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ANOTHER YEAR ANOTHER SURGO

A NOTE FROM THE EDITOR

And in a flash, it's 2026 already – where did the time go? 2025 was a great year for many at Glasgow Medical School; the new Wolfson Library, a brand-new curriculum and record-breaking influx of students joining first year and direct entrants from Brunei, Maylasia and the equally exotic North-East coast of Fife.

SNIMS saw fifteen-hundred medical students swap low-grade-fever for Saturday Night Fever with this year's theme; dancing through time. Costumes were at an all-time high; flocks of Freddie Mercurys and John Travoltas graced the dancefloors of LiveHouse and Aura nightclub, cutting shapes till dawn. Sporting performance was unparalleled with Glasgow remarkably winning every single match across all sports despite Dundee erroneously claiming to be victorious.

Third-year students also celebrated reaching halfway through the MBChB degree up in the Highlands at their halfway ball. A noughties themed night, Cairngorm hikes, a three-course meal dressed to the nines left everyone wanting more and Avie-more.

Hope everyone enjoys the next term and all the best to those with upcoming exams!

Innes Crawford
Surgo Editor-in-Chief 2025-2026

SURGO MEETS REUBEN CURRAN

By Professor Cindy Chew

Congratulations Reuben on the many successes of your band :Panic :Over! It's been a whirlwind - winning Battle of the Bands competition, having your music soundtracking events on ITV and the BBC, playing to sold out shows across the UK, touring Ireland and being selected to represent Northen Ireland at the Osaka Expo 2025 in Japan.

Thank you! Yeah – it's been a bit mad, but great fun.

So, tell us how did it all begin?

The four of us met at my sixteenth birthday party and thought "We should start a band". Just as we were setting up our jamming sessions – COVID-19 struck. I remember us trying to practice together during those early days – online at first then outside with social distancing – it's not what you would say is ideal or the usual "rock band" origin story. Also – my guitar skills were very limited at the beginning!

I'm sure you are just being modest! Were you musical at an early age?

I feel like I've probably been singing before I can even remember; sometimes I joke that it began when I came out of the womb! When I was about seven years old my mum asked me whether I wanted to play football or rugby, but in response, I told her that I just wanted to learn to play the piano! I never looked back and still play it frequently to this day, having also spent some time playing the oboe during my school years. I had a few guitar lessons at the age of 11 but didn't pick it back up properly until the band started going.

Tell us what's happened since 2020?

After a bit of practice, we started busking and playing in bars - mainly playing covers. Soon we started writing our own songs – which was fun – and releasing our own music on Spotify.
Our first "ticketed" show was in 2022 – that was amazing! I remember everything about that night. 2023 – we entered the "Battle of the Bands" competition. THAT was just incredible. When we got into the finals it was a mad run to change my flights and family holiday plans etc just to make it physically to the finals. We only went and won it! Since then, it's been more gigs, tours and most recently Japan!

The :Panic :Over band consists of Ben Simms, Charlie Gribbons, Dharesh McCarthy and Reuben Curran.

Wow that sounds amazing! Can you share some highlights from your exciting rock and roll life?

The electric feeling of playing your music live to people who like it! That's just indescribable! (Reader at this point, Reuben's face glowed with a light within – eyes alive, smile uncontainable, as if the music itself was shining through them). The incredible opportunities - meeting people, visiting and experiencing different parts of the world: Japan, London, Galway. It's brilliant! Osaka for example – it was so different! The beautiful architecture, the culture, the food … the wagyu beef was unreal! Of course, we also visited Universal Studios and I bought a guitar from one of the awesome stores in the city!

You'll always remember Osaka when you see / play that guitar! Now all this sounds really terrific – but hold on. Aren't you a medical student, studying a demanding professional degree? How do you square the rock and roll life, with band practice, writing music all that stuff with studying / passing exams? Some of us struggle with just the studying bit!

That's a good question: I've always wanted to do Medicine. So that will always be a priority. We generally have some notice to our music events. I just make sure I have my studying scheduled-in ahead of time, so I can really be 100% present during the performances you know. Have fun and enjoy the whole experience. Not have that fun bit marred by trying to squeeze studying in while travelling or when the rest of the band is having fun. That balance seems to work.

Fabulous! Being organised, planning and spacing studying with fun things. The epitome of "work-life balance" but also "work hard, play hard". Being resourceful and having a back up plan too – from that holiday-competition finals story!
I find that having different interests, hobbies and activities outside of the "work of medicine" gives me perspective and helps me balance my head out. It also helps me knuckle down and focus on medicine when I am supposed to. Does music do that for you? Can you share a little bit more?

Throughout my time studying medicine, the importance of keeping a work-life balance has been stressed by many senior students and teaching staff. Having music as an outlet whether going solo in my uni flat or linking up with the boys back at home has been so beneficial alongside my studies. If I'm ever feeling worked up after a stressful day it quickly takes the weight off my shoulders. It's also a really nice way of separating my studies into chunks; especially when my guitar is only as far as the corner of my room!

Panic :Over after winning the Rockshore Battle of the Bands competition.

Looking at your life now: what would you say to your 16-year-old self if you had the chance?

If I had the chance I would probably say something along the lines of "keep at it, you're doing great!" Deciding to study medicine probably happened around the same time as the birth of :Panic :Over. I knew that I would have both to contend with, albeit I didn't realise that the jamming around with my mates would go on to give the opportunities that it has done to this day. I have met so many amazing people through studying medicine here in Glasgow, and through playing music for others, near and far – I wouldn't change it for a thing, and I'm so grateful to have both!

And looking forwards: where do you see yourself in 5–10 years' time? Are we going to have another "Emeli Sande" from Glasgow?

Hey, you never know! Emeli took on music full time before she had graduated, which is something I'd feel more reluctant to do myself. My plan is to split the eggs up, balance the books, however you like, and see where it goes. Making sure that I devote the right amount of time to each is essential, and I feel like it's going well so far! Who knows – maybe I'll find myself gigging around the world and acting as tour doctor part time!

