8807 Wildridge Drive, Austin
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7/5/94

Dear Editor,

Although my practice involves commercial divers, I noted with some agreement the two articles in the March issue concerning diabetic divers. Dr Sullivan's mention of Dr Ken Kizer deserves further comment.

Dr Kizer is a former US Navy diving medical officer; we received our training together. Ten years ago, in a Canadian scuba magazine, he discussed the medical evaluation of diabetics for diving. Kizer outlined six criteria which he believed should make the diabetic acceptable:

- a mature individual who accepts his condition and the need for special care; no evidence of denial or self-destructive tendencies; able to plan and foresee;
- good understanding of diabetes in general and his own case in particular; the interactions of diet, exercise, and insulin;
- physically fit and regularly participating in exercise or athletics without difficulty;
- no evidence of chronic nervous or cardiovascular impairment;
- willing to follow conservative bottom times and diving in general, avoiding tricky or challenging diving;
- finally, a dive buddy who knows and is comfortable with the diver's diabetes and knows how to help if there is an insulin reaction.

As Kizer's writer-successor, I was so impressed with this article that I wrote a follow-up in 1988, adding a few thoughts of my own. Shortly after, I was contacted by a Canadian university diving officer concerning a diabetic marine biologist from Ireland who wanted to come for a year's post-doctoral work. Letters from his general practitioner, diving club, and former university indicated he met the criteria outlined above and had been diving many years with no unusual difficulty.

Assuming the diving officer had firm administrative support, I recommended he allow the scientist to dive. During his time in Canada, there were no problems (with all the diving done in cold water).

Clearly, many diabetics cannot meet these criteria, perhaps most; those who do could be the safest folk in the water. While I do agree with the general prohibition or scepticism regarding diabetics, Kizer's criteria make good sense and can help dissect out those diabetics who are the exception to a sound general rule. As he said himself "Many of these diabetics are active and athletic people who suffer no functional impairment .... not surprisingly, a number are interested in scuba diving".

Gordon Daugherty

ASTHMA AND DIVING

1423 Pittwater Road
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15/5/94

Dear Editor,

It is with some reluctance that I venture to comment on statements made in the recent Journal (March 1994). However, in the interests of accuracy the following points should be discussed as they bear directly on the reputation of the Society.

1 Asthma

It is stated that "Asthmatics are over represented in diving fatalities".[1] This appears to be untrue in relation to Australia and New Zealand. I have copies of the Coronial records of 201 Australian and 120 New Zealand scuba diving related fatalities. In only four of the deaths (Aust SC 81/1, Aust SC 84/5, NZ SC 81/2 and NZ SC84/1) could asthma have been a possible cause of death. In these cases there were significant additional factors present capable of causing the fatal outcome. There were six deaths in Australia and three in New Zealand where there was a definite, or possible, history of asthma but asthma played no part in the incident (see table on pages 29 and 30). These facts should be remembered in any discussion of the fatality rate in asthmatic divers. Naturally there is no information about the participation rate of asthmatics in scuba diving because all such divers are reluctant to reveal their condition to doctors.

2 Data reliability

The statement[2] that "Data can never be true or false and are always subject to criticism and analysis" cannot be allowed to remain unchallenged. Unless it is deliberately false or inaccurately collected, data should be accepted as "true". However it may be incomplete, selectively reported, or wrongly focused, and is always at risk of having invalid conclusions drawn from it.

3 Democratic decision making[2]

The statement that to have a post-workshop vote "would also not favourably weigh informed opinion and be subject to the bias of the writers of the draft, the reviewers of the literature (for the benefit of those not well informed about the subject matter) and the analysers of the consequent correspondence" is a clear declaration that careful discussion of "Workshop" decisions is thought undesirable as different conclusions might be reached. To say that critics have misinterpreted the Policy and to disagree with the findings "is not particularly complimentary to the participants" is to personalise a discussion which should be dealing with facts.

4 Decisions cannot be criticised later

The statement[3] that the majority decisions of the next "Workshop" cannot be subject to the critical examina-