



## ISTM Elections 2009 and the Nomination Process

**D**o you want to propose someone (including yourself) for the Presidency of the ISTM or to serve on the Executive Board (Board of Directors)? If so, you have until September 15, 2008 to submit a proposal form for that person to be on the ballot. The form can be obtained by logging into the Member Services section of the ISTM website and clicking the "2009 Election Nominations" link.

The nomination process is structured so as to ensure that the Directors of ISTM represent all parts of the world and that no country or region is excluded from leadership, even though some regions have many more members than others. Presently, ISTM has almost 2,400 members in about 70 countries.

The positions of President and of two Counselors need to be filled this year. The President position is for a two-year term. However, the president serves as President-elect for two years preceding his/her term and then for two years after the term as Past-President

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## The Preparatory Course for the ISTM Certificate in Travel Health

**T**he ISTM is pleased to co-sponsor two preparatory courses for the ISTM Certificate of Knowledge Examination (CTH® Program). The courses will be held from January 23-25, 2009, in Basel, Switzerland, and on March 6-8, 2008, in Philadelphia, Pennsylvania, USA.

The courses will review the Body of Knowledge for the Practice of Travel Medicine as well as updates on recent advances in Travel Medicine. Registration for the Certificate of Knowledge Exam is not a prerequisite for taking the course.

For further information on the course or on the CTH® Program please see the ISTM web site, [www.istm.org](http://www.istm.org).

The North American course is co-sponsored by the Mount Auburn Hospital, a teaching hospital of Harvard Medical School. The Mount Auburn Hospital designates this educational activity for a maximum of 14 *AMA PRA Category 1 Credits™*. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Massachusetts Medical Society for Continuing Medical Education through the Joint Sponsorship of Mount Auburn Hospital and the International Society of Travel Medicine.

The Mount Auburn Hospital is accredited by the Massachusetts Medical Society to sponsor continuing medical education for physicians.

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## What Your ISTM Colleagues Think: Boycotting International Events to Protest Human Rights Violations

**W**hat your ISTM colleagues think...Boycotting international events to protest human rights violations.

This past Spring we sent out another of our queries concerning a philosophical subject related to travel medicine. We asked four questions:

1. **Should we express our personal political convictions to tourists seeking only our health expertise regarding travel to countries that have poor records regarding human rights?**
2. **Should we be apolitical in our travel medicine offices?**
3. **Is it acceptable to go to such a country for humanitarian work but not as a tourist?**
4. **Is boycotting important international events a reasonable response to human rights violations by the country holding the event?**

Just over a hundred ISTM members responded, with many of the responses quite long, and with perceptive insights. So we divided the responses into two articles. The first appeared in the previous issue of NewsShare (May/June 2008) and is available on our website.

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(for a total of six years). Each Counselor position is for four years. A nominating committee, in accordance with criteria set out in our bylaws, has been formed by the Executive Board.

Any ISTM member with paid up dues is eligible for nomination. However, it is desirable for a candidate to have the following qualifications:

- Prior service on ISTM committees or ISTM-sponsored initiatives
- Publication of travel medicine-related clinical or research articles in the *Journal of Travel Medicine* (italics), other journals or books
- Contributions to the biennial CISTM
- Leadership experience working with national or international professional societies or groups
- Professional experience in the field of Travel Medicine

For each open position, the nominating committee will carefully review all the names proposed and will select, by majority vote, the names of two nominees most suitable to appear on the ballot in accordance with the bylaws of the ISTM. A link to a secure and anonymous electronic ballot hosted by a professional election firm will be e-mailed to all members in January 2009. Balloting will be open until March 15, 2009. Election results will be announced at the membership assembly in May 2009, at the CISTM11 meeting in Budapest.

The Society bylaws state that no more than three of the seven elected Directors of the Society shall reside on the same continent. The following paragraphs pertaining to the election process are quoted from the bylaws to increase an understanding of this process:

Article 8.1 A nominating committee will be composed of seven members in good standing in the Society representing, insofar as possible,

the various continents and constituencies of the Society (e.g., nursing, academia, private practice). Members of the nominating committee will be appointed by the Executive Board one year before the next Membership assembly and for a term of one year. Two members of the nominating committee will be outgoing counselors and the chairperson of the committee will be the President-Elect.

