



The HORIZON

VOLUME 4, ISSUE 8, AUGUST 2026

- GLP-1 AGONISTS (WEIGHT LOSE DRUGS) : BEYOND DIABETES-THE ETHICAL DEBATE ON "LIFESTYLE" USE
- THE HEALER IN NEED : CONFRONTING THE SECOND VICTIME PHENOMENON IN MEDICAL TRAINING
- IDENTITY RECONSTRUCTION IN MEDICAL SCHOOL FROM A STUDENTS PERSPECTIVE
- MORE THAN JUST SWEATING : HEAT EXHAUSTION VS HEATSTROKE

DEAN'S DESK



Dear students, we at Grodno State Medical University strive to provide students with top-quality education, but that's not it. GRSMU is also a hub for Scientific, Cultural, and Sports related activities. We wholeheartedly acknowledge that International students are an integral part of our university, and we take immense pride in that. 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**

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. 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.

WELCOME TO THE HORIZON



“We all have fascinating stories to share!” 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 and alumni of International faculty at Grodno State Medical University to share their stories. A platform that enables students to share their takes on various curricular and extracurricular aspects of medicine. Thus, the idea of ‘**The Horizon**’, came to life.



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

‘**The Horizon**’ will be a creative intersection where students can freely give commentaries about Lifestyle, Culture, Productivity tips, and more. 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 Dean of the International Faculty, and it will operate under the supervision of the International Students’ Scientific Committee. Students from 1st to 6th year, and even graduates, 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.

For inquiries and submissions.

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EDITOR'S DESK



“ I’m Ronesh Priyashan, a final year medical student at the Grodno State Medical University. As your editor, I see our platform as a canvas where every student can leave their mark. The Horizon Magazine is a reflection of who we are: a collective of curious minds, resilient hearts, and limitless potential. Together with our incredible team of editors, writers, and contributors, I invite you to fill these pages with your voices, your experiences, and your light. Let’s make this summer one to remember.

”



RONESH PRIYASHAN,
EDITOR, JULY-SEPTEMBER 2026



VEKARIYA CHINTAN
EDITOR, JULY- SEPTEMBER, 2026

“ Every student has a story worth telling — my job is just to help them tell it well.” Myself Vekariya Chintan a –4th year student at Grodno State Medical University. Stepping into this role, Chintan is driven by a simple belief: that the everyday experiences of students — the struggles, the small wins, the curiosity that comes with life at GRSMU — deserve a platform as polished and thoughtful as the stories themselves. As Editor, I am focused on shaping Horizon into a space where students feel genuinely encouraged to share their voice, I am looking forward to collaborating closely with writers across all years to make this edition of Horizon more engaging, more polished, and more reflective of the diverse community that makes up GRSMU.

”

And a message to our dearest readers, we would like to invite you all, students and alumni, 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

Miral Vadher

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GLP-1 Agonists (Weight Loss Drugs): Beyond diabetes-the ethical debate on lifestyle use.

GLP-1 agonists are revolutionary weight-loss tools, but their growing use by non-diabetic, "lifestyle" users has ignited a fiery ethical debate about fairness, safety, and what we truly mean by "health." The ethical question isn't whether GLP-1's are cheating. It's whether we're building a world where health is accessible to all or just those who can afford the injection.

WRITTEN BY
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INTRODUCTION

Life is filled with experiences that shape who we are—some bring joy and growth, while others bring challenges. What began as a treatment for type 2 diabetes has evolved into a global phenomenon. Glucagon-like peptide-1 (GLP-1) receptor agonists, including semaglutide (Ozempic, Wegovy) and tirzepatide (Mounjaro, Zepbound) are injectable medications that mimic a naturally occurring hormone, increasing insulin production, slowing gastric emptying, and decreasing appetite by inhibiting hunger centers in the brain. Clinical trials demonstrate average weight reductions of 15–20%, with cardiovascular benefits including a 20% reduction in major adverse events. Semaglutide was FDA-approved for chronic weight management in 2021 (Wegovy), and tirzepatide followed in late 2023 (Zepbound), indicated for patients with BMI ≥ 30 or BMI ≥ 27 with weight related comorbidities.