Thank you Reuben for sharing your story with Surgo! We wish you all the best with your music and also your studies! You can find :Panic :Over's music on Spotify (other streaming platforms are available) and their website : panic-over.com. You can also read a recent press piece on their Japan trip here:

https://www.chordblossom.com/features/tour-diary-panic-over-japanic-over

ETHICS UNDER FIRE

FOUR DIFFICULT ETHICAL SCENARIOS FACED BY MILITARY DOCTORS

By Aidan Wright

As medical students we are taught medical ethics from the very beginning of our training, chiselled into us through interview prep and situational judgement tests. We then apply them throughout our training as doctors, sometimes in a high-pressure environment. Now imagine the same duress whilst in the back of a mobile surgical unit, with the whirring of drones overhead threatening to expose you to enemy fire, miles from the nearest hospital. In both settings doctors abide by the same professional code: to care, to do no harm and to put the patient first. But military medicine creates an environment where these values are placed under immense strain. Is this relevant to us? The BMA seems to think so: three recent BMJ cover pages emphasise the strengthening link between global conflict and health. Admittedly, conflict ethics is only one part of that, but if you are that medic, it is essential to get it right.

Scenario One and Two. Care under fire and treating the enemy – *shoot or save*?

On top of being guided by the GMC's *Good Medical Practice,* British military doctors (Medical Officer or MOs) are also bound by the Laws Of Armed Conflict (LOAC): namely the Geneva conventions. These laws protect medics but also limit what they can do. All medical personnel are protected by being categorised as non-combatants; they cannot be targeted by enemy forces. Even when captured, doctors have a protected status and must be allowed to continue impartial care. **But with these protections come ethical constraints.** For example, MOs are in the military, but are they allowed firearms? Surely this is an obvious clash with, 'Do No Harm'. Would use of such weapons undo everything the Hippocratic oath we swear by stands for? The current consensus is that a doctor may use a small personal weapon to defend themselves and their patients. No other use of force is permitted and any breach of this forfeits their protected status (and is a war crime). This is the first ethical tension: when and how to use firearms while upholding the principles of medical ethics.

Furthermore, the Geneva conventions require doctors to treat everyone impartially, based purely on **clinical need**. *For example, an MO is treating a wounded soldier in an ambulance and is attacked. The team return lawful fire and the doctor critically wounds the attacker. Once the area is made safe, that same attacker is now 'hors de combat' – no longer a threat – and is now the doctor's patient.*

This commitment to impartiality underpins trust in the medical profession itself. In essence, treating the enemy ethically upholds the widespread integrity and neutrality in the medical profession.

Scenario Three. Dual loyalty – *mission or medicine?*

MOs serve two masters: their patients and their commanders. *Dual loyalty* describes the moral conflict when the welfare of the individual clashes with the objectives of the mission.

For example, a soldier with a knee injury is given a week of reduced duties. However, his unit is at high readiness in a time of political tension, and a frustrated commander comes in demanding the injured soldier returns to duty, as the operational effectiveness of the unit has been compromised.

What should the MO do here? The GMC requires that "a doctor's first concern must be the care of their patient." The challenge for a MO is ensuring that operational necessity never compromises this duty. Ethical leadership, and the courage to occasionally stand firm against the chain of command are central to maintaining both military effectiveness and medical professionalism. In such cases, the ethical code safeguards both the medic and the patient.

Scenario Four. Ethics of mass casualty.

In mass-casualty situations, triage replaces equality with necessity. The principle is to save the greatest number of lives with limited resources — even if that means some patients receive delayed or no treatment.

Consider a scenario of a nine casualties in a truck that hits a land mine and explodes. In the truck is five allied soldiers, two detained enemies and two civilians. Regardless of background, all must be categorised and treated; the doctor must put all loyalties and relationships aside. The two enemies are treated first as their injuries are most critical, whilst the five soldiers, some of whom the MO knows and is friends with, must wait. The MO determines one of the civilians has a significant traumatic brain injury - in this environment he is expected to die. Consequently, the other casualties requiring intervention must be prioritised, even though said patient could have stood a chance if in hospital.

Triage decisions are emotionally and ethically taxing. They require balancing utilitarian reasoning with compassion, often in seconds. Military medics use structured algorithms, but behind each decision lies the same GMC principle of acting in the patient's best interests, given the circumstances.

To summarise, military medicine stretches medical ethics to its very limit, creating challenging clashes between compassion, command and loyalty. The lesson learnt is no matter where a doctor is, military or not, sticking to the ubiquitous values outlined to us are paramount to maintaining worldwide trust in the medical profession. Ironically, war paradoxically

refines medicine to its moral core, preserving life and dignity amid chaos and destruction. Wow that got deep, thanks for reading!

Aidan is a third-year medical student at Glasgow and Strathclyde Officers Training Corps with an interest in military health and ethics.

THE GLASGOW UNIVERSITY DES GILMORE ROAD RACE

By Chloe Danno

The Glasgow University 5 Mile Road Race returns for its 62nd year on Saturday 7th March 2026, carrying special significance as it is renamed the Glasgow University Des Gilmore 5 Mile Road Race in memory of Des Gilmore, who sadly passed away in July 2025.

First held in 1963, the race is a cornerstone of the University's athletics calendar. Starting at the Garscube Sports Complex, the two-lap course winds through quiet roads on the outskirts of Glasgow, offering a mix of flat stretches and scenic rolling hills. The race begins at 12 pm and has long been known for its friendly atmosphere and competitive spirit. Des Gilmore was an integral part of Glasgow University Hares & Hounds, joining the club in 1972 and serving as President from 1988 until his passing. A familiar and reassuring presence, Des volunteered tirelessly, supporting training sessions and acting as official timekeeper at the 5 Mile Road Race for many years. Beyond athletics, Des was a respected academic, educator, and mentor, remembered for his warmth, humour, and unwavering commitment to student welfare.

Renaming the race in his honour is a fitting tribute to a man who gave so much to the University and its running community. By taking part, competitors help celebrate Des's remarkable legacy and the event he supported year after year.

Online entry is open until 6th March, with entry priced at £12 (£10 student rate).

AN INTERVIEW WITH DR GENEVIEVE STAPLETON

By Innes Crawford

Dr Genevieve Stapleton is a senior lecturer at the University of Glasgow and is Year One Director for the MBChB course. With a career that spans across the world, we were interested to hear what drove her to move to these places. Transitioning from a career in academia to lecturing when she joined the medical school in 2010, we caught up with the well-known face to find out how she got there.

1) From your biography, I see your studies and employment have spanned all across the globe, would you mind telling us about the different places you have worked and what drew you there?

You're right! I've been so fortunate to have worked in some amazing places across the world. Magnificent Melbourne, Superb San Francisco, Sensational Seattle, Exquisite Edinburgh, then I saved the best – Glamorous Glasgow – to last! I'd like to say that it was all very carefully planned, but actually if an opportunity presented itself, I went for it! Some degrees, and medicine is one of them, can be your passport to the world. So if you are able to, use it! Go see the world! Taking opportunities to learn from and understand different cultures is a great privilege. Glasgow will always be here for you when you decide to come back.

