

REDUCED GRADIENT BUBBLE MODEL: DIVING ALGORITHM, BASIS, AND COMPARISONS

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INTRODUCTION

Diving models address the coupled issues of gas uptake and elimination, bubbles, and pressure changes in different computational frameworks. Application of a computational model to staging divers is called a diving algorithm. The Reduced Gradient Bubble Model (RGBM) is a modern one, treating the many facets of gas dynamics in tissue and blood consistently. Though the systematics of gas exchange, nucleation, bubble growth or collapse, and decompression are so complicated that theories only reflect pieces of the decompression sickness (DCS) puzzle, the risk and statistics of decompressing divers are straightforward. And folding of DCS risk and statistics over data and model assumptions is perhaps the best means to safety and model closure.

Let us first consider DCS risk, and then take a look at the RGBM against that background. The RGBM uses risk analysis to fit its model parameters optimally to DCS data. That tightens model dynamics to field incidence of DCS.

STATISTICS AND RISK ANALYSIS

Computational algorithms, tables, and manned testing are requisite across a spectrum of activities. And the potential of electronic devices to process tables of information or detailed equations underwater is near maturity, with virtually any algorithm or model amenable to digital implementation. Pressures for even more sophisticated algorithms are expected to grow.

Still computational models enjoy varying degrees of success. More complex models address a greater number of issues, but are harder to codify in decompression tables. Simpler models are easier to codify, but are less comprehensive. Some models are based on first principles, but many are not. Application of models can be subjective in the absence of definitive data, the acquisition of which is tedious, sometimes controversial, and often ambiguous. If deterministic models are abandoned, statistical analysis can address the variability of outcome inherent to random occurrences, but so called dose-reponse characteristics of statistical analysis are very attractive in the formulation of risk tables. Applied to decompression sickness incidence, tables of comparative risk offer a means of weighing contributing factors and exposure alternatives. At the basis of statistical and probabilistic analyses of decompression sickness is the binomial distribution. The binomial distribution is the fundamental frequency distribution governing random events:

DCS Binomial Risk

Decompression sickness is a hit, or no hit, situation. Statistics are binary, as in coin tossing. Probabilities of occurrence are determined from the binomial distribution, which measures the numbers of possibilities of occurrence and nonoccurrence in any number of events, given the incidence rate. Table 1 lists corresponding binomial decompression probabilities, $P(n)$, for 1% and 10% underlying incidence (99% and 90% nonincidence), yielding 0, 1, and 2 or more cases of decompression sickness. The underlying incidence, p , is the (fractional) average of hits. As the number of trials increases, the probability of 0 or 1 occurrences drops, while the probability of 2 or more occurrences increases. In the case of 5 dives, the probability might be as low as 5%, while in the case of 50 dives, the probability could be 39%, both for $p = 0.01$. Clearly, odds even percentages would require testing beyond 50 cases for an underlying incidence near 1%. Only by increasing the number of trials for fixed incidences can the probabilities be increased. Turning that around, a rejection procedure for 1 or more cases of decompression sickness at the 10% probability level requires many more than 50 dives. If we are willing to lower the confidence of the acceptance, or rejection, procedure, of course, the number of requisite trials drops. Table 1 also shows that the test practice of accepting an exposure schedule following 10 trials without incidence of decompression sickness is suspect, merely because the relative probability of nonincidence is high, near 35%.

Questions as to how safe are decompression schedules have almost never been answered satisfactorily. As seen, large numbers of binary events are required to reliably estimate the underlying incidence. One case of decompression sickness in 30 trials could result from an underlying incidence, p , bounded by .02 and .16 roughly. Tens more of trials are necessary to shrink those bounds.

Table 1. Probabilities Of Decompression Sickness For Underlying Incidences

N (dives)	n (hits)	$P(n)$	$P(n)$
		$p = .01$ $q = .99$	$p = .10$ $q = .90$
5	0	.95	.59
	1	.04	.33
	2 or more	.01	.08
10	0	.90	.35
	1	.09	.39
	2 or more	.01	.26
20	0	.82	.12
	1	.16	.27
	2 or more	.02	.61
50	0	.61	.01
	1	.31	.03
	2 or more	.08	.96

Biological processes are highly variable in outcome. Formal correlations with outcome statistics are then generally requisite to validate models against data. Often, this correlation is difficult to firmly establish (couple of percent) with fewer than 1,000 trial observations, while ten percent correlations can be obtained with 30 trials, assuming binomial distributed probabilities. For decompression analysis, this works as a disadvantage, because often the trial space of dives is small. Not discounting the possibly small trial space, a probabilistic approach to the occurrence of decompression sickness is useful and necessary. One very successful approach, developed and tuned by Weathersby, and others for decompression sickness in diving, called maximum likelihood, applies theory or models to diving data and adjusts the parameters until theoretical prediction and experimental data are in as close agreement as possible.

Validation procedures require decisions about uncertainty. When a given decompression procedure is repeated with different subjects, or the same subjects on different occasions, the outcome is not constant. The uncertainty about the occurrence of decompression sickness can be quantified with statistical statements, though, suggesting limits to the validation procedure. For instance, after analyzing decompression incidence statistics for a set of procedures, a table designer may report that the procedure will offer an incidence rate below 5%, with 90% confidence in the statement. Alternatively, the table designer can compute the probability of rejecting a procedure using any number of dive trials, with the rejection criteria any arbitrary number of incidences. As the number of trials increases, the probability of rejecting a procedure increases for fixed incidence criteria. In this way, relatively simple statistical procedures can provide vital information as to the number of trials necessary to validate a procedure with any level of acceptable risk, or the maximum risk associated with any number of incidences and trials.

One constraint usually facing the statistical table designer is a paucity of data, that is, number of trials of a procedure. Data on hundreds of repetitions of a dive profile are virtually nonexistent, excepting bounce diving perhaps. As seen, some 30-50 trials are requisite to ascertain procedure safety at the 10% level. But 30-50 trials is probably asking too much, is too expensive, or generally prohibitive. In that case, the designer may try to employ global statistical measures linked to models in a more complex trial space, rather than a single profile trial space. Integrals of risk parameters, such as bubble number, supersaturation, separated phase, etc., over exposures in time, can be defined as probability measures for incidence of decompression sickness, and the maximum likelihood method then used to extract appropriate constants:

Table Risk

A global statistical approach to table fabrication consists of following a risk measure, or factor p , throughout and after sets of exposures, tallying the incidence of DCS, and then applying maximum likelihood to the risk integral in time, extracting any set of risk constants optimally over all dives in the maximization procedure. In analyzing air and helium data, Weathersby (USN) assigned risk as the difference between tissue tension and ambient pressure divided by ambient pressure. One tissue was assumed, with time constant ultimately fixed by the data in ensuing maximum likelihood analysis. Hundreds of air dives were analyzed using this procedure, permitting construction of decompression schedules with 95% and 99% confidence (5% and 1% bends probability). These tables were published by US Navy investigators, and Table 2 tabulates the corresponding nonstop time limits ($p = 0.05, 0.01$), and also includes the standard US Navy (Workman) limits for comparison. Later re-evaluations of the standard set of nonstop time limits estimate a probability

rate of 1.25% for the limits. In actual usage, the incidence rates are below 0.001%, because users do not dive to the limits generally.

Table 2. Nonstop Time Limits For 1% And 5% DCS Probability

depth d (fsw)	nonstop limit t_n (min) $p = .05$	nonstop limit t_n (min) $p = .01$	nonstop limit t_n (min) US Navy
30	240	170	
40	170	100	200
50	120	70	100
60	80	40	60
70	80	25	50
80	60	15	40
90	50	10	30
100	50	8	25
110	40	5	20
120	40	5	15
130	30	5	10

Implicit in such formulations of risk tables are the assumptions that a given decompression stress is more likely to produce symptoms if it is sustained in time, and that large numbers of separate events may culminate in the same probability after time integration. Though individual schedule segments may not be replicated enough to offer total statistical validation, categories of predicted safety can always be grouped within subsets of corroborating data. Since the method is general, any model parameter or meaningful index, properly normalized, can be applied to decompression data, and the full power of statistical methods employed to quantify overall risk. While powerful, such statistical methods are neither deterministic nor mechanistic, and cannot predict on first principles. But as a means to table fabrication with quoted risk, such approaches offer attractive pathways for analysis.

