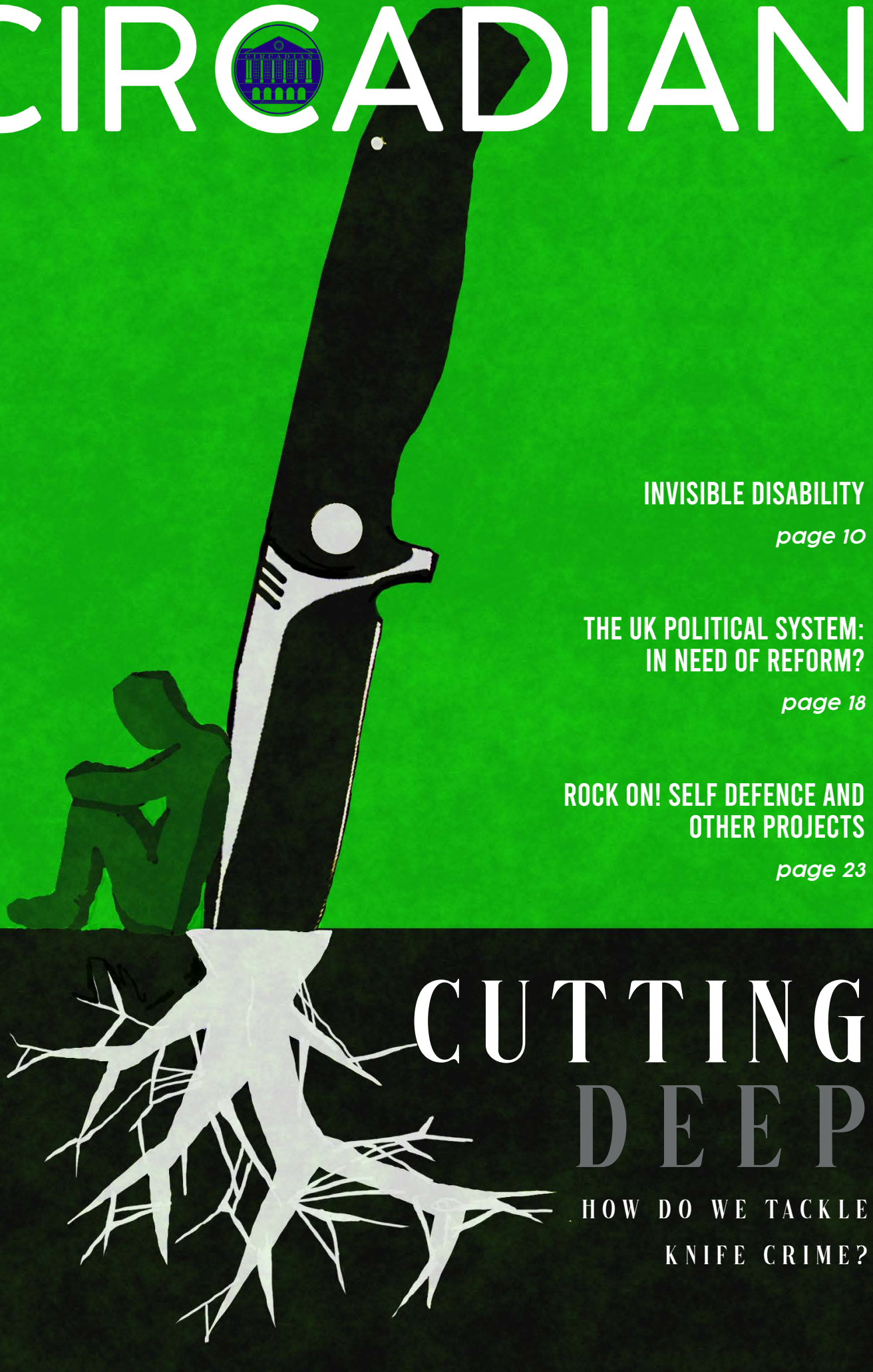
FEBRUARY 2020
ISSUE 2

THE VOICE OF BARTS AND THE LONDON
FREE

CIRCADIAN



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HOW DO WE TACKLE KNIFE CRIME?

OUR TEAM

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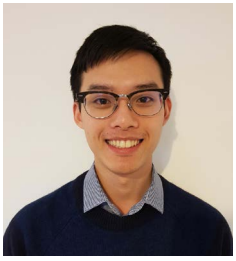

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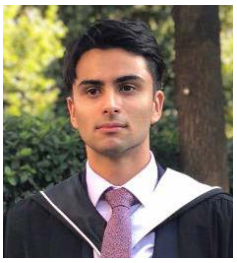

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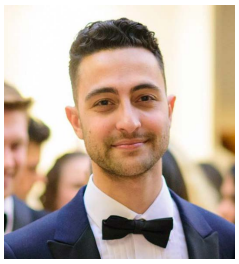

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WANT TO GET INVOLVED?

We're always looking for people who want to write about the latest developments in healthcare, student life or just anything that matters to them!

If you have an idea for an article, don't hesistate to contact any of the people above and we'll do our best to get it published! If you have any questions or want to send in an article, you can contact us by emailing circadian@bartslondon.com.

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EDITORIAL

Barts and The London is home to over 3,000 students studying the healthcare sciences in the heart of the East End. Although it is privilege to study in this unique and diverse community, the east end has gained a reputation of being one of the 'rougher' parts of London.

The Metropolitan Police have ranked Tower Hamlets as the fifth most dangerous borough in the capital. As a result, safety is an inevitable topic that surfaces within our Barts community. With continual growth year on year, our community is expanding at an incredible rate, of-course our safety is given, or is it?

Is the university upregulating security to meet the demands of this increasing cohort? How safe do you feel? Especially after recent reports of knife crimes being seen in all parts of London, especially right at our door step.

This issue explores the theme of safety within Barts and The London, shedding some light on the community's attitude to safety with exclusive interviews with trusts that are heavily active in this area. Of course, it's not all doom and gloom. We also bring you up to date on current affairs within our university as well as analysing the prominent national issues.

We are really excited about the future of Circadian, despite being only our second issue, (third if you include the Freshers special!), we have received tremendous support from the student body as well as external organisations. With this support, we hope that circadian will continue to expand and become a fully integrated and integral part of our Barts and The London community.

Happening Around BL

BL Surgical Society

We've kicked off a busy year full of careers evenings and skills workshops; covering Ophthalmic, Max-fax, Breast and Plastic surgery so far, with lots more to come. We have also hosted our first ever Surgical iBSc Fayre with talks from all major London courses, and some cheeky cheese and wine! We're so excited to celebrate girl power with our Women in Surgery event next month, followed by our biggest conference yet!

BL Tennis

We will be hosting a SOCIAL TOURNAMENT on Sunday 9th February 11am-4pm at Lee Valley. We are asking members of BL Tennis to find a doubles partner who is a part of a different club/ society! We are welcoming players of all standards to join this fun, snack and drinks-filled day – so find your partners and sign up! Trophies will be given to the winners! Have a look at our facebook event for more details!

BL Christian Union

"Who Am I?" - try genuinely asking yourself this question.The answer is going to be beautifully personal to you. We had a week of events exploring identity, considering Am I More than - My Sexuality, What Others Think of Me and My Achievements, seeing that finding our identity primarily in these things is problematic. Perhaps we were created for something else, something which truly fills that void within.

BL Friends of MSF

We're all about raising awareness and funds for the world's leading emergency medical aid organisation! We collaborated with QM Arab soc to host a speakers event on aid in the Middle East and also joined them to host a fun cultural night filled with music, games and quizzes! Keep an eye out for the exciting things we have to come!!

BL Indian Society

BL Indian Society have been busier than ever this term with sell out events. Our Diwali celebrations saw over 200 people come for a night of entertainment, food and more! We also have regular social for all our members. Expect these to continue in the next term and look out for our event of the year which is also happening this term!

BL Peer Assisted Learning (PAL)

We are an educational society that spans across all 5 years at BL. You can look forward to the following events and activities we have planned over the next term (details on FB): 1 to 1 tutoring for year 1 and 2 students, small group sessions for year 3 and 4, pre ICA crash courses for years 3 and 4, national revisions for finals, OSCE teaching for year 3 and 4, and mock exams for year 1 and 2 students.

Rock Projects

ROCK Projects has kicked of this academic year with a bang! All thanks to our amazing volunteers, who have taken their time out to contribute to our East London community. From helping our very own Barts/QM students, school children & the homeless community, we have taught Self-Defence, BLS & fed/clothed the needy! Get involved in our monthly Street Kitchen and numerous other events this term! IG: @rockprojects

BL LGBT+

LGBT+ Soc had a fantastic time together as we all gathered just before the end of term for our Christmas Potluck. Some of our members also ran the Red Run on World Aids Day to raise money for HIV services across London-and raised over £250 for Positive East! Since coming back, we've kicked off the year with a bang at our karaoke night. We had a great time belting out some classic tunes and catching up. Happy NY!

BL Drama

In December, the Zebraphiles put on their annual Barts show. It was a hilarious evening, and even drew audience from some other London medical schools. This term we put on our pantomime 'Dancing Queen of the Rings', an inspired combination of Lord of the Rings and the songs of ABBA. Directed by Grace Catchpole, Ross Johnston and Angela Fitzpatrick, the first night was an absolute sell out - thank you to all who came!!

BL Music

Last term was a busy term for BL Music! Our Fresher's Concert, Christmas Carols and Bart's Guild Christmas Concert were all a huge success. If you missed out on our wonderful performances, check out our YouTube channel (https://bit.ly/36OfoWy). We are currently preparing for our Barts Arts concert which will take place on 31st March in the Old Library!!

BL Argudent

BL Argudent, a newly formed dental debate society, has hit the ground running this year, hosting a number of events. Our first event was an introduction to debating, preparing our members for events to come. The highlight of the term was a Staff vs Student debate in Laird Hall with a great turnout and excellent debating from both sides. We are currently planning our next event, a Dentists vs Medics debate.

Barts Community Smiles

This month we have been focused on Sugar Awareness Week. We have partnered up with King's Smilesoc to promote this and for a week we encouraged students at Mile end campus to take part by giving up "free sugars" and swapping them for healthier, sugar-free alternatives! Also, Action On Sugar invited us to the House of Commons to discuss what we could do on a national level to help tackle the problem of Sugar in the UK.

BL Yoga

Here at BL Yoga we've been enjoying our calming weekly sessions with our amazing teacher Yasmine. We are currently preparing for our annual Yoga retreat on the peaceful shores of Devon! More details and information on how to sign up are available on the BL Yoga Facebook page.

Griffin Community Trust

December highlights include a Christmas party where Shaftesbury residents had festive pie and mash, crafts, games and carols. In January we organised Chinese New Year celebrations at Toynbee Hall and an afternoon for everyone at a local pub, where 50 of us had a great lunch and took part in a closely fought quiz. Applications to live in Griffin House are now open - check out our website for more information!

Want to be featured in this section? We'll be sending out a form to student groups before the next issue comes out so keep an eye out!

CUTTING DEEP

BY KRISHNA SRUTHI VYDYULA

19TH OCTOBER 2019

BBC

"STRATFORD STABBING: BOY, 15, KILLED IN EAST LONDON"

13TH JANUARY 2020

London Evening Standard

POPLAR STABBING: BOY FOUND IN POOL OF BLOOD AFTER KNIFE ATTACK

IN BOTH CASES, THE PERPETRATORS WERE 15-YEAR-OLD MALES ARRESTED FOR MURDER AND GRIEVOUS BODILY HARM.

In July 2019, I took a taxi from Whitechapel to Heathrow. My driver Rizwan and I sat in bleary 5am-silence for a while, before he opened with the customary "Where you off to then?". In his own words, Rizwan "should've been a politician"; the man has strong opinions on everything from house rents ("You're being ripped off woman") to racism ("I'll go back to my country if they let me take the diamond"), delivered with an air of indisputable authority. A former youth worker, Rizwan was laid off, when budget cuts closed down several youth centres (places for young adults to engage in after school activities and seek mentorship). It was our ensuing conversation on the rising rates of youth knife crime and gang violence that inspired months of research and interviews, resulting in this article.

In 2017, young people aged 15-19 years represented 35% of all perpetrators of violent crime and 10% of victims, a gross overrepresentation considering they only make up 5% of the population. "Broadly speaking, austerity and the related socioeconomic impact has created an environment where many young people feel forced to use criminogenic means to achieve fundamental needs," says Ms. Lisa Rowles (Director of Evidence and Innovation, at the charity Khulisa).

"OFTEN THE YOUNG PEOPLE WE WORK WITH ARE ALREADY UNDER PRESSURE TO BE THE BREADWINNER. IN THIS ENVIRONMENT, THEY ARE EASY PREY TO GANGS, DRUG PEDDLING, AND THE RELATED AND INEVITABLE VIOLENCE."