The Ethical Fault Lines :

1. Medical Necessity vs. Cosmetic Enhancement:

The most visceral ethical tension lies in who should receive these drugs and why. Approved indications are clear obesity or overweight with comorbidities. Yet off-label use among individuals without obesity or diabetes is rapidly expanding, driven by celebrity endorsements, social media, and the pursuit of aesthetic ideals. A sociomedical perspective published in *Obesity* argues this phenomenon reveals "Deeper tensions between medical innovation, weight stigma, and the social value attached to thinness". Weight loss has become "A visible marker of personal virtue, performative achievement, and conformity to dominant beauty ideals".

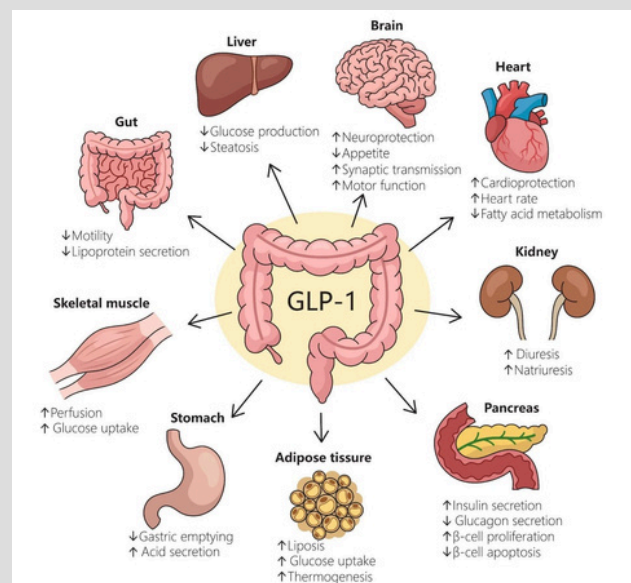
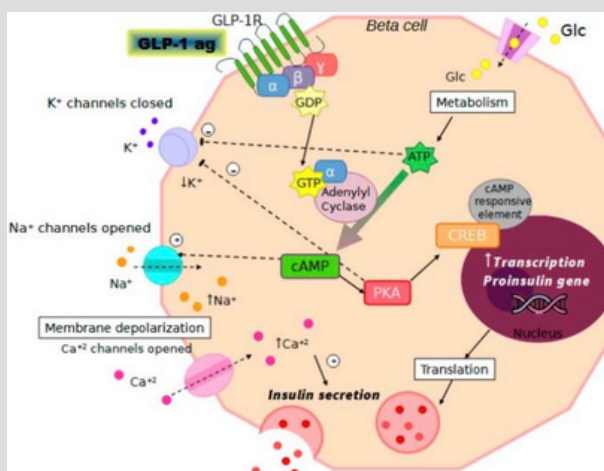
Critics like fitness trainer Jillian Michaels have called this "The easy way out". The "argument from virtue" posits that using medication to circumvent lifestyle effort is morally problematic. Proponents counter that obesity is a chronic disease, we don't deny antihypertensives based on moral judgments about salt intake.

2. Access, Equity, and the Two-Tier System:

Perhaps the most consequential ethical concern is who can afford these drugs. Annual costs often exceed \$8,000 per patient in high-income markets. A 2024 *Lancet* analysis of 13 high-income countries found that nine fully deny reimbursement for weight management, including Australia, Germany, Italy, and the UK. The authors argue blanket coverage denials are unethical, recommending targeted policies that maximize benefits while managing costs.

The UK exemplifies this crisis: obesity prevalence is nearly double in the most deprived areas (36%) compared to the least (20%). NHS rollout criteria, BMI ≥ 40 plus four of five specific comorbidities are arguably the strictest in NHS history. Meanwhile, over 1.5 million access these drugs privately. As one editorial concludes: "At present, more than 1.5 million people access GLP-1 RAs privately, while NHS provision remains tightly rationed, creating a two-tier obesity treatment system".

