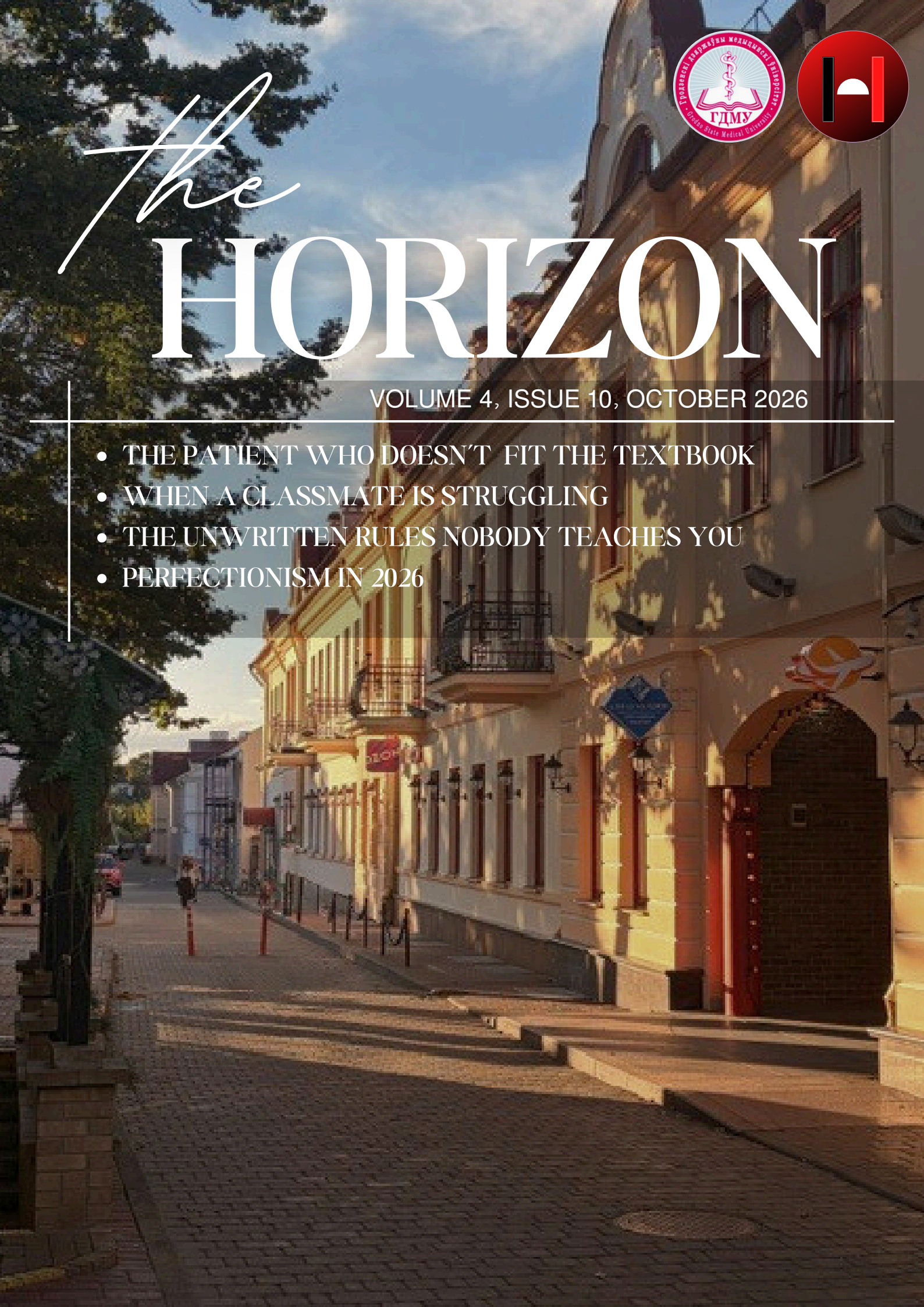




The HORIZON

VOLUME 4, ISSUE 10, OCTOBER 2026

- THE PATIENT WHO DOESN'T FIT THE TEXTBOOK
- WHEN A CLASSMATE IS STRUGGLING
- THE UNWRITTEN RULES NOBODY TEACHES YOU
- PERFECTIONISM IN 2026

DEAN'S DESK

Dear students, we at Grodno State Medical University strive to provide students with top-quality education, but that's not it. Grodno State Medical University is also a hub for Scientific, Cultural, and Sports related activities. GrSMU celebrates its uniqueness in diversity, for in its true essence our university is a junction where students from various backgrounds and cultures come together as one big family. Grodno State Medical University is glad to work with students from different countries and provide them with a stage to represent their nation and culture.



DEAN OF FACULTY OF INTERNATIONAL STUDENTS
DR. ALEKSANDER ALEKSANDEROVICH STENKO

We wholeheartedly acknowledge International students as an integral part of our university, and we take immense pride in that. GrSMU has always encouraged students to explore further and beyond in every field they try their hands at. I hope that you like the novel concept of **'The Horizon'** - a magazine that serves as a platform for the students to voice their opinions, share their takes, and present their points of view.