2) Before joining the medical school in 2010, I see you had a career in academia. Could you briefly outline the types of research you contributed to and any implications this has on clinical practice/your progression to director of MBChB1?

My research interests have mostly concerned intracellular signalling and how just one little addition of a phosphate group on one particular molecule can change the entire fate or response of the cell! Crazy! The cell is utterly fascinating. But I didn't start there. My first research job was as a technician in Melbourne working on Schistosomiasis. In contrast, when in Seattle I was working on meiotic maturation of oocytes in starfish (this was great because twice a year we had to go to the beautiful Pacific Northwest and collect the starfish!) But my love is cancer (the research not the disease itself). However, I left that all behind to move into medical education, and I have found this to be equally fascinating and rewarding. I continue to do research, but this time, in medical education while still sharing the wonders of the cell (and who doesn't love the cell cycle?) and the basic processes underpinning cancer with students and maybe future oncologists.

3) Do you have any tips for students who are new to Glasgow Medical School and some more for getting through first year?

How long have you got… Here are my top wo! Tip one: Make some friends who are also studying medicine, even just one. It can be a bit tough at times so a friend who understands and shares the highs and the not-so-highs is invaluable. MedChir and other student societies can really help with this. Tip two: get to know the staff a bit more. Medical school is not like high school. We're all in this together, so come to drop-in, say hello, bring baking. We love getting to know you all and we are here to help in any way we can.

The Wolfson Medical School Building[1].

4) Having been elected honorary president of MedChir for 25/26, you clearly have strong ties with the society and enjoy MedChir revue. What is your favourite Medchir memory?

Honestly, it was such an honour to be asked. Thank you so much. That in itself is a memory I will treasure for a long time. However, some other favourites….. any performance by the netball girls or Tragic Mike at the Medchir Revue, actually the Medchir Revue in general – what a great night!, and some memories of very 'vigorous' ceilidh dancing with rugby players! Enough said.

5) Got any favourite eateries or bars/pubs in the Glasgow?

Too many: Crabshakk for great seafood, Ka Pao for the set menu (and no it is not too much food), GaGa (great food and atmosphere), and Sylvan (food is amazing and they make a pretty good cocktail too).

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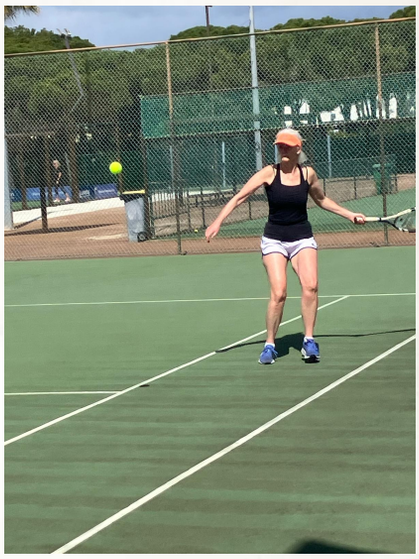

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Interested? Email surgo_uofg@yahoo.com with your article idea or visual abstract and the team will be in touch.

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AN INTERVIEW WITH PROFESSOR PAUL GLEN

By Innes Crawford

Professor Paul Glen is an upper gastrointestinal surgeon who works at the Queen Elizabeth University Hospital, with interests in oesophageal cancer, cancer palliation, Barrett's oesophagus and ERCP. He also holds the position of Honorary Clinical Associate Professor at Glasgow Medical School and is Year 4 lead. We caught up with Professor Glen earlier this month with to learn a bit more about his work and how he ended up as such a well-known face at MedChir.

1) What got you into medicine, was it always a long-term ambition or did it come later at School/was there a lifetime event that motivated you?

I went to school in Strathaven and there weren't loads of people that studied medicine or law from there, but I was good at science and was advised that medicine would be a good thing to go for. Noone in my family was a doctor so the only things I knew about it was what I had seen on television dramas or in books. It seemed like a good thing to go for so I applied for medicine. I didn't get accepted to Glasgow at first, I think because one of my Highers was Music, but my school Chemistry teacher Mr Steele wrote a letter on my behalf and I was offered a place in Glasgow. This was my preferred choice and I thought it would have been a bit warmer than Aberdeen who had accepted me, Music higher and all.

2) At medical school I see you were once a president of MedChir, have you any highlights from your time on committee?

When I was at medical school, I wasn't the hardest worker or getting the highest marks in exams but I did really like the social aspect of the school and the job. I went to the MedChir day in freshers week and was amazed that all the clinical year students would speak to the new people and made quite a few friends across the years that year. MedChir was great for getting to know people in your own year and in the years above and below. In third year I knew pretty much all of my year, and a good number of people in the two years above and two years below. This made nipping out to the shop a bit tricky as I would bump into so many people I knew and sometimes get waylaid and dragged into the union. I loved the Revue and our year would get together on Saturdays to start writing our sketches from January onwards to try and win. In those days each year was allocated 20 minutes and had to perform and keep the attention of the quite demanding audience.

3) Becoming an upper GI general surgeon must have been a demanding training pathway across many years. During that time what has changed and what are you yet to see advance?

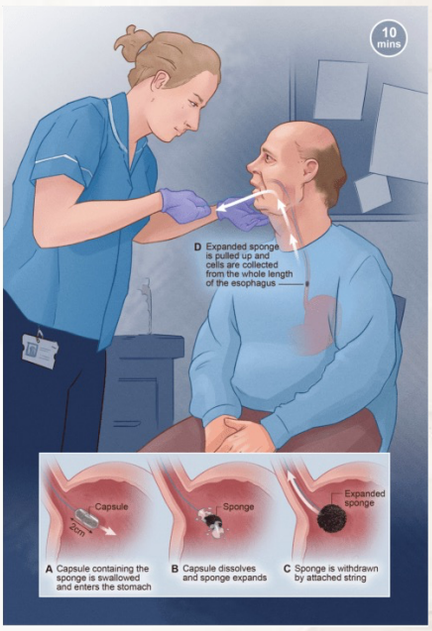
I was attracted to upper GI surgery by the variety of options we had for treatment. For example, gallstones may require medical treatment, endoscopic treatment, laparoscopic surgery or open surgery and I like having the ability to offer all these and work out with the patient what is the best option for them. One thing I have noticed is that surgery for quality of life, which is a large part of my work, has been given less priority. I operate on patients with difficulty swallowing, bad reflux or stomachs that don't empty and this is a significant impact on quality of life but patients will not die because they don't get an operation. Whenever there is a list that requires cancelled due to lack of beds or lack of staff and my colleagues have cancer operations, it is my lists that suffer and we do see patients waiting for up to two years for quality of life surgery. I think we will see a move from procedures that require hospitalisation; towards endoscopic or day case surgery treatment for these conditions due to the pressures on acute hospital beds.