Globally, the picture is starker. With 2.5 billion adults overweight or obese and the global economic impact exceeding \$4 trillion by 2035, the WHO recently added GLP-1 RAs to its Essential Medicines List. Yet without coordinated action, these drugs "risk becoming the latest emblem of the innovation access gap that divides people in rich and poor countries". The HIV/AIDS experience offers a painful parallel: antiretroviral therapy cost over \$10,000 annually at the turn of the millennium; coordinated global action drove prices down 99%.



3. Safety, Unknowns, and "Off-Label" Risk:

Off-label use among individuals without obesity raises profound safety concerns, as there is "A lack of clinical justification or safety data in this population". Known risks include gastrointestinal side effects, pancreatitis, gallbladder disease, and anesthesia-related complications. Long-term effects remain unknown; the WHO has highlighted limited long-term safety data. Emerging research also suggests potential neurological and psychiatric risks for patients with specific genetic backgrounds. Furthermore, the rise of counterfeit products and compounded injections introduces additional safety risks.

4. Stigma, Medicalization, and the "Easy Way Out":

Paradoxically, these drugs both reflect and reinforce weight stigma. Users face public backlash for "cutting corners". A 2025 study found that patients on anti-obesity medication face "effort-based sanctions and social penalties". Yet denying effective medication to those who need it is itself a form of discrimination. GLP-1 agonists risk "medicalizing weight and increasing weight stigma"—while simultaneously offering liberation from a condition that carries immense social and health burdens.

A Way Forward : Ethical Prescribing

A collaborative approach, "rooted in ethical responsibility, patient education, and regulatory oversight, is essential to prevent healthcare inequities". Recommendations include strengthening prescription regulations, improving public awareness, and ensuring informed consent. As one review concludes: "Despite increasing usage and the potential benefits... financial and regulatory barriers create significant challenges". GLP-1 receptor agonists "may indeed be a blessing, but only if applied judiciously within the context of holistic obesity management".

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The Healer in Need: Confronting the Second Victim Phenomenon in Medical Training

The "Second Victim" Phenomenon: When the Healer Needs Healing: This addresses the psychological trauma medical students and residents experience when a medical error occurs or a patient has a bad outcome. It's a crucial but often taboo topic, exploring the guilt, shame, and anxiety that can follow. The article discusses institutional support, personal coping mechanisms, and how to prevent burnout from this specific source of stress.

WRITTEN BY
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INTRODUCTION

When a patient suffers a poor outcome or a medical error occurs, the focus is rightly on them. However, medical students and residents often become the "second victims". Suffering in silence from profound guilt, shame, and anxiety. This blog explores the impact of this trauma on trainees, the institutional and personal strategies that can help, and the urgent need to change the culture of medicine to support its own.



This powerful image of an ER doctor grieving the loss of a young patient went viral and perfectly captures the raw emotion of the "second victim" experience. It depicts a physician in scrubs, crouched down against a wall, visibly overwhelmed with grief.



THE UNSEEN CASUALTY

In the high-stakes world of medicine, the focus is and must remain on the patient. Yet, when an error occurs or a patient suffers a poor outcome, there is another casualty who is often overlooked: the medical professional involved. This is the "second victim" phenomenon, a term that describes the significant emotional and psychological trauma experienced by healthcare providers following an adverse patient event.

For medical students and residents, who are at the most impressionable stage of their careers and often working under immense pressure, the impact can be particularly devastating. Studies show that a significant majority of trainees experience symptoms of being a second victim, with one study finding that over 60% of healthcare students and residents present typical symptoms. This burden, if left unaddressed, can lead to burnout, long-term mental health struggles, and even a decision to leave the profession.

THE EMOTIONAL TOLL: WHEN GUILT AND SHAME TAKE OVER

The first step in healing is understanding the nature of the wound. The psychological symptoms of a second victim can be all consuming. Research reveals that common responses include acute anxiety, persistent doubts about clinical decisions, hypervigilance, and overwhelming guilt. A study of surgical residents found that despite a high prevalence of errors, only a small percentage received any formal support, leaving them to manage their distress in isolation.



The journey through this trauma has been described as a series of stages, mirroring the grieving process. It often begins with shock and denial, followed by anger and a period of “bargaining” wishing for a different outcome before potentially settling into a deep depression. For trainees, this is compounded by a fear of judgment from supervisors and peers, a fear that their career is over before it has truly begun, and a feeling of shame that conflicts with their identity as healers. These emotions can trigger a cascade of physical symptoms, including insomnia, loss of concentration, and even symptoms consistent with post-traumatic stress disorder.