'The Horizon' is a medium of extended communication where we can learn a lot from one another. I highly appreciate this initiative and personally support it. I look forward to reading the interesting blogs written by you.



DR. MEHUL H. SADADIWALA, FOUNDER,
CLASS OF 2023

FROM THE FOUNDER

For the longest time, I have had this idea of starting a magazine. But not just any conventional magazine, one that shall serve as a platform for the students of International faculty at Grodno State Medical University to share their stories. A platform that enables students to share their outlooks on various curricular and extracurricular aspects of medicine. A creative intersection where students can freely give commentaries about Lifestyle, Culture, Productivity tips, and more. Thus, the idea of **'The Horizon'**, came to life.

Throughout the years, many individuals at GrSMU have inculcated valuable skills and gained experience with a fair share of success in various disciplines. Maybe you run a successful YouTube channel or an educational website, or maybe you are a successful student-researcher or an educator, and so much more. **'The Horizon'** enables students to share their personal experiences. The insights that you share will encourage other students to take further strides and explore future possibilities.

'The Horizon' is supported directly by the Respected Dean of the International Faculty, and it operates under the supervision of the International Students' Scientific Committee. Students from 1st to 6th year, can submit their blogs to this magazine. The articles should directly or indirectly revolve around student life to share knowledge and the collective growth of students.

WELCOME TO THE HORIZON



EDITOR'S DESK

“

I'm Shreeji Patel, a 3rd year student in Grodno State Medical University. It is a great honor for me to become an Editor-in Chief of The Horizon for autumn issue. Being the publication of our own University, Horizon reflects the story of our path from students to Doctors. My deep desire for the next issue of Horizon is to make it shine as a symbol of the best student magazine. So that our readers, being students themselves, could find in its pages a bit of their own path, the one leading to the become a Doctor. In the next Autumn issue, I would like to see Horizon filled with the articles reflecting the most remarkable achievements. We are going to be a part of the future, and I want our own piece in it.



PATEL SHREEJI MINALKUMAR,
EDITOR-IN-CHIEF, OCT-DEC 2026

”



SATHWARA DEVANSHI RAKESH,
EDITOR-IN-CHIEF, OCT-DEC 2026

“

I'm Devanshi Sathwara, a third-year medical student at Grodno State Medical University, and I'm honoured to take on the role of Editor-in-Chief of The Horizon.

Through this edition, I hope we continue to give space to new ideas, and celebrate the many dimensions of student life. I look forward to working with our team and create something engaging, meaningful, and memorable.

”

And a message to our dearest readers, we would like to invite you all, to share with us the blogs that directly or indirectly revolve around student life, to share knowledge and experiences that has had an impact on your growth within and outside the bounds of our university.

Concluding, let us alter the limitations of our individual efforts and collectively explore limitless Horizons.

Cover Credits

Ridma Gavesini Mahavatta

THE PATIENT WHO DOESN'T FIT THE TEXTBOOK

Modern medicine is universal and standardized. Diseases across the globe call for uniform treatments, and equal care, regardless of a patient's gender. While the Hippocratic Oath compels us to treat every patient with equal care, it raises a few critical questions: do biological differences across the genders demand distinct treatment pathways? Medicine claims to be standardized, but, whose body has established that standard? Ultimately, how do we treat the patients that simply do not fit the textbook?

WRITTEN BY
PRISHA SIDDHARTH CHITRE
CLASS OF 2031

INTRODUCTION

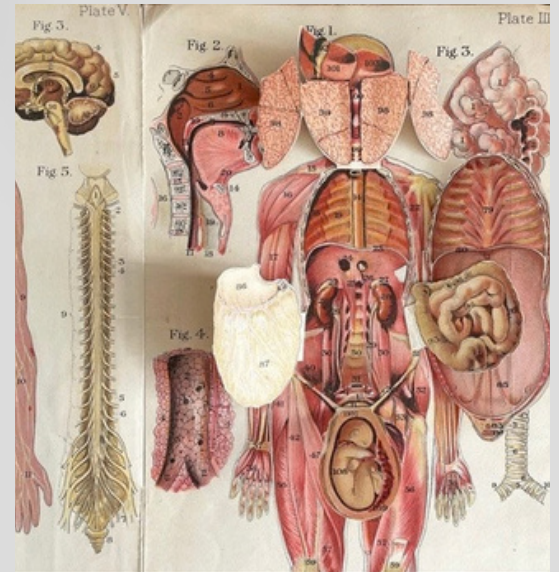
In the 1900s, a strange phenomenon was observed. Women displayed symptoms like dissociation, panic, numbness, and violent episodes. Hastily labelled “hysteria”, these symptoms were often brushed aside with a generic explanation about women being “too emotional”. Yet when men returning from war displayed trauma-related symptoms, they were given diagnoses such as “shell shock”, “battle fatigue”, or “war neurosis”. It took decades before trauma-related disorders were formally recognized as PTSD in 1980. So why did similar symptoms receive such different explanations? And how far back does this practice go?

For centuries, medicine treated the male body as the universal human default. Women were often viewed either as “small men” with broadly similar physiology or as volatile, erratic deviations from the male norm because of their reproductive biology. The philosopher Aristotle even described the female body as an imperfect version of the male body.