Article 8.2 Six months before the next Membership assembly, the nominating committee shall submit to the Secretary-Treasurer the names of two nominees for each office to be elected. At least three months prior to the annual meeting, the Secretary-Treasurer shall send a ballot to each member eligible to vote. The ballots shall be returned to the Secretary-Treasurer. To be valid a ballot must be received by the Secretary-Treasurer at least six weeks prior to the membership assembly.

Article 8.9 No more than three elected members of the Executive Board shall reside on the same continent when elected. The sequence of the elections will be President, President-Elect, then counselors. If three members re-

siding on the same continent are elected, those proposed later in the sequence of elections will drop out as supernumerary candidates; within the counselors, the ones having received fewer votes will drop out.

By unanimous votes each of the previous Executive Boards has reiterated that all elections are guided but not bound by the following considerations:

1. The President-elect should be elected from a different continent than the current President-elect.
2. One of the Directors should be a nurse counselor who should be elected from a continent different from the continent of the outgoing nurse counselor.

Please note that your nominations should be guided by the interpretation of Article 8.9 and the geographic composition of the Executive Board in 2009 at the time of election (see below).

*Alan J. Magill, M.D.  
ISTM President-Elect  
Chair, Nominating Committee*

**Geographic Composition of the Executive Board in 2009 at the Time of Election**

Past-President	Frank von Sonnenburg	Europe
President	Alan J. Magill	North America
President-elect	To be elected	Should be non-North American
Counselor	David R. Shlim	North America
Counselor	Eric Caumes	Europe
Counselor	To be elected	Open
Counselor	To be elected	Open

\*\*\*Executive board member to be a nurse

**Nominating Committee Members:**

1. Alan J. Magill (USA) President-elect, Committee Chair
2. Nancy Piper-Jenks (USA) outgoing nurse counselor
3. Ron Behrens, (UK), outgoing counselor
4. To be appointed by the Committee Chair.
5. To be appointed by the Committee Chair.
6. To be appointed by the Committee Chair.
7. To be appointed by the Committee Chair.



————— “What Your ISTM Colleagues Think: Boycotting International Events to Protest Human Rights Violations,” cont. from p. 1 —————

Below are some of the more interesting responses. Some responses have been combined for the sake of space.

>There are not many countries to visit if one feels very strongly about human rights abuses of minorities.

>Perhaps one way to help bring down totalitarian states is for more travellers to go there, not fewer. Most such states discourage tourism because their leaders do not want visitors to tell the rest of the world how bad things are, and to prevent their own people from communicating with visitors and discovering how much better conditions are elsewhere. North Korea is a prime example. I believe tourism has helped China to become more democratic.

> It is almost impossible to be apolitical. If travellers come to me for medical advice to visit a country with a terrible record on human rights, likely I would keep my mouth shut. But isn't that tacit approval of what they are doing?

>I think we as travel medicine providers should be apolitical in our offices. Once a patient has come to see us, they have already decided upon their plans. Making our views known will not likely change their plans, but it may alienate the patient, decreasing the likelihood of a return visit.

>Physicians should be diplomatic, not apolitical. Physicians are not meeting their obligations to society when they remain apolitical. It is one of the reasons the American Medical Association is so ineffective in getting health-related legislation enacted.

>Putting personal politics into medicine is nothing but destructive. There are ample outlets to put pressure on regimes one considers criminal or base including donations or volunteer work for churches, non government organizations and human rights watch groups, for example. Our focus must be on the traveler's health and safety.

>Many countries with bad human rights records are also poor, often due to the ineptitude of the government. But visitors do help the local economy. Visitors help the people throw off the yoke of oppression.

>Nothing is more off-putting than a political view you don't agree with on the wall in someone's workplace.