Khulisa was founded in a post-apartheid South Africa in 1997, focusing on reducing violence and crime in some of the world's most dangerous cities. A testament to their success, they won a 'Best Practice Model of Transformational Social Impact' award in 2006 from the UN Office of Drugs and Crime. In 2007, the British chapter of Khulisa was founded with the aim of working with youth in communities, schools, and prisons to identify and mitigate factors that lead to engaging in violence and crime.

Youth violence, Ms. Iman Haji (Research and Programme Coordinator at Khulisa) explains, is usually an amalgamation of factors, ranging from mental and physical stressors due to poverty, a lack of mental health support and education on wellbeing, cyberbullying, and peer-pressure. "Almost all our participants have experienced childhood trauma due to Adverse Childhood Experiences (ACEs)," continues Ms. Haji. ACEs, usually divided into Abuse, Neglect, and Household Adversity (parental mental illness, substance abuse, domestic violence, etc.) are known to affect brain development, leading to poor decision making, impulsiveness and a tendency to react with violence instead of logic. These factors often culminate in expulsion or suspension from school, resulting in poor employment prospects, increased exposure to negative influences, and engagement in criminal activity. According to a 2019 education committee report, school exclusion is the single largest predictor of crime and antisocial behaviour. Cue budget cuts in the past decade resulting in a lack of youth clubs and community spaces in deprived areas, the product is a generation of youth easily accessible for exploitation in unsupervised spaces such as public parks and shopping centres, with knives being the weapons of choice.

HISTORICALLY, THE RESPONSE TO CRIME HAS TAKEN THE FORM OF INCREASED POLICE PERSONNEL, STOP-AND-SEARCHES, AND MAKING KNIFES INACCESSIBLE TO YOUTH.

'[However] there is an emerging understanding that these issues won't go away with enforcement alone,' says Mr. Michael Carver, Lead Nurse for Violence Reduction at Barts Health. In this role, Mr. Carver is responsible for conducting research into the demographics and trends in violence, to determine how health services can help prevent future injuries. In 2018, Mayor Sadiq Khan commissioned the

ROADMAP TO SUCCESS; A GLIMPSE INTO KHULISA'S PRISON PROGRAMME

CHILDREN PARTICIPATING IN ACTIVITIES THROUGH KHULISA'S SCHOOL PROGRAMMES

establishment of Violence Reduction Units, modelled after existing systems in Glasgow. The endeavour adopts a novel Public Health approach to violence, an interdisciplinary undertaking consisting of media campaigns (such as 'London needs you alive'), funding grants for community youth centres, and partnerships with third party sectors. A product of the VRU is the 'NHS Violence Reduction Network', which has helped establish teams of caseworkers at the Royal London in partnership with Tower Hamlets Council, St. Giles Trust, and Victim Support. Similar ventures exist in the other three major London Trauma centres to ensure the presence of trained workers to deal with young patients holistically.

"WE USED TO TREAT SOMEONE AND SEND THEM STRAIGHT BACK INTO THE SOCIAL CIRCUMSTANCESTHAT MAY HAVE HARMED THEM IN THE FIRST PLACE", CONTINUES MR. CARVER.

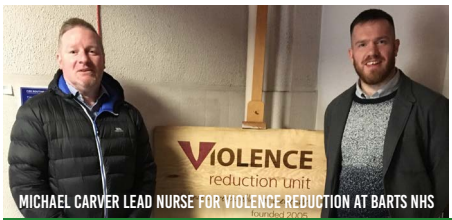
"Now we try to understand what's happened, the precipitating factors, and if we can do anything to prevent it from happening again." However, traditionally the role of the Health Service is to treat injuries and illness and offer advice on prevention; Is addressing the social side of youth crime really our responsibility? "It is absolutely our responsibility. Perhaps not legally, but it should be our moral responsibility," states Mr. Carver. As a demographic, 70% of young people witness real life violence once a month, and 16% witness it daily. The research on ACEs and deprivation also shows their association with long term morbidity including smoking, alcohol use, poor diet and of course, a tendency towards violence victimisation and perpetration resulting in bodily harm. From a public health perspective, a young person's admission into hospital is a crucial opportunity to identify and address circumstances which, left untreated, stand to burden themselves and the NHS through the life course of the victim. Consequently, there is also a call for General Practitioners to become more informed on recognising ACEs and referring to appropriate community services.

There is no single solution to youth crime; it is a symptom of underlying social circumstances leading to exclusion, requiring a systematic approach to mitigate the root causes. "The most difficult part is showing these young people they have other options," Says Mr. Shafiur Rahman (Executive Director of the Osmani Trust, a youth charity based in Whitechapel). "We need to offer them something better than quick money from drugs and gangs." One of the Trust's main initiatives is the 'Aasha Program', which provides mentoring, hobbies, employment counselling and gang mediation for at risk-youth aged 12-25, aiming to help prevent exclusion and reintegrate them into the community.

At Khulisa, the interventions fall under three categories; prevent, rehabilitate and reintegrate. Their trauma-informed approaches are based on the latest research in neuroscience and neurodiversity, seeking to teach emotional regulation, increase self-confidence and aid rational decision making to deter criminal engagement. The success rates are impressive, with only a 7% reoffending rate among their participants. Both charities are working on their community strategies and building partnerships and expanding their presence in schools to reach more children at a younger age.

FOR A CITY THAT BOASTS OF CANARY WHARF, THE SHARD, AND THE OPULENCE OF SOUTH KENSINGTON, LONDON'S UNDERBELLY OF DEPRIVATION AND ITS CONSEQUENCES ASTOUND ME.

How this came to be, and what that says about our social and political structures is a separate discussion (Rizwan has lots of unflattering opinions), but the gory headlines and pools of blood are the realities that face many children today. However, if there is one thing I have learnt writing this, it is that London has woken up. The Public Health approach to violence has worked in Scotland to dramatically reduce their crime rates, and London's multidisciplinary approach is rising to the challenge. Coupled with increasing awareness of and research into the factors surrounding youth crime, I am hopeful that we have started down the right path.



MICHAEL CARVER LEAD NURSE FOR VIOLENCE REDUCTION AT BARTS NHS

FOR MORE INFORMATION, LOOK UP:

WWW.KHULISA.CO.UK

WWW.OSMANITRUST.ORG

IF YOU'RE FEELING INSPIRED TO VOLUNTEER, BE SURE TO CHECK OUT STREETDOCTORS CHARITY.

SAFETY LAST?

How safety concerns on Whitechapel campus have gone from bad to worse

by Harris Nageswaran

IF YOU'VE EVER BEEN A PART OF BLSA HELP SQUAD, THE GROUP THAT HELPS THE FRESH-FACED STUDENTS MOVE INTO THEIR NEW STUDENT ACCOMODATION, CHANCES ARE THAT YOU WILL HAVE BEEN ASKED AT SOME POINT WHETHER "IT'S SAFE AROUND HERE?"

It's a tricky question to answer, one that requires balancing the realities of living in East London without scaring the living daylights out of a Fresher and their family. My answer to that has always been that "as long as you're sensible and take reasonable precautions, then you'll be fine". With every year though, that question has left me requiring more and more pause for thought; and now from everything I've seen - I'm not sure I can say that anymore.

The Metropolitan Police stats for January to October 2019 leave us in no uncertainty as to the scale of the problem. There were 29,193 crimes in Tower Hamlets over this period, giving it the award of being the sixth most dangerous borough in London, providing the filling in an undesirable sandwich between our neighbours Hackney and Newham. While those numbers paint a broad picture, the real problems seem to start and end much closer to home; there is an overwhelming failure by QMUL to deal with problems already known to them.

RECURRING PROBLEMS, RECURRING FAILINGS

Whether it's witnessing a stabbing outside of the Garrod Building, being verbally assaulted by a rough sleeper or being followed leaving the library – students here experience things that no other students do. While it may be possible to attribute some of those to the reality of the area we study in, too many are a result of the inaction, bordering on incompetence from the University and its security team.

One of the biggest issues facing security on Whitechapel campus is the lack of clarity for students over what comes under their jurisdiction, where it overlaps with that of Barts Health NHS Trust and indeed, what isn't their jurisdiction at all. In theory, regardless of whether it is strictly on QMUL land

or not, any incident that occurs to a student because they were accessing a University building should be reported to Whitechapel security.

In practice however, a significant number of incidents that occur to students go unreported. While there are many reasons for this, it is at least partly due to the fact that many incidents occur on the streets around QMUL buildings, and security, despite lobbying from student representatives, have failed to bring in an easy way to reporting incidents occurring around Whitechapel. Fundamentally then, we are left with a security team who are unaware of the realities of being a student here.

Of course, one of the biggest reasons that students don't report incidents to security, is that from experience, they have very little faith that they will do anything to resolve or prevent the same incident occurring again. What's the point in reporting your bike stolen from the Library secure area, when nothing has changed from the last time a bike was stolen, or worse, that security saw your bike being stolen but did nothing about it (as one student was told).

BY THE 3RD TIME YOU'VE REPORTED THAT PEOPLE ARE SHOOTING UP WITHIN THE LIBRARY COURTYARD, IT BECOMES HARD TO BELIEVE THAT THE UNIVERSITY CARES ABOUT YOUR SAFETY AND WELLBEING.

During rehearsals for BL Drama's last Panto, students became better acquainted with the people smoking and dealing illicit drugs on the steps outside of Laird Hall (having reported them since mid-October) than security themselves, apart from one time they came in to make sure we had booked the room. To me as a student, the message was clear - this is a University that prioritises room bookings over student safety.

CAN MONEY ALONE FIX THESE ISSUES?

The scale of the issues described above means it's unlikely there will be a quick fix – though the University is certainly taking this issue more seriously of late. Upon learning of the scale of the issue,

Professor Colin Bailey, the Principal of Queen Mary University of London, has pledged over £1 million to improve security across all campuses. Among the improvements being proposed are overhauls of CCTV, security personnel wearing bodycams and perhaps most promising of all, an increase in the number of patrols.

WHILE THESE ARE CERTAINLY STEPS IN THE RIGHT DIRECTION, THERE IS NO SIGN OF YET THAT THERE HAVE BEEN EFFORTS TO IMPROVE THE FLAWED CULTURE OF LISTENING TO STUDENTS AT WHITECHAPEL.

The University leadership prides itself on what it calls a culture of 'co-creation', a buzzword they have adopted to prove that they have put student voice at the centre of what they have done last few years. In the same period however, student reps (including myself) had seen our concerns about safety being brushed aside by University staff; such as ignoring our calls to improve lighting around the Library, Floyer House, Laird Hall, the Blizard Building and the BLSA Building. It was only after considerable lobbying efforts that we were able to get the University to install new lighting outside of one of the buildings requested, the Garrod Building, with obvious improvement.

Without this sign that the University aims to rebuild the trust between students and security that it so sorely needs, Queen Mary's investment in security will simply paper over cracks. Students need to be able to not only see security (instead of them being hidden away in the Garrod Building watching telly), but believe that when they report something to them, they care enough to do what they can to prevent it happening again.

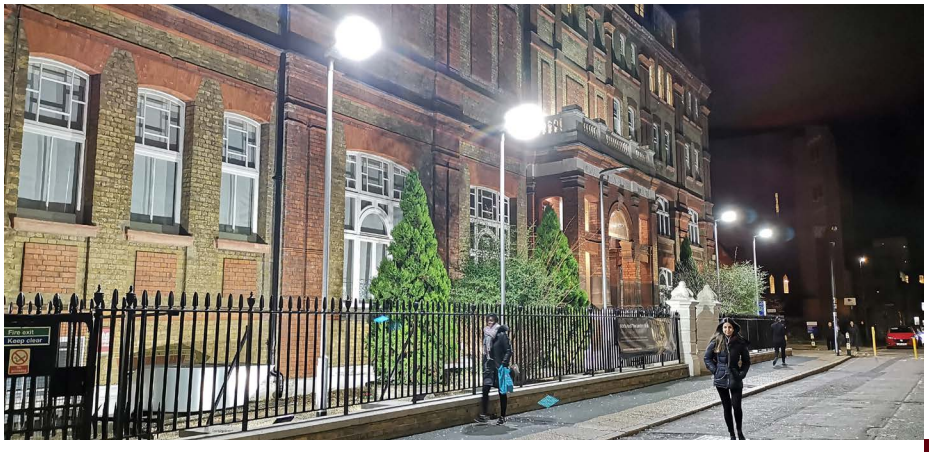
If they don't listen to students, I'm afraid that the next time a prospective student asks whether this campus is safe, students will be forced to tell them something that could scare them away. In the meantime, we as students will have to take more responsibility over our safety – if only the University would take some responsibility too.