For the past 10-15 years, a probabilistic approach to assessing risk in diving has been in vogue. Sometimes this can be confusing, or misleading, since definitions or terms, as presented, are often mixed. Also confusing are risk estimates varying by factors of 10 to 1,000, and distributions serving as basis for analysis, also varying in size by the same factors. So, before continuing with a risk analysis of recreational profiles, a few comments are germane.

Any set of statistical data can be analyzed directly, or sampled in smaller chunks. The smaller sets (samples) may or may not reflect the parent distribution, but if the analyst does his work correctly, samples reflecting the parent distribution can be extracted for study. In the case of dive profiles, risk probabilities extracted from sample profiles try to reflect the incidence rate, p , of the parent distribution (N profiles, and p underlying DCS rate). The incidence rate, p , is the most important metric, followed by the shape of the distribution in total as measured by the variance, s . Smaller samples might be used to estimate risk, via sample incidence, r , with samples possibly chosen to reduce computer processing time, overestimate p for conservancy sake, focus on a smaller subregion of profiles, or any other reason. Thus, one might nest all 12 DCS incidence profiles in a smaller sample, $K = 1,000$, so that the sample risk, $r = 12/1,000 = 0.012$, is larger than p . Usually though the analyst wishes to mirror the parent distribution in the sample. If the parent is a set of benign, recreational, no decompression, no multiday dive profiles, and the sample mirrors the parent, then both risks, p and r , are reasonably true measures of actual risk associated with recreational diving. If sample distributions chosen are not representative of the class of diving performed, risk estimates are not trustworthy. For instance, if a high risk set of mixed gas decompression profiles were the background against which recreational dive profiles were compared, all estimates would be skewed and faulty (actually underestimated in relative risk, and overestimated in absolute risk). For this parent set, N is large, p is small, with mean, $M = pN = 0.0015 \times 7896 = 12$, and the applicable binomial statistics smoothly transition to Poisson representation, convenient for logarithmic and covariant numerical analysis (on a computer). Additionally, any parent set may be a large sample of a megaset, so that p is itself an estimate of risk in the megaset.

Turns out that our parent distribution above is just that, a subset of larger megaset, namely, the millions and millions of recreational dives performed and logged over the past 30 years, or so. The above set of profiles was collected in training and vacation diving scenarios. The set is recreational (no decompression, no multiday, light, benign) and representative, with all the distribution metrics as listed. For reference and perspective, sets of recreational profiles

collected by others (Gilliam, NAUI, PADI, YMCA, DAN) are similar in context, but larger in size, N , and smaller in incidence rate, p . Data and studies reported by many sources quote, $N > 1,000,000$, with, $p < 0.00001 = 0.001\%$. Obviously our set has higher rate, p , though still nominally small, but the same shape. So our estimates will be liberal (overestimate risk).

To perform risk analysis, a risk estimator need be employed. For diving, dissolved gas and phase estimators are useful. Two, detailed earlier, are used here. First is the dissolved gas supersaturation ratio, historically coupled to Haldane models. The second is the seprated phase, central to the RGBM (and all phase models). For recreational diving, both estimators are roughly equivalent, because little dissolved gas has separated into free phases (bubbles). Analysis shows this true for all cases examined, in that estimated risks for both overlap at the 95% confidence level. The only case where dissolved gas and phase estimators differ (slightly here) is within repetitive diving profiles. The dissolved gas estimator cues on gas buildup in the slow tissue compartments (staircasing for repets within an hour or two), while the phase estimator cues on bubble gas diffusion in the fast compartments (dropping rapidly over hour time spans). This holding true within all recreational diving distributions, we proceed to the risk analysis.

Nonstop limits (NDLs), denoted t_n as before, from the US Navy, PADI, and NAUI Tables, and those employed by the Oceanic decometer provide a set for comparison of relative DCS risk. Listed below in Table 3 are the NDLs and corresponding risks, r_n , for the profile, assuming ascent and descent rates of $60 \text{ fsw}/\text{min}$ (no safety stops). Haldane and RGBM estimates vary little for these cases, and only the phase estimates are included.

Table 3. Risk Estimates For Various NDLs.

$d \text{ (fsw)}$	USN $t_n \text{ (min)}$	PADI $t_n \text{ (min)}$	NAUI $t_n \text{ (min)}$	Oceanic $t_n \text{ (min)}$
35	310 (4.3%)	205 (2.0%)		181 (1.3%)
40	200 (3.1%)	140 (1.5%)	130 (1.4%)	137 (1.5%)
50	100 (2.1%)	80 (1.1%)	80 (1.1%)	80 (1.1%)
60	60 (1.7%)	55 (1.4%)	55 (1.4%)	57 (1.5%)
70	50 (2.0%)	40 (1.2%)	45 (1.3%)	40 (1.2%)
80	40 (2.1%)	30 (1.3%)	35 (1.5%)	30 (1.3%)
90	30 (2.1%)	25 (1.5%)	25 (1.5%)	24 (1.4%)
100	25 (2.1%)	20 (1.3%)	22 (1.4%)	19 (1.2%)
110	20 (2.2%)	13 (1.1%)	15 (1.2%)	16 (1.3%)
120	15 (2.0%)	13 (1.3%)	12 (1.2%)	13 (1.3%)
130	10 (1.7%)	10 (1.7%)	8 (1.3%)	10 (1.7%)

Risks are internally consistent across NDLs at each depth, and agree with the US Navy assessments in Table 2. Greatest underlying and binomial risks occur in the USN shallow exposures. The PADI, NAUI, and Oceanic risks are all less than 2% for this set, thus binomial risks for single DCS incidence are less than 0.02%. PADI and NAUI have reported that field risks (p) across all exposures are less than 0.001%, so considering their enviable track record of diving safety, our estimates are liberal. Oceanic risk estimates track as the PADI and NAUI risks, again, very safely.

Next, the analysis is extended to profiles with varying ascent and descent rates, safety stops, and repetitive sequence. Table 4 lists nominal profiles (recreational) for various depths, exposure and travel times, and safety stops at 5 msw . DCS estimates, r , are tabulated for both dissolved gas supersaturation ratio and bubble numebr excess risk functions.

Table 4. Dissolved And Separated Phase Risk Estimates For Nominal Profiles.

profile (depth/min)	descent rate (msw/min)	ascent rate (msw/min)	safety stop (depth/min)	r RGBM	r ZHL
14 msw/38 min	18	9	5 msw/3 min	.0034	.0062
19 msw/38 min	18	9	5 msw/3 min	.0095	.0110
37 msw/17 min	18	9	5 msw/3 min	.0165	.0151
18 msw/31 min	18	9	5 msw/3 min	.0063	.0072
	18	9		.0088	.0084
	18	18		.0101	.0135
	18	18	5 msw/3 min	.0069	.0084
17 msw/32 min	18	9	5 msw/3 min		
SI 176 min					
13 msw/37 min	18	9	5 msw/3 min		
SI 174 min					
23 msw/17 min	18	18	5 msw/3 min	.0127	.0232

The ZHL (Buhlmann) NDLs and staging regimens are widespread across decompression meters presently, and are good representation for Haldane risk analysis. The RGBM is newer and more modern (and more physically correct), and is coming online in decometers and associated software. For recreational exposures, the RGBM collapses to a Haldane dissolved gas algorithm. This is reflected in the risk estimates above, where estimates for both models differ little.

Simple comments hold for the analyzed profile risks. The maximum relative risk is 0.0232 for the 3 dive repetitive sequence according to the Haldane dissolved risk estimator. This translates to .2% binomial risk, which is comparable to the maximum NDL risk for the PADI, NAUI, and Oceanic NDLs. Again, this type of dive profile is common, practiced daily on liveboards, and benign. According to Gilliam, the absolute incidence rate for this type of diving is less than 0.02%. Again, our figures overestimate risk.

