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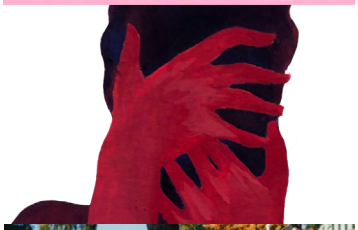

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FRONT COVER BY MELISA CETIN

MASTHEAD

EDITORIAL

Hello and welcome to 'Spring Forward', the fourth full issue from Circadian. This issue aims to be to be something of a more hopeful issue, about the world emerging from the events of the last few years in a more positive way.

At the risk of sounding a tad dramatic, it seems that we as a society have been at a crossroads for a few year, in a way that is bigger than any one event or person alone.

Politically, we've seen the rise of nationalism across the world, from the Philippines to India, and from Brazil and the UK. We've seen a slow decline of Western collaborative leadership, from the USA temporarily leaving the Paris Climate Accord and World Health Organisation, to the UK leaving the EU on unceremonious terms. It's not all doom and gloom of course, and later in this issue we have an article about vaccine inequality that touches upon the COVAX global vaccine distribution scheme, which aims to provide some leadership.

The digital revolution has reached saturation into every part of modern life, from social media to smart homes, to cryptocurrencies. In response, we've also started to see a reinvigoration of personal privacy measures, from GDPR legislation to individual deactivation of social media accounts. Social media has also changed the political and campaigning landscape, and given a powerful platform to views on all sides of the political spectrum. It has helped fuel social campaigning and education such as through the Black Lives Matter movement, but also fuelled those opposing social change. It is inevitable then, that social media platforms have become a daily battleground of these issues.

Our understanding of how unsustainable our reliance on fossil fuels is, as well as practices that cause the release of greenhouse gases has yet to see major systemic change and, as time runs out, requires more drastic changes if we are to prevent future catastrophe. And last but not least, COVID-19 has accelerated and prompted our society to change like no other single event in our lifetimes. The traditional workplace, consulting room and classroom, and the environment surrounding them, has been challenged to it's core and it remains to be seen whether it will or should go back to how it was before.

As a society, we are more connected and have more information at our fingertips than any generation before us, but with that information comes a responsibility to question it and use that information in the right way. Fundamentally, our society as a whole has been asked a number of questions about what it is, and what it wants to be. Where we go next is entirely dependent on how we decide to respond, if at all.

Harris Nageswaran
Editor-In-Chief

@blcircadian

circadian@bartslondon.com

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ILLUSTRATION BY MELISA CETIN


Spring
Forward

How To Save A Life

by Harris Nageswaran

How many people does it take to try and save a life?

Clichéd openings aside, it's a question that has given me much pause for thought when I look back and (shudder) reflect on my experiences of the last year or so.

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Earlier this year, one of my friends was telling me about his experience working as a HCA on a COVID ward at Northwick Park Hospital. From his account it seemed clear that it had left a deep impression on him; he described the isolation of being surrounded by co-workers who had never met before that night, and of the brutality of proning a patient, hidden in a swirl of sheets that helped maintain the objectification.

Most strikingly, I felt his despair at the situation; of the scale of people coming in shift after shift to try help - seemingly to little effect. Dozens of hands had been conducted into an orchestra of care, some proning, others typing frantically; and yet the faces behind the hands, this huge crowd of well-wishers, would likely never be known to the person they were trying to save.

It painted quite the picture for me, and yet the more it lingered, the more I couldn't help but see another story within - one of overwhelming humanity. I saw a willingness of scores, if not hundreds of people, to work all working towards saving this one life, despite the difficulty in seeing the benefit of their actions.

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My time at medical school has been understandably centred around the clinical setting, and I spent relatively little time thinking about all the other elements. In the last 12 months however, I found myself, quite unwittingly, entering a whole new world of non-clinical roles.

I started volunteering as an active response volunteer at The Royal London Hospital in April 2020, in what was the peak of the first wave, and it seemed like the entire hospital was in a state of flux.

Wards would disappear then reappear on another floor, guidance on where and what we could do was changing week-by-week, and cages upon cages of unexpected donations would come streaming in for distribution before the next came in.

The volunteers I worked with were a cross-section of East London, with no real distinguishable pattern in age, gender, ethnicity or experience. Throughout the highs and lows of the pandemic, and there were many, I always felt it heartening going to work with the volunteers; inspiring even. The atmosphere, of a group of people from all walks of life; a mix of people who were retired, furloughed, students, but importantly all united in facing the daily challenges of the hospital, was thankfully infectious.

I found myself interacting with an ever-expanding list of people through this role, whether that was working with the bereavement office to track down the property of deceased patients, or visiting the porters in the basement to secure some of that in-demand PPE, or liaising with the chaplaincy to communicate with families of patients.

Fundamentally, (almost) every new person I met pushed my belief away from the cynical pit I found myself encircling, and appreciate just how lucky we are to have the health system we do.

It's a common turn of phrase that the NHS is run on the goodwill of those who work for it. While that seems to be a dangerous, unsustainable position for our healthcare system to be in; I cannot deny the truth in that.

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Public attention on the pandemic, and healthcare generally, almost exclusively spotlights more clinical staff like nurses or doctors or healthcare assistants. While I'm sure it makes better TV clips, it means that as a society we often fail to appreciate just how many people are working to improve the lives of each and every patient.

It is often said that it takes a village to raise a child, and I would argue that sentiment applies just as much to healthcare too; from what I can see, it also takes a village to save a life.

ILLUSTRATION BY MELISA CETIN

In Conversation with Professor Chloe Orkin

Prof.Chloe Orkin is a Consultant Physician at the Barts Health NHS Trust, running HIV clinics and a HIV/HCV research unit. She is also a clinical professor of HIV at Queen Mary, clinical lead for COVID-19 research at Barts Health, current chair of the British HIV Association, and Athena SWAN Chair for the SMD at Queen Mary, and the Vice President of the Medical Women's Federation.

Tell us a bit about your journey into this field; how did you become interested in HIV/AIDS and what was it you wanted to change in the field?

I became involved in HIV for two main reasons. Firstly, because I have always found microorganisms fascinating; I was the top student in virology and microbiology at my medical school in Johannesburg. Secondly, a very close friend of mine had HIV as did many of our circle of friends. I wanted to help him and others and it seemed the perfect career for me.

We've read about your campaigns, such as U=U and Going Viral. Could you tell us a bit more about them, and what challenges you encountered in executing them?

In 'GOING VIRAL' I led 9 hospitals in testing for HIV and viral hepatitis in emergency departments. This is important because people were presenting late due to late/missed diagnosis and this high-profile testing week campaign was a way of highlighting the importance of making these lifesaving diagnoses [earlier].

U=U is an international campaign which was not spearheaded by me, but as Chair of the British HIV Association, I supported and strengthened the 'Undetectable=Untransmittable' message by being the first medical society chair to use the words 'zero risk'. Others had called the risk 'negligible', which is very hard for patients to believe or make sense of. Zero risk is clear and believable and can reassure people that they cannot pass on HIV.

What does a regular day in your life look like? How do you balance your clinical and research responsibilities?

At the moment it looks like chaos! I am leading on delivery of the COVID vaccine clinical trials for Barts Health NHS Trust and QMUL. I also do HIV clinics and still have active HIV trials and research papers and presentations to write and give…. As well as my gender and equality work which takes time too.

As the incoming president of the Medical Women's Federation, what did your journey there look like, and what is your vision for the role?

I was elected VP in 2019. I plan to work to understand and improve the seriously detrimental effects that COVID-19 pandemic has had on women's careers and to engage and involve the junior members of the organisation.

As clinical lead for Covid research, how did it feel to work in a time pressured environment, and under scrutiny from the public and university?

There is a lot of pressure from all sides. The best thing I can do is to try to remind myself of the importance and value of the contribution I am trying to make, and to try to work as hard as I can to give my best, even on the most difficult days.

What advice would you give to current and future medical students who want to make a public health difference and develop a diverse career like yourself?

Be true to your interests and follow a speciality/path that feels like something you (and not your parents!) genuinely want to do. Be prepared to fail and pick yourself up again. Find your people and develop your friendships at medical school and during your training, they will sustain you for life. Take opportunities to work abroad and broaden your perspective, and take up enrichment activities. Realise that at times things will be very hard but you are becoming one of the most incredible things anyone can become. A Doctor.

U=U, as Prof.Orkin says, stands for 'Undetectable=Untransmittable', referring to the fact that having an undetectable viral load means that a person cannot transmit HIV to another individual. This campaign serves to reduce the fear and stigma surrounding individuals with HIV, and shows people that there is an effective treatment, if not cure. The U=U consensus statement was launched by the Prevention Access Campaign in 2016 and was endorsed by the BHIVA in 2017.

The Medical Women's Federation is the 'largest and most influential body of women doctors in the UK'. Founded in 1917, it has been active since then in helping advance the careers of women doctors in the UK, fighting discrimination, and campaigning for important causes such as abolition of female genital mutilation, ensuring family friendly employment and proper treatment of women suffering from sexual abuse or domestic violence.

THE IMPORTANCE OF TRYING NEW THINGS

BY DANIEL NIE

The coronavirus pandemic has undeniably changed the way we live our lives.

There are so many things that we would normally do and love to do, and yet by law and necessity, we cannot do. The result is that we have had to adapt the way we live according to the circumstances. Having said that, the pandemic and lockdown has produced silver linings in the midst of dark clouds, and although not immediately comparable, have brought immense value to our lives by creating more space for reflection and introspection in life. I would like to share some of the things I have recognised about myself and life during the lockdown period in the hope that it can benefit you as well.

From observations of myself and friends, I see a ritualistic tendency in the way we live our lives; what I mean by that is that we have a general predisposition to order our lives in a particular way and forming routines in the day, week, month and year. There seems to be a reassuring rhythm to life. My time at medical school has reinforced that belief and I'm sure this is relatable to many of my peers. For example, during my term-time days, I would normally wake up an hour before I have to leave for lectures or placements in order to freshen up, get dressed, read the Bible, pray and have breakfast. I would plan to arrive at my destination 10 minutes before I am due there to ensure punctuality and account for any unexpected delays. I would go into placements from Monday to Friday and usually get back to have dinner at 6pm before relaxing or doing further study. Saturday would be my recreation day where I would be free to do what I enjoyed and Sunday would be my day-off, where I would dedicate the time to going to church and fellowshipping with other Christians.

There tends to be a negative reaction when we consider rituals as they can be deemed as restrictive, old-fashioned and loathsome, but I think routine is generally a good thing and a fact about the human race - which explains why we get stressed and anxious when new events force us to change our habits. We are a ritualistic species.

Not only do I see a rhythm to life, I also see distinct seasons to life. A very wise writer once quipped:

> ***"There is a time for everything, and a season for every activity under the heavens: a time to be born and a time to die, a time to plant and a time to uproot... a time to weep and a time to laugh, a time to mourn and a time to dance... a time to search and a time to give up...a time to keep***

and a time to throw away, a time to tear and a time to mend, a time to be silent and a time to speak...”

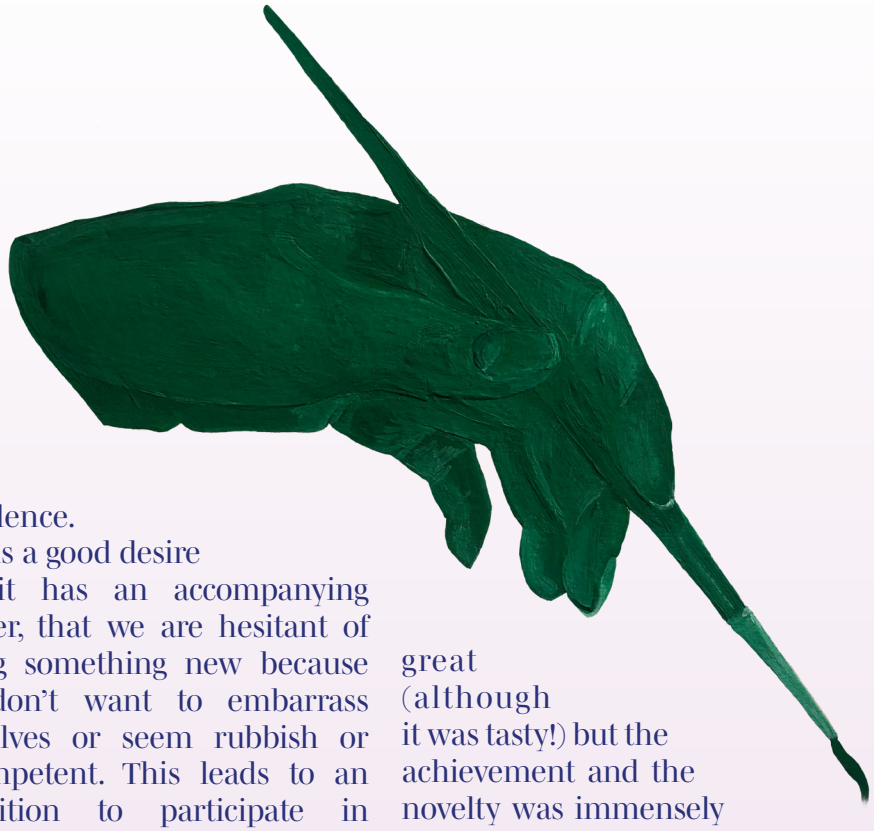
We all have seasons to life. Whether it’s primary school, secondary school, university, work, retirement; singleness, married life, parenthood; time in your parents’ house, time to move out into university, time to set up your own household; time of great happiness, time of great sadness, time of mediocrity, etc. It seems that the coronavirus pandemic too, is a season that has been imposed on all of us.

What different seasons in life have in common is that they all force us to embark on something radically new and this is a terrifying prospect for most people and dare I say, especially medical students. We, as medical students, are prone to having a perfectionist mind-set. This is probably because we have a track-record of achieving highly and expect to do so in the future; we have a desire to strive for excellence.

This is a good desire but it has an accompanying danger, that we are hesitant of trying something new because we don’t want to embarrass ourselves or seem rubbish or incompetent. This leads to an inhibition to participate in new activities which leads to a stagnancy of life. I’ve noticed these characteristics in myself which has robbed me of joy in the adventure of life.

Bitter pill swallowed, I recognised this and the lockdown, paradoxically, provided the motivation to try something new.

There is an exhilarating nature to trying new things! I would recommend this to be an art-based hobby to be a well-rounded person since we tend to be science-centric. I’m almost ashamed to say it but this year was the first time I baked a cake and made brownies! It took a lot of time and the end-product didn’t look great (although it was tasty!) but the achievement and the novelty was immensely satisfying! There is a restless vibe in London which compels us to do the same routines all the time but it is so important to resist this sentiment. Take the time out to try something new and learn! You may find it to be better than you think!