Queen Mary is more than aware of various security issues on the Whitechapel campus. Our Security team at Whitechapel aims to support our students and keep them safe within this environment. Our team move criminals such as drug dealers and tailgaters off campus frequently and we ask that students who witness such anti-social behaviour to immediately report this to Security so that firm action can be taken.

UNIVERSITY STATEMENT IN FULL:

WE HAVE SET OUT THE FOLLOWING ENHANCEMENTS AND PLANS FOR THE WAY IN WHICH THE SECURITY SERVICE IS PROVIDED AT OUR WHITECHAPEL CAMPUS:

- AN ADDITIONAL MILLION POUNDS IS TO BE SPENT ON ADDITIONAL SECURITY STAFF FOR ALL CAMPUSES. FOR WHITECHAPEL THIS MEANS ONE EXTRA SECURITY GUARD ON DUTY AT ALL TIMES
- THE RECRUITMENT OF A UNIVERSITY CRIME REDUCTION MANAGER TO BE PROACTIVE IN REDUCING OPPORTUNIST CRIME
- £250K ALREADY SPENT ON IMPROVING CCTV AND A FULL UPGRADE CURRENTLY OUT TO TENDER
- ACCESS TECHNOLOGY TO BE REPLACED
- A CONSULTATION ON THE IDEA OF HAVING A LOCAL POLICE OFFICER ASSIGNED TO THE UNIVERSITY
- IMPROVED LIAISON AND INFORMATION SHARING AGREEMENT WITH THE NEIGHBOURHOOD POLICE TEAM
- OUR CRIME PREVENTION ADVISORY GROUP INCLUDES THE STUDENTS' UNION AND THE LOCAL POLICE AND TOWER HAMLETS ENFORCEMENT TEAMS



IMPROVED LIGHTING OUTSIDE OF THE GARROD BUILDING CAME ABOUT AFTER HEAVY LOBBYING FROM BLSA REPS, BUT LIGHTING HASN'T BEEN IMPROVED ELSEWHERE AROUND CAMPUS

Invisible Disability

BY LUCY EDGAR

In a city as large and as busy as London, it's easy to forget that everyone has an entire world within their head, filled with ideas and perspectives, people and passions.

This is maybe reflected in their personality and how they present themselves to the world but, as with most things, the true extent of a person's mind is rarely exhibited to anybody. We are all mad… it's just that usually it's only the walls of our rooms and homes that see the true extent of that madness. Nowadays, the word 'mad' has become taboo to be used as a descriptor, which is a good decision in moving towards a neurodivergent society. But what about the people who can't help but be 'mad' - something about them that means that they have to have outbursts and eccentric moments and manic periods and days spent staring at the wall.

These are the invisible disabilities which we hear so much about, but most of us never really try to understand the people who have learning difficulties, personality or social abnormalities, or mental health issues. We call these invisible disabilities because there is no way of telling them at a glance, you don't diagnose these from scans or blood tests, and you might not be able to tell even if your best friend has one.

How would you feel if you were in a professional environment where everybody says, it's okay for everyone else to be different and to be mentally diverse, but not necessarily you. Even having dyslexia deserves raised eyebrows to many purists and traditionalist students and teachers within the university. I have spent time recently thinking about visible and invisible disabilities. As someone with a so called 'invisible' disability I sometimes find myself questioning the use of that word. Sometimes I feel that my disability is very visible - just ask me to stand up and speak and I am certain my stutter will make an appearance or ask me to write an article and I can promise my dyslexia will be there. It doesn't stop me doing these things but it does make it harder, especially the jokes and laughs I get from people who don't realize that I'm not just 'having a moment' when I misspell 'generalised' or can't say the word 'synonym'. I don't mind these too much, but when people still ask me what living with dyslexia is like and whether I'm worried about times when I will be on wards and have to make an instant decision or times when I will be writing prescriptions and spelling something wrong - I have to say that's not how dyslexia works. I am not less able to be a doctor if I have dyslexia; my decision making and logic skills are just fine - it's just that the education system isn't built for people like me who learn in different ways to most people.

I am disabled because society makes me disabled. I know that sounds awfully self-centred but hear me out; the educational system we are a part of is an inherently disabling environment that affects not just some of us, but almost everyone.

The disability comes from out of date traditional teaching and unhealthy competition and relationships within the University.

What many people who do not have a disability may not realise is that when a person has a disability, visible or invisible, their environment makes a massive impact on the severity of the disability and sometimes the visibility of the disability.

For example, as a dyslexic student, I am considered to have an invisible disability, whereas a student with say a medical condition requiring an assisting apparatus (anything from a colostomy bag to a crutch or walking frame) are considered to have a visible disability.

However, remove the word student, and my disability becomes less important to society, it becomes even less visible.

My employer will most likely not take into account my dyslexia, however many visible disabilities will play a greater role in employment and ability in many employer's eyes; conversely put me in an exam room with many people with visible disabilities and my disability may affect my ability to do well far more than those with a physical disability. And then there are those who fall in between- do people with partial hearing or who are partially sighted have a visible or invisible disability? Are people with colour blindness disabled?

Realistically there is no way to say whether someone is disabled unless you ask them. I have conducted some interviews with students with learning and physical differences and I asked them the question 'Are you disabled?'. It sounds like a very probing question, and almost quite offensive in some ways, but having asked it to a few people I found that it was a question they had never thought to ask

themselves. The answers differed massively from people who were 'disabled and proud', 'technically were but don't associate with it' or the most surprising 'I am not but I tick it when it's asked because that is what I am defined as'. The final circumstance interested me the most. Someone who gave me a similar answer was a male student with a visible disability, he told me that he doesn't consider himself disabled. Furthermore, his close friends didn't consider him disabled. This was due to the simple fact that in daily life he doesn't find himself limited in any way. Of course, sometimes certain accessibility measures are useful to maintain normal life but overall this student felt that his medical condition was so well managed it negated the disability. We also discussed people's attitudes to him, when people treated him as though he was disabled in a negative or unhelpful way it made the student feel more disabled; conversely, when peers acknowledged his disability but didn't interfere unless asked, it reduces the disability and made it more of an invisible disability.

On the other hand, some of the people with invisible disabilities I met expressed sometimes feeling very vulnerable and unable to do normal activities in day-to-day living. This calls back to the ever-changing nature of disabilities, a visible disability can become invisible in the correct environment and an invisible disability can very suddenly become extremely visible. Not all described themselves as 'disabled' but all expressed an uncertainty as to where they fell on the ability spectrum.

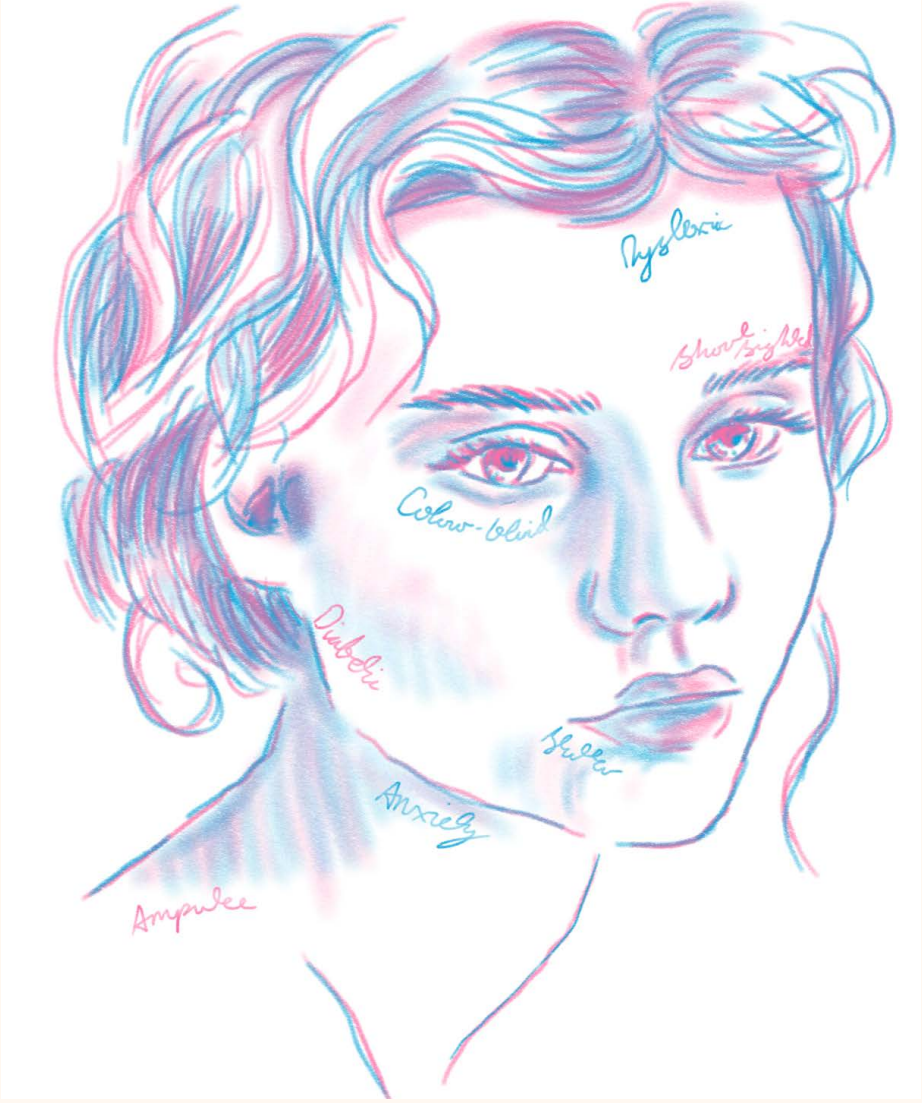
Some even felt bad to be associated with being disabled because of feelings of guilt that physically they were able compared to many people with the more 'stereotypical' visible disabilities; 'physically I can do everything, but I am just unable to function normally'.

As students we aim to look after people, and we can't do that if there's something wrong with us. I mean it's just hypocritical to group yourself with someone with a painful chronic disease when you have been dealing with a purely mental illness - isn't it? This is a form of internalised guilt which is reinforced by our environment more than any other factor. Most of us don't feel that we have a right to feel the way we do, we are not dying, in physical pain or grief, it's all in our head and so of course we can go on and be bloody grateful while we're at it. However, every day we cannot 'choose to be happy'.

There is no choice sometimes, except to do the bare minimum and when we can't do that and we are tired and scared we are told to just do something you enjoy, to cheer ourselves up and buck up.

Despite living in the 'snowflake' generation, we still cannot begin to verbalize our mental and emotional pain because every day we see it belittled in the way our peers talk about mental illness in their slang and offhanded descriptors, being told that someone is acting 'schitzo' if they are in a manic period or that they are 'depressing' when they have to cancel plans. However, having been active in student groups and interested in student welfare, I have to think that these words we use almost daily are also used to belittle our own issues, because when we try to help ourselves, we are belittled by everyone else. When we go to tell our doctors, they say its stress and lack of sleep, that we need more iron or less caffeine, to talk to our mums and stop playing on our phones, to go home and contact counselling.

Everyone has hard times and at university these times can sometimes feel amplified when seemingly we go through things alone. Most of the time, these times end, and people can return to their regular schedules with a little help. It is always the temptation to pretend that these moments never happened, because to admit that they did can call back to moments that many of us would rather forget. That doesn't mean that they didn't happen. It doesn't mean that at one point everything private and invisible within our own heads became suddenly very visible.



NOBEL PURSUITS: THE STORY OF THE 6 NOBEL PRIZE LAUREATES OF BARTS AND THE LONDON

BY RAKIN CHOUDHURY

Chapter 1

An Impulsive Genius: Sir Ronald Ross

WITH SIX NOBEL LAUREATES ATTACHED TO ITS NAME AT ONE POINT OR ANOTHER, ST BARTHOLOMEW'S HOSPITAL MEDICAL COLLEGE HAS A HEALTHY TRACK RECORD WHEN IT COMES TO PICKING UP NOBEL PRIZES.

It should not come as a surprise. While we cannot boast the ruthless efficiency with which Oxbridge churns them out (nor LSE's knack for collecting the misfit 'Nobel' Prize in Economic Sciences), we did get there first and have been winning them since day one. Or at least day two.

Sir Ronald Ross received the second Nobel Prize for Physiology or Medicine in 1902 "for his work on malaria, by which he has shown how it enters the organism and thereby has laid the foundation for successful research on this disease and methods of combating it". In doing so, he became the first British Nobel Laureate; although he was originally born in India, his father a general in the English army.