Effects of slower ascent rates and safety stops are noticeable at the 0.25% to 0.5% level in relative surfacing risk. Safety stops at 5 m for 3 min lower relative risk an average of 0.3%, while reducing the ascent rate from 18 msw/min to 9 msw/min reduces relative risk an average of 0.35%.

Staging, NDLs, and other constraints imposed by decometer algorithms are entirely consistent with acceptable and safe recreational diving protocols. The estimated absolute risk associated across all ZHL NDLs and diver staging regimens analyzed herein is less than .232%, and is probably much less in actual practice. That is, we use $p = 0.006$, and much evidence suggests $p < 0.0001$, some ten times safer.

Validation Protocols

Validation procedures for schedules and tables can be quantified by a set of steps based on statistical decompression analysis:

1. select or construct a measure of decompression risk, or a probabilistic model;
2. evaluate as many dives as possible, and especially those dives similar in exposure time, depth, and environmental factors;
3. conduct limited testing if no data is available;
4. apply the model to the data using maximum likelihood;
5. construct appropriate schedules or tables using whatever incidence of decompression sickness is acceptable;
6. release and then collect profile statistics for final validation and tuning.

Questions of what risk is acceptable to the diver vary. Sport and research divers would probably opt for very small risk (0.01% or less), while military and commercial divers might live with higher risk (1%), considering the nearness of medical attention in general. Many factors influence these two populations, but fitness and acclimatization levels would

probably differ considerably across them. While such factors are difficult to fold into any table exercise or analysis, the simple fact that human subjects in dive experiments exhibit higher incidences during testing phases certainly helps to lower the actual incidence rate in the field, noted by Bennett and Lanphier.

Certainly there is considerable latitude in model assumptions, and many plausible variants on a theme. Many models are correlated with diving exposure data, using maximum likelihood to fit parameters or other valid statistical approaches, but not all. Most have been applied to profiles outside of tested ranges, when testing has been performed, in an obvious extrapolation mode. Sometimes the extrapolations are valid, other times not.

REDUCED GRADIENT BUBBLE MODEL

Utilitarian procedures, entirely consistent with phase mechanics and bubble dissolution time scales, have been developed under duress, and with trauma, by Australian pearl divers and Hawaiian diving fishermen, for both deep and repetitive diving with possible in-water recompression for hits. While the science behind such procedures was not initially clear, the operational effectiveness was always noteworthy and could not be discounted easily. Later, the rationale, essentially recounted in the foregoing, became clearer.

Pearling fleets, operating in the deep tidal waters off northern Australia, employed Okinawan divers who regularly journeyed to depths of 300 *fsw* for as long as one hour, two times a day, six days per week, and ten months out of the year. Driven by economics, and not science, these divers developed optimized decompression schedules empirically. As reported by Le Messurier and Hills, deeper decompression stops, but shorter decompression times than required by Haldane theory, were characteristics of their profiles. Such protocols are entirely consistent with minimizing bubble growth and the excitation of nuclei through the application of increased pressure, as are shallow safety stops and slow ascent rates. With higher incidence of surface decompression sickness, as might be expected, the Australians devised a simple, but very effective, in-water recompression procedure. The stricken diver is taken back down to 30 *fsw* on oxygen for roughly 30 *minutes* in mild cases, or 60 *minutes* in severe cases. Increased pressures help to constrict bubbles, while breathing pure oxygen maximizes inert gas washout (elimination). Recompression time scales are consistent with bubble dissolution experiments.

Similar schedules and procedures have evolved in Hawaii, among diving fishermen, according to Farm and Hayashi. Harvesting the oceans for food and profit, Hawaiian divers make between 8 and 12 dives a day to depths beyond 350 *fsw*. Profit incentives induce divers to take risks relative to bottom time in conventional tables. Three repetitive dives are usually necessary to net a school of fish. Consistent with bubble and nucleation theory, these divers make their deep dive first, followed by shallower excursions. A typical series might start with a dive to 220 *fsw*, followed by 2 dives to 120 *fsw*, and culminate in 3 or 4 more excursions to less than 60 *fsw*. Often, little or no surface intervals are clocked between dives. Such types of profiles literally clobber conventional tables, but, with proper reckoning of bubble and phase mechanics, acquire some credibility. With ascending profiles and suitable application of pressure, gas seed excitation and any bubble growth are constrained within the body's capacity to eliminate free and dissolved gas phases. In a broad sense, the final shallow dives have been tagged as prolonged safety stops, and the effectiveness of these procedures has been substantiated *in vivo* (dogs) by Kunkle and Beckman. In-water recompression procedures, similar to the Australian regimens, complement Hawaiian diving practices for all the same reasons.

While the above practices developed by trial-and-error, albeit with seeming principle, venous gas emboli measurements, performed off Catalina by Pilmanis on divers making shallow safety stops, fall into the more *scientific* category perhaps. Contrasting bubble counts following bounce exposures near 100 *fsw*, with and without zonal stops in the 10-20 *fsw* range, marked reductions (factors of 4 to 5) in venous gas emboli were noted when stops were made. If, as some suggest, venous gas emboli in bounce diving correlate with bubbles in sites such as tendons and ligaments, then safety stops probably minimize bubble growth in such extravascular locations. In these tests, the sample population was small, so additional validation and testing is warranted.

Only a handful of hard and fast conclusions about DCS can be drawn from present knowledge. So elementary as to be innocuous, they are stated:

1. bubble inception or phase separation is the primary event triggering simple decompression sickness;
2. prevention of decompression sickness amounts to prevention (as a limit) of bubble inception or phase separation;
3. gradual pressure reductions prevent bubble formation.

As known by many, after the above attempts at consensus usually diverge. Modelers and table designers must then supply, or assume, gas exchange models, trigger points, and safe diving protocols which prevent or, at least, minimize phase inception and bubble growth.

Present notions of nucleation and cavitation suggest that decompression phase separation is random, yet highly probable, in body tissue. Once established, a gaseous phase will further grow by acquiring gas from adjacent saturated tissue, according to the strength of the free-dissolved gradient. Although exchange mechanisms are better understood, nucleation and stabilization mechanisms remain less so, and computationally elusive. Stochastic Monte Carlo bubble tracking methods are powerful, but only in supercomputer environments, due to the large number of events required for meaningful statistics over simulation time spans. Exchange models for entrained bubbles and coalescence dynamics are similarly complicated. In all cases, more knowledge about gas micronuclei and size distributions, tissue sites, thermodynamics properties, stabilization, and excitation mechanisms is necessary before computing power can be leveraged to decompression modeling.

But even with a paucity of knowledge, many feel that empirical practices and recent studies on bubbles and nuclei shed considerable light on growth and elimination processes, and time scales. Their consistency with underlying physical principles suggest directions for table and meter modeling, beyond parameter fitting and extrapolation techniques. Recovering dissolved gas algorithms for short exposure times, phase models link to bubble mechanics and critical volume trigger points. Bubble and phase models support the efficacy of recently suggested safe diving practices, by simple virtue of dual phase mechanics:

1. reduced nonstop time limits;
2. safety stops (or shallow swimming ascents) in the 10-20 *fsw* zone, 1-2 *min* for dives in the 40-90 *fsw* range, 2-3 *min* for dives in the 90-240 *fsw* range;
3. ascent rates not exceeding 30 *fsw/min*;
4. restricted repetitive exposures, particularly beyond 100 *fsw*, based on reduction in permissible bubble excess over time;
5. restricted spike (shallow-to-deep) exposures based on excitation of additional micronuclei;
6. restricted multiday activity based on regeneration of micronuclei over longer time scales;
7. smooth coalescence of bounce and saturation limit points, consistent with bubble experiments;
8. consistent model treatment of altitude diving;

Bubble models also tend to be consistent with the utilitarian measures observed for diving practice. Conservatism may be downplayed in some meter implementations, yet medical authorities are becoming increasingly concerned about long term effects of breathing pressurized gases. On firmer principles, bubble models tend to corroborate safety measures in multiday diving, and thus one might reasonably expect to witness their further development. Said another way, bubble models have the right physical signatures for diving application.

