



Update from the Professional Educational Committee/Exam Subcommittee

Phyllis Kozarsky, on behalf of the Exam Subcommittee

As you are aware from NewsShare and other communications, the Exam Subcommittee has been investigating the concept of setting an international standard for the practice of travel medicine. The Body of Knowledge for travel medicine has been completed and will be published in the near future in our journal, *The Journal of Travel Medicine*. It is in outline form and represents the hard work of a number of people in our Society who took the time to think about the topics that comprise our new subspecialty. Furthermore, experts from around the world have weighed the various topics in terms of their importance in our daily practices. This Body of Knowledge will be useful to anyone considering practicing travel medicine, and for those developing courses or other teaching tools.

The more challenging issue before us is whether to pursue the development of an exam that, if successfully completed, would result in the awarding of a Certificate of Knowledge in travel medicine. Many who have responded to our surveys have shown support for this concept, and enthusiasm for an international undertaking—the first in any medical field. There is natural concern about cost, venue, study materials, language, cultural differences, and other issues.

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Correction

The last issue of NewsShare contained an article about yellow fever by John Cahill of Providence, R.I., USA. His name was inadvertently omitted from the article. We apologize for our error. Editor.

If an exam is developed, it would certainly not be forced upon anyone and it would not seek to override any national society's initiatives. It would be aimed at nurses and physicians alike, and cover the basics of the practice of travel medicine. The cost of the development of such an exam, its ongoing maintenance, as well as other key issues are being actively discussed among the Executive Board at this time. We will keep you informed of any news as it becomes available. In the interim, if there are questions, suggestions, or concerns, please feel free to contact me directly.

Here is a more detailed chronological summary of the history of this endeavor:

Initial Planning Meeting

In 1999, the International Society of Travel Medicine (ISTM) began to explore the possibility of developing a certificate of knowledge in

Society News

Message from ISTM president Charles Ericsson

In keeping with the suggestion of the Long Range Planning Committee, I have prepared preliminary guidelines for an initiative to have conferences during the interim years that CISTM (Conference of the ISTM) does not have a meeting. Please note that I have tried to position these as requiring minimum input from ISTM resources other than our advertising and educational efforts. With careful planning these meetings might prove to be a mechanism to defray the costs for the ISTM interim year Executive Board meetings. I think it is imperative for ISTM to try to have meetings and foster education in parts of the world that heretofore have been underserved by ISTM. I think the membership might also enjoy meetings that better stress issues of some of less developed touristic destinations. This plan, however, also recognizes that ISTM must proceed carefully and not overextend our finances at this time in our growth.

I have already negotiated—with the approval of Louis Loutan, our president-elect—to have an interim Executive Board meeting held in 2002 in conjunction with the biennial meeting of the Asia Pacific Travel Health Society in Shanghai, China. The Chinese sponsors of this meeting have graciously agreed to cover the travel and meeting expenses of our Executive Board and Committee chairs in return for our teaching efforts.

At issue is whether we might also call this planned meeting the first such collaborative meeting with ISTM under the guidelines set out in the attached draft.

The Executive Board will consider this proposal at its next meeting in Innsbruck. Meanwhile I would appreciate critique from the membership with suggested changes of this draft, so that what is considered in Innsbruck can be at its most refined state. Please direct your comments via e-mail to the ISTM secretariat Brenda

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Bagwell, at istm@mediaone.net. Here is an overview of the draft:

Conferences in Collaboration with the International Society of Travel Medicine

Objectives

To have a scientific conference in collaboration with responsible organizers biennially in years that CISTM currently does not meet and, ideally, in regions of the world currently not as actively served by CISTM.

To have an International Society of Travel Medicine Executive Board meeting financed at least in part by the conference.

Requirements in Overview

For ISTM to collaborate with an organizer and commit its name and teaching expertise to the success of the conference the following requirements should be met:

- The scientific focus of the conference would ideally concentrate on the region in which the conference is held.
- The interim year Executive Board meeting would be financed, at least in part, by the meeting.
- Executive Board members would commit their expertise to teaching in the regional conference.
- There would be no up-front, direct ISTM fiscal commitment for the conference.
- While ISTM would commit to advertising and promoting the conference, organizational input by ISTM would be kept to a minimum.
- The ISTM Executive Board would approve the conference location and initial plans of the organizing committee.
- An appointee of ISTM would sit on and participate in the planning activities of the organizing and scientific committees.