On his father's wishes, Ronald Ross was sent from India to enrol at St Bartholomew's Hospital Medical College in 1875. It was a thing in the nineteenth century too. His interests spanned many subjects, however, and he continued to pursue these in his career, from writing poetry to composing songs. He was also a talented mathematician, which he put to use in developing models for the study of malaria epidemiology.

His Nobel Prize work would come as a result of serving in the military as part of the Indian Medical Service, upon the recommendation of his mentor, and 'Father of Tropical Medicine', Patrick Manson. Manson suggested India due to the easy access to malarial patients, although Ross would be relocated away from these patients to a cholera outbreak. Despite being limited in resources to put forth for scientific endeavour, Ross discovered malarial parasites in the gut of 'dappled-wings' mosquitoes in 1895 and later showed the life cycle of the parasite by its transmission to infected sparrows through mosquito bites in 1898.

He would continue work on the prevention of malaria throughout his career, leaving India to take up a number of posts in the UK in the study of tropical medicine. This included becoming Professor and Chair of Tropical Medicine of the Liverpool School of Tropical Medicine (the first institution of its kind in the world), and being the Director-In-Chief of the Ross Institute and Hospital for Tropical Diseases (now a part of the London School of Hygiene & Tropical Medicine).

But Ross's Nobel Prize was one of the earliest of many controversies surrounding the award of Nobel Prizes. While he was the first to show the life cycle of the malarial parasite, he did so in birds (upon the recommendation of Peter Manson). It was Italian zoologist, Giovanni Battista Grassi, who described the complete life cycles of three separate malarial parasites in Plasmodium falciparum, Plasmodium vivax, and Plasmodium malariae in humans. Most importantly, as a zoologist, Grassi was able to identify the vector of the human malarial parasite, famous to all medical students, the female Anopheles mosquito.

Ross deserved the Nobel Prize and accordingly received seven nominations in each of 1901 and 1902 (as well as a further one in 1904 from someone who had obviously slept through the ceremony two years prior as a result of missing their daily dose of quinine). But such a Prize would usually be shared and the money split between Ross and Grassi. But Ross was infamous in the scientific community as being a difficult and egotistical man. He carried out a defamatory campaign against Grassi, accusing him of fraudulent research and the independent arbitrator, Robert Koch, fully backed Ross.

So Ross won the Prize but would continue to have many feuds with the scientific community. He was jealous of his mentor, Manson, and notably did not thank him in his acceptance speech. It is also worth noting that Robert Koch won the Nobel Prize for Physiology or Medicine in 1905, but he did not feature among either of Ross's nominees for the Prize that year (although there was no suggestion of any animosity between the two).

Of course, if any of these criticisms are levied against Ross, we can always distance ourselves and say that he did not qualify at Barts. In fact, Ross gained his medical qualification as a Licentiate of the Society of Apothecaries (as did Elizabeth Garrett Anderson, although the Society were quick to close the loophole which allowed female applicants behind her). The Society were recognized by the General Medical Council as a legitimate alternative authority for registering medical professionals until 2008. Incidentally, Ross gained the qualification on his second attempt; there is hope for us all, as long as we act like jerks.

Chapter 2

A Shared Laboratory: Sir Henry Hallet Dale & Sir John Vane

If the question was posed, what do all six winners of the Nobel Prize associated with the St Bartholomew's Hospital Medical College have in common, what would one's answer be?

They all come from Barts is a correct guess, but as fellow Barts alumnus John Watson might say, "no ****, Sherlock". They all won the Nobel Prize in Physiology or Medicine is an incorrect guess, Barts bests both UCL and Imperial by boasting a solitary Peace Prize. They are all men, also correct, also sadly true of most Nobel Laureates. Hmm… To avoid a difficult conversation, let us narrow the question: what do two of the Barts Nobel Laureates have in common? A shared laboratory is the answer.

Sir Henry Hallett Dale shared the Nobel Prize in Physiology or Medicine in 1936 for "discoveries relating to chemical transmission of nerve impulses." Given the reason behind recognizing Dale, one might consider him to have more in common with a Barts alumnus who won the Prize four years prior. Professor The Lord Edgar Adrian won the Nobel Prize in 1936 with a not too dissimilar motivation for "discoveries regarding the functions of neurons."

But it is Sir John Vane, winner of the Nobel Prize in Physiology or Medicine in 1982 (shared with two others for "discoveries concerning prostaglandins and related biologically active substances"), who made three mentions of Dale in his Nobel biographical. But why would Vane do so, given he, by this point in his career, by all accounts, had not yet had any affiliation with St Bartholomew's Hospital Medical College?

In fact, Vane and Dale's respective connections to Barts are quite the reverse of the other. Dale was born in Islington, the same present-day borough of St Bartholomew's Hospital. He would go onto complete his clinical years at the hospital in 1900-1902, after studying physiology and zoology at Trinity College, Cambridge.

Vane was a Worcestershire man who trained as a pharmacologist at the University of Birmingham, never undertaking a medical qualification. It was not until 1986 that he would set up shop as an academic at Barts, founding the William Harvey Research Institute which, to this day, is one of six research institutes at the medical school and a continued centre of excellence for research into vascular disease and inflammation.

It is the middle years where Vane and Dale have more in common. Both working in academia within the University of London (Dale at UCL and Vane at the Royal College of Surgeons), both would be tapped up to enter the world of industrial science by the Wellcome Foundation, to work as pharmacologists at the Wellcome Physiological Research Laboratories.

In Dale's case, the approach came from Henry Wellcome himself in 1904, and Dale would become Director within two years. For Vane, he was immediately made Group Director in 1973 at what was then known as the Research and Development Directorate. Vane noted how he was conscious of Dale's similar position to his own; both hesitated over accepting the offer due to the advice of friends in academia. Dale was advised by his friends that he would "be selling my scientific soul for a mess of commercial potage". Vane would say "Those friends were wrong; like Dale I accepted and had no regrets."

John Vane's Nobel Prize would come from work he had done earlier at the Royal College of Surgeons, identifying the mechanism of action of aspirin in relation to prostaglandins. His research also enabled the development of the first ACE inhibitors.

Henry Hallett Dale's Nobel Prize came from his later work at the National Institute for Medical Research in 1914, where he identified acetylcholine as a chemical neurotransmitter, indicating synaptic transmission was chemical rather than electrical. Dale's principle is used to describe neurones by the neurotransmitters they release.

But they were both the eminent pharmacologists of their day. Henry Hallet Dale received eleven nominations for the Nobel Prize between 1926 and 1935, culminating in ten nominations in 1936, including one from Lord Edgar Adrian. He also nominated his co-recipient, Otto Loewi and later, in 1945, Howard Florey, who once undertook a fellowship at The London Hospital.

Despite coming to Barts after winning his Nobel Prize, it is John Vane's legacy as a member of the faculty which is felt more keenly today. His name adorns a building at Charterhouse Square. As a matter of fact, when attending the retirement Festschrift of Professor Sir Nick Wright, I did ask whether he was actually retiring or would just keep working anyway. "It's like this guy", said a senior member of staff, gesturing to the John Vane Science Centre behind us, "I would not be surprised if he was back in his office the next day".

Hard work, it seems, is necessary to win a Nobel Prize. And here I was thinking the only thing holding me back from winning one was that it cannot be awarded posthumously.

THE PAINFUL TRUTH

BY SIRAJ ABUALNAJA, NEUROSCIENCE EDITOR

PAIN CATEGORISES ITSELF INTO TWO GENERAL CATEGORIES, PHYSICAL AND MENTAL. WHETHER IT IS THE PAIN YOU FEEL WHEN YOU STEP ON A LEGO, OR IF IT'S THE PAIN YOU FEEL AFTER A BREAK-UP, PAIN IS SOMETHING THAT IS FELT, AND NOT USUALLY MEASURED.

In the field of Neuroscience, defining pain and how we treat it remains, for the most part, a mystery. One thing is certain however, pain has a purpose: self-preservation. Interaction with a painful stimulus will signal the brain that the body is in danger and therefore the body must elicit a reaction in order to survive. However, if pain persists with the absence of the stimulus, then it becomes problematic. Chronic pain, such as long-term back pain, is ubiquitous throughout the world. Pharmaceuticals are typically used to suppress these signals to ease pain, but new research suggests that by interacting with the body's own systems – the ascending and descending pathways – can be amplified to reduce pain organically and with minimal side effects.

Pain is sensed by sensory neurons called nociceptors. Nociceptors respond to external stimuli by producing electrical signals that will be routed to axons, which are found within nerve fibres that relay this signal to the spinal cord. Pain is transmitted within nerve fibres called Að- and C-fibres. Such that the former has thin sheaths and senses quick, acute pain signals, while the latter is without sheaths and senses slow pain (e.g. heat, burns, and dull aches). The activation of these receptors and fibres is a result of multiple "pain gates," including the sodium channel Nav1.7. This regulates the passage of sodium ions into the axons, which can cause pain. Obstruction of this gate with molecules via drugs or gene therapy may allow doctors to tailor pain therapies and treatments to their patients.

Once the painful stimulus reaches the spinal cord, it is then projected to various areas of the brain. The somatosensory cortex is activated and helps to identify the location of the pain, while the anterior cortex can trigger an emotional response to it. Ultimately, the brain will process and send out its commands to the spinal cord resulting in the brake of ascending signals in the dorsal horn and periaqueductal gray to dampen down the pain signals.

Current treatments for chronic pain (i.e. long-term and often worsening with time) involve opioids. Opioids typically work by binding to a protein on the surface of nerve cells called the mu-opioid receptor, causing it to interact with other proteins. For example, morphine will bind to a mu-opioid receptor resulting in an increase in potassium conductance and decrease in calcium conductance, causing decreased excitability and release of neurotransmitters, thereby blunting the painful stimulus. However, while the action of these drugs will alleviate pain, its communication with other proteins results in pleasurable feelings. Additionally, the body develops a tolerance to these drugs, meaning that higher doses are required to not only alleviate pain, but to trigger the sense of euphoria that accompanies this analgesic. Consequently, continuous use of opioids can lead to addiction.

Hence, alternative therapies such as gene therapy or drugs that target the Nav1.7 channels are favoured. Usually, gene therapy involves a number of genetic loci. However, in the case of Jo Cameron, two genes responsible for her absence of pain were identified. The 66-year old Scottish woman did not require any form of analgesic following surgery for arthritis in her hand. Growing up, Cameron would frequently discover bruises around her arms and legs. When she was nine, she had broken her arm and did not realise until three days later when her mother noticed discolouration and swelling. Even during her two pregnancies, Cameron did not feel any pain during delivery. It was discovered that two neighbouring genes called, FAAH and FAAH-OUT were mutated, thereby reducing the breakdown of anandamide, a neurotransmitter providing relief of pain. As a result, Cameron has an excess of this neurotransmitter, protecting her from feeling any pain. Similarly, a handful of children from the same clan in Pakistan were also found to be resistant to pain. These children were street performers who would make a living by stabbing themselves and walking over hot coal without eliciting a single reaction. It was found that these children had a mutation in a gene called SCN9A, which is known to be involved with pain signalling. It is believed that this gene yielded malformed versions of the Nav1.7 protein, preventing the entry of sodium ions into the cell. A different mutation to what Jo Cameron had, but yielding the same outcome.

THE AVERAGE TEMPERATURE OF COAL USED FOR FIREWALKS IS 578 DEGREES CELSIUS

Would future treatments therefore involve mutating the genes found in both cases? The answer is no, it is unlikely as pain is still an essential part of living a long and healthy life. Nevertheless, developing drugs that can reduce the breakdown of anandamide or Nav1.7 blockers is something that can be used in the near future. Other therapies include deep brain stimulation (DBS) in targeting the emotional centres of pain. A study from trial at the Cleveland Clinic used DBS to target this emotional centre in 10 patients who had chronic neuropathic pain following stroke. Tiny electrodes would be implanted in the part of the brain involved with processing emotions. These electrodes would be wired to an electronic device in the chest and deliver mild shocks to the implantation site at a rate of nearly 200 a second. Research in this field demonstrated promising results with improvements in patients' quality of life, well-being, and independence. Virtual Reality (VR) is another avenue for pain management. A study from the University of Maryland demonstrated that the use of VR eases patients' pain and improves mood and anxiety when relaxing images are displayed.

ALTHOUGH RESEARCH IS STILL IN ITS INFANCY, THE SEARCH FOR SAFE AND EFFECTIVE TREATMENTS REMAINS WITHIN REACH. EACH DAY EXCITING NEW DISCOVERIES ARE BEING MADE, MAKING THE JOURNEY TO ERADICATING CHRONIC PAIN AN EXCITING ENDEAVOUR.