Phase Versus Haldane Models

Suunto, HydroSpace, and Abyssal Diving have released products incorporating a this phase algorithm, the Reduced Gradient Bubble Model (RGBM), for diving. An iterative approach to staging diver ascents, the RGBM employs separated phase volumes as limit points, instead of the usual Haldane (maximum) critical tensions across tissue compartments. The model is inclusive (altitude, repetitive, mixed gas, decompression, saturation, nonstop exposures), treating both dissolved and free gas phase buildup and elimination. NAUI Technical Diving employed the RGBM to schedule nonstop and decompression training protocols on trimix, heliox, and nitrox while also testing gas switching alternatives for deep exposures. The RGBM has its roots in the earlier work of the Tiny Bubble Group at the University of Hawaii, drawing upon and extending the so-called Varying Permeability Model (VPM) to multiday diving, altitude, and mixed gas applications. While certainly not radical, the RGBM is both different and new on the diving scene. And not unexpectedly, the RGBM recovers the Haldane approach to decompression modeling in the limit of relatively safe (tolerably little) separated phase, with *tolerably little* a qualitative statement here.

The Suunto VYPER/COBRA/STINGER are RGBM-based decometers for recreational diving (plus nitrox), while ABYSS/RGBM is a licensed Abysmal Diving software product. The HydroSpace EXPLORER is a mixed gas decompression meter for technical and recreational diving, as is the ABYSS/RGBM software vehicle. and description. All are first-time-ever commercial products with realistic implementation of a diving phase algorithm across a wide spectrum of exposure extremes. And both accommodate user knobs for additional conservatism. Expect RGBM coded software to surface in new meters and software packages on the Internet.

Here, our intent is to (just) look at the underpinnings of both meter and diveware implementations of the RGBM algorithm, one with extended range of applicability based on simple dual phase principles. Haldane approaches have dominated decompression algorithms for a very long time, and the RGBM has been long in coming on the commercial scene. With recent technical diving interest in deep stop modeling, and concerns with repetitive diving in the recreational community, phase modeling is timely and pertinent. And, of course, since the RGBM extends the VPM, much of the following applies to the VPM directly.

Recent years have witnessed many changes and modifications to diving protocols and table procedures, such as shorter nonstop time limits, slower ascent rates, discretionary safety stops, ascending repetitive profiles, multilevel techniques, both faster and slower controlling repetitive tissues, smaller critical tensions (*M*-values), longer flying-after-diving surface intervals, and others. Stimulated by observation, Doppler technology, decompression meter development, theory, statistics, or safer diving consensus, these modifications affect a gamut of activity, spanning bounce to multiday diving. Of these changes, conservative nonstop time limits, no decompression safety stops, and slower ascent rates (around 30 *fsw/min*) are in vogue, and have been incorporated into many tables and meters. As you might expect, recent developments support them on operational, experimental, and theoretical grounds.

But there is certainly more to the story as far as table and meter implementations. To encompass such far reaching (and often diverse) changes in a unified framework requires more than the simple Haldane models we presently rely upon in 99% of our tables and dive computers. To model gas transfer dynamics, modelers and table designers need address both free and dissolved gas phases, their interplay, and their impact on diving protocols. Biophysical models of inert gas transport and bubble formation all try to prevent decompression sickness. Developed over years of diving application, they differ on a number of basic issues, still mostly unresolved today:

1. the rate limiting process for inert gas exchange, blood flow rate (perfusion) or gas transfer rate across tissue (diffusion);
2. composition and location of critical tissues (bends sites);
3. the mechanistics of phase inception and separation (bubble formation and growth);
4. the critical trigger point best delimiting the onset of symptoms (dissolved gas buildup in tissues, volume of separated gas, number of bubbles per unit tissue volume, bubble growth rate to name a few);
5. the nature of the critical insult causing bends (nerve deformation, arterial blockage or occlusion, blood chemistry or density changes).

Such issues confront every modeler and table designer, perplexing and ambiguous in their correlations with experiment and nagging in their persistence. And here comments are confined just to Type I (limb) and II (central nervous system) bends, to say nothing of other types and factors. These concerns translate into a number of what decompression modelers call dilemmas that limit or qualify their best efforts to describe decompression phenomena. Ultimately, such concerns work their way into table and meter algorithms, with the same caveats. The RGBM treats these issues in a natural way, gory details of which are found in the References.

The establishment and evolution of gas phases, and possible bubble trouble, involves a number of distinct, yet overlapping, steps:

1. nucleation and stabilization (free phase inception);
2. supersaturation (dissolved gas buildup);
3. excitation and growth (free-dissolved phase interaction);
4. coalescence (bubble aggregation);

5. deformation and occlusion (tissue damage and ischemia).

Over the years, much attention has focused on supersaturation. Recent studies have shed much light on nucleation, excitation and bubble growth, even though *in vitro*. Bubble aggregation, tissue damage, ischemia, and the whole question of decompression sickness trigger points are difficult to quantify in any model, and remain obscure. Complete elucidation of the interplay is presently asking too much. Yet, the development and implementation of better computational models is necessary to address problems raised in workshops, reports and publications as a means to safer diving.

Qualitative RGBM Features

The computational issues of bubble dynamics (formation, growth, and elimination) are mostly outside the traditional framework, but get folded into halftime specifications in a nontractable mode. The very slow tissue compartments (halftimes large, or diffusivities small) might be tracking both free and dissolved gas exchange in poorly perfused regions. Free and dissolved phases, however, do not behave the same way under decompression. Care must be exercised in applying model equations to each component. In the presence of increasing proportions of free phases, dissolved gas equations cannot track either species accurately. Computational algorithms tracking both dissolved and free phases offer broader perspectives and expeditious alternatives, but with some changes from classical schemes. Free and dissolved gas dynamics differ. The driving force (gradient) for free phase elimination increases with depth, directly opposite to the dissolved phase elimination gradient which decreases with depth. Then, changes in operational procedures become necessary for optimality. Considerations of excitation and growth invariably require deeper staging procedures than supersaturation methods. Though not as dramatic, similar constraints remain operative in multiexposures, that is, multilevel, repetitive, and multiday diving.

Other issues concerning time sequencing of symptoms impact computational algorithms. That bubble formation is a predisposing condition for decompression sickness is universally accepted. However, formation mechanisms and their ultimate physiological effect are two related, yet distinct, issues. On this point, most hypotheses makes little distinction between bubble formation and the onset of bends symptoms. Yet we know that silent bubbles have been detected in subjects not suffering from decompression sickness. So it would thus appear that bubble formation, per se, and bends symptoms do not map onto each other in a one-to-one manner. Other factors are truly operative, such as the amount of gas dumped from solution, the size of nucleation sites receiving the gas, permissible bubble growth rates, deformation of surrounding tissue medium, and coalescence mechanisms for small bubbles into large aggregates, to name a few. These issues are the pervue of bubble theories, but the complexity of mechanisms addressed does not lend itself easily to table, nor even meter, implementation. But implement and improve we must, so consider the RGBM issues and tacks taken in the Suunto, HydroSpace, and ABYSS implementations:

1. Perfusion And Diffusion

Perfusion and diffusion are two mechanisms by which inert and metabolic gases exchange between tissue and blood. Perfusion denotes the blood flow rate in simplest terms, while diffusion refers to the gas penetration rate in tissue, or across tissue-blood boundaries. Each mechanism has a characteristic rate constant for the process. The smallest rate constant limits the gas exchange process. When diffusion rate constants are smaller than perfusion rate constants, diffusion dominates the tissue-blood gas exchange process, and vice-versa. In the body, both processes play a role in real exchange process, especially considering the diversity of tissues and their geometries. The usual Haldane tissue halftimes are the inverses of perfusion rates, while the diffusivity of water, thought to make up the bulk of tissue, is a measure of the diffusion rate.

Clearly in the past, model distinctions were made on the basis of perfusion or diffusion limited gas exchange. The distinction is somewhat artificial, especially in light of recent analyses of coupled perfusion-diffusion gas transport, recovering limiting features of the exchange process in appropriate limits. The distinction is still of interest today, however, since perfusion and diffusion limited algorithms are used in mutually exclusive fashion in diving. The obvious mathematical rigors of a full blown perfusion-diffusion treatment of gas exchange mitigate against table and meter implementation, where model simplicity is a necessity. So one or another limiting models is adopted, with inertia and track record sustaining use. Certainly Haldane models fall into that categorization.

