Friday May 21st

Workshop on emergency ascent training: Part 2

Chairman	***Gorman and Richardson***
1630-1645	Introduction *(Gorman)*
1645-1715	Diving incidents necessitating an emergency ascent in Australasia *(Acott)*
1715-1745	A training agency perspective of emergency ascent training *(Cummins)*
1800-1845	A medical perspective of emergency ascent training *(Knight and Williams)*
1845-1900	Summary *(Richardson)*
1900-2000	Discussion and formulation of SPUMS policy on emergency ascent training.

Saturday May 22nd

A review of diving and hyperbaric medicine in Australia and New Zealand

Chairman	***Paton***
1600-1630	A progress report on DIMS *(Acott)*
1630-1645	Discussion
1645-1715	A progress report on clinical hyperbaric studies at the Royal Adelaide Hospital *(Williamson)*
1715-1730	Discussion
1730-1800	A progress report on diving medicine studies in the Royal New Zealand Navy *(Gorman)*
1800-1815	Discussion

LETTERS TO THE EDITOR

LAMBADA DANCING ON A TIGHTROPE

NATIONAL ASSOCIATION OF SCUBA DIVING SCHOOLS-AUSTRALASIA INC.
Unit 7/15 Walters Drive
Osborne Park, W.A. 6017

Dear Editor,

I write in response to Dr Des Gorman's editorial "Lambada Dancing on a Tightrope''[1].

During the preparation of the AS4005.1 NASDS consistently voted in favour of a mandatory medical examination for all candidates for scuba diving instruction. Indeed, Dr John Knight[2] mentioned NASDS' consistent support.

For at least the last 14 years NASDS has maintained a mandatory standard which requires all recreational divers trained by NASDS (FAUI) to have completed a comprehensive medical. The maintenance of this standard has perhaps been to our commercial detriment.

The NASDS medical standard was at first based on the AS2299 diving medical. Subsequently minor variations were made and did not vary in any substantial manner from the SPUMS endorsed medical[3] or the ultimate Australian Standard format published in AS4005.1.

NASDS strongly believes and recommends that all diving medicals should be carried out by physicians trained in diving medicine. Our failure to vote for this as a requirement for AS4005.1 was based on practical issues and not on a divergence of philosophy. Any requirement to make compulsory the conduct of diving medicals by diving doctors was, in our view, unworkable. Even today, there appear to be too few physicians trained in diving medicine. Until such time as more trained physicians are available, which we hope is not too far away, the compromise of providing the general practitioner with solid guidelines to conduct diving medicals is the only realistic choice.

We admit that our funding of DES has been spasmodic. This has been due to tough economic times. In any event we have managed to pay many thousands of dollars to DES. NASDS has always made donations free of any strings and currently NASDS maintains a fifty cent levy on a diver's entry level certification.

At the time of developing the current funding support for DES, NASDS was promised, as were the other agencies, access to data compiled through the Australian Patient Safety Foundation (APSF) Critical Incident Monitoring programme. These are statistics which the agencies need to gauge the effectiveness of their instruction and are generally more useful than reports on accidents (deaths). To date, only one such report has been received[4] by NASDS and that was in January 1990.

Dr Gorman's comments on the sale by NASDS of DCIEM Tables are at best described as his side of this complex issue. Unfortunately there is neither the time or the space in this letter to fully detail all aspects of this matter. Suffice to say that conflict between APSF and NASDS arose when both parties could not achieve a mutually beneficial business arrangement for the sale of the DCIEM tables.

Given NASDS' history of no-strings-attached financial support for DES, our continued endorsement of DES, our consistent commitment to diving safety through the promotion of the DCIEM Tables, and our earlier attempts to reach a commercial compromise with RAH/APSF, Dr Gorman's comments were totally uncalled for.

NASDS has for many years been an associate member of SPUMS and a keen supporter of the Society's goals. Our record of support is probably unmatched by any other certification agency. Our failure to attend annual SPUMS conferences has been due to lack the finance and time. A situation, I'm sure, in which we are not alone.

NASDS believed that we had a close and warm relationship with SPUMS and the medical profession. Dr Gorman's editorial did nothing to contribute to the further development of this relationship. We are disappointed.

Ian Milliner
National Manager, NASDS Australasia Inc.
(Lately Federation of Australian Underwater Instructors)

References

1. Gorman D. Lambada dancing on a tightrope. *SPUMS J* 1992; 22(3) 126-27
2 Knight J. The SPUMS diving medical submission to Standards Australia. *SPUMS J* 1992; 21(4) 231-35
3 *SPUMS Diving Medical*. March 1992.
4 Pilot incident study results. *Divesafe* 1990; No 1 (January): 4-5

MALARIA PROPHYLAXIS

Traveller's Medical and Vaccination Centre
2nd Floor, 393-397 Little Bourke Street
Melbourne, Victoria 3000

Dear Editor,

It was pleasing to read the DES column in the November DIVE LOG Australia Magazine. Some important issues were highlighted concerning diving in areas where chloroquine resistant malaria occurs and they are worth bringing to the attention of SPUMS members.

The first issue is that a range of personal protection measures to avoid mosquito bites is essential and diving medicine practitioners should offer this specific advice to divers at risk.

Secondly, it is reassuring to read the SPUMS statement on the avoidance of mefloquine (Lariam) for malaria prophylaxis for these areas because of its known side effects and adverse reactions. This is consistent with the policy of the Traveller's Medical and Vaccination Centre clinic's throughout Australia, which also supports the use of alternatives to mefloquine for divers. P.N.G., Solomons, Vanuatu, parts of Indonesia and Malaysia and Indo-China all report chloroquine and antifolate drug resistant malaria.

It is worth reminding divers that doxycycline is associated with photosensitivity reactions so a maximum - protection blockout is appropriate for divers using doxycycline.

Lastly, the differential diagnosis of non-specific flu like symptoms of weakness, tiredness, headache; myalgia, vomiting and abdominal pains in diver in tropical areas includes malaria as well as D.C.S. and specific testing for malaria should be performed.

A Gherardin

TRAINING FOR DIVING MEDICALS

Avondale Accident & Medical Clinic
PO Box 19-253, Avondale, Auckland 7
New Zealand

Dear Editor,

As a newcomer to the New Zealand chapter of SPUMS, one who attended its recent annual scientific meeting, I am disappointed that the ANZ diver death series[1] is subject to fallacious interpretation by an apparent majority of Society members.

The study is a retrospective exercise in data collection which is bereft of any mathematics more complex than elementary addition and from which only the most tentative of conclusions can be drawn.

It should not be used to support arguments for compulsory post graduate training of those doctors who wish to conduct recreational diver medicals. Although the authors would have found at least 25% of the (dead) divers medically unfit had they taken a history before the fatal dive, no evidence is presented as to what proportion of a matched population of divers who did not die while diving would have survived such a history taking.

In over half of all divers who died in this series, that event occurred shortly after exhaustion of the air supply (56%), and/or problems with buoyancy (52%), and or/a failure of the buddy system (59%). On this evidence, efforts to prevent deaths in recreational divers should concentrate on reducing the incidence of these precipitating factors by ensuring that all divers receive appropriate training, and that throughout their diving career they continue to dive in accordance with that training.

Rhys Cullen

Reference

1 Edmonds C and Walker D. Scuba diving fatalities in Australia and New Zealand. *SPUMS J* 1989; 19 (3): 94-104.