ISTM Members and Travel Clinics

Hans O. Lobel

The most important function of the ISTM is to improve the quality of travel medicine, especially the quality of the services provided to travelers. Such services are generally dispensed in travel medicine clinic settings. Most clinics are operated by government health departments, occupational medicine departments, university health services or by private physicians. Much of the advice is given by nurses under medical guidance.

In the year 2000, the 1,608 members of the ISTM reported working in a total of 545 travel clinics. On the continents with at least 100 ISTM members, between 29 and 42 percent of the members reported that they worked in a travel clinic. This percentage ranged from 28.5% of the members in Europe, 35.9% in North America, and 42.4% in Oceania (Australia, New Zealand and Fiji):

Continent	No. Clinics	No. ISTM Members	Clinics/ Members	% ISTM Members Working in a Clinic
North America	338	942	338/942	35.9
Central & South America	1	10	1/10	10.0
Europe	127	445	127/445	28.5
Oceania	50	118	50/118	42.4
Asia	18	54	18/54	33.3
Africa	11	29	11/29	37.9
Total	545	1608	545/1608	33.9

Countries in which a high proportion of ISTM members reported associations with a travel clinic included: The Netherlands, 56.5%; Austria, 50.0%; Australia, 45.5%; and Canada, 41.5%. One-third of the ISTM members in the USA and the UK reported working in a travel clinic.

Listings of travel clinics by ISTM members provides two important services: a source of medical referrals by travel agencies and transportation companies to their customers; and access to medical care for travelers in foreign countries. During the past year efforts have been made to increase the number of listings of travel clinics by ISTM members. Also, the website (www.istm.org) has been modified to provide instant access to travel clinics. This access is facilitated by the instructions on the travel clinic page and the individual country pages. Separate pages are also available to register a new travel clinic and to update the information on a registered clinic.

The travel clinic listings are maintained through the good offices of Shoreland, Inc. and Ms Brenda Bagwell, the Administrative Assistant of the ISTM.

7th Conference of the International Society of Travel Medicine CISTM 7 in Innsbruck, Austria

Make every attempt to attend CISTM 7. It promises to be an unforgettable meeting. You can find up-to-the-minute details - program, downloadable forms for registration, hotel reservation, and an on-line abstracts submission facility at www.istm.org.

Innsbruck is a fascinating city, an old university town that is at the center of Europe. The spectacular backdrop of the surrounding mountains and a successful blend of old world charm and ultramodern technology, including one of the most modern convention center in Europe, makes Innsbruck the perfect place for both education and recreation.

Consider coming early and attending the Wilderness Medicine pre-meeting course featuring an excellent International/Austrian faculty—reason enough to attend the meeting.

We recommend that you reserve your hotel room as soon as possible and that you use the Hotel Reservation Form. Mail/fax the form to PCO Tyrol Congress. Please do not send the form to the CISTM secretariat.

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travel medicine. The credential would be international in scope and designed for physicians and nurses who practice travel medicine.

The first step in investigating the feasibility of a certificate program was an orientation to the certificate development process. An international panel of 15 travel medicine experts participated in the orientation session, which was conducted April 12-13, 1999. Topics discussed during the orientation included:

- types of governance and committee structures needed to support a certificate of knowledge program;
- business aspects of the proposed program (e.g., pricing and financing);
- psychometric issues (e.g., methods for determining what is to be assessed, and strengths and weaknesses of various assessment measures);
- legal concerns pertaining to credentialing programs;
- issues related to marketing and strategic planning.

Based on discussions that occurred during this meeting, ISTM elected to continue to investigate the feasibility of developing a certificate of knowledge program. Specifically, it was decided that a needs assessment survey would be conducted.

Needs Assessment Survey

A cover letter and a 1-page needs assessment survey were distributed to ISTM members and meeting attendees at the Montreal meeting in the summer of 1999. Four hundred seventy-nine professionals returned the completed survey. Overall, the respondents reported a substantial level of interest in the program; 52% indicated that they were very interested in obtaining the credential and an additional 27% reported moderate interest. The most common benefits of the certificate, as reported by the respondents, were: professional development/personal satisfaction and enhanced professional credibility. The most notable concerns regarding the credentialing process were: a po-

tential lack of study materials, the possibility that there would be no economic benefit to becoming credentialed, and the specific country in which the examination would be administered.

Given the apparent level of support for a certificate of knowledge program, the ISTM Executive Board decided to continue to explore the feasibility of the program and concurrently, launched a body of knowledge survey.