4) Tell us about the Cytosponge and it's role in your clinical practice.

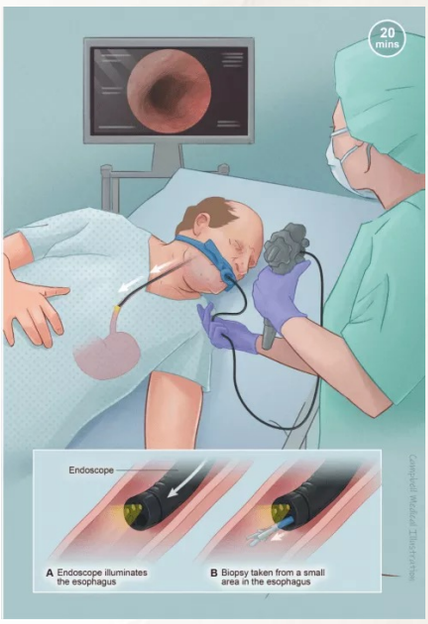
Sponge sampling of the oesophagus has been about for a while but only used in the trial setting. A sponge, compressed in a gelatin capsule attached to a bit of string is swallowed and the capsule dissolves in the stomach. The sponge expands and samples the oesophagus on the way up as it is pulled out. When COVID happened I was worried about all the patients with Barretts out there as we were not doing any elective endoscopy at all, only emergency, and a number of them would have worsening pathology.

The cytosponge is a small capsule that expands into a sponge when swallowed[1].

We introduced sponge testing across Scotland and published our outcomes in the real world setting. We know oesophageal adenocarcinoma has a very poor outcome and that it has this at least 10 year lead condition of Barretts. Anything we can do to identify it earlier, without overburdening our endoscopy service, is important in improving outcomes.



Cytosponge offers minimally invasive surveillance which can be performed in primary care[2].



Traditional screening for Barrett's involves endoscopy often under sedation[2].

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MS SOCIETY WALK
A STUDENT PERSPECTIVE ON ADVOCACY AND COMMUNITY HEALTH

By Shaha Alajeel

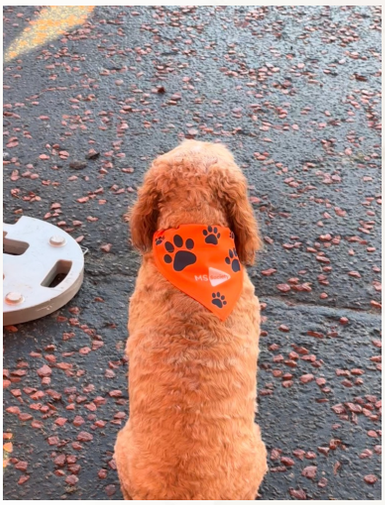
The MS Society Walk in Glasgow began with an early morning briefing, where participants gathered at the Nelson Monument in Glasgow Green, designated as the main meeting and start point for the event. Volunteers were given an overview of the day's structure, allocated their specific roles, and briefed on ensuring attendees' safety and accessibility. The event brought together over 300 participants who completed 1km, 5km, 10km and 20km routes, all starting and finishing within Glasgow Green.

One of the most meaningful and impactful aspects of the day was meeting organisers, volunteers, and participants, many of whom were personally affected by multiple sclerosis (MS), whether through living with the condition themselves or supporting close family members and loved ones. MS is a chronic autoimmune disorder characterised by inflammatory demyelination within the central nervous system, leading to variable neurological symptoms including sensory, motor, cognitive, and visual impairment[1+2].Engaging directly with people affected by the condition emphasised the variability of disease progression and the day-to-day functional obstacles and limitations that are often underrepresented and overlooked in clinical teaching.

One volunteer shared their aspiration to build a career in speech and language therapy, with a focus on neuro-rehabilitation, specifically supporting individuals with MS in managing dysarthria and dysphagia, as well as broader communication challenges.[2,3] This reinforced the value and necessity of multidisciplinary care in long-term management of neurological conditions, where healthcare workers, like physiotherapists, occupational therapists, speech and language therapists, neurologists, and specialist nurses, all work collectively to enhance overall wellbeing rather than only focusing on pharmacological treatment.[4] Through these conversations, I learned how clearly defined professional roles within the MDT translate into coordinated patient-centred care, thereby reinforcing the role of collaborative practice beyond theoretical teaching.

From a public health standpoint, this event also demonstrated how community-based initiatives can raise awareness, combat stigma, and promote physical activity across a broad population. Such events contribute to research, educational programmes, and patient support services, all directed to enhancing early diagnosis and long-term disease management.

All in all, the experience offered a valuable reminder that medicine extends beyond hospital settings. Engaging with patients and advocacy organisations, like the MS Society, in community spaces gives us the opportunity to better understand the lived experience of chronic disease, and underscores the importance of holistic, compassionate care in future clinical practice.



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MEDICINE BEYOND THE HOSPITAL
BROADENING HORIZONS IN MEDICINE

By Shaha Alajeel

When medical students picture their future careers, the hospital ward or clinic is often the first place that comes to mind. Yet, modern medicine stretches further beyond these familiar environments. From aviation to remote expeditions, disaster zones, and hyperbaric chambers, clinicians are increasingly practising in fields that challenge conventional definitions of clinical care. Exploring these emerging areas underlines the range of opportunities within medicine and encourages a wider perspective on where medical training can lead.

One such area that exemplifies this breadth is aerospace medicine, which focuses on the health and performance of individuals working in aviation and spaceflight environments. Practitioners in this field evaluate pilots' fitness to fly, assess the physiological effects of acceleration and altitude, and contribute to operational safety within both commercial and wider flight aviation. As interest in commercial spaceflight and long-duration missions continues to grow, aerospace medicine is garnering increasing recognition as an emerging speciality.