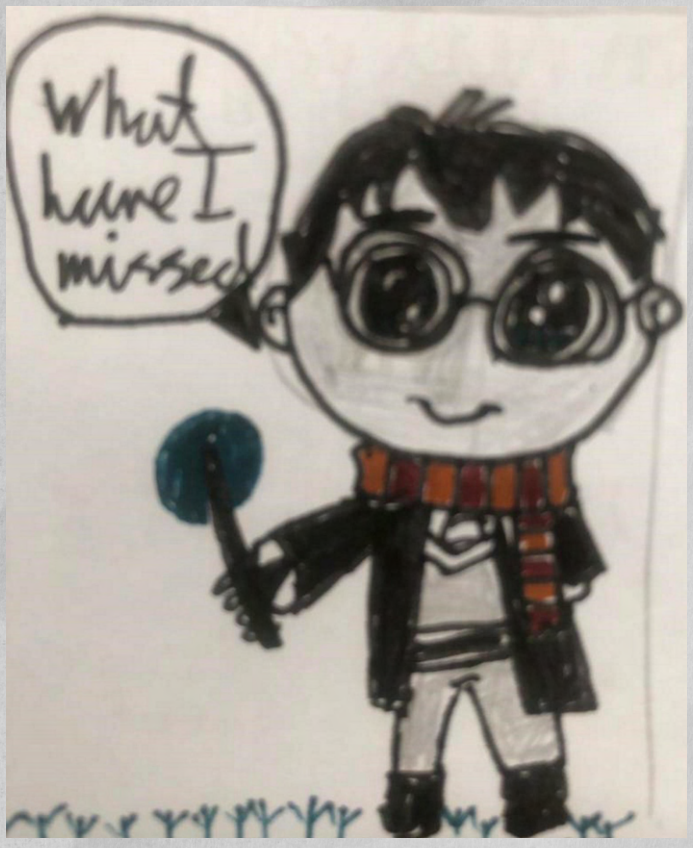
ILLUSTRATIONS BY LILY COLTON

BEING 8 DURING A PANDEMIC

BY TOM CULLINANE

WHEN COVID OUTBREAKS HAD JUST STARTED, IT WAS NEAR THE TIME OF MY BIRTHDAY.

I was very lucky because my birthday in March was just before we went into lockdown. At first, I thought COVID wouldn't be as bad as it is now but when my trip to Norway for my birthday got cancelled, I knew something bad was coming our way. Things I did to keep myself busy during this period were to draw, read lots of Harry Potter and learn more about history and maths. After about a month I went back to school.



SUMMER/JUNE-AUGUST

At this time, I had returned to school for almost two months because my parents were key workers. Things were gradually getting back to normal, other than that not everyone was in school. In my weekly mag [the Phoenix] there was a comic contest and to keep myself busy, and I entered the contest for fun. Before we went into the summer holiday my sister's old teacher was teaching me. Then when the summer holidays finally arrived, my sister, mum and I went to our Grandma and Grandpa's house for three weeks. We also went to see our cousins and then stayed at home for another three weeks. I enjoyed playing with my cousins because it gave me hope that we could get through this virus and we should all have courage. Things I enjoyed doing was to ride my bike, going to the playground and visiting my favourite beach, Boggle Hole.

AUTUMN AND WINTER /SEPTEMBER- NOW

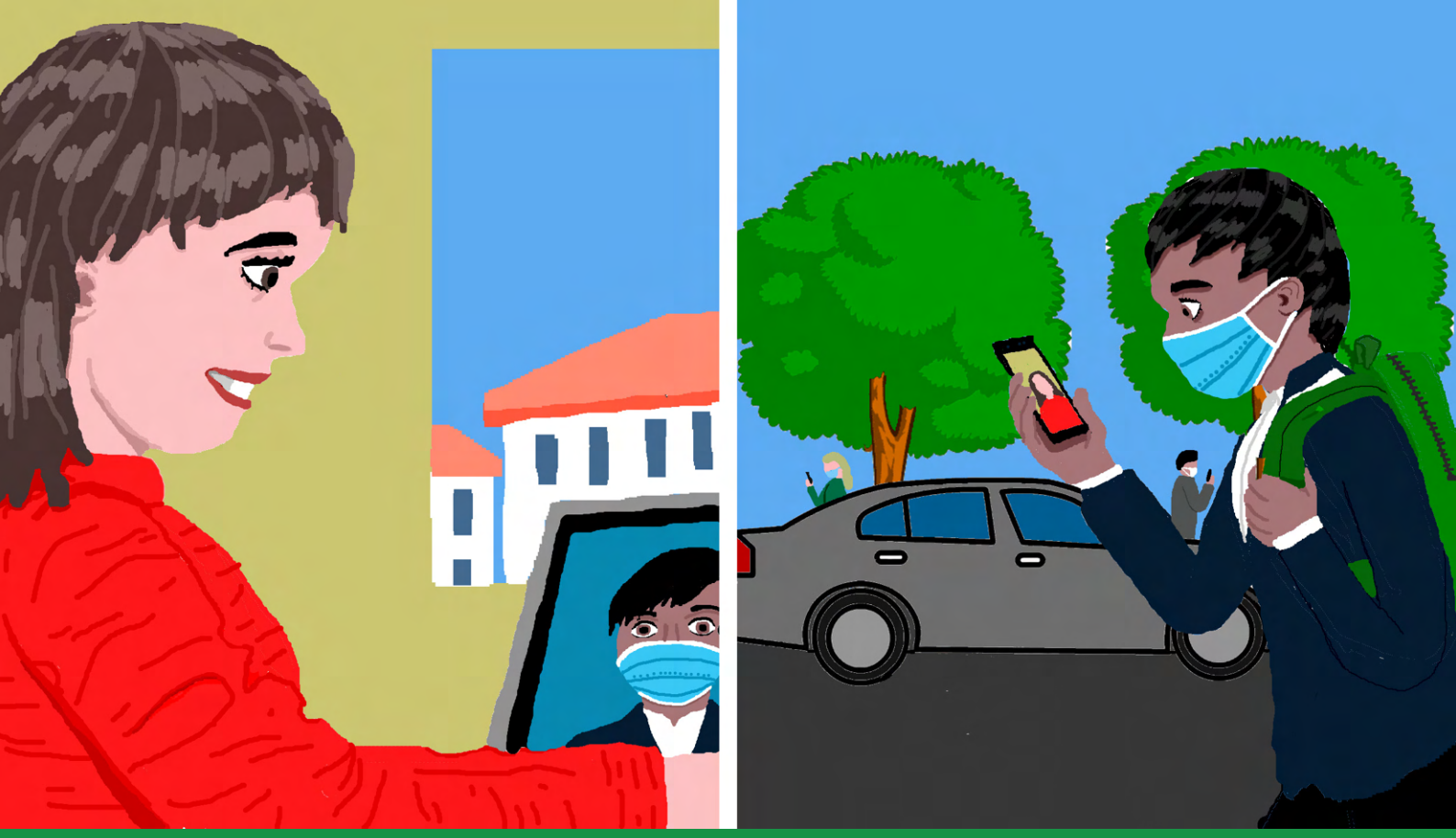
As summer came to a slow halt and autumn took its place, school became closer and closer to what it used to be. As all my friends came back to school, I started year 4. I could now see my friends but if they weren't in my bubble, then I would have to stand two metres apart from them. All my friends in my class were so kind to me because they were just so friendly. Some days I could suggest games to them and they would usually play them with me. As kids were really jolly and people were putting up their Christmas trees and decorations, school was preparing for the Christmas dinner. Unfortunately, someone in my class got a positive test and my class had to self-isolate, and I also missed the class party for the second time running. [I didn't know whether it was a good or bad thing]. Now not all my friends are back at school and some are struggling but I hope soon that they can come back. Now we have the vaccine hopefully we have a bright future ahead of us.

WHAT I'VE ENJOYED

Reading, Drawing, Seeing my sister enjoy brownies
My grandmas and grandpa have been vaccinated

WHAT I'VE MISSED

Going to clubs, my family, playing sports, playing with all of my friends and family and my aunties



Conquering the Pandemic

by Siraj Abulanaja, Editor-At-Large

Out of shape and out of mind. Constantly tired, hungry, and lacking motivation. A statement that resonates with many of us.

This pandemic has changed every aspect of our lives. If we were not hooked on our phones and laptops before, our screen-time reports delicately remind us that our average usage hovers at around 3-4 hours (if we're being modest). From studying to socialising, it seems that life can be lived from the comfort of our own homes. Naturally, with time, we hit a wall – a sort of plateau. If you are anything like me, plateauing is one of the worst feelings. Days can often seem to repeat, and when you look back, the only significant thing you have accomplished is binge-watching 5 different programmes in less than two days. While this is quite an impressive feat, it probably won't help with dragging us out of this stagnant lifestyle. So, what can we do to break this spell of unproductivity and laziness?

Well, a glimmer of hope comes as the seasons change and the sun stays up with us a little longer. The cold harsh winter is behind us and it is time to get up and spring forward into a summer filled with optimism and hope. Begin by making goals and setting targets for yourself each day, no matter how small or insignificant they may be. If you aim to exercise, start by taking walks in the park. If your goal is to become more studious, try starting by setting yourself just 15 minutes of revision a day. After all, Rome was not built in a day and your habits won't either. Settling in a routine is a good thing. Many will argue that routines are boring – but what's wrong with boring if it means accomplishing the goals you set out to achieve?

A lot of us may believe that our biggest opponent is the pandemic, but in reality, the only thing stopping you from growing is you, the reader of this article. This short article isn't meant to patronise or disparage those struggling with the current situation, but it is meant to encourage healthy habits that may help others reach their full potential. As a withered winter flower eventually blooms in the heart of spring, hopefully we can do the same.

ILLUSTRATION BY SAMIL HOSSAIN ARA

Safe not Silent

by Rebecca Walker

My first impression of the room is that it is small and unassuming.

A desk and chair fill most of the space; there is a smaller table in the corner with a box of tissues on it. I could not describe it as cosy but it definitely felt private, which is something I needed for the conversation I was about to have.

As the anticipation for that conversation builds, I can feel harsh palpitations racking against my rib cage and a thick lump is lodged in my throat. I feel strangely parched and as if I could cough, but I avoid it considering what that means nowadays. These are feelings I am all too familiar with and they are part of the reason I'm here.

After years of panic attacks, intensely depressive episodes and invasive suicidal thoughts, I decided to take the step that, in hindsight, I wish I had taken far earlier.

I contacted Advice and Counselling. The whole procedure to organise an appointment had been easy, but not painless. My silence had felt like the only power I had, over what I had acknowledged long ago was mental illness, and somehow, I felt I was doing those years of resolve a disservice. Even though I knew staying silent was trapping me in a dangerous cycle that wreaked havoc on every aspect of my life, it was familiar territory. Talking to someone about what I was going through? That was unfamiliar and terrifying, but also necessary.

The first step in contacting the Advice and Counselling service was to fill in an online form that asked questions about my wellbeing, mood and whether I had been having suicidal thoughts. Within a couple of days, the service responded and offered me an appointment with a counsellor. The appointment would be online, of course, but they offered me a room in the department if I did not feel I had sufficient privacy at home.

And that is how I ended up in a small and unassuming room where something happened that has changed my life forever. According to the British Association for Counselling and Psychotherapy, 1 in 5 people have consulted a counsellor or psychotherapist. Even with the weight of stigma associated with talking therapies, around 20% of our population has needed to talk to a counsellor or psychotherapist at some point in their lives. When I look back on the things that held me back from getting help in the first place, stigma had a role to play. It was not that I thought less of talking therapies, but I felt guilty accessing those services.

In my mind, a certain type of person needed those services, and I was not that person; I did not have any past traumas that had instigated my problems and all in all I have been very lucky with my lot in life.

What would I even talk to a counsellor about? How ungrateful I was for having all these beautiful things in my life and yet feeling the way I do? In the small and unassuming room, I learned a lot about myself and the ways in which I think. With the help of the counsellor I confronted not just what I was feeling, but why I felt that way. They helped me find the strength to go and talk to my GP, who was as supportive and kind as I hope to be as a doctor in the future.

Through the Advice and Counselling service, I was also able to see a psychiatrist, and after almost a decade of self-diagnosis it was official: generalised anxiety disorder (GAD) and depression. It was no surprise to me, but finally acknowledging my feelings for the past decade as a medical condition like any other and getting treated for it has changed everything.

It is not so much that I do not get the feelings I did before, because in truth I still do.

Medication has helped with my depression but has been much less effective in managing my anxiety. Being in a pandemic in particular, means there is plenty to be anxious about and it often feels like my panic-prone brain monopolises on that. GAD takes things that seem like normal anxieties and exponentially amplifies them, to the point where the very thing I am worrying about is ridiculously unlikely to ever happen.

Something important that I took away from counselling is what it means to look after myself. Instagram and other social media outlets seem to have glamourised the idea of 'self-care'; one post in particular recommended a fancy bubble bath, a clay mask and a glass of wine to sooth a troubled mind. As luxurious as it sounds, that type of self-care is not for everyone; sitting in a bath alone with my anxieties all buzzing around my mind was almost hellish and adding alcohol to the mix ended up as a disastrous cocktail. That is not to say that it would not work for

someone else, as that bubble bath could be exactly what someone needs after a stressful day.

IT IS MORE TO SAY THAT SELF-CARE DOES NOT ALWAYS LOOK AS PICTURE PERFECT AS INSTAGRAM LEAD ME TO BELIEVE.

I have found a good way to judge whether a self-care activity is working is to take note of how I feel before and after said activity. Anyone who has experienced anxiety is familiar with the conflicting feelings of burnout and being 110% alert simultaneously; if this improves, the self-care activity is worth repeating for me. Painting my nails, face masks and bubble baths can be for pampering; taking self-care seriously means pursuing activities that help me feel less burnt out and more resilient to the craziness happening in the world around me.

Self-care activities that work for me are not the ones that I expected to work. One thing that has been incredibly effective has been spending time with dogs; I joined a site called 'BorrowMyDoggy' that puts me in contact with dog owners in my area that are looking for people that can walk their dog or look after it for a few hours. Not only was spending time with loveable dogs amazing, but it also gave me a change of scenery by getting me out of the flat and into my local parks. I was noticeably more relaxed after these walks. Another activity that has been an emotional outlet is putting on some sad music and letting myself cry. I can freely let out big ugly sobs and all the negative emotions that have accumulated with it. I listen to audiobooks I used to listen to as a child that help me feel safe. These activities are tried, tested and actually help. Maybe they are not quite Instagram worthy, but they work for me. I guess what I am trying to say here, is that self-care is not a one-size-fits-all approach to wellbeing.

In my experience, finding things that actually add to my wellbeing has helped improve my ability to cope with daily challenges, which some days can be just getting out of bed. Looking ahead into the future, it seems the end is tantalisingly in sight for this pandemic. Isolation and spending every day much like the day before has taken its toll on everyone. Looking after each other and our own mental health is more critical than ever before. Counselling helped me muddle through the complicated emotions that were poisoning my life and self-care has helped me build up energy reserves to deal with any problem that rears its head. It is far from perfect but I have not felt this hopeful about the future in a long time. I hope this message reaches anyone who needs encouragement to talk about what they are going through or is finding it hard to look after themselves at the moment.

REACH OUT TO SOMEONE YOU CAN TALK TO; REACH OUT TO A COUNSELLOR; IF SITTING IN YOUR BED CRYING HELPS YOU GET THROUGH IT, THEN DO NOT FOR ONE SECOND FEEL ASHAMED TO DO IT.

CONTACT DETAILS FOR QM ADVICE AND COUNSELLING:

PHONE NUMBER:

020 7882 8717

WEBSITE:

welfare.qmul.ac.uk/our-services/

OTHER SERVICES YOU CAN CONTACT:

YOUR GP

SELF-REFER TO PSYCHOLOGICAL THERAPY SERVICES (IAPT) - YOU NEED TO BE REGISTERED WITH A GP

nhs.uk/service-search/find-a-psychological-therapies-service/)

SAMARITANS 24-HOUR HELPLINE:

116123

URGENT NHS MENTAL HEALTH HELPLINE:

nhs.uk/service-search/mental-health/find-an-urgent-mental-health-helpline

IMAGE FROM UNSPLASH

DECOLONISING FGM

A CULTURAL CLAIM OR HUMAN RIGHTS VIOLATION?