This attitude did not disappear with modern medicine. It found its way into research too.

In the mid-20th century, women were frequently excluded from clinical research, particularly women of childbearing potential. The intention was protection.

The consequence was an enormous evidence gap. For years, medical research had far less information about how many drugs and treatments affected women.



Once a research population becomes the “standard”, everything built from that research can inherit its blind spots.

Apparently, the world was basically built for a 5'9", 170-pound guy, and everyone else was just expected to adapt. For decades, crash-test standards relied heavily on male-sized dummies, while female anatomy and biomechanics were inadequately represented. Medicine faced a similar problem.

Take the heart attack. The “classic” presentation taught for decades often centered around crushing chest pain radiating down the left arm. But women can experience myocardial infarction with symptoms such as shortness of breath, nausea, unusual fatigue, or pain in the jaw, back, or upper abdomen. If a textbook description becomes a rigid checklist, a patient whose symptoms don't match it can be harder to recognize.





The same problem appears with medication. Men and women can differ in body composition, metabolism, enzyme activity, and drug clearance, meaning the same medication can produce different concentrations, effects, or adverse reactions. The history of zolpidem, commonly known as Ambien, is one striking example. Women were found to clear the drug more slowly, prompting the FDA to recommend lower doses for women after evidence showed that morning blood levels could remain higher.

Conditions such as PCOS have often been reduced to a reproductive problem or framed primarily around fertility, despite their complex endocrine and metabolic features. Persistent stereotypes about women being “emotional” can also influence how symptoms such as pain, fatigue, or psychological distress are interpreted.

Science keeps giving us more reasons to question the idea of a universal body.

So what exactly makes women biologically different from men? - The answer isn't simply hormones. Sex-related biological differences can arise from chromosomes, gene expression, hormones, immune function, body composition, metabolism, and cardiovascular physiology. Women have, on average, stronger immune responses, which may predispose them to a relatively higher prevalence of autoimmune diseases. Differences in capacity to metabolise drugs, variations in detoxification, and body composition can alter how medications are processed. Cardiovascular disease can also manifest differently between women and men, including differences in vascular function and disease patterns.

Medicine has begun to recognize this. Women are now routinely included in clinical research, sex is increasingly considered as a biological variable, and researchers are investigating differences in disease, pharmacology, and treatment response more deliberately.

But recognizing the problem is not the same as solving it. Medical education, research, clinical guidelines, and drug development still need to move away from the assumption that evidence derived predominantly from one population will automatically apply perfectly to everyone. The goal isn't to create completely separate medicine for men and women. It is to understand when biological differences matter and account for them when they do.

Medicine needs standards. Textbooks need patterns. Clinical guidelines need consistency. But a standard should guide the physician, not define the patient.

For centuries, medicine has asked patients to fit the textbook. However, it is time we ask about the outliers, the exceptions. The people who have suffered for years due to set standards that became the norm, creating generations worth of women who were neglected, misdiagnosed, and forced to live in pain. It is time we consider them, their anatomy, and their right to live a normal life.

Know the difference

Heart attack warning signs differ between women and men



And this is where the “default patient” stops being just a historical idea. It becomes a clinical problem. Misconceptions about women's bodies can also survive long after science has moved forward.

None of this means that every man or every woman is biologically identical to every other member of their sex. It shows just how complicated the concept of a “standard” body really is

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THE SUPPORTIVE FRIEND: WHEN A CLASSMATE IS STRUGGLING

Medical students often hide their struggles, but sometimes the person sitting next to you is quietly suffering. This blog explores how to recognize when a peer is struggling, how to offer support without overstepping, and the importance of a compassionate community.

WRITTEN BY
MAITRI JAISWAL
CLASS OF 2031



THE SILENT STRUGGLE BEHIND THE WHITE COAT

Medical school is demanding academically, emotionally, and physically. Yet, many students suffer in silence, fearing that admitting struggle is a sign of weakness or incompetence. Research reveals that medical students face disproportionately high rates of depression, anxiety, and burnout compared to their non-medical peers. Half of all medical students report symptoms of burnout, which can negatively impact both individual health and professional development.

The challenge is that struggling often looks invisible. In a culture that encourages perfectionism and hiding vulnerability, students become experts at masking their distress. They show up to lectures, complete their assignments, and maintain a composed exterior all while quietly falling apart inside.

RECOGNISING THE SIGN:

So how do you know when a classmate is struggling? The signs are often subtle but observable. Research on the early detection of struggling medical students identifies several key indicators: lack of participation, poor academic performance, withdrawal from social interactions, and general signs of distress. These signs can appear long before formal academic failure occurs.

