all at Guy's Hospital on the occasion of their three-hundredth Anniversary Reception, Gala Dinner and Dance which is being held this evening.

I was deeply touched to be reminded of Guy's role in medical innovation and caring for the local community for a truly remarkable three-hundred years, and was delighted to learn that your unstinting commitment to skill, professionalism and dedication is being marked today.

As you gather for this historic celebration, I send my warmest good wishes to all those who are present for a most significant event.

CHARLES R

8th May, 2026

Guy's Hospital: 300 Years

Dear Sir,

I was delighted to receive a copy of this commemorative tome, having spent much of my professional life within the walls of Guy's and King's as did my late husband, Patrick O'Driscoll, Consultant Oral Surgeon, who both trained and worked at Guy's for almost 50 years1.

The special tricentennial edition, conceived and edited by the Guy's, King's College, and St Thomas' Hospitals (GKT) Gazette Committee, provides a digest of the life and achievements of the Guy's Hospital community. It commemorates a significant milestone in the history of one of London's most esteemed medical institutions.

This book serves as a celebration of three centuries of healing and innovation, most especially in the past 50 years. It is a testament to some of the individuals who have shaped Guy's Hospital, established through the philanthropic efforts of Thomas Guy. However, it is crucial to acknowledge the countless unsung heroes who dedicated their lives, expertise, and compassionate care to the hospital and its patients. As stated in the Passim, including all those who have significantly contributed to the life of the Hospital would necessitate the publication of several volumes.

The book includes historical perspectives, clinical accomplishments, research advancements, and educational innovations, especially over the past 50 years. It also describes social and community aspects, including sports, student societies, and staff activities.

The interdisciplinary nature of the hospital's life is evident in the book, which features concise profiles of individuals who have made a notable impact in the past five decades. I was particularly delighted to see Bill Edwards, the Curator of the Gordon Museum, highlighted. The Gordon Museum, itself, has been a hub for Guy's staff and students for over a hundred years. During my recent visit to the Gordon, I had the pleasure of meeting Professor Sir Cyril Chantler. The Gordon Museum has been at the heart of academic and clinical activity for both staff and students, past and present.

The book's accessible short articles provide insightful information about the life and times at the hospital, embodying diversity and inclusivity. Readers can dip into the book and discover captivating facts and records. For instance, I didn't know that Robin Bret-Day grew sweet peas, or that a Roman road ran under Honor Oak Park!

I extend my congratulations to the current Gazette Editor, Morgan Bailey, and the Editor of the tome, Arnav S. Umranikar, and the GKT Gazette Editorial Committee, for producing such an engaging book. Compiling such a work is not an easy task!

Yours sincerely,

Patricia A Reynolds

Professor Emeritus

King's College London

The Crests of Thomas Guy and William Hunt

Michael O'Brien

William Hunt (1750 – 1829) is buried in the crypt of the Guy's Hospital Chapel together with Thomas Guy and Astley Cooper. The painted glass windows (1858) are in his memory. He was a very wealthy philanthropist and Governor of the Hospital. In his will he left £180,000 to the hospital, worth about £25m today. The centre block and South wing of Hunts House was completed in 1853 and the North wing in 1871. The crests of Thomas Guy and William Hunt were erected high up on the centre block and can be clearly seen in this etching which was published in 1892*. The crests were moved to the present site when Hunts House was demolished in 1998 prior to the construction of the present building and can be seen behind railings on the West side of Great Maze Pond opposite the Cancer Centre.

Reproduced from Wilkes S. Bettany GT. A biographical history of Guy's Hospital. Ward, Lock, Bowden, London 1892

The family crest of William Hunt

The crest of Thomas Guy

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

Features

The Colonnade Guy's Hospital

Covers and Photos

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

Our front and back covers are fantastic illustrations by Christine Yue (MBBS4).

Illustrations accompanying articles by Zainab Abdur Rahman (MBBS4).

Guy's 300: Celebrating Our Past, Inspiring Our Future

Roz Miah **Teacher Development and Scholarship Operations Officer, KUMEC**

Photography by David Tett

"Guy's 300 wasn't just a celebration of the past - it was a celebration of the people, innovation and community that will shape the next 300 years."

There are moments in university life that remind us we are part of something much bigger than ourselves. The 300th anniversary celebrations of Guy's Hospital were exactly that.

Across a remarkable week of community events, Guy's Campus was transformed into a space of celebration, history, pride and possibility. Students, staff, alumni, clinicians, local communities and friends of Guy's came together to mark three centuries of care, discovery, education and service. It was vibrant, moving, joyful and genuinely inspiring - the kind of moment that deserved to be seen, remembered and shared.

That is why this Freshers edition of GKT Gazette is shining a spotlight on the celebration. Because for those joining GKT this year, this is not just history. This is your inheritance.

More than 300 years of history

Guy's Hospital has stood at the heart of healthcare, education and community for 300 years. Generations of students have trained here. Generations of clinicians have cared here. Generations of alumni have gone on to shape medicine, dentistry, health, research, policy, education and society far beyond the walls of the campus.

The anniversary celebrations captured the magnificence of that legacy. From community engagement and exhibitions to student involvement, campus activity, heritage moments and shared celebration, the week reflected everything that makes GKT special: its people, its pride, its energy and its commitment to making a difference.

The photographs featured in this issue capture some of those moments. They show the faces, places and atmosphere of a community that continues to honour its past while looking boldly to the future.

Why this matters to new students

If you are joining GKT this September, welcome. You are arriving at a very exciting time. You are not simply beginning a course. You are becoming part of a living legacy that stretches across Guy's, King's and St Thomas'. You are

joining a community shaped by generations of students who studied, volunteered, competed, campaigned, performed, led societies, built friendships, created traditions and left their mark.

GKT is not only about lectures, placements, exams and qualifications. It is also about belonging. It is about showing up, getting involved, meeting people, discovering opportunities and contributing to something that will continue long after you graduate.

The 300th anniversary of Guy's reminded us that institutions are built by people. Their stories, their service, their curiosity, their friendships and their courage are what give a place its identity. Now, it is your turn to add to that story.

A message to alumni

To our alumni, this celebration was also for you.

Whether you trained at Guy's, King's, St Thomas', GKT, or have contributed to this community in another way, your memories and experiences are part of the fabric of who we are. The anniversary celebrations were a reminder that the GKT story is not locked away in archives. It is alive in the people who lived it, taught it, shaped it and continue to champion it.

GKT Gazette wants to hear from you. Your stories matter. Your photographs matter. Your memories of campus life, student traditions, clinical training, societies, sport, friendships, challenges and celebrations all help connect past, present and future GKT generations.

This is your invitation to contribute, reconnect and help inspire the students who are only just beginning their journey.

GKT Gazette wants you

This issue is more than a magazine. It is an invitation. We want GKT Gazette to become a place where students, alumni, staff and the wider community can see themselves reflected. A place for stories, photographs, memories, achievements, events, opinions, opportunities and ideas. A place that celebrates the full life of GKT, from Freshers' Week to alumni reunions, from campus traditions to major anniversaries, from hidden histories to new student voices.

You do not need to be a professional writer to contribute. You simply need something to share.

You may want to:

- Write about your first few weeks at GKT
- Share a photograph from a society, sports team or event
- Interview an alumnus or staff member
- Reflect on a campus tradition
- Submit a memory from your time at Guy's, King's or St Thomas'
- Promote an upcoming student or alumni event
- Celebrate a student group, project or achievement
- Contribute to our heritage and anniversary features
- Help us document the road to King's 200 in 2029
- If you have a story, we want to help tell it.

From Guy's 300 to King's 200

The 300th anniversary of Guy's Hospital gave us a powerful reminder of what can happen when a community comes together. It also gave us a glimpse of what is still to come.

In 2029, King's College London will celebrate its 200th anniversary. That milestone will be another major moment for our university community, and GKT Gazette wants to be there to capture the build-up, the celebrations and the people who make it memorable.

So, freshers, returning students, alumni and friends of GKT: watch this space. This is only the beginning. The next chapter of GKT is being written now - in classrooms, clinics, common rooms, societies, sports teams, events, reunions and conversations across campus. And the best part?

You can be part of it.

Read it. Share it. Subscribe. Contribute. Get involved.

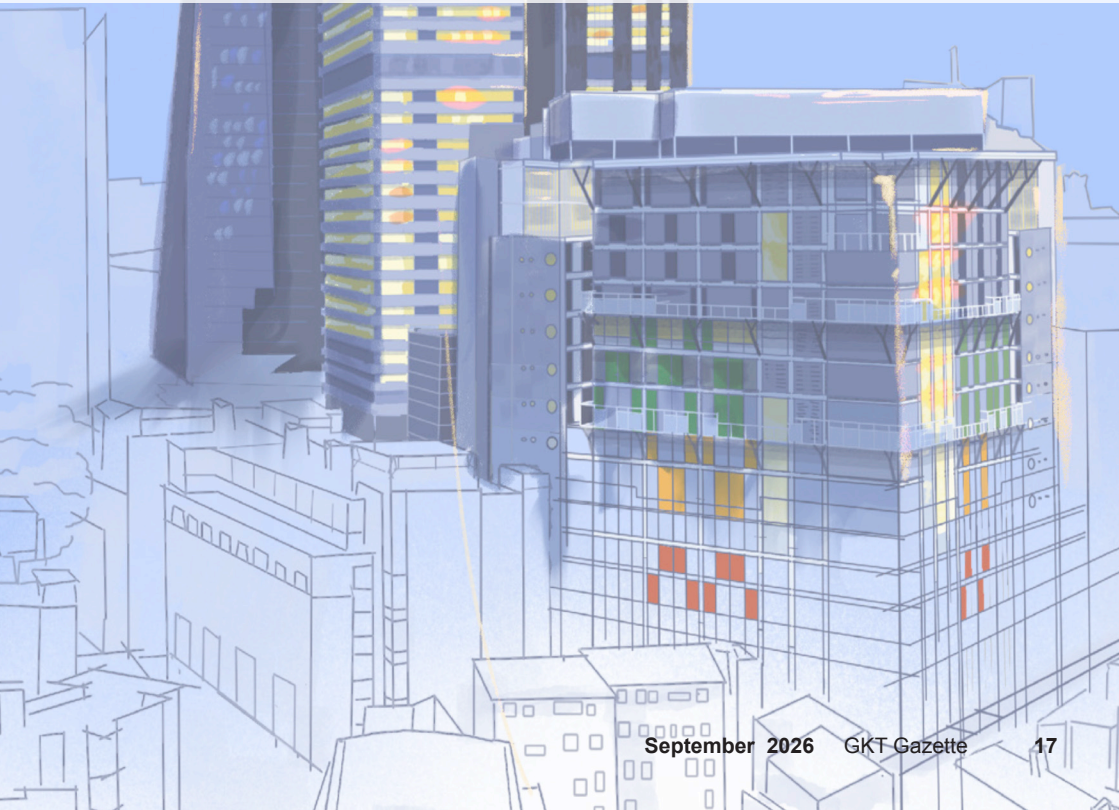
Welcome to GKT Gazette.

Welcome to the story.

Page 16 shows the Guy's 300 Gala Dinner and Dance, held at the Park Plaza Hotel in Westminster, with members of the Gazette (8th May 2026)

The Guy's Tricentenary: A conversation with Arnav Umranikar, principal author and coordinator of *Guy's Hospital: 300 Years*

Himanshi Aggarwal **MBBS3** & Esha Dewa **MBBS2**



"It gives students a creative outlet, it allows us to have a discussion about what is happening, it gives people ideas about their careers and is a real forum for engagement"

It is an incredible privilege to be a member of the GKT community during the illustrious tercentenary milestone of Guy's Hospital: not only does this serve as an empowering reminder of all we can achieve, but also invites extensive, inspiring reflection upon our pioneers, research, education and personalities. All this and more is showcased in 'The Guy's Hospital: 300 Years' book holding over 110 articles spanning 580 pages saturated with rich history.

Himanshi and I (Esha) were thus very keen for our interview with Arnav Umranikar, the fifth-year medical student leading the compilation and operations of the publication. Noteworthy through the interview was Arnav's steady zeal for delivering meaningful craft - whilst he delivered illuminating insight into the tangible construction and content. We hope that this feature captures the visionaries, the learners, the impassioned, to seek and culture the wealth of innovation and knowledge it has to offer.

Between The Binding

With over 500 pages and dozens of contributors, how did you decide which articles to include? Do you have an example of an article that was particularly painful to cut?

With over five hundred pages, creating the book was a shift from Arnav's experience editing the 'GKT Gazette,' usually consisting of around 80 pages, displaying Arnav's immense commitment. His outline of the process is prefaced by "a long discussion about what we wanted in [the book]" with "trustees of the Gazette, including Professor Stephen Challacombe, Mr Bill Edwards and Dr Simon Hughes, as well as the students listed in the back".

Arnav illustrates how weighted by a "very long initial list", they "were going to arrange it department by department, or what they've done in the last fifty years" before narrowing down "the ones that had the most consequential impact on Guy's as an international centre", reinforcing the book's testimonial purpose to commemorate the unwavering global significance of the hospital.

Admitting the challenge of condensing and selecting, Arnav notes that he "always felt like [he'd] rather [the book] be longer than shorter", adding doing so is also "very good value for what people pay!" Despite how one may predict a student having undertaken such a mighty task may wish a hiatus, we were encouraged by his enthusiastic unravelling for plans for a "future Gazette" article, bouncing from strength to strength in his restless penmanship. He shares that "as [he] was compiling [the book], [he] was thinking [whether he] could write an article about other things, like the partnership of Guy's Hospital with the John Hopkins Hospital in Baltimore, which is one of the most outstanding centres of medicine in the world that even now, final year medical students can go to on their elective."