BY EMILY CHAMBERLAIN, GLOBAL HEALTH EDITOR

Trigger Warning: This article discusses forms of trauma, including intergenerational trauma, sexual/physical assault, and mental health

* * *

Female Genital Mutilation/Cutting (FGM/C) is a deeply seated cultural practice and is currently thought to be performed in 28 countries worldwide. It involves the forcible removal of the external genitalia of female presenting people, ranging in severity and expectation between both families and cultures. The topic as a whole contains a lot of nuance, as does the practice: from a small cut in the hood of the clitoris to its complete excision with the labia minora and majora. In the most severe cases, (known as type 3, infibulation) the wound may be sewn closed so that the vaginal/genital area is completely sealed, leaving a hole about the size of a matchstick. This creates impacts throughout a person's life; physically there can be life-long pain and constant risk of infection, along with complications arising from sex and childbirth. Girls often have to be 'opened up' on their wedding nights, providing surety of virginity to the husband. Emotionally, the trauma is continuous for those that go through the process, but many continue the cycle either because it is what is expected in their community or, because a common

response is to normalise trauma, it becomes viewed as the right thing to do.

The cultural reasoning behind FGM is essentially the initiation into womanhood. Following reasons also include preparation for the pain of childbirth, increasing marriageability and modesty, and the reduction of female pleasure during sex and therefore prevention of adultery. There is discussion as to its promotion in regards to religious theology, but there is no religious text that actually advocates or allows for such action. However, in many cases it is so normalised that the reasons are not even considered; it's simply 'just done' and can be culturally comparable to getting your ears pierced. This brings forward the next piece of nuance regarding FGM: age. Girls are cut at different ages up to the age of 15, and often not told what is going to happen to them. Many communities see it as a celebration, and the female relatives gather to help – aiding the confusion and resulting trauma. This means it can be difficult to determine comprehension, and is where the universality of human rights can get complicated.

We live in an ever increasingly diverse society that sees continual migration of groups and cultures, and therefore a need for their political representation and recognition. 'Multicultural' or 'cultural pluralism' policies allow for various cultural norms while also addressing issues that affect all members of the community. Here, there can be special 'cultural rights' brought into law that represent specific cultural differences or exemptions. This is different from bifurcationist options which allow cultural traditions to be practised privately but still require minority groups to assimilate in public. Although cultural relativism is widely accepted, there are varying beliefs as to the extent to which they should be held and how this affects cultural autonomy. The philosopher James Rachels argues that cultural relativism is a flawed notion, that doesn't allow for the development of criticality and morality. However, this can be a fairly westernised and colonial view that doesn't address the value of culture and brings into question how morality is founded on cultural belief. Cultural relativism applied to feminism could equally give women the protection of the universality of human rights whilst also protecting the power of autonomy over their own bodies.

The social model by Kukathas (in relation to cultural relativism) argues for minority groups to determine their own norms without state intervention, and the right of people to join or partake in any cultural associations they wish as long as they are willing. However, this model is also problematic as it assumes that there is no forcible presence on an individual – through oppression, indoctrination or stigma and fear. The key word also, is 'willing'. To be willing to undergo a procedure such as FGM/C, there needs to be a certain level of measurable comprehension, which is hard to determine among minors and the age at which they are seen as adults varies between cultures. It can be argued, therefore, that the issue of FGM/C needs to be separated between FGM/C performed on unconsenting minors and willing adults. However, there still remains the immeasurable subjectivity that comes with cultural identity and conditioning, and the resulting fear of stigma or exile that often prevents people from speaking out.

Here we experience yet another approach of significance, one of anthropological versus philosophical. Feminism of colour argues that where western feminists view cultural practises such as purdah or polygamy as oppressive, they are treated as acts in isolation of their culture and not according to relative moral norms. In westernised society the idea of dieting is not only a normal, everyday occurrence, but a capitalised one. In the Global South conscious starving of oneself would be seen just as morally questionable as westernised society views the other cultural norms discussed. Moreover, addressing FGM/C from a western position tends to be rooted in colonial views on/approach to morality. Only a few days ago, a study was published by FORWARD (Foundation for Women's Health Research and Development) and the University of Huddersfield exploring the problems that are arising as a result of the special status awarded to FGM/C by the UK governemnt since 2014. Whilst there has been a commitment to child safeguarding, the implementation of policies has been heavy handed, not culturally sensitive, and racist. This leads to a disconnection and alienation of communities through colonial impositions, no matter how well intentioned.

There have however been successful mitigation attempts. Sarah Tenoi is a project manager for Safe Kenya and advocate for ending FGM/C in her community. They approach this by spreading education through Maasai songs, embedded with informative messages regarding the dangers of FGM/C and further discussion with all members of the community. Including all members in these discussions is particularly important as it not only challenges the stigma and silence that surrounds the topic but it also disrupts the patriarchal element of these continuing cycles, as men are included in the discussions and pass on and encourage the spread of the discourse that uncut girls are still marriable. The project also suggests an alternative to FGM/C, developed directly with members of the community. It still involves a ceremony, but instead the girl has her head shaved and milk poured on her thighs. After, they are given a bracelet and wear the traditional headdress that signifies the transition from girl to woman. In the first five years of the project running, they managed to reduce the number of girls being cut by 30% in their communities and encouraged consequent replications in other communities that have also proved successful.

This latter example is a perfect show of how decolonial approaches to cultural change are needed to be sourced from within communities, with no threat to the traditional practises of these cultures. Education is at the forefront of the resolution to FGM/C, but equally cannot be one imposed by those outside of these communities who do not have a right to enforce an opinion on these practises.

ILLUSTRATION BY LILY COLTON

Great Expectations

Health policy under the Biden-Harris Administration

by Preethi Subramaniam, Global Health Editor

It has been one month since President Joe Biden and Vice President Kamala Harris were installed in their respective offices following months of campaigning, Republican-led attacks on the integrity of their election victory, and an insurrection at the US Capitol. President Biden presented himself in both the Democratic primaries and the eventual election against former President Trump as the moderate candidate who could unite an increasingly divided America, bringing together Democrats and Republicans on policies that would help the American people. His policies are reminiscent of that of former President Obama, which is especially evident in his health policy positions. While politicians in the left-wing of the Democratic Party such as Senator Bernie Sanders have embraced a single-payer Medicare-for-All plan (casually referred to as M4A), President Biden has been intent on protecting and expanding the outreach of the Affordable Care Act (also referred to as Obamacare). But before analyzing the Biden-Harris healthcare position, it is important to understand what health policy in America looked like before President Obama and what the Affordable Care Act is.

A BRIEF HISTORY OF AMERICAN HEALTH POLICY

Possibly the first real attempt to establish a nationwide health service began with President Theodore Roosevelt in 1912. Roosevelt was the founder of the Progressive Party whose platform included a national health service very similar to the German health-insurance program masterminded by Otto von Bismarck a few years earlier. These similarities were more noticeable several years later when the United States entered World War I and following phenomena such as the Red Scare (when the fear of communism spreading was intensely promoted) ended the Progressive Party's attempts to push their health policy program into state legislatures.

Years later, the infamous Black Tuesday of 1929 signified the beginning of the Great Depression which saw rates of nationwide poverty and unemployment that were unrivaled until the ongoing pandemic. President Franklin Roosevelt took the reins of the presidency at this time and put forward a New deal, a series of public policy proposals and financial reforms designed to help Americans with recovery from the Depression. One of the many proposals in the New Deal was the Social Security Act, arguably his most famous legacy still in use today. The original bill included a vague plan of comprehensive healthcare coverage

but the American Health Association, a private healthcare lobby that allied itself with the GOP, helped to push the idea that universal healthcare was bringing the United States closer to being a socialist republic because he was trying to push the powers of governments past reasonable limits. In order to get the bill passed through the United States Congress, Roosevelt was forced to drop the inclusion of a national health insurance program. This back-and-forth about the role of government and how far its limits can or should be pushed to deliver its citizens healthcare continues to be the main point of contention in health policy between the GOP or the present-day Republican Party and the Democratic Party.

The following decades did not result in much by way of a nationally unified healthcare plan. President Harry Truman proposed a Fair Deal to stop inflation and raise the minimum wage in his 1949 State of the Union address. In his Fair Deal, he also included the Hill-Burton Act which provided financial support to hospitals and health facilities so that they could modernize and keep up with growing and ageing populations. There were also a variety of acts that provided funding for the research regarding the diagnosis, prevention, and treatment of cardiovascular, metabolic, and neurological diseases. But there was still no plan to ensure health coverage for Americans.

It was not until President Lyndon B Johnson (in office 1963-1969) that there was some semblance of a federal health insurance plan to cover Americans. As part of his Great Society, a series of programs that was rooted in ambitious reform of domestic policies that were not working for the American people, Johnson made two amendments to Roosevelt's Social Security Act. While the initial act did not include universal health coverage, Johnson's amendments resulted in the creation of Medicare and Medicaid. This legally required the provision of federal health insurance to adults over the age of 65 and for poorer individuals who required public assistance.

PRESIDENT OBAMA AND THE AFFORDABLE CARE ACT

President Obama signed the Affordable Care Act (ACA) in March 2010. The main aim of the ACA was to lower the cost of health insurance so that more people could get coverage. The ACA legally required people to be insured either through an employer or otherwise or pay tax penalties as per a concept known as "individual mandate". This forced people to buy insurance instead of waiting for a time of need to do so. Obama also built on the work of Johnson by expanding the eligibility of Medicaid so that more people could be covered by the scheme.

But perhaps the most spoken about part of the ACA is what it has done for people with pre-existing conditions. Before the passage of the ACA, people who had chronic illnesses or certain medical conditions prior to starting a new health care plan were said to have "pre-existing conditions". These include diabetes, HIV, and cancer. Insurance companies who received their applications for health insurance could deny these individuals coverage or inflate their rates. The Pre-Existing Condition Insurance Plan (PCIP) in the ACA made it illegal for insurance companies to deny coverage on this basis.

The Affordable Care Act is the first major piece of healthcare legislation in the United States after the passage of Medicare and Medicaid. But that is not to say that it is perfect. The US still spends the most amount of money per patient per year because insurance providers have not lowered their costs. Providers have also managed to find loopholes within the ACA to increase profits. They have been pulling out of ACA's online marketplaces that allow individuals to compare health insurance plans and select the one best for them. Around 1 in 3 counties only have one insurer. The eternal debate of the limits of the federal and state governments comes up several times with the numerous provisions of the ACA, most importantly with Medicaid expansion. Several states have opted against this expansion, creating what is called the Medicaid coverage gap, in which individuals eligible for coverage are not covered, of several million people. The ACA is still tied to insurance which people receive from their employers who find it more cost-effective to pay the penalty that the ACA imposes for not paying for employee coverage rather than doing just that, leading to millions of people not being insured.

The Act passed the House of Representatives with a narrow 220-215 vote and passed the Senate with many disappointed Republicans. Since then, it has been subject to criticism and scrutiny, with many efforts to repeal it in legislative houses and both state appellate courts and the Supreme Court. Perhaps this is a metaphor for the ACA itself- popular enough to scrape by, but not enough to solve some of America's biggest healthcare problems.

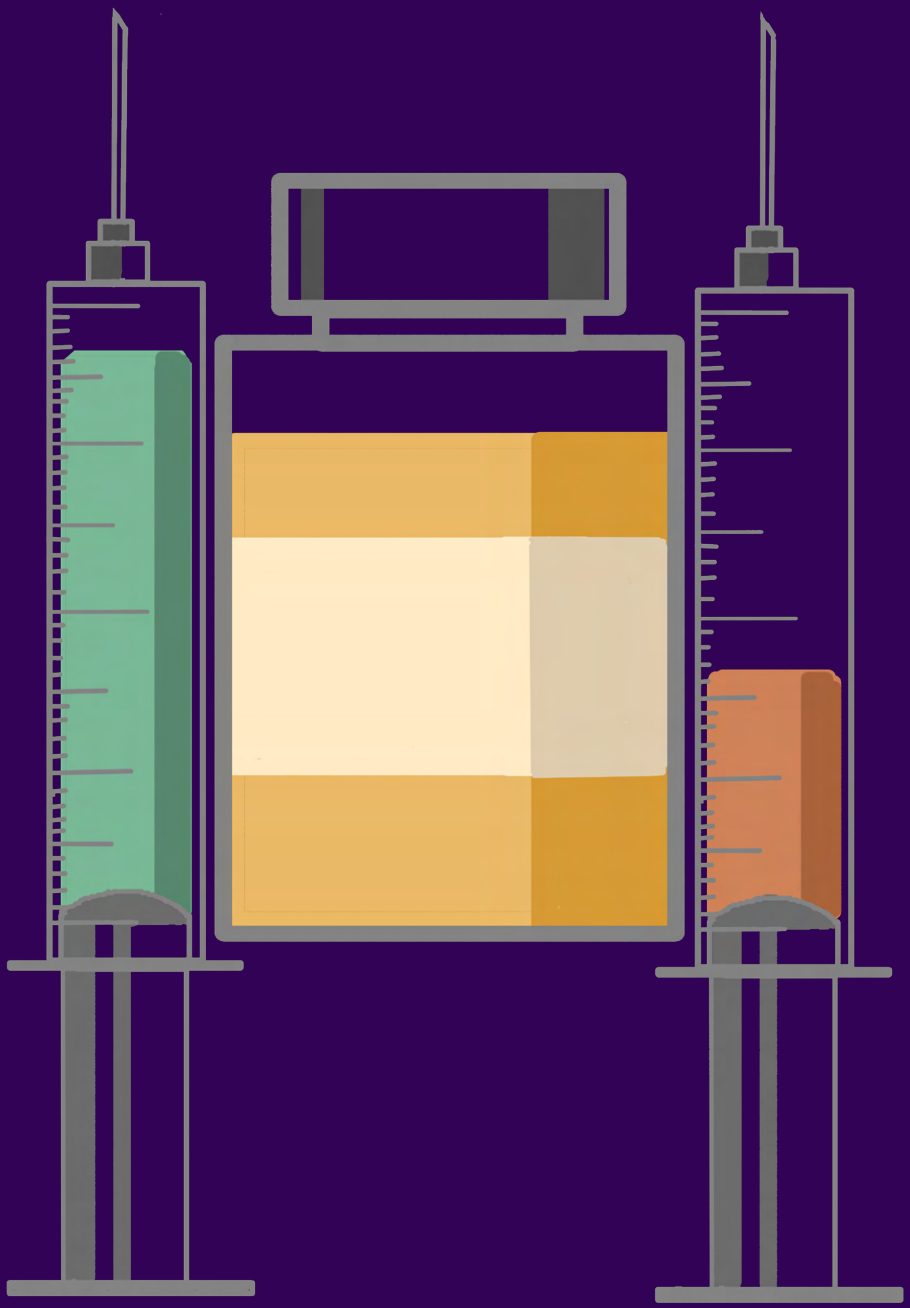
PRESIDENT BIDEN AND THE ACA

President Biden was by then-President Barack Obama's side during the formation and the passage of the ACA and cites it as an inspiration frequently. He had campaigned on the idea of making some changes to the familiar ACA, most notably with a public option. While the ACA helped expand Medicaid and cover pre-existing conditions, it just made alterations to health insurance and a very privatized healthcare system. Biden intends to add a public option like Medicare, allowing Americans to choose between a private insurance or the public option. He also planned to close the Medicare coverage gap by eliminating premiums and making sure that the public option available to them covers all of the benefits they would otherwise be entitled to. Biden's campaign promises also included automatically enrolling lower-income Americans who already received financial support through other means such as the Supplemental Nutrition Assistance Program (SNAP, also called "food stamps").