ACADEMIC AND PROFESSIONAL SIGNS

- Missing classes or clinical rotations
- Noticeable decline in academic performance
- Difficulty concentrating/appearing distracted
- Procrastination and poor self-regulation



EMOTIONAL AND SOCIAL SIGNS:

- Withdrawing from social activities & peer groups
- Expressing hopelessness or self-doubt
- Increased irritability or emotional reactivity
- Visible sadness or flat affect

PHYSICAL SIGNS:

- Changes in sleep patterns either sleeping too much or too little
- Noticeable changes in appetite or weight
- Poor hygiene or self-care
- Looking consistently fatigued



According to Anjali Kala, LISW, a therapist at Cleveland Clinic, “The typical signs of depression being visibly sad, stepping back from social activities, and a change in demeanor can certainly be indicative of mental health challenges, but these symptoms can vary from person to person”. She also notes that “missing classes could be a sign that a student is isolating or not functioning as per normal routine”

Sometimes, the signs are even more subtle. A classmate who engaged in discussions may become quiet. Someone who participated in study groups may start studying alone. A friend who always had lunch with the group may disappear during breaks. These changes can be the first indicators that something is wrong.

BREAKING THE SILENCE: HOW TO APPROACH A STRUGGLING PEER

Approaching a classmate who may be struggling requires care and sensitivity. The goal is not to diagnose or fix, but to offer support and connection. Here are some strategies:

1. Start with observation, not judgment. Frame your concern around what you have noticed rather than making assumptions. For example: “I’ve noticed you haven’t been around lately. I just wanted to check in.”

2. Choose a private, comfortable setting. Avoid approaching someone in a public space where they might feel exposed or defensive. A quiet corner, or a private message can create space for honest conversation.



3. Listen without trying to fix. Often, what struggling peers need most is to feel heard. Allow them to share without immediately offering solutions. Validate their feelings by saying things like, “That sounds really tough” or “I can understand why you’d feel that way.”

4. Normalize the struggle. Studies show that peer-facilitated support groups help students realize their experiences are normal and shared. Remind your peer that many students struggle and that asking for help is a sign of strength, not weakness.

5. Offer practical support. During high-stress periods like exam preparation, students often need instrumental support help with meals, errands, or study materials. A simple offer to bring coffee, share notes, or study together can mean more than you realize.

6. Know your limits. You are a friend, not a therapist. If a peer is in crisis or expresses thoughts of self-harm, know when to involve professional support. Many schools have confidential counseling services and crisis resources.



THE POWER OF COMMUNITY

Peer support programs in medical schools have shown remarkable results. One study found that after attending structured peer discussion sessions, student’s self-reported well-being improved significantly from a mean score of 3.25 to 3.89 out of 5.93% of participants reported a positive effect on their well-being. Participants valued “The opportunity to connect honestly with peers and have experiences normalized”.

Medical students often shift their reliance on support systems throughout their training. Early in medical school, peers offer solidarity in an unfamiliar academic setting. During clinical rotations, emotional support becomes more relevant. During residency applications, shared challenges rekindle peer connections. Understanding these shifting needs can help us support each other more effectively.

CREATING A CULTURE OF CARE

Ultimately, being a supportive friend is about building a culture where struggling is not a source of shame. Many medical students fear that showing signs of depression or mental health problems may cause them to be deemed “unfit” by peers and professors. This fear keeps them silent and suffering alone.

Peer support programs can help normalize feelings of uncertainty and sadness. Student led initiatives like “The Gathering Rounds” at Memorial University provide safe, supportive environments where learners can share experiences and resources. One participant described it as “a reminder that we get through it together”.

CONCLUSION

The person sitting next to you in lecture, your study partner, your clinical rotation buddy they may be struggling in ways you cannot see. They may feel isolated, overwhelmed, and uncertain. Your simple act of reaching out, of noticing, of caring it matters. It can be the lifeline they need.

Medical training is difficult enough. No one should have to face it alone.

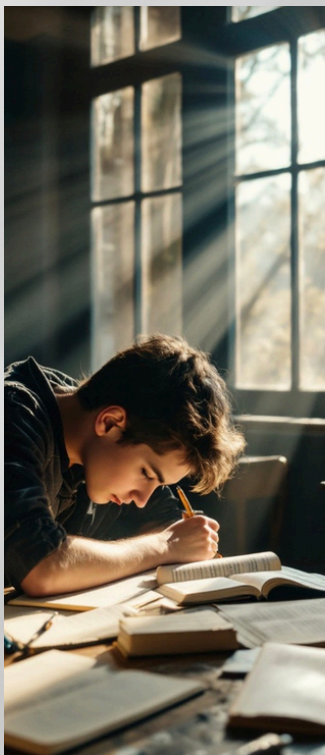
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THE UNWRITTEN RULES NOBODY TEACHES YOU

Every med student learns to project competence at the bedside long before they actually feel competent — and this piece explores that gap through the lens of the “hidden curriculum,” an established concept in medical education research describing everything students absorb informally (through role modeling, culture, and unspoken norms) alongside the official coursework.

WRITTEN BY
CHINTAN VEKARIYA
CLASS OF 2028



INTRODUCTION

How to “Act Like a Doctor” Before You Feel Like One?

- Why “acting like a doctor” before feeling like one is a structural reality of clinical training, not a personal failing?

What the hidden curriculum actually is

- The double edge of the hidden curriculum: it's how good bedside manner and professional judgment get transmitted, but also how cynicism, eroded empathy, and performative professionalism creep in.