As a medical student, how did you find that balance between your clinical workload and the journey of writing this book?

First and foremost, Arnav stresses and ensures it is plain that he "was not the only person that worked on this" and that this project was a team endeavour. From the trustees who provided a "great deal of time and advice" on how to take on a project of this magnitude; to the designers who painstakingly worked on the layout, designs and illustrations to ensure that the "book looks absolutely beautiful" to the editors "talents and skills" that ensured each article was a delight to read. The G300 edition could not have been achieved without his "outstanding team", which played a massive role in making this possible.

Although at times he was "overwhelm[ed]", as of course anyone would be if entrusted with such a monumental anniversary piece, he states "I had no regrets" in taking this project on. As an intercalating student at Imperial, then as a fourth-year-medical-student, with dissertations, looming QIPs (quality improvement projects) and progress tests, this edition certainly demanded much dedication, but he felt "a strong sense of responsibility". To us, it was clear that his loyalty towards the Gazette, and furthermore GKT, was palpable, and rightfully so, considering how he and his co-editor, Morgan, had relaunched the Gazette post-years of inactivity. Arnav, states, "These pieces of work shape how we as a community and as an institution view ourselves and our confidence in ourselves." When Arnav and Morgan went into the Gazette as co-editors "[they] were inspired by the people at Guy's, King's and St. Thomas'" who had achieved great things, and "made [him] think [they] could do great things too." He adds simply: "I hope it delivers."

Led by Legacy

Did any part of the book change how you see GKT?

Throughout, Arnav articulated through a lens of pride in attending the GKT School of Medicine, feeling the tangible impact of it being a hub "that has influenced medicine as we live it" having been "already very conscious of the history" learning about seminal figures in pathology such as Thomas Addison, Richard Bright and Thomas Hodgkin (perhaps the most familiar to a Guy's Campus resident!).

Nonetheless, whilst acknowledging that this impressive past is "why (he) got involved in the Gazette in the first place", engaging with the book's making on such a high level inevitably brought new perspectives upon Arnav. Grounded by an exclamatory "Wow!", he reflects that "There are just so many things in the book that made (him) realise that it is not just the giants of the far past that have had an influence, but the giants of today that are still at Guy's, still doing things that we are privileged to be able to be a part of." A credit he places particular emphasis on is Guy's breakthroughs in robotics, drawing upon its transformative precedent in "transplantation and the way we designate different tissues based on immunological markers", all the more supported by the trail of superlatives it holds. As Medical students in the place of the world-first robot eye cancer operation and the largest UK robotic surgery programme to tackle COVID-19 backlog, we are inclined to ponder how this rapidly developing landscape will appear in the face of our emerging careers.

How has exploring the such diverse history of GKT and engaging with many professionals influenced your own pathway in Medicine?

GKT's name is decorated across medicine, nursing and dentistry, from the pioneers of transplantation and cancer treatment to breakthroughs in renal medicine and immunology, to the figures still shaping these fields today. Immersing himself in that legacy left its mark. "I knew I wanted Guy's to somehow feature in my life again," Arnav notes, "perhaps in a rotation at some point in the future." Now in his fifth year, he will soon be graduating, lending the work a particular weight. While completing the final edits of G300, he was left feeling "very sentimental." Over months spent pouring over the institution's as well as studying the art of medicine he had inevitably developed a "real affinity and attachment to the place."

Yet he is careful to separate feelings from direction. The compilation of the book itself hadn't altered his plans: "Although the book is about medicine, it isn't medicine itself, so it didn't change my plans." What it did enlighten him about was perhaps less tangible; his sense of what it means to be part of the field of medicine. "When you join medicine, you join a certain standard," he reflects, "and it applies to the first-year medical student as much as it does to [the] Professor." Medicine is a public profession, one handed with an extraordinary amount of trust,

and with it comes a certain code of conduct; from the way you carry yourself, to how "you treat the public and your patients." These stakes, in his view, reach well beyond the individual. If that trust were to erode, "people can't rely on [it, and] they find other ways to solve their problems", an outcome which is "damaging for society at large."

That sense of duty extends to the book's own formation and legacy, whereby the rigor of both the editing and design processes reflected the high expectations intrinsic to the personnel, institutions, and wider profession the text represents. In the acknowledgements, Arnav and his team deliberately looked ahead, "we look forward to seeing how future generations will improve on our attempt to chronicle the last 50 years."

Spirit and Succession

During the making of this book, how did you find the GKT Gazette fit into the wider GKT and KCL communities?

To understand the Gazette's place today, it helps to go back to where it all began. Originally the Guy's Hospital Gazette, it was "first printed in 1872, during the height of the Victorian Era", Arnav mentions as he explains. A time when Guy's, King's and St. Thomas' were separate entities, each with their own unique students and traditions. This changed in 1982, when Guy's, St. Thomas' and the Royal Dental School merged to become the new United Medical and Dental School (UMDS). King's College London, on the other hand, who had been training their own medical students since 1834, establishing their hospital and college too, joined the UMDS in 1998 to become GKT, as we know it now.

Over the years with various changes, the Gazette has remained a steady constant. Reporting on culture, opinions, sports, advancements and more, the Gazette has always been a motif behind GKT. "Offering a creative outlook, space for discussion, alongside a place to share ideas and find footholds into careers", with not only students but also faculty contributing to its overall development. "It is a real forum for engagement" within the GKT community.

As for how it fits into the wider KCL, "that is a harder question". The merger is recent enough that the "same historical wealth and relation to KCL isn't quite there" yet. But this feels like less of a gap and more so a work in progress, arguably the point of bringing these institutions together. "Currently, the GKT Gazette focuses on medicine, dentistry, nursing and physiotherapy", although those focuses "may change over time" as these roots deepen.

The edition reportedly reached the King. What was that like for you? Did you know that was on the cards?

Despite the said intricacies of planning and coordinating the structure and scope of the book, what was admittedly unforeseeable for Arnav (yet an exceptional surprise!) was discovering its very place in the Royal Library, having reached His Majesty The King himself through Professor Challacombe's diligence.

11th May 2026 brought the commemorative visit by His Majesty to the Cancer Centre at Guy's, that saw the unveiling of a celebratory plaque for Guy's Hospital's 300thAnniversary as well as recognition of the 10 years since the Cancer Centre first opened. This visit ignited a moment to reflect on the unparalleled universal connection Guy's helps to facilitate: The King spent time speaking with people receiving treatment in the Chemotherapy Village enlightened through his own medical journey, a touching day of strength, insights and empathy among the heart of innovation and research.

This sentiment hugely enforces Guy's role as a paramount national institution, as Arnav delved into and delineated his own experience investigating the archives: "you can see photos of the Prince of Wales 100 years ago at rugby

matches, and Princess Anne opening up the dental school!" - a true testament to rooted foundations that have flourished and flowered to attract attention from royal figures.

What do you hope a GKT student in 2126, the quadricentenary, will make of this book and GKT at large?

Arnav grounds the question before he answers it. "Well, firstly," he says, "I hope there is a GKT, and a Guy's and a Gazette, and that all of our or our equivalents are able to have this discussion in the first place." He suspects that a student in the future would look back at us as much as we look back on them and hopes above all that this work he has taken on will carry on. Medical school is only a short five (or six) years, yet there is so much that can be drawn from it that ultimately changes so much of who you are as a person: "Being young and in your early twenties, soaking everything in." There's proportionally not as many responsibilities so "it's a great thing to take some responsibility and give back in some way."

His hope for that distant student is a simple one. "I hope that in 100 years, students like yourselves can look back at the book, be proud of Guy's in 2026, and see it as a chapter in a continuing lineage of greatness." But he also points out that "but it might be humanoid robots that are learning medicine then."

Final reflections Reflections on the Gazette, Guy's 300, and what the future holds for Arnav

We found ourselves thinking about the past. As we leaf through the archival Gazette to meet our predecessors, what strikes us most is the sheer enormity of shared experiences between the students who came before and the students of today. It almost catches you off guard, the realisation that they, too, were just students at university. From discussing the happenings of the dissection room to their Christmas show to displaying results of their sports matches, they recorded the same aspects of university life you'd find if you opened up the Gazette today. There is, admittedly, a sense of it being far bigger than yourself. And it is, but at the same time, you realise that it really isn't? Everyone starts somewhere, and at the end of the day, they were all once GKT alumni that went on to achieve great things. I would hope and assume that this same sentiment is a reflection that one might make of us in the future.

The G300 was Arnav and the editorial team's contribution to the anniversary, landing amidst a week that marked the occasion in full. Between the 5th to 8th May 2026, the hospital threw its doors open: three days of community events in the Science Gallery courtyard, from live surgical simulations to the unveiling of the new da Vinci 5 robotic system to students' exhibitions alongside reminiscing the achievements of the past with the Gazette's own archive display, all under the theme of "300 years of caring for the community." Three centuries of care commemorated in the space of four days. With all of these past advancements in the field of healthcare, we can only hope that Guy's and GKT continues to be a trailblazer in ensuring the excellent care of future patients and communities. As Arnav put it, "This book made me appreciate the profession of medicine", with his understanding of the giants before us deepening his sense of what "[he had been] training for" and the profession "[he is] joining, or have joined." Looking ahead, Arnav plans to pursue internal medicine, with a dream of returning to his alma mater as a consultant in cardiology at St. Thomas' or oncology at the renowned Guy's Cancer Centre. Beyond the clinical path, he's drawn to research, data science, and economics, as well as London's start-up scene, particularly drug discovery, and may pursue those interests professionally further down the line. This profession, this legacy, this endeavour is as he puts it "one that is worthwhile and has great impact.

Alumni Reflections: One Year as a Doctor

Dr Jade Bruce **F2**

It's difficult to believe that only a year ago we were pushing passmed aside and donning graduation gowns to celebrate becoming doctors, a huge undertaking but one we worked hard for. Now, scattered widely across hospitals and specialties, another cohort of GKT doctors steps up to begin working as F1s. As GKT alumni wrap up their first year as doctors, they share their highs and lows, pearls of wisdom and practical advice.

Dr Alanna Wyncoll, F2

Which rotations did you undertake as an F1?
Acute Medicine/Stroke, Care of the Elderly, Colorectal Surgery

Where have you been located over the past year?
Bedford Hospital

Which rotations will you undertake as an F2?
Paediatrics, Cardiology, Trauma and Orthopaedic Surgery

Where will you be located as an F2?
Still at Bedford Hospital!

Briefly, summarise your experience as an F1
I have found F1 a really fulfilling year – in my DGH there's been a lovely balance of feeling well-supported but also having some independence (especially during on-calls), putting into practice what we learned during med school.

What have you learned over the past year?
I've learned a lot about what makes a good doctor. In F1 and F2, we're all still developing our clinical acumen, but by communicating clearly with patients, and being a reliable, hard-working colleague, you can be so valuable!

What have you found most challenging?
It did feel in-the-deep-end during the first month. There's a lot to get to grips with that's individual to your hospital (IT systems, where to find things on the ward, how to refer to different specialties). I'd say be kind to yourself during the initial weeks – I found once I'd got my head round these things, everything seemed to slot into place.

What have you found most rewarding?
Having responsibility for my patients. At first, it feels like a heavy weight to have patients allocated to you, and you are accountable for getting jobs sorted and escalating if need be. But it is incredibly rewarding to feel like you're a core part of their hospital journey and to advocate for them.

What advice would you give to medical students?
Speak with your F1 friends in your new hospital and friends in other hospitals, to share your experiences (good or bad!) In the first few weeks the camaraderie is very needed as you settle in. And bake some cakes for your team – it will earn you lots of favours!

How are you feeling ahead of starting F2?
A little daunted by the idea of having to take referrals! And I can't say I wasn't a bit shocked when I saw the F2 rota schedule... But generally optimistic and excited to start the next job!

Dr Jordan Jackson, F2

Which rotations did you undertake as an F1?
Inpatient psychiatry, geriatric medicine, acute internal medicine

Where have you been located over the past year?
Lambeth Hospital, St. Thomas' Hospital

Which rotations will you undertake as an F2?
General Surgery, Emergency Medicine, Obstetrics & Gynaecology

Where will you be located as an F2?
Lewisham Hospital

Briefly, summarise your experience as an F1
One of the most fun years of my life, it felt so fulfilling and rewarding to make use of 5 years of medical school and hard work. It was tough and a lot of work but helped me develop both professionally and personally, and in a career where you're able to make real change to people's lives.

What have you learned over the past year?
I've learned how I manage in stressful situations, how to communicate effectively and compassionately with patients and colleagues, and the importance on having reliable colleagues! Importantly, I learned about hospital politics, bed and resource pressures, inter-specialty conflict. A lot of these issues actually guide patient care and outcomes more than one would hope.

What have you found most challenging?
The main challenge I encountered was the recurrent feeling that being an F1 can often mean 'doing the work' that nobody else really wants to do, especially when it comes to grey areas between allied health professionals. It felt as though being willing to do anything and everything was expected and being open about how this was unfair was preaching to the choir. Another challenge was dealing with patients or family members who are quite resistant to care. It felt frustrating to try and convince people that they're unwell and need treatment. However, I do think this is intrinsically linked to health literacy and socio-economic conditions, that if anything is a sign we need to do more to educate the public to make wise health decisions.

