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Changing Faces of Healthcare

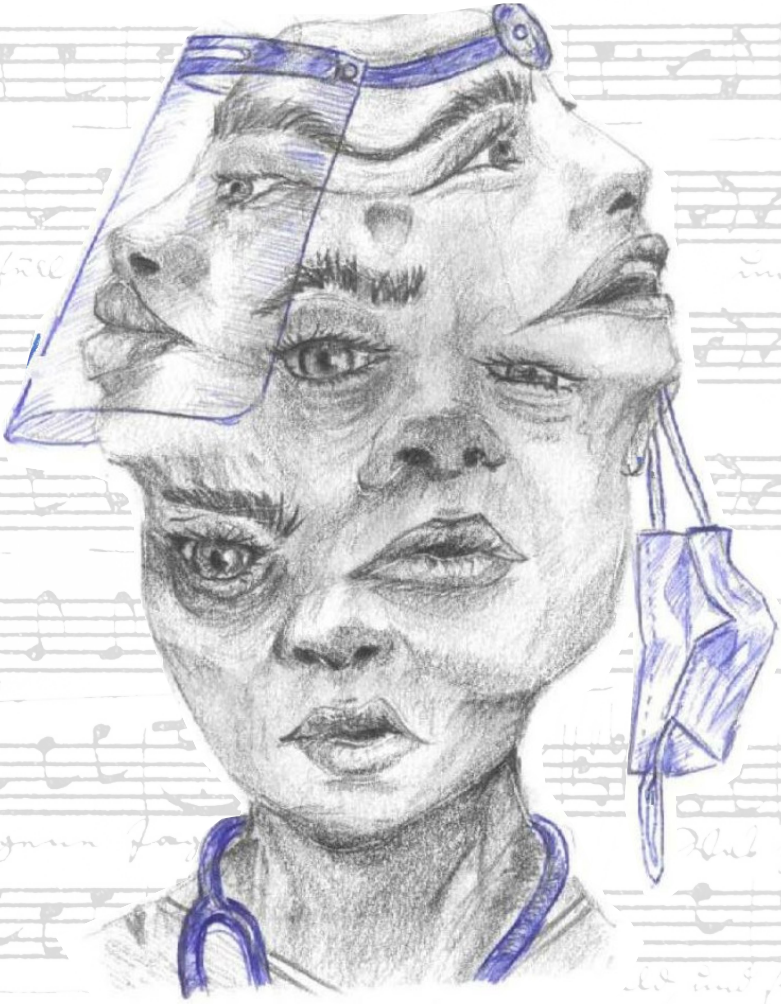

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Photo from Guy's Tower, Nayan Perera MBBS1

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Passim: Changing Faces of Healthcare

Editors - Arnav Umranikar & Morgan Bailey
MBBS3

Dear readers,

This issue marks the 1-year anniversary of the 133rd volume of the *Guy's, King's and St Thomas' Hospitals Gazette*. It is fair to say we are immensely proud of how the *Gazette* has progressed and are incredibly thankful to our board of trustees, our alumni readership, the staff support and the enthusiasm of our student colleagues. These, amongst other factors, have allowed us to restore the jewel in the crown of GKT.

And whilst we tend to resist changes to our *modus operandi*, we are continuing to listen to feedback and adapt accordingly. For this issue, we are proud to showcase our new section, *News & Opinion*, which will try and feature short-form bulletins - as well as longer commentaries – on news from within and without GKT. We hope this acts as a platform for student voices and discussion; voices which grow increasingly fainter in our world of rights and wrongs, black and white; less debate and more strife. We hope the *Gazette* remains GKT's canvas, and we cannot wait to showcase the rainbow we have painted.

We are also pleased to announce the return of our *Nursing Corner*, featuring pieces from the *Florence Nightingale School of Nursing*.

The theme, *Changing Faces of Healthcare*, should need little explanation. Unprecedented levels of strike action from our medical workforce. War in the Middle East. The Royal College of Physicians holding the 3rd ever Emergency General Meeting in its 505-year history, in response to the controversy surrounding Physician Associates.

As stressful and confusing our world-in-flux may appear, there is much to be hopeful about. And whilst we may be in the eye of the storm, let us not allow these barrages to erase our empathy, kindness and compassion for others – and for ourselves.

After all, it is better to give than to receive – *Dare Quam Accipere*.

Yours,

The Editors

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.

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

Letters to the Gazette

Professor Richard Phillips

Dear Sir,

I met RJWP early in my career, as part of my induction to GKT. It was immediately apparent how exceptional he was and how much everyone in the School relied on him as a knowledgeable colleague and source of considered and expert advice.

As my career with GKT progressed, Richard became a mentor as well as a friend. There was no such thing as a quick question or a five-minute chat, even during the most hectic of periods in the academic year, Richard was always kind and giving of his time, attention and experience. He had the respect of so many colleagues and other mentees alike.

Richard provided so much context about why things were done a certain way at GKT. The long history of the three medical schools before they combined as one, the aspirations for the preceding curriculum and the compromises that had needed to be made. All of these were invaluable insights as we followed a similar journey with Curriculum 2020. I learnt so much about his career as he told me how he had led this part or that Phase over the years. Only by putting the jigsaw together did it become apparent that Richard had directly touched the lives of so many colleagues and students in so many ways.

Many people would have been incapable of being anything other than protective of something they had cherished and managed for so long. Richard was always enthusiastic about giving advice about how to avoid the mistakes of the past and build on successes. He was honest in explaining compromises while accepting that contexts changed. It was during these conversations that he became my most cherished professional mentor.

Richard was not merely a mentor in the professional sense but also a true friend to those fortunate enough to know him. His boundless patience, unwavering support, and willingness to share his knowledge made him exceptional. Richard was the embodiment of compassion. He was always ready with a warm smile and an open heart. He had an uncanny ability to make people feel valued, cherished, and heard, no matter the circumstances. He always shared his love of opera and travel with friends and mentees, creating links that transcended the boundaries of work.

I will always remember Richard's kindness, his expertise and his generosity of himself. His absence will leave an irreplicable void in my life, his memory will be a source of inspiration.

Professor Chris Holland
Dean, Kent and Medway Medical School

Reader Correspondence

Dear Dr Lavelle and Sir,

I read, with much interest, your article in The Gazette about Hedley Atkins. As I qualified in 1969 so we must have been at Guys at the same time.

My father, also a surgeon, was a few years senior to Hedley and knew him well. I also met Sir John Coneybeare who was another of his contemporaries. It was these connections and my ability to play rugby that got me into Guy's. One of my sons followed me to the hospital, he also played rugger but was very bright as well!

I was a senior dresser on the firm in the summer of 1969 and much enjoyed the privilege. As you say Sir Hedley may not have been the greatest technical operator but he was an excellent teacher, although he once remarked " ...all I'm any good for now is to tell anecdotes!"

After I qualified I was fortunate to do a two week locum on Sir Hedley's firm. As I left Guy's, I felt bold enough to ask the great man for a reference for my first job. He graciously obliged. "This young man" he wrote "will make a splendid house physician".

Despite the fact that I had applied for a house surgical post, and damned by faint praise, I got the job. My ultimate destiny though was a happy life in rural general practice.

With all good wishes,

Robert Scholefield

Penguins Against Cancer: Penguin Peloton Fundraiser Appeal

The Penguin Peloton will be fundraising again for Penguins Against Cancer (PAC), this year the ride will start at Guy's Hospital Tower and finish at Blackpool Tower.

Over 3 days in early May, 40 riders, a mix of students and Guy's alumni, will tackle 250 miles with the aim of raising £50,000 for PAC.

To find out more and to donate, please follow the link at: penguinsagainstcancer.org.uk/events

Editors' Correspondence

A note to our readers,

Volume 133 will span the tenure of our appointed editorial positions, rather than reflect the changing year of publication. We hope you continue to enjoy Volume 133 of the GKT Gazette. Please continue to send in your thoughts and opinions on our issues and any articles for submission to our email (gktgazette@kcl.ac.uk) or postal address - we really do read every one of your correspondences. Watch our webpage (kcl.ac.uk/lsm/gazette) regarding news of some exciting projects we are working on behind the scenes. More to follow.

Yours,
the Editors

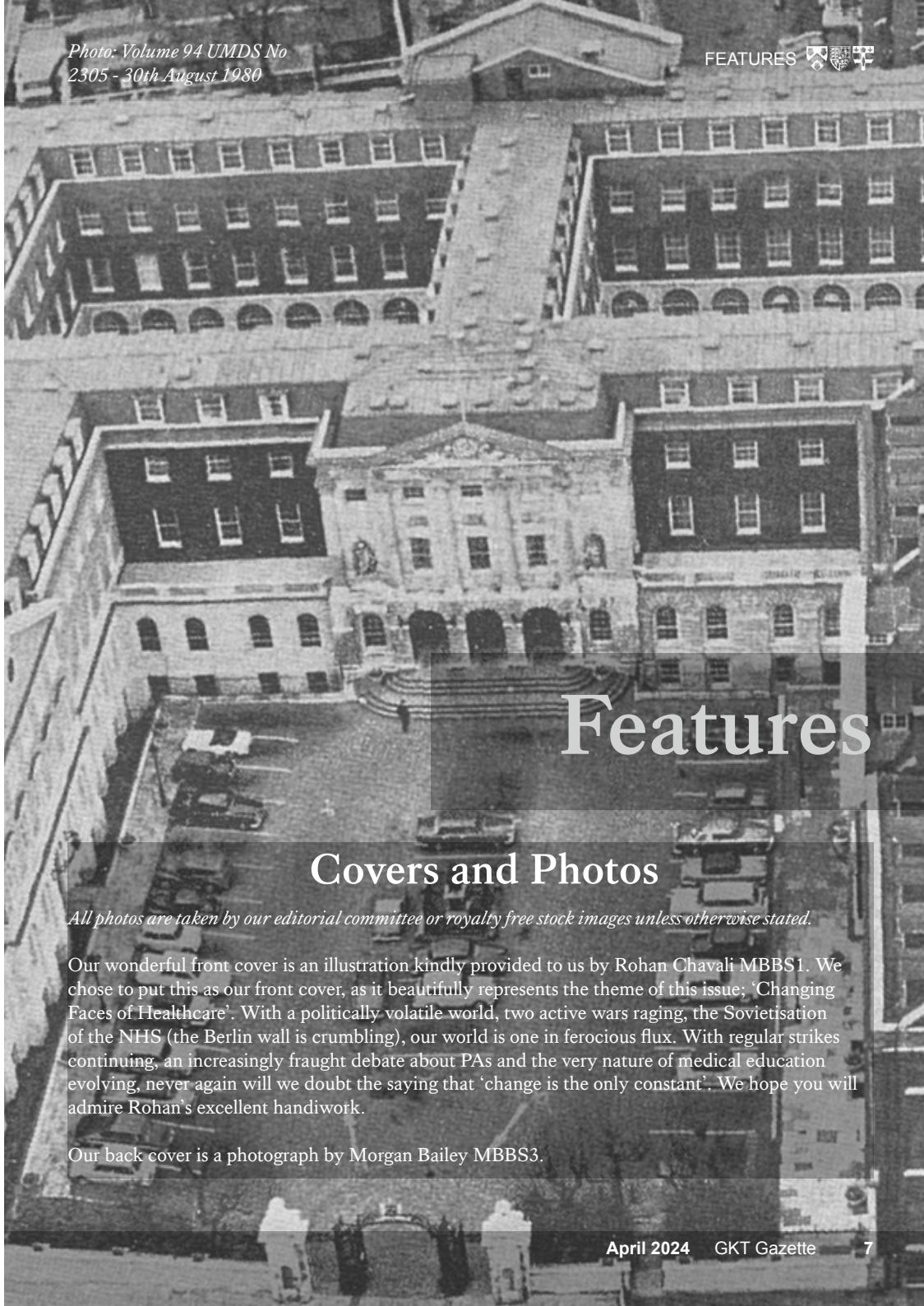


Photo: Volume 94 UMDS No 2305 - 30th August 1980

Features

Covers and Photos

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

Our wonderful front cover is an illustration kindly provided to us by Rohan Chavali MBBS1. We chose to put this as our front cover, as it beautifully represents the theme of this issue; 'Changing Faces of Healthcare'. With a politically volatile world, two active wars raging, the Sovietisation of the NHS (the Berlin wall is crumbling), our world is one in ferocious flux. With regular strikes continuing, an increasingly fraught debate about PAs and the very nature of medical education evolving, never again will we doubt the saying that 'change is the only constant'. We hope you will admire Rohan's excellent handiwork.

Our back cover is a photograph by Morgan Bailey MBBS3.

Healthcare in Gaza

The Pinnacle of Paradox

Noor Amir Khan **MBBS2**

The Gaza Strip: a 'graveyard for thousands of children'. [1] 85% of the population displaced from their homes. [2] 21,000 dead - and counting. [2] The numbers have reached such staggering heights that I, like many others, struggle to comprehend the sheer enormity that they possess beyond a flurry of flashing images, news headlines, threads of conversation and outcry. Yet, when given the opportunity to write for the News & Opinion Section of the Gazette, this tangled web of statistics and feeling was (and has been) the only subject on my mind. Consequently, the following article is not solely an inquiry into the health of the Palestinian people, but an account of my personal exploration of the topic - on an individual and collective level.

At present, the most recent escalation has undeniably led to a poorer standard of healthcare. With no functional hospitals in North Gaza [3], healthcare workers face an extraordinary amount of pressure as they re-evaluate the safety of medical interventions. The result: a self-perpetuating cycle of worsening healthcare as the scarcity of PPE for medical professionals, antibiotics and appropriate medical equipment increase the rates of sepsis and post-operative infections. A lack of anaesthetics, analgesics and other medicines also compromise patient care. Moreover, this feedback loop is only exacerbated by the environment. With a lack of fuel to power solid waste collection, insects, rodents and stray animals enter an already-failing ecosystem as vectors for the transmission of infection. Clean water is unavailable for many, leading to poor sanitation and hygiene, further increasing pressure for treatment as preventative healthcare measures fall short. As internet connection dwindles, sudden eruptions in disease trends cannot be effectively monitored, leading to a delayed response time. The interplay between these factors has given rise to a changing medical landscape with over 33,000 cases of diarrhoea and 54,000 upper respiratory tract infections, alongside an increased emergence of chicken pox, skin rashes, scabies and lice. [4] Ultimately, this vicious cycle rubs salt in the wounds of vulnerable patient groups - from individuals who are pregnant, immunocompromised or living with disabilities [5], to those requiring urgent operations or medical interventions. [4]

When interviewing Sarah* (a Palestinian Dental Student at King's) I received insight into how the health crisis in Gaza has adversely affected her friends and family. She shared the story of a friend's grandfather in Gaza: aged 82, a wheelchair user and patient who requires four sessions of dialysis a week for kidney failure. Under the current circumstances, this has been reduced to two sessions and, as of our last conversation, was threatening to be cut down to one. Forced to flee twice - initially from his home in North Gaza to Khan Younis Hospital and subsequently from the hospital to a refugee camp - he now lives in a "plastic-wrapped tent" whilst caring for his wife who lives with dementia. In normal circumstances, a change in environment for someone living with dementia decreases 'physical, mental, behavioural, and functional well-being,' resulting in higher stress levels and, at length, a poorer quality of life. [6] With two evacuations and the backdrop of war, this has been extremely distressing for the couple, to say the least. To make matters worse, her dentures are damaged, meaning she has limited access to food in a population where 93% of Gazan civilians are already facing 'crisis levels of hunger'. [7] With the decline in kidney function, increasing care needs of his wife, poor mobility and nutrition, the situation is clearly, in Sarah's words, "a living nightmare".

UPDATE: Sarah's friend's grandfather has now passed away due to lack of treatment. We are not currently aware of his wife's health status.

Whilst the quality of medical support being provided is suffering at present, this is only the tip of the ice-berg. The Dahlgren-Whitehead Rainbow Model (1991) maps the social determinants of health: a wide variety of socio-economic, social and individual characteristics that affect a population's overall healthcare quality. [8] Although many of these factors have been affected, access to healthcare services is a long-standing, deep-rooted issue in Palestine that has only worsened in nature.

After being diagnosed with gastrointestinal lymphoma and breast cancer in 2023, Sarah's grandmother's experiences have echoed this sentiment. The combination of the 'blockade of the Gaza Strip, presence of Israeli settlements in the occupied Palestine territory and separation wall around Jerusalem,' have resulted in a lengthy process as Palestinians navigate permit applications, limited transport and even financial insecurity in order to access the treatments they require. Many patients die in this limbo as they await a response for their application to receive medical care. [9]

Despite living in Hebron (which is much safer than the Gaza Strip), Sarah's grandmother was not exempt from this process. After acquiring the necessary permits, her journey began: waking up at 4am to set off via coach, bringing Sarah's uncle (her mandatory companion) and stopping at each checkpoint for the obligatory paperwork checks before reaching the hospital for 7am. With poor wheelchair access, many of the passengers (who are often cancer patients) have to be carried on and off, 2 hour delays occur frequently if an individual doesn't have their paperwork and financial burdens build as breadwinners take time off to accompany patients. After several expeditions, her breast biopsy was undertaken in Ramallah City, whereas her surgery and chemotherapy were completed in al-Mutala Hospital in East Jerusalem. In the aftermath of October 7th, however, she has not been able to receive the necessary follow-up care to monitor cancer resurgence.
As individual lives come to an end, years of continuous exposure to instability, conflict and displacement have been embedded within generations to come. With a 15-year old's lifespan covering five periods of intense bombardment, [10] the identification of over 800,000 children for psychosocial support (before the events of October 2023) is tragically unsurprising. [1] Many exhibit classic symptoms of PTSD such as bed-wetting, nail-biting, changes in temperament and disrupted sleep - as well as physiological manifestations through rashes and fevers. [10] This begs the question, however, of diagnosis - how can a patient have PTSD if the source of their trauma has not yet come to an end? In summary, even with a hypothetical end to the conflict, it is likely that a mental health crisis will be left behind in its wake.

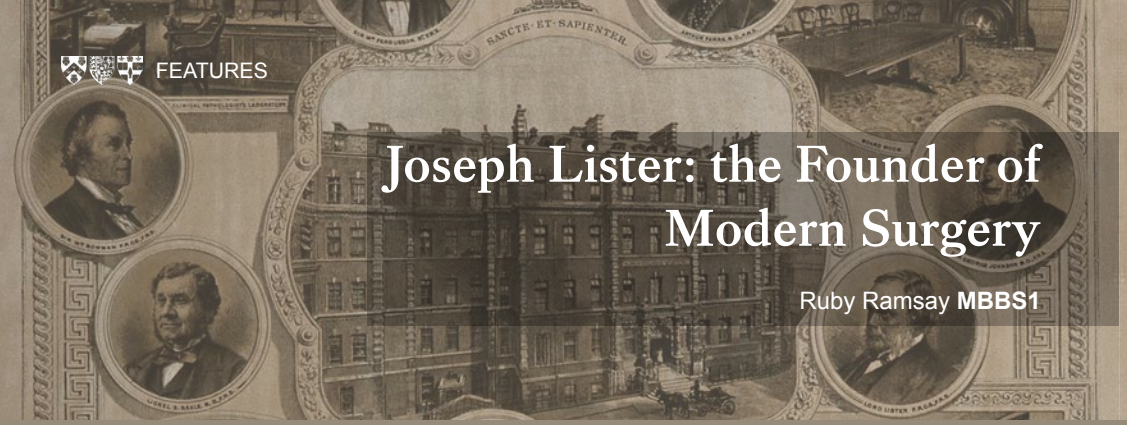
After embarking on this journey, I now see the healthcare system in Gaza as the pinnacle of paradox - a sort of man-made natural disaster where past, present and future come together. Decades of friction between tectonic plate boundaries (poor access to healthcare), the ongoing earthquake (insufficient healthcare quality) and the upcoming aftershocks (the spillage of physical and mental health epidemics into a post-war future), come to mind. Yet, as the Palestinians are caught within the net of a shattered medical infrastructure, they continue swimming to the surface. Ultimately, woven between their suffering and loss lies a resilient people, enriched by their love for their culture and community.