THE DOUBLE EDGE

Nobody hands you a syllabus for this part. There's no lecture titled “How to Stand at a Bedside Like You Belong There,” no exam on when to nod gravely versus when to ask a clarifying question, no rubric for how much confidence to project when you have no idea what you're looking at. And yet every attending, resident, and patient you meet is reading you for exactly these signals before you've earned the right to know what you're doing.

This isn't an accident of your particular school. It has a name in medical education research: the hidden curriculum.

Medical educators define the hidden curriculum as the unwritten, unofficial lessons students absorb alongside and sometimes instead of the official one. It doesn't live in a textbook.

It lives in the way an attending rolls their eyes after a patient leaves, in who gets interrupted on rounds, in which specialties get spoken about with reverence and which get quietly mocked, in what happens to the resident who admits they don't know an answer versus the one who bluffs.

Researchers trace the concept back decades, but it's become an especially active area of study since the early 2010s, as educators started recognizing that this informal layer of training transmitted through role modeling, institutional culture, and the countless small interactions of clinical life can shape a student's professional identity as much as, or more than, the formal curriculum ever does.

One scoping review of the concept in residency training found its effects touch everything from how trainees communicate with patients to which specialties they end up choosing.

In other words: while you're memorizing the Krebs cycle, you're simultaneously being trained just as rigorously, just invisibly in how to perform competence. The core tension is structural, not personal.



Clinical training puts you in a room with a patient who needs answers, a preceptor who's evaluating you, and a body of knowledge you've had access to for maybe eighteen months. Nobody in that room benefits from you narrating your uncertainty in real time. So you learn quickly, and mostly by watching to modulate your voice, stand a certain way, ask questions that sound like you already suspect the answer, and defer at exactly the moments deference is expected.



This is, in a strange way, adaptive. Patients in a teaching hospital are trusting you with things that matter, and a wavering, visibly panicked med student doesn't inspire the confidence that helps someone actually open up about their symptoms. But the same skill that protects the patient relationship can also start to feel like a performance you can't turn off a persona that shows up before the underlying competence does, and that nobody explicitly taught you how to build or how to eventually stop needing.

Research on the hidden curriculum is clear that it's not purely a bad thing. Positive role models an attending who admits uncertainty honestly, a resident who treats a scared patient with real patience teach through the same invisible channel. Students describe learning some of their most durable professional habits not from a lecture but from watching someone do the job well when no one was grading them for it.

But the same channel transmits the opposite just as efficiently. Studies on the hidden curriculum have linked it to the erosion of empathy over the course of training, rising cynicism, and a gap between what students are formally taught (trust your patient's report of their pain) and what they observe modeled around them (skepticism toward certain patients, dismissiveness toward certain complaints).

One study following UK medical students found the hidden curriculum operating through role modeling, institutional culture, and even something as small as how you're expected to dress with professionalism sometimes experienced less as an internal value and more as a performance requirement handed down from senior faculty.

The unsettling part is that almost none of this is designed. Educators themselves often don't realize which of their own behaviors are teaching which lessons. The curriculum is hidden partly because the people running it don't always know they're running it.

WHAT TO ACTUALLY DO WITH THIS

You can't opt out of the hidden curriculum it's not a class you can skip. But naming it changes your relationship to it. A few things worth holding onto:

- The performance is real, but it isn't you. The version of yourself that stands confidently at a bedside before you feel ready is a genuine skill you're building not evidence that you're a fraud. Impostor syndrome and professional performance often get tangled together; they're not the same thing.



- Notice who you're copying, and why. When you catch yourself adopting a phrase, a tone, or a habit from someone you're rotating with, ask honestly whether it's something you'd choose on reflection or something you're absorbing by osmosis because it's what "sounds like a doctor."

- The gap between competence and confidence is supposed to close slowly. The unwritten rule nobody says out loud is that everyone above you once stood in the same gap. The acting isn't the opposite of becoming for most people, it's the mechanism by which becoming actually happens. The formal curriculum will teach you medicine. The hidden one is teaching you how to be a doctor and it's worth paying at least as much attention to, precisely because no one's going to test you on it directly.

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PERFECTIONISM IN 2026: WHEN “GOOD ENOUGH” NEVER FEELS ENOUGH

This blog is dedicated to every medical student who has ever walked out of an examination remembering only one mistake, while forgetting the countless things they did right. May we learn to value progress over perfection, and compassion over self-criticism.

WRITTEN BY
THAKUR KAREENA
HARESHSINH
CLASS OF 2030

INTRODUCTION

In a world driven by competition, social media, and constant achievement, are medical students striving for excellence or quietly losing themselves in the pursuit of perfection?

"You did well. So why are you still upset?"