What have you found most rewarding?
I found that though it may be hard to notice at first, being a doctor almost uniquely allows you to make lasting, almost immediate changes to peoples' lives. This could be providing immediate medical or surgical treatment but can also involve the larger social therapies that the hospital can organise, such as physiotherapy, packages of care or further outpatient investigations.

What advice would you give to medical students?
My advice for medical students: ensure you enjoy your life as a student because you have your entire career to lock in. Of course, you should focus on your exams and ensure you work hard, but you'll never be a student again and should enjoy the wonders of a summer holidays and student finance!

How are you feeling ahead of starting F2?
Both nervous and excited, it's a step up in responsibility but also a chance for you to 'flex your muscle' a little bit and practice medicine in a way that's slightly more personal to you. It'll also be very interesting to have new baby doctors asking you for help and how to do things when you're still feeling like a baby doctor yourself!

Which rotations did you undertake as an F1?
General Surgery (6 months), Endocrine/ Gen Med (3 months), Acute Med (3 months)

Where have you been located over the past year?
Buckinghamshire

Which rotations will you undertake as an F2?
Obstetrics and Gynaecology, Respiratory and GP

Where will you be located as an F2?
Buckinghamshire

Briefly, summarise your experience as an F1
I started on general surgery which felt like trial by fire. On my first shift I had to insert an NG tube as I was the only doctor on the ward. Initially, I felt very overwhelmed but soon settled into the rhythm of the ward round and on calls. I feel that I'm yet to get used to night shifts. Even the shifts that were stressful felt calmly chaotic.

Dr Natasha Ssozi, F2

What have you learned over the past year?
To not beat myself up after every little mistake, otherwise it can knock on your confidence.

What have you found most challenging?
Handing over jobs, I've had to try and learn that it's not always possible to finish everything in one shift.

What have you found most rewarding?
As horrible as it can be at times, giving patients a diagnosis, especially for some of my patients that have been unwell. Although it can be distressing, I've found that most patients and their families appreciate understanding what is going on.

What advice would you give to medical students?
Do as many cannulas and bloods as you can because this will be a skill that will be escalated to you often; if you know how to do ultrasound cannulation, you will be well loved on the ward. Also please escalate when you feel out of your depth, you will never know everything and it's not a sign of weakness to ask for help early.

How are you feeling ahead of starting F2?
I'm excited to move on to new specialties, however I feel quite nervous about taking on the mantle of SHO as it feels like quite a lot of responsibility.

What does it mean to perceive?

Neha Narendran **MBBS3**

What does it mean to perceive? Why are each of our versions of reality so variable? And what is it that distinguishes us from the rising power of AI? From Locke's 'Essay Concerning Human Understanding' in 1690, to the dawn of a new age of computerisation, this article seeks to connect the history and future of perception, just as perception binds us to our past, present and future selves.

Recently I revisited John Locke's longstanding 'Inverted Spectrum' thought experiment. He proposes: how am I to know if when I see blue you are not really seeing green? His argument is still debated by philosophers and begins this journey of untangling the web of perception. Let us consider the idea of 'qualia': the subjective element of our conscious experience - the smell of fresh clothes or the feeling of pain. These are experiences that are individual and private, and therefore, we are each said to have different qualia. Now, as with most ideas in philosophy, qualia remains a topic under much debate (whether they are purely physical pathways in the brain or something utterly non-physical which causes these occurrences), this would have enough material to be an article in its own right! The biggest issue with the inverted spectrum problem is the inability to test it. For example, if someone had been taught that the colour green was in fact called the colour blue then how can we validate their perception? We can never prove or disprove Locke's theory. We can never truly visualise life as the person next to us, and unfortunately this means we will only ever have a sample size of one.

I argue the 'inverted spectrum' theory can be representative of perception in all walks of life. It can be applied to the variability of responses a single situation elicits from us. Our individual thought processes and our subsequent actions will inevitably be unique. This may be as a result of our upbringing, our environment, and our sensory encounters in our life thus far. Lysa Morrison, a TEDx speaker with a background in psychology, argues this is due to the 'filtering' system our brain performs. When our brain interprets information, we each make use of various filters. These delete, distort, and generalise the information we face. These filters are shaped by culture, values, beliefs, identity, and emotional and physical states. Having watched this captivating talk, I found the most interesting factor affecting our internal filters to be our emotional states. Take twins- even with the same genetic makeup, their perception of the world largely differs. The same can happen with any of us; the way we react in emotional peaks versus moments of calm can lead us to have starkly different perceptions of our realities. We are not only physically dissimilar, but have constantly changing emotional outlooks on our life. The neurological perspective on this considers changes in the hormones released and neurotransmitter concentrations during certain states. These variations modulate brain activity and plasticity, altering what we notice or ignore. Acute cortisol release can make our processing sharper and us more susceptible to noticing small details. Conversely, the release of melatonin makes our cerebral processing slower and slows our psychomotor reflexes.

Our biological state affects our perception but also the formation of the memory that follows. Humans are incredibly unreliable narrators but perhaps this is not always negative.

The emergence of Artificial Intelligence (AI) has made us look inward to entertain the possibility of being replaced by a digital substitute. The overwhelmingly positive introduction of models such as ChatGPT have made it easier to gather knowledge than ever before, and are difficult to ignore. Yet, there is an element of apprehension as technology becomes quicker and more precise every day. Who is to say AI could not be indistinguishable from us in the near future?

After hearing a lecture by Dr Edward David, Director of the AKC programme at King's, on 'Re-thinking thinking', I was struck by a point he made about how thinking is distinct from that of a machine. Dr David argues that responding to a scenario is not the same as understanding it and this is where we differ from our ever-evolving digital counterparts. In short, we are often guilty of hastily defining AI to have the capacity to think when thinking requires intentionality. What does it mean to think if there is no purpose behind the idea? What is the point of the creation of an image or a poem if it does not represent something to us? I came to the realisation that we are differentiated, in fact, by the volatility of the human condition. AI shines in fields of repetition and automation, often exceeding our ability to memorise. Humans, however, bring elements of experience, creativity and intuition that computerisation fails to replicate. Many counterarguments exist; to explore a few:

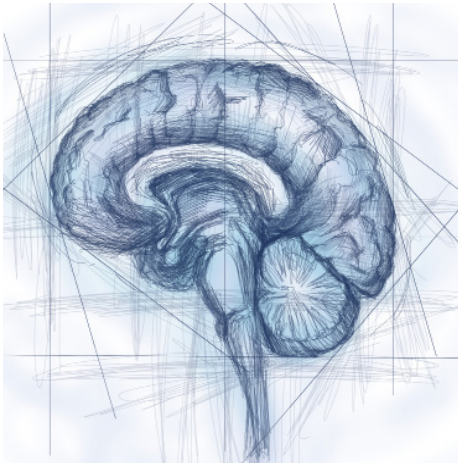
1. How is training an AI with data any different to nurturing an infant to develop their innate knowledge?

2. Consider a model with the capability to receive sensory input i.e. a robot. How can we deny it has the skill to think?

3. If our perspectives are shaped by an ability to refine our knowledge from the mistakes we make, how is this contrasting from researchers teaching an AI to evolve from its own?

Plenty more such arguments exist, and it would be unreasonable of me to invalidate these perspectives. However, I believe AI cannot duplicate our emotional spontaneity. Machine intelligence may be able to develop over time or process sensory information as we do, yet can never use these encounters to generate a new experimental solution, reflect on art or empathise with a friend. These are inherently human traits, and I believe they are vital to being a thinker. Our eccentricities not only make us unpredictable narrators but are a defining factor of our identity.

So, I ask, what does it mean to perceive? Perception is how we connect with the world around us, how we immerse ourselves in sensory experiences, and how ultimately this bridges the gap between thinking and feeling. Each of us has our own form of perception which accompanies the unreproducible nature of our lives. Perception shapes our identity and vice versa; something digital cognition cannot truly grasp. While I may not have provided tangible answers for the questions we set out to consider, I hope I have left you with a curiosity - that to perceive is not merely to see but everything else it evokes within us.



Illustrated by Zainab Abdur Rahman

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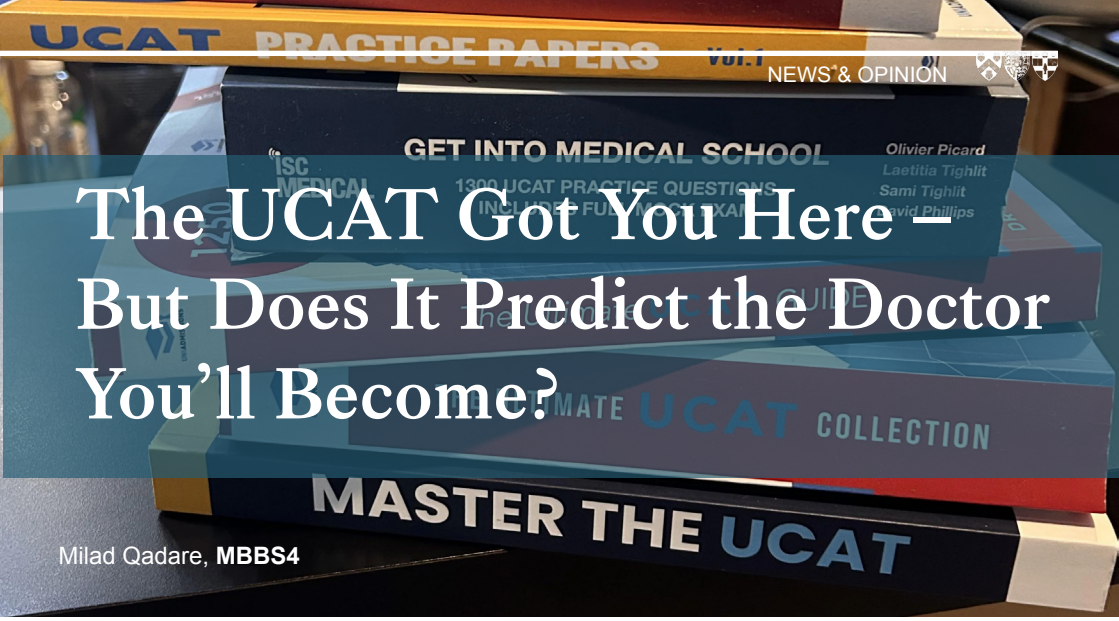
News & Opinion

The architects' model of Phase III



The UCAT Got You Here – But Does It Predict the Doctor You'll Become?

Milad Qadare, **MBBS4**

1) Introduction

The University Clinical Aptitude Test (UCAT) is a computer-based admissions test introduced in 2006, used by universities across the UK, Australia, New Zealand and Singapore to help select applicants for medical and dental degrees.

The test has four sections: Verbal Reasoning (VR), Decision Making (DM), Quantitative Reasoning (QR), and Situational Judgement (SJT) — testing, respectively, your ability to interpret written information, apply logic, solve numerical problems, and judge appropriate professional behaviour. Until 2025, the UCAT also included Abstract Reasoning (AR), testing pattern recognition in visual information.

If you're reading this as a medical or dental student, you know the UCAT all too well — your score played some part in getting you here. But now it's behind you, it's worth asking: is it actually a good measure of potential? Does performing well in a time-pressured test tell us anything about how you'll perform at medical school, or the doctor you'll become?

The UCAT is designed to assess aptitude rather than academic achievement, since academic ability is already shown through qualifications such as A-Levels. Rather than testing scientific knowledge, it assesses cognitive and behavioural traits relevant to medicine: critical thinking, logical reasoning, problem-solving and interpreting information under time pressure; the SJT examines how candidates handle scenarios involving professional ethics. In theory, then, the UCAT looks beyond what an applicant knows and instead assesses how they think, reason and respond — qualities that might matter in a future healthcare professional.

2) Does UCAT performance predict success at medical school?

Does doing well in the UCAT actually translate into doing well at medical school? The evidence suggests yes, but only to a limited extent.

A systematic review by Greatrix et al. (2021) found that UCAT scores were associated with performance in medical school assessments, though these relationships were generally weak. The overall UCAT score and VR score were the most consistent predictors, particularly for knowledge-based rather than skills-based

assessments, and there was some evidence that this predictive relationship persisted throughout medical school.

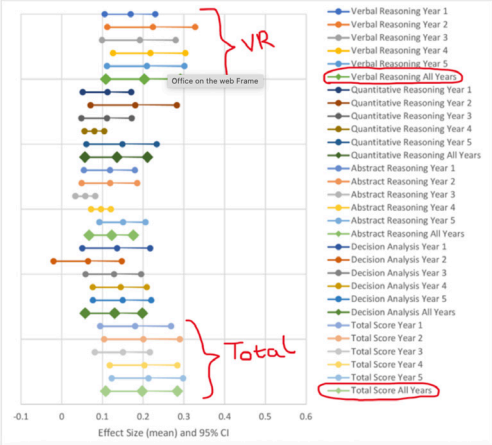


Figure 1: the aggregated relationships between each UCAT subtest (and total score) with all assessments included in the studies for each programme year – adapted from Greatrix et al. (2021)

These relationships also tended to look stronger in small, single-university studies than in the larger multi-centre datasets pooling results across many schools, a hint that some of the modest correlations reported may shrink further as more rigorous evidence accumulates.