THE INSTITUTIONAL RESPONSE : BUILDING A “ JUST CULTURE “

The traditional culture of medicine, which has historically been one of perfectionism and blame, is a fertile ground for the second victim phenomenon. Trainees often fear the “inquisition” that can follow an error, leading them to internalize the event and struggle in isolation. To truly support our future physicians, a fundamental cultural shift is needed moving from a culture of blame to a “Just Culture”.

In a Just Culture, errors are recognized as a complex interplay of individual actions and flawed systems. The goal is not to assign blame but to learn and improve patient safety. This approach creates an environment where trainees feel psychologically safe to acknowledge mistakes and seek help without fear of retribution. Institutional support is the most critical factor in mitigating the negative outcomes associated with the second victim phenomenon.

A LIFELINE : PEER SUPPORT AND PERSONAL COPING

While a supportive institutional framework is essential, the frontline of immediate support often comes from peers. A powerful study found that over 80% of healthcare providers strongly desire to discuss their emotional challenges with a respected colleague after a traumatic event. Structured peer support programs, such as the RISE (Resilience in Stressful Events) program, have become a gold standard. These programs train volunteers to provide psychological first aid active listening, validation of feelings, and normalization of the reaction to their fellow colleagues. While peer support offers crucial short-term relief, professional counseling and structured mental health support remain vital for those whose symptoms persist.



For individual trainees, developing healthy coping mechanisms is also key. This involves:

- **Accepting Responsibility, But Not All the Blame:** Acknowledging one's role in an error is a crucial first step, but it should be done in the context of recognizing the systemic factors that may have contributed.
- **Breaking the Cycle:** It's common to replay the event over and over in your mind. Recognizing this "circular thinking" is crucial, and breaking the cycle requires active effort often by speaking to someone.
- **Talking About It:** The shame of an error festers in silence. Talking to a trusted mentor, family member, or friend can help put the event in perspective.
- **Using the Error as a Catalyst:** The event, however painful, can be a powerful opportunity for learning and growth, whether it's improving a clinical skill or identifying a flaw in a clinical system.

CONCLUSION

The “ Second Victim ” phenomenon is not a sign of weakness . It is a predictable and human response to a traumatic event. Our medical schools and training hospitals have a moral and professional obligation to protect the well-being of their trainees. By fostering a Just Culture, implementing robust peer support networks, and ensuring access to professional mental health services, we can help the healers heal. Only then can we build a resilient medical workforce prepared to provide the best care for the patients who are the “ first victims. ”

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IDENTITY RECONSTRUCTION IN MEDICAL SCHOOL FROM A STUDENTS PERSPECTIVE

This blog helps us to understand how medical school plays a major role in cognitive, social, emotional and ethical identity reconstruction.

WRITTEN BY
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INTRODUCTION

Medical school is usually described as demanding, thorough and transformative but medical school does not only teach you the art and science of medicine, it quietly changes who you are by initiating a multifaceted process of identity reconstruction. It fundamentally changes the perspective of who you are, how you act, how you think, how you feel and how you relate to the world.

🧠 THE COGNITIVE RECONSTRUCTION

Medical school completely changes the way you process information. In the early stages of training, the sheer volume of material forces a reliance on rote learning. However, as you advance, a profound cognitive shift occurs:

- **From Facts to Mechanisms:** You stop merely cramming high-yield facts and begin seeing systemic mechanisms.
- **Adaptive Clinical Reasoning:** Memorization transitions into building clinical reasoning, which promotes highly adaptive problem-solving skills in high-pressure environments.
- **Complex Meaning-Making:** This phase is not simply about accumulating knowledge. It alters how you ask questions, structure arguments, and makes sense of chaotic, complex clinical situations. Through this evolution, your brain shifts from acting like a basic hard drive storing data to operating like a highly analytical clinical engine.