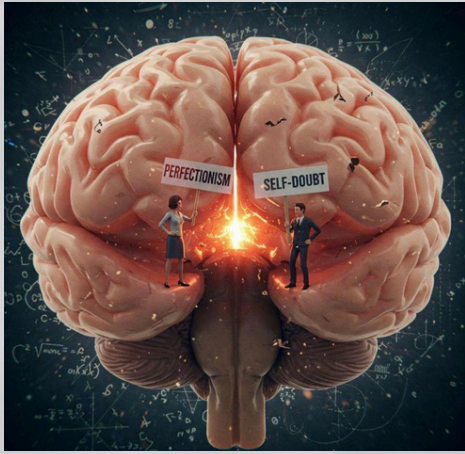
This question stayed with me after my Propaedeutics of Internal Medicine mini practical examination last semester. I had spent days preparing for every practical. I revised each examination step repeatedly, practised with my friends, and walked into the examination feeling confident. During the practical, I answered almost everything correctly. When the results were announced, I had scored 8 out of 10.

Later, I found out that I had forgotten one small but important step I hadn't asked the patient to hold their breath during the examination. It was a genuine mistake, but I couldn't let it go. For the rest of that day, and honestly, throughout the entire weekend, I kept replaying that moment. Instead of feeling happy that I had performed well overall, I focused on that one forgotten step. I wasn't celebrating my success. I was punishing myself for my mistake. Looking back, I realize it was never really about those two marks.

I have always found myself overthinking whether everything I do is "good enough." Whether it's studying, participating in extracurricular activities, pursuing a hobby, or even writing something like this, I often feel that it has to be 100% perfect.



If I make even a small mistake, I immediately wonder, "What will people think?" or "What if they think I'm not good enough?" A few weeks later, I had a conversation with one of my seniors that completely changed my perspective. He had just finished his gynaecology examination and looked genuinely disappointed. I assumed the examination hadn't gone well. But he had prepared thoroughly, revised every topic, practised consistently, and walked in feeling confident. Unfortunately, he drew a particularly difficult question set. Although he answered all four questions and scored 7 marks, he couldn't stop thinking about the answers he wished he had given better. Listening to him, I realized something: just like me, he wasn't upset because he had performed poorly. He was upset because he had expected himself to perform perfectly. The American Psychological Association describes perfectionism as involving unrealistically high standards combined with excessive self-criticism when those standards are not met.



Reading this made me pause. I realized perfectionism isn't simply about wanting to do well; it is about never feeling that what we do is enough.

EXCELLENCE IS NOT THE SAME AS PERFECTION

Excellence encourages us to learn, accept feedback, and improve. Perfectionism makes even our achievements feel incomplete. Forgetting one clinical step wasn't what upset me most; what upset me was feeling that I had failed to meet the impossible standards I had set for myself.

I see this mindset around me too. Some students hesitate to answer questions during viva or mini exams because they are afraid of making a mistake in front of teachers. Some spend hours rewriting notes because they don't look "neat enough." Others feel guilty for taking an evening off, even after studying all day. And in 2026, this pressure can feel even harder to escape.

We have AI tools, online lectures, and countless study resources available instantly. These are incredible opportunities, but social media can also make us feel as though everyone else is doing everything perfectly. We see colour-coded notes, perfect study schedules, research publications, conference presentations, and impressive achievements. Without realizing it, we compare our everyday lives with someone else's highlights.

Sometimes, after scrolling through social media, I feel like everyone else is managing everything perfectly while I'm still trying to balance lectures, practical records, exams, hobbies, and a little time for myself. But we rarely see the anxiety before a viva, the disappointment after an examination, or the self-doubt that can exist even when someone is doing well.

WHEN PERFECTION BECOMES A BURDEN

Unhealthy perfectionism has been associated with stress, anxiety, burnout, and self-criticism. The desire to become a better doctor can slowly turn into a fear of making even the smallest mistake.

Medicine is a profession built on lifelong learning. Even experienced doctors continue updating their knowledge, discussing difficult cases, seeking feedback, and learning from new evidence. If learning never truly ends, expecting ourselves to be perfect as students is unrealistic. The goal of medical education isn't to produce perfect students. It is to prepare future doctors who are curious, compassionate, capable, and willing to keep learning.

For me, the first step has been accepting that making mistakes during training doesn't make me a bad future doctor. It makes me a student and that is exactly what I am supposed to be. When I think back to my Propaedeutics of Internal Medicine practical examination, I no longer remember it as the day I lost two marks.



I remember it as the day I began questioning why one small mistake had the power to overshadow everything I had done right.

Maybe that's what medical school is really trying to teach us.

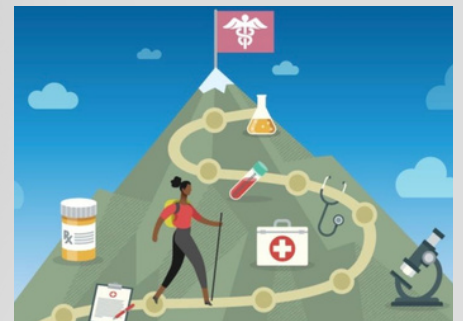
Not perfection, but progress.
Not flawless performance, but lifelong learning.

Not the pressure to know everything today, but the humility to keep learning tomorrow.

"Patients may never ask whether their doctor scored full marks in every examination. But they will always remember a doctor who listened carefully, continued learning, admitted mistakes with honesty, and treated every patient with compassion. Perhaps that, more than perfection, is what truly defines a good doctor."