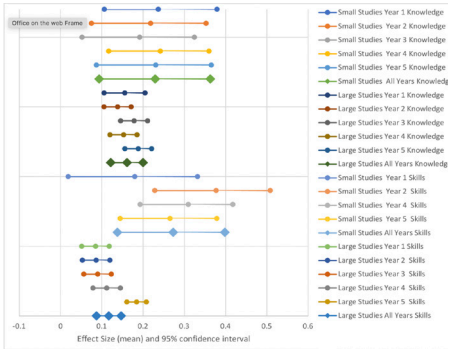


Figure 2: relationships between UCAT total score and assessment outcomes, split by study size — small, single-institution studies (upper half) show consistently larger effect sizes than large multi-centre studies (lower half) — adapted from Greatrix et al. (2021)

A second systematic review by Bala et al. (2021) reached a similar conclusion: the cognitive total and VR again showed the strongest evidence of predicting academic performance, but most of the available evidence found no significant relationship at all, and where one was found, it was weak. The SJT weakly predicted professional behaviour during medical school, though notably, the only study in their review to look beyond graduation found that UCAT scores did not predict whether newly qualified doctors would later face fitness-to-practise sanctions for health or conduct reasons.

Both reviews also suggest that the UCAT provides some additional predictive value beyond previous academic achievement, such as A-Level performance, although this added value appears to be small.

So, the UCAT is not meaningless: certain parts of it appear to tell us something about how a student might perform at medical school. But it is far from a crystal ball. And predicting who will perform well at medical school is not necessarily the same as predicting who will become a good doctor.

3) Is the UCAT fair?

The next question is whether the UCAT itself is a fair exam — though what does 'fair' really mean? On paper, it offers advantages: every candidate sits a standardised test, scores are comparable, and access arrangements exist for eligible candidates. But standardisation does not mean everyone starts on equal footing.

Lambe et al. (2012) surveyed almost 800 UCAT applicants and found that preparation time, access to advice, resources used and school type were all linked to performance. Only 30% first heard about the UCAT from a teacher or career advisor, and how informed candidates felt their school was varied sharply by type — compre-

hensive, grammar and independent schools reported better guidance than sixth-form or further education colleges. This gap showed up in scores too: compared with sixth-form college candidates, those from fee-paying grammar schools scored 131 points higher on average (out of 3,600), and comprehensive-school candidates 97 points higher. Attending a commercial preparation course however, made no significant difference, suggesting the issue is less about who can afford tutoring, more about who knows what to prepare for.

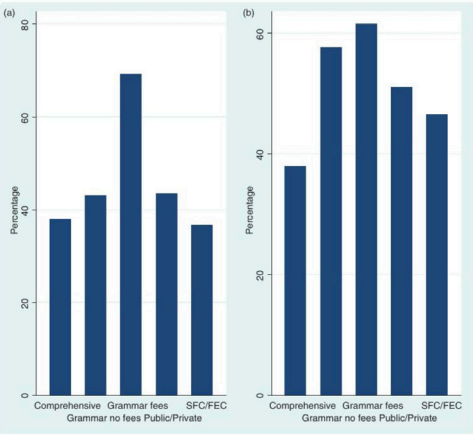


Figure 3: (a) percentage of applicants advised to prepare for the UCAT by a teacher or career advisor, and (b) percentage who felt their school was fully informed about the test — both by school type — adapted from Lambe et al. (2012)

This matters more when the UCAT is compared with the alternative. Tiffin et al. (2014), studying over 8,000 medical applicants, found that many of the same sociodemographic factors linked to UCAT performance also predicted A-Level attainment — applicants from independent or grammar schools performed better on both. However, school type had less influence on UCAT scores than on A-Levels, suggesting the UCAT may reduce the impact of educational background compared with academic achievement alone.

The picture was not entirely positive, though. The UCAT appeared more sensitive than A-Levels to some other characteristics, including sex and whether English was an applicant's first language, suggesting the UCAT may be less affected by certain inequalities, but more affected by others.

And perhaps that is the more interesting question. Rather than simply asking whether inequality exists in UCAT performance, we should ask whether the UCAT reduces the inequalities already present in medical admissions, or simply reproduces them in a different form.

4) Does any of this tell us who will be a good doctor?

The final question we are all wondering is: does any of this actually tell us whether we will become good doctors?

Being quick at verbal or numerical reasoning under time pressure is obviously not the same as communicating with a distressed patient, showing empathy, working within a team, or applying clinical judgement in real life — qualities that cannot easily be captured by a computer-based aptitude test. But that does not necessarily discredit the purpose of the UCAT.

Medical schools must differentiate between thousands of already-strong applicants, and meeting each one personally at this stage is unrealistic — so the UCAT has a place, giving universities a standardised, scalable way to compare candidates beyond grades alone.

Perhaps the problem is not that we use the UCAT, but how much we expect it to tell us. It can offer some indication of future academic performance, but that is very different from predicting the kind of doctor someone becomes. The UCAT may help decide who gets through the door, but communication, empathy, resilience and professionalism are developed long after the score is forgotten.

5) Conclusion

Whether you scored in the top percentile or barely cleared the cut-off, if you're reading this as a fresher, your UCAT has already done its job — it got you through the door, but from here, that score matters very little.

The UCAT is not a useless test. It gives medical schools a practical way to compare thousands of capable applicants, and the evidence suggests some indication of how students may perform at medical school. But its predictive power is limited, questions remain around fairness, and no aptitude test can fully capture what makes a good doctor.

So, perhaps the UCAT was never supposed to predict the doctor you will become — that part starts now.

Cadaveric Dissection

Kavya Venkatesh **MBBS2**

The practice of cadaveric dissection has a tumultuous history, being intertwined with religion, ethics and social beliefs. Initially a method to learn anatomy and improve physicians' understanding of the various body systems, its benefits have evolved over time to become not just a provider of physical information, but simultaneously teach future doctors the importance of recognizing mortality. By introducing it within the first week of medical school, there is no doubt this concept is vital to the career we are working towards in many ways. Yet, this age-old tradition, rooted in the historical prestige synonymous with medicine, is currently fighting a battle to remain present in our modern world. Marked by reduced cadaver donors, trained anatomists and increased resources being required to maintain it as a part of medical curriculums, universities around the country are searching for ways to modify how anatomy is being taught. During this transformational period, it's worth considering the relevance of when dissections are introduced into medical education. Typically included in year one, I believe the two anatomies featured in dissection - one of physical structures, and the other of building your own clinical identity - is better off being taught further along a medical student's journey.

I remember my first dissection opened with a moment of silence. Standing at the table, I was struck by how much trust my donor and their family had placed in us, first-year medical students. Their gift demanded respect, and in that moment the weight of that responsibility felt clear. But as the weeks went by, that feeling slowly faded. Each time I returned to the lab, my focus narrowed to the day's checklist: reflect the skin, expose a muscle group, identify a nerve. The initial shock of uncovering the cadaver had softened into routine. Was this a positive development attesting to my professional ability, or a negative repression of my emotions and morality to distance my actions from my conscience?

To make matters worse, the scalpels, forceps and scissors that were shoved into my hands inadvertently turned the donor's skin, fat, muscle into the canvas for my trial and error of learning how to make incisions. Within the first session itself, I had accidentally cut into a muscle and severed an artery. The task for the day? Simply separate the layers of the skin till I reached the fascia.

The first reality check of my actions came only after a few months of weekly dissections - I was making the final cut to open up the cadaver's chest, and upon lifting the ribs out of the cadaver, I was confronted with masses of dead tissue caused by cancer inside my donor's chest. The extent of the necrosis was so much so, that more than half the session was spent clearing it, revealing a tiny left lung by the end. For the first time in months, I imagined the person behind the pathology, and I realized how long it had been since I had thought of the donor as anything other than a body to study.

The ease with which I had slipped into an objective mindset so quickly, viewing the cadaver as a body rather than a life, frightened me and forced me to question the grim nature of dissections. As a first-year medical student, was I mature enough to be in this room, continuously aware of the weight of my actions? Should

this even be part of a first-year curriculum? On the other hand, isn't it better to experience this inescapable disengagement of the medical career early on? Recognizing the problem is the most important step for any solution after all.

That moment forced me to reflect on what dissection is meant to teach. The technical learning is obvious: identifying structures, navigating tissues, understanding spatial relationships. But there is another layer that receives far less guidance: the challenge of acknowledging the tension between necessary clinical distance and the humanity of the person who once occupied the table. No one tells you when you've drifted too far into detachment or when you need to pause and remember the life that preceded your lesson. Just as anatomy can't be taught, these guiding introspections to developing the maturity necessary to be aware of this shift in behaviour is also self-guided. That responsibility needs to be taken upon by students individually.

First-year students arrive with limited clinical context and little framework for integrating emotional insight with technical learning. Without that foundation, it's a slippery slope to treating dissection as a purely mechanical task, mistaking numbness for professionalism. It begs the question if encountering cadavers later in training - after seeing patients, hearing their stories, and understanding the trajectory of illness - might allow students to balance compassion and objectivity more intentionally. The purpose would shift from building basic foundations to an avenue of consolidating learning, not only of anatomy but of the course of disease and its consequences.

I will wholeheartedly agree there's been little else so far in medical school which has been as humbling, sombre and invaluable as the experience of seeing my 'first patient' for the first time. The initial session will always stay with me as will the one where I saw the effects of my cadaver's metastasised lung cancer. These are opportunities which are distinct even from what clinical placements can offer you, since it requires you to assume the physician's role as a respectful professional rather than 'a healer'. It's a welcome shift from the responsibility that doctors spend so much of their daily lives stepping into - hurriedly looking to treat, find a solution, perform damage control. In this context, the damage has already been done. Now, it's time to accept where modern medicine couldn't help the patient any longer and acknowledge these limitations. In a similar manner, perhaps it's time to consider the shortcomings of the way dissections have been previously integrated into medical curriculum, and reflect on the ways this teaching method can be modified to stay relevant.

The Brazilian Prescription:
Can Home Visits Heal the NHS?

Aathi James Thiru-Lewis **MBBS3**

The NHS is a defining part of British identity, yet it is facing a profound and escalating crisis. Chronic understaffing, widening health inequalities, and growing pressure on general practice are straining the system to breaking point. As future medical professionals, diagnosing the symptoms of this systemic illness is no longer enough. We must move towards prescribing treatments that are truly effective.

Where do we look for inspiration? Perhaps surprisingly, to Brazil. Its Unified Health System (SUS) and the Family Health Strategy (FHS) have driven measurable improvements in population health through a model of sustained, community-based primary care.

What might once have been dismissed as 'policy tourism' has now entered mainstream UK health planning. In fact, government-backed pilots across the NHS are already adapting this Brazilian model.

This article examines the FHS's structure, the evidence behind it, and what its adoption signals for the future NHS and for us, the students who will soon be working within it.

The Search for a Lifeline

The appeal of the Brazilian model isn't ideological romanticism; it's results-driven.

While the NHS was founded on universal coverage, access, and outcomes are now highly uneven across the UK. Brazil's SUS, established in 1988, embedded universal health care as a constitutional right. Crucially, it built a primary care model capable of reaching communities facing severe inequality, geographic fragmentation, and limited resources.

The Family Health Strategy's success rests on shifting from reactive, appointment-driven medicine to anticipatory, sustained care delivered directly in the community.
The NHS waits for patients to knock. Brazil goes to their door.
The question for us, then, is whether a system designed to address Brazilian inequality can meaningfully inform the renewal of primary care in the UK. Early evidence from UK pilots suggests it can and already is.

The Brazilian Engine: Home Visits Over Appointments

The FHS operates on the principle of territoriality. Each integrated team is assigned a fixed catchment area, typically covering around 3,000 residents. They are responsible for the health of every person within that boundary, ensuring universal coverage whether or not an individual is registered or actively seeking help.

An FHS team is a highly integrated, salaried unit focused on prevention. The standard composition includes a General Practitioner (GP) and Nurse for clinical leadership, a Dental Team, and most critically, 4-6 Community Health Workers (CHWs).

The Community Health Worker (Agente Comunitário de Saúde, CHW) is the system's engine. They must reside in the exact community they serve, enabling them to enter homes armed with trust and cultural knowledge, not just medical credentials.

The CHW's main duty is to conduct regular, often monthly, home visits to every family. This routine presence allows for systematic work: they monitor pregnant women, track long-term conditions and provide advocacy; they also link residents to clinical care and alert services to social issues, such as poor housing or food insecurity.

This direct, routine presence is the most effective way to address the social determinants of health long before illness forces a patient into an emergency GP appointment.

The Proof: Why Prevention Pays

Documented improvements show the FHS systematically reduces the need for expensive, reactive care.

The model is credited with a massive reduction in Ambulatory Care-Sensitive Hospitalisations (ACSHs)—admissions preventable with effective outpatient care. Between 2001 and 2016, the FHS contributed to a 45% decrease in ACSHs across Brazil.

The financial case is compelling: the FHS achieves a 45% reduction in preventable hospitalisations whilst costing just $50 per person per year, making it highly cost-effective compared to hospital-centric systems.

This adaptability became especially visible during crises. When Zika and later COVID-19 hit, FHS teams could rapidly mobilise, adapt communication channels, and maintain continuity of care—long before centralised health data systems caught up. Facility-based systems often lack this level of rapid responsiveness.

From Rio to Westminster: The NHS Takes the Leap

What was once a model to study is now actively implemented. The NHS integrates this approach through its Community Health and Wellbeing Worker (CHWW) programme, operating primarily within Primary Care Networks (PCNs).

