Economic savings could be made by eliminating the Brighton Executive Centre, transferring their computer to Dr S Paton in Sydney and all mail coming from ACOM to go to the Secretary. Dr Knight presented several budgets for next year with varying increased subscription levels.

It was decided that

1.1 Members would pay $80, Corporations $80, Associates $40.

1.2 The financial and subscription years would be the calendar year from January to December.

1.3 Subscriptions, due in July 1992, would be for eighteen months (to December 1993). Because of the low value of the New Zealand dollar there would be an option for New Zealanders to pay six months and twelve months subscription fees.

1.4 These decisions to be ratified at the AGM.

Meeting closed at 1920.

**SUPPLEMENT TO AS 4005.1-1992**
**Medical form for prospective scuba divers**

Standards Australia has produced pads of 50 copies of the medical form for prospective scuba divers (appendices B and C of AS 4005.1-1992). They are the same as those in the SPUMS Diving Medical (published March 1992).

The pads cost $ 18.00 each (36 cents a form). The catalogue number is AS 4005.1 Supp1-1992. Standards Australia have offices in all capital cities.

# LETTERS TO THE EDITOR

**SPUMS JOURNAL - FOR DOCTORS OR DIVERS?**

Diving Medical Centre
66 Pacific Highway
St Leonards
New South Wales 2065
August 1992

Dear Editor,

In recent journals there has been a disturbing increase in the number of articles by diver training agency representatives.[1,2]

When these people are promoting their own products or attitudes, it would be more fitting for these to be distributed by their agency newsletters or via general diving magazines. Dive instructors and training agencies have far more time to devote to self promotional articles than do hard working physicians. I believe the Journal, for which I have the utmost regard and admiration, would be better served by not assisting these promotions.

In medical journal articles there is usually a presumption of truth. This is often not so with the propaganda from commercial organisations, even those written under the guise of a pseudo-medical discussion.

These articles detract from the value of the Journal and also allow the agency to promote both inaccuracies and falsehoods, often without rebuttal. They are then able to, and do, infer SPUMS endorsement. The commercially orientated authors can quote from the SPUMS Journal, even though they are in fact quoting from their own work. This gives even more authority to their inaccuracies.

I was particularly offended by Mr Cummins' article, which was accepted with minimal critical review, in which he blatantly threatens the DES organisation with reduction of funding if they continue to promote what is internationally accepted as one of the safest decompression tables, that of the DCIEM. He warns us that "agencies do not donate money to competitors", presumably comparing DCIEM to PADI (RDP) tables. In the previous Journal Ray Rogers tried to explain why the RDP was associated with so many decompression sickness cases, but omitting one obvious explanation.

Unfortunately, it is inferred that "he who pays the piper, calls the tune". Both SPUMS and DES have an obligation to divers to promote the tables which they consider the safest, irrespective of the view of any training agency. Also, whether DES combines with the Australian Safety Patient Foundation and/or Dive Safe, should not be determined by a commercial diving organisation.

Some other inconsistencies were evident in the article. He states that "very few, if any, accidents occur in training or under direct supervision of a diving professional". This is certainly promoted in the PADI handbook he referenced. An independent article, written by Dr Robyn Walker[3] in the same SPUMS Journal, described the experience in Townsville in 1990 and demonstrated that "27.5% of

the divers treated for decompression sickness and 50% of the cerebral arterial gas embolism victims were participating in basic certification courses under the direct supervision of a qualified diving instructor". The difference in the two statements is informative. In one case the motivation is advertising and promotion of a diving myth. The other is a presentation of factual data. Unfortunately, as they both occur in the same journal, they are likely to get equal prominence in the memories of the subscribers. No prizes for guessing which one will be quoted to trainees.

Dr RM Walker pointed out that every diver treated for DCS attested that the divers were within the particular table limits. But only in 32.5% were they within the limits of the DCIEM tables. There are also no prizes for guessing which agency tables headed the list for causing DCS.

Mr Cummins' criticisms of medical examinations and the implied value of his agencies questionnaire, as opposed to an examination by a diving medical qualified physician, were unsupported by any data. The facts, supplied by Dr John Parker in his excellent articles on diving medicals[4,5,6] in a previous SPUMS Journal, were not even mentioned, let alone referenced. This was despite the careful analysis of both the value of the medical examination and the relative inadequacy of a PADI "questionnaire".

Agency criticism of the "conditional medical" presumes that the client must only be given an assessment according to what is desired by instructor organisations. I do not doubt that many organisations would prefer medicals performed in a specific manner and in fact the AS 4005.1 is designed for this. Nevertheless the medical is not done as a service to the training agency. It is done as a service to the diver, who is paying for this service. Thus if it is prudent to counsel the diver or potential diver in such a manner as to improve his safety, then this should be done. If it offends the training agency, then so be it. Insurance companies, diving contractors and others who require a medical to be performed as a service to them, pay for it.

Fortunately, Mr Cummins has now reduced his stated cost of the diving medical to $60, as opposed to the $170 that was quoted in his Bulletin article. Presumably it was not possible to persevere with that inaccuracy when confronted with a knowledgeable audience.