But Biden is not inheriting the presidency at a normal time, when executing his plans would only take reluctant unity from Democrats and Republicans in the House and Senate. He is forced to lead in the midst of a pandemic that has the staggering death toll of more than 500 000 American lives, manage a vaccine rollout, and pull the country out of an economic crisis. With two historic Senate victories from Georgia, he has both houses under Democrat control. Hence, his journey in making changes to healthcare policy may look different to that of his predecessors, with perhaps less political opposition but increased challenges created by the pandemic. At a time when the state-funded vs privatisation of healthcare debate is a hot topic globally, including in the UK, we wait to see how the landscape will change in the US, and in turn influence our own systems.

IMAGE FROM UNSPLASH

VACCINE INEQUALITY



by Farrah Farnejad

As of the 18th of February 2021, more than 16 million people have received their first coronavirus vaccination in the UK. The UK has also ordered 407 million doses of 7 different vaccines, making them one of the countries who ordered the most vaccine doses relative to their populations.The development of the COVID vaccination and organisation of the vaccine programme has been of immense benefit to citizens and their families. However, as the vaccine has begun to be rolled out to other countries, concerns have been raised about inequalities relating to which countries actually receive the vaccines. Health experts have stated that due to higher income countries buying more doses, many poorer countries may not have access to the vaccine, leading to a lack of immunity. This has the potential to create worldwide socioeconomic issues.

A Global Health Innovation centre has confirmed that HICs (High Income Countries) have 4.2 billion vaccine doses, in comparison to the 670 million that LMICs (Low Middle Income Countries) hold.

The World Health Organisation (WHO) has sent warnings of a "catastrophic moral failure" due to the inequalities in vaccine policies, and the EU has also "threatened to restrict exports" if there is not a fair distribution of the vaccines.

Health experts such as Professor James Chalmers, respiratory medicine expert at the University of Dundee, say that the UK should share their Coronavirus vaccines with the poorest nations throughout the world. Professor Chalmers said that those living in LMICs which make up 75% of the population are lacking help. He explains that "That can't be fair, that can't be right if you have a global commitment to public health", stressing the importance of making sure everyone receives

a good quality of life. Many news programmes have also commented on the disparity seen in that our national vaccine programme will be vaccinating young and low risk individuals, while those at high risk in high poverty countries will not be receiving the vaccine.

In regard to this issue, the WHO has led a scheme called COVAX (COVID-19 Vaccinations Global Access), which is a "global initiative aimed at equitable access to COVID-19 vaccines.". This scheme is also led by two organisations; the Global Vaccine Alliance (Gavi) and the Coalition for Epidemic Preparedness Innovations (Cepi). The aim of COVAX is to accelerate the manufacture and development of Coronavirus vaccines, and to ensure the sharing of vaccines, by guaranteeing fair access to all countries worldwide. They also have aimed to ensure that LMICs will receive the vaccines at the same time as HICs. This was in reply to Tedros Adhanom, director of the WHO, who highlighted the unfairness of the more vulnerable populations in poorer countries receiving the vaccinatinos after younger, healthier individuals in other countries. He stated that around 49 HICs had more than 39 million vaccination doses administered, only one LMIC had been given 25 doses.

As LMICs have more challenges such as higher poverty rates, weaker healthcare systems, higher disease prevalence, and poorer living conditions, they are more at risk to getting the virus compared to other countries. Additionally, the country's lower overall income results in them not being able to afford as many vaccines for their vulnerable population.

The lack of vaccines provided to LMICs can also affect HICs and disrupt the economy for both. Wealthier nations rely on lower income countries for cheap labour sources, so if more individuals are ill or dying, there won't be as many workers to transport or process materials.

As the pandemic is a global issue, it needs to be tackled jointly by countries across the world. Even if higher income countries vaccinate their populations first, this pandemic will still be an ongoing issue. The WHO suggests that at least 70% of the world population needs to have immunity, which could take until 2024. However, if these doses were allocated to all countries to protect health workers, the elderly, and those with underlying conditions, this may speed up the process of decreasing deaths.

WHAT IS GOING TO BE DONE?

Countries around the world have suffered, and are still suffering, from the impacts of the COVID pandemic. The issue of vaccine distribution highlights that countries across the world need to join together in order to reach immunity from coronavirus. Many individuals, professors and countries have urged that we need to look out for the world as a whole, and not just aim to get at the top of the vaccine league tables.

COVAX have raised around £3.4 billion so far, and the US, UK and EU have pledged money to help this scheme. Although this helps the populations greatly, COVAX says they need another £1.4 billion to reach their 2021 target of providing 1.3 billion doses to LMICs. There are issues surrounding persuading other countries that this is what needs to be done.

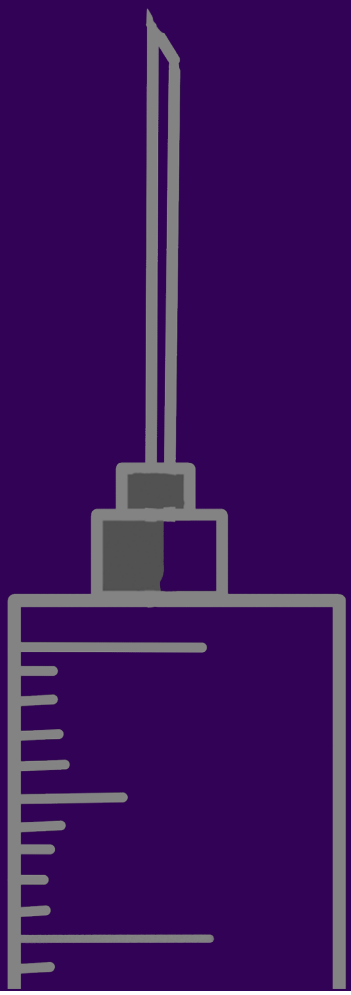
Nations such as the UK are aiming to provide vaccinations to health care workers and vulnerable populations in other countries once they have finished vaccinating their high priority groups. Margaret Harris, WHO spokesperson, has told countries that "rather than rushing to vaccinate one country, we need to be doing the lot and we need to be doing it together." The UK has replied to this by telling the WHO that they are the biggest supporter of COVAX's global vaccination programme and will ensure vaccination access to all countries worldwide.

The UK has met their target of donating £250 million to COVAX in January, and have now mobilised around $1 billion from other global donors. On the 19th of Febuary 2021, the EU has announced an additional donations of 500 million euros to contribute to support vulnerable countries in stopping the virus spread. The EU has donated over 2.2 billion euros, and is one of the leading contributors to the COVAX scheme, with Germany pledging another 900 million euros last week.

The support provided to COVAX is growing, with countries such as Canada, Japan and Germany who have committed to funding the scheme.

Other countries are being persuaded to join together to donate vaccines, funds and help LMICs to overcome this challenge. The pandemic has been dreadful for individuals and countries as a whole, especially to poorer nations due to their economy and healthcare.

The issue of vaccine distribution inevitably comes down to the moral responsibility felt by nations to support other countries in need.



ILLUSTRATIONS BY LUCY EDGAR

The Tip of The Iceberg?

by Zibad Javed

COVID-19 has taken a toll on all members of the population across the globe. The SARS COV-2 virus has been identified as a respiratory virus displaying a myriad of signs and symptoms. For many, an infection may lead to only mild symptoms or go entirely unnoticed. However, a significant proportion of infected individuals experience severe and debilitating consequences.

Now over a year since the pandemic was declared, we can establish that COVID-19 is far more than just an illness with respiratory impact. I believe, based on available research and my personal experiences, that COVID-19 is a multi-system illness, with profound effects on several bodily systems. To further complicate this, disease manifestation with COVID-19 varies among differing age groups from extremes like paediatric multisystem inflammatory syndrome (PIMS) seen in the younger population to thromboembolic events and multiorgan system failure in adults. In this reflective piece, I aim to delve deeper into how this novel ailment impacts the older person both in the secondary healthcare setting and society.

To best manage any disorder or disease, I have learnt that it is key to identify how the illness manifests in particular age groups. This includes recognising deviations from typical presentations and the impact of comorbidities and existing drug treatment on disease progression. Whilst on my care of the elderly rotation at Queen's Hospital, Romford I observed some crucial differences in presentation of patients infected with COVID-19. Several older patients had presented with delirium (namely the hypoactive subtype) and falls and did not necessarily exhibit the common symptoms of fever, cough, dyspnoea, or anosmia. Furthermore, patients complaining of arthralgia and myalgia would not necessarily have a fever beyond 38 degrees, thus indicating the need to lower the threshold for diagnosing fever. The lack of consistent data on this novel outbreak in conjunction with atypical presentations has made it a challenge to recognise and manage the disease efficiently.

Furthermore, increasing age is a known risk factor for developing severe illness with COVID-19. The reasons behind this are multifactorial. Firstly, increasing age increases the likelihood of suffering from dysfunction and disease. Secondly, as individuals become inflicted with illness, they simultaneously accumulate more and more medications, with the side effects of medications requiring further drugs to be taken to counteract those complications. This troubling cycle has led to the development of the START and STOPP criteria to tackle polypharmacy in our comorbid, ageing population.

Owing to this, I have seen healthcare professionals face challenges surrounding management of the initial COVID attack but also the aftereffects of the infection on the body. For example, at Queen's Hospital a patient with existing heart failure and cardiovascular risk factors had encountered a severe COVID infection for which he required non-invasive ventilation. Several months later, he presented to the hospital again with difficulty breathing. Hence, I believe that life after the pandemic will involve management of such patients whose bodily systems have not fully recovered from the impact of the virus or alternatively have had their pre-existing ailments worsened.

The social impact of the pandemic has been equally significant. The social circumstances of an older person have added to their vulnerability to contracting the virus. If family are unable to provide extensive support, the older individual may require a daily package of care up to four times a day for assistance with household chores, cooking, and personal hygiene or alternatively choose to live in a residential care home. Although essential, interaction with carers and social workers in such a scenario puts our older population at increased risk of contracting the virus.

By virtue of this, we have heard of discrepancies in supplying personal protective equipment to care home staff leading to an unreasonable number of cases and subsequently deaths in this environment. Additionally, avoidance of interpersonal interaction has placed countless difficulties on more vulnerable, dependent members of our society to perform basic activities such as shopping, cooking meals and cleaning. Unfortunately, this has given rise to further problems such as increasing isolation and depression. Poor management of household cleanliness and hygiene has also led to an increased likelihood of falls from trip hazards as well as non-COVID infections. This brings to light the enormity of the effects of the pandemic on our older population where infection with COVID is seen to merely be the tip of the iceberg.

To conclude, the novel coronavirus outbreak has had significant implications on healthcare and livelihoods. Its economic, political, health, and educational impact has been profound with aftereffects expected to be felt for years to come. My own experiences have highlighted to me the variation in disease presentation between differing age groups and the dire need for research to bring consistency and efficiency to the health and welfare of all members of the population.

The Ethics of AI in the Brain

by Miruna Cibotar

Innovative machine learning devices enable patients with debilitating conditions to conduct actions that were otherwise impossible. Brain-Computer Interfaces promise great development of therapies while showing potential for entertainment and cognitive enhancement. Concerns about privacy, agency and the essence of human existence justify this as the "greatest ethical challenge that neuroscience faces today", leading to new parameters of personal technological invasiveness.

HOW IS MACHINE LEARNING CURRENTLY UTILIZED?

Brain-Computer Interface (BCI) devices have been used as assistive technologies for patients who are unable to perform motor functions for communication and movement due to spinal cord injuries or amyotrophic lateral sclerosis. Robotic prostheses and BCI spellers bridge the "muscular" gap between the desired action and neural input in people who are paralyzed or locked-in. This "artificial" control requires direct detection of brain activity through electrodes and ability to decode signals conveying intention. Artificial Intelligence (AI) translates this information into executable output that is calibrated through motor cortex cognitive tasks to assemble a puzzle of unique neural networks (digital reconstructions of neurons designed to mimic how the brain processes and learns information).

Machine learning (describing how neural networks learn to recognise patterns) is also utilized in seizures by following the previously mentioned principles where changes in brain activity are detected and characterised as an impending seizure by the neural network, allowing quick detection (perhaps of a seizure yet to happen!) and treatment. Contemporary research aims to remodel similar technology to treat Parkinson's disease. Neuroscientists are currently constructing an electrical model of the brain based on the interpretation of AI algorithms that will certainly change our perspective on memory and disease to enable safer testing of drugs and manufacturing of therapeutic devices.

WHAT ARE THE ETHICAL IMPLICATIONS OF AI TECHNOLOGIES?

The novel field of Neuroethics focuses on optimising medical care through machine learning advances in the ability to monitor and influence the brain while balancing the concomitant issue of ethical decision-making and agency. The symbiosis between man and technology is a delicate matter that raises questions such as "How much is what I am experiencing my own thought pattern?" and "Should anything have control over one's actions?" The ability to act in accordance to one's choices stands at the forefront of the sense of self. In this regard, assistive BCIs are instrumental in enabling the manifestation of behaviours in immobilized patients while promoting human dignity through increased independence. Unfortunately, life is never as simple as that.

AI algorithms discern intention from neural signals with a degree of uncertainty, resulting in imprecise output. For example, BCI spellers use a similar technology to the "AutoCorrect" feature of texting. Based on common phrases and grammar, this software aids in sentence formation however, more often than not, it proves ineffective in the majority of user experiences. Now, taking into consideration the lack of precision in calibration of input in spellers, the concern about truthful expression becomes more apparent. The issue is enhanced by the human experience of not vocalizing our every opinion. This privacy of thought is breached when AI devices act out on the input to reveal an attitude that would not normally be made public, leading to a conflict of interest.

Beyond the ethical dilemma of agency, a legal responsibility must be attributed to the actions of people. Envision the difficult situation where a robotic limb executes a harmful operation in response to anger that the user would have normally controlled and not have conducted. What is the extent of responsibility and consequence of the aggressor? Although an extreme example, the dichotomy between private thought and outward behaviour is frequently reiterated as a problem by those living with such technologies. Patients say they feel as though they have a "shared or hybrid agency" and wonder, "how much is you anymore".

Personality changes have been observed in some users and taking in consideration the impact on autonomy, their ability to consent to continue or stop a treatment might be affected. Particularly non-communicative persons in a state of pseudocoma have a significantly impaired capacity to offer informed consent. A conundrum is created if another person has the ability to terminate the treatment against the patient's desire, by implying that the technology reduces one's ability to decide for themselves. The philosophical assessment of complex dilemmas is vital in understanding the effects of deep learning and devising a moral methodology of distribution of such treatments with specific consideration to commercialisation of new devices.

FUTURE PROSPECTS AND CONSIDERATIONS

The relationship between humans and AI has to progress in an ethical manner. Neuroethics remains true to its aim of maximising the benefits of emerging techniques while minimizing their harm however, the development of consumer tools is notoriously covert and subjected to oversight. This germinal stage of technological advancement of brain devices is crucial for laying the foundations of an adequate approach to mass production of BCIs for non-therapeutic usage. Within the last two decades, the abrupt introduction of phones rapidly changed the nature of communication through social media and, changing the way we see the world and indeed our reality.