The influence is direct and intentional: the NHS 10-Year Plan (2025) identifies Brazil's Family Health Strategy as a guiding example. To support this policy adaptation, Health Secretary Wes Streeting has invited Brazilian health experts to DHSC roundtables to contribute to the plan's formulation.

Early UK pilot results strongly validate the model for the British context:

The Churchill Gardens Pilot, Westminster: Results were striking in this early site: cancer screening +82%, immunisation uptake +47%, and a 7.3% reduction in GP appointments. Equity Focus: Notably, these improvements were most pronounced in areas of highest deprivation proving the CHWW model is a tool specifically designed to close equity gaps, not just enhance universal service.

The era of merely observing Brazil academically is over. We, as future clinicians, must be prepared to integrate the CHWW into our working lives.

A Warning: Mind the Traps

The transfer of the FHS model raises significant ethical and systemic challenges. We must critique its potential pitfalls to prevent the NHS from replicating its weaknesses.
The concept of a health worker conducting monthly household visits may clash with UK cultural norms around patient privacy and the sanctity of the private home. The success of the CHW is rooted in solidarity, and building trust here requires clear messaging and continuous

ethical evaluation. This is the Privacy Paradox.

We must also look at Avoiding Austerity Traps. The FHS is often framed as "doing more with less," operating on extremely low per capita funding. The NHS must be cautioned against viewing the CHWW programme as an 'austerity innovation'. If we do not back this new workforce with protected, long-term funding, we risk replicating Brazil's history of high CHW burnout and turnover. This is not optional; it is a professional responsibility.

Finally, the Boundary Test is acceptance. The medical establishment must embrace the CHW role. The CHW's deep knowledge of social factors is often more critical than any clinical test result. Their expertise must be respected and integrated into care planning.

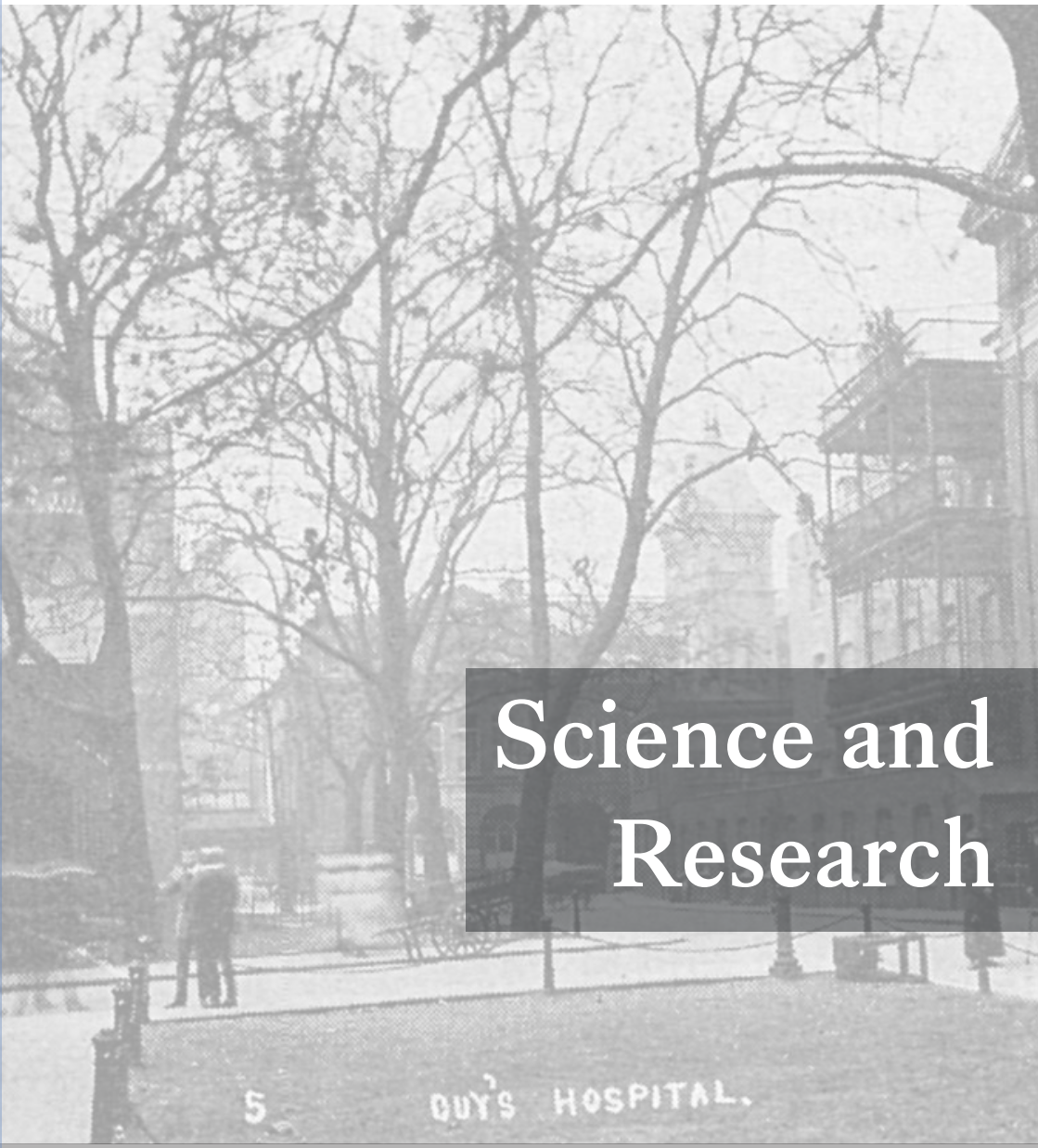
The Path Ahead

The NHS's adoption of community-focused health workers signals more than a policy shift—it's a recognition that the system must fundamentally change direction to survive. The Brazilian model proves equitable healthcare is not only a moral commitment, but a practical one, founded on prevention, continuity, and local trust.

As future clinicians, our role is changing. We will be working alongside CHWs, social prescribers, and multidisciplinary teams whose everyday presence in patients' lives will shape the determinants of health long before illness reaches the clinic.

GKT students and new doctors will be at the forefront of this shift partnering with community health workers to reshape what preventive medicine means in Britain. Understanding and defending this transformation will be essential if we are to deliver genuinely universal care in the decades ahead.

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



Science and Research

What makes us conscious?

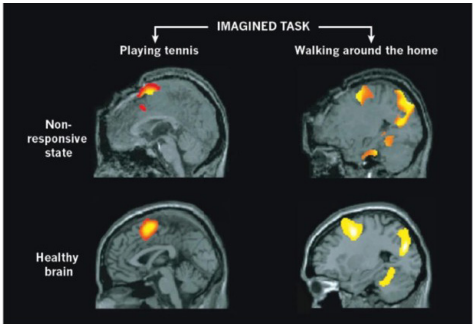
Shreya Mittal **MBBS5**

The definition of consciousness is most famously analogised by Thomas Nagel. Imagine you are a bat using sonar to navigate. Within our realm of human experience, is it possible to truly imagine what it is like to use sonar?

> Consciousness, by this definition, is the subjective feeling (qualia) that arises from an objective experience. Others add the qualities of thought and reflection to the definition.

To paraphrase Brian Cox - despite great advances in neuroscience, we are nowhere near understanding the following question:

How does consciousness arise from physical processes in the brain?



Brain activity in people in an apparently non-responsive state can be similar to that of healthy people. Credit: Adrian M. Owen

Certain large-scale brain networks appear particularly important in generating our subjective experience. In particular, thalamocortical loops are believed to help integrate sensory signals across the cortex to support our conscious perception. Additionally, prefrontal cortex activity has been reported to be reduced in schizophrenia and other psychotic disorders.

We can examine the neuronal activity of patients in a coma. The below image displays fMRI images of the brain activity of a non-responsive 23-year-old woman following a severe brain injury (Figure 1). In response to verbal commands, such as 'imagine playing tennis', activity was observed in her supplementary motor area, as is seen in healthy individuals.

Further studies have suggested that this brain activity is detectable in 10-20% of non-responsive individuals. However, brain activation to external signals does not prove that these individuals are undergoing a subjective experience.

Nonetheless, this information has been used to explore whether brain stimulation in comatose patients can increase observed consciousness. Thalamic-stimulation of a man in a minimally-conscious state enabled him to communicate his recognition of family members through eye movements, implying that conscious processes were at work.

The fundamental limitation of current neuroscience is that although it can identify the neural mechanisms associated with conscious experience, it cannot explain why or how physical neuronal activity is accompanied by a subjective experience.

Theories for the emergence of subjective experience

There are various theories for how subjective experience arises from physical processes in the brain, however each has important limitations.

One theory, *Integrated Information Theory (IIT)* suggests that consciousness arises not from a single area or process in the brain, but from the summation of neuronal activities. IIT proposes that a system has a higher level of consciousness if the interaction between its components yield a greater sum total of information than the sum of the individual components. Akin to how resistance acts in a parallel circuit.

Studies of patients under anaesthesia have shown correlations between the mathematical integrated total of activity (phi) from IIT and the state of anaesthesia. However, anaesthesia is not a direct or uniform measure of consciousness, as different anaesthetic agents can produce distinct alterations in awareness. Whether IIT explains how neural activity gives rise to subjective experience remains unresolved.

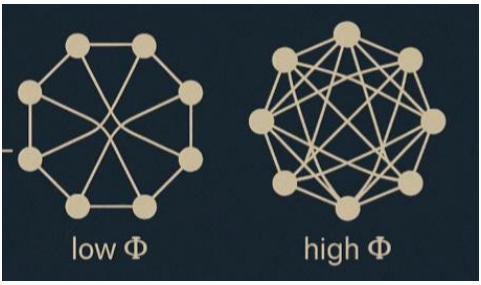


Figure 2 - The increased sum of neuronal activity in the right hand diagram suggests a higher level of consciousness (measured by phi).

What role do memories and prediction play in perception?

The other predominant theory of consciousness is the Global Workspace Theory by Baars and Dahaene. This theory proposes that consciousness occurs due to certain unconscious processes "winning" attention and becoming available to reasoning and memory.

Can you attempt to imagine what the current moment would feel like if you had no previous memories of existence? Would it feel like anything at all?

A linked theory suggests that prediction using our memories is vital to produce our subjective experience. The Bayesian Brain proposes that our brains are prediction machines; they predict the most likely outcomes at any given moment using available input and prior knowledge.

> Imagine you are walking in a forest and hear a rustle. Your brain will consider the possibility of wind, another person, or an animal, assigning predictive values (known as precision weighting) to each option based on your prior experiences.

According to this theory, your conscious experience is your brain's best current model of the world.

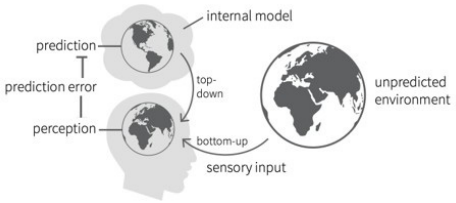


Figure 3 - Top-down and Bottom-up predictive coding in the Bayesian Brain.

In schizophrenia, predictive and self-monitoring mechanisms may be disrupted. Misattribution of self-generated inner-speech as external speech can lead to an altered perception and prediction of reality.

The Bayesian Brain theory could also explain phenomena such as dreams feeling real and the placebo effect.

The potential role that memory plays in influencing and generating our subjective experience is not one to be overlooked.

Quantum theory of consciousness

Beyond theories based solely on macro-neuronal activity, some scientists and philosophers have suggested that quantum processes may contribute to consciousness. Nevertheless, these ideas remain highly controversial. Roger Penrose and Stuart Hameroff propose that quantum processes occurring within neuronal microtubules may contribute to conscious experience.

Others argue for the metaphysical theory of panpsychism: that consciousness is a fundamental property of matter itself. This is presumably present in all biological matter, but more powerful as the system gets larger. This theory is highly contested.

What can artificial intelligence machines tell us about consciousness?

In 1950, Alan Turing famously proposed the question "Can machines think?". Since then, AI models have outperformed humans in Chess and Go through inventing novel, creative strategies. Although modern AI operates very differently

from the human brain, both biological and artificial systems can be viewed as prediction engines that learn from experience.

As Artificial General Intelligence (AGI) approaches human-level performance across diverse tasks, the pressing question is whether we will be able to distinguish between an AGI mimicking human consciousness versus an AGI truly experiencing a subjective experience - if this is at all possible. If consciousness arises solely from sufficiently complex information processing as proposed by *Integrated Information Theory*, then future AI systems may one day be conscious. The reality is likely to be more complex, requiring sequences of memory and inherited context, as the *Global Workspace Theory* and the *Bayesian Brain* suggest.

Alternatively, if consciousness depends on uniquely biological properties of living neural tissue, then even highly intelligent AI may remain devoid of any inner experience. Fascinatingly, researchers are already exploring this possibility through biocomputing; combining living neurons with silicon hardware.

Ultimately, AI may well be the very thing that unravels the mystery of consciousness and redefines how we see ourselves.

"Consciousness is, at once, the most familiar thing in the world, and the most mysterious thing in the world" - David Chalmers.

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

AI in Skin Cancer Detection: are we ready for it?

Tresa Martin **MBBS3**

Digital health and artificial intelligence (AI) are becoming far more prominent in the lives of both patients and clinicians, and new medical technologies are beginning to make their way into the NHS. I was fortunate enough to attend a talk given by Dr Joshua Luck, Head of Medical Affairs at Skin Analytics, regarding the use of Deep Ensemble for Recognition of Malignancy (DERM), an artificial intelligence medical device designed for skin cancer detection.