>We are recognized for our expert opinions with regards to travel and health advice. As a tourist you don't have to close your eyes for the conditions in that country, but on the other hand, that's another platform. As a tourist you're out to seek the beauty and culture of that country. The number of countries with some humanitarian issues is endless. Should we advise people not to travel at all? Our political leaders should address these things. It's lack of guts on their part that somebody else has to.

>I have at this time chosen not to use my patients as captive audiences to proselytize my views. Providing health care is my primary mission in that setting and I pursue my political beliefs and other agendas through alternative avenues on my own time.

>Many travelers are poorly informed about human rights conditions and other social issues in the countries they plan to visit. Yes, it is our task to enlighten and inform travelers on the true conditions in those countries. Do not leave the dissemination of such information to our governments and to the travel industry. These often act according to their self-interests. Travel health professionals, for the most part, are well informed about conditions in various countries. Telling travelers-to-be how it is can be done in a neutral way - mentioning only the facts: let the consequences and interference be drawn by the patient.

>During the 40 years of Communism most of us in Eastern Europe felt that the West did little or nothing to rally public support against our leaders. There were no boycotts against our countries. Western countries rarely criticized our leaders on human rights grounds, and when they did they were careful to be diplomatic. Decreasing or disappearing tourism is a clear and financial signal that something is wrong.

>I don't think that boycotting major events like the Olympics makes a difference in the host countries' behavior. At best it is a symbolic gesture. What is more effective is protesting before the sites are chosen.

>If people ask about China I tell them that I personally would not go to China because of their treatment of Tibet and that I do not buy Chinese goods.

>If I were an athlete I would refuse to go.

>It is fantastic that Steven Spielberg pulled

out of Olympic work and that so much protest has gone on round the world.

>Boycotting international events is a reasonable and effective way of registering our abhorrence of repressive regimes.

>A British athlete was asked recently if he would boycott the Beijing Olympics because of China's record on human rights. He said, "Athletes train for many years to reach Olympic levels in their field. Once the decision has been made to hold the games in a given country - we cannot have personal opinions on politics interfere with the event." Health professionals are in the same situation: we cannot let personal political persuasions cloud our judgement when advising travellers and can only highlight and address the issues relevant to the individual for a visit to a given destination.

>I assume these questions were brought forth by the upcoming Olympic Games in China. Unfortunately, the Olympic Games have come to reflect the ills of the world rather than the coming together of mankind for the celebration of peace and harmony. At one time Olympics were for amateur athletes competing for the fun of competing. When that proved to be a farce, paid athletes were allowed to enter. Then drugs began to rule the roost. Now Olympic sites are fortresses to prevent attacks from terrorists. In light of the state of the world will boycotts and such make a difference? I do not think so.

>Is boycotting important international events a reasonable response to human rights violations by the country holding the event? NO - it just further isolates them. We need communication and interaction and a strong military to achieve Peace in the world.

>It is acceptable to go to a totalitarian country for humanitarian work but not as a tourist.

>Boycotts should be organized by organizations at the same level as the organization sponsoring the event, not by an individual physician refusing travel preparations for an individual patient. If a government or its representatives maintain they are pro xx value (human rights, etc.) then that government's representatives should not attend an event that is held by a group that negates that xx value unless it is to debate the issue. Alas, I am sure there are many financial arguments that are profit-based that will be found to contradict

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*“What Your ISTM Colleagues Think,”  
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this premise. Private individuals must live with their own consciences but they should be educated to make informed decisions. Freedom of choice must be maintained unless that choice is deemed to be of danger to the public at large. However, this premise does not seem to affect many countries. Look at gun control or land mines and you have an answer. Money appears to be the all-important value above everything else unless a person is personally touched by the lack of the xx value or right and then they think again. But even that capacity for thought is quite often short-lived once their personal issue is cleared up, and we are back to money!>I suppose you are thinking of the Olympics. I think the big problem was that the games went to China in the first place assuming that this would be incentive for the Chinese to change their approach to human rights. VERY NAÏVE!!! So, yes, a boycott generally can work if all stick together and don't go. And the world would have made its disapproval clear. Otherwise, there is no point. But would international opinion REALLY change a country's politics and handling of human rights??? Doesn't seem to work in Zimbabwe either...