Financial and Strategic Planning Meeting

On October 18, 1999, members of the ISTM Executive Board and Phyllis Kozarsky MD, Chair of the Certificate of Knowledge Committee, met to discuss a proposed budget for the program, possible sources of program funding, and a timeline for a May 2001 inaugural examination administration. In addition, the participants engaged in some preliminary strategic planning to define the potential benefits of the credential for travel medicine professionals and their employers, potential obstacles to program development, and strategies for enhancing the success of the program. At the conclusion of the meeting, the participants agreed that the program concept was potentially feasible and that ISTM should proceed with investigating sources of funding.

Body of Knowledge Study

In September 1999, the ISTM Executive Board commissioned a study to identify the scope of knowledge for professionals working in the field of travel medicine worldwide. It was expected that the findings of the body of knowledge study would be used to guide the development of curriculums and training programs in travel medicine and the professional development of individuals practicing travel medicine. In addition, if ISTM were to develop a certificate of knowledge in travel medicine, the body of knowledge study would serve as a vehicle for establishing the content validity of the credentialing process.

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A 15-member committee, composed of representatives of the ISTM Board and membership, was selected to oversee the body of knowledge research. These travel medicine experts met on April 12, 1999 to draft a core body of knowledge for the global practice of travel medicine. After undergoing additional reviews by the committee, the body of knowledge was converted to survey format. The survey was mailed to a panel of 110 experts who were representative of the diversity within the profession. Sixty-eight surveys were returned, resulting in a return rate of 62%. Results of this survey can be used to determine the level of importance that various topics play in the daily practice of travel medicine.

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Program Development Schedule

If ISTM decides to proceed with the development of a certificate of knowledge program, it will be necessary to complete the following tasks:

1. Conduct a question-writing drive to obtain questions for the certification examination.
2. Review the body of knowledge survey data and develop the examination specifications based on these data and the consensus of experts from the examination development committee.
3. Review the “raw” questions obtained from the question-writing drive and revise and delete as necessary.
4. Assemble, review, and finalize the examination.
5. Develop program procedures and materials, including eligibility requirements and candidate bulletin of information.
6. Administer examination, scan answer sheets, and determine passing score.

It is assumed that ISTM will print and mail all program materials, conduct the question-writing drive, process candidate applications, respond to candidate inquiries, and arrange and supervise the test administration.

Budget estimates for the project and the means of financing it remain to be worked out, but these costs will be considerable. Moreover, once the certificate program is developed, the consulting costs associated with maintaining the program will depend on whether a new examination form is developed for each biannual administration or the initial examination form is used for subsequent administrations. Given the high costs associated with the development of the program and the fact that the credential will be relatively low stakes (i.e., not for purposes of licensure or primary specialty board certification), the latter option may be the more desirable.

Leptospirosis Outbreak, Following International Sports Event, Sabah Borneo

GeoSentinel Surveillance Network



The recently discovered outbreak of leptospirosis among Eco-Challenge participants demonstrated the depth of experience within the GeoSentinel network in evaluating tropical infectious diseases, the value of the network as a surveillance tool, and the value of partnerships between ISTM, CDC, and health care providers around the world.

Early on the morning of September 10, Charles Easmon, site director at The Hospital for Tropical Diseases in London, England, reported 4 cases of acute febrile illness—suspected to be leptospirosis—among athletes who participated in the 12-day Eco-Challenge Sabah 2000 Adventure Race. Immediately David Freedman queried all 26 GeoSentinel site directors with a request to immediately notify GeoSentinel of any other suspected cases.

Within hours, Brad Connor, site director at Travelers Health Services in New York, responded with a report of one case. This case provided two important pieces of information: copies of e-mail correspondence from participants beginning September 6, which indicated at least 15 others had become ill; and an e-mail alert from the race organizers on September 8 to all race participants, indicating they were aware of a larger number of ill participants. That same afternoon, Jay Keystone, site director at Toronto Hospital Tropical Disease Unit in Toronto reported 4 additional cases. By 17:00 that day, Phyllis Kozarsky and Marty Cetron in Atlanta were consulted. Because the suspected disease is treatable and because many individuals were still in the incubation period, it was determined that there

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was an urgent need for a worldwide alert. A decision was made to utilize all broader resources available to GeoSentinel. By 22:00 that evening a worldwide alert went out by e-mail to all GeoSentinel sites, to ProMed, TravelMed (ISTM listserv of 400 subscribers), TropMed (ASTMH listserv of 200 subscribers), the entire ISTM membership of 1,200 travel medicine specialists in 55 countries, and a request to the IDSA network to post to their 800 U.S.-based infectious disease specialists. A copy of this was forwarded to the race organizers.