Skin cancer is one of the most common types of cancer, with melanoma in particular sadly being a common cause of cancer-related death in young adults. The stage at diagnosis yields a significant impact on prognosis, with cancer localised to the primary site having a 99.4% five-year survival rate, however if there are distant metastases, this falls to only 29.8% (BMJ Best Practice, 2026).

Guidelines, until recently, recommended assessing melanoma using dermoscopy, and did not recommend routinely using computer assisted tools or 'confocal microscopy,' (National Institute for Health and Care Excellence (NICE), 2022a). However, recently NICE has recommended that DERM can be used during the 'evidence generation period (3 years)'. DERM is an artificial intelligence-based skin lesion analysis device, which can screen, triage and assess potential skin cancers. It was trained on over 230,000 NHS patients and has been granted a phase 4 AI in Health and Care Award by NHS AI Lab. DERM would be an option to assess skin lesions referred to the urgent skin cancer pathway, but it is not yet routinely used, nor has DERM received appropriate regulatory approval. If DERM comes into routine use, it could be used to free up capacity within dermatological services, but currently further evidence is required to assess how DERM affects clinical capacity and importantly whether it can assess skin lesions with equal accuracy on black and brown skin. (NICE, 2026).

An observational study sponsored by Skin Analytics Limited (Skin Analytics Limited, 2021) provides some evidence for using DERM in the National Health System (NHS). The published results showed that the artificial intelligence as a medical device (AIaMD) component of DERM could detect both melanoma and non-melanoma skin cancer with 'accuracy comparable to specialists,' (Marsden et al., 2024). The direct comparison with dermatologists highlights the clinical usability of DERM and additionally the outcomes were compared to histologically confirmed diagnosis and consultant dermatologist diagnosis if necessary, which shows the validity of a diagnosis by DERM. Importantly, the study (Marsden et al., 2024) also included health economics, suggesting that there could have been savings of greater than £100,000 and greater than 150 hours of specialist time (assuming non-malignant outputs meant no further patient management was required). On the other hand, this was a single centre study conducted in London, and the results may not be generalisable to other parts of the country with different population demographics. The study was not large enough to identify 'any malignant lesions in patients with darker skin,' and so the

performance of AIaMD in these patients has not been assessed, and thus, DERM may not be as useful in patients with darker skin. Additionally, the sensitivity by tele-dermatologists was higher than that of AIaMD to identify malignancies, although this study was carried out at a centre with well-established tele-dermatology, which is not the case throughout the country, and sensitivity could differ depending on clinicians and centres less experienced with tele-dermatology. The conflict-of-interest statement shows that several authors are involved in Skin Analytics, potentially introducing bias, and a risk of selective reporting is something to be cautious of here. DERM appears to have potential in reducing clinics in workload and acting as a technological assistant in melanoma diagnosis, however more research needs to be done into how the results change when applied in multiple hospitals across the country, and whether it yields similar results in darker skin.

A limitation of several studies regarding AI in skin cancer detection, is that models have not been adequately trained on some FitzPatrick skin tones, meaning that AI is more likely to miss melanoma in these patients. Despite the fact that melanoma is more common in patients with lighter skin tones, it is still vital to make sure AI systems incorporate 'diverse training populations…' (Tjiu and Lu, 2025), and there is a need for more diverse datasets for AI training in the future.

Many people might be wary about using AI in cancer detection for several reasons. Who is held accountable when mistakes are made? What happens to the data collected by AI and who has access to it? Would overuse of AI cause the diagnosis skills of doctors to become poorer? Whilst AI has potential to become a powerful tool in medicine, it has a long way to go if it's going to be properly regulated and trusted by patients and doctors.

There are many future directions for AI, one being multimodal AI, as this closely mimics clinical decision making, taking into account dermoscopy images, clinical photos and patient history. Additionally, explainable AI may be preferred to unexplained AI, as it addresses transparency issues, and mistakes made can be more easily spotted and corrected. Future research should move beyond measuring just sensitivity and specificity, and could explore more clinical outcomes such as potential cost-effectiveness, (for example through lower resource utilisation, as shown by Marsden et al., 2024) and importantly, patient impact, in order to find how much AI can help with real-world issues.

In conclusion, research into how AI can support clinical decisions in skin cancer diagnosis is still ongoing, and there is a need for more prospective studies and real-world evidence to evaluate the effectiveness of AI use for both clinicians and patients. Furthermore, it's important to consider whether AI is more effective in primary care or secondary care settings, or whether it is used best in tele-dermatology (as explored by Marsden et al., 2024). Some evidence shows less experienced dermatologists would benefit more from using AI to assist with clinical decisions- shown by Winkler et al., (2023), however even between experienced dermatologists, diagnoses can vary and AI may have a role there in the future too. Overall, the literature referenced in this article shows that AI can be a useful tool in skin cancer detection, however there is still more research to be done in order to prove it's safe for all patients if clinically implemented, and figure out where AI can be most effective in practice.

Pancreatic Cancer Pill Doubles Patient Survival Time in Advanced Disease

Naim Ghantous **Intercalating**

RASolute 302 trial receives standing ovation at ASCO Annual Meeting 2026

I distinctly recall my placement within the hepatobiliary unit at St Thomas', rounding on patients with manifestations of liver failure, hepatitis and autoimmune biliary disease, however the most vivid amongst these memories was with a patient I saw somewhere in the middle of this morning ward round. As the door shut, I almost felt the air silently being drawn from the room, the vivacity of the consultant and registrars being tempered and subdued. This was a middle-aged gentleman, who had previously been diagnosed with a metastatic pancreatic ductal adenocarcinoma, and the concrete updates we had managed to provide for the other patients had turned dilute and brittle in the face of this frail and exhausted man.

Pancreatic cancer is one of the most lethal and therapeutically challenging malignancies in medicine, with the majority of patients presenting with advanced disease at the time of diagnosis. The 5-year survival rate sits at 7%, the lowest amongst all common cancers, and those with previously treated or metastatic disease tend to receive non-specific cytotoxic chemotherapy regimens, which yield low incidences of treatment response and are complicated by a significant toxicity profile. However, striking through the nihilistic landscape of pancreatic cancer therapy are the results of the Phase 3 trial for daraxonrasib, a once daily oral medication which has been demonstrated to double survival time for patients with previously treated metastatic pancreatic cancer. These findings – published in the New England Journal of Medicine - have been hailed as revolutionary, receiving a standing ovation at the 2026 meeting of the American Society of Clinical Oncology (ASCO), and leaving several audience members seemingly overcome with emotion. This article serves to cultivate brief insight into the trial itself, a mechanistic breakdown of the novel therapy, and most critically what this means for patients with metastatic pancreatic cancer.

The RASolute 302 trial was a phase 3, international, open-label, randomised trial, recruiting 500 patients across 59 sites and 6 coun-

tries previously treated for metastatic pancreatic ductal adenocarcinoma (mPDAC). Participants were randomly assigned to receive daraxonrasib, a potent oral RAS inhibitor, or traditional chemotherapy of the investigator's choice, reflecting contemporary clinical practice. The daraxonrasib group exhibited a median overall survival time of 13.2 months, compared to 6.7 months in the chemotherapy group. Daraxonrasib was also associated with a higher proportion of treatment response, longer time to deterioration based on patient-reported scoring of pain and overall health quality, and a lower incidence of significant adverse effects than chemotherapy.

Daraxonrasib itself operates via blocking KRAS (Kirsten rat sarcoma viral oncogene homologue), a protein which becomes overactive as a result of mutation in the RAS-G12 variant, subsequently driving tumour growth. The majority of mutations occur as substitutions at KRAS codon-12, leading to constitutive activation of RAS and accumulation of the guanosine-triphosphate (GTP)-bound state of RAS, known as RAS(ON). This is the primary mechanism of cellular proliferation in over 90% of PDAC, reflected within the RASolute cohort whereby 91.8% of patients were RAS-G12 positive, with RAS-signalling also playing a role in tumours lacking RAS-mutations. RAS-type oncoproteins, once considered 'undruggable', are now at the behest of a rapidly evolving landscape of RAS-inhibitors, with daraxonrasib representing a new generation of RAS(ON) multiselective inhibitors. This novel mechanism is capable of shutting off KRAS proteins irrespective of whether there is a KRAS-mutation present or not, and regardless of which variant it is. Importantly for patients, daraxonrasib achieves all of this as an oral medication, potentially mitigating the risk profile and quality-of-life impact associated with hospital visits for intravenous chemotherapy infusions.

In the world of clinical science where validation is often seen as a luxury, the standing ovation (with some audience members in tears) that the findings received at ASCO this year is truly emblematic of this positive step in what has been a decades-long battle of attrition. Dr Brian M. Wolpin, principal investigator for the RASolute 302 trial and Professor of Medicine at Harvard University, described the data as "unprecedented" and "practice-changing", with the consistency of outcome data solidifying daraxonrasib as a new standard of care in mPDAC. Thus, ensuring these trials' availability in the United Kingdom is critical, a sentiment echoed by Anna Jewell, Director of Services, Research and Innovation at Pancreatic Cancer UK:

"Crucially, these results suggest that daraxonrasib is able to keep the cancer under control for longer. There are now several KRAS inhibitor drugs in clinical trials around the world, which are showing promising results. We now need to ensure that these clinical trials are available in the UK, and that crucially these new treatment types are fast-tracked for approval, as recognised in the national cancer plan."

As I write this, RASolute 303, a 900-patient Phase 3 trial is being deployed across 12 sites within the UK, with principal investigator and clinical oncology lead at University Hospitals Birmingham Shivan Sivakumar, predicting that "the whole landscape of pancreatic cancer is going to change in the next couple of years".

Daraxonrasib is no magic pill, and pancreatic cancer has not received a cure, however patients and caregivers have been offered hope in the form of precious survival time, mitigating the quality-of-life impact of hospital chemotherapy infusions, and a more manageable side-effect profile. Perhaps by the end of this decade, the evidence-base for KRAS-inhibitors as the standard treatment modality for mPDAC will continue to flourish, and patients much like the one I spoke to with the hepatobiliary unit at St Thomas' will begin to feel the tangible effects of this breakthrough.

Palliative Care: What is it and what needs to change?

Tresa Martin **MBBS3**

In recent years, there's been increased awareness about palliative care facilities in the UK, and discussions regarding how palliative care fits in with the assisted dying debate. What are the current challenges in palliative care, and would overcoming these barriers mean that less people would support legalising assisted dying?

The aim of palliative care is to reduce suffering by managing medical symptoms and psychosocial issues, whilst setting goals of care. A common misconception about palliative care is that it's a hospice. Actually, hospice care is a type of palliative care service for people with a life-limiting illness, whereas palliative care focuses on improving quality of life and can be provided at any time. Research by Glover and Kluger (2019) suggests that the early incorporation of palliative care can lead to better outcomes such as improved quality and length of life.

Palliative care doesn't just take place in a hospital; it can be at home or at a hospice. For an ageing population, this is especially important, as more people will have an experience in palliative care. The benefits include "increased survivability, improved mental health and better symptom management" (Masters et al, 2024) and many people, including myself, believe that more funding should go into palliative care services so more people can benefit from this patient-centred care.

Palliative care benefits the NHS as a whole. Sleeman K et al. (2021) write that "there is strong evidence that palliative care can contribute to meeting the goal of reducing acute unplanned hospital admissions. This is incredibly important at a time when the NHS is faced with bed shortages and long waiting lists. Furthermore, because palliative care can allow some patients to remain in their own homes, it has potential to reduce the transition to acute hospital services. Reflecting on my own experience shadowing hospital ward rounds, I am aware that sometimes patients cannot be discharged in hospital because they may not have social support, despite being medically fit for discharge. Investing more in palliative care services and social care can allow these patients to be discharged from hospital beds and transition smoothly back into their own homes, which is more comfortable for patients and additionally would decrease waiting time for beds in acute medical wards.

A key question I want to bring attention to, is, what's supposedly 'lacking' in palliative care, that some people feel the need to bring in assisted dying, and can something be done to change this? One problem is that despite the fact we have free palliative care services on the NHS, some dying patients can still experience pain that cannot be relieved. It is incredibly difficult to watch a loved one live in pain, and lose their quality of life, and some people would prefer to choose how and when they die, even if that means it's sooner rather than later.

A systematic literature review by Jones et al. (2023) demonstrated some key issues with palliative care provision, notably a lack of resources - for example a lack of hospice beds - and also highlighted that the short GP consultation times weren't sufficient to address the needs of patients

with multiple comorbidities. GPs are already very pressurised in regards to time management, and when it comes to particularly vulnerable patients who need extensive palliative care, many feel that the support is not enough. Some GPs felt that they lacked the training in palliative care to provide care to patients needing it. GPs see a huge variety of patients every day, and perhaps more extensive training in palliative care is needed to provide the support that patients need in the community.

Some argue that we should be focusing on improving our palliative care system, rather than focusing on assisted suicide. There are concerns that the doctor-patient relationship could be damaged if patients feel that doctors may 'give up' on them, and patients, particularly the vulnerable and elderly, may feel that they are a burden, and feel pressurised into choosing assisted suicide. Some people remember the case of Harold Shipman, the serial killer doctor who murdered over 200 of his patients by injecting them with opiates, and some are worried that it would be easier for malpractice like this to take place under an assisted suicide law.

