your parachute, are long since gone. Ejection today is done using a series of explosive charges. First the cockpit canopy is blown off, then the seat and occupant explode out as a single entity to be separated later. To prevent any jack in the box manoeuvres while stationary the seat is fixed by a series of pins and my only task in the preflight countdown was to check that all such pins were visible and lined up in front of me. I counted them at least a dozen times.

Sit well back into an easy chair, look over your right shoulder, and watch the world receding at speed and you will probably begin to understand the feelings on take off. Suddenly realising that we were climbing vertically I faced the instruments. The artificial horizon had turned itself inside out and the air speed indicator and the altimeter were chasing each other. I opened my mouth to say to the pilot that my certificate went only to 15 000 ft but he got there before me. As we banked a moment later I first became aware of a gentle hug from my G-suit and from then on the only sensation of gravity was the occasional squeezing and relaxing of my outer garments.

With eyes firmly fixed on the instrument panel orientation in space was no problem and since the outside view was most often vast expanses of nothingness it was almost easier to watch the instruments dancing than to crane my neck. Even when something was pointed out to me I found it took a little time before I actually caught sight of it. If the sensory clues on position—that is, visual, vestibular,

and tactile—all add up to zero then the brain is happy; but if one of them suggests that the flyer is upside down while all the others know that he is upright then emesis occurs. The view was superb. The mountains were about 60 miles away breaking through cloud. As I looked for them the pilot pointed them out. "High, at about 11 o'clock over your left shoulder." I looked up and had been admiring them for a few seconds when my brain worked out that at 12 000 ft I must be looking down on the mountain from above. I threw up.

The ground crew who so lovingly fitted me into my flying gear had, at the same time, warned me that they would be none too pleased if any one of a million knobs and switches were exposed to gastric acidity. In my haste to eject into the little blue bag I completely forgot to switch off the microphone in the face mask. For a few moments the inside of the pilot's dome must have echoed like the sound track of a monster movie. There was a suitable pause, while I recovered breath and composure, before he said, without a trace of a smile in his voice, "Would you like to try a loop?"

The landing was success all the way. While the pilot did all the work I was busy giving thumbs up to the control tower. Rolling to a stop the seat was quickly disarmed and I was let out. Strolling over to the hangar (it is difficult to swagger when clutching a little paper bag) I could not help wondering what effect inside and outside loops would have on a coronary artery bypass graft.

Death in the clouds

RICHARD WAKEFORD

We are half way through the entrée when the call goes out, "If there is a medical doctor on board would he please make himself known to the cabin staff." A quick glance up and down the cabin expecting to see the usual forest of willing medical and paramedical hands, but no one responds.

The cabin staff look anxious. I put an arm out to a hurrying stewardess and say something tentative like: "I'm not a doctor but if it's an issue of resuscitation then perhaps I can help." "Please come," she says. At the back of the aircraft an elderly man, his face an unhealthy colour, is lying on the floor. A stewardess puffs oxygen from a mask towards his face. She is joined by a steward. Together they start to make a fair attempt at mouth to mouth inflation and external cardiac massage.

At the man's head stands another volunteer who looks as uncomfortable as I feel. We exchange credentials. He graduated in medicine from Harvard ten years previously but has never practised medicine. He subsequently qualified as a lawyer. I explain that I am a psychologist who works in medical education research. I have helped develop teaching materials on the management of cardiac arrest, so I may have some relevant skills—I can pass an oropharyngeal tube (on a manikin, anyway).

We take over inflation and massage. It is messy: the man is incontinent. We ask for the medical equipment. A first aid box appears which contains bandages—and a tube, thankfully. The airway clear and tube inserted, we ask what other medical equipment is available to monitor vital signs. There is none.