Wilderness and expedition medicine represents another emerging speciality, in which clinicians deliver care in remote or extreme environments where access to conventional healthcare may be restricted. Clinicians in this field support humanitarian missions, research expeditions, and high-altitude or polar exploration. The speciality demands adaptability and strong clinical judgement, often in resource-limited settings. Such experiences underscore the critical role of resilience, preparation, and interdisciplinary collaboration in providing beyond traditional clinical settings.

Closely connected to these fields is humanitarian and disaster medicine, which revolves around delivering care in areas impacted by humanitarian crises, including conflict, force displacement, and natural disasters. Clinicians working in this speciality may operate in low-resource, unstable environments, where adaptability and rapid decision-making are crucial

Undersea and hyperbaric medicine portrays another example of how medical practice can stretch beyond standard clinical settings. This speciality involves the management of diving-associated conditions alongside the therapeutic use of hyperbaric oxygen within dedicated clinical environments. Practitioners often rely on the collaboration of surgery, emergency medicine, and rehabilitation services, thus establishing the multidisciplinary character of care within specialised physiological settings.

Together, these specialities and many others like them, echo the diversity of modern medical careers and the versatility of medical training, from aviation and exploration to humanitarian and remote medicine. Exposure to these fields during medical school may be limited; however, student societies, electives, and academic initiatives continue to create opportunities for exploration, all of which broaden students' perspectives and emphasise the plethora of ways clinical knowledge can be applied beyond the hospital.

As medicine evolves, so do technological advancements, global mobility, and the environments in which healthcare professionals practise. Learning about these diverse fields allows students to approach career planning with greater openness and curiosity. Recognising the scope of opportunities within medicine broadens professional horizons while underscoring the adaptability and evolving relevance of medical training in an increasingly interconnected world.

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WHAT'S ON THIS SEMESTER?

SAVING LIVES THROUGH STEM CELL DONATION: AN INTERVIEW WITH HANNAH HALL

By Shaha Alajeel

Anthony Nolan is at the forefront of stem cell donor recruitment across the UK. We spoke with Hannah Hall, a University Coordinator, about how students are getting involved, the ongoing donor shortage, and the powerful impact of stem cell donation.

Anthony Nolan is widely known for its stem cell donor registry, but its work extends well beyond this. Could you give a brief overview of the organisation's core mission, and could you tell us a little bit about your role as University Coordinator?

Anthony Nolan's core mission is to save and improve the lives of people with blood cancer and blood disorders through stem cell transplantation and cellular therapies. But, while many people recognise us for running one of the world's leading stem cell donor registries, our work also includes funding ground-breaking research, providing specialist post-transplant nursing support, influencing policy, and offering vital patient and family services.

As the University Coordinator, my role focuses on recruiting students to the stem cell register through our student network, 'Marrow'. We currently have around 40 Marrow groups at universities across the UK. My team supports our student volunteers to run events on campus to recruit potential stem cell donors. My job is very varied, with lots of opportunities to travel to support at events, and I love working with our passionate and inspiring volunteers. What makes it especially rewarding, is that our impact feels very tangible, with 1 in 100 of the people we recruit at universities will go on to donate their stem cells to a patient in need! Research shows that younger donors provide better outcomes for patients, so it's really vital we do this work to reach young people!

Despite growing public awareness, stem cell donor shortages persist as a significant challenge. From your viewpoint, what continues to limit donor recruitment?

Most of the people we talk to have never heard of the Anthony Nolan stem cell register, so a lot of my work is about raising awareness!

There are also lots of misconceptions about the donation process, nowadays nine out of ten donations are done via the blood stream and only one in ten require an operation to extract the stem cells.

Young people also have increasingly busy lives and many competing priorities so joining the stem cell register may not feel urgent or personally relevant.

Ethnic disparities in donor matching continue to be a recognised challenge in stem cell transplantation. How does Anthony Nolan work to overcome this, and how can universities help with improving diversity within donor registries?

Patients are most likely to match with someone from a similar ethnic background, yet the registry does not currently reflect the full diversity of the UK population. Anthony Nolan works with diverse partner organisations to build trust and raise awareness, which is particularly important for communities who may feel disconnected from medical institutions or unaware of the pressing need for more diverse donors.

Universities can play a pivotal role here too, as they are naturally very diverse institutions. Marrow groups often make a conscious effort to collaborate with cultural and faith societies, ensuring recruitment drives are inclusive and visible across diverse student groups.

University-based recruitment is central to Anthony Nolan's work. Beyond the increase in donor numbers, how does student engagement play a part in the wider culture of health advocacy and awareness on campus?

When students engage with our volunteers and consider joining the stem cell register, it often opens the door to wider conversations about health, cancer, and how they can make a difference. A conversation at a donor recruitment stand about stem cell donation can prompt someone to consider giving blood, talking to their relatives about organ donation, or getting involved in other forms of volunteering and advocacy.

We encourage our Marrow volunteers to be both advocates and educators on campus. Through our training and resources, we provide them with insights into the behind-the-scenes work at Anthony Nolan, the science of transplantation, and the stories of our patients and donors, so that they feel confident to lead these conversations with their peers.

Your work involves engaging directly with students across a number of institutions. What have you found to be most effective when it comes to motivating young people to engage with donation and advocacy initiatives?

I've found that the most effective way to engage students comes down to three things. Firstly, enthusiasm and emphasising the life-changing impact that signing up asa potential stem cell donor can have. Secondly, being clear and knowledgeable when explaining the process, sharing the statistics, and letting them know that joining the register only takes a few minutes and a simple cheek swab. Finally, peer-to-peer advocacy works really well. When student volunteers lead events, other students are much more likely to get involved!

For medical students specifically, how can engagement with organisations like Anthony Nolan foster a deeper understanding of transplantation medicine and patient advocacy beyond their curriculum?

Medical students play a crucial part in Marrow and make up a large proportion of our student volunteers. It was a group of medical students who set up Marrow at the University of Nottingham 27 years ago. Marrow has since recruited almost 200,000 potential donors!

For medical students, getting involved with organisations like Anthony Nolan offers opportunities to hear directly from donors, patients, and specialist scientists and clinicians. It helps them deepen their understanding of the matching process, transplantation, and other important factors, such as the psychological impact on patients and donors. We aim to bring these perspectives to our conferences and training days for volunteers.

It also reinforces the importance of advocacy. By learning about the challenges of donor shortages and health inequity, medical students may gain a broader perspective on the systemic barriers that exist in healthcare.

Looking forward, what advances in donor recruitment, transplantation, or student engagement are you most hopeful about in the years ahead?