Inert gas transfer and coupled bubble growth are subtly influenced by metabolic oxygen consumption. Consumption of oxygen and production of carbon dioxide drops the tissue oxygen tension below its level in the lungs (alveoli), while carbon dioxide tension rises only slightly because carbon dioxide is 25 times more soluble than oxygen.

Arterial and venous blood, and tissue, are clearly unsaturated with respect to dry air at 1 atm. Water vapor content is constant, and carbon dioxide variations are slight, though sufficient to establish an outgradient between tissue and blood. Oxygen tensions in tissue and blood are considerably below lung oxygen partial pressure, establishing the necessary ingradient for oxygenation and metabolism. Experiments also suggest that the degree of unsaturation increases linearly with pressure for constant composition breathing mixture, and decreases linearly with mole fraction of inert gas in the inspired mix.

Since the tissues are unsaturated with respect to ambient pressure at equilibrium, one might exploit this window in bringing divers to the surface. By scheduling the ascent strategically, so that nitrogen (or any other inert breathing gas) supersaturation just takes up this unsaturation, the total tissue tension can be kept equal to ambient pressure. This approach to staging is called the zero supersaturation ascent.

The full blown RGBM treats coupled perfusion-diffusion transport as a two step flow process, with blood flow (perfusion) serving as a boundary condition for tissue gas penetration by diffusion. Depending on time scales and rate coefficients, one or another (or both) processes dominate the exchange. However, for both the VYPER and ABYSS implementations, perfusion is assumed to dominate, simplifying matters and permitting online calculations. Additionally, tissues and blood are naturally undersaturated with respect to ambient pressure at equilibration through the mechanism of biological inherent unsaturation (oxygen window), and the RGBM includes this debt in calculations.

2. Bubbles

We do not really know where bubbles form nor lodge, their migration patterns, their birth and dissolution mechanisms, nor the exact chain of physico-chemical insults resulting in decompression sickness. Many possibilities exist, differing in the nature of the insult, the location, and the manifestation of symptoms. Bubbles might form directly (de novo) in supersaturated sites upon decompression, or possibly grow from preformed, existing seed nuclei excited by compression-decompression. Leaving their birth sites, bubbles may move to critical sites elsewhere. Or stuck at their birth sites, bubbles may grow locally to pain-provoking size. They might dissolve locally by gaseous diffusion to surrounding tissue or blood, or passing through screening filters, such as the lung complex, they might be broken down into smaller aggregates, or eliminated completely. Whatever the bubble history, it presently escapes complete elucidation. But whatever the process, the end result is very simple, both separated and dissolved gas must be treated in the transfer process.

Bubbles may hypothetically form in the blood (intravascular) or outside the blood (extravascular). Once formed, intravascularly or extravascularly, a number of critical insults are possible. Intravascular bubbles may stop in closed circulatory vessels and induce ischemia, blood sludging, chemistry degradations, or mechanical nerve deformation. Circulating gas emboli may occlude the arterial flow, clog the pulmonary filters, or leave the circulation to lodge in tissue sites as extravascular bubbles. Extravascular bubbles may remain locally in tissue sites, assimilating gas by diffusion from adjacent supersaturated tissue and growing until a nerve ending is deformed beyond its pain threshold. Or, extravascular bubbles might enter the arterial or venous flows, at which point they become intravascular bubbles.

Spontaneous bubble formation in fluids usually requires large decompressions, like hundreds of atmospheres, somewhere near fluid tensile limits. Many feel that such circumstance precludes direct bubble formation in blood following decompression. Explosive, or very rapid decompression, of course is a different case. But, while many doubt that bubbles form in the blood directly, intravascular bubbles have been seen in both the arterial and venous circulation, with vastly greater numbers detected in venous flows (venous gas emboli). Ischemia resulting from bubbles caught in the arterial network has long been implied as a cause of decompression sickness. Since the lungs are effective filters of venous bubbles, arterial bubbles would then most likely originate in the arteries or adjacent tissue beds. The more numerous venous bubbles, however, are suspected to first form in lipid tissues draining the veins. Lipid tissue sites also possess very few nerve endings, possibly masking critical insults. Veins, thinner than arteries, appear more susceptible to extravascular gas penetration.

Extravascular bubbles may form in aqueous (watery) or lipid (fatty) tissues in principle. For all but extreme or explosive decompression, bubbles are seldom observed in heart, liver, and skeletal muscle. Most gas is seen in fatty tissue, not unusual considering the five-fold higher solubility of nitrogen in lipid tissue versus aqueous tissue. Since fatty tissue has few nerve endings, tissue deformation by bubbles is unlikely to cause pain locally.

On the other hand, formations or large volumes of extravascular gas could induce vascular hemorrhage, depositing both fat and bubbles into the circulation as noted in animal experiments. If mechanical pressure on nerves is a prime candidate for critical insult, then tissues with high concentrations of nerve endings are candidate structures, whether tendon or spinal cord. While such tissues are usually aqueous, they are invested with lipid cells whose propensity reflects total body fat. High nerve density and some lipid content supporting bubble formation and growth would appear a conducive environment for a mechanical insult.

To satisfy thermodynamic laws, bubbles assume spherical shapes in the absence of external or mechanical (distortion) pressures. Bubbles entrain free gases because of a thin film, exerting surface tension pressure on the gas. Hydrostatic pressure balance requires that the pressure inside the bubble exceed ambient pressure by the amount of surface tension, γ . At small radii, surface tension pressure is greatest, and at large radii, surface tension pressure is least.

Gases will also diffuse into or out of a bubble according to differences in gas partial pressures inside and outside the bubble, whether in free or dissolved phases outside the bubble. In the former case, the gradient is termed free-free, while in the latter case, the gradient is termed free-dissolved. Unless the surface tension is identically zero, there is always a gradient tending to force gas out of the bubble, thus making the bubble collapse on itself because of surface tension pressure. If surrounding external pressures on bubbles change in time, however, bubbles may grow or contract.

Bubbles grow or contract according to the strength of the free-free or free-dissolved gradient, and it is the latter case which concerns divers under decompression. The radial rate at which bubbles grow or contract depends directly on the diffusivity and solubility, and inversely on the bubble radius. A critical radius, r_c , separates growing from contracting bubbles. Bubbles with radius $r > r_c$ will grow, while bubbles with radius $r < r_c$ will contract. Limiting bubble growth and adverse impact upon nerves and circulation are issues when decompressing divers and aviators.

The RGBM assumes that a size distribution of seeds (potential bubbles) is always present, and that a certain number is excited into growth by compression-decompression. An iterative process for ascent staging is employed to control the inflation rate of these growing bubbles so that their collective volume never exceeds a phase volume limit point. Gas mixtures of helium, nitrogen, and oxygen contain bubble distributions of different sizes, but possess the same phase volume limit point.

3. Bubble Seeds

Bubbles, which are unstable, are thought to grow from micron size, gas nuclei which resist collapse due to elastic skins of surface activated molecules (surfactants), or possibly reduction in surface tension at tissue interfaces or crevices. If families of these micronuclei persist, they vary in size and surfactant content. Large pressures (somewhere near 10 atm) are necessary to crush them. Micronuclei are small enough to pass through the pulmonary filters, yet dense enough not to float to the surfaces of their environments, with which they are in both hydrostatic (pressure) and diffusion (gas flow) equilibrium. When nuclei are stabilized, and not activated to growth or contraction by external pressure changes, the skin (surfactant) tension offsets both the Laplacian (film) tension and any mechanical help from surrounding tissue. Then all pressures and gas tensions are equal. However, on decompression, the seed pockets are surrounded by dissolved gases at high tension and can subsequently grow (bubbles) as surrounding gas diffuses into them. The rate at which bubbles grow, or contract, depends directly on the difference between tissue tension and local ambient pressure, effectively the bubble pressure gradient. At some point in time, a critical volume of bubbles, or separated gas, is established and bends symptoms become statistically more probable. On compression, the micronuclei are crunched down to smaller sizes across families, apparently stabilizing at new reduced size. Bubbles are also crunched by increasing pressure because of Boyle's law, and then additionally shrink if gas diffuses out of them. As bubbles get smaller and smaller, they probably restabilize as micronuclei.