*Name changed to preserve anonymity.

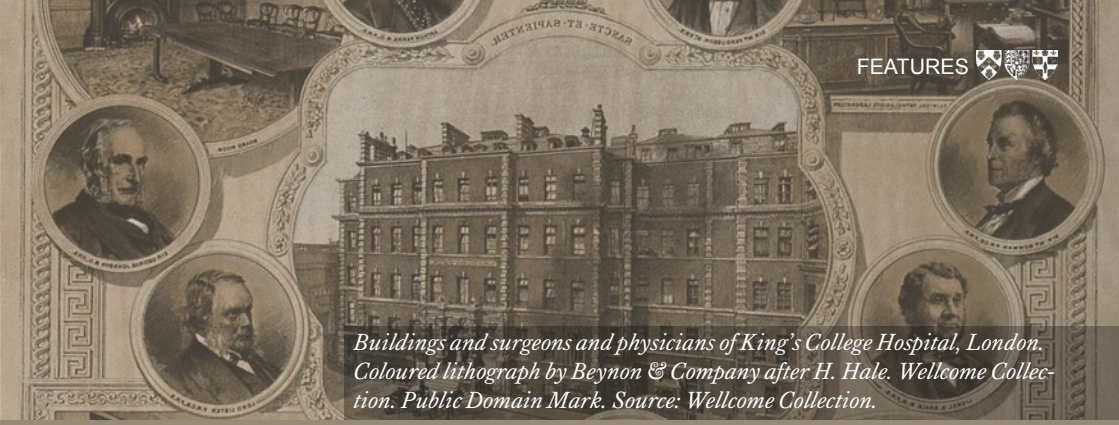
References are available on request at gktgazette@kcl.ac.uk

Joseph Lister: the Founder of Modern Surgery

Ruby Ramsay **MBBS1**



FEATURES



Buildings and surgeons and physicians of King's College Hospital, London. Coloured lithograph by Beynon & Company after H. Hale. Wellcome Collection. Public Domain Mark. Source: Wellcome Collection.

It is early 19th century London. Death and disease hang in the air. Rapid population growth has led to overcrowding. Over a third of the population live in absolute poverty. Cholera, Tuberculosis and Influenza torment Londons residents. Operating rooms are filthy. Hospitals are for the poor and depend on charity. The health of the nation is dismal.

It is also a time of progress and innervation. Chloroform has recently been established as an anaesthetic. Wilhelm Röntgen has discovered X rays, and aspirin has just been synthetically synthesised for the first time. Industrialisation, a sink and a source of health.

Joseph Lister was born in 1827 to a prosperous and educated family. His father was a pioneer in designing lenses for the compound microscope. Lister was encouraged in his study of the natural sciences from an early age.

By December of 1850 Lister had completed his preclinical medical training at UCL. Early on being identified as an able student. Leaving with many awards. Post residency at University College Hospital, becoming a house surgeon, Lister made a key observation.

During the autopsy of a young boy who had died of a blood poisoning disease Lister noted a yellow pus present at the humerus bone, through the brachial and axillary veins, ultimately finding multiple abscesses in the lungs. Lister concluded the multiple but similar pus sites pointed to a single origin of infection. An infection starting in one location and spreading throughout the body. Lister later described how his interest in

Joseph Lister, 1st Baron Lister [1827 – 1912] surgeon. Wellcome Collection. Attribution 4.0 International (CC BY 4.0). Source: Wellcome Collection.

germ theory and its relation to surgery sprung from the observations made here.
At this time, it is estimated that 1 in 4 patients died from infection on surgical wards. Surgical gowns remained unwashed, stains an identifier of experience. A characteristic stink hung in the air. Surgeons' hands were dirty. The airing out of the hospital was deemed sufficient to protect patients from disease.
In September of 1853, Lister arrived in Edinburgh to continue his training. By 1855 he became a lecturer. It was also here that he became a revolutionary. He began washing his hands before surgery, sterilising instruments and using a carbolic acid spray as an antiseptic in the operating theatre. He noted a marked drop in infection and a complete lack of sepsis on his surgical ward after the implementation of carbolic acid spray and antiseptic treatment of wounds. A drop in death due to infection from 46% between 1864 and 1866 to 15% between 1867 and 1870. A fantastic feat. The start of a global change in surgical practice.

This incredible feat did not remain unnoticed. Listers work was accepted both locally and in Germany, then a major pioneer of surgical innervation. Traditionalist London however remained unconvinced.

It is in 1877 that Lister accepts a position that will perennially link him to our institution. He undertakes the chair of clinical surgery at King's College Hospital. He had previously been critical of London medical teaching. A well-known divide existed between the North and South, based on the South's postulated lack of scientific grounding and over reliance on practical hospital medicine as opposed to Edinburgh's great focus on a strong scientific foundation. Two conflicting ideals in a world where reputation still largely overshadowed evidence.

He took the position on the proviso that he could radically change the teaching style of the institution, a condition that was met. In doing so he faced considerable friction from staff and students at the start of his position. Having previously talked poorly of the institution he was now a constitutive part of.

Arguably the catalyst to his later esteem was a revolutionary operation he carried out in 1877, wiring together a fractured kneecap. A new and high infection risk surgery that resulted in complete recovery. Something of a triumph. During his 16 years at King's College his operations were visited by many from far and near. His techniques became emulated and death from infection dropped drastically. He was celebrated in his lifetime and continued to be thought of as a key figure in the transition of surgery from a back street hobby to a safe and evidence-based process. Undoubtedly Lister was the founding user of antiseptics in surgery. Many see him as the founder of modern surgery itself.

Medical Students' Association Communities Week

Rabia Rehman **MBBS1 (EMDP 1B)**
Maheen Siddiqui **MBBS2**

This January, we held communities week to help fundraise money for the charities we are supporting this year in the MSA; Evelina London Children's Charity and Water Aid.

Evelina London Children's Charity aim to improve the experience that young people have in hospital by providing the money for innovation and better support for patients and staff. Water Aid helps provide access to clean water, education, and overall better hygiene! They have several projects in various countries to provide the most effective solutions.

We started the week off boxing in high spirits with KCL Amateur boxing society (our VP Ifrah threw a few punches too – releasing final year exam pressure in the right way?!?!) From simple warms ups to learning punches, and from friendly sparring practice to an intense sparring line-up (the timer and intense boxing sounds all setting the scene), the event was full of learning and thrill. Thank you to KCL Amateur boxing society for providing a great intro to our med students!

On Tuesday, we followed up with the coaster painting event, which made for a relaxing way to end a long day (a great gift idea as a bonus). We had all sorts of artistic masterpieces, including trees, landscapes, cats, and others! The room was filled with creativity (and lots of inspiration pictures from Google!)

We then ended with teddy bear making, a wholesome evening of crafting felt teddy bears to be donated to children! Even through the severe scissors shortage (which was eventually resolved thanks to a trip to Rymans and touring all the campus classrooms for stationary) and the room switch, the bears and bear makers both remained undeterred, and we ended up with some incredibly cute soft bears (which the kids will hopefully love)!

Finally, our events team led GKT Take Me Out to finish off the week. A full lecture theatre, incredible panellists, contenders, and cabbage-throwing skills made for one eventful night!

All in all, it was a week full of action, wholesomeness, laughter, friends and lots of memories and stories to reminisce on in the future! As if that wasn't enough, together, we also managed to raise an amazing £125 in support of our charities throughout the week. Thank you so much to everyone who so generously donated and attended our events, your support will be much appreciated by our charities!

Keep an eye out for further events we have throughout the year so we can continue fundraising for our charities and supporting the amazing work they do!

FEATURES

Examen Rex Est: the Tyranny of the Exam

Arnav Umranikar **MBBS3**

I can think of a few contemporaries who, on the face of it, seem to actively enjoy exams. You know, the folk who seem to skip every day of clinical placement the month before an exam, to 'optimise their use of time'. And where, I hear you ask, do they invest this most valuable of resources? The hallowed and august encyclopaedia of medicine; passmedicine.com. Even the name of that cornucopia is depressing; why is passing simply the ultimate ideal?

What's disconcerting, quite aside from fellow students, is meeting actual clinicians who seemed to have never escaped this exam-centric behaviour. It is sad to say that a lot of the teaching I have experienced can lapse into what is 'high yield' for exams. As if the point of my coming to medical school is to become an excellent exam sitter, rather than an excellent doctor.

The essence of what I am trying to strike at with these examples is the mind-virus that seems to derange many of us when the topic of exams flits across our subconscious. I don't for a moment want to pull any wool over any eyes and pretend that I, as some demi-god, am above this. The stress that exams bring with them, as well as the cost of not performing to the standard one would like or need to, are obvious and I don't wish to insult anybody's intelligence by elaborating any further.

But why should assessment preclude attendance to, what I consider, the real classroom, which is the ward or the clinic? Why should the purpose of teaching change, when exams come, go and are forgotten about? A conversation about a patient's existential experience of life and death and the limbo in between is far more enlightening than a generic vignette on a question bank or given to an actor in a simulated teaching session. A discourse with clinicians about their real-time reasoning of technically and emotionally volatile situations is more useful than preparing for a multiple-choice exam, where we don't get elaborative feedback anyway.

Forgive me for speaking anecdotally, and thence generalising, but it appears that those who show up to clinical placement are the ones who appear to actually want to become medical professionals. Which was, the last time I checked, the point of a medical school. One, perplexingly, hears chatter bandied about in regard to using the transferable skills a medical degree affords in order to throw one's weight around in Canary Wharf. As if said people believe that is the ultimate reason why they are in medical school; to juggle abstract, arbitrary financial instruments on the one hand and funky pills and wacky powders on the other. But I digress...

We are, of course, required to attend our placements, not least through the use of portfolios. The ploy of using signoffs is an extremely deep-rooted one and precipitates a cynical, transactional relationship between clinicians and students. This neurotic addiction of completing signoffs is depressingly universal. To the point where, having introduced myself to a surgeon in a clinic, one of the first things I was told was along the lines of 'Let's try and get your examination done on the first patient, so you can go off and enjoy a breakfast and coffee'... He seemed to think that, like blackmailing an addict with a fix, he could shut me up, buzz me off and continue his clinic 'fuss-free'.

Perhaps it's experiences like that, that dissuade students from coming to placement. Clinicians make everything about assessments, which then causes the students to internalise this and emulate them, which no doubt amplifies the original attitude of the clinicians when teaching them. The vicious circuit must be broken.

*

These problems, I am sure, are no doubt relatable or at least familiar. I don't propose a solution, indeed perhaps the conundrum is insoluble. I may take this opportunity, however, to provide a possible contributor to the formation of this rot.

Exams can rather be characterised in a similar way to how Winston Churchill characterised democracy; 'Indeed, it has been said that democracy is the worst form of Government except for all those other forms that have been tried from time to time....' It is the least-worst system; thence I'm not advocating for the abolishment of them, but for a lack of emphasis on them.

Particularly so when the new set of Progress Tests introduced into the 2023/2024 academic year to better mirror the Applied Knowledge Test prioritises more rote, and less genuine reasoning. It is odd that in the age of the 'Artificial Intelligence Revolution', it hasn't crossed the exam board's mind that a mindless task like learning guidelines can be done far more efficiently by a Large-Language-Model, like ChatGPT, than our monkey minds. Whereas the domains of human intelligence, at least as of now, are completely negated; creativity, thoughtfulness, and the synthesis of disparate areas of knowledge.

I was leafing through Randolph M. Nesse's and Richard Dawkins' (of 'The Selfish Gene' repute) excellent chapter titled 'Evolution: Medicine's Most Basic Science' in the 'Oxford Textbook of Medicine 6th Edition'. The following passage caught my eye;
''Physicians are increasingly being educated as if they are technicians, identifying problems and applying officially approved solutions. This makes very poor use of medicine's most valuable resource. We select medical students carefully

because we want—or should want—doctors who think.''

The current system betrays this ideal. Wouldn't an essay style examination system, or a viva voce, better equip us for real life, and be more challenging, engaging, and interesting? Make us actually think a bit more. I don't expect any change to occur, mind you. The medical school will rebut by saying the scale of such an operation would be far too large and costly to implement. As if it would be very different to administrating an OSCE, or more costly than the hundreds of thousands of pounds they wire to the Excel Centre for siting our Progress Tests.

More broadly, medical schools need to think about whether they are prepared to dilute the calibre of their doctors. They are doing this because they need to get more doctors to graduate, and are lowering the bar to doing so, probably at the behest of HM Government. Quite apart from the mediocrity of this 'lowest-common-denominator' thinking, such a solution isn't going to stem the gaping holes that the NHS is haemorrhaging from, as its medical graduates flee towards the New World or Down Under.

Ultimately, all of this takes the pleasure out of learning for the enjoyment of learning itself, which I hope you will agree, is a great pleasure indeed. Knowing for the sake of knowing is a wonderful thing. As that greatest of wits, Oscar Wilde, once wrote; 'all art is quite useless'. We must also heed Galen's words 'that the best physician is also a philosopher'; a lover of wisdom in the etymological sense of the word. It is only through a recognition of these ideals that we can hope to vanquish the tyranny of the exam.

*

Finally, may I indulge in some etymology? You may have noticed the title of my article and wondered why I named it that. 'Rex' in Latin means 'king'; which is where we get the derivatives; 'regal', 'regnal', 'regalia', 'regicide', among others, I am sure. 'Tyrannus' in Latin, derived from 'tyrannos' in Greek is where we get the word 'tyrant'. Though we associate this latter word with cruel, greedy despotism, in the classical world, the former was a general term for the ruler of a 'polis', which was the general term for a Greek city state. As an aside, the word 'polis' is where we get the words 'politics', 'policy' and 'police'. Asides from making you look really cool at cocktail parties, all of this might deepen the meaning of words like 'tyrannosaurus rex', 'cosmopolitan' and 'metropolis' that we would otherwise glaze unknowingly over.

I will take this opportunity, for those who have made it this far, to point readers in the direction of the lexicographer Susie Dent and the polymath Stephen Fry, who do such wonderful things with words.

Dental Corner

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

The Art in Dental Precision: The First Stepping Stone to Becoming a Dental Professional

Abigail S. Q. Cheong **BDS2**

Abstract

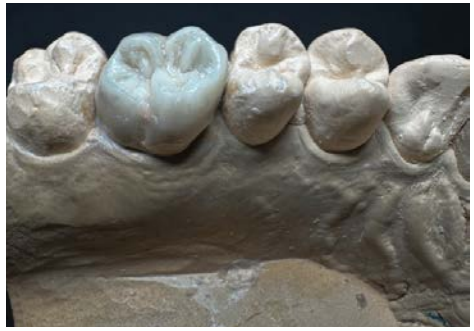
Waxwork, a fundamental and artistic skill in dentistry, marks the initial transition from the theoretical to the clinical side of dentistry. Consisting of wax-ups and wax carving, waxwork is often the first opportunity for students to hone their manual dexterity skills needed as a clinician when working in the small oral cavity of a patient. Waxwork is often regarded as a valuable skill in dentistry as it mirrors the meticulous craft of sculpting restorations (or shaping in the case of composite) to precisely reinstate the shape and function of broken-down teeth affected by caries or fractures.

More than half of a general dental practitioner's workload could involve the replacement or repair of existing restorations (1), and in cases where practitioners are unable to shape or carve direct materials accurately, the resultant restorations have limited durability, potentially shortening the lifespan of treated teeth.

One goal of dental professionals is to save healthy teeth through the restoration and maintenance of occlusion, function, form and aesthetics. There are transferable skills between those required as a dentist to carry out these necessary restorative procedures and those that can be refined through waxwork. In this article, I aim to focus on the link between waxwork and clinical skills, highlighting its importance for dental students as the first stepping stone to becoming a dental professional.

Figure 1. Wax carving of a mandibular right canine. Taken from Instagram @ abicheong

Figure 2. Wax-ups of a maxillary right first molar. Taken from Instagram @ abicheong.



Introduction

The two major techniques used in tooth waxwork are firstly, tooth-orientated techniques whereby a whole tooth is carved from a wax block (see Fig. 1), which assists the students in acquiring knowledge of the basic shape of each tooth. The second is wax-ups (see Fig. 2), an additive technique which uses tooth landmarks differentiated by contrasting coloured wax on articulated sets of models. This technique begins with the placement of wax cones, indicating cusp tips, in the correct location relative to the adjacent and opposing teeth, followed by cuspal, marginal and triangular ridges with the gaps filled in between. As occlusion and articulation with the opposing dental arch are constantly checked throughout the exercise, the tooth carving technique allows for a greater appreciation for the occlusal morphology of teeth.

Similarities between waxwork and direct restorations:

Amalgam restorations

These require the over-packing of amalgam material into cavities followed by the intricate carving of fissures and fossae to attain the anatomical form within the tooth cavity. This process draws parallels with the precision needed in wax carving, where a dental carver (a double-ended surgical instrument) is utilised to carve and contour the wax in precise angles, mirroring the distinctive cusp and fissure patterns inherent in human teeth.

Composite restorations

As an illustrative example, the art of wax-ups (see Fig. 2) embodies akin proficiencies found in composite restorations, whereby composite material is placed incrementally within the cavity to restore the original form of the broken-down tooth. Once tooth margins are established, attention can be directed towards forming the fissures through specific placement of molten wax droplets. As with any other skill, this attention to detail and execution improves through repetitive practice and continuous refinement in laboratory sessions. Consequently, I consider laboratory sessions essential as they complement the content taught in tooth morphology lectures.

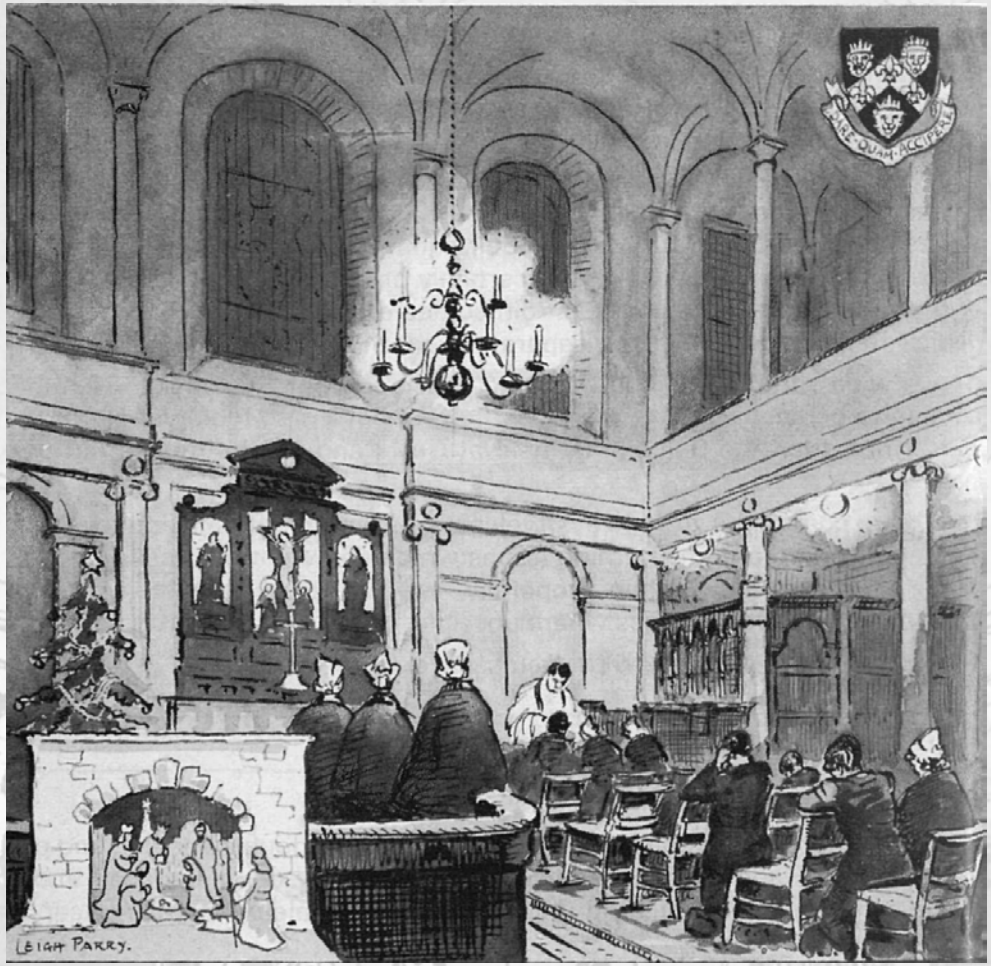
Discussion

I believe that, in preparation for the restoration module, dental students would benefit from getting early exposure in laboratory wax sessions and practising with dental tools alongside tooth morphology lectures, to improve manual dexterity skills and shape them into becoming better clinicians. Moreover, practical laboratory sessions present a faster avenue for students to grasp tooth morphology, as proposed by the constructivist learning theory. The resulting increase in the student's confidence and competency in tooth morphology, will enable them to become more efficient in practice, consequently improving clinical standards and increasing patient satisfaction.