MUSIC THERAPY IN MENTAL HEALTHCARE

BY EMMA WINDLE, MUSIC THERAPIST

IT IS WELL UNDERSTOOD THAT MUSIC HAS INTRINSIC THERAPEUTIC BENEFITS; MOST OF YOU WILL HAVE EXPERIENCES OF USING MUSIC DURING DIFFICULT PERIODS OF YOUR LIFE, TO SOOTHE, REASSURE AND REMIND YOU OF HAPPIER TIMES.

However, you may not realise that there are a group of Allied Health Professionals who are trained to use music clinically to support patients who are experiencing mental distress. We are music therapists and use creative music making and receptive music listening to work with a wide range of clients in many different settings.

Music therapy can be defined as "… the professional use of music and its elements as an intervention in medical, educational, and everyday environments with individuals, groups, families, or communities who seek to optimize their quality of life and improve their physical, social, communicative, emotional, intellectual, and spiritual health and wellbeing. Research, practice, education, and clinical training in music therapy are based on professional standards according to cultural, social, and political contexts" (Kern, 2011).

Music therapy comes under the bracket of 'arts therapies' which includes music therapy, art therapy, dramatherapy and dance-movement therapy. Music therapists must be trained to a master's level and be registered with the Health and Care Professions Council (HCPC). Most music therapy work is underpinned by psychodynamic, humanistic and person-centred approaches. There is an emphasis on building a therapeutic relationship with the client through improvising, songwriting, singing known songs, listening and through verbal discussions. Music therapists will often be looking to support clients through connecting with others, expressing themselves non-verbally and verbally, building confidence and finding hope and empowerment, amongst other aims.

Research suggests that music therapy is helpful for patients with schizophrenia (Geretsegger et al., 2017), depression and anxiety (Aalbers et al., 2017), dementia (Zhao et al., 2016), in child and adolescent psychiatry (Gold, Voracek and Wigram, 2004), for premature infants (Standley, 2002) and children with autism spectrum disorders (Geretsegger et al., 2014). At the Unit for Social and Community Psychiatry at QMUL a large, multi-centre, National Institute for Health Research funded randomised controlled trial is taking place to test the effectiveness of three forms of group arts therapies (art, music and dance movement therapy) for patients in community mental health care. This is the largest trial of its kind and the first to take into account patients' preferences for different art forms.

As a music therapist at East London NHS Foundation Trust (ELFT) and PhD student at QMUL, I am researching patient preferences in the arts therapies in adult mental health services. I have found that receiving a preferred treatment is significantly associated with lower dropout rates, and stronger therapeutic alliance (Windle et al., 2019). Therefore I would urge you, as the future generation of doctors, to learn about alternative treatments, so that you can suggest different options for your patients. Collaboration with healthcare professionals from other fields leads to more holistic care and increased opportunities for patients to have a say in their treatment pathway.

If you would like to know more about the arts therapies in adult mental health services, follow this link to watch a video created by service users and therapists at ELFT:

YOUTUBE.COM/WATCH?V=GMRSVV1PJMQ

References

Aalbers, S. et al. (2017) 'Music Therapy for Depression', Cochrane Database of Systematic Reviews. doi: 10.1002/14651858.CD004517.pub3.

Geretsegger, M. et al. (2014) 'Music therapy for people with autism spectrum disorder', Cochrane Database of Systematic Reviews, 2016(3). doi: 10.1002/14651858.CD004381.pub3.

Geretsegger, M. et al. (2017) 'Music therapy for people with schizophrenia and schizophrenia-like disorders', (5). doi: 10.1002/14651858.CD004025.pub4.www.cochranelibrary.com.

Gold, C., Voracek, M. and Wigram, T. (2004) 'Effects of music therapy for children and adolescents with psychopathology: A meta-analysis', Journal of Child Psychology and Psychiatry and Allied Disciplines, 45(6), pp. 1054–1063. doi: 10.1111/j.1469-7610.2004.t01-1-00298.x.

Kern, P. (2011) World Federation of Music Therapy. Available at: https://www.wfmt.info/2011/05/01/announcing-wfmts-new-definition-of-music-therapy/.

Standley, J. M. (2002) 'A meta-analysis of the efficacy of music therapy for premature infants', Journal of Pediatric Nursing, 17(2), pp. 107–113. doi: 10.1053/jpdn.2002.124128.

Windle, E. et al. (2019) 'Association of Patient Treatment Preference With Dropout and Clinical Outcomes in Adult Psychosocial Mental Health Interventions A Systematic Review and Meta-analysis', JAMA Psychiatry, pp. 1–9. doi: 10.1001/jamapsychiatry.2019.3750.

Zhao, K. et al. (2016) 'A systematic review and meta-analysis of music therapy for the older adults with depression', International Journal of Geriatric Psychiatry, 31(11), pp. 1188–1198. doi: 10.1002/gps.4494.

WHAT THE EPM?

BY EVA PHILLIPS, NATIONAL ISSUES EDITOR

EDUCATIONAL PERFORMANCE MEASURE (OR EPM) IS ONE OF THE WAYS APPLICANTS FOR THE UK FOUNDATION PROGRAMME (UKFPO) ARE RANKED ON A COMBINATION OF CLINICAL AND NON-CLINICAL SKILLS, COMPRISING THE KNOWLEDGE AND PERFORMANCE OF THE MEDICAL STUDENT.

On application to the programme, students are given a decile ('EPM decile score') ranked against the other students from their medical school who are applying for UKFPO in the same year. Each decile correlates to 34-43 points (i.e. 1st decile = 43 points, 5th decile = 39 points etc.) and this is combined with 7 points available for educational achievements (these include additional degrees (maximum 5 points) and publications (maximum 2 points)). Thus, the maximum score for EPM is 50 points, 43 of which are directly affected by the ranking system used at each medical school. The remainder of the application score is a maximum of 50 points owing to the result of a student's Situational Judgement Test (SJT).

There is no common system between medical schools in the UK, so each has the freedom to decide how they rank their students into equally-sized deciles based on academic performance. Recently – based on requests by BL medical students for a review of the current system – the medical school (in collaboration with the BLSA) has conducted a consultation on how BL calculates EPM deciles. Of 1731 students, 618 responded (35% response rate).

Prior to the results of this consultation, BL students were ranked into deciles each year based on their results from Papers B, C and D (End of Year (EoY) Written Paper - Key Knowledge and its Application, EoY Data Interpretation and EoY OSCE, respectively). In other words, these deciles are based upon EoYs, and the continuous assessment (Paper A) and SSCs (Paper E) are not included in the calculation. The EPM ranking is cumulative, thus taking into consideration a student's marks from the previous years upon calculation of a yearly decile. I.e. at the end of Part 3 (Year 3 or GEP Year 2) the EPM decile is calculated in combination with the student's deciles in Part 1 and Part 2 of the course. This is not the aspect of the process that students disagreed with.

Instead, students were concerned with how the years are weighted within the process. In other words, in the system prior to the consultation, each year is weighted equally to the next (with years 1-4 each making up 25% of a student's EPM point score, or years 1-3 weighing 33% each in the case of GEP students). That is to say, Barts utilised a non-weighted calculation system. This was of concern to a number of students as many believed that a more accurate representation of clinical competence is examined during the clinical years of the course. Conversely, others felt that it would be unfair to change the current system given that they had already worked hard in their first and second years, believing that their ranking would reflect this equally.

The results of the EPM consultation showed that 69% of students preferred a weighted system. Furthermore, 49% agreed on the weighting system where Y1 = 15% of EPM decile, Y2 = 25%, Y3 = 30% and Y4 = 30%. With regards to when the students wished for this weighted system to come into action, students in years 1, 2 and 3 preferred for it to be implemented for all current cohorts at 70%, 74% and 67% respectively. In opposition, 53% of current fourth year students preferred for the weighting system to be implemented for new cohorts only.

The consultation results were discussed by the Junior and Senior Student-Staff Liaison Committees (which comprise of the Pre-Clinical and Clinical representatives, Sidhant Singh and Artemis Mantzavinou respectively, student representatives from all years, and a variety of relevant staff members). Following these discussions, a final view was taken forward to the Medical Assessment Committee for recommendation to the Medical Education Committee. This final view was that a weighted system of 15%, 25%, 30%, 30% would be implemented for all students starting Part 4 (Year 4 or GEP Year 3) from September 2020 onwards. Thus, in line with the responses from the fourth year students, students starting year 5 in September 2020 will not be affected and will remain on the current non-weighted system. For GEP students, the weightings will be 30%, 35%, 35% for years 1 through 3, and for those on the 3-year direct entry programme, years 1 and 2 will be weighted equally (50% each).

THE UNITED KINGDOM'S ELECTORAL SYSTEM: A SYSTEMATIC DISENFRANCHISEMENT OF STUDENTS?

BY MAX HENTGES, POLITICAL EDITOR

DEMOCRACY IS MERELY AN IDEAL - AN ABSTRACTION THAT THE PREFERENCES OF CITIZENS SHOULD BE TRANSLATED INTO REPRESENTATIVE INSTITUTIONS.

Electoral systems are designed to most accurately align with the ideals of democracy and dependent on the public perception that these systems are fair and fulfill expectations. Like many others watching the exit polls, the December 2019 General Election results were unexpected to say the least, with the Conservatives securing their largest majority since 1987 while Labour faced their worst defeat since 1935. Unprecedented election results, such as this one, are understandably frustrating for many hopeful voters worried about the future of the UK and the fate of public services such as the NHS (a comprehensive article on this topic appears on the next page); however, understanding how the UK electoral system functions—whilst comparing its strengths and limitations to the systems employed by other democracies—offers a glimpse into how the 25.7 million votes cast actually translates into the formation of a government and what, if any, change is necessary going forward.

WHAT ARE THE OPTIONS?

The importance of electoral systems is often overlooked. As the only form of political participation for most, the structure of these systems can have profound outcomes on the way a country is governed—such as by strengthening a national legislature over the sovereignty of regional lawmakers. The following will describe and compare the three main types of electoral systems currently used by democracies and will explore the consequences thereof.

The three main types of electoral systems are majoritarian, proportional and mixed. A majoritarian system defines winning candidates as those that gained the most votes in a given electoral district or constituency. Majoritarian systems can employ either single-member plurality systems—where every district only sends one representative to parliament—or multi-member plurality systems—where several candidates can be elected within a single district. The United Kingdom and many prior British colonies use the former, meaning that the candidate that wins the most votes within each district can become an MP. This is commonly referred to as first-past-the-post.

The second type of electoral system, proportional representation, allocates seats—as the name implies—in proportion to the total number of votes for each party. There are many variants of this system with the most common using party lists. Party lists mean that the party defines the candidates which can assume office. Proportional representation systems are currently the most common system employed by democracies.

The third variant of electoral systems is a mixture of the majoritarian and proportional system. As such, voters have two choices on ballot papers: one for their most preferred party and a second for the candidate in their particular district. Thus, the party can influence the makeup of the parliament through party lists while candidates can also be elected directly by their constituency. The mixed system was developed (relatively) recently and is used in countries such as New Zealand and Germany. Although each of the three variations of electoral systems aim to achieve the same goal—to enable every citizen to have an equal voice in government—structural differences in systems have profound implications on the makeup of a legislature.

HOW DO DIFFERENCES IN ELECTORAL SYSTEM STRUCTURE AFFECT POLICYMAKING?

The single-member district majoritarian system used in the UK was among the first to utilize the system of dividing a country into regions with each member of parliament representing their given region. Although this system has stood the test of time—still in use since the 13 th century—it comes with numerous limitations, some of which contradict key democratic ideals. The primary limitation of a majoritarian system is that votes for non-mainstream parties are rendered nearly useless as these parties face tremendous obstacles to even gain a single seat in parliament.

For example, if a candidate of party A receives 40% of the vote in a constituency while candidate B only receives 35% and the remaining 25% to candidate C, candidate A will still be declared the winner, despite only receiving 40% of the constituency's votes. This means that the remaining 60% of voters are represented by

an MP whom they didn't vote for. If democracy means that each person has an equal say in how a country is governed, then this system fails. In comparison, a proportional system does not suffer from this limitation as each party receives the same number of seats as the proportion of votes they received. Using the same example as above, assuming a legislature has 100 seats, party A would receive 40 seats, party B with 35 seats and party C with 25 seats. Hence, proportional systems better reflect the makeup of the electorate in parliament.

If proportional representation is 'fairer' than the majoritarian system, then why didn't the UK adopt this system in the first place?

The answer lies in the inexplicit strengths of the majoritarian system. Firstly, the majoritarian favors consensus within parliament by typically only enabling two parties to gain substantial seats with one representing the majority and the other the opposition. This contrasts with countries that use proportional representation, such as Italy, where many disagreeing parties with no clear majority cause a high degree of fragmentation and short-lived coalitions.