The negative effects of this can be seen in the unanticipated rise of mental health issues and an increasing gap in understanding between generations. Similarly, hasty implementation of reality altering AI technologies could lead to complications that cannot just be removed. Furthermore, the scientific community must educate the public through media in a more accurate manner in order to shape the expectations of current BCI technologies and ensure the general understanding of the implications of potential commercial gadgets. Fortunately, researchers are considering the concerns mentioned in this brief essay and many more in their process of discovery and application of innovations while learning from current studies and promoting interdisciplinary transparency.

IMAGES FROM PIXABAY

Happening Around BL

BL Women's Hockey (@blwhc)

BLWHC has had a fab start to 2020+1! We helped organise and take part in a running challenge fundraiser for Cancer Research UK with other women's Uni hockey clubs around the country. All together we managed to raise over £1,600! We also celebrated LGBT+ History month by highlighting hockey legends who identify within the community to share their stories. From international heroes to local clubs to our own members, check out our instagram (@blwhc) to see our celebration of all things LGBT+ in BLWHC! The captains have also been hard at work organising team fitness, ensuring the club is pitch ready when that time (finally!) comes. Also, keep your eyes peeled for another MIND charity challenge we're planning for March!!

BL Students for Global Health (@bartssfgh)

In March we will be putting on lots of interesting events to celebrate Asian Heritage Month! Focusing on health in Asian communities, you can expect to see a Griff goes Global, Reading Club and a Watch Party (Watch Credits to Give Credits). Keep an eye on our socials for more! Instagram: @bartssfgh Facebook: Barts and The London Students for Global Health.

BL Lacrosse (@bllacrosse)

This month, BL Lacrosse did a challenge to fundraiser for Drs of the world UK. We manage to complete 10,000 squats in 15 days and raise over £150 for this amazing charity. We have been also running yoga and HIIT sessions to keep our members active during this lockdown We have also participated in the Good Lad Initiative organised by QMBL Movember.

BL Boat Club (@blrowing)

Lockdown 3.0 may have brought on the water training to an end, but the club has been running a 21 minutes for 2021 challenge. Throughout February we have been running daily zoom workouts for our members. These range from HIIT workouts to yoga to walking or running. Lockdown can be hard on mental health so this 21 minutes per day challenge was the perfect way to keep members active, while not overloading them with training on top of busy work and uni schedules.

BL Cricket (@bartscricket)

At Barts Cricket we have not let another case of lockdown fever hold us down! Multiple Joe Wicks HIIT sessions and Online yoga, are a few ways we are preparing for the upcoming season by managing our fitness through virtual means. Furthermore, participating in Movember and the Good Lad Initiative has allowed our society to touch on various topics such as mental health and general wellbeing. Which was deemed a great success by multiple members of Barts Cricket. Still managing to organise weekly socials is something we are very proud of as a club. From 'virtual tables' to Barts Crickets Got Talent, we have continuously been growing the club by allowing all members to still have a taste of normality through such alien times.

BL Friends of MSF (@bartsmsf)

We are so happy to see the interest in Friends of MSF grow throughout our many events this year. Thank you to everyone that participated in our recent Stravathon fundraiser and photo competition! As elections are coming up we want to invite anyone that is passionate about supporting the work of MSF and leading creative events to join the committee. This year we have held movie nights, speaker events, a cooking class, a virtual pub quiz, a running fundraiser and language lessons. Keep an eye out on our social media for more events and for information on running for a position on committee!

BL SAMDA (@barts_samda)

At SAMDA we're passionate about widening access into Medicine and Dentistry! We provide support throughout the UCAS application process from personal statements, to entrance exams, to navigating the interview process! As a volunteer you can make a meaningfully help a young person achieve their potential. One amazing way you can get involved is through our mentorship scheme. You and a team of volunteers will be paired with a school and deliver virtual talks. Over the year you will build rapport with these students and provide tailored support. This is a great opportunity to give back to the community, help overcome barriers to accessing STEM careers and also work on your leadership and communication skills!

BL Music (@blmusic)

Over the year, the musicians at BL have been busy at work submitting recordings to us for our online concerts. We've had three concerts in the first term, which all included solo performances, group performances, and some very fun watch along socials over Zoom. We have our final concert of the year, Barts Arts, in collaboration with the other performance groups at BL (Dance and Drama). If you would like one of your performances to be showcased on our Youtube channel, make sure to send it in to us via our email or socials. We want to see what you can do, whether you're a pro or have just started! Join us for our final concert, Barts Arts, on the 25th of March 2021.

BL Plastic Surgery (@blplasticsurgsoc)

Keep your eyes peeled on BLAPRAS' socials as they have an exclusive members only Abstract Workshop on the 25th of March. This event will be led by Mr Wee Lam, the Editor of the Europen Journal of Hand Surgery.

BLAPRAS are also in the midst of planning some exciting events including a remote surgical skills session and a plastic surgery virtual summer course.

To keep updated make sure to follow @ blplasticsurgsoc and find us on the Society app!

BL Netball (@blnetball)

At BL Netball, we have a weekly welfare schedule to make sure we stay in touch and keep people involved! Everything is optional, and there is no commitment.

We have weekly socials and sunday workouts with a netball coach, and also have a regular book club, BLM forum, yoga classes with a yoga teacher, collabs with other clubs (such as the lovely BL Dance) and many other ways to get involved! We also have weekly welfare drop-in sessions. There is something for everyone, and there are ways to get active within the cub such as our FGM campaign and various fundraising we get involved in. Drop us an insta dm at @blnetball or message the President, Costanza, for more info!

BL Sexual and Reproductive Health (@blsexualhealth)

So far this year, we have hosted a few talks from Decolonising Sexual Health, to LGBT+ Inequalities in SRH and female sexual dysfunction, as well as a careers panel for those who are interested in how to get into this specialty. We have also had regular watch parties and book club/discussion groups about various topics around SRH. Coming up in March, we'll have a discussion where we'll explore some of the issues that sex workers face with access to healthcare and their rights.

Find us here to keep up to date with our events: https://linktr.ee/blsrhs

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!

Homelessness in East London: an issue ignored for far too long

by Hassan Naima

The upheaval of our lives due to COVID continues to reveal issues in our country. Our NHS has been worked to the bone, small businesses are forced to bring their shutters down permanently, and we are all cooped up at home. However, there is an issue that has been on the rise well before the pandemic. Homelessness in London. Due to austerity measures, layoffs and a constant trend of increasing prices in Britain, and more specifically London, more and more find themselves on the rough side of the street.

East London bears the biggest brunt of Homelessness. In fact, the borough of Newham had a homelessness rate of 1 in 24 in late 2018, more than 4% of the borough's population. Closely followed were the Boroughs of Haringey, Kensington and Chelsea and Westminster, boasting similar statistics. Yet the issue has been made invisible, our government taking a 'out-of-sight, out of mind' approach. Home prices both sale and rent have steadily chugged along over the past decade, not to mention the increasing council tax. It's not just the bureaucratic costs to consider. Locals in Newham will quip that the cost of a bus these days is 'enough to cover three buses some years ago'. With the constant inflation and costs, combined with annual wages not keeping pace, life in London is becoming increasingly difficult.

All this was before the COVID outbreak sweeping us off our feet. Now with a pandemic in play and wave after wave of lockdowns set in place, the situation has gotten much worse. The immediate impact is obvious: since less employers need people around, layoffs are becoming alarmingly frequent. For those who live barely making ends meet, the loss of an income source can be absolutely devastating. It is estimated that about 20,000 families have been made homeless since the beginning of the first lockdown. To add insult to injury, some charities that helped provide food, sanitary items and warm clothing have had to suspend their activities due to the strict regulations put in place. For example Barts and The London's Islamic Society ran a monthly street kitchen to feed and clothe the homeless but had to suspend its activities due to lockdown rules.

So, what can you do to help?

- Be aware of how severe the problem is in your area
- Find out what facilities are available to help in your area.
- Being aware of the issue and the solution makes you more equipped to handle it.
- If you can afford it, donate to some homeless charities like Shelter who help take people off the street.

Student Union Election Results

THE FOLLOWING STUDENTS HAVE BEEN ELECTED TO ROLES ON THE BLSA BOARD FOR THE ACADEMIC YEAR 2021/22. WELL DONE TO ALL THE STUDENTS WHO PUT THEMSELVES FORWARD AND RAN IN THESE ELECTIONS, ESPECIALLY CONSIDERING THE CHALLENGING CIRCUMSTANCES WE ALL FIND OURSELVES IN.

BLSA PRESIDENT - ROB TUCKER

VP BARTS - NUMA ALI

VP LONDON - VARVARA EVGENIOU

ALLIED COURSES PRESIDENT - POLEN BAREKE

DENTAL PRESIDENT - JAD SURESH

WELFARE OFFICER - LUCY EDGAR

ENGAGEMENT OFFICER - CARL EVANS

CLINICAL REP - JAMES TAVNER

PRECLINICAL REP - RAHMA HEGY

DENTAL REP - SIMRAN SANGHERA

GOZO REP - YOUSEF SALEM

SOCIETIES OFFICER - KAROLINA WIECZOREK

SPORTS OFFICER - OLIVIA DUPERE

VOLUNTEERING OFFICER - MAHNOOR AHSAN

RAG OFFICER - ANNIE MAE WRIGHT

BAME REP - SHIVANI GANESH

INTERNATIONAL REP - PANAYIOTIS STAVRINOU

LGBT+ REP - AMELIA JONES

WOMEN'S REP - BECKY HOSKYNS

ENTS OFFICER - LIAM NICHOLSON

ENTS OFFICER - SIMI LAKHANI

ALUMNI OFFICER - KIRIANA LAGDEN

EXTERNAL AFFAIRS OFFICER - IBRAHIM DINAH

SUSTAINABILITY OFFICER - MINAHIL KHAN

SECRETARY - THAARABI THARMAPATHY

FOR MORE DETAILS VISIT WWW.BARTSLONDON.COM

BL Sport in Lockdown

by Jessica Challenger, Sports Editor

With fixtures and in-person training cancelled, many of our sports clubs have not only been training and hosting socials virtually, but also doing some great charity work and raising awareness of a variety of causes. I spoke to Netball, Men's Football and Boat Club to see what they've been up to over the past few months.

BL Netball

BOW FOODBANK AND FGM AWARENESS

WHY DID THE CLUB DECIDE TO HAVE EVENTS AND RAISE AWARENESS FOR BOW FOODBANK?

We usually do fundraiser via the Netball Ball, but obviously due to the pandemic we knew this couldn't happen. We had been doing some volunteering at the foodbank via Annie (the BL volunteering officer), and the girls were absolutely loving it and were really touched by the amazing work they were doing.

During a committee meeting, one member mentioned the Bow Foodbank Fundraiser and how they really needed donations with the statistics shocking us. We therefore thought why not do a fundraiser for something we really cared about, and was so important, especially just before Christmas.

Because of COVID, and with so many of our girls working & volunteering in the NHS, we saw first-hand just how difficult the situation was and couldn't imagine people going hungry - around 1,500 kids are fed by Bow Food Bank and the possibility of them losing their source of food was horrifying.

WHAT DID THE CLUB DO TO HELP?

We decided to do 16,000 step ups in 10 days, having chosen that number as the foodbank's costs had risen from £2,000 to £16,000 during the pandemic. We ended up smashing our £1000 target by day 2, so we raised it to £2000 and ended up raising £2,120.

We also pushed girls to spread awareness and donate to the foodbank if they could - as of course doing step ups is not everyone's thing. We also didn't want to add any pressure to any girls experiencing difficulties with exercising or eating, something that had been prominent in COVID. That's also why we made sure step up counting was anonymous, so there was no competitive element and people didn't feel pressured during the challenge.

HOW CAN PEOPLE GET INVOLVED WITH THIS CAUSE?

In terms of what people can do, volunteering at the food bank is an amazing experience worth doing! Raising awareness for the current fundraising campaign is also so important (they still need to raise a huge amount more just to stay afloat because of COVID), and just donating food or money if you can - we know we are students and often don't have too much spare money, so even just a share goes a long way!

WHAT HAVE YOU BEEN DOING FOR THE FGM AWARENESS CAMPAIGN?

We have also been working on an Female Genital Mutilation (FGM) awareness campaign, and incorporating elements such as mapping in Tanzania as work to help map areas NGOs need to help tackle FGM. We also held a film screening to raise awareness about the cultural traditions behind FGM, and the facts too, to raise awareness as to why people do it and how heavy the cultural side of it is. We also collaborated with Students for Global Health (SfGH), and we invited a speaker to come on the 25th February to speak to us on this topic.

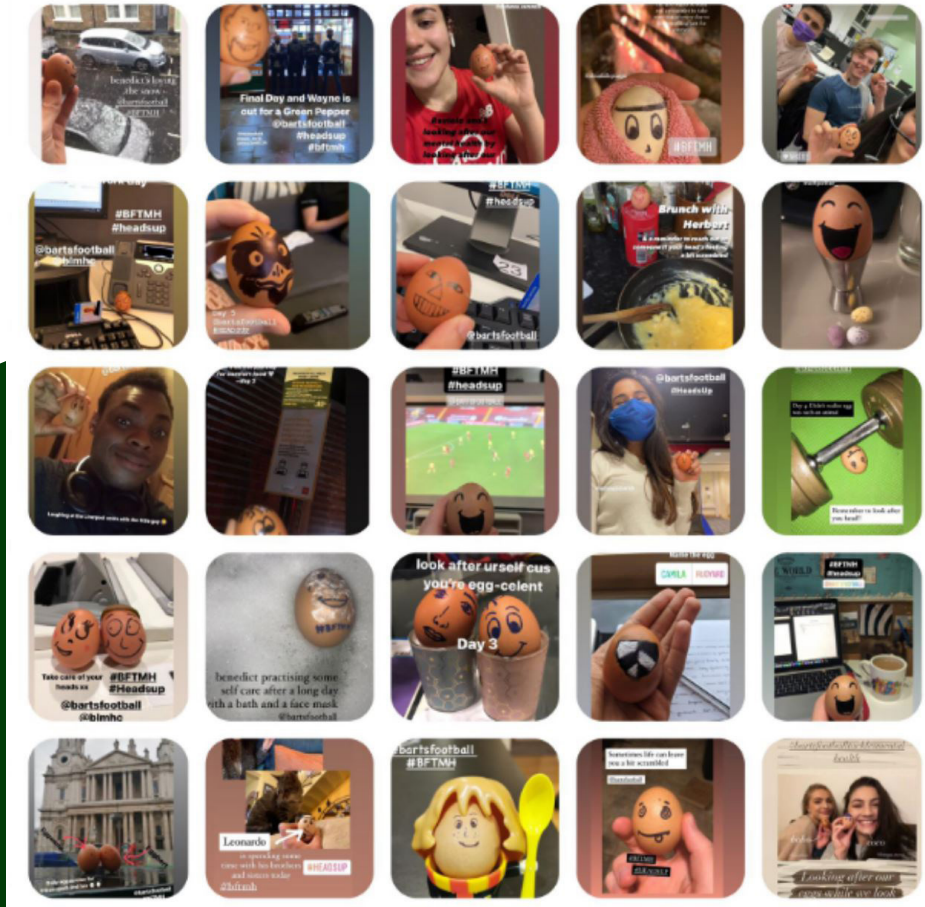
BL Men's Football

BARTS FOOTBALL TACKLES MENTAL HEALTH CAMPAIGN

WHY DID THE CLUB DECIDE TO HAVE EVENTS AND RAISE AWARENESS FOR MEN'S MENTAL HEALTH?