Conclusion

Waxwork has improved my 3D perception and capacity to conceptualise the intricate dimensions of teeth. This has proven instrumental in facilitating the transition from theoretical tooth morphology lectures to practical restorations in clinics. It has helped me to cultivate an appreciation for dental irregularities and provided a learning platform to be taught by skilled technicians. This hands-on experience has solidified my understanding of tooth form, enabling a swifter application of lecture content to practical tasks due to an improved visualisation of basic tooth shape, thickness and proportions. The practice and repetition of waxwork refines a student's 3D perception and ability to look at tooth form as an art, as opposed to a technical set of mathematical angles and measurements which I have found to be less useful following the initial stage of understanding basic tooth form. Honing the transferable skills collated in waxwork and mastering precision on an isolated wax tooth takes us one step closer to carrying out more complex restorations, and is an important stepping stone prior to performing aesthetic restorative procedures on real patients.

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



Nursing Corner

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

Doctors and Nurses Relationship

Jessica Mulligan **3rd Year Adult Nursing BSc**

The relationship between Nurses and Doctors can be a complicated one. However, unlike in most TV shows the complications do not come from secret affairs. The difficulties come from an effective nurse-doctor relationship being central to positive patient care.[1] There are so few professions requiring colleagues to maintain the standard of respect, trust, and joint decision-making required from all the members of the multi-disciplinary team which is made no easier by the current short staffing, waiting lists and lack of lunch breaks.

The dynamic between nurses and doctors is always changing and evolving. Historically, doctors had a lot more dominance and control over nurses than in current practice, but this is still a strong stereotype. One of the central causes was that as medicine was being developed doctors were responsible for teaching and hiring nurses.[2]This created an unbalanced power dynamic where nurses were just there to help the doctors.

This dynamic was intensified by some of the theories published on how nurses and doctors should interact. For example, in 1967 Stein published a paper titled 'The doctor-nurse game'. The paper stated that when a nurse or doctor wants to make a suggestion neither should act as though they want to make a suggestion. The theory not only created a further divide between doctors and nurses but could risk patient's safety.

However, since nursing became a university degree in 2009, the level of training and responsibilities of nurses have continued to increase, with new nursing roles continuing to be created. For example, student nurses are taught a variety of cardiac assessments, allowing them to aid in the diagnosis of patients, which they were not able to do before. The evolving role of nurses has contributed to the developing dynamic between nurses and doctors as responsibilities change meaning nurses and doctors can

support each other in new ways.

Furthermore, to further understand people's experiences of the dynamic between healthcare professionals in practice; nursing, midwifery and medical students shared some of their experiences on placement.

"There are all kinds of stereotypes on which speciality of doctors are antisocial or arrogant, but truthfully you can't know someone until you meet them. I've had doctors who act like I'm an idiot, but I've also had that from other nurses, pharmacists, physiotherapists, and everyone you could meet in the hospital. So, however fun it is to joke about doctors being annoying the majority are willing to listen to your suggestions and answer any questions. At the end of the day, we are all a team for the patient, with different roles to play. A nurse is a medical professional who is with the patient all day, so their knowledge and ideas should be respected. The same as how a doctor's knowledge and ideas should be respected and by working together the patient has the best chance at a positive outcome" – 3rd-year student nurse.

"I know I'm a medical student but some of the best tips I've had have been from student nurses and nurses on wards where I was too nervous to talk to the consultants. The stereotype of nurses is that they are kind and caring so I find them more approachable than some of the doctors I've had placement with. However, some of the nurses I have met have been so rude. I understand that people can have bad days and the stress of the NHS can make that worse, but some nurses can just be mean. This is the same for all allied health professions, there will always be people who are just mean. I just try to remember that for every mean person I come across, there are five who are there for the patient and will be willing to help." – 2nd-year medical student

"Midwives are specialised medical professionals who are trained to look after mother and baby. So, when doctors just come in at a complication, they don't know them like the midwives who have been there all day do. So, when doctors have just come in, set out the standard plan and not asked any questions they completely miss that the mum may refuse that because of her preferences. However, on a positive note, I love it when doctors ask your opinion in an MDT meeting. It makes you feel like a valued member of the team. Everyone in the meeting should feel like their contribution is valued because they are there for a reason. Also, everyone being able to and feeling confident will help create a more person-centred care plan for the mum." – 3rd-year student midwife.

"I feel that there is definitely an ingrained societal superiority complex of doctors over nurses even if that is not true of every doctor or nurse. However, I feel like it can also go the other way. For example, some nurses and other allied health professionals can assume that doctors and medical students are rude from the offset." – 4th-year medical student.

In conclusion, the relationship between doctors, nurses and the interdisciplinary team has always been complicated. However, all challenges can be overcome through teamwork and maintaining the patient as the priority.

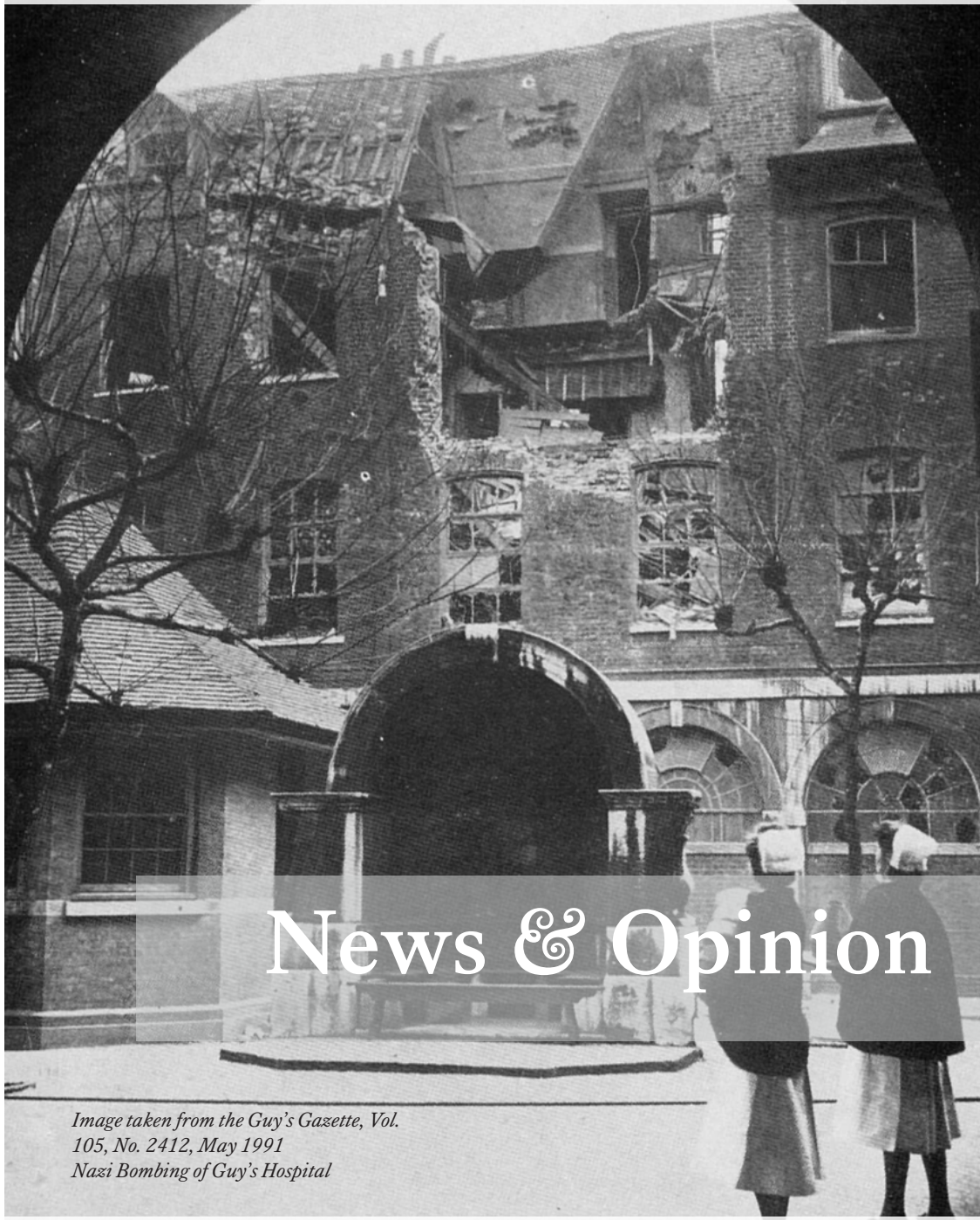
References available on request at gktgazette@kcl.ac.uk

Online Friends Shop

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

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

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



News & Opinion

Image taken from the Guy's Gazette, Vol. 105, No. 2412, May 1991
Nazi Bombing of Guy's Hospital

GKT School of Medical Education Faculty Update

Professor Nicki Cohen **GKT Dean of Medical Education**,
Dr Sam Thenabadu **GKT MBBS Programme Director London** and
Dr Russell Hearn **GKT MBBS Programme Director Portsmouth**

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

Here at GKT, we have been busy working on several projects to improve learning and the student experience for GKT students.

As part of this, we have been progressing with exciting plans to open a branch campus for 54 graduate entry medical students in Portsmouth, working with colleagues at the University of Portsmouth and associated clinical sites. To support this work, Dr Russell Hearn has been appointed as MBBS Programme Director in Portsmouth. Dr Hearn is a Reader in Medical Education at King's College London, a GP Partner in North London and Primary Care Dean for NHS England. In sharing our world-renowned expertise in medical education, we will be helping to address healthcare in an area with some of the lowest number of doctors per patient in the UK, particularly in Primary Care. Training doctors in the area will increase the number of doctors who learn, train and remain in the area for their careers.

The branch campus will follow the same curriculum as our London programme. As an institution, UoP is particularly highly regarded for its simulation learning in allied health and for interprofessional education. Working with the University of Portsmouth we will incorporate Case-Based Learning in both cities to enrich the learning experience of all students. The first few cohorts of KCL students in Portsmouth will have the privilege of belonging to both universities. In the long run as the new campus curriculum develops the University of Portsmouth will be seeking to open its own independent medical school in the next 5 years or so with our support.

In London, the MBBS programme continues to strengthen. Dr Thenabadu, a Reader in Medical Education and Honorary Consultant in Emergency Medicine at KCH, comments that the post-Covid world remains a very busy one for academics and clinicians. But, that the appointment of new directors for Quality and Student Support, a Reader in MBBS Assessment and school leads for Inclusive Education and Careers, has brought renewed energy and innovation to the faculty with an exciting, shared purpose.

Furthermore, the curriculum refresh has confirmed exciting changes across the programme for next academic year, including a reading week in Stage 1 semester 1 for students to take stock of their first 2 months at university; more focused physiology and anatomy and a Projects fair in the latter weeks of Stage 1 to showcase the wonderful opportunities that lie ahead.

The refresh also recognises the challenges students feel in learning the profession, and we are developing a new block 'Transition to Clinical Practice', collaborating with current students and clinical colleagues, to introduce core aspects of this transition. In Stage 2 every student at all sites will have a Clinical Tutor to deliver bedside teaching through the 2nd year around the core history and examination topics in medicine and Case-Based Learning.

Finally, community remains at the heart of what a GKT doctor is. The desire to respect and value identity has been a core driver this year with the "Hello My Name is" badge campaign extended to all years of the programme and the option to add pronouns on badges and email sign offs. A 'name-coach' function has been supported to add the pronunciation of your name to your sign offs and faculty and students alike have embraced this.

The new updated GKT vision statement will, we hope, fill all with a sense of shared purpose – 'GKT shapes its graduates to be doctors who are compassionate, critical thinkers, making a positive difference across society'. A busy year for all involved with the school, *but* with an even more exciting one ahead.

The Sterilisation of Guy's:

the Large Committee Room becomes yet another lifeless classroom

Morgan Bailey **MBBS3**

The Large Committee Room, tucked behind the General Classroom in the Hodgkin Building, has almost overnight been stripped and converted into an indistinguishable sterile classroom as of April 2024.

Previously it had been home to original handmade tables and chairs, a hand-woven carpet brandishing the Guy's Hospital Coat of Arms, and a grandfather clock gifted by a student in the 18th century – all illuminated by a canopy of glass chandeliers. Many a historic occasion took place in the room, including the decision to merge Guy's with St Thomas' Hospitals medical school, forming United Medical and Dental Schools of Guy's and St Thomas' (UMDS) - the precursor to our beloved GKT.

At the Gazette we are disappointed to see another piece of history befell to the blob that is the King's corporate and sterile brand. Had we been located upstream on the Thames, or perhaps on the river Cam, I am certain the room would still be alive today.

On the plus side, the Gazette is aware that the portraits and furniture have been relocated to storage by the Guy's and St Thomas' Foundation, who are the purveyors of most historic artifacts on our historic Guy's Campus. We are currently unaware of the location of the carpet, or if it will be retained.

To discuss the conversion of the Committee Room further, I had the opportunity to speak to the King's Estates, the guardians and bastions of our buildings and spaces. The message was clear: whilst there is recognition of the importance of maintaining our history, there is a clear need (with a simultaneous lack of) space that is both functional and accessible to a variety of students.

The Gazette recognises this challenge, in addition to the good work achieved at St Thomas' House, which has blended the old with the modern, and retained parts of the original oak panelling. Though much of the historic signage and furniture has similarly been relegated to storage at Guy's and St Thomas' Foundation archives.

The 300th anniversary of the first patient at Guy's Hospital is next year. Much of what was – and what is - is at risk of being lost and consigned to the pages of the Gazette. We implore students to stand firm to protect our buildings and history.

Do you agree or disagree?
Please send your thoughts and opinions to gktgazette@kcl.ac.uk for consideration of publication in subsequent editions!

Professor Richard Trembath, Executive Director of King's Health Partners announces plan to step down

Jade Bruce **MBBS4**

Read our interview with Prof Trembath in our 150th Anniversary edition (March 2023), available at kcl.ac.uk/lsm/gazette

At the start of 2024/5 academic year, Professor Richard Trembath will step down from his role as Senior Vice President for Life Sciences and Health and Executive Director of King's Health Partners.

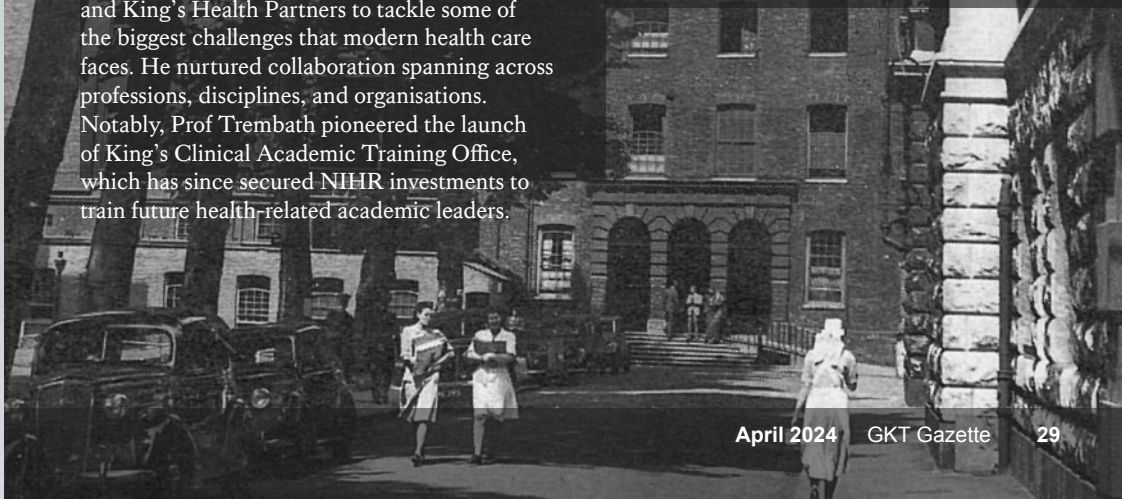
Prof Trembath studied Medicine at Guy's Hospital Medical school, and subsequently trained at the Institute of child health before moving to the University of Leicester (1992) where he was appointed as Foundation Chair of Medical Genetics. Prof Trembath is a world leader in the field of genetics, focusing his research on identifying human disease genes using a range of technologies.

During his time as Executive Director of King's Health Partners Prof Trembath supported KCL and King's Health Partners to tackle some of the biggest challenges that modern health care faces. He nurtured collaboration spanning across professions, disciplines, and organisations. Notably, Prof Trembath pioneered the launch of King's Clinical Academic Training Office, which has since secured NIHR investments to train future health-related academic leaders.

Moving forwards Prof Trembath shared:

"I look forward to working closely with the KHP Board, Executive and university leadership, particularly as we implement KHP priorities in Personalised Health, Digital Health and Data Sciences and Population Health, widen the scope of our Mind and Body programme and expand our educational and training support."
"Thank you to everyone across the partnership for all that you continue do to support the aims and ambitions of King's Health Partners, as we seek to improve patient care and health outcomes."

As a long-time supporter of the Gazette, we wish Prof Trembath the best of luck in his next role.



KCL Announces New Graduate-only Medical School with University of Portsmouth

Charlotte Mulcahy **MBBS4**

On the 13th of December, KCL announced a partnership with the University of Portsmouth to deliver a 4-year graduate medical course through their branch site – a campus located outside of London. The decision to collaborate with Portsmouth was in response to a severe shortage of General Practitioners in the area, as well as the nationwide growing demand for NHS doctors.

A graduate entry medical programme (GEM) differs from the classical medical degree as it takes only 4 years, compared to the typical 5 years. At KCL they only accept students who already have a degree in a Bioscience subject, although some medical schools accept a wider range of degrees. This allows students who do not get into medical school at 18, or students who develop an interest in the profession later in life to train when they are older. Upon graduation, students obtain a medical degree, like students taking the traditional route. KCL, and numerous other Medical Schools, have ran similar programmes for several years, but this expansion means the number of places on the KCL GEM programme will rise from 23 to 77.

Current GEM students at KCL receive centralised teaching at Guy's campus and attend clinical placements in hospitals across South London. The students enrolled on the new course co-delivered by the University of Portsmouth will receive their teaching at a new branch campus in Portsmouth and will attend hospital placements in Portsmouth city. While The University of Portsmouth has never trained medical students before, it does offer courses in Dental Nursing and Hygiene. The University of Portsmouth will take students from 2024, and those who graduate will obtain medical degrees from KCL. Portsmouth then aims to take its own students from 2028.

Although KCL has advertised this news positively, current students on the GEM course at KCL have expressed some concerns. One student commented, 'I think this is wild, the university can barely manage running the King's course, I hardly think they should be setting the standard for other universities like Portsmouth!' Another student echoed this sentiment saying, 'I think it's good they're expanding for more GEM places but I wonder how KCL plans to actually oversee another programme when they struggle so much to handle the amount of students they have in London'.