One of the characteristics of this process was the speed with which everyone involved communicated and passed on the information. By early the next morning, September 11, both ProMed and IDSA had posted the alert.

As a result of the alerts, Devon Hale in Utah and Russell McMullen in Washington found the names of local participants from the race web site and attempted to contact their respective local participants. An ISTM member in South Africa and three members in the United States also

notified GeoSentinel about cases. “This (the response to this outbreak) really shows what GeoSentinel and electronic dissemination can accomplish,” said David Freedman.

Reports of the outbreak had also been gathered by the Idaho and California state health departments and an outbreak investigation was undertaken by the CDC. GeoSentinel agreed to be a rapid conduit to public health authorities in countries with known participants. On Wednesday, September 12, the CDC supplied GeoSentinel with lists of contacts for all Australian, Canadian, and UK participants and requested assistance in contacting participants or relevant public health authorities. GeoSentinel site coordinators Jay Keystone in Canada, Charles Easmon in London, and Graham Brown in Australia were instrumental in making these connections in their respective countries. Within 48 hours of the first

“Within 48 hours of the first GeoSentinel query, health authorities in Canada, Australia and the United Kingdom were contacted and began case finding activities.”

GeoSentinel query, health authorities in Canada, Australia and the United Kingdom were contacted and began case finding activities. Through the assistance of Peter Buck at Health Canada, the 19 Canadian participants were notified of their potential exposure and interviewed as part of the investigation. With the help of Meirion Evans at the Communicable Disease Surveillance Center in Wales and his colleagues in Ireland, all 22 of the participants from the United Kingdom were notified and interviewed. Finally, with the assistance of Margo Eyerson-Ananan at the Commonwealth Department of Health and Aged Care, the 12 Australian participants were notified and interviewed.

By 10:00 AM, Wednesday, the Associated Press picked up the ProMed posting and contacted GeoSentinel. The next morning the story ran on the AP Wire. Brad Connor was contacted that same day by the New York Times for more information. News of the outbreak was given coverage in the Thursday edition of the newspaper.

The Eco-Challenge outbreak demonstrates that the growth of partnerships between ISTM, CDC, and other medical societies, governments, and private providers has become one of GeoSentinel’s greatest assets. Continued public health response and collaboration of this sort serves to effectively contain infectious diseases and minimize disease related morbidity. “GeoSentinel is an exciting adventure in the way global surveillance data can be turned into information for action,” said Marty Cetron.

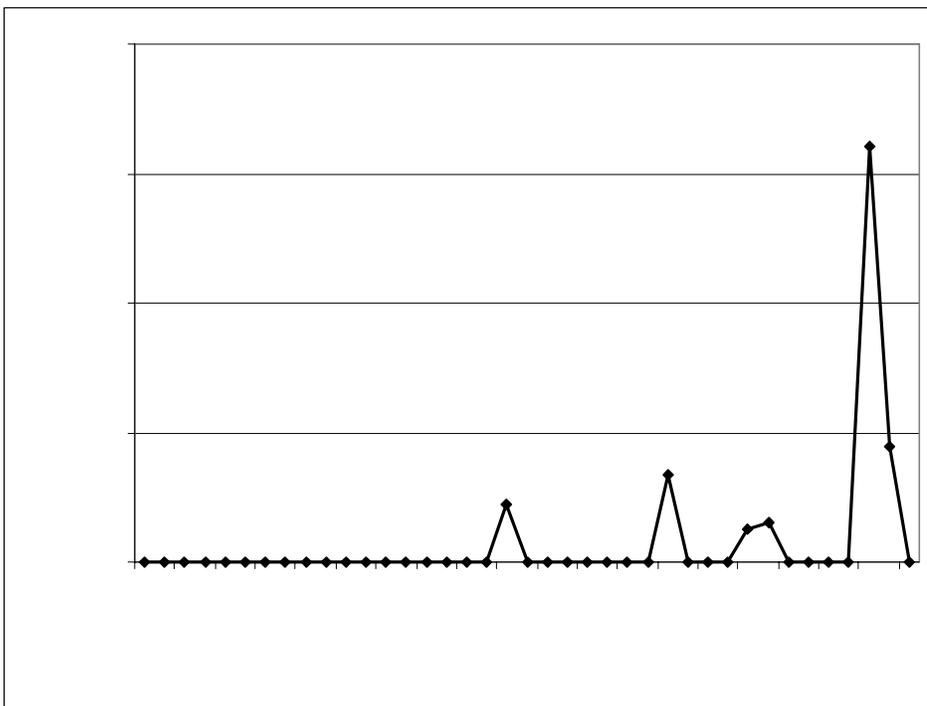


Table 1: Leptospirosis as a percent of morbidity in GeoSentinel each month.