Dedicated to every medical student who has ever walked out of an examination remembering only one mistake, while forgetting the countless things they did right.

May we learn to value progress over perfection, and compassion over self-criticism.



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Divya Dilshara (Jul 2025 - Sept 2026)
Ahamioje Omosenobua Precious (Oct 2026 - Present)

DEPUTY EXECUTIVE SUPERVISORS

Oso Jesutofunmi Eunice (Oct 2026 - Present)

SOCIAL MEDIA CONTENT EDITORS

Patel Prarthna (Oct-Dec 2026)



The HORIZON

Become our NEXT EDITOR-IN-CHIEF

Do you have a passion for writing, creativity, leadership, and teamwork? The Horizon is now inviting applications for the position of Editors-in-Chief for enthusiastic and committed individuals who wish to take a leading role in shaping the magazine's vision and impact.

EXPECTED SKILLS

- **Excellent Communication Skills** - Must possess strong spoken and written English proficiency, with the ability to communicate ideas and provide input to the authors clearly and professionally.
- **Strong Teamwork & Professionalism** - Applicants should be excellent team players who:
 1. Are easily reachable and responsive.
 2. Can effectively manage responsibilities and consistently meet deadlines.
 3. Maintain healthy and respectful communication with peers and contributors.
- **Technical & Creative Adaptability** - Candidates should be comfortable using digital tools, gadgets, and creative platforms such as Canva or similar software (Selected candidates will receive specific training for executional and operational skills).
- **Leadership & Collaborative Spirit** - We are looking for individuals who naturally inspire those around them and can foster a culture of creativity, enthusiasm, and meaningful contribution within The Horizon community. Ideal candidates should possess strong leadership qualities and the ability to positively encourage peers, classmates, and friends to share their perspectives through insightful, informative, and engaging blogs. As Editors-in-Chief, applicants should be able to cultivate participation and maintain momentum.

APPLICATION REQUIREMENTS:

- **Academic Year Requirement** - Must be a student currently studying in Year 2 to Year 6.
- **Prior Contribution to The Horizon** - Must have previously written at least 3 blogs for The Horizon.

If you believe you meet these requirements and are interested in taking up the role of Editor-in-Chief, we encourage you to apply. Submit your resume (with proof of 3 blogs & a clear photo) and a ~ 300 word cover letter (pdf) highlighting your motives, vision & suitability for the role on our email: thehorizongrsmu@gmail.com ✉

AUTHOR GUIDELINES FOR BLOG SUBMISSIONS

These guidelines are intended to make the submission process clear and straightforward for all prospective authors. Please read the following instructions carefully before preparing your submission.

1. CHOOSE YOUR TOPIC

Authors are free to propose topics that are relevant, engaging, informative, and appropriate for the readership of The Horizon Magazine. Before deciding on a topic, authors must review the Google Sheet containing the topics of blogs that have already been published over the years. Click on the link icon at the bottom of the page. The purpose of the Google Sheet is to help authors identify topics that have already been covered to prevent unnecessary repetition of previously published blogs and help identify areas and subjects that have not yet been explored, encouraging fresh and original ideas.

Important: Please check the Google Sheet carefully before finalising your topic. If your proposed topic is substantially similar to a previously published topic, consider modifying your approach or selecting a different topic.

2. SUBMIT YOUR PROPOSED TOPIC FOR APPROVAL

Do not begin writing the complete blog immediately after selecting a topic. Before writing the article, send a brief description of your proposed topic to: thehorizongrsmu@gmail.com

Your email should briefly explain: 1. The proposed title or topic. 2. What the blog will discuss. 3. The main perspective, idea, or message of the article. 4. Any particularly relevant angle you intend to explore.

A short paragraph is generally sufficient. The purpose of this preliminary step is to allow the editorial team to assess whether the topic is suitable for publication and sufficiently distinct from previously published content.

3. TOPIC REVIEW AND APPROVAL

Once your proposed topic has been submitted, the editorial team will review it. The topic will primarily be assessed for: 1. Suitability for The Horizon Magazine. 2. Appropriateness for a diverse student readership, originality, distinctiveness, relevance, and interest to readers. 3. Overlap with previously published topics

The editorial team may approve the topic, request modifications, or suggest that the author consider an alternative topic. Please wait for confirmation before proceeding with the complete article.

4. WRITE YOUR BLOG

Once your topic has been approved, you may begin writing your blog. The completed blog should be 700–1000 words. Authors should aim to present their ideas clearly and effectively within this range. Avoid unnecessary repetition, excessive background information, or content that does not directly contribute to the central theme of the article.

Blogs should be: 1. Engaging, clear, easy to understand, well-structured, and logically organised. 2. Original and written in the author's own words. 3. Informative, thoughtful, or reflective, depending on the topic.

Authors are encouraged to use suitable headings and paragraphs to make longer articles easier to read.

5. SUBMIT THE COMPLETED BLOG

Once your article is complete, submit it to: thehorizongrsmu@gmail.com. The blog should be submitted as an unflattened PDF or Word document. Please ensure that the submitted file is the final version that you wish the editorial team to review.

