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EDITORIAL

The Editor's Diary: 7/7–21/7

These two weeks have passed by in a surrealistic haze. On the morning of 7/7 I had a more leisurely start to my Thursday morning than usual and deferred catching the Northern line tube to Warren Street underground station at 0800 in favour of an hour of editorial work at my desk. Just before 0900 my wife warned me that there were problems of an unspecified nature on the underground network, so in spite of the Mayor's £8.00 ($15.00) congestion charge, I drove into work for a private clinic at The Portland Hospital for Women & Children. En route my car radio informed me of the grisly events that were unfolding as a result of four terrorist bombs in central London. By the time I got to my office the London emergency plan had kicked into action, all elective surgery in my hospital had been cancelled and I was asked to hold myself on ''standby''. Meanwhile University College Hospital (UCH), next door had started to admit the worst of the casualties from the atrocities at Edgware Road and Kings Cross stations.

During my *very quiet* clinic (many of my patients couldn't make it because the transport system had shut down) I had time for reflection. ''What earthly use would I be in dealing with this kind of carnage?'' After all, I am semi-retired, I haven't dealt with accident and emergency cases for nearly 30 years and I can't remember when I last 'cracked' a chest. Fortunately I was not called upon; I was not tested and found wanting. Whilst the A&E department at UCH dealt masterfully with their task, my colleagues in the editorial offices of the British Medical Journal (BMJ) were not so lucky. The number 30 double-decker bus exploded in Tavistock Square just before 0900 splattering the façade of BMA house with shrapnel, blood and body parts. According to accounts in the next issue of the BMJ, members of the editorial board rushed out to help the wounded and dying. Some of these desk bound doctors hadn't practiced clinical medicine for years but at least they remembered how to maintain airways, apply pressure to arterial bleeding and set up an IV infusion. I think I might just have been able to do that but I ended the day reminding myself that I was joining the ranks of front line doctors in an urban war against terrorism and should brush up my skills in resuscitation. It also occurred to me that these kinds of episodes shake our complacency as super-specialist surgeons and reinforce the need for general surgical journals such as the one you are reading.

Two days later, I was on my way to the University Hospital of Indianapolis as a visiting professor at the invitation of a very bright young surgical professor Dr. Susan Clare. I was overwhelmed with the kindness and hospitality I received yet bitterly jealous of the wonderful resources, both human and architectural, they had at their disposal. They even have a monorail system built at the cost of $40,000,000, to carry you from one end of the campus to the other! Yet as they were the first to admit, there is an underclass or ''indigenous'' population without health insurance who present with grossly advanced cancers that have been neglected for fear of the costs they might incur. Even in the under funded UK NHS we rarely see such large and fungating breast cancers.

Perhaps the most amazing ''gee whiz'' experience I enjoyed there, was a visit to the University of Indiana's brand new department of bio-informatics. This was a kind of marble Disneyland of special effects. Amongst all the new technology of illustration, education and conceptual modelling, the most remarkable image that remains etched in my memory was that of a ''virtual reality'' human cadaver. To achieve this phantom they relied on a prisoner on death row to donate his body. After

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his execution (don't ask!) his body was fixated and cut up into thousands of thin salami slices. These were all photographed and the body was reconstructed into a virtual three-dimensional world. Using special spectacles I could visualize this phantom floating in front of me. His head could be rotated or tipped at will by moving my hand with a special ''ray gun''. The body could then be dissected in three dimensions either in saggital or coronal section at will. All that was missing, mercifully, was the stench of formaldehyde. Although a brilliant teaching aid, my friends and I had serious ideas for developing this technology for cancer research as an aid to understand the fractal dimensions of tumours.

This then brings me to another meaning of virtual reality; that is the ''virtual community'' in science that has been a consequence of modern IT. Through this technology, like-minded people can work together in any part of the world with the proximity of their ideas being more important than geography. I have certainly found it easier to collaborate with clinical scientists in Australia, USA and India than with say colleagues down the road at Guys or Barts.

Having recovered from my jet lag and caught up on my e-mails (please whoever it is out there, I do not need further supplies of viagra) I set out again to my clinic via Warren Street tube station on the Northern line. This time the bombs failed to detonate properly and we witnessed a suspect being chased into UCH by 300 heavily armed cops. He is still at large and I still haven't had time to revise my resuscitation skills. Is it paranoia or are they really out to get me?

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