However, there was some positive feedback: 'I think it's a good idea increasing the number of places for medicine and lowering the competition – and hopefully more doctors in a low uptake area.' Another student shared, 'I think it is a good initiative as it would mean there would be more medical places in the country plus the collaboration of KCL which has good ranking in the medical field would put University of Portsmouth in a good position. The only concern I can think of is the logistics and whether it would put the current students here at KCL at a disadvantage'. Currently it's not clear if there will be an impact on current students.

Many Universities across the country have been opening new medical schools, reflecting the government's plan to expand medical school places. The government released a press statement announcing they were increasing medical school places by 205 in 2024. Imperial College London recently announced a partnership with the University of Cumbria to train students in the Northwest. Again, this is a route for students who already have degrees.

This may seem initially positive but there is growing concern that increasing medical school places is not the fix it appears to be.

Across the NHS there are 'traininbottlenecks', referring to the high competition of training posts once qualified. This has led to an increase year upon year in the number of doctors who halt their training to go abroad, work as a locum or take a break from medicine altogether. It also takes 4-6 years to train one student in the UK, meaning the NHS will not immediately benefit from the increase in medical students. Equally, training students in Portsmouth does not guarantee that students will train and work in Portsmouth upon graduating, especially as junior doctors are sent somewhat randomly across the country. This means the new medical school may not outrightly help improve the shortage of GPs in Portsmouth.

It may appear that on the surface, this is a positive move from KCL to help expand the numbers of doctors being trained in the UK. However, KCL needs to address concerns from current GEM medical students, and the government needs to consider more solid ideas to address the current issues the NHS experiences.

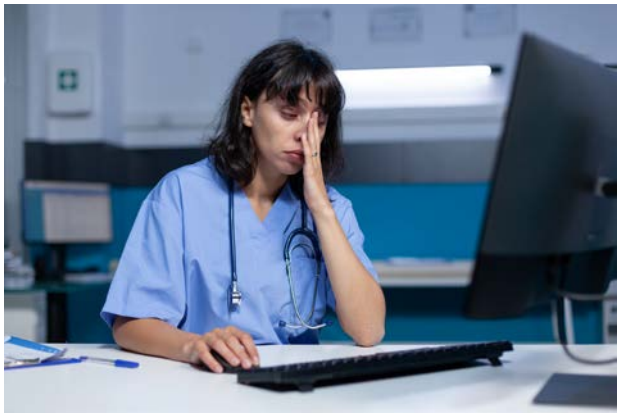
References are available on the request at gktgazette@kcl.ac.uk

Luftmensch

Trixica Kapdee **MBBS1**

Derived from Yiddish *luft* and *mentsh*, this noun directly translates to 'air human being' or 'air man', but the sentiment behind this term can be defined as 'a person unconcerned with the practicalities of earning a living'.[1,2] In light of the current economic and political landscape in the UK, this word may be an apt description for the prospective and current medical student.

It is no secret that junior doctor wages have not increased in line with inflation. The British Medical Association calculations show that pay awards for junior doctors in England have delivered a real term pay cut between 2008/9 and 2021/22 of 26%.[3] Put more simply, junior doctors' income (when adjusted for inflation) has decreased by over a quarter since 2008, making it more challenging for doctors to maintain the same standard of living. The medical profession is not unique in this aspect, but the magnitude of the real terms pay cut reflects inadequate compensation considering the scope of responsibility of the junior doctor role.



This then raises the question as to why medicine remains such a lucrative choice for study. With such stringent academic requirements coupled with the highly publicised condition of the NHS and coverage of recent strikes, medical students can be called neither unintelligent nor unaware. We reached out to current MBBS first year students to ask why they chose to pursue medicine, despite the knowledge of the difficulties associated with this career.

"The main reason why I chose to study medicine in the UK is because the healthcare system places a great emphasis on not only improving a patient's length of life but also their quality of life. This is exemplified by the movement of healthcare towards precision medicine, personalised therapies and the importance placed on mental health and having a healthy lifestyle. Moreover, at the centre of everything that doctors work towards is the patient. As an international student, one of the most appealing factors to study medicine in the UK is the autonomy given to patients - the power to be in control of one's own treatment and care. Additionally, the UK plays an important role in medical research and innovation, which was especially evident in the effort to develop a COVID-19 vaccination. Despite there being issues regarding the pay of junior doctors, their working conditions and the toll that their jobs take on their physical and mental health, it gives me hope to know that in the future I will be able to make a meaningful impact in patients' and their families' lives."

- Shriya Karlapudi

"Despite the financial challenges faced by clinicians, I decided to pursue a career in medicine as I believe medicine offers a continual opportunity for learning and teaching. The significant and direct impact doctors have on public health is both rewarding and provides encouragement for the empowerment and betterment of healthcare in general. Personally, as someone whos interests lie in various fields, the main attracting factor to becoming a doctor was the opportunity to explore different specialities during training."

- Abbie Premakumar

"The rewarding nature of the career, its ability to contribute to the community, and the emphasis on maintaining a life outside of medicine align with my purpose. I appreciate the opportunity to pursue my passion in photography and videography without compromising on my interests."

- Harshil Shah

The realities of working life cannot be ignored, but the students of GKT are driven by more than the practicalities – *luftmensch*, indeed.

Physician Associates: A fraught debate amidst an NHS in crisis

Jade Bruce **MBBS4**

Amidst the turmoil of an NHS already at breaking point, the debate surrounding the role of physician associates (PAs) stands as one of the most contentious in NHS history.

First established in the US in the 1960s, PAs were later introduced into the NHS In 2003 to support the workforce and improve patient access to care. The role of PAs is defined by the faculty of physician associates as 'healthcare professionals who work as part of a multidisciplinary team with supervision from a named senior doctor'. Today, PAs work within the wider multi-disciplinary team (MDT) to care for patients in a range of primary, secondary and community settings.

To become a PA, students must typically hold an undergraduate degree in the bioscience field and subsequently complete an intensive 2-year post-graduate programme in PA studies. Once qualified, PAs complete many similar tasks to doctors, including clerking patients, completing clinical skills, and ordering tests. Notably, PAs are unable to order tests involving ionising radiation or to prescribe. Although rigorous, the training programme lacks the depth and breadth of medical training which usually lasts 5-6 years.

The government rationalises that the expansion of PAs will reduce the workload of doctors and reduce patient waiting times. Such an improvement would be welcomed by the 6,323,017 individual patients awaiting care and 1.3 million NHS staff who are working in a system with 112,000 vacancies. The NHS is in crisis and precariously balanced at a tipping point. But are PAs the solution?

NHS England argues that increasing the PA workforce is a 'rare and significant' opportunity to make large-scale improvements to the NHS, insisting that 'PAs are not a substitute for Doctors'. Some say the support of PAs frees doctors to complete other tasks. As PAs tend to have more continuity and fewer rotations than junior doctors, they can become adept at certain tasks and more familiar with specific clinical areas. They are often well-placed to help newly qualified Doctors find their feet when they enter new environments.

However, others rebuke that since PAs require supervision from doctors and are unable to prescribe, they add to the workload of doctors. In practice PAs often perform an equivalent, and sometimes redundant with, those of junior doctors, leaving the role and scope of practice of PAs nebulous.

One notable distinction between doctors and PAs emerges... price. Although initially (and controversially) paid more than foundation year doctors, in the long-term PAs are cheaper. As PAs expand, concerns arise over the potential decline in the utility of doctors within the NHS. There is worry that if PAs are employed as a cheaper alternative, they may dilute the traditional role of doctors. We are forced to question: what does it mean to be a doctor?

Historically, the role of the doctor was well defined by the GMCs good medical practice, outlining 'the duties of a doctor'. Updated in January 2024, the document now outlines the 'the duties of medical professionals', a catch all document for Doctors, PAs, and anaesthetic associates. In February 2024, it was announced that PAs are to be regulated under the GMC, a move described by the BMA chair as 'another slap in the face' for UK doctors who are already deeply undervalued.

The BMA stressed that 'the Government is encouraging false representation by supporting the impression that PAs can do everything doctors can do'. Contrary to improving regulation and patient safety, combining different roles under the same regulatory body will surely only increase ambiguity. The tragic death of Emily Chesterton, who died following misdiagnosis by a PA and erroneously believed they had been reviewed by a doctor, highlights the dangers of misidentification and the more limited medical education of PAs.

The Royal College of Physicians (RCP) held an extraordinary general meeting on Wednesday 13th of March to discuss the role and regulation of PAs and share pre-meeting survey data assessing practicing doctors' views on the role of PAs. The RCP has since been accused of data fraud and scandalous misrepresentation of pre-meeting survey data to appear falsely positive.

The resoundingly negative data was released in full on the 18th of March. The data showed that of the 2141 doctors surveyed 55.3% reported that the term physician associate is unclear within the MDT. Notably, 77.21% of internal medicine trainees reported that PAs limited their training opportunities, reflecting apprehensions that expansion of PAs may negatively impact doctors training and progression, in turn raising patient care concerns.

As the debate continues, tensions have developed among health care professions. There are some reports of personal hostility towards individual PAs who, like doctors, work hard to provide patients the best care possible. PAs find themselves in a challenging position, caught in heated crossfire, with uncertain safety measures, career progression or regulation.

Meanwhile, doctors, already burned out and actively striking for better working conditions and pay restoration, may choose to work abroad or privately. There are fears of marching closer towards a two-tier healthcare system: an NHS ran primarily by PAs with oversight from consultants, and private healthcare ran primarily by doctors.

As the fraught debate continues to unfold, the future of the NHS and its changing workforce remains shrouded in uncertainty. Above all, patient care and safety must transcend political ulterior motives and personal friction to remain the absolute priority.

The Hidden Cost of Medical School

Charlotte Mulcahy **MBBS4**

Some say you can teach yourself medicine online, you just need to pay for a subscription.

Medical school is expensive... Current fees for UK students stand at £9250 a year and £48,600 for international students. On top of tuition fees, there are numerous additional costs, including accommodation (the average rent of a room in London surpasses £980pcm), food costs, travel and everyday expenses. Not to forget the necessary stethoscope, currently available on *Amazon* for £89.99. However, there is one essential expense which remains largely unspoken: question bank services.

As many medical schools have transitioned from traditional essay style exams to multiple choice question (MCQ) style progress tests, several question bank services have emerged, often set up by current doctors. These websites provide an unofficial bank of MCQs in a similar format to medical exams, covering topics ranging from anatomy and physiology to clinical decision making. Questions include a neatly summarised hypothetical patient scenario and ask you to decide on the most appropriate management. Arguably, *PassMedicine* is the best-known. The platform has a simple design, boasting a bank of 9713 questions which fit the style of the new Medical Licensing Assessment coming into force in 2024.

Since their inception, these sites have grown and developed and similar platforms like *Quesmed* and *BiteMedicine* have also entered the market. Many of the platforms offer question banks for professional postgraduate exams and for additional exams, such as the Prescribing Safety Assessment. As well as offering questions with explanations, many of them contain online 'textbooks' and incorporate online videos or live tutorials which you can access to understand topics. Each of them displays the percentage of users which selected the same answer as you and the comments sections under questions can provide a forum to ask fellow students for further clarification (or provide comic relief). When studying alone on these sites and struggling with the questions, it can be comforting to know that others in the comments are feeling the same.

Quesmed has also followed the well-loved *GeekyMedics* to provide an OSCE section of their website where you can access checklists and scenarios to prepare for these exams. By paying for the additional OSCE resources you can now use *Quesmed* to revise for the entirety of your medical school exams – provided that you pay for each add-on service individually.

Undoubtedly, most medical students have purchased at least one of these services to study for their exams. It's unlikely you will find many recently graduated doctors who cannot, at least in part, owe some of their medical school experience to these question banks. With many students paying for multiple services, nearly everyone has given money (and their trust) to them.

The use of these services is expected within the medical community. The question: 'Do you use Passmed or Quesmed?' is a key debate amongst medical students. But why does everyone use these services? There is no doubt that they have sleek and intuitive designs packed full of relevant information. However, one of the key reasons for their popularity is that there is simply no alternative. Medical schools often fail to provide adequate mock materials, even though MCQ testing is well-established. Understandably, anxious students will turn to online services when current doctors, older students and peers swear by them. If everyone is using these services, there is an inherent pressure to use them for fear of lagging behind your cohort.

Currently, *PassMedicine* costs £30 a year, *Quesmed* £39.99 or £59.99 if you want access to their OSCE resources. Newly formed *BiteMedicine* costs £95.90 a year for their full package, and *GeekyMedics* charges £65 a year for their 'Knowledge and Skills Bundle'.

Although bursaries and scholarships exist to help students with the costs of fees and living, so far there are no existing funds to cover the cost of these services. Every year, universities pay for students to access a wealth of online journals and subscription services for free (or at least it is covered in the cost of their tuition fee). Why then, do universities not cover or provide bursaries to cover the cost of these question bank services?

For medical schools to provide funding for these services would be to legitimise them – and that's the key problem. These services are not legitimate, official or approved in anyway. Students trust in good faith that question banks will cover and provide the relevant information for them to pass their exams. Universities are unlikely to endorse these startups when the content is unregulated.

These services often claim that their question bank writers are professionals who also contribute to the bank of questions that medical schools use to write their exams. However, there is little way to confirm this is true nor to ensure that the information in questions is accurate and up to date. Instead, students race through these questions in the hope that it will improve their score in the next exam. While there is no viable alternative, these services will continue to be the most popular revision tool for students... maybe in a few years the NHS will have its first work force trained primarily on *PassMedicine*.

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

Medical Apprenticeships

Widening Participation or Widening the Gap?

Emma Francis-Gregory **MBBS2**

For many, medical school is synonymous with extensive student debt, and juggling working part-time jobs employment to cover living costs and alongside countless the hours of unpaid workspent on hospital wards during placement blocks. However, for a handful of students embarking on a new and unique medical apprenticeship, this is set to change.

Piloting in 2024, the Medical Doctor Degree Apprenticeship pathway from NHS England aims to recruit individuals from a wider range of backgrounds, especially for those whom the traditional university route may not be appropriate. Funding has been secured for the first 200 apprentices, offering these students the opportunity to learn on the job and be paid for the privilege. The universities delivering this new pathway must be approved by the GMC and all graduates will enter foundation training alongside their traditionally educated peers. Furthermore, the NHS has stressed that these courses will be 'comparable' to the traditional route into the profession. (Health Education England, 2023)

There are widespread concerns regarding the new training pathway: whilst the BMA welcomed a new '*innovative approach to education and training*', they warned that the new degree pathway must adhere to the same high standards as traditional medical degrees (BMA, 2023). Moreover, a number of clinicians have voiced concerns that the apprenticeships will elicit a two-tier system, in which quality of care offered varies between doctors educated via the two pathways (O'Dwyer, 2023). This may result in compromised patient safety, particularly if insufficient weighting is given to the underpinning physiology and pharmacology usually covered in the non-clinical years of traditional MBBS programmes. As a student on the accelerated Graduate Entry course, I bypassed the designated pre-clinical year within the King's curriculum. Despite being equipped with the skills and knowledge from three years of undergraduate education and my Biomedical Sciences degree, there have been many occasions since starting my medical career where I have struggled with the scientific underpinnings, and felt unprepared for aspects of our learning. Tackling medical school without any formally taught scientific foundations would be incredibly challenging, and would leave students ill-prepared for identifying and treating abnormalities seen in disease if they are unable to understand the physiological norm. With the distribution of apprentices' time between academic and clinical environments yet to be determined, it is essential that the hands-on nature of the apprenticeship does not come at the detriment of fundamental academic knowledge.

Furthermore, there are concerns that the new degree pathway will not be internationally recognised (O'Dwyer, 2023). With one survey reporting that almost a third of current medical students are planning to emigrate to pursue medicine elsewhere (Ferreira, 2023), doctors trained via the apprenticeships may inadvertently find themselves unable to follow suit. Whilst this may improve the retention of UK-trained doctors, removing the ability of individuals from disadvantaged backgrounds to make an important choice regarding their future may not align with improving opportunities.

Despite these concerns, it is universally agreed that medicine and medical schools should be diversified. As explored in detail in a previous edition of the GKT Gazette (Bruce, 2023), children of doctors are 24x more likely than their peers to become doctors themselves (Laurison, 2019). Furthermore, in 2016, it was reported that only 4% of UK doctors are from working-class backgrounds. This is much lower than other professions that are traditionally associated with privilege - such as law or journalism (Social Mobility Commission, 2016). Any steps taken to widen access to a medical career are welcomed by the profession, but these should undoubtedly be delivered with no risk of compromise to patient safety. Additionally, in order to meet the aim of widening access to traditionally underrepresented groups, such as individuals from low progression to university schools, lower socioeconomic backgrounds and those who are the first generation of their family to access higher education, the scheme should directly recruit from these applicant pools.

Ensuring that the apprenticeships are awarded to those NHS England are setting out to help will be crucial to the success of the scheme. This could be approached via quotas utilised to ensure adequate representation from traditionally underrepresented groups, giving priority to care leavers and young carers, or using geodemographic data such as POLAR scores to guide eligibility (Office for Students, 2022).

There is a clear need for additional UK-trained doctors. But if not via the apprenticeships, then how? A number of new medical schools have opened in the areas of the UK most desperate for new doctors, Portsmouth is soon to offer a new graduate entry pathway in partnership with KCL ahead of their own medical school opening in 2028 and 205 additional places are also being funded by the government in the coming academic year (UK Government, 2023). For 2024 entry, 24,150 applications were submitted via UCAS competing for ~10,000 medical school places (UCAS, 2023; Office for Students, 2023). Given the competition ratios, the above measures seem to barely scratch the surface of the issue – without even considering the challenge of retaining the cohort within the NHS further down the line.

One GP suggested that the money would be better spent increasing funding and bursaries for lower-income students embarking on the traditional pathway, thus improving accessibility for students from lower income backgrounds (Salisbury, 2023). This, coupled with continued commitment to widening participation pathways, such as the Extended Medical Degree Programme offered by GKT, may be a more suitable option to ensure equity and recruitment of students from a wider socioeconomic pool. With so little information currently available, it is challenging to gauge whether the new pathway represents a new era of accessibility and representation in medicine, or the devaluing of a degree programme that has long been regarded as one of the best in the world.

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

STIs are climbing, can NHS England climb faster?

Ismaeel Ahmad Ayoob Syed **MBBS2**

A staggering uptick in gonorrhoea and syphilis. Two-thirds of council areas in England fighting a rise in sexual infections. Sexual health consultations rocketing from 2013 to 2022. It seems England's sexual health services are at the edge of a precipice.

Over the past decade, the tug of war between increased demand for sexual health services and resource scarcity has become dramatically serious and is at 'breaking point.' Whilst some of the inflated STI diagnoses can be attributed to increased diagnostic testing, perhaps because of better access or widespread awareness, a spike in infections within the community should also be held accountable.

The Local Government Association (LGA) represents the councils providing sexual health clinics. They conducted a recent analysis revealing the fall in funding for public health. This poses a formidable challenge to the NHS. Lack of funding makes for a serious blow to STI management, contraceptives, reproductive health counselling, amongst other sexual health services - that are imperative for long-term improvement in sexual health in England. To add on, the funding cuts contribute to inadequate professional training which can alter the quality and timeliness of services in the sexual health sector.

Dr. Claire Dewsnap, President of British Association for Sexual Health and HIV emphasises on the urgency and necessity of battling this issue, by drawing up on evidence collected from the LGA:

'*This data not only demonstrates the deeply concerning trajectory of STI infection growth but also the need for a robust national strategy, backed up by adequate funding. As demand for care increases, without imminent action, we compromise our ability to safeguard the sexual health of our nation.*'

To navigate this, the LGA has gripped the steering wheel and requested the government to clarify what the next public grant allocations are, alongside making a case for increased funding for sexual health services. The Parliamentary Women & Equalities Committee held a session to discuss the evidence of rising STIs for people aged 15-24, presented by Prof Chris Whitty (chief medical officer for England), Rachel de Souza, and Dr Claire Dewsnap.