This is Concorde. At twice the speed of sound the noise level is

high and the floor vibrates. We can detect no cardiac output but suspect that in these surroundings we never would, even with a stethoscope. We can see no spontaneous breathing. We massage and inflate. Nothing. After a while we wonder how long we should go on, how long we could go on. The doctor lawyer is unhappy about being party to this decision. Unqualified to diagnose death and incompetent to do so, I have nevertheless to decide whether to continue—in which case we all go to some God forsaken spot in eastern Canada—or to stop. I remember the lectures and ward rounds at which I have been a "participant observer." Wasn't lack of pupillary reflex a key sign? There is no reflex, nor any other sign. We can detect no life. We stop. The aircraft bends towards New York.

The staff are grateful. No wonder: there are insufficient staff for two of them to spend much time resuscitating passengers, the rest of whom want their coffee and brandy. And the passengers are grateful: Concorde is not going to go to Goose Bay or wherever. You do not pay £1400 to be diverted to Goose Bay.

Emotionally and physically drained, I try ineffectually to clean and tidy the body, but we have not yet finished. "Regulations," we are told, "prohibit an aircraft landing with a body in the gangway. Could you possibly get him back in a seat?" I suggest that this would be inappropriate. So we heave him between the back two rows and struggle to manoeuvre the body so that no part protrudes into the aisle. Concorde shoots past Long Island, lowers its nose, and drops arrogantly on to the runway at Kennedy Airport.

Two armed and bulky New York Port Authority policemen board. They seem to have to bend to push down the gangway to the rear. Key witnesses cannot disembark until statements have been taken down. "What time did the death occur?" "That's difficult, it was over the middle of the Atlantic, whose time do you mean?" But the police are in no mood for quibbling. "American time." The doctor lawyer says medical things to the police. And, after our addresses are taken, we are permitted to go.

In the terminal I sit exhausted with a beer, awaiting my

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connection. Has it all happened? Have I really just flown the Atlantic in three and a half hours, leaving London in the dusk, watching the sun rise out of the west as we raced it? Did I see the sky turn dark purple as Concorde floated up towards space? It is now precisely the time it was when we left England. So the rest, was that real? I want to talk to someone. But I'm far too British, so that must wait until I am with my friend in Boston. She listens and is kind. But sleep comes hard that night.

Weeks later I write to the chairman of British Airways, Lord King. Concorde may well be the only aircraft flying the Atlantic with no health professional aboard, it is so small and expensive. So shouldn't a member of its cabin staff be a nurse? And shouldn't the emergency equipment be better? Lord King writes back at length

with statistics. "In 10 years of Concorde operations your experience was only the second death." Apparently, better equipment is subject to problems and restrictions outside the airline's control. But the airline is considering expanded medical training for some cabin staff "to enable them to function in a paramedical role when required." Perhaps they should also include the emergency medical kit now compulsory on United States aircraft—stethoscope, sphygmomanometer, airways, syringes, and needles.

Better equipment and more fully trained staff might have made "my experience" one that was less characterised by feelings of utter helplessness. They might also have enabled us to do a better job. But they would probably not have prevented one of the most harrowing experiences of my life.

WHO's kidding?

NEW PUBLIC HEALTH FORCEFIELD (Kickbush 1986)

This diagram was prepared by the World Health Organisation. If you did not know that, would you think it was: [Tick one only]

- (a) A page from Leonardo da Vinci's notebooks showing his design for a bow and arrow that shoots round corners ☐
 - (b) A Department of Transport traffic sign erectors' training manual ☐
 - (c) A dish of asparagus spears, peas, diced carrots, and a banana by a trendy chef ☐
 - (d) Stage plan for a production of a hard rock musical based on the *Seven Against Thebes* ☐
- (For one extra point: which are the Seven? Draw symbol here)

Complete the following sentence in not more than 20 words:

I think that the money used in producing meaningless diagrams like this would be better spent on

.....

(Obscene, blasphemous, or libellous suggestions may be disqualified.)

First prize: A crate of Perrier water
 Second prize: Two packets of brown rice
 Third prize: A Brussels sprout

Entries to: The Editor,
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