>What about the poor and old people who have been displaced to make way for all this Olympic construction work. Would a boycott have helped them?

>Boycotting events such as the Olympics only hurts the athletes who have prepared for four years for the event. It would be interesting for someone to look into whether such boycotts in the past led to any political change.

>Whether or not institutions should boycott countries or events should depend on the purpose of the organization. While we might have debates within our own publications about the subject, I again believe that we should impart information, not opinions, to the public.

>Boycotting is a reasonable response to human rights violations and a potentially effective means of influencing those carrying them out. A good example of this principle was the sporting boycott of South Africa.

— “The Preparatory Course for the ISTM Certificate in Travel Health,” cont. from p. 1 —

## About the ISTM Certificate of Knowledge Examination (CTH® Program)

The ISTM Certificate of Knowledge Program was created to:

- Establish an international standard for travel medicine practitioners
- Encourage individual and global professional development in the area of travel medicine
- Formally recognize individuals who pass the Certificate of Knowledge Examination

- Serve the public by promoting quality travel medicine services
- Demonstrate the global validity of epidemiological data and of preventive strategies

The ISTM welcomes applications from all qualified professionals who provide travel medicine-related services on a full- or part-time basis. The exam is open to all licensed travel medicine professionals, including physicians, nurses, pharmacists and others. Both ISTM members and non-members are eligible to participate.

The ISTM plans to give the next exam at CISTM11 in 2009 in Budapest, Hungary.

## News from the Royal College of Physicians and Surgeons of Glasgow

### Founder Membership of the Faculty of Travel Medicine.

The Faculty of Travel Medicine is continuing to offer Founder Membership to appropriately qualified and experienced travel medicine practitioners.

However, a Founder Membership awarded solely by experience will come to an end in December 2008. Thereafter, membership of the Faculty (MFTM RCPS(Glasg)) will be open only to individuals who have the following qualifications:

- Diploma in Travel Medicine from the College or the University of Glasgow plus a higher qualification such as an MSc, MN, MPhil or PhD in travel medicine.
- Successful passing of the College's Membership examination in travel medicine, the first of which is planned for November 2009. There will also be a category of Membership open to those who hold the Diploma in Travel Medicine plus suitable substantial experience. Details of this category of Membership will become available in 2009.

The Faculty is multidisciplinary. It is open to health professionals other than those in medicine. Nurses and other health professionals with the Diploma in Travel Medicine or other similar qualifications are invited and encouraged to apply. Fellowship of the Faculty will of course remain a category of membership

for those who have made substantial and special contributions to the specialty.

Building on the success of the University of Glasgow's Diploma and MSc courses, as well as the College's Diploma in Travel Medicine, the Faculty aims to ensure high standards of travel medicine clinical practice. It achieves this through:

- Developing its examinations in the tradition of the College's high standards;
- Organising and supporting high quality ongoing Continuing Professional Development;
- Encouraging the incorporation of the specialty into undergraduate curricula;
- Relating closely to other involved institutions and specialties, such as general practice, nursing, public health and tropical medicine;
- Representing the specialty at all levels; and
- Developing constructive relationships with the public and the media.

Further information can be found on the Faculty's website at

[http://www.rcpsg.ac.uk/Travel%20Medicine/Pages/mem\\_spweltravmed.aspx](http://www.rcpsg.ac.uk/Travel%20Medicine/Pages/mem_spweltravmed.aspx)

If you wish to apply for Founder Membership or Fellowship, please contact

James Beaton, the College's Executive Secretary by email at [james.beaton@rcpsg.ac.uk](mailto:james.beaton@rcpsg.ac.uk) or telephone +44 (0) 141 227 3204.

# Travel Medicine Meetings - Hungarian Style

Peter Felkai, MD



Győr is a beautiful mid-sized town in Hungary near the Austrian and Slovakian borders. Its geographical position has made it an ideal stopover for tourists and traders for centuries. That is the reason the town was selected to host the Hungarian Travel Medicine Conference this past May. The conference brought together many of the doctors involved in travel medicine in our country: travel health specialists, wilderness medicine experts, and insurance and assistance medicine practitioners.