Another statement that, "I am aware that no agency included (free ascent practice) in their training", is semantic quibbling. Free ascent practice is still being performed while under instruction, although not always in this guise. Sometimes it is part of, or the result of, "ditch and recovery" (doff and don) or "out of air" ascents. The same dangers exist.

During the same week as the publication of Mr Cummins' paper a legal case, specifically related to dive instructors doing free ascent training, was submitted to me for assessment. Also, that week, PADI took legal action against Dr Douglas Walker, to prevent him from discussing some confidential information on the causes of deaths amongst scuba divers, during his attendance at a Queensland meeting on diving Health and Safety. This was not a good example of the "new age of cooperation", described by Mr Cummins. Nor was his ostracism of Dr Robert Thomas.[7]

I am not in any way criticising individual instructors. My point is that some instructor training agencies are using SPUMS Journal for promoting misleading and sometimes false beliefs. In fact, I think the individual instructors are probably being misled as much as doctors. As Dr R M Walker pointed out, 16% of those treated in Townsville were instructors.

Dr A Sutherland, in the same journal, described two cases of air embolism during scuba training in swimming pools. One of Dr RM Walker's cases was of a similar nature. The instructors are at similarly great risk, as demonstrated by "Project Stickybeak" statistics[8] and those of the deaths amongst recreational divers and instructors, described elsewhere.[9]

It is for this reason that I would encourage individual instructors, not the prodigious instructor agencies, to be associate members of SPUMS. Unfortunately, at this stage, they are likely to read, and get support for, their own agencies propaganda in our Journal!

I am aware that because I have publicly disagreed with the PADI propaganda, I am now likely to be lumped with Dr Bob Thomas as a contemptible "high profile diving medical personality", or receive a threat of legal action or a solicitor's letter, like Dr Douglas Walker. I am proud to be associated with both. I do not represent SPUMS (nor did Dr Thomas), but (like Dr Walker) I do believe that, in the interests of diving safety, I should not be intimidated into silence.

Diving doctors should strive for diver safety, whether it involves dive table recommendations, training contributions to diving accidents, treatment facility availability, medical standards or "conditional" medicals. I think these should be decided on the basis of what is best for the diver, and not what is best for one training agency. Perhaps we also should not "promote the opposition."

Carl Edmonds
Director
Diving Medical Centre

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## DIVERS' EARS

Whitsunday Diving Medical Centre
P.O. Box 207, Airlie Beach
Queensland 4802
10 July 1992

Dear Editor,

On a recent two day diving trip on the Great Barrier Reef with 20 recreational divers, (19 of whom had medical or nursing qualifications), every diver had their ears examined before diving commenced and after all diving had ceased.

The group consisted of 9 males and 11 females with varied diving experience.

| Number of dives | Number of divers | Percentage |
|---|---|---|
| 1 - 10 | 9 | (45%) |
| 11 - 50 | 8 | (40%) |
| 50 plus | 3 | (15%) |
| | 20 | |

Diving the weekend the divers had an average 5.3 dives (range 2-7).

Of the 20 divers 5 (25%) had symptoms of aural barotrauma of descent. Only one had to stop diving prematurely. At the end of all diving 10 (50%) divers were seen, on direct inspection of the tympanic membrane, to have aural barotrauma involving 16 ears.

| Grade | Ears affected | Symptomatic ears |
|---|---|---|
| 1 | 11 | 2 |
| 2 | 1 | 1 |
| 3 | 4 | 2 |
| **Total** | **16** | **5** |

The 10 divers with aural barotrauma came from all the experience groups in approximately the same ratios in the group.

| Number of dives | Divers affected | Percentage |
|---|---|---|
| 1 - 10 | 5 | (50%) |
| 11 - 50 | 4 | (40%) |
| 50 plus | 1 | (10%) |

It was interesting to note that over the weekend 5 divers were taking Sudafed tablets for symptoms of mild upper respiratory tract congestion. Of these 5 divers, 3 suffered aural barotrauma, 2 with symptoms, but no one had to stop diving prematurely.

Also interesting was that 7 divers used transdermal hyoscine (SCOP) patches as prophylaxis for sickness despite a favourable weather forecast.

Although anecdotal this weekend demonstrated that
1 Aural barotrauma is very common in recreational diving despite diving experience (and medical knowledge).
2 Subclinical aural barotrauma is also very common.
3 Grade 1 aural barotrauma can be symptomatic and grade 3 can be asymptomatic.
4 Decongestants (especially pseudoephedrine preparations) and transdermal hyoscine are commonly used by divers.

John Parker

## HIGH TECH DIVING

### A response to the editorial in the Jan-Mar 1992 SPUMS Journal.

Hamilton Research Ltd
80 Grove Street, Tarrytown
New York, 10591-4138
5 August 1992

Dear Editor,

The essay on "high tech" diving by Des Gorman in the 1992 Jan-Mar issue of *SPUMS Journal* stands firmly as the opinion of one of the most knowledgeable and respected members of the international diving community and would not normally require a response. However, the essay mentions my involvement, and lest by default I be assigned the role of the villain in the piece, I feel a response is necessary. That involvement, by the way, has not been very great in Australia, but I seem to have found myself in the middle of several issues in the US related to technical and special mix diving, some of which deserve discussion.