Client Travel Tips

Dominique Tessier, MD, CCFP, FCFP

In a busy travel clinic, it is difficult to cover all the important aspects of travel medicine. After the recommendations regarding vaccine preventable diseases, vector-borne disease prevention, the prescription of medication for malaria prevention and self treatment of travellers' diarrhea, the traveller may not be listening to you anymore. A simple document addressing "comfort" issues to be given to the patient at the end of the consultation may be helpful.

We made such a document into a colourful poster, with nice icons, and placed it on the waiting room wall. Very popular! It is with pleasure that I share it with you, hoping you will leave the source on the document.

Tips that travel clinics can pass on to their clients

Check the specific entry request for each country to be visited. Consult the Consular information for travellers. You can call to the consulate or visit this web site: www.dfait-maeci.gc.ca/travelreport/intro_.asp Note: this reference is in French. An English version is available by clicking "English."



Travel light. Bring the very minimum you will need. Call the place where you will stay to see what they have available. Forget about irons and blow dryer. In most cases, these only mean more weight. If you are good at minimizing, you may be able

to manage with carry-on luggage only. This could save you 30-45 minutes both at departure and arrival (with your ticket, you can go directly to the departure gate and get your boarding pass there). Of course, this also avoids luggage not taking the same route as you. Luggage on wheels is a bit more expensive, but is usually worth it. Kids love to pull them. In general, a plastic-coated photo or a colour string can help identify your checked luggage and avoid common mistakes.

Get yourself comfortable.

Especially for long flights, bring a few extras: inflatable pillow, ear plugs, eye mask, slippers or warm socks and some reading and writing items. If you are tall or have joint pains, ask for an aisle seat to stretch your legs. Otherwise, window seat are more comfortable as the wall allows you to lean against it to sleep. If your back gives you trouble on flights, also ask for an aisle seat, enabling you to get up and walk about more frequently without disturbing the other passen-



gers. If you will be in a hurry on arrival, ask for seats in the front of the plane.

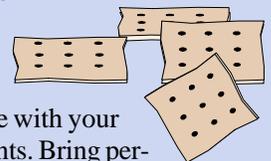
Bring a book, cartoons, magazines, CD player, writing material and, why not, your travel diary to work on en-route.

Hydration is a must. Humidity level on commercial flights is extremely low, less than 15%. The longer your trip, the more it will affect you, causing headaches and dryness of your skin and mouth. Bring your own small bottle of water that can be refilled during the flight. And use a nasal lubricant like Salinex® or Rhinaris®. Avoid caffeine and alcohol; these are diuretics. Gaseous drinks may increase flatulence.



Eat what is good for you.

Special meals can be ordered, if you notify the airline at least 72 hours in advance. You can also have your request put in your profile with your frequent flyer accounts or travel agents. Bring personal items like citrus fruits, nuts and dried fruits, crackers, granola bars and chocolate. Snacks are most appreciated by kids. Gum will help during landing. Most food items cannot be brought into a new country. You may have to discard what's left, if any, on arrival.



Most airlines offer the following special diets: Hindu, kosher, Muslim, Japanese, Children's, fruit plates, fish and sea food, diabetic, without gluten/sulfite/lactose, low fat, low calories, low sugar, soft diets.

For infant formula preparation, take the powder form instead of liquid. Most airlines can warm infant bottles on board. But it is much easier to put the pre-measured amount of powder in a plastic bag (like Playtex®) and to use a cali-

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brated bottle to add the amount of warm water required. Then you need only one bottle bag holder. This saves a lot of room, and decreases the risk of spoiled milk.



Food allergies. Carry your own EpiPen® if you or your children suffer from food allergies. Peanuts are a major problem. Most North American and European airlines have banned peanuts on their flights. But they cannot control what other passengers bring aboard. For a child who is seriously allergic, inform the passengers in the nearby seats, explain the risk to the child ("candies" found on the floor), and be prepared with an EpiPen® on hand.

Prevent motion sickness. Many medications are now available to decrease this uncomfortable feeling. Transdermal patches (Transderm V®) can be used but they must be applied at least 12 hours before departure. Closing your eyes may help. Never leave with an empty stomach; this increases the risk.