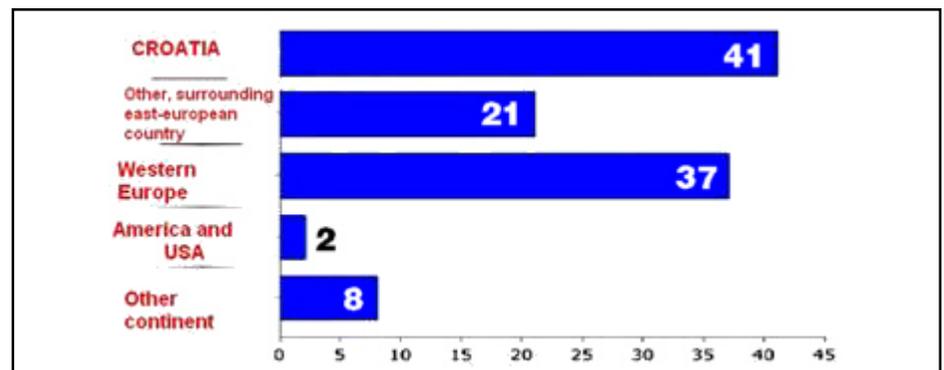
In Hungary, travel medicine can be roughly divided into four arms:

- **Prevention.** Vaccinations, chemoprophylaxis and giving information.
- **Wilderness medicine.** Preparing travelers for extreme sports and adventure travel, and providing advice regarding the safety of the sports (especially for winter sports and diving) and the safety aspects of the equipment involved.
- **Travel insurance medicine:** Advising travelers about travelers' insurance. Policies have changed from those available in the past under Communism. Now there are a wide variety of policies available. Travelers are made aware of the risks of activities, the benefits and costs of available insurance, and how to file for claims when necessary.
- **Assistance medicine.** This deals with organizing medical providers abroad for Hungarian travelers, managing repatriation processes, and treating travelers when they return home sick or injured.

The agenda at our May Conference was dedicated to these topics. All the invited speakers were top ranking scientists and leading experts in their fields. Also, the Conference helped start spreading publicity for the upcoming Conference of the International Society of Travel Medicine (CISTM11) to be held in May 2009 in Budapest, the capital of Hungary.

One of the more notable outcomes of the Conference was the realization by the participants that Hungarian travel medicine practitioners must tailor the body of knowledge in this field to the specific needs and customs of Hungarian travelers. An analysis of our travelers revealed that, for example, their international destinations are quite different from those of travelers of other countries and therefore, most of our travelers do not need vaccinations.

Figure 1 (below). Percentage of Hungarian travelers visiting various destinations. The total adds up to more than 100% because some travelers visit more than one region on a single trip.



Travel medicine is a young discipline in Hungary. It was introduced as an entity only in 2004, the same year that our country joined the European Union. That is the year that the first travel medical publications and textbook were published in Hungarian. Some topics generally considered as being a part of travel medicine already existed. Administering vaccines, for example, was in fact further advanced in Hungary than in some other EU countries. Also, there had been previous conferences on infection control and migration issues. However, the conference in Győr was the first that brought together all the specialists in travel medicine and related subjects.

Travel medicine was an immediate success in Hungary for two reasons. Membership in the EU made travel abroad much simpler and resulted in Hungary becoming one of the border countries of the EU. We suddenly had to face the issues of migrants and refugees, a task for which we were not prepared. The problem was intensified this year when Hungary became a member of the Schengen countries.\* It is important to realize that Hungary has the longest Schengen border in the EU making Hungary a convenient crossing point from the rest of the world into the EU. The significance of this was emphasized by the fact that the Conference was attended by top ranking police officers, the General of the Border Guard, and representatives of the Office of Immigration and Nationality.

A notable guest of the Conference was Professor Doctor Hans Dieter Nothdurft, who opened the Conference on behalf of Professor Doctor Frank von Sonnenburg, the president of ISTM. Professor Nothdurft pointed out

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Peter Felkai, MD

the importance of an international congress in Hungary. His presence emphasized the growing significance of travel medicine in our country and our attempts to improve our knowledge to international standards.