For now, a spokesperson from the department of health and social care has confirmed an allocation of more than 3.5 billion GBP to England's authorities for public health, including sexual health services. They also added that this will increase every year for the next 3 years too.

'*We continue to work closely with the UK Health Security Agency, local authorities and NHS England to manage pressures on sexual reproductive health services and improve access to routine services.*'

From a medical student's perspective, it is crucial to understand and engage with these real-world challenges. The sexual health crisis coupled with the funding cuts is a clear example of how medical practice converges with public health and policy and why it's an opportunity for students like me to assimilate the fundamental role of healthcare decisions and its impact on our community.

It also highlights the need for innovative breakthroughs in policy, and novel approaches for technology that can help ameliorate healthcare and improve its delivery and accessibility. Plus understanding the weight of this situation helps us advocate for positive change and uphold our professional responsibilities. We can contribute, even in the slightest, to shape the sexual healthcare landscape around us. This lays a foundation for our active involvement in healthcare policy for the rest of our careers.

Talking about sexual health, and breaking down barriers that come with it, puts our foot on the ladder that fosters a culture that breaks stigmas, empowers individuals, and prioritises inclusivity of underrepresented groups. We need to create a narrative that advocates for health and information. It is pivotal when we're ascending this ladder to raise awareness of disparities in funding, actively promoting policy changes, and equipping sexual health professionals with the finest skills.

Time after time, we, as a healthcare community, have been progressively making change and finding newfangled techniques to keep shinning up this ladder. But now, the real ascent must begin. Disease is climbing up with us and is proving to be swift and able. We need to climb faster.

Concept creep: evolution of medical diagnoses into widespread afflictions

Trixica Kapdee **MBBS1**

"I'm so OCD." *"I was triggered."* *"I dated a narcissist."*

It is not rare to have heard (or perhaps even used) one of these sentences in daily discourse, but historically, these terms were constrained to the fields of psychiatry and psychology.

This adoption of previously clinical terminology into the common lexicon has been dubbed 'concept creep', first described by Haslam in 2016.[1] Concept creep can be defined as the gradual expansion of the meaning of harm-related concepts. While its disciplinary home sits within psychology, psychiatric terms also fall within its domain of relevance, prompting consideration of this phenomenon from a medical point of view.[2]

The casual use of psychiatric and clinical terms in everyday conversation reflects a broader societal shift in how we perceive and discuss mental health and medical conditions. There are several contributing factors to this. People are now more aware and educated about mental health issues, and clinical terms are used to describe behaviours seen outside of the clinic. This increased awareness may be attributed to the instant access to information the internet provides, which in term may reduce stigma and facilitate open conversation. The question that arises is whether the appropriation of these terms dilutes their clinical significance, or if it serves to raise awareness and foster empathy.

For example, uttering "I'm so OCD" to describe a penchant for order or cleanliness may seem harmless, but using such terminology flippantly can overlook the profound impact that genuine OCD can have on individuals. The trivialisation of such conditions through casual language risks diminishing the seriousness of mental health struggles.

Similarly, the use of terms like 'triggered' to describe emotional reactions may minimise the experiences of individuals dealing with trauma or psychological distress. It is crucial to recognise that clinical diagnoses are not mere catchphrases for everyday inconveniences but represent genuine challenges that individuals face.

The proliferation of psychiatric terms into everyday discourse is not confined to casual conversation alone; it extends into popular culture, social media, and even dating dynamics. Describing someone as a 'narcissist' based on certain behaviours witnessed during a relationship has become commonplace. It is understandable that individuals use such words to make sense of their experiences. Clinical terms provide a precise and accurate way to describe a specific condition. Using a word like 'narcissist' succinctly conveys what many other words would fail to capture. However, this casual usage raises concerns about oversimplification and misappropriation of serious conditions.

As we navigate this natural semantic expansion of language, the medical community must engage in ongoing discussions about the implications of this phenomenon, both in terms of patient understanding and societal attitudes toward mental health.

The use of clinical terms in everyday life represents an opportunity to reduce stigma, foster empathy through knowledge and encourage supportive conversations. Using clinical language demonstrates how mental health conditions are regarded as legitimate medical issues as opposed to taboo topics. The public may be encouraged to have constructive discussions about the challenges people with mental health conditions face, as well as better equipped to offer (or ask how to offer) support. This increased awareness may also support individuals dealing with mental health conditions in articulating their experiences and may serve to encourage them to seek support.

Medical professionals and educators play a pivotal role in promoting accurate information and dispelling misconceptions surrounding mental health. Encouraging a nuanced and empathetic approach to language use can contribute to a more inclusive and understanding society.

The 'concept creep' of medical diagnoses into widespread afflictions reflects a broader societal shift in how we discuss and perceive mental health. While the casual use of clinical terms in everyday conversation may facilitate dialogue, it also poses risks of trivialisation and misappropriation. Striking a balance between fostering open conversations about mental health and maintaining the integrity of clinical language is essential for creating a more informed and compassionate society. It is not rare to have heard (or perhaps even used) one of these sentences in daily discourse, but historically, these terms were constrained to the fields of psychiatry and psychology.

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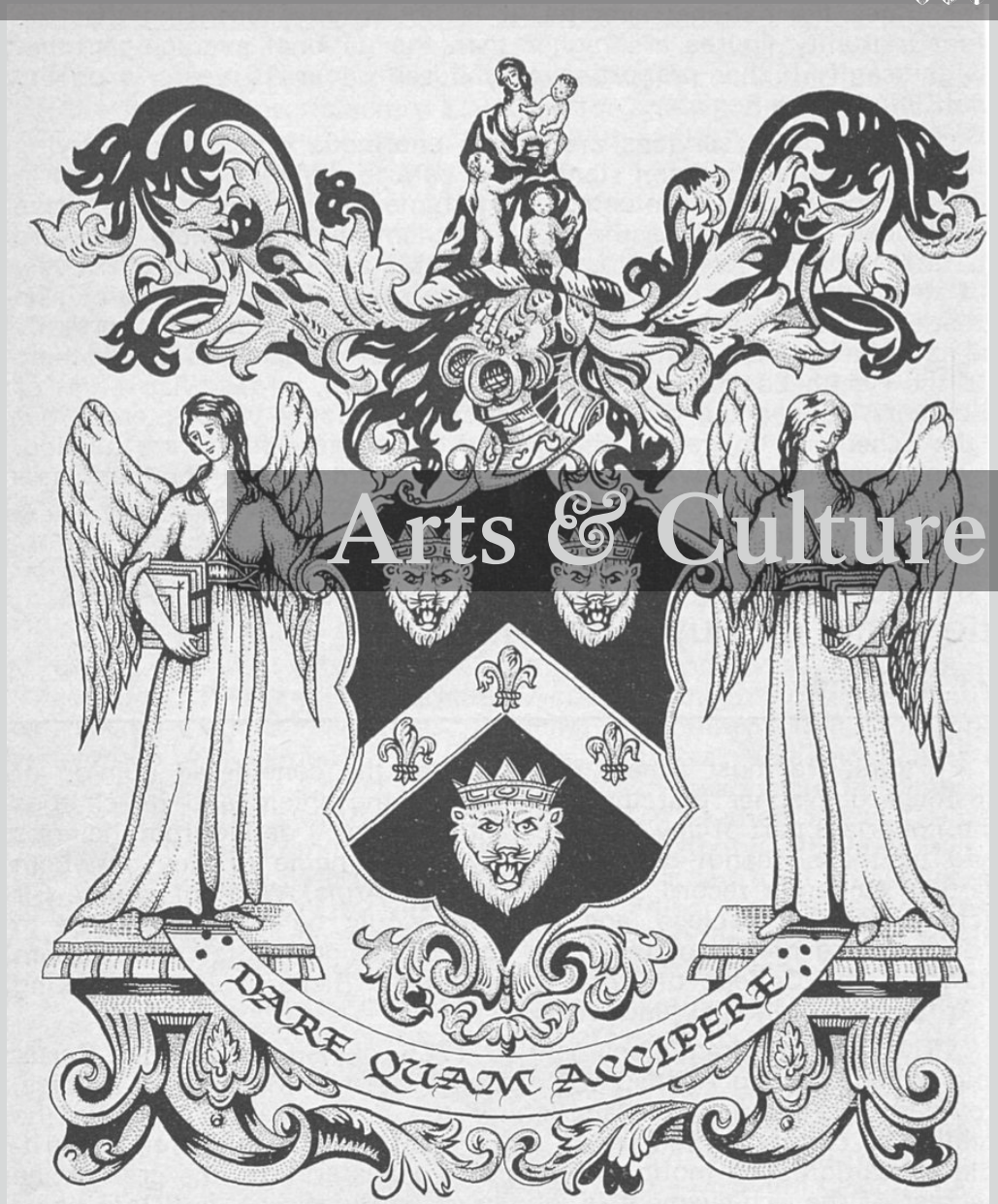
Arts & Culture



"These are the arms, crest, supporters and motto belonging to the Hospital in the Parish of St. Thomas in Southwark, founded by Thomas Guy."

Book Review: Divided by Annabel Sowemimo

A vital and unflinching exploration into the colonial roots of modern healthcare

Naim Ghantous **MBBS1**

In 2023, NHS doctor, sexual and reproductive health registrar, activist and academic, Annabel Sowemimo, marked the release of *Divided*, the progeny of her work on gal-dem, an influential platform led by writers of colour (a platform which is unfortunately closing down).
Its full title: *Divided: Racism, Medicine and Why We Need to Decolonise Healthcare*, resolutely conveys the nature of its contents: the meticulous dismantling of institutional racial inequalities through the unflinching confrontation of the discipline's entrenched colonial legacy, one that is often left unspoken. Annabel Sowemimo takes a truly all-encompassing approach, intertwining several aspects of contemporary medicine, history, and personal experience to communicate the totality of how racial discrimination has and still influences modern medicine.

Underpinning the book's deconstruction of injustice in medical science is the idea that scientific thinking, both intentionally and unintentionally, has been weaponised to reinforce ideas of racial subjugation and racial superiority. The expeditions of wealthy colonial physicians – many of whom owned plantations - in the 18th century, alongside the classification system of Carl Linnaeus, are explored as potent examples. However, it is Francis Galton's fostering of eugenics that is most thoroughly deconstructed as a clear method of providing scientific basis for white racial superiority, a motive that is made all the more sinister by Sowemimo's harrowing description of The Eugenics Collection in London, and her encounter with the very instruments Galton used. The concept of eugenics centres around the idea that, through selective breeding, humanity could be removed of undesirable characteristics and social ills. Alongside contemporary popularity in polygenism, the idea that humans are descended from several (one of which being believed to be superior) ancestors, eugenics was routinely paraded as *'irrefutable scientific truth'* by those with vested interest in the preservation of racial oppression. The searing truth the book unfolds is that, even though we are centuries removed from the dehumanisation of black individuals through ideas such as eugenics and polygenism, the damage that they have done ripples into contemporary history and society.

Prejudicial views on the sexuality of black people (originating from colonial scientific thinking) were seen as appropriate grounds to extend the Tuskegee Syphilis Trials (1932-1972) by several decades and withdraw potential treatment. 600 African American men living in Macon County Alabama suffering with syphilis were recruited, their condition left to progress under the illusion of receiving free medical care for an unspecified blood condition. This continued decades after treatment was discovered. Sowemimo effectively employs this example to introduce the most tragic paradox of the book, that an alarming scale of development in healthcare is founded from the discrimination of non-white individuals. Out of the Tuskegee Trials emerged the discovery that penicillin could treat syphilis, and it was the exploitation of Puerto Rican women in a similar US-funded experiment that led to the inception of the first contraceptive pill. However, it is her analysis of the origins of obstetrics and gynaecology and the continued injustices present in the field that is the most striking, emphasised by her experiences as a sexual health doctor. In one of the most powerful sections of the book, Dr Sowemimo describes the *'cries for help'* she receives from black women that feel their health is being neglected by a system rooted in the idea that individuals can somehow be more impervious to pain on account of their race. What is even more harrowing however, is the connection Divided describes between surgeons performing untested and unregulated procedures on black women in plantations, and the contemporary idea that non-white individuals are medically *'stronger'*. The ravaging social consequences of historical, racially informed medical thinking present themselves in a worrying loss of hope in an institution that is tasked to defend our most fundamental human right – health.

It is these social consequences that *Divided* aims to re-contextualise to the reader, Dr Sowemimo firmly describing that *"there is often a failure to understand that science is not created in a social vacuum"*. It is with this mindset that Divided looks to the future, with both hope for positive change and cautionary warnings for the repetition of old mistakes. One of the more insightful ways this is applied is in Sowemimo's discussion around technology and AI, given its rising prevalence in medicine. If we utilise current thinking when constructing the algorithms for AI in healthcare, are we unknowingly perpetuating the mistakes of our past? The idea of history repeating itself is critical to *Divided* and is incorporated in most of the book's chapters as a sobering reminder of what could happen if the status quo is not challenged. Equally however, *Divided's* grand story is full of status quo challengers, most notably Malone Mukwende, who as a medical student authored a textbook which documents the pathological skin changes that can occur on darker skin shades. Interviews with individuals like Mukwende occur throughout, not only elevating the already rich sense of authenticity and perspective the book holds, but also providing inspiring reminders of what we, even only as medical students, can do to induce real change in the social healthcare landscape. Even if it is questioning the many reference values we use in medical practice (such as estimated GFR which the book critiques in depth), and how they are standardised, we can establish positive discussion. These conversations can then lead to increased opportunity for student research initiatives like Mukwende's to get off the ground, and challenge the status quo - a key theme in Sowemimo's writing.

As an individual with family in healthcare, I have seen first-hand the toll of racial discrimination on those in the NHS, and the borderline superhuman expectation for non-white individuals in healthcare to take the brunt of it silently and strongly. Perhaps the greatest strength of *Divided* is its impassioned, erudite vocalisation of that paralysing feeling.
Nonetheless, this is only one of many poignant and powerful insights that run at the heart of *Divided*'s monumental analysis into the colonial roots that still asphyxiate the medical world. It is the interweaving of Dr Sowemimo's individual experiences however, in my view, that mobilises her overwhelming passion and humanity, which transforms the text into an urgent, rallying cry for change.

Divided is absolutely an essential read for individuals across the medical strata.

Our thanks to the Wellcome Collection for supplying a review copy.
Available now at bookshop.org

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

A Thrilling Night of Musical Bombast

A review of GKT Music Society's Orchestral Winter Concert

Naim Ghantous **MBBS1**

As someone who spent much of his school lunchtimes ensconced in his guitar, within the plastered cubicles we call music rooms, concerts hold quite a special place in my heart. The rehearsals growing progressively more vivacious, the inevitable technical issue on the day and "wait a minute... didn't we cut that bar out?"

All jokes aside, those fond memories, my passion for music as a whole, and the coercion of some very talented performing friends were more than enough for me to take the bus down on a cold December evening to St George the Martyr on Borough High Street.

I was greeted with a welcoming display of cupcakes and refreshments, and offered a festively decorated program for the evening to come, which included a large variety of solo, small group, choral and orchestral pieces. On the topic of variety, the instrumental range of the group came into full focus as I sat down on the cues, with an array of violins, flutes, cellos, brass and more in the hands of the performers, of course dressed in sleek concert blacks. Above all however, I felt that there was a strong sense of community, looking around to see parents, siblings, partners and friends all in a warm, buzzing commotion that filled the room with cheer.

The orchestra's venerably decorated musical director Alex Borland, a first class graduate of the King's College London music department began, ensuring that the show would be top class.

His promise was excellently delivered from the get go, with GKT's choir taking full advantage of the church's acoustics to provide a moving performance of Bob Chilcott's Midwinter, and that very standard of musical display did not falter for the rest of the night. I feel it particularly necessary to mention the prowess of the solo performances, with Sebastian Ng playing Chopin exquisitely alongside Sanika Kale's excellent vocal performance of Bing Crosby's White Christmas.

It was the orchestra however that was the unstoppable driving force of the evening. Led by an extensive string section centre-stage, providing a grand showing of Beethoven's 7th and an even grander display of Marquez's Danzon No.2, which was arguably the most electric piece of the night. Regardless, my personal favourite came to be when the forces of both the choir and orchestra coalesced, to give a truly stunning portrayal of Walking In The Air, which left me - and the rest of the audience - in considerable awe.

Whilst the evening paid homage to seminal

Image taken from the UMDS (Guy's) Gazette, Vol. 93, No. 2290, 31st March 1979

may have been an uncomfortable and rather humbling harkening back to the days of school choir (I wonder who!), but nonetheless it gave the concert a much more dynamic feel and only strengthened the sense of community in the room. This reached its peak of course in the final act of the night, which was a frankly ingenious reimagining of the 12 Days of Christmas. It involved different groups, depending on what campus they were on or their role in the concert for example, being assigned specific lines that they had to stand up and sing. What ensued was a frantic yet endearing mess of people shooting up and down in their seats, voices growing out of breath with every round and the occasional waves of laughter provoked by the more passionate vocalists in the audience. After a series of well-deserved congratulations, gift-givings and applause, I rushed to my friends in the ensemble to celebrate their hard work and an incredible night of music.

I find myself in eager anticipation as to what the GKT Orchestra can achieve in the future, and I would strongly suggest that you should be there for it.

Sketch by Dr. Bannister.

John Fry Medical Reunion 2023

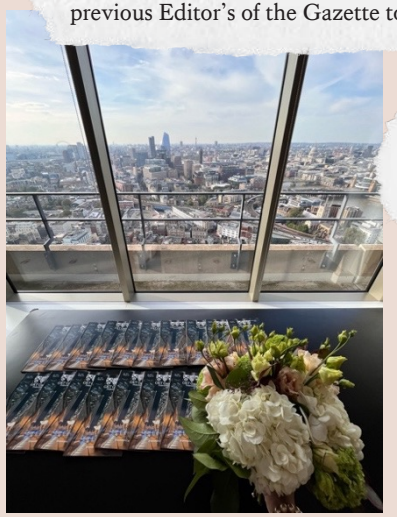
Zaynah Khan **MBBS3**

On Tuesday 10th October 2023, I found myself carrying a box of our GKT Gazette Fresher's Edition (2023) up to Roben's Suite, at the top of Guy's Tower, for the John Fry Medical Reunion 2023!

It was so wonderful to talk to Guy's Alumni, to hear their stories of how so much has changed over time: our campus, the view, as well as the practice of Medicine.

It was even more enlightening having conversations with and hearing people's memories of the GKT Gazette from their time at medical school, decades ago.

I heard so many heartfelt accounts and anecdotes about specific articles and topics from previous editions that stayed with them. Even getting to hear from previous Editor's of the Gazette too!



Getting the opportunity to meet, hear the incredible presentation, and get a signed copy of 'The Honourable Doctor' from Professor Nick Black, the guest speaker of the event, was truly memorable for me too!

Empowering Physicians: The Vital Role of Mental Health Education in Medical Training

Yamini Aparna Chodavarapu **MBBS2**

Amidst the rigours of medical education and demands of clinical practice, prioritising mental health has become increasingly paramount. As the pressures of medical education intensify, so does the strain on students' well-being; the journey to becoming a physician is not just an academic challenge, but a demanding voyage requiring resilience, empathy, and self-care. Therefore, it is time for a fundamental shift in how the medical community addresses mental health in medical school that acknowledges its significance and seamlessly interweaves it into the fabric of medical education.

Medical school is known for its challenging and extensive academic curriculum. These can often contribute to elevated levels of stress, burnout, and mental health concerns among students. Studies reveal staggering rates of depression and anxiety in medical students who represent the future frontline of healthcare, underscoring the necessity for mental health education to be ingrained in the medical school experience.