Bring all your medications in your hand luggage. The luggage compartment of the aircraft may not be heated, bringing the temperature down to minus 55°C. Injectables like insulin and EpiPen® may freeze and break. Inhalers are also very sensitive to freezing. Other medication may be "transformed" without showing any sign of it. Never mix different medications in the same bottle to save room. Custom agents do not appreciate it. If needed, ask your pharmacist for smaller containers with proper labels on each of them.



Get the special attention your condition requires. On flights and cruises, you can usually request the following special services: oxygen (for severe anaemia and cardio-respiratory problem); an escort at airports (for the visual and hearing impaired and for children travelling alone); wheelchairs designed for aircraft aisles (most wheelchairs in use are too large for these aisles); guiding dog; special fares for accompanying persons; hearing adapters for the audio system; and baby hammocks, for example.

Extra clothes in your carry-on luggage. This may be a good idea just in case your luggage does not reach the same destination as you.

Carry travel insurance. You never know when you might become ill or have an accident. Insurance is important, even if you have an ongoing medical problem that may not be covered. Be honest. Accidents and other illnesses will be covered.

Be patient. On most trips, delays of one kind or another are almost inevitable. Try to avoid tight connection. And take life, and travel, with a smile.



The Canadian Health Network, in collaboration with the Canadian Public Health Association, have recently made available on its web site, in English and in French a document on Frequently asked Questions (FAQ) regarding immunisations. I was one of the consultant and I believe this document can be helpful for your clients. You will find answers to the following questions :

- What is a vaccination and how does it work?
- Why do we need to get vaccines against diseases that have been wiped out?
- Are vaccines safe?
- How well do vaccines work?
- What are the common myths about vaccination?
- When should children be vaccinated?
- When should adults be vaccinated?
- What vaccinations should I get if I am going to travel outside Canada?
- Are there any reasons why someone should NOT be vaccinated?
- Where can I get vaccinated, and do I have to pay?

The FAQ web site is as follows :

www.chn-rcs.ca/html/faq/chntopiccategory_13e.html (English)

www.chn-rcs.ca/html/faq/chntopiccategory_13f.html (French)

www.dfait-maeci.gc.ca/travelreport/intro_.asp

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Philosophical Thoughts On Travel Medicine As a Specialty

David Shlim MD

It's been almost thirteen years since travel medicine practitioners first convened in Zurich, Switzerland to talk about the problems of giving health advice to travelers. Professor Robert Steffen, who hosted that first meeting, expected forty or fifty people to attend. Four hundred people showed up. The International Society of Travel Medicine was born at the next meeting in Atlanta in 1991, with attendance of 800 people. Attendance grew in subsequent meetings, reaching a high of over 1800 people at the last meeting in Montreal in 1999. This strikes me as a remarkable amount of interest in a field that has little formal recognition (you can't even be listed under travel medicine in most telephone books in the USA), and few full-time practitioners. Although a busy travel medicine practice may supplement the income of a physician, and provide interesting full-time employment for nurses or nurse practitioners, there are only rare examples of people for whom travel medicine is truly a career.

So, if travel medicine is not a career for most people, what is it? In some ways, the most relevant model is that of a hobby, analogous to bird watching. When we get together at meetings, we find that we enjoy talking about interesting sightings—typhoid fever from India, malaria from Indonesia, trypanosomiasis from Tanzania. We are comparing our life lists—as birders keep track of all of their sightings. None of us holds all of the knowledge relevant to the field—it's simply too vast. We frequently look to others for specialized information. Is there yellow fever risk at Iguassu Falls? Are there any areas of Thailand for which one should recommend Japanese encephalitis vaccine? What is the exact malaria situation in Laos? Does doxycycline have any long-term side effects? When we get together, we enjoy finding that we know as much as other people, or filling in the gaps in our knowledge.

The focus of travel medicine, and the philosophical center, has always been the

pre-travel visit. The emphasis at this encounter is on prevention: what to eat, what to avoid, what immunizations to take, which medicines to take prophylactically, what to do about animal bites, motor vehicle safety, airline travel, how to self-diagnose and treat diarrhea, colds, or malaria, how to purify water, how to manage birth control and avoid sexually-transmitted diseases. And so on. If we were conscientious about sharing with the adventurous traveler all possible prophylactic advice, the pre-travel visit would last sixteen hours.