Men's mental health is something that needs to be spoken about more; put simply, a large number of men suffer from mental health issues and find it difficult to speak about it. One of the reasons for this is the stigma around men not being able to express their feelings, such as due to disruption of the so called 'masculine image'.

This is something as a football club we wanted to address and ensure men know that they can communicate their feelings with peers.



WHAT DID THE CLUB DO FOR THIS CAMPAIGN?

Week 1 of the campaign revolved about the eggs you can see above! Mental health can be as fragile as an egg, and we therefore encouraged students to carry around an egg and protect it as if it were their head i.e. their mental health. This had really good engagement from not only BL football members, but also members from other clubs.

In week 2, we asked people how lockdown had affected their mental health and advice for coping mechanism in these unprecedented times. Our Freshers had fantastic views on how the club had held events to help their university experience.

For week 3, we teamed up with BL Dance, BL Open Minds, and BL Women's Football to do a Zumba class, a healthy minds mental health workshop and a fitness session with each of those groups respectively.

In week 4, we had the Barts Tackles Mental Health Quiz which well attended by the Barts and The London Community. All the money raised went to the mental health charity MIND.

HOW CAN PEOPLE GET INVOLVED WITH THIS CAUSE?

We host these kinds of events for Men's Mental Health every year now, so next time we do it would be really great if even more people attended and help us raise awareness that much more, as well as increase the amount of money we raise.

BL Boat Club

MOVEMBER AND GOOD LAD INITIATIVE

WHY DID THE CLUB DECIDE TO TAKE PART IN MOVEMBER AND GOOD LAD INITIATIVE?

Movember was something we hadn't done before as a whole club, and being such a large BL group we wanted to get involved as we were passionate about men's mental health and opening up a conversation surrounding that. We then got involved with the Good Lad Initiative (now rebranded as Beyond Equality) following Movember.

The Good Lad Initiative aims to provide space for teams to talk through difficult issues surround masculinity and the expectations placed on us as men, in order to create a healthier environment within the club, and so that people feel more able to approach their teammates if they are having a difficult time. This is in order to help address the underlying issues behind the fact that men tragically disproportionately die from suicide. GLI also gave us the opportunity to talk about other important issues such as consent and privilege, so that we can work on creating a sports club which is more welcoming to everyone and address unhealthy and toxic cultures within sports teams.

WHAT DID THE CLUB DO FOR THIS CAMPAIGN?

For Movember we raised £2,883. Alongside the men growing moustaches for the month of November, the women's squad also joined in by running during the month and some members of the club undertook additional challenges. One of our club members (Kieran) rowed the distance from our boathouse to France (200km) on a rowing machine over the month.

For the Good Lad Initiative, along with BLWP, we joined a guided discussion where we spoke through important topics that we otherwise had not taken the time to have as a club.

HOW CAN PEOPLE GET INVOLVED WITH THIS CAUSE?

You can contact the QMBL Movember ambassadors at qmblmovember@gmail.com

You can find more information on GLI at www.goodladinitiative.com

LEARNING FROM SIR JOSEPH ROTBLAT

BY DR DUNCAN VEASEY, ALUMNUS SBHMC

Dr Duncan Veasey is a consultant in occupational, military and post trauma psychiatry retiring (definitely) this year in Nova Scotia.

* * *

In 1970, as a callow seventeen-and-a-half-year old, I first set foot in Charterhouse Square in black cord jacket, old school tie and desert boots, the fashion at the time. I expect I was wearing trouserings of some sort and I was carrying an overlarge brief case my dear mother had given to her doctor to be. I stepped into the formidable presence of Professor Rotblat who interviewed all of his 1st M.B. students personally.

We were a mixed bag of arts graduates; those had only taken two science A levels; a couple of nurses, a lab technician and arts A level students like me. This was the first time I had ever met a genius and because of the way I had completed a form, he got the impression that I had never studied maths at all, which was not a terrific start. He did not think I would cope!

I had hated physics and maths until, whilst working the summer in a fish and chip shop kitchen on Southend seafront, I had devoured in addition to too many chip butties, science fiction writer Isaac Azimov's excellent 3 volume "Understanding physics." Reader, I finally did.

We got good support at Barts. I recall my tutor was a Dr. Smith, Lecturer or Reader, who would set us most traditional style physics questions like: "A vandal on a bridge wants to drop a brick down the funnel of an approaching steam engine" etc. combining speeds, weights, velocity and goodness knows what else. (It is an interesting fact that this type of Physics question has a long history. The Confederate general Daniel Harvey Hill, a grumpy man who really hated the Union, was a professor of maths who used to frame all of his questions in a similar style: "Two Yankees run away from the battlefield at Buena Vista at different speeds." I expect his statuary has tumbled all over the Tarheel State this year!)

I coped, but then came nuclear physics. Professor Rotblat's lectures were utterly wonderful. He had of course known all of the players, Einstein and everybody else, before resigning from the Manhattan Project on moral grounds, a brave career move indeed. His amazing enthusiasm for the subject was communicated to us in increasingly excited Polish accented English, interspersed with such astonishments as being able to work out logarithms in his head. (Younger readers may not recall slide rules and log tables and I expect everything now is done now with a computer or telephone.)

It was such an intellectual tour de force I kept his lecture notes for many years. I finished my 1st MB year with the equivalent of a Grade 1 S level and seven A levels across the Arts and Sciences which made me a very well-educated young gentleman indeed. It has been downhill all the way since.

I last time I saw Sir Joseph was in the College Committee. I had been elected Chairman of the Student Union, a position to which I was wholly unsuited in terms of character, temperament and intellect. We had put forward a cutting down of the punishing 2nd MB science courses - and were successful but then we made an attempt to give those who failed 2nd MB more chances at the exam.

Our progressive Dean at the time, Professor Reginald Shooter, pathologist, had invited the Student Union Chairman and one other to attend College Committee meetings. Mercifully, I was supported by Terence Kealey, a brighter bear who went into science full time and became a professor of biochemistry, running Buckingham University and a famous opponent of breakfast! (Sound man when the enemy is at the front).

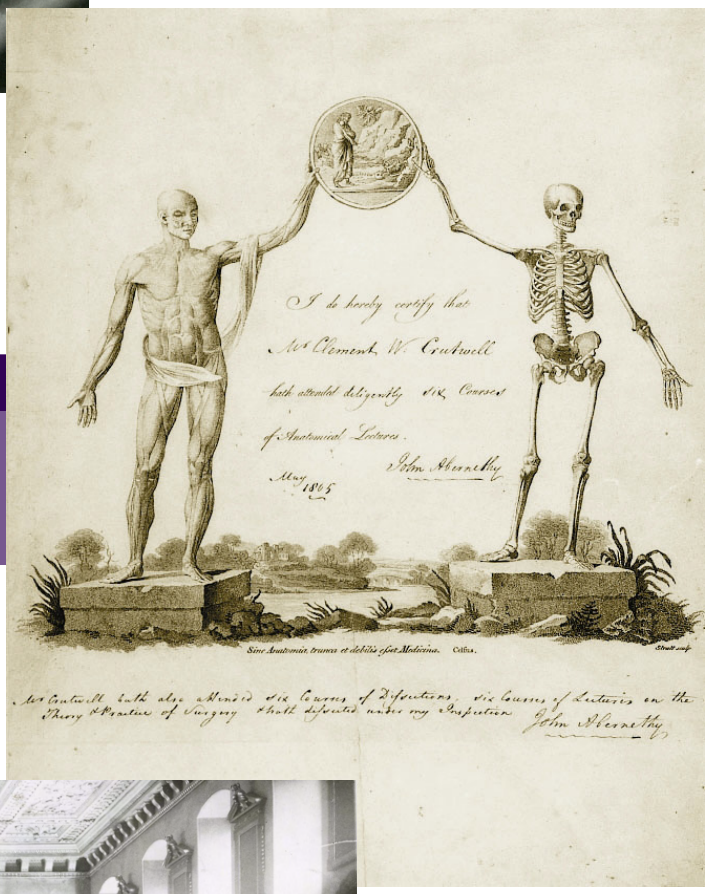
This was an amazing experience, seeing our lords and masters, frightening senior consultant surgeons, thrashing seven bells out of each other whilst the whole show was completely controlled by that urbane master of committee Jerry Taylor, Professor of Surgery. Our proposal generally fell on deaf ears, save for Professor Rotblat. He looked me straight into the eye and said that he supported our proposal, not, he pointedly said, because of our document I had presented which was intellectually worthless, but out of compassion! Well, you can't win 'em all and I have never had pretentions to equal Sir Joseph nor indeed Professor Kealey, in any intellectual or political stakes.

He most famously sought world peace and nuclear disarmament through the Pugwash Conferences on Science and World Affairs run at Cyrus Eaton's Thinkers' Lodge in Pugwash Nova Scotia, a couple of hours from where I now live. He and the Conference jointly won the Nobel Peace Prize.

It's a small community of 700 souls or so and the big, gated Eaton estate. The name comes as I'm sure readers will recognise from the Mi'qmaw word for shallow waters. Curiously 'Captain Pugwash' is generally quite unknown as a cultural reference here and, though folks can tell you quite a lot about lobster, I doubt many of the locals know much about the good professor. He was a wonderful man and a truly inspiring teacher. You do not meet many such in your life.

RLHMC/P/1/8 (PART)

STUDENTS BEING TAUGHT IN THE LONDON HOSPITAL MEDICAL COLLEGE PATHOLOGY MUSEUM, C.1930S



SBHPP/CRU/1

CERTIFICATE OF ATTENDANCE AT JOHN ABERNETHY'S ANATOMICAL LECTURES, ST BARTHOLOMEW'S HOSPITAL, 1805

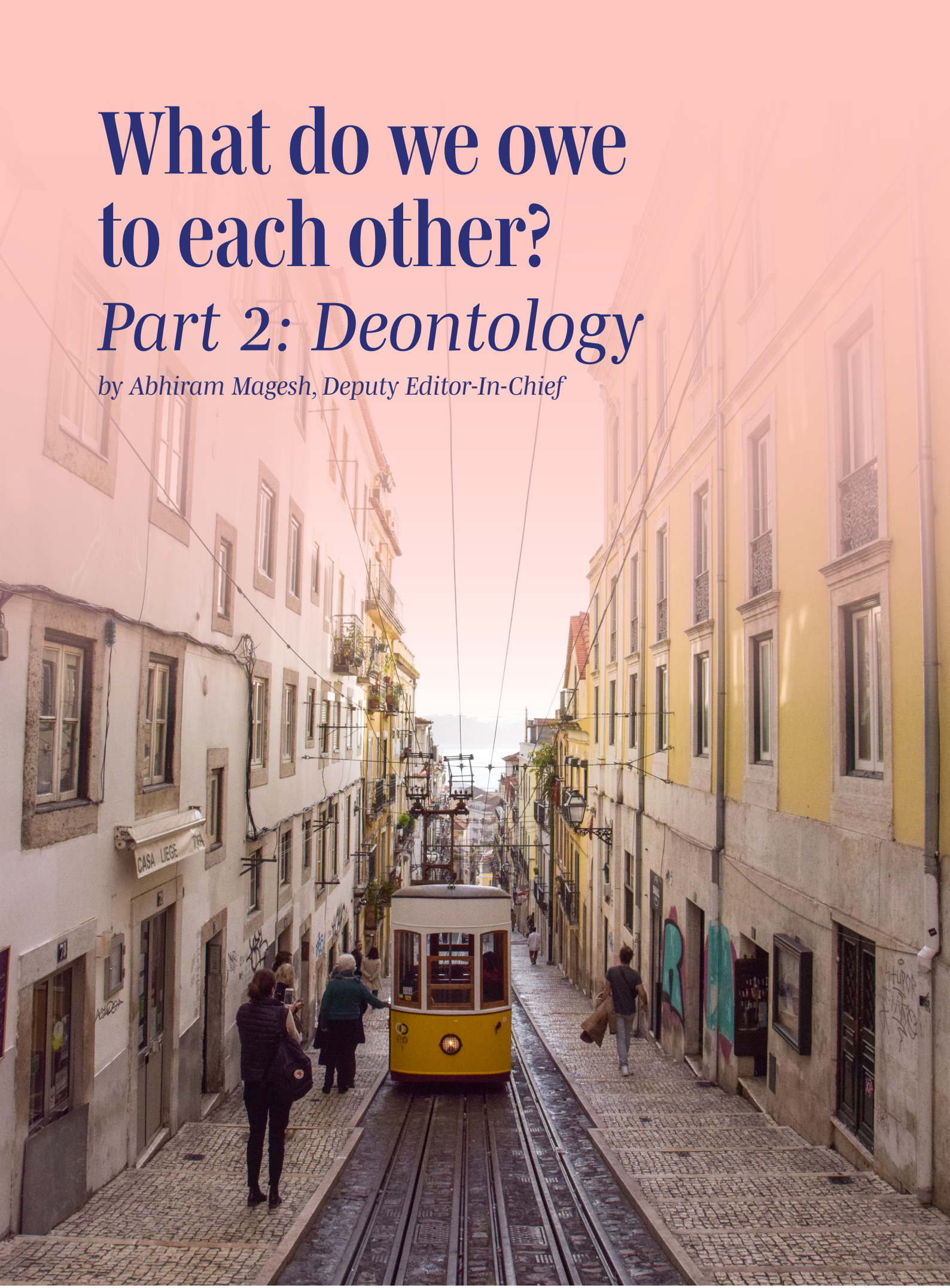
SBHMS/P/10 (PART)

STUDENTS SITTING THE MB EXAM IN THE GREAT HALL, 1949

What do we owe to each other?

Part 2: Deontology

by Abhiram Magesh, Deputy Editor-In-Chief



It has been almost a year and two months since the critically acclaimed (by my mum) first part of this crash course philosophy series was published.

And although we have had not one but three lockdowns thanks to the efforts of our dear leader and his loyal lackey, I have managed to procrastinate this, the second part of the What do we owe to each other series, until today, only a few weeks before my next ICA.

Regardless, the question is one, we as a country, have had to ask ourselves throughout this time of personal sacrifice. It has been, I hope, a time of reflection and a time for thought. As future medical professionals, I have expressed in the previous part, the importance of the privileged position we will find ourselves in and the impact of our choices on the people we treat. And sometimes those choices will yield unexpected and perhaps unwelcome outcomes.

In the previous part, I talked about Utilitarianism, a consequentialist philosophy that would provide no refuge to you ethically in the case the outcome is pernicious or downright detrimental.

Deontology, however, has your back. In many ways it can be thought as the direct opposite of consequentialist ethics. In Deontological theories, the reason and motivation behind your actions, rather than the consequence of the outcome, are the most important when determining the morality of the action. So, if for example, you donated £100 to a charity because you wanted to help and support the cause, that would be morally righteous according to Deontology. But if the intention was to embarrass someone else by donating more than them, then as the intention is morally questionable, the action would be deemed wrong, despite the outcome being the same.

Now even if you have just skirted the periphery of philosophy, you will no doubt have heard of one of the giants of the enlightenment, Immanuel Kant. And if you have not, congratulations on having a social life in senior school rather than gawking at the sheer audacity of enlightenment thought in the historical context.