On the other hand, there have been many testimonies about relatives describing their loved ones losing their dignity and quality of life as they were unable to access assisted suicide, and people want to have autonomy over their death. We already have people in the UK, who can afford it, travelling to other countries in order to die by assisted suicide, so some argue that assisted suicide should be made available in the UK, so that everyone gets access to it.

For some healthcare professionals, the very idea of allowing assisted suicide seems to go against the core principles of medicine, such as 'do no harm,' as usually we aim to save life at any cost, and assisting a patient to die can seem like doing the opposite of caring for patients. For others, being able to support patients in whatever way possible, and stop their suffering, is very much in line with our core values.

Would maximum investment in palliative care services mean that the demand for assisted dying legalisation absolutely evaporates? I don't think so. Whilst more investment in palliative care may provide better quality of life to a huge number of patients, ultimately there would be some people who believe assisted dying is the best option for them. This doesn't mean that we shouldn't focus on improving palliative care- my point is that palliative care services should ideally be as well-funded as possible, with professionals who are confident in the care they are providing, so that when patients are facing a chronic illness or are near the end of their lives, palliative care is not a scary option, and it is an option that really supports patients in vulnerable situations and improves their quality of life as much as possible.

Hopefully more research can be done to keep improving our existing palliative care facilities, and provide personalised support for patients who need it, both in hospital and in the community.

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

Making the Most Out of Dental School: Tips for First Years from a Final Year!

Ariela Veizaj **BDS5**

Welcome to King's College London Dentistry!

My name is Ariela, and I'm a final year at KCL. Alongside my own journey through dental school, I have also spent the past four years helping students with their dental school applications. Over that time, I've noticed that many of the same questions and concerns echoed. So, here is some advice I wish I'd known when I started.

1. Don't let the degree define your whole identity.

Dental school can be very demanding and sometimes feel like it is taking up all of your time. However, I've found that the people who get the most out of the degree tend to be the ones who also have a life running alongside it.

Of course, you need to attend clinics and pass your exams, but this is also the time to enjoy yourself, make new friends, and dive into hobbies.

Your degree is important, but it is only one part of who you are. Looking back from final year, many of my favourite memories have nothing to do with the course itself.

2. Say yes to societies.

First year is probably the easiest time to experiment, and as a fresher you will have the opportunity to try out loads of different things. Definitely go to the freshers fair and sign up for things that interest you.

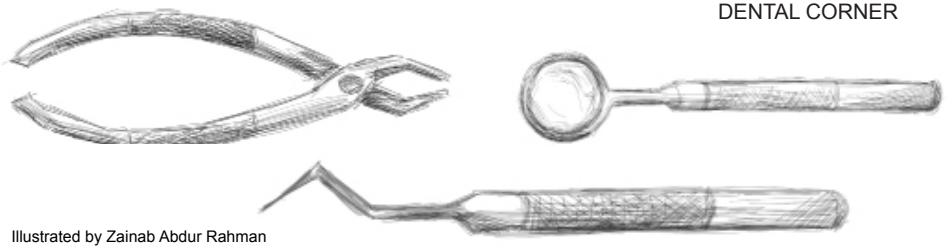
Societies are one of the best ways to meet new people and make new friends. Later on in the year, having something that gives you a break from clinics and studying also makes a huge difference to your university experience.

Don't feel that all of your achievements at university need to be dentistry-related. Getting involved in sport, for example, can open up opportunities that you might not expect. Many university sports have British University Championships, and depending on the sport, even beginners can find opportunities to compete at a national level. The point is, you never know where saying "yes" to something in first year might take you!

3. Find the study method that works for you.

Everyone tells freshers to "stay on top of it from day one," and while it's good advice, I don't believe it's particularly helpful on its own.

Spend the first term experimenting with different revision methods, note-taking methods, flashcards, study environments and routines. There is no "right" way to study, and what works for others may not work for you. The earlier you figure out how you learn, the better.



Illustrated by Zainab Abdur Rahman

By the time you reach your clinical years and your timetable gets busier, you want to already know what works for you. Don't wait for exam season to figure it out.

4. Slow now doesn't mean slow forever.

Dentistry is one of the few degrees where excelling academically is only a part of the picture. Manual dexterity is also a core element of the course, and develops through repetitions.

Don't compare yourself to other students and trust that speed will come with practice. Embrace the learning experience and treat dental school as what it is: a safe environment to take your time, make mistakes, ask questions and build good habits. You won't have the same luxury when you graduate.

5. Don't feel pressured to buy everything immediately.

New students frequently ask about buying loupes. My advice is to wait until fourth or fifth year before splurging.

Loupes can be a great investment, but only once you've developed your own working style. Use your first few years to build up some clinical experience and improve your ergonomics. Don't rush into buying expensive equipment before you work out what you want from it.

You also really don't need loupes from first year. Focus on developing your foundational clinical skills first, and when the time comes, you'll be in a much better position to choose a pair that genuinely suit you.

6. Feeling behind is normal.

Dental school is hard and everyone will have moments where they struggle. Don't compare yourself to others, and follow your own timeline.

If you are struggling, don't wait until things become overwhelming before asking for help. KCL has support systems and can implement practical measures to help you manage different aspects of the course.

Final thoughts

Dental school is a long journey. There will be difficult weeks and setbacks. Remember that you earned your place on a highly competitive course - you have what it takes to complete it!

You don't need to have everything figured out from the beginning. Take each year as it comes, give yourself time to learn, and don't be afraid to ask for help when you need it. Most importantly, enjoy the experience along the way.

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

Arts & Culture

H R H The Prince of Wales at Guy's Hospital, 1921

What Did We Know?

By **Dr Colin Stern**

Following a long and illustrious career as a Consultant Paediatrician at St Thomas' Hospital, Dr Colin Stern has cultivated an impressive literary repertoire of genre-spanning prose and poetry. He is the author of critically acclaimed works including *Listening to Mother*, A *Catafalque for Ann* and *Sailor-y-Pent*. *What Did We Know* serves as a submission from the man himself.

What did we know, when we began
To practice medicine? I know
That I knew little. Each young man
And woman needed time to grow.

Weeks passed, we watched, we learned to do
What others taught us on the ward.
Amazed that knowledge helped us through
To aid the sick, to health restored.

With luck, we added new ideas,
Assisted in fresh ways to heal.
Learned how to calm our patients' fears
And tried to sense how they must feel.

Toward the end of working life,
We knew we had acquired some skill,
Whether with stethoscope or knife,
Ambitions held we did fulfil.

Now, gathered here, some sixty years
Since licences were granted us,
We look back, happily no tears,
Knowing we weren't superfluous.

Where did the revolution in mental health care come from?

Will Bench MBBS1

Review of The Man Who Closed the Asylums: Franco Basaglia and the Revoluton in Mental Health Care by John Foot

If any at all, the word 'deinstitutionalisation' can conjure a singular picture of liberation of new age mental health, particularly for a green medical student. It's easy to think of mental health care as before and after the era of asylums, but as ever, the reality is more nuanced.

In The Man Who Closed the Asylums, by John Foot, son of the veteran Paul Foot, describes Italy's reform of the psychiatric system through the life of Franco Basaglia. Meticulously researched, Foot narrates how, after his own imprisonment, the psychiatrist Basaglia developed and legitimised a movement of critique of asylums which led to the legislation of Law 180, phasing out asylums in Italy. After his death, the Italian philosopher Noberto Bobbio, said that Basaglia was responsible for 'the only real reform in Italy's history'..

Foot's story begins with Franco Basaglia's arrival at the primitive psychiatric hospital of Gorizia in 1961, where he had been appointed Director. On his first day, Basaglia signals his intention by refusing to permit the restraint of patients - poetic in where he has come from and to where he will go.

Basaglia was born into a wealthy Venetian family in 1924, and qualified as a doctor in Padua. He then studied psychiatry and philosophy, also becoming involved in the anti-Fascist movement and in 1944 was imprisoned for 6 months in prison for related activities including covering the blackboards of the university with 'Death to the Fascists, Freedom for the people'.

His political education was accelerated in prison, particularly through readings of Erving Goffman, Franz Fanon, and Primo Levi - variously interrogating institutions and their impression on the body and mind. The relationship between confinement and power would be the thread making its way through Basaglia's career.

Later he would say arriving at Gorizia was like going back to prison. Only his charge had been anti-Fascism in Mussolini's Italy, and his patients', mental illness. This reflects his enduring slogan that 'la libertà è terapeutica" (liberty is treatment).

As Director, Basaglia manifested his recent literacy in Gramsci's 'march through the institutions' by utilising the power he hated the existence of to implement the change he wanted to see. He set about removing strait-jackets and other physicality of post-War Italian psychiatry. Patients were encouraged to write a magazine, socialise with doctors who no longer wore white coats, and go on outings. The revolutionary formed an eclectic 'Équipe' of dedicated staff who disagreed frequently but were united by looking outward to new approaches for patients.

Foot skilfully maintains a necessary critical distance, remaining alert to the dynamic but ever-present question of risk in psychiatry while also taking care not to romanticise the resistance that the movement for which Basaglia became a figurehead encountered from many. He describes an episode in which Basaglia and a colleague were tried (later cleared) for manslaughter of the wife murdered with an axe the day after one of their patient was released.

Basaglia later moved to Trieste, where his experiments in deinstitutionalisation became more visible. Here he began to open the asylum, progressively integrating individuals into society while emphasising the need to concurrently develop variations of community-based care including mental health centres, social housing and employment opportunities.

This work would culminate in Law 180, the 1968 mandate to prohibit new asylums being created, and to initiate the phasing out of current ones.

Basaglia's contention with treating Law 180 as a complete victory was that legal abolition is necessary but not sufficient to eliminate the downstream sociality of mental distress, including stigma. Foot emphasises it is here that deinstitutionalisation rhetoric can often fall short in overlooking the political and social commitment away from institutions necessary to make community-based care successful. We still see this today, and perhaps even more so, when conversations are understandably more concerned with limited resources, and can be defensive regarding the remit of services.

Nevertheless, this work on Law 180 was recognised as distinctive because it emerged from the collective activism of staff and institutional experimentation with evidence, and importantly resulted in a formal mandate.

Foot's skill is in both his detailed narrative history of a man and movement, as well as portraying this episode in the history of psychiatry as brimming with the critical reasoning we are reminded so often the importance of, to the extent the words can be removed of meaning. Basaglia asked questions of what he saw and used his directive to respond to the answers, always seeking to understand the life of the patient through a deeply sociological and humane lens, rather than a diagnosis.

The value of this book lies in its ability to describe the intricate history and practicalities of how the status quo can realistically and healthily be reimagined. The practices of Basaglian psychiatry remain controversial to some, and arguably overlooked in the Anglosphere, but well understood to be fundamentally and radically optimistic. This account is really a demonstration of institutional and structural determinants of health through the case study of a complicated man. A man who contained contradictions like anyone; a doctor who smoked heavily, and someone distrusting of power while ultimately using it to enact change. But a man who understood the insidiousness of individualising mental health, and the power of the collective.

Franco Basaglia, repubblica.it

Spinning Needles - Orientating the Moral Compass between East and West

Christine Yue **MBBS4**

The four pillars of medical ethics have long been hailed as the beacon of medical practice. To many, these golden standards that govern how we practice seem infallible, natural to us. The Farewell (Lulu Wang), directed in 2019, challenges us as medics to interrogate these assumptions and reconsider whether our definitions of right and wrong are truly objective. The movie revolves around Billie, a Chinese-American girl who returns to China with her family to visit her terminally ill grandmother, Nai Nai. With her American upbringing, she serves as a surrogate for western viewers as her ideals clash with her Chinese family. While the family hides the cancer diagnosis from Nai Nai, Billi is torn between telling the truth and respecting their decision.

The premise of lying to a terminally ill patient seems despicable at first, however the film expertly utilises this set-up to offer a nuanced exploration of the difference between collectivism and individualism. Multiple wide-shot scenes showcase the family as a collective front, gathered around the dinner table laughing, discussing a wedding, while concealing the gravity of Nai Nai's illness. The shared "secret" is only alluded to through fleeting glances and euphemisms. The camera frequently isolates Billie, cutting between her looks of discomfort and the expectant faces of her family, zooming back in on her as her words finally die on quivering lips. This contrast visualises her alienation and the ethical dilemma at the film's core.

Billie's parents justify the decision, saying they want Nai Nai to spend the last of her days happily without fear. Her mother recalls having to suppress her own grief in the past and urges Billie to do the same, and not to burden others with her sadness. Billie's uncle offers a cultural rationale, saying how in the East, a person's life is part of a whole, and that as a family it is their duty to carry the emotional burden for Nai Nai.

Death is seen as inherently taboo and the negative emotions associated are perceived as harmful. Family members in a collective context feel responsible for protecting one another, therefore decision-making is often shared. Happiness is prioritised even if it originates from deception.

This contrasts the western emphasis on individualism where personal agency is prioritised and ethical action at every small step is valued, regardless of emotional consequences.

These differing attitudes and interpretations of medical ethics extend into medical practice. In the film, Nai Nai's test results are disclosed not to her, but to the family who assure her she's healthy. When Nai Nai's health deteriorates, even the doctor himself lies and downplays the illness as per the family's wishes. The camera focuses on Billie and the doctor as they have a "secret" conversation in front of Nai Nai and the family whose confused faces are blurred out in the background. She points out that lying is wrong and that doing so would be illegal in American healthcare to which the doctor replies that if it's for good, "it's a good lie".