Even if we spend a great deal of time with the prospective traveler, there is no guarantee that it is time well spent. Elaine Jong, one of the pioneers of travel medicine, recently started reviewing the pre-travel encounter from the point of view of educational theory. Studying people after such an educational encounter leads to the conclusion that they can retain only seven new pieces of information at a given visit. If we give them thirty new pieces of information, we don't even know which seven are remembered.

Prevention is a virtue in medicine. However, in travel medicine, prevention is an illusion. We know that travelers are going to get sick and injured, and would be better off physically, and occasionally mentally, if they stayed home. From a purely risk oriented perspective, it makes more sense to talk people out of the trip than to help them prepare for it. However, travel also has benefits. A recent article demonstrated that middle-aged men at risk for coronary artery disease have a reduced risk of mortality if they have a vacation each year. (1)

Many travel medicine practitioners share in the feeling of excitement of travel to exotic places: there is no way to obtain the exact sense of a place without going there. The cacophony of sounds, or the silence of emptiness. The eyes and smiles of a new culture. The odors of waste competing with the aromas of exotic food. The jostling intensity of market places,

the uncertainty of travel arrangements, the rare but intoxicating feeling one gets when one lets go of hope and fear and just flows along in new situations. There are certain destinations that never disappoint: such as the Taj Mahal in India, or the viewpoint of Mt. Everest, called Kala Pattar. People remember how they felt at these places long after they forget the diarrhea they endured to get there.

Some travel medicine practitioners have never traveled, and never will. They read the books, go to meetings, and focus on the risks. The benefit side has not yet been personally experienced. However, there are plenty of models for this in medicine—both men and women health practitioners offer advice on how to have a baby successfully without having done so themselves. Most of their clients travel either for enjoyment or employment. Those who travel for enjoyment can weigh the risks and benefits of a given journey. The travel medicine practitioner can help the traveler match the level of travel experience, level of health, and physical capability to the trip that they are contemplating. Travel medicine is at its best when, in addition to parading out the lists of risks and preventive behavior, we help the person sitting in front of us choose their trip wisely. The ability to help match the person to the trip is enhanced by having done such a journey one's self. Those who travel for business have a specific reason for going, and one can just try to optimize their preparation.

Through these thirteen years, the International Society of Travel Medicine has made amoeba-like attempts to extend a pseudopod and embrace a broader view of travel medicine. These other areas of focus include diagnosing and treating returned travelers, taking care of travelers while they travel, focusing on the special issues related to people who are visiting friends and relatives, taking care of immigrants and refugees, and most recently and appropriately, starting to focus on the

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health implications that tourism places on the host countries. The society ingests these attempts at diversity, but does not always digest them. Partly because some of these areas present larger and more insoluble problems than whether typhoid vaccine is indicated for a given trip. It takes the concerns beyond those of the hobbyist—the bird watcher—to continue the metaphor, to those of someone working in environmental protection, or wild-life preservation. It becomes real work.

So, instead, we retreat to where we are comfortable. Sitting with a prospective traveler in a room decorated with travel posters. We are extremely conscientious and utilize the best available resources. However, I think we are still nagged by uncertainty: how do we know the actual risks, and does our advice actually lower that risk? We fret over which anti-malarial to recommend, but then find that almost all cases of malaria in travelers occur in travelers who did not take any prophylaxis. How do we reach these travelers?

Knowing when and where to recommend malaria prophylaxis is also a dilemma for the travel medicine practitioner who doesn't want to paint with too broad a brush. The risk of malaria is often measured by the rate in local people from reports of diagnoses at local health posts, whether confirmed by smear or not. The risks may be over—or under—estimated. Accurate maps of malaria risk are hard to obtain, and even harder to trust. Malaria may exist up one river valley and not in another. And it can change the following year. *Falciparum* malaria is popping up unexpectedly in many parts of India, probably carried by the migration of infected workers. Workers imported to the Dominican Republic from Haiti to repair hurricane damage in resorts unexpectedly brought malaria to the tourists. Once recognized, the risk was subsequently eliminated.

Furthermore, does any degree of risk of malaria constitute a reason for giving prophylaxis? Does a risk of 1 in 100,000 warrant prophylaxis for everyone? What about 1 in a million? Do we understand

risk at all? How do we measure a disease risk to travelers when there has yet to be a single case in a traveler? Is the goal of travel medicine to prevent the first case in a traveler, or to react appropriately after cases have occurred? Is a risk of 15 per 100,000 a high risk or a low risk? Is it simply up to the travel medicine practitioner to draw these lines? We know that some practitioners recommend almost all vaccines and prophylactic measures in all circumstances, figuring that the only errors are in not giving something. Others are more circumspect. Are the outcomes different among patients leaving both types of practitioners?