6. IMAGES AND VISUAL MATERIAL

Images are not compulsory. However, authors may include images if they enhance the blog or help illustrate its content.

If you wish to include images: 1. Submit up to 5 images along with your blog. 2. Where applicable, ensure that you have the appropriate permission or rights to use the images. 3. Use images that are relevant to the article. 4. Avoid including unnecessary images merely for decorative purposes.

If an image requires attribution or credit, please provide the relevant information along with your submission.

7. REFERENCES AND SOURCES

References are not mandatory but preferred, authors may provide citations for relevant articles, studies, books, websites, or other sources that helped inform the blog. A maximum of 5 references may be submitted.

References are particularly encouraged when the blog: 1. Makes factual or statistical claims. Uses information obtained from specific academic sources. 2. Discusses scientific or medical information. Refers to published research.

Authors should ensure that references are accurate and correspond to the claims made in the article.

8. AUTHOR INFORMATION

Every author must provide the name they wish to have displayed in the published blog, along with their year of graduation. Please include these details with your submission.

AUTHOR: [FULL NAME]
YEAR OF GRADUATION: [YEAR]

If the author wins for their content, the name mentioned in the published blog will be mentioned on their certificate and will not be subjected to any changes or alterations later

9. EDITORIAL REVIEW AND PUBLICATION DECISION

After the completed blog has been submitted, it will undergo editorial review. The editorial team will assess the submitted article for factors including: 1. Compliance with the submission guidelines. 2. Quality and clarity of writing.

Authors will receive an email informing them whether their submitted blog has been approved for publication or not. The editorial team may also contact an author if revisions or clarification are required before a final publication decision is made.

10. CONTENT AND SENSITIVITY GUIDELINES

The Horizon Magazine aims to provide a welcoming platform for students and graduates with diverse backgrounds and perspectives. Authors should therefore exercise appropriate judgment when discussing sensitive subjects. It is strongly advised to refrain from content that could unnecessarily offend, demean, or hurt the religious, political, cultural, national, or personal sentiments of others.

AUTHORS SHOULD AVOID:

- Hate speech or discriminatory content.
- Personal attacks or harassment.
- Content targeting individuals or groups in a derogatory manner.
- Unsubstantiated allegations presented as facts.
- Material that is unnecessarily inflammatory or offensive.
- Content that could reasonably cause harm to the reputation or dignity of others.

This does not prevent authors from discussing serious, controversial, or complex subjects. Such topics may be explored when approached thoughtfully, respectfully, objectively, and appropriately for the magazine.



THE HORIZON BLOG SUBMISSION PROCESS AT A GLANCE

01

EXPLORE PREVIOUS TOPICS

REVIEW THE DESIGNATED GOOGLE SHEET TO MAKE SURE YOUR PROPOSED TOPIC HAS NOT ALREADY BEEN COVERED.

02

CHOOSE YOUR TOPIC

DEVELOP AN ORIGINAL AND ENGAGING IDEA SUITABLE FOR THE HORIZON MAGAZINE.

03

SUBMIT YOUR PROPOSAL

EMAIL A BRIEF DESCRIPTION OF YOUR PROPOSED TOPIC TO THEHORIZONGRSMU@GMAIL.COM

04

WAIT FOR APPROVAL

THE EDITORIAL TEAM WILL REVIEW THE PROPOSED TOPIC AND NOTIFY YOU WHETHER YOU MAY PROCEED.

05

WRITE YOUR BLOG

PREPARE A 700–1000 WORD ARTICLE BASED ON THE APPROVED TOPIC

06

PREPARE YOUR SUBMISSION

ATTACH YOUR COMPLETED BLOG AS AN UNFLATTENED PDF OR WORD DOCUMENT, ALONG WITH ANY OPTIONAL IMAGES AND REFERENCES.

07

PROVIDE AUTHOR DETAILS

INCLUDE THE NAME YOU WISH TO FEATURE AND YOUR YEAR OF GRADUATION.

08

SUBMIT THE COMPLETED BLOG

SEND EVERYTHING TO THEHORIZONGRSMU@GMAIL.COM.

09

EDITORIAL REVIEW

THE EDITORIAL TEAM WILL REVIEW THE COMPLETED SUBMISSION.

10

PUBLICATION DECISION

YOU WILL RECEIVE AN EMAIL INFORMING YOU WHETHER YOUR BLOG HAS BEEN APPROVED FOR PUBLICATION.

The Horizon Reference Database, click on link icon or scan QR



FINAL CHECKLIST FOR AUTHORS

Before submitting your blog, please make sure that:

- I have checked the Google Sheet for previously published topics.
- My proposed topic is sufficiently original and distinct.
- I have submitted my topic for approval before writing the complete blog.
- My blog is between 700 and 1000 words.
- My article is appropriate, clear, original, and well-structured.
- I have prepared the submission as an unflattened PDF or Word document.
- I have included no more than 3–5 images, if I am using images.
- I have included no more than 5 references, if I am using references.
- I have provided the name I wish to feature in the blog.
- I have provided my year of graduation.
- My content is respectful and does not defame, offend or target others.
- I am sending the completed submission to thehorizongrsmu@gmail.com.