This begs us as medical professionals to reconsider how we interpret the pillars in light of cultural values and how we subsequently judge others on this. Lying to Nai Nai would go against the medical pillar of "autonomy", stripping her of the truth about her health and ability to make decisions for herself based on that information. On the other hand, medical professionals are also sworn to "non-maleficence" and "beneficence". It could be argued that knowing the truth would weigh heavily on Nai Nai and ultimately ruin her quality of life in her final period on earth.

This film underscores the differences in cultural mindsets between the East and the West in a medical setting; it challenges us to rethink to what extent moral values are objectively universal and right. By shedding light on cultural contexts and justifications for both sides, it invites us to re-evaluate how we practice medicine, to question what we truly prioritise and where we draw the line on compromising certain pillars/values in order to achieve others. The Farewell doesn't offer definitive answers to these questions, but serves to confront our biases and remind us that those practicing differently may not necessarily be wrong.

The Farewell dir. Lulu Wang (US, 2019)

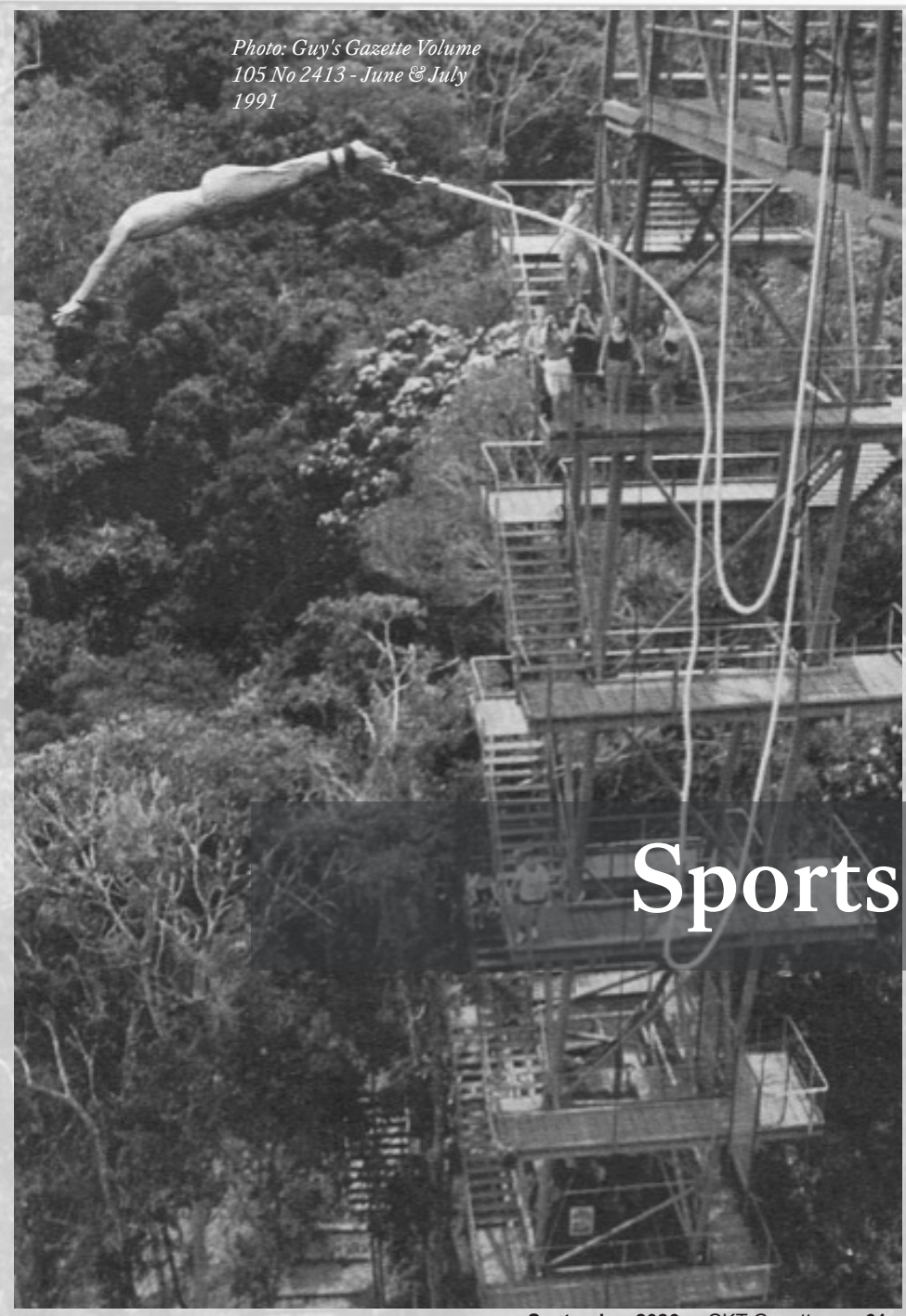


Photo: Guy's Gazette Volume 105 No 2413 - June & July 1991

Sports

25/26' at GKTMHC

Nayan Perera **MBBS4**

This year was a big one for the GKT Men's Hockey Club. As Freshers' Week came, GKT Hockey were at the Welcome Fair in Old Billingsgate and the MSA fair on Guy's Campus, speaking to plenty of new university students looking for a sports society to join. A healthy number of new students came along to the trials and have since weaved their way right into the fabric of the club!

During the opening weeks of the season, many in the club began visiting The Blue Maid on Borough High Street more often, as they were the new front-of-shirt sponsor. The revamped pub provided a great place for some early socials in the year and was the host of the most memorable challenges taken on by the committee for the Movember charity. A list of milestones for donations was drafted, and the charitable GKT members passed all of them. This meant committee challenges including buzzcuts, and blue moustaches were reached. But the longest was a 24-hour challenge in The Blue Maid, where some of our committee spent a full day in the pub (drinking a pint to remove an hour) and showed their true dedication to the charitable cause.

The hockey season was great for the club, with new members slotting into all three men's teams. The 3rd XI built on their success the season before and now sit on the precipice of a potential season one tier up this year. The 2nd XI also had a strong season in the league, and a thrilling cup run which unfortunately ended on penalties in the semi-final. The 1st XI playing in the highest tier had a challenging season but still ended with success winning the Macadam Cup (for

the 10th, or is it 11th time in a row?) in April in front of a crowd of the GKT Hockey Men's and Women's clubs.

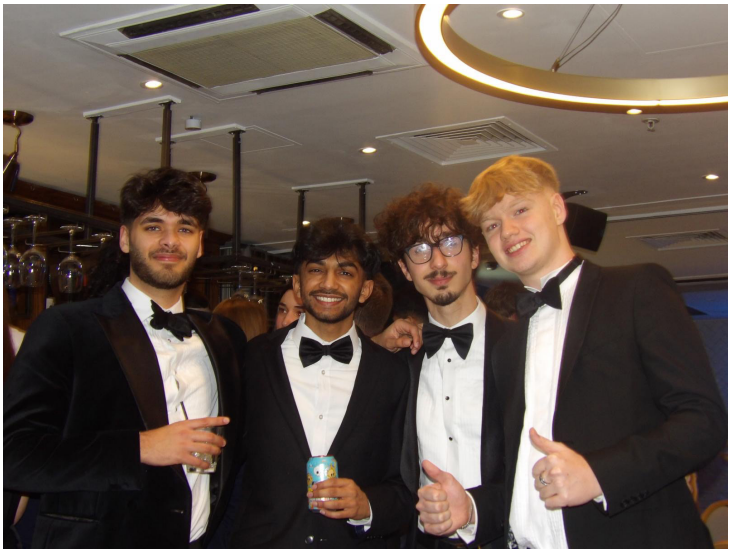
The club had fun and competitive seasons on the pitch, and off the pitch had some great socials throughout the year. The highlights include an excellent tour of Liverpool, an Alumni Ball and afterparty, an inter-uni tour to Southampton, endless Wednesday student nights at Guys Bar and a magnificent end to the 25/26 year with AGM in April.

This year also sees the departure of several bastions of GKTMHC, some of which have dedicated 5 or 6 incredible years to the club and have left a truly indelible mark on it. In the wake of the old guard leaving comes new and exciting leadership, spearheaded by Alexi Carver (Club Captain) and Ashwin Hull (Treasurer), alongside our new team captains Pratosh Atreyas (1XI), Jack Stig Anderssen (2XI), and Dan Irwin (3XI).

This is only a brief summary of an expansive year, but members new and returning made plenty of memories and achievements and await a new season returning to the club as university starts again and welcoming new students to the sport. If you are keen to be a part of the finest hockey club in London, whether you have never picked up a stick or you practically sleep next to one, catch us at the Welcome Fair and MSA Fair this September!

Graduates from GKTMHC:

Oli Moss, 1st XI
Alex Holmes, 1st XI
Arun Sarkar, 1st XI Captain 25/26
Rens Mijnhardt, 1st XI
Fintan Davoren, 3rd XI Vice-Captain 24/25
Jacob Egan, Treasurer 25/26
Rob Farquhar, 2nd XI Captain 25/26
Nick Solly, LUSL Captain 25/26
Ethan Buttery, 1st XI Vice-Captain 24/25
Sam Landells, Treasurer 24/25
Aqeel Mohamed, Treasurer 23/24
Sam Rawlins, Social Secretary 23/24
Jamie Krens, 1st XI Vice-Captain 22/23
Sahib Duhra, Alumni Secretary 25/26
Sam De Vaux, Club Captain 23/24
Sherief Benamer, Club Captain 24/25



Sidelined

Ayana Pathak **MBBS3**

At 11pm on Sunday 19th of July, I watched London pass by in vignettes: through the fluorescent-white glow of a kebab shop window, workers huddled around a small television. In high-rise new builds, young couples cosied up on couches in front of their 65-inch flatscreens. The teal flash of Deliveroo drivers weaving through the traffic - one eye on the road, the other on their phone screens. Teenagers racing past on Lime bikes through Rotherhithe; their phones propped up on their handlebars. The murmuring chatter of friends sporting their football tees in crowded pubs, spilling over onto the streets. I was driving across London, listening to the BBC commentary over the last 30 minutes of the World Cup Final.

This summer, a world so divided found common ground, if only for 90 minutes at a time. The tension before a match could be felt in the sticky smog of London's evenings; the relief, in the bus driver's smile in the next day's morning sunshine. Strangers embraced strangers over a shared shirt colour. Laughter floated up into still skies above the Prince of Peckham. Teammates understood each other perfectly on the pitch, despite not speaking each other's tongue. It seemed Football could unify us all. This narrative goes back to Winter 1914. British and German soldiers are said to have ceased their fire, no man's land becoming their football pitch in the midst of the Great War. Football was a medium that could transcend the barriers of language, race, nationality, and class. Could it transcend gender too?

Amongst the unity, a more negative discourse was playing out online – one where women's place in the World Cup was up for debate. This became apparent through the prevalence of misogynistic TikTok trends mocking women for enjoying football. One trend stood out to me, where men would ask a woman to name a footballer. If her response was too specific, it was met with suspicion – the insinuation being that another man had given her this knowledge, as though that were more plausible than her simply knowing the sport herself. This painted a bigger picture: a woman's intelligence about football was only legitimate once traced back to a male source. Her expertise wasn't allowed to be her own.

Growing up in southeast London, football was part of the culture that surrounded me. Footballs were kicked before assembly in the school driveway, banned from the corridors and played on floodlit pitches after the school day was over. Yet it often feels like football is a secret club that I'm only allowed to watch from the sidelines. There is a feeling of envy when watching men openly express their interest in football. They do not need to prove their passion for the game. They are not asked to name players,

cite statistics, or justify their presence. For men, loving football is easy – a sport they are encouraged to play, a community where their belonging isn't questioned.

So why are women not included in the football conversation? England's Lionesses have won the UEFA Women's Euro in 2022 and 2025 (1). Yet as recently as 2019, England's Women's World Cup matches drew barely a quarter of the viewers that the men's tournament did (2). Are we giving women the same platform as men when it comes to football? Closer to home, at Guy's Campus, GKTWFC committee members reflected on their own experiences with the sport. "Football culturally was seen as a rough and 'manly' sport," one member recalled. "Girls were more encouraged to do gymnastics, ballet or tennis." That divide, they said, hasn't disappeared — "there have been, and still are, so many barriers: cultural, societal, financial, that have hindered women's football." The problem, another member pointed out, reaches far beyond any one campus or country: "It's tricky globally to pass on the importance of women's sport, let alone women's football, which has been gate-kept from women throughout the world for decades."

Illustrated by Zainab Abdur Rahman

So, what can we do here at Guy's to even out the playing field? GKTWFC has already begun answering that question - creating a space for women to enjoy and play football, breaking records and overcoming stereotypes along the way. "Being part of GKTWFC means a lot to me," one member reflected. "It's a community that's encouraging, fun and motivating." Another put it more simply: "It means the world. You become part of a community that's bigger than yourself." With over a hundred new faces joining every year, GKTWFC's presence alone is breaking down barriers — not just through competition, but through a culture that values wellbeing as much as winning. As one member put it: "What I love is how we emphasise being the 'finest football club in the world' — it really brings a sense of pride, belonging and humour to the game. And it really is."

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Editorial Team

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Email: gktgazette@kcl.ac.uk
Instagram: @thegktgazette
Website: kcl.ac.uk/lsm/gazette

GKT Gazette,
Room 3.7, Henriette Raphael House,
Guy's Campus, London,
SE1 1UL

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Heres to another adventure...

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