The RGBM postulates bubble seeds with lipid and/or aqueous skin structure quantified by an equation-of-state (EOS). Bubble seeds are assumed permeable to gas transfer across skin boundaries under all crushing pressures, unlike the varying permeability model (VPM). The size of seeds excited into growth is inversely proportional to the supersaturation gradient. At increasing pressure, bubble seeds permit gas diffusion at a slower rate, because of skin tension. The RGBM assumes bubble skins are stabilized by surfactants over calculable times scales (on

the order of hours), producing seeds with variable persistence in the body. Bubble skins are probably molecularly activated, complex, biosubstances found throughout the body. Whatever the formation process (tribonucleation, lung lining, external fluids, stochastic gas molecular collisions, blood flow and vortices), the RGBM assumes the size distribution is exponentially decreasing in size, that is, more smaller seeds than larger seeds in exponential proportions.

4. Slow Tissue Compartments

Based on concerns in multiday and heavy repetitive diving, with the hope of controlling staircasing gas buildup in exposures through critical tensions, slow tissue compartments (halftimes greater than 80 minutes) have been incorporated into some algorithms. Calculations, however, show that virtually impossible exposures are required of the diver before critical tensions are even approached, literally tens of hours of near continuous activity. As noted in many calculations, slow compartment cannot really control multiding through critical tensions, unless critical tensions are reduced to absurd levels, inconsistent with nonstop time limits for shallow exposures. That is a model limitation, not necessarily a physical reality. The physical reality is that bubbles in slow tissues are eliminated over time scales of days, and the model limitation is that the arbitrary parameter space does not accommodate such phenomena.

And that is no surprise either, when one considers that dissolved gas models are not suppose to track bubbles and free phases. Repetitive exposures do provide fresh dissolved gas for excited nuclei and growing free phases, but it is not the dissolved gas which is the problem just by itself. When bubble growth is considered, the slow compartments appear very important, because, therein, growing free phases are mostly left undisturbed insofar as surrounding tissue tensions are concerned. Bubbles grow more gradually in slow compartments because the gradient there is typically small, yet grow over longer time scales. When coupled to free phase dynamics, slow compartments are necessary in multiding calculations.

The RGBM incorporates a spectrum of tissue compartments, ranging from 1 min to 720 min, depending on gas mixture (helium, nitrogen, oxygen). Phase separation and bubble growth in slower compartments is a central focus in calculations.

5. Venous Gas Emboli

While the numbers of venous gas emboli detected with ultrasound Doppler techniques can be correlated with nonstop limits, and the limits then used to fine tune the critical tension matrix for select exposure ranges, fundamental issues are not necessarily resolved by venous gas emboli measurements. First of all, venous gas emboli are probably not the direct cause of bends per se, unless they block the pulmonary circulation, or pass through the pulmonary traps and enter the arterial system to lodge in critical sites. Intravascular bubbles might first form at extravascular sites. According to studies, electron micrographs have highlighted bubbles breaking into capillary walls from adjacent lipid tissue beds in mice. Fatty tissue, draining the veins and possessing few nerve endings, is thought to be an extravascular site of venous gas emboli. Similarly, since blood constitutes no more than 8% of the total body capacity for dissolved gas, the bulk of circulating blood does not account for the amount of gas detected as venous gas emboli. Secondly, what has not been established is the link between venous gas emboli, possible micronuclei, and bubbles in critical tissues. Any such correlations of venous gas emboli with tissue micronuclei would unquestionably require considerable first-hand knowledge of nuclei size distributions, sites, and tissue thermodynamic properties. While some believe that venous gas emboli correlate with bubbles in extravascular sites, such as tendons and ligaments, and that venous gas emboli measurements can be reliably applied to bounce diving, the correlations with repetitive and saturation diving have not been made to work, nor important correlations with more severe forms of decompression sickness, such as chokes and central nervous system (CNS) hits.

Still, whatever the origin of venous gas emboli, procedures and protocols which reduce gas phases in the venous circulation deserve attention, for that matter, anywhere else in the body. The moving Doppler bubble may not be the bends bubble, but perhaps the difference may only be the present site. The propensity of venous gas emboli may reflect the state of critical tissues where decompression sickness does occur. Studies and tests based on Doppler detection of venous gas emboli are still the only viable means of monitoring free phases in the body.

The RGBM uses nonstop time limits tuned to recent Doppler measurements, conservatively reducing them along the lines originally suggested by Spencer (and others), but within the phase volume constraint. The VYPER im-

plementation penalizes ascent violations by requiring additional safety stop time dictated by risk analysis of the violation.

6. Multidiving

Concerns with multidiving can be addressed through variable critical gradients, then tissue tensions in Haldane models. While variable gradients or tensions are difficult to codify in table frameworks, they are easy to implement in digital meters. Reductions in critical parameters also result from the phase volume constraint, a constraint employing the separated volume of gas in tissue as trigger point for the bends, not dissolved gas buildup alone in tissue compartments. The phase volume is proportional to the product of the dissolved-free gas gradient times a bubble number representing the number of gas nuclei excited into growth by the compression-decompression, replacing just slow tissue compartments in controlling multidiving.

In considering bubbles and free-dissolved gradients within critical phase hypotheses, repetitive criteria develop which require reductions in Haldane critical tensions or dissolved-free gas gradients. This reduction simply arises from lessened degree of bubble elimination over repetitive intervals, compared to long bounce intervals, and need to reduce bubble inflation rate through smaller driving gradients. Deep repetitive and spike exposures feel the greatest effects of gradient reduction, but shallower multiday activities are impacted. Bounce diving enjoys long surface intervals to eliminate bubbles while repetitive diving must contend with shorter intervals, and hypothetically reduced time for bubble elimination. Theoretically, a reduction in the bubble inflation driving term, namely, the tissue gradient or tension, holds the inflation rate down. Overall, concern is bubble excess driven by dissolved gas. And then both bubbles and dissolved gas are important. In such an approach, multidiving exposures experience reduced permissible tensions through lessened free phase elimination over time spans of two days. Parameters are consistent with bubble experiments, and both slow and fast tissue compartments must be considered.

The RGBM reduces the phase volume limit in multidiving by considering free phase elimination and buildup during surface intervals, depending on altitude, time, and depth of previous profiles, Repetitive, multiday, and reverse profile exposures are tracked and impacted by critical phase volume reductions over appropriate time scales.

7. Adaptation

Divers and caisson workers have long contended that tolerance to decompression sickness increases with daily diving, and decreases after a few weeks layoff, that in large groups of compressed air workers, new workers were at higher risk than those who were exposed to high pressure regularly. This acclimatization might result from either increased body tolerance to bubbles (physiological adaptation), or decreased number and volume of bubbles (physical adaptation). Test results are totally consistent with physical adaptation.

Yet, there is slight inconsistency here. Statistics point to slightly higher bends incidence in repetitive and multiday diving. Some hyperbaric specialists confirm the same, based on experience. The situation is not clear, but the resolution plausibly links to the kinds of first dives made and repetitive frequency in the sequence. If the first in a series of repetitive dives are kept short, deep, and conservative with respect to nonstop time limits, initial excitation and growth are minimized. Subsequent dives would witness minimal levels of initial phases. If surface intervals are also long enough to optimize both free and dissolved gas elimination, any nuclei excited into growth could be efficiently eliminated outside repetitive exposures, with adaptation occurring over day intervals as noted in experiments. But higher frequency, repetitive and multiday loading may not afford sufficient surface intervals to eliminate free phases excited by earlier exposures, with additional nuclei then possibly excited on top of existing phases. Physical adaptation seems less likely, and decompression sickness more likely, in the latter case. Daily regimens of a single bounce dive with slightly increasing exposure times are consistent with physical adaptation, and conservative practices. The regimens also require deepest dives first. In short, acclimatization is as much a question of eliminating any free phases formed as it is a question of crushing or reducing nuclei as potential bubbles in repetitive exposures. And then time scales on the order of a day might limit the adaptation process.