Kantian ethics are foundational to deontological philosophy. Bear in mind that there are other theories within the deontological school of philosophy, but we will focus on Kant, as it provides a good basis with which to explore the others if you so wish.

Kant argues that the highest good must be both good in and of itself and good without qualification. The former can be achieved if it's "intrinsically good", and this itself is based upon moral absolutism, the idea that there is an absolute right and wrong in the world. The latter, only if the addition of that thing in any situation, will never make it ethically worse. An example where a thing may fall short is pleasure. In of itself, it is good, but it is not good without qualification, as there are people who can feel pleasure at the suffering of others, which is an ethically abhorrent situation. He therefore concludes:

"Nothing in the world—indeed nothing even beyond the world—can possibly be conceived which could be called good without qualification except a good will"

With this startling revelation, you may well be thinking, what is considered good will? Well do not fret, my boy Kant has got you: a person can be deemed to have good will, if their action respects the moral law. Kant constructs this moral law using the central idea of the categorical imperative, which has three significant formulations:

1. Act only according to that maxim (i.e., your will and intent) by which you can also will that it would become a universal law.

2. Act in such a way that you always treat humanity, whether in your own person or in the person of any other, never simply as a means to an end, but an end in and of itself.

3. Every rational being must act as if he were through his maxim, always a legislating member in a universal kingdom of ends.

Properly explaining and expanding on these formulations would turn this medical school magazine article in to a philosophical magnum opus for which I have neither time, word count nor intellectual capability to concisely explain, and that is forgetting about other Kantian ideas, such as perfect and imperfect duties and the formulation of autonomy among others; the man was either a genius or, much like all enlightenment thinkers of the age, getting absolutely smashed on caffeine, it's probably a combination of them both.

The main idea here is that if a person's maxim, became a universal law, would it be morally right and just? The only absolute good is goodwill, so the determining factor as to whether an action is right, is through the will/ motive of the person.

Despite the intricate concepts, backed up by a coherent albeit reasonably debatable line of logical reasoning, it should not be too hard to see the issues with this rigid school of thought. There are many critiques out there of the entire school of deontological thought and Kantian ethics with its categorical imperative, and no, that is not just from sore consequentialists and the bad boys of the philosophical world.

In the first part of the series, I asked you to consider the trolley problem and the organ transplant variant with the eyes of an avid Utilitarian, to see how that philosophy can be applied in difficult moral situations. I would now ask you to re-consider those same problems with the eyes of a Deontologist and Kantian. Would the actions be different? Are they morally justified? Is one situation ethically superior to the other depending on your school of thought?

Why not get in touch with your thoughts and as always, happy philosophising!

IMAGE FROM UNSPLASH

Lunch Lockdown

by Farrah Farnejad

School is a place where we go to learn, make friends and take part in activities. For some students, school is a place where they are able to eat a meal. In January 2020, around 1.4 million children (17.3% of students) qualified for free school meals in England.

Due to poverty, many families are not able to afford lunch for their children; leading to concerns about students being malnourished and too hungry to concentrate at school. Access to free school meals has helped to tackle health inequalities, and to improve health issues such as obesity due to their healthy ingredients. Additionally, there has been a large improvement in the academic achievement for pupils living in poverty.

Due to the COVID lockdown, schools have been closed, so changes have been made in order to continue this program. Children who were eligible for free school meals are still able to receive them in a food voucher or parcel. However, concerns have heightened about the standard of the food parcels; Gavin Williamson, Education Secretary, said he was "absolutely disgusted." Images of these food parcels that were provided to students were posted on social media.

WHAT FOOD PARCELS ARE SUPPOSED TO CONTAIN

A school is supposed to provide food for students during the COVID lockdown if they normally qualify for free school meals. Children at home during the lockdown are supposed to receive food parcels or vouchers from schools during term, with food parcels being the recommended option. Schools are also able to consider other arrangements such as shop/supermarket vouchers if they are unable to provide food parcels. Schools receive their usual funding for free school meals during term, with an extra £3.50 per week per student. They are also able to later claim up to £15 weekly per pupil for the vouchers, in addition to their free school meals.

The government stated that the food parcels should contain food items instead of pre-prepared meals, not rely on extra home ingredients, cater for special diets (allergies, vegetarian, religious), and contain items which parents can use to prepare healthy lunches throughout the week.

However, Twitter posts circulated showing the lack of worth and nutrition within these food parcels, showing that they were not sufficient for the week and that they "simply do not meet the standard."

Photos began circulating on Twitter; some food parcels only consisted of carrots, two potatoes, baked beans and few other items. Chartwells, the foodservice company who was distributing these meal packages, had stated that the parcels should last for five days instead of ten days.

The department for education website also states that meal vouchers should be "£15 per eligible pupil, per week" and that schools are able to be reimbursed for this amount. However, the value of the photo above is worth around £5. One mother commented that her son's package was missing vegetables, beans and a loaf of bread.

Another parent described her parcel as containing "five baps, a small tin of tuna, a small block of cheese, six small juices, five apples and a pack of biscuits."

Marcus Rashford, footballer and school meals campaigner, describes the school meal parcels as "not good enough" and "unacceptable." He has highlighted the poor quality of food parcels and has also campaigned free school meal plans to be provided over the holidays, after MPs had voted against this.

HEALTH ISSUES

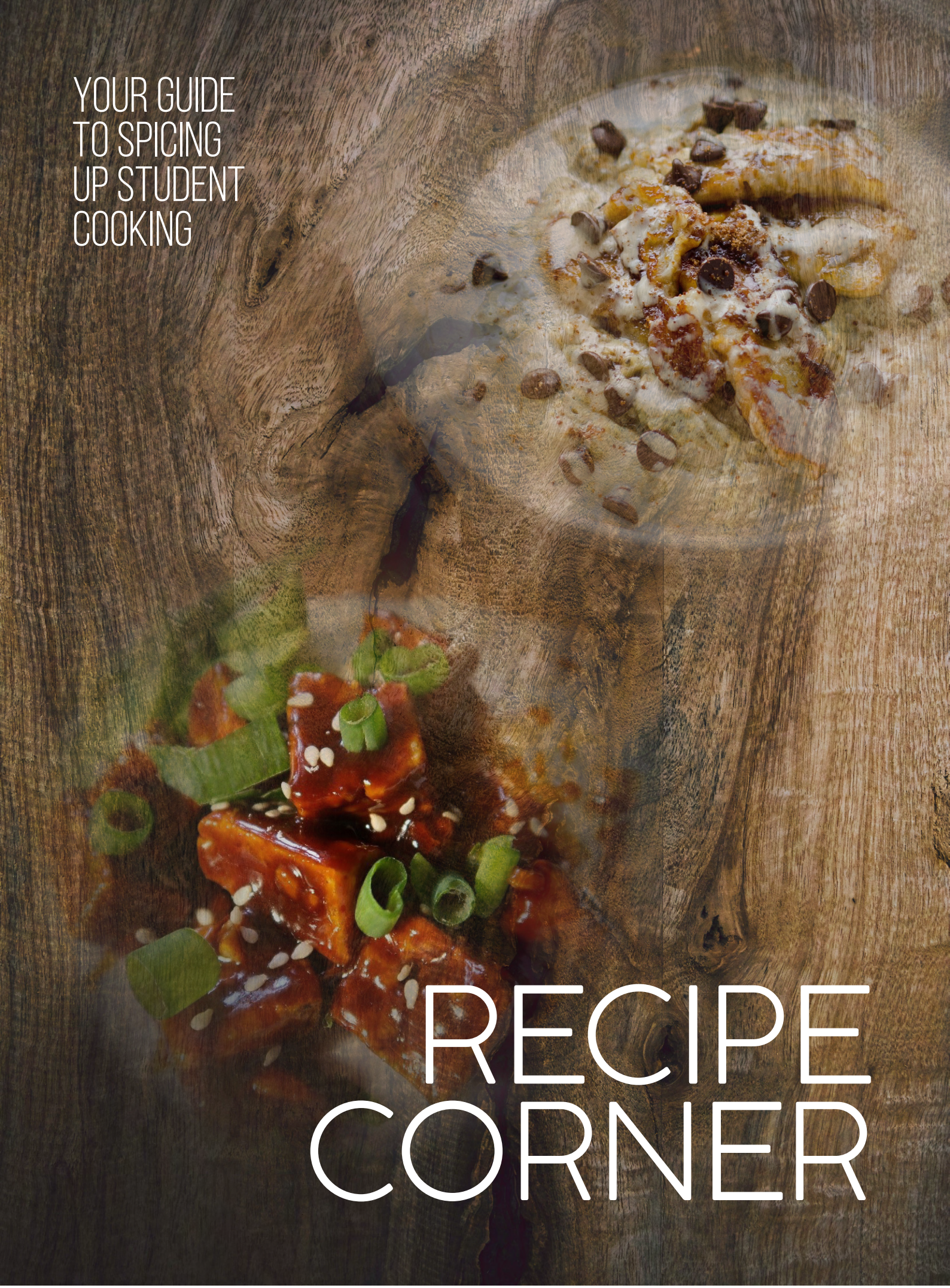
In order to grow, live and learn, children (and adults) need to eat food from groups of protein, fruits, vegetables, grains and dairy. Schoolchildren receiving free school meals are not obtaining enough nutrition from their food, which can lead to decreased concentration and a lack of growth. A primary school principal has also warned that some schoolchildren may suffer from "malnutrition" due to the lack of nutritious school meal replacement. Even for students not receiving the food packages, fulfilling nutrition requirements can be an issue as parents with lower incomes or busy work schedules are more likely to cook with cheaper food options, which often are unhealthy.

Poor nutrition can lead to stress and tiredness, and for a student who is studying, this will decrease their academic performance. As some of these students are also in their developmental years of primary school, this poses as a larger issue for their futures. Malnutrition can lead to health issues such as stunted growth, diabetes and heart disease. The Barker hypothesis proposes that low nutrition in children increases the susceptibility to other health complications later in life such as obesity, diabetes and hypertension. It also proposes that lower birth weight is associated with a greater risk of coronary heart disease during middle age.

The English government had initially stated that they wouldn't provide parcels/vouchers over the half term in February. However, as a result of a million people signing Rashford's petition, the UK government has provided a winter food grant of £170 million to help families in need of essentials.

Although this has helped many families, this issue highlights what the government response would have been if Rashford or other members hadn't chosen to campaign and get involved. Would there have been children left without food across the UK? Poverty and malnutrition are prevalent issues throughout the world and in the UK. Children require a healthy balanced diet, irrespective of the family's income, and issues like this need to be addressed in order to provide solutions.

IMAGE FROM UNSPLASH



YOUR GUIDE TO SPICING UP STUDENT COOKING

RECIPE CORNER

This is a dinner to impress your family, friends, and flatmates – it's so delicious, vegan, and easy too! If you can't invite people over yet, make it for them and drop it round. You could even have a virtual dinner party...

The gochujang is the star of this recipe, you should be able to find it in your local supermarket in the world food section (I get mine from Sainsbury's), or you can try a local Asian supermarket instead! This Korean red hot pepper paste has a slight warmth and sweetness to it that really brings the barbeque sauce to life.

If you give this recipe a go, take a picture and tag @blcircadian and @abeforthhh because we'd LOVE to see your recreations.

Korean Fried Tofu with Coconut Sticky Rice

serves two

INGREDIENTS:

For the Crispy Tofu:

- 110g Extra Firm Tofu
- Half an inch of Fresh Ginger finely grated
- 25g Cornflour
- 2 tsp Sesame Oil (or substitute vegetable)
- Salt and Pepper for seasoning

For the Coconut Rice:

- 150g Sushi Rice
- 125ml Coconut Milk
- 100ml Cold Water
- 1 generous pinch of Salt

For the Sauce:

- 3 Tbsp Dark Brown Soft Sugar
- 1 Tbsp Gochujang (Korean Chilli Paste)
- 1 Tbsp Soy Sauce
- 1 Large Garlic Clove crushed (or more if you're a garlic fiend like me)
- Small piece of grated Ginger
- 1 tsp Sesame Oil
- Optional: Sesame Seeds, Spring Onion, and Crunchy Veg (I like Sugar Snap Peas)

RECIPE INSPIRED BY A BBC GOOD FOOD - "KOREAN FRIED CHICKEN"

METHOD:

1. Pre-heat your oven to 200 Degrees Celsius
2. Soak your sushi rice in a bowl of cold water for 20 mins.
3. Drain and cut your tofu into 1-inch pieces, then press for 20 minutes: lay the pieces between kitchen towel and place a heavy book on top (Kumar and Clarke is my saviour for all situations).
4. While the tofu is pressing, rinse the sushi rice in a fine mesh sieve under cold water for 30 seconds, then set aside to drain fully.
5. Add the drained rice to a saucepan with 100ml cold water, 125ml of coconut milk and a generous pinch of salt. Cover with a lid and bring almost to the boil over a high heat. Don't let the water fully boil as this will make the rice stick to the pot!
6. Reduce the heat to low until very gently simmering and cook, with the lid on, for 10 minutes.
7. After the tofu pieces have pressed, toss them with the sesame oil and season with salt, black pepper and ginger.
8. Then coat them with the cornflour until completely covered. This is what makes your tofu become crispy!
9. Bake the cubes on a lined tray in the oven for roughly 20 minutes until they are perfectly crispy.
10. After the rice has been cooking for 10 minutes, remove the pot from the heat and keep covered for a further 10 minutes before serving.
11. While the rice is resting, make the sauce by popping all the sauce ingredients into a saucepan and heating through for around 3 minutes until syrupy- put aside and keep warm. The sauce will thicken up if it cools, just heat it up again before serving!
12. Once all the components are ready, toss the tofu into the sauce then serve with the coconut rice and veg. Don't forget to garnish with the spring onion and sesame seeds if you want to be fancy…it makes the pictures look chefy.

TIPS:

- If you don't have sushi rice, then you can use other short grain rice instead. The ratio of rice to water should be 2:3. Try to leave the rice undisturbed for the whole cooking and resting process!
- If you want to mix it up a bit, try getting a flavoured tofu such as the Tofoo Co Smoked one.
- Put on a banging playlist and dance around the kitchen while you're waiting. This is non-negotiable.
- Secret: I didn't actually have any weighing scales or even a lid to my saucepan when I made this recently (I'm in halls whilst on placement in Southend) so I had to make do with some guesswork and improvisation! Don't be afraid to experiment with cooking, it adds to the fun of it.

IMAGE FROM ABI YOUNG

COOKING TO IMPRESS

by Abi Young

We all start the new year with good intentions: Try and read before going to bed; Limit ourscreen time; Wake up earlier for placement so that I have time for breakfast rather than eating a banana on the Hammersmith and City Line?

Whilst I may not be of much help with the first two suggestions, I can give you an idea for a quick breakfast that is both nourishing and tasty. All you have to do is add your toppings in the morning on top of the base mixture and you are good to go. It is easily transported in Tupperware so that if you are running low on time, a mushy banana on TFL is not your only option.

Controversial opinion, but breakfast is probably my favourite meal of the day and arguably should be a source of enjoyment rather than simply fuel. In light of this, I am also presenting you with a flashy weekend breakfast/ brunch recipe for when we have a bit more time on our hands.