Professor Nothdurft explained the ISTM to the participants. He mentioned the main aims of ISTM and the subjects to be presented at CISTM11. It was reassuring to hear that the ISTM program coincides nicely with the basic elements of the four arms theory of the Hungarian travel medicine program. The Conference also gave us the opportunity to exchange ideas with a member of the ISTM executive committee. Hopefully, this will open the door for ISTM and Hungarian travel medicine practitioners to work together and will help us with scientific research.

Hungary is looking forward to hosting the CISTM in Budapest in May 2009.

\* The term "Schengen" originated from a small town in Luxembourg where, in June 1985, seven European Union countries signed a treaty to end internal border checkpoints and controls between member states. The number of countries that are members of the Schengen group has grown to 29, including 25 European Union states and four non-EU members (Iceland, Norway, Liechtenstein and Switzerland). The Schengen group of countries has a population of more than 400 million.

*Dr. Felkai is Medical Director and Chairman of the Travel Medicine Section of MEBOT, The Hungarian Society of Life Assurance Medicine.*

## Final Travel Destinations - Suicide

Gary Podolsky, MD



One of the unspoken tragedies affecting overseas travelers is suicide.

Overseas suicides are frequently not thoroughly investigated and may be classified as accidents to save surviving family members' turmoil and embarrassment. Apparently, expatriates are especially at risk, but there is mounting evidence that some people travel specifically to end their lives.

Given the remote location of many expatriates this is a difficult condition to anticipate - knowing how an individual will adjust to a new environment, for example - and to intervene with preventative measures. Clinicians advising prospective long term travelers should be on the alert for warning signs such as mental illness and substance abuse. Such individuals should be referred to appropriate mental health workers, and, when necessary, advised to delay or forgo travel.

It has become clear to travel medicine practitioners that some individuals travel for the wrong reasons, trying to escape personal problems or their "demons" at home, wrongfully believing that they will be more content far from home, sometimes the farther the better. But, in fact, they may be leaving behind the few stabilizing influences in their lives and entering strange new environments that they are particularly poorly equipped to cope with.

Suicide for some travelers is marked by repeated attempts, recovery and relapse. For others, it is short - their first attempt at suicide is successful, and therefore their last.

There is usually no single cause that prompts a suicide. While there may well be a single triggering event, deeper reasons for a suicidal act are usually involved. The suicidal event has been described as a "punctuation mark at the end of the story" - the attempt being the culmination of longstanding problems.

Suicide should be addressed systematically, rather than focusing on individual, unrelated cases, as is often done. Some individuals suffer from depression, battling suicidal thoughts over many years. For others, suicide is a spontaneous act, borne of impulse, lowered inhibitions due to alcohol or drugs, and easy access to lethal means. Since so many factors are operative, predicting individual acts is difficult. Problems may be classified as depression, psychosis, addictions (alcohol, drugs, gambling) or chronic substance abuse. All have in common the inability of people to think clearly about themselves. Yet only a fraction of people afflicted with these diagnoses actually do attempt suicide.

Social isolation is a key risk factor for suicide, especially in elderly, and is often caused by widowhood, geographic separation from other family and friends, and physical infirmities that limit mobility. Paradoxically, over-socialization with peers in adolescents can contribute to the suicide contagion among those who identify sympathetically with the initial suicide victim.

In travelers, especially long term ones, additional factors come into play. They may be exposed to different outside values and lack of support from friends, family or coworkers who would otherwise help them. Some cultures condone violence against women and ethnic minorities. Some cultures (or countercultures among traveler enclaves) tolerate or even encourage alcohol and substance use. Travelers may be heavily conflicted in such situations and may be influenced to accept these new values.

### Warning signs for travelers

Travel medicine professionals often see potential travelers only one time. But a few probing questions will often bring to light underlying mental instability that requires further evaluation. One very simple question to ask

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is, why are you traveling? Signs of a major depression include a lack of regular pleasure or happiness with activities, disturbed sleep and appetite.