I'm excited about the opportunity to expand our Marrow network to more universities, reaching even more students and giving them the chance to sign up as potential stem cell donors. Every new

donor added to the register could make a real difference in someone's life, so continuing to grow our presence on university campuses to save more lives is very important.

I'm also hopeful that advances in medical research that will reduce complications with transplantation, which will improve outcomes for patients. We also excitingly opened our cell collection centre in Nottingham last year, which will improve the availability of beds for donors, and help ensure that more successful transplants are able to take place!

Finally, what has been the most rewarding and fulfilling aspect of your work with Anthony Nolan so far?

I love getting out to events and working with our volunteers to sign up potential donors. Knowing that events that I've been to and helped organise have already led to donors being found for patients is an incredible feeling! I also love seeing our volunteers grow in confidence and really flourish during their time as 'Marrowers'.

On a more personal note, I had the opportunity to run the London Landmarks Half Marathon for Anthony Nolan and meeting other runners and being cheered on by colleagues and supporters was a truly magical experience! It really brought home how important the work we do is, and it was very moving hearing the reasons why everyone was running and supporting!

WHO SHOULD WE INTERVIEW NEXT?

Have a say in who we interview in the next edition of Surgo.

Interested? Email surgo_uofg@yahoo.com with your article idea or visual abstract and the team will be in touch.

Don't delay, submit your article today!

AEROSPACE MEDICINE AT THE UNIVERSITY OF GLASGOW

By Andrew Baird

What is Aerospace Medicine?

Aerospace medicine, also known as aviation and space medicine, is the medical specialty concerned with the study of factors affecting the human body in flight. It was recognised as a specialty by the General Medical Council (GMC) in 2016[1,2].

Additionally, aerospace medicine encompasses areas such as medically certifying pilots, aeromedical retrieval, and the design of life support systems for air and spacecraft[1,2]. It is an exceptionally broad field, with considerable overlaps with anaesthetics, critical care, emergency medicine, and primary care[2].

Furthermore, aerospace medicine has links to almost every specialty due to the multisystem effects of flight.

The Contemporary Importance of Aerospace Medicine

For the first time since the Apollo programme, astronauts are preparing to leave low Earth orbit. The United States' National Aeronautical and Space Administration (NASA) is currently aiming to launch its Artemis II mission in April of this year, with astronauts being set to return to lunar orbit. This, alongside Artemis III, which plans to land a crew on the Moon in the next few years, will place human spaceflight firmly back in the public spotlight[3].

In January, an astronaut aboard the International Space Station (ISS) returned to Earth early for medical reasons, marking the first medical evacuation from the ISS[4]. This

NASA's SpaceX Crew-11 shortly after being recovered post medical evacuation[4].

event underscored the importance of aerospace medicine, and that the field is essential to sustaining a human presence in space.

Aerospace medicine sadly remains absent from the curricula of most British medical schools, despite being a GMC-recognised specialty and one of growing importance.

The Society

The Glasgow University Space Medicine Society was founded by Dr Christina Mackaill in 2016. Dr Mackaill has since contributed extensively to the field, including publishing work on methods for CPR in hypogravity and microgravity[5,6].She is currently collaborating on a paper with Dr J.D. Polk, Chief Medical Officer at NASA.

The society later expanded in 2017 to become the Aviation and Space Medicine Society, incorporating aviation medicine due to the significant overlap between the fields, and following the GMC's recognition of Aviation and Space Medicine as a single specialty.

Our Goals

Our primary goal for the society this year is to increase awareness of aerospace medicine and to inspire more students to explore the specialty. It remains a relatively niche specialty, so we aim to build a strong base for the years to come.

We aim to regularly run events to promote aerospace medicine, including hosting speakers across a wide range of topics, spanning both aviation and space domains. We also hope to build the momentum required to host a conference and are open to collaborating with other student aerospace medicine societies to make this a reality.

Per Aspera Ad Astra

As the Artemis era of human spaceflight gets underway, aerospace medicine will only grow in significance.

From the psychiatric challenges of deep spaceflight to the physiological consequences of microgravity, and from high-G physiology to the lifelong monitoring of astronaut health, aerospace medicine occupies a unique position at the intersection of clinical medicine, extreme operational environments, and human spaceflight.

We invite students, medical and otherwise, to explore aerospace medicine as it enters a new era of relevance.

Editor's note: This article was written prior to NASA's February 2026 press conference regarding Artemis III.

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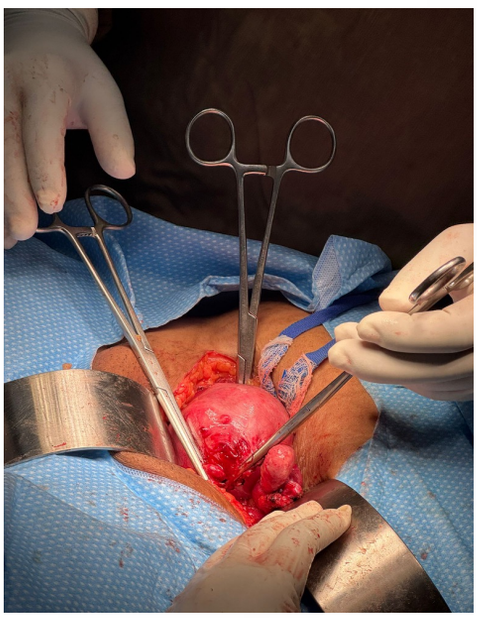
SURGO VISION

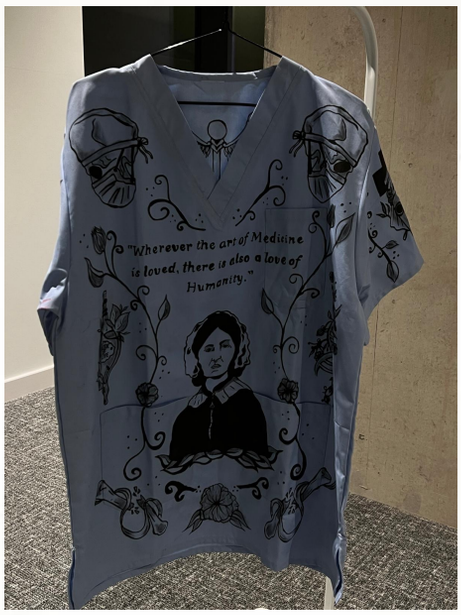


Chloe Danno (Year 4)

During my elective at Mount Hope Women's Hospital in Trinidad, I observed a hysterectomy in which a large 25cm 3 kg uterine fibroid was removed. The case was striking not only for the size of the fibroid but also for what it revealed about disparities in global healthcare access. The patient had endured significant pelvic pain for far longer than would typically be expected in Western healthcare systems due to limited surgical capacity and long waiting lists. Witnessing this procedure was a powerful reminder of how resource availability can shape patient journeys and outcomes. I am pleased to report that the patient made a full recovery following surgery, with complete resolution of her pelvic pain symptoms and proved a powerful personal learning experience.