If we are “bird watchers”, then perhaps we need to create a more accurate atlas of sightings. The Geosentinel Network is an incredible start to this effort, but is currently focused on recognizing and reporting new or unexpected risks. We need to create a mechanism of sharing all case reports, linked to the probable country of origin of the disease. The extraordinary effort that Mary Wilson made a decade ago to map diseases according to geographic origin should be continued, with a focus on the specific risk to travelers.

I think that we have matured as both a society and a field sufficiently to place closer scrutiny on the advice we have traditionally given, and the sources of information we have traditionally used. We spend many hours a year counseling travelers on how to avoid diarrhea, without any evidence that we are preventing even a single case of traveler's diarrhea. We even have occasional evidence to the contrary—that pre-travel counseling makes no difference as to whether a traveler gets diarrhea. Maybe this time should be spent teaching self-diagnosis and treatment of traveler's diarrhea. It may be that the pre-travel visit of the future may not resemble our current model—or our current model may be confirmed as the best possible way to prepare travelers. We won't know until we examine our assumptions critically.

It will be an exciting adventure to try to knit up the loose ends of our knowledge. Our society embraces a wide breadth of resources: tropical medicine specialists,

infectious disease practitioners, public health officials, epidemiologists, vaccinologists, virologists, occupational medicine practitioners, gastroenterologists, refugee workers, family practitioners, nurses, and many others. If we learn to ask the critical questions, we may be able to get to more beneficial recommendations, and more satisfying answers to our patients questions. Doing so will help turn our hobby into a more professional endeavor.

We may have had a fresher, more open approach to our problems at the beginning. At the end of four hours of discussion on malaria prophylaxis at the Zurich meeting, Dr. David Bradley concluded by saying, “If the previous discussion seems clear and to the point to anyone here, then they clearly haven't been listening.”

1 Gump BB, Mathews KA. Are vacations good for your health? The 9 year mortality experience after the multiple risk factor intervention trial. *Psychosom Med* 2000; 62: 608-612.

2 Zuckerman JN, Steffen R. Risks of hepatitis B in travelers as compared to immunization status. *J Travel Med* 2000;7:170-174.

Dr. Shlim has organized a travel medicine conference for this summer in Jackson Hole, Wyoming that may help to accomplish the goals expressed in his editorial. *Medicine for Adventure Travel 2001* will focus on “What do we know, and how do we know it?” in travel medicine. He has assembled a broad faculty of the leading thinkers in the field. The conference will look critically at our sources of knowledge in travel medicine for perhaps the first time. The meeting is July 19-24, 2001. For further information, visit the *Medicine for Adventure Travel* website at <http://atrav.com/mat>, or e-mail Dr. Shlim at drshlim@wyoming.com.





Announcements

The Medisys Travel Health Clinic.

The 12th Conference on the Health of International Travellers. November 29th and 30th 2001.

Inter-Continental Hotel, 360 Saint-Antoine Street West, Montréal. Contact Dr. Dominique Tessier or Mrs. Nicole Côté.

Medisys Travel Health Clinic 500 Sherbrooke West, Suite 1100, Montréal, Quebec, CANADA H3A 3C6 Tel : 514.499.2773

Fax: 514.845.4842

Email: nicolecote@medisys.ca

Marine and Dive Medicine, April 8-

12, 2001, Cozumel Mexico. Sponsored by the Wilderness Medical Society. Recognized experts in dive and marine medicine present core curriculum as well as current updates. Hands-on workshops. Pre-conference dive certification course. For more information: 1-800-800-6819. E-mail: wms:@wms.org

9th Update Travel & International Medicine, April 20-22, 2001, Seattle,

Washington (Four Seasons Hotel). Sponsored by the University of Washington Schools of Medicine and Nursing. An outstanding faculty of internationally recognized experts will cover a wide spectrum of topics relevant to physicians, nurses, and other health care professionals who provide advice and care to travelers, expatriates, and migrant populations. Contact: CME, 1325 4th Avenue, Suite 2000, Seattle, WA Seattle WA 98101-2506. Tel: 800-869-2633. Website: www.uwcmce.org

Wilderness Medicine Summer Conference & Annual Meeting of the Wilderness Medical Association.

Whistler, British Columbia, Canada. Topics to be discussed: mountain medicine, aquatic medicine and backcountry medicine. For more information: 1-800-800-6819. E-mail: wms:@wms.org

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