Without a clear majority, proportional systems struggle to effectively govern and develop policies. Moreover, as the party controls the list of candidates that can run for election, proportional systems allocate tremendous power to the individual parties themselves. Although parties can nominate candidates in each district in the majoritarian system, voters still have the ability to vote for an actual candidate.

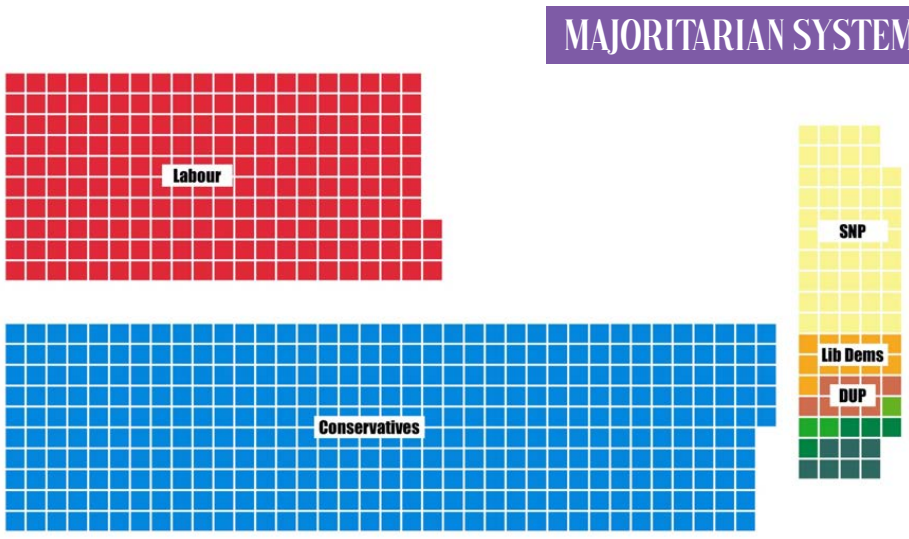
The second strength of the majoritarian system is that it filters out extremes of belief. For example, if 5% of all voters favor an ultra-nationalistic, anti-immigrant party, in a proportional electoral system, that party would receive 5% of all seats in parliament. This is not the case in a majoritarian system. Only unless a party attain more votes than any other in a given district can they be able to send their candidate to parliament. Returning to the example of the ultra-nationalist party, only if the majority of voters in the constituency have an anti-immigrant, nationalistic mindset—an unlikely occurrence—could they overpower moderate voters and gain a seat in parliament. Thus, the structure of a majoritarian system favors more centrist, moderate parties whilst making it more difficult for extremist ones to gain representation. Whether favoring moderate parties conforms to the values of democracy is debatable, however, most accept this as a necessary compromise to ensure political tranquility.

Despite favoring moderate parties and filtering out those at the extremes of the political spectrum, the majoritarian system comes at a cost for newly established parties—often supported primarily by many young people—which have an increasingly more difficult ability to gain representation. This partly explains why the Green Party of England and Wales has experienced little electoral success whilst its European counterparts have made tremendous progress in recent years.

Even if the UK adopted a proportional representation for the December 2019 General Election—not compensating for changes in voter-favorability for smaller parties—the Labour, Liberal Democrat and Green party would have been able to secure dramatically more seats than they did under the current majoritarian system (see graphic). For this reason, an increasingly larger number of Labour MPs—led by the political pressure group the Electoral Reform Society—is lobbying to replace the first-past-the-post system with proportional representation.

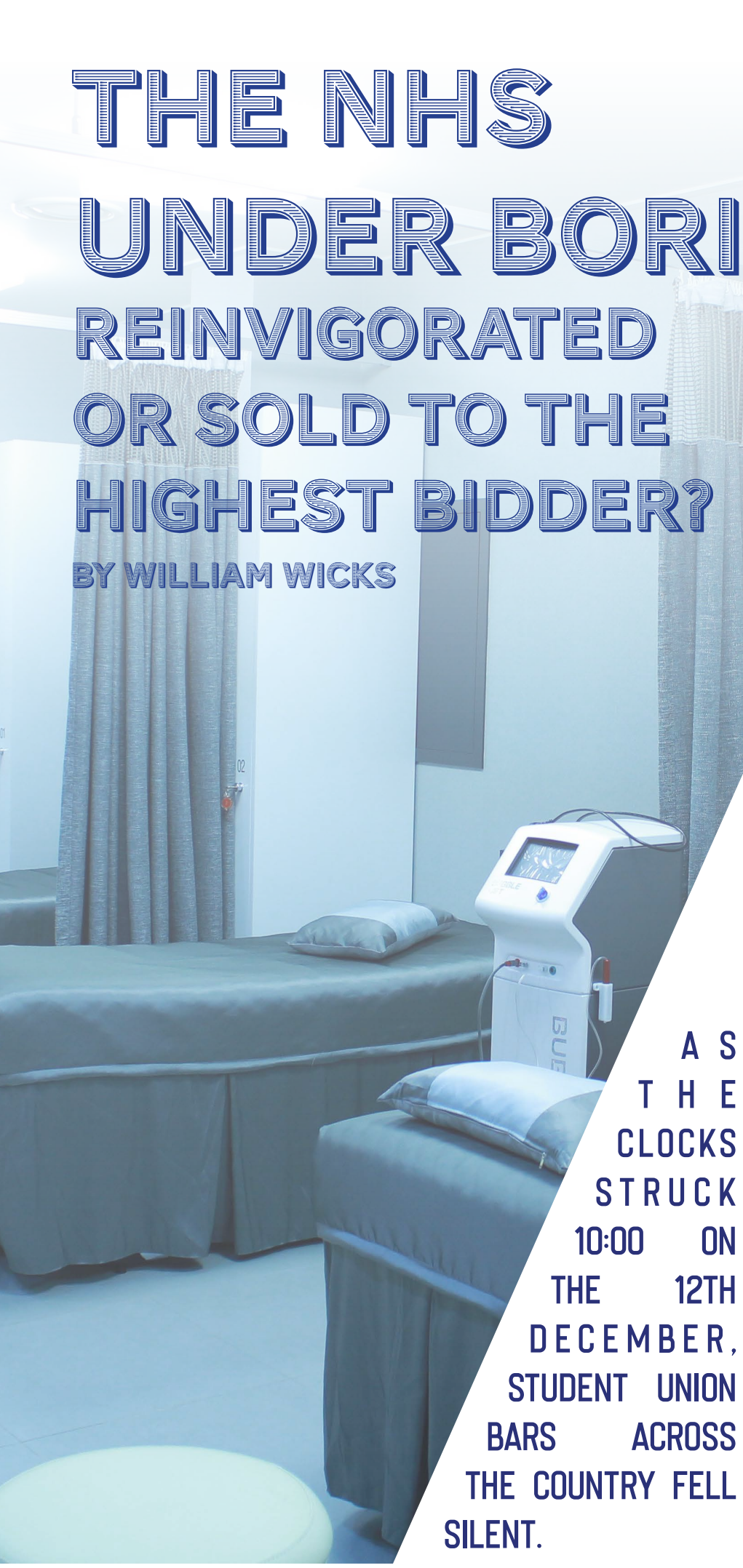
WHAT DOES THIS MEAN FOR STUDENT VOTERS IN THE UK?

The structure of the majoritarian system has two key consequences for student voters. Firstly, because constituencies in the UK are determined based on both population and geographic area, this often disfavors cities such as London, where the majority of voting students are found. Secondly, the majoritarian system favors moderate parties, hence preventing fringe parties primarily backed by student voters—such as the Green Party—from gaining representation in government. These two factors, often leading to student-voters feeling disenfranchised, highlights the need for electoral system reform.



THE NHS UNDER BORIS - REINVIGORATED OR SOLD TO THE HIGHEST BIDDER?

BY WILLIAM WICKS



AS THE CLOCKS STRUCK 10:00 ON THE 12TH DECEMBER, STUDENT UNION BARS ACROSS THE COUNTRY FELL SILENT.

The shouts of "ooohh Jeremy Corbyn!" dissipated as the exit poll was released and Huw Edwards uttered those three dreaded words: Conservative majority likely. As each hour passed the extent of the Labour parties utter capitulation became more apparent. The ethical coffee shops and wine bars of London were especially quiet the next day as the reality that the Tories had won an 80-seat majority began to sink in. Not only had the Conservatives won the election, but they had won it decisively. Managing to secure their best election result since 1987, when Margaret Thatcher was their leader. Although this will be the Tories' tenth year in power, small majorities, coalition governments and Brexit have limited their attempts to enact even wider-reaching conservative policy.

However, 2020 will undoubtedly stand in striking contrast to their previous nine years in government. No more knife-edge votes in the commons; opposition members will no longer be able to take control of the order paper and Lindsay Hoyle's interpretation of standing order 24 means MP's will no longer be able to stifle the Tories ability to enact policy by holding emergency debates and introducing legislation like the Benn Act. With a weakened opposition and such a large majority, the government now have five years to enact their vision for the future of the UK. This will likely include sweeping and potentially unpopular reform of public services including the NHS.

We have already seen the difference such a decisive victory makes; earlier this month, the EU withdrawal agreement passed its third reading in the commons by 99 votes and the UK is now set to leave the European Union on the 31st January 2020 at 11:00pm. Prominent Brexiteer and ERG member, Mark Francois, has even proposed a

motion for Big Ben to strike to celebrate our departure at an estimated cost of half a million pounds. This emboldened Conservative government is certainly in stark contrast to Theresa May's government, who for months attempted the Sisyphean task of introducing their Brexit legislation, to no avail. They are determined to "get Brexit done" and enact their domestic agenda and to hell with the naysayers.

Ever since the 2016 Brexit referendum, the NHS has taken centre stage of political discussion. I seem to remember our now prime minister bumbling around the country in a big red bus which had a less than truthful slogan emblazoned on its side. However, we cannot just blame Brexiteers for weaponising the NHS for their own political gain. Remainers and so called "Project Fear" claimed that in the event of an out vote, there would be immediate medicine shortages and all European NHS workers would spontaneously disappear in a puff of smoke.

Nigel Lawson, former Chancellor of the Exchequer, observed that, "the NHS is the closest thing the English have to a religion". This is borne out by the doublespeak operated by most British politicians. Most now dutifully refer to the healthcare system as "our NHS" and "privatisation and reform" have been entirely expunged from briefing papers and speeches. The NHS also took centre stage in the final week of the December General Election when the Daily Mirror released a photo of four-year-old Jack Williment. Jack was brought to hospital with suspected pneumonia and due to a lack of beds was forced to wait on a pile of coats, highlighting what many saw as a funding and capacity crisis within the health service. These events are just snapshots of the many occasions on which the NHS has been a central issue in British politics over the recent year. Politicians on all sides of the political spectrum have made it clear--in public at least--that they are supportive of the NHS and increased funding. Now the Tories have their majority, it remains to be seen whether such enthusiasm will continue.

When I began to write this piece, I felt it was important to understand the commitments the Tories made on the NHS during this most recent election campaign. When I read a transcript of the Queen's Speech and the Tory manifesto I was pleasantly surprised. At first glance the documents were filled with promising commitments;

£1 billion for social care, 50,000 new nurses, 40 new hospitals. I was filled with optimism that Boris Johnson would help reinvigorate the health service. However, on closer inspection, to say these promises stretch the truth would be an understatement. In reality 18,500 of these "new" nurses already work in the NHS, the government will only upgrade 6 hospitals by 2025 and the government has not yet decided what this £1 billion will be spent on, stating "[we hope] to seek cross-party consensus on proposals". Many also are worried that Boris, desperate to agree a trade deal with the US in a post-Brexit Britain would be willing to provide lucrative contracts to American firms and allow further privatisation of the NHS. Although the government has since stated the NHS is not for sale, leaked documents of preliminary talks do not explicitly take the NHS off the table.

It is very easy to blame all the woes facing the NHS on the Tory tightening of the purse strings and a lack of funding. How then do you explain the similar problems facing the NHS in Scotland. The SNP government, who spend 6.3% more per patient than England, still fail to meet their A&E waiting times since 2017 and the opening of a new hospital in Edinburgh, which has been delayed for 8 years. Unquestionably, there are significant structural problems facing the NHS which none of the major political parties are willing to address for fear of negative press. How is it that the NHS is still the world's biggest purchaser of fax machines and uses one out of ten of the world's pagers? Moreover, since there is a determination that healthcare is paid for exclusively through tax receipts and is free at the point of delivery, it's inevitable that a country with an ageing population will find it increasingly difficult to fund this system if its ambition is to spend within its economic means. Surely a sensible approach to liberate further funding for the NHS would be to introduce some form of limited patient responsibility. Perhaps by introducing a small fee for GP appointments for those who can pay—a proposal favoured by eight of ten GP's –could be such a reform. Furthermore, until the government centralises PFI debt and explicitly states extra funding is for front line services, this money will be used to offset growing costs and pay off a Trust's debt

This new government finds itself at a profound moment in the NHS' history. We can all agree that the NHS requires increased funding, which is why the government is set to enshrine its new NHS funding settlement into law; however, the government must also identify and eliminate the root causes of the health service's pressures. In order to have effective healthcare system, we must also improve our prison system, education system, police service and social care system. To improve the NHS, an overhaul and improvement of all public services is required. This is no easy task. The question is whether Boris Johnson is up to the challenge.

