THE WORLD AS IT IS

AUSSIE RULES: A PERSONAL OPINION

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The medical profession is no more exempt from fashions than any other human activity, though some of its beliefs, based on ancient texts whose truths were accepted as gospel, persisted unquestioned for centuries. In more recent times fashions in diagnosis and treatment have come and gone more rapidly but have been as unquestioned for a time, as is any dogma, until successfully challenged. In the 16th century Humours defined a person's state of health. In this century Vitamins, (bowel) Toxins, Stress, Viruses or Free Radicles have each in turn been credited with being THE true cause of disease. Indeed, Nature and Nurture are still fighting for supremacy as being critical in defining an individual, with the new discoveries about genes providing equivocal support to one or other side in turn. Diving medicine has not escaped the curse of Accepted Truths, though this may not be immediately apparent to everyone. And now we have the era of Evidence Based Medicine, which rather unjustly assumes that everyone has, until now, formed their opinions out of thin air, or little better. So how does our (sub) speciality rank in this era of questioning ?

In an unusual example of admitting medical uncertainty, the grand division between a diagnosis of Air Embolism or of Decompression Sickness, which was first declared in the 1930s, has been modified, even if not formally abandoned. It is now considered correct to use the diagnostic label "Decompression Illness" for most cases. The reasoning is that the differential diagnosis may be difficult because the two conditions may co-exist as cause of the symptoms, and the basic treatment is the same for both. An additional reason may be that our understanding of the pathological changes in this syndrome is now accepted as being too simplistic and unable to explain, among other things, the response to delayed recompression. In fact there may be a mix of three significant factors, air emboli, decompression produced gas emboli, and tissue bubbles. But is this reason enough to "change the label" to hide our uncertainty or should it be a spur to further research?

The main problem area, in which there are unresolved differences, in basic diving medicine opinions is in defining minimal medical standards for acceptance for diver training. This is to be expected, because there cannot be an absolute standard to cover every field of human activity. Indeed if there should be such a standard developed it is highly unlikely than any single person would satisfy it! We must live with compromise, accepting that the factors of determination and skill shown by some with "disabilities" will prevent them from being labelled "disabled" from activities they wish to pursue. We need to be careful in use of the label "disability" as this may be true only in the context of the degree in which it is present rather than being an absolute. Unfortunately, Diving Medicine has claimed to be able to define the border between the Medically Fit to Dive and the Unfit to Dive. Unfortunately, because the standards are significantly different in different countries and these differences have not been reconciled.

The power which indoctrination wields over decision makers has been well illustrated during past "Workshop" discussions on the importance of a history of asthma in relation to diver safety. The absence of neutral research into this subject is deplorable, and made the more so because it is generally accepted that there are many asthmatic divers in the real world. One problem is that there is so much logic in banning such persons from diving, using compressed gases, that there has been (and continues to be) a reluctance to consider morbidity and mortality data which could be non-supportive of the belief. The problem has not been made any easier by the past claims by the medical profession to be able to define the cut-off point by a medical examination (both the medical history and physical examination) and the pleasure this has given the diving instructor organisations, their insurers, and the legal profession. These non-medical bodies are only too pleased to allow others (doctors) to assume the responsibility for drawing lines in the sand, possible an appropriate description of basing rigid opinions on an insecure base.

Another matter where diving medicine expertise has intruded has been on whether an out of air ascent should be included as an essential element in primary training. Strongly held views have bedevilled attempts to hold a rational discussion of this problem. Here also reference to morbidity and mortality reports, and the collection and examination of data from incidents where an out-of-air situation occurred should be the basis of any discussion. Consideration should be given to whether the protocols of this "training" can reasonably be considered to actually *train*, as contrasted with allowing the person to experience a controlled and supervised trial ascent.

As long as the diving organisations continue to use the term "Advanced Diver" for those who take a second course immediately after their initial course, there will be doubts about their understanding of the critical factors to diver non-survival, the most significant of which is inexperience. This reflects on the validity of present training protocols. There is no justification, however, for the diving medicine community continuing to drag its feet

in the matter of reviewing the advice it gives on safety matters wherein it should have competence.

Samuel Johnson, the great lexicographer, reportedly noted in 1734 that "it is incident to Physicians, I am afraid, beyond all other men, to mistake subsequence for consequence". In conclusion, let me propose, with due acknowledgment to the advertising agency for the Aussie Rules organisation, a remedy to this criticism he so succinctly encapsulated, that we adopt the advice of their advertising and say:

"Evidence based Diving Medicine? I'd like to see that !"

Dr D G Walker is a foundation member of SPUMS. He has been gathering statistics about diving accidents and deaths since the early 1970s. He is the author of the series of Provisional Reports on Australian Diving-related Deaths which have been published in the Journal covering 1972 to 1992. His address is P.O. Box 120, Narrabeen, N.S.W 2101, Australia. Fax + 61-02-9970-6004.

SPUMS NOTICES

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Requirements for candidates

In order for the Diploma of Diving and Hyperbaric Medicine to be awarded by the Society, the candidate must comply with the following conditions:

1 The candidate must be a financial member of the Society.

2 The candidate must supply documentary evidence of satisfactory completion of examined courses in both Basic and Advanced Hyperbaric and Diving Medicine at an institution approved by the Board of Censors of the Society.

3 The candidate must have completed at least six months full time, or equivalent part time, training in an approved Hyperbaric Medicine Unit.

4 All candidates will be required to advise the Board of Censors of their intended candidacy and to discuss the proposed subject matter of their thesis.

5 Having received prior approval of the subject matter by the Board of Censors, the candidate must submit a thesis, treatise or paper, in a form suitable for publication, for consideration by the Board of Censors.

Candidates are advised that preference will be given to papers reporting original basic or clinical research work. All clinical research material must be accompanied by documentary evidence of approval by an appropriate Ethics Committee. Case reports may be acceptable provided they are thoroughly documented, the subject is extensively researched and is then discussed in depth. Reports of a single case will be deemed insufficient. Review articles may be acceptable only if the review is of the world literature, it is thoroughly analysed and discussed and the subject matter has not received a similar review in recent times.

6 All successful thesis material becomes the property of the Society to be published as it deems fit.

7 The Board of Censors reserves the right to modify any of these requirements from time to time.

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will be held on the island of **Layang Layang**, Malaysia

Friday April 30th to Sunday May 9th 1999

The Guest Speakers will be Dr Richard Moon (USA), who was a guest speaker at the 1997 ASM at Waitangi in New Zealand and Dr Alf Brubakk (Norway), who attended the 1998 ASM in Palau The Convener of the Annual Scientific Meeting is Dr Chris Acott. The provisional title of the theme of the meeting is *Gas bubble injury and its treatment.*

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Speakers at the ASM must provide the printed text and the paper on disc to the Convener before speaking.

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