🧑‍🤝‍🧑 THE EMOTIONAL RECONSTRUCTION



Emotional identity reconstruction takes place as students leave the lecture halls and go into the wards where they witness patients' vulnerability, ethnic complexity, responsibility and uncertainty making the students develop adaptive skills and empathetic reflection which deepens resilience, ethical sensitivity and empathy. Witnessing human suffering alters your emotional balance. You learn that medicine is not just about solving clinical problems, but it is also about being present, being a good listener, and holding space for human experience. The emotional need of medical training teaches students to balance their own feelings with the needs of their patients. It plays a huge role in the development of medical students as compassionate caregivers.

THE SOCIAL RECONSTRUCTION

As you move through training, your relationship shifts. It is a process of social acculturation.

Social Reconstruction occurs through engaging in medical cultures, developing peer relationships, mentorship, role modelling, and building professional communication habits.

Peer relationships play a vital role in providing emotional support and allowing students to navigate the stresses of training together.

Mentorship also plays a vital role in social identity reconstruction.



Positive Role models inspire students to develop professional behaviors and values.

You start losing your old identity as a regular person, and you take on the heavy social burden of a future doctor. Suddenly, old friends and family don't understand your schedule anymore and family dinner becomes a place where you give medical advice.

This shift can feel isolated at times, but it also marks the beginning of belonging to a community that shares your purpose, language, and professional mission.

THE ETHICAL RECONSTRUCTION

Autonomy

- Respect patient self-determination
- Patients have the right to accept /reject recommendations for medical care if they have appropriate decision-making capacity

Beneficence

- Doing what is best for the patient
- Definition of 'what is best' may derive from the physician's judgment or the patient's wishes (Autonomy)

Non-Maleficence

- *Primum non nocere* - "First, do no harm"
- Physicians are fallable, we are equally capable of harming as we are helping our patients

Justice

- Fair allocation of resources
- Patients in similar situations should have access to the same care

Training to be a physician also demands a total overhaul of your internal moral compass. This final, deeply reflective transition changes your baseline logic for making decisions: Beyond Civilian Intuition: Before entering the clinical space, your everyday sense of right and wrong is naturally anchored in personal emotions, family upbringings, and gut reactions. Objective Clinical Frameworks: This is a profound, often uncomfortable mental transition. You must systematically train yourself to evaluate life, death, and human vulnerability through the strict lens of patient autonomy, beneficence, and justice, rather than your personal feelings.

INTEGRATION OF ASPECTS

Altogether, the cognitive, social, emotional and ethical aspects of identity reconstruction which takes place in medical school are linked together. It is challenging but beautiful and deeply human and as you go through these changes you discover that you are not just learning the science of medicine, but you are learning the art of becoming someone who can hold the life of another person with care.

CONCLUSION

THE WHITE COAT METAMORPHOSIS

The journey through medical school is much more than an academic milestone. It is an intricate, psychological metamorphosis. By the time you get your degree, the cognitive, emotional, social, and ethical reconstruction is complete. You do not just leave with a diploma; you step forward as a completely re-engineered individual, ready to bear the immense weight of the white coat. This metamorphosis is the foundation of lifelong learning, reminding every new doctor that growth does not end at GRADUATION, it continues with every patient, every challenge, and every act of care.

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More Than Just Sweating: Heat Exhaustion vs. Heatstroke

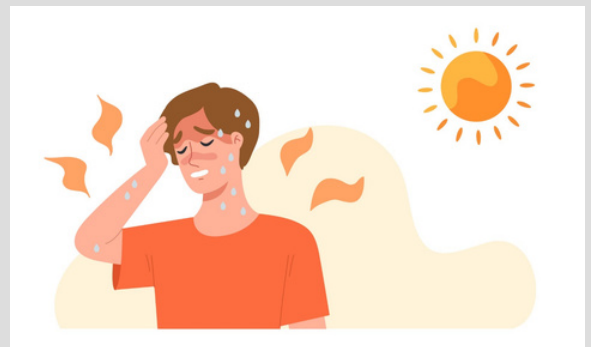
As the weather gets warmer, we tend to spend more time outside under the hot sun. It's important to understand the risks associated with extreme heat. While most people have heard of heat exhaustion and heatstroke, knowing the differences between the two could save a life. This blog focuses on the key physiological differences, core temperature thresholds, and critical neurological symptoms that signal a progression from exhaustion to a life-threatening heatstroke emergency.