The RGBM generates replacement bubble seed distributions on time scales of hours, adding new bubbles to existing bubbles in calculations. Phase volume limit points are also reduced by the added effects of new bubbles.

RGBM Versus Haldane Profiles

So, having waded through the foregoing, a next question is how does the RGBM compare with classical Haldane models as far as staging ascents, limiting multiexposures, and treating mixed gases? Generally, for short nonstop air diving, the RGBM reproduces the Spencer limits. For multiday diving in spans shorter than 1-3 hrs, the RGBM reduces nonstop limits by 10% to 20% depending on surface interval, depth, altitude, and duration of present and previous dive. Multiday diving is impacted to lesser degree. Some comparisons appear in Table 5 for 3 days of repetitive air diving (120 fsw/10 min twice a day with 45 min surface interval). Computer choices are illustrative, not inductive.

Table 5. Nonstop Limits For VYPER/RGBM And Haldane Air Multidiving

Computer/Algorithm	Dive 1 (min)	Dive 2 (min)	Dive 3 (min)	Dive 4 (min)	Dive 5 (min)	Dive 6 (min)
VYPER/RGBM	10	6	9	5	9	5
COBRA/Haldane	10	9	10	9	10	9
DATA PLUS/Haldane	12	6	12	6	12	6
DELPHI/Haldane	10	10	10	10	10	10
DC11/Haldane	6	6	6	6	6	6
DC12/Haldane	9	7	9	7	9	7
ALADIN/Haldane	8	8	8	8	8	8
ALADIN PRO/Haldane	10	7	10	7	10	7
SOURCE/Haldane	12	9	12	9	12	9

The VYPER/RGBM (first dive) nonstop limits (depth/time) are 150/6, 140/7, 130/9, 120/10, 110/13, 100/17, 90/22, 80/28, 70/36, 60/51, 50/69, and 40/120. In the mixed gas arena, Table 6 lists nonstop time limits for ranged trimix, that is, 13% to 17% helium, 61% to 53% nitrogen, and 26% to 30% oxygen, according to RGBM and RGBM/ZHL (Buhlmann).

Table 6. Trimix Nonstop Limits For RGBM And RGBM/ZHL (Haldane).

Depth (fsw)	RGBM (min)	RGBM/ZHL (min)
80	28	26
90	23	22
100	19	18
110	16	15
120	14	13
130	12	11
140	11	10
150	10	9

These limits are used by NAUI Technical Diving for training purposes. While both sets of nonstop time limits are different in Tables 5 and 6, the more dramatic effects of the RGBM show up for deep staging, as seen in Table 7. Comparative deep schedules for a trimix dive to 250 fsw for 30 min are contrasted, following a switch to air at 100 fsw and a switch to pure oxygen at 20 fsw on the way up. RGBM and RGBM/ZHL are again employed, but with and without conservative safety knobs. In the case of RGBM/ZHL, the outgassing tissue halftimes are increased by 1.5 in the conservative case, while for RGBM the bubble excitation radius is increased by 1.2 for comparison. Deeper stops are noticeably requisite in RGBM, but total decompression times are less than RGBM/ZHL. The trimix is 33% helium, 51% nitrogen, and 16% oxygen.

NAUI Technical Diving Operations has released a set of ranged RGBM Trimix and Helitrox Tables (ranged RGBM Nitrox Tables will follow soon). They can be obtained from NAUI Worldwide Headquarters (Tampa). The Trimix Tables hold for 24% - 40% helium, 16% oxygen, with a switch to pure oxygen at 20 fsw. Similarly, the Helitrox Tables range 13% - 17% helium, and 26% - 30% oxygen, with a switch to pure oxygen at 20 fsw as with the Trimix Tables.

Maximum descent rate is 90 *fsw/min*, and maximum ascent rate is 30 *fsw/min*. Minimum repetitive interval is 3 *hrs*, with a maximum of 2 dives. Flying time is 24 *hrs* for a single dive. At altitude, the standard (Wienke) equivalent sea level depth method for scaling depths at altitude to sea level for table entry can be used. Deeper stops and shorter deco times are the usual features of diver staging in the full RGBM Tables.

Table 7. Deep Schedules According To RGBM And RGBM/ZHL (Haldane)

Stop	Depth (<i>fsw</i>)	RGBM/ZHL (<i>min</i>) (<i>standard</i>)	RGBM (<i>min</i>) (<i>standard</i>)	RGBM/ZHL (<i>min</i>) (<i>safer</i>)	RGBM (<i>min</i>) (<i>safer</i>)
1	180	0	0	0	1
2	170	0	1	0	1
3	160	0	1	0	1
4	150	0	1	0	1
5	140	0	1	0	2
6	130	0	2	0	2
7	120	0	2	0	2
8	110	0	2	1	2
9	100	0	2	2	2
10	90	2	2	3	3
11	80	2	2	4	3
12	70	2	3	5	4
13	60	5	5	8	6
14	50	7	6	12	7
15	40	12	9	18	19
16	30	18	12	28	13
17	20	16	10	28	11
18	10	28	16	48	18
		93	77	147	98

That in a nutshell is a comparison of major differences between phase and dissolved gas models. The phase models recover dissolved gas models for short and nominal exposures, but require deeper stops and shorter decompression times for longer and exceptional exposures. A rundown of the software configuration of the RGBM used in full blown simulations follows. The package is under constant refinement and updating.

1. Module: Three major routines (RGBMNX, RGBMHX, RGBMTMX) for nitrox, heliox, and trimix.
2. Source Code: 1640 Lines
3. Language/Compiler: FORTRAN 77/90, BASIC.
4. CRAY YMP Running Time: 1 *sec* for deep trimix profile with 5 gas switches on way up.
5. Input: altitude, bottom mixture, ascent/descent rate, switch levels and gas mixtures, pre-dive breathing gas, safety knobs, previous dive history.
6. Output: controlling tissue compartments, stop depth and times, supersaturation gradient, permissible supersaturation, effective bubble and gas parameters, critical phase volume, dive profile.
7. Cost: \$5800

Diving Conservatism

In finishing, a few clinical observations are listed, not to scare the reader, but rather to point out that diving, like all other environmentally changing activities, has its own set of risk factors. Risk, obviously here, relates to pressure changes and exposure times:

1. in 1976, Palmer and Blakemore reported that 81% of goats with CNS bends and 33% with limb bends exhibited permanent spinal cord damage on autopsy;
2. in 1978, the same investigators reported that clinically bent, but cured, goats, also exhibited brain damage on autopsy;
3. in 1979, a Workshop in Luxemborg reported that even asymptomatic dives may cause permanent brain and spinal impairment;
4. in 1982, Idicula reported CT scans of the brains of veteran divers showed characteristics similar to punch drunk divers;
5. in 1984, Edmonds conducted psycholological and psychometric studies on abalone divers in Australia and reported strong evidence for dementia;
6. in 1985, Hoiberg reported the USN divers who once suffered the bends had a higher rate of headaches, vascular diseases, and hospitalizations than a matched sample who had never been bent;
7. in 1986, Morris reported that English divers with more than 8 years experience has significantly poorer short term memory;
8. in the 1980s and 1990s, Workshops repeatedly voiced concern about the long term effects of transient hematological changes in divers, such as sedimentation, red cell configuration, alteration of lipoprotein, platelet reduction, and vascular stress;
9. in 1984, Brubakk noted ultrasonically detected bubbles (VGE) in animals for as long as a month after hyperbaric exposure;
10. now, Calder examines the spinal cord of every diver in the United Kingdom who dies of any cause;
11. in 1985, Dick reported that mild (self) neurological complaints are common after diving and go untreated, and that many serious cases never violated the USN Tables.

Of course, it comes as no surprise that the medical community continues to push for shorter and shallower exposures, ultra conservatism in tables and meters, and all other risk ameliorating avenues. Enough said here, the above list points out some concerns for all of us.

Conservative approaches, coupled with the most correct biophysical models, are the best means for staging diver ascents. Period.