Apple Crumble Overnight Oats

serves one

INGREDIENTS:

- 40g oats
- 120ml milk/plant based alternative milk
- 2 tablespoons of natural yoghurt
- 1 teaspoon of cinnamon
- 1 teaspoon of honey
- 1/2 apple grated
- 2 tablespoons of ground almonds

METHOD:

1. The night before you intend to eat your overnight oats, mix together the oats, yoghurt, milk, cinnamon and honey in a Tupperware container or bowl.
2. Cover and store overnight in the fridge.
3. In the morning, grate half an apple over the mixture and sprinkle the ground almonds over the top. Add more cinnamon to taste.

OTHER TOPPING IDEAS:

- Sliced Banana and a tablespoon of peanut butter
- Chopped dates and walnuts
- Frozen berries and desiccated coconut

TALLY'S TOP TIP - TO GET AHEAD FOR THE WEEK, DOUBLE OR TRIPLE THE BASE MIXTURE AND THEN YOU CAN ADD YOUR TOPPINGS THE NEXT MORNING!

'French Toast' Crumpets

serves two

INGREDIENTS:

- 4 crumpets (shop bought or homemade if you are feeling particularly ambitious)
- 2 eggs
- 125ml milk/plant-based milk alternative (I prefer oat milk but any type will suffice)
- 1 Tsp vanilla extract
- Knob of butter/splash of light sunflower oil/splash of vegetable oil

TOPPING IDEAS:

- Banana coins, maple syrup and chopped pecan nuts
- Frozen berries, Greek yoghurt and cinnamon
- Grated Cheddar cheese and Marmite

METHOD:

1. Break the eggs into a bowl. Add the milk and vanilla and whisk together well with a fork.
2. Pour the mixture into a dish or baking tray and lay all four crumpets into the mix.
3. Leave the crumpets to soak for two minutes on each side.
4. Put your frying pan on a medium heat and allow the butter or oil to melt until it starts to spit from the pan. Place your crumpets into the pan and pour any excess egg mixture around the edges of the crumpets. Cook for 2-3 minutes on each side until golden brown. Be careful as you flip them!
5. Dish up and add toppings of choice.

IT IS AS SIMPLE AS THAT! I HOPE THAT THESE RECIPES BRIGHTEN UP YOUR MORNINGS AND START THAT PRODUCTIVE MORNING ROUTINE OFF THE RIGHT WAY.

IMAGES FROM UNSPLASH & TALLY ABRAMOVICH

BREAKFAST IDEAS

by Tally Abramovich

The 'Old El Paso' Fajita kit has legendary status in many a student kitchen. The combination of 'Fajita seasoning', tortilla wraps, chicken strips, onions and mixed bell peppers (everyone knows the green and yellow pepper are significantly less tasty than their crimson counterpart, yet the 'mixed selection' is far friendlier on the pocket) amalgamate into a crowd-pleasing, minimal effort dish. Yet, I often empathise with the vegetarians or vegans present at the table, who get a sub-par offering of the above, minus the chicken. Vegetarian and vegan food requires more imagination and care than simply cutting out an ingredient from a dish, therefore I present you with a solution to satisfy both carnivores and vegetable aficionados alike.

Pricing: Using Ingredients from Morrisons (if you brought a whole pack of the following ingredients: onions, garlic, limes and chilli's) the cost per person would come to £2.37 (= £9.49 in total).

Black Bean and Plaintain Wraps

serves four

INGREDIENTS:

- Pack of shop brought tortilla wraps (white, wholemeal or seeded – whatever takes your fancy)
- Black Beans - 2x tins of black beans
- 1 red onion, finely chopped
- 2 cloves of garlic, crushed
- 1 tablespoon of smoked paprika
- Tablespoon of oil
- Salt and pepper to taste
- Plantain - 2x plantains, chopped into coins on a diagonal slant
- Tablespoon of oil
- Guacamole:
- 2x avocados
- 1 lime, juiced
- 1 chilli, finely chopped (remove the seeds if you are heat averse)
- Salt to taste

Toppings:

- 200g feta, crumbled
- Bunch of coriander, roughly chopped

METHOD:

1. Put a frying pan on a medium heat and fry the onion in a tablespoon of olive oil for approximately 10 mins until sweet and starting to turn golden brown
2. Add the crushed garlic and smoked paprika and fry for 2-3 minutes until well combined with the onion.
3. Drain the black beans and add to the pan. Lower the heat and simmer for 10-15 minutes. Get on with the rest of your preparation whilst the beans cook.
4. To make the guacamole, halve the avocados and scoop the flesh into a bowl. Mash the avocados with a fork, adding the chilli and lime juice, along with a generous pinch of salt. Set aside to serve later with your wraps.
5. Heat a second frying pan with a tablespoon of oil and butter. Wait until the pan is REALLY hot and then add the plantain coins. Fry for a few minutes on each side until soft and golden brown. When finished, add a good pinch of salt.
6. Once the beans are bubbling and softening, use a potato masher or fork to mash half the beans in the pan, in order to create a thick sauce. Ensure to leave half the beans un-mashed. Add salt and pepper to taste.
7. Dry fry in a pan or warm the tortillas in the oven.
8. Once the tortillas are warm, serve alongside the black beans, plantain slices and guacamole. Top the wraps with crumbled feta and chopped coriander for extra zing.

TIPS:

- You can use any cheese here – I like feta but grated cheddar cheese would also be good
- Again, sub in whatever spices you have – ground cumin, chipotle or fajita seasoning would work!
- My preference would be to fry the black beans in oil and the plantain in butter but work with what you have.

IMAGE FROM UNSPLASH

FLATMATE MEALS

by Tally Abramovich

'NOMADLAND'

A STORY FORETELLING A NEW, OVERLOOKED, AND ITINERANT GENERATION

BY JULIUS VON ABENDORFF, FILM CORRESPONDENT

Frances McDormand in the film NOMADLAND. Photo Courtesy of Searchlight Pictures.

After a disruptive year for cinema, director, Chloé Zhao's 'Nomadland' is a quiet neo-western drama that has become 2021's Oscar frontrunner.

It's the tale of a "house-less" (as opposed to homeless) baby-boomer, Fern, who is gracefully played by Frances McDormand. Having lost her full-time job, husband, and entire town in the years following the 2008 financial crash, Fern lives in her van endlessly traversing the vast expanse of the American West. On her eventful journeys, she meets "nomads" like herself, making friends and finding fleeting moments of a close-knit community.

The cinematography of magnificent landscapes, paired with Ludovico Einaudi's piano soundtrack, is skilfully contrasted with Fern's little van and its bucket toilet. Set against the backdrop of America's varied and beautiful landscape, the viewers share the experiences of reticent nomadic loners making profound human connections. For a brief moment, Fern is seen looking out of her van at a lone bison. For me, this represents the nomads; they, like the dignified bison, are noble beings deserving our respect. These modern-day nomads are portrayed as a self-reliant tribe, that funds their way through ignored but essential jobs – whether that be in a gigantic Amazon warehouse, to farming sugar beets, or cleaning restrooms. Like the bison, which is still a herd animal, Fern sometimes needs to rely on others. This is exquisitely shown when Fern is forced by circumstances to disturb a grumpy fellow nomad. These two nomads eventually find solace together and connect with each other.

One of the settings, Badlands National Park, is a barren but beautiful place.

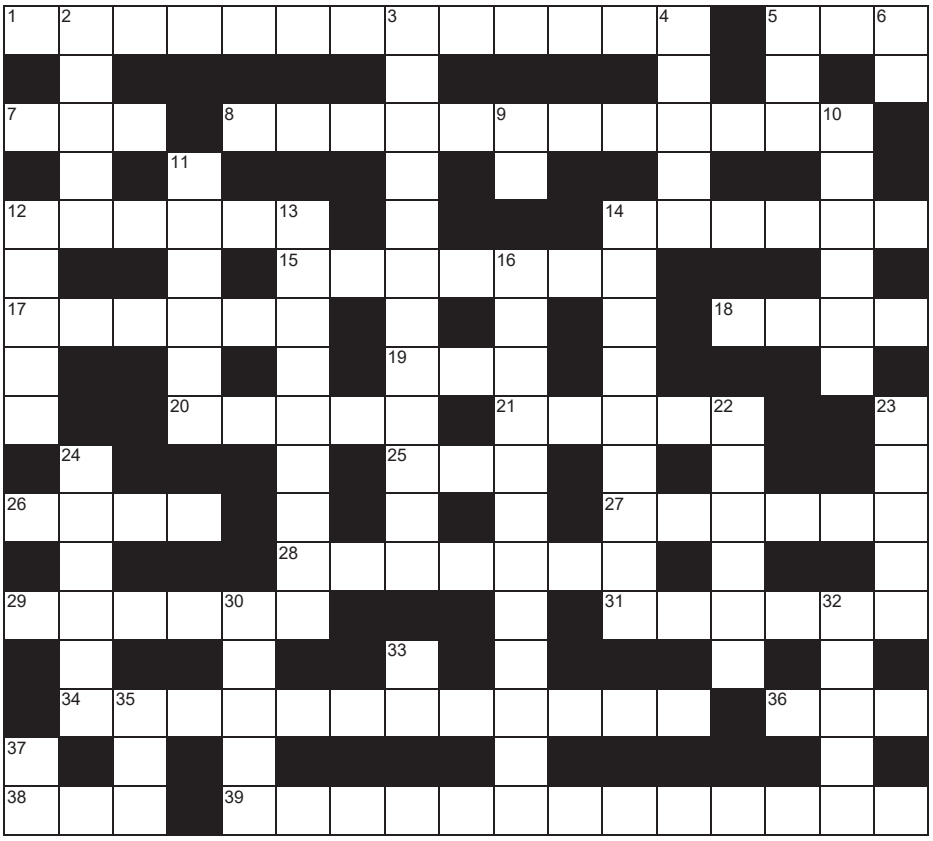
This was like the economy at the time, truly difficult to live in, with many hard-working people reduced to poverty through no fault of their own. Nonetheless, hopes, dreams, joys and laughter endured.

In this aspect, 'Nomadland' foreshadows a new and different older generation, whom Fern's brother-in-law says, "chuck everything and hit the road", hoping to find some semblance of the happy life.

We in the UK and other places can relate to that in this period of economic difficulties. Whilst our "house-less" may not take the same form as those in 'Nomadland', the film still makes us empathise with and realise that there's a forgotten and neglected part of a society. 'Nomadland' is unique in portraying these issues in a bleak, striking, and outstandingly acted Hollywood western.

Nomadland will be available in the UK on STAR on Disney+ from 30 April 2021

IMAGE VIA EPK.TV



CROSSWORD

BY EDDIE ANDERSSON

ACROSS

1. Shot best served very, very cold (6,7)
5. Toilet swamp (3)
7. Month that might (3)
8. Vehicle odour wetness is found in starch (12)
12. Fade FC doesn't have the jolt (6)
14. C-C (6)
15. Officially cancelled (article 50?) (3)
17. Airman docks his boat (6)
18. Speed without food (4)
19. Trying for a target; like in French (3)
20. Timer of goodness (5)
21. Hello and goodbye; heard on the islands (5)
25. I will, but poorly (3)
26. Colour mixed up in lube (4)
27. State of Fanning (6)
28. An itchy Cindy (7)
29. Confuse to see bum (6)
31. A well-researched blade (6)
34. Minor bridge is well decorated (12)
36. Can't pass this test, what a clot! (3)
38. Decay (3)
39. Chap I bribe is c; a two headed puller (6,7)

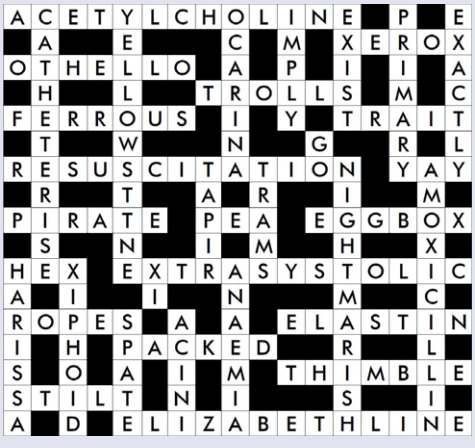
DOWN

2. The worst chocolate bar (5)
3. Abbr. (12)
4. Neither E nor L is on this course (5)
5. Little part between the teeth (5)
6. Ancient game on the move (2)
9. Squat adherer has a good base (2)
10. Hemingway sounds sincere (6)
11. If he can't swallow this, put him in the ground (6)
12. 2 parts worth 10¢ (5)
13. France rag is aromatic (9)
14. A odd alien fights infection (9)
16. VP 2021 (6,6)
22. C≡C (6)
23. Gene is almost a betrayal (5)
24. C=C (6)
30. Workwear curbs your cleaning (5)
32. Listful (5)
33. I would, ask to see your license (2)
35. Our brave and noble president, oh captain my captain! (3)
37. Sub-rouge (2) – infra+red – IR

ANSWERS TO ISSUE 3'S CROSSWORD

ACROSS
1. ACH! Muscle messenger (13) - ACETYLCHOLINE
9. Copy company est. 1906 (5) - XEROX
10. Occupational therapist greeting is Shakespeare's jealous lover (7) – Occupational Therapist = OT, Greeting = HELLO -> OTHELLO
11. Internet bullies from under the bridge (6) - TROLLS
12. Bloody irony (7) - FERROUS
13. Art it carries genetically (5) – Anagram of "art it", TRAIT
15. Creationists ir bring back to life (13) – anagram of "creationists u" = RESUSCITATION
19. Palindromic cheer (3) – YAY
21. 3.14 frequency sails the high seas (6) – 3.14=PI, frequency=RATE -> PIRATE
22. Urinal vegetable (3) - PEA
23. Ovo-pugilist for carrying food (6) – ovo=egg, pugilist=boxer -> EGGBOX
24. Wicked spell is six (3) - HEX
26. O Scottie's X-Ray out of the heart (13) – anagram of "O Scottie's X-Ray" = EXTRASYSTOLIC
29. Prose useful for tying (5) – anagram of "prose" = ROPES
32. Stretchy protein (7) - ELASTIN
33. Crammed? Sounds like a pact (6) – PACKED
34. Sewing equipment no stranger to Monopoly (7) - THIMBLE
35. Tilts to make you a foot taller (5) – anagram of "tilts" = STILT
36. London's latest longitudinal line (9,4) – ELIZABETH LINE

DOWN
2. Cheeriest at, insertion of a tube (11) – anagram of "cheeriest at" = CATHETERISE
4. Musical instrument is an aria con (Zelda?) (7) – anagram of "aria con" OCARINA
5. Fairy inclined has a suggestion (5) – Fairy=IMP, inclined=lie(LY) = IMPLY
6. Former sac is real (5) – former=Ex, sac=cyst. Ex-cyst=EXIST
7. First (7) - PRIMARY
8. Clay ext. is precise (7) – anagram of "clay ext" = EXACTLY
14. Ancient Chinese game is on the move (2) - GO
16. Trunked mammal fades out (5) - TAPIR
17. South London's light green transport system (5) - TRAMS
18. Scary sleep is in hi hamstring (11) – anagram of "hi hamstring" = NIGHTMARISH
20. co-amoxiclav - clavulanic acid (11) – AMOXICILLIN
24. Lharass chili paste (7) – anagram of "l harass" = HARISSA
25. Tiny sternum (7) - XIPHOID
27. 11th Chinese leader (2) – 11=xi - XI
28. Hb < 130/115 (7) – ANAEMIA
30. Spree is a pest (5) – anagram of "a pest" = SPATE
31. Lung berrys (5) – ACINI



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