WRITTEN BY
SHARONE
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What's the difference between Heat Exhaustion and Heat Stroke?

When someone's feeling drained after a hot day in the sun, it's not unusual to hear them say, "I think I have heatstroke," or "I've had too much sun." But often, what they're experiencing is heat exhaustion, not heatstroke. When someone's feeling drained after a hot day in the sun, it's not unusual to hear them say, "I think I have heatstroke," or "I've had too much sun." But often, what they're experiencing is heat exhaustion, not heatstroke.

Heat exhaustion occurs when your body loses excess water and salt, typically through sweating. On the other hand, heat stroke is a serious medical emergency that occurs when your body is unable to control its internal temperature. It's a medical emergency that can lead to permanent organ damage or death if not treated rapidly.



The Core Temperature "Tipping Point"

One of the main ways doctors tell the difference is by looking at the body's core temperature:

- Heat Exhaustion: The body temperature is usually raised but remains below 40°C (104°F). The body is still trying to cool itself down.
- Heatstroke: The body temperature rises to 40°C (104°F) or higher. At this point, the "thermostat" in the brain stops working, and the body can no longer regulate its own heat.

The Red Flags : Neurological Symptoms

The biggest tell that someone has moved from exhaustion to stroke is how their brain is functioning. Because the brain is very sensitive to heat, it is often the first organ to show signs of failure.

In heat exhaustion, the person might feel dizzy, have a headache, or feel sick to their stomach, but they are still "all there" mentally.

In heatstroke, the Central Nervous System (CNS) begins to fail. Look for these critical signs:

- Confusion or agitation.
- Slurred speech.
- Seizures.
- Loss of consciousness or fainting.
- Inability to walk straight.

Who is Most at Risk?

While anyone can get sick from the heat, certain factors make it much more likely:

1. Age: Infants and children (under 4) and older adults (over 65) are at higher risk because their bodies don't regulate temperature as efficiently.
2. Medications: Some medicines for blood pressure (diuretics or beta-blockers) or allergies (antihistamines) can reduce your body's ability to stay hydrated or sweat.
3. Chronic Illness: People with heart, lung, or kidney disease are more vulnerable.
4. Humidity: When humidity is high, sweat doesn't evaporate off your skin. If the sweat can't evaporate, your body can't cool down.
5. Lack of Acclimatization: If you aren't used to the heat (like during the first heatwave of the summer), your body hasn't learned how to cool itself efficiently yet.



How to Prevent Heat Illness?

The best way to treat a heat emergency is to make sure it never happens.

- Hydrate Early and Often: Don't wait until you are thirsty to drink water. If you are working hard or exercising, consider a sports drink to replace the salt you lose through sweat.
- Dress for the Weather: Wear lightweight, light-colored, and loose-fitting clothing. Dark colours soak up the sun's heat, and tight clothes don't allow air to circulate.
- Time Your Day: If possible, do your outdoor activities in the early morning or late evening when the sun is less intense.
- Take it Slow: If you aren't used to working in the heat, start slowly. Gradually increase your time outside over several days to let your body adjust.



Sweating: A False Clue?

A common myth is that people with heatstroke always have dry skin. While it is true that many people stop sweating when they have heatstroke, people who are exercising hard (like athletes or labourers) might still be sweating heavily even though they are in heatstroke. Don't wait for the skin to be dry to call for help.

What should you do?

If you suspect heat exhaustion:

1. Move the person to a cool, shaded area.
2. Give them water or a sports drink.
3. Loosen their clothing and use cool mist or wet towels.
4. If they don't feel better within 30 minutes, seek medical help.

If you suspect heatstroke:

1. Call emergency services immediately.
2. Move them to the shade.
3. Cool them down fast: use ice packs on the armpits and groin, or soak their clothes with cold water.
4. Do not try to give them a drink if they are confused or unconscious, as they might choke.

Remember: Heat exhaustion is a request for rest; heatstroke is a race against the clock. Stay hydrated and stay cool!

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