Furthermore, clinical rotations are pivotal experiences in medical education, offering students invaluable hands-on learning opportunities. These rotations expose students to the emotional toll of illness suffering and loss. Witnessing the complexities of healthcare delivery and confronting their own limitations can evoke much stress, anxiety, and self-doubt.

Implementation would require a multifaceted approach, starting with comprehensive wellness programs. These would provide students with tools for self- care and resilience, consisting of workshops, counselling services, and peer support networks. Moreover, further integration of mental health topics into the existing teaching framework could ensure that students can better recognise and address mental health concerns in themselves and others around them. Encouraging more open discussions about mental health issues that commonly prevail amongst students can help dismantle barriers to seek the necessary support and ensure medical students can optimise their emotional well-being.

After all, being a medical professional is not only about having knowledge and clinical expertise but also needs one to have the capacity for empathy, reflection, and self- care. Medical schools pushing for better mental wellness provisions would help cultivate an environment wherein a doctor's mental wellbeing is valued equally to their academic and professional achievement.

In effect, prioritising mental health education isn't solely a moral obligation, but an investment in the sustainability of the medical profession for our future doctors. A holistic approach allows medical schools to fulfil their mission of producing competent and compassionate physicians, who are well-equipped to navigate the complexities of their profession whilst giving precedence to their mental health.

The GKT Gazette Zine

Dear Readers,

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

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

Our motivation was to bring the Gazette off the page, effectively creating a channel to allow discussions between the authors and readership in real-time. We understand that, as students at GKT, it can be difficult to spend time writing articles or on artistic endeavours; many of us are limited by perfectionism, others by time. We, therefore, felt the need to create a safe space for students to take full ownership of the creative process - not for an achievement or grade but the opportunity to share a little corner of one's world, unique experiences or stories.

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

Best Wishes,

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

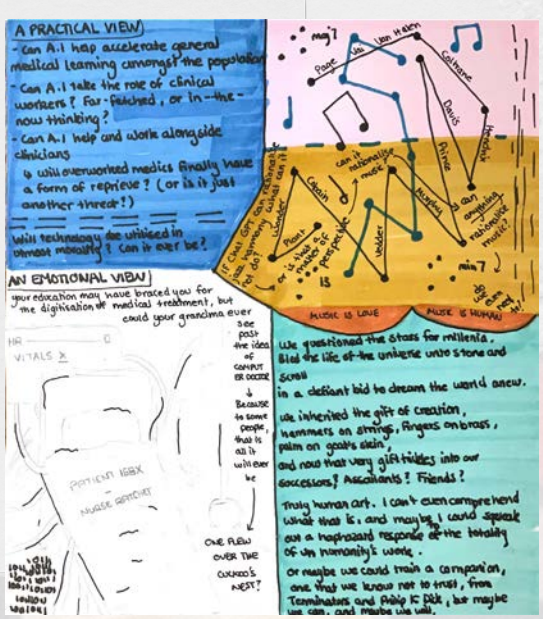
Please send us your thoughts, illustrations or comments to gktgazette@kcl.ac.uk, or view our postal address on page 2.

*What is a *Zine*?

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

No. 1

No. 2



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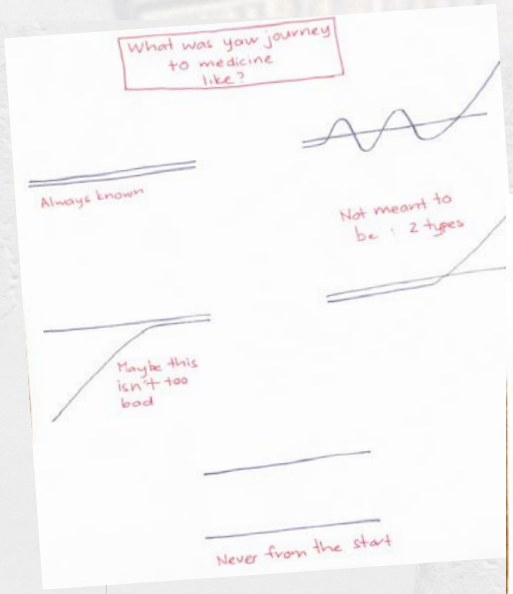

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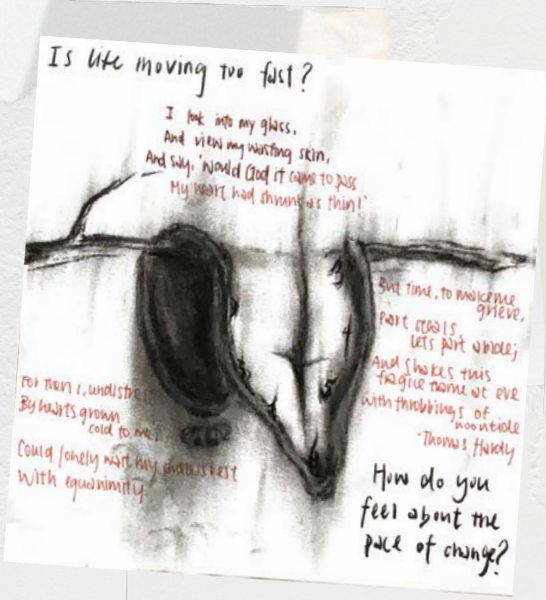

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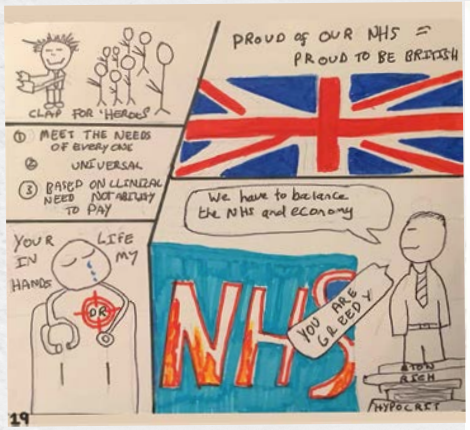

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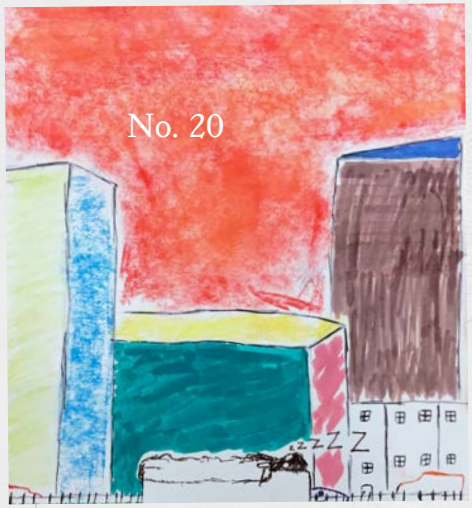

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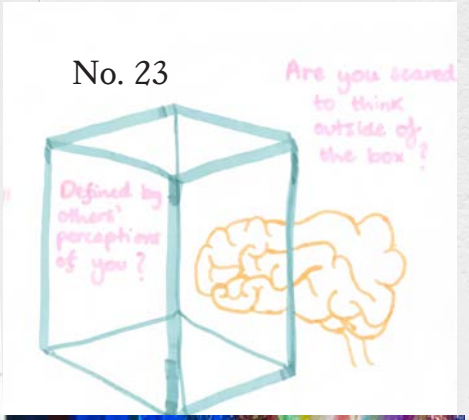

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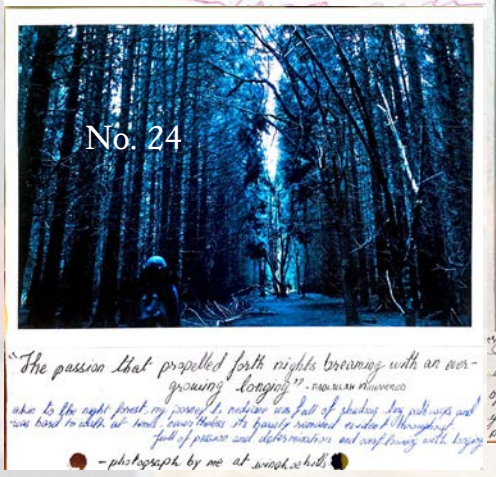

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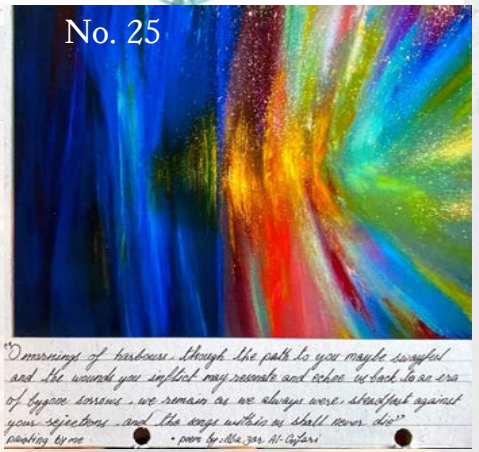

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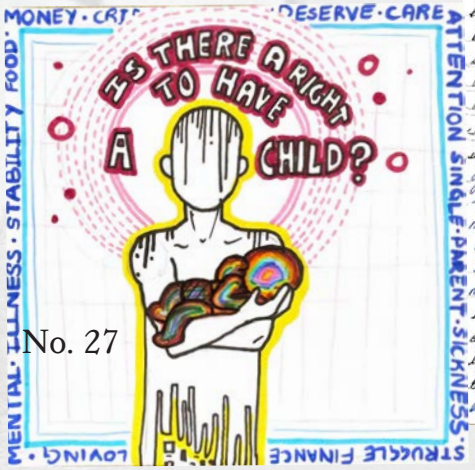

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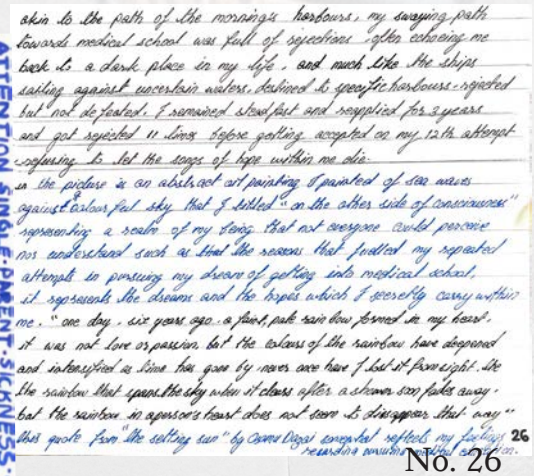

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★CONTRIBUTORS:★

1-2 = DOES AI HAVE A ROLE IN MEDICINE? (NAIM GHANTOUS)
3 = IS TO BE A SURGEON JUST TO BE PROFICIENT IN THE OPERATING ROOM? (ROHAN CHAVALI)
4 = IS CHANGE A GOOD THING? (YVONNE ZHOU)
5 = DOES SOCIAL MEDIA CONNECT OR ISOLATE YOU? (NUSAYBAH ALAM)
6 = HOW IMPORTANT IS ANATOMY IN A MODERN MEDICAL CURRICULUM? (MORGAN BAILEY)
7 = HOW DO YOU FEEL ABOUT THE NHS?
8 = ADVICE
9 = "CLIVE" THE ORIGAMI CRANE
(ANJALI ARACKAL)
10 = IS CHANGE A GOOD THING?
11 = WHAT WAS YOUR JOURNEY TO MEDICINE LIKE?
(CHIEN JIN SOH / ZOE)
12 = DO OUR BODIES HAVE A PERFECT DESIGN? (ANANYA DANGRA)
14 = IS LIFE MOVING TOO FAST, HOW DO YOU FEEL ABOUT THE PACE OF CHANGE? (LARISSA ALDRIDGE)
15 = OUR DAMAGE TO THE BEAUTIFUL ENVIRONMENT (NAYAN PERERA)
16 = HOW CAN WE HELP PATIENTS MANAGE THE EMOTIONAL IMPACTS OF THEIR CONDITIONS, BETTER? (HUNED MAMAJIWALA)
17 = IN LIFE IS IT BETTER TO FOCUS ON THE BIGGER PICTURE - OR IS THE DEVIL IN THE DETAILS? (GRAHAM BOOKER)
18 = DO OUR BODIES HAVE A 'PERFECT' DESIGN? (BAVESH JAWAHAR)
19 = HOW DO YOU FEEL ABOUT THE NHS? (JADE BRUCE)
20 = IS UNIVERSITY TRULY THE BEST TIME OF YOUR LIFE? (ARNAV UMRANIKAR)
21 = 'I LAY ASLEEP' (INIGO GORDON)
22-23 = DOES SOCIAL MEDIA MAKE YOU FEEL MORE CONNECTED OR MORE ALONE? (SHREYA MITTAL)
24-26 = WHAT WAS YOUR JOURNEY TO MEDICINE LIKE? (SARA OSMAN)
27 = IS THERE A RIGHT TO HAVE A CHILD?
28 = WHAT WAS YOUR JOURNEY TO MEDICINE LIKE?
(KATHRYN RAJ)
29 = DOES HEALTHCARE FOCUS TOO MUCH ON CURE AS OPPOSED TO PREVENTION? (ALEXANDRA HAMMOND)
30 = HOW DO YOU FEEL ABOUT THE NHS? (SOPHIA FANG)

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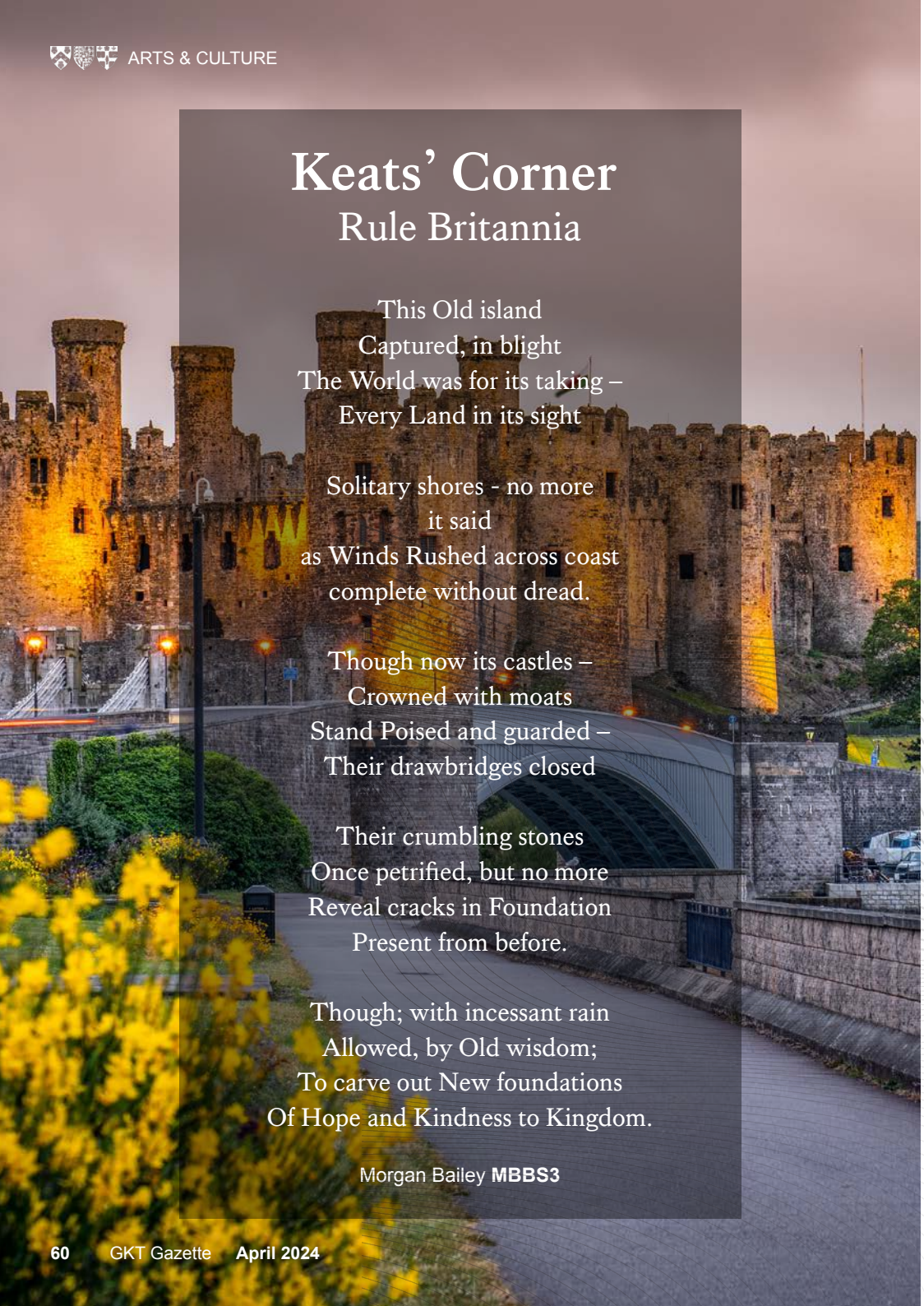


Keats' Corner

Rule Britannia

This Old island
Captured, in blight
The World was for its taking –
Every Land in its sight

Solitary shores - no more
it said
as Winds Rushed across coast
complete without dread.

Though now its castles –
Crowned with moats
Stand Poised and guarded –
Their drawbridges closed

Their crumbling stones
Once petrified, but no more
Reveal cracks in Foundation
Present from before.

Though; with incessant rain
Allowed, by Old wisdom;
To carve out New foundations
Of Hope and Kindness to Kingdom.

Morgan Bailey **MBBS3**

A Silent Conquest

In the hush of twilight's embrace,
Where logic's boundaries gently erase,
A senseless blot upon the sky,
Echoes of Vallées's futures lie.

Defiant dullness in the celestial stance,
Under stars that watch and glance,
An audible pulse, loud and clear,
Sings of a world, close yet not near.

Only silence, thick and deep,
Whispers secrets for the soul to keep,
Avenging egos, bruised and torn,
In Cartesian planes, newly born.

Credibility, a melody fine-tuned,
In the dance of shadows, opportune,
Leans on truths empirically sought,
In Beaufort's scale, lessons taught.

A fleeting moment, swift and bold,
Perched on cloud edges, fearless, cold,
Stoking fires of dreams alight,
Through oscillations, sharp and tight.

Coandă effect, a theory bright,
Gives lift to my thoughts in dreamy flight,
An alternative view, in the sky's wide dome,
Crafting sense from the senseless foam.

In this warp and weft woven tight,
With physics' thread, in the failing light,
Revelations drawn from dreams and flight,
Unravel the senselessness of the night.

An anxious grip, firm and stark,
Guides the mind through shadows dark,
Yet in this chaos, oddly serene,
Lies a beauty, raw and unseen.

In the heart of turmoil, wild and free,
A quiet truth whispers to thee,
In the senseless dance of time and space,
Lies a tranquil, hidden grace.

Jasmine Makker **MBBS5**

News from the Medical Students' Association President 23-24

Ciana Dsouza **Intercalating iBsc Primary Care**

This year we have been hard at work – and we are incredibly proud of having achieved so much so far this year on behalf of our student body. We started the year with the GKT Clinical Fair – bigger and better than last year, with candy-floss machine and refreshments thanks to our efforts in securing faculty funding. Contuining the momentum, we hosted successful events for students across all years, from the Boat Ball to Take Me Out in the Greenwood lecture theatre. We also successfully continued the age-old tradition of GKT Halfway Ball for our MBBS Stage 2 Year 3 cohort.

We know you have all been enjoying GKTeach – we are grateful for all the positive feedback you send to us. We also see many of you making use of our Stage 3 placement advice talks and using the pear assisted learning (PALS) scheme.

Here at the MSA we send a huge congratulations to GKT for taking part in the UH Race Across London Event – and as we are the best medical school in the World – I should not need mention that WE WON!

We raised an incredible £150+ for our chosen charities through our communities week events, which included inclusive events such as coaster painting and teddy bear making.

Keep your eyes peeled, and yes we do see you – 800+ items have been purchased so far in our merchandise drops – it is amazing to see everyone repping GKT merch during late night cram pity-parties in New Hunt's House Library.