Denver Correia (Year 3)

For my first clinical placement block, I rotated across the respiratory wards of the Glasgow Royal Infirmary. This was an insightful and incredibly valuable learning opportunity – everyone from the staff to the patients were both supportive and encouraging, allowing myself ample opportunities to develop and solidify my clinical and communication skills. A top placement tip I got told on my first day was – *'Everyone else is also learning when you are on placement, so be proactive, make yourself part of the team, speak up if you have an opinion or question and you'll enjoy every bit of this opportunity'.* These words had an important impact throughout the five weeks and helped me learn much more than I initially thought I would while on the wards. I would highly recommend this!



Shaha Alajeel (Year 3)

Wherever the art of medicine is loved, there is also a love of humanity".

This scrub top represents what drew me to medicine in the first place: a balance between science and humanity. In a field often driven by precision, it is easy to forget that care is also an art, shaped by compassion and connection.

Behind every set of scrubs is more than a student or clinician; there is a story, a purpose, and a set of values. This design is a reminder that medicine is not only about treating disease, but about carrying humanity into every interaction.

VAPING: AN EMERGING MULTI-SYSTEMIC PUBLIC HEALTH CRISIS

By Denver Correia

Walking down a high street anywhere across Scotland, it would be difficult not to notice the bright and attractive vape shops that have quickly sprouted up into business. Developing as an all-round alternative to traditional cigarette smoking, e-cigarettes (or vapes) has been popularised globally since the 2010s, as a cost-effective and innovative substitute. Results from the Office for National Statistics has now estimated that people who use e-cigarettes have outnumbered smokers in the UK; a result driven by using vaping as a smoking cessation tool, alongside lucrative flavours and advertising strategies[1].

While this might not seem concerning, data from the World Health Organization estimates these results to be replicated globally, with around 100 million people worldwide using e-cigarettes[2]. Unsurprisingly, poor initial efforts to tackle the addictive element of vapes, accompanied by its increased reliance as a smoking alternative has expanded the role of vaping beyond its harm reduction benefits. Historically, there was always a consensus among the scientific community that e-cigarettes posed a lower risk than traditional smoking, however, this perspective has now been challenged[3-5].

Vaping has been researched to pose a multi-systemic risk to human health affecting the respiratory, cardiovascular, and nervous system. Several studies have demonstrated that the use of e-cigarettes is linked to an increases in airway irritation, epithelial injury, and arterial stiffness[5]. Interestingly, a recurring finding across research in this field is that the mechanisms through which e-cigarettes impact human health differs significantly from those associated with traditional cigarette smoking.

Evaluating the risk of e-cigarette use in conditions which require a longer latency period, such as cancer, has shown substantial evidence vaping could be linked to an elevation in biomarkers involved in cancer development[6]. Other studies have also demonstrated that the rapid nicotine consumption from e-cigarettes can hamper efforts to quit vaping, inducing a difficult cycle of dependency that has multi-systemic effects from increased anxiety to suicidal tendencies[7,8].

When comparing the risks and adverse events linked with smoking, it might still be accepted that vaping as a smoking cessation tool would render less harm to the user. However, the long-term effects of vaping and the addiction associated with nicotine consumption have not been holistically considered when advancing this argument.

Nevertheless, we need to be proactive – awaiting results from long-term studies on e-cigarette use would hamper any public health benefits that early interventions could offer. If the government wants to reduce the long-term impacts that e-cigarettes can have on public health, immediate action is needed to enforce the recently passed Tobacco and Vapes Bill (2026). Moreover, stricter controls need to be balanced with further regulations that could reduce and limit the use of e-cigarettes across the country.

As a future doctor, my concerns are particularly with the younger e-cigarette users, especially those who live in areas with increased socioeconomic deprivation, have easier access to e-cigarettes and are more likely to suffer the multifactorial impacts of chronic use. Recent evidence from systematic and umbrella reviews indicates that e-cigarette use among young people is associated with a range of adverse outcomes, including later cigarette smoking, alcohol consumption, respiratory issues such as asthma and cough, and poorer mental health[9].

My fears are not limited to Scotland and the United Kingdom; as similar to smoking, I am worried about the impact e-cigarettes can have on people in other countries, particularly those with lax public health polices or fewer government regulations. Educating our future generations and a global call to action are the way forward in our fight against the rise in e-cigarettes.

Finally, universities need to urgently address gaps in knowledge among medical students on the harmful effects of e-cigarettes, the risk of long-term nicotine addiction and the wider health consequences it poses. Education on the rise of e-cigarette or vaping associated-lung injury (EVALI) needs to be further advanced, alongside counselling strategies for patients who are chronic vapers. Providing the next generation of doctors with this training is essential, as new research on the health impacts of vaping continues to emerge[10].

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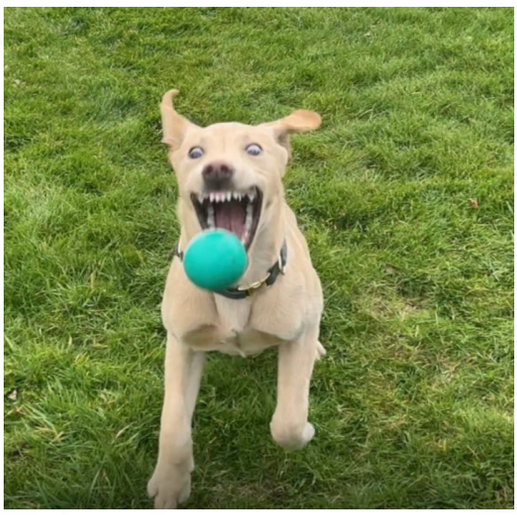
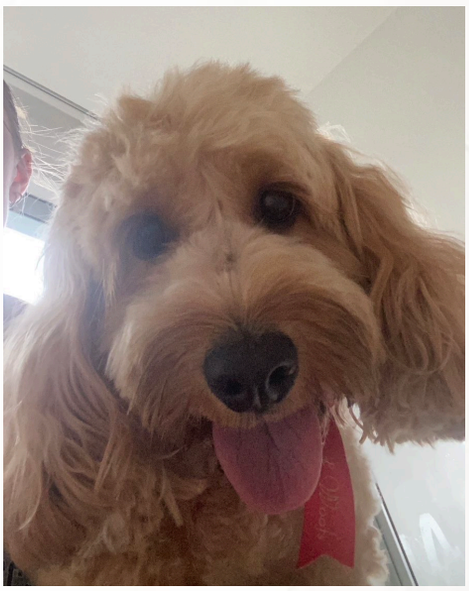
PETS OF THE WOLFSON

Name: Hugo
Owner: Innes Crawford (Year 3)
Age: 9 years old
Funny story: Hugo has the GI tract of a well-oiled incinerator. Over the years he has successfully digested and excreted a bra, multiple socks and an apron.
Editor's note: Since writing, Hugo partially ate two bars of soap. He's fine.