RGBM Validation And Testing

Models need validation and testing. Often, strict chamber tests are not possible, economically nor otherwise, and models employ a number of benchmarks and regimens to underscore viability. The following are some supporting the RGBM phase model and (released) nitrox, heliox, and trimix diving tables:

1. counterterror and countermeasures (LANL) exercises have used the RGBM (full up iterative deep stop version) for a number of years, logging some 450 dives on mixed gases (trimix, heliox, nitrox) without incidence of DCS – 35% were deco dives, and 25% were repets (no deco) with at least 2 hr SIs, and in the forward direction (deepest dives first);
2. NAUI Technical Diving has been diving the deep stop version for the past 4 yrs, some estimated 400 dives, on mixed gases down to 250 *fsw*, without a single DCS hit. Some 15 divers, Fall of 1999, in France used the RGBM to make 2 mixed gas dives a day, without mishap, in cold water and rough seas. In Roatan, similar week long decompression diving activities have been logged for the past three years;
3. modified RGBM recreational algorithms (Haldane imbedded with bubble reduction factors limiting reverse profile, repetitive, and multiday diving), as coded into Suunto, ABYSS, HydroSpace decometers, lower an already low DCS incidence rate of approximately 1/10,000 or less. More RGBM decompression meters, including mixed gases, are in the works (3 not named at this time). Some 200,000 dives are estimated using RGBM meters, with only 1 reported case of DCS;

4. a cadre of divers and instructors in mountainous New Mexico, Utah, and Colorado have been diving the modified (Haldane imbedded again) RGBM at altitude, an estimated 350 dives, without peril. Again, not surprising since the altitude RGBM is slightly more conservative than the usual Cross correction used routinely up to about 8,000 ft elevation, and with estimated DCS incidence less than 1/10,000;
5. within decometer implementations of the RGBM, not a single DCS hit has been reported in nonstop and multi-diving categories, beyond 200,000 dives or more, up to now;
6. extreme chamber tests for mixed gas RGBM are in the works, and less stressful exposures will be addressed shortly – extreme here means 300 *fsw* and beyond;
7. probabilistic decompression analysis of some selected RGBM profiles, calibrated against similar calculations of the same profiles by Duke, help validate the RGBM on a computational basis, suggesting that the RGBM has no more theoretical risk than other bubble or dissolved gas models (Weathersby, Vann, Gerth methodology at USN and Duke).
8. all divers and instructors using RGBM decometers, tables, or NET software have been advised to report individual profiles to DAN Project Dive Exploration (Vann, Gerth, Denoble and many others at Duke).
9. ABYSS is a NET software package that offers the modified RGBM (folded over the Buhlmann ZHL) and soon the full up, deep stop version for any gas mixture, has a fairly large contingent of tech divers already using the RGBM and has not received any reports of DCS.
10. outside of proprietary (commercial) and RGBM Tables, mixed gas tables are a smorgasboard of no longer applicable Haldane dynamics and discretionary stop insertions, as witnessed by the collective comments of a very vocal and extremely competent, experienced technical diving community.

Because DCS is binomially distributed in incidence probability, many trials are often needed (or other close profiles) to fully validate any model at the 1% level. Additionally, full validation requires DCS incidences, the higher the number, the better, contrary to desired dive outcomes.

ADDITIONAL READING

References span a wide spectra of technical diving material and details, broaching historical to modern developments. Entries are alphabetically and chronologically listed.

Berghage T.E. and Durman D., 1980, US Navy Air Recompression Schedule Risk Analysis, Nav. Med. Res. Bull. 1, 1-22.

Bowker A.H. and Lieberman G.J., 1964, Engineering Statistics, Engelwood Cliffs: Prentice-Hall.

Boycott A.E., Damant G.C.C., and Haldane J.S., 1908, The Prevention Of Compressed Air Illness, J. Hyg. 8, 342-443.

Buhlmann A.A., 1984, Decompression/Decompression Sickness, Berlin: Springer Verlag.

Gernhardt M.L., Lambertsen C.J., Miller R.G., and Hopkins E., 1990, Evaluation Of A Theoretical Model Of Tissue Gas Phase Growth And Resolution During Decompression From Air Diving, Undersea Biomed. Res. 17, 95.

Hamilton R.W., 1975, Development Of Decompression Procedures For Depths In Excess Of 400 Feet, Undersea And Hyperbaric Medical Society Report, WS: 2-28-76, Bethesda.

Hempleman H.V., 1952, A New Theoretical Basis For The Calculation Of Decompression Tables, Medical research Council Report, UPS 131, London.

Hennessy T.R. and Hempleman H.V., 1977, An Examination Of The Critical Released Gas Concept In Decompression Sickness, Proc. Royal Soc. London B197, 299-313.

Hills B.A., 1977, Decompression Sickness, New York: John Wiley And Sons.

Le Messurier D.H. and Hills B.A., 1965, Decompression Sickness: A Study Of Diving Techniques In The Torres Strait, Hvaldradets Skrifter 48, 54-84.

Neal J.G., O'Leary T.R. and Wienke B.R., 1999, Trimix Diving, Fort Lauderdale: Underwater Dynamics Incorporated.

Nishi R.Y., Eatock B.C., Buckingham I.P. and Ridgewell B.A., 1982, *Assessment Of Decompression Profiles By Ultrasonic Monitoring: No Decompression Dives*, Defense And Civil Institute Of Environmental Medicine Report, D.C.IEM 82-R-38, Toronto.

Parzen E., 1970, *Modern Probability Theory And Its Applications*, New York: John Wiley And Sons.

Powell R.P. and Rogers R.E., 1989, *Doppler Ultrasound Monitoring Of Gas Phase Formation And Resolution In Repetitive Diving*, *Undersea Biomed. Res.* 16, 69.

Vann R.D., Dovenbarger J., Wachholz C., and Bennett P.B., 1989, *Decompression Sickness In Dive Computer And Table Use*, *DAN Newsletter* 3-6.

Vann R.D., Grimstad J., and Nielsen C.H., 1980, *Evidence For Gas Nuclei In Decompressed Rats*, *Undersea Biomed. Res.* 7, 107-112.

Weathersby P.K., Survanshi S. and Homer L.D., 1985, *Statistically Based Decompression Tables: Analysis Of Standard Air Dives, 1950-1970*, Naval Medical Research Institute report, NMRI 85-16, Bethesda.

Weathersby P.K., Homer L.D., and Flynn E.T., 1984, *On The Likelihood Of Decompression Sickness*, *J. Appl. Physiol.* 57, 815-825.

Wienke B.R., 2001, *Technical Diving In Depth*, Flagstaff: Best.

Wienke B.R., 1993, *Diving Above Sea Level*, Flagstaff: Best.

Wienke B.R., 1994, *Basic Diving Physics And Applications*, Flagstaff: Best.

Wienke B.R., 1992, *Numerical Phase Algorithm For Decompression Computers And Application*, *Comp. Biol. Med.* 22, 389-406.

Wienke B.R., 1991, *Basic Decompression Theory And Application*, Flagstaff: Best.

Wienke B.R., 1990, *Reduced Gradient Bubble Model*, *Int. J. Biomed. Comp.* 26, 237-256.

Wienke B.R., 1986, *DECOMP: Computational Package For Nitrogen Transport Modeling In Tissues*, *Comp. Phys. Comm.* 40, 327-336.

Workman R.D., 1965, *Calculation Of Decompression Schedules For Nitrogen-Oxygen And Helium-Oxygen Dives*, USN Experimental Diving Unit Report, NEDU 6-65, Washington DC

Yount D.E. and Hoffman DC, 1986, *On The Use Of A Bubble Formation Model To Calculate Diving Tables*, *Aviat. Space Environ. Med.* 57, 149-156.

Yount D.E., 1979, *Skins Of Varying Permeability: A Stabilization Mechanism For Gas Cavitation Nuclei*, *J. Acoust. Soc. Am.* 65, 1431-1439.

Yount D.E. and Strauss R.H., 1976, *Bubble Formation In Gelatin: A Model For Decompression Sickness*, *J. Appl. Phys.* 47, 5081-5089.

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