We are also looking forward to the rest of the year – our Blues & Shields awards ceremony will take place in June, with nominations opening mid-March. We cannot wait to celebrate with you all at the incredible work we have achieved this year. We are also excited to see everyone at our iBSc graduation ball!

Thank you to the entire committee of 23-24 for their hard work - and we cannot wait to get going again in September!

MSA Love,
Ciana Dsouza
MSA President 2023-24

Photo: UMDS (Guy's) Gazette, Volume 101 No 2373 - 6th June 1987
A Group of Medical Students in 1909

Science and Research

A group of medical students in 1909. Arthur McNair is standing second from the right; Mr. Omar Shaheen's father, Hassan, is standing on the far left; and the father of Mr. Ian Todd (the current President of the Royal College of Surgeons; is standing third from the left. Sir Charles Symonds, the eminent surgeon, is third from the right in the front row.

The Stemness Odyssey: Dancing on the Edge of Creation and Destruction

Jasmine Makker **MBBS5**

In a way, we are all explorers charting the complex topography of the human body—a terrain so intricate that we're constantly startled by new revelations. On this long odyssey, we've stumbled upon landscapes as enchanting as they are vexing, none more so than the realm of cancer. It is here that we encounter "stemness", a biological enigma that embodies both the protagonist and the antagonist of our tale.

The Physiological Canvas and the Pathological Paradox

In the normal course of human life, stem cells are like the maestro of an intricate biological symphony. These cells, understanding cues from their environment, regenerate, giving rise to the multitude of cells that make up our various tissues. Much like Hanahan and Weinberg's defining characteristics of functional cells, their physiological state commands six pillars: self-renewal, differentiation, spatial organisation, communication, adaptation, and, remarkably, self-regulation[1]. These are the primordial architects of life, demonstrating physiological stemness at its best: harmonious, essential for life, and strikingly versatile, orchestrating cellular proliferation and differentiation to morph from a zygote to a viable being. Yet, these features aren't static. In the evolving stage of life, stem cells adapt, shift, and mature along with the tissues they inhabit. They are the sages of cellular society, knowing when to act and when to rest.

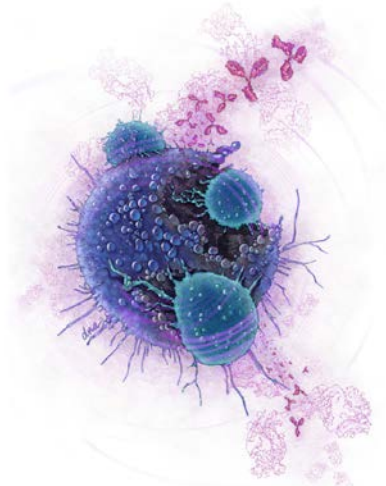
But even the wisest of sages can falter, and so can this physiological harmony. When their balanced dance turns discordant, pathological stemness takes the stage, creating an environment ripe for malignancies, where transformed cells manage to sustain proliferative signalling, evade growth suppressors, resist cell death, and master the art of invasion[1]. These rogue, protean cells become the cellular insurgents, wielding the same powers they once used to sustain life, now to propagate a cancerous uprising, raising profound questions about the duality of biology.

Tracing the Evolution: The Enigma of Cancer Stem Cells

Much like Darwin's finches, cancer cells, over time, have evolved. As Sherwin Nuland might remark, they bear witness to nature's incessant experimentation. It is through lineage tracing that we've unearthed cancer stem cells (CSCs). These cells are elusive, defying easy identification, shifting traits, and often lying in wait, silently evolving in hosts who may feel perfectly well. They can be rare, but their rarity belies their potential for catastrophe. In this verdant maze of cellular complexity, they are both the chameleon and the jaguar —masters of disguise and potent killers. They have the ability to drive tumour initiation, seed relapses and metastases, and are often resistant to being fully eradicated by treatment.

The study of the cellular microcosmos illuminates the CSCs' masquerade. For instance, the expression of one particular oncogene is positively correlated with the maintenance of "stemness" in glioblastoma-initiating cells[2]. On the other hand, a differential expression of cell surface markers on CSCs has been proposed to support their development into committed progenitors—cells that are fated for tumour development. For instance, leukaemia-initiating cells guise under the mask of a cellular marker also found on the life-sustaining haematopoietic stem cells, mimicking the healthy, whilst aiding and abetting the morbid[3].

Conventional therapies like chemotherapy and radiation, though powerful, often miss the mark. They shrink the tumour but spare the CSCs. As a result, cancer recurs. The sustenance of CSCs may be fuelled by factors that increase tumour vascularisation, allowing local and metastatic growth. These pro-angiogenic factors provide a promising therapeutic target. Yet as we adapt to this knowledge and introduce anti-angiogenic therapies, these cells reveal another hallmark: they activate alternative cell signalling pathways, defiantly sidestepping our strategies[4].



Immune cells attacking a cancer cell— Alexandra Webber, DNA illustrations.

Future Directions: Unanswered Questions

Our journey through this cellular labyrinth has been fraught with both revelation and frustration. Several compelling yet unanswered questions loom on the horizon, beckoning for further inquiry. Could breakthroughs in decoding the genetic fingerprints of cells offer a more sophisticated means of identifying these CSCs, hidden within diverse tumour populations? Additionally, the microenvironment of tumours is increasingly recognised as a co-conspirator in cancer pathogenesis: Could targeting its interactions with CSCs yield more effective therapeutic strategies? Furthermore, could novel markers offer a more precise lens through which to identify and eradicate them? And ultimately, is it possible to discern between pathological and physiological stemness at the molecular stratum, and identify patterns to predict and break the cycle? Delving into these questions could unearth strategies to selectively eliminate CSCs while sparing our benign, essential cells.

Epilogue

We stand on the edge of a frontier, equipped with more knowledge than ever before, yet humbled by what remains to be discovered. In this odyssey, where science flirts with the metaphysical and cells dance on the edge of physiological harmonies and pathological dissonances—between creation and destruction—we search for the elusive elixir that might finally tame the chaos. As we pen our discoveries with the ink of evolution and punctuate them with the hallmarks of disease, they beckon us to keep probing, challenging, and reimagining our healthcare paradigms, policy decisions, and collective human values along the way. Our tale, while far from over, promises to be one of the greatest ever told—a story of discovery, resilience, and unyielding hope that takes us ever closer to solving one of life's most profound mysteries.

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

From Cosmetics to Conflict – An interview with Mr. Naveen Cavale

Sammer Atta **MBBS3**

From the eager eyes of a medical student, the field is rapidly progressing into a new technological era: an age where surgeons orchestrate wonders using robots to perform the most intricate of procedures. Although this is increasingly the case in the field of surgery, plastics has taken a more conservative approach; for the surgeon's eyes, hands and imagination are far more valuable than what our artificial counterparts currently have to offer. As Mr. Naveen Cavale, consultant plastic surgeon at GSTT put it, "All you need is your hands, a knife, fork and a light."
I had the pleasure of interviewing Mr. Cavale; we explored the current climate of the medical field from his expert perspective, and touched upon his humanitarian and private work, along with the stigmas surrounding the field.

Mr. Cavale's journey into medical school was not straightforward; "I initially didn't get in ended up retaking A levels and took a year out." Having become a consultant at the age of 40, he accentuates how he does not regret "taking his time". Whilst for many medical students, completing medical training as quickly as possible is the ultimate goal: it was a relief to hear how it's not the be-all and end-all to not become a consultant by one's early 30s. We ought to enjoy the journey – though this is easier said than done when junior doctors earn less than baristas. Nonetheless, "we all get there in the end; very few people get wasted by the medical system."

What led to his decision to become a plastic surgeon? For Mr. Cavale "5 minutes" was all it took: one small moment that defined his entire career. It was during his final year that he was scurrying around, lost in the old UCLH building, and was met by "a consultant in plastics who was enthusiastic to show a massive necrotising fasciitis case which had spread from breast to knee". Many years have passed since, but I was amazed by how vividly Mr. Cavale described the event – truly reflecting the tremendous impact this one experience had. This may resonate to several of you readers: a particular case you witnessed that ignited your passion for a specialty... or completely shut down any possibility of pursuing it!

What if it was not only due to the events of that one fateful day which led to my interviewing him today? It was no surprise that he became a plastic surgeon: for the beauty of the field stems from its incredible range of presentations; it is truly a "head to toe" science. Every new case requires a meticulous new plan and process; and as a result, provides a unique realm of satisfaction that differs from other conventionally "repetitive" specialties. Incidentally (or not!), Mr. Cavale's diverse weekly schedule is moulded (pun intended) by the enormous variety of different surgeries he conducts. A canvas within a canvas if you will.

"I always worried about getting bored, my biggest fear in terms of work-related things is boredom."

From radiology to surgery to general practice, there is an immense variety of options for all aspiring medics to explore. Even with such a plethora of possibilities, it can be difficult to continue to be interested: performing the same procedure repeatedly can become arduous over time. For some, being called "doctor" loses its flare, and the burning passion of the once-zealous medical student within extinguishes. A "work-work" balance is Mr. Cavale's solution. Engaging in a new activity every day keeps him interested: one day for private clinic, one day for private surgeries, one day for GSTT elective surgeries, interwoven within several teaching sessions.

"If all you do is fix brakes on Ferraris, it may seem glamorous, but when you try to train the next person, you're going to inevitably get a bit bored with the repetitiveness, and not be a great teacher as a result."

Mr. Cavale's work extends beyond the bounds of London's operating theatres. In 2014, 5 years after becoming a consultant, he discovered that one of his orthopaedic colleagues had travelled to Gaza to provide humanitarian relief after a recent bombing. A plastic surgeon was also required. Of course, it is no surprise that such an opportunity would have sparked an interest in Mr. Cavale, and a few weeks later, after a ceasefire had taken place, he travelled to Gaza himself.

Why was a plastic surgeon required, and not a vascular surgeon too? What is particularly interesting is the futility of general, vascular, and neurological surgeons in areas of war and conflict. Modern day warfare is lethal: the sheer effectiveness of this era's weapons means that any damage to organs and major blood vessels will almost always result in death. Therefore, the majority of injuries that people survive with in war are those of the limbs which is why plastic and orthopedic surgeons are in high demand in these settings.

Unfortunately for such places of conflict, the help provided by external parties is limited, and

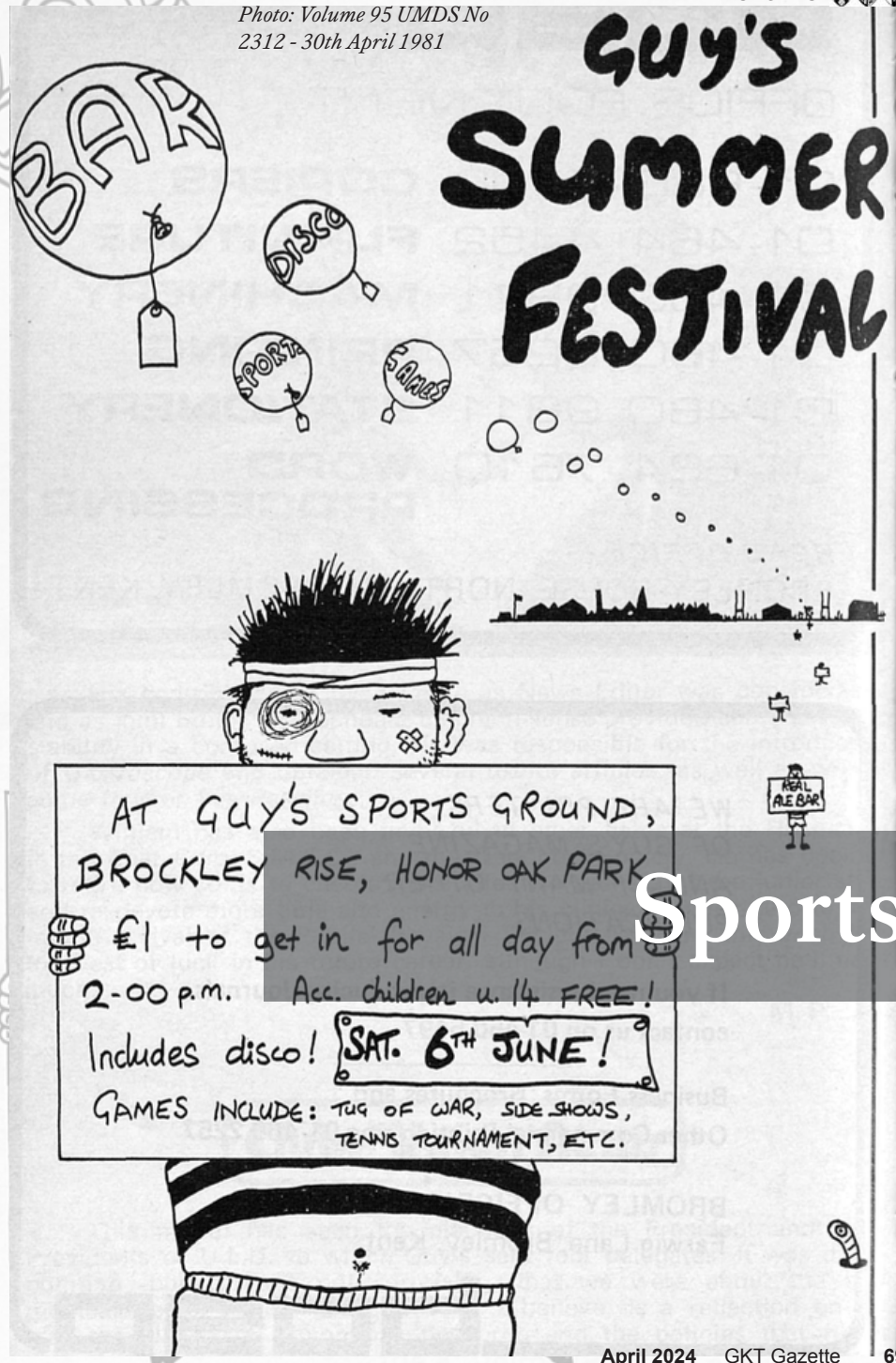
a consequence is "travelling, doing complicated surgeries which result in complicated complications that cannot be managed by local teams". Rather; "if you're a guest in someone's home, don't take over the cooking! So, do not just do their work but rather opt to work with them, help them out, and hopefully learn and share". This strategy has significantly improved the skill set of Gazan surgeons and as a result, they have become much better at dealing with limb injuries independently. As medics of developed countries, we should seek not to do the job of those who work there, but rather collaborate with them.

After discussing such a sorrowful subject, I decided to explore another aspect of his work. Mr. Cavale is one of the founding members of the "REAL Clinic" in Battersea, in which he performs cosmetic surgery as part of his private work. A controversial topic now, especially with the surge of mental health awareness in recent years, particularly with regards to body dysmorphia. Is cosmetic surgery a potentially unhealthy solution to an intrinsic psychological problem?

"Plastic surgery is not a cure for body dysmorphia, they will have the same issues before and after surgery. But surgery does help people feel a little better about themselves."
To operate or not to operate. "Choosing the right people to do it on is key," is Mr. Cavale's ethos when it comes to treating such patients: a good plastic surgeon must be able to identify which patients have underlying psychological issues in contrast to those who merely want to rectify, what is for them, a minor nuisance. It was reassuring to know that Mr. Cavale only makes recommendations in the best interest of the patient, however it can often not be as clear-cut as recognising 'healthy' patients is ultimately down to "experience that helps to figure out who should be operated on". Thus the importance of a mentor in such situations is paramount – newcomers to the field should seek further advice when unsure of whether to operate. Of course, this should not only be limited to the field of plastics – for being able to assess the mental health of patients is a vital component of all medical practice. It can start by asking a simple question about the patient's mood during a consultation – a small remark can make a stark difference.

Whilst this article focuses on the field of plastics, I hope to highlight the broadness and variety of avenues within the field of medicine, and a plethora of ways to pursue your interests above and beyond the theatres or wards of a hospital. With the hot-topic surrounding AI soon "replacing" the role of clinicians, I invite you to ponder on that thought once again, for medicine is an art: from people skills to creative surgeries, it is the practitioner's eagerness to solve a case that drives the impossible to be possible. While current technology possesses knowledge, it does not yet possess passion.

Photo: Volume 95 UMDS No 2312 - 30th April 1981



Sports

Rucking through the years: GKT Women's Rugby Football Club turns 30!

Sami Lewis **iBSc Anatomy**

This year marks the 30th Anniversary of Guy's, King's and St. Thomas' WRFC, the Women's Medics Rugby Team of King's College London. Thirty years ago, a group of WAGs of the Guy's Hospital Men's Rugby Team decided to try their own hands at rugby. What started out as a bit of fun at a 7s tournament, has now evolved into a force to be reckoned with within Women's rugby.

This momentous occasion was celebrated on September 16th with past and present girls coming together for a day filled with honor and gratitude for the incredible journey this team has undertaken over the past three decades.

The 30th celebrations started on a scorching morning at Honour Oak Park, with Team Blue taking on Team Gold in a match for the ages. Team Blue was captained by alumnus Hebe Talas and team gold by the current-captain Cloé Ragot. Both teams had a mixture of current and old girls with some GKT playing legends returning to light up the pitch. Despite a close game, team blue clenched the victory with a full-time score of 29 - 26. This marked the beginning of an annual alumni match. Post-match pints allowed for a dissection of some of the iconic moments of the game, most notably the 'dick of the day' award going to Milly Gibson for actively stepping to the side to allow Sasha Cutten, a GKT icon to score a try unopposed.

Celebrations continued on into the evening at The Governor's Hall, St Thomas' Hospital for the Anniversary Ball where players and alumni swapped the rugby boots for dancing shoes. Some GKT stars took to the stage, recounting and reminiscing their favorite club memories.

After dinner, the Hall transformed into a lively dance floor - where rugby girls demonstrated once more there is nothing that they cannot do. Festivities escalated in true GKT-style at pop-world. Forget about wins and losses, the evening was all about celebrating the GKT-spirit that has carried through the last 30 years and the life-long friends made along the way.

Once a Guy's Girl, always a Guy's Girl.

Heart and Determination

GKT Men Seize Victory Through Pens, Women's Courageous Stand Against RUMS

Nana Ossei **MBBS3**

The Gazette gives thanks to the King's College London Students' Union (KCLSU.org) for kind permission to re-publish the images used in this article.

Introduction

The fourth day of Varsity brought an electric atmosphere to the New River Sports Centre as GKT FC Men's and Women's first teams squared off against their RUMS counterparts. Morgan Lawrence (GKT), a third-time Varsity player, shared: "Excited to get out there with the boys again. It's my third varsity; the first time we won and the second time we lost, so it's time to get our revenge". Despite a challenging season, GKT Women's Captain Iona Shah remained optimistic: " We're really excited to be playing against RUMS".

GKT FC Men's Starting XI:
Johannes Jansen (Goalkeeper)
Mikhail Aziz-Picardet (Defender)
Liam Walsh (Defender)
Michael Hulley Prescott (Defender)
Adam Motara (Defender)
Sean Wynn (C) (Midfielder)
Freddie Jennings (Midfielder)
Thiago Woldesus (Midfielder)
Bohdan Koshchavets (Attacker)
Anry Kikava (Attacker)
Marlon Ordoñez (Attacker)

Subsitutes:
Saif Mukadam (Attacker)
Morgan Lawrence (Attacker)
Jacob Cameron (Midfielder)
Jack Lindsay (Defender)
Dunbarin Onabowale (Defender)

RUMS FC Men's Starting XI:
Rhys Hughes (Goalkeeper)
Dom Sidwell (Defender)
Casper Carlsson-Metcalf (Defender)
Theo Rifkin-Zybutz (Defender)
Alex Heatley (Defender)
Joe Vijayanathan (C) (Midfielder)
Josh Schlanker (Midfielder)
Harry White (Midfielder)
Tom Grand (Attacker)
Xane Safdar (Attacker)
Fedor Belyakov (Attacker)

Subsitutes:
Anan Kuleindiren (Midfielder)
Demi Ojo (Attacker)
Charlie Song-Smith (Midfielder)
Euan Sexton (Midfielder)

Men's Game

The Men's game kicked off with both sides contesting for dominance very early on, with last year's defeat adding a layer of determination for GKT.