Name: Bruno
Owner: Lily Avenell (Year 3)
Age: 5 years old
Fun fact: Bruno suffers from irritable bowel syndrome (IBS).



Name: Margo
Owner: Aidan Wright (Year 3)
Age: 2 years old
Funny story: Margo once collapsed from exhaustion after playing fetch with a house sitter.

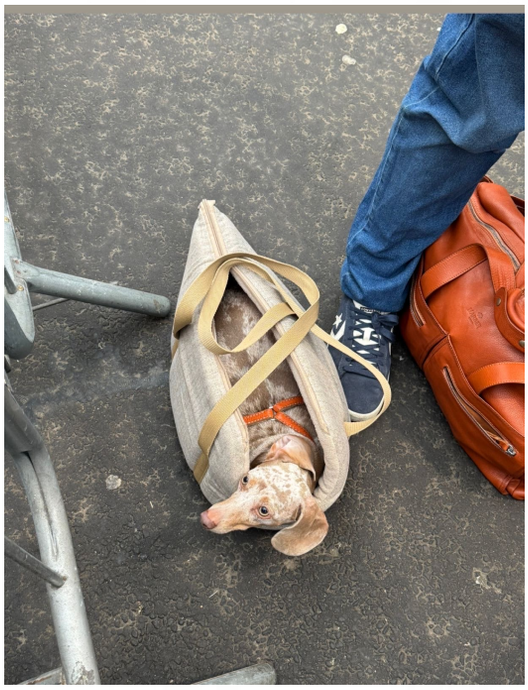


Name: Nessie
Owner: Lucy Campbell (Year 3)
Age: 5 years old
Funny story: Nessie once had to go to the vet because she hit her head of the glass door barking at her own reflection.

PETS OF THE WOLFSON

Name: Scout
Owner: Ben Tait (Year 3)
Age: 1 year old
Fun fact: Scout once ate an entire packet of condoms.

Name: Macleod
Owner: Ellie Hamilton (Year 3)
Age: 11 years old
Funny story: The above photo was taken after Macleod rolled in horse faeces for twenty minutes.



Name: Unknown
Owner: Unknown
Age: Unknown
Funny story: This photo was taken while waiting in Edinburgh for 6 hours for a delayed train, where Yassien (Year 3) decided to take a photo and play with it.

Name: Jess
Owner: Rebekkah Knipe (Year 3)
Age: 11 years old
Funny story: One time when we were camping, she peed on my dad's sleeping bag because it was green thinking it was grass.

TAIL LIGHTS

By Professor Cindy Chew

Happy belated New Year 2026 and Chinese New Year of the Horse! I hope you are all comfortably settled into the hum of the academic year and enjoying the brightening days as we look forward to the arrival of Spring.

I shall attempt to "TikTok"-esque this post.

#1:
"Study the Science of Art. Study the Art of Science.
Develop your senses – especially learn how to see.
Realise that everything connects to everything else."
A popular modern interpretation, Leonardo da Vinci

.

A self-help entrepreneur's post came onto my timeline. I was struck that while the post's primary aim was to generate income (he is a multi-million dollars "solopreneur") – a lot of what he wrote (10 min read) is very applicable to the **study** and **practice** of Medicine! Maybe for some people – even a philosophical take on life. ***Effective learning*** to be a doctor requires more than just attending 1 lecture or reading the companion chapter in Kumar and Clark once. Let me know your thoughts! https://www.x.com/thedankoe/status/2010042119121957316?s=46&t=tG6xqr1eDEm7HBu-BLOiA)

#2:
"To study the phenomenon of disease without books
Is to sail an uncharted sea, while to study books without patients
Is not to go to sea at all."
"Medicine is learned by the bedside and not in the classroom."
Sir William Osler, "Father of Modern Medicine"

Effective learning for a doctor is also about experience - time in service. What we call "***authentic, experiential learning***". (Which is different to the competency-based model). At this early stage in your career – a work around is speaking to experienced doctors, learn from their experiences. *Failing that* – read about it. I was struck this month by Dr David Triska's the harrowing blogs of his experiences as a GP and companion to a relative in hospital ("*The Long Silent Scream into the NHS*"). Check it out and let me know what you think? https://davetriska.substack.com

#3:
"***A diagnosis can be a burden as well as a benefit."***
Trisha Greenhalgh, GP
"The earlier we diagnose, the more we risk turning healthy people into patients."
Margaret McCartney. GP
"The challenge is not simply detecting abnormalities but knowing which ones matter."
Richard Gunderman, Radiologist

In the modern age of resource constraints, it feels very much like imaging is the backstop. The least dangerous thing to do in a less-than-ideal scenario – "let's just do a scan to be sure"-ism. Yet, the Radiology work force is extremely short – with just under 389 in Scotland when 863 is needed by the Government's calculation[1,2]. This leads inevitably to outsourcing reporting to teleradiology companies, large numbers of "incidental findings" (unrelated to why the scan was being performed), with implications on patients worry and harms from follow up investigations and procedures as well as cost to society. The conundrum is discussed in greater detail by prominent Radiology leaders here : https://shorturl.at/1uHBB. Read it and let me know your thoughts. (Ironically – all this contributes towards the GDP... go figure).

Remember to balance work with life. Mark the words of Eric Bane (Dr Sloan, Grey's Anatomy) in his message to his children before his death from ALS. So send in your art or photographs to the ***Surgo Vision competition*** or turn your student audits into ***Visual Abstracts!*** Top 5 submitted get published, win some money AND compete at the end of the year for a further £100 top prize.

Until the next Tail Lights, enjoy the term and good luck with exams!

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