Be Britain still to Britain true,
Amang ourselves united;
For never but by British hands
Maun British wrangs be righted!
No! never but by British hands
Shall British wrangs be righted!

- ROBERT BURNS

BROKEN BRITANNIA

BY ABHIRAM MAGESH, ONLINE EDITOR

AND SO IT IS DONE! THE BRITISH EXIT FROM THE EUROPEAN UNION.

It's only been half a decade and yet it seems that this debate, if it could even be reasonably called that with the insidious interests playing their petty plots of debaucherous deceit and deception, is finally over. We've left after all. Theres nothing more to it.

But if that were really the truth, then why does division still ripple through our nation? Indeed while the 'Remoaners' have carried their arms home and probably soaked out their sadness in their own salty tears, (I know I have anyway), the tension of disagreement and disenfranchisement has inexorably discombobulated our national conversation.

I'VE OFTEN HELD BREXIT AS SYMPTOM, RATHER THAN A CAUSATION FOR THIS EGREGIOUS DIVIDE.

While there has always been the ebb and flow, the push and pull of ideas and political philosophy throughout our history, Brexit seems to have inexplicably torn through the very fabric and foundation of the nation, not unlike how a 5 year old would approach their presents on Christmas day.

In essence, the question of Brexit: Remain or Leave, I would posit, is actually on the periphery of a much greater question about who we are. What does it mean to be British? Disappointingly, all my fan mail to my MP regarding this central question has had nary a reply and so I'm forced to use my own limited brain capacity that is not devoted to medicine to ponder the answer.

May 8th, 1945 the year of our lord as it was known then, should probably be ringing the bells of any true patriot as it is VE day. Britain had hurled herself into the horror that is war, with the grit, determination and somewhat uniquely British nonchalantness that has come to be revered as part of our national values in the modern era. And while victory was achieved in totality, and the world had all of 1 second to enjoy it before pointing their spears at each other again (The Cold War of course, keep up), Britain had to settle into a modern era where it found that while victory had seemed total and complete, it was more Pyrrhic then the battle of Asculum (279 BCE) which the term actually originates from.

THE COUNTRY WAS A SHELL OF THE IMPERIAL GLORY IT HAS ONCE SUBSUMED ITSELF WITH, AND SO HAD TO DISMANTLE THE EMPIRE THAT HAD GIVEN HER A FOREMOST PLACE AMONG NATIONS.

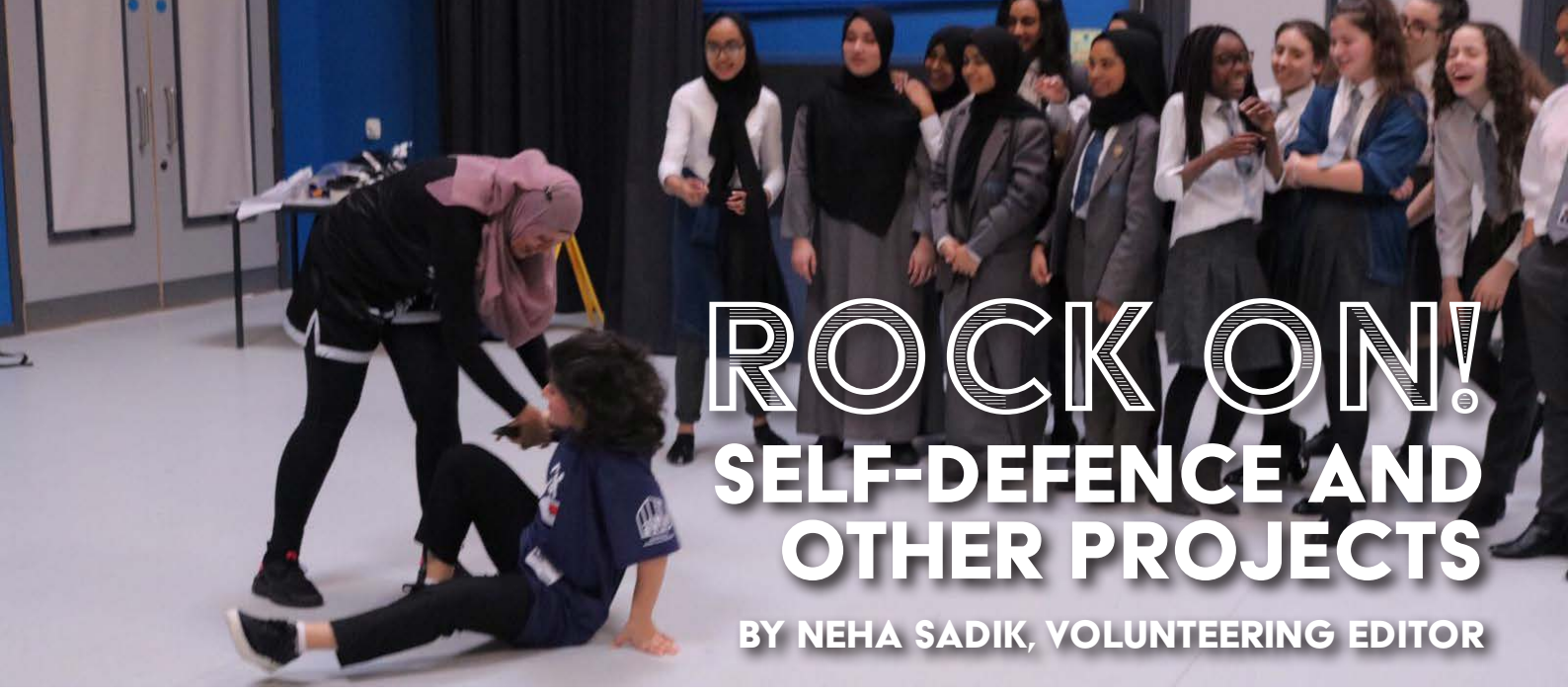
Lord Harlech, the ambassador to the US in 1962, told the New York Times then: "In the end it may well be that Britain will be honoured by historians more for the way she disposed of an empire than for the way in which she acquired it." And while the acquisition was 'questionable' to put it mildly, the disposal was certainly not honourable. After all, the majority of the modern world's conflicts could probably be brought back to some stuffy old white dude with a classic Napoleonic beard with unruly side-burns drawing an arbitrary line across a piece of paper.

And so, finding herself in a much different position than she was used to on the world stage, from starring role to ensemble, Lady Britannia kept calm and carried on, basically what she did best, while internal conflict about the central question of identity and role in the world bubbled beneath the surface.

Now unlike Britain, Germany had had a time of it. In the words of Henning Wehn on Would I Lie to You? "We gave everything a go". At the same time as Britain was ungraciously divesting herself of her empire, Germany was wrestling with the actions of its past and I don't think I need to dissect the horrors that their nation had to come to terms with. Since its conception in the mind of the then Minister President of Prussia, Otto von Bismarck and consequent inception in 1871, Germany had its foundations in Prussian militarism (Furor Teutonicus), which the maxim from Bismarck himself succinctly describes: "Blood and Iron". However, multiple government forms and 2 world war defeats later, Germany was forced to reckon with that all important central question: What does it mean to be German? And while I have no idea whether they actually have an answer or not, I'm not German if my flowery English didn't make that blatantly obvious; It certainly seems they are closer to their answer then we are to ours. After all, the stats speak for themselves, Germany outranks us in most metrics despite having started in a more devastating position at the end of the War than we did.

BREXIT IS OVER. AT LEAST FOR NOW, AND WE WILL HAVE TO DEAL WITH THE CONSEQUENCES AS THEY COME.

But more importantly, if we are to succeed in this century and not fall into the oblivion of history books like so many other civilisations before us, we must embark upon a new national conversation, centred on our own national identity and vision for the country. Being of the liberal mindset (Yes I'm a libtard, sue me), I believe in a progressive nation, and that is the vision I have for the country I love. And so we come a full circle, to the seemingly prophetic words of Robert Burns: "No! never but by British hands Shall British wrangs be righted!"



ROCK ON!
SELF-DEFENCE AND OTHER PROJECTS

BY NEHA SADIK, VOLUNTEERING EDITOR

"HELP OTHERS WITHOUT ANY REASON AND GIVE WITHOUT THE EXPECTATION OF RECEIVING ANYTHING IN RETURN" – ROY T. BENNETT

This quote perfectly encapsulates the spirit of charity and giving back in an exceptional volunteering group at Barts and the London. ROCK (Reconnecting Our Community Through Kindness) the outreach division of ISoc, has been very busy this year with numerous projects aimed at benefiting the people of East London in one way or another. The overall purpose of the ROCK team is to provide a platform for students to build, support and help the community, especially those suffering from socioeconomic inequalities.

Of their many projects, a couple stand out as great examples of altruism and thought behind charity. They hold a soup kitchen for the homeless members of Whitechapel on a monthly basis, collecting donations from local cafes and restaurants. This chance to have a hot drink and nutritious food is a precious opportunity for those who have fallen on hard times, especially during the winter months. Because of the hard work of the project leads and clever marketing in homeless hubs there has been amazing growth, from barely 10 people showing up 2 years ago to 40-50 presently, with some regulars as well.

Husna Ali, fourth year medic and ROCK co-lead, also makes it clear that ROCK is not just for the vulnerable, but for the future of the community. This belief is evident in 'Suture the Future', a student-lead outreach event where children from less privileged backgrounds are given an interesting practical in suturing, whilst hearing a talk which advocates healthcare careers. In certain social circles, a lot of people view jobs in the health industry as an unachievable concept, which this interactive session aims to overcome.

Another project from ROCK is 'Guard Up', a newly developed self-defence project focused on improving the safety and confidence of young women in the area. As all Barts students probably know, Tower Hamlets is not the safest borough, with the Met Police concluding that it is one of the most dangerous places to live in London according to their 2019 data.

Violent or sexual crimes are disproportionately likely to affect women, so the idea behind the self-defence was to empower female school children to protect themselves in a dangerous situation.

The leader behind Guard Up, Husna, was inspired to develop this project after training in taekwondo and hapkido (a Korean martial arts form). Seeing the impact of this teaching on fellow students, and the sense of security and self-confidence she felt herself was revolutionary. She believes it's a feeling everyone should possess, so anyone may walk to the shop when it gets dark without feeling worried or nervous. Unfortunately, she has also witnessed some Islamophobic incidents and seen people in abusive relationships, which has led her to believe that simple self-defence is a vital skill! After coming up with a plan for Guard Up sessions and getting it checked by the university, Husna and other integral members of ROCK ran a trial session at Bow School. They chose this school because of difficulties the female students have been experiencing, as the school only recently became co-ed, and therefore the vast majority of the student body is still male. 6 Barts volunteers were trained by an external women's self-defence educator, then they went to the school and delivered their session. Thanks to the great feedback they got, they have decided to train up lots of volunteers and head to schools which need them!

With extensive research behind the most effective methods to teach for self-defence, a couple of simple techniques have been hand-picked for sessions. These are movements which can get girls out of wrist-grabbing or shoving, which are amongst the more common attacks. Above all, the girls will be taught de-escalation, so they can remove themselves from an unsafe environment. With a lot of support from volunteers and committee, ROCK is not just dreaming of a safer community, but working towards it one class at a time.

GET INVOLVED WITH ROCK BY VOLUNTEERING WITH WHITECHAPEL STREET KITCHEN ON THE 19TH AND THE GARDEN PROJECT ON THE 26TH OF FEB!

PROJECT PLAY: THE FUN, THE FUNKY, AND THE MESSY

BY ALEXANDER BENEKE

On the seventh floor of the Royal London nestled in amongst the paediatric wards, there exists the Playspace, where four times a week a team of volunteers don their signature purple shirts and get together to put on a session of fun activities for the children and teenagers of the surrounding wards looking for a distraction from the unending boredom of a hospital bed.

This can take the shape of messy painting, flurries of glitter, and copious amounts of PVA glue in a classic session of arts and crafts, or something a bit calmer (though admittedly, not by much) like board games or origami. But in true Project Play fashion, every session manages to produce things you could scarcely imagine, from surprisingly complex pipe cleaner animals to the most heart-warming letters to parents and friends.