The first 20 minutes saw GKT dominate the game with a period of real sustained pressure. Early attempts from GKT forced some good defending and a class fingertip save from the RUMS goalkeeper. RUMS then grew into the game creating several half chances, but the first half finished 0-0, with GKT narrowly edging them in performance.

The second half resumed with GKT piling on the pressure. A key substitution saw Saif (GKT) score a lovely volley from 18 yards out into the bottom corner to make it 1-0, followed by euphoric celebrations from GKT.

At around the 70th minute mark, the momentum shifted with RUMS starting to push back with some good substitutes coming on against tired legs. GKT thought they'd seen the game out when Tom (RUMS) equalised in the 90th minute with a tidy finish from a header across goal to make it 1-1.

The game ultimately went to penalties, with GKT going onto win 4-3 (5-5) after Johannes (GKT) provided two class saves to see GKT return to being Varsity holders.

Goalscorer Saif (GKT) had much to say post-match commenting: "Just want to say great performance from both teams. Just happy I could contribute to the win and score a goal". GKT Captain Sean Wynn rounded off by commenting: "I couldn't be prouder of what is a really young team going and playing with such confidence and authority on such a big occasion". The mood wasn't all sour on the other side, with the RUMS Captain commenting: "Looking forward to next year to reclaim the trophy".

Women's Game

After the triumphant victory of the GKT Men's, the day's events moved onto the Women's game between GKT and RUMS. The two teams last met in NAMS, which ended in a full time score of 2-2, with RUMS later winning on penalties.

This gave the GKT Women the much needed venom as they started the first 15 minutes of the first half very strong. GKT came close to scoring with a few chances in the RUMS box but ultimately couldn't convert. RUMS didn't sit back and equally pushed back hard, playing some beautiful football. This culminated with Alyiah (RUMS) using her quick feet and turns to tap it past the keeper making it 1-0. Soon after, Ali (RUMS) made it 2-0 with a tap-in after an assist from Alyiah (RUMS), ending the first half with a score of 2-0 to RUMS.

The second half began with a fight as GKT were keen to get one back. Unfortunately, GKT conceded midway through the second half as Ali (RUMS) tapped it past the keeper again to make it 3-0. The GKT Women continued to put their all into the game and produced more

GKT FC Women's Starting XI:
Myah Chetanwala (Goalkeeper)
Eleanor Todd (Defender)
Alicia Barclay (Defender)
Montse Martí (Defender)
Mara Bortnowschi (Defender)
Neha Nouman (Midfielder)
Hetty Hill (Midfielder)
Daisy Powell (Midfielder)
Hana Roob (Attacker)
Bente Van Der Graaf (Attacker)
Iona Shah (C) (Attacker)

Subsitutes:
Abby Musselwhite (Defender)
Kat Von Allwörden (Defender)
Maria Marasescu (Midfielder)
Ana Rivera (Attacker)
Cidel Barahona (Attacker)

RUMS FC Women's Starting XI:
Safia Safdar (Goalkeeper)
Liv Lloyd-Williams (Defender)
Lydia Jeremiah (Defender)
Kiera Leonard (Defender)
Lena Hege (Defender)
Zaina Alavi (Midfielder)
Diya Jain (C) (Midfielder)
Anika Kyrdalen (Midfielder)
Alyiah Seow (Attacker)
Carolin Niederauer (Attacker)
Ali D'odorico (Attacker)

Subsitutes:
Zuva Dengu (Defender)
Emilia Parsons (Midfielder)
Catherine Martins (Midfielder)
Olivia Pickford (Attacker)
Leyla Cilek (Attacker)

chances but were unable to convert any. The game ended with a final score of 3-0 to RUMS Women's but it can't be understated the valiant effort the GKT women showed.

Despite the defeat, GKT Women's Captain Iona Shah was proud of her team's fight: 'We did put in a good fight especially towards the end. It was a great atmosphere with all the support from family and friends who came". RUMS Women's Captain Diya Jain had much to say, commenting: 'Honestly, it felt amazing to play varsity. We have been such a strong and consistent team this season".

When asked, both captains highlighted the growth of Women's football. Captain Shah (GKT) commented: "I can see Women's football growing even further within the university. We've had so much interest from girls who have never kicked a ball before joining university, so it's really clear that women are gaining more confidence to start playing". Captain Jain (RUMS) celebrated its rising recognition, stating: "As a woman that plays and loves the sport, I am glad this is being recognised more".

The day showcased the best of university sports, with both GKT teams exemplifying remarkable determination and resilience. Special appreciation goes to the friends, family and organisers who supported this historic event, underscoring the spirit of community and sportsmanship that defines Varsity matches.

Congratulations to the Men's team for their thrilling penalty shootout win and to the Women's team for their tenacious performance.

KCL Fencing's Annual Charity 24-hour Fenceathon

Roy Yan **MBBS3**

Hi all! My name is Roy, a third-year medic and the current President of KCL Fencing Club. I'd like to introduce the Gazette readership to the club's annual charity event, the Fenceathon. As one might be able to deduce, the event consists of a fencing marathon taking place over 24 hours, traditionally during February from Friday to Saturday at 4 pm and held at the Great Hall on Strand campus as well as live-streamed online on our Twitch channel. The Fenceathon is always done to support a charity nominated by the committee, with previous charities including the British Heart Foundation, Médecins Sans Frontières and the Amber Trust.

The club has always had a philanthropic streak at its heart; before the Fenceathon started in 2018, members would run up Guy's Hospital Tower Wing's 30 floors in full fencing gear for charity. While certainly impressive, I can understand why the Fenceathon was adopted as it plays better to our strengths and is more visually interesting to friends and family watching. Owing to the Fenceathon's nature, many turn up at the start of Friday evening and fence to midnight, at which point most take a break and leave the graveyard shift to a few brave souls until Saturday morning, when fresh replacements take over and carry the effort to the end in the afternoon. Our members generally treat this as an extended training session and a chance to spend the night with friends for a good cause.

This year, the club chose to support The Brain Tumour Charity and had record-breaking attendance this year from both KCL and GKT students as well as external fencers, with three brave GKT troopers (including myself!) staying up and fencing for the entire 24 hours. The charity representatives also came to visit in the morning and congratulate us on our hard work. Finally, thanks to the massive support of well-wishers, friends and family watching in-person as well as online, we hit our initial fundraising goal of £1000 in six hours and eventually raised £1562, both of which had never been done before in the past six years!

I hope reading this has opened your eyes to our contribution to the many student-run charity events run across the year and that you'll consider tuning in to watch us go at it again for Fenceathon 2025 or even join the club! Beginners are more than welcome and we'd love to teach you about the wonderful sport of Fencing.

Professor Emiritus Newell W Johnson Obituary

CMG, FMedSci, MDSc, PhD, FDSRCS (Eng), FRACDS, FRCPath (UK), FFOP(RCPA), FOMAA, FICD, FHEA (UK)

Saman Warnalulasuriya and Stephen Challacombe

Professor Newell Walter Johnson died on 20 January 2024. He was Emeritus Professor of Oral Health Sciences, Faculty of Dentistry, Oral & Craniofacial Sciences, King's College London and Honorary Professor of Dental Research, Menzie's Health Institute Queensland, Griffith University, Australia. He was active in research until the end, sharing as principal investigator in MIMSA, a COVID research study with colleagues in the Centre for Host Microbiome interactions at KCL.

Newell joined King's College London (formerly KCSMD) in 1993 having served London Hospital Medical College as Professor of Oral Pathology, as Director of the Medical Research Council Dental Research Unit, London and Nuffield Research Professor of Dental Sciences, at the Royal College of Surgeons England; At King's Dental Institute in addition to his duties as Professor of Oral Medicine & Pathology he was the Director, Research & Postgrad Education, 1984-2003. Following his retirement from King's in 2005 Newell took up the position of the Foundation Dean/Head of School of Dentistry & Oral Health, Griffith University, Australia; and Professor of Dental Research, Griffith University, Australia; From 2009 and till recently he served as a Senior Fellow, Menzies Health Institute Queensland.

Newell's Honours include the International Association for Dental Research Distinguished Scientist Awards in Oral Medicine and Pathology, 2005 and for International Oral Health, 2017 ; the John Tomes Medal of the British Dental Association for Outstanding Service to the Profession and the Association, 2004; President, Section of Odontology, Royal Society of Medicine for their bicentenary year, 2004-5; and President of the British Society for Dental Research for 2004-6. He is one of four Dental Fellows of the Academy of Medical Sciences from the KCL Faculty of Dentistry, Oral and Craniofacial Sciences (out of 10 in the UK). The most senior honour was appointment by Her Majesty the late Queen Elizabeth II as a Companion of the Most Excellent Order of St Michael and St George (SMG) in 2011 for services to oral health and to public health internationally.

Newell was a prolific researcher and during his long academic career was supervisor to 30 successful PhD students. He was much loved by his trainees particularly those who came to the UK for postgraduate studies from the Commonwealth Countries. Newell had a remarkable drive in all research activities he conducted on dental caries, periodontal diseases, tropical diseases affecting the oral cavity and oral cancer. He authored many textbooks, published over 600 research articles with a citation H index of 92

Newell was 85 years old at the time of his death and is survived by his first wife Pauline and his two daughters Sarah and Nicola, and 3 grandchildren. His second wife Jeannette, died in 2016. The world has lost a brilliant academic, researcher and a mentor and we have lost a cherished friend.

Robert Greenwood Walton Obituary

Robert Greenwood Walton, M.D., of Modesto, California, met his goal of living a century when he celebrated his 100th birthday on February 13, 2023. He passed away on April 21, 2023 at his beloved Frank Lloyd Wright home, where he lived for 62 years.

Walton was born in Burnley, Lancashire, England. At the age of 17, in 1940, he entered medical school at Guy's Hospital, London the same year Britain entered the Second World War. The fact the famous teaching institution was situated at London Bridge made it a prime target for Nazi bombers. Robert was an eyewitness to the horror. Too young to be drafted, he served in the Home Defense where, for the privilege of being a medical student, he was expected to help with bomb victims. He learned to think fast or face the consequences.

After the war Walton was a Captain, Regimental Medical Officer in the British Army of the Rhine, in Occupied Germany. Taking care of healthy soldiers waiting for discharge orders, he prescribed sports, among them, horseback riding, show jumping and steeplechase. Here Walton honed his equestrian skills, courtesy of his attachment to the Royal Horse Guards!

After the war, Walton acquired an internal medicine residency post at Vancouver Hospital. When he decided to become board certified in dermatology it meant a move to Stanford University Hospital. To complete the three-year residency requirement, he finished up at University of Michigan. He passed in the top three in the USA for the American Board of Dermatology and Syphilology exams.

He met his future wife, Mary Elizabeth Lee, a nursing student in a class Walton guest lectured. They were married on June 27, 1953, in her hometown of Midland, Michigan and then moved out west.

During their amazing 63-year marriage, the couple produced six children, managed a cattle ranch, grew the sport of polo, all the while treating patients in a large practice. As professor of dermatology at Stanford, he started, managed, and grew the tumor, mole and melanoma clinics. Dr. Walton is known for several scientific papers that introduced new concepts that changed previous theories.

Polo was his passion. He was past president of the United States Polo Association and was instrumental in growing the sport of outdoor and indoor polo, providing players, a polo field and horses. All six children played polo and three of his sons were internationally rated polo players. On a local level, Dr. Walton founded the Modesto Polo Club and supplied the field.

To his wife's midwestern family, he was a dapper Brit, drinking scotch on the rocks and asking everyone to give a speech at dinner. Though he was always proud of his British heritage, Walton became a U.S. citizen. He once remarked if he had stayed in Britain, he wouldn't have attained the success the United States afforded him. He loved America.

Robert G. Walton is survived by his six children: Betsy, Rob, Bil, Susan, F.D. and Mary Alizon Walton; his four grandchildren: Madeleine, Sophia Walton Alford, Will and Mary Alizon Walton; three great-grandchildren: Delmar David, Robert Callaghan and Frederick Harrison Walton; and Tessa Callaghan Lord, the mother of his great-grandchildren.

Walton was predeceased by his wife, Mary Elizabeth (nee Lee) and his grandson, Delmar Carroll Walton.

Professor Stephen Challacombe, the Gazette chairman, gave us a brief history. Bob Walton was a founding member of the John Fry Medical Alumni group, and a very strong supporter of Guy's and the Rugby club. He was a dermatologist at Stanford, and for many years came over to Guy's for alumni reunions.

Burial at Oak Grove Cemetery, Knight's Ferry, California. Memorial contributions may be made to: Polo Players Support Group, Inc., 516.528.3821, www.polosupport.com, dave@polosupport.com; Community Hospice Foundation, 209.578.6370 heart@hospiceheart.org; Modesto Masonic Lodge 206, 209-524-3238; Paralyzed Veterans of America, 800-424-8200, www.pva.org.

Maurice Lessof, clinical immunologist; emeritus professor of medicine, Guy's, King's and St Thomas' hospitals; and chairman of Lewisham Hospitals NHS Trust, has died at the age of 99.

Professor Maurice Lessof Obituary

clinical immunologist, allergologist, and medical educator

Rebecca Wallersteiner (wallersteiner@hotmail.com)

This obituary was originally published in The BMJ (BMJ 2023:382:p2254), 29th September 2023.

Lessof was born in London, the son of Noah Lessof and Fanny (née Slonim). He grew up in Clapton, east London, with his sister, Elizabeth, on the same street as all his cousins. As the only boy he was much adored. His parents were Jewish immigrants from Russia, having escaped the pogroms that followed Russia's defeat in the war with Japan, and worked together making leather goods. Educated at the City of London School, Lessof enjoyed art as well as academic subjects, and during the second world war he was evacuated with the school to Marlborough. He later told his family that he would have liked to study architecture, but his parents' dream was for their only son to be a doctor and they were very proud when he was accepted by King's College, Cambridge, to study medicine.

At medical school, Lessof was not the most devoted student—he and his friend Edwin Besterman spent many nights climbing and ingeniously balancing bicycles on college spires, and he travelled round postwar Europe, attending left wing student congresses, rather than revising. He applied for service to the Royal Air Force and the Royal Navy, but was rejected by both—the second rejection was followed by an explanation that he had tuberculosis, which he had unknowingly contracted from a patient on the wards. He spent 18 months recovering at a sanatorium, after having one lobe of his lung removed; it took him years to feel completely well.

Career

After graduating, Lessof did his clinical training at Guy's Hospital, London. He held various junior hospital posts at Lambeth Hospital, Guy's Hospital, the Canadian Red Cross Memorial Hospital in Buckinghamshire, and Johns Hopkins Hospital, Baltimore, USA. In 1967 he was appointed senior lecturer and clinical immunologist at Guy's. He went on to become professor of medicine (1971-89) at the United Medical and Dental Schools of Guy's and St Thomas' (now Guy's, King's and St Thomas'), where he supervised 11 professorial posts and had a substantial managerial, teaching, and research commitment.

On his retirement the Guy's Hospital Gazette published a tribute: "Maurice Lessof's contributions to Guy's and to medicine generally are innumerable and ongoing. He is, first and foremost, a kind and concerned physician and an excellent one. Greatly admired as a teacher, he excels in patient and lucid exposition, drawing on an extensive stock of personal experience and a very broad knowledge of the literature. His chosen specialty, clinical immunology, is typically a challenging emerging area of clinical medicine to the advance of which he has made major personal contributions. To the young who flow unceasingly through this institution he is an ever courteous, ever available, supportive, but uncompromising and demanding guide. To those of us fortunate enough to have grown older with him, he has been a loyal, critical, quizzical, always constructive colleague."

He married Leila Liebster, the daughter of Lionel Liebster, a GP in Tottenham, on 24 November 1960 and they had three children—Nicholas, Suszy, and Carli. The couple shared a birthday (different years) and hosted wonderful joint birthday parties, bringing together their family and friends from different parts of their lives.

Medical educators

Both Lessof and his wife made a considerable contribution to medical education. Martin McKee, professor of European public health at the London School of Hygiene and Tropical Medicine, recalled, "Leila and Maurice's greatest legacy is their many junior staff who went on to hold senior positions in the NHS or academia. Leila would claim that it was her ability to pick those with potential but, in reality, it was the way that she and Maurice gave younger people every possible opportunity to develop their skills and how they opened the many doors in British medicine to which they had access so that others could follow. Both maintained a keen interest in the achievements of those they had trained long after they had moved on to other things."

Cyril Chantler, retired paediatrician and paediatric nephrologist, said, "I knew Maurice from my days as a medical student when he was a senior registrar. He and Leila lived in Trinity Church Square next to my digs in Trinity Church Square, near Guy's. Watching him trying to wash his car, probably on Leila's instruction, was hilarious. He was a much better doctor and it was he who pointed out to me that he needed a house physician after my pre-registration year. Lucky me. It is perhaps inevitable that when you are young and inexperienced you make mistakes. For a doctor that can be both dangerous and scary. Maurice was kind both to his patients but also to the people who worked for him, and I always knew I could tell him when I had, or sometimes when I thought I had, made a mistake. He always listened patiently and provided support and good advice. I knew I was safe and could learn. I am not at all sure young doctors feel the same today. Later on he helped my career in many ways and I am not alone in this. He was a wonderful man and an excellent doctor."

Food industry

Lessof wrote, "My personal interests and the responsibility of my own group was in clinical immunology, with a special interest in allergy, food allergy, and other problems related to food." This resulted in his becoming adviser in allergy to the chief medical officer, where he advised the Food and Drug Federation on problems of the food industry, largely concerned with food labelling. As medical adviser to the Leatherhead Food Research Association he helped to set up their food intolerance database, similar databases in other European countries,

and a European Commission funded report on the occurrence of severe food allergies. In 1997, on their behalf, he also edited a book, Food Allergy Issues.
Lessof was also the editor of four and sole author of a further two books on allergy and immunology. He was also the first or associated author of over 100 papers in scientific journals.

Portrait of Maurice Lessof, in the Education Centre at University Hospital Lewisham, honouring his outstanding charimanship of Lewisham Hospital Trust 1993-1997

He served as senior censor, member of the council, and senior vice president of the Royal College of Physicians, London (1986), where he provided guidance and leadership and chaired the college committee on clinical immunology and allergy. Outside immunology, he was senator of London University in 1983-85 and chairman of Lewisham Hospital Trust in 1992. He was a life member of the Royal Society of Medicine.

He was an honorary member of the British Society for Allergy and Clinical Immunology and an elected member of the Society of Scholars of the Johns Hopkins Hospital, a fellow of the American Society for Immunology and Allergy, and a council member and committee chairman of the Collegium Internationale Allergologicum and the International Association of Allergy and Clinical Immunology. He was a member of the Athenaeum Club from 1973 and served on the general committee from 2000 to 2003. He was listed as a noteworthy physician and medical educator by Marquis Who's Who.
In his little spare time he enjoyed travelling and painting, as he never lost his love of art. In retirement, he took up sculpting. Both Lessof and his wife were active members of West London Synagogue.

Maurice and Leila Lessof were described by their family and friends as "a couple and a real partnership—very different and very equal." "His gentleness, decency, and kindness shone through, even when he was no longer entirely sure who anyone was." In his last few years he had dementia and died peacefully at home, a few months after Leila (see obituary: doi:10.1136/bmj.p2253).
He was predeceased by his sister, Elizabeth (who died aged 101), and survived by his three children—Nick, a paediatrician; Carli, a social researcher; and Suszy, coordinator of the European Observatory—and his grandchildren, Noa, Gabriel, Maya, Ila, and Louis.

Maurice Hart Lessof (b 1924; q Cambridge/Guys, London, 1947; FRCP, MA Camb), died from advanced old age on 3 August 2023

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