Travel medicine practitioners should be aware of current thinking about suicide prevention. As a society we should be on the lookout for “marker conditions”: absenteeism at work or school, drunk driving, family disputes that escalate into violence, sexual abuse, harming children, self-destructive behavior, binge drinking and pain caused by medical conditions, to name just a few.

Individuals with these conditions should consult their health care providers to rule out medical conditions that could cause depression and, if necessary, see a mental health professional for further treatment. Once a diagnosis is made, proper treatment, support, and follow-through must be done. Those with significant mental illness should be assessed for their safety. For travelers, it is wrong to ignore these problems hoping they will improve while away from home.

Mental health experts generally believe that well-constructed suicide prevention programs make a difference. A program conducted by the United States Air Force succeeded not only in reducing the suicide rate by 33% but also by reducing severe family violence, homicides, substance abuse, and even accidents, and by equally wide margins. This suggests a commonality to all these social issues and that they can be addressed by using an integrative approach combining available resources. Early intervention into social ills prevents suicide - even long before afflicted individuals have suicidal thoughts.

For travelers, it is important to recognize that even mental health treatments - psychotherapy and medication, for example - do not necessarily alter the outside real world life stresses of vulnerable individuals. These situations, which are often common among expatriates, can block recovery, intensify psychiatric distress and propel vulnerable individuals into a downward spiral leading to self-harming behavior.

A well-designed prevention strategy needs to address both individual and societal influences. The more important risk factors include: major psychopathology, e.g. depression, bipolar, or schizophrenia and conduct disorder; alcohol and/or substance abuse/dependence; personal and family turmoil; financial problems; poor school or work performance; vio-

lence and legal problems; and prior attempts and family history of suicide. Older travelers may have additional concerns such as (health)conditions with pain; role function decline; social dependency or isolation; and loss of a spouse.

### Pre-travel clinic screening

While travel clinics are obviously not the place for in-depth mental evaluations, travel health professionals should be alert to the red flags of individuals at risk of suicidal tendencies. It is important not to allow potentially suicidal travelers to leave the country. Travel clinics should be more than a place to “get shots.” Travel health professionals have a role as advocates for a client’s total health, even if they do not provide all the services themselves.

### Educating Travelers

Companies with employees overseas should train their employees to recognize in themselves and in coworkers the warning signs of culture shock. These include chemical dependency and mental illness through altered behavior, withdrawal), reduced performance in the workplace, and unexplained absences. Companies may implement screening for chemical dependencies, depression or mood changes, and violence towards an intimate partner or spouse. The health status of spouses and dependants should be included in such a program as well.

### Overseas crisis intervention

Ideally access to care should be available for expatriates. Treatment should be supportive with continuity of care and interagency communication. This often requires repatriation because lack of resources overseas. Interventions should be implemented immediately especially for individuals with recurrent psychotic episodes, seriously mentally ill patients who are non-compliant with their treatments, and depressed individuals with chemical dependency. Since there is generally no single cause for mental illnesses, no single intervention prevents all suicide deaths.

Overseas, finding help can be difficult. One resource is the International Association for Medical Assistance for Travelers ([www.iamat.org](http://www.iamat.org)). This is a free directory of worldwide doctors. They charge a fixed rate. Travelers’ assistance insurance companies may be another resource.

### Changing attitudes

Unfortunately, prevailing attitudes to mental illness and suicide contribute to a “conspiracy of silence.” A general belief persists that there is little that can be done to prevent or treat such illnesses. In fact, increasingly, mental illnesses can often be prevented, alleviated or treated well enough so that people can go on with their lives. The public needs to be aware of the prevalence of suicide, and know how to respond when someone they know is struggling with suicidal thoughts and intentions.

(This article was prepared from the following sources based on current psychiatric and suicide literature and adapted to travelers’ own unique situations. Special thanks to Robin Dirks and Jenny Anderson of the University of Manitoba Canada, Centre for Students for their assistance with this subject.

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## NewsShare

the Newsletter of the International Society of Travel Medicine

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