Each session is led by one of Project Play's own heroic Lead volunteers, who meticulously organise each session and bring their own individual spark to the activities. But the most energy and positivity undoubtedly comes from the focus of our whole operation: the children themselves, as with gap-toothed grins stretched wide, they laugh, play, and create works of art. From watching them go about their artistic activities, however, you learn one of the most fundamental and sobering rules of Project Play: despite what you think, you are not better at arts and crafts than a 4-year-old.

This year, under the wonderful management of Presidents Eva and Angharad, Project Play has continued to flourish and is continually reaching new heights, helping more children than ever before with word of Project Play spreading even beyond paediatrics and reaching children in ever more far flung departments.

From my perspective, in this last year and a half Project Play has been one of the absolute highlights of my time at Barts, and every time I turn up to a session it always feels like an immense privilege to be a part of such an incredible organisation. Without fail, from the banter with the teammates to the playing and joking with the kids, every session of Project Play will always be the best part of any week.

ON WEDNESDAYS WE WEAR GREEN

BY MYURRI LOHESAN AND KEAGAN WITTS

1:30PM. SATURDAY 6TH JULY 2019. TRAFALGAR SQUARE

"Running call! Patient fallen off the top of a bus stop, take gases and get there quick!" Calls to patients with this particular mechanism of injury are, unsurprisingly, a bit of a rarity for everyone, but regardless of their injury, we are still expected to be the first medical response for members of the public and often get there far before the ambulance service. This was a call that a first aider from BL received whilst giving medical cover with St John Ambulance at London Pride this year. Amazingly, the patient walked into the treatment centre on their own but required Entonox, morphine, and a doctor to relocate a broken finger and check over their back before a quick trip to hospital for the appropriate scans.

In some ways, these are some of the benefits of being a volunteer with St John (no, there's no 's'...), having to deal with a very wide variety of patients with uniquely different conditions whilst also having the clinical autonomy and responsibility to deal with the patients yourself (and praying that the ambulance is not too far behind sometimes). But on top of the great experience that you get, there are other added benefits such as the ability to develop in a wide field of specialties (ambulance crew, communications, training, cycle response, extrication/crowd response, youth work, driving, fundraising etc.).

Becoming a part of one of the largest volunteer healthcare teams in the country, comes with special benefits of going to large events completely free (London Marathon, Concerts, New Years Eve and a lot more). We also have specialist support in place for student healthcare professionals that volunteer with us, giving them the opportunity to practise skills they might not do much otherwise.

Our patient stories are not always as exciting this one, though. Sometimes, it's as simple as dressing a wound, giving some paracetamol, or just talking to a patient. However, regardless of the ailment or the query, our volunteers will always be there to lend a hand with a smile on our face.

So, if you're interested in doing something a bit different that will help you grow as a person, if you want a bit extra clinical experience, or if you have a keen interest in the prehospital setting, then why not join a fantastic team that does something just a bit out of the ordinary and has a lot of fun whilst doing it?

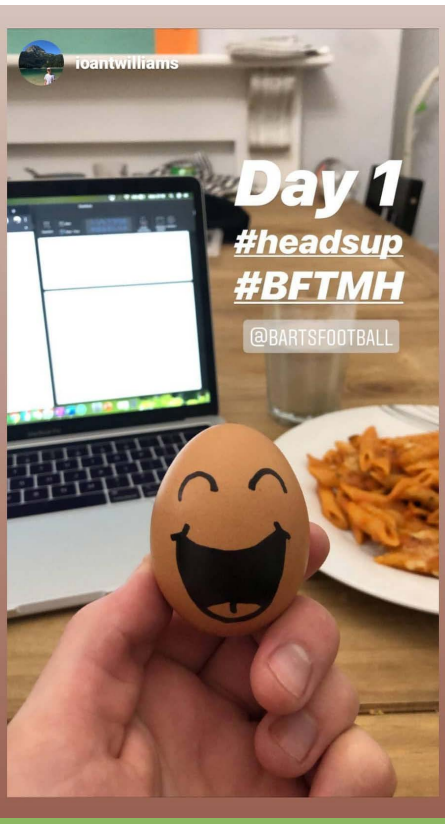
IF YOU ARE INTERESTED IN JOINING THE SOCIETY TO LEARN FIRST AID OR JOINING THE UNIT AS A VOLUNTEER, PLEASE EMAIL NATALIA.PERDEK@SJA.ORG.UK OR MYURRI.LOHESAN@SJA.ORG.UK

MEETINGS ARE HELD EVERY WEDNESDAY 6-8PM IN BANCROFT (WHERE YOU DO YOUR ANATOMY AND PHYSIO LABS), ROOM 1.13.

(OH, AND BY THE WAY, WE GET 20% OFF NANDOS WITH EMERGENCY SERVICES DISCOUNT)

@QMULLINKS

'Do It With Thy Might' is a campaign aimed at celebrating the student body and the work they do to make the Barts and The London community so special. If you think someone or some group that should be nominated, let us know!



To coincide with 'Blue Monday' BL Football ran their mental health awareness campaign, in which they challenged students to look after a raw egg for a week. The campaign was aimed to get students thinking about how fragile everyday mental health is and encouraged many students across BL to take part!

"DO IT WITH THY MIGHT"

013

~Types of Election Candidates~

Lou

KEEN BEAN

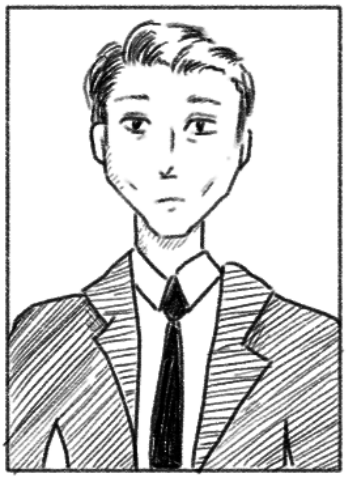
- PBL enthusiast
- Always at lectures
- Spent 3months on their manifesto.

HAPPY GO LUCKY

- Social-Sec
- Friends with everyone
- Doesn't mind if they don't get elected (but secretly does)

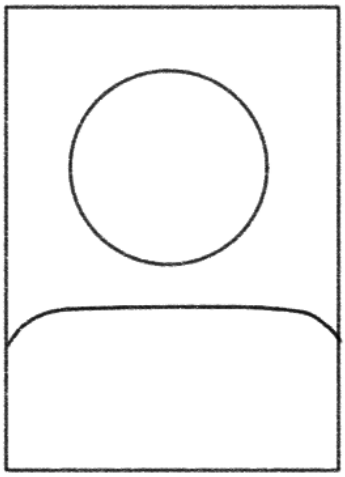
FAMILIAR FACE

- Major BNOC
- Probably been on the board before
- Always in the Griff



HARDCORE HEADBOY

- Hadn't heard of them befor elections
- Scary photo
- Always wears a suit



GRAPHIC DESIGN IS MY PASSION

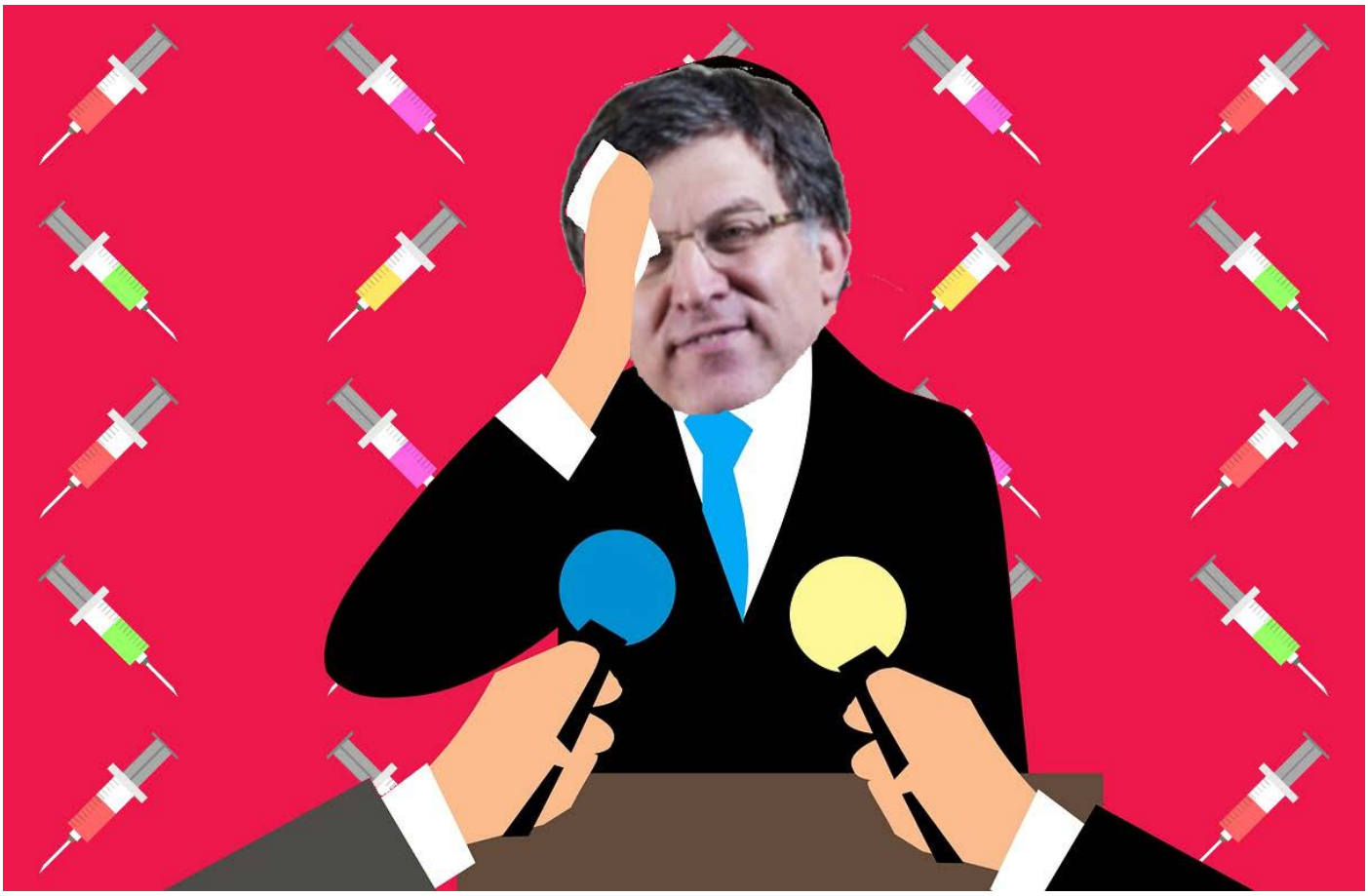
- Who are they?
- No seriously.
- Who?

DID IT ON A DARE

- Who knows, maybe they could get elected?
- Maybe?

PROF. WANTHONY ARRENS EXPOSED?

BY PENNY SILLEN, EX-POLITICAL CORRESPONDENT



Barts and The London School of Medicine and Dentistry has been left in a state of what can only be described as mild crisis, as it was revealed that none other than Dean for Students, Professor Wanthony Arrens was at the centre of a massive anti-vaxxer network based here at Barts and The London.

The allegations surfaced after a surprising number of students were found to not be vaccinated, apparently due to Professor Arrens placing enemy operatives within occupational health who answered to 'Hail Hydra'.

We can reveal exclusively thanks to sources within the Medical School that apparently the issue would have been much bigger if not for the actions of Head of Assessment, Pimesh Natel who allegedly went rogue and decided to take matters into his own hands.

After donning a costume (which he found surprisingly quickly) and insisting that fellow staff called him 'The Vaccine', Professor Pimesh allegedly disobeyed direct orders from The Principal and infiltrated Occupational Health.

Once there, he reportedly spiked the water cooler with an extract of elderflower and rubella, a personal cocktail of his that he dubbed 'Rubellaflower'. Within the next 3 days, 7 staff members who experienced symptoms were rounded up by Professor Natel and told they were not 'Fit to Sit', which Professor Natel has been using as his catchphrase.

In an attempt to clear his name, Professor Wanthony held a open lecture slot in the Perrin Lecture Theatre last week, where students were allowed to ask him any question. As expected however, he expertly dodged and deflected their questions like the lovechild of a ballerina and politician.

Following this debacle, Barts Health NHS Trust was forced to declare their hospitals a 'BL student free zone', and saw an immediate effect, as whole wards of previously ill patients suddenly recovered simultaneous to perform a rousing rendition of 'Defying Gravity from the musical 'Wicked'. Other NHS Trusts are now running trials to see if they too can prove that infections are in fact caused by medical students instead of pathogens.

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